Final Report:

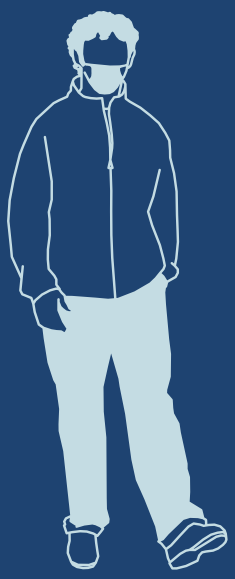
Landscape Analysis of Community and Civic Engagement in the Estern Mediterranean Region

June, 2021

World Health Organization

REGIONAL OFFICE FOR THE Eastern Mediterranean

CONTENTS



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INTRODUCTION

In 2019, the Global Action Plan (GAP) on Healthy Lives and Well-being was launched by health, humanitarian and development agencies[1] to accelerate country progress on the health-related Sustainable Development Goals (SDGs): in particular, SDG3, to "Ensure healthy lives and promote well-being for all at all ages". This plan focuses on seven accelera-tor themes and on gender equality as key areas where a closer collaboration of the 12 GAP agencies can help countries to accelerate progress on the health-related SDGs and recover from the impact of the COVID-19 pandemic. One such accelerator area is Community and Civic Engagement, based on the understanding that a more systematic engagement with communities/civil society can help accelerate progress toward the health-related SDG targets in countries. The accelerators are being led jointly by WHO/UNAIDS at global level.

The current pandemic has highlighted and heightened the importance of community engage-ment in supporting public health measures during the management of the pandemic, and in preventing and preparing for future health emergencies. Community engagement can serve to address and prevent health and gender inequities during the COVID-19 pandemic[2]. Com-munity engagement in a public health emergency brings together the network of affected communities. Engaged communities participate in recovery by contributing their distinct skills, capacities, knowledge, and perceptions[3].

There is limited availability of systematic reviews and meta-analysis on community engage-ment in EMR, although there is anecdotal evidence to suggest that much work in community engagement has occurred. The involvement of communities and civil society is often ad hoc, short-term, unsustainable or unsystematic. Hence, the need to assess the situation in EMR in relation to community and civil society engagement in terms of facilitators, enablers, barri-ers, capacities, and community assets; and provide guidance and recommendations to utilise community strategies, enhance resilience, and reduce risk from health emergencies.

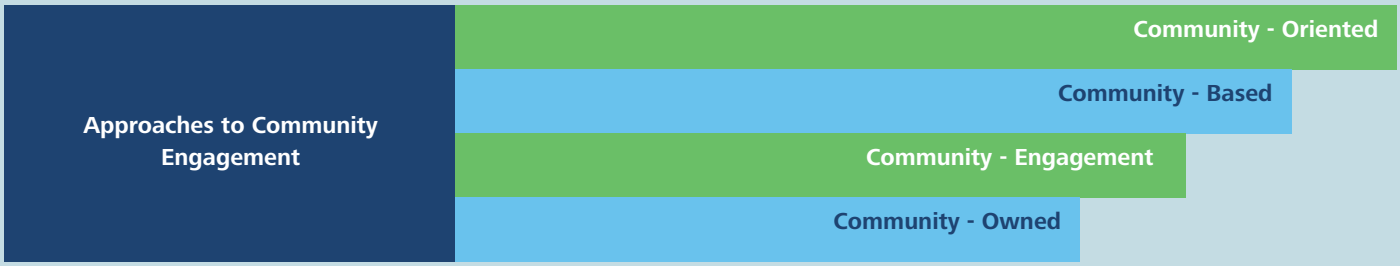


Figure 1 - Levels of community engagement (WHO, 2021)

What is Community Engagement?

"A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes" - (WHO, 2017)

Communities play active roles in the identification of health issues and the allocation of resources.

1 Gavi – the Vaccine Alliance, Global Financing Facility, Global Fund to Fight AIDS, TB and Malaria, UNAIDS, United Nations Development Program, UN Population Fund (UNFPA), UN Children's Fund (UNICEF), Unitaid, UN Women, World Bank Group, World Food Program and World Health Organization.

2 Role of community engagement in situations of community transmission, WHO Interim Guidance, May 2020.

3 https://emergency.cdc.gov/cerc/ppt/CERC_CommunityEngagement.pdf.

OBJECTIVES

Specifically, the objective of this assignment was threefold:

1	2	3
		
Identify and map – in seven countries (Afghanistan, Jordan, Lebanon, Morocco, Paki-stan (GAP countries) and in Iraq and Yemen) – the types and range of community and civil society stakeholders which are or could be more meaningfully engaged in the response to the current pandemic, and future health crisis or the work of multilateral agencies active in health more generally.	dentify – in the seven counties and regionally – the enablers, challenges and good practices of community and civil society engagement during response operations and the health sector more generally.	Identify the barriers and gaps – including in terms of capacities, competencies, com-munity assets, infrastructures and resources – for sustainable engagement; and pro-vide evidence-based recommendations to enable more meaningful community and civil society engagement in terms or preparedness for future health emergencies and an acceleration of progress toward the health-related SDGs.

APPROACH AND METHODOLOGY

In order to achieve those objectives, MAGENTA followed a three-stage methodology, summarized in the diagram below and more details can be found in the inception report:

Figure 2 - Methodological approach

The three stages of this assignment were completed between February and April 2021, as per the below:

