

Enhancing community engagement and involvement in crisis-responses

THE PARES TOOLKIT

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PARES at a glance

6

Six partners

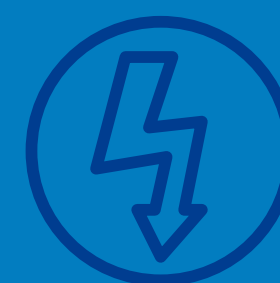
London School of Hygiene & Tropical Medicine, UK
 Makerere University, Uganda
 Jimma University, Ethiopia
 Eastern Technical University, Sierra Leone
 Blue Ventures, Madagascar/UK
 Wageningen University, The Netherlands



4

Four countries

Ethiopia,
 Madagascar, Sierra Leone, Uganda



8

Eight crisis contexts

Flood, drought, cyclone, Covid-19, Lassa, Malaria, unsafe water, traditional-biomedicine tensions

32

Thirty-two detailed case examples



86

Eighty-six analyses of context-mechanism-outcome cases

INTRODUCTION

“Before, they came and told us what to do. This time they asked us what we know. That made us speak freely.” (elder, Kenema District, Sierra Leone)

A toolkit to transform partnership with communities to build resilience to crises

About this toolkit

The Building Partnerships for Resilience (PARES) global health research group is funded by the UK's National Institute for Health and Social Care Research (NIHR). The London School of Hygiene & Tropical Medicine (LSHTM), UK co-lead the consortium with Makerere University, Uganda, in collaboration with Jimma University, Ethiopia; Eastern Technical University, Sierra Leone; Blue Ventures, Madagascar and Wageningen University, The Netherlands.

Over five years (2021–2025), these partners worked together in four countries to produce a series of case studies of community engagement and involvement (CEI) actions in eight different crisis settings.

This toolkit is derived from the evidence in these case studies about what actions work, why and in what contexts. All materials are also available from the [Learning Platform](#) of the PARES website.

Who is this toolkit for?

This toolkit is aimed to support crises-responses by policy decision makers, programmers, humanitarian response agencies, local leaders, training institutions and researchers from any sector. This toolkit can inform the user what types of actions and approaches (“mechanisms”) can successfully build crisis-resilience and help protect health in crisis settings.

How to use this toolkit

This toolkit presents actions that have been found to be effective in involving and engaging communities to build resilient crisis responses. These can contribute to:

- Embed community engagement and involvement in routine practice for crisis-response
- Inform policy and practice to maximise effectiveness of crisis-response
- Prioritise steps to build linkages and collaboration between the healthcare systems and local community structures
- Inform planning and financing of resilience-building activities
- Inform programme indicators development for monitoring and evaluation

The toolkit can help to identify how community engagement and involvement mechanisms can work in different contexts. The PARES mechanisms are not a blueprint but provide a useful starting point to identify and support mechanisms that can be used in each unique context to build resilience. The toolkit should be used together with the linked case study material, which highlights effective actions and challenges.

PARES Framework for engaging communities to build resilience

Case study data were analysed using realist-informed approaches that examined the **contexts** within which crisis-response actions occurred, the **mechanisms** of action by which communities were engaged and involved in crisis-response

(what was done by whom in what circumstances) and what resilience and health **outcomes** they resulted in. Across these case studies we identified a wide range of mechanisms through which crisis-responses were achieved. By “mechanism” we mean “underlying entities, processes, or structures which operate in particular contexts to generate outcomes of interest” (Dalkin et al. 2015). From our diverse case studies, we identified cross-cutting mechanisms that were present in multiple countries and crises. These mechanisms were synthesised into three “domains”, that is a “sphere of activity or knowledge”. These domains are:

1. Social dynamics and structures
2. Operational systems & processes
3. Learning and capability development

Each domain has a defined set of evidence-based CEI mechanisms (10 in total) that contribute to building local resilience to crises. These are shown in the framework below. The framework provides a basic structure on which courses of action can be built. This document outlines 32 case examples that illustrate how the different mechanisms within each domain operate and suggests possible actions and indicators for each.

As shown in the PARES Framework, the mechanisms are interconnected and collectively strengthen local resilience to both acute and chronic crises. No single mechanism is sufficient on its own. Achieving long-term community resilience requires attention to the full range of mechanisms, each of which may become more, or less, relevant depending on the context and timing. Multiple mechanisms often operate simultaneously, which is why they are presented in a circular rather than linear model.

The circular design also reflects the continuous nature of how these mechanisms function. For example, in settings where there is distrust in health emergency responses, working with trusted local leaders can help rebuild confidence in health systems. If this practice becomes embedded, it shapes the context for future crises. Our case studies provide multiple examples of this. From Ethiopia and Uganda, local elders and leaders blended scientific knowledge with locally understood knowledge and values to trigger drought and flood preparedness actions. To Sierra Leone, where a Lassa fever program was transformed through institutionalising CEI actions (e.g. routine meetings to receive and reflect on local (mis)understandings of disease risk and prevention) which reshaped people's relationship with the health system: “this is the first time doctors came here to listen, not to tell us we were wrong”. Understanding and institutionalising effective CEI mechanisms that build better resilience to health crises and better connections between local communities and responding health systems, is an iterative process that requires time, repeated action, and ongoing learning across the full set of mechanisms.

What is “community”?

The toolkit is centred on community-centred crises-responses. “Community” can mean different things to different people. For example, a community of practice can be worldwide, but a “local” community may be considered a village, and individuals present in a village but linked to formal systems (e.g. health or agricultural extension workers) may also be seen as part of the local “community”.

UNHCR's Emergency Handbook defines communities in crisis settings as “a group of people often socially or geographically connected experiencing or recovering from a major disruption like disaster, conflict, health emergencies” (UNHCR nd). In PARES we understand communities are made up of many different individuals and groups, with differing power relations and dynamics. Every community has people who will be excluded and marginalised even from local community structures. Community-wide engagement and involvement is the most effective way of ensuring resilience to crises can be built.

Conventional approaches to community engagement too often view ‘community’ as a homogenous group. Ignoring power relations, divisions and different groupings within communities, which means that certain groups, often the most marginalised, end up unrepresented – this is particularly evident and harmful in crisis settings. The complex interplay between community members and social systems and between health workers and the health system, shapes crisis response both positively and negatively (Richards et al. 2020).

What is community engagement & involvement?

Community engagement & involvement (CEI) is become increasingly recognised as essential in crises-responses and social development, yet definitions differ. From a research perspective it has been defined as “active involvement of communities throughout the research process, using participatory approaches and working in partnership with key stakeholders to improve the relevance, value, and conduct of health research” (NIHR 2025). From a program perspective, Unicef has defined it as “increasing the participation, collaboration and voice of communities for more effective results” (Unicef nd). The World Health Organisation (WHO) has defined four levels of engagement and participation: *inform, consult & involve, collaborate and empower* (WHO 2020). Previous work by some of the PARES partners on the West African Ebola outbreaks (*Rethinking Humanitarian Approaches*) resulted in *guidance* on five steps for governments and international humanitarian response agencies to enhance community engagement and involvement in responses to pandemic outbreaks (and similar crises). To date, however, empirical studies of *how* CEI has been put into practice in the context of crisis-response, have been scarce (Sahani

et al 2024). This toolkit provides case study evidence to underpin each identified CEI mechanism that can contribute to building local resilience to crises.

What is resilience?

