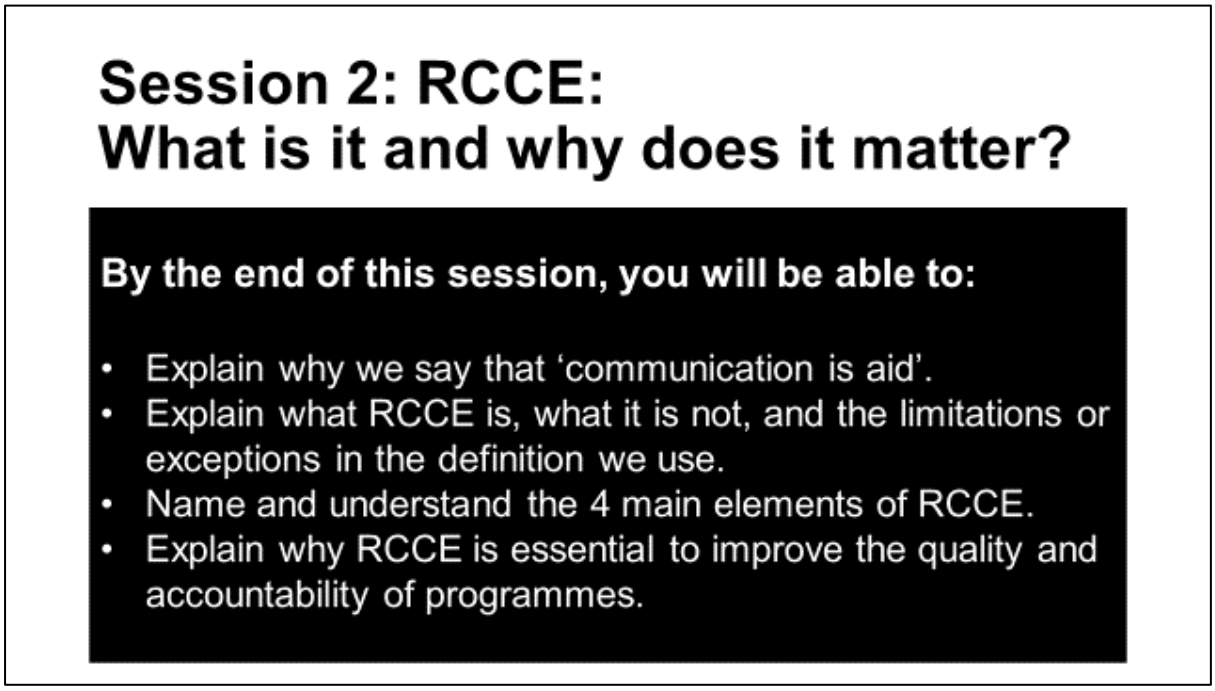
[FACILITATOR NOTES]



Slide 2.8: COVER: Session 2: RCCE: What is it and why does it matter?
Duration: 60 min
Time: 09:00-10:00

Format: Presentation by facilitator, small group discussions, group discussion.
Materials: Slides, video, flip chart, markers.

Learning objectives:
- Understand what we mean when we say 'communication is aid'.
- Understand what RCCE is, what is not, and the limitations or exceptions in the definition.
- Name and understand the 4 main elements of RCCE.
- Explain why RCCE is essential to improve the quality and accountability of programmes.

Contents:
- What do all (public health) emergencies have in common?
- What is RCCE?
- The 4 pillars or RCCE.
- RCCE is not…
- Why is RCCE important. Lessons from Ebola and Covid-19.

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Slide 2.8: By the end of this session, you will…
Duration: 1 min
Speak to the slide to introduce the learning objectives for this introductory first session

Slide 2.9: What do all (public health) emergencies have in common?
Duration: 5 min.

Put the following question to the participants: *what do all (public health) emergencies have in common?* Take a few comments from participants and see how those connect or not with the points in the slide.

[NOTES FOR FACILITATORS: Public health is in between brackets because we are going to be talking about elements that are common to all types of emergencies.

Large scale emergencies may have many things in common but for the purposes of this training module we want to **draw participants towards understanding that RCCE contributes in important ways to achieving more effective** (e.g. lives saved, better use of skills and resources**…) and accountable humanitarian and development action** (e.g. more power sharing, the ability to hold different actors to account…).

