1. BACKGROUND

In November 2015, WHO convened a consultation workshop to provide advice and input to the development of a strategic framework to support WHO’s role in community engagement in emergencies. The consultation workshop brought together around 70 experts and specialists drawn from UN partners, academia and the three WHO levels to advise on principles, directions and practical actions for strengthening WHO’s work related to community engagement in outbreaks and health emergencies.

Community Engagement has been identified as a cross-cutting priority in WHO’s Emergency Reform agenda as outlined in WHO Emergency Reform: Roadmap for Action. The report serves as a blueprint for the reform process and calls for a plan/strategy with “operational capacity for effective community engagement, including work in outbreaks and other health emergencies” is required as part of the Roadmap.

To this end, the workshop aimed to clarify WHO’s role in community engagement in outbreaks and emergencies.

The planned outputs and outcomes of the workshop were to obtain:

i. Agreement on the scope of community engagement and related approaches in the context of outbreaks and health emergencies
ii. Inputs for WHO’s role and functions in community engagement (and related fields) in outbreaks and emergencies
iii. Identify linkages to be made with emergency risk communication
iv. Recommendations for improving coordination of community engagement interventions during outbreaks and health emergencies
v. Recommendations for joint capacity building

The consultation workshop was convened by WHO’s Project Team on Emergency Reform; the Department of Communications, Office of the Director-General; with workshop design and facilitation from the Knowledge Transfer and Training for Outbreaks Team located at HQ within the Outbreaks and Health Emergencies cluster.

The workshop adopted a participatory approach. To this end, the number of presentations was limited. Breakaway sessions were frequently used to stimulate discussions and understand partners’ expectations and needs regarding WHO's role in risk communication.
2. WORKSHOP OUTPUTS

Over the two-day workshop, participants considered challenges, opportunities and priorities for WHO’s role and work in community engagement in the context of outbreaks and health emergencies.

2.1 Guiding principles for WHO community engagement in outbreaks and emergencies

Participants discussed and highlighted the following:

i. People and communities should be at the centre of WHO’s work in outbreaks and health emergencies. The concept of community is informed by the context of emergencies and the different perspectives of those involved and affected.

ii. Effective community engagement occurs at all times and not just during emergencies. It extends beyond the scope of emergency risk communication (ERC); and is one of the many important strategies used in emergencies. The community engagement sector appreciates the link between community engagement and emergency risk communication.

iii. Community engagement is part of a set of strategies and approaches that intersect with health promotion, behavioural change communication, social mobilization on the one hand; and meaningful community ownership on the other.

iv. It is important to build upon existing community engagement structures, networks, systems, programmes and initiatives during “peace times” and leverage these connections during outbreaks and emergencies. Building effective community engagement needs to occur throughout the risk management cycle.

v. Individual and community perceptions and reactions may be very different to those of the experts. This is related to communities’ social, cultural, religious and political contexts. Responders need tools and resources to appreciate these contexts better and tailor the emergency response to community needs.

vi. There is a dynamic tension between responders and communities which must be understood, appreciated and factored in, when engaging communities during outbreaks and health emergencies. Social and power dynamics are always at play. Responders need to understand and engage with them appropriately.

vii. Technical knowledge must be “translated” into the contexts of the communities, with their participation.

viii. WHO’s role in community engagement could include leading in some areas, working with others in ensuring key outcomes, coordinating interventions and “getting out of the way” in other instances.

ix. The primary role of community engagement must rest with national governments and stakeholders. Therefore national and local capacity building must be supported.

x. Effective WHO involvement in community engagement must be geared to enable the international emergency response to be “socialized” or tailored to the local context. This will help build on national and locally owned action.
2.2 Situating Community Engagement

The following was presented as a starting point for discussion to see at high level key components that link with community engagement.