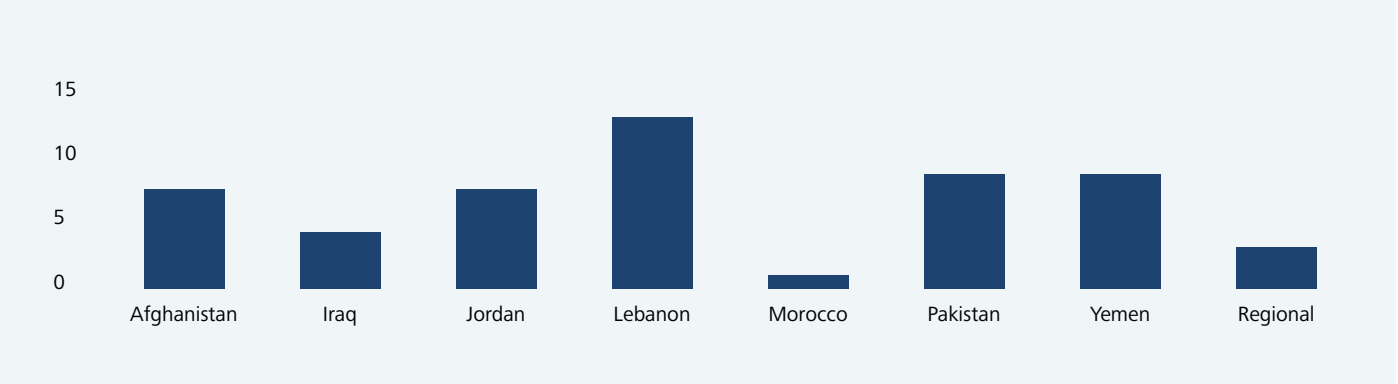


Figure 3 - Key Informant Interviews Location

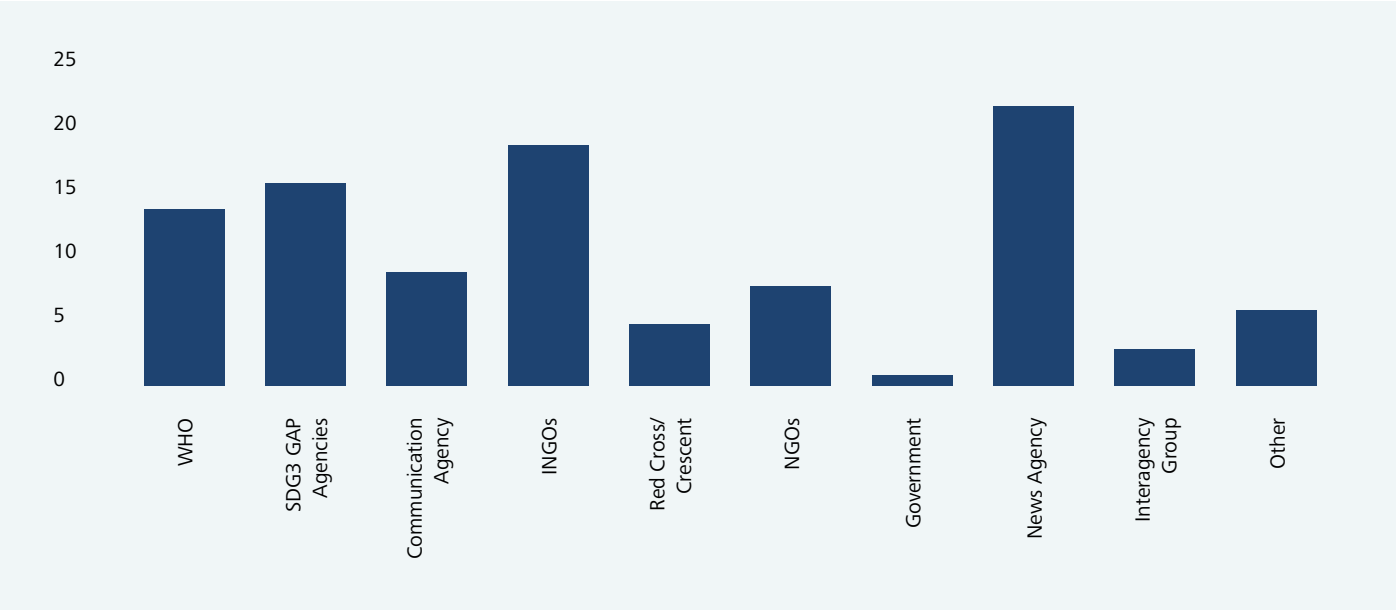


Figure 4 - Literature review sources

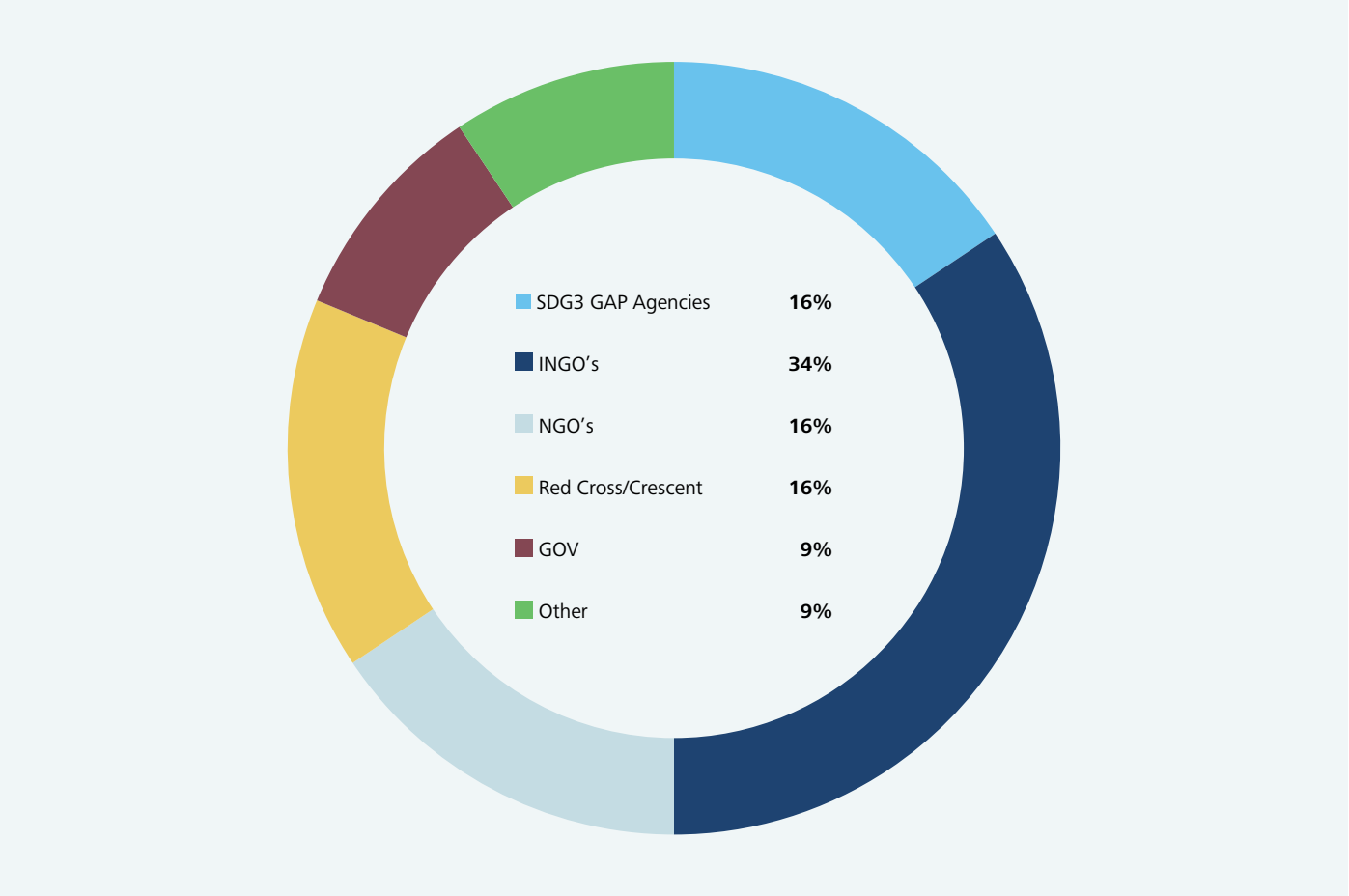


Figure 5 - Key Informant by type of organisation

Stage 1 (18 Feb 21 – 29 Mar 21): Data gathering via a literature review and key informant interviews (KIIs). We reviewed over 100 documents from a number of sources and conducted over 50 interviews in the seven countries, as shown in figure 3, 5 and 5 below:

Stage 2 (22 Feb 21 – 15 Apr 21): Analysis of data to inform a mapping of relevant community and civil society stakeholders, and the identification of regional good practices.

Stage 3 (5 Mar 21 – 22 Apr 21): Development of five thematic, narrative case studies; and a summary and detailed recommendations report.

RESEARCH FRAMEWORK

During the inception phase, MAGENTA developed a framework to guide the data collection and analysis. This framework was developed utilising the socio-ecological model and informed by the community engagement principles published in February 2021 by the RCCE Collective Service[4]. The framework is based upon current community engagement practices, challenges, enabling factors, capacities, assets and successes, themes for data gathering/key informant interviews, and data collection methods.

Key RCCE principles/Themes	Understand community context	Build trust	Ensure/ maintain community buy-in	Work through community solutions	Listen, analyse, respond to feedback	Discourage stigma, rumours	Coordinate with all response actors	Data collection methods for assessment
Current practices **Who is doing what and where? Which tools and approaches are used? What are the roles and responsibilities?**	Through which channels is CE taking place: What are the key initiatives for CE: Institutional? Civil society? Community?	What is the level of trust between: Community- authorities? Civil society-authorities? Communities-civil society?	What practices help to ensure/maintain community buy-in: Institutional? Civil society? Community?	What are the current community solutions practiced?	Are communities informed of the actions taken based on their feedback?	What are the sources of rumours, etc?	What partnerships are being leveraged? Institutional? Civil society? Community?	Desk review/KIIs
Challenges/barriers **What factors have prevented community engagement?**	What are the barriers to CE? Institutional? Civil society? Community?	What factors lead to decreased trust: Community- authorities? Civil society-authorities? Communities-civil society?	What factors have prevented community buy-in: Institutional? Civil society? Community?	What are the challenges for community solutions: Institutional? Civil society? Community?	Are there any challenges to get back to communities? Challenges to share which operational decisions have been taken?	What are the barriers to Addressing/countering rumours, etc?	What are the challenges to effective coordination: Institutional? Civil society? Community?	Desk review/KIIs
Enabling factors **What factors have enabled or supported community engagement?**	What are the enabling factors for CE: Institutional? Civil society? Community?	What factors enhance trust: Community- authorities? Civil society-authorities? Communities-civil society?	What factors have enabled community buy-in: Institutional? Civil society? Community?	What are the enabling factors for community solutions: Institutional? Civil society? Community?	What are the enabling factors for getting back to communities and closing the feedback loop?	What can be done to counter/address rumours, etc?	What are the enabling factors for effective coordination: Institutional? Civil society? Community?	Desk review/KIIs
Capacities/assets **What community assets/resources are there?**	What are the community assets?	What capacities exist to enhance trust: Community- authorities? Civil society-authorities? Communities-civil society?	What assets and capacities help to ensure/maintain community buy-in: Institutional? Civil society? Community?	What are the capacities for community solutions?	What are the capacities/assets available for feedback: Institutional? Civil society? Community?	What capacity is there to counter/address rumours, etc: Institutional? Civil society? Community??	What are the capacities for effective coordination: Institutional? Civil society? Community?	Desk review/KIIs
Successes/impacts **What has been easy to do so far? What are the successes?**	What has gone well in CE? Institutional? Civil society? Community?	What successes/ impacts has trust led to?	What successes in ensuring/ maintaining community buy-in?	What are the successes/ impacts of community solutions?	What has been going well regarding getting back to communities?	What successes have there been in countering rumours, etc?	What are the successes in and impact of effective coordination?	Desk review/KIIs
Needs **What can enhance CE?**	What is needed to better engage with communities: Institutional? Civil society? Community?	What can restore/maintain trust between: Community- authorities? Civil society-authorities? Communities-civil society?	What is needed to help to ensure/maintain community buy-in: Institutional? Civil society? Community?	What is needed to enhance community solutions: Institutional? Civil soc? Community?	What is needed to enhance feedback to communities: Institutional? Civil society? Community??	What are the sources of rumours, etc?	What are the needs for effective coordination: Institutional? Civil society? Community?	Desk review/KIIs

