



My Brother SG

HERE FOR YOUR HEALTH

*A Guide to Effective RCCE
Engagement in Large, Closed
Communities:*

An Evolving Network in RCCE in the COVID-19
Migrant Worker Outbreak in Singapore
April 2020 – February 2021

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*“It is in that space of AUTHENTICITY and VULNERABILITY,
that HUMAN CONNECTION can be made.*

And with that, the sowing of TRUST.

And with that, the birth of a MOVEMENT.”

*—Dr. Tam Wai Jia, Project Lead of the RCCE efforts in the migrant worker outbreak in Singapore
and Founder of Kitesong Global*

VULNERABILITY.
HUMANITY.
TRUST.

Abbreviations

ACE	Assurance, Care and Engagement
CCF	Community Care Facilities
CMSC	COVID-19 Migrant Support Coalition
COVID-19	Coronavirus Disease 2019
CTQ	Construction temporary quarters
FAS	Forward Assurance and Support
FCD	Factory-converted dormitories
FGD	Focus group discussion
GOARN	Global Outbreak Alert and Response Network
HOME	Humanitarian Organization for Migrant Economics
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
KAP	Knowledge, Attitudes and Practices
MOMFWCare	Ministry of Manpower Foreign Worker Care
NGO	Non-Governmental Organisation
NUHS	National University Health System
NUS	National University of Singapore
PBD	Purpose built dormitories
PCR	Polymerase Chain Reaction
PPE	Personal protective equipment
POC	Point of Contact
RCCE	Risk Communication and Community Engagement
SARS-CoV-2	Severe Acute Respiratory Syndrome coronavirus 2
SWOT	Strengths, Weaknesses, Opportunities and Threats
TWC2	Transient Workers Count Too

UHC	Universal Health Care
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Table of Contents

<i>Acknowledgements</i>	2
<i>Abbreviations</i>	4
1. Preface	9
1.1 What is this guide about?	9
1.2 Who is this guide for?	9
1.3 How was this guide developed?	10
1.4 How do I use this guide?	10
1.5 A Note on Our Partners	11
2. Executive Summary	13
3. Introduction	15
3.1 RCCE: A Critical Enabler of Outbreak Response	15
3.1.1 What is RCCE?	15
3.1.2 Why is RCCE important?	16
3.1.3 Challenges of delivering RCCE	16
3.1.4 Importance of RCCE in Marginalized Communities	17
3.2 COVID-19 Outbreak in Singapore	18
3.2.1 The Outbreak Among Migrant Worker Communities	18
3.2.2 The Context of Migrant Workers in Singapore	19
3.3 The RCCE Approach in Singapore	21
3.3.1 Making the shift: A unilateral to participatory approach	21
3.3.2 Why a people-centered, community-led approach matters	22
3.3.3 <i>Rationale for this work</i>	22
4. Establishing a comprehensive, sustainable self-driven RCCE network	23
4.1 How did the RCCE service emerge?	23
4.2 How the RCCE service and network operates now	24
4.3 A Conceptual Framework and Working Logic Model	25
4.4 Theory of Change: How does it work?	26
4.5 Establishing a Project Structure	28
4.5.1 Acknowledging the RCCE Gap	28
4.5.2 Creating an Enabling environment for RCCE	28
4.5.3 Evolution of the Singaporean Strategy	29
5. Early Development of RCCE in the Dorm Response	32
5.1 Messy Realities at the Start	32
5.2 Understanding the Landscape	35
5.2.2 Understanding the Migrant Worker Community	37
5.2.3 Understanding Other Actors and their Priorities (i.e. enabling environment)	39
5.3 Getting Stakeholder Buy-In Early	40
5.4 The Importance of Strategic Positioning	41
5.5 The Importance of Creating a Strong RCCE Team from Scratch	46
6. Systems Falling Into Place	53

6.1 A Multimodal Approach Developing Multimodal Engagement Platforms	53
6.1.1 General Challenges and Ways to Overcome them	53
6.2 Health Booklets	54
6.2.1 Workflow: Broad Principles	61
6.2.2 Challenges and ways to overcome them:	62
6.3 Posters	63
6.3.1 Challenges and ways to overcome them	63
6.4 Face-to-face Engagements	64
6.4.1 Development Process	64
6.4.2 Identified challenges and corresponding solutions	67
6.4.3 A case example of a creative participatory approach: Kitesong workshops	68
6.4.4 Table comparison between RCCE approach at the start of the COVID-19 outbreak among migrant workers in Singapore and the participatory approach that evolved in response to emerging needs.	69
6.5 Digital Engagements	70
6.5.1 Social Media Contests	71
6.5.2 Comics	72
6.5.3 Live Webinar Sessions	74
6.6 Mental Health Professional Support Network	76
7. Conclusion	76
7.1 Lessons Learned: What is needed for an effective RCCE programme?	76
7.2 Challenges and Future Efforts	78
7.2.1 Feedback from Migrant Workers	78
7.2.2 Long term vision	85
7.2.3 Challenges:	85
7.2.4 Future Efforts	87
References	89

List of Tables

Table 1. Inputs to Logic Model for RCCE with migrant worker population	29
Table 2. Example of SWOT analysis of dormitory site to inform design of RCCE efforts	36
Table 3 Challenges and Solutions to create multi-lingual RCCE resources	53
Table 4. Summary of challenges and corresponding solutions when developing patient health booklets	62
Table 5. Summary of challenges and corresponding solutions when developing posters	63
Table 6. Summary of tailored My Brother SG approaches to RCCE with migrant workers	69
Table 7. Independent sample t-test results for effect of activity on feelings of agency/empowerment	79
Table 8. Independent sample t-test results for effect of activity on understanding and perception of information received	80

Table 9. Reliability of Survey Indicators	82
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List of Figures

Figure 1. Logic Model to reduce negative impacts of COVID-19 among migrant worker community	27
Figure 2. Initial RCCE team structure	49
Figure 3. Formal Organizational Structure of RCCE Network	50
Figure 4. Excerpts from health booklets developed for use at CCFs	54
Figure 5. Excerpts from health booklets showing inclusive messaging to patients attending CCFs	55
Figure 6. Cover page of CCF patient booklet	57
Figure 7. Multilingual presentations of CCF patient booklet	58
Figure 8. COVID-19 health and emotional support messaging in CCF patient booklet	58
Figure 9. COVID-19 messaging in excerpts of CCF patient booklets	60
Figure 10. COVID-19 Prevention messaging in CCF patient booklets	61
Figure 11. Social media advert for COVID-19 related messaging contest hosted by Kitesong	71
Figure 12. Artwork submissions submitted to My Brother SG via social media	72
Figure 13. Inspirational messaging via comic illustrations developed by My Brother SG	73
Figure 14. Inspirational messaging via comic illustrations developed by My Brother SG	74
Figure 15. Webinar advertisement for health promotion programming	75
Figure 16. Results for awareness and understanding of preventing spread.	81
Figure 17. Preferred help seeking sources by migrant workers in the study	81
Figure 18. Potential barriers to migrant workers seeking help from different sources	82

Annexes

- A. KAP surveys
- B. Volunteer recruitment package
- C. Translation template example
- D. Volunteer form for translators
- E. Health Booklets
- F. Posters
- G. Face-to-face engagement workflow
- H. Comics
- I. Live webinar series
- J. HealthServe Psychosocial Care
- K. Face-to-face engagement training manual
- L. Multilingual online surveys

1. Preface

1.1 What is this guide about?

The Interim Guidance on COVID-19 for Outbreak Readiness and Response Operations developed by IFRC, IOM, UNHCR and WHO addresses specific needs in camp-like settings and the surrounding host communities, in scaling up readiness and response operations through multi-sectoral partnerships.[1, 2] The RCCE efforts in the outbreak among migrant workers in Singapore complements this guidance to ensure migrant workers quarantined in large, closed communities are not stigmatized, are provided with timely and accurate information in accessible forms and appropriate languages, and are engaged in response plans, and strategies.[2]

This guide to *Effective RCCE in Large, Closed Communities* describes the service and system level RCCE interventions that emerged bottom-up in a responsive way to deliver effective RCCE in this context, during the COVID-19 outbreak among migrant worker communities in Singapore, where 43 purpose-built dormitories and hundreds of smaller factory-converted dormitories experienced lock-down from April to August 2020. It illustrates not only the cruciality of RCCE, but how it can be delivered effectively, while reflecting on the “messy realities” of everyday practice amidst the context of a public health crisis. While approaches to RCCE are often described in terms of their principles for practice, this guide provides rich description and detail about how these principles can be realized and delivered most effectively. Challenges and lessons learnt provide crucial guidance for future steps.

The guidance provided here also describes how to embrace existing stakeholders, a growing network of robust partners and community participation to inform and improve RCCE approaches in crises. The consolidated toolkit provides an overview of the various elements of a creative community-led, people-centered RCCE programme and provides guidance and tools for scale-up and spread in other contexts.

1.2 Who is this guide for?

This guide is intended for field mobilisers, public health personnel, government authorities and non-government organizations who wish to deliver RCCE interventions through participatory practice, in alignment with global strategy and best practices for RCCE. It is especially for those working in the context of large, closed communities during an infectious disease outbreak such as COVID-19, in any context globally.

As advised in the revised COVID-19 Global Risk Communication and Community Engagement Strategy (WHO), people centered and community-led approaches, that are data-driven and reinforce capacity and local solutions and enhancing collaborations, result in increased trust and cohesion to ultimately reduce negative impacts of COVID-19.[3] The participatory approach recognizes that communities, even marginalized and vulnerable ones such as migrant communities, have the agency, power and autonomy to influence the spread of COVID-19.[4] Through regular

two-way communications, the participatory approach recognizes the strengths inherent in every community and leverages upon them to amplify the power of communities to take charge of their health.[4, 5]

“Communities, even marginalized and vulnerable ones such as migrant communities, have the agency, power and autonomy to influence the spread of COVID-19.”

1.3 How was this guide developed?

This guide was developed by assessing the needs of end users through focus group discussions, key informant interviews, surveys and local steering committee meetings, describing the key inputs and activities, consolidating and packaging the tools and products used to deliver interventions, and detailing the logic model and programme theory through consultation with a local steering committee and technical advisory group.

1.4 How do I use this guide?

This guide is not intended as a rigid or prescriptive “how to” blueprint for undertaking RCCE initiatives.

It aims to impart the spirit of community engagement and empowerment through its emphasis on building relationships, restoring human connection and fueling hope through embracing authenticity, vulnerability and celebrating humanity, to propel agency and inspire change.

This guide serves as a reference tool for community mobilizers, and is intended to provide guidance, based on our team’s experience during the COVID 19 outbreak, for designing and implementing RCCE approaches. However, each context locally or globally, has its own cultural perceptions, risk levels, local capacities and limitations.

As such, it is recommended that mobilisers apply the principles behind the workflows and protocols and adapt them accordingly to suit their own contexts, to ensure maximal cultural relevance and programme effectiveness. Revisions should be made according to the evolving situation and receptivity to the RCCE interventions. This guide could also be used to influence comprehensive training packages directed at community engagement.

1.5 A Note on Our Partners



[NUS Yong Loo Lin School of Medicine](#) and Kitesong Global were the initial collaborating partners initiating My Brother SG.

NUS YLLSoM is Singapore's leading medical school providing funding, staff support and medical student volunteers for this project.



[Kitesong Global](#) is an international non-profit that empowers underserved communities through the power of narrative. It provided the initial infrastructure and volunteer recruitment in the earliest phase of the RCCE efforts.



[NUHS](#), [SingHealth](#), and [NHG](#) are the three Regional Health Clusters meeting Singaporean's healthcare needs. They undertook the healthcare of all migrant workers during the COVID-19 outbreak, supplying healthcare manpower and crucial leadership. Volunteers support ongoing health messaging ensuring accuracy, translation and cultural appropriateness.



[HealthServe](#) NGO is a migrant worker non-profit that provides healing and hope to migrant workers. They play a significant role in providing mental health support and physical provisions to migrant workers through on-ground engagement during the COVID-19 outbreak. They also spearhead the migrant worker peer support programme.



[COVID-19 Migrant Support Coalition \(CMSC\)](#) is a fully volunteer-run group-up initiative that met the immediate supply, mental wellness and learning engagement needs of migrant workers during the COVID-19 outbreak.



[Bangladeshi Migrant Workers in Singapore](#) is a ground-up movement on a Facebook page managed by a migrant worker collaborator and social media influencer, Shipon Omar Faruque, who reaches tens of thousands of workers through his co-developed RCCE messages via social media videos.



[GOARN](#) is a global network of outbreak response partners. It provides expertise, guidance and provides an international context for the model represented by Brother SG.

2. Executive Summary

This practical guidance manual is an illustration of how RCCE was done in a large, enclosed setting with migrant worker communities in Singapore. Most of the RCCE interventions originated from a ground-up approach that happened organically, without formal strategic planning. However, as the principles of RCCE gained recognition by leaders on-ground, the RCCE approaches became better informed with the principles of the revised strategy.

This guide is developed by the local RCCE working group based on a consolidation of the RCCE programme for the purposes of providing guidance and insights, and sharing creative approaches to RCCE as the outbreak evolved. It aims to impart the spirit of community empowerment through its emphasis on building relationships, restoring human connection and fueling hope through embracing authenticity, vulnerability and celebrating humanity, to propel agency and inspire change.

2.1 What does this guide focus on?

This guide draws on and summarises principles of community-led, people-centred approaches, and aims to provide a unique case example of RCCE implementation among diverse migrant worker groups in a large, closed setting during the COVID-19 foreign worker dormitory lockdown in Singapore from April to August 2020.

The rationale for this practical guidance manual is to illustrate and reflect upon a set of innovative ground-up, participatory RCCE approaches implemented in a large, enclosed setting with migrant worker communities in Singapore during the COVID-19 lockdown, which were informed with the principles of the revised Global Response RCCE strategy.

2.2 Background and Context

Singapore's first identified COVID-19 infection case was a Chinese national from Wuhan, tested on 23 January 2020.[7] By August 2020, Singapore had reported over 55,000 laboratory-confirmed cases of COVID-19 in a total of 5.7 million population, the highest number of cases per 100 000 in Asia.[8, 9] Migrant workers comprised 94.6% of the Polymerase Chain Reaction (PCR) diagnosed cases, with a prevalence rate of 16.3% compared with 0.04% in the local population.[9,10]

RCCE was a challenge for these large, diverse communities of migrant workers living in high-density accommodation. Ad hoc, poorly organised health communication early in the dormitory outbreaks risked compounding pre-existing vulnerabilities by disconnection from traditional social networks. RCCE efforts were not prioritised initially, and an overarching strategy was slow to develop.

2.3 What guiding steps and principles should inform RCCE work among migrant workers in large, closed communities?

To develop our initiative, critical steps were identified:

1. Conducting a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis
2. Undertaking Knowledge, Attitudes and Practices (KAP) research to establish baselines
3. Curating and developing content
4. Establishing a variety of distribution channels and communication modalities
5. Engaging key stakeholders from other non-profit organizations, healthcare clusters, and high-level ministries (i.e. Ministry of Health, Ministry of Manpower)
6. Recruiting manpower to form a team comprising staff, hired translators and volunteers
7. Expanding outreach to migrant workers in non-purpose built dormitories such as factory-converted dormitories (FCDs) and construction temporary quarters (CTQs).

Optimizing the chances of success in the RCCE programme depended on some broad key principles, which included:

- Focusing on Agency, autonomy and empowerment
- Focusing on establishing a human connection
- Early engagement with migrant workers on-ground and partnering inherent hierarchy personnel structures
- Early engagement of stakeholders to ensure national coordination
- Bilateral communication with migrant worker groups
- Adopting a streamlined 3-pronged approach
 - COVID-19 prevention/management
 - Mental Health Prevention
 - Chronic Disease management
- Using multiple modes of dissemination
- Overcoming bureaucracy made less nimble by the pandemic
- Growing a vibrant volunteer and donor network
- Scaling up

2.4 What were some lessons learned in setting up a novel RCCE service from scratch?

Generalizable lessons learnt in setting up a novel RCCE service were:

1. Anticipate frustrations, barriers, setbacks and conflict. Value the preexisting efforts of stakeholders.
2. Never lose sight of the perspective from the community you are in engaging.
3. Look on each problem is an opportunity.

4. It takes a team, even if it is formed from scratch during the outbreak, to keep the work sustainable and growing.
5. Create a common vision to galvanize a team together.
6. Commit to key principles and values decided upon by the team, such as a commitment to high standards of work, flexibility in times of crisis, and humility to learn from mistakes.
7. As the team grows, start establishing structures within the leadership team.
8. Invest meaningfully in nurturing leaders within your team.
9. Experience challenges such as high volunteer turnover rates positively and leverage on them to the situation's advantage.
10. Commit to establishing partnerships to leverage on one another's spheres of influence.

2.5 What can we expect in the next six months?

Our RCCE network has grown to become a growing web of partners committed to the objectives.

As the “My Brother SG” network grows to include more partners regionally and globally, it looks forward to working towards the vision of sustainability and longevity by building upon the relationships within and outside the network while supporting its members to continue engaging and empowering migrant workers for better health.

3. Introduction

3.1 RCCE: A Critical Enabler of Outbreak Response

3.1.1 What is RCCE?

Risk communication and community engagement (RCCE) are essential components of a broader health emergency preparedness and response action plan.[6]

It describes two distinct but interrelated approaches to supporting communities to adopt disease safe behaviors and take community action in support of ending disease transmission.[5] The global strategy outlines how RCCE should be nationally led, community-centered, participatory, trust-nurturing, open and transparent, integrated, data-informed, coordinated, inclusive and accountable, to promote trust and social cohesion to reduce the negative impacts of COVID-19.[3]

Risk communication refers to an ongoing exchange of information based on organizational development, message development, audience research, audience relations, message delivery, and media relations.[7] Simply, it is the two-way and multi-directional communication and engagement with affected populations so that they can make informed decisions to protect themselves and their loved ones.[6] In the context of the COVID-19 pandemic, it includes the range of communication actions required through the preparedness, response and recovery phases,

in order to encourage informed decision making, positive behavior change, and the maintenance of trust.[6]

Community engagement, on the other hand, is a critical component of civil society, international development practice and humanitarian assistance. It is based on the simple premise that communities should be listened to and have a meaningful role in processes and issues that affect them.[8]

3.1.2 Why is RCCE important?

RCCE is a key pillar in COVID-19 preparedness and response planning.[9]

Access to accurate information is a basic right. It allows people to make informed decisions to protect themselves and their families. It is thus important that communication occurs transparently in various languages, formats, and media that are contextually appropriate and accessible for all groups in a community.[9-11]

During the early days of the pandemic, the identification of infectious clusters, super spreaders and community outbreaks caused widespread fear among the public, resulting in social stigma and discrimination against certain groups [12]. Those from marginalized communities experienced multiple intersecting stigmas, negatively impacting social justice, which comprises agency (the capacity of individuals to act independently and to make their own free choices), respect, and association (the capacity to connect and participate) [13]. Ultimately, this led to hazardous public health consequences: delayed presentation of symptomatic patients to healthcare services and under-detection of infectious individuals[18].

