World Health Organization

Risk communication and community engagement for Marburg virus disease outbreaks

Interim guidance November 2024

Key points

- Marburg virus disease (MVD) is an epidemic-prone illness caused by either the Marburg or the Ravn virus. It is clinically similar to Ebola virus disease (EVD) and belongs to the same family of filoviruses. It has a high case fatality rate ranging from 24% to 88%.
- In recent years, MVD outbreaks have become more frequent and have spread to countries previously unaffected by the disease.
- Previous MVD outbreaks have highlighted the critical need for risk communication and community engagement (RCCE) strategies that are tailored, adaptable and evidence-based. These strategies can inform and empower communities to take protective actions and co-create effective, life-saving interventions, ultimately helping to control and prevent further transmission.
- The goal of RCCE efforts in MVD outbreaks is to align response actions with community needs, capacities and expectations. By actively engaging communities, RCCE aims to raise awareness about MVD transmission risks, encourage appropriate and early healthcare-seeking behaviours, and support the adoption of protective measures and contact tracing.
- RCCE strategies and interventions are essential for fostering collaboration and local action while also building and maintaining trust between affected communities and health and other service providers. Additionally, they help create a healthy information environment by addressing concerns and misinformation, which often arise during disease outbreaks.
- Member States are advised to adapt existing EVD RCCE plans, strategies and tools for use in MVD outbreaks whenever possible.

Summary recommendations for equitable and effective RCCE action

1. Allocate sufficient resources to RCCE so at-risk communities are ready to respond to outbreaks.
2. Collect, analyse and use social and behavioural data and evidence to guide MVD readiness and response measures.
3. Rapidly communicate risks relating to MVD through multiple channels; share tailored messages that raise awareness, encourage seeking healthcare, and explain uncertainty.
4. Address infodemics though integrated community feedback mechanisms; counter misinformation with accurate health information.
5. Understand, prevent and address MVD stigma and discrimination.
6. Involve communities in planning and implementing MVD readiness and response measures, with particular focus on ensuring safe and dignified burial practices for those who have died from MVD symptoms.

Introduction

Purpose

The purpose of this interim guidance is to provide recommendations for planning and implementing RCCE activities that protect and empower communities during MVD outbreaks. The guidance is designed for national and subnational health responders involved in RCCE for MVD readiness and response. It is also relevant to other stakeholders, such as partner organizations, ministries (such as those involved in social protection), and academics, who contribute to RCCE activities. The document is meant to be adapted alongside national multi-risk/ multisectoral plans, leveraging existing expertise, coordination mechanisms and partnerships.

Methods

The recommendations in this document primarily draw on existing WHO guidance and tools for EVD management and for risk communication and community engagement as referenced throughout the sections. The have been adapted and updated for the context of MVD. A scoping literature review was conducted to identify published tools, resources and studies with scientific evidence supporting the document's recommendations. Further, the recommendations include recent RCCE lessons learned from WHO's response to MVD and EVD outbreaks.

Document development and review benefited from consultations with the following WHO technical teams in Geneva: Viral Haemorrhagic Fever, Infection Prevention and Control, and Border Health and Mass Gathering. RCCE focal points from The WHO Regional Office for Africa and from the Collective Service also reviewed this document. These consultations and reviews were instrumental in providing additional references and in assessing the accuracy, feasibility and acceptability of the recommendations and overall contents of this document.

MVD epidemiology

MVD is a severe, often fatal illness in humans. The virus is initially transmitted to humans through prolonged exposure to mines or caves inhabited by Rousettus aegyptiacus fruit bats, which are known to carry the Marburg virus *(1-3)*. Once introduced into the human population, the virus can spread through direct human-to-human transmission. This occurs via direct contact through broken skin or mucous membranes with the blood, secretions, organs or other body fluids of infected individuals. It can also spread through contact with contaminated surfaces and materials, such as bedding or clothing *(3, 4)*. Major transmission risk factors include *(5)*:

Initial introduction in the human population:

- people visiting or working in mines or caves inhabited by fruit bat colonies.

After initial introduction to humans:

- people providing care to patients who have symptoms of MVD, especially if infection prevention and control practices are inadequate;
- close contact with patients who are sick with MVD, particularly at later stages of the disease, or contact with surfaces and materials contaminated with body fluids;
- unprotected contact with the body of a deceased MVD patient.

Why is RCCE important for responding to MVD outbreaks?

RCCE is crucial to national outbreak readiness and response planning because it helps ensure that interventions taken to protect communities are rapid, equitable and effective.

Risk communication involves real-time exchange of information, advice and opinions between experts or officials and those members of the public who are facing health hazards *(6)*. Community engagement brings people into the process by helping them to understand the risks and co-develop acceptable, workable health and response practices *(6)*. Together, these two components empower communities and position them as essential partners in devising emergency readiness and response plans that are appropriate to them and inclusive. RCCE also strengthens other response activities, such as surveillance, contact tracing, infection prevention and clinical management. RCCE has been vital in responses to major public health events, such as the COVID-19 pandemic, EVD epidemics and outbreaks of cholera and mpox *(7)*.