The ultimate objective of this brief discussion is to **draw out participants' own understanding and professional and personal experiences of (public health) emergencies** both as humanitarian workers and also as citizens.

(Note: animation)
1. **Affected communities are always first responders.** Whether local citizens, municipal government workers, community-based and faith-based organisations, spontaneously formed groups of volunteers or the local private sector, etc. crisis-affected populations always initiate the first relief efforts. Very often, they will be providing assistance and, at the same time, in need of assistance themselves, having also been affected by the crisis.

(Note: animation)
2. **Information (and by extension communication) is a form of aid in its own right.** Timely, accurate and actionable information is vital to help people make informed decisions and actively participate in their own relief and recovery.

(Note: animation)
3. **Engaging with to those affected is key to increase both the effectiveness and accountability of humanitarian action**. The increasing focus on the 'localisation of humanitarian aid' and on 'accountability to affected people' recognises the roles of affected people both as assisters and of recipients of assistance; and acknowledges that engaging local communities is vital to the effectiveness and accountability of humanitarian and development operations. This is of course easier said than done but that's why we are here today, right?

(Note: animation)
4. **Emergencies always reveal inequalities in POWER within a society.** It reveals those who have, and those who have not. Whether we are talking about money, housing or jobs; access to information, or even basic recognition of citizenship – who's considered a legitimate citizen can't be assumed – emergencies reveal disparities in who has and who has not power and influence, both legitimate or forced upon, within a community.

Ask participants for some quick feedback/thoughts – do they agree? Have they seen these dynamics operating in real life?

Photo credit: ICRC (www.icrc.org/en/document/photojournalism-call-entries-2018-edition-visa-dor-humanitaire)

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[NOTE FOR FACILITATORS: This is just an example, for your reference, in case it is useful during this particular conversation (i.e. no need to use it)]

During Ebola in West Africa (2014-2016), community engagement was essential in order to understand community risk perceptions, stigmatization and the degree to which communities trusted authorities.

For example, inadequate communication and engagement with communities when designing response measures fuelled fear and mistrust. This led patients to reject lifesaving care. It prompted doctors to go on strike. And it also resulted in burial teams being attacked.

Similar issues of mistrust and miscommunication impacted previous response efforts including the 2009 swine flu pandemic and the 2015 Zika outbreak in Central and Latin America.

During the Ebola outbreak in West Africa, the initial resistance towards safe and dignified burials was fuelled in part by the widespread belief among community members that the body bags used by responders were actually filled with rocks or dirt to hide the fact that body parts had been removed and sold.

Communities demanded to be able to see for themselves that the body of their loved one was in the bag and had not been manipulated. To respond to this need, Red Cross teams began to use semi-transparent bags so that the body could be viewed safely by grieving family members. They also incorporated customary practices into safe and dignified burial protocols. These adjustments were well received by the community and contributed to reducing the opposition to safe and dignified burials.

Slide 2.10: VIDEO: Communication is aid
Duration: 5 min (2'30'' video + 2' group discussion)