Over the course of several more recent large-scale pandemics (H1N1, Ebola, Zika and COVID-19), more concerted efforts have been made globally to better define, integrate and resource RCCE initiatives into outbreak response and adapt RCCE strategies to local contexts.[12] The revised global RCCE strategy moves from the directive, unilateral communication characterizing early stages of the COVID-10 response, towards people-centered participatory approaches proven to promote trust and social cohesion, reducing negative impacts of outbreaks.[3] The four main objectives of being community-led, data-driven, collaborative, while reinforcing capacity and local solutions have emerged as priority areas.[3]

3.1.3 Challenges of delivering RCCE

While communication to the public on a regular basis about what is known and unknown about COVID-19, what is being done, and actions to be taken is crucial, it is challenging to implement. Responsive, empathic, transparent and consistent messaging in local languages through trusted channels of communication, using community-based networks and key influencers and building capacity of local entities, is essential to establish authority and trust, but often difficult to

facilitate.[9, 11] Communicating uncertainty and risk while addressing public concern can lead to a range of outcomes, some of which are unexpected- including a loss of trust and reputation, economic impacts, and unfortunately, a loss of life.[13] Navigating cultural nuances, preventing the spread of mis- and disinformation amidst an “infodemic”, exploring different and correct modalities of communication are some of the known challenges.[14].

Even so, these can be overcome through known strategies such as:

1. Establishing a strong and cohesive RCCE partner coordination at global, regional and country levels for a more effective response.
2. Communicating science based information and recommendations in a timely manner that address critical risks and counters misinformation.
3. Accelerating priority research and innovation in social sciences to support the implementation of public health measures and to ensure participation of at-risk and affected communities to ensure effectiveness and efficiency of the response and accountability towards people.
4. Enhancing country-level capacity to roll out effective and coordinated RCCE approaches through identification of capacity needs, provision of simplified tools and resources, distance-based training and guidance and rapid deployment of RCCE expertise.[15]

3.1.4 Importance of RCCE in Marginalized Communities

As with all communities, utilising RCCE approaches can be challenging among marginalised groups, such as large, diverse communities of migrant workers living in high-density accommodation, as in Singapore’s case.

Migrant worker communities who live apart from the general population may be stigmatised and excluded from national response plans.[16] Left unchecked, this may lead to mistrust towards authorities and responders, and increased barriers to outbreak control.[16] Migrant workers in Singapore have diverse language, ethnic and cultural backgrounds.[17] They may be illiterate or have lower education levels which may be a challenge to understanding more technical health information.[18] Many may not have or be used to technologies such as smartphones and may choose to prioritize basic needs over gathering information.[18] Latest updates about the disease may also not be available in an appropriate or accessible language or format to them.[18]

As the crisis highlighted fragilities within nations around the world, our response calls for deep reflection on societal structures and our future response to address inequities and ensure “no one is left behind”. [1]

It is thus essential to work with communities in these settings to identify sustainable solutions. Gathering basic information, implementing community perception surveys, tailoring strategies and activities to the target groups, addressing stigmas and regularly checking what works and what

does not are key steps to engaging vulnerable groups.[18] During major infectious disease outbreaks, listening to and understanding their concerns and risk levels can help anticipate and mitigate harm that can arise both from the outbreak and from response interventions that have social and economic consequences. Information and support must be targeted, accurate, current, and adapted to cultures, ages, and educational levels. It must be provided in a variety of convenient available modalities which allow for the provision of timely communications during an evolving response.[18]

3.2 COVID-19 Outbreak in Singapore

3.2.1 The Outbreak Among Migrant Worker Communities

Singapore's first identified COVID-19 infection case was a Chinese national from Wuhan, tested on 23 January 2020.[19] In March 2020, the first cases in foreign workers were identified and in April 2020, two large migrant worker dormitories were gazetted as isolation areas because of clusters of confirmed COVID-19 cases there.[20] On April 14, a “three-pronged strategy” was adopted to curb the spread of the virus, where all dormitories were under lockdown; workers who tested positive and their close contacts were isolated; healthy and essential workers were moved to alternative accommodation such as military camps and empty housing blocks.[21]

On June 1, the government announced that the first batch of 60 dormitories and its 8,000 residents would be “cleared” of COVID-19, meaning that residents of that dormitory or block within their dormitory would consist only of workers who had either recovered from COVID-19 or tested negative.[21] These workers could return back to work, along with another 32,000 COVID-19-cleared workers earlier transferred to alternative lodging sites.[21]

After the end of Singapore's two-month circuit breaker on June 2, many dormitories continued to remain in lockdown. On July 24, it was announced that save for 28,000 migrant workers still serving out their quarantine, the rest of the migrant worker population in dormitories would be cleared of COVID-19.[21]

By 15 August 2020, Singapore reported 55 661 laboratory-confirmed cases of COVID-19 in a total of 5.7 million population, the highest number of 975.8 cases per 100 000 in Asia.[22, 23] Migrant workers comprised 94.6% of the cases, with a prevalence rate of 16.3% compared with 0.04% in the local population.[23, 24]

By 7 August 2020, all 323'000 migrant workers residing in dormitories were tested for the virus, in preparation for safe transit back to work.[25] By end August, most workers had returned to work.[21]

3.2.2 The Context of Migrant Workers in Singapore

Migrant workers contribute significantly to Singapore's economy, comprising 24.3% of Singapore's population and 37% of its workforce, numbering nearly 1.4 million people.[17]

Governed by unique social and immigration policies, migrant workers are separated into visa categories related to skills and earnings. Male 'Work Permit' holders are the largest category, numbering 716,200 or 12.7% of Singapore's population.[26] They originate from a set of approved source countries, mainly Bangladesh, India, and China, and perform low-skilled work in selected sectors such as construction, manufacturing, marine, shipyard, process, or service. This document uses the term "Migrant Worker" to refer to male Work Permit holders.[27]

3.2.2.1 Residential Accommodation of Migrant Workers

With a population of nearly 5.7 million, a living density of 7,810 per square kilometer, Singapore is considered one of the top five most densely populated countries in the world.

Migrant workers in Singapore live in varying types of accommodation. Approximately 323'000 migrant workers reside in one of 43 purpose-built dormitories in Singapore, specially built with features for their needs, approved to accommodate up to 25,000 residents, housing 6 to 32 residents per unit.[23] [23, 25, 28-30]

There are barracks-style and apartment-style residential buildings.[31]

Barracks-style accommodation: Barracks-style dormitories contain multiple units with communal showers, toilets and kitchens. They are generally more crowded, with fewer management guidelines in place. These may be licensed purpose-built dormitories or less regulated factory-converted dormitories, which are living spaces converted from discarded warehouses or industrial buildings.[31]

Apartment-style dormitories: Apartment-style dormitories offer amenities such as shower and cooking facilities, and toilets within each housing unit. They are modelled after public housing facilities, and tend to be run by managing agents with stricter and better management guidelines.[31]

Other migrant workers are housed in dormitories converted from disused industrial sites and other unlicensed residences.[23, 28] These are typically less regulated and house anywhere between a dozen to hundreds of workers. Although a minimum of 4.5 square meters of 'living space' per worker in purpose built dormitories (PBDs) is mandated, nearly half breached licensing conditions every year.[29, 30] While a minority reside in public housing among Singaporean residents, the majority live in accommodation away from spaces designated for housing purposes.

3.2.2.2 Media Consumption of Migrant Workers

Accurate assessments of people's favoured channels of communication, their most trusted sources, level of literacy and media literacy, preferred languages and formats for receiving and sharing messages are essential to communicate with multiple and diverse population groups.[32]

Migrant workers in Singapore are culturally diverse and speak many languages.[17] Majority of them come from Bangladesh, India and China, while others come from Myanmar, Indonesia, Thailand and Philippines.[33] Differences in power distance, individualism, masculinity, uncertainty avoidance, and long-term orientation affect the way they assimilate and receive information.[34, 35]

Based on our focus group discussions, we discovered Bangladeshi and Tamil workers are heavy social media consumers, especially Facebook and Tiktok. Both groups rely heavily on text messaging applications such as WhatsApp, though Bangladeshi workers are also closely connected by IMO, a text messaging application that is well-known for its audio and video calling functions. Chinese migrant workers, on the other hand, obtain information primarily via a text messaging application called WeChat, which is pre-loaded onto their china-made cell phones. Their phones do not allow downloading of local cell phone applications such as the Ministry of Manpower Foreign Worker Care Application (MOMFWC Care App) due to restrictions placed by China on external applications, contributing to a communication barrier between them and Singaporean updates. Potential challenges in RCCE include receiving misinformation or not being "plugged in" locally, as their news source is primarily from overseas. Workers from the Thai and Burmese communities are connected by closed Facebook groups within their own communities.

While social media can be a powerful channel of communication, it can also facilitate rapid spread of mis- and disinformation.[14] Opportunities to counter this must thus be quickly maximized.

3.2.2.3 Health & Healthcare Access of Migrant Workers

Migrant workers fall outside the jurisdiction of local labour laws with regards to minimum wage, employment mobility and occupational rights such as rest days or vacation. Excessive debt burdens due to recruitment fees ranging from S\$8000 to \$14000 for jobs paying gross monthly salaries ranging from S\$500 to S\$800 impose heavy financial burdens on workers. This is particularly so for South Asian workers, as workers from mainland China often find ways to circumvent the high agent fees.[36]

Low-wage migrant workers commonly work between 12 to 16 hours a day, without rest days or annual leave. They are most concerned about their employment and finances.

As such, beyond COVID-19 related queries, their health-seeking behavior is mostly governed by their ability to pay.[36]

While migrant workers are legally entitled to healthcare provided by their employers and supported by private insurance, they have not been eligible for government subsidized medical care since 2007. Separated from the national UHC (universal health coverage) system, they face barriers to timely and adequate healthcare access.[33]

Among migrant workers, there is evidence of lower perceived need for chronic disease care and reluctance to seek care. While psychological distress is estimated to be 15–20% of migrant workers, there is poor availability of mental health services. High medical costs, employer gatekeeping of healthcare, and vulnerability to repatriation further compound their challenges. Due to social isolation at dormitories, they lack access to effective surveillance and early-warning systems and health services.[33]

High levels of stigma towards mental illness are common in the home countries of migrant workers. This, and the scarcity of mental health services for migrant workers in Singapore amplified needs for focused mental health support, especially during the mass quarantine and lockdown.[37]

3.3 The RCCE Approach in Singapore

3.3.1 Making the shift: A unilateral to participatory approach

The revised COVID-19 Global Response RCCE Strategy recognizes the emphasis on people-centered participatory approaches to RCCE.[3]

As with many countries around the world at the beginning of the outbreak, health messaging in Singapore initially focused on increasing knowledge about preventive measures to reduce COVID-19 transmission and infection.[3] Communication was directive and one-way primarily.

However, as the outbreak evolved and the need for effective RCCE was recognized, individuals comprising healthcare providers from different health clusters and non-profit organizations came together as an organic RCCE working group. It soon became apparent that health messages not only needed to be translated, pictorial, culturally sensitive and contextual, it was most powerful when co-delivered by agents of trust, especially migrant worker leaders themselves. It also became clear that migrant workers needed to be listened to and participate in the messaging being directed at them. Through leveraging on the inherent hierarchy structure in dormitories, migrant worker leaders were excellent sources of information, in person or digitally. When migrant workers were shifted geographically from one location to another due to separation and quarantining of workers based on their test results, social media dissemination became a powerful means of communication. Over time, individuals from the various organizations in the RCCE working group began to appreciate the importance of having a centralized, coordinated nationwide strategy in RCCE that

was rooted in people-centeredness and community-led approaches that improved trust in authorities and social cohesion, with the ultimate effect of minimizing the detrimental effect of COVID-19, as supported by the revised COVID-19 Global Response RCCE strategy.[3]

3.3.2 Why a people-centered, community-led approach matters

The four strategic objectives for RCCE, as set out by the revised COVID-19 Global Response RCCE strategy, are to be community-led, data driven, collaborative, and to reinforce capacity and local solutions.[3] This emphasizes the need for ground-up, participatory approaches to RCCE, for efforts to be adaptive, localized, sustainable, empowering and impactful.

RCCE, when implemented in an integrative manner, can complement, support, encourage and accelerate action by filling information gaps, providing resources and tools for taking action.[3]

When integrated across other biomedical response pillars in humanitarian response efforts, community engagement activities can create strong functional linkages between community-level prevention and other aspects of the response, enhancing their effectiveness.[5] Biomedical solutions can only go so far without the support of communities, especially in the context of COVID-19 where the solutions are currently solely social and behavioural.[38] Without two-way communication platforms between response actors and communities, misinformation, confusion and mistrust can undermine efforts to save lives.[5, 38] Never before has history presented the opportunity like now for RCCE to be integrated collaboratively into the different response pillars to safeguard the health and safety of all.[5, 9, 38]

3.3.3 Rationale for this work

While experience of past outbreaks can and must continue to guide RCCE response efforts, the COVID-19 revised Global Response strategy encourages an openness to innovative solutions, given the evolving COVID-19 situation and emerging data.[3, 5, 39]

The rationale for this practical guidance manual is to illustrate and reflect upon a set of innovative ground-up, participatory RCCE approaches implemented in a large, enclosed setting with diverse migrant worker communities in Singapore during the COVID-19 lockdown in Singapore beginning April 2020, which were informed with the principles of the revised Global Response RCCE strategy. This document draws on principles of community-led, people-centred approaches, and aims to provide a unique case example of RCCE implementation among diverse migrant worker groups in a large, closed setting.

4. Establishing a comprehensive, sustainable self-driven RCCE network

4.1 How did the RCCE service emerge?

Soon after the first cases of COVID-19 positive migrant workers were identified in Singapore, Singapore implemented large-scale institutional isolation units called Community Care Facilities (CCFs) to combat the outbreak in the community by housing low-risk COVID-19 patients, most of whom were migrant workers, from April to August 2020.[40] The CCFs were created by converting public spaces such as exhibition halls into healthcare facilities. They operated via a protocolized system, augmented by telemedicine to enable a low health care worker-patient ratio. In the first month, nearly 4000 patients, most of whom were migrant workers, were admitted to four halls.[40]

Given that Singapore's public health care system is divided into three regional health clusters, each cluster was tasked with operating various community isolation facilities. While operationalizing the set-up was quickly implemented, RCCE for patients was slow to develop. Several ad hoc on-ground efforts were undertaken within each cluster to address communication challenges with migrant workers, including the development of multilingual health brochures, posters and announcements, by healthcare providers serving at the facilities.

As time passed, healthcare providers interested in developing improved communication resources began to form an informal cross-cluster network to pool multilingual resources, streamline resources and avoid duplicative efforts, via sharing a digital cloud of resources.

In May 2020, health workers at CCFs faced communication challenges with migrant worker patients. They requested support via text message from a medical doctor with a background in public health and art. In response, a group of volunteer doctors were galvanised to develop a pictorial, multilingual health booklet to include in a welcome pack aimed at orientating incoming patients.

The urgency of the request prevented formal intervention development work and necessitated the assistance of a local non-profit organization to overcome bureaucratic print processes. The booklet was rapidly developed based on understanding the unique needs of the patient population, contextual realities of migrant worker living conditions and best available information. The booklet aimed to provide culturally sensitive information and advice during their stay.

“Our on-ground teams were thrilled to know about the resources. It was a wise move that the booklets did not have overt branding by any health institution and were thus perceived to be non-partisan and universal, allowing for easy uptake nationwide.”

—Ms. P, a corporate communications leader from a health cluster

According to stakeholder feedback, the lack of overt branding by any single regional health cluster enabled wide uptake of the booklets across clusters. This was the first widely used single resource across clusters, which initiated conversations and partnerships leading to the formation of what became the RCCE working group.

Individuals from various health clusters, migrant worker non-profit organizations and government authorities who expressed interest in the booklets connected via text messaging groups and email chains to form the first RCCE working group, which consulted one another, provided feedback and networked strategically to discuss RCCE plans ahead.

One member of the local steering committee reflected that while it seems that the non-partisan branding of the resources helped to amalgamate the initial RCCE working group, it was in fact the “multi-partisan” and inclusive approach it took that led to its wide uptake and galvanizing of various stakeholders.

“The unique thing about this particular movement was to see all the Regional Health Clusters coming together and backing it up. In usual circumstances, the institutions would all try to outdo one another. But these resources had everyone’s logo on it. It gave the Regional Health Clusters a common platform. Senior leadership was happy for us (doctors from different health clusters) to contribute without question, and gave all their support, which was very heartwarming.”

—HR, Local steering committee member, Tamil speaking doctor

4.2 How the RCCE service and network operates now

The RCCE service and network has evolved to become “My Brother SG”, a network of local partners passionate about “engaging and empowering migrant workers in Singapore for a better tomorrow”. It offers a networking platform bringing migrant-worker related authorities (Ministry of Manpower and Ministry of Health), health institutions and non-profit organizations together to close gaps, avoid duplicative efforts, and align goals for maximal synergy in RCCE.

Currently, representatives from partner organizations meet on a monthly basis to strategize upcoming RCCE efforts, align efforts synergistically and amplify collective RCCE efforts.

The tagline, “Here for your health” reflects its priority to address health issues migrant workers face in three primary areas, namely 1. COVID-19 prevention, 2. Mental health issues and 3. Chronic disease prevention and management.

MISSION:

To ensure a nationally coordinated effort in RCCE (risk communication and community engagement), through effective two-way communication built upon a foundation of trust.

VISION:

A healthy and happy migrant worker community

It functions by:

- Providing a robust networking platform with key partners, including local authorities such as Ministry of Manpower and Ministry of Health, and international partners such as GOARN and WHO through its technical advisory group
- Providing contextualized multilingual, health literate resources for migrant worker outreach
- Providing expertise in health messaging and community engagement for migrant workers

It believes in a “1+1=3” concept, where the collective aligned efforts of multisectoral partners result in a greater outcome than the sum of its parts.

4.3 A Conceptual Framework and Working Logic Model

Establishing a comprehensive, sustainable RCCE service and network required a working logic model to anchor our processes. This was done methodically through various steps:

1. Feedback on the working logic model was collected through local steering committee meetings, consultative meetings with an international technical advisory group, as well as focus group discussions and key informant interviews with end users and key stakeholders.
2. Detailed notes were taken from each meeting, and the audio recordings were transcribed and translated into English where necessary.
3. Segments of feedback which illuminated various segments of the logic model were reviewed and analyzed.
4. Other key issues that surfaced and emerged through the discussions and feedback sessions which did not code neatly into the logic model were taken into consideration.

5. The analysis was used to describe the programme logic model and to identify gaps and further questions about how the RCCE service and network was working and could be improved upon.
6. The logic model was presented to stakeholders such as the local steering committee, technical advisory group, and government authorities such as Ministry of Health or Ministry of Manpower for feedback.
7. The final working logic model was then updated to describe how the programme works.

4.4 Theory of Change: How does it work?

A theory of change that emerged is that increased levels of participation and engagement in RCCE activities among migrant workers will lead to the community's increased sense of empowerment and autonomy, ability to prevent disease and thus result in increase in not only in reduction in transmission of COVID-19, but also reduction in stigma and improvement in overall well-being, including psychosocial dimensions.