![Diagram showing multidisciplinary systems for health](image)

2.3 Key questions discussed

A series of questions that emerged from the Emergency Risk Communication workshop convened from 24-25 November were discussed in small groups. Key ideas that emerged are highlighted below:

**Q1: How can we scope out a forward-looking strategy for CE? What new approaches for CE need to be used in 21st century emergencies?**

- Ensure responsive, participatory and representative decision-making at all levels.
- Build mechanisms to systematically, include community engagement in national health policy, planning, implementation, monitoring and evaluation processes. To this end, we need to utilize and strengthen existing mechanisms/networks to deliver health (e.g., the Global Fund model). Community engagement for emergencies must be embedded into existing systems, such as health systems, disaster preparedness, Global Fund, partner’s initiatives and support the development of adaptive capacity.
- Articulate the building blocks of systems to develop health, what is WHO’s role and that of partners.
- Ensure the use of communication tools and systems to keep all partners abreast of community engagement plans and activities.
- The Sustainable Development Goal (SDG) 16 resonates with community engagement and will facilitate a movement towards community engagement. Need to re-visit the definition of community engagement beyond Ebola.

**Q2: How do approaches and issues in CE in outbreaks and emergencies differ in urban and rural settings?**

- *Urban settings are home to diverse and complex communities:* There are multiple cultures, languages ethnicities and other differences in urban areas. Population density can also vary dramatically. The role of traditional healers can differ in the two settings.
• **Access to media is different:** Access is more complex in urban areas. Coverage of communication channels such as mobile phones and services, electronic media, social media can differ between urban and regional areas.

• **Intense political influences can happen at national and local levels.** There can be an absence of pre-existing structures for community engagement. The availability of money or resources at national and local levels influence how community engagement is done at these levels.

• **Differences in access to healthcare and information:** In urban areas, it could be easier to find people with the right skills, as compared to rural settings.

• **Community outreach approaches:** For pandemics, both urban and rural communities will be affected, so outreach will be more complex and require different approaches.

• **Community engagement will be different at the various levels of the country:** CE will differ in a country depending on whether it is national, within the capital city or in other towns.

• **Media Reaction:** Emergencies in urban settings tend to be picked up by the media faster and can have an impact on external perceptions and the quality of support provided to the response.

• **CE Capacity Building:** There is a need to build existing NGO and civil society organizations' capacity in health issues.

**Q3: How can we scale-up communication engagement in a big emergency?**

- WHO should focus on its technical leadership capacity and skills.
- Support the strengthening of a functioning health system before an emergency.
- Support countries to set standards for community engagement (ToRs, SoPs, financing, etc.).
- Document best practice and approaches that worked in various settings and adopt them.
- Share best practice.
- Bring in community engagement skills and expertise to support the response.
- Tap into the community health worker system and structures for accessing communities.
- Be inclusive and exhaustive when including “actors.”

**Q4: How can the relationship between responders and communities be improved?**

- **Learn from communities.** Let them take the lead. Respect communities and you will be respected. Listen and seek to understand family and cultural dynamics.

- **Create opportunities for communication engagement** right from the start. Include partners in the development of SoPs.

- **Receptive versus reactive.** Prepare frontline responders to connect with the community and receive their input before taking action. Be aware of how easily trust is built and broken.

- **Culturally Appropriate.** Develop and use a culturally sensitive protocol for community engagement.

- **Manage fear.** Some fear is needed for community action but this needs to be balanced and addressed with the appropriate emergency risk communication strategy.

- **Frontline staff need consistent messaging.** Bring communications and technical teams together to develop and agree on the messaging to ensure consistent messages and actions.

- **Responsiveness to community needs.** Help to improve service delivery and follow through to keep trust. Bring or link to resources (food, meds, equipment, etc).

- **Engage anthropologists and other social scientists** and ensure that they are deployed with initial response/assessment teams and provide real-time advice and analysis from the outset.

- **Ensure government understands the consequences of emergency actions,** such as using force or engaging the military.
Q5: What disciplines and professions are needed for CE in emergencies?