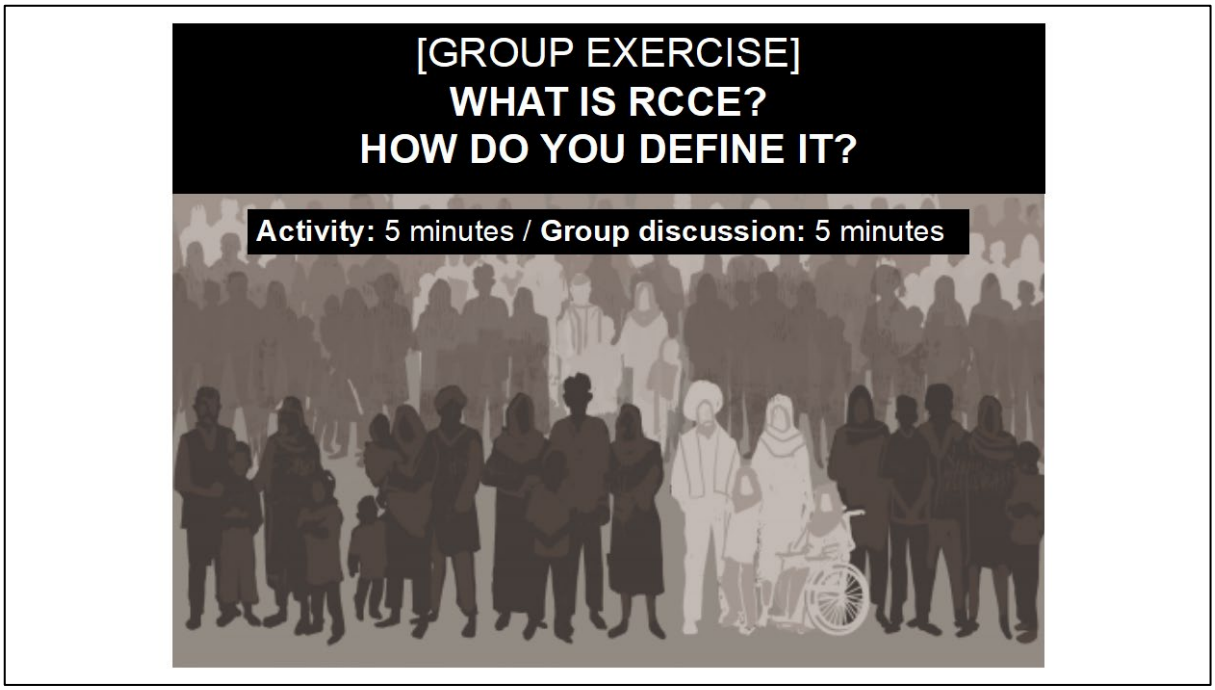
[NOTE FOR FACILITATORS: The clip is linked into the slide and – ideally – you should be able to play it from there. In case this does not work, as a backup, the clip is also available from YouTube: www.youtube.com/watch?v=Uibg0JREldc]

This video was produced by BBC Media Action and Internews in 2010 through the "infoasaid" project (the names says it all, right?). It should bring together a number of the elements discussed in the previous slide.

Play the video and ask for a couple of comments on what participants thought of it.

The objective of the previous two slides is to assist participants frame the discussions in the next sections on WHAT RCCE is and WHY it matters.

Credit: infoasaid.

