Collective approaches to risk communication and community engagement in the Ebola response in North Kivu, Democratic Republic of Congo

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Acronyms

AAP	accountability to affected populations
C4D	Communication for Development
CAC	Cellule d'Animation Communautaire (Community Action Cell)
CASS	Cellule d'Analyse en Science Social (Social Science Research Unit)
CCE	communication and community engagement
CCEI	Communication and Community Engagement Initiative
CDC	Centers for Disease Control and Prevention
CFWG	Community Feedback Working Group
CLIO	Comité Local Inter-Organisation (Inter Organisation Local Committee)
CRC	Congolese Red Cross
CRIO	Comité Régional Inter-Organisation (Inter Organisation Regional Committee)
CWC	communication with communities
CWG	Communication Working Group
DRC	Democratic Republic of Congo
EERC	Ebola Emergency Response Coordinator
EERT	Ebola Emergency Response Team
EpiCell	Epidémiologique Cell (Epidemiology Cell)
ETC	Ebola treatment centre
FAQ	frequently asked question
FBO	faith-based organisation
GBV	gender-based violence

HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HHI	Harvard Humanitarian Initiative
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
IEC	information, education and communication
IFRC	International Federation of the Red Cross and Red Crescent
IMS	Incident Management System
INGO	international non-governmental organisation
IO	international organisation
IPC	infection prevention control
KAP	Knowledge, Aptitude and Practices
LNGO	local non-governmental organisation
MoH	Ministère de la Santé Publique (Ministry of Health)
MSF	Médecins Sans Frontières (Doctors without Borders)
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PSEA	prevention of sexual exploitation and abuse
RCCE	risk communication and community engagement
RECO	Relais Communautaire (Community Health Volunteer)
SSHAP	Social Science in Humanitarian Action Platform
SOP	standard operating procedure
SRP	Strategic Response Plan
ToR	term of reference
TWB	Translators without Borders

UN	United Nations
UNEERO	United Nations Emergency Ebola Response Office
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMEER	United Nations Mission for Emergency Ebola Response
WASH	water, sanitation and hygiene
WFP	World Food Programme
WG	working group
WHO	World Health Organization

Executive summary

On 1 August 2018, the 10th epidemic of Ebola virus disease was declared by the government of the Democratic Republic of the Congo (DRC). With a total of 3,463 cases and more than 2,200 deaths (WHO, 2020a), it is the world's second largest Ebola epidemic after the West African outbreak. On 17 July 2019, the World Health Organization (WHO) declared the Ebola outbreak in DRC a 'public health emergency of international concern' (WHO, 2019a). This report examines how a collective approach to risk communication and community engagement (RCCE) was implemented, and the lessons from the Ebola crisis in North Kivu.

Accountability to affected populations (AAP) has proven to be essential in controlling the epidemic through effective RCCE, but it has been a struggle in DRC. Several factors limited the collective approach to RCCE in this outbreak. The epidemic occurred in a complex environment with intersecting humanitarian, governance, conflict and health risks (OCHA, 2019b). Long-standing situations of protracted crises marked by population displacements,[1] food insecurity and violations of human rights, were further exacerbated by the epidemic, with an estimated 1.4 million people in need of humanitarian assistance in 2019 in Eastern DRC (ibid.). This complexity partly explains issues around community mistrust (which led to attacks against actors in the Ebola response), and perceived risks and barriers to the uptake of protective behaviour.

Finding a systematic and predictable model of coordination to collectively engage with communities in a meaningful and coordinated way has been a significant challenge. A limiting factor was that the response's medical focus meant it was largely dominated by medical personnel and RCCE was deprioritised and undervalued. The lack of common understanding of what RCCE entails, and what a collective approach to RCCE is, inevitably made the collective approach to RCCE difficult to implement.

It is questionable as to whether current RCCE practices in DRC amount to a collective approach. While respondents recognised the need to establish effective coordination mechanisms and practices to enable a collective approach to RCCE, its coordination had many flaws including fragmentation and a lack of buy-in, collective spirit or dedicated capacity. Lack of clarity over leadership and poor coordination in the collective approach to RCCE is mirrored in the overall Ebola response; opportunities were missed to create a cultural shift in the management of the crisis.

Lessons learned from the 10th Ebola outbreak must be seized both for current and future responses in DRC, as well as globally, to support more systematic and collective approaches to RCCE. The crisis is a glaring example of the extent to which a medical approach needs social traction. The following recommendations should be considered in the current government-led response to Covid-19 and to the 11th Ebola outbreak in Equateur, DRC:

1. **Effectively integrate RCCE as an integral part of public health crisis preparedness and response at country and global levels.** Considering how integral community engagement is to prevention and management of a health crisis, RCCE partners globally should invest in working with governments, particularly Ministries of Health (MoHs), as well as with WHO

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1   In the second half of 2019, more than 600,000 people were displaced in the Kivus and Ituri provinces (OCHA, 2019a).

and UNICEF to strengthen capacity for RCCE. To do so and to ensure stronger buy-in, RCCE specialists should work more effectively with public health professionals and epidemiologists by adopting their language and methodologies. Health experts need to be convinced to move towards two-way feedback approaches, and to integrate strong community engagement practices in relevant languages, formats and channels.

2. **Build on existing practices and structures.** When a public health crisis occurs, RCCE partners should advocate with decision-makers and power holders to build on existing RCCE mechanisms, rather than create parallel systems. This includes building on existing community structures and institutions as well as current coordination around community engagement, communicating with communities and accountability to affected people.

3. **Effectively integrate and work with local actors.** RCCE partners should advocate for and support RCCE coordination and activities to be inclusive of local stakeholders, particularly religious leaders, faith-based organisations (FBOs), community-based organisations and organisations representing specific groups such as people with disabilities, as well as representatives of affected populations. International RCCE partners can play a pivotal role in linking local actors with donors, UN agencies and government and ensuring the inclusion of local actors.

4. **Scale up and adapt good practices.** RCCE partners should build on the current partnership between the Social Science Research Unit (CASS) and the Red Cross feedback mechanism and approach and integrate this into training on collective approaches to communication and community engagement (CCE) and RCCE as examples of response-wide mechanisms. Partners must document potential areas for improvement and disseminating learning at the global level so that good practices can be replicated in other crises (both public health and humanitarian crises). There should also be further reflection on how such approaches could be adapted to other contexts and integrated into discussions on RCCE and national-level plans for preparedness and disaster response.

5. **Invest in dedicated neutral coordination capacity and leadership** from the onset of a response. The right expertise must also be in place and local and regional actors should be included. Training in coordination and on the collective approach also needs to be provided to future coordinators.

6. **Strengthen coordination to enable collective approaches to RCCE.** Leadership of, investment in and coordination of collective approaches have suffered from unclear leadership and poor coordination of the overall Ebola response. Recognising that strong and effective coordination is a pre-requisite for a collective approach, public health response leaders and humanitarian leaders should ensure efforts are made to make collective approaches to RCCE better known and understood by leadership and coordination actors. To avoid a fragmented approach, one agency should be designated as part of preparedness for leading RCCE and collective approaches to RCCE alongside the MoH.

7. **Review the DRC Ebola coordination structure to inform future public health crisis responses.** A review of the DRC Ebola response and coordination structure should be carried out as part of a system-wide review of public health response and coordination architecture. An evaluation should reflect on why current practices in humanitarian coordination are unable to adapt in response to a public health crisis led by government. Such a review should consider how to inform a public health crisis coordination response mechanism where humanitarian coordination already exists.

8. **Donors should consider their role in ensuring a collective approach to accountability in any response is agile and localised.** Donors could have a stronger role in advancing the AAP/protection against sexual exploitation and abuse (PSEA) agenda, including through strengthening funding requirements or conditional

funding. A percentage of funding could be automatically allocated to an inter-agency feedback mechanism, including PSEA, for any Inter-Agency Standing Committee (IASC)-activated scale-up response. Donors can also play a key role in pushing the localisation agenda by including eligibility criteria that ensures part of their funds will be channelled to local organisations, along with capacity-building support when needed. Finally, donors need to encourage agility through flexible funding to ensure community insights are heard and lead to change in the response.

1   Introduction

On 1 August 2018, the 10th Ebola epidemic was declared by the government of the DRC, affecting two eastern provinces: North Kivu and Ituri. With a total of 3,463 cases and more than 2,200 deaths as of 31 May 2020 (WHO, 2020a), it is the world's second largest Ebola epidemic after the West African outbreak. On 17 July 2019, WHO declared the Ebola outbreak in DRC a 'public health emergency of international concern' (WHO, 2019a).

The Ebola epidemic in DRC is intertwined with years of conflict, insecurity, chronic and acute humanitarian needs and population displacements. These difficulties were exacerbated by the epidemic: the Humanitarian Needs Overview (HNO) estimated that almost 1.9 million people in at-risk health zones or 'hotspots' are in need of humanitarian assistance (OCHA, 2019a).

This complexity has meant the response faced significant access challenges as well as community distrust (also referred to as 'resistance'). This has led to targeted attacks against actors in the Ebola response. Approximately a year into the response, a perception survey carried out in Béni, North Kivu revealed that only 27% of affected communities agreed with decisions made by humanitarian actors; 19% believed their opinion was taken into account; and just 34% knew how to make a complaint or give feedback (HHI, 2019).

AAP is essential in working to control the epidemic through effective RCCE, but it has been a struggle in DRC. Organisations who worked both in the West African and DRC responses felt they were able to engage communities and show accountability as individual organisations. However, the real challenge was in finding a systematic and predictable model of coordination to collectively engage with communities. As one interviewee stated:

> It was that one response, the West Africa Ebola response in 2014–2016, where we realised that it is about the coordinated and collective effort. This is what the Grand Bargain 'participation revolution' calls for: coordination, standardisation, etc., all the things that help to bring us together.

1.1   Definitions

For the purpose of this report, the research team defines a collective approach to CCE as:

> a multi-actor initiative that encompasses the humanitarian response as a whole, rather than a single individual agency or programme, and focuses on two-way communication, providing information about the situation and services to affected communities; gathers information from these communities; and closes the feedback loop by informing the communities as to how their input has been taken into account. The goal of a collective approach to CCE is the increased accountability to and participation of affected communities in their own response. [2]

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2   This definition is meant to help with the clarity of the report rather than propose a definitive definition of collective approaches to CCE. The definition is based on an initial literature review and inception interviews, which informed the development of this working definition by the research team.

In the context of the Ebola response the term 'risk communication and community engagement' is preferred to 'communication and community engagement' to reflect the additional objective of behaviour change in the context of a public health crisis. In this context, the population must be at the centre of the response in order to receive timely, accurate information on the virus and how to adopt health-seeking behaviour. The emphasis is on 'processes and approaches to systematically engage and communicate with people and communities to encourage and enable communities to promote healthy behaviours and prevent the spread of infectious diseases during public health events' (IFRC, 2019a: 2). This partly requires translating scientific knowledge into accessible and easy-to-understand messages so that communities can act upon it. WHO guidelines on RCCE for the Ebola outbreak include key CCE elements (WHO, 2018):

• Two-way communication with affected populations.
• Supporting community communication needs.
• Management of rumours, perceptions, misinformation.
• Participation of communities.
• Engaging communities.

It is important to acknowledge that the term RCCE is relatively new and emanates from the often-used terms 'risk communication' and 'community engagement'. RCCE includes strong elements of community ownership in preventing, preparing for and responding to a health crisis, partly through community feedback approaches to inform decision-making processes for the response and closing the feedback loop. It became more prominent in public health crises following the West Africa Ebola response.