A working logic model with relevant indicators for monitoring and evaluation is indicated as below. Social media analytics to track digital reach, engagements and Likes/Follows were particularly important.

Figure 1. Logic Model to reduce negative impacts of COVID-19 among migrant worker community

INPUTS	ACTIVITIES	OUTPUT	OUTCOMES/IMPACT		
			Short term	Medium Term	Long term
<p><u>Human resources</u></p> <ul style="list-style-type: none"> ○ Project manager/ executive administrator ○ Technical Communications (IT/social media) personnel ○ Graphic Designer ○ Research staff ○ Migrant workers ○ RCCE local steering committee ○ International technical advisory group ○ Student volunteers ○ Resource group volunteers <p><u>Physical resources</u></p> <ul style="list-style-type: none"> ○ Funding ○ Office ○ Print materials ○ Writing and craft materials ○ -Communications materials for advocacy, branding ○ Training materials for mobilisers 	<ul style="list-style-type: none"> ○ Conducting baseline activities such as SWOT analyses, focus group discussions, KAP surveys etc ○ Delivery of RCCE programme via tailored provision of information products (booklets, posters, webinar, podcasts etc.) and participatory workshops.) ○ Setting up a strong RCCE team comprising volunteers and staff ○ Capacity building through migrant worker ambassadors programme, training of mobilisers etc. 	<ul style="list-style-type: none"> ○ # of hard and digital copy booklets and posters printed and distributed ○ # of audio messages produced ○ # of points -of-contacts (POCs) disseminated to ○ # of online downloads ○ # of Follows/Likes ○ # of digital engagement (shares/questions/comments) ○ # of viewers for online videos produced, length of view time ○ # of views ○ # of FB Live programs conducted ○ # of Live viewers ○ # of total views ○ # of face-to-face engagements conducted ○ # of health ambassadors trained ○ # of training videos produced ○ # of views of training videos ○ # of engagements conducted after watching video 	<ul style="list-style-type: none"> ○ Increase # of migrant workers receiving health literate, culturally competent health information regularly ○ Increase # of migrant workers who have increased health awareness and enhanced understanding of COVID-19 (how to prevent spread and to protect individual/group health) ○ Migrant workers feeling more empowered and having greater agency ○ Increase # of migrant workers who know when to seek help ○ Increase # of migrant workers who seek medical help appropriately ○ Increase # of mobilisers, volunteers and advocates equipped to engage migrant workers constructively ○ Greater alignment in RCCE goals ○ More, structured, consistent and streamlined health communication messaging ○ Better coordination in RCCE implementation 	<ul style="list-style-type: none"> ○ Increase in proportion of migrant workers who know how to prevent spread and to protect individual/group health ○ Increase in proportion of migrant workers who practice chronic disease prevention and management ○ Increase in health service utilization by migrant workers ○ Increase in trust and rapport between migrant workers and health authorities 	<p>Reduction of negative impacts of COVID-19 among migrant worker community</p> <ul style="list-style-type: none"> ○ Decrease in COVID-19 transmission rates among migrant workers ○ Decrease in chronic disease among migrant workers ○ Decrease in suicide and self-harm rates among migrant workers ○ Increase in overall well-being, autonomy and empowerment of migrant workers

<p>Strategic positioning</p> <ul style="list-style-type: none"> ○ Stakeholder buy-in from senior leadership of various health and migrant worker related organizations ○ Strong partnerships with government ministries, health clusters and non-profit organizations ○ Trust between partner organizations and within the RCCE local steering committee ○ Good leadership and standard operating procedures within RCCE team 	<ul style="list-style-type: none"> ○ Governance through regular local steering committee and technical advisory group meetings that include migrant workers ○ Advocacy activities through physical outreach, attending closed-door ministerial feedback sessions, research papers, reports and publications produced 	<ul style="list-style-type: none"> ○ # of meetings conducted ○ # of stakeholders present ○ # of outreach activities ○ # of ministerial sessions ○ # of research papers, reports and publications produced 	<ul style="list-style-type: none"> ○ Heightened awareness of RCCE as a response pillar ○ Increased awareness of importance of social science research in RCCE and outbreak control 	<ul style="list-style-type: none"> ○ Reduction of variability and improvement in consistency and quality of RCCE efforts ○ Strengthened network of RCCE partners ○ Increased support and funding for RCCE research and RCCE programs 	<ul style="list-style-type: none"> ○ Strengthened and integrated RCCE approach across all response pillars to enhance outbreak control and prevention ○ Robust social science research services to support future outbreak control and prevention work
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4.5 Establishing a Project Structure

4.5.1 Acknowledging the RCCE Gap

RCCE is a novel concept to many in and outside of outbreak response. There was confusion over its role with dormitory operators, many in government circles and those supporting the overall dormitory response regarding communications as “nice to have” and useful for mental health.

RCCE efforts were mostly poorly coordinated, especially initially, and was fronted by non-governmental organizations (NGOs) and individuals volunteering from government ministries and health service providers. In a traditionally paternalistic healthcare and governmental system such as that in Singapore[41], it was also challenging to encourage mobilisers to move away from traditional paternalistic, authoritarian educational one-way approaches, towards people-centred, community-led community engagement approaches. It was rapidly realised by the informal RCCE working group that pictures and accurate translations were key, distribution had to be multimodal and two-way dialogues were necessary for effective RCCE.

4.5.2 Creating an Enabling environment for RCCE

Advocating the essential nature of RCCE as a core outbreak response pillar to slow transmission and minimise morbidity and mortality was critical. An enabling environment for RCCE to thrive was imperative to the germination of the RCCE service and network.

4.5.3 Evolution of the Singaporean Strategy

Due to challenges such as the lack of existing RCCE awareness, structure and leadership, steps to implement RCCE programmes seldom occurred chronologically. This section below details the steps recommended to get RCCE efforts off the ground in the midst of an outbreak, based on research gathered from focus group discussions and key informant meetings.

4.5.3.1 Logic Model

LOGIC MODEL: INPUTS

Besides strategic positioning, other key inputs in our logic model include human and physical resources:

Table 1. Inputs to Logic Model for RCCE with migrant worker population

1. Strategic positioning:	2. Human resources:	3. Physical resources:
<ul style="list-style-type: none">○ Stakeholder buy-in from senior leadership of various health and migrant worker related organizations○ Strong partnerships with government ministries, health clusters and non-profit organizations○ Trust between partner organizations and within the RCCE local steering committee○ Good leadership and standard operating procedures within the RCCE team	<ul style="list-style-type: none">○ Project manager/ executive administrator○ Technical Communications (IT/social media) personnel○ Graphic Designer○ Research staff○ Migrant workers○ RCCE local steering committee○ International technical advisory group○ Student volunteers○ Resource group volunteers	<ul style="list-style-type: none">○ Funding○ Office○ Print materials○ Writing and craft materials○ Communications materials for advocacy, branding○ Training materials for mobilisers

Strategic Positioning

Acknowledging the RCCE gap and engaging broad high-level stakeholder buy-in proactively and early on in the outbreak, was key in amplifying its presence on-ground. Being able to articulate the critical, added value of RCCE, and being able to demonstrate impact was key.

Once high-level stakeholder buy-in from the various hospital directors, Chief Executive Officers and Chief Operating Officers was sought, their support gave these efforts credibility among medical team leads at the various facilities.

Strategic positioning of RCCE was thus a key input in our logic model framework, comprising:

- Broad and early stakeholder buy-in from senior leadership of various health and migrant worker related organizations
- Strong partnerships between government ministries, health clusters and non-profit organizations
- Trust between partner organizations and within the RCCE local steering committee
- Good leadership driving the RCCE team forward
- Healthy working ethos within the RCCE team
- Clear standard operating procedures within RCCE team

LOGIC MODEL: ACTIVITIES

The activities involved in the set-up of the RCCE programme included:

- Delivery of RCCE programme via tailored provision of information products (booklets, posters, webinar, podcasts etc.) and participatory workshops.
- Setting up a strong RCCE team comprising volunteers and staff
- Capacity building through migrant worker ambassadors programme, training of mobilisers etc.
- Governance through regular local steering committee and technical advisory group meetings that include migrant workers
- Advocacy activities through physical outreach, attending closed-door ministerial feedback sessions, research papers, reports and publications produced

LOGIC MODEL: OUTPUTS

Key indices developed from these activities included:

- Numbers of hard and digital copy booklets, posters and collaterals distributed
- Number of downloads of digital copies in various languages online
- Number of social media engagements
- Number of stakeholder and local steering committee meetings conducted
- Number of face-to-face engagements and outreach activities conducted

However, there were limitations to several of these indices.

For example, while government authorities agreed to disseminate the resources digitally to dormitory operators, there was no efficient or technologically-savvy way to track the dissemination of these messages from the dormitory operators to the migrant workers.

While several hard copy booklets were given out as a preferred mode of communication voiced by migrant workers, several roadblocks were faced when many organizations maintained that digital dissemination was sufficient, since they did not have manpower to distribute the hard copies.

The indices were thus used as a proxy of engagement and continues to be refined as the programme grows.

LOGIC MODEL: OUTCOMES AND IMPACT

Short term goals include:

Migrant worker-related goals:

- Increase in the number of migrant workers receiving health literate, culturally competent health information regularly
- Increase in the number of migrant workers who have increased health awareness and enhanced understanding of COVID-19 (how to prevent spread and to protect individual/group health)
- Migrant workers feeling more empowered and having greater agency
- Increase in the number of migrant workers who know when to seek help
- Increase in the number of migrant workers who seek medical help appropriately

RCCE-related goals:

- Greater alignment in RCCE goals
- More, structured, consistent and streamlined health communication messaging
- Better coordination in RCCE implementation
- Heightened awareness of RCCE as a response pillar
- Increased awareness of importance of social science research in RCCE and outbreak control

Medium term goals include:

- Increase in proportion of migrant workers who know how to prevent spread and to protect individual/group health
- Increase in proportion of migrant workers who practice chronic disease prevention and management
- Increase in health service utilization by migrant workers
- Reduction of variability and improvement in consistency and quality of RCCE efforts
- Strengthened network of RCCE partners

Ultimate long-term goals include:

Reduction of negative impacts of COVID-19 among migrant worker community

- Decrease in COVID-19 transmission rates among migrant workers
- Decrease in chronic disease among migrant workers
- Decrease in suicide and self-harm rates among migrant workers
- Increase in overall well-being, autonomy and empowerment of migrant workers
- Strengthened and integrated RCCE approach across all response pillars to enhance outbreak control and prevention

- Robust social science research services to support future outbreak control and prevention work
- Increased support and funding for RCCE research and RCCE programs

5. Early Development of RCCE in the Dorm Response

5.1 Messy Realities at the Start

As with any novel outbreak, processes take time to fall into place.

The uncontrolled spread of the outbreak among migrant worker communities meant needing to produce critical outputs before processes.

Even before a system was put in place, there were on-ground requests by healthcare workers working at community isolation facilities for culturally sensitive, health literate resources in various languages bridge the communication gap with migrant workers situated in dormitories, community isolation facilities, as well as those awaiting swab test results at swab isolation facilities. Health workers were concerned regarding rising anxiety among migrant workers due to language barriers, misinformation and fear of the unknown leading to self-harm and suicide incidents.[42]

The immediate need was to provide information. However, no team, leadership structure or funding was in place so we improvised in the following way: volunteers from the local medical school and general public were recruited through a small local non-profit organization to translate and develop the health resources, with input from infectious disease specialists and healthcare providers serving at the community isolation facilities.

In starting with a product, we suddenly realized all the gaps.

The system was thus put in place through the doing.

These steps and gaps included conducting a rapid SWOT analysis, establishing baselines, curating content, establishing a variety of distribution channels and communication modalities to use, how to engage key stakeholders from other non-profit organizations, healthcare clusters, and high-level ministries, how to recruit manpower and how to expand our reach to migrant workers in non-purpose built dormitories such as factory-converted dormitories (FCDs) and construction temporary quarters (CTQs).

To develop our initiative, these steps were crucial:

1. Conducting a SWOT analysis
2. Undertaking KAP research to establish baselines
3. Curating and developing content
4. Establishing a variety of distribution channels and communication modalities to use
5. Engaging key stakeholders from other non-profit organizations, healthcare clusters, and high-level ministries (i.e. Ministry of Health, Ministry of Manpower)
6. Recruiting manpower to form a team comprising staff, hired translators and volunteer
7. Expanding outreach to migrant workers in non-purpose built dormitories such as factory-converted dormitories (FCDs) and construction temporary quarters (CTQs).

While it is now clearer how the service operated, the unpredictability of a crisis meant that at the outset the processes were unclear, and people had to work with limited pre-existing infrastructure, little manpower or funding.

“Success in this area requires a tolerance for uncertainty and unpredictability, as well as for holding the vision and conceptual framework in mind, and delivering that through providing leadership and creating structures.”

Learning to fail forward was a precious lesson, since challenges cropped up unexpectedly and unpredictably in unusual circumstances.

Example 1:

For example, in trying to produce the first pilot print of 20'000 health booklets, it took ten days. Typeface issues between different computer systems for languages such as Bengali and Burmese were common; printing companies were given strict constraints during the nationwide partial lockdown period known as “circuit breaker” and not allowed to work weekends; bureaucratic procurement processes within health institutions meant being unable to award print jobs and obtain funding swiftly.

As such, it was critical to leverage creatively on other means to reach the end.

Collating orders for the second print even before the first print was out, collating feedback via digital versions from migrant worker contacts, garnering volunteers from non-health institutions such as non-profit organizations or companies forced to stop work, reaching out to private donors for funding and bypassing institutional red tape by contracting print companies directly were solutions.

Example 2:

Another challenge was illustrating the migrant worker cartoons in a way that was culturally relevant and sensitive. While some ethnic groups wore distinctive wrap skirts and had distinct facial features such as facial hair, others did not and it was important to keep the illustrations accessible to a variety of groups. In the end, a variety of migrant worker characters with different features were used, with a bias towards Bengali and Tamil workers, who comprised the large majority of migrant workers in Singapore.

Pencilled draft illustrations and digital drafts of the booklets were shared via text messaging with informal migrant worker contacts to gain feedback. Where this was not possible, feedback was obtained from Singaporean resident volunteers who shared the same country of origin as the migrant workers.

People demanded communication resources. They were produced with challenges, but they were delivered nonetheless.

Leadership was critical. It was important to keep forward looking, and maintain a spirit of encouragement and enthusiasm, especially when most of our team comprised student volunteers and volunteers from the general public.

A common vision to “help our migrant brothers”, stemming from the motivations underpinning the need for social justice, was key. This was revealed in several volunteer applications and focus group discussions.

This became the glue that gelled complete strangers together to work proficiently, amidst challenging circumstances and demanding deadlines.

5.2 Understanding the Landscape

Understanding the context of the outbreak response was crucial.

It was critical to assess the working structure and hierarchy of different actors, their ground level priorities, and constraints in order to better prioritize which relationships to build upon and how to leverage existing opportunities for RCCE efforts.

In our situation, it was helpful to understand the roles of the medical personnel, non-profit organizations, and how the FAS (Forward Assurance and Support) teams and Assurance, Care, Engagement (ACE) teams, comprising police officers and personnel from Ministry of Manpower respectively, partnered healthcare providers and dormitory operators to meet the needs of migrant workers.

In hindsight, a SWOT analysis would have been immensely useful.

A rapid SWOT analysis (Table 1) can help with strategic decision-making during crisis and assist with navigation of power dynamics to facilitate partnerships and buy-in. Understanding the roles of the FAS teams and healthcare providers on-site helped facilitate the implementation of RCCE programmes since it was crucial to obtain their support, buy-in and in many instances, manpower help. This analysis helped inform decision-making and action such as assessing readiness in RCCE implementation and obtaining stakeholder buy-in.

Table 2. Example of SWOT analysis of dormitory site to inform design of RCCE efforts

	Helpful	Harmful
Internal factors	Strengths	Weaknesses
Internal factors are strengths and weaknesses.	<ul style="list-style-type: none"> ○ Many healthcare providers on-site were volunteers who were highly motivated to go beyond their call of duty. ○ Good relationships were built between medical teams, FAS teams and dormitory operators, allowing for combined efforts in RCCE engagements, reducing the extra workload for all. ○ Internal dormitory resident hierarchies were in place to support in identifying by requesting the room and floor leads of each facility to gather together, socially distanced, for engagements. 	<ul style="list-style-type: none"> ○ Medical personnel and dormitory operators were often overwhelmed with ground needs. ○ Medical students and members of the public were not encouraged to help, even with socially-distanced RCCE efforts. ○ Weakened levels of organization amongst migrant workers, due to reorganization of their living spaces.
External factors	Opportunities	Threats
External factors are threats and opportunities.	<ul style="list-style-type: none"> ○ The recruitment of swabbers made it possible for the medical teams to be less overwhelmed and possibly engage in conducting RCCE activities. ○ Various NGOs were producing different kinds of health communication resources which could be used. ○ A few migrant workers were contributing to the development of some communication materials. ○ Some migrant workers had connections and experience in engaging with local non-profit organizations. 	<ul style="list-style-type: none"> ○ Dormitories with recurrent waves of infection had to undergo mass swabbing exercises which wiped out any potential manpower on-site for RCCE activities. ○ Dormitory operators began to tire with never-ending responsibilities of meeting the basic needs of sometimes thousands of migrant workers. ○ Some migrant workers lacked access to resources to meet even basic needs or address transmission.

Based on the team’s experience, understanding the strengths, weaknesses, opportunities and threats unique to each site was key to the success of starting any RCCE efforts. Generally, sites with good control of the outbreak, good leadership management, strong beliefs in the importance of RCCE and adequate manpower were more motivated to engage in RCCE activities. Sites with

poor control of the outbreak, chaotic leadership structures, scepticism towards the value of RCCE and insufficient manpower to run day-to-day operations were most resistant to RCCE efforts.

Nonetheless, one of the challenges across the different sites was coordinating RCCE efforts, since each site had different challenges, thresholds of comfort and leadership. For example, while some sites paid migrant worker leaders stipends to be health ambassadors and go room-to-room sharing health messages, others preferred not to risk spread.

At the initial part of the outbreak, RCCE efforts varied widely.

A SWOT analysis at each site helps one to assess the landscape and its receptivity to RCCE efforts.

5.2.2 Understanding the Migrant Worker Community

Understanding the perspectives, concerns, priorities, aspirations, strengths and experiences of migrant worker communities was critical. Conducting ground surveys, however informally, working with internal hierarchies among dormitory residents and mapping media consumption channels among different cultural groups were important steps to understanding the needs of the diverse migrant worker communities.

Migrant worker non-profit organizations were also a valuable resource, as many of them had valuable experiences and insights to share regarding modes of communication and expected receptivity.

5.2.2.1 Surveying the Ground

KAP Surveys:

Knowledge, Attitudes and Practices (KAP) surveys at two different dormitories with a total of three groups of 12 men each, were done as part of consultation with migrant workers by assessing their baseline knowledge, attitudes and practices for development of the booklet. At each location, printed surveys in Bengali, Tamil and Mandarin were given to a sample size of 12 men of each language. A translator and medical doctor supported each language group together, through each question.

A wider KAP was not possible due to manpower shortage.