- Community developers/facilitators
- Public health analysts
- Health promotion professionals
- Social workers
- Social scientists and anthropologists
- Community volunteers
- Health care workers including community health workers
- Trainers
- Information and knowledge management professionals
- Coordinators and managers
- A new “community engagement professional” – define, train, practice, get experience for them

Q6: How can social scientists best be used for CE in emergencies?

- Understand the difference between longer-term, acute and embedded work managed by social scientists and anthropologists. The latter two can be used in emergencies. Know the difference between academic and applied scientists in this area. Social scientists can work either remotely or in the field.
- Use of mixed methods can improve community engagement. Use findings in an operational manner and as evidence-base to shape response interventions.
- Supervision of social scientists is difficult in the field. WHO and others don’t have staff in the field who are knowledgeable enough in these fields to provide supervision. Organize internal structures to work with sociologists and anthropologists.
- Develop a new cadre of experts – Humanitarian or Emergency Anthropologists.
- “Socialize” WHO’s emergency response teams and personnel.
- Develop guidance and tools.

3. RECOMMENDATIONS FOR WHO REFORM

3.1 Individual advice

3.1.1 Put communities at the centre of emergence work - Ask, hear, join, lead

a. Recognise that communities are heterogeneous entities with existing tensions and complexities that can become more pronounced during times of stress. Recognize the diversity of communities. Communities are shaped by culture and faith.
b. Involve communities from the outset of an emergency response in order to understand their experience, views and concerns before any action. Communities must own the response. Let communities initiate action – support them in doing this.
c. Absorb and understand what communities are and are not telling us and why. Be a leader in listening to those affected. Ensure that different groups of the community are being engaged, e.g. women, elderly, youth and disabled, etc are included to ensure an inclusive response.
d. Empower communities and families.
e. Seek feedback from communities on lessons learnt and make for improving the response for future outbreaks and emergencies. Keep the community informed through out to build trust.

3.1.2 How should WHO approach CE in emergencies?

a. Ensure community engagement is prioritized and supported with human and financial resources.
b. Strengthen and support community engagement prior to outbreaks and emergencies so that the structures are already in place in order to readily activate during an emergency.
c. During peace time, build on and extend community engagement work that already exists
d. Build on WHO strengths and target resources appropriately where needed.

3.1.3 **Collaborate - Listen to and work with partners available on the ground**

a. Strengthen relations with those involved in the day-to-day engagement on the ground (volunteers, community health workers, faith based organizations) for a smooth transition to engagement in an emergency.

b. Build capacity with partners for community engagement in emergencies.

c. Leverage relationships with existing community based organizations (for leadership and diversity). Local community-based organisations are the closest and most aware of the needs in their communities. Make space at the table for their voices and respect their views.

d. Coordinate better with international partners, especially UNICEF and MSF, IFRC to map community engagement resources and needs in order to close gaps. Develop a Memorandum of Understanding (MoU) with UNICEF.

3.1.4 **Policy and practice in WHO**

a. Integrate community engagement into the contingency plans and emergency response plans as a core part of work.

b. Incorporate community engagement in emergency risk communication and strengthen WHO’s mandate in this area.

c. Include community engagement expertise as a standard practice in all outbreak investigations, rapid assessments and response teams.

d. Include community engagement actions in preparedness plans and risk communication national plans.

e. WHO should have a clear position on what it can offer in community engagement at global, regional, national and community levels. Develop a clear framework for community engagement with community partners and experts and get their advice on how to implement it.

f. Provide context for community engagement strategy and messaging.

g. Establish mechanisms for community engagement strategy and messaging.

3.1.5 **Resources and tools**

a. Ensure adequate resources for community engagement, such as training and building networks/partnerships.

b. Identify community's preferred means of communication channels (radio, community events, etc).

c. Properly resource community engagement as a function with a strategic and outward-looking focus.

d. Mapping of NGOs. In each country have an updated database of local NGOs who do community engagement and build relationships with them to share information, updates and funding when possible.

e. Clarify concepts and relevant tools.

f. Build and maintain an information sharing platform for sharing lessons learned and best practice with specific communities (knowledge sharing).