[4] Established by WHO, UNICEF and IFRC in 2020 to enhance coordinated community-centred approaches.

CHALLENGES AND LIMITATIONS

During the KIIs, further details of additional in-country key interviewees were requested – to be provided either during the interview or subsequently by email – including national NGOs, CBOs, CSOs, FBOs, etc. A limited number of contacts were provided. However, subsequent attempts to contact CBOs, etc. resulted in very few KIIs, due to (i) technical (i.e. phone/internet) issues; (ii) potential interviewees not responding; or (iii) time factors/lack of suitable dates/time available.

KII follow-up

During the KIIs, interviewees were asked to identify and describe the good practices, challenges/ barriers, and successes for civil society/community engagement partners and stakeholders in their country. They were also asked to provide any relevant documentation highlighting the above. A reminder was sent following the interview to many WHO/UNICEF country offices (COs). EMRO followed up with further requests to WHO-COs.

The follow-up requests for further documentation provided limited details on good practices and challenges and almost no information on successes/impacts (see caveats/limitations below). Hence, MAGENTA conducted additional intensive research to identify additional good practices, challenges and successes in each of the seven countries, including:

UN agency/INGO reports, websites and social media.

National NGOs/CBOs/ CSOs/FBOs reports, websites and social media.

Health/Protection/ WASH Cluster members reports, websites and social media.

International/local media and social media reports, research and surveys.- Journal articles

Information provided

- The KIIs themselves provided valuable information on the good practices and challenges, and some limited information on successes/impacts – as did the MAGENTA research. However, there was an expectation that additional information would be forthcoming from the country stakeholders. Hence, the results of the research were limited in that:
- There was limited internal documentation – in particular research/surveys/reports/data/statistics/evidence – provided by interviewees (following the KIIs):
  - WHO Eastern Mediterranean Regional Office and a limited number of WHO/UNICEF country offices provided written documentation of interven-tions/good practices.
  - 'Grey literature' and other unpublished documents of UN agencies, academia, governments, etc. were not available/ provided.
- Several NGOs did provide written documentation/reports/research.

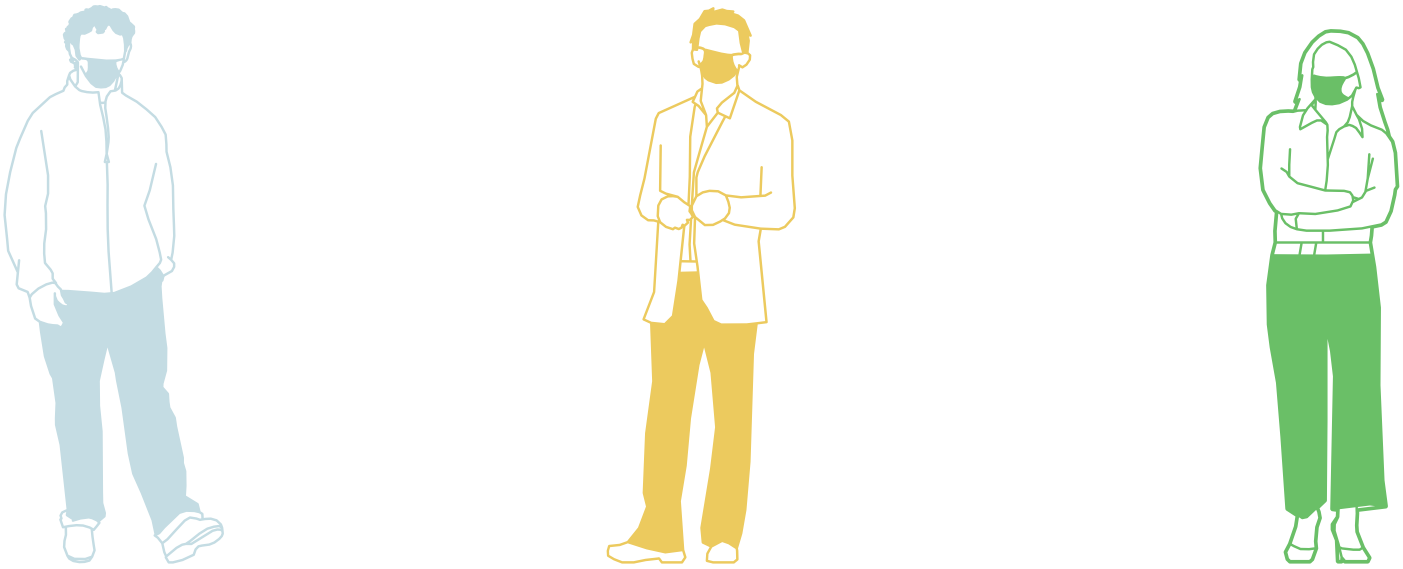
These limitations have not prevented the analysis/results described below, in terms of challenges, good practices, and capacities, however, the lack of statistical data and evidence has limited the assessment of successes/impact of interventions.

Other challenges

- Due to COVID-19 being on-going in all seven countries, the interventions on community engagement and others were incomplete. Hence, some outcomes/impact are not yet identifiable, so successes are identified as proxy indicators. Moreover, impromptu engagement among and activities conducted by individuals/informal groups were not able to be assessed due to the access issues created by the pandemic.
- There are different levels and interpretations of community engagement (see Figure 1). For most of the seven countries in this project, the level of engagement is more fo-cused on community-oriented engagement, i.e. communities are informed on issues, with the aim of mobilising them to participate, in this case, in COVID-19 prevention and protection measures (in part related to the restrictions described above). In one or two countries, communities have played more of a role of consultation regarding health services and some involvement with health service providers, but in most the level of real collaboration, empowerment and ownership was not yet reached.
- The need for in-country increased information/data-sharing will come up as a firm recommendation from this assignment.

KEY FINDINGS

- The results of the research are largely based on the KIIs and desk/literature research conducted by MAGENTA. The latter was largely based upon publicly available material/documents. Hence, the results do not include much of the potential 'grey literature' and unpublished documents of UN agencies, academia, governments.
- The following section provides a regional summary of the good practices and enablers, challenges and barriers, and successes. Full details can be found in the MAGENTA-WHO EMRO Good Practices and Challenges Report, compiled as part of this project. The results are structured according to the community engagement (CE) principles (based on the Inception Report Framework).



REGIONAL GOOD PRACTICES AND ENABLERS

Community actors, health and frontline workers, are crucial in supporting communities during emergencies – particularly in settings where health systems are saturated or overwhelmed – through **knowing local context**, **maintaining or building trust**, **engaging community members**, and **finding community-based solutions**:

- Countries and communities benefitted from the expertise established in existing disease preparedness processes/systems/resources: polio teams, for example (in Afghanistan/ Iraq/Lebanon/Pakistan/Yemen), with trained, trusted, respected, familiar staff were reassigned to counter COVID-19. Their knowledge of the community context, skills in community outreach, and how to look for signs and symptoms were crucial in supporting compliance with protection measures, surveillance, contact tracing.