1.2 Methodology

This report is part of a larger study commissioned by UNICEF on behalf of the Communication and Community Engagement Initiative (CCEI)[3] to identify solutions to address current bottlenecks and challenges to community engagement, as well as to develop evidence of the added value and limitations of collective approaches. This paper, on the Ebola crisis in North Kivu, focuses on examining collective approaches to CCE in a complex public health crisis.

A literature review and stakeholder mapping were conducted, followed by remote and in-country interviews and in-person participation in three coordination meetings and/or working groups.[4] More than 50 documents on the country context and the ongoing Ebola (and humanitarian) response in North Kivu were reviewed in French and English. The review covered a range of sources, from strategy papers, response plans, coordination meeting minutes and needs assessments to social science research briefings, community feedback presentations and newspaper articles. The research team reviewed secondary data on the perspectives of affected people in the Ebola response in North Kivu and on issues relating to communication preferences (languages and channels of communication), as well as perceptions of the response, rumours around the Ebola disease and the response itself.[5] Given the wealth of existing data, the

3   The CCEI was created in 2017, comprising several agencies such as UNICEF, the UN Office for the Coordination of Humanitarian Affairs (OCHA), the IFRC and the Communicating with Disaster Affected Communities (CDAC) Network. The global Initiative seeks to improve the quality and effectiveness of emergency responses 'through a harmonised, timely, systematic and predictable collective service for CCE with affected communities' (CCEI, 2017). The CCEI was recently integrated under the IASC Results Group 2 on Accountability and Inclusion.

4   The research team participated as observers at two working-group meetings: the Communications Working Group (CWG) led by the UN Ebola Emergency Response Coordinator (UNEERO) and the Community Feedback Working Group (CFWG) led by the RCCE Commission (co-lead: IFRC).

5   The research team accessed the CASS Google Drive, which included their research reports and briefs, briefing from Social Science in Humanitarian Action Platform (SSHAP), the Knowledge, Aptitude, Practice assessments (supported by the Harvard Humanitarian Initiative (HHI)), the IFRC community feedback presentations, the Translators without Borders (TWB) language assessments, and more.

decision was taken not to conduct focus group discussions with affected communities.

Interviews covered a range of stakeholders, with a focus on those engaged in coordination efforts on RCCE via various platforms. A total of 45 interviews with 54 separate interviewees were conducted in DRC and remotely. Semi-structured interviews were conducted with stakeholders from government (11%), local non-governmental organisations (LNGOs) (11%), international non-governmental organisations (INGOs) (22%), United Nations (UN) agencies (36%), other international organisations (IOs) (9%), donors (4%) and research organisations (7%).

The research faced some challenges and limitations:

1. Key documents, such as meeting minutes and internal strategy documents, were hard to access or provided late in the research process.

2. Mapping key stakeholders was difficult due to the lack of a readily available contact list, particularly for in-country informants. As a result, mapping relied on online sources, the literature review and snowballing techniques.

3. The low response rate to interview requests limited the number of interviews, especially with local organisations and top-level leadership of government and UN agencies.

4. High turnover among humanitarian actors meant that a small proportion of interviewees had only recently taken up their posts, limiting their understanding of the overall response.

5. The lack of effective implementation of a collective approach to RCCE, along with respondents' lack of understanding of what a collective approach to RCCE is, meant that the research focus on collective approaches was difficult to articulate to respondents.

2 State of the collective approach to risk communication and community engagement in the Ebola response

2.1 Navigating a complex and multi-layered coordination architecture

The humanitarian response architecture in DRC has evolved since the onset of the crisis and has been adapted around the Ebola situation; thus it is new to the government and national and local organisations. Such architecture makes coordination and collaboration between stakeholders complex and dynamic and creates various opportunities and challenges for a collective approach to RCCE.

In August 2018, the Ebola epidemic was declared a Public Health Emergency and the response was led by the MoH with the support of WHO (and the United States Centers for Disease Control and Prevention (CDC)). They were guided by several Strategic Response Plans (SRPs) and WHO's Incident Management System (IMS).[6]

In May 2019, the IASC activated its Humanitarian System-Wide Scale-Up Activation Protocol for the Control of Infectious Disease Events (see IASC, 2019).[7] This was meant to 'help optimise coordination and response capacity in affected and at-risk areas, strengthen engagement with communities, and bolster preparedness actions' (The New Humanitarian, 2019). As a result, the Ebola Emergency Response Team (EERT) was set up to support the international response to the epidemic. The EERT is co-chaired by the Ebola Emergency Response Coordinator (EERC, UN) and the Assistant Director-General of WHO.

In 2020, two main coordination structures are in place to support the response: the MoH and WHO-led public-health response (Pillar 1) and the United Nations Emergency Ebola Response Office (UNEERO) coordination structure (Pillars 2–5). More detail on these structures (including an organigram) can be found in Annex 1. These Ebola-specific

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6   While an OCHA-led humanitarian response was active in North Kivu with operational clusters, a decision was made to create a different coordination system for this 10th Ebola outbreak, based on of the Sierra Leone pillar system (now institutionalised for all outbreak responses through the WHO IMS system). The ninth Ebola outbreak response in Equateur (DRC) was managed through the existing cluster system. Why the WHO IMS system was put in place when a cluster system was already operational remains unclear despite this being repeatedly asked during the research.

7   No further extension and started phasing out from 27 March 2020.

coordination systems exist separately and alongside the long-established OCHA-led coordination system, which focuses on DRC's existing humanitarian situation.

2.2 An overview of RCCE activities

2.2.1 The RCCE Commission

The RCCE Commission (part of Pillar 1) was established as a standalone commission, co-led by UNICEF (with WHO initially) and MoH. UNICEF acts as a financial intermediary, receiving the Ebola funding for RCCE related activities, which is then channelled to operational partners such as INGOs and LNGOs, including the MoH personnel working for the RCCE Commission. UNICEF is also a major operational partner.

The Commission is only one of several working groups and initiatives that bring together actors around RCCE and CCE. This fragmented coordination system for the overall Ebola response has led to a fragmented coordination approach to RCCE (see Figure 1).

Under the Strategic Response Plan 4.1 (SRP4.1), the RCCE Commission's role was strengthened as it is leading work on community engagement (one of six strategic objectives) (MoH, 2020a). In addition, five out of six guiding principles in the Plan relate to communication, community engagement and AAP. The Plan calls for leaders of the response to listen and adapt according to the needs and concerns expressed by communities, and highlights the link between effective community engagement and securing community access, acceptance and ownership of the response from the affected population. The work of the RCCE Commission is critical as it cuts across all other commissions.

In November 2019, the RCCE Commission developed a Strategic Plan for Risk Communication and Community Engagement, aligned with the priorities set in the SRP4.1. The strategy mainly focuses on strengthening partnerships with communities and having communities as drivers of the response.

Box 1: System-wide accountability in a public health response and integration in the Humanitarian Response Plan

In a traditional humanitarian response, the Humanitarian Coordinator (HC) and Humanitarian Country Team (HCT) are held accountable by the Emergency Relief Coordinator for meeting key commitments outlined in a 'compact' or accountability framework. The compact can be adapted but commitments related to gender-based violence (GBV), PSEA, collective accountability and centrality of protection are compulsory.
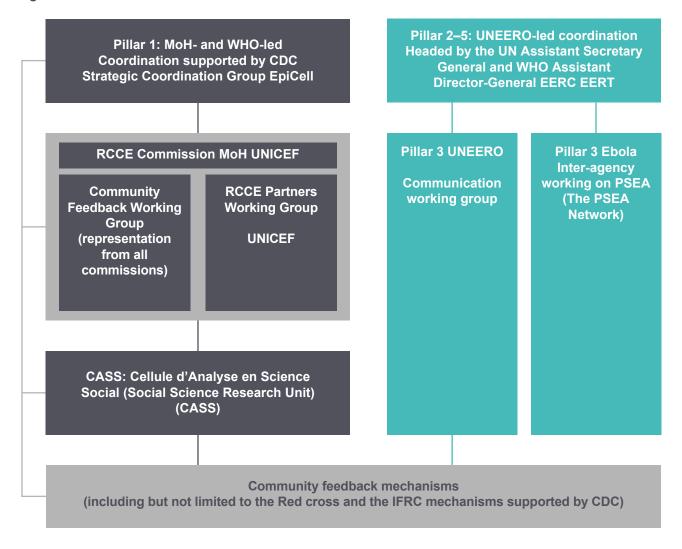
OCHA, which has developed strong expertise on community engagement-related (previously called communication with communities (CWC)) policies and mechanisms, usually leads the coordination of a humanitarian response. However, no such framework exists for ensuring a system-wide culture of accountability for a public health crisis led by a host government and supported by WHO (although WHO policy and guidelines refer to RCCE and community-led approaches for a public health crises).

In DRC, the public health crisis response was undertaken in parallel to a pre-existing humanitarian response, mostly by the same NGOs in North Kivu. This leads to questions around whether the humanitarian response should include the Ebola component within its collective accountability framework.

The strategic plan and objectives of the RCCE Commission are supported by different partners implementing a range of common services, starting with common development of RCCE messages and translation services into relevant languages (for a full picture of these common services, please refer to Annex 1, Box A1).

The RCCE Commission is supported by two working groups: the RCCE Partners Working Group and the Community Feedback Working Group (CFWG). These groups feed information, recommendations and other plans for approval to the RCCE Commissions as well as convene representatives of other commissions (for further details on these groups, see Annex 1).

Figure 1: RCCE-related coordination structures

Pillar 1: MoH- and WHO-led Coordination supported by CDC Strategic Coordination Group EpiCell

Pillar 2–5: UNEERO-led coordination Headed by the UN Assistant Secretary General and WHO Assistant Director-General EERC EERT

RCCE Commission MoH UNICEF

Community Feedback Working Group (representation from all commissions)

RCCE Partners Working Group UNICEF

Pillar 3 UNEERO Communication working group

Pillar 3 Ebola Inter-agency working on PSEA (The PSEA Network)

CASS: Cellule d'Analyse en Science Social (Social Science Research Unit) (CASS)

Community feedback mechanisms (including but not limited to the Red cross and the IFRC mechanisms supported by CDC)

2.2.2 Other RCCE-related coordination structures under UNEERO

A range of other coordination structures or working groups also address RCCE under the coordination system led by UNEERO (Pillars 2 to 5). These work in parallel to the coordination structures under Pillar 1 and are not necessarily integrated with each other.

UNEERO Communication Working Group (Pillar 3)

The Communication Working Group (CWG) was created in September 2019, following UNEERO's roll-out. The CWG is led by communication specialists and meetings are conducted in English and attended primarily by staff from UN agencies and INGOs (RCCE specialists, Country Directors, communications officers and advocacy officers). The CWG was intended to support Pillar 3 of the response and

covers institutional communication and some risk communication activities. It has convening power (under UNEERO) and brings together experts from different agencies to develop crucial risk communication-related messages in a timely fashion. There is no systematised coordination between the CWG and the RCCE Commission (and consequently no official validation of messages by the RCCE Commission). Instead, individual agencies or UNICEF personnel attending meetings in both pillars ensure a minimum of information is exchanged.