Key findings: Knowledge of social distancing and hand hygiene practices were excellent. Approximately half the workers at both sites correctly identified that COVID-19 is predominantly transmitted through aerosol transmission. They were not aware of asymptomatic transmission and

were unaware of potential transmission via contaminated surfaces. Handwashing and social distancing practices were reported to be good. Attitudes were measured using a 5-point Likert scale. At both sites, workers had mixed feelings about the quarantine, with some expressing more frustration than others. Workers were ambivalent about their capacity to protect themselves. Nearly all expressed great trust in the Singapore government and the healthcare system to take care of them. The KAP surveys informed the intervention illustrated and written content. Given the opportunity to refine the questions, investigating their trusted resources of communication and literacy levels would have been appropriate.

Pros:

- This was a rapid assessment of ground knowledge, attitudes and feedback, through which health communication resources could be adjusted.

Lessons learned:

The limitations of this approach were obvious:

- Ideally, each man would complete the survey independently, with a professional translator accompanying him. However, due to the shortage of manpower, this was the best that could be done.
- Ideally, pre and post surveys would be done, in larger numbers across more sites, to achieve statistical significance.

5.2.2.2 Working with Local Hierarchies

For RCCE efforts, it is essential to work with existing community structures, where these structures are trusted sources of organization and information.

Inherent in every dormitory are existing hierarchies among migrant workers which were active partners for designing and implementing RCCE efforts. Every room has a room lead, and every floor, a floor lead, who is a migrant worker leader in some operational capacity such as in disseminating important information from dormitory operators or maintaining the area's cleanliness. Leaders are usually identified if they have a good command of English, have spent many years in Singapore, have good conduct, and who hold a supervisory role at work.

While room and floor leads naturally became the points of contacts at food collection points daily, they also quickly became part of a communication chain utilized by dormitory operators, FAS/ACE teams and medical personnel. At some sites, floor leads were even appointed as ambassadors to distribute food, disseminate information room to room or function as translators. Some migrant worker leaders were also engaged on a regular basis in face-to-face engagement sessions, socially-distanced and wearing masks, to hear their feedback, address concerns and answer questions. In return, they were given a small stipend. In some instances, healthcare providers created outreach teams comprising volunteer native speakers and doctors to obtain feedback from migrant workers via telephone, to share with relevant authorities.

Pros:

- Working with existing hierarchies was helpful, given many of these room and floor leads had contextual insight of challenges, and had the respect of their contemporaries.

Lessons learned:

- Initial communications were done in English and faced poor receptivity due to lack of understanding.
- At some sites, where movement of men to segregate those with infections from those without was significant, room and floor leads were appointed and reappointed arbitrarily.
- Utilization of a communication chain

5.2.2.3 Mapping Media Consumption Channels

While dormitory operators favored the used of free online text messaging services such as WhatsApp, community isolation facility staff favored the use of another similar service called Telegram, and Ministry of Manpower favored the use of PDF bulletins sent to dormitory operators via email, it was clear that RCCE efforts needed to be more user-centric.

Upon consultation with various non-profit organizations, the digital main avenues of communication for each language group were established.

Language groups	Main Modes of Communication
Bengali	Facebook, IMO (a text messaging service with audio and video functions)
Tamil/Hindi/Telugu	Facebook
Chinese	WeChat
Thai/Burmese	Facebook groups

While these communication channels were not penetrated at the early phases of the outbreak, these served as informative channels upon which a digital marketing campaign was built upon later.

5.2.3 Understanding Other Actors and their Priorities (i.e. enabling environment)

As with any outbreak response situation, the on-ground realities can be challenging. With a diverse number of actors each pursuing their own agenda, it is important to gain insight into their priorities, to help one navigate their current approaches and capacity to engage in RCCE efforts, and look for areas of collaboration and synergy. This may be done through a stakeholder mapping exercise to understand key stakeholders and what their interests are in engaging in RCCE. While stakeholder mapping in the midst of a crisis may be reactive and intuitive, it can inform engagement and partnerships strategically.

High level ministries such as Ministry of Manpower, Ministry of Health and the Joint Task Force often had high-stake national priorities. It was important to gain their trust by sharing with them

the resources produced, the extensive reach we had with migrant workers, the core concerns and challenges of migrant communities and our willingness to co-develop messages with them, to amplify their health messaging efforts through alternative sources of dissemination.

Health Institutions had corporate marketing concerns and were more willing to adopt new risk communication resources when the branding was non-partisan. For reprints, once trust was gained, health institutions valued the RCCE partnership cemented by having their logos printed on the risk communication resources, and shared on their social media platforms for publicity.

Non-profit organizations often have specific areas of focus and it was important not to duplicate efforts. HealthServe NGO, for example, focused on the provision of mental health services, while the COVID-19 Migrant Support Coalition (CMSC) with help from Its Raining Raincoats, Transient Workers Count Too (TWC2) and Humanitarian Organization for Migrant Economics (HOME), focused mainly on the factory converted dormitories. Kitesong Global worked with the health clusters to produce the multilingual resources and distributed them to the various facilities, with the help of Mercy Relief. While unfamiliar with the outbreak response structure, they were able to contribute with their extensive experience with migrant workers. Combining RCCE efforts and sharing resources was often done collaboratively and non-politically, since each NGO recognized that there was enough work for everyone.

Dormitory Operators had varying priorities. Those at larger, well-organized dormitories had better leadership structures, were often able to cope better with the surge of work, and thus, be better able and more willing to help with RCCE activities. Those overseeing unregulated factory-converted dormitories were often less enthusiastic and did little beyond ensuring the basic needs of their workers were met. It was thus important to gain their buy-in by sharing the perspective that doing more preventative work through RCCE efforts now would save them future inconvenience and financial losses by preventing recurrent outbreaks and extended lockdowns.

Medical teams were often highly motivated as many health care providers on-site were volunteers. Their priority was the well-being of the migrant workers and reducing the number of positive cases. Once the importance of RCCE was communicated to them (for example by highlighting the work they were already doing informally in this area), it was easy to garner their support. Many of them helped to conduct and engage migrant workers in face-to-face engagements, as well as provide feedback to the RCCE working group about on-ground concerns.

Forward Assurance and Support (FAS) Teams from Ministry of Manpower and the police force were committed to the safety and security of the migrant workers. Highlighting to them the value of RCCE being able to allay fears, address concerns and mitigate acts of violence or self-harm was key to gaining their buy-in.

5.3 Getting Stakeholder Buy-In Early

As part of the early phases of the outbreak response, several health clusters and other migrant worker organizations had created their own brand of RCCE resources such as posters and

brochures, with their logos printed on them. This could have been due to a variety of reasons such as structural, operational or funding reasons resulting in each institution creating their own materials. This made adaptation of their materials by other institutions difficult. Reach was thus limited, since institutional branding circumscribed the extent of spread of their resources. RCCE efforts were sporadic, ad hoc and met with duplications.

The planning team had perceived that the health booklets and posters developed were good products to communicate risk and engage migrant workers. They were multilingual, health literate, contextualized, created with migrant workers' feedback and piloted with feedback collected for further improvement. Nonetheless, without nationwide buy-in, their impact would be limited.

Prof. Dale Fisher, chair of the GOARN Steering Committee in Singapore, expressed the need for a coordinated, nationwide health communications effort and recommended proactive, broad engagement of major high-level stakeholders from the various health clusters overseeing the migrant worker facilities nationwide.

A high-level meeting comprising the Chief Executive Officers of the various healthcare clusters was called for, to present to them the importance of RCCE in an outbreak response. Once clear recognition and value of RCCE work was obtained at a high level, connections were made between different clusters to work together. This extended to senior leadership and representatives of migrant worker non-profit organizations, Ministry of Manpower and Ministry of Health. Consultations requesting feedback of RCCE materials via email and teleconference calls, adjusting our approach in response to feedback, offering the resources without charge, offering to include their logos on all resources resulted in trust being built. Updates and feedback from the resource distribution were exchanged in a single email chain connecting various partners, building towards a more centrally coordinated network of RCCE partners.

Stakeholder buy-in appeared to be obtained when organizations began to reach out for more resources, offer feedback, and referred other organizations to our team for requests for additional print runs.

5.4 The Importance of Strategic Positioning

Early stakeholder buy-in from health organizations, authorities and community members, close coordination and planning together partners, proactive two-way communication with community members, conducting ongoing assessments to identify evolving knowledge, attitudes and practices about the community, and ensuring all people groups are reached are known to be essential for effective RCCE.[15]

In particular, the Singapore RCCE experience illustrated the need for leadership in the area of RCCE, tolerance of uncertainty during rapidly evolving situations, a committed understanding of community perceptions, a closely connected network between RCCE working group members, and RCCE leaders who are engaged with community members, such as healthcare providers from common countries of origin and who speak the same language.

Some principles which emerged as being particularly helpful in regards to strategic positioning to optimize successful RCCE included:

1. Broad and early stakeholder buy-in from senior leadership of various health and migrant worker related organizations

“Each person in the team has access to different groups of stakeholders. Making use of each team member’s networks to bring together stakeholders to help with RCCE planning facilitates helps get things done well.”

—Mr. F, representative from government authority

Early in the RCCE response, duplication arose from like-minded groups in different settings but once discovered during meetings comprising diverse stakeholders from various organizations, it was possible to galvanize efforts, centralise resources and leverage on one another’s strengths. Official wellness representatives were appointed at each site of various health clusters to manage RCCE efforts, RCCE activities were made compulsory and RCCE programmes were better coordinated among partners.

2. Diversity in the RCCE local steering committee

“We are strong because we are multidisciplinary- not one group can do it all.”

—Prof Dale Fisher, chair of GOARN Steering Committee in Singapore, RCCE local steering committee member and member of technical advisory group

Diversity in the planning committee enabled different viewpoints to be considered and different strengths to be leveraged upon. This had to be balanced against the trust which had been formed within the team to facilitate best outcomes. Synergy, partnership and teamwork were buzzwords often used at local steering committee meetings to reflect the non-competitive and collaborative nature of the network.

“In fact, I think we can be even more multicultural- we should include more people with rich experiences working in different cultures and contexts.”

—Ms. S, RCCE local steering committee member, Lead of Communications of migrant worker NGO

3. Strong partnerships between government ministries, health clusters and non-profit organizations

It was important to establish the RCCE network as a robust partnership of various stakeholders which would enable leverage on one another's strengths. Since every organization had a slightly different strength in terms of target audience reach, mode of dissemination and approachability for migrant workers, every partner had a part to play.

4. Trust between partner organizations and within the RCCE local steering committee

“Some of us knew each other already before the outbreak and all of us had first-hand, on-ground experience fighting the outbreak among the migrant worker community... it was clear we were all passionate about the same cause (to help migrant workers)- so it was easy to trust each other and collaborate with the information we shared.”

—S, RCCE local steering committee member, Lead of Communications in migrant worker NGO

“Something that has helped us achieve buy-in with multiple stakeholders is the RCCE team not coming across as being exclusive. My Brother SG... the name is very inclusive, the name and entity is very emotive... it reflects the sincerity in our intentions and efforts and that is very important. Also, our friendship within the team goes a long way. It's clear no one wants any self-glorification, we all just want to put our efforts into something collaboratively.

—HR, RCCE local steering committee member, Tamil-speaking doctor

Trust was a key theme which emerged during the focus group discussions, as it enabled different organizations to share information freely and non-competitively without fear of politics, misuse of information or stealing credit.

“Our RCCE network... I would like to liken it to a cafe where people come in, feel comfortable and feel supported or facilitated to do their stuff for RCCE... It's not competitive.”

—MC, RCCE local steering committee member, Bengali-speaking doctor

5. Passion and commitment by RCCE team members

Trust was also reinforced by the theme of a “common passion” among stakeholders to uphold the migrant workers’ well-being above all, expressed through each individual’s willingness to volunteer their own time for this cause, personal enthusiasm and regular attendance in meetings.

“When people with a common vision come together, we are bound by our passions. For this crisis, we were baptized with fire, we banded together with anyone with the same vision, so we became comrades in war. The vision (to help our migrant workers) compelled us to rally together, especially because there was the common sentiment that our brothers have been neglected for a long time. It took a pandemic for us to recognize that their welfare has been neglected. Being on the ground and forefront of the COVID-19 outbreak made it natural for us to want to do this work (in RCCE).”

—HR, RCCE local steering committee member, Tamil-speaking doctor

From the crisis, emerged individuals from various health clusters who were passionate about RCCE work. Friendships with these key individuals led to a process of institutional trust-building, and grew the beginnings of an RCCE working group.

6. Good leadership driving the RCCE team forward

“Thanks to the RCCE team lead’s energy and drive to bring different stakeholders of common interests together regularly, the RCCE network could grow and different initiatives could be rolled out meaningfully... Without strong passion and conviction, it is difficult to deal with so many uncertainties in this area of work.”

—Mr. F, RCCE local steering committee member, representative from government authorities

Other essential leadership qualities of leaders of future RCCE services which emerged from focus group discussions and key informant interviews with members of the local steering committee included:

- Confidence in leading a team
- Need to appear non-partisan and diplomatic amidst different stakeholders
- Need for soft skills, such as empathy, respect, good listening and communication skills

- Openness in hearing and responding to a variety of perspectives and viewpoints and a sense of collaboration
- Commitment to hear the needs of migrant workers
- Flexibility to adapt programmes to evolving ground situations
- Ability to stay positive amidst stressful situations
- Ability to resolve and manage conflicts among people
- Need for creativity
- Need for courage to take risks amidst crisis
- Passion for the cause in RCCE to help migrant workers

Crisis leadership is not easy, to lead a big entity during turmoil is another thing altogether. Our lead is welcoming, non-competitive, people-centric, and is able to connect with migrant workers from various ethnicities. They warm up to her in the videos she speaks in- the support she has won from workers from different ethnicities is amazing. You need someone like that.”

—HR, RCCE local steering committee member, Tamil-speaking doctor

7. Healthy working ethos within the RCCE team

“I admire the openness of communication we have in the team. Voicing out misunderstandings is difficult to do but our team members have exercised professionalism in promptly responding to concerns raised, showing respect for one another.”

—Dr. L, RCCE local steering committee member, Infectious Disease

Focused group discussions within the RCCE team enabled us to discover the ethos that has contributed to successful aspects of the programme. These include:

- Strength in being multidisciplinary, having a variety of stakeholders with different backgrounds, including migrant worker representatives and tapping on one another’s strengths
- A culture of open and honest communication, including willingness to listen to varied feedback, clarify unmet expectations and misunderstandings, treating one another with respect, professionalism, having a flat hierarchy, being punctual for meetings
- A culture of continuous learning and improvement to create better solutions through combined brainstorming
- Commitment and passion to improve the lives of migrant workers

8. Clear standard operating procedures within RCCE team

Standard operating procedures within the RCCE team which emerged included:

- Performing KAP surveys and collating ground level feedback, doing analysis to identify the problem/s
- Defining the strategy for the RCCE programme
- Developing an action plan and implementing it, and evaluating it to find ways of improvement
- Ensuring regular checkpoints to refine or expand certain aspects of the programme, reviewing what has been done, and to improve and learn from the problems encountered
- Ensuring timeliness, accuracy, standardisation of messaging and alignment with government authorities
- Engagement of the entire local steering committee to obtain feedback to ensure a collaborative effort

Areas of improvement which emerged from the discussions included:

- A need to have even more diverse representation of organizations outside of healthcare
- A need to have representatives with greater cultural diversity, especially those from the countries of origins as migrant workers

5.5 The Importance of Creating a Strong RCCE Team from Scratch

Creating posters to recruit student volunteers and graphic designers, inducting them properly, creating a vision and motivational strategies for long-term volunteer engagement to keep the work up at a sustainable pace were plugs in the gaps along the way. This is detailed in our Volunteer Recruitment package (See Annex B).

One might be able to pull off creating one health brochure at the start, but to create edited reprints, more collaterals and build upon a foundation to create enough momentum to drive a health campaign takes more than an individual.

It takes a team, even if it was formed from scratch during the outbreak, to keep the work sustainable and growing.

Here is what we learnt.

1. To Create a Team, Create a Vision

At the start of the outbreak response, no team dedicated to RCCE efforts existed.

In fact, content was drawn from health resources pooled together by a group of doctors serving at a CCF, and re-curated into pictorial format. The entire process required an illustrator, graphic designer, printing services, delivery services, fundraising, collection of

feedback via text or photos taken and closing the loop by updating volunteers, donors and partners involved in the journey.

Most of these individuals did not know each other and volunteered themselves from various sources- non-profit organizations, hospitals, schools etc. As such, a common goal was necessary to draw the right people and to keep them motivated. Drawing up a vision for the future was an excellent opportunity to invite migrant worker representatives to articulate their aspirations and hopes.

MISSION:

To engage and empower our migrant workers to be health ambassadors in their communities

VISION:

Health equality in all aspects of care for migrant workers

Our method was to create critical health communication resources which were culturally-sensitive and health-literate to empower migrant workers to take charge of their own health.

This common mission and vision galvanized our volunteers to work hard under challenging circumstances with tight turnarounds.

2. Commit to Key Principles and Values

Commitment to key principles was another way to keep standards high, amidst a stressful and challenging RCCE environment.

A detailed volunteer form requesting a personal statement, skillsets and an accompanying contract committing to the work also helped to set standards and expectations high. See Appendix B (<https://drive.google.com/drive/folders/1IGCvmkw0i8uj0HsfpZOPTWvFZprjoCze?usp=sharing>)

3. Quality

We hold all our volunteers to a high standard of work. Because every product will be printed and reproduced for tens of thousands of people, we expect the work to be done meticulously to perfection.

4. Timeliness

Timing is everything in risk communication. As such, we emphasize the gift of availability to our volunteers. In the volunteer contract, we expect all volunteers to state their available number of hours per week, and state their commitment to maintaining open communication lines and be prompt to respond to meet deadlines.

5. Service

Service is a value we hold in high esteem, to place others, especially those who are marginalized, before ourselves. This is of great value especially during an outbreak.

6. Humility

Being willing to accept correction is highly valued. We accept mistakes and failures, but prize the ability to learn from them.

7. Flexibility

Working in rapidly-evolving environments during acute phases of the outbreak can be stressful. Staying flexible and adaptable helps to keep the team buoyant, resilient and motivated.