"Tell the truth. Don't force people. Don't pressurise. Don't tell people what to do. Don't op-pose beliefs. Don't tell people that they are wrong." (INGO interviewee, Pakistan).

- Networks of community health workers, volunteers, and community-based organisations had previously been established and trained in community engagement and social mobilisation (in Afghanistan/Jordan/Lebanon/Pakistan/Yemen) in relation to polio and cholera, for example. They are important in increasing knowledge and understanding of COVID-19 and future health emergencies. As with polio teams, these community actors are trusted, credible, and are accountable to – and from within – the community, which can result in higher uptake of disease prevention/protection measures.

"…our services are recognised at so many levels. Our performance is appreciated …but in the end, it is the smile spread across the face of a cured patient which keeps us going." (Lady Health Worker, Pakistan)

- Youth/young people – having received training on health issues, leadership and communication skills, and social mobilisation – were engaged to support the response to COVID-19 across the region, formally in groups/networks, or informally in spontaneous mobilisation. Their support included: helping elderly/vulnerable community members with provision of food and non-food items; provided advice on disease mitigation measures to peers and families; monitored compliance among peers, families, businesses, with protection measures; and collected and analysed data on the impact of COVID-19.

"Youth volunteers are agents of change in their communities: creating, and implement-ing their own initiatives, identifying and involving marginalised groups, such as the dis-abled, youth and elderly, and trying to ensure representation for all." (Anon, Royal Health Awareness Society, Jordan).

- Religious leaders were engaged and mobilised in the response to COVID-19. Religious authorities and COVID-19 response organisations engaged with leaders, and involved them in developing plans and interventions, thereby facilitating their buy-in, motivation and commitment to mobilising communities. In Iraq, Shiite clerics issued *fatwas* to promote social distancing and avoid religious gatherings/ceremonies, saying that it is a mandatory religious task[5]; in Pakistan, leaders acted as intermediaries between authorities and communities, mobilising the latter through health information based on the Koran; and in Yemen, leaders made recommendations to ministries based upon community needs, and helped communities to comply with COVID-19 measures[6].

5 Al-Monitor (2020). Iraqi government officials, clerics unite against COVID-19 - Al Monitor: The Pulse of the Middle East (al-monitor.com).

6 UNICEF Yemen (2020). COVID-19 Risk Communication & Community Engagement Stories from the Field

UN agencies/INGOs/national/community actors, and media organisations developed innovative initiatives to **listen to, analyse, and respond to feedback**, and **discourage stigma, rumours and misinformation** that can lead to ignoring of COVID-19 measures and/or vaccine hesitancy:

- In Afghanistan, Iraq and Lebanon, Internews produces monthly rumour bulletins countering prevalent rumours amongst communities/aid workers/media actors[7] [8]. From October 2020-March 2021, Internews collected 1,152 rumours on social media, 409 (36%) of which were posted by healthcare workers, mainly concerned with treatments/cure (49%); COVID-19 being a hoax (25%); and vaccination (18%). In 2021, the trend has moved to COVID-19 vaccines, concerned with vaccine safety[9]. BBC Media Action/ Care/Save the Children and others have also developed information sharing, learning platforms, and feedback/complaints mechanisms, while UNICEF has the 'U-report'[10] as a social messaging/data collection system to improve engagement.

"Feedback has led to a change in reporting of the virus. Before the emphasis was on how many people had died, how many people were sick with COVID-19. But community feed-back stressed the importance of highlighting people's recovery from COVID-19, emphasising hope rather than fear." (Lebanon Red Cross Society interviewee).

- Where COVID restrictions prevented movement, online, SMS and phone calls were used, for example, to address misinformation and rumours among peers and families through monitoring of online/social media sources, and countering/ updating with accurate information. While social media is not necessarily community engagement in itself, it can trigger engagement in a digital space, through an exchange of ideas/contributions. on peers, families and communities (through telephone, SMS, online assessments, etc.).

COVID-19 has provided opportunities to enhance **collaboration and coordination** between all responders to health emergencies:

- In six countries (insufficient information was available from Morocco) inter-agency groups, RCCE taskforces, GAP Committees, health and other clusters, etc., were established or resurrected, and worked to varying degrees of success in collaboration and coordination: including between different sectors, for example, health, protection, and WASH clusters; and in linking communities and community groups/actors with local authorities. COVID-19 led to less traditional actors and partners being identified, mobilised and empowered during the response. COVID-19 also led governments to closer cooperation, between ministries, such as MoH, MoI, MoE, Islamic Affairs (MoIA), Youth, in particular.

"Throughout the response process there was close cooperation between WHO/MoH. This enabled MoH to have confidence in WHO. The reinforcement by WHO was im-portant for giving credibility to the government." (WHO interviewee, Iraq)

7 Internews (2020). https://internews.org/sites/default/files/2021-03/Internews_Global_Rumor_Bulletin_03_2021-03.pdf and https://internews.org/covid-19/rumor-bulletins

8 Internews (March 2021). Global rumour bulletin #3. Misinformed messengers: healthcare workers as an unexpected source of rumours in the pandemic.

9 Ibid.

10 UNICEF (2021). U-report: https://www.unicef.org/innovation/ureportCOVID19

REGIONAL CHALLENGES, BARRIERS AND GAPS

Community engagement, **buy-in** and **community solutions** are not always the priority of national authorities:

- In some countries – for example, Afghanistan, Iraq, Jordan, Lebanon and Yemen – communities have developed resilience and coping strategies, due to political issues and dual governance, conflict and/or frequent health and other emergencies. But they don't necessarily yet have the capacity and structures to be responsible for their own solutions. They are not sufficiently empowered, are not provided with or have access to resources, and do not have sufficient capacity/training[11]. Moreover, regular political/ governmental leadership change further disempowers populations, leading to limita-tions in engagement and implementation of interventions[12].
- Community representation is not always representative. The persons speaking on be-half of communities are often political or religious figures, with their own point of view, not necessarily that of the community. This can result in marginalised groups having no voice. The power dynamics in IDP camps/settlements often mean that minorities and certain sections of the populations are denied or limited in access to services. Such marginalised community members need appropriate, accountable community representatives who represent – and are selected – by the whole community, and who are trusted, well-connected, influential and can articulate community ideas.

"We ensure that identification/selection of representatives is appropriate, and trusted and transparent persons chosen: those who are known to, understand, and can articulate the views of, the community." (Mercy Corps interviewee, Iraq)

Despite initiatives described above to **listen, analyse**, **respond to feedback**, and **discourage stigma** and **rumours**, systems and mechanisms remain insufficient:

- UN agencies have different/conflicting systems – and no standard, systematic approach and triangulation of sources – for data collection, analysis, feedback, trend-spotting, and rumour-tracking. Hence, data collection, rumour tracking, feedback is not done effectively: it is not collected in a timely manner; often the technology is insufficient; and the data is not analysed sufficiently well and provided back to the community. The feedback time/lead time is crucial to ensure usable data, and build confidence and trust.

"Feedback mechanisms are not accountable to people, generally not collected in a timely manner, nor analysed sufficiently well and provided back to the community." (INGO interviewee, Afghanistan)

- Community complaints occur in most countries about the mechanisms include that it is not community serving, but merely collecting programmatic information: focused on social media discourse and the production of reports, but not working together with community members in a meaningful, accountable way. Social listening and community feedback must be part of a broader effort to engage communities in health emergency responses, and counter general mistrust in the information provided by authorities, as well in the authorities overall. Those already marginalised, excluded, and the most vulnerable are particularly affected as they have little or limited access to social media/Internet.

"There is a perception that hotlines raise people's expectations about getting a quick re-sponse to a complaint or question: when those expectations are not met – because of a lack of feedback or the feedback does not lead to a proper response – people are more frustrat-ed with the response overall." (INGO interviewee, Yemen).

