World Health Organization

WHO COMMUNITY ENGAGEMENT FRAMEWORK FOR QUALITY, PEOPLE-CENTRED AND RESILIENT HEALTH SERVICES

FRAMEWORK DEVELOPMENT WORKSHOP

Cape Town, South Africa, 22-24 March 2017

This report is the output of a 3-day technical workshop to examine the links between community engagement, quality, people-centred and resilient health services and communities. The workshop was convened by WHO through a collaboration between the Health Promotion and Social Determinants Unit (HPD) in the WHO Regional Office for Africa and the Service Delivery and Safety Department (SDS) at WHO headquarters.

Acronyms and Abbreviations

AFRO	WHO Regional Office for Africa
CEQ	WHO community engagement framework for quality, integrated, people-centred and resilient health services
CHW	community health workers
CHP	community health programme
CSDH	WHO Commission Report on Social Determinants of Health
EVD	Ebola virus disease
HPD	Health Promotion and Social Determinants Unit
HIS	Health Systems and Innovation Cluster
IHI	Institute for Healthcare Improvement
IPCHS	WHO Framework for integrated people-centred health services
MOH	Ministry of Health
NCD	noncommunicable diseases
QA	quality assurance
QI	quality improvement
QHC	Universal Health Coverage and Quality Unit
SDG	Sustainable Development Goals
SDS	Department of Service Delivery and Safety
UHC	universal health coverage
WHO	World Health Organization

Contents

6

Foreword

The response to the Ebola virus disease (EVD) outbreak of 2014 provided an opportunity to learn what did and did not work in terms of community engagement. These important lessons have implications for strengthening health systems and communities. The message from Ebola was clear: transmission rapidly slowed and stopped when the health sector, response agencies and developmental partners learnt to work with (and not only for) local families and communities affected by Ebola.

As the Ebola outbreak evolved and communities in the three Ebola affected countries (Guinea, Liberia and Sierra Leone) resisted measures to prevent further transmission of infection, the World Health Organization (WHO) and partners took unprecedented actions, such as recruiting community engagement staff and positioning them at the district level, mobilizing WHO health promotion officers from neighbouring countries and deploying international experts from the social sciences. This was done to try and bridge the structural, technical and institutional barriers that were preventing the integration of local knowledge and culture into technical and operational decision-making and responses.

In the WHO African Region, Dr Matshidiso Moeti, the Regional Director, elevated and placed the Health Promotion and Social Determinants of Health (HPD) unit within the Office of the Director, Programme Management (DPMO) to coordinate the mainstreaming of health promotion and social determinants of health across all technical programmes, in order to effectively address universal health coverage (UHC). At the WHO Headquarters level, the Service Delivery and Safety (SDS) department, in the Health Systems and Innovation (HIS) cluster prioritized the integration of community engagement as a key action for resilient, people-centred health systems. Both these initiatives make an important, and often missing, connection between community, people-centred approaches and quality in UHC. Relationships built and maintained during the delivery of routine services and programmes are drawn upon during emergencies. There is an urgent need to institutionalize a better and more sustainable way of engaging with service users, their families and local communities so that significant and marginalized voices are solicited, heard and acted upon throughout the entire service and programme planning cycle.

This will require fundamental shifts in the way WHO and Members States understand and engage collaboratively with service users, their families and local communities. It will take a change in the mind-set, attitudes and practices of health professionals at all levels of the health system. The legacy of Ebola left little doubt for the global health community: it can no longer be "business as usual". Ebola laid down the gauntlet for the emergence of a self-learning, self-adaptive and self-leading workforce able to support and collaborate with communities as co-creators of health and well-being.

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Preamble

Community engagement: a cornerstone of quality, safe and people-centered services

The 2014 Ebola outbreak in West Africa was the largest the world had ever known and it triggered the most protracted Ebola response in history. The experience brought home and reinforced that context and culture matter and clearly demonstrated the interdependent and reciprocal relationship between health service providers, responders and health service users, their families and communities.

The actions or lack of action of service providers and response teams had a deep impact on community understanding and reactions. In the midst of wide community distrust and sometimes outright rejection of outbreak control and prevention measures in Ebola-affected countries, WHO and partners, in an unprecedented move, began to substantially invest in ways that addressed the social and cultural dimensions of epidemic response in an attempt to close the "distrust gap" between EVD response teams and the surrounding communities.

These investments included: i) the recruitment and deployment of social scientists and WHO social mobilization staff, ensuring that they were embedded and/or worked closely with technical and operational response staff as well as supporting social mobilization partners at national, sub-national and district level; ii) applying transdisciplinary and interagency interventions to rebuild trust between service providers and communities; and iii) the integration of community engagement into relevant WHO technical guidelines and recommendations such as: safe and dignified burials[1], implementation of community care centres[2]; and recruitment of people recovered from Ebola as potential donors for convalescent whole blood and plasma therapy[3].

AFRO regional priorities and actions to elevate health promotion and social determinants

The WHO regional office for Africa has been supporting its Member States to address social determinants of health and health equity since the launch of the WHO Commission Report on Social Determinants of Health (CSDH) in 2008. The strategic priorities for this area of work have been further strengthened through decisions taken at global and high-level meetings namely, the World Conference on Social Determinants of Health (2011); the UN-High Level Meeting on NCDs (2011); and the 8th and 9th WHO Global Conference on Health Promotion (2013 and 2016).

Furthermore, in Dr Moeti's WHO Africa Health Transformation Programme (2015), the Regional Director for the WHO African Region, identified social determinants of health and equity as a key strategic priority for the region.

[1] http://www.who.int/csr/resources/publications/ebola/safe-burial-protocol/en/
[2] http://www.who.int/csr/resources/publications/ebola/patient-care-CCUs/en/
[3] http://www.who.int/csr/resources/publications/ebola/convalescent-treatment/en/
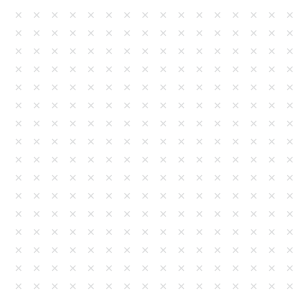
The Health System and Innovations cluster's priorities and actions to integrate and mainstream community engagement at WHO headquarters

The Service Delivery and Safety Department (SDS) was established to support countries to move their health systems towards universal health coverage (UHC) by increasing access to safe, high quality, effective, people-centred and integrated services. During the Ebola outbreak in West Africa, SDS was responsible for coordinating early recovery activities which were grounded within the WHO Framework on integrated people-centred health services (IPCHS), placing people at the centre of service delivery efforts. The emphasis was on seamlessly transitioning between early recovery and long-term health systems strengthening revolving around infection prevention and control, the health workforce, surveillance and an essential package of services with a strong community component.

As a direct outcome of these experiences, SDS established an area of work on community engagement for resilience and quality within a newly created unit focusing on quality aspects of universal health coverage[4]. The intention was to ensure that important and significant lessons learnt on engaging with communities during the EVD response could be sustained in a structured and systematic way through mainstreaming and integrating a range of engagement processes within long-term efforts to strengthen health systems. Such an approach would strengthen quality universal health coverage and prepare health systems to engage with communities at strategic interfaces – a prerequisite for trust and a feature of effective emergency response that aids recovery and resilience of both communities and health systems and enhances health security.

Collaboration in support of innovation and generation of policy options for community engagement

In June 2015, AFRO/HPD and SDS/HIS agreed on a number of technical and strategic priorities to identify and address critical linkage points between health systems/service delivery and service users/communities. The focus has been on innovative engagement models and mechanisms that mainstream and integrate community engagement to support continuous quality improvement in services and programmes. The aim is to ensure that services and programmes help build resilient health systems and communities.

This workshop to develop a community engagement framework was one of the jointly agreed outputs and leverages the Organization's mandate to generate evidence and practice-based guidance for promoting effective community engagement.

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[4] Universal Health Coverage and Quality Unit (QHC): http://www.who.int/servicedeliverysafety/areas/qhc/en/

Executive summary

Executive summary

In March 2017, the Health Promotion and Social Determinants Unit (HPD) in the WHO Regional Office for Africa (AFRO) and the Service Delivery and Safety Department (SDS) at WHO headquarters jointly organized a technical workshop to examine the links between health systems and communities. Participants were tasked with developing a community engagement framework for quality, people-centred and resilient health services and communities (CEQ). This workshop was the result of a systematic, structured and consultative process undertaken by WHO to fill a much-needed technical gap and therefore represents an important milestone.

The three-day workshop was the culmination of the following preparatory efforts, which involved:

1. a scoping and mapping of community engagement interventions and practices that included a desk and literature review, a review of WHO guidelines with community level interventions and interviews with 12 WHO programme focal points;

2. commissioning a synthesis of lessons learnt from Ebola from community, disciplinary, donor, health and WHO perspectives;

3. a survey of national health promotion officers in WHO country offices in the African Region; and

4. a review and selection of WHO collaborating centres and academic institutions willing to form a small network to support the work of the Secretariat and countries.

The purpose of the workshop was to develop: a definition of community engagement relevant to quality, integration and people-centred approaches; and a comprehensive framework and conceptual model that explicitly recognized multiple connect-points between communities and health systems. It was important for the community engagement framework to focus on the human architecture of health systems and how interdependent relationships between people who populate the health system and those who use the health system are formed and maintained through daily interactions which in turn shape the perceptions, decisions, and actions of both service users and service providers.

Community engagement is neither synonymous nor interchangeable with community mobilization or community health programmes (CHPs). The definition of community engagement that emerged from the deliberations of the workshop is as follows:

Community engagement is 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.

The definition is guided by these caveats:

• Stakeholders comprise multiple communities that could include community members, patients, health professionals, policy-makers and other sectors.

• Desired relationships are characterized by respect, trust and a sense of purpose.

• Health-related issues include public health events such as emergencies.
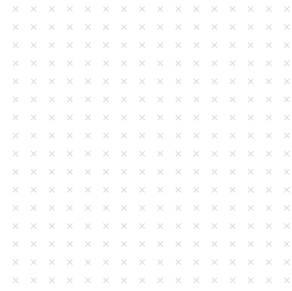
Engaging with communities is therefore not the sole responsibility of community health workers (CHWs). In fact, the CEQ framework identifies a function and prerequisite on the side of health systems – to create an enabling culture of engagement that facilitates the work of CHWs so they do not bear the full brunt of the community engagement work. The CEQ framework provides direction on how to integrate engagement functions, and what kind of research may be needed to successfully implement the WHO Framework on integrated people-centred health services (IPCHS), as well as a range of WHO resolutions that require the active participation and engagement of health service users, local communities and civil society.

Health systems already engage with communities which present latent opportunities for routinely building and strengthening trust, as well as soliciting feedback that can be used for improvement. Engagement should be seen as a core business of health services and programmes. The CEQ Framework intends to guide the work of WHO and countries so that community engagement becomes routinely managed and not an afterthought.

