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Abbreviations:


AFRIYAN, African Youth Network; CADMEF, Association of Deans of Medical Faculties of French-speaking African Countries; COVID-19, coronavirus disease; CSO, civil society organization; CSO Initiative, Civil Society Organization Initiative; FENSA, Framework of Engagement with Non-state Actors; HCW, health care worker; HIV/AIDS, human immunodeficiency virus/acquired immunodeficiency syndrome; IPC, infection prevention and control; KPI, key performance indicator; MoH, Ministry of Health; NGO, nongovernmental organization; OAY, Organization of African Youth; PHE, public health emergency; PHEIC, public health emergency of international concern; RCCE, risk communication and community engagement; REPONGAC, Central Africa NGO Regional Network; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; SDG, sustainable development goal; WCO, WHO Country Office; WHO, World Health Organization; WHO-AFRO, World Health Organization Regional Office for Africa

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The WHO African Region Initiative on Engaging Civil Society Organizations in Responding to the COVID-19 Pandemic: Best Practices and Lessons Learned for a More Effective Engagement of Communities in Responding to Public Health Emergencies

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Abstract

Engaging communities is a key factor in efficient response to public health emergencies (PHE). Previous and recent outbreaks have shown that civil society organizations (CSOs) can mobilize the communities to better prepare and respond to a PHE. Consequently, the World Health Organization (WHO) Regional Office for Africa (AFRO) implemented an initiative to partner with community leaders by engaging CSOs. The Civil Society Organization Initiative (CSO Initiative) aims to work directly with well-established community-based organizations to accelerate whole-of-society preparation and response. Twenty-three CSOs from 12 WHO African Region Member States have been supported financially and technically to implement effective community-based interventions to respond to the coronavirus disease (COVID-19) pandemic. After 1 year of implementation (2021), the successes, challenges, and recommendations for maximizing future engagements with CSOs are outlined. As the COVID-19 outbreak is again underlining, partnering with established CSOs to engage diverse social groups from various communities can help provide a timely and efficient response to a PHE.

On January 30, 2020, the World Health Organization (WHO) declared the epidemic of SARS-CoV-2 (COVID-19) a public health emergency of international concern (PHEIC¹).² The first case on the African continent was detected on February 25, 2020. The pandemic quickly spread within the Region. In 2021, the continent was affected by at least 3 major COVID-19 resurgences. The total direct mortality and morbidity impact of the COVID-19 pandemic in the years 2020–2022 was reportedly lower on the African continent (11 895 000 reported infections and 253 000 reported deaths³), when compared with other geographical contexts.⁴ However, the pandemic has had a severe impact on the health system. It has been estimated that the disruption in reproductive, maternal and child health services, including immunization services, could lead to more than 30% additional maternal and newborn deaths. Also, the socioeconomic impact of the pandemic has had a direct impact on the rise in the prevalence of food insecurity, which was estimated in Africa in 2020 as equivalent to the 5 preceding years combined, and therefore on malnutrition rates. Vulnerable communities have been deeply impacted by this new crisis, particularly in humanitarian settings where even baseline health care access is a challenge.

The process of reaching and engaging communities remains complex and even more so during emergencies. Response operations to a public health emergency (PHE) usually rely mostly on technical and medical structures of the ministry of health (MoH) or national/international partner organizations, such as global health institutions. The role and involvement of structured community and social groups have previously been limited, although the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic has created a dynamic to better engage civil society organizations (CSOs) and communities in the response.⁵ CSOs may still appear as “untapped resources” for an effective and timely response to PHEs and notably during outbreaks.⁶ Thus, the engagement of new and non-traditional social groups is an avenue that needs to be further explored and structured. Of particular importance is the question of how to maximize the use of CSOs or other community-based resources or networks for a timely and effective response to a PHE.