The Ebola inter-agency working group on PSEA (the PSEA Network) (Pillar 3)

A national PSEA network, led by the United Nations Population Fund (UNFPA) under the wider humanitarian response, was in place prior to the Ebola outbreak, but was suspended in the Ebola-affected eastern provinces for reasons that

remain unclear. Instead, an Ebola inter-agency working group on PSEA (the PSEA Network) was created in late October 2019.[8] The Network falls under the UNEERO office (Pillar 3) and is led by a PSEA Advisor from UNFPA, who is managed by the EERC. Funding constraints are a major challenge to implementing its workplan, with current funding only covering the salary of the PSEA Coordinator. To date, there is no inter-agency PSEA mechanism, but most organisations have their own systems in place, often consisting of a hotline coupled with other non-phone-based channels to report allegations of sexual exploitation and abuse. The PSEA Network has led on the development and implementation of the Code of Conduct, which every individual involved in the Ebola response, including all MoH staff, was expected to sign by 30 March 2020.

2.2.3 The IFRC Red Cross feedback mechanism and the Social Science Research Unit (CASS)

The IFRC Red Cross feedback mechanism, supported by CDC
At the onset of the Ebola response in DRC the IFRC set up a large-scale community feedback mechanism covering all the Ebola-affected health zones in North Kivu and Ituri. The mechanism collects feedback from communities affected by Ebola on their perspectives of the crisis and the response. It relies on the DRC Red Cross Society's (CRC's) 800 trained volunteers from the local area, who all speak the local language and are familiar with the socio-cultural and political context.[9] According to respondents, this feedback mechanism – which has become a common service available to all actors – collates data and the analysis is openly shared and can be used by anyone to inform individual and collective decision-making. With more than 600,000 data points, this is by far the largest feedback data system rolled out at scale in the

Ebola response. With the support of OCHA, a Humanitarian Data Exchange platform was set up, enabling those working in the Ebola response to access community feedback data trends per location, supported by example comments. Finally, a weekly presentation of the analysis is presented at the CFWG in Goma and other sub-coordination, at the EERT general meetings and sometimes at the CWG meetings under Pillar 3.

The Social Science Research Unit (CASS)
Started in January 2019, the Social Science Research Unit (CASS) aims to 'provide programmatic guidance through a better understanding of population behaviours and perceptions and identify potential causes of epidemiological trends' (MoH, 2020b). The unit has four specific objectives:

1. collecting and analysing social and behavioural science data;
2. influencing the response (interventions and approaches);
3. monitoring the implementation of research recommendations; and
4. building the capacity of local social science teams.

From mid-2019, the CASS and IFRC have been working closely together to triangulate the feedback data with the results of the research.

Findings from CASS research are presented to the general coordination meeting as a standing point on the agenda, to the sub-commissions (one by one) and to sub-coordination, which develop recommendations to ensure ownership and feasibility. Implementation of recommendations are systematically tracked through an online tool called MONITO and the impacts of interventions are reviewed. While there is no systematic presence of the CASS at RCCE Commission meetings, collaboration

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8   At the time of the study, there had been no specific collaboration between the CFWG and the PSEA Ebola Network as its coordinator does not participate in the working group's meetings. The Ebola PSEA Network is, however, represented at national PSEA meetings, with the vision that at the end of March 2020 the Ebola Network would be transferred under the national one and cover both the Ebola and humanitarian responses.

9   For more on how these volunteers collect data, see Annex 1.

exists with multiple examples of concrete support provided by the CASS to the RCCE Commission.[10]

2.3   A collective approach to RCCE?

None of the 54 individuals interviewed for this study had heard of a collective approach to RCCE. The majority of respondents explained the collective approach in terms of a coordinated approach that:

1. avoids overlapping of activities, duplication of efforts/partners in the same area;
2. maps actors, is clear on the roles and responsibilities of actors involved in coordination and interventions, promotes meaningful and productive collaboration including pooling resources and focuses on complementarity between actors; and
3. harmonises approaches such as common messages and promotes the flow of information.

Several respondents said that there is no clear distinction between a collective and a coordinated approach. Some interviewees added to the coordinated approach the need to have a common vision, a common direction, or a common objective through, for instance, a common strategy. For others a collective approach would be community engagement that is meaningfully cross-cutting throughout all aspects of the response. Others explained the collective approach in terms of the objectives of CCE: to provide clear and understandable messages, to put community at the centre, to understand the situation, the actors involved and their roles, and for them to engage or take ownership of the response.

Although a high number of respondents felt there was currently no collective approach in the Ebola response, many identified common services that could constitute a collective approach, such as the Red Cross feedback mechanism, supported by CDC. Similarly, the CFWG was reported by some interviewees as having the potential to become part of a collective approach as it is meant to rally the commissions and partners to discuss community feedback collected through different means with the common objective of adapting the response.

However, interviewees emphasised that these do not yet constitute a collective approach. The Red Cross feedback mechanism is still perceived very much as an IFRC/CRC system (at the Goma level in particular) rather than a system for the benefit of all actors. There is also a lack of wider buy-in of the RCCE approach, which is reflected in many commissions' lack of regular participation in the CFWG. The recommendations discussed in the meetings of CFWG are tracked, but there is no commitment to ensure commissions systematically act on the feedback from communities.

A minority of informants reported other initiatives as potential elements of a collective approach. One example is the SRP because it is a strategy with clear guidelines and activities, with each commission having to report daily and monthly on a set of indicators. The CASS was also perceived as a collective approach as its activities cut across all commissions. However, neither of these examples are directly linked to RCCE, nor have they enabled a systematic approach to it, meaning that the collective approach to RCCE is still very much absent from the response

The RCCE Commission has the potential to become a collective platform by bringing a diversity of expertise and supporting collaboration, the pooling of tools, training packages, information, education and communication (IEC) materials and messages that are accessible to all partners. At present, however, as discussed below, the RCCE Commission is a coordinated approach that fails to inform collective decisions or influence collective outcomes.

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10 Around 50% of the CASS current recommendations fall under the remit of the RCCE Commission. The CASS leads regular Knowledge, Attitude and Practices (KAP) assessments resulting in clear recommendations for all commissions (including the RCCE Commission) and for the general coordination.

3 Lessons from the Ebola response

It is questionable whether current RCCE practices amount to a collective approach. The fragmented and disconnected coordination of RCCE through different structures, working groups and initiatives means there is a lack of clarity on how these platforms interact with each other. Resources are not necessarily used effectively and efforts often fail to become more than the sum of their parts.

This challenge is compounded by the lack of understanding of what a collective approach to RCCE is, particularly at the senior and leadership level. Without a commitment to a collective approach from the leadership level, it is impossible to achieve in practice. This undermines opportunities for the response to influence collective action and decision-making.

Several factors limited the collective approach to RCCE in this 10th Ebola outbreak. The epidemic occurred in a complex environment of intersecting humanitarian, governance, conflict and health risks, including pre-existing health risks such as cholera and measles (OCHA, 2019b). Long-standing situations of protracted crises, marked by population displacements,[11] food insecurity and malnutrition and violations of human rights, were further exacerbated by the epidemic. This complexity partly explains issues around community mistrust, and perceived risks and barriers to the uptake of protective behaviour.

The response's medical focus meant it was largely dominated by medical personnel; RCCE was deprioritised and undervalued. The lack of common understanding of what RCCE entails, along with the fact that no actors seemed to know what a collective approach to RCCE is, inevitably made the collective approach difficult to implement.

While respondents recognised the need to establish effective coordination mechanisms and practices to enable a collective approach to RCCE, its coordination had many flaws, including fragmentation and a lack of buy-in, collective spirit or dedicated capacity. Finally, there was no clear leadership in ensuring a collective approach to RCCE and opportunities were missed to create a cultural shift in the management of the crisis. This section delves further into these challenging factors, while also identifying some enabling elements.

3.1 The complex crisis environment: mistrust, risks and lack of uptake

Response-wide efforts towards effective RCCE were greatly hampered by the lack of consideration for making the public health response fit for DRC's complex crisis environment. In many ways, the Ebola response failed to be conflict-sensitive or integrate the needs of affected people beyond the public health crisis, leading to mistrust, perceived risks and a lack of uptake of protective behaviour.

This was particularly significant in terms of the government and the army's role in the response. The Ebola epidemic came at a time when communities' trust in the government and army was extremely low. The DRC government was already struggling to deal with conflict; more than 130 armed groups were present in the country and there were several army offensives against local armed groups during the Ebola response.

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11 In the second half of 2019, more than 600,000 people were displaced in the Kivus and Ituri provinces (OCHA, 2019a).

The national Congolese army and the police also increased their presence to help manage the Ebola response. This contributed to population distress and blurred the identities between parties to the conflict and those involved in the Ebola response (MSF, 2019).

The framing of the response as a public health crisis rather than a humanitarian one has sidelined existing good practices commonly implemented in humanitarian responses. Some interviewees revealed this framing meant the 'do no harm' approach and the centrality of protection have not been adequately considered. For example, security and access challenges were addressed by a counterthreat (police and army) leading to a militarisation of the response rather than the acceptance approaches commonly adopted by humanitarian actors. One donor stated that it was 'counterproductive to be going to the communities not having a humanitarian approach where you should care about acceptance'.[12] Serious attacks against responders were reported, including against the Médecins Sans Frontières (MSF) Ebola treatment centres (ETCs) in Katwa and Butembo in February 2019, which led the organisation to stop its operations. Indeed, more than 300 attacks against Ebola health workers were recorded in 2019 (MSF, 2019).

Public health outcomes were also prioritised over effective community engagement in this framing. There was tension between the time it takes to engage with communities and the public health emergency imperative to stop Ebola transmission. For example, according to interviewees, infection prevention control (IPC) teams faced pressure to conduct household decontamination swiftly, even when faced with refusals as communities felt that their rites and practices were being swept aside. Safe and dignified burial teams were also pressured to act within a maximum of 72 hours.

Mistrust in the response was further exacerbated when large numbers of responders were brought in from outside the local area who did not speak the local Nande language. This was a major constraint. As one interviewee pointed out: 'We were all presumed guilty until proven innocent by the communities and that was the biggest issue since the beginning.' One year after the epidemic began, a study found 25% of respondents believed that Ebola was introduced for political gain, as a way to exterminate Nande people, and to provide business opportunities (CASS, 2019a).[13] General mistrust of individuals and organisations coming from outside the community meant that interventions were not always accepted and advice on how to protect against Ebola was not taken up. For example, a CASS (ibid.) study found that the main factor influencing decisions to vaccinate children is trust in the person giving the vaccine. Contextual factors were not adequately considered, meaning that the initial mistrust of outsiders continued. As one interviewee reflected:

> The feedback we are receiving from communities is not limited to the Ebola response but also to the general conflict environment and it is important for teams to understand this. The North Kivu context means that the teams need to know how to handle community perceptions, to receive feedback regarding the 'conspiracy massacre theory' as they see anything strange as an external manipulation to exterminate them. The process of changing social behaviour therefore takes time and requires an understanding of this particular context of intervention.

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12 Acceptance in the North Kivu context, which is fraught with conflicts, is pivotal: 'Acceptance involves obtaining the approval, consent and cooperation of communities, local authorities and other stakeholders […] Central to obtaining acceptance is clarifying the role and motivation of response actors. This means adhering to a standard code of conduct, such as the core humanitarian principles of neutrality, impartiality and independence' (Fairbanks, 2020).