The CEQ Framework also reminds us of the critical link between health, human development and well-being. The foundation of "community engagement" is "human engagement". Understanding human engagement in the context of changing populations and health systems breaks down disciplinary and professional silos, and gets people working together to address the complexities and specificities of health challenges in the 21st Century.

Policy-makers, health planners, clinicians, researchers, nongovernmental organizations, development partners and donors can benefit from the process followed as well as the outputs of the workshop. This is the first step in shifting the dominant paradigm of "educating, telling and selling" that still too often permeates the attitude and practice of health services and programmes towards service users and communities.

This workshop report details the process undertaken, the issues discussed and captures the key outputs. It is an essential go-to document that begins to articulate a broader, inclusive approach to enhance the health security of populations while aiding the recovery and resilience of communities and health systems. The merits of collaboration across the organization and partners to achieve the goal of the CEQ framework are undisputed and require the support of all. The community engagement framework developed in the workshop is summarized below and is described in detail on page 24.

Framework Development Workshop

A community engagement framework for health systems to connect with communities for quality, integrated, people -centred and resilient services

	Enabling conditions		Capacity development for implementation		Outcomes
	Resources	**A prepared worldforce**	**Capacity development**	**Implementation**	
Governance	Leadership				
Peace	Values (trust, respect, caring and teamwork)				
	Shared vision/mission/purpose				
	Time	Technical management and leadership competencies and skills	Shared assessment and analysis of the situation	Context-specific approaches	Policies, clinical and technical guidelines and practice, health care and services across prevention, promotion, curative, rehabilitation and palliation	Changed conditions and systems
Democracy	Spaces/ platforms/ technology that support participatory processes	Accountability, self-awarness, personal and team responsibility, value-based decision-making, integrity and ethical behavior				Improved outcomes
Dialogue	Tools	Interdependence & agency Empathy, compassion, receptive states	Shared agenda-setting and planning	Defined roles and responsibilities	Participatory monitoring and evaluation (feedback loop)	
Participation	Skills and practices in communicating and connecting	Coordination (collaborative and systemic thinking and action)			Continuous quality impovement (co-adaptation and implementation)	
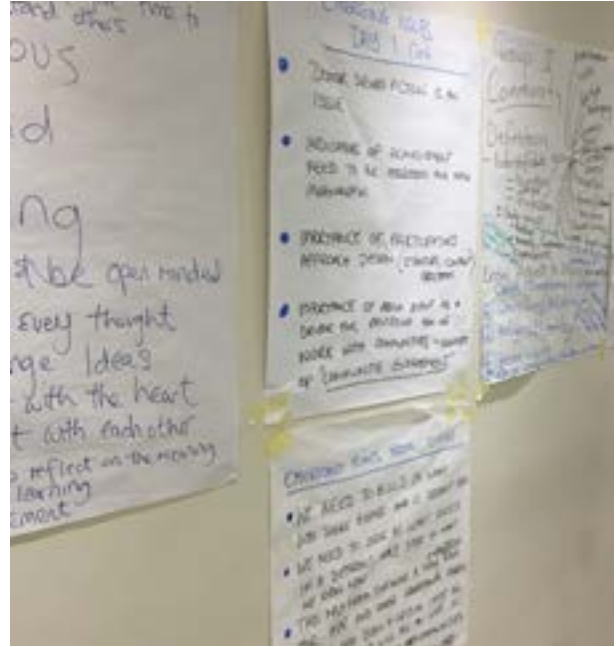
Workshop rationale

Workshop rationale

Framework Development Workshop

The 2014 Ebola virus disease response in West Africa represents a watershed, both for global health and for the World Health Organization. It became abundantly clear:

- that there was and is no universally agreed definition of "community engagement" within the health sector;
- that "community engagement", a term coined and widely used in public health research, was introduced into the EVD response lexicon as a counterpoint to traditional mobilization and messaging approaches – it was used to signify more meaningful and authentic engagement with Ebola-affected communities;
- that major public health emergencies revealed and reinforced the central role of communities in support of a more effective and lasting response effort, hence, the importance of coordination and engagement of the health sector and response agencies, to build meaningful relationships with local communities and each other; and
- that WHO did not have sufficient evidence to issue policy recommendations on community engagement for Member States.

Consequently, in 2017, the Department of Service Delivery and Safety (SDS) initiated a process to develop ethical, evidence-based policy options on community engagement. This workshop took stock of major lessons learnt from multiple and diverse perspectives as part of a multi-pronged and systematic approach. The purpose was to develop a CE framework that mainstreamed community engagement as part of routine public health practice, delivery of services and into the core business of health systems – rather than being considered an after-thought. The CEQ Framework will guide the future community engagement activities of WHO and Member States as an integral part of health systems strengthening strategies, introducing and implementing integrated people-centred health services, improving quality of services/programmes, and thereby contribute to the resilience of health and community systems.

Objectives

- Validate definitions and scope of community engagement in relation to:
  a. *quality;*
  b. *integration of services/programmes; and*
  c. *resilient health systems.*
- Review theoretical models and propose a meta-model that informs the selection of a package of engagement interventions relevant to health systems.
- Develop metrics and mechanisms for adaptation and field-testing (implementation research) in selected countries using programmatic entry points with sustainability and scalability as an end goal.

Outputs

- A meeting report with preliminary recommendations for country introduction, adaptation and implementation.

Outcomes

- A community engagement framework designed to support the resilience of health systems and communities ready for country validation, adaptation and implementation.
- Contribution to global learning, practice guidance and research agendas.

1. Context and lessons learned
2. Health systems and community linkages
3. Framework architecture and building blocks
4. Theory and models
5. Measuring success
6. Country ownership and adaptation
7. What is our story?
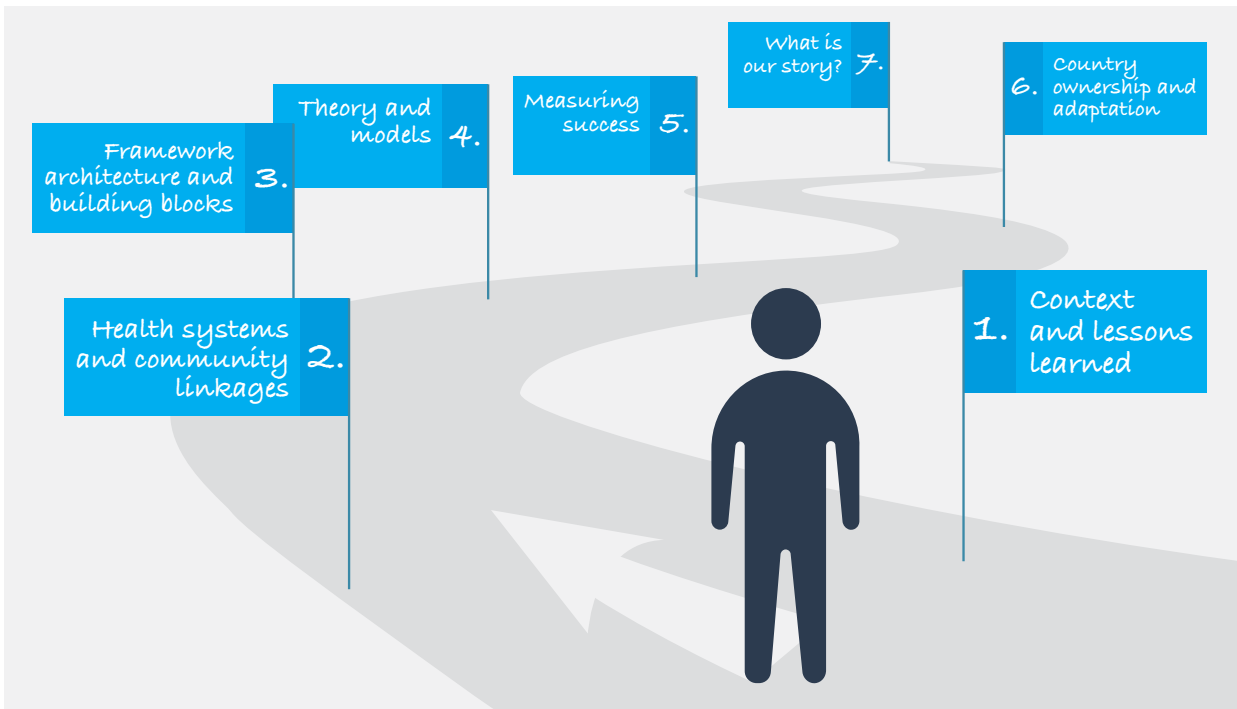
Principles

- Ensure the needs and priorities of countries are central.
- Focus on the practical application of multi-disciplinary models and planning frameworks.
- Promote horizontal and vertical linkages by building on what exists and what works. Address behavioural and social determinants of health across services and programmes.

Methodology, content and design

- Ground the workshop in participants' realities using evidence- and practice-based experience.
- Set clear expectations and facilitate maximum contribution to harness collective intelligence and resources to meet outcomes and deliverables.
- Provide a safe but challenging experience for participants to unpack sensitive and complex issues.
- Be open to co-development and co-construction, ensuring a multidisciplinary and integrative approach which draws on medical, social and human sciences, to meet workshop objectives and outcomes.
- Workshop flow:
  - *Part 1 – How did we get here? Understanding the current context*
  - *Part 2 – Exploration and reflection*
  - *Part 3 – Building the CE framework*
  - *Part 4 – What will it take? Getting ready to operationalize the CE framework.*

It was important for the workshop to model and demonstrate community engagement in action and to show that "process" is critical for generating quality outputs and impact. The ability of the workshop to meet objectives and generate the outputs depended on several factors: building a climate of trust, appreciation and respect through which participants' strengths were recognized and contributions sought; the selection of participants with relevant experience, expertise and ability to work in a multidisciplinary environment; the selection of process tools, methodologies and careful crafting of questions relevant to each stage of the workshop; the competencies and skills of facilitators to be mindful, respond to an unfolding process and promote, deep engagement, connection, inclusion, participation, and reflection.

Framework Development Workshop

The community engagement framework for quality, integrated and people-centred health services (CEQ) and underpinning model

The community engagement framework for quality, integrated and people-centred health services (CEQ) and underpinning model

Improving the quality of health care and services and being responsive to the needs and preferences of local communities cannot be done without the individuals and teams responsible for designing, managing and delivering health care talking and interacting with each other, as well as engaging with service users and other stakeholders about how best to do this. On the side of the provider, traditional approaches to engaging service users, families and local communities have broadly focused on better information provision and the improvement of communication skills. While on the service user side, the focus has tended to be on empowering patients, families and communities to be more literate in using and navigating the health system, as well as working through representation and mechanisms to improve accountability of health systems.

