Engaging with communities in health emergencies: Building readiness, response and resilience
ABSTRACT

This brochure presents examples from the WHO Regional Office for Europe on the central role that community engagement has played during the COVID-19 pandemic and other emergencies. It argues for investment in community engagement as an integral part of the entire emergency cycle.

KEYWORDS

COMMUNITY ENGAGEMENT, CIVIL SOCIETY ORGANIZATIONS, EMPOWERMENT, INCLUSIVE GOVERNANCE, EMERGENCY PREPAREDNESS

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Abbreviations

CSOs  civil society organizations
CE  community engagement
RCCE-IM  risk communication, community engagement and infodemic management
TGEU  Transgender Europe (civil society organization)
The global COVID-19 pandemic has challenged governments and international organizations to respond at speed. It has also confirmed that community engagement (CE) is crucial to public acceptance and uptake of preventative measures, and in turn a successful emergency response: never before has CE figured so highly as a key public health intervention in emergency response.

During the pandemic, and subsequent emergencies such as the war in Ukraine, the mpox outbreak and the earthquakes in Türkiye, communities have rallied to support vulnerable people with health services, interventions and supplies, and to amplify health information and advice.

As part of the communities they serve, civil society organizations (CSOs) are a valuable resource that provide an avenue beyond the health system for reaching diverse population groups, including those that are most vulnerable and underserved. They can create a bridge between health authorities and citizens, thus increasing trust and access to culturally appropriate services.

With experience and presence in many countries in the European Region, WHO is successfully supporting health authorities to work both directly with communities and through CSOs. This work is strongly supported by several global and regional frameworks. Investing human and financial resources in CE can save lives and help to better prepare for future emergencies.

CE is intrinsically linked to risk communication and infodemic management. This brochure focuses on CE, presenting stories from around the WHO European Region that illustrate the importance of engaging with communities, and the many benefits of reaching them through CSOs. It is intended to be used to advocate for CE to health authorities and other government sectors, partners and stakeholders involved in emergency preparedness and response.
Never before has CE figured so highly as a key public health intervention in emergency response. As such, it needs investment at every step of the emergency cycle.

**CE and empowerment is a win-win.** Experience shows that gaining the trust and active participation of communities is key to controlling outbreaks and epidemics and protecting people’s health in humanitarian emergencies. Communities are much more likely to trust and support response strategies they have co-created.

**Partnerships between health authorities and communities can maximize reaching vulnerable and/or underserved groups.** Through this collaboration, community structures for hard-to-reach groups can be created and activated, and sustainable solutions can be identified.

Health authorities and communities have a shared responsibility for planning, design and delivery of community interventions in a health emergency. Within the new health emergency preparedness, response and resilience architecture, CE is a key component of the community protection system and calls for shared accountability.

**Inclusive governance is a prerequisite of CE. To improve how we address future emergencies, it needs heavy investment now.** In the response, recovery and build back better phases of an emergency, countries can establish solid mechanisms to embed communities in emergency decision-making with a bottom-up approach and allocate funds to work with CSOs that benefit both communities and governments. With financial support, community actors like CSOs can be empowered to be agents of change.
The critical role of infodemic management in health emergencies

Communities are the primary source of capacity to tackle emergencies, whether through local governments or local partners, before national governments and international partners can step in. Through community engagement (CE), communities are empowered to co-design and co-deploy response interventions.

With their close, trusting links to communities, civil society organizations (CSOs) and health and social workers have long provided services and support during emergencies, particularly to underserved or hard-to-reach groups. Strong examples of this include the COVID-19 pandemic and the mpox response, where communities have complemented the work of health authorities by rallying to target and support key populations with health services and advice and contributing to emergency recovery.

Partnerships with community actors – such as faith-based organizations, community leaders, youth, health workers, journalists and CSOs – can create a bridge between government, health authorities and people, promoting trust, providing responsive and accountable services, and increasing acceptance and uptake of emergency interventions.

CE contributes to the following strategic frameworks:

- the sustainable development goals (1);
- the International Health Regulations (2005) (2);
- the Thirteenth General Programme of Work 2019–2023: promote health, keep the world safe, serve the vulnerable (3); and

Lessons from the pandemic and other emergencies

The COVID-19 pandemic, the war in Ukraine, the mpox outbreak and earthquake response in Türkiye have underscored that everything starts and ends at community level. It is communities that step up to tackle emergencies before national governments step in, and health behaviour change is dependent on the acceptance of measures by communities.

