[HANDOUT 01] RCCE: What is it and why it matters

• What is RCCE? Rising above and beyond definitions

RCCE stands for 'risk communication and community engagement'. This concept has a lot in common with concepts you may already be familiar with (CEA – community engagement and accountability; AAP – accountability to affected populations; C4D – communication for development… just to mention a few).

RCCE refers to the field of work that focuses on engaging with communities to understand their needs and ensure they have access to timely, accurate information specifically in public health emergencies. The label 'RCCE' has its roots in the Ebola crisis in West Africa (2014-16).

RCCE is the agreed interagency terminology being used in the COVID-19 response
Regardless of the many similar terms that might be used in the humanitarian sector, RCCE is the agreed interagency terminology being used in the COVID-19 response. Globally, the lead agencies for RCCE are WHO, UNICEF and the IFRC.

RCCE is a relatively 'new' label… No agreed definition as such
Compared to many other areas of health specialisation, risk communication, and RCCE generally, are relatively 'new' as a field. This means that there are still ongoing debates and discussions about exactly how we should define it and what it includes. So far there is no formally agreed definition.

WHO defines 'Risk Communication' as…
The World Health Organisation (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 the people most at risk to understand the situation and to adopt protective behaviours. It also allows 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).

… and considers 'community engagement' as one of the 'many communications techniques' within RC
Increasingly, the public health sector is understanding how important community engagement is to the success of responses to health emergencies. In its definition of risk communication, WHO includes community engagement as one of the many communications techniques used (others are media and social media communications, mass communications and stakeholder engagement). (WHO, 2020).

The Red Cross Red Crescent Movement puts CEA at the centre of its work
The RC/RC Movement defines Community Engagement and Accountability (CEA) as the process of engaging communities and individuals to encourage and enable them to adopt protective behaviours and to listen to communities' needs, feedback and complaints. If humanitarian response is to be effective, it is essential that communities are able to actively participate and guide emergency programmes and operations across all phases (adapted from IFRC, ICRC, 2016).

The CEA work of the Movement is anchored has four main elements: life-saving information; community feedback; behavioural change; and community-led solutions. The IFRC also applies those 4 concepts in its approach to RCCE. In theory and in practice, RCCE and CEA have a lot in common.

Definitions matter. Collaboration matters more.
Each field, terminology or area of expertise can bring important and unique perspectives to the same challenge, but in the end, they tend to overlap one another.

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. Ultimately, communities do not care about our definitions and terminological conundrums. Why should they?

- **Why does RCCE matter?**
  Tackling COVID-19 within and with collaboration from communities

According to the WHO (2018; 2020), RCCE is important because:

1. **People have the right to be informed** and understand the health risks they face, in addition to receiving practical advice on how to protect themselves and their loved ones.
2. RCCE helps to **alleviate confusion and avoid misunderstandings** and hence to **build trust** in the response. This increases the probability that health advice will be followed.
3. RCCE helps to **transform and deliver complex scientific knowledge** in a way that is understood by, accessible to, and trusted by communities.
4. It helps to **bridge the gap between perceived risks** within affected and at-risk populations, and those seen by experts and authorities – those perceptions tend to differ.
5. It is **essential for outbreak surveillance, case reporting, contract tracing**, safe and dignified burials, caring for the sick, providing support for survivors, **and much more**.

According to the IFRC (2020), lessons from previous health emergencies – most recently Ebola – have demonstrated that RCCE is vital because:

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, many people may not be able to access treatment. COVID-19 will not be controlled simply by treating cases, but by stopping transmission in the community.

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, we can collectively end this epidemic. By doing so we can increase the relevance, acceptance and ownership of those solutions. If we fail to engage meaningfully with communities, the activities and services we undertake will likely not be used and accepted, wasting time and resources.

3. To effectively engage with communities, we need to build trust. RCCE is participatory and community-based in nature. To succeed, it requires the establishment of 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, report cases, and, quite possibly, they will not use the medical services we provide to tackle the pandemic. Acceptance and usage of other health services may even decline when there is a lack of trust.

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 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 feedback. In this way, communities can see that we are listening and responding to their real concerns. Operationally, it is not a question of just changing what we say (messages). We need to change what we do and how we do it (response approach).

5. We need to be responsive to the real issues and concerns people have. During an epidemic, there is often a lot of confusion. Rumours about the disease may come from many different sources. Conflicting information may circulate. When rumours spread faster than the truth and contradict accurate health information, it can stop people from protecting themselves and undermine our risk communication efforts.

Only by truly putting people at the centre of our work can we 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. This is a position increasingly taken by donors, too. Participatory approaches and mechanisms to facilitate community feedback are often now frequently required in project funding applications.