CSOs are non-state actors that englobe a large diversity of organizations, including medical nongovernmental organizations (NGOs), youth activist CSOs, and community relay organizations. Some of the groups can help engage diverse communities for a major PHE response. They are well known to members of the community and the leaders have established credibility in the eyes of the local community as well as health authorities, which can, for instance, facilitate the adoption of proven public health measures, including vaccination. CSOs are linking the health authorities, humanitarian actors, and local communities.⁷ CSOs play a critical role in decision making (governance), planning, monitoring, and accountability, and can therefore accelerate whole-of-society preparation and response. CSOs also provide access to high-vulnerability groups (population within a country that has specific characteristics that make it at a higher risk of needing humanitarian assistance than others or of being excluded from financial and social services, including health access) for delivering medical and non-medical interventions, for instance, in humanitarian settings. The pre-existing community trust in CSOs improves the effectiveness of community-based response, and thus improves the whole response to health emergencies.

This study is the result of 1 year (January to December 2021) of data collection on the WHO Civil Society Organization Initiative (CSO Initiative) both at regional, national, and subnational levels. The WHO Regional Office for Africa (WHO-AFRO) has developed regular reporting mechanisms with the CSOs, including weekly coordination meetings. Interactions also included regular phone calls and email exchanges with CSO leaders and with the focal points of the WHO Country Offices (WCOs). Additionally, regional meetings with CSOs were organized and allowed for the collection of in-depth information directly from the leaders of the CSOs. Eventually, in Cameroon, Congo, Gabon, and Senegal, WHO-AFRO field missions were given the opportunity to interview ministries of health and direct beneficiaries of the project and underline the key outcomes, challenges, and proposed solutions.

Discussion

In 2019, the WHO launched a call for proposals to participate in the initiative in all the 47 countries of the WHO African Region. Proposals were reviewed at the WHO-AFRO and in WCOs, which resulted in the selection of 23 CSOs (Table 1). Criteria for selection included over 2 years of existence, legal recognition at the national and local community levels, the ability to develop health interventions (focusing on outbreaks), and the quality of the proposal (which was evaluated by a team of WHO technical and financial experts). Organizations selected had to go through several of the WHO's legal, administrative, and financial processes, known as the *Framework of Engagement with Non-state Actors*⁸ (FENSA), prior to being integrated into the initiative.

National and local organizations were engaged in 12 African countries (Figure 1; Table 2) in close partnership with the MoH and the WCOs, covering most subregions of the continent. The CSO Initiative included humanitarian and non-humanitarian settings. Additional synergy was achieved by engaging with regional CSO networks, such as the Network of National NGO Platforms of Central Africa (REPONGAC), which was active in Cameroon; Democratic Republic of the Congo and Gabon; and the Association of Deans of Medical Faculties of French-speaking African Countries (CADMEF) in Côte d'Ivoire and Mali.⁹ The local leaders of these CSOs have the experience of responding to outbreaks through the engagement of communities. This experience was built through the CSOs' response

Table 1. Civil society organizations engaged in the WHO CSO Initiative

Local and country CSOs	
Algeria:	Algerian Muslim Scouts
Burkina Faso:	Red Cross National Health Society
Cameroon:	COPAD (Coopération pour la Paix et le Développement)
	Global Care
	APSOLDD
	Collectif pour la Paix et le Développement
Congo:	Médecins d'Afrique
Gabon:	ROPAGA (Réseau des Organisations et des projets associatifs au Gabon)
	FNAPH
	Samba Mwana
	AS de Don Bosco
Côte d'Ivoire:	CADMEF
	Médecins d'Afrique (MDA)
DRC:	CNONGD (Conseil National des ONG du Développement)
	ASEPROVIC
	APDF
	LIFDED
Kenya:	Organization of African Youth (OAY Kenya)
Mali:	CADMEF
Nigeria:	GoalPrime Nigeria (GPON)
Senegal:	Badienou Gokh
	National Association of Health and Development Journalists
	National Association of Community Actors
Zimbabwe:	Dot Youth Zimbabwe
Regional CSOs	
	REPONGAC—Cameroon, DRC, Gabon
	CADMEF—Association of Deans of Medical Faculties of French-speaking African Countries
	MDA—Côte d'Ivoire, Congo, DRC, Kenya

to the HIV/AIDS pandemic, Ebola virus disease, cholera, measles, and other epidemics that affected the African continent. By engaging with new and non-traditional CSOs, diverse segments of the population could be reached, including high vulnerability groups such as the older adult population and those with disabilities.