Trust is a fundamental prerequisite of behavioural change. During the pandemic, CE came to the forefront in achieving behavioural change and supporting other response functions (including testing, tracing and vaccination). Available data suggest that, after an initial increase in the months after the COVID-19 outbreak began, people's trust in national governments reverted to its pre-pandemic levels as the emergency wore on (5). This is when CSOs and community groups, as the bridge between health authorities and citizens could make a difference to the efficacy of the response.

Time and time again, emergencies teach the importance of using social structures and trusted networks and influencers, plus culturally relevant messaging, conveyed through trusted sources. Social and cultural relevance is built through community feedback, and interventions informed by it are those that have most success in the long term.

The recent mpox outbreak confirmed that guidance needs to be both technically sound and socially and culturally appropriate if it is to be listened to and acted on by communities at risk. Developing interventions with affected communities and deploying them through their established and trusted platforms were central to bringing down the number of cases in the Region.
Casting the emergency response "net" wider

Several vulnerable groups can potentially be neglected in an emergency response (6, 7), such as older people, people with disabilities, children, women, pregnant women, the LGBTQIA+ community, and refugees and migrants. Leaving them behind can create a cluster of populations that need higher attention from the health system in the short, medium and long term. Engaging these groups early on in the response through the CSOs that serve them may prevent a worse severity of disease and deaths as well as related costs.

Widening health inequities in the European Region are leading to reductions in trust in institutions, reinforcing social fractures and leaving excluded communities further behind (8). One example of this is the over 40% difference in vaccine coverage between high- and low-income countries in the Region (9). There is evidence that some vulnerable and underserved communities in Europe have slipped through the emergency-response net. People with disabilities, refugees and migrants, minorities or those at risk of gender-based violence, for example, have been impacted harder than others by the COVID-19 pandemic and the war in Ukraine. The mpox outbreak also saw groups such as sex workers and trans individuals left behind.

CSOs often represent underserved groups who may not feature in official statistics (10). However, according to a rapid survey conducted from 20 May to 4 June 2021 by WHO, the European Public Health Alliance and EuroHealthNet, only 9% of CSOs reported being able to participate and communicate regularly with governments through established channels (11).

An assessment from the United Nations Office for Disaster Risk Reduction Stakeholder Engagement Mechanism (12) stated that:

“civil society organizations adapted swiftly during the pandemic by leveraging existing local disaster risk reduction networks and programmes. Many organizations were able to swiftly adapt existing disaster risk reduction programmes designed for other hazards and quickly initiate new ones, which contributed to reducing exposure and vulnerability and to building adaptive capacity in the context

of the COVID-19 pandemic. Key elements of success were local presence, partnerships and existing networks of trusted relationships with vulnerable groups. These actions were seen across all facets of disaster risk reduction in the immediate wake of the COVID-19 pandemic.”

Inclusive governance at the core

Inclusive governance promotes the participation of community groups in decisions that affect them and is at the core of CE and a successful emergency response. Inclusive governance empowers people to contribute to society, promotes trust in government and social cohesion (13) and provides accountable services that reach everyone who needs them. The COVID-19 pandemic, the war in Ukraine and the mpox outbreak proved that CE is key for public acceptance and uptake of preventative measures, and in turn a successful emergency response. Designing, delivering and measuring interventions together creates accountability and more sustainable solutions.

Working with community influencers is an important part of inclusive governance. Building and maintaining meaningful connections with trusted influencers such as CSOs, youth, religious leaders, health workers, journalists and community leaders can provide key insights and facilitate effective CE when emergencies hit. Influencers tend to be well respected within their communities and can help to communicate health information and advice in a way that is appropriate and relevant.

Investing in inclusive governance pays dividends in emergencies, as recommended by the Fourth meeting of the International Health Regulation Emergency Committee on the Multi-Country Outbreak of mpox (14). Evidence suggests that countries with formal CE in normal times can leverage established communication channels better and are more efficient in their health emergency response than those who miss out on the assets held by communities (15). Community-led partnerships are key to efficient and cost-effective coordination throughout the emergency cycle, to gain and transfer knowledge and leverage resources.

