HOW CAN YOU MEASURE WHAT YOU CAN'T DEFINE? A QUALITATIVE STUDY EXPLORING COMMUNITY ENGAGEMENT AT MÉDECINS SANS FRONTIÈRES

by

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Disclaimer: this dissertation was written as part of the Master of Science of Public Health's curriculum at the Institute of Tropical Medicine (ITM). It has not been subjected to peer review. The views expressed in this document are those of the author and do not necessarily reflect those of the ITM or any other party. Possible inaccuracies, factual errors and acknowledgment of due credit to the work of others, are the sole responsibility of the author.

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Summary

Community engagement is not a new or novel idea in health programs. It rose to prominence with Alma Ata Declaration in 1978, stating that “people have the right and duty to participate individually and collectively in the planning and implementation of their health care” (1, p.3) and remains a concept lauded by global health actors, such as World Health Organization, the World Bank, and International Non-Governmental Organizations (INGOs) as the International Committee of the Red Cross, Oxfam, Médecins Du Monde, and Médecins Sans Frontières. CE is an element often mentioned as being linked to accountability, ownership and sustainability of health programs, be it disease control or quality of care, but also to social determinants of health through its empowering principles. Despite the recognition of its importance on the international health agenda, challenges remain in its incorporation in health programs.

This thesis used a qualitative, case-based approach to explore, document and analyse how “community engagement” is defined, perceived, and evaluated in the medico-humanitarian context in order to identify challenges and determine opportunities in moving towards truly integrating communities into health interventions, particularly in the case of INGOs working in LMIC.

The case study was realized within the INGO Médecins Sans Frontières (MSF). I purposively selected MSF staff from three diverse missions located in Democratic Republic of the Congo (DRC), Lebanon, and Venezuela. The missions, and per mission 2 projects, were chosen to represent a variety of different health programs (NCD, SRH, emergencies, Ebola, HIV, and vector-borne diseases), as well as diverse cultures and histories. I conducted a document review of MSF documentation and 55 semi-structured interviews. The participants represented different institutional levels, from headquarters, mission and project level. I included staff in a diverse set of roles, both medical and non-medical, as well as national and international staff. Data collection took place between January and April 2021. Interviews were conducted in French, English, and Spanish, translated and transcribed. Transcripts were coded using NVivo coding software and thematically analysed in an iterative process.

Our findings showed that in MSF institutional policy, strategic and operational documents, community engagement (CE) was repeatedly mentioned in the frame of enhancing quality of care, fostering accountability through collaborative decision-making, and empowering patients and communities in their health. While this obligation of engaging in dialogue with communities and integrating communities in project cycles was described in institutional documentation, the field reality differed greatly in health programs. Community engagement was perceived as important by all interviewees and in all contexts, but definition of what community engagement was and its objectives, as well as its process, and evaluation varied significantly. Findings show that while field projects may establish links with local communities, MSF largely remains the sole decision-maker on the medical and humanitarian content, and communities are punctually engaged, largely on terms determined by the organization. Tensions between framing communities as active participants in the project cycle or passive beneficiaries created further challenges for incorporating this approach to foster quality of care, accountability or ownership.

While MSF documentation highlights CE as a process to promote quality of care and accountability for its programs, interviews and examples from all health programs demonstrated that the importance of CE was largely – or even solely - perceived as a benefit concerning the results of the organization's activities such as access and acceptance of activities, or increase of awareness and control of disease. There is a clear ambiguity and discordance between the the utilitarian frame, as observed by the field teams and the empowerment frame, which is considered an opposite paradigm, aiming to empower communities.

Although many coordinators at project level conceptualized CE as a participatory process, they questioned the capability of the organization to work with this approach due to MSF's asymmetry of power with communities, resource prioritization, and predominant biomedical approaches. Disparities between international and national staff were identified as barriers to the success of working within the communities, among others due to the former's lack of understanding historical trauma and exclusion of certain individuals and communities.

Evaluation of community engagement was perceived as essential and possible. In the face of lack of clear responsibility, measuring community engagement was often realized by health promotion teams, and concentrated particularly on a quantitative assessment of outputs, such as frequency of meetings with stakeholders or number of people educated, and outcomes such as behavioural change, but not the process of CE.

To conclude, there is an obvious disparity between MSF institutional policy and implementation at the program level. While there is a strong acceptance of CE to be essential, data show that MSF hardly

engages with communities in a participatory process. With little prioritization of CE relative to other MSF activities, and little guidance on the process to involve communities in decision-making, and challenges in power sharing, it remains difficult for missions and projects to apply this approach in health interventions.

Should the organization be interested in improving the way they engage with communities there needs to be a concerted effort to change the way communities are viewed in their interventions, and consider the capacities they bring. While a single model of CE is not possible, the organization needs to clearly determine the rationale and process of CE prior to launching programs. In this light there needs to be training on approaches, ideologies, and objectives of community engagement at all levels of the organization. There will need to be dedicated resources placed at project and mission level to facilitate this, and a more rigorous way to monitor and evaluate CE in MSF activities.