8. Commit to Building Reliable Teams from Scratch

Ideally, one would create a core leadership team and sub-teams that functioned under them. Tight timelines and scarcity of resources, of course, prevented this step-wise approach. As volunteers threw themselves into action, we started most crucially with a 3-person team, comprising:

1. A team lead overseeing the work
2. A student deputy lead coordinating the translation teams
3. A graphic designer overseeing all the visual communication branding

The team lead was in charge of:

- Overseeing the RCCE work
- Creating high-level partnerships, consulting partners
- Collecting feedback from the frontlines on-ground and from subject matter experts
- Fundraising
- Liaising the print and delivery of resources
- Shaping the future of the RCCE team

The student deputy lead was in charge of:

- Recruiting new volunteers and inducting them
- Managing volunteers and assigning them to the various translation groups
- Creating translation templates (See Appendix C) and coordinating the translations for the 8 different languages

The graphic designer was in charge of:

- Typesetting and layouts of all creative resources
- Creating brand identity

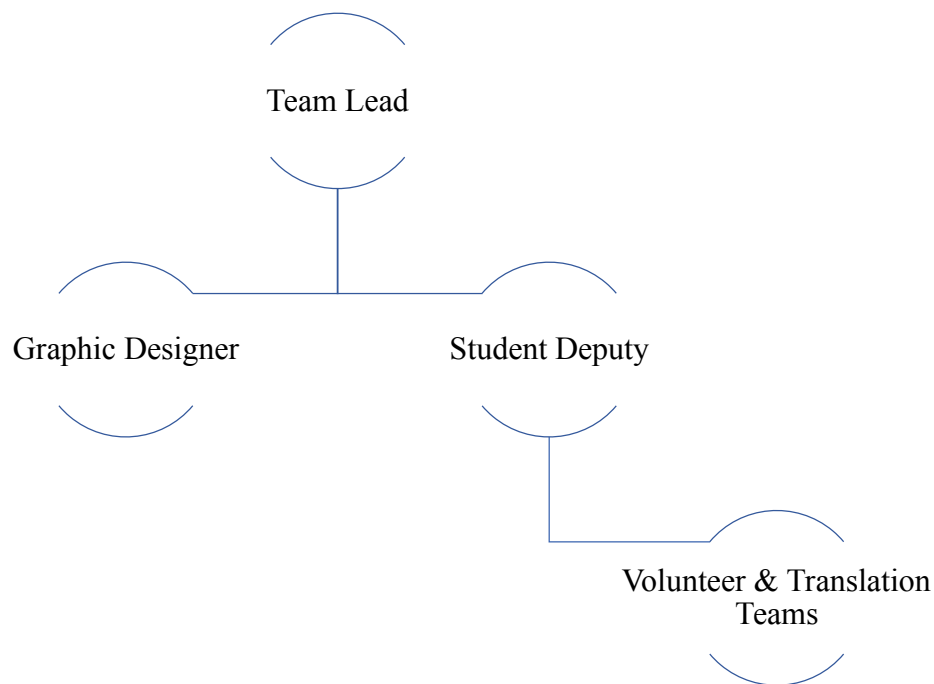


Figure 2. Initial RCCE team structure

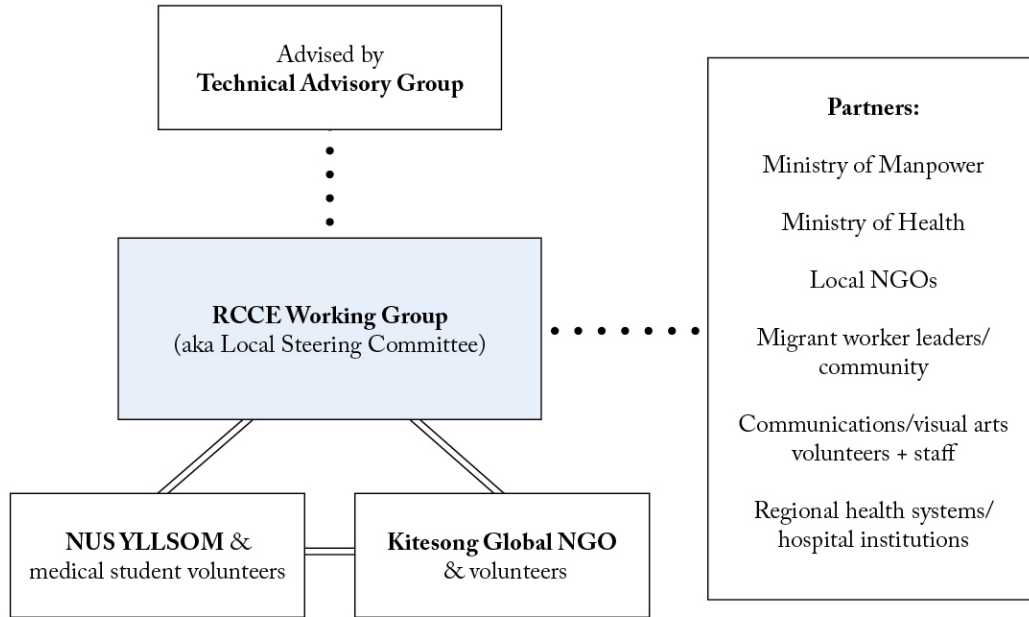
As the work grew, this workable but fragile structure had to renew itself and adopt a more robust structure.

Being a final year medical student, the deputy lead's role in the RCCE team opened a broad door welcoming healthcare students who wanted to play a role in helping migrant workers but were prevented to due to high-level policy restrictions. This gave birth to a heavily student-led initiative which eventually became a formal, school-recognized Global Health Leadership programme led by a student leadership team overseeing the treasury, translation, print resources, digital campaign and administrative aspects of the team.

The voluntary work contributed by the graphic designer from the non-profit organization was justifiably a full-time role, which was first compensated by private donors but later, absorbed as a legitimate cost by the regional health system.

This fragile leadership structure, initially run organically by a passionate group of friends and volunteers, thus evolved into a robust RCCE leadership team comprising Student Engagement Co-directors, an Executive Creative Director, and an Administrative representative operating within a milieu of external stakeholders, a formalized RCCE Working Group, and technical advisory group.

Structure of RCCE Network



Legend:

- • • • Connected to
- ==== Close connection with

Figure 3. Formal Organizational Structure of RCCE Network

9. Work Collaboratively with Partners

With an outbreak of this magnitude, no single entity could accomplish all the work on its own.

What started out as a small effort by a small non-profit organization Kitesong Global, soon grew into a strong and close partnership with the National University of Singapore Yong

Loo Lin School of Medicine, leveraging on its funding, establishment, infrastructure and volunteer pool of medical students.

Conventionally, getting the partnership of all three health clusters and other migrant worker non-profit organizations by a lone non-profit who was new and unestablished would have proved challenging. Miraculously, this came to fruition.

Interestingly, the platform that cemented collective solidarity among all the key stakeholders was a weekly comic initiative called “Keep Hope Alive”.

Humorous and guileless, it was the perfect medium through which stakeholders felt they could endorse with their institutional logo, without cumbersome bureaucracy. The partnership with NUS also brought credibility.

As the weekly comics and existing social media digital engagements snowballed into a digital health campaign called “My Brother SG”, this birthed as a collective nation-wide initiative to engage migrant workers through two-way communication via a social media webpage (www.facebook.com/mybrothersg)

Unexpectedly, the greatest collaboration was with a Bangladeshi migrant worker social media influencer who collaborated with us to conduct regular talk shows on social media, garnering as many as 60’000 views by the Bangladeshi community.

We learned, that every key partner has a sphere of influence. By leveraging on one another’s spheres of influence, we can do so much more.

Other Key Ingredients for Success

1. Commit to nurturing leaders

A commitment to nurture leaders was extremely important. Volunteer turnover was high, since many people joined to help in the acute phase of the outbreak.

Even in an outbreak, invest meaningfully in a few key relationships in your leadership team and commit to nurturing leaders. It will pay off.

However, to maintain the integrity of the ongoing work, commitment to nurture a few key student leaders proved critical to ongoing volunteer recruitment and moving the work

forward progressively. In the bigger scheme of things, this also helped to raise a generation of socially-conscious, globally-minded student leaders with a heart to give back to society.

2. Commit to team rejuvenation

Towards the third month of the outbreak response, the leadership team started to experience burnout. What was helpful was sharing photos of migrant workers enjoying the fruit of their labour from the frontlines. This was not only incredibly rewarding, but empowering. Since many team members had other full-time jobs or academic commitments in school, it was important to release them without feelings of guilt or discouragement. For team members who needed a break, it was important to release them and invite them to handover to a friend who could take over their work. In later phases of the RCCE work when the outbreak was better controlled, it was then important to allow team members regular breaks, rest on weekends and seasons of restoration.

A high volunteer turnover rate, when seen through the lens of team rejuvenation, can be experienced positively.

3. Commit to stay flexible

A commitment to stay flexible enabled the team to adapt to changing situations. During the acute phase of the outbreak, ground needs were continually changing. It was important to stay malleable and adaptable without being frustrated.

Where possible, encouraging your team to have a flexible mindset will stand them in good stead of staying on top of a crisis.

The generalizable lessons from this experience are:

1. It takes a team, even if it is formed from scratch during the outbreak, to keep the work sustainable and growing.
2. Create a common vision to galvanize a team together.
3. Commit to key principles and values decided upon by the team, such as a commitment to high standards of work, flexibility in times of crisis, and humility to learn from mistakes.
4. As the team grows, start establishing structures within the leadership team.
5. Invest meaningfully in nurturing leaders within your team.
6. Experience challenges such as high volunteer turnover rates positively and leverage on them to the situation's advantage.
7. Commit to establishing partnerships to leverage on one another's spheres of influence.

6. Systems Falling Into Place

As the needs for communication resources were met, processes and systems began to fall into place. While the section before describes some of the messy on-ground realities, this section details the workflows and processes of each end product.

6.1 A Multimodal Approach Developing Multimodal Engagement Platforms

Health booklets and posters were first created. But these alone had limitations. A multimodal approach thus grew, ensuring opportunities for two-way communication, feedback and dialogue.

6.1.1 General Challenges and Ways to Overcome them

Here were some general challenges faced in creating these multi-lingual resources, and accompanying tips to overcome them.

Table 3 Challenges and Solutions to create multi-lingual RCCE resources

Challenges Faced	Tips and Advice
<i>Translations</i>	
There was difficulty among translators in finalizing the translations as different individuals had different ways and styles of translating the same content.	<ul style="list-style-type: none"> ○ A translation group leader, whose language style is most similar to what migrant workers prefer, should be assigned.
Difficulties in typesetting were encountered due to multiple rounds of edits made by translators from adjustments made from feedback received, and the graphic designers' inability to understand the different languages. This resulted in wrong placement of translated texts.	<ul style="list-style-type: none"> ○ Clear line-by-line dual-language translation templates should be created with tracked changes, so that the graphic designers can work with placing translated text accurately. ○ See Appendix C for example of translation template. ○ The final translation should be proofread by a migrant worker representative or someone equivalent who has an intimate understanding of the language.
Edits made often required quick turnaround times, resulting in stress placed on volunteer translators.	<ul style="list-style-type: none"> ○ Volunteer translators should be screened for their commitment and availability using a volunteer form (See Appendix D). ○ In the long-term, volunteer translators who display competency should be offered hired roles with a contract.

- A single leader should coordinate the workflow with group leaders in charge of their particular languages.

6.2 Health Booklets

Health workers at CCFs faced communication challenges with migrant worker patients. They requested support via text message. In response, a group of volunteer doctors were galvanised to develop a pictorial, multilingual health booklet to include in a welcome pack aimed at orientating incoming patients. The urgency of the request prevented formal intervention development work. The booklet was rapidly developed based on understanding the unique needs of the patient population, contextual realities of migrant worker living conditions and best available information. The booklet aimed to provide culturally sensitive information and advice during their stay.

Content was drawn from health resources pooled together by a group of doctors serving at a CCF, and re-curated into pictorial format. The illustrations included characters that were friendly, relatable and culturally sensitive, with feedback obtained via migrant worker text messages.

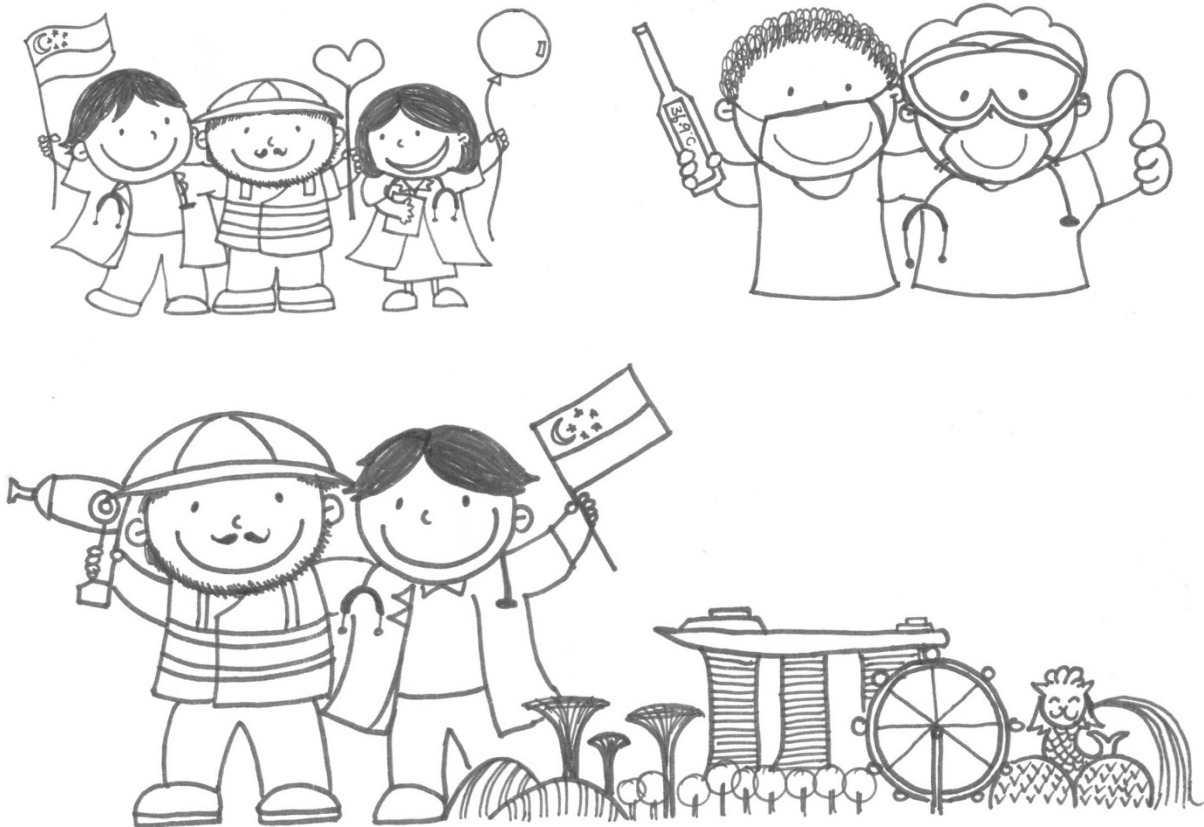


Figure 4. Excerpts from health booklets developed for use at CCFs

Healthcare knowledge was woven into a thematic message of encouragement, echoing Singapore's Prime Minister's speech which stated, "You are one of us, we will take care of you."

Dear Brother,

We know you may be worried or confused.

But remember...

YOU ARE ONE OF US.



WE WILL
TAKE CARE
OF YOU.



Figure 5. Excerpts from health booklets showing inclusive messaging to patients attending CCFs

As shared earlier, KAP surveys at two different dormitories with a total of three groups of 12 men each, were done as part of consultation with migrant workers by assessing their baseline knowledge, attitudes and practices for development of the booklet. A wider KAP was not possible due to manpower shortage. A translator and medical doctor supported each language group together, through each question. Attitudes were measured using a 5-point Likert scale. The KAP surveys informed the intervention Illustrated and written content.

Entitled “Recovering from COVID-19”, the CCF booklet conveyed health information to encourage migrant workers in their recovery and reinforced policy decisions ensuring coverage of COVID-19 related medical care.

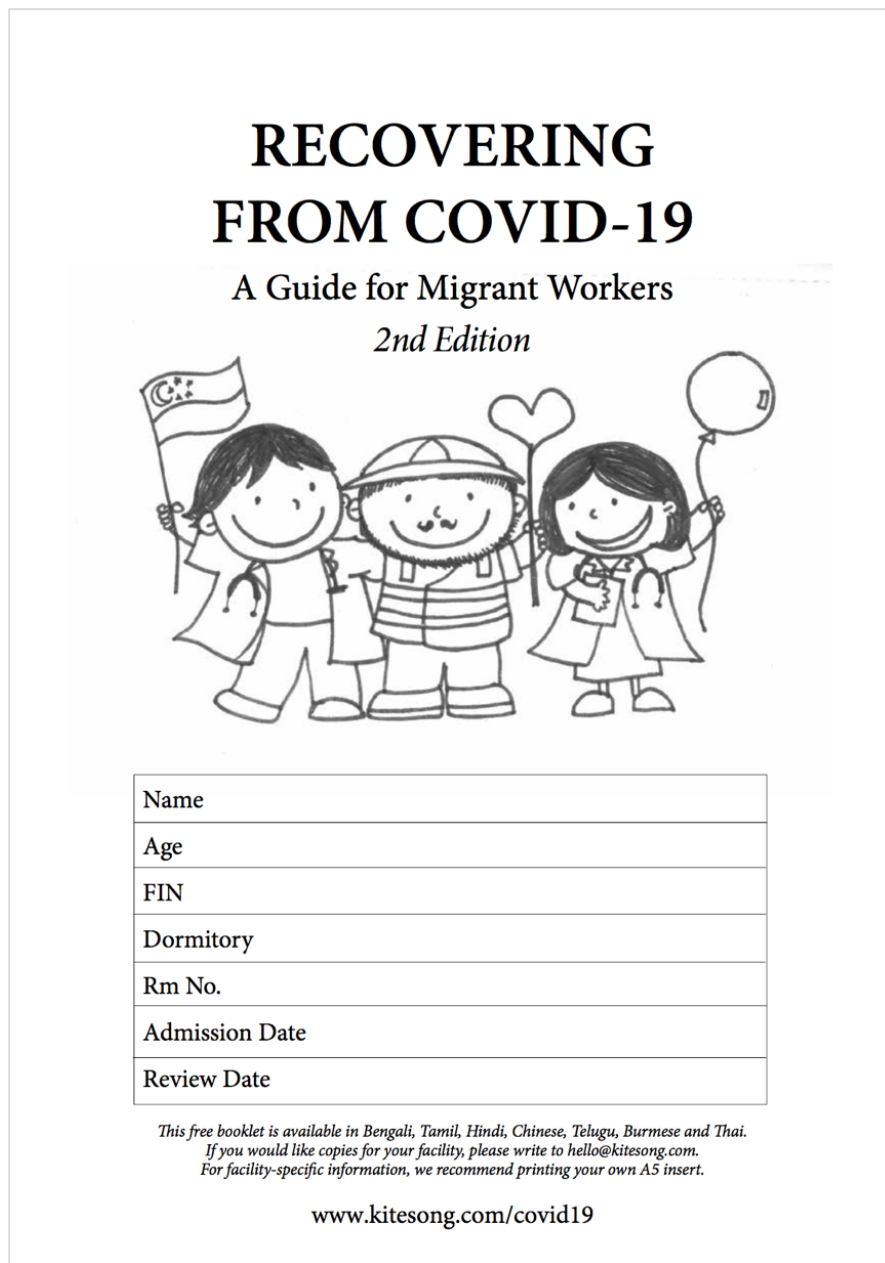


Figure 6. Cover page of CCF patient booklet

The CCF booklets were a key component of the intervention package. They were modified and customized to other types of migrant worker residential facilities. The booklets were aimed at migrant workers at dormitories, those awaiting test results and those who had tested positive and were isolated in Community Care Facilities. They were translated into seven languages favoured

by the foreign workers: Bengali, Tamil, Hindi, Mandarin, Burmese, Thai, Telugu. A distinguishing cover was developed for each of the three versions, with illustrations conveying a strong sense of community, relatedness and engagement, drawing elements from objects and infrastructure from their living quarters to ensure contextualization and relatability.