RCCE can help communities build and maintain trust in health authorities, raise awareness about MVD transmission and protective measures, and foster collaboration between response teams and communities. Although clinical vaccine trials against MVD began in 2024, there is currently no licensed antiviral treatment or vaccine against the disease. Given the absence of vaccines or antiviral treatments, RCCE is critical: accurate information encourages safe behaviours, which reduces transmission; timely communication and engagement encourage early healthcare-seeking and supportive treatment, which improve survival rates.

Managing information during an outbreak is also crucial. Infodemic management—handling the flood

of both accurate and false information in the physical and digital space *(8)* —is a critical part of RCCE. It aims to create healthy and trustworthy information environments by identifying and addressing concerns, information voids, misinformation and disinformation and by responding to community concerns

Recommendations

Note: Generic activities relevant to each of the recommendations in this document are set out in the RCCE checklist in Annex 1; they can be adapted for MVD.

1. Allocate sufficient resources to RCCE so at-risk communities are ready to respond to outbreaks

Readiness, in the context of disease outbreaks, is a country's ability to respond to a health threat quickly and appropriately, when required. It builds on the preparedness phase of the health emergency management cycle and serves as the link between preparedness and immediate response. Experience shows that countries that systematically prepare their health and emergency systems can respond more rapidly, cohesively and equitably to threats. This can shorten the duration of outbreaks, curb their impact, and ultimately save lives. Readiness activities are a foundation for RCCE efforts when outbreaks occur. MVD outbreaks are relatively uncommon but are a very serious public health concern. in areas where there are risks of an outbreak it is very important that broader RCCE mechanisms are in place which can rapidly pivot to focus on MVD.

Readiness capabilities determine how rapidly and effectively countries can mobilize in anticipation of an MVD outbreak. Investing in readiness requires concerted efforts from governments, partners, response pillars and other stakeholders to build capabilities across several technical areas of RCCE (refer to the RCCE readiness and response checklist, Annex 1). Investing in these RCCE capabilities will support communities to be ready to respond to any disease outbreak. It is particularly important that financial and human resources are allocated for readiness activities with health care workers. During the early stages of an outbreak, they are at heightened risk of MVD infection during the course of their work and may also contribute to transmission of MVD to their patients and other contacts.

To enhance readiness for MVD, human and financial resources are needed to:

- Identify areas at high-risk of MVD, including locations inhabited by Rousettus bat colonies such as mines, areas bordering MVD-affected zones and regions with previous MVD outbreaks.
- Prime coordination systems so response actors and communities are always ready to work together when disease outbreaks occur. In high-risk areas ensure that broader readiness activities consider MVD.
- Review and update existing multi-hazard RCCE strategies and plans using intelligence from local surveillance, epidemiological data and social and behavioural evidence. Include risk assessments of MVD in annual plans.
- Engage with communities and their representatives to understand socio-cultural contexts and facilitate the co-development of priority actions.
- Emphasise actions that support adoption of protective behaviours, early healthcare-seeking and means of identifying and reporting MVD cases.
- Communicate about risk factors, protective measures and uncertainties related to MVD to ensure that communities most at risk are informed and prepared.

The principles set out in the 10 steps to community readiness package can be adapted to RCCE practice in MVD contexts *(9)*.

2. Collect, analyse and use social and behavioural data and evidence to guide MVD outbreak readiness and response measures

RCCE action during MVD outbreaks must be informed by social and behavioural evidence from affected and at-risk communities. Communication of evidence on community dynamics can support every programmatic component of RCCE in MVD response as well as stakeholders in other response pillars.

The "community data for action" section of Annex 1 provides additional information on methods and tools. When generating evidence specific to MVD, it is important to identify and review existing evidence and assess where there are gaps. Refer to studies related to EVD outbreaks where these are available and relevant. When collecting and analysing new contextual social and behavioural data, focus first on areas at highest risk of MVD.

A systematic approach to collecting, analysing and using evidence will help to ensure data are relevant and useful:

- Consider using the 5 steps for the application of behavioural science to public health: define, diagnose, design, implement and evaluate.
- An Integrated Outbreak Analytics approach can support an effective process for generating and using diverse sources of evidence relating to an infectious disease outbreak.

Recommendations for use of social and behavioural data and evidence relating to MVD:

Identify vulnerable populations at risk of MVD exposure and transmission; **settings** at risk of an MVD outbreak; and drivers of MVD infection risks in those populations and settings.

Make assessments of what people know and believe about MVD; attitudes and practices in relation to MVD, including how burials are conducted, how people seek care when they are sick and concerns about quarantine measures and treatment centres; perceptions of MVD risk; levels of trust in public health authorities; barriers and enablers to adopting protective behaviours and early access to healthcare, particularly for high-risk populations.

Understand community capacities, vulnerabilities, priorities, needs and expectations related to MVD.