This exploratory study contributes to the broader literature on community engagement in health programs. Particularly, it provides a new perspective, namely from the position of healthcare workers in INGO settings, on the perception of CE, together with its process, rationale, and challenges. As such, it contributes, from this perspective, to an increased understanding on how CE effects accountability towards patients and communities, as well as quality of care. In the future, it would be interesting to expand the audience of this study, including other INGO’s, with different approaches of community engagement, and, also, local population and communities, the so-called beneficiaries of INGOs, to examine their perception of level of involvement.

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List of Abbreviations

ANC Ante-natal Care

MSF Médecins Sans Frontières

CE Community Engagement

EH Environmental Health

FieldCo Field Coordinator (Synonymous with PC)

HIV Human Immunodeficiency Virus

HOM Head of Mission

HP Health Promotion

ICRC International Community of the Red Cross

IFRC International Committee of the Red Cross and Red Crescent

INGO International Non-Governmental Organization

LMIC Lower Middle Income Country

MEDCO Medical Coordinator (mission level)

MDM Médecins du Monde

MSF Médecins Sans Frontières

NCD Non-Communicable Disease

OCB Operational Centre Brussels

PC Project Coordinator (Synonymous with FieldCo)

PHC Primary Health Care

PI Principal Investigator

PMR Project Medical Referent

PNC Pre-Natal Care

PODIS Point de Distribution (distribution points)

PUC Pool d’Urgences Congo (Emergency Pool Congo)

PVVIH Personnes Vivant avec le HIV (people living with HIV)

SDG Sustainable Development Goals

SRH Sexual and Reproductive Health

UHC Universal Health Coverage

WHO World Health Organization

Chapter 1: Introduction

1.1 Community Engagement & Health

The inclusion of community[1] engagement[2] in health programs is not a new nor novel idea. The Alma Alta declaration of 1978 placed primary health care and the social determinants of health at the forefront, underlining that health interventions must be acceptable politically, socially, and economically and that health care had to be accessible to communities and their members through "full participation", challenging the – at that time - dominant biomedical paradigm of health interventions (1). This importance has been cemented with the SDGs and their focus on a participatory process in health (5). More than 40 years following the Alma Ata Declaration, community engagement has been recognized as an essential element in public health, such as disease control during epidemics, vector-borne disease, non-communicable diseases, as well as chronic disease prevention and control (6-11). It has also become a prominent topic in health research, as an essential element to include in case management strategies, but also it has its place in the ethics of research (12-15). The role of CE has also played a role in medical anthropology, and broadening the understanding of perceptions and beliefs, of a disease and related interventions, so as to raise awareness, and/or to design and adapt health intervention to the perceptions, values, and needs of a particular community (16,17). CE has become something not only to increase utilization of services, but also as an element to overcoming social determinants of health, as well as a participatory process within the frame of health as a human right (18).

CE an important element for access for access to health and utilization of services, but also when considering health system functioning. Successful approaches have been demonstrated to improve

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[1] Here we define community engagement, building on the work of Zakus and Lysack (2). Community is defined as both a geographical locale, but also a social one of shared interests, values, and identity, including epidemiological communities of those that may be more vulnerable to a particular disease. It is a group that can be classified by an outsider or by those that form part of the group itself (3)

[2] We have decided to use the term engagement synonymously with what is often expressed in literature as 'participation'. We have taken this decision as we feel that engagement better represents the dynamic social process of communities who are not passive in their health but people have the " right and responsibility to make choices and therefore, explicitly or implicitly, to have power over decisions that affect their lives" (4). In health, this coming together of people involves them identifying and implementing mechanisms to make decisions to improve their health and health care. Engagement, rather than participation, is also the terminology used at MSF.

sustainability of health programs, accountability, and quality of care (19). It has been linked as a key factor in achieve UHC (20). Contrarily, failures in understanding the process of community engagement and consequently its integration in health interventions, can have negative effects on the lives and rights of patients and communities.

CE is particularly important considering the work of INGO and large multinational bodies in the context of LMIC. Humanitarian INGOs over the past 40 years have played dominant roles in responses to famine, war, as well as epidemics, and continue to do so (21). Since 1990 NGOs and foundations have channelled billions of USD into health programs (22). This large proportion of financing spent by INGOs and international agencies calls to question issues on sovereignty and even further highlights the need for these INGOs to have the full participation of communities with whom they work.

With its prominence in the global health agenda and discourse, a plethora of health and 'humanitarian' organizations have placed CE in their policies and strategic documents. CE is included in organizational policy, technical guidance, as well as in mission statements of ICRC/IFRC, MDM, MSF, and Oxfam (23-26).