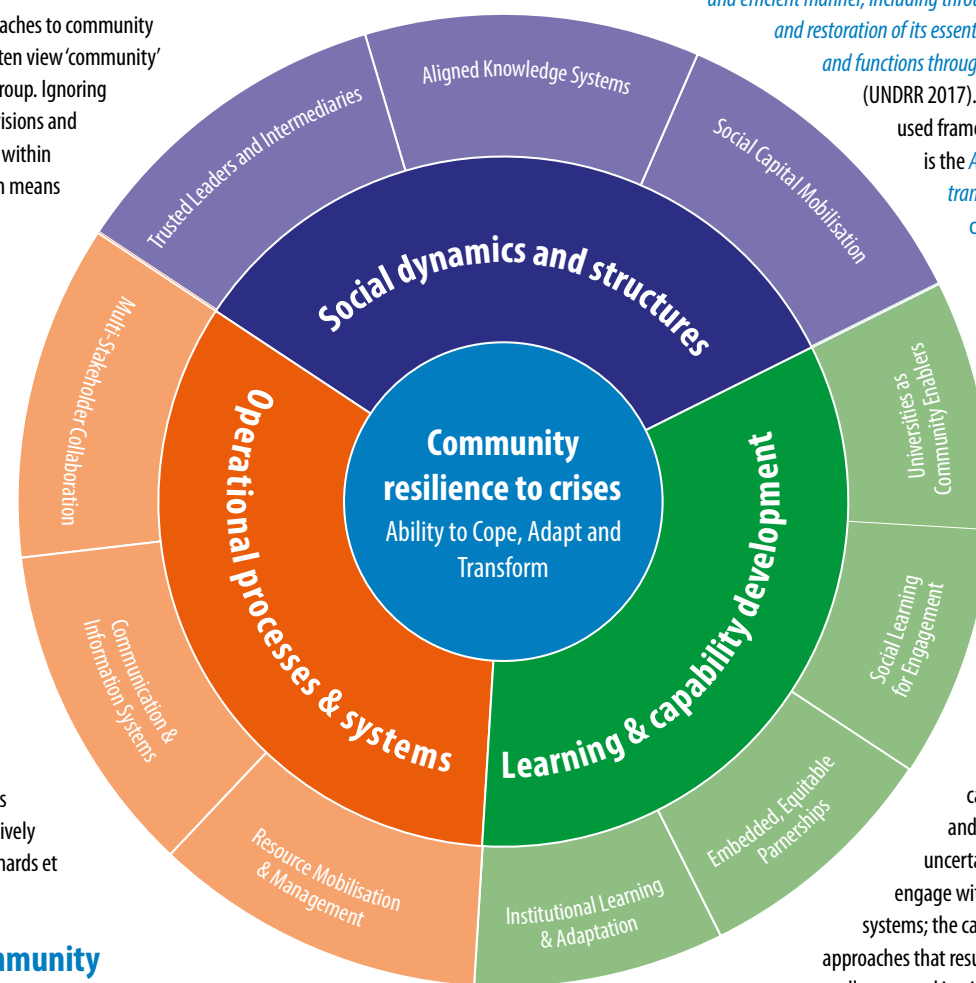
The UN Office for Disaster Risk Reduction defines resilience as “*The ability of a system, community or society exposed to hazards to resist, absorb, accommodate, adapt to, transform and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management.*” (UNDRR 2017). Another widely used framework for resilience is the *Absorb, adapt and transform* resilience capacities framework (Oxfam 2017).

In a health context four types of capacity have been identified as necessary for healthcare systems to be resilient: the capacity to combine different types of knowledge; capacity to anticipate and cope with uncertainties; capacity to engage with other complex systems; the capacity to develop approaches that result in socially and contextually accepted institutions (Blanchet et al. 2017).

Crisis-response and humanitarian agencies often conceptualise crises as “shocks” and the “shock cycle” involves mitigation and preventative measures throughout the planning cycle (European Observatory on Health Systems and Policies 2020). There are four defined stages that those seeking to respond to crises should prepare for:

- Foresight, Prevention & Preparedness (horizon scanning, planning, mapping);
- Shock onset and alert (surveillance and early warning; timely, quality information and feedback/exchange);
- Shock impact and management (absorption, adaptation and transformation);
- Recovery, learning and legacy (lessons learned; building & sustaining future resilience capacities).

The PARES CEI mechanisms to build resilience are important at all stages of this cycle. The CEI mechanisms we identify across the three domains of the PARES model can be used to achieve resilience across different crisis settings.



COMMUNITY ENGAGEMENT & INVOLVEMENT MECHANISMS

SOCIAL DYNAMICS AND STRUCTURES

The first domain of the PARES model is focused on **the social dynamics (relationships, trust, norms), local structures and collective organisation**. The CEI mechanisms in this domain contribute to building resilience by working with trusted and legitimate authorities and structures to align knowledge systems and mobilise social capital.

There are three mechanisms in this domain:

- **Trusted leaders and intermediaries**
- **Aligned knowledge systems**
- **Social capital mobilisation**

Trusted leaders and intermediaries

***Definition:** local leaders, authority figures and community institutions that have trust and legitimacy in the eyes of local people and can interpret and validate information, encourage compliance and mobilize collective action.*

In contexts where communities face climate or disease risks and distrust messages or instructions from outside their communities (including from

government, foreign NGOs or international agencies), if trusted leaders or intermediaries (e.g. traditional leaders, elders, religious leaders, disaster/disease survivors, community-based health workers) can interpret and translate external information with local knowledge and values, then communities are enabled to understand risks and strengthen community trust in risk warnings and messages, leading to earlier action, greater adherence to guidance, and improved resilience & health outcomes.

Examples of actions

For Communities:

- Support leaders who share and interpret risk information by using trusted early warnings to recognise extreme weather risks early, coordinate planting and resource decisions, mobilise savings, strengthen food storage, and support collective water management.

For Government:

- Institutionalise collaboration between district climate services, extension workers, and trusted local leadership structures (e.g. elders, local authority leaders, village health leaders and community committees) to deliver and interpret early warning information and support coordinated disaster preparedness.

For NGOs/health programmers:

- Facilitate regular pre-season forums that link scientific climate experts, extension workers, and community knowledge holders, while supporting community planning, savings groups, and local food and water management systems.

For Funders:

- Support sustained communication, collective preparedness, community institutions (e.g., VSLAs, food banks, water committees), and long-term partnerships that strengthen anticipatory drought resilience efforts.

Suggested indicators

- % of community members reporting trust in local leaders/intermediaries as sources of crisis information
- Evidence of regular community engagement activities led or coled by trusted leaders (e.g., religious leaders, elders, women leaders, youth leaders).
- Evidence of crisis-response decisions that are made through recognized traditional and formal leadership structures
- Evidence of community members attending meetings voluntarily (without demands for incentives/ compensation) in response to crisis meetings called by local leaders/intermediaries.



“The leaders act as a bridge between us and the community. They help us understand community concerns and also help the community understand our services.” Healthcare worker, Kailahun District, Sierra Leone

Case examples

Ethiopia – drought – trusted leaders

In the drought-prone Borana zone, communities experience recurrent climate shocks and place strong trust in traditional leadership and indigenous knowledge that exist alongside government structures. In the study settings, the two came together, with the meteorology office generating evidence-based forecasts while wise men provided traditional seasonal forecasting, drawing on prior experience and local indicators. Through joint interpretation and communication by local “wise men” and other elders, local leaders, health extension workers, and agricultural development agents, drought information was perceived as credible, relevant, and actionable, motivating communities to prepare early and coordinate collective responses. As a result, households and leaders took timely preparatory actions such as protecting assets, adjusting livelihoods, and planning ahead, reducing losses and strengthening community adaptive capacity to drought.

Uganda – drought – trusted leaders

In drought-prone districts of Kasese and Katakwi, trusted local leaders and intermediaries play a central role in translating early warning signals into coordinated preparedness actions. Past experiences with externally driven messaging have generated scepticism toward formal warnings. However, in the study villages, ecological indicators such as delayed rains, crop-stress or drying water sources were discussed alongside scientific seasonal forecasts in partnerships between community knowledge holders (elders, water user committees, village health teams) and formal actors (NGOs and district extension workers) and risk communication was co-created and translated into meaningful messages. When these messages were communicated by trusted figures such as Local Council level 1 leaders, Village Health Teams, elders, and extension workers using trusted channels such as community meetings, door-to-door visits, religious gatherings, households were more likely to perceive risk as credible and urgent. As a result, communities were more likely to take anticipatory action and activate collective preparedness rather than delay response until impacts were severe. Response actions included adjusting planting calendars, protecting shared water sources, storing food, and supporting vulnerable households. The combination of trusted authority and locally grounded interpretation transforms early warning information from advisory messages into socially reinforced obligations for collective action.

Sierra Leone – Malaria-CHWs – trusted leaders

In Kailahun District, where local community leaders (local chiefs, elders, village committee members) are trusted and have legitimacy, their involvement in recruiting and supporting Community Health Workers (CHWs) strengthened CHW-led malaria services by enhancing social trust, acceptance, and accountability of their work. In the study villages, the endorsement of CHWs by local leaders helped to legitimize them, reduce community scepticism and encourage early care-seeking for malaria symptoms. Local leaders also acted as mobilizers, reinforcing key health messages and promoting positive health behaviours. Additionally, local leaders provided oversight and mediation, ensuring CHWs remained responsive and trusted. This collective trust, supported by strong social networks, helped increase service utilization and adherence to treatment. As a result, communities are better able to respond adaptively during health system disruptions, ultimately improving continuity of care and reducing malaria-related morbidity.

Sierra Leone – Lassa – trusted leaders

In Kenema District, Lassa fever messaging had previously been delivered by socially distant hospital staff and external partners, empowering local champions transformed community response. Respected figures such as religious leaders, traditional authorities, survivors and community health workers were trained to communicate biomedical information through trusted cultural channels. Messages were reinterpreted as locally endorsed guidance rather than external directives, making preventive practices socially acceptable and reinforced within communities. Survivor testimonies shared in public forums and radio programmes countered fatalistic beliefs, reframed treatment-seeking as achievable and reduced stigma. Religious and traditional leaders linked disease prevention to moral and communal responsibilities, shifting adherence from individual compliance to collective obligation grounded in shared values. This integrated approach increased credibility of health communication, strengthened community ownership, reduced stigma toward survivors, stimulated demand for early testing and improved willingness to engage with formal care.