11 Key informant interviews in March 2021: Afghanistan, Iraq, Jordan, Lebanon and Yemen.

12 Key informant interviews in March 2021: Afghanistan, Iraq and Yemen.

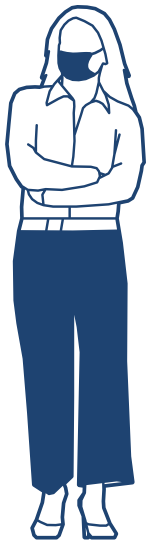
The COVID-19 response brought about enhancements in **coordination and collaboration** described above, however there is scope for further improvement:

- Structures were not always integrated as part of the overall response coordination mechanism: for example, RCCE not being part of the planning/decision-making process, and not always linked to the other pillars of the response. Line ministries were not always included in the coordination structure (mainly led by MoH), and in some, Jordan and Lebanon, for example, ministries – such as the MoI, MoE and MoIA – mainly relied on the community to support response efforts.

"There is a lack of capacity within and coordination between the Ministry of Public Health and partners." (Interviewee, Afghanistan)

- The identification and mapping of community actors on the ground is limited and insufficient. There is some ad hoc mapping on some of the emerging community-led initiatives and newly formed community groups in response to the pandemic, but this is not a rigorous systematic process across all partners/implementers. Systematic mapping – including the involvement of and engagement with – community actors/groups and local authorities can potentially enhance emergency preparedness and response, through identification of roles and responsibilities, and community capacities, skills and assets.
- Despite the establishment/realignment of collaboration mechanisms, information-sharing – including of best practices/ lessons learned – between UN agencies, and with INGOs/NNGOs/community organisations remains insufficient in all countries, thereby hindering the latter in community engagement in the response to health emergencies.

"The political huddles at all levels have been difficult to overcome, including getting gov-ernment partners to be inclusive and evidence-based." (UN interviewee, Yemen)



CONCLUSION

COVID-19 presented an opportunity for governments – in all seven countries – to ensure that national plans/goals absorb the COVID-19 response programme, take up some of the initiatives/interventions, and boost health and other basic services. The systems, structures, processes and partnerships that had been established prior to COVID-19 in all countries have been strengthened and in some cases, formalised. Inter-agency Groups, and RCCE taskforces/working groups have been strengthened in some countries, with more clarity on roles and responsibilities, including the involvement of community-based organisations, and provincial/municipal authorities. For example, insights are shared and discussed in (mainly RCCE) coordination meetings and organizations are producing regular reports on community insights, such as Internews and UNICEF. These together with the new partnerships developed and empowered during the COVID-19 crisis, constitute a more robust mechanism for preparedness, prevention and response in future emergency situations. The COVID-19 response also enabled some of the ground work to be undertaken for a more coordinated approach in refugee/migrant camps, and for social cohesion in host communities, and this must continue to develop further to ensure equal access to response support, services and vaccination. On the regional level an inter-agency group for the systematic sharing, discussion and action on social listening and community feedback insights has been established and is co-chaired by UNICEF, WHO and IFRC.

The following sections highlight some of the country good practices and challenges. Full de-tails of all country good practices, challenges and successes can be found in the MAGENTA-WHO EMRO Good Practices and Challenges Report, compiled as part of this project.

Afghanistan

Outreach campaigns on COVID-19 successfully reached at-risk populations[13]. Initially COVID-19 was thought by many to be a conspiracy/part of a 'Western agenda', but outreach helped them to understand the issues/risks, and take preventive measures: for example, in 2021[14] more people are wearing face masks outside in urban areas. There is generally trust towards vaccine uptake: there is a consensus among males/females that they will have the vaccine for COVID-19 if offered. Community members think that most will trust and accept the vaccine. Moreover, most people now want to know when, where and how they can access COVID-19 vaccine, and there is an acceptance of any authorised COVID-19 vaccine[15].

However, trust in the government's response to the pandemic remains, perceived to be due to interventions marred by state corruption and nepotism. This will also likely impact upon vaccination, where there already existed a degree of lack of trust in the healthcare infrastructure, as seen in the polio campaigns. Trust issues are com-pounded by often inadequate and inconsistent messaging and miscommunication – often leading to the spread of rumours – and a perceived lack of transparency and accountability in feedback mechanisms.

Iraq

The strategy adopted by INGOs in partnership with community actors, in which the latter guide the planning, design and implementation of communication/engagement interventions was effective in increasing compliance with COVID-19 protection measures[16] [17]. High levels of people are now practicing hand-washing, mask wearing, avoiding physical greeting, and avoiding gathering in crowds. Community members – previously reluctant – have over recent years began to demand more engagement in decision-making. Health directors also call for more engagement with communities. COVID-19 further increased demands[18]. Perceptions of vaccination in 2021[19] have also improved, with high levels planning to get vaccinated and approving of vaccination to protect others.

13 High risk districts: 25 districts identified by IOM to be at greater risk of disease spread due to returns/recorded cases.
14 WHO (2021).
15 BBC Media Action (2020).
16 Mercy Corps (2021). Key Informant interview with Mercy Corps, Iraq. Conducted in March 2021.
17 World Bank (2021). Behaviourally Informed Interventions for Covid-19 Vaccine Take-up: Updates and preliminary insights from Iraq, February 2021.
18 Ibid.
19 Ibid.

Trust is also an issue in Iraq, where communities require more information and raise questions and suspicions about COVID-19/ vaccination, but do not think that they are receiving satisfactory answers. The trust deficit also extends to NGOs, with a per-ception that they are 'chasing funds' for community engagement and not conducting interventions appropriately. Despite some positive signs on vaccination perception, there are still information gaps, where the community perception is that they need more details of vaccine efficacy, safety, and side effects.

Jordan

Community engagement and communication partners – including MoH, UNICEF, WHO, RHAS – organised an effective national COVID-19 campaign (*Elak o Feed*), including dissemination of key messages from trusted sources to increase knowledge on COVID-19 and vaccination, maintain trust and counter misinformation[20]. This resulted in high awareness of COVID-19 risks; willingness to undertake a COVID-19 test if having symptoms; behaviour change in the form of high uptake of COVID-19 protection measures, such as distancing, handwashing, wearing face masks[21]; and reduction in risks of COVID-19 spreading.

While youth-led initiatives were important, the COVID-19 response was a more 'top-down', hospital-/clinician-based approach, which did not fully engage/mobilise primary healthcare (PHC) workers, who are well-represented at community level. NGOs/ CBOs also have the potential for greater involvement and engagement, includ-ing in the current vaccination-related activities. This would also enhance overall col-laboration and coordination. Rumours and misinformation on social media about vac-cines are leading to vaccine hesitancy, with vaccine side effects the main cause for hesitation.

Lebanon

Partners provided training for key municipality staff, who interacted with COVID-19 response crisis centres – comprising doctors, nurses, volunteers, social workers – and enabled connections with communities to respond to COVID-19. Municipal Crisis Cells worked with local groups/FBOs/religious leaders/local authorities proactively and engaged community members through enhancing knowledge, skills, and enthusiasm to support community-based approaches. This approach had the active participation of communities in containing the virus by adopting safe health practices, promoting health seeking behaviours and community action and support for the most vulnerable. It also including feedback mechanisms for community members to verify achievements from their perspective[22].

For many people, COVID-19 is not a priority: the economy is the priority. People rely on daily work, without which there is no pay, and a struggle for even basic necessities. Hence, despite receiving information about COVID-19, the protection measures are not always followed. Where information was available it is perceived by many to be contradictory, thereby resulting in mistrust of authorities/health service providers, the latter also having anxieties and sometimes expressing negative views about COVID-19 mitigation and vaccination. The impact on vaccination is compounded by a lack of vaccines available, and rumours and misinformation circulating.

Morocco

Initiatives were introduced to improve listening, analysis and feedback from community members, including on the response to COVID-19, including: scanning and analysis of media/social listening; and COVID-19 call centres were established for advice, feed-back, and complaints. The involvement of the Federation of Medical Students – active for 10 years and raising awareness on NCDs – helped in COVID-19 aware-ness/feedback, and worked with schools providing scientific information for fami-lies/teachers/communities. Religious leaders, previously engaged in providing advice and information on other issues, were reoriented to provide information at Friday prayers.

20 Ministry of Health of Jordan (2021). RCCE COVID-19: National RCCE Campaign Baseline Survey, January 2021.

21 Ibid.

22 IFRC (2020). Role of Municipal Crisis Cell in Response to COVID-19: The case of Al Abbassiyeh Municipality Disaster Risk Reduction Unit, Lebanese Red Cross.