Despite the apparent consensus on the importance of CE and inclusion of this concept in health programs among the plethora of large international institutions and INGOs, challenges remain in moving from policy and theory to practice. In existing literature, various hypotheses exist to explain why, despite the recognition of the importance of CE on the international health agenda and in health programming, there are failures in its implementation. First, policy-makers and project planers often underestimate or omit the financial, time and human resources investment required to develop relationships in the communities and to include them in the project's lifecycle (27). Second, an array of definitions for CE exists with hazy understanding of objectives or rationales, conditions, and processes of community engagement pose additional challenges for its implementation and evaluation (28-30).Third, there is often an overt focus on the mechanisms of CE rather than the processes and context, including power and control. (31,32). Finally, challenges in how to define and conceptualize CE as a social process or intervention creates challenges in evaluation impact of health outcomes results in less willingness of decision-makers and those involved in health interventions to invest in the approach(7).

Existing theoretical literature outlines the barriers to effectively implementing CE and its evaluation, and studies, using various designs, have been conducted to evaluate CE in health programs, (9,10,33,34). Nonetheless, to the author's knowledge, there a paucity of research exploring and evaluating how CE is defined and perceived by INGOs, particularly humanitarian organizations, and how it is implemented and evaluated in their programs. If INGOs are to contribute to the effort to achieve universal health coverage, well-being and quality health care for all, and ensure that health interventions are sustainable, and remain accountable to their patients and communities, there is a need to better understand what community engagement is and what this process means for INGOs and the communities they work with. This gap has been addressed in this thesis in the thesis chapter four and five.

1.2 Objectives

This research sought to understand how community engagement is defined, perceived and measured by INGO operating in LMIC, in order to be able to assess challenges or opportunities in community engagement incorporation into health programs, as well as to design new approaches to measure CE process and impact in health interventions.

The research question of this study is:

> *How is community engagement perceived, implemented, and measured in the medical-humanitarian settings?*

The specific objectives are:

1. To revise in literature the various hypotheses explaining why there are failures in the 'Community Engagement' implementation, despite the recognition of its importance on the international health agenda and in health programming.
2. To describe the understandings, the objectives, perceptions, and reported implementation/process of "community engagement", from the perspective of MSF headquarters and field teams
3. To analyze and assess, in 3 field MSF programmes, community engagement in MSF activities, concerning its focus, implementation process, challenges and strengths, putting this against models of community engagement in health and disease control programs, described in literature
4. Comparing differences between MSF documentation on CE and staff perceptions of it and its implementation

1.3 Positionality

I have been an employee of MSF for over 5 years. I worked primarily as a Health Promotion Manager. This insider position both gives me several advantages, and presents risks relative to data collection analysis and interpretation of findings. These benefits and risks will be detailed briefly below.

CE has been a topic of discussion at MSF since the 2014-16 West Africa Ebola outbreak. While it has been tied to operational needs, it has been a prominent topic in the HP communities. It is through my field work as an HP that I first became familiar with the debates on CE in humanitarian interventions. This topic was again brought to the forefront of institutional debates following the response to the 2018-2020 Ebola Outbreak that occurred in North Kivu and Ituri provinces of DRC, where I was part of one of the emergency teams.

My experiences and position at MSF provide advantages for this study. For example, easier access to organization documentation, and familiarity with the organization's structure, which facilitates contacting interviewees, as well as an insider's perspective of CE at MSF.

There are also several risks. First, as a member of the organization I could be motivated to protect it. To not influence the analysis, I purposively shared findings throughout data collection with thesis coaches outside the organization, discussing my interpretation relative to the literature, and requesting feedback. My view as a white, international staff from North America also represents only one side of a multi-faceted story.

My objective with this study is not to simply criticize medical humanitarian interventions themselves or MSF. Instead I wish to approach the topic of CE with a critical perspective, and attempt to highlight inconsistencies, challenges, and tensions, with the goal of improving how communities and patients are considered in health programs led by non-state actors.

Chapter 2: Methods

2.1 Study Design

To meet the objectives stated above, I chose a case-based approach with multiple sites. MSF Operational Centre Brussels (OCB) was my case study, and the multiple sites were various missions and medical interventions that the organization is carrying out. The case study will be detailed in chapter 3.

I used two different methodologies to explore the research question. First, a review of MSF documents and international literature (scientific & grey), followed by a qualitative study consisting of in-depth semi-structured interviews.

2.2 Document Review

The review of MSF documentation included MSF policies and operational documents, as well as mission, project, medical and operational strategies. This included mission/project monitoring documents, operational quality frameworks, medical guidelines, as well as medical, health promotion, and operational knowledge base documents.

A non-systematic literature review on CE was also conducted through citation and reference tracking. I focused primarily papers addressing the nature and process of CE, frameworks on CE, and evaluating CE or challenges in evaluating CE. I included articles in English, French, and Spanish. Relevant components were used in the discussion section (chapter 5).