The WHO approach to engagement involved the "3 E's" of *Engage, Enable and Empower*, with emphasis on enabling and empowering CSO members to strengthen community preparedness and response.¹⁰ The WHO-AFRO used the 3 E's to build a network of CSOs to achieve synergy and increased effectiveness through community-based approaches. Through the initiative, CSOs were engaged across 6 COVID-19 response action areas, namely coordination, risk communication and community engagement (RCCE), infection prevention and control (IPC), community surveillance, case referral, and vaccination.

The WHO-AFRO provided financial and technical support to the CSOs engaged in the initiative. The COVID-19 Solidarity Response Fund¹¹ and the WHO Foundation provided financial support to the initiative. Technical support was organized at the regional and national levels. At the regional level, a dedicated team from the WHO-AFRO COVID-19 incident management service team oversaw the support. The team comprised the COVID-19 incident manager, the regional project manager, and technical experts from IPC, RCCE, vaccination, and procurement teams (grant manager and procurement officer). At the national level, the

Table 2. Number of total beneficiaries per CSO, country, and area of intervention

CSO	Country	Total number of beneficiaries	Area of intervention
Muslim Scout	Algeria	260 000	- IPC (COVID-19 prevention kit distribution) - RCCE - Vaccination promotion
National Red Cross	Burkina Faso	3 236 973	- Surveillance - RCCE - Vaccination promotion - AHC
REPONGAC	Cameroon	40 000	- IPC (COVID-19 prevention kit distribution) - RCCE - Vaccination promotion
MDA	Congo	48 000	- IPC - WASH - Rehabilitation of health facility - Mapping - Training - RCCE
CADMEF	Côte d'Ivoire	1000	- IPC - Research on the level of COVID-19 infection among HCW - Vaccination promotion
REPONGAC	DR Congo	24 000	- IPC (COVID-19 prevention kit distribution) - RCCE - Vaccination promotion
REPONGAC	Gabon	40 000	- IPC (COVID-19 prevention kit distribution) - RCCE - Vaccination promotion
OAY	Kenya	25 000	- IPC (WASH intervention in public transport, COVID-19 prevention kit distribution) - RCCE - Vaccination promotion
CADMEF	Mali	500	- IPC - RCCE - Research on IPC among HCW
GPON	Nigeria	45 000	- RCCE - Vaccination promotion - AHC
Coalition of CSOs	Senegal	50 000	- Case referral - RCCE - Vaccination promotion
DoT Youth	Zimbabwe	30 000	- RCCE - Vaccination promotion - Vaccination access

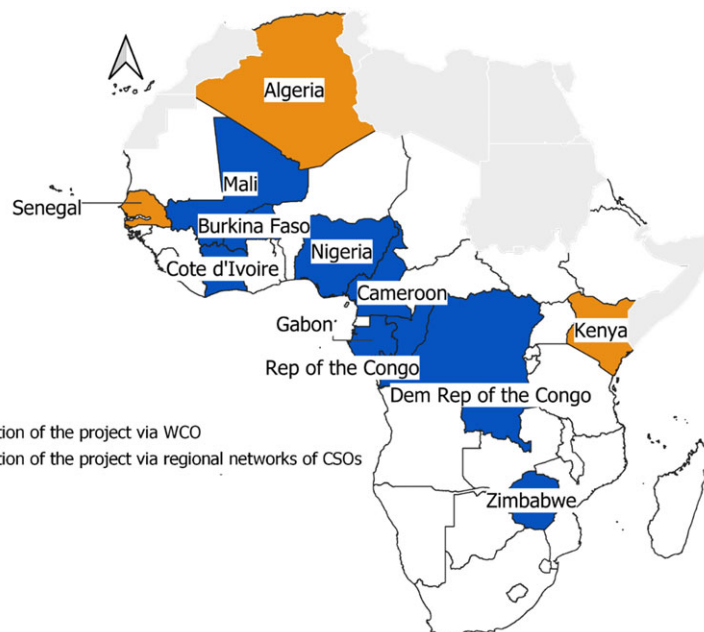


Figure 1. Twelve African nations with national civil society organizations engaged in the WHO CSO Initiative.