13 A recurrent theme on social media and in communities, which was confirmed by the Red Cross community feedback mechanism, is around the 'Ebola Business' or the belief that the Ebola response was meant to provide economic gain for some people rather than help communities affected by the virus. This perception has in some respects been confirmed as fact, following allegations of fraud and corruption (see The New Humanitarian, 2020).

Communities also saw a disparity between significant humanitarian needs, which for years have been unmet, and the money flowing in for the Ebola response. Several interviewees noted that 'the problem of Ebola is not about Ebola. Ebola has rarely been the number one priority of the communities. We told them to wash their hands, but they had no water'. A severe measles outbreak was also ongoing, but communities felt only the Ebola response was getting resources. Actors such as MSF understood how trust could be gained through balancing a rush towards the Ebola epidemic with the need to address other crucial health-related needs of the communities (Vinh-Kim Nguyen, 2019). This eventually led to the creation of Pillar 3 – the UNEERO response including the CWG – which was intended to address non-Ebola needs in order to increase communities' acceptance of Ebola-related interventions.

3.2 A medical approach to the response: de-prioritisation, instrumentalisation and lack of good practices on RRCE

The leadership of the response, predominantly from medical backgrounds, had a restricted understanding of RCCE. This proved detrimental as opportunities were missed to listen to and embed community feedback in the response. The focus on the medical objective of quickly breaking contamination chains, coupled with an emphasis on numbers and quantitative indicators, meant that community engagement and its role in preventing the further spread of the virus was not prioritised until early 2019. This delay had lasting consequences for the impact of RCCE.

3.2.1 De-prioritisation and narrow understanding of RCCE

Community feedback was not deemed important by leaders of the response because its qualitative nature was considered non-scientific and thus not useful. As one interviewee said: 'Unless you find a quantitative way of showing qualitative data, biomedical experts hardly look at you as somebody who is providing evidence of things that you need to change'. Community feedback reports

were mostly perceived by the response leadership and other commissions as being solely for the RCCE Commission. Anthropologists involved in the response reported similar challenges; due to the qualitative nature of their research, it was disregarded by the leadership and it took much collective effort to ensure it was considered. In contrast, some respondents argued that if data had been presented in a more compelling and succinct manner, it would have been possible to bridge the gap on language, culture and working approaches between the humanitarian and the health communities. This would have supported efforts to involve the wider biomedical community and make the leadership listen.

The predominance of medical staff in the response also led to differing understandings of what RCCE entails and ultimately narrowed its objectives. Understandings of RCCE not only differed from one agency to another (including the government); the concept of it was never widely understood. The RCCE Commission has been and is still referred to as the 'Communication Commission', revealing perceptions that it focuses on risk communication rather than community engagement. For example, one senior-level interviewee described the objective of risk communication as supporting the community 'to perceive and understand the risk and to define with the community the actions it can take, lead, in order to limit the risks and impacts on the daily lives of its people'. Interviewees reported that too often RCCE was 'something being done to people' rather than a two-way discussion where responders would listen to communities. Even within the RCCE Commission, a narrow understanding of RCCE means that the RCCE strategy focused on telling affected people what they should or should not do. The element of ownership was often left out by implementers, leaving communities disempowered. As a result, many interviewees felt that community engagement failed to include elements of ownership and accountability.

There was a lack of consensus on how accountability should be integrated in the response and its link to the RCCE Commission. For some, accountability should not have been embedded in the RCCE Commission's remit;

instead it should be part of the overall response and trickle down to all components, ensuring concrete actions are taken. Other interviewees felt it was impossible to separate accountability from community engagement as the two are intertwined, while others considered community engagement to be cross-cutting (i.e. communities should be at the centre and leading everything) and as such should not have been positioned under the RCCE Commission. These opinions reflect the internal policies of some of the main RCCE-partner organisations and highlight a significant impediment to implementing a collective approach.

3.2.2 Instrumentalisation of RCCE for other ends

In addition, RCCE activities were generally perceived by the wider response to be a method for resolving community incidents and issues between communities and the Ebola responders. Indeed, RCCE partners were often perceived as useful only when responders faced community resistance. There were recurrent references in interviews to RCCE partners being the 'clean-up crew' or 'firemen' who 'put out fires' after interactions with communities had gone wrong. RCCE was not understood as being integral to the response or something that all actors should be involved in on a daily basis. Consequently, some respondents felt that the approach to RCCE was reactive rather than proactive, and reluctantly implemented as part of the response.

RCCE was perceived by many as a tool to 'break down reticence, to deal with the community attacks against the responders' or that its objective was 'to get community structures and members to comply with the response'. Underlying this perception was the belief of many in the response that the problem lies with communities. The continuous use of terms such as 'resistance',[14] 'reticence', 'refusal' and 'reluctance' in interviews highlighted that many involved in the response blamed

communities for any challenges. As a result, as one interviewee concluded: 'We have reversed the client–agency relationship: we are the communities' clients and it is them (communities) who have to change their behaviours, not us (the response)'. This reversal was clearly reflected in the early indicator of the RCCE Commission relating to 'lifted resistance',[15] which some RCCE partners considered to be coercive rather than related to communication and community engagement. These beliefs and perceptions were at the heart of why the Ebola response was reluctant to adapt in light of community feedback.

3.2.3 Lack of good practices on RCCE

The lack of consensus on what RCCE entails and its resulting de-prioritisation in the response was further compounded by the RCCE Commission's lack of clear and formalised guidelines or standard operating procedures (SOPs) and activities.[16] As one interviewee reported:

> We could have [SOPs] to help professionalise RCCE in the view of medics who think if you do not write it down then it does not count. Instead, now it is seen as something 'a bit fluffy', you just need to hire a bunch of local people, you give them a 45-minute training and then tell them to go talking to the communities.

As a result of these cultural differences, good RCCE practices were not integrated early in the response and mistakes were made, including delays in using the right language (see Box 2). Field teams, such as the IPC teams, were not trained systematically in RCCE and did not collaborate with the RCCE Commission until late 2019. According to interviewees, this resulted in inappropriate interventions and culturally disrespectful behaviours, hampering acceptance of the response. Teams went in

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14 Some informants mentioned their dislike of the word 'resistance' as implying communities are doing something wrong, which was not the case in their opinion.

15 *Résistance levée* in French.

16 UNICEF, with the support of key RCCE partners, is planning to develop community engagement standards. This initiative has the potential to bring more clarity and consensus on what RCCE should cover.

Box 2: Inclusion and languages to control the spread of Ebola

Using the right language and terminology around risk communication has proved challenging. Before 2019, there had been no specific assessment to deepen knowledge of communities' preferences regarding languages and formats used for communicating with them about Ebola. Risk communication materials used in the first six months of the response were overwhelmingly in French, with some in Swahili but not in Congolese Swahili. This effectively excluded a significant proportion of communities, such as women and elders who only speak a local language (TWB, 2019a). Additionally, Ebola response teams' use of Lingala – a stigmatised language associated with the Congolese military – meant that people avoided them at the beginning of the crisis.

The challenge was therefore to adapt risk communication to a multilingual environment, requiring materials to be translated into Nande, Congolese Swahili and local dialects derived from Swahili to cover the needs of all population groups and health workers. The Translators without Borders (TWB) language assessment in Beni showed that communication partners were using specific medical terms in French (for lack of knowing the correct translation into the local language), creating confusion, frustration and fear among the population (TWB, 2019b). This partly explains why studies continue to show a large proportion of people lacking knowledge around Ebola and its symptoms.* Through the TWB initiative, RCCE Commission partners have worked to adapt risk communication formats, provide translations and create a glossary for responders. Considering what communities understand from the common messages conveyed to them (through field testing communication materials) was also pivotal.

* Note: In a KAP study, 49% of respondents explained that it is because Ebola symptoms were not clearly understood and known that community members are not trusting the Ebola diagnostic from the ETC (CASS, 2019a).

without first engaging with traditional leaders or understanding community dynamics. Indeed, one interviewee reported being told by a community leader, 'the Ebola response entered through the roof, not the front door'.

The set-up and payments of community-based structures such as the RECO (*Relais Communautaire* – community health workers),[17] and the payment of fees to security forces to escort responders in insecure areas all compounded the lack of community acceptance. This also undermined local humanitarian action. Local NGOs reported struggling with a lack of budget and could not always get community members to engage. As one local NGO member stated, 'we have monetised the response. Before the RECO[18] were volunteers but with Ebola they started to get paid. Teachers have even abandoned their classrooms to become RECO'. This person added that as a result of paying for community volunteers, not all RECO volunteers were perceived as legitimate by communities: 'Letters were received from communities criticising a choice of RECO they would not accept'.

3.2.4   Progress in integrating RCCE in the response

As the epidemic continued, an increase in 'community resistance'[19] and multiple attacks against responders led to community engagement and feedback being considered by other commissions. RCCE partners started to recruit more local people and more community engagement work was done with existing community structures, which ultimately supported acceptance and access. One good

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17 RECO have been created as a 'community engagement structure' to support the response in alerts, community tracing and surveillance, etc. The government decided, against the advice from NGOs, to pay these RECO, initially $10/day/person.

18 According to respondents, this also led to former community health workers being replaced by new ones in a non-transparent manner and undermining the notion of building on existing public health resources.

19 The use of quotation marks is intentional to reflect the language used by respondents rather than a conscious choice of wording from the authors.

practice was the creation of Rapid Intervention Teams made up of religious leaders from different faiths, women and youth representatives, Nande community leaders and business representatives. These individuals are trusted and well-known in their respective communities and are solicited when RCCE field teams cannot manage a specific issue with a community.

The RCCE Commission's credibility has grown, with the coordination leadership and other commissions increasingly recognising its central role in the response. Field interventions are now much better coordinated between commissions, allowing RCCE teams to engage with communities prior to interventions, such as safe and dignified burials or vaccination.

Listening to community feedback is now more systematised and integrated in the response's overall strategy, along with the institutionalisation of the CFWG. There are some examples of two-way communication starting to emerge, such as the frequently asked questions (FAQs) document on Ebola, jointly developed on the basis of community feedback and made available in local languages. The CASS work to understand community perceptions of the response, risk, and barriers and enablers for uptake of protective behaviours also had a great impact on tailoring some aspects of the response to communities' perceptions and feedback.

The Ebola response in DRC demonstrates the need for RCCE partners to engage more systematically with public health responders to sensitise them on what RCCE entails. This is particularly essential for the response in terms of community engagement, ownership and accountability, as is emphasising the link between RCCE and access, acceptance and security.

3.3 Flawed coordination

Leadership of, and commitment to ensure, an effective and collective RCCE response was undermined by a range of factors outlined below, mirroring to some extent the lack of clear leadership, accountability and coordination of the overall Ebola response.[20]

3.3.1 Fragmentation of coordination structures for RCCE

Neither the high number of coordination structures for RCCE nor the centrality of RCCE in strategic plans led to an effective and collective RRCE response. While this was partly due to the factors outlined above, flawed coordination around RCCE was a key element. Research on collective approaches to CCE points out the need to have effective coordination structures and practices in place (Barbelet, 2020) and a collective spirit to support coordination (Holloway and Fan, 2020). However, coordination of the Ebola response was generally fragmented, especially regarding RCCE where multiple coordination structures worked in parallel and failed to come together as a collective endeavour.

The creation of UNEERO was intended to strengthen international support for coordination, but interviewees claimed that it had little impact because of its lack of integration with existing parallel working groups.[21] The use of the WHO IMS early in the response (which characteristically employs a top-down approach) has hindered collaboration and created a breeding ground for working in siloes. Indeed, there was consensus from interviewees that both inter-commission and inter-pillar collaboration has been challenging.