2.3 Qualitative Study

2.3.1. Sampling Strategy of the Qualitative Study

A purposive sampling strategy was used. Three missions/sites were chosen: Democratic Republic of Congo, Lebanon, and Venezuela. In each of these missions two projects were chosen (see Table 4). The missions were chosen for their historical and geographic diversity. Projects were selected to represent various different medical interventions. This approach was taken to allow a comparison across different contexts and medical activities, as well as to facilitate the identification of common themes across the organization's work.

A purposive sampling approach was also taken for interview participants. Participants from all institutional levels were selected, headquarters in operational and medical departments, coordination level, and project level, including managers and staff. This was to represent those that validate operational budgets, set medical guidelines, as well as those responsible for mission (country) level activities, and those at project level and most proximal to communities. I selected both medical and non-medical participants, and balanced both international and national staff (sample detailed in the following section).

2.3.1 Qualitative Data Collection Methods

We conducted semi-structured in-depth interviews between January and April 2021. Themes explored included: definition of CE, relevance of CE medical-humanitarian interventions, the objectives of CE for MSF, the process (who is involved, why, and when, decision-making, changes, over time), experience of CE in their work, evaluation of CE (process, outcome, impact). Throughout the interviews, more specific questions were raised related to challenges, opportunities, and interactions between guidelines/policies/guidance and reality of CE at MSF.

Interviews were audio-recorded with the agreement of participants, if audio-recording was not agreed only notes were taken. Due to COVID19, as well as time and resource restrictions all interviews were conducted by phone or video call. In total 55 interviews were conducted, with an average length of 60 minutes. The tables below describe the population of participants.

Table 1: Description of Participants Department or Mission

Department or Mission	Total Number
Operations Department (Brussels, Belgium)	4
Medical Department (Brussels, Belgium & Johannesburg, South Africa)	5
DRC Mission	18
Lebanon Mission	14
Venezuela Mission	14

Table 2: Description of Participants International or National Recruited

Staff Classification[3]	**Percentage (%)**
International	44
National	56

Table 3: Description of Participants by Professional Profile

Technical Profile[4]	**Percentage (%)**
Medical & Paramedical (Doctors, Nurses, Midwives, Social Workers, Mental Health, Health Promoters etc.)	68
Operational (HOM, PC, DO of Operational Cell)	28
Support Staff (HR, Finance, Supply, Logistics)	4

2.3.2 Ethics & Informed Consent

The study was approved by the MSF Ethics Review Board, as well as the review board of the Institute of Tropical Medicine's IRB, in January 2021. All participants provided informed consent prior to participation in the study.

To obtain informed consent, written consent forms were provided to all prospective participants, in English, French, or Spanish (see annex I). The PI explained the aim of the research, the risks/benefits resulting from participating in the study, as well as the possibility to withdraw from the study at any given time. If they agreed to to participate they were sent an informed consent form in containing further details on the research project and ethical procedures. When the interview was scheduled the consent form was reviewed orally.

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[3] International staff are staff recruited abroad and deployed to various countries. Also called expatriates or expats. These deployments last 6-24 months, but the average deployment was 3.5 months for OCB in 2019. National staff are staff that are recruited in the country of origin to work in their country of origin.

[4] This is the classification of profiles used by MSF OCB given the profile of an individual

Participants who had access to a printer and scanner, printed and signed their consent form before sending it back digitally. The majority of participants opted for oral consent. In this case the prospective participant was read the informed consent form, asked if they had any questions or concerns, and then asked whether or not they wished to participate. If the participant agreed, this was recorded, and a copy of the audio file sent to the participant.

2.4 Qualitative Data Analysis

Once interviews were conducted they were transcribed in the language of the interview (English, French, Spanish), then translated to English for analysis. We used iterative thematic content analysis, to code the interviews. MSF documentation was also revised and coded thematically. NVivo software was used for content analysis. Analysis of reoccurring topics and issues, were organized into patterns, and distilled into dominant themes. Themes were grouped by position within the organization, as well as mission, and health program, then compared and contrasted. Frameworks on CE proposed by Arnstein, Rocha, Rifkin, Draper, Popay, and Brunton were used in the analysis of data (4,28,35-38).

Chapter 3: Case Study

The following subsections detail the organization used as a case study in this research. Below, the background of the organization, its structure and governance will be expounded. After with the missions and projects included in the case study will be detailed.