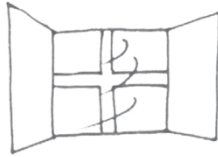


Figure 7. Multilingual presentations of CCF patient booklet

Content and illustrations were created in consultation with frontline healthcare professionals to align the messages with national guidelines including the latest advice, with migrant workers in-person at dormitories.

Figure 8. COVID-19 health and emotional support messaging in CCF patient booklet

How can I protect myself and others?



Keep your room well ventilated.



Cover your mouth with tissue when you cough or sneeze.



Throw your used tissue in a bin, then wash your hands.



Don't shake hands.



Don't touch your face.



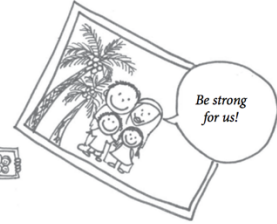
Disinfect common surfaces like door handles and light switches frequently.



Avoid touching common surfaces like door handles and railings.

Stay Mentally Strong

Stay connected with your loved ones!



Listen to music, watch videos.



Pray or meditate. But keep a metre apart from others.

Don't mingle with men from other rooms.



Read only reliable sources. Filter out rumours. Stay hopeful!

All versions addressed the distress migrant workers might have felt due to the quarantine, testing and relocation, conveying a sense of emotional validation and empathy. All versions also emphasized health messages including social distancing, masks and hygiene habits.



Behind our masks,
Are friendly faces.

You are not alone.

WE ARE FIGHTING COVID-19 WITH YOU.

You have COVID-19
but it is mild.

We expect you will recover fully.

This is a safe place
for you to recover,
so that you will not
spread it to others.



Figure 9. COVID-19 messaging in excerpts of CCF patient booklets

Entitled “How to Protect Yourself from COVID-19”, the dormitory version emphasized key messages such as recommending that men not mingle with those from other rooms and to avoid praying in close proximity, providing explanations why. These messages arose from on-ground feedback, based on the workers’ behaviours and cultural practices.

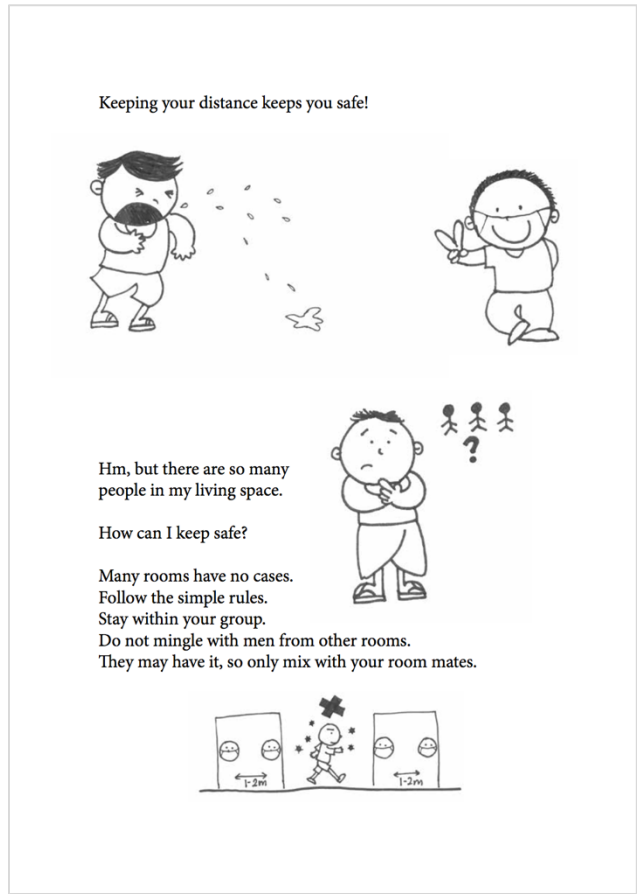
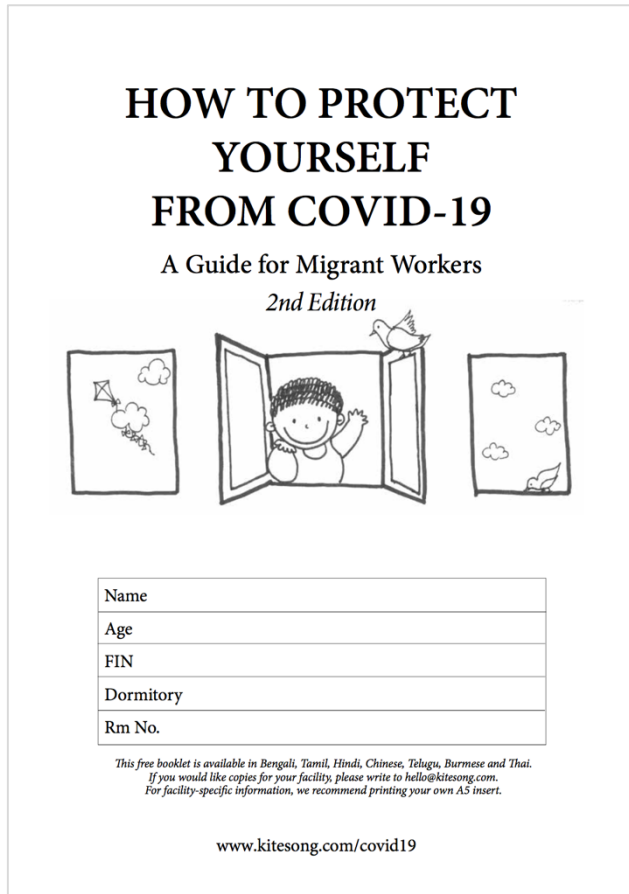


Figure 10. COVID-19 Prevention messaging in CCF patient booklets

Entitled “Awaiting your test results”, the booklet addressed the uncertainty during awaiting test results and communicated the implications of the result.

Engagement was done early with the other healthcare institutions to ensure stakeholder buy-in. A pilot print of 20,000 booklets was distributed across the three Regional Health Systems in Singapore for distribution to the various facilities. The booklets were updated to keep pace with the rapidly evolving policies in swab and serology testing and with feedback received. Four print runs of 90,000 booklets in total were distributed in hard copy across Singapore. They were also disseminated via a freely available phone messaging application by Ministry of Manpower to facility operators.

6.2.1 Workflow: Broad Principles

For all resources produced, the broad principles we adopted were:

1. Close engagement of migrant workers at every stage

- Always assess community needs and aspirations.
- Seek migrant worker feedback and consultation during early stages, such as the draft phase of illustrations and content creation
- Seek their feedback at all stages, in particular, post-translation, to ensure language nuances are preserved.
- Where possible, encourage their direct participation on a leadership level such as their involvement as broadcasters, co-hosts, judges in online contests etc to encourage empowerment and sustainability.
- While feedback might be difficult to obtain on a large scale during the outbreak, individual feedback, where possible, may be sought rapidly for quick content adjustment.
- Steps can be taken to obtain widespread feedback on RCCE resources via online surveys at a later stage, as in our case.

2. Early engagement of stakeholders

- Keep high level stakeholders, especially those from health institutions and relevant government ministries closely updated.
- Seek their input and advice early.
- Intentionally build relationships with key actors to build trust.

3. Pilot before scaling up

- First-time implementations are key learning events.
- Assess wins and losses quickly before repeating or scaling programmes up.

For specific workflow on producing health booklets, see Appendix E.

6.2.2 Challenges and ways to overcome them:

Table 4. Summary of challenges and corresponding solutions when developing patient health booklets

Challenges Faced	Tips and Advice
<i>Obtaining Orders from facilities</i>	
Dormitory operators declined booklets, due to the reasons of being overwhelmed and facing shortage of manpower to distribute booklets. Many voiced preference for digital means of distribution instead of physical copies, due to convenience.	<ul style="list-style-type: none"> ○ Build relationships with dormitory operators early and win trust. ○ Help dormitory operators troubleshoot bottlenecks and offer solutions. In many dormitories, this was easily overcome by distributing booklets at food collection points. ○ Share results from initial feedback collected, about migrant workers feedback on preferences for physical booklets, and the fact that not every worker has a smartphone.

Difficulty in ordering booklets in correct languages the right quantities due to lack of information.	<ul style="list-style-type: none"> ○ Work closely with dormitory operators to obtain estimated demographic profiles in each dormitory.
<i>Printing</i>	
Bureaucratic procurement processes from health institutions created bottlenecks.	<ul style="list-style-type: none"> ○ Streamline procurement processes ahead of time. ○ Prepare a backup strategy.
Printing took longer than expected due to quarantine and work closure constraints.	<ul style="list-style-type: none"> ○ To minimize the risk of delay, divide the print orders among 2 or 3 print companies.
<i>Delivery and Distribution</i>	
Manpower shortages in distribution of health booklets	<ul style="list-style-type: none"> ○ Leverage help from other non-profit organizations and volunteers.

6.3 Posters

Six different kinds of posters were developed and translated into three other languages: Bengali, Tamil and Mandarin. The six posters contained reinforcements of health messages in the booklets, as well as messages of problematic areas that needed to be addressed.

23,000 copies were distributed island-wide to various facilities. To facilitate participation and ownership migrant workers were encouraged in posting them at popular sites including corridors and pillars near supermarket and automatic teller machine queues.

These booklets and posters drew on 160 volunteers from a non-profit organization to translate, typeset, print and coordinate distribution of the booklets. Stakeholder engagement with various regional health systems revealed that the non-partisan branding of the booklets was a draw factor for different health institutions across Singapore to adopt the booklets.

For specific workflow on producing posters, see Appendix F.

6.3.1 Challenges and ways to overcome them

Table 5. Summary of challenges and corresponding solutions when developing posters

Challenges Faced	Tips and Advice
Facilities receiving the posters were already overwhelmed with the outbreak response and found it difficult to put the posters up.	<ul style="list-style-type: none"> ○ Engage on-ground stakeholders and build relationships and trust early. ○ Help brainstorm ideas to relieve facility managers of work, such as having migrant workers paste the posters up in their rooms and common areas, which also empowered them to take ownership.

Facilities received several posters from different organizations.

- Create a non-partisan branding for the posters for easy uptake.
- Persuade on-ground stakeholders to adopt the posters as an extension of the health booklets, to reinforce health messages and create a campaign around them.

6.4 Face-to-face Engagements

While the health booklets and posters were well-received, they lacked an important personal component and a capacity for two-way communications. The empowerment of workers to engage in the outbreak response was limited with hard copy written materials and they were not nimble enough to deliver large scale rapid communications that were often required.

The hard copy booklets and posters paved the way and became a tool for active engagement and empowerment, through which conversation and then action could be launched via face-to-face, digital and social media platforms.

6.4.1 Development Process

The shortage of manpower dedicated to RCCE efforts prevented wide uptake of face-to-face engagements at the start. Through stakeholder engagement of senior leadership across health clusters, credibility and trust was built to start delivering some form of face-to-face engagements. The illustrator and curator of the health booklets and posters, with a background in public health and art, curated accompanying participatory workshops that facilitated migrant worker engagement. These were often piloted with a single group of men who were usually floor leads, at a dormitory site with supportive on-ground staff. Resources were kept simple, such as using simple laminated print-outs. Feedback was obtained informally via on-site translators, where possible. If the workshop was perceived to be well-received by the migrant workers, they were scaled up and shared with other interested healthcare workers who were eager to conduct similar sessions. Ideally, if more time was permitted, these face-to-face engagement sessions could be co-curated with input from other more experienced migrant worker NGOs.



Photo Credit 1: My Brother SG

The idea and importance of conducting face-to-face sessions had to be socialized. One way this was done was via edutainment videos created by the curator of the workshops. These were spread via text messaging to various health clusters and Wellness representatives to share the importance of face-to-face engagements. The videos were kept light-hearted, inspirational, and motivating, to encourage others to try similar approaches. The rewards of face-to-face engagements were emphasized- trust built between authorities and migrant workers, mitigation of harm, faster presentation of patients with symptoms, reduced spread, and ultimately, a reduction in the negative effects of COVID-19.

Face-to-face engagements at various facilities were carried out. Relationships between the RCCE team and dormitory operators, and internal dormitory resident hierarchies were leveraged upon by requesting the room and floor leads of each facility to bring their booklets and gather together, socially distanced, wearing masks. Where resistance to RCCE efforts was met, a SWOT analysis was done to gauge the receptivity, and engage on-ground staff to gain buy-in gradually.

The engagements served to provide a platform for feedback from representative migrant workers. On-site translators were often not available and sometimes activities were specially curated to overcome language barriers while maximising migrant worker engagement.

For example, in one activity, posters of a language different from the audience's native tongue would be shown and the audience would be asked to interpret the illustrations. A volunteer from the audience who could speak basic English would be invited up to explain the crowd's interpretations. Then, the poster would be flipped over to reveal the same poster in their native language. The volunteer would then read and explain the poster to his community. Such interactive engagements not only helped to build rapport and camaraderie, but also served as a training. These workers could scale the messaging using the same methods on return to their rooms.



Photo Credit 2: My Brother SG

During these sessions, the activities stimulated conversations to issues the men faced. For example, in going through the poster entitled “See a doctor when you have any of these symptoms”, workers shared that sometimes their friends were afraid to seek medical attention. Informative audio podcasts, announcements and explanations by loud hailer, and video testimonials recorded by COVID-19 positive migrant workers were created and shared in response.

In another face-to-face activity the audience would be guided to the handwashing section of the booklet, which suggested culturally significant songs to sing while washing hands. These songs were selected in consultation with the volunteer translators.

The Bengali song, “Arma Korbo Joy” means “we will overcome” and the Tamil song “Oruvan Oruvan mudhalali” means “we are all equal, we are bosses”. During this activity at one dormitory, a Singaporean security guard who spoke Tamil was energized to lead the migrant workers in this song, and eventually became empowered as a health ambassador, co-conducting subsequent sessions with the healthcare team.



Photo Credit 3: My Brother SG

The vision was to scale messaging via migrant worker health ambassadors and empowered to be leaders in their own communities at the dormitories, encouraging safe practices to reduce transmission.

For a series of specially curated face-to-face engagements, and their accompanying training videos, translated instructional videos, please refer to our Face-to-Face Engagement Training Manual in Appendix K.

For specific workflow on curating and conducting face-to-face engagements, see Appendix G.

6.4.2 Identified challenges and corresponding solutions

Challenges Faced	Tips and Advice
Some facilities had insufficient manpower to support these face-to-face engagements.	<ul style="list-style-type: none"> ○ Start small. Successful initial engagements may attract requests for more similar engagements and help.
Insufficient trainers and facilitators to lead these face-to-face engagements.	<ul style="list-style-type: none"> ○ Engage high-level stakeholder buy-in early to ensure allocation of manpower resources for RCCE efforts. ○ Start volunteer training early.

	<ul style="list-style-type: none"> ○ Produce training videos and use them early to train volunteers. ○ - Conduct train-the-trainer programmes early to ensure programme can be scaled up.
Many facilities preferred digital modes of engagement as it was more convenient.	<ul style="list-style-type: none"> ○ During stakeholder engagement, be forthcoming about the benefits of face-to-face engagements among communities that are more personal and communal. ○ Emphasize the benefits of receiving feedback from workers to better manage outbreak control.
Being dressed in PPE made face-to-face interactions less personal.	<ul style="list-style-type: none"> ○ Names of the healthcare personnel and a large printed photo of themselves can be pasted on the chest of the person conducting the workshop.

6.4.3 A case example of a creative participatory approach: Kitesong workshops

Unfortunately, face-to-face engagements could not be co-curated with extensive input from other migrant worker NGOs, since they themselves experienced manpower strains.

A series of participatory workshops was thus developed from a doctor’s non-profit organization called Kitesong Global, which uses pictorial stories to create platforms for dialogue and conversation. These workshops were curated, and then advice was sought from healthcare workers with extensive experience working with migrant workers to solicit their input and feedback. They were then piloted at Community Care Facilities, which frequently had sufficient manpower and infrastructure to support more elaborate and larger engagements.

The Kitesong series of workshops encourages health workers to use the power of visual pictures and storytelling to create platforms of conversation around abstract themes such as freedom, hope, trust and faith, to facilitate the development of individual "Aha" moments that lead to collective action.

It begins by first inspiring people to rediscover their dreams, and using them as a powerful motivation for positive change and action. In one of the workshops, through the heartfelt sharing of a lyrical picture story about a kite and the author’s personal experience of finding hope through her dreams, the resulting vulnerability and authenticity created a bond of trust between mobilisers and communities, paving the way for more effective communication. The creation of a common ground through bridging themes such as overcoming adversity fosters hope and trust between mobilisers and communities who would otherwise be separated by cultural, social and socio-economic gaps.

This human connection is the hallmark of the series of Kitesong workshops, which believes in being “socially distanced, but humanly connected.” The activities, interactions and sessions planned from this approach require a paradigm shift by mobilisers.

This series of workshops draws upon broad principles of participatory approaches, which believe in two-way, facilitative experiences instead of top-down, one-way communications. It also adopts the approach of early stakeholder engagement and a non-partisan branding, which became a significant draw factor in galvanizing the three main regional health systems to rally together in a stand of solidarity, leading to the creation of an RCCE local steering committee, to better coordinate national efforts in RCCE.

6.4.4 Table comparison between RCCE approach at the start of the COVID-19 outbreak among migrant workers in Singapore and the participatory approach that evolved in response to emerging needs. (*Adapted from Community-Led Ebola Action (CLEA) Field Guide for Community Mobilisers*)[43]

Table 6. Summary of tailored My Brother SG approaches to RCCE with migrant workers

	Typical approach of RCCE efforts in early phases of the outbreak	The “My Brother SG” approach
Communications approach	<ul style="list-style-type: none"> ○ Top-down, one-way ○ Heavy reliance on convenient modes of communications such as digital means ○ Communication channels are mobilizer-centric (e.g. telegram) 	<ul style="list-style-type: none"> ○ Bottom-up, two-way ○ Determined to create a combination of digital and face-to-face engagements to maintain a human touch, with the aim of developing rapport and trust ○ Communication channels are tailored to communities (e.g. WeChat for Chinese migrant workers, Facebook or IMO messaging for Bangladeshi/Tamil workers)
Message Creation	<ul style="list-style-type: none"> ○ Health messages are created by authorities at high levels, according to their perception of urgency 	<ul style="list-style-type: none"> ○ Health messages are curated alongside communities, prioritizing their interests and questions
Frequency	<ul style="list-style-type: none"> ○ Frequency is determined by manpower availability and convenience to translators and healthcare providers 	<ul style="list-style-type: none"> ○ Frequency is initiated by and discussed with communities. Mobilisers adapt their schedules to meet the needs of the community.
Face-to-face facilitation style	<ul style="list-style-type: none"> ○ Didactic teaching ○ Impersonal ○ Language may be a barrier 	<ul style="list-style-type: none"> ○ Participatory ○ Authentic, draws on personal experiences to bridge cultural, gender and social gaps

		<ul style="list-style-type: none"> Overcomes language by creatively curating activities that rely heavily on pictures
Resources and Methods	<ul style="list-style-type: none"> One-dimensional resources containing lists of “dos” and “don’ts” with minimal explanations and poor health literacy 	<ul style="list-style-type: none"> Participatory tools that use storytelling, visuals (posters, booklets, videos) as a platform for conversations, gently guiding participants to self-realization and action
Assumptions underpinning communication approaches	<ul style="list-style-type: none"> One-way communications often assume a deficit lens by the people. There are social, cultural and language gaps between migrant workers and us, mobilisers. It is challenging to bridge these gaps. Community members are less educated, uncooperative, and need to be convinced to change their mindsets and health behaviors. Community members have many questions and concerns (e.g. related to food, accommodation, concerns of employment and remittance) that are impossible to address. Community members are dangerous and may be potentially violent during lockdown. 	<ul style="list-style-type: none"> Two-way communications assume people are resourceful in their own ways and look to draw on these strengths. The social, cultural and language gaps between migrant workers and us can be bridged by focusing on basic human needs and values (i.e. desire for freedom, hope for better outcomes) Community members desire to create positive change, to prevent and control future outbreaks. Community members can be well-informed and motivated to contribute to the solution, if given appropriate platforms to air their concerns and receive answers to their questions. Community members require dignity and care and deserve a basic level of food, living standards and medical care.
Motivations for Change	<ul style="list-style-type: none"> Desire to return to work, financial stability 	<ul style="list-style-type: none"> Desire to achieve their dreams through igniting sense of purpose and hope. Builds upon community solidarity and trust in authorities to help them towards a better future.