3.1.6 **Human resources**

a. Invest in people with the right skills.

b. Strengthen and entrench WHO leadership for health emergencies by recruiting the right skills set, and capacitate staff across all levels of WHO, especially country office staff.

c. Raise awareness amongst WHO staff about the organization’s role and work on community engagement.

d. Invest in training and expanding national capacity in community engagement.

e. Create a cadre for professionals with multidisciplinary capacities and skills to take forward this work.
f. Include trained anthropologists as part of WHO staff who are ready to interact with community leaders when emergencies or outbreaks occur.

### 3.2 Group recommendations

Workshop participants discussed WHO’s emergency reform in the area of community engagement and highlighted four priority areas for action:

1. Develop a **conceptual framework** for community engagement in emergencies.
2. Establish and strengthen mechanisms for coordination of community engagement in emergencies across sectors.
3. Define and **resource country level functions**
4. Develop the **investment case** for community engagement and emergency risk communications in emergencies

**Specific recommendations for WHO include:** Ten building blocks for WHO’s reform of community engagement in emergencies

- **Develop a conceptual model for community engagement in emergencies:** Conduct a literature review of established models and frameworks for community engagement in public health programmes to inform its work in CE in emergencies. Draw on models that exist such as those of the Global Fund, the social-ecological model, community-based participatory conceptual models, etc.
- **Access to expert advice:** Establish an internal working group and convene a community engagement advisory group to pull together experiences and best practice from other health, community and humanitarian fields.
- **Develop guidance and guidelines:** Advocate for national to shift from a biomedical to a participatory and socialized model of community engagement and response.
iv. **Training on participatory approaches** to shift the paradigm from dictating to interactive engagement with communities.

v. **Get and use feedback**: Articulate a *feedback loop* from communities to alter/shape/guide response and recovery, whilst also ensuring that the outcomes of this dialogue are fed back to communities.

vi. **Formalize WHO structure**: Agree on internal structures and protocols to support community engagement.

vii. **Coordination**: Identify and develop existing capacity and mechanisms to include community engagement.

viii. **Consistency**: Ensure consistency with emergency risk communication activities and approaches.

ix. **Link to development**: Situate the health response in broader development and SDG agenda.

x. **Develop partner networks**: Establish agreements with partners, and rosters to deploy as needed

### 5. NEXT STEPS

Moving forward, a number of issues should be addressed in the first instance as part of efforts to strengthen WHO’s community engagement activities:

1. **Expanding WHO’s community engagement network** - There was agreement that while the consultation was valuable and timely, there needed to be more experts and practitioners who have experience in community engagement present.

2. **Establishing a community engagement working group in WHO** - There is currently no locus for community engagement in emergencies in WHO. While forward planning associated with emergency reforms is underway, a group of internal staff (WHO and its partnership programmes), from the three levels of the Organization should be convened in a working group on community engagement in emergencies.

3. **Support synergies between community engagement and emergency risk communication** - There is recognition that community engagement is a strategy used in emergency risk communications. At the same time, there is appreciation that community engagement is a larger, specialized area which has a broader scope and requires specific expertise. Community engagement and emergency risk communication activities should work closely together as WHO’s emergency reform progresses.

**Attachments:**

- WHO Emergency Reform Consultation Workshop: Community Engagement concept note
- Workshop Agenda
- List of reference materials for the WHO Emergency Reform Consultation Workshop on Community Engagement

**Notes**

This report was written for the Reform Project Team by Dr Gaya Gamhewage, PED/OHE who designed and facilitated the workshop. Mr Andy Seale, consultant was the co-facilitator. Mr Glenn Lavereck from the Health Promotion Team in NMH; Dr Sylvie Briand, Director PED/OHE, Dr Sally Smith, UNAIDS; and Dr David Nabarro, Chair of the Advisory Group on Reform provided expert inputs.
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