3.1.1 Médecins Sans Frontières

Médecins Sans Frontières (MSF) is a medical-humanitarian organization that was formed in the 1971 in France by a group of medical doctors and journalists and now has over 65,000 employees, 51,000 of them locally hired and based staff, and operates in more than 60 countries (39). They self-identify as an international, independent medical-humanitarian organization providing assistance to populations in distress, and pledge in their charter to provide assistance and aid to those in distress irrespective of race, religion, creed, or political convictions, while remaining impartial and neutral (40). An essential element of the organization has been its value of *témoignage*, or bearing witness and speaking out for their beneficiaries, as well as proximity with their beneficiaries. It receives over 97% of its budget from private donors, allowing it what it terms 'independence' to act where the organization determines the need is greatest (39).

While the organization emerged as one responding to medical needs in emergencies, the portfolio of medical activities has expanded and changed over the years (41). Projects are now categorized as projects by default or projects by choice[5], and can consist of both direct projects (where MSF staff carry out medical activities) or indirect (where the organization supports other organizations or institutes). This classification is determined after a needs assessment, which is the first step in the project cycle (see Figure 1) (43). Projects are proposed either during the Multi-Year Annual Review of Operations (MY-ARO), or during a Committee Project (COPRO) set up for the redirection of resources. Following a *Humanitarian Health Needs Assessment,* a concept note outlining the target population, and main objectives, along with

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[5] Default projects are those considered as responding to peaks in morbidity and mortality, generally in epidemics, conflict, and natural disasters. Choice projects are where there is an "added value of MSF to disrupt the status quo" (42, p.5) in the response to chronic problems.

needed resources and timeline is established for project initiation. This must be validated by the Operational Directors and should be in line with the *Operational Prospects,* which are published every 3 years and detail the organization’s operational priorities.

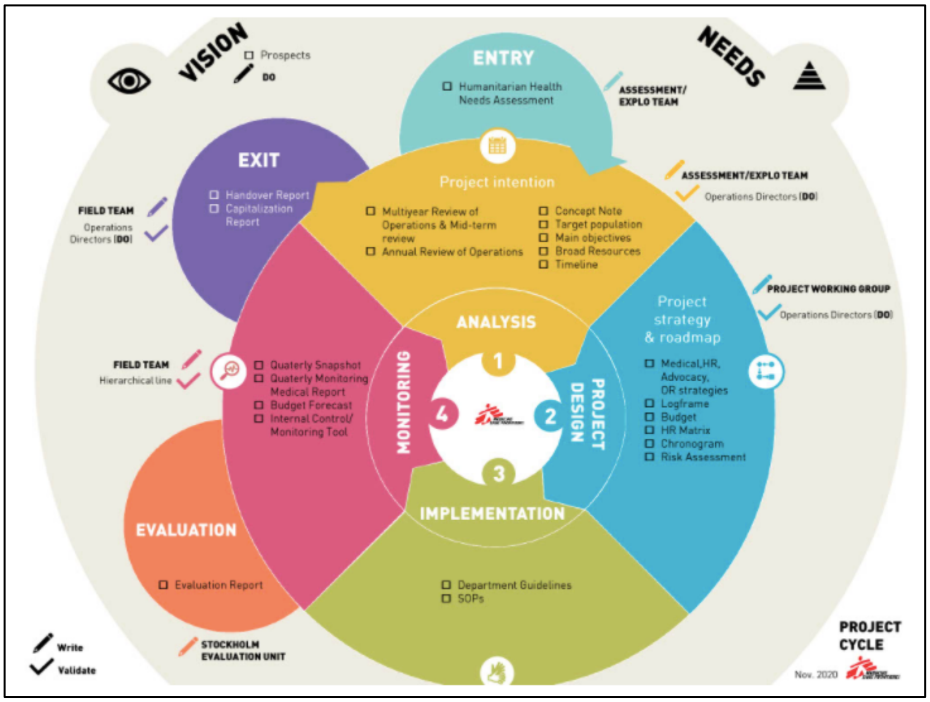

Figure 1: Project Cycle of MSF, OCB Operational Documents, May 2021

3.1.2 Structure & Governance Levels

Operational centers (OCs) of MSF are located in Europe and host technical departments, as well as operational departments that validate the budgets and provide support for the missions, where activities take place. Each OC is quite distinct in priorities and ways of working (44). In each country where MSF intervenes is a mission, and in each mission there are projects. Projects and mission coordination (capital-based teams) are composed of medical and non-medical personnel. At coordination level you will find the Medical Coordinator and Head of Mission, as well as other technical coordinators, such as Logistics, HR, Finance, and Supply Coordinators. Missions are responsible for the national strategy, advocacy with national bodies, and coherence between projects. They are also in direct contact with the operational department at the OCs. Projects are responsible for the local strategy design and implementation, as well as collaborating with locally-based actors, formal or informal. The mission coordinators are the line managers of the medical (PMR) and non-medical (FieldCo or PC) at the project level.