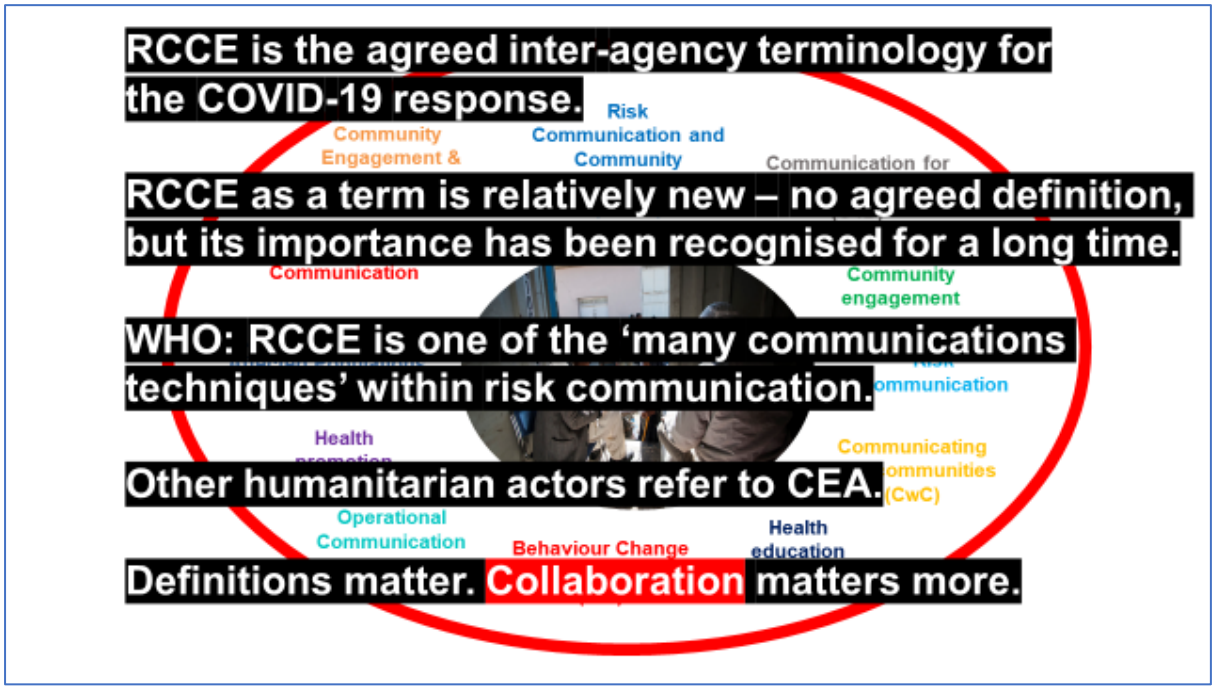


Slide 2.11: EXERCISE: What is RCCE? How do you define it?
Duration: 10 min.
Format: Group work followed by group discussion.

Instructions
- Each group to take a flip chart and a marker and write their definition of RCCE, in 5 minutes.

Group discussion (5 minutes)
- Ask one group to volunteer, or choose the group that seems more dynamic at this stage to present its results. The other groups can add anything they had written down not covered by the presenting group.

Pic: www.hrw.org/report/2020/04/28/disability-not-weakness/discrimination-and-barriers-facing-women-and-girls



Slide 2.12: So what is RCCE? Rising above and beyond the terminology
Duration: 10 min.

Objective
After the participants have shared their definitions of RCCE, the objective of this slide is to engage participants in a discussion of their own experiences of different 'community interaction models' and terminologies. Ultimately, the facilitator will stress the importance of being able to rise above the terminology and definitions and collaborate with other organisations.

Ask participants how many of them are familiar with the different labels shown in the slide (before the animation places the black strips onto the screen). Take a couple of comments from participants. If labels included in the slide featured in participants' definitions, you can point this out.

Begin the animation and present the following 5 points [NOTE FOR FACILITATORS: text provided below not to be repeated *verbatim* except, if you want, for the definitions]

(Note: animation)
RCCE is the agreed interagency terminology for the COVID-19 response.
Risk Communication and Community Engagement (RCCE) is the name of the field of work relating to information and community work specifically in public health emergencies. In its current form, RCCE has its roots in the Ebola crisis in West Africa (2014-16). It is the agreed inter-agency terminology for the COVID-19 response. Globally, the lead agencies for RCCE are WHO, UNICEF and the IFRC.

(Note: animation)
RCCE is relatively 'new'… No agreed definition.
Compared to many other areas of public health emergency response, this focus on risk communication generally, and RCCE in particular, is relatively 'new'. This means that there are still ongoing debates and discussions about its definition and its role.

(Note: animation)

WHO: RC. CE, one of the 'many communications techniques' within RC.

[NOTE: Read] The WHO defines risk communication as the real-time exchange of information, advice and opinions between experts, community leaders, or officials and the people who are at risk. It allows people most at risk to understand and adopt protective behaviours, and authorities and experts to listen to and address people's concerns and needs so that the advice they provide is relevant, trusted and acceptable (WHO, 2018).

[NOTE: We will talk more in detail about RC in the next session]

Increasingly, public health actors understand how critical community engagement is to successfully responding to health emergencies. In its approach to risk communication, WHO includes community engagement as one of the many communications techniques used (WHO, 2020).

(Note: animation)