The result of this fragmented structure is an excessive number of meetings that all compete for attendance. Central-level RCCE meetings lacked a strategic approach, were rigidly led and focused too much on information updates. As a

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20 For more on this, see IASC (2020).

21 Respondents also mentioned that one of the lessons learnt from the 2014–2016 West Africa outbreak was the importance of avoiding the creation of parallel structures like the UN Mission for Ebola Emergency Response (UNMEER) (DuBois et al., 2015) and again in DRC with UNEERO.

result, operational partners' attendance at RCCE Commission meetings was irregular and limited. Instead, the RCCE Partners meeting had a wider audience as it was perceived as being more efficient and producing concrete results. Several interviewees declared they no longer attended RCCE Commission meetings as the partner meeting was sufficient.

Fragmentation also hampered fast action and made the roles and responsibilities of the various coordination structures unclear. This is particularly problematic for a public health crisis response where rapid messaging and action are crucial to fight the spread of the virus. A process is in place through the RCCE Commission to validate, centralise and disseminate risk communication messages – including through maintaining a bank of messages and drawing on the expertise of different partners to translate, field test and design communication materials. However, current validation practice at the Commission level undermines this process. It was too often reported that getting messages through the Commission hindered effective and rapid risk communication. This perception was shared by members of other commissions that referred to the RCCE commission as the 'holding centre'.

The CWG from UNEERO has also been involved in developing messages. However, on some occasions, this led to similar activities running in parallel,[22] usually involving the same organisations but not necessarily all pulling in the same direction. Many interviewees said the CWG's role was not initially envisioned as supporting risk communication but rather focusing on media and external communication. They reportedly stepped in to work on risk communication to fill a gap left by the RCCE Commission and because they were better able to pull experts from WHO, CDC and others. Messages designed through the CWG need to be validated by the RCCE Commission but there is no clear procedure in place for this. It is left to

UNICEF or other organisations to connect these initiatives, but this is not done systematically. Roles and responsibilities on messaging must be clarified to concentrate efforts towards the collective objective of producing and disseminating timely, useful and appropriate messages to support the response.[23]

3.3.2 Flawed integration of RCCE in coordination system

The RCCE Commission is positioned at the same level as the other seven commissions but its cross-cutting nature is not clearly reflected either in the organigram (see Annex 1) or in the way it works with other commissions. Interviewees felt that, to be more effective, RCCE either needs to be better integrated in the overall response or the Commission should sit directly under the General Coordination (for example, in the cluster system the working group on CCE often sits at the inter-cluster coordination level). Opinions were divided regarding the degree to which the Commission was effectively integrated into the response architecture. The fact that the RCCE is under a standalone commission formalises its importance and key role in the response, but also tends to restrict RCCE as the responsibility of one commission alone. Here lies the main challenge: the barrier to operationalise the cross-cutting nature of the RCCE.

All respondents noted that the commissions work in silos and consequently the RCCE Commission's integration with the other commissions needs significant strengthening. The RCCE Commission is often perceived as having a supportive role rather than directly contributing to the response's overall strategy. The cross-cutting nature of its work is understood by some, but not applied due to a lack of strategic vision by the response leadership and its operating model. Significant positive efforts have been made to reinforce inter-commission coordination and

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22 For example, the work on the '25 difficult questions' or on the 'survivor' issue, ongoing in parallel in the CWG and in the RCCE Commission.

23 The disjointedness of coordination structures is also reflected by the lack of collaboration until very recently between the PSEA Network and the RCCE partners. No connection has yet been made with the PSEA Network around development of messages and dissemination through the multiple channels used by the RCCE Commission, and the PSEA Coordinator was not participating in the CFWG.

collaboration, such as the formalisation of multi-disciplinary teams that bring together individuals from each commission, although this remained marginal. RCCE partners have done a lot of advocacy with other commissions to foster the understanding that CCE is the responsibility of all responders.

At the subnational level, RCCE focal points were embedded in each commission to enhance the cross-cutting nature of RCCE. Results were mixed because the same practice was not replicated at the central level and the role of focal points was not systematically implemented. While in some cases interviewees were not aware of these experts being in place, in others their effectiveness seems to vary depending on whether they have the capacity to influence and be listened to within their commission and whether the commissions' leadership hold them accountable. In addition, these focal points were not systematically attending RCCE Commission meetings. Where this system worked well, such as in Butembo, focal points acted as a bridge between commissions, resulting in stronger integration, better flow of information and enhanced collaboration.

3.3.3 Challenges with coordination capacity, expertise and neutrality

The RCCE Commission initially lacked both dedicated capacity and adequate expertise to lead coordination of the Commission, which greatly delayed its ability to be a meaningful and efficient coordination structure.

Initially the co-leadership of the RCCE Commission was shared by WHO and UNICEF in support of government leadership. There was, however, no dedicated capacity in UNICEF to carry out this role. Indeed, this position was covered by the Communication for Development (C4D) programme staff who had both UNICEF programme and RCCE Commission coordination roles and responsibilities. High turnover of C4D staff further hampered UNICEF's ability to support effective coordination, as any new person had to recreate working relationships with both the government

and the RCCE partners. Despite the clear need to have a dedicated person to support coordination in a predictable and timely manner, it reportedly took more than six months to secure funding and recruit this role. One donor speculated as to how much UNICEF had in fact embraced this co-lead position, while several interviewees from international organisations explained that WHO took on co-leadership because UNICEF could not manage this on their own due to a lack of dedicated capacity. This led to a vacuum in leadership as well as confusion over roles and responsibilities regarding leadership and accountability between WHO and UNICEF. While the co-leadership was later clarified, with only UNICEF supporting the MoH to lead the RCCE Commission, this was never officially communicated to partners, compounding existing frustration and confusion.

Having a gap in coordination leadership proved detrimental to ensuring response-wide coordination, information management, analysis and strategic planning between partners at the onset of the response. The recruitment of a Senior Advisor[24] was praised by all partners, who mentioned a significant change in coordination practices from October 2019 onwards. Sub-commissions were also fostered by more senior-level staff with the objective to strengthen leadership and rapid decision-making at the field level.

In addition to capacity issues, a second challenge in coordination was the lack of adequate expertise for supporting collective approaches to RCCE. Some respondents highlighted that, until September 2019, coordinators tended to be technical experts without the required coordination skills and competencies. Expertise in coordination tends to be dismissed or not prioritised when recruiting coordinators, with implications for bringing organisations together and fostering consensus. Additionally, a significant number of respondents questioned whether UNICEF had the right technical expertise to be leading the RCCE Commission. Although UNICEF is well-known for its strong expertise in C4D, many argued

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24 Only 60% of this person's time was dedicated to the coordination of the RCCE Commission.

that this did not match the risk communication expertise needed in the Ebola response, particularly regarding community engagement and the swift development and adaptation of risk communication messages at the core of the strategy. Several interviewees felt this initial missed opportunity in getting the right people with the right expertise weakened the RCCE response, stating: 'they had the leadership role in communication but not the right strategy for risk communication and too few staff specialised in the field'.

Interviewees also questioned whether the RCCE Commission was led by the right organisations and actors in order to ensure neutrality. Both UNICEF and the government leads on the RCCE Commission faced difficulties in being perceived as neutral in their coordination roles. UNICEF's role as a neutral facilitator was greatly challenged by its role in funding and implementing RCCE activities. As a financial intermediary, the co-lead on the RCCE and a significant operational partner, UNICEF was perceived to have created a 'monopolistic situation'. Its funding of the RCCE Commission and its government counterpart was highlighted as a potential bias because the government would wish to align with UNICEF's strategy. For a collective approach to be fostered it is critical to have a co-lead for the RCCE Commission that is perceived as neutral and representing all partners fairly. As summarised by one respondent: 'Partners want someone who represents the collective rather than UNICEF'.

Ultimately, the creation of the Senior Advisor role was meant to compensate for the absence of a neutral and independent coordinator. The role is positioned at a strategic level and its neutrality is reinforced by the fact that its funding is managed in Beni by the operations team and not by the Senior Advisor in UNICEF. Respondents felt that the creation of this position had a significant impact on the quality of coordination, consistency of meetings and on the collective spirit, with more efforts to meaningfully involve all actors.

Several respondents felt that OCHA should have been involved in coordinating the Commission from the onset of the crisis, as it would have ensured a more neutral approach, leading to buy-in from all partners. Critically,

OCHA would have acted as a bridge between the wider humanitarian coordination, as it has a stronger role under Pillar 3 of the integrated response for this reason. As the philosophy of Pillar 3 is to respond to non-Ebola needs, it would have made sense for OCHA to also be involved in the RCCE Commission. OCHA has substantial expertise in coordination and information management, which would have been useful to the Commission as well as complementing UNICEF's (and WHO's) technical expertise in RCCE.

The government's co-leadership of the RCCE Commission raises several questions: for example, what capacities were allocated by the MoH; did ways of working allow for meaningful collaboration, co-coordination and capacity building; and did UNICEF have room for manoeuvre under the government's leadership? While the government has dedicated capacity since the creation of the RCCE Commission and subsequent sub-commissions, it was unclear if this was the right capacity. Respondents stated that MoH staff capacities needed strengthening both in terms of coordination and technical RCCE expertise. This challenge was reflected by the limited ability of government RCCE Commission staff to negotiate and work across pillars. Several interviewees also emphasised the dynamics between the MoH and UNICEF as being very sensitive, with the MoH seeing its role as very much in charge and UNICEF as more of an operational partner and financial intermediary (one interviewee described this role as 'deputy lead' rather than co-lead). This was echoed by reports that the government leadership, particularly at the central level, was marked by limited space for partners to voice opinions and concerns; this partly led to the creation of the RCCE Partners Working Group.

3.3.4 Lack of buy-in and consensus
The move towards a collective approach to RCCE has been thwarted by significant delays and challenges to disseminate and implement a common strategy between partners, but most importantly by disagreement over the strategy content and overall direction. While very late in the response, the creation of an RCCE strategy in November 2019 was seen as

a positive development. However, the strategy development process was perceived as top-down and lacking sufficient inclusion and participation by the wider RCCE community – this was mentioned repeatedly by respondents. Disagreements over its direction were not given sufficient space to be debated and alternative voices were not always included. A small number of interviewees described the coordination decision-making process as a 'dictatorship' or 'monopoly'[25] and reflected on their organisation's struggle to be heard in strategic decision-making processes, either at the strategic coordination or RCCE Commission level. This resulted in some key RCCE partners being unaware of the Commission's strategy and some seeing the strategy as a way to seek funding rather than provide a common framework for implementation.

The top-down decision-making approach also led to strong disagreement on how community engagement and community structures should support the strategy, which led to the establishment of parallel community relay systems. This decision was not made by the RCCE Commission leadership, but by the MoH/WHO leadership overall. Similarly, the latest strategy around the revival of the Community Engagement Cell (CAC)[26] seems to be controversial among RCCE partners. Some considered that during an emergency was not the right time to introduce new structures (the Ebola response supported 3,914 CACs – some were new and others pre-existing and revitalised) because it diverted a lot of energy and support from responding to very concrete needs, such as communities' pressing questions on vaccination and survivors. Some partners considered this strategy wrong as it was imposed by the government without real operational need. It was felt that more and more community engagement units were being created without first mapping what was already available.