“If the elders’ forecast aligns with the meteorologists’ prediction, it is accepted as credible; if it does not, the issue is shared with other elders and the community, discussed collectively, and a consensus-based interpretation or decision is reached.” Community leader, Elway District, Borana, Ethiopia

Aligned knowledge systems

Definition: *interpretation and alignment of traditional or indigenous knowledge with scientific or technical knowledge platforms leads to messaging being considered credible and therefore acted on.*

In contexts where communities face climate or disease risks, or other challenges, and are unsure which information to trust (scientific forecasts, biomedical messages, rumours), if trusted intermediaries (traditional leaders, chiefs, wise men, religious leaders, locally active health and humanitarian responders)

can help to align and interpret scientific/biomedical information with local knowledge and values, then community trust in the warnings & messages is strengthened. Dialogue, negotiation and sometimes compromise between trusted intermediaries and “scientific” actors is part of the process. When alignment (or complementarity) of messages can be achieved, this leads to earlier action, greater adherence, and improved resilience & health outcomes (reduced exposure, lives saved) and strengthens ongoing collaboration between communities and response actors.

Examples of actions

For Communities:

- Maintain and use trusted local communication channels. Validate warnings collectively and activate preparedness structures early.
- Share your local knowledge about illness and transmission with healthcare workers and request/participate actively in dialogue sessions to co-create disease responses in your chiefdoms or villages.

For Government:

- Institutionalise village disaster committees (or equivalent) and recognise, local leaders, elders, and village health structures as formal early-warning intermediaries. Invest in translating forecasts (weather; disease outbreaks) into locally actionable guidance.
- Ensure community engagement is a standard part of outbreak/disaster response protocols, ensuring district health teams allocate time and resources for two-way dialogue rather than one-way health messaging.

For NGOs/health programmers:

- Work through existing trusted leadership rather than parallel communication systems. Support the co-production of early warning information using Indigenous and scientific knowledge.
- Train and reward traditional practitioners (e.g., traditional birth attendants), as they already collaborate closely with local health facilities during health worker absences.
- Train and deploy community engagement facilitators who can build sustained, respectful relationships with communities, using open interviews, storytelling, and discussion methods that value local expertise alongside medical science.

For Funders:

- Fund sustained communication engagement and communication (especially in high-risk settings), in addition to technical inputs, before disasters rather than response-only funding.
- Fund long-term community engagement infrastructure and facilitator capacity, not only disease-specific programmes, recognising that trust-building and co-production of knowledge require sustained investment beyond acute outbreak periods.

Village elders in Ethiopia discussing drought response



Suggested indicators

- #/evidence of engagement activities where traditional knowledge and scientific knowledge are intentionally aligned/negotiated (i.e., co-designed, negotiated content, co-presented sessions).
 - Surveys, interviews/focus group discussions
- #/evidence of co-created knowledge products (e.g., messages, guides, radio scripts, risk maps) incorporating both knowledge systems.
 - Review of materials
- Reported usefulness of aligned/negotiated knowledge, e.g., by communities and partners
 - Surveys or interviews/focus groups,
- Reported use of aligned/negotiated knowledge to inform district- or local-level decisions, e.g., by communities and partners
 - Surveys or focus groups, observation, stories of change, and interviews.
- Evidence of structured and regular decision-making platforms where community elders, local leaders, and technical experts can jointly interpret forecasts and agree on preparedness actions.
 - Observations, meeting records
- Degree of inclusiveness of the dialogue or co-production forums
 - Observations, materials review, interviews/FGDs

Case examples

Uganda – flood – knowledge systems alignment

In flood-prone districts of Kasese and Katakwi, communities experience recurrent climate shocks within contexts characterised by constrained state response capacity, uneven infrastructure, and strong reliance on local leadership and experiential knowledge. In this context, elders, meteorological officials, local authorities and embedded crisis-responders (Red Cross) combined their knowledge for early warning; indigenous ecological indicators such as river swelling and unusual rainfall patterns aligned with scientific early warning information which was then communicated through trusted local leaders and established community structures. When these warnings reflected lived experience and were delivered by legitimate actors such as local council leaders, elders, village health teams, and disaster committee members, communities perceived the information as credible, relevant, and actionable increasing their willingness to respond to early warning messages. As a result, households and community leaders undertook anticipatory actions, including early evacuation, protection of assets and water sources, and mobilisation of collective preparedness activities including activation of villages savings associations and water committees. Collectively, these actions led to reduced exposure to flood hazards and strengthened community response capacity and resilience across repeated flood events.

Ethiopia – drought – knowledge systems alignment

In drought-prone Borana Zone, both scientific forecasting systems and indigenous knowledge traditions play important roles in understanding seasonal climate patterns. Meteorological offices generate scientific drought forecasts, while local “wise men” conduct traditional seasonal forecasting using local indicators and accumulated experience. In the study villages, collaboration was facilitated by disaster risk management offices who brought together scientific experts and traditional forecasters to compare and jointly interpret their forecasts before the onset of drought. When scientific forecasts and traditional indicators aligned, confidence in the predictions increased; when they differed, discussions helped clarify uncertainty and refine interpretation. These actions resulted in information that was perceived as more credible and meaningful to the community. The combined knowledge provided a stronger evidence base for preparedness planning and supported coordinated early action to reduce drought impacts. Actions included communities being more willing to discuss risks collectively and consider preparedness actions before drought impacts intensify.

Sierra Leone – traditional-biomedicine tensions – knowledge alignment

When the Ebola crisis ended health professionals drew some lessons. To exclude village stakeholders, herbalists, and TBAs was a mistake. A more inclusive approach for Covid-19 eased tensions and enabled collaborative work. Information flowed more easily through cooperation between health workers and communities. Freedom to choose and respect for these choices also brought more reliability and trust. This eradicated fear, and increased confidence in diagnosis. Locally, in Kailahun District there is now a hybrid health system based on improved collaboration and cooperation between some traditional practitioners (traditional birth attendants (TBAs), herbalists and bone-setters) and biomedical practitioners in government health facilities. In the study villages this has reduced fear, secret treatments, and misinformation. Growth of mutual respect in rural Community Health Centres and Peripheral Health Units brought stronger synergy between the two distinct health systems and eventually enabled them to work together. For example, midwives now call on TBAs as advisors since they are seen as more “positive”; TBAs also refer pregnant women to health centres as soon as pregnancies depart from normal. Herbalists will also refer patients to health workers for tests, for example if they suspect malaria.

Sierra Leone – Lassa fever – knowledge systems alignment & co-production

In Kenema District where prior Lassa fever responses had dismissed local illness understanding and provoked resistance, community engagement created conditions for fundamentally changed relationships. Facilitators and health workers replaced predetermined messaging with facilitated dialogue through open interviews, storytelling, and respectful comparison of local and medical explanations. Community members felt heard, valued, and safe to share knowledge about rodents, fever patterns, and care-seeking pathways, generating mutual respect and recognition. This triggered a shift in thinking that reinterpreted engagement as collaborative rather than corrective. Consequently, community members assumed active roles in awareness-raising, household monitoring, and early case reporting. Locally expressed concerns about isolation, treatment rumours, and social consequences were incorporated into message design and response procedures, reinforcing shared ownership. Community leaders, ward committee members, and CHWs then proactively reinforced agreed messages within their networks, resulting in transparent communication, reduced resistance, earlier care-seeking, and community-driven uptake of control measures.

Social capital mobilisation

Definition: pre-existing social networks and mutual support systems provide the foundation for coordinated and collective community actions & can be enhanced with external support to enable communities to prepare for, absorb and recover from shocks more effectively than individuals acting alone.

In contexts where public systems (water, health commodities, infrastructure)

are underresourced, intermittent, or have withdrawn (e.g. when supporting NGOs depart), or been destroyed (e.g. by cyclones) leaving gaps, if communities frequently mobilise collective structures (local savings groups, pooled funds, selfhelp projects, water committees, cost recovery schemes, local engineers, volunteer networks) and take ownership of response actions, then vulnerability is reduced and everyday resilience beyond project cycles is strengthened. However, poverty limits what can be done without external support.

Examples of actions

For Communities:

- Closely collaborate with and seek support from NGOs operating in the area to address the community’s problems.
- Collaborate and seek health information and care from the local community health workers (CHWs) to cope with the health effects of any crisis.