Yet, compassion, empathy and trust have been widely cited as important attributes or hallmarks of quality care. Often, the perception of quality of care is shaped by relational and contextual factors and not necessarily the efficacy or safety of clinical or technical interventions alone. Despite these observations, traditional approaches have missed important opportunities to improve quality by ignoring how culture and context shape not only the relationships between people, but also how the outcomes of these relationships and human interactions influence the way that health services and health care are organized, delivered and experienced. Consequently, patient-provider interaction continues to be sub-optimal across, high-, middle- and low income countries. At the same time, national health programmes ranging from HIV/AIDS, immunization, and malaria to sexual, reproductive, neonatal, child, adolescent and maternal health, routinely struggle to engage with communities in ways that factor in their needs, builds trust and ensures that programme objectives and health outcomes are reached, in a sustainable way.

The purpose of the CEQ framework is to provide a coherent framework that links existing tools, practices and approaches and aligns them in a way that leads to changed conditions and systems. For the first time, these changes are initiated from inside health systems and potentially optimize system performance, lead to better-quality, safer care and services and contribute to improved health outcomes at the individual, community and population level.

Consequently, the building of relationships is central to the community engagement framework which identifies key areas where engagement processes, practices and procedures can be embedded to support better connection, communication and relationship building between individuals, teams, departments, institutions and stakeholders (including communities). In particular, the CEQ framework:

a. identifies core contextual features and elements of health systems that influence interactions between people within health systems and between the health workforce and communities;
b. addresses, structural, technical and institutional barriers that are both specific to and commonly experienced by major health progammes at national and sub-national level; and
c. recognizes that the health workforce must have foundational engagement capacities as a precondition to help them understand local context and ensure they and the services they provide are community-competent.

Enabling conditions

Governance

The prevailing attitudes, behaviours and interactions occurring in populations and institutions within sovereign states are shaped by societal, historical, cultural and political factors. These factors inform how governance structures and processes are designed to ensure accountability, transparency, responsiveness, the rule of law, stability, equity and inclusiveness, empowerment and broad-based participation.
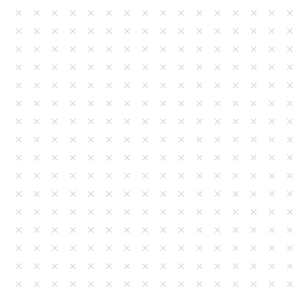
Health systems at the national, sub-national and community level operate within this environment and consequently, interpersonal, professional and community relationships are highly contextual and dynamic. For example, countries that have experienced war, humanitarian disasters and/or repressive regimes will be different in comparison to countries that have not. These factors need to be considered and addressed in any engagement and empowerment approaches.

Leadership, values and articulating a shared purpose

It is highly unlikely that a compassionate and caring health workforce will spontaneously emerge from health systems that have authoritative, fragmented and siloed infrastructures and programmes. Health systems can be difficult places to work and efforts to transform them will require strong and committed leadership based on core values, a clearly articulated mission and a shared sense of purpose. Organizational values guide and align daily individual and team behaviours with strategic priorities and goals. They can also help to manage internal expectations and stakeholder values and concerns.

Resources

Health systems literature traditionally characterizes resources as, for example, financial inputs, facility, equipment and infrastructure. The CEQ framework identifies latent resources that, if managed differently or invested in, can significantly contribute to personal and institutional resilience and performance. These resources are: time; spaces and technology that support participatory processes and collaboration; relevant tools, and methods for information-sharing, planning, decision-making and managing group processes; and specific communication skills that demonstrate deep listening to communicate and connect with others with purpose, respect and authenticity.

A prepared and supported workforce

The health workforce is the most significant asset of a health system. Yet, it is often the resource that is most taxed and overlooked when issues of empowerment and engagement are being considered. How well the health workforce is prepared to engage with other professionals, sectors, patients, their families and local communities will influence how well trust is built, the effectiveness of consultation and coordination functions, and how health problems and issues are defined and addressed. Poor engagement knowledge and competencies of health service providers can have long-term and systemic effects on health system performance (including staff morale, stress and burnout), service uptake and use. The increasing pressure on health professionals to engage more in dialogue and solicit the opinions and preferences of service users, has to be considered as populations have become more well-informed and literate. These "soft skills", and the science behind them, are often not taught in professional health education training, which focus much more on technical competencies.

Capacity development

The CEQ framework identifies four key priority areas for health services and programmes that need to be developed to support effective implementation. These are:

- capacities for shared assessment and analysis of the situation;
- capacities to design context-specific approaches;
- capacities for shared agenda-setting and planning; and
- capacities for defining roles and responsibilities.

A tailored package of engagement knowledge, competencies and skills, drawn from multiple disciplines and existing tools, methods and practices include, but are not limited to, the following:

• reflective practice, systemic thinking and receptive states;
• interpersonal communication and collaborative teams;
• adult-based and learner-centred training programmes and strategies;
• facilitating group processes (meetings and workshops);
• using quantitative and qualitative data for decision-making and programming; and
• developing cultural competence.

These capacities are activated by an enabling environment created through values-based leadership with a prepared workforce at all levels of the health system, ready to consciously engage, align and link their function to a shared purpose and mission. Supporting the emergence of reflective health professionals capable of designing context-specific approaches and able to clearly define roles and responsibilities is an important precursor to being able to connect and work effectively within existing partnerships, networks and community structures. Helping health professionals understand and take account of community culture, perceptions, experiences and expectations in their interactions with service users and their families can get to the real reasons and concerns that will influence prevention, promotion and treatment decisions and responses. It can also help to know how to build on the potential capabilities of each community as they evolve and adapt over time.

Implementation

A pressing challenge for health services and programmes is how to adapt and implement national policies, clinical and technical guidelines and best practices, across prevention, promotion, curation, rehabilitation and palliation. The challenge is two-fold: first, how to adapt and apply global and national guidance in the local context, and second, how to plan and manage a process (engaging stakeholders and practitioners) to implement, assess how well this was done and identify intended and unintended outcomes for further adjustments.

> The CEQ framework explicitly recognizes that a robust monitoring and evaluation (M&E) framework with relevant indicators used for strategic decision-making linked to community and health service feedback mechanisms is critical for the successful design and implementation of health interventions, services and programmes

Some key questions related to M&E include:

• What would success look like from a community and health perspective and how would we know it?
• What counts as evidence – to whom and for what purpose? How can we capture and share important data so it contributes to implementation and continuous improvement?
• What processes and factors seem to accelerate progress in implementation and which impede it? How can this be linked to changes in intended outcomes?

It is important to establish platforms for the monitoring and reporting of activities and indicators of success; to engage community members in monitoring and reporting activities and in systematically reflecting on the data and what it means; to develop feedback mechanisms that use qualitative and quantitative data to help key stakeholders effectively engage with each other and contribute to a coherent and informed response; and to ensure transparency and available, timely data on progress and impact, that is tailored to multiple stakeholders.
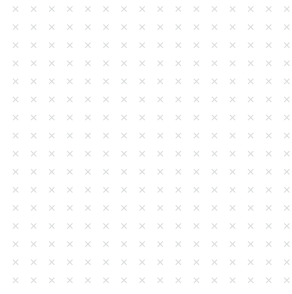
Outcomes

The CEQ framework has been designed to stimulate observable changes in the condition of health systems and communities. On the health systems side they may include: the responsiveness of health services and systems; a changing system's parameters (e.g. expectations, norms and culture), and increased cross-sectoral and inter-professional collaboration. Impact would also be seen on health inequalities, as the needs of vulnerable populations are incorporated and rights and gender issues are meaningfully addressed. On the community side, observable changes may include increased and pro-active community action on health issues, ongoing community learning and action on further health priorities, as well as communities mobilizing their own resources.

Model underpinning the community engagement framework

There was consensus by the team working on developing the model underpinning the CEQ framework that "process" and "relationships" were the most important terms coming out of the discussions. It was critical to capture change as an underlying character and understand the process of relationships. The CEQ framework and model also needed to:
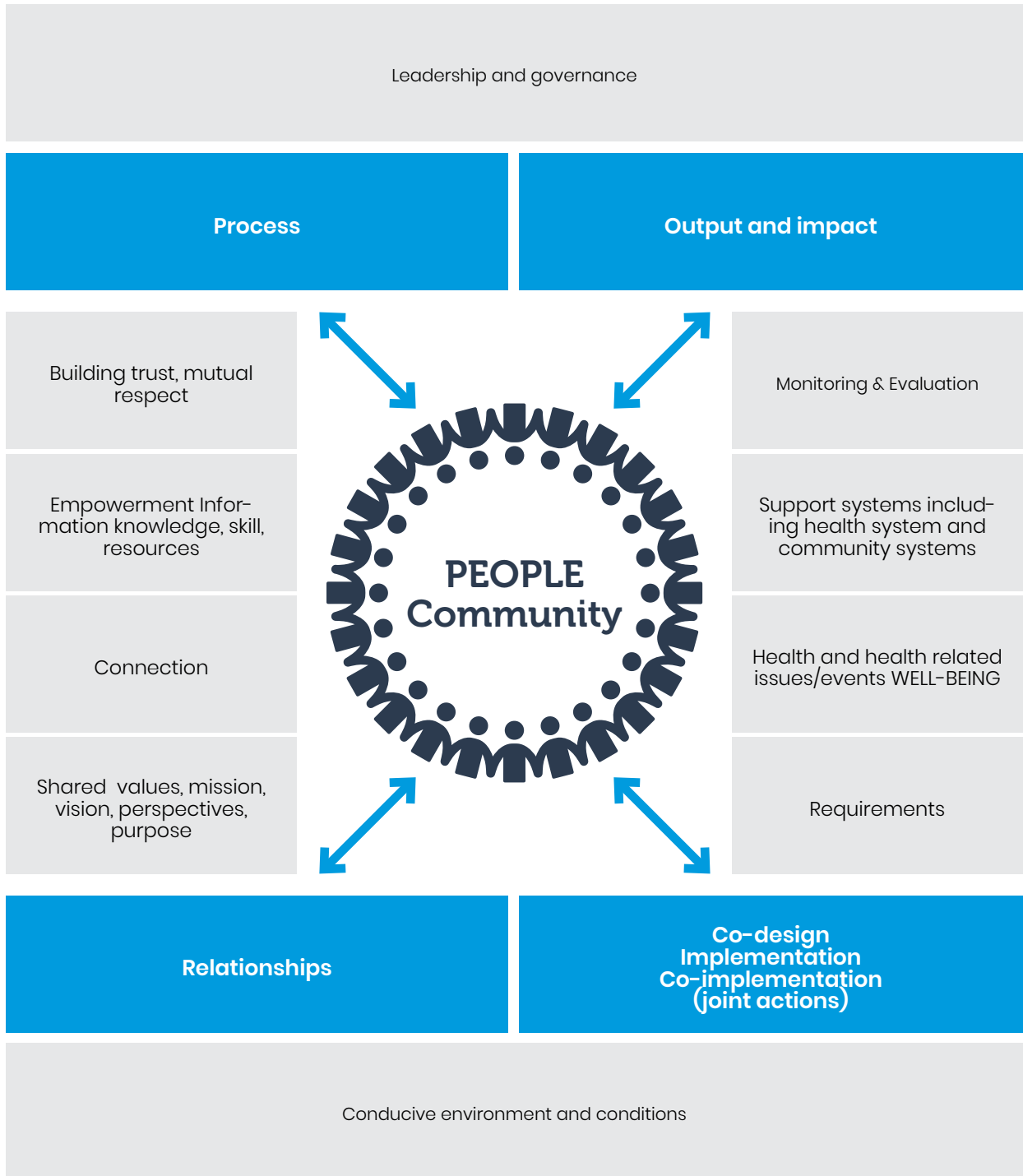
- be simple
- be adaptable (outcome has to be part of the modeling)
- convey an underlying dynamic process
- address core components
- be understandable to different actors and stakeholders
- empower communities
- be understood by a "complex systems" approach
- raise critical consciousness
- be informed by practice-based evidence

The CEQ framework recognizes that strength in any system comes from connections. This is especially the case with human systems. If health care systems are to exhibit strength and resilience when tested, they must be built on strong interconnections between health care professionals and community members. To create and sustain such a system, each must work together, sharing information, building trust, and engaging each other in such a way that goals become mutual and everyone feels empowered to contribute to the system's success. To enable such connections, leadership needs to be imbued with a knowledge and vision of how such a system can be created, developed and constantly evolve as the needs of the community and the demands on the system change.