1. Lesbian, gay, bisexual, transgender, intersex, queer/questioning and asexual.
To reap the benefits of community insights and assets, countries must invest in:

- mechanisms for ongoing dialogue and collaboration between government and civil society, such as community boards and stakeholder dialogue mechanisms;
- arrangements to provide financial support to community groups in an emergency to implement interventions, which are flexible to allow resources to be repurposed for an emergency;
- community-based service provision in emergencies and multistakeholder project delivery; and
- sustainable capacity building to participate in emergency readiness, response and resilience among CSOs, communities, service providers and health authorities.

Enabled and engaged communities have greater readiness, response and resilience in emergencies, meaning they are more likely to support health authorities’ interventions. Empowered communities have the voice, the means and the cohesion to recognize their gaps and assets, and find sustainable ways to engage with others to meet their needs and unlock resources to support emergency response.
Examples of CE’s return in investment

The benefits of CE are broad and far-reaching, so calculating an accurate financial return on investment is difficult. However, new research offers evidence on the benefits of investment in CE: a recent study on a vaccination and information caravan in North Macedonia, in which health-care workers reached out to traditionally vaccine-resistant communities found a 318% increase in vaccination on the day of the visit with respect to the pre-intervention average and an estimated 34.8% increase in vaccination rates over the two weeks following the caravan visit. They estimate the cost-effectiveness of the caravan as US$ 25.4 per additional vaccination (16).

Elsewhere, a WHO Regional Office for Europe publication on investment in Europe found that:

> “Investing in social networks can increase people’s resilience to threats to health and well-being and improves recovery from illness. Social capital is reciprocally associated with better health and well-being. For example, every single unit spent on health volunteering returns between 4 and 10 in benefits, which is shared between service users, volunteers and the wider community. A health champions community project has shown an SROI [Social Return on Investment] of 3.55 for every unit spent (17).

It is worth remembering that even intangible benefits arising from CE activities can bring widespread and long-lasting changes:

> “The returns are not outputs of a project, such as number of people who attend a community preparedness meeting, but the things of value that result from that meeting. These outcomes could be wide ranging, depending on the project, but include things such as reduced anxiety, faster recovery, or returns unrelated to disasters, such as networking that facilitates performance during non-crisis situations (18).”

To build forward better, CE needs heavy investment

CE needs sustained resources, including human capital, thus reliable funding is crucial (19). Academics also point out that non-profit groups may be unable to participate in meaningful disaster-related activities if it means diverting their otherwise scarce resources to yet another mission (20).

During the COVID-19 pandemic, countries of the European Region have increased investments in CE capacity to respond to the emergency. However, much of the capacity currently in place is repurposed from related areas of work, like health promotion, and is based on COVID-19 emergency funding which will end at some point in the medium term. Gaps in funding for community groups were exacerbated by the pandemic; assessments of community needs carried out for mpox and the Ukraine response have identified this as a continuing challenge for local responders.

The frustrations of having limited CE expertise and resources are combined in many countries with the challenging social, legal and policy environments, as highlighted by the pandemic. Trust in authorities, which was already fragile in some countries, has been further damaged by changes in response, uncertainties and mis/disinformation. People became fatigued by preventive and protective measures required by health authorities, as well as the prolonged COVID-19 response. These issues were also perceived as barriers to the dissemination of mpox health advice when this outbreak hit. Because of their trusted status, CSOs are well placed to mediate public health advice in ways that gain the continued acceptance of the communities they represent. However, all too often, CSOs and other community-based organizations have remained underutilized as a bridge between health authorities and communities.

These points made need to be addressed with innovative solutions enabled by sustained capacity at every step of the whole emergency cycle.
The WHO Regional Office for Europe CSO Empowerment Initiative

In March 2021, the WHO Regional Office for Europe started working with 11 CSOs that serve a wide range of population groups, such as refugees and migrants, Roma populations, people living with disabilities, older people, religious leaders, women and communities impacted by conflict, in eight countries (Table 1). The project piloted bottom-up approaches to working with national governments in emergencies. The focus of each CSO led project was determined by the CSOs and communities themselves.