For Government:

- Coordinate and collaborate with NGOs that can provide long-term assistance to build resilience in hard-to-reach communities; facilitate NGO presence at the local level to achieve sustained impact.
- Recognize and use community health workers embedded within the community to enhance access to basic health services, such as malaria testing and treatment, during crisis response.

For NGOs/health programmers:

- Be directed by community needs and engage with local knowledge, structures, and resources to maximise the impact of initiatives for crisis response and community resilience.
- Work with and through CHWs who are embedded and trusted by the community to enhance community engagement and involvement in crisis response.

For Funders:

- Provide funding for NGOs to enhance their flexibility and pivot their approaches and programs to respond to emerging, community-led needs, facilitating sustained engagement in crisis response.
- Fund CHW-led initiatives to improve community engagement and involvement in crisis response.

Suggested indicators

- # of collective actions initiated by communities (e.g. clean-ups, surveillance, support to vulnerable households).
 - Surveys, community records
- Experiences of working together within and across communities and with external partners.
 - Qualitative research to generate illustrative stories
- % of households reporting reliance on community support networks during stress or shock.
 - Surveys
- # of active mutual aid groups, savings groups, women’s groups, youth groups.
 - Surveys
- Evidence of community solidarity, shared problem-solving, or coordinated risk reduction.
 - Qualitative stories from interviews/FGDs
- Evidence of bylaws or policies and guidelines in relation to existing groups

“Since we are often confronted with natural disasters, we have been thinking about what we need to do to protect our lives. And the training we received from these NGOs also reinforced (our knowledge).”

Village resident, Ambanja District, Madagascar

Case examples

Madagascar – cyclone/post-cyclone flooding – social capital

Communities are the custodians of important knowledge and understanding– a form of social capital – that stakeholders could utilise to inform their interventions in the response to cyclone-related crises. When this knowledge is harnessed to ensure any interventions are appropriate (in this case choosing locations for wells) this leads to better outcomes (in this case improved water security during a cyclone). When this knowledge and understanding is ignored, interventions risk being less effective and resilience is less likely to be built. Harnessing this social capital to facilitate local ownership of any programme or new resources leads to sustained positive impacts of any intervention. Strong community relationships and a willingness to support those in need, another form of social capital, can also be harnessed to ensure equitable distribution of resources and support in a crisis, as well as to help facilitate collective action.

Uganda – drought and flood – social capital

In flood- and drought-prone districts of Kasese and Katakwi, community groups provide a foundation for collective response to climate shocks. When warnings about floods or prolonged dry spells are communicated through trusted leadership structures, communities activate existing networks such as Village Savings and Loan Associations), Savings and Credit Organisations, elders’ councils, and water committees. These structures mobilize financial and social capital through savings withdrawals, small loans, and mutual support. Group bylaws, regular meetings, and shared norms enable coordinated action, including supporting vulnerable households, protecting shared resources, and organizing preparedness activities. Collective structures also link communities to district government and NGO programmes, improving access to training, agricultural inputs, and recovery support. Through these mechanisms, social capital strengthens preparedness, supports recovery, and reinforces trust and shared responsibility within communities facing recurrent climate shocks.

Ethiopia – drought – social capital

In Borana communities, strong customary governance systems and indigenous social protection traditions shape how people organize and respond to drought. Elders and traditional courts provide culturally legitimate authority and serve as key platforms for sharing information and guiding community decisions. Through regular village meetings, elders discuss community wellbeing, share seasonal forecasts or warnings, and encourage households to prepare for anticipated drought conditions. At the same time, the indigenous mutual support system known as ‘Buusaa Gonofaa’ promotes solidarity and collective responsibility, ensuring that households support one another during difficult times. Together, these cultural institutions foster accountability, participation, and cooperation. As a result, communities coordinate preparedness actions, support vulnerable households, and strengthen their collective capacity to cope with recurring drought.

Sierra Leone – Malaria-CHWs – social capital

Communities often provide social capital in the form of volunteer (or minimally remunerated) community-based health positions. In Kailahun District community members gathered in village meetings to select trusted individuals to work as community health workers (CHWs), which created strong trust and ownership because the community health workers were chosen from within the community and by the community itself, with the blessing of the Chief. After receiving training and being deployed, the CHWs regularly visited households, shared health information, and worked with community leaders and committees, strengthening local cooperation, communication networks, and collective action around health.

See also:

Ethiopia – Covid-19 – resource mobilisation



OPERATIONAL PROCESSES & SYSTEMS

The second domain for building resilience through CEI is focused on **equitable and responsive operational processes and systems**. This covers the structures, the functions, the mechanisms and processes through which engagement and communication happens and communities organise and respond.

There are three mechanisms in this domain:

- **Multi-stakeholder collaboration**
- **Communication and information systems**
- **Resource mobilization and management**

Multi-stakeholder collaboration

Definition: *coordinated partnerships enhance mobilisation of government, NGOs, traditional authorities & community organizations to build local resilience through better preparation for and response to crises.*

The existence and quality of partnership and collaboration platforms—from village committees to district task forces—shapes coherence, speed, and sequencing of action. In contexts with functioning, aligned coordination platforms, mechanisms to clarify roles (who does what, when) and sequence actions across actors and levels, if mutual accountability via coordination platforms and alignment of plans with local governance structures reinforce actions rather than contradict each other, then faster, more coherent preparedness and response actions are produced.

“Working with NGOs has allowed us to extend our reach and improve our response efforts for the displaced,” Town clerk, Kasese Municipality, Uganda



Uganda – validation workshop

Examples of actions

For Communities

- Initiate and participate in village disaster committees and structures, share local knowledge, and identify vulnerable households for preparedness and response.
- Form inclusive village alert teams to support early detection and rapid reporting of suspected cases.
- Use information from multi stakeholder platforms to take timely action during crises and cooperate with authorities in response efforts.

For Government

- Strengthen district disaster coordination structures and maintain transparent, regular engagement across administrative levels and with humanitarian actors.
- Formalize community engagement roles within DHMT standard operating procedures and surveillance guidelines.
- Use multi stakeholder platforms to mobilize communities, coordinate crisis response, and enhance risk communication.

For NGOs/health programmers

- Work through existing district and community coordination platforms and align interventions with district plans and local leadership.
- Broker sustained relationships between researchers, district authorities, and community governance structures using embedded local facilitators.
- Support or establish multi stakeholder platforms that enable sustained community engagement in preparedness and crisis response.

For Funders

- Invest in long term partnerships that strengthen local governance structures and coordination platforms linking communities, authorities, and civil society.
- Prioritize funding for sustained, embedded facilitation teams rather than short-term consultative visits or rapid project cycles.
- Provide resources to governments and NGOs to maintain multi stakeholder platforms that ensure meaningful community engagement in crisis response.

Suggested indicators

- Evidence of functioning communication platforms or networks and escalation pathways mandated by national policy.
 - Meetings records, observation, Kkey informant interviews
- Evidence of functioning multistakeholder coordination mechanisms – with evidence of joint planning, strategies, actions and review (e.g. committee, platform, cluster).
 - Meetings records, observation, key informant interviews
- # of joint meetings held between community reps, government, NGOs, faith actors, traditional authorities.
 - Key informant Interviews, observation, records
- # of collaborative agreements reached and/or actions implemented from meeting decisions.
 - Key informant Interviews, observation, records
- Documented roles and responsibilities for disaster management – from national, sub-national and local structures.
 - SOPs, guidelines
- # of joint initiatives or co-delivered actions (e.g., early warning, referral pathways).
 - FGDs, in-depth interviews
- Stakeholder appraisal of collaborative actions
 - Surveys with Likert scales; interviews/FGDs on perceived inclusiveness, transparency, responsiveness.

Case examples

Uganda – flood and drought – multi-stakeholder collaboration

In Kasese and Katakwi districts, responses to floods and drought involve collaboration among community leaders, district authorities, NGOs, and humanitarian organizations. Existing governance structures such as Local Council level 1 leadership, village disaster committees, and district technical departments serve as coordination platforms where information is shared and response activities are aligned. NGOs and other partners with established presence in these districts work through these platforms alongside local leaders and community representatives. These structures help identify vulnerable households, disseminate warnings, and coordinate actions across sectors including agriculture, water, and health. Because coordination occurs through familiar and legitimate local systems rather than externally created structures, people in study villages perceived joint planning as credible and efficient. This improves information flow, reduces duplication of activities, and supports more coherent responses during floods and drought.