More specifically, all members benefit from using an analytical framework that recognizes the need for mutual engagement, empowerment, and a realization that every circumstance is best managed in a context-specific manner. Further, each person is well served if they develop strong collaborative skills so as to be able to engage across communities and societies, to effectively move through conflicts, to craft policies, procedures, and practices along with the necessary monitoring and evaluation, to achieve constant quality improvement in the system and in health indices. These analytical frames and engagement skills can be taught and improved throughout the system, from each and every professional to all community members. Widespread skill is truly the underpinning component of empowerment that in turn, enables the strongest and most resilient system.

In the 21st Century, we have a large and growing body of research that recommends that we shift from 'telling and selling' (top down instruction and guidance) to 'sharing and caring' (working with members

Community engagement model for the CE framework

Leadership and governance

Process

Output and impact

Building trust, mutual respect

Empowerment Information knowledge, skill, resources

Connection

Shared values, mission, vision, perspectives, purpose

PEOPLE
Community

Monitoring & Evaluation

Support systems including health system and community systems

Health and health related issues/events WELL-BEING

Requirements

Relationships

Co-design Implementation Co-implementation (joint actions)

Conducive environment and conditions

of the community, recognizing the value and power of local expertise). Research tells us that when we develop the ability to effectively combine the wisdom, knowledge and concerns of all those involved, that we can achieve a much greater and more sustainable process of continuous quality improvement than we ever thought possible just a few years ago. The model proposed takes this research into account and offers its framework and recommendations accordingly.

The model is designed to reflect the complexity described above. Systemic interconnection is never easy to illustrate, in this case the use of bi-directional arrows that connects every dimension to the people in and working with the community is intended to convey that all the elements indicated are necessary to create and sustain strong and resilient systems that consistently provide quality patient and system experience in the context of continuous improvement. This is achieved by all working together to build trust, knowledge and the skills needed to work towards a mutually created vision for quality health care. Measurable and meaningful outcomes both demonstrate the efficacy and quality of a health care system and define the goals for all who participate in it.

WHO/A. Bhatiasevi

Framework Development Workshop

Generating the CEQ and underpinning model

Generating the CEQ
and underpinning model

Aligning participant expectations, workshop process, content and outputs

↘ Process

Once the workshop was officially opened and the workshop objectives, outputs and methodology were presented, participants were asked to draw a self-portrait and to briefly describe what aspects of their previous roles, experiences and strengths could be considered relevant to meeting the workshop objectives and to share this with others.

Following introductions, participants were asked to consider what kind of values and behaviours would ensure that they would meet their objectives and reach a successful outcome. It was agreed that they would hold each other accountable to these "rules of engagement" which were displayed in a prominent position in the workshop room.

✔ Outputs
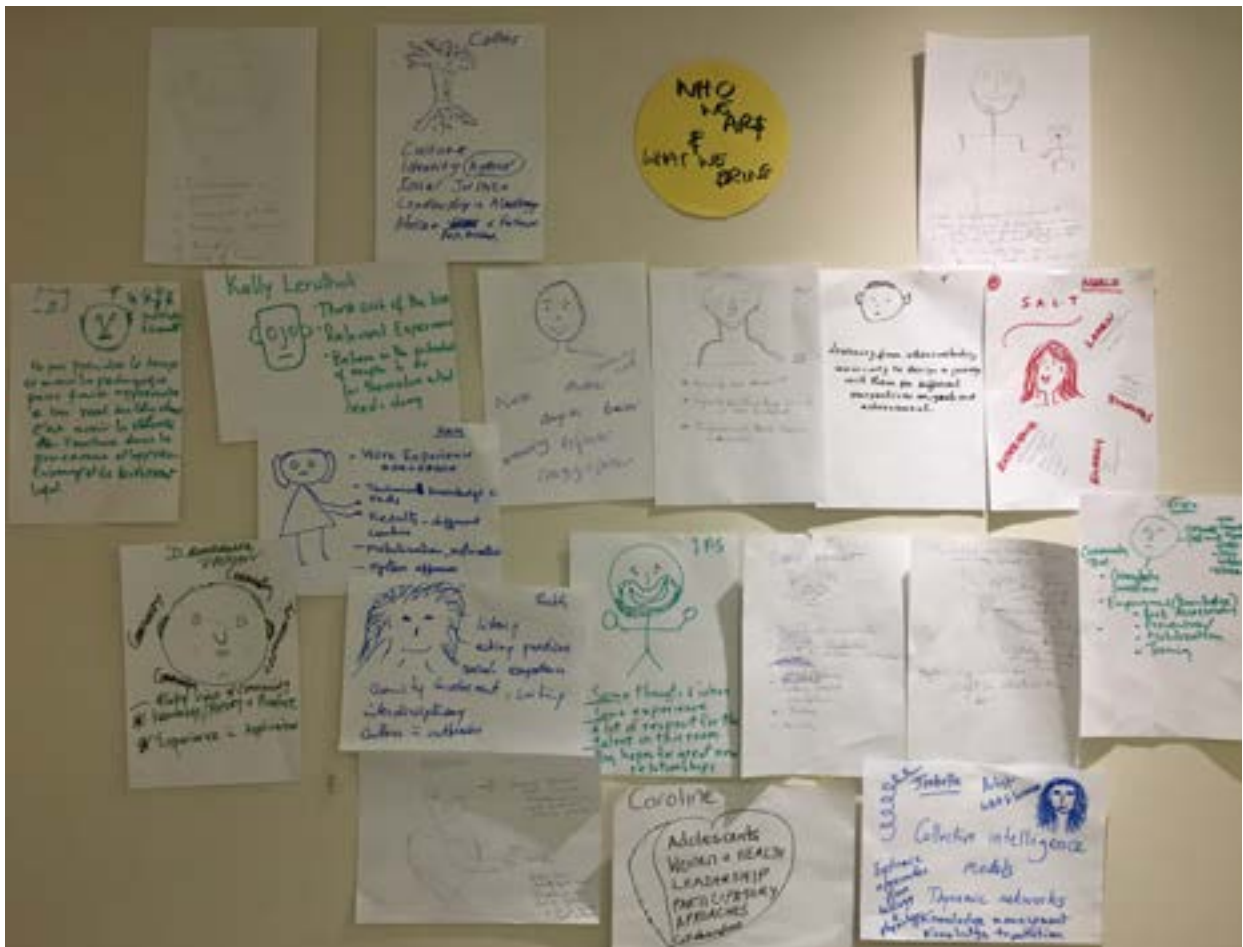
Our rules of engagement

✔ be kind
✔ be curious
✔ be caring
✔ connect with the heart
✔ don't be judgemental
✔ value every thought
✔ listen and be open-minded
✔ exchange ideas
✔ be respectful and give time to understand others
✔ interact with each other
✔ allow space to reflect on the meaning of our learning

Exploring context and lessons learnt from the EVD outbreak in West Africa

↘ Process

A series of presentations in two parts with a discussion around a set of reflective questions.

Participants were asked to note down their answers to the following questions which were used to generate discussion during the plenary:

1. What questions (if any) were stimulated?
2. What insights (if any) emerged for you?
3. What resonated most with you?

Summaries of presentations
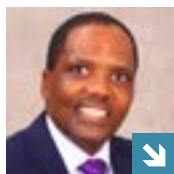
WHO, regional priorities:
Mr Peter Phori, WHO Regional Office for Africa, Brazzaville

An overview was provided of how the WHO African Region is addressing new and re-emerging threats to public health. Examples and evidence were given of the regional burden of diseases and the major causes of health inequalities arising from the interaction of social determinants of health. These included social, economic, demographic, environmental, and political factors that represent barriers for vulnerable or neglected populations to access quality health services across the life course. The Region is placing emphasis on reducing health inequities through actions addressing the social determinants of health and supporting the SDGs through various inter-sectoral actions for health which include "health in all policies" and "whole-of-government" approaches, community engagement, social dialogue, and good governance for health.

The presentation also highlighted that the African Region has already established initiatives to integrate community engagement, monitor health inequities, and develop guidance on how to implement "health in all policies" so that the determinants of health can be addressed through multisectoral action.

Finally, mention was made of the presentation of the health promotion strategy of the African Region 2011-2022 to the Technical Resource Group (TRG) for the HPD unit which met before the CE framework development workshop. The TRG were invited to make inputs to the regional strategy and the WHO/AFRO forthcoming Biennium 2018-2019 programme budget plan.

Some of the proposed activities made by the TRG were: the need to strengthen efforts in community engagement in response to health emergencies and outbreaks; coordination across sectors; strengthening health systems within the context of people-centred approaches; enhancing health literacy of programmes, projects, and policies beyond health; ensuring the contribution of programmes to health promotion (focusing on policy advocacy and community engagement) and social determinants of health (focusing on the causes of illness, NCDs risk factors, neglected tropical diseases, maternal and child health, etc.)

The TRG also recommended documentation of country experiences on community engagement, with a focus on success stories, challenges, and opportunities in the African Region. This could be done by technical group writing workshops convened by WHO.
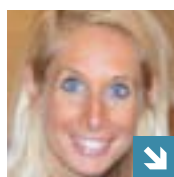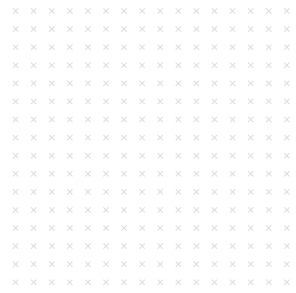
WHO headquarter scoping review:
Ms Isabelle Wachsmuth, WHO, Headquarters, Geneva

The findings from a WHO-HQ scoping review of community engagement to lay foundations for future work by the WHO Service Delivery and Safety Department were presented. The scoping review was also used as preparation for the CEQ framework development workshop content and proceedings. This included: a) a desk and literature review to identify relevant interventions; b) an examination of WHO guidelines that contain recommendations on community level interventions; c) systematic reviews and single studies on community engagement through the use of specific databases (Author Mapper and Health Systems Evidence) or scientific journals; and d) structured interviews with 12 WHO programme focal points to get a deeper qualitative understanding of how WHO guidelines and strategies have been interpreted and implemented.