IFRC/ICRC: CEA

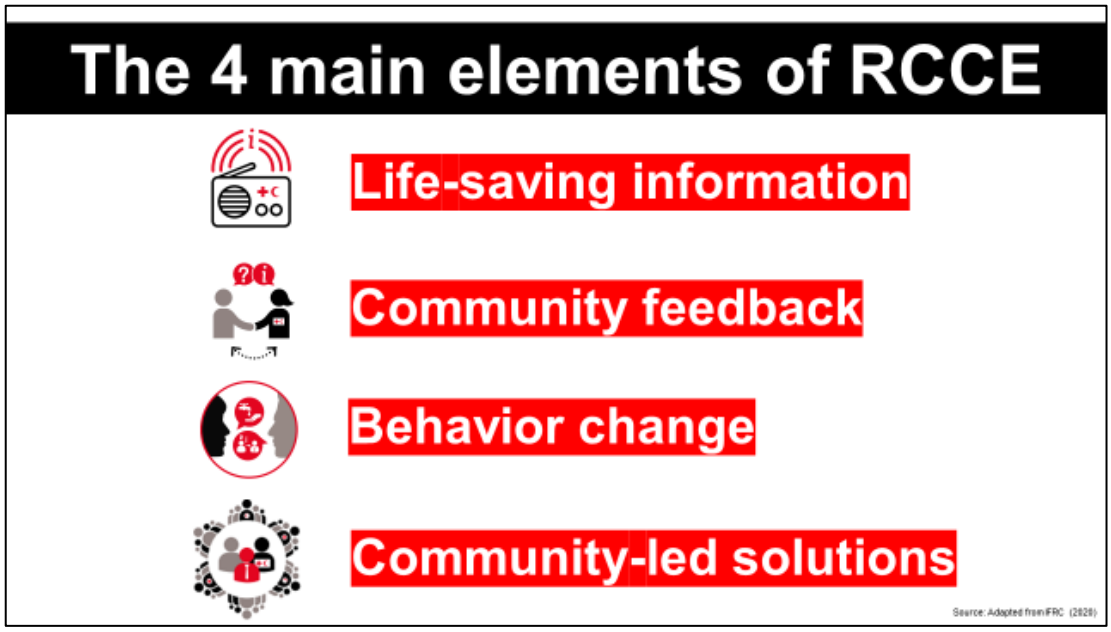
[NOTE: Read] The IFRC and the ICRC define Community Engagement and Accountability (CEA) as the process of engaging communities and individuals to encourage and enable them to adopt protective behaviours and for humanitarians to listen to communities' needs, feedback and complaints, ensuring that communities can actively participate and guide emergency programmes and operations across all phases (IFRC, ICRC, 2016).

(Note: animation)

Definitions matter. Collaboration matters more.

Each approach, terminology or area of expertise can bring important and unique perspectives to the same challenge. In fact, they often overlap one another and there is a lot of common ground. Definitions matter, but however many different disciplines, terminologies and labels may exist, that cannot be an excuse for a lack of collaboration and cooperation because coordination is crucial.

To close this discussion, ask participants whether people, communities out there, ultimately care about our definitions and terminology… Get a couple of answers and move on.



Slide 2.13: The 4 elements of RCCE
Duration: 4 minutes.

In the IFRC's approach to CEA, there are four main elements that are at the centre of their work on RCCE. These four elements summarise a useful and simple-to-understand approach to RCCE. There are, of course, more, as we have seen in the previous before.

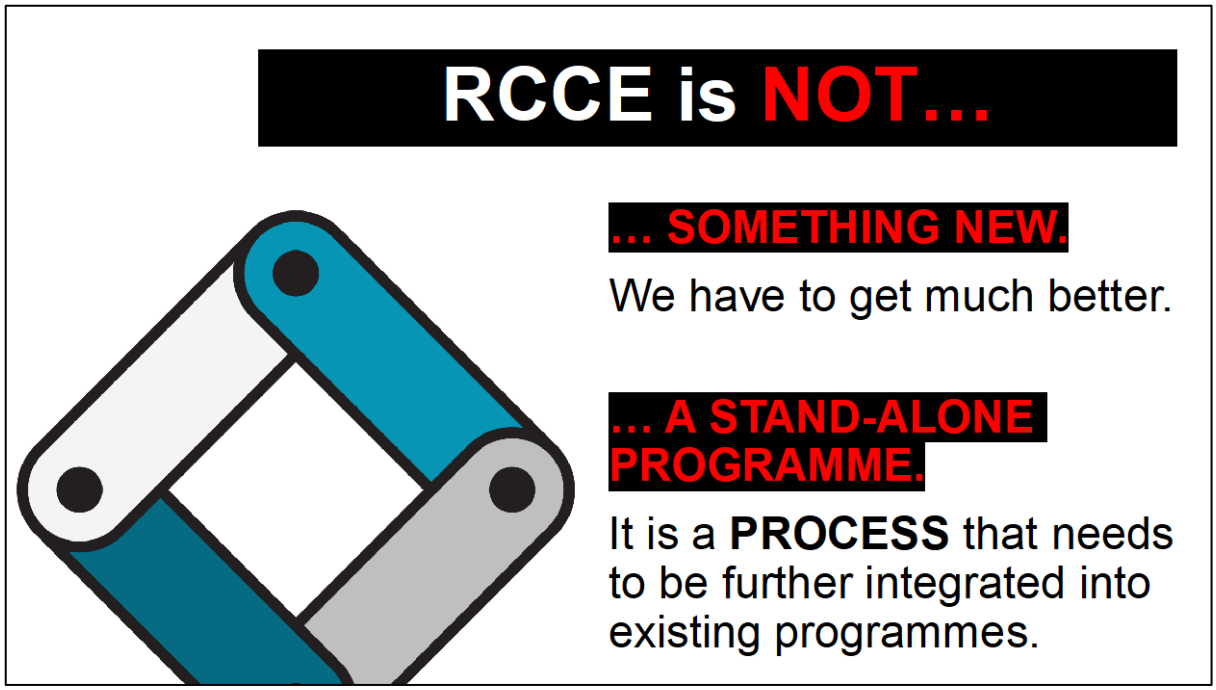
[NOTE FOR FACILIATORS: The text provided here is for your reference only, not to be used verbatim necessarily].