Despite advanced planning, the groundwork had not been laid to respond to COVID-19; and whilst the MoH was leading the communication strategy, there was no action plan for NGOs.

Pakistan

Religious leaders/scholars acted as trusted intermediaries between authorities and communities, providing information during prayers, disseminating key public health messages via video messages, based on the Koran, and offering their social pages for dissemination of materials and messages. The engagement of the National Islamic Advisory enabled involvement of leaders at the planning stages and enhanced their buy-in and commitment to mobilising communities in response to COVID-19. This involvement convinced people to comply with COVID-19 guidance, which would otherwise have not been followed. This engagement resulted in prevention of instances of disease spread from religious activities, while enabling continuity of religious activities in compliance with COVID-19 prevention measures[23].

While there were many important community engagement interventions, community-driven development is often established by the state: and not based on civil society engagement. There has been insufficient systematic mapping of community ac-tors/ organisation to identify potential opportunities for collaboration in future emergen-cies. Hence, communities don't have the capacity/structures to be responsible for their own solutions, are not empowered, and don't receive sufficient capacity building.

Yemen

COVID-19 has led to greater understanding of how to manage future crises: through implementation of risk communication in multi-stage dynamic plans. In this case, three stages: (i) to ensure access to lifesaving information, prevent panic, sensitise on basic prevention and care measures; (ii) Limit human to human transmission, contain infection; ensure people protect themselves from exposure; and (iii) Continuity of services. Each stage is evaluated for impact before moving on to the next[24]. COVID-19 was a pivot for understanding of the need to plan and prepare for health emergencies. The effective plan highlighted the crucial role played by national/community organisations in building confidence and trust, ensuring interventions are community-owned, and increasing knowledge on and compliance with COVID-19 through engagement with trusted sources including health workers and community volunteers[25].

However, there is a perception that humanitarian actors are not doing enough to reach communities: funds for humanitarian programmes, rather than for food insecuri-ty have caused a backlash against humanitarian organisations on social media. Peo-ple's concerns and priorities are not focused COVID-19, but on numerous other is-sues. There are also perceptions that the humanitarian sector is not sufficiently ac-countable to the population, and responsive enough to people's needs, for example, community feedback mechanisms not utilsed effectively, or not being secure in pro-tecting people from retaliation if they complain.

23 National Islamic Advisory Group [NIAG] (2020). Pakistan: front-liners of COVID-19.

24 UNICEF (2020). Community engagement plan.

25 UNDP (2021) 2020 COVID-19 Response recap newsletter, UNDP Yemen Office

RECOMMENDATIONS

The recommendations are described in relation to the Community Engagement principles outlines in the Framework above.

Understand the community context

Mapping (Country offices):

- **Identify/map all community actors on the ground including potential roles/responsibilities, capacities, assets, skills**: This is a rigorous process to be conducted at the country level – involving community actors themselves and local authorities – and also serving as a means of engaging and mobilising community-level actors and organisations.
- **Map the communication ecosystem, including favoured channels, trusted influencers/ sources of information, levels of literacy, health literacy, media literacy**: and the ways in which different groups prefer to and are able to receive and share information. Analyse digital literacy, and the effectiveness of 'digital engagement' during COVID-19.

Data and evidence (Regional/Country offices)

- **Enhance evidence, data collection/analysis, including social data and socio-economic aspects** (involving community actors in the collection): including assessment of approaches targeted at localised needs/priorities, including engagement with excluded and marginalised populations; and analysis of strategies that have worked at scale or have potential to be scaled-up.
- **Establish formal multi-agency data and information sharing mechanisms/platforms** in collaboration with community actors: including for documentation and sharing of best practices/lessons learned to inform emergency prevention/preparedness/response. The challenges in obtaining and centralising the data are slowing down efforts for sustained community engagement. The creation of a regional dashboard with possibility to do country-focus would help visualise and actualise the data in an operational manner.
- **Increase regional/country social-behavioural research – to inform planning and strategy development**: including on compliance with mitigation measures, causes of vaccine hesitancy, and attitudes towards new vaccines: including in-depth qualitative research with different population groups (when feasible in relation to COVID-19), such as excluded and marginalised groups.
- **Develop GIS-based maps to highlight data collected on capacities and assets** [26]: such as hospitals, health facilities, pharmacies, municipalities, quarantine places, etc. at a provincial/local level; and showing areas with high numbers of COVID-19/other disease cases and limited numbers of interventions, to support and enhance planning and interventions.

Build trust

Develop trust (Regional/Country offices)

- **Develop relationships of trust with all partnerships**: trust is an ongoing process, hence identify and work with existing trusted structures, processes and personnel – such as polio teams in Afghanistan/Pakistan or cholera structures in Yemen; religious leaders; respected community actors, such as teachers, nurses, religious leaders, etc. – over long durations to build confidence and trust and ensure that interventions are community-owned.

Ensure community buy-in

Community planning and design

- **Harness the momentum of COVID-19 to increase the meaningful participation of community actors/group in the planning, design and implementation of interventions**: through formal structures that link them to national/ international organisations and local authorities, and based on the information/assistance they need, how they can/want to participate, and utilising their skills, experience, and community assets.

Religious authorities and leaders (Regional/Country offices)

- **Engage with higher religious authorities** (such as the National/regional Islamic Advisory Group), and incorporate Islamic guidance related to health, hygiene, sanitation and infection (for example, the curriculum being developed for

26 For example ArcGis https://www.arcgis.com/index.html

religious leaders/FBOs at a Cairo University, through the regional Islamic Advisory Group). Their role should be embedded within a wider, multi-sectoral intervention umbrella secular and religious institutions and schools.

- **Provide training/capacity building for religious leaders to ensure that they are able and motivated for two-way engagement with community members** (rather than one-way broadcasters of information in mosques, etc.) and intermediaries with authorities: involve them in planning and design of interventions to learn from them; work with leaders who are community-oriented, understanding of and committed to women's/children's rights, and advocates for change. Their role should be embedded within a wider, multi-sectoral intervention umbrella of secular and religious institutions and schools.

Work through community solutions

Planning (Regional/Country offices)

- **Develop strategies in advance for all public health emergencies**: and lay the groundwork for implementation, including training of risk communication actors, development of an adaptable Action Plan for pandemics, infectious diseases, identify potential resources, and produce templates for information/advice/SOPS available for quick adaption to new health emergencies.
- **Focus interventions on micro-planning contextualised at local level, strongly associated with local norms** (rather than standardised national awareness campaigns): taking into account local realities, demographic, geographic, socio-economic, political, social, cultural factors; and addressing the barriers/enablers relevant to specific behaviours for specific groups of people (including for those with existing illness, who may not be able to comply with pandemic protection measures).
- **Develop multi-sectoral interventions/programmes that aim to address community priorities, such as livelihoods and basis services**: conduct community dialogue, listen to the community, understand their needs. Community engagement/mobilisation/participation takes time: first livelihoods are necessary to ensure compliance with disease protection/mitigation measures.
- **Involve young people/youth groups in the development of emergency prevention/preparedness and response plans**: their involvement should be genuine and not 'tokenism', as peer educators, community mobilisers, and promoters of inclusion.

Capacity (Regional office)

- **Review multi-agency capacity building training/resources/initiatives with the view to integrating and institutionalising into a single distinct RCCE curriculum for preparedness and response to emergencies**: Develop training modules – on notifiable diseases, non-communicable diseases, vaccination, hygiene and sanitation for risk communication/community engagement/social mobilisation/C4D/communication personnel, health workers, frontline workers/volunteers, vaccinators, health champions, etc. to ensure that they have the necessary knowledge and skills to protect themselves and provide sufficient advice to others.[27] [28].
- **Organise a joint review with Ministries of Education to assess the potential to introduce a module on notifiable diseases**, outbreaks, NCDs, vaccination into the national curriculum.