Inform MVD readiness and response strategies and support RCCE decision-making that aligns with people's needs and priorities.

Inform the design and adaptation of information and communications content shared with local populations.

Equip community-based practitioners (such as public health promoters, community health workers and outreach workers) to engage effectively with local populations, strengthening community-led actions and trust; and communicate clearly about MVD prevention and control.

3. Rapidly communicate risks relating to MVD through multiple channels; share tailored messages that raise awareness, encourage healthcare-seeking behaviour and explain uncertainty

3.1 Identify channels for tailored risk communication

A key part of RCCE for MVD is understanding which audiences need to be reached and identifying the most effective channels to communicate with them. By understanding this communication ecosystem, the people formulating MVD communication content can ensure that accurate information for target audiences reaches people ***where they are*** and in the manner they prefer. The use of ***multiple*** communication channels helps to ensure that information reaches as many affected and at-risk communities as possible.

To optimize communication efforts:

Map communication channels: Identify and map the main ways people communicate and receive information. Assess which are most preferred and trusted by different audience groups. Because preferences for communication may vary, this mapping should be disaggregated by audience segments (e.g. age, location, literacy level). Common channels include radio, television, social media platforms, community meetings and mobile phone messaging.

Identify trusted spokespersons and influencers: Determine which trusted community representatives, spokespersons and influencers different audience groups rely on. Collaborating with these figures will help communicators amplify their messaging and ensure that it resonates with communities; it can also help them address information voids or misinformation circulating within their communities.

Adapt content for specific channels: Tailor communication content and formats to the appropriate media. Ensure that each channel and audience receives messaging – such as visuals for communities with lower literacy rates or short, text-based messages for mobile platforms – that has been adapted to their characteristics and expectations.

Engage trusted community platforms: Use established, local platforms, such as faith-based organizations, youth groups or community radio stations, to engage audiences. These platforms are essential for reaching groups that might not rely on mainstream media.

3.2 Identify and engage with key audiences

Identifying and targeting key audiences helps to ensure that RCCE is relevant, culturally sensitive and reaches those at risk of MVD. Each audience requires tailored messaging and communication approaches to maximize impact and promote protective behaviours during MVD outbreaks.

The general public

In areas affected by or at risk of MVD, members of the general public should understand their risk of MVD and how to protect themselves. Since MVD is being detected in locations previously unaffected by the disease, many people who are at risk of contracting the disease may be unfamiliar with MVD, its symptoms, and how it spreads *(9-12)*. Risk communicators should prioritize sharing clear, comprehensive information on transmission, symptoms, risk factors (e.g. behaviours and settings), preventive measures and the importance of early treatment.

Actions:

- Disseminate health information on MVD rapidly, through trusted, widely accessed channels.
- Adapt communication to the public's knowledge gaps, attitudes and behaviours. This should be based on social and behavioural evidence (refer to recommendation 2).
- Ensure RCCE strategies align with community contexts (for example, market days, religious events, and lifestyles, such as eating, praying and sleeping times) and socio-economic priorities.
- Incorporate community feedback into messaging and assess whether communications resonate with local concerns (refer to recommendation 4).

Healthcare workers

Healthcare workers, including doctors, nurses, paramedics and community-based practitioners, play a key role during MVD outbreaks as trusted sources of information *(10, 11)*. Providing them with accurate information helps them better serve their communities and improve response efforts *(12)*. Healthcare workers are both an audience for risk communications, as well as risk communicators themselves. They must be made aware of their own risks of exposure to MVD. Knowledge of infection prevention and control (IPC) measures is essential to protect themselves and prevent onward transmission of MVD to their patients and other contacts.

Actions with healthcare workers:

- Co-design or tailor information, education and communication (IEC) materials with healthcare workers so they are suited to the populations they serve.
- Disseminate IEC materials in healthcare facilities.
- Provide guidance on IPC measures, contact tracing, community-based surveillance and providing public health information. Information provided by health workers can be targeted to specific groups, e.g. as those involved in prenatal or postnatal consultations, public engagements with pregnant or breastfeeding women and other members of the public.
- Offer RCCE training and regularly update healthcare workers with the latest MVD information.
- Engage healthcare workers in media campaigns and community outreach efforts.
- Support their role in collecting community feedback and tracking misinformation (refer to recommendation 4).

Funeral and burial organizers and mourners

Funeral and burial organizers and mourners often conduct rituals involving close contact with the deceased, such as washing the dead body and handling the body's intimate clothing and bedding. In areas where there are MVD outbreaks, these practices pose serious risk of spreading MVD infection. It is essential that RCCE practitioners ensure that there is supportive engagement with those performing burial rituals so that they take adequate IPC measures while maintaining a culturally acceptable and dignified process.

Actions:

- Identify key cultural figures who handle funerals and burial rituals.
- Provide guidance on safe and dignified burial practices, including protective measures for mourners (refer also to recommendation 6 below).
- Work sensitively with faith leaders and family members during funerals to share information about MVD.