(Note: animation)
1. **Life-saving information:** Provision of timely, accurate, easily understood and actionable information, delivered using the most appropriate communication approaches to encourage people to adopt safe health practices and to reduce fear and stigma and counter rumours and misinformation.

(Note: animation)
2. **Community feedback:** Establishing community feedback mechanisms in order to understand (in a safe and confidential way), the beliefs, fears, rumours, questions, suggestions and complaints that communities have about COVID-19, and to analyse them and act upon them to guide the response.

(Note: animation)
3. **Behavior change:** Going beyond information sharing and awareness raising and encouraging behaviour change. This requires first, knowing what barriers may prevent people from adopting safe health practices and, second, recommending context-relevant actions people can do to prevent and reduce the spread of the disease.

(Note: animation)
4. **Community-led solutions:** Identifying and supporting community-led solutions for preventing the spread of infection and bringing the outbreak under control. This means asking people what they know, want and need, and then involving them in designing and delivering COVID-19-related services and prevention approaches that aim to improve the effectiveness of our community interventions and sustain the changes we promote.



Slide 2.14: RCCE is not…
Duration: 1 minute.

[NOTE FOR FACILITATORS: Based on questions we often get asked it is important to clarify two common misconceptions about RCCE. The text provided below is not to be repeated verbatim. It is meant to provide some context].

RCCE IS NOT NEW… While the term RCCE is relatively new - participatory approaches are meant to be in the DNA of humanitarian action. HOWEVER, we all recognize that there are gaps in how we involve communities in humanitarian and development work, and that participation doesn't always happen in a systematic and predictable way, or to a high quality. In short, we need to get much better at it, particularly when it comes to include the most vulnerable. We will discuss WHY shortly.

What *is* perhaps new is that people, empowered by technology (e.g. mobile phones and social media), can now raise their voices louder and demand greater interaction with and accountability from their governments and humanitarian and development organizations. The expectation and demand for accountability is not new. BUT technology is amplifying and helping people to articulate and coordinate those demands. Also, the reality is that we can no longer turn a blind eye/deaf ear to the demands. These are certainly new developments.