Sierra Leone – Lassa fever – multi-stakeholder collaboration

In Kenema, the research team established operational coordination platforms to address fragmented vertical structures that had limited connectivity between biomedical and community systems. Embedded CEI facilitation teams comprising CHWs, frontline health workers, and volunteers were positioned at chiefdom level for approximately three months to serve as intermediaries between communities and formal health authorities. Standardized reflection templates were developed through which these teams documented community concerns, feeding into monthly reflection meetings between the district health authorities, the US-Lassa programme staff and local hospital staff, where operational implications were discussed. Community representatives were enabled to participate directly in district coordination platforms, and negotiated role clarification between

chiefs, CHWs, and surveillance officers was brokered to resolve tensions around authority and accountability. This multi-level architecture enabled rapid operational adjustments, such as pre-referral family engagement to address resistance, sustained coordination, improved surveillance responsiveness, and operational coherence across district, chiefdom, and community levels; that transitioned from externally facilitated project to community-led practice with institutional integration.

Ethiopia – Covid-19 – multi-stakeholder collaboration

In Jimma zone, the Covid-19 initially created pandemic, fear and misinformation which hindered preventive actions. The establishment of Emergency Response Task Forces at various government administrative levels, followed by the formation of Jimma Emergency Response Center (JEOC), which coordinated and organized response activities, provided a structured framework for collaborative Covid-19 response. Building on Jimma University’s long-standing community partnerships and the trust established through its community-based education and peacebuilding initiatives with religious and cultural leaders, the JEOC effectively mobilized local participation. It organized teams focused on case management, rapid response, risk communication, and surveillance, fostering community engagement in awareness and early case detection. Using respected local figures, including traditional and religious leaders, the JEOC conducted awareness campaigns. Strong political commitment and inter-sectoral collaboration enabled effective communication, planning, and action across sectors. By leveraging communities’ respect for local leaders, these coordinated efforts improved trust, awareness, and participation in preventive measures, ultimately enhancing community acceptance and adherence to Covid-19 response strategies.

See also:
Madagascar – cyclones – communication and information systems

Communication and information systems

Definition: Multi-channel co-created communications are effective at sharing and coordinating information & supporting long-term disaster-preparedness and response.

The form, timing, and framing of communication determine how people

interpret risk and what they feel compelled to do. If communication is timely, trusted, co-created, reflects community feedback and delivered by trusted messengers, then the information and messages are better understood and perceived as salient and efficacious, which drives earlier and more appropriate action.

Examples of actions

For Communities

- Share and maintain trusted communication channels with external agencies, engage in dialogue platforms, and act early on warnings from respected leaders.
- Participate in joint learning and response activities (e.g., vector tracking for malaria), using new knowledge to adapt local practices and strengthen resilience.

For Government

- Coordinate with NGOs and community structures to identify trusted communication channels, work with traditional leaders in early warning systems, and ensure communities have the resources needed for crisis response.
- Replace one way messaging with participatory communication approaches (forums, radio call ins) and integrate community generated insights into national planning and preparedness strategies.

For NGOs/health programme implementers

- Use trusted community communication channels, address barriers to preparedness, and work with local leaders and messengers (elders, HEWs, ADAs) to deliver clear early warning information.
- Support reciprocal, contextualised communication through training and joint activities, and recognise how participatory research (e.g., malaria vector tracking) shifts community understanding and behaviour.

For Funders

- Allocate sufficient resources for grantees to identify and use trusted communication channels, and to support immediate crisis response alongside longterm risk reduction.
- Invest in communitybased communication systems, trusted local messengers, and the wider rollout of participatory approaches that strengthen local action and resilience.

Suggested indicators

- Evidence of functioning communication platforms or networks and escalation pathways mandated by national policy.
 - Meetings records, observation, KII
- Evidence of functioning multistakeholder coordination mechanisms – with evidence of joint planning, strategies, actions and review (e.g. committee, platform, cluster).
 - Meetings records, observation, KII
- # of joint meetings held between community reps, government, NGOs, faith actors, traditional authorities.
 - Key informant Interviews, observation, records
- # of collaborative agreements reached and/or actions implemented from meeting decisions.
 - Key informant Interviews, observation, records
- Documented roles and responsibilities for disaster management – from national, sub-national and local structures.
 - SOPs, guidelines
- # of joint initiatives or co-delivered actions (e.g., early warning, referral pathways).
 - FGDs, IDIs
- Stakeholder appraisal of collaborative actions
 - Surveys with Likert scales; interviews/FGDs on perceived inclusiveness, transparency, responsiveness.

Case examples

Madagascar – cyclone – communication and information systems

When the meteorological office issues cyclone warnings district authorities are notified. They liaise with long-standing NGO partners and local authorities at the village level to support preparedness actions. The presence of embedded partners has built trust and a willingness among people to engage with them. Training and support (from NGOs) offered to minimise post-cyclone flooding risks was readily taken up, as was support for the cyclone early warning system. The sharing of timely meteorological communication preceding and during a cyclone, triggering the early warning system, has led to timely community mobilisation and an effective response to the cyclone. Embedded NGOs and local authorities communicate with community using coloured flags, megaphones, and whistles, asking people to stay in their houses, while constantly listening to information on radio about the progress of cyclone. NGOs provide radios to households who do not have them. These combined approaches were trusted and observed to work by communities who put the preparedness actions into practice. This led to an observed reduced death rate during cyclones, increased community resilience (e.g. management of food) and increased community trust towards the supporting NGOs and local authorities.

Sierra Leone – Lassa fever – communication and information systems

In Kenema District, previous Lassa fever risk communication relied on one-way health talks and outbreak announcements allowing no feedback or discussion of concerns. Study researchers established participatory dialogue platforms which fundamentally changed information flow. Village forums, radio call-in programmes, and facilitated question-and-answer sessions replaced didactic instruction with reciprocal interaction. Community members articulated fears, rumours and lived experiences directly to health workers and researchers, who responded in real time to clarify misconceptions and contextualise medical procedures. This two-way communication enabled mutual learning: communities revised their understanding of isolation, referral, and treatment, while health actors gained insight into social consequences of their practices. As participatory communication became routine and community input visibly shaped response messaging, trust was reinforced. Communities saw their questions reflected in modified health messages as proof that engagement was genuine, strengthening confidence in health authorities. The result was sustained community engagement, increased voluntary care-seeking, improved cooperation with surveillance, and reduced misinformation in previously resistant villages.

See also:

Ethiopia – drought – trusted leaders

Sierra Leone – malaria-Science Shops – Universities as enablers

“When they [elders] notice that the water volume in the river is swelling, they begin to alert the rest of the community by hitting drums [...] and those with megaphones begin alerting people.” District Technical Official, Kasese District, Uganda)



Community members and leaders at a workshop to discuss flood and cyclone responses, Madagascar

Resource mobilization and management

Definition: the coordinated mobilization of internal resources and strategic engagement with external support builds resilience.

Material resources and flexible delivery models determine whether local

healthcare and response systems bend or break under stress. In contexts where resources are pre-positioned and delivery models are flexible, if rapid adaptation and continuity of resources can be mobilised, then protection of essential services and reduction of harm is realised.

Examples of actions

For Communities

- Strengthen oversight and accountability for community health funds, participate in sensitisation, and support transparent VHCmanaged costrecovery schemes.
- Mobilise local resources and networks to support vulnerable households and respond to crises, including approaching trusted NGO partners when additional needs arise.
- Engage proactively in early warning, preparedness, and resiliencebuilding activities that enhance local capacity to cope with shocks.

For Government

- Strengthen national and district supply chain systems for malaria commodities, including establishing buffer stocks at multiple levels.
- Institutionalise and fund local support mechanisms for vulnerable groups, and coordinate with NGOs to reach hardtoreach communities.
- Facilitate longterm NGO presence and integrate communitygenerated insights into planning and crisis response.

For NGOs/health programme implementers

- Promote participatory decisionmaking in health financing, support CHWs and VHCs with training on supply chain and financial accountability, and strengthen lastmile distribution.
- Leverage local social networks and trusted community structures to ensure equitable crisis support and effective communication.
- Make longterm commitments, build trust, and be guided by communityidentified needs, knowledge, and resources.

For Funders

- Provide sustainable financing for CHW programs, malaria commodities, and supply chain strengthening, including digital logistics systems.
- Support government and NGO efforts to improve livelihoods and resilience among vulnerable groups, enabling flexible crisis response.
- Commit to longterm, flexible funding that incentivises NGOs to partner closely with communities and adapt to emerging local needs.

Suggested indicators

- Presence of communitymobilized resources (funds, labour, equipment, transport, facilities).
 - Best available evidence e.g. from interviews, FGDs, survey
- % of households receiving livelihood or preparedness support during crises.
 - Survey
- Nature and examples of community contributions (in-kind, voluntary hours, cash, testimonies).
 - Interviews, FGDs, surveys, stories
- Examples of partnerships established for livelihood protection (cooperatives, business associations).
 - Surveys, qualitative methods
- Evidence of rapid mobilisation of resources during emergencies.