Faith-based leaders

Faith-based and religious leaders are highly influential in shaping social norms and behaviours, especially during communal events. Engaging these leaders can help expand the reach of MVD messages and encourage communities to adopt protective practices during religious activities.

Actions:

- Establish partnerships with religious leaders to co-develop and disseminate tailored MVD messages.
- Train faith-based leaders on how to share MVD information and promote protective behaviours, and, especially, safe and dignified burial practices.
- Encourage faith-based leaders to incorporate content about MVD prevention and healthcare seeking at religious gatherings (e.g. pilgrimages, vigils, parades, sermons) and community dialogues.

Media professionals

Media professionals can be essential partners in communicating accurate, timely public health information to the public and can create links between responders and communities *(13)*. During an MVD outbreak, working with the media can help RCCE messaging reach a broad audience and can prevent the spread of misinformation (see recommendation 4). Media professionals can also mitigate stigma and discrimination (recommendation 5), for example, by disseminating descriptions about the experiences and challenges faced by individuals and communities affected by MVD *(14)*. Failure to engage with members of the media can undermine disease-control efforts if it limits their access to accurate information about the outbreaks, response efforts and interventions.

Actions:

- Map the media landscape to identify the most trusted and frequently accessed media channels.
- Provide media professionals with regular MVD briefings, media dialogues and access to fact-checked information.
- Partner with the media for campaigns that raise MVD awareness, dispel myths and address knowledge gaps identified by the social and behavioural evidence.
- Build media capacity through training and support to enhance their role in managing misinformation.

Traditional healers

Traditional healers are trusted by many, particularly in rural and underserved areas, making them important allies in RCCE efforts for MVD. In some settings, traditional healers are the preferred source of health-care, rather than formally trained healthcare providers *(15)*. When approached with sensitivity, they can be successfully engaged to promote safe practices and support contact tracing in the communities they serve *(16, 17)*.

Actions:

- Map traditional healers and include them in RCCE planning and training on IPC measures for MVD.
- Use their influence to share health information in IEC materials and media campaigns.
- Establish partnerships to ensure traditional healers understand signs and symptoms of MVD; promote early treatment-seeking through the formal public health system; and know how to support contact tracing.

Traditional leaders

In many contexts, traditional leaders hold significant sway over community norms and behaviours. Engaging them can help promote safer practices and amplify MVD public health messages.

Actions:

- Establish partnerships with local leaders to disseminate accurate information and guidance about MVD.
- Encourage leaders to model protective behaviours and advocate for safe practices.
- Involve them in RCCE activities such as training, mentorship and peer education.

3.3 Develop and adapt key messages to inform communication materials

Key messages are the essential points of information that response actors need target audiences to hear, understand and remember. These messages form the foundation of broader communication materials and content, helping communities access clear and accurate guidance on measures implemented by the Ministry of Health (MoH) and local authorities. They are bite-sized sentences that clearly explain facts, concepts and information in a way that is consistent and factual.

Recommendations for effective messages:

Adapt key messages to local contexts: Ensure all MVD messages are tailored to specific audiences and local settings, incorporating social, behavioural and epidemiological data. Effective messages reflect local cultural, linguistic and contextual nuances.

Translate and adjust for accessibility: Translate messages into relevant local languages, considering factors such as literacy levels, access to information channels (e.g. internet, radio) and special needs, including those related to disabilities.

Test messages with local audiences: Conduct tests with representatives of the target communities to verify that messages are easily understood and actionable and that they align with local knowledge and perceptions.

Review and update regularly: As the MVD outbreak evolves and new evidence or guidance becomes available, revise key messages to reflect the most current information. This ensures they remain accurate and relevant.

Use existing resources: Use existing resources like the Marburg message bank developed by WHO, adapting them to local circumstances to save time and ensure quality.

Following the recommendations for effective messages will help ensure that the key messages communicated are both impactful and responsive to the needs and realities of the communities facing an MVD outbreak. As information evolves, key messages will change and must be updated accordingly.

Key MVD messages for communities (as of November 2024):