6.5 Digital Engagements

The multilingual resources were hosted centrally (www.kitesong.com/covid19). Digital channels such as freely available phone messaging application networks between dormitory operators and the Ministry of Manpower were leveraged on to increase reach.

6.5.1 Social Media Contests

In an effort to promote interaction between the health resources and migrant workers, a social media contest was held, calling for artistic submissions such as poetry, prose and short films that conveyed messages of encouragement inspired by the health booklets and posters. This was birthed through consultation with South Asian migrant workers, many of whom are media savvy and enjoy short films.

Figure 11. Social media advert for COVID-19 related messaging contest hosted by Kitesong

Although the contest poster was translated into 7 other languages, submissions received were only in Bengali, Tamil, Hindi, Telugu and English, reflecting language groups that used social media. Artistic submissions (Figure 11) were also submitted to My Brother SG and posted on social media sites, promoting migrant workers to share them among themselves. These efforts were amplified when key migrant worker social influencers were engaged as judges to promote the contest.

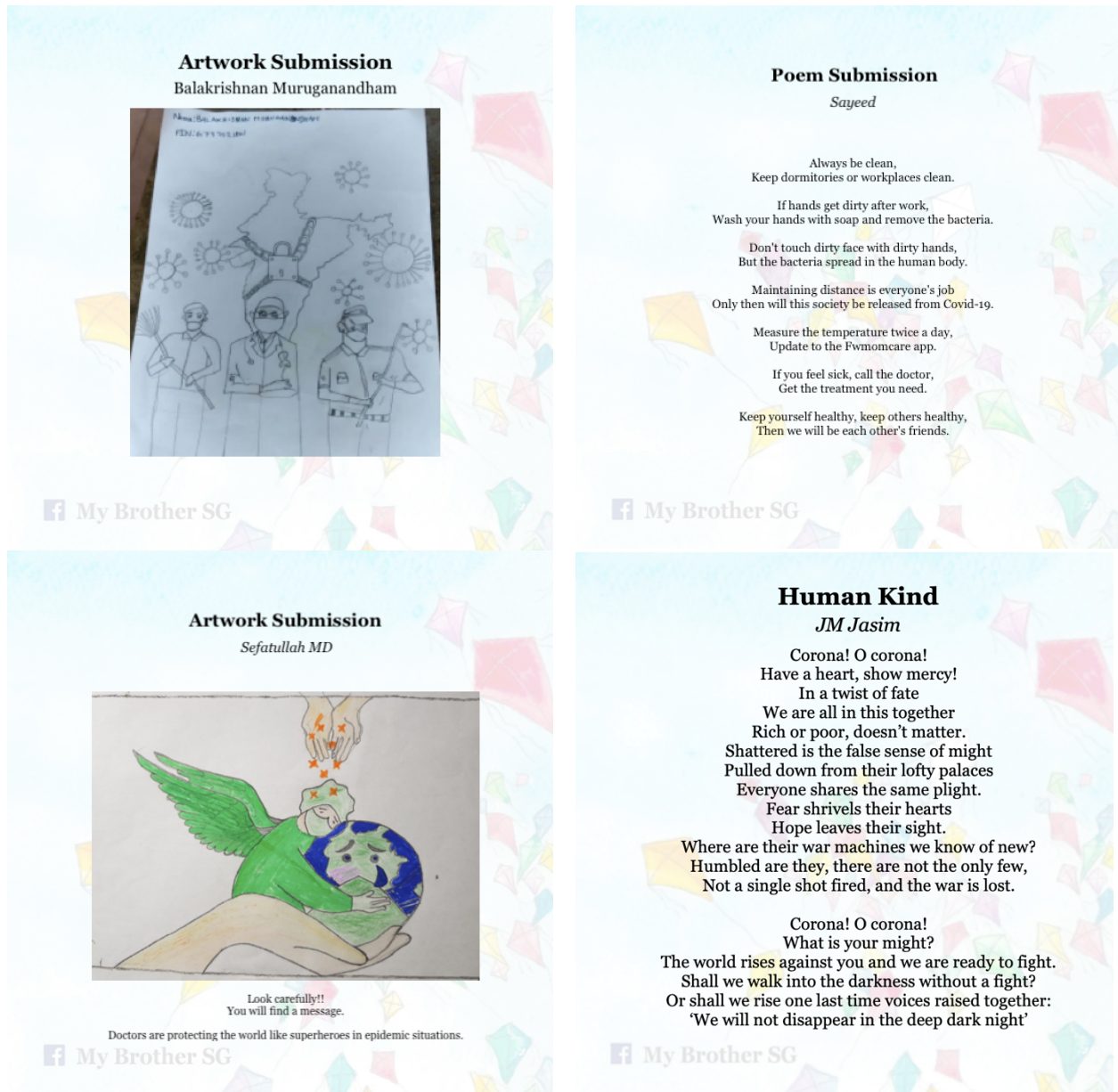


Figure 12. Artwork submissions submitted to My Brother SG via social media

It became clearer with time that migrant workers had their preferred means of digital consumption. Through on-ground feedback and focus-group discussions, media consumption preferences could be mapped to each language group.

6.5.2 Comics

As the social media contest gained traction, the social media page was renamed from “Kitesong Singapore” to “My Brother SG”, as a larger platform and means to engage migrant workers interactively long-term, with the vision of engaging and empowering them. The name change was

triggered by conversations between members of the local steering committee who perceived that a more inclusive name would win the support and buy-in of a network of organizations, compared to a name belonging to a single NGO.

Since majority of migrant workers used Facebook, this became the main platform of our digital outreach.

To create relevant content on a regular basis, comic messages were co-developed with non-profits, health institutions and migrant workers. Based on the theme “Keep Hope Alive”, these started off as an inspirational series of hope-filled comics to show support and solidarity of health institutions and government authorities for migrant workers.



Figure 13. Inspirational messaging via comic illustrations developed by My Brother SG

The poetic, metaphorical style of these comics were especially aligned with the cultures of migrant workers from Bangladesh and India, where majority of workers came from.

The comics were shared digitally thrice a week, then bi-weekly and weekly as the need for updates fell.

For specific workflow on producing comics, see Appendix H.



இதையும் நாம் கடந்துசெல்வோம்!

உங்கள் மனதை வலுவாக வைத்திருங்கள்

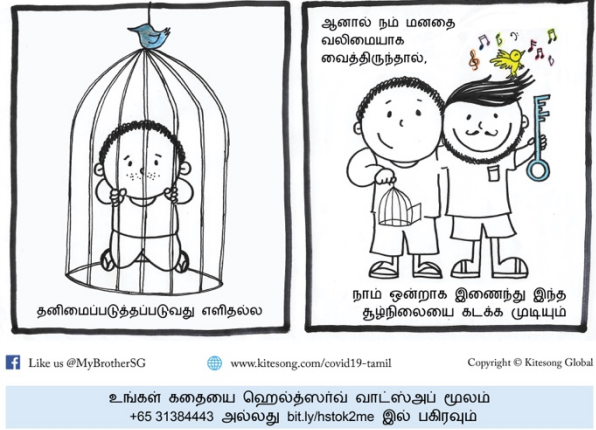


Figure 14. Inspirational messaging via comic illustrations developed by My Brother SG

6.5.3 Live Webinar Sessions

The launch of the comics coincided with the launch of online live webinar sessions, co-hosted by migrant workers and healthcare providers. This idea was birthed through the feedback that migrant workers struggled with many ongoing questions about their health and future, and needed ongoing reassurance on a friendly, trusted platform.

Together with migrant worker social media influencers, fortnightly topics were curated between migrant workers and doctors, and guest speakers were invited. These were hosted on a common online social networking service co-hosted between doctors and well-known migrant worker personalities answering health-related questions submitted by migrant workers reached as many as 60,000 per episode (https://business.facebook.com/watch/live/?v=822170215265500&ref=watch_permalink).



Figure 15. Webinar advertisement for health promotion programming

The first Bengali episode was anchored by migrant worker social media influencers, a Bangladeshi doctor and a member of the RCCE steering committee. The heartfelt and inspirational sharing of the Kitesong story drew strong emotive comments posted by Bangladeshi migrant workers and a viewership of 14'000.

This reinforced the thought that health messages sent with an inspirational slant and via creative means can be a successful means of RCCE.

As more migrant workers transited to work and Wi-Fi was no longer made free by the government, shorter video clips called 'Mythbusters' were created for online circulation. Based on the questions tackled during the live webinars, these provided quick snippets to answer burning questions.

For specific workflow on conducting live webinar series, see Appendix I.

As the situation evolved, it was imperative to adapt our approach.

6.6 Mental Health Professional Support Network

During the lockdown of migrant worker dormitories in Singapore, the potential mental health burden caused raised the attention of psychiatrists and psychologists around Singapore.

Through word-of-mouth, a group of volunteer psychiatrists, counsellors and volunteers galvanized together with a non-profit organization called HealthServe to establish a collaborative model to address the psychosocial aspects of care to prevent marginalization of these communities. Through a videoconferencing platform, virtual counselling sessions were set up in various languages throughout the outbreak, especially to address migrant workers in high-risk situations, such as roommates of workers who had taken their lives. See Appendix J attached.

A crisis hotline was set up to engage calls and text messages from migrant workers to alleviate mental distress and refer workers-at-risk to appropriate channels. These were advertised through the health booklets and other collaterals. Ad hoc online debrief sessions were also proactively set up by on-ground workers and psychiatrists to address high-tension situations like on-site suicide attempts.

Reference to: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7561276/>

7. Conclusion

7.1 Lessons Learned: What is needed for an effective RCCE programme?

In summary, principles which were helpful in optimizing the success of the RCCE programme included:

- 1. Early engagement of stakeholders to ensure national coordination**
To prevent duplication of efforts and chaos in RCCE coordination, different stakeholders were contacted early at a high level, to galvanize efforts and map out competencies. It was helpful to reassure everyone that each stakeholder had a key part to play.
- 2. Early engagement with migrant workers on-ground and partnering inherent hierarchy personnel structures**
Early engagement of migrant workers on-ground by providing translator services and sharing information in a timely and calm fashion, with frequency, clarity and regularity helped to prevent dis and misinformation, and alleviate anxiety. Partnering inherent hierarchy personnel structures helped ensure spread of the messages by empowering floor leads.
- 3. Encouragement of two-way communications**
Face-to-face engagement sessions, KAP surveys and live webinars were excellent ways to encourage two-way communications and collect useful feedback to adapt RCCE responses.

4. Focus on establishing human connection

Using participatory approaches such as storytelling, theatre, film personal dialogue, fostered trust through authentic relational connections and facilitated listening and two-way communication.

5. Focus on Agency, Autonomy and Empowerment

Recognizing the dignity inherent in every migrant worker contributed to igniting their leadership, triggering their sense of hope and purpose, and fostered a sense of agency, autonomy and empowerment.

6. Use of multiple modes of message dissemination

Multiple modes of message dissemination were used to reach migrant workers, leveraging on established communication networks offered by different partners.

7. Overcoming bureaucracy made less nimble by the pandemic

Bureaucratic processes which caused delays were overcome with strategic and creative solutions, such as leveraging on the more nimble infrastructure of non-profit organizations to translate and print resources quickly.

8. Growing a vibrant volunteer and donor network

The commitment to volunteer and donor engagement, appreciation and recruitment helped to ensure longevity and sustainability of the RCCE work even when the outbreak was under control.

9. Agreeing on and adopting a 3-pronged approach

1. **COVID-19 prevention/management**
2. **Mental Health Prevention**
3. **Chronic Disease management**

Discussing and agreeing on the future strategy of RCCE efforts was important to help align efforts and streamline communications to migrant workers.

10. A commitment to scale up

Setting up a local steering committee and technical advisory group, galvanizing stakeholders to maintain strong partnerships and establishing an organized internal organizational infrastructure helped provide the foundation to scaling up the work. This included strategic invitations to local and international representatives, recruiting a team of hired translators and recruiting a volunteer resource group of native language speakers to contextualize and assist with health messaging.

7.2 Challenges and Future Efforts

7.2.1 Feedback from Migrant Workers

Feedback from migrant workers was collated from online surveys and focus group discussions (FGDs) between December 2020 and February 2021, informing us of the challenges they faced, and thus directing us in our future RCCE efforts. Between December 2020 and February 2021, 9 FGDs were conducted. Three FGDs were conducted with 20 Bengalis speaking workers, 3 FGDS were conducted with 19 Tamil speaking workers, 1 FGD was conducted with 7 Chinese speaking workers and 2 were conducted with 17 Myanmar speaking workers. They were conducted mainly over zoom, except for the Chinese workers which were conducted in-person.

7.2.1.1 Feedback from Online Surveys

Data Collection

Data was collected from 831 migrant workers. However, 81 responses were removed due to lack of informed consent and satisficing. The final sample consisted of 750 responses. Of these responses 543 were collected using the English version of the survey, 16 responses were from the Chinese version of the survey, 29 responses were from the Tamil survey and 156 responses from the Burmese survey.

Demographic Information of Participants

The migrant workers' age ranged from 21 to 52 (Mean age = 33.82; Standard deviation = 5.28). They were predominantly primary school educated, earned from S\$500-S\$1000 per month, and had been in Singapore from 1 to 25 years (Mean number of years = 7; Standard deviation = 3.9).

Effect of Activities on Indicators

The results of the analysis showed that face-to-face engagements, Facebook webinars and the My Brother SG comics significantly increased migrant workers' feelings of agency and empowerment related to covid-19 transmission while the other activities (i.e., health booklets, posters, PA broadcasts, workshops and videos) did not affect their feelings of agency and empowerment (Table 5). These findings suggest and support the hypothesis that two-way interactions through a personal human touch, whether digitally or face-to-face engagements, are essential in promoting agency and empowerment in effective RCCE communication.

Table 7. Independent sample *t*-test results for effect of activity on feelings of agency/empowerment

RCCE Activities	Results
Face-to-Face Engagements	$t(748)=2.03, p = .04^*$
Comics	$t(748)=4.12, p = .00^{**}$
Facebook Webinars	$t(748)=3.04, p = .002^*$
Workshops	$t(748)=.31, p = .76$
PA Broadcasts	$t(748)=0.03, p = .97$
Videos	$t(748)= -.40, p = .00$
Information in Health Booklet	$t(748)=.20, p = .84$
Information from Posters	$t(748)= .08, p = .94$

p*-value <.05; *p*-value <.001

The results also indicated that the information provided via face-to-face engagements, Facebook webinars and the My Brother SG comics were significantly culturally competent, regular, sufficient, and linguistically comprehensible as opposed to the other activities, such as PA broadcasts, health booklets, posters, workshops, and videos (Table 3). Similar to the findings for the effect of RCCE activities on feelings of agency and empowerment, these findings suggest that participatory approaches which encourage two-way interactions are more effective in increasing migrant workers' understanding and perception of sufficiency of RCCE messaging. Such approaches could allow migrant workers and RCCE communicators to directly communicate and clarify any misunderstandings and questions despite cultural differences, thus increasing understanding of RCCE messaging. It is also possible that building rapport and trust with the migrant worker community through such interactive methods facilitates migrant workers' acceptance of RCCE messaging from individuals outside their community, which in turn could affect their understanding of the messages received.

Interestingly, the workshops did not have a significant effect on migrant workers' rating of their feelings of agency and empowerment, or their understanding and perception of the sufficiency of information disseminated during RCCE activities, even though it was interactive, suggesting that the workshops were not effective in increasing migrant workers' understanding of RCCE messaging. However, this could be related more to the fact that only a very small proportion of migrant workers (i.e., 81 workers) who participated in the survey were actually involved in the workshops, thus, diminishing the reported effectiveness of the workshops in disseminating information. Alternatively, in light of the positive feedback from migrant workers about the workshops, these findings could mean that while the workshops were not effective in communicating about COVID-19, it was effective in helping migrant workers cope with COVID-19 through other means, for example, by helping with their mental health.

Table 8. Independent sample *t*-test results for effect of activity on understanding and perception of information received

RCCE Activities	Results
Face-to-Face Engagements	$t(748)=3.14, p = .002^*$
Facebook Webinars	$t(748)=2.09, p = .04^*$
Comics	$t(748)=2.99, p = .003^*$
Workshops	$t(748)=.053, p = .96$
PA Broadcasts	$t(748)=.37, p = .71$
Videos	$t(748)= -2.03, p = .04$
Information in Health Booklet	$t(748)=1.57, p = .12$
Information from posters	$t(748)= .04, p = .97$

p*-value <.05; *p*-value <.001

On the other hand, the activities did not significantly affect migrant workers' knowledge of when to seek help. However, this does not necessarily mean the activities were ineffective in achieving this outcome. The migrant workers reported a very high average score (i.e., 4.67 out of 5) when reporting their knowledge of when to seek help. This suggests a ceiling effect, where migrant workers were already highly knowledgeable of when to seek help and thus, engaging in the activities did not drastically increase their knowledge any further.

The results also showed that the RCCE activities conducted did not affect migrant workers' awareness and understanding of how to prevent spread. However, it should be noted that this indicator was operationalised as migrant workers' frequency of engaging in precautionary behaviors to prevent spread. As such, the migrant workers who participated in the survey did indicate situational factors that act as significant barriers to them participating in measures to prevent spread. For example, several participants stated that they were unable to practice safe-distancing due to space constraints in the dormitories. Hence, an inability to engage in precautionary behaviors could be inhibiting the effect of the activities on migrant workers' awareness and understanding of how to prevent spread. Thus, it is not possible to conclude that the RCCE activities undertaken did not increase awareness and understanding of how to prevent spread from the results of this study (Figure 15).