3.1.3 Missions & Activities

This case study focuses on the Operational Centre Brussels (OCB) and its activities. In 2019 OCB ran 109 projects in 38 countries (each country represents a “mission”) (39,45). Missions of Democratic Republic of Congo (DRC), Lebanon, and Venezuela were purposely selected as study sites to allow comparison and contrast between regions with different histories and dynamics. The aforementioned missions have also been selected given the diversity of medical activities so as to provide a comparison to what the definition, process, and measurement of community engagement was across emergency and non-emergency projects, as well as in epidemic responses, environmental health, NCD care, HIV programs, and environmental health. The table below details the various missions and projects included, their medical activities, and resources as outlined in mission and project documents (46-54).

Table 4: List of missions and projects included in case-study. Includes stated medical objective and summary of medical activities, in addition to staff and budget.

Mission	*Project*	*Objectives & Medical Activities*	*Staff & Budget*
Democratic Republic of Congo (DRC)	VIH/SIDA Kinshasa	**Objectives:** Reduce morbidity and mortality from HIV in city-province Kinshasa. Provide quality care for HIV patients in setting of low prevalence and low resource. Advocacy for change at political and public health level.	12 international staff 152 national staff
		Activities: **Community Level:** Adherence clubs for youth and adolescents, education and screening at secondary schools and churches, support of *PoDis* run by PVVIH groups for screening and rapid distribution of ARV **Primary Level:** support of 5 different health centers in OPD activities, logistic support, training of healthcare workers, minimal patient education and communication activities **Secondary Level:** Support of two hospitals in health area, training of medical staff, logistic support to hospitals, support of referral system, minimum patient support and education **Tertiary Level:** hospitalization and treatment of complex cases, IPD, OPD, physical therapy, laboratory, patient support and education, operational research	
	Pool d'Urgence Congo (PUC)	**Objectives:** Through ongoing surveillance and monitoring system, deploy rapid medical and humanitarian aide for punctual interventions in areas where there is a high need but no other capable medical or humanitarian actors. Advocacy on medical and humanitarian needs to improve access and availability of care.	14 international staff 65 national staff €3-6 million, approx.
		Activities: surveillance, emergency care in conflict or situations of mass displacement, vaccination (e.g. yellow fever, measles), response to outbreaks (e.g. Ebola or cholera) including screening, identification of cases, treatment, screening and treatment of malnutrition, screening and treatment of malaria, distribution of mosquito nets. PUC was highly involved in Ebola responses in 2018-2020.	
Lebanon	South Beirut	**Objectives:** Empower communities and patients through improving self-care & heath literacy, setting up patients support groups, & clarify pathways to address acute medical needs. Access to proper NCD care for refugees through advocacy. Sexual reproductive health with midwife-led model of care.	6 international staff Approx. 160 national staff €5 million
		Activities: ANC and PNC consultations, deliveries, termination of pregnancy, pediatric consultations, vaccination, family planning/contraceptive consultations and provision, psycho-social consultations and support, home-based nursing care, NCD (diabetes, hypertension, consultations, medications, and follow up care social work home visits and assessments for referral, patient support and education, health promotion activities,	
	Bekha Hospital Bar Elias	**Objectives:** Engage in secondary for high number of vulnerable citizens, migrants and refugees with limited access to care in an expensive and privatized health system. The focus has been on elective surgery but since September 2020 operations are oriented towards diagnosis and treatment of COVID	Approx. 9 international Staff Approx. 150 national staff €4.58 million
		Activities: normally OPD for wound care, IDP for surgery, health promotion. With COVID reorientation surgery on hold and activities are intensive care treatment for COVID (5 beds), and IPD for COVID patients (15 beds). Health promotion.	
Venezuela	Anzoátegui	**Objectives:** Provide access to primary healthcare. Improve access of primary and stabilization care, at decentralized level. Increase capacity of delivery, obstetric and new born care services in the project area, in collaboration with local authorities.	8 international staff, 81 national staff €2 million
		Activities: primary care, ANC and PNC consultations, family planning/contraceptive consultations, malaria, care for victims of sexual violence, identification, treatment and monitoring of malnourished patients, and community health promotion activities	
	Sifontes, Bolivar	**Objectives:** Contribute to the reduced morbidity and mortality of people living in and transiting through n the Sifontes municipality	14 international staff, 129 national staff €3 million
		Activities: Support to government's malaria program, support of referral service between primary and secondary level, rehabilitation of secondary level hospital, management of serious cases of malaria at primary level.	

Chapter 4: Results

In this chapter I will review the results. In each section I will review what was outlined in the organization's documentation, followed by perspectives and examples described by interviewees. The sections are as follows:

- How CE is defined and its objectives at MSF (4.1)
- Process of CE, contrasting what is written in MSF documentation and examples from health interventions. (4.2)
- Who is involved in CE (4.3)
- Challenges to CE as outlined by interviewees (4.4)
- How CE is evaluated at MSF (4.4)

If differences were found between missions or health programs I have detailed them in subsections within the main section. If there was no significant difference between a mission or health program and the general findings there is no extra subsection.