- MVD is caused by the Marburg virus, which can be transmitted by an infected person to other people and is often fatal.
- The virus is initially transmitted by fruit bats to people who have had prolonged exposure in caves or mines inhabited by fruit bat colonies. It can then spread among humans through close contact with someone infected.
- The virus often spreads to a family member or local healthcare worker who is not wearing proper personal protective equipment while caring for someone ill with MVD or while handling the body of someone who has died of MVD.
- Signs and symptoms of MVD begin abruptly, with high fever, chills, severe headache and severe tiredness. Muscle aches and pains are also common symptoms. Symptoms become increasingly severe and can include nausea, vomiting, chest pain, a sore throat, stomach pain and diarrhoea that may contain blood.
- To protect yourself, your family, and your community, make sure that anyone showing symptoms of MVD is taken immediately to a designated treatment centre where they will receive care isolated from others.
- DO NOT treat patients at home. If you or someone in your family or community has symptoms of MVD, seek immediate medical assistance from local health professionals who can provide patients with safe and appropriate care. Please immediately call the local hotline at [XXX].
- Once you are at a hospital or treatment centre, health professionals and support personnel will provide you with whatever help is needed for your recovery.
- Seeking care early when you are sick will improve your chance of survival and limit the risk that you will transmit the disease to your loved ones.
- People who have died from MVD should receive safe and dignified burial. It is very important to not touch or wash the body of anyone who has died with symptoms of MVD.
- Allow burial teams to take a swab from the mouth of the deceased to test for MVD. If the test result is positive, then the team will ensure that the deceased will be safely buried, while allowing you to mourn in an acceptable and dignified way. The burial teams might advise that you not perform some rituals that would involve touching, washing or kissing the body.
- Make sure to follow and apply the advice given by your community leaders and authorities to protect yourself and your loved ones from this disease.
- Note that people who don't have symptoms cannot transmit the disease.
- To stop transmission, people who had close contact with an MVD patient will be identified as contacts. They will have their health monitored for 21 days. This allows for early detection of the disease and early access to care, which improves their chance of survival and reduces the risk of transmission to others.

3.4 Communicate uncertainty

Communications with the public must be transparent about the uncertainties surrounding MVD risks, outbreaks and interventions. It is essential that the information provided explains clearly what is known, what remains unknown and what actions are being taken to address those gaps in knowledge *(18, 19)*.

To build trust within communities, communications should be open and direct about the current state of information. Clear, empathetic language that addresses uncertainty can include phrases like, "There is still much we don't know…", "The evidence we have now, though incomplete, suggests…", and, "We will continue to keep you updated as we learn more". Authorities should also direct people to reliable sources of information, such as health authority websites, hotlines and trusted local resources.

The use of risk communication practices that acknowledge uncertainty while maintaining openness will foster trust and help communities stay informed as the situation evolves.

4. Address infodemics though integrated community feedback mechanisms and social listening; counter misinformation with accurate health information

In an increasingly digital age, effective RCCE must address the complexities of infodemics that can significantly affect public understanding during health crises. Establishing robust systems for listening to communities is essential for capturing timely and relevant community perceptions, as well as emerging myths or misinformation. Outbreak response efforts are most effective when community voices are heard, and responders act transparently on community concerns. By encouraging questions and responding openly to feedback, interventions can be adjusted based on community input, helping to build trust and ensuring more effective responses during outbreaks.

4.1 Establish feedback mechanisms

Feedback mechanisms are systems that community members can use to provide information on their views, concerns and experiences. They can improve access to relevant community perceptions and concerns, timely response to these is essential for RCCE and other MVD response pillars *(20)*. These systems help outbreak responders hear from communities and act on what they are hearing in a systematic and efficient way, which helps to build trust and ensure more effective responses *(21)*.
The Collective Service resource, Evidence-based lessons for effective community engagement *(21)* provides further information on feedback loops and other community engagement practices. This resource, which was developed for EVD, can be adapted for MVD.

Recommendations for community feedback mechanisms:

Develop and strengthen community feedback mechanisms that are simple for community representatives to engage with.

Be inclusive by actively reaching out to different groups within the community to enable their participation and to learn how they prefer to share feedback and receive answers. A community is not homogeneous.

Encourage people to ask questions and respond to them, adjusting interventions based on community input, rather than merely seeking acceptance.

Act transparently by addressing community concerns openly, explaining decisions and actions taken or not taken, and demonstrating accountability for response measures.

4.2 Conduct social listening and respond to the infodemic

Social listening, both online and offline, is essential for understanding the information environment and how it affects health behaviours. It involves gathering data on knowledge gaps, beliefs and attitudes from diverse sources to inform RCCE strategies. Disease outbreaks are often accompanied by questions, concerns and information voids, as well as misinformation and disinformation. Misinformation can elicit fear, confusion and mistrust of health authorities, all of which may hinder uptake of protective measures and undermine overall response efforts *(22, 23)*. MVD-related rumours, misinformation and disinformation have been expressed through a range of false narratives and conspiracy theories. These have included incorrect content about the availability of treatments and vaccines, the risks of MVD infection, its origins and spread and stories about witchcraft. False narratives can influence peoples' healthcare seeking behaviours and adherence to protective measures. It is therefore crucial to develop strategies to manage the infodemic and ensure communities receive timely, accurate and context-specific health information through trusted channels.

Use of evidence from social listening can help RCCE practitioners manage the infodemic by stay ahead of harmful narratives and counter misinformation. This will support MVD response efforts which are effective, trusted and impactful.

Recommendations for effective social listening and addressing misinformation:

Collect data from multiple online and offline platforms, such as community feedback mechanisms, social media, focus groups, healthcare worker feedback and media monitoring.

Analyse social listening data regularly to identify emerging trends, circulating misinformation and evolving community concerns.