This CSO initiative reached 2 373 000 people overall, with:
- 4150 community members consulted
- almost 50 000 individuals receiving direct support
- nearly 1000 people empowered through capacity building.

Table 1. CSOs involved in the Empowerment Initiative

<table>
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<th>Country</th>
<th>CSOs</th>
<th>Target</th>
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<td>Religious communities</td>
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<td>North Macedonia</td>
<td>Association for Emancipation, Solidarity and Equality of Women</td>
<td>Roma population</td>
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<tr>
<td>Georgia</td>
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<td></td>
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<td>Ukraine</td>
<td>Institute for Peace and Common Ground</td>
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</tbody>
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The benefits of engaging with CSOs to reach communities during the COVID-19 pandemic and other emergencies - stories from the CSO initiative and beyond

**Benefit 1: Resilience**

CSOs can help communities identify and build local capacity to respond to emergencies. Involving communities empowers these communities, and empowered communities that are engaged in the emergency preparedness process become more resilient. Resilient communities can become agents of change in present and future emergencies.

A joint initiative with Roma Communities in North Macedonia established three community boards in different municipalities (21). These boards were made up of informal leaders and influencers from within Roma communities, as well as representatives from municipal authorities, including health, education, police and social services. Community members were trained in community resilience techniques such as resource mapping and coalition-building. The boards foster inclusive governance, making sure the views and needs of the communities they serve are taken into account by the national authorities in North Macedonia.

A WHO-Civil Society Task Force was established in January 2018 at the invitation of WHO Director-General Dr. Tedros Adhanom Ghebreyesus (22). The ad hoc task force developed recommendations for how CSOs can foster greater collaboration, both with WHO and with other CSOs, to help achieve the Thirteenth General Programme of Work. The Ad Hoc Task Team on the WHO-Civil Society Engagement found that:

**In emergency settings, there is increased need for the vital role of CSOs in identifying, coordinating, and delivering an appropriate response. The availability of adequate, timely, and accurate information is essential to the efficiency and effectiveness of any emergency response. CSOs are uniquely positioned to make such information available given their proximity to and embedded links with communities and vulnerable or marginalized populations. This proximity also means local and national CSOs can increase the relevance and coverage of any response and can ensure resources get to hard-to-reach populations. As such, CSOs are well placed to deliver effective emergency response. CSOs’ experience and understanding of realities on the ground, specialist crisis management capacities, and strong relationships, are complementary to WHO’s technical expertise and relations with public actors. The combined action of both parties can deliver a quicker, coordinated, more culturally appropriate emergency response (https://civilsociety4health.org/app/uploads/2018/12/WHO-cso-report.pdf).**
Benefit 2: Proximity

CSOs are close to communities, can access hard-to-reach groups, and often act as first respondents to a crisis or unexpected new needs because of their constant presence and grassroots constituency. Civil society’s “eyes and ears” can help to draw attention to gaps in provision or barriers to emergency response.

Trainings and focus group discussions with health workers and psychosocial support groups for women at risk of violence were led by Union Sakhli, a Georgian CSO, partnered with the WHO Regional Office for Europe (23). Using the experience of victims of domestic abuse, the project built the capacity of health workers to provide services to over 300,000 patients in their care, better equipping them to recognize the physical and psychological signs of violence in the future.

Benefit 3: Trust

CSOs’ proximity with and respect from local communities gives them a deep knowledge of social and cultural dynamics. These relationships build trust and can impact behavioural change. Partnerships with civil society bring the benefit of these existing trusted relationships, something that can be more powerful than material resources.

With support from the WHO Regional office for Europe, the CSO Mosaica – Religion, Society and State established the Kavod/Karama Project (24). Spanning religious affiliations, the project further advanced the overall resilience and readiness of all Israeli communities, combining scientific soundness and religious appropriateness, at national and local levels. Through the project, 12,000 more people were vaccinated against COVID-19.
**Benefit 4: Flexibility**

CSOs and especially small grassroot organizations can easily adapt to new challenges and social needs as they emerge. With their deep understanding of the groups they represent, CSOs can adopt new modalities and flex to meet their changing needs in emergency situations.

Together for Children, a network of Greek CSOs who support people with disabilities, adapted their work to help isolated students with cognitive disabilities get online to continue their studies during the pandemic, maintaining their education, social bonds and improving their mental health (25). The project has also developed the first analysis in Greece on the pandemic’s impact on children and young adults living with disabilities.