“Community organizations helped distribute essential supplies like masks and hand sanitizers to those in need. They also organized volunteers to provide assistance with tasks like grocery shopping for vulnerable individuals who couldn’t leave their homes.” Key informant, Seka

Chekorsa District, Jimma, Ethiopia



Local goods, Sierra Leone

Case examples

Sierra Leone – Malaria-CHWs – resource mobilisation

Decentralised CHW-led malaria services in Kailahun district improved timely access to malaria treatment, bringing testing and treatment closer to communities. Through Village Health Committees, communities established small cost-recovery schemes where households pay meagre fees to procure malaria drugs which are supplied by a local drug store owner during stock-outs to CHWs and their local health facility. This community-managed fund and supplies enabled CHWs to maintain the availability of essential malaria commodities and provide prompt treatment. As a result, communities experienced reduced delays in accessing care, improved continuity of malaria case management and strengthened the feeling of local ownership of health services which reinforced peoples’ trust in using them.



Ethiopia – Covid-19 – resource mobilisation

Trusted community members—such as community leaders, religious leaders, Abba Geda’s, and Hadha Siinqees—work alongside local government to strengthen cultural norms of mutual support during crises and mobilise resources to ensure that assistance reaches vulnerable groups. Local leaders help coordinate efforts with established community structures, enabling effective identification of households in need. The local administration further supports this process by assigning selected community volunteers, women group leaders, household group leaders, and health extension workers to identify and prioritize vulnerable individuals. Through collaboration across sectors, task forces, religious leaders, and community volunteers collectively mobilize resources using their social networks. This coordinated effort ensures fair and equitable distribution of food and essential items. Overall, in the study areas of Jimma zone these combined actions helped protect atrisk households, prevent the spread of the virus and reinforced community resilience and solidarity.

See also:

Madagascar – cyclone – embedded and equitable partnerships

Houses built on stilts to protect from flooding in Madagascar

LEARNING AND CAPABILITY DEVELOPMENT

This third domain for is focused on **actions and approaches that build and sustain long-term capacity for resilience and learning**. The CEI mechanisms in this domain concern how to embed institutional and social learning on equitable partnerships and adaptive capacities to sustain services and resilient crisis response.

Institutional learning and adaptation

Definition: Internal feedback and learning loops, reinterpreting “non-compliance” (from the community perspective) and institutionalising the codesign of crisis response-actions can achieve procedural change that builds trust and resilience.

- There are four mechanisms in this domain:
- Institutional learning and adaptation
 - Embedded and equitable partnerships
 - Social Learning for engagement
 - Universities/institutions as community enablers

Where institutions embed community engagement and involvement practices into their ways of working, they strengthen relationships and trust, and build system- and institution-level capacity to respond to community feedback and experiences. If institutions ensure CEI is practiced, embedding reflection and learning, this then enables institutional systems to transform to better understand the perspectives of and better meet the needs of communities, which leads to better engagement with the health system and to improved health outcomes.

“This is the first time the doctors came to listen, not to tell us we are wrong.” (elder, Kenema District, Sierra Leone)

Examples of actions

For Communities

- Request opportunities for giving feedback and for dialogue with service providers

For Government

- Work to institutionalise feedback and reflection sessions into service delivery and community engagement processes

For NGOs/health programmers

- Seek feedback, and work to ensure that this feedback is systematically reflected upon
- Capture and embed learning and insights from this reflection

For Funders

- Invest in institutionalising the capturing and systematic reflection on community feedback: human resources, feedback and information management systems, infrastructure and processes for reflecting and learning

Suggested indicators

- Examples of adaptive changes/responsiveness made to community procedures based on learning e.g.
 - Number/nature of new practice procedures/protocols, revised engagement guides
 - Existence of feedback and reflection mechanisms.
 - Evidence of a feedback, reflection and learning process;
 - Written records of reflection meetings undertaken;
- Evidence of actions generated as a result of these reviews e.g. from interviews/observations.
- Community satisfaction with institutional responsiveness.
 - Satisfaction surveys;
 - Number of community complaints.
- Budget allocation for feedback and learning processes.
 - Existence and utilisation of budget line for this process.

Case examples

Sierra Leone – Lassa – institutional learning

In Kenema District, clinical and surveillance practices at the Lassa fever hospital and the district health management team had previously focused mainly on standardised biomedical protocols with limited incorporation of community experience. The introduction of regular, facilitated reflection sessions brought together nurses, surveillance officers, researchers and district officials to review community feedback and testimonies. Exposure to these perspectives activated reflexive reasoning, reframing perceived non-compliance as rational responses to communication gaps. Institutional actors became more willing to adapt practices, shifting from rigid, top-down messaging to empathetic, context-sensitive communication. Narratives about isolation and family separation fostered institutional empathy, prompting procedural changes such as clearer

referral explanations, revised patient information materials and family-inclusive pre-isolation counselling. These adaptations reduced confrontation and improved cooperation. As reflexive learning became embedded, community feedback informed coordination meetings and operational planning, creating iterative feedback loops. This adaptive process strengthened perceptions of responsiveness and accountability, enhancing trust, institutional legitimacy and the overall flexibility of the Lassa fever response system.

See also:
Sierra Leone – Malaria-Science Shops – universities as enablers
Ethiopia – Covid-19 – multi-stakeholder collaboration
Sierra Leone – Malaria-CHWs – resource mobilisation

“We realised we were answering questions people were not asking. The science was correct, but it did not touch their experience.”

(Lassa fever clinician, Kenema District, Sierra Leone)



Discussions of Covid19 response actions, Ethiopia

Embedded and equitable partnerships

Definition: Long-term presence of NGOs, equitable partnerships of locals & external responders, delegation of decision-making authority, and commitment to skills-building support long-term resilience

Where NGOs have been present for many years, they are better known, more trusted and they often enjoy good relationships with community members and groups. Additionally, they often have a good understanding of local social

norms, beliefs, power dynamics, trusted & legitimate leadership and the presence and role of community groups and structures. Their local presence and good community relationships can be leveraged by external actors to improve access to services, or to offer support during a crisis. If this can enable working in partnership with communities, then it leads to more effective support and more equitable community engagement to meet local needs and build local resilience capacities for the long-term.



Interviews on community response to Covid19, Ethiopia

Examples of actions

Communities

- Engage with NGOs whom you have come to trust, articulate your needs to them

For governments

- Facilitate NGOs to have a long term and strong local presence
- Strengthen collaboration between all actors

For NGOs/ health programmers

- Be prepared to make long term commitments to communities
- Invest in a strong local presence and in building trust
- Work to ensure equitable engagement from communities
- Work through local structures and systems as much as possible

Funders

- Provide long term support for NGOs and incentivise them to maintain a strong local presence
- Invest in ensuring equitable community engagement (such as gender transformative programming)

Suggested indicators

- Evidence of government and donors engaging and coordinating with embedded NGOs and community structures
 - Record of all locally present agencies (NGOs, government agencies)
 - Documentation of formal long-term engagement with NGOs (such as MoUs, partnership agreements, SLAs etc)
 - Documentation of community groups and structures
 - Evidence of coordination activity at local level, such as regular coordination meetings
- Evidence of effective and equitable community engagement
 - Record of joint planning and decision making
 - Community member satisfaction with their engagement and involvement (survey interviews/FGDs)
 - Presence of specific strategies to ensure equitable engagement

Case examples

Madagascar – Cyclone – embedded and equitable partnerships

NGOs who have been working in a region for a long time develop a good understanding of local communities. When they are willing to listen and respond to community needs, their work is more impactful and they build trust. When such an NGO saw that poor natural resource management practices caused persistent mangrove destruction and depleted fish stocks, they approached local leaders to ask if they could help. Local leaders were willing to work with them to mobilise local labour to help with mangrove restoration and riverbank protection. Communities negotiated material support (household goods) in return for their labour. These efforts, together with long-term support from the NGO for better natural resource management, enabled villagers manage marine resources more sustainably (both mangrove forests and fisheries), resulting in noticeable improvements to fish stocks (meaning better food and financial security) and better protection from cyclone wind damage (protecting life and livelihoods).

Uganda – flood and drought – embedded and equitable partnerships

In Kasese and Katakwi districts, NGOs such as the Red Cross and SOCADIDO maintain long-term partnerships with communities and district authorities. These organizations work through established governance structures including Local Council level 1(LC1) leadership, Village Health Teams, disaster committees, and community groups. Through training, technical support, and joint planning

processes, external partners strengthen community capacity to interpret climate risks, adopt adaptive practices, and coordinate preparedness activities. Because these organizations maintain sustained engagement and collaborate closely with trusted local leaders, communities perceive them as legitimate partners rather than external actors. This enables continuous knowledge exchange and strengthens the ability of communities and local institutions to adapt to changing environmental conditions. These embedded partnerships therefore contribute to long-term learning and the development of durable resilience capacities.