4.1 How is Community Engagement Defined and What are the Objectives at MSF?

4.1.1 As Stated in MSF Documentation

Strategic Orientations[6] paint CE as an embedded process throughout an intervention related to listening and understanding communities, including power relationships, as well as their solutions for health problems. In the document MSF states that "*Connecting with communities for [MSF] will be about embedding operations in the realities of communities' struggles. It will be about ensuring that [MSF] understand the communities* […] *It will be about ensuring that [MSF] listens and learns how communities are addressing the challenges that they face and the language they use to explain power dynamics that are at the root of their exclusion"* (42, p. 17-18). They also link this to quality of care and acceptance of

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[6] The Strategic Orientations are written every 3 years by each OC and are meant to guide the priorities and approaches of the implementation of MSF's programs.

their health programs stating specifically that "*connecting to the community is about increasing our relevance, the quality of our care, the leverage we can exert and the acceptance we can obtain*"(42, p.18).

The organization also has a specific CE strategy tied to their Strategic Orientations, as well as a position paper on CE in epidemics, specifically COVID19. In the CE guidance paper specifically focused on the organization's COVID19 responses, CE is defined as "*the strategic process of working collaboratively with and through communities in project design, implementation, monitoring and exit*"(55, p.1). They highlight that "*communities have a wealth of skills, lived experiences and insight that are pertinent"* (55, p.1). They go on to state that CE is often misunderstood as an intervention or activity and that instead it must be seen as a *process* essential to build community trust, that requires listening and acting on feedback, as well as the spirit of collaboration and sharing with communities. The call for time, space, and support of communities that entails an inclusive and participatory approach to decision making on needs and responses.

In MSF OCB's Community Engagement Strategy 2020-2023, they explicitly define CE as "*the obligation of an organization and its staff, particularly in the medical act, to account for its activities, accepts responsibility for them, and to disclose the results in a transparent manner. […]It also entails an obligation to provide people with the opportunity to understand and influence and critique key decisions that are made*" (56, pg. 1).

In strategic mission and project documentation CE was not explicitly defined. However, phrases such as "*engaging with communities*", "*empowering communities*" were cited. Several strategies outlined the need to "*engage and listen and incorporate* [communities] *in* [MSF] *project*", they also described CE as increasing awareness and acceptance of MSF. In many documents there was a synonymous link between HP and CE. As such, we examined HP project strategies.

In HP project strategies CE approaches and objectives were more specifically described. Different levels of CE were detailed as informing, consulting and collaborating, and involving communities (57). In these documents the term communities was often used interchangeably with "*target group*" or "*population"*. In HP strategies CE was defined as empowering communities to improving control over health. (50,52,58-60).

4.1.2 Perception from the Interviewees

When asked for a definition of community engagement, the majority of interviewees defined CE as process of continual connection towards communities. Many specifically underlined the importance of listening, dialoguing with, and understanding individuals and communities around MSF's interventions. As in the Strategic Orientations, interviews emphasized, the bidirectional relationship of CE were identified as key elements.

When participants spoke of the process of CE, this was formulated as throughout MSF's project cycle in a given intervention, "*CE from explo*[7] *to project closure and handover*". It was often underlined that inclusion of communities, and listening to them, at the beginning of a project was key to understand who communities were, and how they lived, and how they perceived their health needs.

4.1.2.1 Definition of Communities in Community Engagement

Between participants there was discordance relative to the defined role of communities throughout the process of CE. Two perspectives of communities emerged. The first in which communities were framed passively within the process of CE. The second in which communities were framed in an active role in the process of CE.

In the passive frame, CE was described as a mechanism to better understand communities, and based on the better understanding of them, develop adapted health promotion messages to inform patients and their communities. This was expressed by one participant, *" [CE is] to make the community aware of the recent condition or the recent situation*" or another who said "*community engagement is to give communities the possibility to adapt to [MSF's] intervention, to accept it*". Another participant described similarly CE "*there are people in communities that are ignorant. Through community engagement we can correct their ignorance".* Communities were positioned as the target and object of activities for the organization's goals.

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[7] Explo is an abbreviated term for *exploratory*. It is the initial exploratory mission that is conducted when MSF is investigating needs in a given area and determining if it can respond to them

In the active frame, interviewees framed CE as a process of listening and dialoguing to be able to include communities in decision-making aspects of the project, and facilitate creating solutions with communities. One participant described it as such, *"[CE] is a way that we consider opinions, integrate them, and how we work with community and their decisions. So, every step we go, we are sure that the community is with us. They're not outside our work"*. Many people described this process as a way to increase networking with communities and actors, to collaborate together, or spoke about community resilience. Communities in the active frame were seen as actors themselves contributing to the design and implementation of a health program.