Commit to honest and inclusive communication

Inclusion (Regional/Country offices)

- **Establish an Inclusion Task Force and identify target groups who are at higher risk (migrants, IDPs, disabled, elderly) and/or under-served**: ensure inclusion of all groups affected/at-risk in emergencies. Formulate information and messaging that avoid the stigmatisation of certain groups. Allocate dedicated budgets to promote and enhance the inclusion of those at risk of exclusion; continuously identify and analyse factors contributing to risk of exclusion of different groups and individuals; and invest in raising awareness among groups at risk of exclusion around their rights and entitlements, as well as availability of services and ways to access them.
- **Define criteria for community representation and develop processes that ensure fair and transparent community representation**: preferred community representatives are from community actors/groups within – and selected by – the community, and who have credibility and transparency, and are trusted, well-connected and influential in the community.
- **Counter the prejudice and stigma towards people with disabilities that prevent them from effectively integrating into society**: advocate for public facilities including schools/health facilities are equipped to ensure access for people with

27 WHO (December 2020). COVID-19 vaccination training for health workers (including: six modules, video lectures, quizzes, job aids, interactive exercises, downloadable presentations).

28 PAHO (January 2021). Communicating about Vaccine Safety: Guidelines to help health workers communicate with parents, caregivers, and patients.

disabilities; and for local communities, local authorities and humanitarian organisations to take into account their basic needs and listen to them. Humanitarian actors should train staff on key concepts and skills to work with specific groups such as people with disabilities and older people.

Listen, analyse, respond to feedback

Feedback mechanisms (Country offices)

- **Establish (or enhance) – with the input of community actors/groups – transparent, confidential, genuinely two-way community feedback mechanisms** that: (i) collect data in a timely, systematic manner and from different sources; (ii) analyse data – including to identify trends in behaviours and perceptions; and (iii) provide findings back to the community – including those who can use it to catalyse change – in a constructive, timely, transparent way, for acting on and use in developing/revising strategies. Ensure that women and girls, people with disabilities, and marginalised/excluded groups have access to mechanisms: which should also include non-digital features to ensure inclusiveness.

Discourage stigma, rumours

Rumour tracking (Country offices)

- **Establish (or enhance) rigorous, formal systems[29] to understand rumours/misinformation, identify how, where and by whom are they are being generated, the populations exposed, and why they believe the rumours;** and develop strategies to rapidly respond, including through influencers, celebrities, health champions. Develop integrated data and statistics systems, on a common platform, with quality control, transparency and which engage communities[30]. Involve young people/youth groups in monitoring/responding to misinformation on digital media, and enhance their capacity to do so through training.

Coordinate with all response actors.

Coordination (Regional/country offices)

- **Build on the lessons learned from collaboration in the COVID-19 response by strengthening inter-agency groups/RCCE taskforces/working groups/Clusters through a formal structure/framework/mechanism**: for integrated, multi-sectoral community engagement planning and coordination in response to emergencies: with clearly defined roles and responsibilities/SOPs, including for the involvement of involvement of community actors/leaders, local media, and multi-sectoral national/provincial authorities and ministries (Health, and Education, Foreign Affairs, Interior, Trade, Agriculture, Social Affairs, etc.).
- **Enhance collaboration between non-communicable (NCD) and communicable disease (CD) sectors**: looking at the links between them, including NCD contributing factors to COVID-19/other infectious diseases, prevention and management of NCDs, and involving community actors in messages, communication tools and interventions targeting the vulnerable.
- **Develop a coordinated approach in refugee/migrant camps to shift to alternative modalities for continued service delivery** – involving INGOs, NNGOs, ministries, UN agencies – through enhanced programming and/or funding. Ensure that services are fairly distributed, and all nationalities receive equally. Support a dedicated focal point in MOH to coordinate different units and with partners (UN and NGOs) on migrant and refugee issues.

Resource mobilisation

- **Advocate to donors to be more accepting of community-based approaches and activities, and willing to fund them**: the success of community-based approaches is often linked to multi-year and flexible funding.

29 For example, Internews (https://internews.org/covid-19/rumor-bulletins and https://internews.org/sites/default/files/2021-03/Internews_Global_Rumor_Bulletin_03_2021-03.pdf

30 UNHCR-WFP Joint Hub. https://wfp-unhcr-hub.org/

ANNEX A. KEY INFORMANT INTERVIEWS SAMPLE QUESTIONNAIRE

GOVERNMENT/INSTITUTIONAL/UN INTERVIEWS

A. INTRODUCTION

1. Introductions/Consent to recording the interview
2. Brief summary of project/purpose of interview
3. Can you briefly describe your role: in terms of prevention/preparedness for/response to public health emergencies, including COVID-19.
4. As the purpose of this project relates to good practices in community engagement, how does your role relate to CE?
5. What was the objective of the intervention: Behavioural/structural?
6. What was the context/target population (general, migrants)/age/population size/population reached?

B. COMMUNITY ENGAGEMENT

Community engagement interventions

1. What were/are the key areas that WHO/UNICEF/MOH engaged the community and civil society in: for preparedness/response for COVID-19, pandemics, etc.
2. What partnerships were/are leveraged to for preparedness/response, and vaccine uptake?
3. Who were/are the groups available at the community level for mobilisation activities (NGOs, CBOs, FBOs, frontline workers, teachers, etc.)?
4. How did you communicate with communities?
5. What areas of the response did/can the community play an active role in?

C. COORDINATION/CAPACITY

Part 1. Coordination

1. Are there civil society coordination mechanisms to enhance liaison/engagement?

Part 2. Capacity

2. Do agencies/ministries have sufficient capacity to engage with community actors?

D. COMMUNITY ENGAGEMENT RESULTS

Part 1. Strategies and approaches

1. What are the key strategies/methods/approaches for effective community engagement?
2. To what degree are those scalable, replicable, sustainable?

Part 2. Enablers and barriers

3. What were/are the key enablers that promote community engagement?
4. What are the main challenges/barriers/gaps faced by CSOs in community engagement for preparedness/response?

Part 3. Results

1. How has social media/technology/mobile apps been used to engage the communities?
2. What is the level of trust among communities (of govt/local authorities/NGOs)?
3. What was the evidence for the results achieved (or proxy indicators)? For example:
4. What were the key results/outcomes/impact of the intervention? For example, in terms of changes in behaviour, policies, services, structures, regulations.
5. What are the follow-up steps planned? e.g. for vaccination

NGO LEVEL INTERVIEWS

A. INTRODUCTION

1. Introductions/Consent for recording the interview
2. Brief summary of project/purpose of interview
3. Can you briefly describe your role: in terms of prevention/preparedness for/response to public health emergencies, including COVID-19.
4. As the purpose of this project relates to good practices in community engagement, how does your role relate to CE? What are the key activities?
5. What was the objective of the intervention: Behavioural/structural?
6. What was the context/target population (general, migrants)/age/population size/population reached?

B. COMMUNITY ENGAGEMENT

Community interventions

1. What were the existing NGO-led initiatives in the preparedness/response to public health emergencies/COVID-19? What were the entry points for engaging communities?
2. How did NGOs meaningfully engage with communities on COVID-related issues?
3. How does the NGO communicate with communities?
4. Who were the community level actors who contribute to community engagement (e.g. peer educators, volunteers, champions, committees, CHWs, FBOs)?

C. COORDINATION/CAPACiTY

Part 1. Coordination

1. What is the link to/engagement with government structures (national/local)?
2. How have NGOs outside the public health area been integrated into the response?
3. What society coordination mechanisms to enhance liaison/engagement?

Part 2. Capacity

4. Do agencies/ministries have sufficient capacity to engage with community actors?
5. What is the implementation capacity of NGOs/CSOs (financial, organisational, human, technical)?

D. COMMUNITY ENGAGEMENT RESULTS

Part 1. Strategies/approaches

1. What are the key strategies/methods/approaches for effective community engagement?
2. To what degree are those scalable, replicable, sustainable?

Part 2. Enablers/barriers

3. What were/are the key enablers that promote community engagement?
4. What are the main challenges/barriers/gaps faced by CSOs in community engagement for preparedness/response?
5. How has social media/technology/mobile apps been used to engage the communities?
6. What is the level of trust among communities (of govt/local authorities/NGOs)?

Part 3. Results

7. What was the evidence for the results achieved (or proxy indicators)? For example:
8. What were the key results/outcomes/impact of the intervention? For example, in terms of changes in behaviour, policies, services, structures, regulations.
9. What are the follow-up steps planned? e.g. for vaccination

CIVIL SOCIETY INTERVIEWS

A. INTRODUCTION

1. Introductions/Consent for recording the interview
2. Brief summary of project/purpose of interview
3. Can you briefly describe your role: in terms of prevention/preparedness for/response to public health emergencies, including COVID-19.
4. As the purpose of this project relates to good practices in community engagement, how does your role relate to CE? What are the key activities?
5. What was the objective of the intervention: Behavioural/structural?
6. What was the context/target population (general, migrants)/age/population size/population reached?