WCOs designated focal points of the initiative. Tailored technical support was developed, including the transmission of guidelines¹² and updates on COVID-19; the revision of training modules, other technical documents or communication tools disseminated in the communities; the organization of capacity-building sessions; and liaising with the WCOs or other partners for specific requests. WHO technical support also included regular reporting mechanisms to ensure strong monitoring and evaluation,¹³ both through technical and financial reports and weekly coordination meetings. The weekly coordination meetings were organized mainly online using the Team[®] application. During field missions, coordination meetings were organized face-to-face with the leaders of the CSOs. The technical and financial reporting included monthly reports with a form providing information on the following fields: project overview, progress status summary, the status of milestones, planned milestones for the next month, status of monitoring and evaluation indicators, outcome/impact (planned and actual), activities and progress, financial status, issues, challenges, risks, success stories and case recommendations, lessons, next steps, and recommendations. Best practices were also reported monthly using a specific form that captured the following: public health characteristics of the issues, the problem being addressed, population affected by the problem, impact of the problem, strategy engaged in addressing the issue, objectives, activities (how and where the activities were carried out—including indicators), implementers and collaborators (when and where the activities were carried out), resources, results of the activities, outputs and outcomes, assessment of implementation of the activities, discussion and conclusions, benefits to the population, contribution to other public health programs, negative adverse effects, lessons learned from implementing this activity, and recommendations.¹⁰ The weekly coordination meetings, led by the WHO-AFRO project manager and the WCO CSO focal points, saw the participation of the CSO senior management team with WHO-AFRO and WCO experts, depending on the topic of the intervention, priority, and context of evolution of the intervention.

With this support, the 23 CSOs involved in the initiative have strongly impacted COVID-19 response in the 12 targeted countries. The CSO Initiative has supported the Sustainable Development Goals¹⁴ (SDGs), more particularly SDG 3, good health, and well-being, “to ensure healthy lives and promote well-being for all at all ages.”¹⁵ Meanwhile, the initiative contributed to the WHO second “billion target,”¹⁶ which advocates for a “billion more people better protected from health emergencies.”¹⁶ The initiative is integrated in the WHO general program of work (2019–2023), including the following outcomes:

- Improved access to quality essential health services
- Countries prepared for health emergencies
- Reduced risk factors through multi-sectoral approaches

Moreover, the CSO Initiative is aligned with the WHO strategic preparedness and response plan, more precisely with the following pillars:

- Coordination, planning, and monitoring
- Maintaining essential health services and systems
- Vaccination

The impact of the initiative is measured with the 10 WHO key performance indicators (KPIs) detailed in the WHO COVID-19 strategic preparedness and response plan,¹⁷ notably:

- KPI 4: percentages of countries with at least 70% implementation of key planned RCCE activities such as development, adaptation, and rolling-out of new messages to the population and engagement of the most vulnerable groups
- KPI 9: performance of countries that realized at least 5 tests per 10 000 population per week
- KPI 19: percentage of countries with at least 70% of the general population fully vaccinated

The diverse and complementary nature of the CSOs active in the initiative has led to quality and community-based interventions in various levels of response and managed to reach 3 800 473 direct beneficiaries. Specific areas of intervention include surveillance and contact tracing, IPC at health facilities¹⁸ and at community levels, RCCE,¹⁹ community case referral, community-based operational research, vaccination promotion, and inclusive governance. As part of this initiative, CSOs have been able to respond efficiently and quickly²⁰ to health emergencies, demonstrating sound technical and operational capacities and capabilities to develop high-impact interventions at the community level according to WHO criteria. The efficiency of CSO interventions can be measured through 2 main criteria: first, the capacity to directly reach the community and hard-to-reach populations to implement tailored activities to support the vulnerable population during outbreaks, and, second, the ratio between WHO financial support to CSOs (between US \$25 000 and US \$75 000 per CSO) and the COVID-19 response outcomes in all the targeted countries. It is noteworthy that the cost of CSO interventions is far below the cost of already existing projects to respond to outbreaks. This can be explained by the lower running cost of the CSOs compared to governmental, intergovernmental, and global health agencies. The rapid intervention of the CSOs can be measured through the WHO criterion that a response should be launched in less than 48 hours after the detection of an emergency.²⁰ For the CSO Initiative, we considered the time between the agreement and financial transfer and the deployment of the CSOs. Eventually, the 23 CSOs supported by the WHO have been able to participate in the governance of the COVID-19 response in their respective countries by participating in local and national COVID-19 task forces, which foreshadows long-term and sustainable change in the approach of responding to the PHE.