**Benefit 5: Participation**

CSOs can promote the engagement of a wider group of people in the decision-making process. They not only give community members a voice, but improve the outcomes of participatory processes, particularly when it comes to vulnerable groups. People who participate in the decisions that affect them are more likely to be accepting of measures, and influence others to be more accepting too.

The Serbian CSO, the IDEAS Centre for Research and Social Development was supported by the WHO Regional Office for Europe to engage with migrant communities in Serbia and with the health services that treat them in reception, transit and asylum centres (26). New guidelines to support migrants and refugees were drawn up from this collaboration, thirty health mediator roles were created within the medical staff of reception, transit and asylum centres, and health workers employed in primary health settings were trained in culturally sensitive approaches and practices, COVID-19 prevention and interventions, and referral mechanisms between health and social services.

**Benefit 6: Mediation**

CSOs are champions in promoting dialogue building consensus and mediating to solve conflicts in society. Their knowledge of local languages, culture and the trust they often enjoy makes them indispensable partners for helping communities come together, respond to and recover from acute crises.

The CSO Institute for Peace and Common Ground has been working in Ukraine for almost a decade with communities affected by conflict. Although the organization had not previously worked directly in the health field, when COVID-19 appeared, it became clear that high levels of trust could be strengthened to increase uptake in vaccination and COVID-19 preventative measures. The Institute worked with two communities in the Donetsk and Lugansk regions to map community needs and capacity during the pandemic and train community representatives.
The benefits of engaging with CSOs to reach communities during the COVID-19 pandemic and other emergencies – stories from the CSO initiative and beyond

Continued

on community responses and social cohesion (27). This resulted in Siverska and Troitska residents developing community resilience plans co-designed with local authorities to tackle vaccine hesitancy that could benefit a total of 18,268 community members.

Benefit 7: Service delivery

Health authorities and international organizations rely heavily on civil society implementing partners to deliver essential health care services during outbreaks, conflicts, disasters and other emergencies. Their expert knowledge of at-risk groups and the ability to operate easily within the local context, including target-language abilities, make engagement with CSOs highly desirable.

To support older people during the COVID-19 pandemic, a WHO Regional Office project was initiated together with the CSO Resource Centre for the Elderly in Kyrgyzstan. Older adults were engaged to make and distribute 3000 fabric masks to the community and 350 older adults were consulted to help understand the challenges of the pandemic (28). A Council of Paramedics was created to engage older adults with medical backgrounds to take an active part in the pandemic response, and they successfully coordinated the vaccination of over 70,000 people.
The benefits of engaging with CSOs to reach communities during the COVID-19 pandemic and other emergencies – stories from the CSO initiative and beyond

Continued

BENEFIT 8: Capacity building

Capacity building in health is a central aspect of sustainability as imparting practices, approaches, and skills enhances future abilities of communities, CSOs and governments to improve health outcomes. CSOs play an important role in their own capacity building and that of the communities they serve. This capacity building is an important element of community empowerment. In an emergency, capacity-building of CSOs, communities and health workers can provide authorities with ways to address the needs of particular groups, and provide communities with skills, structures, systems and leadership to enable their own health outcomes.

In June 2021, to tackle COVID-19 related constraints and distress experienced by Slovenia’s refugees and migrants, the Slovenian CSO IZRIIS institute ran the Safe4ALL project (29). IZRIIS engaged nongovernmental organizations through trainings and discussions to better support refugees and migrants. They also conducted lively school workshops for young people to understand their perceptions about this population group and deliver training materials to 60 middle schools and 450 primary schools.

These initiatives informed IZRIIS outreach to refugees and migrants. Through the engagement of CSOs and staff and volunteers in asylum centres, and through social media the project reached out to refugees and migrants in Slovenia with reliable, accurate, and culturally relevant information about COVID-19.
Soon after the first cases of mpox were identified in the WHO European Region in May 2022, WHO Member States began to report rapidly rising and worrying spikes in transmission, with patients often experiencing painful and unfamiliar symptoms. It quickly became clear that the outbreak was impacting mostly gay, bisexual and other men who have sex with men and although less-well documented, communities of trans and gender-diverse people linked to the same sexual networks. Alongside programmes of epidemiological surveillance and testing, urgent community outreach and insights were needed to ensure that key populations could protect themselves and prevent onwards transmission.