Identify circulating misinformation through regular social listening and feedback mechanisms, prioritizing concerns that need responses.

Develop infodemic insights reports to assess public health risks posed by misinformation and provide recommendations for targeted interventions. Following the *How to build an infodemic insights report in six steps* can help RCCE practitioners prioritize responses *(24)*.

Incorporate insights from social listening into RCCE strategies and adjust communication efforts to reflect the changing information landscape.

Use trusted channels of communication to disseminate accurate, targeted information that addresses specific misinformation and gaps.

Counter misinformation by disseminating accurate, contextualized information frequently. To address knowledge gaps and fears, include updates on what is known and unknown about MVD.

5. Understand, prevent and address MVD stigma and discrimination

Social stigma in the health context refers to the negative association between a person or group sharing certain characteristics and a specific disease *(25)*. During an outbreak, individuals recovering from MVD, populations perceived to be at risk, those discharged from transit or quarantine centres and their families may face significant stigma and discrimination. The highly infectious and often fatal nature of MVD, coupled with the relative unfamiliarity many people have with it, makes it particularly likely to trigger stigma. This stigma can arise from the imposition of public health measures, such as social distancing, isolation and contact tracing, which can lead to further alienation of affected individuals from their communities.

The consequences of stigma and discrimination can be severe, often resulting in psychological harm, including feelings of moral discredit, social devaluation, disempowerment and, in extreme cases, suicidal ideation. It is very important for RCCE practitioners to collaborate closely with affected families, survivor programmes and mental health support teams to implement dedicated and inclusive interventions to combat stigma *(26)*.

Recommendations to address MVD stigma include:

Analyse infodemic insights to identify and respond to circulating narratives of stigma and discrimination.

Include individuals experiencing stigma, including discharged patients and other survivors, in social and behavioural data collection to better calibrate interventions that meet their needs.

Use the social and behaviour evidence to conduct interventions that involve and engage those experiencing stigma, including discharged patients and other survivors.

Disseminate evidence about stigma to partners who can help ensure the physical and emotional safety of affected individuals.

Advocate for the reintegration into their communities of individuals who have faced stigma through targeted community engagement efforts.

Provide training to media professionals on preventing stigma and discrimination in their reporting.

Focus messaging and materials on the contextual factors or behaviours fuelling the outbreak rather than labelling affected individuals or communities.

Develop and disseminate messaging that directly counters stigmatizing narratives. Use clear language to emphasize that MVD spreads through close contact between people, not due to any personal characteristics, and that anyone in close contact with someone exhibiting symptoms of MVD is at risk.

Use appropriate language. Refrain from using language, images or graphics that incite fear or focus on specific groups, activities or communities.

Collaborate with the communities to ensure the safety of those experiencing stigma.

6. Involve communities in planning and implementing MVD readiness and response measures, with special attention to safe and dignified burial practices for those who have died from MVD symptoms

Community engagement is critical for fostering active involvement and participation of affected communities in outbreak readiness and response activities. It involves building long-term relationships between outbreak responders and existing community structures, co-designing solutions and fostering open dialogue to understand the community's needs. Such engagement promotes the uptake of life-saving interventions and builds trust in both the authorities and the overall response *(6)*.

In the context of MVD outbreaks, community engagement approaches should emphasize enabling community-based surveillance (CBS) and conducting safe and dignified burials.

6.1 Community-based surveillance

CBS is a public health initiative designed to improve early detection, assessment and rapid management of disease outbreaks by leveraging the capacity of community members to carry out surveillance activities *(27)*. It relies on trained community health workers and volunteers to detect, report and monitor cases within their communities *(28)*. CBS should be a cornerstone of MVD readiness efforts, contributing to active surveillance, early warnings and responses that systematically capture cases and deaths in the community, particularly in areas with limited access to health facilities *(29)*. CBS by no means represents a substitute for a national surveillance system, but is used instead to complement and strengthen existing facility-based surveillance systems.

Recommendations for successful CBS for MVD:

Involve trusted community representatives in the design of local CBS systems, ensuring the surveillance is relevant and accepted. This can mean co-designing systems with local leaders and allowing communities to nominate suitable CBS workers *(30, 31)*.

Aim for diverse recruitment: Recruit CBS teams from within affected communities that comprise a diverse group of individuals, including health workers, traditional healers and community leaders, if appropriate. This helps build trust and facilitates greater acceptance of CBS efforts.

Support CBS teams: Provide thorough training for CBS teams so they can apply MVD case definitions and identify potential cases accurately. They must also be provided with the necessary tools and resources to perform their surveillance duties effectively and engage the community on health-related issues.

6.2 Conduct safe and dignified burials

Close contact with the body of a person who has died from MVD poses a serious risk of transmission. Communities must be informed about this risk and encouraged to adopt protective behaviours when handling the dead and planning funerals or cremations.

In some settings funerary and burial practices involve close, intimate contact with the deceased. Such practices, deeply rooted in socio-cultural traditions, have significant potential to transmit highly communicable diseases like MVD.