3.3.5 Lack of collective spirit: competition and localisation

Willingness to collaborate for a common objective is a key factor for a collective approach that encompasses all involved in the response. Yet, competition – rather than a collective spirit – between actors prevailed, sometimes leading to a lack of consideration of the essential role of local organisations until late in the response.

A high number of respondents referred to power dynamics between different Ebola response actors having caused tensions and unnecessary delays. The initial double co-leadership of the RCCE Commission (WHO and UNICEF) was perceived by one respondent as 'competing agencies doing their things'. This 'clash of approaches' is echoed, for example, in a WHO RCCE toolkit designed in Butembo:

> The diversity of actors in the RCCE (WHO, UNICEF, Ministry, NGOs…) has led to poor coordination of activities. Each of these actors carrying out the same activity according to its own logic, its own resources and its own indicators. This dispersion had a direct impact on the effectiveness of the response's actions (WHO, 2019b).

A number of interviewees reported a 'labelling concern' (organisations wanting to see their feedback mechanism and data being used and reported), which prevented the optimisation of resources and risked losing credibility with the community because of a multiplicity of mechanisms and little focus on closing the loop. One interviewee summarised: 'We are missing a collective approach, everybody is a little bit protective of their own complaint feedback mechanism, they want their feedback to be heard'.

Respondents felt that when agencies' branding and labels were put aside, for instance with the CASS, this collective spirit successfully led

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25 Monopoly by MoH and UNICEF/WHO.

26 CACs were part of a government initiative that began in 2012. CACs are units made of community members trained in risk communication and supporting community participation. CACs are permanent structures, grounded in communities and supporting RCCE activities on an everyday basis. They are also used to escalate community feedback to the RCCE Commission and to alert the coordination to possible Ebola cases.

to collective outcomes. Though fully funded by UNICEF, the CASS does not have a UNICEF stamp and so is not perceived as a UNICEF-only initiative. UNICEF made sure the work of the CASS was useful for everyone, instructing the CASS manager to 'share everything at 150%'. This was further facilitated by having a CASS manager who believed in these principles and effectively acted upon them. The CASS made a genuine effort to disseminate research and co-create recommendations by engaging at multiple levels, often (sub)commission by (sub)commission. This has created buy-in, ownership and a feeling of collective responsibility. Through collective and collaborative working relationships, the CASS has been able to better operationalise the cross-cutting nature of its work. CASS studies also cross-reference other mechanisms such as the Red Cross community feedback mechanism. Through this way of working, the CASS was able, according to many respondents, to develop and maintain good relationships with key actors including the government, WHO, UNICEF and INGOs. Working with local researchers with the right set of language skills also added to its capacity to build relationships.

The lack of collaboration around RCCE and more generally in the Ebola response can be seen in the relationships between UN agencies, INGOs and local actors. Disagreement on the content of the RCCE strategy and competition over funding led to INGOs advocating to donors not to channel all funding through UN agencies, including a request that 40–60% of funding go directly to INGOs during the post-Ebola transition. Rather than competition over funding, a respondent argued that this request was made because UN agencies were dedicating funding to controversial projects and did not allocate funding for gender and inclusion projects. At the same time, funding UN agencies such as UNICEF has allowed some funding to reach local NGOs (part of the strategy under Pillar 3, which aims

to increase the number of contracts for small LNGOs in order to enhance sustainability and community ownership).

However, despite funding being channelled to local NGOs through UN agencies, there was a lack of meaningful inclusion of local actors in the response and in RCCE. Most respondents recognised that there was initially a missed opportunity to localise the response by working with LNGOs, grassroots associations and existing community structures. One interviewee highlighted the initial lack of inclusion and consideration of FBOs. FBOs are extremely important in Eastern DRC where they manage 60% of schools and 40% of the health system (Balibuno et al., 2020). FBOs reportedly struggle to access funding from UN agencies with Bernard Balibuno, CAFOD DRC Country Representative, speaking at a public event in March 2020, mentioning that there was 'no walking the talk' regarding localisation.[27]

At the RCCE level, most respondents also stated that LNGO representation within the Commission and the CFWG was marginal, particularly at the central level, with only the largest LNGOs participating. LNGO respondents were generally positive regarding the Commission as it enabled them to access resources such as pre-designed and pre-translated messages for which they did not have budget. From mid-2019, LNGOs, FBOs and other civil-society organisations were able to become much more involved in implementing RCCE activities after receiving grants from UNICEF, the government and small private donors. However, their participation in coordination meetings was inconsistent and very much linked to whether they had active funding and could dedicate staff to attend meetings. One interviewee confirmed that lack of funding for civil society organisations hindered their participation, citing the PSEA Network's struggle to engage with local women's associations as an example.

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27   ODI event 'Lessons learned? Responding to Ebola in the DRC', 18 March 2020.

3.4 The role of leadership

A top-down commitment from the response leadership is critical for bottom-up feedback to be accepted, owned and acted upon (see Box 3). RCCE partners have pushed for this. Advocacy was done at all levels to sensitise commissions and the coordination to be more receptive to community feedback. CDC, UNICEF and RCCE partners all joined in a collective effort to support this despite coordination challenges.

A community feedback workshop in July 2019 in Goma was a turning point. With the support of the IFRC, the RCCE Commission organised and led the workshop with the participation of RCCE partners, representatives from all commissions, and the strategic coordination group. A key outcome was the institutionalisation of the CFWG and an official written statement from the National Coordinator that all commissions needed to attend this working group on a weekly basis. However, so far only 40–60% of the commissions participate regularly. In some areas, such as Mambasa, the RCCE Commission is reporting attendance to the Coordinator, which tends to enhance participation. In Goma, the presence of the National Coordinator at the meeting is not regular but is often accompanied with greater participation from the other commissions.

A cultural shift is needed: commissions (and their leaders and decision-makers, including UN agencies) must accept bottom-up working and adapt operating modalities based on feedback from communities. Many concrete examples were provided on how the response has adapted some of its protocols as a result of community feedback or studies done by the CASS. For instance, the safe and dignified burial teams have adapted the burial procedure in many ways: allowing a family member using protective equipment to participate, changing the design of body bags, and training community teams to ensure safe and dignified burials. Visits to ETCs were organised for traditional and religious leaders to counter rumours about the centres being places where people were killed. Food distributions have also been adjusted following

Box 3: Protection against sexual exploitation and abuse: a victim of the lack of leadership

Following a report from IRC in March 2019, the World Bank requested the creation of a collective reporting mechanism related to PSEA, dedicated to the Ebola response and set up and managed by IRC (they specifically wanted IRC to lead the set-up of this collective reporting mechanism). IRC designed a project encompassing the whole Ebola response with PSEA alerts channelled directly to the leadership of the response rather than IRC. Funds transferred by the World Bank to the MoH were supposedly allocated to implement the project. IRC recruited one person who arrived in June 2019; however, by December 2019 no funds were received by IRC and so the project was never implemented.

This example underscores the need for a strong commitment at the top and for the leadership of the response to ensure accountability mechanisms are prioritised and followed through. Several respondents shared their profound disappointment regarding the minimal efforts of the leadership to tackle sexual exploitation and abuse when evidence of such cases where brought to light. Some interviewees drew a parallel between this lack of prioritisation and the predominantly male composition of leadership and management in the response.

feedback from communities that they are rejecting certain food because of its origin (e.g. flour from Rwanda).

Unfortunately, there was consensus from respondents that these successes were a minority and did not reflect systematic consideration of community feedback for decision-making and adaptation of projects. Identical feedback is returning every week with no concrete answer or accountability for how these comments have been taken into consideration. The fragmentation of feedback mechanisms across partners and the quality of the information presented by the CFWG was perceived by some respondents as contributing to the lack of leadership engagement. Without

high-level strategic buy-in and commitment to collective accountability, the hard work to collect community feedback will be in vain. The CFWG needs more consistent access to and support from the leadership of the Ebola response to ensure each commission owns the recommendations stemming from the analysis of the feedback.

In conclusion, further top-down commitments are required to take RCCE to the next level. Feedback is collected, analysed and heard through different channels but still needs to systematically reach the response leadership to influence strategic decisions on who should be accountable for ensuring it trickles down to effective programmatic adaptations and to communicating back to communities about what is being done as a result of their input. In cases where action is not possible, it is also important to communicate these decisions or limitations regarding resources to community members (i.e. closing the feedback loop).

4 Conclusion

Lessons learned from the 10th Ebola outbreak must be seized both for current and future responses in DRC, as well as globally, to support more systematic and collective approaches to RCCE. The crisis is a glaring example of the extent to which a medical approach needs social traction. The previous outbreak in West Africa highlighted the pivotal importance of community engagement for all actors engaged in a response, and the negative consequences resulting from the late prioritisation of community engagement. Yet, the Ebola response in DRC deprioritised RCCE (particularly the community engagement element), failed to create coordination mechanisms and ways of working that enabled a collective response, and, against the advice of many RCCE partners, the leadership focused on a narrow understanding of RCCE.

Even with the political complexities involved in responding to the Ebola outbreak in Eastern DRC, lessons on how to effectively engage communities and conduct RCCE in a public health crisis have not been integrated into preparedness at country level or into the global public health response at practice level. This led to delays in deploying adequate and dedicated capacities, and a failure to work effectively with existing community structures and institutions to ensure the right leadership drove a response based on community feedback and community dynamics. Instead, parallel structures were created at all levels and a lack of effective collaboration prevailed.

Without high-level buy-in and more steering from the leadership, recommendations from the CFWG still lack ownership from key stakeholders and recommendations are yet to be translated into action. Collective efforts to consider and act on community feedback will benefit the overall response in terms of access and acceptance, through enhancing trust and continuously informing effective community engagement strategies.

There were a number of positive elements in the response. The CASS and the Red Cross community feedback mechanisms, supported by CDC, ensured data was being documented and information was analysed and shared in a systematic way. They also invested time in discussing the information and co-creating recommendations, which led to some operational changes in the response.

Learning from the RCCE coordination and activities in the Ebola response in DRC, the following recommendations can be drawn and should be considered in the current government-led response to Covid-19 and to the 11th Ebola outbreak in Equateur, DRC:

1. **Effectively integrate RCCE as an integral part of public health crisis preparedness and response at country and global levels.** Considering how integral community engagement is to prevention and management of a health crisis, RCCE partners globally should invest in working with governments, particularly health ministries, as well as with WHO and UNICEF to strengthen capacity for RCCE to be a central feature of preparedness and response. To do so and ensure stronger buy-in, RCCE specialists should work more effectively with public health experts and epidemiologists and should adapt by using the language and methodologies of health professionals and epidemiologists (using quantitative evidence and formalised guidelines for example). Health experts need to be convinced to move beyond simple health messaging towards two-way feedback approaches, as well as integrating strong community engagement practices in relevant languages, formats and channels.

2. **Build on existing practices and structures.** When a public health crisis occurs, RCCE partners should advocate with decision-makers and power holders to build on existing RCCE mechanisms, rather than create parallel systems. This includes building on existing

community structures and institutions as well as current coordination around community engagement, CWC and AAP.

3. **Effectively integrate and work with local actors.** RCCE partners should advocate for and support RCCE coordination and activities to be inclusive of local stakeholders, particularly religious leaders, FBOs, community-based organisations and organisations representing specific groups such as people with disabilities, as well as representatives of affected populations. International RCCE partners can play a pivotal role in linking local actors with donors, UN agencies and government where international actors have a specific influence. International RCCE partners should use their influence to ensure the inclusion of local actors in coordination mechanisms and decision-making fora as part of collective approaches to RCCE.