Ethiopia – drought – embedded and equitable partnerships

In contexts of drought-related health stress, patriarchal gender norms, and limited household resources, the presence of health extension workers, women development armies, fathers' groups, and supportive NGOs provides platforms for inclusive health engagement and trusted service delivery. When men and women are actively engaged in health and nutrition activities and see the benefits of preventive actions, men's understanding of shared household responsibility increases and support for women's participation strengthens, leading to improved health-seeking behaviours, including timely vaccination, nutrition screening, and greater uptake of preventive and promotive health services during drought.

See also:

Madagascar – cyclones – communication & information systems

“They [embedded NGOs] do not come only when there is a camera. They have been with us even when no one was watching.”

Village resident, Kasese District, Uganda



PARES researchers share learning at Eastern Technical University, Sierra Leone

Social learning for engagement

Definition: Survivor testimony, visibility of recovery & sharing of positive health-seeking and treatment experiences provide “seeing is believing” evidence that health-sector engagement is beneficial.

Visible recovery provides social proof of successful treatment; when community members share positive treatment experiences (including through survivor

“At first, I was not sure about the CHW, but when my neighbour’s child was treated and recovered, and the chief kept talking about it, I started trusting him.”

Mother in Gooh, Kailahun District, Sierra Leone



Sharing findings on indigenous knowledge and learning in flood and drought response, Uganda

testimonies or community discussions) they provide hope and normalisation of treatmentseeking. If there is public sharing of positive experiences via trusted platforms, then social learning can be triggered which shifts normalised beliefs from “care leads to death/shame” to “care can work,” which in turn shifts behaviour towards early engagement with healthcare systems as beneficial.

Examples of actions

For Communities:

- Create or extend platforms for deliberation and planning of required community action
- Approach government services or NGOs to provide support for deliberation platforms and community action

For Government:

- Acknowledge and support social structures and learning capacity of communities.
- Allow space for sensible, locally supported adjustments of national policies and regulations.
- Provide community-level basic funds for establishing independent community action

For NGOs/health programmers:

- Participate in community programmes as much as having communities participate in health programmes

For Funders:

- Support independent community action through non-earmarked funds

Suggested indicators

- Evidence of community initiative for dialogue and dissemination
 - testimonies, community recognition of improved outcomes *qualitative*
- Evidence of community initiative for seeking support from health system
 - trust in accessing referral or support services. *Qualitative/survey, IDIs*
 - Increase in referrals or service uptake after survivor-led sessions *clinic records, survey*
- Recognition of local knowledge and community wisdom to overcome barriers for effective emergency relief and sustained health care
 - transport, stigma, gender norms, safety concerns. *Qualitative stories, IDIs, FGDs*



Discussions of how women cope with drought and nutrition in Ethiopia

Case examples

Sierra Leone – Lassa – social learning

In Sierra Leone, there are regular but scattered outbreaks of Lassa fever, an acute viral haemorrhagic illness. In Kenema, a major city in the east of the country, a Lassa ward is part of the Kenema Government Hospital. However, connections between the facility and local communities were overall poorly developed. An initiative to improve this triggered further social learning in the communities where engagement activities were employed. Community engagement teams facilitated survivor participation in outreach activities. Survivors became community messengers, sharing testimonies during dialogues, radio programmes and religious gatherings about treatment, recovery and reintegration. Respectful care and recovery stories created reinforcing feedback loops. Community engagement teams and health workers highlighted examples where community reporting led to timely action. Motivation for participation sustained beyond immediate outbreaks through continued dialogue attendance, ongoing surveillance collaboration and household preventive practice adoption.

Sierra Leone – water insecurity – social learning

In Bunumbu, a village in Kailahun District, communities were dealing with poor drinking water facilities. Water treatment plants and piped water supply systems, introduced several decades ago, have deteriorated. When these systems still functioned, people neglected traditional water wells. A severe outbreak of diarrhoea in 2002 created an immediate crisis. People then began to put pressure on their Paramount Chief which triggered his action to report the sicknesses to the DHMT in Kailahun Town. The chief also began to engage and arrange outside help (e.g. chlorine for wells). Community leaders also approached the staff at the peripheral health unit facility (PHU), who undertook health education activities for prevention and control of water-borne disease, teaching people about how

to prevent diarrhoea (hand washing, boiling the water and also chlorinating the drinking water). The interactions with the PHU created increased awareness of water borne diseases and hygiene practices and also reduced people’s hesitation to seek advice from PHU staff so that people reported more promptly to health facilities.

Sierra Leone – traditional-biomedicine tensions – social learning

Practices of traditional healers are often portrayed as unsophisticated and dangerous. However, their role in the community is often better understood as a pivot in social health learning. Our study on this topic in rural Sierra Leone showed that there is gradient of widespread knowledge about herbal medicine among the people, more specialised knowledge of traditional healers and the health staff of peripheral health units (PHU). An example is the way bone fractures are treated. In case of a fracture, family members collect herbs and rub it over the painful spot. If severe pain continues, they will consult a local ‘bonesetter’ who can offer treatment for several types of fractures. Past experiences of bonesetters being unable to control infection means that today in case of severe fractures and open wounds, bonesetters will refer to PHU staff for further treatment or hospital referral. These incidences thus are reminders for people to maintain their knowledge of herbal medicine as well as learning about how the local health system operates, combining traditional treatment and formal health care. Cooperation, therefore, is based on mutual respect reflecting greater mutual knowledge of capabilities.

See also:
Sierra Leone - Malaria-CHWs - trusted leaders

“In my experience as a lecturer in Bunumbu, universities are key enablers in water security by working alongside communities as partners rather than subjects.” Retired lecturer, Bunumbu, Sierra Leone

Universities as community enablers

Definition: Through promotion of CEI best-practice and embedding CEI in research & teaching, resilient community responses can be brokered and triggered by staff and programs from universities and other research institutions.

If researchers respond to acute health challenges through equitable interaction with local people and a commitment to co-creation, and this facilitates pooling of knowledge and co-creation of locally sustainable solutions, then transformative social and institutional learning is enabled.



Science shop activities on mosquito trapping, Sierra Leone

Examples of actions

For Communities:

- Approach local universities for inclusion of practice-based learning and community-based research on community resilience.

For Government:

- Strengthen the community service role of universities through curriculum change and research capacity for community-based research. Liaise to international networks for citizen science and community-based organisation, e.g. <https://livingknowledge.org/>

For NGOs/health programmers:

- Include university staff and students in response and prevention activities.
- Strengthen research capacity of NGOs through setting up research activities in collaboration with local and international universities

For Funders:

- Earmark funding for community-based research, different from research with community impact

Suggested indicators

- Community leaders know where to go for research
 - Qualitative interviews/focus groups and surveys
- University students are trained in community-based research
 - Curricula review
- Universities facilitate joint problem definition with communities
 - Activities review
- Universities have a policy for transdisciplinary research
- Research-based solutions are used in the community and supported by community health workers



Case examples

Sierra Leone – Malaria-Science Shop – universities as enablers

A Science Shop employs the research capacity of universities in support of communities. In Bo district, Sierra Leone, communities wondered why malaria remained present despite the provision of bed nets and indoor residual spraying. Further study requires comprehensive engagement with the process of disease transformation, in a way that communities can witness and participate research activities. This was done through investigating the mosquito cycle, using traps to catch mosquitoes, explanatory sessions highlighting differences between mosquito species, and searching for breeding sites to catch larvae. Caught larvae were kept in small cages to observe transformation into mosquitoes. Mosquitoes were also tested on presence of plasmodium. This requires laboratory analysis that until now can only be done outside villages. However, small portable test kits are available and shown to the community, allowing on-site analysis. The transparent, on-site research process showed that communities felt engaged and were motivated to participate over an extended period by a belief that they were making progress towards solving the problem of malaria using their own enhanced knowledge as a base.

Sierra Leone – water insecurity, universities as enablers

The researcher – a member of staff of the university, and keen to lay a good foundation for cooperation between future neighbours – asked a representative sample of stakeholders in the village to review the history of water supply in *Bunumbu*. They once had a piped water supply built with French aid in the 1960s. There was no provision for maintenance or training of technicians. The scheme eventually collapsed, and pipes and equipment were stolen. As villagers told the sad story of the decline of the Degremont scheme and the subsequent lack of maintenance and replacement, terminating in an outbreak of cholera, people began to see the events in a new light. They realized that due to a failure to

maintain the earlier pipe borne scheme they had been reduced to relying on the chief's well (a spring under the hill behind Bunumbu). Because of widespread of gastro-intestinal infections from well water, they now recognized they needed to keep this source clean, organized to enact by-laws, and used fees from fines to pay for water supply monitors. This kicked into life a virtuous circle. The Paramount Chief was able to engage external help, and the researcher worked with staff of the local Peripheral Health Unit to focus more on outreach regarding water and health. One issue under discussion (as of March 2026) is publicly posting regular figures on monthly infections with gastro-intestinal disease. Posting figures on infection proved a powerful tool for motivating good local participation during the Ebola epidemic (2014-15), and the hope is that this can be extended to water supply protection.