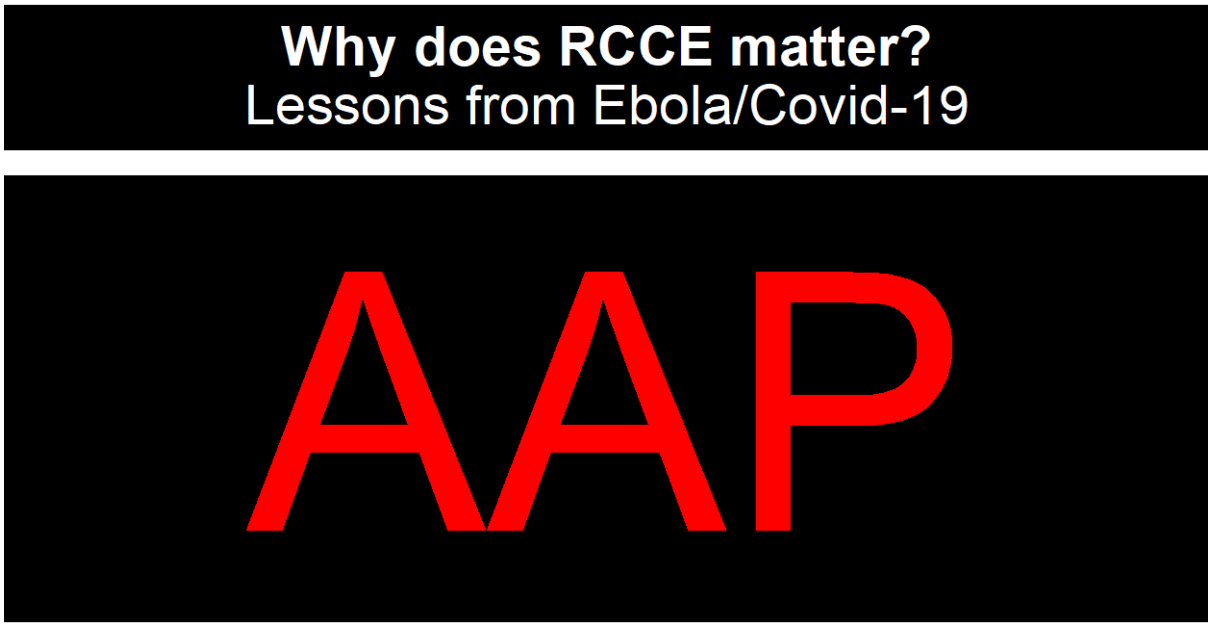
RCCE IS NOT A STAND-ALONE PROGRAMME… RCCE does not represent a stand-alone activity (or field of work). Rather, it should become integrated into existing programmes so that it improves the quality and accountability of our work.

HOWEVER, the world around us is constantly changing. Conflicts are more complex and last longer. Mobile phones and social media are becoming universal phenomena. And people, empowered by technology, expect – and demand – greater interaction with and accountability from their governments, the media and humanitarian and development organizations.

Slide 2.15: EXERCISE: What is RCCE? How do you define it?
Duration: 10 min.
Format: Group work followed by group discussion.

Instructions
- Each group to take a flip chart and a marker and write down all the reasons why RCCE is important.
- Ask them to think about how RCCE can benefit both communities and also their own organisation.

Group discussion (5 min)
- Pick one group to present its points. Then the other groups can add anything they had written down that not mentioned by the presenting group.
- Using the handout ([HANDOUT 01] RCCE: What is it and why it matters, section 2: What does RCCE matter? Tackling COVID-19 within and by communities) make sure the group has covered all the points listed – they will surely have a lot of good insights beyond those compiled in the handout.
- Conclude by informing participants that there is a handout ([HANDOUT 01] RCCE: What is it and why it matters) which summarises what RCCE and why it matters. Make the handout available (following relevant COVID-19 protocols).



Slide 2.16: Why does RCCE matter? Lessons from Ebola/COVID-19
Duration: 4 min.

The objective of this slide is to share some lessons learnt from the IFRC in recent previous health emergencies, most recently Ebola.

[NOTE FOR FACILITATORS: The text provided is not to be repeated *verbatim*. It is meant to provide some context].

According to the IFRC (2020) previous health emergencies have demonstrated that RCCE is vital because:

(Note: animation)
1. Epidemics start and end in communities. If we do not stop the spread of infection in the community, cases will continue to overwhelm hospitals. Treatment is important but is not the solution – and in countries like Afghanistan treatment might not be easy to access. The spread of COVID-19 will not end by treating people who are already infected, rather by stopping transmission of the virus in the community.

(Note: animation)
2. We need to recognise communities as 'experts' in their own situation and 'partners' to end this epidemic. Only by working in partnership with communities and community groups, acknowledging their expertise and skills, listening to their ideas, and supporting some of their solutions, can we collectively end this epidemic. By working this way, we can increase the relevance, acceptance and sense of ownership of those solutions. If we fail to work this way, we risk implementing activities and providing services that will not be used or accepted, wasting time and resources.

(Note: animation)
3. To work in partnership with communities, we need to build trust. RCCE is – by its very nature – participatory and community-based. Its success depends on establishing trust between those who know (experts), those in charge (authorities) and those affected (communities). If communities do not trust us, they will not listen to us, comply with public health measures, allow us safe access to communities, and report cases. They may not be

willing to use the medical services we provide to tackle the pandemic and the use of other health services, as a result of that mistrust, may even decline.