From the outset of the mpox response, through regular CSO meetings the WHO Regional Office for Europe worked with organizations representing gay, bisexual and men who have sex with men to understand their risk perception, behaviours and acceptance of protective and preventive measures in order to better reach this population with health services and public health advice. However, one year after the start of the outbreak, the Regional Office recognized that to eliminate mpox in the Region, outreach and insights into further marginalized and underserved communities were needed. Working with the CSO Transgender Europe (TGEU) among others, they made sure that the need to reach underserved groups were included in key documents targeted to health authorities and other stakeholders. These documents include Considerations for the Control and Elimination of Mpox in the WHO European Region update 25 April 2023: the Need for Integrated National Operational Plans (30), A Risk Communication, Community Engagement and Infodemic Management Toolkit for Mpox Elimination: 17 May 2023 update (31) and Eliminating Mpox in the WHO European Region – a Response with Communities at its Heart: a Case Studies Compendium (32).
Recognition and inclusion are helping to build trust with underserved communities. At a ballroom event in Berlin (a celebration and networking event that many individuals from the trans and gender-diverse community are likely to attend) the Regional Office’s engagement with the community by event organizers was acknowledged:

“On the International Day Against Homophobia, Biphobia and Transphobia, the World Health Organization, released a campaign called Eliminating mepox: Placing affected populations at the heart of the response. This campaign, together with the toolbox makes sure that the language includes very explicitly marginalized members of the community, that were not included before, such as trans people, sex workers […] Now that the language has been updated, this is an invitation from the WHO and the TGEU for all of you, members of the marginalized community, you, men that have sex with men, trans people, sex workers, all of us here present, to go and use what we finally have achieved. Go and get tested, get vaccinated and get treated. Have conversations with each other, with your friends, your lovers, your family. We live in a sex positive world.

Amanita Calderon-Cifuentes, HIV Advocacy and research officer, TGEU (33).

The war in Ukraine – mediating between refugees and health providers

As of May 2023, over 8 million refugees from Ukraine were recorded across Europe, with over 5 million registered for temporary protection schemes (34). All the countries surrounding Ukraine have welcomed these refugees and the addition of such large numbers of people into national health services has presented challenges. Country capacity to address the enormous mental health needs of those fleeing from war zones is just one area in which the Regional Office has offered support.

To provide much-needed psychosocial support to Ukrainian refugees, the WHO Country Office in Romania contracted seven cultural mediators through United Nations Volunteers. The cultural mediators who have professional backgrounds in medical science, psychology and social science, and as refugees themselves, are well-placed to understand the needs of new arrivals. They can communicate in Ukrainian and Russian as well as having some Romanian and have been deployed in five cities with a high number of refugees: Brașov, Bucharest, Cluj, Galați and Târgu Mureș (35).

The mediators work in United Nations Children’s Fund Blue Dot refugee clinics (36) in the country, general practitioner offices and in the wider community to facilitate communication between health-care providers and refugees. Blue Dot services are free of charge, and the volunteer mediators’ work includes psychological first aid and counselling as well as an introduction to the Romanian health-care system and support with medical referrals; and counselling and information in cases of bullying and domestic, psychological, social, financial and sexual, and other types of violence. As volunteers give feedback on refugees’ health concerns to authorities, services are better aligned with need.
Why invest in CE through WHO in Europe?

Why CE in the European Region?

The European Region represents a dramatic diversity of countries; culturally, economically and geographically, and there is a wide disparity in emergency preparedness. CE in the Region has not been traditionally systematic. All too often, CSOs and other community-based organizations have remained underutilized to bridge health authorities and communities.

In the last three years, countries of the European Region have increased investments in risk communication, community engagement and infodemic management (RCCE-IM) to respond to the COVID-19 pandemic but much of the capacity in place is repurposed from related areas of work and is based on COVID-19 emergency funding which will end at some point.

Stable funding, allowing for long term planning and investment in CE will help build the capacity of health authorities to have community support to the response, enhance acceptance and uptake of protective measures and leverage on community assets.