B. COMMUNITY ENGAGEMENT

Community interventions

1. What were/are the existing CSO-led initiatives in the preparedness/response to public health emergencies/COVID-19? What are the entry points for engaging communities?
2. How did CSOs meaningfully engage with communities on COVID-related issues?
3. How does the CSO communicate with communities?
4. Who are the community level actors who contribute to community engagement (e.g. peer educators, volunteers, champions, committees, CHWs, FBOs)?
5. What areas of the response did/can the community play an active role in?

C. COORDINATION/CAPACITY

Part 1. Coordination

1. What is the link to/engagement with government structures (national/local)?
2. What partnerships are leveraged to engage with communities and address health risks?
3. How have CSOs outside the public health area been integrated into the response?
4. What society coordination mechanisms to enhance liaison/engagement?

Part 2. Capacity

5. Do agencies/ministries have sufficient capacity to engage with community actors?
6. What is the implementation capacity of CSOs (e.g. financial, organisational, human, and technical)?

D. COMMUNITY ENGAGEMENT RESULTS

Part 1. Strategies and approaches

1. What are the key strategies/methods/approaches for effective community engagement?
2. To what degree are those scalable, replicable, sustainable?

Part 2. Enablers and barriers

3. What were/are the key enablers that promote community engagement?
4. What are the main challenges/barriers/gaps faced by CSOs in community engagement for preparedness/response?
5. How has social media/technology/mobile apps been used to engage the communities?
6. What is the level of trust among communities (of govt/local authorities/NGOs)?

Part 3. Results

7. What was the evidence for the results achieved (or proxy indicators)? For example:
8. What were the key results/outcomes/impact of the intervention? For example, in terms of changes in behaviour, policies, services, structures, regulations.
9. What are the follow-up steps planned? e.g. for vaccination

COMMUNITY INTERVIEWS (CHWS, RLS, YOUTH)

A. INTRODUCTION

1. Introductions/Consent for the interview
2. Brief summary of project/purpose of interview
3. Can you briefly describe your role: in terms of prevention/preparedness for/response to public health emergencies, including COVID-19.
4. As the purpose of this project relates to good practices in community engagement, how does your role relate to CE?
5. What was the objective of the intervention: Behavioural/structural?
6. What was the context/target population?

B. COMMUNITY ENGAGEMENT

Part 1. Community interventions

1. What were/are the existing community-led initiatives in the preparedness/response to public health emergencies/COVID-19? What are the entry points for engaging communities?
2. Who are the community level actors who contribute to community engagement (e.g. peer educators, volunteers, champions, committees, CHWs, FBOs)?
3. How have NGOs/CSOs/authorities engaged with communities on health/COVID issues?
4. What areas of the response can the community play an active role in?

Part 2. Community needs

5. What are the additional skills, capacities, competencies are required by community members (including women and youth as partners)?
6. What are the practical tools/technologies available/needed at the community level?
7. What are the roles played by different sub-populations in the response?

C. COORDINATION/CAPACITY

Part 1. Coordination

1. What is the link to/engagement with government structures (national/local)?
2. What partnerships are leveraged to engage with communities and address health risks?
3. What society coordination mechanisms to enhance liaison/engagement?

Part 2. Capacity

4. Do agencies/ministries have sufficient capacity to engage with community actors?
5. What is the implementation capacity of CSOs (e.g. financial, organisational, human, and technical)?

D. COMMUNITY ENGAGEMENT RESULTS

Part 1. Strategies and approaches

1. What are the key strategies/methods/approaches for effective community engagement?
2. To what degree are those scalable, replicable, sustainable?

Part 2. Enablers and barriers

3. What were/are the key enablers that promote community engagement?
4. What are the main challenges/barriers/gaps faced by CSOs in community engagement for preparedness/response?
5. How has social media/technology/mobile apps been used to engage the communities?
6. What is the level of trust among communities (of govt/local authorities/NGOs)?

Part 3. Results

7. What was the evidence for the results achieved (or proxy indicators)? For example:
8. What were the key results/outcomes/impact of the intervention? For example, in terms of changes in behaviour, policies, services, structures, regulations.
9. What are the follow-up steps planned? e.g. for vaccination

ANNEX B. CASE STUDY INPUT/CODING TEMPLATE

Case Study input/coding template:

Good Practice and Lessons Learned in Community Engagement in preparedness for/response to health emergencies, including COVID-19

A. INTRODUCTION
Year:
Theme/principles/focus area:
Country:
Title:
Interviewee role/responsibility:
Purpose/objectives of intervention: **Behavioural (what behaviour, resistance, motivation):** **Structural (policy, service. institutional):**
Context/Target group (e.g. general/migrant)/age/population size/population reached:
Key partners:
B. COMMUNITY ENGAGEMENT
Part 1. Community interventions 1. What were/are the existing community-led initiatives in the preparedness/response to public health emergencies/ COVID-19? How did NGOs/CSOs/authorities engage communities? 2. What were the entry points for engaging communities? 3. Who are the community level actors who contribute to community engagement (e.g. peer educators, volunteers, champions, committees, CHWs, FBOs)? 4. What areas of the response did/can the community play an active role in?
Part 2. Community needs 1. What are the additional skills, capacities, competencies required by community members? 2. What are the practical tools/technologies available/needed at the community level? 3. What are the roles played by different sub-populations in the response?
C. COORDINATION/CAPACITY
Part 1. Coordination 1. What is the link to/engagement with government structures (national/local)? 2. What partnerships are leveraged to engage with communities and address health risks? 3. What coordination mechanisms are there to enhance liaison/engagement?

Part 2. Capacity

1. Do agencies/ministries have sufficient capacity to engage with community actors?
2. What is the implementation capacity of CSOs (e.g. financial, organisational, human, and technical)?

D. COMMUNITY ENGAGEMENT RESULTS

Part 1. Strategies and approaches

1. What were the key strategies/methods/approaches applied?

- Was the intervention/good practice based on a thematic area:

    1. Role/input of frontline/health workers
    2. Role/input of CSOs/CBOs/Women's groups
    3. Role/input of religious leaders/FBOs
    4. Youth-led initiatives
    5. Technology-based innovation
    6. Facilitated by non-state actors in reaching populations
    7. Local authorities facilitating community engagement
    8. People engaged through CE messaging and dialogue

- Was the intervention based on or did it illustrate any or a combination of the CE principles:

    1. Understand the community context
    2. Build trust
    3. Ensure community buy-in
    4. Work through community solutions
    5. Generate a community workforce
    6. Commit to honest and inclusive communication
    7. (7) Listen, analyse, respond to feedback
    8. Do not criminalise actions
    9. Discourage stigma, rumours
    10. Coordinate with all response actors.

1. To what degree are those scalable, replicable, sustainable?

Part 2. Enablers and barriers

2. What were/are the key enablers that promote community engagement?
3. What were/are the main challenges/barriers/gaps faced in community engagement for preparedness/ response?
4. How has social media/technology/mobile apps been used to engage the communities?
5. What is the level of trust among communities (of govt/local authorities/NGOs)? How was it established/maintained/ restored?

Part 3. Results

6. What was the evidence for the results achieved (or proxy indicators)? For example:

- % trusting in sources of information
- % perception of how dangerous the COVID-19 risk is to your community?
- % perception of efficacy of protective measures, incl vaccines
- % trusting in health service provider, incl vaccines
- % intention to get vaccinated
- % individuals who trust authorities and partners leading the COVID-19 response

7. What were the key results/outcomes/impact of the intervention? For example, in terms of changes in behaviour, policies, services, structures, regulations.

Next steps:
(9) What are the follow-up steps planned?

Criteria for selection of case studies:

- Evidence of results achieved, or strong proxy indicators or potential for results for communities - behaviours, policies, services, structures, changed
- Reflecting UNICEF Minimum Standards and Indicators for Community Engagement
- Diversity of experience: in terms of geographical spread, demographics (populations and sub-populations), range of strategies and partners
- Focus on localising community engagement – prioritising experiences at community level (rather than high level processes)
- Scalable, replicable, sustainable approaches

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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