For example, a tool to assess the impact and monitor attacks on health care workers (HCWs) was developed in Burkina Faso through joint action of the health cluster, including the Burkinabé Red Cross. The health cluster is a strategic and operational platform deployed in humanitarian settings with the objective to prepare for and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations through timely, predictable, appropriate, and effective coordinated health action.²¹ Red Cross community volunteers oversaw data collection in the targeted region. The outcomes allowed for adaptation of training to HCWs and health care security agents in the fragile and vulnerable central and northern regions of Burkina Faso. Sharing the results through the CSO Initiative regional platform will benefit other CSOs facing the same situation in humanitarian settings. Moreover, the community volunteers also organized information and sensitization activities on the COVID-19 epidemic, including the promotion of vaccination in targeted areas of central and northern regions of Burkina Faso in a humanitarian setting. This community-based

intervention relied on mass communication campaigns, and discussions through focus groups with community leaders (political, traditional, religious, and civil society) helped maintain and reinforce trust in public health measures for hard-to-reach populations. The financial and technical support provided by WHO-AFRO through the initiative to operational partners engaged with marginalized groups, such as people living with disabilities and people living in areas affected by a major humanitarian crisis, has contributed to impact WHO actions at grassroots levels far beyond the traditional beneficiaries of WHO actions.

Another example at the regional level is REPONGAC. Through this platform, community-based response actions were implemented in collaboration with national CSOs in Cameroon, the Democratic Republic of the Congo and Gabon. REPONGAC trained 90 focal points on risk communication and community engagement and on COVID-19 vaccination promotion. In Cameroon, REPONGAC trained 37 focal points on risk communication and community engagement and IPC to respond to the COVID-19 hotspots in Yaoundé. The focal points deployed to the 4 biggest markets of the city to inform and sensitize the population on COVID-19 prevention and vaccination. Furthermore, outreach to religious leaders in the churches and mosques included adapted information sessions. REPONGAC members also implemented IPC interventions in the hotspots, providing soap, hand sanitizers, and facemasks. The focal points managed to reach 40 000 direct beneficiaries during these interventions.

In Gabon and the Democratic Republic of the Congo, CSOs conducted observations and organized discussions with community leaders directly in the communities to collect information about knowledge, attitudes, beliefs, and practices so that communications could be better adapted to those communities. RCCE and COVID-19 epidemic key facts training based on WHO materials^{12,18} was accomplished for 30 community volunteers in each country, and they provided information to the communities in public spaces. This included mass communication campaigns and focus groups with community leaders, women, informal sector workers, and the youth. These efforts were expanded to target schools and universities. Overall, 120 000 people were reached in the 3 countries served by REPONGAC.

Partnering with medical community CSOs is fundamental to ensure that HCWs are better protected and integrated in the response at all levels. This was done through the engagement of the CADMEF network in Côte d'Ivoire (Medical University of Bouaké) and in Mali (Faculty of Medicine and Dentistry of the University of Sciences, Techniques and Technologies of Bamako). In Côte d'Ivoire, CADMEF worked on the COVID-19 infection among HCWs in Bouaké. CADMEF developed recommendations on adapted measures to better protect HCWs during epidemics. CADMEF organized COVID-19 screening for HCWs in several health facilities, reaching 1000 HCWs. The outcomes were presented to health authorities and other key stakeholders.