Ethiopia – Covid-19 – universities as enablers

Jimma University has a strong commitment to community service. Besides a medical centre, all university programmes have incorporated community-based learning activities, bringing students to surrounding villages for several periods during their training. For this reason, the university was a central actor in the response to Covid-19. The university headquartered the Jimma Emergency Response Center (JEOC), together with the Jimma Zone and Jimma Town Health Office. The community service of the students was turned into dissemination of knowledge and action for Covid prevention and diagnostics. Volunteer groups included returned university students, who actively promoted hygiene practices and establishing WASH facilities. They also supported law enforcement efforts, working with community police to encourage adherence to the recommended preventive measures. Moreover, Jimma University Community Radio was utilized to provide continuous information by inviting health professionals to inform the community about the virus and prevention methods. This radio station broadcasts in the local language and reaches over one million listeners in Jimma Town and the surrounding areas, covering a 120 km radius.

To what outcomes do PARES CEI mechanisms contribute?

Across our case studies we observed seven different types of outcomes that the PARES CEI mechanisms appear to contribute to:	2. Coordinated, cohesive social action and collective ownership
Timelier & more effective response to crises (outbreaks, floods, cyclones etc.)	3. Improved continuity & quality of essential services
	4. Better health and wellbeing outcomes
	5. Better social outcomes (social protection and livelihoods)
1. Greater legitimacy and trust in crisis responders (of all kinds) and their actions	6. Greater knowledge sharing, learning and adaptive capacity

The table below shows the number of case studies that the outcome occurs in and some case examples of each outcome.

Table 2: Outcomes observed arising from PARES CEI mechanisms

Outcome type and strength of evidence	Case examples (links to cases can be accessed from the list opposite)
1. Timelier & more effective response (8 case studies) (34 mechanisms)	Ethiopia – drought – trusted leaders; Uganda – drought – trusted leaders; Uganda – flood – knowledge alignment; Madagascar – cyclone – communication systems; Sierra Leone – Lassa – communication systems; Uganda – flood & drought – multi-stakeholder collaboration; Sierra Leone – Lassa – multi-stakeholder collaboration; Sierra Leone – Lassa – social learning
2. Greater legitimacy & trust (8 case studies) (41 mechanisms)	Sierra Leone – malaria-CHWs – trusted leaders; Sierra Leone – Lassa – trusted leaders; Ethiopia – drought – knowledge alignment; Sierra Leone – traditional–biomedicine tensions; Madagascar – cyclone – communication systems; Uganda – embedded partnerships; Ethiopia – Covid-19 – resource mobilisation; Sierra Leone – Lassa – institutional learning
3. Coordinated, cohesive social action & collective ownership (8 case studies) (29 mechanisms)	Uganda – drought – trusted leaders; Madagascar – cyclone/post-cyclone – social capital; Uganda – drought & flood – social capital; Ethiopia – drought – social capital; Sierra Leone – malaria-CHWs – social capital; Madagascar – cyclone – embedded partnerships; Uganda – embedded partnerships; Ethiopia – Covid-19 – resource mobilisation
4. Improved continuity & quality of essential services (4 case studies) (18 mechanisms)	Sierra Leone – malaria-CHWs – trusted leaders; Sierra Leone – malaria-CHWs – resource mobilisation; Sierra Leone – traditional–biomedicine tensions; Ethiopia – drought – embedded partnerships
5. Better health & wellbeing outcomes (5 case studies) (22 mechanisms)	Sierra Leone – malaria-CHWs – trusted leaders; Sierra Leone – Lassa – communication systems; Sierra Leone – traditional–biomedicine tensions; Madagascar – cyclone – embedded partnerships; Sierra Leone – Lassa – social learning
6. Better social outcomes (social protection & livelihoods) (5 case studies) (17 mechanisms)	Ethiopia – drought – trusted leaders; Uganda – drought – trusted leaders; Madagascar – cyclone/post-cyclone – social capital; Ethiopia – Covid-19 – resource mobilisation; Madagascar – cyclone – embedded partnerships
7. Greater knowledgesharing, learning & adaptive capacity (7 case studies) (11 mechanisms)	Ethiopia – drought – trusted leaders; Uganda – flood – knowledge alignment; Sierra Leone – Lassa – social learning; Sierra Leone – malaria – Science Shops; Sierra Leone – Lassa – institutional learning; Uganda – embedded partnerships

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List of case studies by country, crisis type and CEI mechanism

The documents listed below are hyperlinked. They are also available from the PARES website learning platform:

<https://www.lshtm.ac.uk/research/centres-projects-groups/pares#learning-platform>

Ethiopia

Drought

Supporting evidence

[Ethiopia – Drought – Supporting Evidence](#)

Social dynamics

[Ethiopia – Drought – Trusted Leaders and Communication](#)

[Ethiopia – Drought – Knowledge Integration](#)

[Ethiopia – Drought – Social Capital and Collective Action](#)

Learning and capabilities

[Ethiopia – Drought – Embedded and Equitable Partnerships](#)

Covid-19

Supporting evidence

[Ethiopia – Covid19 – Supporting Evidence](#)

Operational systems

[Ethiopia – Covid19 – Resource Mobilization and Management](#)

[Ethiopia – Covid19 – Multi-sectoral Collaboration](#)

Learning and capabilities

[Ethiopia – Covid19 – Universities as Enablers](#)

Madagascar

Cyclones/Floods

Supporting evidence

[Madagascar – Cyclones – Supporting Evidence](#)

Social dynamics

[Madagascar – Cyclones – Social Capital & Collective Action](#)

Operational systems

[Madagascar – Cyclones – Communication & Information Systems](#)

Learning and capabilities

[Madagascar – Cyclones – Embedded & Equitable Partnerships](#)

Sierra Leone

Lassa fever

Supporting evidence
Sierra Leone – Lassa – Supporting Evidence

Social dynamics
Sierra Leone – Lassa – Trusted Leaders
Sierra Leone – Lassa – Knowledge Systems Alignment

Operational systems
Sierra Leone – Lassa – Communication & Information Systems
Sierra Leone – Lassa – Multi-Stakeholder Collaboration

Learning and capabilities
Sierra Leone – Lassa – Institutional Learning
Sierra Leone – Lassa – Social Learning

Water insecurity

Supporting evidence
Sierra Leone – Water Insecurity – Supporting Evidence

Learning and capabilities
Sierra Leone – Water Insecurity – Social Learning
Sierra Leone – Water Insecurity – Universities as enablers

Malaria-CHWs

Supporting evidence
Sierra Leone – Malaria-CHWs – Supporting Evidence

Social dynamics
Sierra Leone – Malaria-CHWs – Trusted Leaders
Sierra Leone – Malaria-CHWs – Social Capital

Operational systems
Sierra Leone – Malaria-CHWs – Resource Mobilisation

Traditional-Biomedicine tensions

Supporting evidence
Sierra Leone – Traditional-Biomedicine Tensions – Supporting Evidence

Social dynamics
Sierra Leone – Traditional-Biomedicine Tensions – Knowledge Systems Integration

Learning and capabilities
Sierra Leone – Traditional-Biomedicine Tensions – Social Learning

Malaria – Science Shops

Learning and capabilities
Sierra Leone – Malaria-Science Shop – Universities as Enablers

Uganda

Supporting evidence
Uganda – Flood – Drought – Supporting Evidence

Drought

Social dynamics
Uganda – Drought – Trusted Leaders and Intermediaries
Uganda – Flood – Drought – Social Capital and Collective Action

Operational systems
Uganda – Flood – Drought – Multi-stakeholder Coordination

Learning and capabilities
Uganda – Flood – Drought – Embedded and Equitable Partnerships

Flood

Social dynamics
Uganda – Flood – Knowledge systems Integration
Uganda – Flood – Drought – Social Capital and Collective Action

Operational systems
Uganda – Flood – Drought – Multi-stakeholder Coordination

Learning and capabilities
Uganda – Flood – Drought – Embedded and Equitable Partnerships



PARES teams at their final workshop in March 2026

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For more information and resources from the PARES consortium visit our website:

<https://www.lshtm.ac.uk/research/centres-projects-groups/pares#welcome>

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