The key findings and gaps were: a) there is no current model for community engagement that is robust enough to address public challenges and which will contribute to achieving public health objectives; b) there is a need to find alternatives to linear end-user engagement; c) the current design of CE interventions do not take into account that engagement and resilience are dynamic processes - not states of being; d) CE research generally ignores the community of health professionals; e) CE research generally focuses on education and information, not on emotions and feelings; f) insufficient attention has been given to the development of CE processes that support an effective sustainability of practices; g) the dynamics between geopolitical communities and communities of practice of health professionals need to be explored to achieve effective engagement; h) the CE literature has not sufficiently investigated the impact of trauma histories on the quality of engagement.
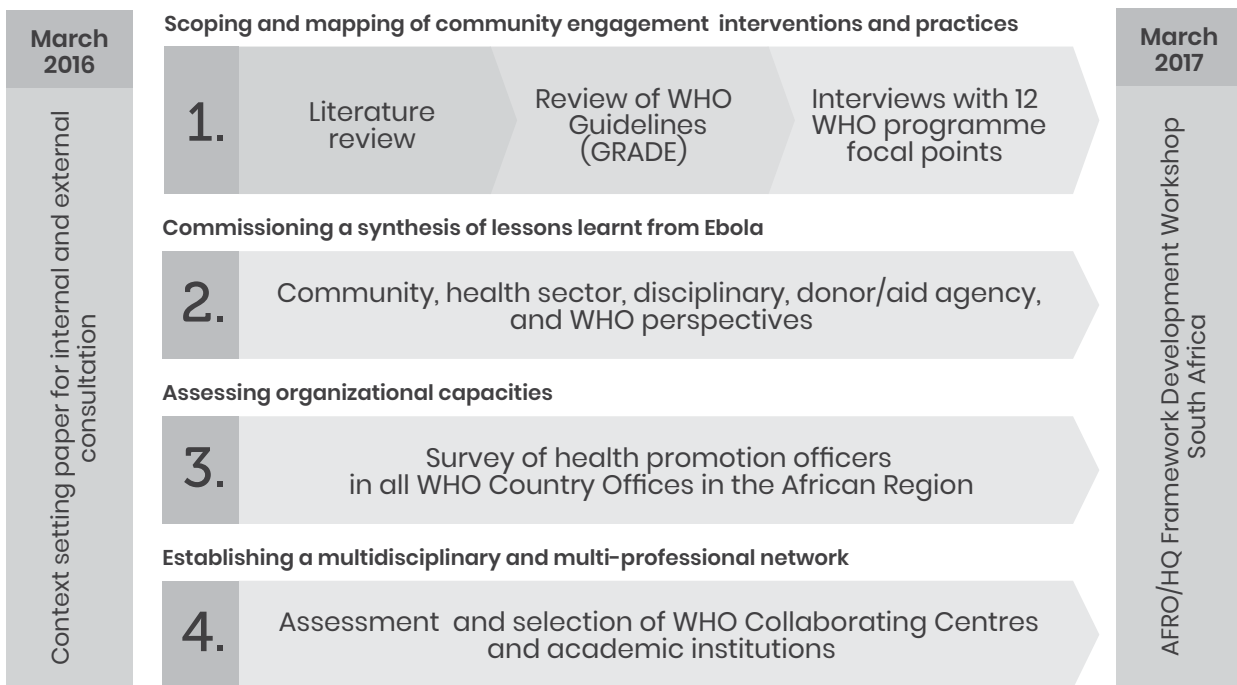
The overall conclusion from the WHO scoping review was that a community engagement model that is sufficiently robust does not exist, one that takes into account existing multiple entry points for engaging with communities and which recognizes the relative levels of power, voice, impact and opportunity for knowledge-sharing and relationship-building inside health systems.

These finding highlighted the need for a comprehensive approach to community engagement that acknowledged a changing world, incorporated recent science and research to generate new evidence. In fact, many of the challenges outlined in a study conducted by Susan Rifkin in 1986 (where she reviewed 200 case studies on community participation) still required attention 30 years later and strengthens the argument for fundamental shifts from within the health sector to people-centred and community competent models with the capability and capacity for local contextualization and tailoring.

WHO CEQ framework development: a systematic and structured approach

March 2016

Context setting paper for internal and external consultation

Scoping and mapping of community engagement interventions and practices

1. Literature review | Review of WHO Guidelines (GRADE) | Interviews with 12 WHO programme focal points

Commissioning a synthesis of lessons learnt from Ebola

2. Community, health sector, disciplinary, donor/aid agency, and WHO perspectives

Assessing organizational capacities

3. Survey of health promotion officers in all WHO Country Offices in the African Region

Establishing a multidisciplinary and multi-professional network

4. Assessment and selection of WHO Collaborating Centres and academic institutions

March 2017

AFRO/HQ Framework Development Workshop South Africa

Quality and quality improvement in health services:
Dr Kelello Lerotholi, Chief of Party Lesotho, USAID Applying Science to Strengthen and Improve Systems Project, Institute of Medicine, USA

"Quality", in the context of health services, is defined as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes"( ). Health systems are constantly striving to ensure that these desired health outcomes are attained. Approaches in this regard have evolved over time from the institution of quality assurance (QA) initiatives to the current focus on quality improvement (QI). The Institute for Healthcare Improvement (IHI), in the United States, has defined quality improvement as "a formal approach to the analysis of performance and systematic efforts to improve it". The context within which this process takes place is defined by the need to ensure that health systems conform to the following criteria: a) they are safe; b) they are effective; c) they have the patient as a focus (i.e., are patient-centred); d) they are timely; e) they are efficient and; f) they are equitable.

In summary, QI methodology works to ensure that the SYSTEMS and PROCESSES are in place to make sure that EVERY patient gets what they are supposed to get EVERY TIME they seek health services.

The connection between resiliency and communities in the 21st Century: Professor John Parrish-Sprowl, Indiana University, Director, Global Health Communication Centre, USA

Community engagement is about the relationship between people, both within the community and between them, and the health care system. To achieve high quality and resilience in health care, all those involved must feel empowered to participate in it as full partners. Thus, to develop quality health systems, attention needs to be focused on the linkages between people with an eye on strengthening their skills and ability to achieve a common vision built on meaningful outcomes. How strong linkages are made can be explained and facilitated from a communication complex perspective. In this framework, communication is understood to mean more than the mere transfer of information; rather, it is a bioactive process that functions systemically both within the body and between people. From neuron to neighborhood, from synapse to society, communication holds the potential to create a receptive environment, one that builds trust and shared vision, or one that is reactive and destructive, undermining system and community performance. Good communication builds strong links between people, along with physically and mentally healthier people.

Lessons learnt from the Ebola virus disease response in West Africa

A further series of presentations were given that focused specifically on lessons learnt from the 2014 EVD response. Participants were invited to reflect on the three questions posed in session 2.

Experiences from Guinea: Mr Issiaga Konate, WHO Country Office, Guinea

The main lessons learnt from Guinea centred around culture and context and the importance of setting up transversal community engagement strategies across all response activities. In addressing hesitancy, it was important to simultaneously take into consideration scientific logic and spiritual and religious beliefs. It was essential to create an enabling environment by properly mapping and engaging all stakeholders providing a continuum of care at the community level and to involve communities in setting up "self-isolation" (micro-cerclage) mechanisms to prevent further transmission of infection and to build trust between communities and health workers.
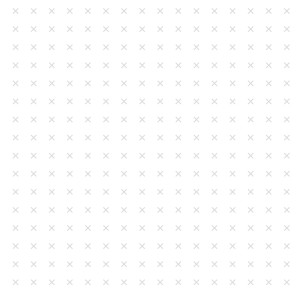
Some key messages were: listening to populations is essential; medical practitioners must have community experience; national health policies, strategies and programmes must focus on community engagement and promote community dialogue to rebuild trust with communities. Emphasizing health actions at the community level and integrating hygiene and handwashing was key.

In the future, Guinea will consider specific actions to integrate these lessons learnt in their health system strengthening strategy, specifically through the development of a national community health policy and the framework for implementation of the community health strategy. They will strengthen community dialogue through social networks, establish an integrated community health model with a minimum package of activities and come up with innovative solutions to the major issue of the social determinants of health through the multisectoral committee on health.

Experiences from Liberia: Dr Ruth Kutalek, Medical Anthropologist, Medical University of Vienna

One of the major lessons learnt from the Ebola response in West Africa was that often communities were involved too little, too late. Communities need to be engaged from the very beginning of a health emergency, and included in all aspects of the response.

Particular attention must be given to involving groups within communities that are often not visible or marginalized and not represented by institutions such as youth groups, etc. In terms of community engagement methods, it is important to employ participatory approaches, and to give communities the power to decide on how best to be involved. One such example is to implement focus group discussions to empower groups and communities to influence decision processes e.g. when policy interventions are needed or concrete public health decisions are to be made.

It is equally important to provide the necessary resources (tools, knowledge, finances) and build community capacity outside of emergencies. Community engagement also means building democratic institutions in a community. Best practice examples were those that involved communities and helped them deal with trauma, stigma and other psychosocial side-effects of the disaster such as "community healing dialogues" in highly affected areas.

Experiences from Sierra Leone:
Ms Asiya Odugleh-Kolev, WHO, Headquarters, Geneva

Major factors influencing community responses during the early stages of the EVD response were fear coupled with messaging-based communication approaches promoting early diagnosis and care when services were not yet in place. This led to distrust between communities and health care providers. WHO, through a collaborative process, with the Ministry of Health and Sanitation (MOHS) in Sierra Leone, national and international partners and multi-disciplinary experts, piloted an initiative on compassionate communication and trust building between response staff and affected communities. The one-day training consisted of a technical video on how to understand and manage fear and an experientially-based learning programme to prepare response staff to engage with quarantined households, their neighbours, and manage what could often be difficult conversations and hostile reactions.

The project encountered a number of internal and external biases and assumptions about the nature, content and purpose of the training programme, which delayed its implementation. The training had several innovative elements such as embedding engagement capacities and skills directly within critical surveillance functions such as contact tracing and case investigation. Evaluation showed that the training contributed to improving relationships between response staff and communities in a positive way. And that it helped bridge the differences in risk perception and risk management between response staff and Ebola-affected families and communities.

Synthesis of key documents from the EVD evaluation literature:
Dr Steve Fawcett, Co-Director, World Health Organization Collaborating
Centre for Community Health & Development, University of Kansas

The WHO Collaborating Centre team examined a selection of Ebola response literature, provided by WHO, for common themes and lessons learnt on community engagement.