In Mali, CADMEF used a WHO-developed surveillance protocol for the COVID-19 infection among health workers to survey 500 medical and paramedical staff in 5 university hospitals in Bamako. The survey, produced by the senior management of CADMEF (university professors, medical doctors, researchers, and post-doctorate students) and aligned with WHO recommendations for IPC,¹⁸ was validated by the National Committee for Health and Life Science Ethics (comité national d'éthique pour la santé et les sciences de la vie—CNESS), and all the participants

signed a consent form. Nearly half of these HCWs treated patients infected with COVID-19. However, not all of them had access to personal protective equipment or knowledge of the proper sanitation protocols.

This survey highlighted the low compliance of personnel with IPC and the high risk of potential health-care-associated infections in health facilities. It also emphasized the need to scale up training on IPC measures and develop an effective IPC implementation strategy with a focus on nonclinical staff to minimize the transmission risk of COVID-19 and other health-care-associated infections in health facilities. Using the results as a template, CADMEF developed a 10-module IPC course for health workers and is pressing for national authorities to institutionalize the IPC course in the medical faculty curriculum and in every technical hygiene committee in health facilities across Mali. These high impact interventions highlight the key role of medical CSOs in the COVID-19 response.

One key partnership for engaging with the youth is the Organization for African Youth (OAY) in Kenya. As a member of the African Youth and Adolescents Network (AFriYAN), and supported by WHO-AFRO, OAY Kenya was active in developing actions to respond to the COVID-19 threat in Nairobi and Kisumu. Youth and religious leaders were informed on the pandemic and vaccination. OAY organized 20 community dialogues to inform the youth on COVID-19 risks and the benefits of vaccination. OAY organized IPC actions on public transportation, providing soap, hand sanitizer, and facemasks on the main bus lines. Young people were targeted further by several campaigns on social media, where health experts from the WHO and the MoH answered participants' questions. Over 10 000 young people participated and directly benefited from OAY support. Additionally, OAY is now integrated in a COVID-19 task force led by the MoH, opening a new opportunity for the youth to actively participate in health governance.

In Zimbabwe, Dot Youth Zimbabwe, another member of AFriYAN, was active in COVID-19 awareness campaigns targeting IPC, vaccination, as well as access to health care for the youth and disabled people in Bulawayo, the second largest city of Zimbabwe. Forty-five youth-led campaigns were conducted, including 36 online. Nearly 30 000 young people were reached through social media, thus contributing to the fight against infodemic. Infodemic, the contraction between information and epidemic, is the circulation of multiple messages in various forms focused on an epidemic that are scientifically correct and/or false, that sometimes contradict each other and whose volume and visibility have increased with the COVID-19 epidemic.²² Dot Youth Zimbabwe's efforts targeting people with disability, including those institutionalized for mental illness, resulted in the vaccination of over 900 people in Bulawayo.

In Senegal, 3 CSOs (Badienou Gokh, National Association of Community Actors, and National Association of Health and Development Journalists) participated in the initiative and engaged in jointly planning activities to respond to COVID-19. The 3 CSOs have been active in IPC, RCCE, and COVID-19 vaccination promotion at the community level in the cities of Dakar, Thiès, and Louga. In Dakar, during the lockdown, CSOs organized home visits to support vulnerable populations, which included referrals for patients in need of care and focused on women and girls. A total of 50 000 individuals benefited from these CSO interventions.

All these outcomes and best practices underline the large operational capacities and capabilities of the CSOs to respond in a

timely and efficient manner to the COVID-19 pandemic, or a future PHE, by engaging various communities, including vulnerable groups. Through the initiative, WHO-AFRO support seems to open new perspectives to partnerships with communities and thus to PHE governance mechanisms, with a more horizontal, integrated, and holistic approach.

Limitations and Recommendations

The following limitations of the study need to be highlighted. First, the CSO Initiative supported only 23 CSOs in 12 countries, which may limit the generalization of the findings. Moreover, most countries were French-speaking (9 among the 12 countries). It would have been interesting to include other countries, for instance, Portuguese-speaking countries, and compare the outcomes. Second, and due to time and financial constraints, field visits were not organized in the 12 targeted countries. This would have helped to better assess the impact of CSO interventions. Third, the study analyzed the short-term impact of CSO interventions, which impact in the medium- and long-term should also be considered. The impact of including CSOs in the governance of the COVID-19 response, for instance, with CSOs participating in the COVID-19 task force at the national level, should be apprehended in a systemic approach.