(Note: animation)

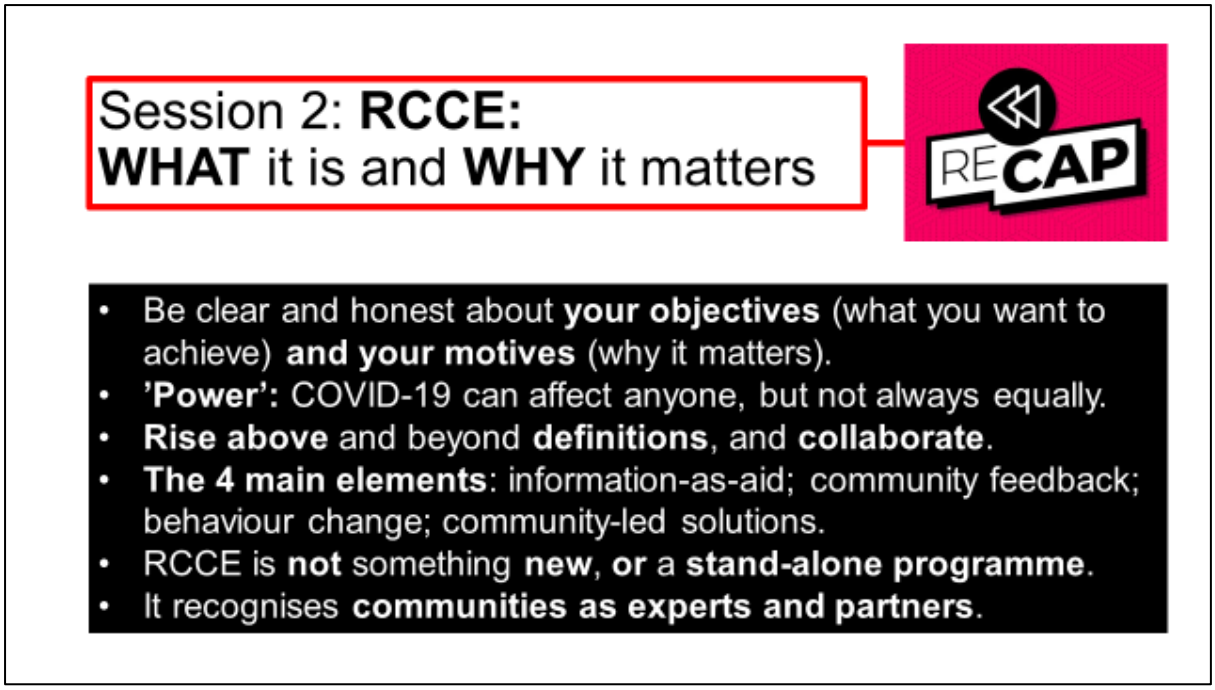
4. **To build trust, we need to listen and act on what communities tell us and to work with them.** Previous public health crises have demonstrated that disseminating public health messages alone won't change people's behaviour. This means that, in addition to identifying and supporting community-led solutions, we need to establish community feedback mechanisms to seek, analyse and act on that feedback. This lets communities see that we are listening and responding to their real concerns. Operationally, it is not just changing what we say (messages) but changing what we do and how we do it (response approach).

(Note: animation)

5. We need to be responsive to the real issues and concerns people have. During an epidemic, confusion and rumours about the disease often emerge from many different sources. Some of these sources may give conflicting information. When rumours spread faster than the truth and contradict accurate health information, it can prevent people from protecting themselves and undermine our risk communication efforts.

(Note: animation)

Only by truly putting people at the center we can be accountable to affected people and be held accountable by them and other stakeholders. **Accountability to Affected People (AAP)** is a responsibility, not a choice. It is also often a donor requirement.



Slide 2.17: RECAP: Session 2: RCCE: WHAT is it and WHY does it matter?
Duration: 3 minutes.

(Note: animation)
If you have time, ask participants what the most important points from this session were…

Take a few comments, show the slide and see the result!

If pressed for time, you can instead simply refer to the slide and ask participants whether there is something missing/they would like to add.