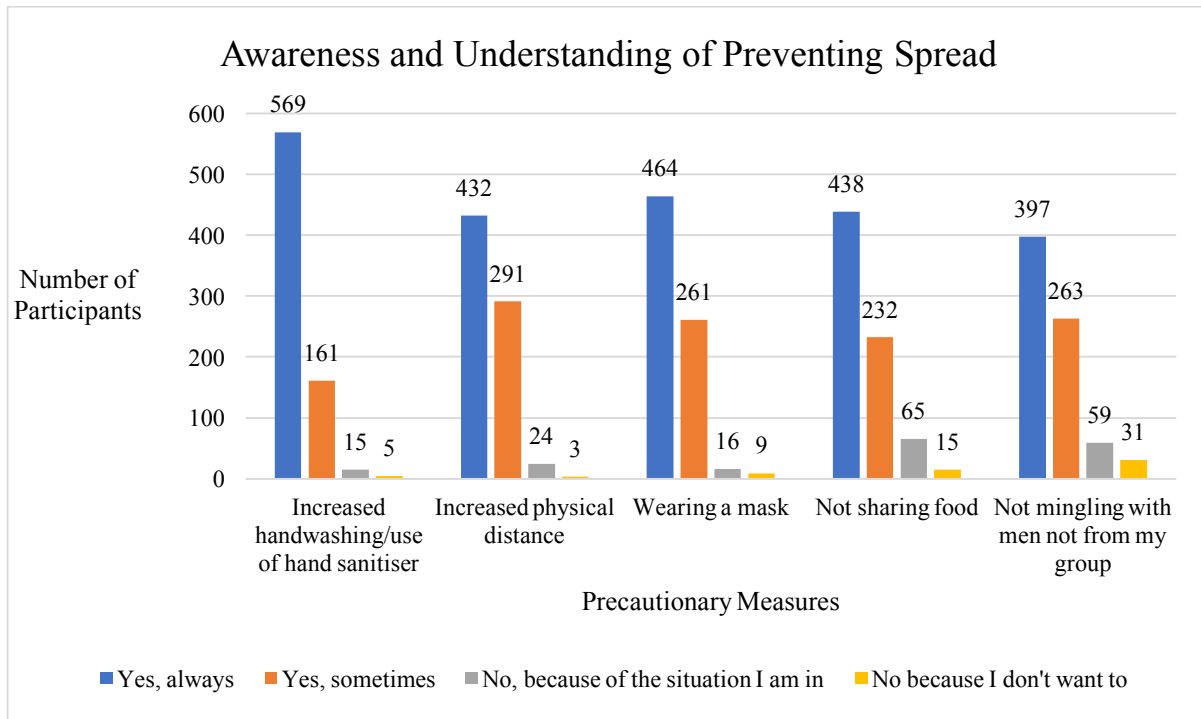


Figure 16. Results for awareness and understanding of preventing spread.

The results for appropriate help-seeking behaviors indicate that migrant workers are more comfortable seeking help from human sources than digital sources (Figure 16).

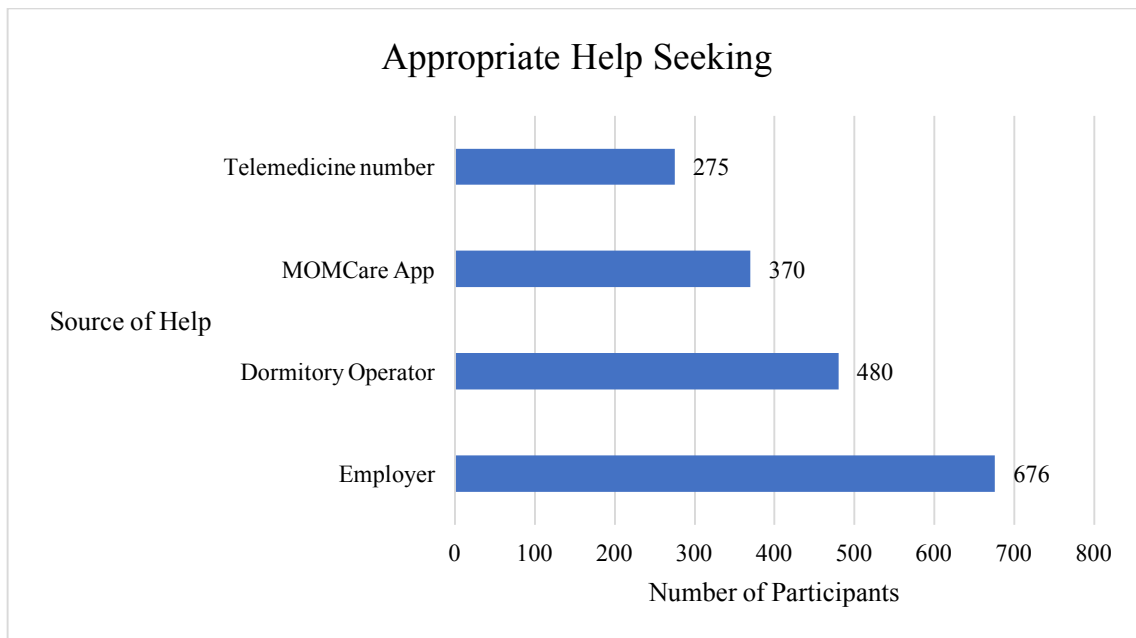


Figure 17. Preferred help seeking sources by migrant workers in the study

This could mean that digital literacy relating the specific health-seeking mediums (i.e., MOMCare app and the telemedicine number) is essential. Participants indicated more barriers to seeking help from digital sources than from human sources (Figure 17). Notably, migrant workers indicated

that they were unsure how to contact the source of help, that they did not know who to contact through digital means, that they did not speak the language, and that they were unsure if they would receive the help they need when seeking help from digital sources than when seeking help from human sources. It should also be noted that significantly more participants indicated that they were unsure of whom to contact when seeking help from dormitory operators than from employers, suggesting that not all migrant workers may have access to their dormitory operators.

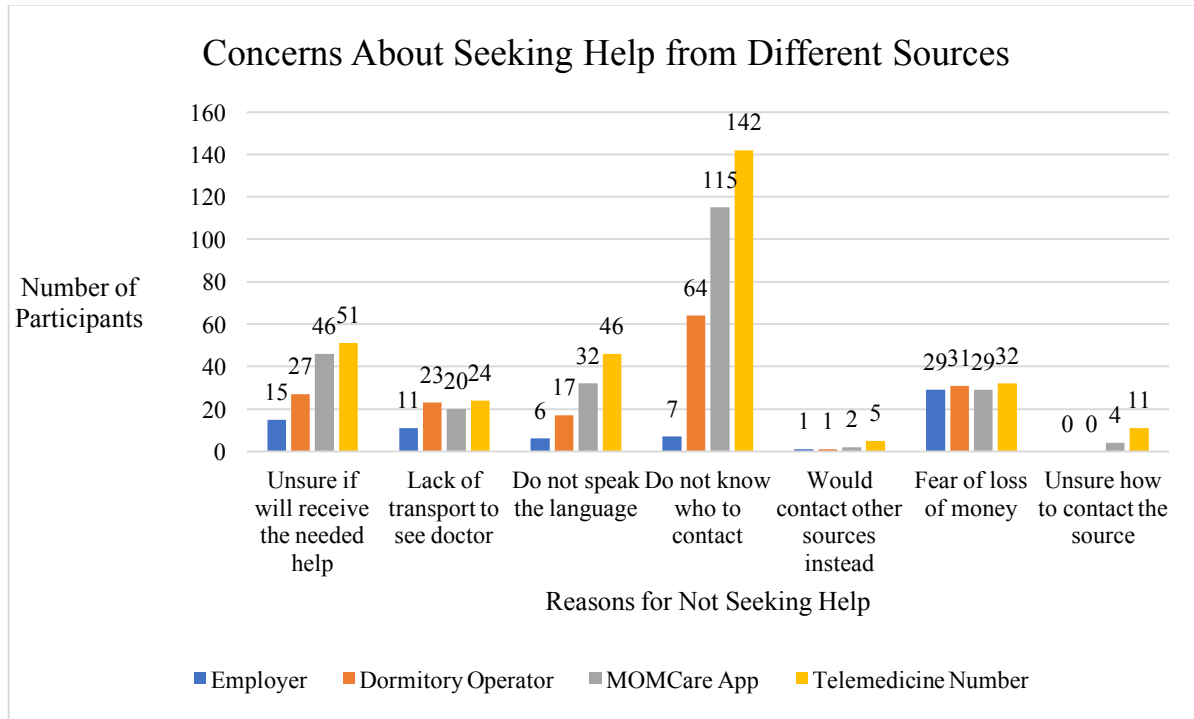


Figure 18. Potential barriers to migrant workers seeking help from different sources

Measuring the Indicators

All the indicators showed good internal consistency (i.e., Cronbach’s alpha, $\alpha > 0.70$) (Table 7). This means that the questions asked in the online survey measured each of the indicators- namely, feelings of agency/empowerment, receiving information, awareness and knowledge of preventing spread, and appropriate help-seeking- consistently, thus, increasing the reliability of the results of this survey.

Table 9. Reliability of Survey Indicators

Indicator	Cronbach’s Alpha Value
Feelings of agency/empowerment	$\alpha = .83$
Receiving information	$\alpha = .84$
Awareness and knowledge of preventing spread	$\alpha = .72$
Appropriate help-seeking	$\alpha = .75$

Limitations

The results from the online survey have provided significant insights into how the RCCE activities have influenced migrant workers' ability to cope with COVID-19. The reliability and accuracy of the survey results were potentially enhanced by the fact that the survey was translated into multiple languages so that migrant workers could respond in their native languages, which they are more likely to be proficient in. While these translations were proofread, conducting backtranslations would have been more effective in ensuring that the translations were understandable to migrant workers. Proofreading involves the comparison of the English and translated versions of the survey to ascertain if the translation matches the English version. Backtranslation, on the other hand, helps to de-contextualise the translation as this relies on the expertise and knowledge of the translator without relying on an English "template". Often, native languages have regional differences. As such, backtranslations could help to ensure greater accuracy in translation by enabling fine-tuning of the translations, such that they could be matched to the English script despite cultural and regional variations, thus, reducing the cultural gap between the translators from Singapore and the migrant workers, and possibly increasing migrant workers' accurate understanding of the survey questions.

Moreover, it is possible that the limited reach of the survey could be a result of digital illiteracy among migrant workers, as suggested by the fact that the participants of the survey reporting that they were unsure who to contact or how to use digital means of communicating sources of help. However, it should be noted that many of the RCCE activities themselves were conducted through digital mediums and the results from the Focus Group Discussions suggest that migrant workers were tech-savvy and dependent on social media for news about COVID-19. Hence, it is important that future studies assess the prevalence of digital literacy among migrant workers, and what groups of migrant workers have more access to such online surveys. For example, in the current study, the online survey was more accessed and completed in some languages- such as Bengali and English- than others- such as Chinese and Burmese-, suggesting that digital literacy could vary by nationality.

Furthermore, unfamiliarity with surveys could have discouraged migrant workers from participating in the online survey. Migrant workers' might also be unaware of what is expected of them when completing the survey. This in turn could affect their responses by increasing biases in responding, such as the social desirability effect- where the participants want to present themselves in the most favourable way possible- and the expectancy effect- where participants provide responses which they think is what the surveyors want. For example, in the present study, many participants left comments about what should be done or what they do to prevent the spread of Covid-19 (e.g., "I always 1-metre distance", "always wear masks") in text boxes asking for feedback about the RCCE activities.

7.2.1.2 Feedback from Focus Group Discussions

Between December 2020 and February 2021, 9 FGDs were conducted of which 3 FGDs were conducted with 20 Bengalis speaking workers, 3 FGDS were conducted with 19 Tamil speaking workers, 1 FGD was conducted with 7 Chinese speaking workers and 2 were conducted with 17 Myanmar speaking workers. They were conducted mainly over zoom, except for the Chinese workers which were conducted in-person.

Feedback from the FGDs is summarized below:

- While Bengali and Tamil speaking workers were well-reached with the RCCE efforts, the Myanmar and Chinese workers had not heard or seen the RCCE messages before.
- Physical copies of booklets and posters were well appreciated.
- Digitally, RCCE efforts in video form were preferred over static forms of digital media such as comics or static social media posts.
- Mental health awareness and skills were articulated as a need:

" There is very little work being done with mental health. MOM has arranged a big platform for mental health but the problem is that is not reaching up to the workers. They are thinking that workers will reach them when they will face the problem but the thing is workers themselves don't know that they have mental health issues, so how will they reach MOM?"

—M005 Bengali Speaking MW

- Personal challenges articulated included continued movement restrictions, resulting in missed life events such as festivals, marriages and deaths in home countries, difficulties in remitting money and loss of a sense of control over cooking food that was culturally palatable due to catered food being perceived as inpalatable.
- Access to healthcare remained a challenge with uncertainties on the subsidization of healthcare and language barriers during consultations being main barriers.
- Economic threats of earning less were a source of stress leading to depression and self harm.
- Persisting overcrowded living arrangements affect workers' sense of self efficacy in preventing COVID-19.

- Frustration due to perceived discrimination

“COVID-19 positive people should be controlled and shouldn’t be allowed to go outside, but not us. But now, they (the authorities) are putting further restrictions on the negative-result person (like us). This is not fair.”

—M009 Burmese speaking MW

“Although there are COVID-19 positive cases amongst Singaporean people, they control only the foreign workers mainly. The patients should be controlled strictly, but not us. They (the authorities) should give (us) equal rights. That’s why we are frustrated. We know that we can’t go outside like before but we want this safety measure to be applied to all people fairly.”

—M011 Burmese speaking MW

7.2.2 Long term vision

The long term vision for the “My Brother SG” network is to eventually create a closely-connected yet broad-based network of migrant worker related organizations from various backgrounds, including government authorities, non-profit organizations, health clusters and even commercial companies, volunteer groups and individuals who wish to support the cause.

With a network that can leverage on one another’s strengths and align efforts in a coordinated manner, the hope is that health messages can be disseminated promptly, widely and seamlessly in the event of a future outbreak, but more importantly, on a regular basis for health prevention.

As the COVID-19 situation improves with mass vaccination exercises, RCCE messaging will shift to building mental health awareness and chronic disease prevention. These efforts will build towards a healthy migrant worker workforce to ensure health equity for all.

Several challenges to achieving these goals remain:

7.2.3 Challenges:

1. Penetrating Migrant Worker communities of all languages

Due to cultural diversity and multiple modes of consuming media and information, penetrating all the various language groups of migrant workers remain a challenge. Although Bengali and Tamil speaking workers comprise the largest percentage of migrant workers in Singapore, the Mandarin speaking worker numbers are also significant. Yet, many of them are not well reached.

“The Chinese workers only have Wechat. They are not as well engaged because their phones are made in China so they don’t have any google chrome, WhatsApp or Facebook. So they only have official information from China which has a third party view of Singapore. The only efforts to engage them came in late June, when MOM has a mandatory reporting system, and their employers pay for a working phone for them. That’s the difficulty we face (with Chinese workers).”

—Mandarin-speaking doctor, local steering committee member, 2nd LSC meeting

2. Addressing Migrant Workers’ Feedback

As seen in the online survey results and focus group discussions, several kinds of feedback from migrant workers are persistent and pervasive, yet challenging to address. One of them is the need to reduce density of workers in their living quarters.

“I have noticed that even after knowing all the rules, we can’t follow them. When we return to dormitories, we are not cautious or alert anymore (like when we are at work). In the initial days, we were afraid of getting infected and we followed the rules. But now, I notice that mask is not being used inside the dormitories, it’s used only at the entry and exit point. Once I am in my room, no one wears a mask. We are using toilets shared among 50 to 100 people.”

—M004 Bengali Speaking MW

“The room that we are living in now is suitable only for 8 people. But now we have to live 12 people in that room. So, it’s very small. At first, they (the authorities) said that during COVID-19, they would enable us to follow social distancing but now it’s not like that and we have to stay as usual in a small place. If we can live with only few people, it would be better.”

—M008 Burmese speaking MW

3. Addressing Mental Health issues of Migrant Workers

Mental health awareness, prevention and treatment continue to be a major challenge.

“Of course, the big challenges were the mental health concerns. It’s really about the stigma towards mental illness that they all come with from their native countries... The knowledge (of mental health) is really low, and the stigma attach to it is very high... Particularly, when we have to start some of the treatments and when we have to explain what this is all about, psycho-educate about the treatments that is required, how long they have to maintain on the treatments, and also ensuring they will able to come. That isn’t successful. Many of them drop out from the psychiatry outpatients. So, we have not been able to effectively follow up on this group of patients.”

—Ms. G, Psychiatrist, local steering committee meeting member, Board member at Migrant worker NGO, 1st LSC meeting

4. Raising up health ambassadors

One of the greatest challenges which remains is in training and equipping migrant workers with the skills needed to be health ambassadors. While a number of organizations have attempted to run health ambassador programmes, the success has been limited due to the lack of time after long working hours by migrant workers and failure to monitor and follow up on engaging peers.

Currently, the Ministry of Manpower is partnering a local migrant worker non-profit organization called HealthServe, to pilot small training sessions for migrant workers at selected dormitories to equip them with psychological first aid skills.

5. Growing the RCCE network

Since the RCCE network is founded and entrenched in informal relationships, these can be fragile unless supported by structural partnerships. Formulating standard operating procedures for recruiting resource group volunteers to help with contextualizing health messages and establishing structured induction programmes will help build a robust system that can scale up.

6. Aligning and streamlining efforts

As the “My Brother SG” network grows to include more partners, it may become increasingly challenging to manage partner expectations, align efforts and streamline engagements. Having regular monthly discussions and building upon the relationships within the network while supporting its members will be helpful in building sustainability longterm.

7.2.4 Future Efforts

1. **Strengthening local support**

As our RCCE work grows, it is hoped that My Brother SG will be recognized and sustained as a credible network of partners providing robust support to migrant workers

health and well-being. Recruiting a larger base of more diverse partners with deepened ties will help to facilitate synergies in leveraging on one another's strengths for the benefit of migrant workers.

Recruiting resource volunteers from members of the public and establishing community service programmes in schools are ways to also help bridge gaps between the main population and migrant worker community, to strengthen the social fabric of Singapore's diverse community. Current efforts to move towards these goals include investing in a branding/marketing consultant to help with establishing brand identity and expanding synergistic partnerships with stakeholders outside the healthcare sector. Significant headway has also been made in partnerships with government authorities.

2. Increasing regional and international support

Future efforts include expanding the local and international network and support for "My Brother SG", as well as sharing local experiences for regional or global scale-up, within each country's unique contexts. Strengthening partnerships with GOARN can help to expand and localize this work in other needed contexts.

3. Advocacy for migrant workers in Singapore

It is intended that the research findings from this project will help inform policy to advocate for the welfare of migrant workers. This includes reducing the living density of migrant workers, improving their dormitory conditions, making RCCE for vulnerable groups a priority in outbreak responses and dedicating organizational and governmental resources for outbreak and mental health prevention among migrant workers. Future endeavours may also extend to other vulnerable groups in Singapore, such as female domestic workers living within private residences.

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