4. **Scale up and adapt good practices.** RCCE partners should build on the current partnership between the CASS and the Red Cross feedback mechanism and approach and integrate this into training on collective approaches to CCE and RCCE as examples of response-wide mechanisms. Partners must document potential areas for improvement and disseminating learning at the global level so that good practices can be replicated in other crises (both public health and humanitarian crises). There should also be further reflection on how such approaches could be adapted to other contexts and integrated into discussions on RCCE and national-level plans for preparedness and disaster response.

5. **Invest in dedicated neutral coordination capacity and leadership** from the onset of a response. The right expertise (a balance between technical expertise and coordination competency) must also be in place, for instance through dedicated surge senior coordinators for RCCE in epidemics, including French speakers, and local and regional actors should also be included. Training in coordination and the collective approach needs to be provided to future coordinators, along with a toolkit so they know what a collective approach to CCE involves and can influence leadership to obtain buy-in.

6. **Strengthen coordination to enable collective approaches to RCCE.** Leadership of, investment in and coordination of collective approaches have suffered from a general unclear leadership and poor coordination of the Ebola response. Recognising that strong and effective coordination is a pre-requisite for a collective approach, public health response leaders and humanitarian leaders (donors, UN agencies and NGOs) should ensure efforts are made to make collective approaches to RCCE better known and understood by leadership and coordination actors. To avoid the fragmented approach observed in the 10th Ebola epidemic response, one agency should be designated as part of preparedness for leading, along with the MoH, RCCE and collective approaches to RCCE.

7. **Review the DRC Ebola coordination structure to inform future public health crisis responses.** A review of the DRC Ebola response and coordination structure should be carried out as part of a system-wide review of public health response and coordination architecture. An evaluation should reflect on why current practices in humanitarian coordination are unable to adapt for a public health crisis response led by government. Such a review should consider how to inform a public health crisis coordination response mechanism where humanitarian coordination already exists.

8. **Donors should consider their role in ensuring a collective approach to accountability in any response is agile and localised.** Donors could have a stronger role in advancing the AAP/PSEA agenda, including through strengthening funding requirements or conditional funding. A percentage of funding could be automatically allocated to an inter-agency feedback mechanism, including PSEA, for any IASC-activated scale-up response. Donors can also play a key role in pushing the localisation agenda by including eligibility criteria that ensures part of their funds will be channelled to local organisations, along with capacity-building support when needed. Finally, donors need to encourage agility through flexible funding to ensure community insights are heard and lead to change in the response.

Bibliography

Balibuno, V., Mbuna Badjonga, E. and Mollett, H. (2020) 'Lessons not learnt? Faith leaders and faith-based organisations in the DRC Ebola response' *Humanitarian Exchange* 77: 14–18 (https://odihpn.org/wp-content/uploads/2020/03/HE-77-web.pdf).

Barbelet, V. (2020) *Collective approaches to communication and community engagement in the Central African Republic*. London: ODI (www.odi.org/publications/16848-collective-approaches-communication-and-community-engagement-central-african-republic).

Barbelet, V. with Bishakabalya Kokere, P., Kandate, E., et al. (2019) *Local humanitarian action in the Democratic Republic of Congo: capacity and complementarity*. London: ODI (www.odi.org/publications/11292-local-humanitarian-action-democratic-republic-congo-capacity-and-complementarity).

CASS – Social Science Research Unit (2019a) 'Analyses de l'étude sur les connaissances, perceptions, comportements de santé de la communauté Butembo Katwa & Kalunguta'. November. DRC: CASS.

CASS (2019b) 'Key recommendations from CASS and from the analysis of Red Cross community feedback'. DRC: CASS.

CASS (2020) 'Présentation de la Cellule d'Analyse en Science Sociale'. DRC: CASS.

CCEI – Communication and Community Engagement Initiative (2017) 'Towards a collective service for more effective humanitarian responses' (www.cdacnetwork.org/contentAsset/raw-data/41a78b02-f486-4918-93fc-4085959a3996/attachedFile1).

DuBois, M. and Wake, C. with Sturridge, S. and Bennett, C. (2015) The Ebola response in West Africa: exposing the politics and culture of international aid. London: ODI (www.odi.org/publications/9956-ebola-response-west-africa-exposing-politics-culture-international-aid).

Fairbanks, A. (2020) 'Security and access in the DRC: implementing an acceptance strategy in the Ebola response' *Humanitarian Exchange* 77: 43–46 (https://odihpn.org/wp-content/uploads/2020/03/HE-77-web.pdf).

HHI – Harvard Humanitarian Initiative (2019) 'Voices from Congo. Poll 18 May 2019'. HHI, May.

Holloway, K. and Fan, L. (2020) *Collective approaches to communication and community engagement in the Central Sulawesi response*. London: ODI (www.odi.org/publications/17046-collective-approaches-communication-and-community-engagement-central-sulawesi-response).

Iacucci, A.A. (2019) 'C4D, CwC, beneficiary communication, CEA, community engagement, CDAC… WTF are we talking about?'. The Unwilling Colonizer, 12 February (https://theunwillingcolonizer.com/2019/02/12/wtf-are-we-talking-about/).

IASC – Inter-Agency Standing Committee (2019) 'Standard operating procedure. Humanitarian system-wide scale-up activation. Protocol for the control of infectious disease events'. IASC, April (https://interagencystandingcommittee.org/system/files/190404_iasc_infectious_disease_scale-up_activation_protocol_web.pdf).

IASC (2020) 'DR Congo: Ebola virus disease response. Operational peer review' (internal document, unpublished).

IFRC – International Federation of the Red Cross and Red Crescent (2019a) 'Risk communication and community engagement. Guidance note for the National Society and IFRC Response Teams'. IFRC, March.

IFRC (2019b) 'From words to action: towards a community-centred approach to preparedness and response in health emergencies'. Commissioned by the Global Preparedness Monitoring Board.

McKay, G., Black, B., Mbambu Kahamba, S., et al. (2019) 'Not all that bleeds is Ebola: how has the DRC Ebola outbreak impacted sexual and reproductive health in North-Kivu?'. New York: IRC (https://reliefweb.int/sites/reliefweb.int/files/resources/srhebolareport1172020.pdf)

MoH – Ministry of Health, Democratic Republic of Congo (2019) 'Plan Stratégique de la Communication des Risques et Engagement Communautaire. Réponse à l'épidémie de la maladie à virus Ebola dans les provinces du Nord Kivu et de l'Ituri, République Démocratique du Congo. Plan Stratégique de Réponse IV (SRP4)'. MoH, November.

MoH (2020a) 'Plan Stratégique de Riposte contre l'épidémie de la maladie à virus Ebola dans les provinces du Nord Kivu et de l'Ituri, République Démocratique du Congo. 4ème édition (PSR-4.1)'. MoH.

MoH (2020b) 'Termes de Référence de la Cellule d'Analyse en Science Sociale'. MoH, January.

MSF – Médecins Sans Frontières (2019) 'Crisis update – March 2020'. MSF (www.msf.org/drc-ebola-outbreak-crisis-update).

OCHA – United Nations Office for the Coordination of Humanitarian Affairs (2019a) 'Aperçu des besoins humanitaires République du Démocratique du Congo'. OCHA, December (www.humanitarianresponse.info/fr/operations/democratic-republic-congo/document/rd-congo-aperçu-des-besoins-humanitaires-décembre-2019).

OCHA (2019b) 'Plan Opérationel d'Urgence. Province du Nord-Kivu et Ex PO. Juillet–Décembre 2019'. OCHA, July 2019 (www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/2019_plan_operationnel_sem2_nord-kivu_ituri_fr.pdf).

OCHA (2020) 'Plan de Réponse Humanitaire, République du Démocratique du Congo'. OCHA, December (www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/drc_hrp_2020_final_web.pdf).

The New Humanitarian (2019) 'Aid community raises highest alert on Ebola'. The New Humanitarian, May (www.thenewhumanitarian.org/news/2019/05/30/aid-community-raises-highest-alert-ebola-congo).

The New Humanitarian (2020) 'How "Ebola business" threatens aid operations in Congo'. The New Humanitarian, June (www.thenewhumanitarian.org/investigation/2020/06/18/Ebola-corruption-aid-sector).

TWB – Translators without Borders (2019a) 'Les populations de l'est de la RDC ont besoin d'avoir des informations sur l'épidémie de maladie à virus ébola dans une langue qu'elles comprennentune évaluation rapide des besoins linguistiques à Goma, RDC'. TWB, March (https://translatorswithoutborders.org/wpcontent/uploads/2019/03/DRC_Ebola_Assessment_FR.pdf).

TWB (2019b) 'We need to talk. Effective Ebola risk communication requires respect and transparency and remains as vital as ever'. TWB, December (https://translatorswithoutborders.org/assessment-effective-ebola-communication-requires-respect-and-transparency/).

UNEERO – United Nations Emergency Ebola Response Office (2019) 'Concept of operations – UN scale-up strategy'. UNEERO (www.un.org/ebolaresponsedrc/content/concept-operations—-un-scale-strategy).

Vinck, P., Pham, P.N., Bindu, K.K., et al. (2019) 'Institutional trust and misinformation in the response to the 2018–19 Ebola outbreak in North Kivu, DR Congo: a population-based survey' *The Lancet* 19(5): 529–536 (www.thelancet.com/journals/laninf/article/PIIS1473-3099(19)30063-5/fulltext).

Vinh-Kim Nguyen, M.D. (2019) 'An epidemic of suspicion – Ebola and violence in the DRC' *The New England Journal of Medicine* 380: 1298–1299 (www.nejm.org/doi/10.1056/NEJMp1902682).

WHO – World Health Organization (2014) 'An introduction to risk communication'. Geneva: WHO (www.who.int/risk-communication/introduction-to-risk-communication.pdf?ua=1).

WHO (2018) 'Risk communication and community engagement (RCCE) considerations: Ebola response in the Democratic Republic of the Congo'. WHO, May (https://apps.who.int/iris/handle/10665/272767).

WHO (2019a) 'Ebola outbreak in the Democratic Republic of the Congo declared a public health emergency of international concern'. WHO, 17 July (www.who.int/news-room/detail/17-07-2019-ebola-outbreak-in-the-democratic-republic-of-the-congo-declared-a-public-health-emergency-of-international-concern).

WHO (2019b) 'Communication sur les risques et Engagement communautaire (CREC) et autres piliers de la riposte en contexte d'urgence sanitaire et d'insécurité'. WHO, December.

WHO (2020a) 'Ebola in the Democratic Republic of the Congo: North Kivu, Ituri 2018–2020' (www.who.int/emergencies/diseases/ebola/drc-2019).

WHO (2020b) 'Ebola virus disease – Democratic Republic of the Congo. External situation report 90'. WHO, April.

Annex 1   DRC Ebola coordination architecture

The humanitarian response architecture in DRC has evolved since the onset of the crisis and has been specially adapted to fit the Ebola situation; thus, it is new to the government as well as national and local organisations.

In 2020, two main coordination structures are in place to support the response: the MoH and WHO-led public-health response (Pillar 1) and the UNEERO coordination structure (Pillars 2–5) (see Figure A1).