Several key challenges in community engagement were noted. First, the workforce for CE needs to be fully trained, on standby, and thoroughly familiar with the roles they are to play. Second, community engagement requires a clear and consistent communications strategy. Third, early and ongoing community engagement, and clear communications by trusted community members, can reduce rumors and resistance to intervention efforts.

Some key inputs and facilitating factors that could help address these challenges included: a) forming partnerships to share resources and responsibilities for community engagement; b) encouraging open dialogue about community concerns—listening for problems and ideas for solution—can reinforce and strengthen community engagement, as well as improve the programme; c) develop a network of profes-

sionals and technical support staff able to build national and local capacity for community engagement; and d) establish financial mechanisms to establish and sustain community engagement in all phases of the effort (e.g., set aside 10% of budget for community engagement activities).

Recommendations for capacity-building and support structures included: a) Supports for community engagement should be context-specific, reflecting the potential capabilities of each community; b) community health councils, action committees, and other support structures can facilitate engagement, ownership, and influence of community members in efforts; c) build capacity and sustained leadership within community health councils through training and technical support for essential community processes (e.g., assessment, planning, intervention); and d) partnership structures—including international, regional and local networks of partners—can improve coordination, efficiency, effectiveness, responsiveness, speed and scale.

Other recommendations for implementation and monitoring and evaluation included: a) implementation teams should engage those with experience of the problem (e.g., Ebola survivors); b) engage those trusted in the community (e.g., village health workers, elders) in disseminating messages; c) effectively coordinate and plan with other sectors—e.g., government, NGOs—which is crucial at local, district, and national levels; d) social mobilization and community engagement (e.g., involving chiefs, elders, religious leaders, Ebola survivors) were critical in bringing about community/system changes, services provided, and accurate health communication that corresponded with bending the curve downwards in EVD rates; e) using an ongoing M&E system—with opportunities for sense-making by partners close to the realities—can contribute to understanding how activities contribute to engagement and improvement; and f) case studies examining the effects of collaborative action on indicators of success (e.g., participation, fuller implementation, outcomes) can help expand the evidence base about what works in community engagement and the conditions under which they work best.

The literature supports several conclusions about what it takes to ensure that CE contributes to improvement with intended outcomes. First, to build long-term resilience, strengthen both health and community systems. Second, the community engagement team can help ensure the influence of community voices (e.g., adding the "dignified" aspect to "safe and dignified burials"). Finally, community engagement can have many advantages; including greater trust, better design of intervention/approach, fuller implementation, necessary adjustments in approach/implementation, reduced resistance/opposition, and community empowerment.

Community systems: Dr Ram Kumar Shrestha, Senior Improvement Advisor, Community Health and Nutrition, ASSIST/USAID project, University Research Co, LLC

Challenges for health care delivery service at the community level include health disparities, access to care, quality of care and health care costs. CHWs are uniquely positioned as liaisons between health facility and communities to help mitigate these challenges. To address the above challenges for CHWs to provide people-centered health services, ASSIST/USAID has developed a Community Health System Strengthening (CHSS) model.

Community Health System model is a remarkable innovation of a visual social system structure that provides a platform for community engagement and empowerment for coordinating services across communities for long-term sustainability. In addition, this model involves managing various social activities, disasters and emergencies through informal and formal groups. The engagement of these community groups and the village committee provides a system for information communication and support and will help us develop the community system framework.
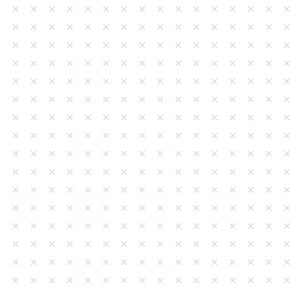
Local communities are not "empty vessels". Health programmes need to understand and work with the existing community system. Even though implementers of health programmes call what they do "community engagement", it is often initiated by outsiders and communities follow because of monetary incentives and not because they are fulfilling some need. We need:

1. to explore the existing horizontal, not vertical, community system e.g. infrastructure, networks and relationships;
2. to develop a strategy that builds on what exists and strengthens the community system, if weak;
3. to build the capacity of the community system to fully engage e.g. selection, design and implementation of health care and services.

The formal vertical health system is linked with the informal horizontal community system, by including health agents such as CHWs/CHVs from health facilities by including them as a member of the village committee. This link facilitates the flow of information and communication from household to community group, to community committee to formal health facility and vice versa. The application of the modern quality improvement approach helps strengthen linkages between community and health facility and thereby provide people-centered health care services.

☑ Outputs

Emerging issues from Day 1

✔ We need to build on what was there before and is present now

✔ We need to look at what exists in a different way based on what we know now

✔ The may mean defining a new expanded and evolved role for Health Promotion and other professional cadres

✔ Trust has been a critical issue in the past wand will be an issue in future work with communities

✔ We need to understand the drivers and pre-requisites to work with communities (situational analysis and health system preconditions)

✔ Donor driven action is an issue

✔ Indicators of achievement need to be addressed and made meaningful

✔ Importance of participatory approach design (structure, content and practices)

✔ Importance of Ebola as a driver for revisiting how we work with communities and the concept of "community engagement"

Defining the purpose and scope of the CE framework

Orientating participants towards the task ahead

�ⓘ Process

Day 2 began with a reflection and focusing exercise. Participants were invited to stand in a circle. The facilitator threw a ball to one member of circle who had to catch it. The person who caught the ball was asked to share key takeaways from the previous day. Once the sharing had finished, the ball was thrown to someone else. This process was repeated until as many people as possible had shared their thoughts in the allotted time.
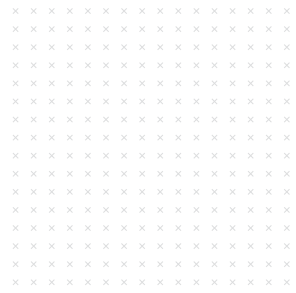
☑ Outputs

Feedback from Day 1:

✔ We are building a sense of community able to accomplish the task ahead of us

✔ An appreciation for the wealth of knowledge in the room

✔ It helped me to reflect on what I need to do differently

✔ The background and context setting helped generate a feeling of "no fear" in what we are doing

✔ We need to be mindful of being practical in application

✔ I gained a deeper understanding of community experiences during the EVD response

✔ I enjoy the "corridor talk" as we explore, discuss and challenge each other

✔ There have been many ideas on community and community engagement all say that they should be at the centre of public health

✔ The methodology of the workshop is extremely helpful and facilitates the work

✔ I enjoyed the synthesis provided by Steve Fawcett

✔ No common definition of community engagement has been presented yet there has been a deepening understanding of EVD and the different levels/layers of engagement needed for effectively responding.

Health system and community linkages from provider and community perspectives

⬐ Process

Participants were divided into two working groups. One group was assigned to look at linkage/interface points from the community perspective and the other to look at linkage/interface points from the health service/programme perspective.

☑ Outputs from Group Work

Group 1: Inter-linkages from a community perspective

The group defined community as a group with clearly defined boundaries. Communities are organized with clear decision-making structures. These structures have protectionism functions and share common concerns. The entry points in terms of CE must be the recognition of significant leaders in the community, namely chiefs, traditional leadership, political leadership, religious leadership and charismatic leaders. There are also formal and informal groups to engage with during CE. At the same time CE practitioners must realize that issues like beliefs and some traditions do not change, or take time to change. There is a need to understand the nature of engagement vis-a-vis the condition at hand. Some conditions require urgency, whilst some might allow longer iterative engagement over time. Capacity-building and CE should be intertwined. The CE framework needs to be dynamic and adaptable to all situations. Trust emerged as one important ingredient for CE.

Group 2: Inter-linkages from a health service/progamme perspective

The group identified formal and passive linkages between health services and communities. Formal linkages were through physical settings e.g. health centres and other infrastructures, professional linkages were through health teams who interacted with communities, basic service providers, and human linkages through listening, showing empathy, and communication. It was acknowledged that communication goes both ways and communities needed to be involved at all levels. Power affects the relationship and interaction between health services and communities. As the health setting becomes less informal, the community shifts from being passive to more active. The was a recognition that service providers are concerned with implementing policy, standards, guidelines, and the organization of services and resources, and may not address the conditions under which they carry out their technical work. Governance and accountability are important as there are key accountability mechanisms and strategies that communities can activate in the citizen-state relationships and roles.

Decision point: the purpose and scope of the CEQ framework

The outputs from the previous session recognized formal and informal connections between health services/programmes and communities. In fact, multiple communities existed within and between health and community systems. These communities could be permanent, temporary or virtual but were interdependent and systemically linked. Interlinked communities needed to be responsible and accountable, not only to their own members, but also to members of other communities that could be affected by their actions. Understanding and addressing how power, prejudice and bias affect individual and group decision-making will be an important component of the CEQ framework.

The scope of the CEQ framework was therefore determined by two aspects:

1. Public health objectives of improving the quality of services, ensuring people-centred care and approaches, and contributing to the resilience of health systems and local communities; and
2. Addressing the shaded area in the Venn diagram – the interface points between health systems and communities.

A diagram to illustrate the scope of the CEQ framework
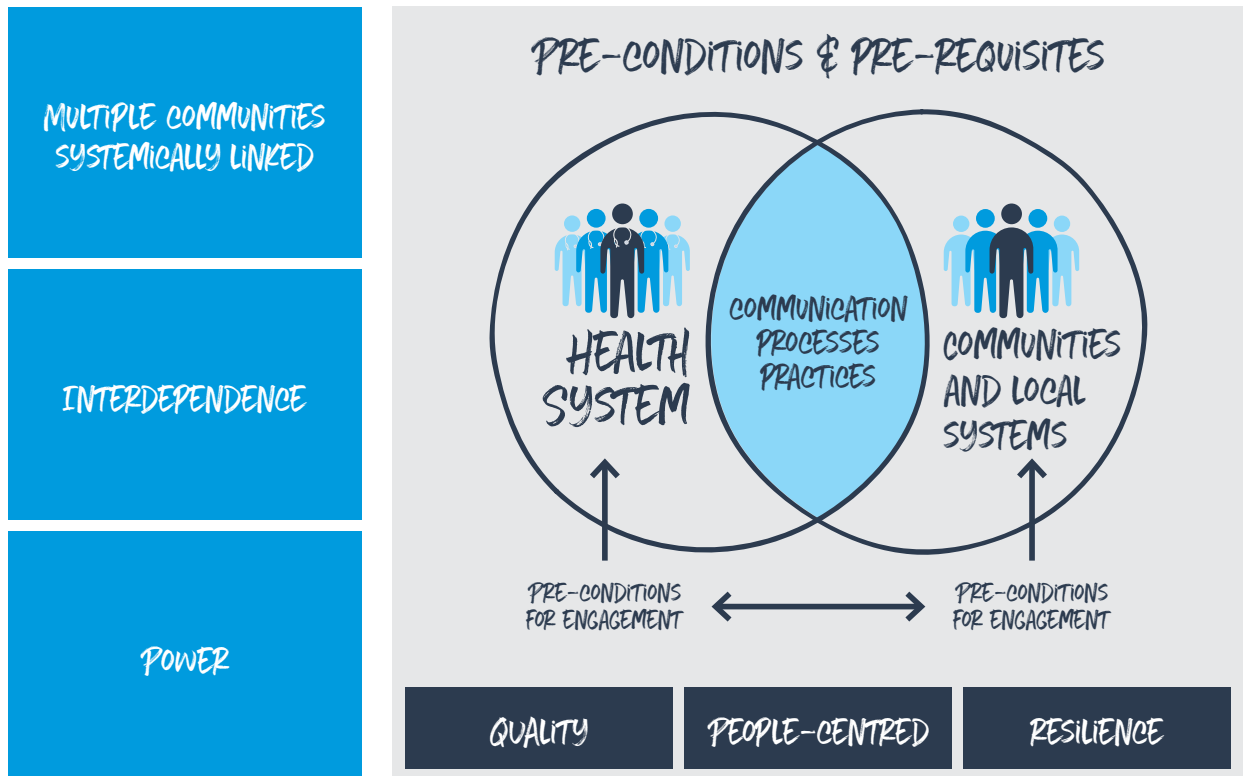
Developing a definition of community engagement for quality, integrated, people-centred and resilient health services