Why WHO Regional Office FOR Europe?

• WHO is on the ground and active in many countries in the European Region and has specific experience of working in countries that are at increased risk of health crises due to vulnerabilities in their health systems.

• WHO has recent and highly relevant experience in Europe of engaging with communities through CSOs, using its tools and tried and trusted methodologies to facilitate engagement. The organization can act as a bridge between bottom-up and top-down approaches, helping ensure meaningful investments.

• The WHO Regional office for Europe has strong links to well-established community groups in Europe. The WHO Regional Office for Europe’s informal CSO regional network facilitates the sharing of best practice, capacity building and productive partnerships.

• Working through WHO as a trusted partner can help change the way health authorities are perceived by communities. Throughout the course of the pandemic and beyond, the WHO Regional Office for Europe remained a trusted source of information in the European Region. While levels of trust varied between countries and over time, WHO is consistently seen as a trusted source of information where it matters most (37).

• The future health emergency preparedness, response and resilience architecture has Community Protection at its core, stressing equity and inclusive community-centred ownership based on systematic engagement with community stakeholders. Partnering with WHO can ensure community protection is embedded in long-term frameworks as health emergency preparedness moves to the top of the political agenda.

Mpox – Building trust with underserved communities
How can WHO support Member States’ health authorities with CE across the emergency cycle?

On prevention, the WHO Regional Office for Europe can engage CSOs to provide accurate health information and advice to reduce exposure to infectious pathogens, for example, related to influenza, hand hygiene and food safety risk.

On preparedness, WHO can support countries to map community stakeholders; develop tools to understand community needs and who they trust; and build local stakeholders’ capacity to respond to an emergency. The Regional Office offers a range of capacity building offerings on CE: the ground-breaking RCCE-IM Plan Creator provides a comprehensive online platform for RCCE-IM practitioners to develop emergency response plans (38); the RCCE-IM School, a multi-day workshop that brings together all the best practices from RCCE-IM in 10 modules (39); and the Capacity Mapping Tool with which users can self-assess their professional skills against desired levels (40).

On readiness, WHO can support countries to develop frameworks to work with civil society to implement emergency interventions on imminent risks, engage community actors to enhance health literacy, and monitor false information and information voids at community level.

On response, the WHO Regional Office for Europe can provide guidance and hands-on technical support to countries’ health authorities to bridge government and civil society, such as on establishing community dialogues, stakeholder forums or working groups. It can also assist in developing strategies to engage key community influencers, such as CSOs, community leaders, health workers, journalists, youth, and religious leaders to co-design and co-deliver emergency response plans.

On recovery, the WHO Regional Office for Europe can establish mechanisms to work with communities affected by the health emergency, understand their challenges and concerns and tailor interventions to reintegrate them into normality and sustain protective measures.
The COVID-19 pandemic marked a watershed moment, putting communities at the core of decision-making in emergencies. It is now clear that the only way health authorities can hope to meet the challenges of future emergencies is if they have the support and cooperation of communities (41).

Failure to recognize and respond to the realities faced by communities may fracture trust in government and risk leaving some of the most vulnerable groups excluded from emergency response behind, causing political alienation and non-compliance with safety measures.

Moving forwards, there is a clear need to more meaningfully include a wider range of community actors in governance to ensure that communities support response efforts and that no one is left behind.

Effective community readiness and resilience require the empowerment of community members to create strong and sustainable structures.

Now is the time to recognize the vast assets and energy held in communities, of which CSOs are often gatekeepers. Stable funding, allowing for long-term planning, flexibility and certainty, is critical to CSOs’ sustainability and currently, a major risk that imperils their capacity to connect hard-to-reach groups to health authorities in an emergency. Allocating human and financial resources to engaging with communities is an investment in local capacity that enhances the national response, saves lives, and bolsters community resilience to face future shocks.


27. Institute of Peace and Understanding. Building community capacity in response to the pandemic in Ukraine. YouTube; 2022 (https://www.youtube.com/watch?v=0OaE2xHzLs&t=46s) (in Ukrainian).


33. WHO Regional Office for Europe. WHO/Europe works with health advocates like Amanita to include trans people in the mpox response. Youtube; 2023 (https://www.youtube.com/watch?v=Q7k_asu2Bses).


The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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