Pillar 1

Pillar 1, as outlined by the SRP4.1 (January–June 2020), is led by a Strategic Coordination Group comprising the MoH General Coordinator, the WHO Incident Manager, other provincial Ministries, UNICEF, the United States CDC and OCHA. Coordination is organised through eight commissions at the provincial level in Goma. Each commission is led by the MoH and co-led by a UN agency or an IO. The UN agency or IO has a dual role: to act as a 'financial intermediary' and to provide technical expertise and support for the operationalisation of the strategy and the coordination of implementing partners. Within this, the RCCE Commission is a standalone commission under the leadership of the MoH and co-led by UNICEF.

General coordination meetings bring together the presidents of each commission and co-lead agency representatives to report on each commission's main updates, achievements and challenges. This coordination system allows a clear chain of command and has been decentralised to every health zone where an Ebola case has been identified, with an operational sub-coordination structure overseeing sub-commissions.

The RCCE Commission
The RCCE Commission was established as a standalone commission, co-led by UNICEF (with WHO initially) and MoH. UNICEF acts as a financial intermediary, receiving the Ebola funding for RCCE-related activities (see Box A1), which is then channelled to operational partners such as international and local NGOs, including the MoH personnel working for the RCCE Commission. UNICEF is also a major operational partner.

The RCCE Commission is supported by two working groups: the RCCE Partners Working Group and the CFWG. These groups provide information, recommendations and other plans for approval by the RCCE Commissions as well as convene representatives of other commissions

The RCCE Partners Working Group
The RCCE Partners Working Group is an RCCE Commission sub-working group created by UNICEF in August 2019, at both central and decentralised level, and was described by respondents as a shadow of the RCCE Commission, with weekly meetings. It brings together the same RCCE partners without

Figure A1: Coordination architecture for the 10th Ebola outbreak in Eastern DRC

Pillar 1	Pillar 2	Pillar 3	Pillar 4	Pillar 5
Strengthening public health response in support of Ministry of Health (led by MoH & WHO, support by CDC)	**Strengthening political commitment, security & operational support to improve acceptance of the response & access to insecure areas (led by EERT)**	**Strengthening support for communities affected by EVD, in collaboration with humanitarian & development actors present in region (led by EERT, supported by UNICEF & OCHA)**	**Strengthening financial planning, monitoring & reporting (led by World Bank)**	**Strengthening preparedness of surrounding provinces & neighbouring countries to reduce risk of spread of EVD (led by WHO & OCHA)**
Risk communications & community engagement (RCCE) Commission (MoH & UNICEF)				
Surveillance, contact tracing & vaccination Commission (MoH & WHO)	Safe work environment & security (MONUSCO/ UNDSS)	Community works (World Bank)	Financial planning & resource mobilisation (World Bank/ OCHA)	Assessing preparedness capacity (WHO)
Laboratories Commission (MoH & WHO)				
Clinical management & isolation Commission (MoH & WHO				
Infection prevention control Commission (MoH & WHO)	Enhanced political engagement (SRSG/EERT)	Community ownership & essential services (UNICEF)	Financial reporting, monitoring & performance management (World Bank/ OCHA)	Strengthening operational readiness (WHO/OCHA)
Safe & dignified burial Commission (MoH & IFRC)				
Psychosocial support Commission (MoH & UNICEF)				
Operational readiness in at risk provinces Commission (MoH & WHO)	Common support services (WFP)	Coordination with the broader humanitarian response (OCHA)	Payments to national workers (World Bank)	Managing cross-border alerts & transmission (WHO/IOM)

Inter-pillar decision-making (led by EERT & supported by OCHA)

Source: adapted from UNEERO (2019)

Box A1: Common services supporting the RCCE Commission

1. Common development of RCCE messages (and scripts for radio emissions) between the Commission's partners and their validation (sometimes field-tested with affected populations) are centralised into a Google Drive accessible to all.
2. TWB provides translation services (e.g. for FAQs and answers), language assessments, multi-language glossary of key terminology (field-tested with affected populations) and training for RCCE partners' staff (including enumerators). These maximise the efficiency of risk communication in the relevant languages across the board.*
3. The IFRC/CRC/CDC community feedback mechanism enables the collection, analysis and presentation of community insights in almost real time to inform strategic decisions.
4. The Internews Newsletter (available in various languages, for communities and response partners) is based on the community feedback collected and analysed by the IFRC/CRC/CDC mechanism. The content of the newsletter is developed in collaboration with IFRC.
5. UNICEF's U-report system, a free SMS-based social monitoring tool for community participation, is designed to highlight issues of concern from and to the population. Information is collected in real time and results are shared with the community.
6. Conversation guides to assist field teams in engaging with traditional healers, religious leaders and others and to discuss the post-Ebola transition.
7. UNICEF's scenario-based guides helping teams to understand potential reactions from the community when faced with Ebola and how to handle and relay these messages.
8. Rapid Intervention Teams (RITs), composed of influential people from communities (religious leaders from various religions, women's groups, youth group representatives, community leaders, market trader representatives, etc.) and initially set-up by WHO, support the response in case there is a significant issue in the community that the RCCE teams cannot deal with.

Many other RCCE activities led by operational partners such as the CRC, Oxfam, Mercy Corps or MSF exist outside of the RCCE Commission plan of activities. These include door-to-door or mass sensitisation, mobile cinemas, interactive radio shows, educational talks, public forums and other information channels.

* Note: TWB translation services were only available from August 2019 onwards, thanks to Humanitarian to Humanitarian (H2H) Network funding.

the government counterpart. According to interviews, it is more technical and output-oriented, enabling dynamic and open exchange between partners and greater efficiency.

The RCCE Partners Working Group effectively does the preparatory work for the RCCE Commission; it develops common messages, discusses challenges, identifies common advocacy points for the attention of the RCCE Commission and develops solutions to potential barriers to be proposed for validation by the Commission and for the attention of the overall coordination of the response (presented at the general coordination meeting). The RCCE Commission tends to approve rather than design activities, but still holds the power.

UNICEF's leadership of the RCCE Partners Working Group is an important avenue for channelling the Working Group's messages to the general coordination meeting. The technical and operational focus means that the Working Group has created a high number of tools and messages, and reports a greater attendance beyond those active in the RCCE Commission. As such the RCCE Partners Working Group could be seen as complementary to the RCCE Commission.

The Community Feedback Working Group (CFWG)
The CFWG is an RCCE Commission sub-working group that meets at the central (Goma) and decentralised levels (e.g. Béni, Butembo). Created in early 2019 and functional since August 2019, the CFWG is led by the government co-chair of the RCCE Commission and co-led by the IFRC.

This working group includes members from all commissions, along with RCCE partners and other operational agencies. The Working Group functions differently in Goma and at the subnational level.

In Goma, the meeting mainly consists of a presentation prepared by the IFRC and the national Red Cross society, which is based on the community feedback mechanism (see sub-section 2.2.3) and highlights key findings from community insights, trend analysis and operational recommendations for each pillar of the response.[28] The CFWG aims to discuss this feedback collectively with all commissions and decide which recommendations should be implemented by specific commissions. It also reviews and tracks the implementation and completion of previous recommendations. It recently started to include more community feedback data from different sources.

At the subnational level, community feedback comes from multiple sources: the Community Action Cells (CACs), the community health volunteers (RECO) and agencies' individual feedback mechanisms, as well as the Red Cross mechanism.[29] The subnational RCCE Commission collates all the inputs weekly and convenes other sub-commissions and partners to discuss and agree on recommendations. At this level, discussions and recommendations are more operational, with immediate actions (e.g. setting up a hand-washing station in X location), while feedback requiring more strategic discussions is sent to Goma (e.g. people are refusing the vaccine due to doubts and suspicion).

Pillars 2–5

The UNEERO coordination structure, led by the EERC, sits alongside the government-led coordination and focuses on Pillars 2–5 of the response. UNEERO was set up to support the public health response, create a conducive operational environment and supervise the international coordination supporting the response. The guiding strategy for the UNEERO coordination is the Integrated Strategy for the Ebola response. From 1 March 2020, a transition process started, with the EERC transferring his responsibilities to the HC. A post-Ebola transition plan is being designed jointly with the government, the OCHA-led humanitarian response, the EERT and financial partners.

These Ebola-specific coordination systems exist separately and alongside the long-established OCHA-led coordination system, which focuses on DRC's existing humanitarian situations and has a devolved Regional Inter-Organisations Committee for North Kivu based in Goma.

Other RCCE-related mechanisms outside of the pillar structure (additional information)

The IFRC Red Cross feedback mechanism

With more than 600,000 data points, this is by far the largest feedback data system rolled out at scale in the Ebola response.

Volunteers collect daily feedback from communities while performing regular door-to-door visits and mass sensitisation activities, where they discuss Ebola and the response activities, disseminate pre-agreed messages and answer questions when possible. All inputs are entered into one dataset, which is then analysed by trained Red Cross local staff. The system was developed together with

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28 The categories include: (i) beliefs, observations and rumours, (ii) questions, (iii) suggestions and requests, (iv) appreciation and encouragement, and (v) threats. Data presented is quantified, for example 16% of the rumours relate to the theme 'Ebola is a government conspiracy'.

29 Although the Red Cross mechanism is to be distinguished from the traditional feedback mechanism due to its solid methodology – thorough process of analysis and visualisation – and to the fact that it includes the widest set of feedback data to be representative of community perceptions.

CDC and handed over to the local teams in May 2020. This analysis is presented weekly at the CFWG in Goma and all affected areas. The Red Cross also shares these weekly presentations, which are discussed during the EERT general meetings attended by senior managers of IOs. Results from the mechanisms are also sometimes presented and discussed at the CWG meetings and other meetings under Pillar 3.

The data informs community engagement approaches and frontline responders' tools such as the 25 FAQs on the Ebola vaccination. It is also used to produce multiple deep-dive analyses on themes such as community perspectives on survivors, and community perspectives on ownership in the response. The data is also used by the CASS.

This is the first time the IFRC has developed such a mechanism at scale for a public health crisis with a National Society. The design of the feedback mechanisms has been one of constant iteration and an example of strategic collaboration. As one interviewee highlighted: 'CDC has a thorough and very big social science research capacity and IFRC and the CRC had the feet on the ground: perfect combination'.

The Social Science Research Unit (CASS)

The CASS sits beside the Epidemiologic Cell of the MoH under the Strategic Coordination Analysis Unit (and therefore is not attached to a particular commission). The CASS was fully institutionalised through agreed terms of reference (ToRs) in March 2019. It is fully funded by UNICEF and receives support from CDC Atlanta, MSF-Epicentre, TWB, IFRC and WHO.

Regarding ways of working, the CASS has developed SOPs clearly describing the process for each study. The starting point is developing ToRs that inform the objective and the necessity of the research, which are developed following a specific request from a commission, from the epidemiologic analysis or from the CASS itself. ToRs are systematically signed off by one of the commissions (e.g. vaccination, RCCE, etc.) and the coordination. Data is then collected, analysed and triangulated with epidemiologic data, other research and sources of information, such as the Red Cross feedback data or KAP assessment.

HPG
Humanitarian Policy Group

The Humanitarian Policy Group is one of the world's leading teams of independent researchers and communications professionals working on humanitarian issues. It is dedicated to improving humanitarian policy and practice through a combination of high-quality analysis, dialogue and debate.

Cover photo: Health workers in Beni, North Kivu region, DRC put on personal protective equipment. Credit: World Bank/ Vincent Tremeau

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