Exploring what community engagement is, is not, or could be

Once the scope and purpose of the CEQ framework had been decided on, attention turned towards developing a definition of community engagement. Several sources were considered and the most authoritative source was the definition stated in the NIH publication "Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement" (second edition). This was considered alongside a simplified definition developed by WHO in a preliminary context-setting paper for the SDS department.
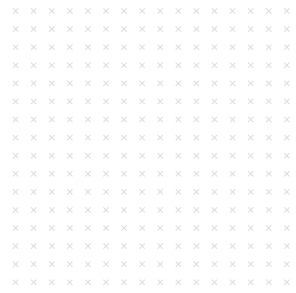
⬊ Process

A three-step process was followed.

Step 1: Participants were divided into three groups. Each group was given a statement that they had to complete in a brainstorming session. Time was given for the statements to be reviewed and an opportunity provided for further inputs.

Step 2: Each group was given the same task and were asked to develop their own definition of community engagement taking into account a) the scope and purpose of the CEQ framework b) the findings from step 1 and c) the definitions from the NIH and WHO.

Step 3: In plenary session, each group was then asked to comment on what they liked about definitions of the other two groups. This was followed by a consensus-generating discussion.

✅ Outputs from Group Work

Community engagement is...

- talking to each other
- an interactive participatory process
- human interaction
- basic school of democracy
- community-directed action
- sharing information to achieve a goal
- good!
- power to the community
- solidarity between members
- conscious involvement in collective life and problem-solving
- a state of mind
- self-governance and organization
- empowering communities to own programmes
- having people on board

Community engagement is not...

- isolate
- donor-driven
- a panacea for social development
- community involvement
- community participation
- deciding for the community
- an activity
- an overnight process
- easy to achieve
- bad
- power over
- teaching communities
- everything needed to influence community outcomes
- a business
- distribution of vaccines
- dictatorship of health service providers' ideas on to recipients
- a top-down approach
- telling people what to do
- considering communities as passive
- a one-way process

Community engagement could be...

- part of the decision-making process to improve health conditions
- a precious actor of social solidarity
- effective collective intelligence
- innovative and disruptive for health systems
- social entrepreneurs
- community empowerment
- community ownership
- building community resilience
- accountability
- platform for equal partnering and engagement
- beneficial to communities
- change agents
- community development
- an effective supportive force for health programmes
- a way of acting on the social determinants of health
- a philosophy, a state of mind, a collective effort

Decision point: definition of "community engagement" for quality, integrated, people-centred and resilient health services

Definition of community engagement for quality, integrated, people-centred and resilient health services:

> **"** *Community engagement is 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."*

The following caveats were agreed:

- Stakeholders comprise multiple communities that could include, community members, patients, health professionals, policy-makers and other sectors.
- Desired relationships are characterized by respect, trust and purpose.
- Health-related issues include public health events such as emergencies.

Building the community engagement framework and model

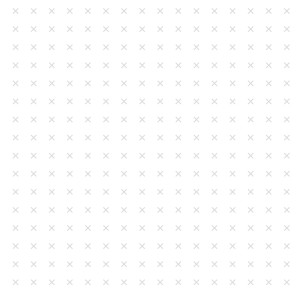### Orientating participants towards the task ahead

⬊ Process

Day 3 began with an appreciation and validation exercise that acknowledged and affirmed the resources held by each individual that were being used and made available as a collective resource for the group. Participants were asked to put their names at the top of a piece of blank paper. They were then asked to hand their piece of paper to someone else. Each person then wrote a statement that recognized a positive skill/ability/characteristic that they had observed about that person during the previous two days, something that they had appreciated. Once everyone had completed a statement for each participant, each paper was returned to their originators.

Assembling the building blocks: Disciplinary and practitioner perspectives

⬊ Process

Participants divided themselves into two working groups. One group worked on the CE framework and another group focused on developing the framework building blocks.

Both groups were asked to consider the discussions and developments during the first two days of the workshop to guide their thinking and discussions. At key intervals, opportunity was provided for both groups to present their efforts so far, ask questions and then incorporate any insights and revisions into their deliberations moving forward.

In addition, a set of resources were shared as reference materials (see annex 3).

Model development group

Framework generation group

Measuring success

⬎ Process

Participants were divided into groups to consider what success might look like and what changes would be observed if the CE framework was implemented.

☑ Outputs from Group Work

What would we see?

- Changes in health/social conditions and health systems
- Communities taking action
- Communities being empowered
- Responsiveness of health services and systems (all)
- Improvements in communication, coordination, trust (mutual), relationships, leadership, ownership, collaboration.

How would we know?

- Increased and proactive community action on health issues
- Communities applying learning and taking on action on further issues
- Community mobilizing its own resources
- Changed decision-making, communication and practice
- Health system agenda changes to reflect community agenda
- Services and programmes able to build and maintain trust and articulate and achieve co-produced objectives and goals.

Considerations for country ownership, adaptation and implementation

Considerations for country ownership, adaptation and implementation

This session focused on introducing the CEQ framework at the country level and on how to effectively engage key stakeholders on the utility and added value of the framework to national quality improvement efforts, as well as generating ownership. Key areas to consider and plan for were:

1. **Identify institutions and conduct a desk review of relevant national documents**

- Ensure lead agencies are briefed and are committed to introducing the CEQ
- Understand the local context e.g. organization of health services, stakeholder and implementing partners, human resource development strategy and plans etc.
- Assess the extent to which some components of the framework exist and are already being implemented
- Conduct a stakeholder analysis (primary, secondary and tertiary... include social scientists)

2. **Prepare institutions and develop a strategy for introduction**

- Use the stakeholder analysis to understand the different levels of introduction and develop tailored strategies
- Work through existing partnership mechanisms and co-develop tailored introduction and engagement strategies

3. **Considerations for CEQ implementation strategies**

- Establish coordination and implementation mechanisms (focal points/teams/task force)
- Identify champions at different levels of the system
- Design a phased Implementation (collaborative in nature) with scale-up as the goal
- Embed mechanisms for continuous monitoring of progress
- Set up periodic learning and sharing sessions.

Framework Development Workshop

> " *Widespread skill (in engagement) is truly the underpinning of empowerment that in turn enables the strongest and most resilient system.*"
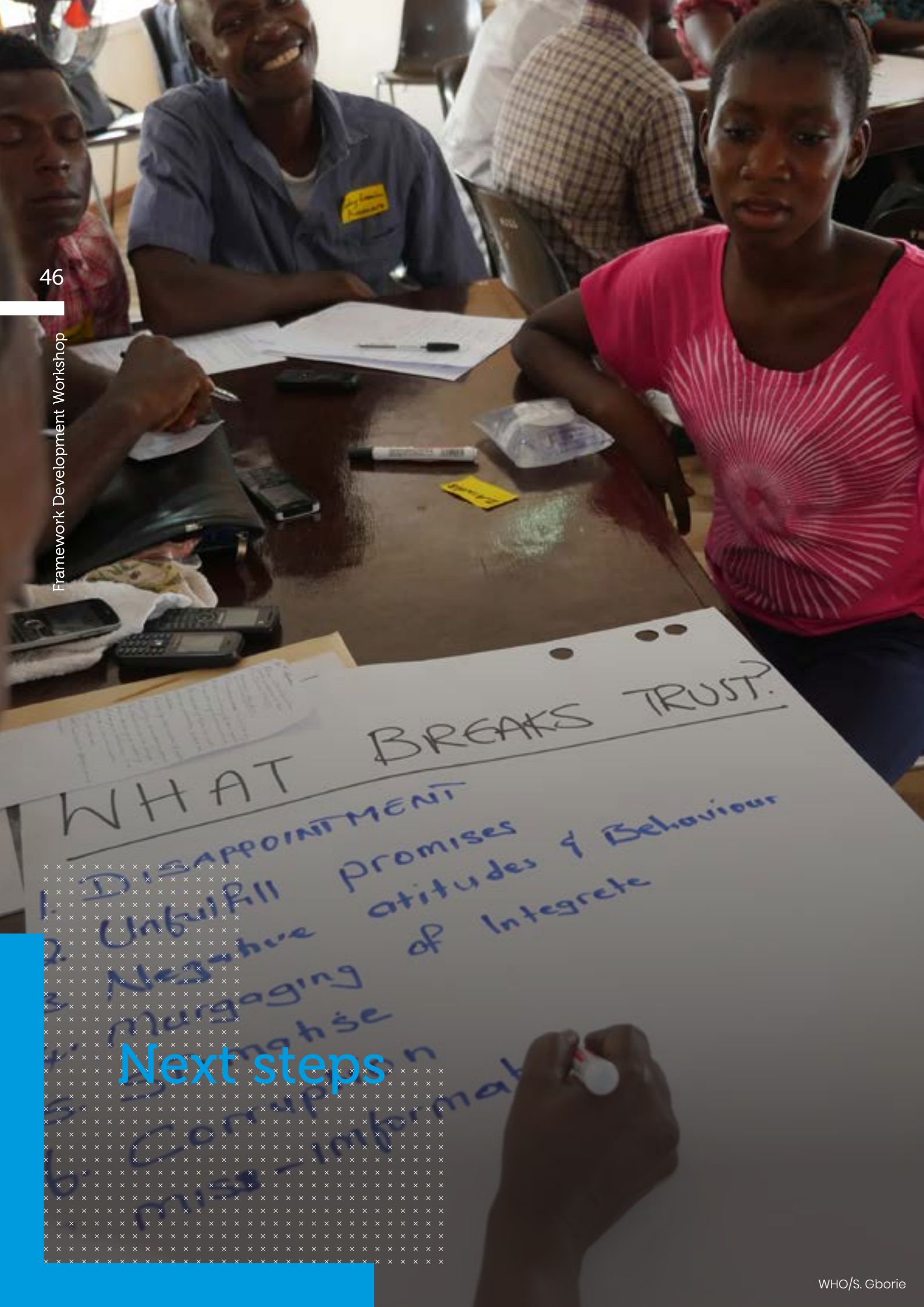
Next steps