When MVD response protocols disrupt these meaningful practices, it is crucial to engage with communities to find safe alternatives that still respect the deceased and their loved ones. Without such collaboration, there is a risk of amplified fear, mistrust and the deterioration of relationships between at-risk communities and health authorities *(32)*.

Evidence from previous outbreaks indicates that communities are often willing to adapt their burial practices if the following conditions are met *(33)*:

1. **Symbolic and emotional needs:** New practices must still satisfy the symbolic, social and emotional needs traditionally met by the original ceremonies and practices.
2. **Community involvement:** Affected communities must be actively involved in shaping any proposed changes.

Only the medically unsafe aspects of the burial practices need to be altered, while other components of traditional rituals can be preserved. When changes are unavoidable, those modifications must still respect religious freedoms and incorporate spiritual and cultural values, all while prioritizing safety.

To ensure burials are both safe and respectful, RCCE measures should focus on the co-development or adaptation of burial protocols with local actors, allowing communities to preserve important funeral and burial traditions without compromising safety.

By balancing respect for cultural traditions with the imperative to prevent transmission, response teams can build trust, reduce fear and prevent the further spread of MVD during burial processes.

Recommendations for safe and dignified burial practices to reduce the risk of transmission when handling dead bodies with suspected or confirmed MVD *(34)*:

Engage trusted community representatives: Work closely with community leaders to adapt local funeral and burial protocols, ensuring that socio-cultural norms and traditions are accommodated within safe practices.

Provide clear communication: Ensure that communication with communities regarding safe and dignified burial procedures is clear, timely and transparent. This will help build trust and understanding.

Discourage risky behaviours: Protect communities by discouraging practices that involve close physical contact with dead bodies. Instead, collaborate with communities to develop alternative, less intimate rituals that are culturally acceptable.

Promote the involvement of health professionals: Sensitively inform communities on the importance of allowing trained health personnel to handle and prepare bodies for burial, as this significantly reduces the risk of infection.

Balance custom with safety: Whenever possible, burial procedures should respect local customs while adhering to infection prevention protocols.

Plans for updating this interim guidance

New MVD outbreaks bring in new experiences that are likely to generate new evidence. Based on that new evidence, which is related to evolving MVD dynamics, the contents of this RCCE interim guidance are expected to change. WHO continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue an update. Otherwise, this interim guidance will expire two years after the date of publication.

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Annex 1. RCCE checklist

The comprehensive checklist of activities in Figure A.1 is designed to help RCCE professionals and responders update or develop MVD readiness and response plans that should be considered during the readiness and response phases of an MVD outbreak. This checklist is a standard WHO tool that supports a number of RCCE products.

Figure A.1. RCCE readiness and response checklist

Area of work	Steps	Activities
Systems and coordination	Readiness	❒ Establish or strengthen RCCE coordination mechanisms, including an inter-agency task force or crisis communication centre and technical working groups for key areas of work, and ensure that content clearance and information-sharing protocols are approved. ❒ Review and update existing RCCE strategies and plans using surveillance, epidemiological, social and behavioural data. Ensure these are linked to broader emergency preparedness and response operational plans and national MVD elimination and control plans. ❒ Set up or strengthen an RCCE team, define members' roles and responsibilities and describe how the team will link to other response pillars. ❒ Map RCCE expertise at all levels, including specific focal points for topics such as preventing and responding to sexual exploitation, abuse and harassment. ❒ Develop a budget, with funding options and a human resource plan, including plans for surge support, if needed.
	Response	❒ Convene and coordinate the RCCE response with government, stakeholders, partners and across technical areas/pillars. ❒ Activate the inter-agency task force or crisis communication centre and ensure content clearance and information-sharing protocols are followed. ❒ Revise and update RCCE strategies and plans according to need and current surveillance, epidemiological, social and behavioural data, new evidence or learnings and community insights. ❒ Implement an approved operational budget and human resource plan, including deployment of surge staff.
Community data for action	Readiness	❒ Review social and behavioural data and identify vulnerable populations, risk factors, priority behaviours and potential barriers and enablers for an effective response. Use this knowledge to inform decision-making at all levels. ❒ Analyse gaps in available social data. A mix of quantitative and qualitative data is best – including community feedback, community listening, polling, situational and behavioural analyses, survey data and data related to preventing and responding to sexual exploitation, abuse and harassment – to understand community knowledge gaps, perceptions and behaviours. Commission appropriate research to fill in any identified gaps. ❒ Establish or strengthen community listening mechanisms and develop or adapt tools for offline and online community listening, including rumour monitoring.
	Response	❒ Regularly conduct rapid assessments of at-risk and affected populations to track changes in knowledge, attitudes, perceptions, behaviours and other social and behavioural variables. ❒ Regularly conduct community listening. Use the findings to develop, adjust and implement RCCE interventions that address any concerns, misconceptions, rumours and unacceptable behaviours, including sexual misconduct. Include affected communities in this process. ❒ Assess the impact of response activities on communities. Ensure plans are in place to manage potential or unexpected impacts (changes to health-seeking behaviours, impacts on job and food security and other economic or social impacts). ❒ Share data with the communities from which they were collected, and update local response activities as new social, behavioural and anthropological data become available.