Furthermore, 8 key recommendations from the lessons learned to improve the initiative should be highlighted. First, it is important to take into consideration the specificities of the WHO African Region, particularly the epidemiological evolution of the COVID-19 pandemic with resurgence phases in most countries in 2021, the rise of variants of concern, and low COVID-19 vaccine coverage (access and acceptance). The partnership with the CSOs must integrate all those variables. The second recommendation is the adaptation of CSO interventions to the public health and security measures in each country, which reduced the number of activities on COVID-19 information and sensitization (curfew, restrictions of public gatherings, and closing of public places). The specificity of humanitarian settings in Burkina Faso, Mali, and Nigeria (fragile, conflict-affected, and vulnerable) challenged the implementation of field activities and CSOs had to adapt their field intervention. The third recommendation is to find ways to better engage local health authorities during all the phases of the initiative. It is particularly important for the sustainability of CSO interventions, given that CSOs provided direct support to the actions of local health authorities. CSOs should be well integrated into MoH PHE response plans. A CSO legal review coordinated by WHO-AFRO also showed some systemic gaps in CSO integration in countries in the region. There is need to advocate for adapted laws to ensure efficient synergy when working with CSOs in case of public health emergencies. The fourth recommendation is to improve infodemic management.²³ CSOs faced the challenge of responding to fake news, particularly online (social media) on COVID-19 and tackling vaccine hesitancy.²⁴ WHO-AFRO recommends the building of CSO capacities in this area to enable them to respond in an efficient and timely manner to rumors and fake news at the community level. The fifth recommendation is focused on WHO administrative procedures for engaging and funding CSOs. The WHO's administrative and financial procedures for engaging CSOs are dated and should be improved. Also, the procedures for engaging CSOs should be better known and understood by both WHO staff and CSO partners. Simplifying these procedures and better adapting them to the context of emergencies will provide added value. The sixth recommendation is to better support the WCOs in engaging and

interacting with CSOs at the national level. Given the governance and political dimensions of CSOs and the fact that this area of collaboration is new, some WCOs have been hesitant to support the engagement of CSOs with the WHO. The WHO-AFRO recommends more advocacy that indicates the importance, relevance, impact, and usefulness of such innovative collaboration. The seventh recommendation is to improve the coordination structure among different CSOs. Coordination between CSO interventions needs to be strengthened. A regional platform will be an asset to tackle this issue. The last recommendation is to provide capacity-building sessions for the CSOs to improve their interventions. CSOs should benefit from regular training in all the following fields: capacity building in project management, community-based surveillance, IPC, RCCE, vaccination at the community level, monitoring and evaluation, and operational research.

Conclusion

If global health institutions have learned anything about PHE in the past few decades, it should be the inevitability of future occurrences. Partnering with established CSOs can help engage communities to respond to a PHE. Global health institutions should continue to provide financial and technical resources to CSOs. The WHO-AFRO plans to scale up and improve the quality and impact of this initiative during 2022. This will include identifying additional CSOs to be engaged, reinforcing their institutional and operational capacities for reaching more people and targeting such specific groups as vulnerable people with a focus on humanitarian settings. A functional consortium of CSOs at regional and country levels will be established to strengthen coordination and enhance collaboration with all the stakeholders. At the global level, the WHO-AFRO will continue to advocate for this new area of partnership through better integration of CSOs in health governance to reinforce community participation and improve preparedness and response to PHEs.

It is also important to continue gathering data to measure the impact of the actions taken by CSOs. For example, vaccination rates in areas where CSOs engaged with the community to provide education about vaccination should be compared with the rates in areas without that intervention. Those metrics will allow researchers to determine which interventions are more successful and guide the expansion of the CSO Initiative toward more effective results. Similar initiatives in other regions should be linked to provide a consistent approach globally. By comparing successful outcomes and lessons learned in different regions in response to different crises, the approach of partnering with CSOs to engage communities can be validated.

Competing interests. None.

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