Next steps

Workshop report

- WHO to draft and circulate the CEQ workshop report for review and finalization with workshop participants
- WHO AFRO and headquarters to circulate it among relevant technical units and invite feedback

Sharing resources

- WHO headquarters to share workshop documents with participants and invite participants to join the global community of practice for community engagement under the Integrated People-Centred Health Services Platform

Piloting of the CEQ framework

- Seek opportunities to pilot the CEQ through existing partnerships and develop detailed implementation plans
- Contribute to global knowledge and learning
- WHO, with the Regional Technical Resource Group of HPD, to develop peer-reviewed papers for publishing
- WHO, with the Regional Technical Resource Group to develop a case study for the WHO Global Learning Laboratory for Quality (GLL)
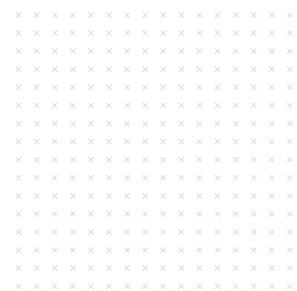
Annexes

Annex 1

Community Engagement Framework Development Workshop
Cape Town, S. Africa, 22nd-24th March, 2017

Framework Development Workshop

Time	Title/description	Purpose	Methodology
DAY 1			
09.00–10.30	**Session 1:** Opening ceremony Welcome and Introductions, Prof. Davison Munodawafa Dr Ed Kelley, Director SDS, HQ (taped message) Overview of the workshop, Ms Asiya Odugleh-Kolev Setting and clarifying expectations Evaluation, Ms Isabelle Wachsmuth	• Answer the question Why are we here? Define the scope for workshop • Describe the working methods and process for the workshop to achieve the objectives • Support ownership and co-development of the process	Verbal welcome Presentation and ice breaker Rules of engagement for the workshop Personal objectives
11:00–12:30	**Session2: Exploring context** **11:00-11:15** WHO, Regional priorities, Prof. Davison Munodawafa/Mr Peter Phori **11:15-11:30** WHO CE scoping, Ms Isabelle Wachsmsuth **11:30-11:45** Quality and quality improvement in health services, Dr Kelello L.M. Lerotholi **11:45-12:00** The connection between resiliency and communities in the 21st Century, Prof. John Parrish-Sprowl	• Focus collective attention • Frame the context in which a CE framework is being developed • Explore what is meant by quality, integration and resilience • Acknowledge existing assumptions and paradigms • Identify the big questions that need to be answered	Plenary presentations and Working groups
13:30–15:00	**Session 3: Lessons learned from the Ebola Virus Disease response in West Africa** **13:30-13:45** Synthesis of key documents, Dr Steve Fawcett **13:45-14:00** Guinea experiences, Mr Issiaga Konate **14:00-14:15** Liberia experiences, Dr Ruth Kutalek **14:15-14:30** Sierra Leone experiences, Ms Asiya Odugleh-Kolev	• Explore and understand experiences of community engagement in the EVD response • Identify key lessons learned from multiple perspectives	Plenary presentations
15:30–16:30	**Session 4: Identifying opportunities for and barriers to engagement**	• Identify key connections and priority linkage points between health systems and service users	Working groups
16:30–17:30	**Session 5: The CE framework** *Step: Purpose and architecture*	• Start the process of assembling the CEF	Plenary presentation and Working groups
17:30	Wrap up of Day 1		

| Time	Title/description	Purpose	Methodology
DAY2			
08:30–09:00	**Review of Day 1**		
09:00–10:30	**Session 5: The CE framework** *Step 2: Disciplinary and practitioner perspectives on the CEF*	• Bring together disciplinary and practitioner perspectives and needs to develop a robust the theoretical underpinning and a model to guide CEF development and implementation	Moderated panel discussion
11:00–12:30	**Session 5: The CE framework** *Step 3: CEF building blocks*	• Construct the building blocks of the CEF	Working groups
13:30–15:00	**Session 5: The CE framework** *Step 3: CEF building blocks continued*	• Construct the building blocks of the CEF	Working groups
16:00–17:30	**Session 5: The CE framework** *Step 4: Measuring success*	• Begin to construct an M&E framework	Presentation and Working groups
17:30	Wrap up of Day 2		

Time	Title/description	Purpose	Methodology
DAY3			
08:30–09:00	**Review of Day 2**		
09:00–10:30	**Session 5: CE Framework** *Step 6a: Country Ownership part 1: Adaptation and implementation*	• Address factors that will affect/influence implementation at country level	Working groups
11:00–12:30	**Session 5: The CE framework** *Step 6b: Country ownership part 2: developing*	• Develop guidance/recommendations to support country adaptation, uptake and implementation	Role play
13:30–15:00	**Session 5: The CE framework** *Step 6c: Country ownership part 2: Supporting processes and mechanisms*	• Identify supporting/enabling processes and mechanisms for introducing and implementing the CE framework	Working groups
15:30–16:00	**Session 5: The CE framework** *Step 7: The narrative*	• Develop a clear and common narrative for the CEF	Working groups
16:00–16:30	**Session 6:** *Next steps, closing remarks and evaluation*	• Opportunity to provide feedback, measure achievements against the expectations identified on Day 1	Moderated plenary
16:30	Close		

Annex 2

List of participants

Name	Title/position	Country	Email
Dr Mohammed Belhocine	Public Health expert/ Retired WHO Representative	Algeria	mohbelho@gmail.com
Dr Ruth Kutalek	Medical Anthropologist, Medical University of Vienna	Austria	ruth.kutalek@meduniwien.ac.at
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Professor Hans Onya	Director, Health Promotion and HEAIDS programmes	South Africa	Hans.Onya@ul.ac.za
Professor John Parrish-Sprowl	Director, Global Health Communication Center and Professor of Communication Studies	USA	johparri@iupui.edu
Professor Collins Airhihenbuwa	Dean, School of Public Health & Social Justice	USA	airhihenbuwaco@slu.edu
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Mrs Caroline Mubaira	Deputy Country Representative Results-based Community Interventions	Zimbabwe	carolmubaira@gmail.com Caroline.Mubaira@ zw.crownagents.com
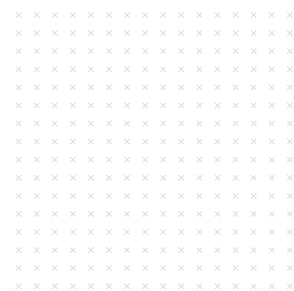
Partners

Name	Title/position	Country	Email
Dr Kelello Letotholi	USAID Applying Science to Strengthen and Improve Systems Project Chief-of-Party	Lesotho	klerotholi@urc-chs.com
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	Title/position	Country	Email
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	Mr Peter Phori Technical Officer, Health Promotion and Social Determinants	Congo	phorip@who.int
	Ms Marthe Rasoanirina Administrative Assistant	Congo	rasoanirinam@who.int
WHO/HQ/HIS/SDS	**Ms Asiya Odugleh-Kolev** Technical Officer, Community and Social Interventions	Switzerland	oduglehkoleva@who.int
	Ms Isabelle Wachsmuth Technical Officer, Innovation for Service Delivery	Switzerland	hugueti@who.int

Annex 3

Framework Development Workshop

A guide to developing community engagement frameworks for action on the social determinants of health and health equity: National Collaborating Centre for Determinants of Health (NCCDH), St Francis Xavier University, Canada.

http://nccdh.ca/images/uploads/Community_Engagement_EN_web.pdf

The architecture and effect of participation: a systematic review of community participation for communicable disease control and elimination. Implications for malaria elimination; Atkinson et al. Malaria Journal 2011, 10:225

http://www.malariajournal.com/content/10/1/225

Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis; O'Mara-Eves et al; Public Health Research Volume 1, issue 4, November 2013, ISSN 2050-4381
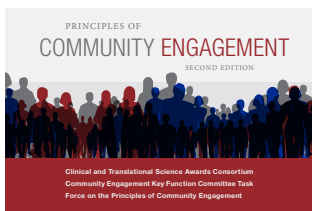
https://www.ncbi.nlm.nih.gov/books/NBK262817/

Core competencies for public health professionals; The Council on Linkages between Academia and Public Health Practice:

http://www.phf.org/programs/corecompetencies

Participation Models, Citizens, Youth, Online: Creative Common:

http://www.nonformality.org/wp-content/uploads/2011/07/Participation-Models-20110703.pdf

Principles of community engagement: Clinical and Translational Science Awards Consortium; Community Engagement Key Function Committee Task Force on the Principles of Community Engagement: NIH Publication No 11-7782, June 2011

https://www.atsdr.cdc.gov/communityengagement/

Time to Listen Hearing People on the Receiving end of Aid: Anderson et Al: CDA Collaborative Learning Projects, December 2012

http://www.alnap.org/resource/8530

A reflective set of questions were provided to participants before the workshop to consider each session. The key questions were:

1. What was/were the most important thing(s) that you got from the session?
2. What did you think about the content of the session?
3. What were the key points that were made?
4. What was there in this session that was of relevance to you?
5. What could you apply to your own context and how?
6. What do you want to follow up on from this session and how?
7. How does the content of this session relate to your assignment?

Follow-up needs were:

- Financial resources and technical support from WHO and partners
- Assurance of continuity and access to the WHO team for continuing discussion on the framework
- Learning by intensive exchanges
- More guidance for the key processes/elements and how to implement them
- Common templates/frameworks and documenting for experiences telling the story of CE
- Apply knowledge and skills acquired in order to advance implementation of CE framework for attainment of sustainable development goals "without leaving anyone behind"
- Continue with this process
- Promote human resources in community engagement
- Be sure that community engagement efforts will be done at local, national and global levels
- Capacity-building and monitoring and evaluation of CE efforts.

Participant quotes:

" *The workshop had a mix of people with different skills. The mix made for rich contributions. Though at times, some found difficulty in giving up their points, generally there was convergence of ideas. The sessions were enriching and thought-provoking. Follow-up sessions based on the work are on-going and refining the model will be useful. Better skill is how we will jointly apply the framework."*

" *Community engagement is a form of democratizing institutions. When we propagate CE in crisis situations, we have to be aware that this might change the way we do things, e.g. epidemiology (e.g. quarantine); empowering people to come to their own decisions, what is useful and what is not, might lead us in directions not anticipated before. CE might have an impact on how we deal with our partners too."*

" *Concepts of "community" and "village" should be re-thought, what about urban and semi-urban areas? Health centre committees are present in almost all villages, so could be used as the first contact point."*

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