Area of work	Steps	Activities
Risk communication	Readiness	❒ Ensure that the highest levels of government are ready to release information to protect the public's health in a rapid, transparent and accessible manner. ❒ Create or review a repository of existing RCCE materials, such as message banks, tools, products and templates. ❒ Map and prioritize trusted and commonly used communication channels and platforms. Assess these for accessibility by people in remote areas, people without digital skills or digital access, and people with low literacy skills or those who may not speak the dominant language, etc. ❒ Identify focal points and media spokespeople for all key partners at all levels; list their areas of expertise in relation to the disease or health emergency threat; if necessary, train them. ❒ Coordinate communication activities and use standard operating procedures for clearance and sharing.
	Response	❒ In collaboration with affected communities, develop, adapt and test messages as the situation and science evolves. ❒ Update interventions and messaging, as recommended public health social measures change and new tools (vaccines, treatments, tests, etc.) become available. ❒ Continue sharing regular and updated information and dialogue using trusted and commonly used channels. ❒ Engage regularly with and provide risk communication content to government, media and other partners so public information can be adapted to and consistent with the latest science and current context. Provide guidance to media outlets on how to access reliable information.
Community engagement	Readiness	❒ Hold discussions with communities to understand socio-cultural contexts and power dynamics of key audiences. ❒ Identify what types of engagement are safe, feasible and acceptable for different communities. ❒ Identify existing platforms (community leaders, civil society organizations, community-based organizations, and key influencers, particularly those accessed by people at risk) and engage communities in decision-making and priority setting. ❒ Establish or strengthen community feedback systems to ensure that community beliefs, questions, concerns and suggestions are heard. ❒ Co-develop priority actions with affected groups to strengthen readiness, build trust and encourage the practice of protective behaviours (risk and needs assessments, strategies, plans, guidance, messaging, etc.). ❒ Design and co-implement interventions and strategies with communities. ❒ Train community engagement teams, including volunteers, and establish surge capacity mechanisms. ❒ Anticipate special information and engagement needs for people who are disabled, illiterate or otherwise marginalized.
	Response	❒ Update and co-implement RCCE interventions and strategies with communities. ❒ Launch community feedback systems. ❒ Launch or strengthen an alliance of influencers and stakeholders who can listen, advocate, inform, address rumours and misinformation and promote health literacy using evidence and data. ❒ Ensure representation of civil society and vulnerable groups. Work closely with other committees and advisory groups. ❒ Engage relevant sectors (government, social and private sector) to manage service and supply needs, assess barriers and strengthen referral systems such as for mental health, gender-based violence, and preventing and responding to sexual exploitation, abuse and harassment. Ensure affected communities are linked to referral systems.

Area of work	Steps	Activities
Capacity building	Readiness	❒ Conduct a needs assessment that includes mapping of existing RCCE human resource capacities and capabilities. ❒ Develop a capacity plan with stakeholders that is based on the result of the needs assessment. ❒ Build the capacity of RCCE teams and other key stakeholders based on the plan developed. ❒ Create standard operating procedures to drive consistency and quality across RCCE interventions and collaboration with partners. ❒ Initiate a continuous, peer-to-peer support system for community mobilizers, responders and networks.
	Response	❒ Adapt capacity-building tools as needed. ❒ Identify and train emergency RCCE staff and potential surge staff on plans and procedures. ❒ Provide refresher or on-the-job training for RCCE responders and spokespersons as interventions and strategies change. ❒ Continue to provide orientation to media professionals and communication networks as the response evolves.
Measurement, evaluation and learning (MEL)	Readiness	❒ Develop/review the monitoring, evaluation and learning framework, including monitoring and evaluation indicators based on the developed RCCE strategy, planned activities and expected outcomes. ❒ Develop/strengthen a real-time monitoring system using existing/adapted tools, such as mobile and manual data collection methods, interactive dashboards and automated data analyses. ❒ Train the RCCE team on the use of relevant tools. ❒ Promote community participation in developing the measurement, evaluation and learning processes. ❒ Develop a system to store, manage and share information and key datasets.
	Response	❒ Continuously revise the measurement, evaluation and learning framework to ensure it is capturing the data needed to measure results and impact. ❒ Where possible, use established, real-time and participatory measurement and evaluations systems, such as mobile or application-based reporting. ❒ Generate evidence and data that allow regular assessment of strategy implementation and impact. ❒ Include civil society organizations and community-based organizations in monitoring, reporting and joint accountability efforts to increase the likelihood of broad community uptake and responsibility for new interventions. ❒ Maintain and strengthen systems to manage and share information, document lessons learned and gather best practices. Disseminate lessons and best practices widely.

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