4.1.2.2 Community Engagement as a Means to Increase Impact of Health Interventions

The majority of examples from participants focused on objectives of CE to inform or educate members in communities. Often CE objectives were framed synonymously with activities and objectives of health promotion teams. Therefore, objectives were often adherence to good practices, or long-term treatment, or related to knowing when and how to seek care, or to change unhealthy behaviours. The ultimate goals in this case were framed as disease control or prevention, and correcting gaps in understanding.

CE was also described by participants as a form of collaborating with focal points or community-based organizations to determine when, where, and with who to carry out certain activities that had been planned by MSF. Similarly, interviewees gave from projects often demonstrated that CE was including members of the community to implement MSF activities.

While strategic documents outlined improving quality of care as an objective of CE, this was rarely mentioned as an objective by interviewees. There were some exceptions, particularly those working as PMRs, MEDCOs and HPs. When discussing quality of care, these participants often associated community engagement to increase quality of care as it facilitated an understanding of a patients' context, their lives, social and environmental determinants of health, while also facilitating a continuous relationship between the organization and the patient and their communities.

4.1.2.3 Community Engagement for Institutional Protection & Acceptance

Another theme that emerged in interviews was the objective of CE to achieve acceptance and protection of MSF in their zone of intervention. PC and HOM were the most often to describe the process of community engagement as essential for the security, access, and protection of MSF teams. Reflecting on this critically, one PC described MSF's relationships with communities as a "*currency of exchange*" or simply of "*protective utility*". Objectives of CE related to security were often explained as the needs to know key stakeholders holding formal or informal power, construct a link or relationship with them so that they would be willing to reach out to MSF in case of security incident, while accepting MSF in their area.

Beyond acceptance of MSF for security purposes, the objective of CE was described as fostering "*buy-in*" of communities. As one participant shared, *"I mean, let's be honest, what we want from them, is for them to have the full buy in. So our operation becomes acceptable for them".* Contrarily to the framing of the process of CE as listening and understand to then adapt the organization's work to communities, here it was framed by interviewees as a process that would encourage patients and communities to accept the intervention planned by MSF.

In another example of acceptance of MSF as an objective of CE, a woman working in emergencies described working with communities as "*prostitution*". She explained that community-based teams were often the first teams sent into communities where MSF was intervening, and the goal was to understand what communities wanted, and give them something that they needed. This was done in order to create acceptance and build trust of MSF by the communities, seen to facilitate acceptance of future activities determined by the organization.

4.1.2.4 Sustainability of Health Programs as an Objective of Community Engagement

Fostering sustainability of projects and medical activities was often mentioned as a rationale of CE. For example, an interviewee working in emergencies said "*without community engagement there is no sustainability* [of MSF project]". However, it remained unclear in interviewees' discourses how they defined sustainability and the practical link between CE and achieving sustainability of health programs.

Other interviewees mentioned links between sustainability and CE when they lamented the lack of success there was of CE facilitating handovers during project closure due to lack of ownership by communities. For example, a participant on reflecting on a project that had closed after 15 years, described that nothing remained of the health since MSF left as MSF had only included the community to do what they needed them to do.

4.1.2.5 Accountability of MSF as an Objective of Community Engagement

Although one of the objectives of CE in organizational policy is to promote accountability, this was rarely discussed by interviewees as an objective. In the rare cases this was described as an objective of CE, participants remarked that dialogue with communities to foster accountability were missing in the organizations work. They also highlighted in these cases that there few or no mechanisms in place to monitor and evaluate MSF's accountability towards communities.

4.1.2.6 Differences between Missions

4.1.2.6.1 In the DRC Mission

Relative to other missions the DRC mission had the tendency for the objective of CE to focus on educating, informing, and promoting access to care in communities. In interviews with staff from the PUC they generally linked community engagement to the objective of increased understanding and awareness in communities to promote ownership and sustainability. As one coordinator working in emergencies described:

" If the community does not take ownership in the action MSF is running, [MSF] *risks not to have an impact moving forward. It's not good, even with the PUC, that once MSF leaves everything breaks down, otherwise we stay in this vicious cycle. I believe that when a person participates in an intervention MSF is conducting, he better understands the importance of MSF and why we are intervening.* […]. *If we speak to leaders in these communities, those who are listened to by others, and they understand our actions, they then can help their communities understand.*[…] *Most of our problems are linked to behaviour and understanding. If I come, I'm a stranger in this community. People will say 'who is this guy to tell me what to do?' But if someone who knows the community well comes and says 'look once we lived like this, but the world evolves'. In this case I think people can quickly understand and accept.* […] *The success* [of CE] *is when beneficiaries understand the message and accept it and when we can show them their interests are related to the action* ".

There was also often an equation between HP and CE. In the PUC documents the two were listed synonymously as "*HP/CE*" (48,60). As one interviewee working at coordination level said:

"*We often say we are doing CE because we are doing HP, but it's not because we do an awareness session on hand washing that we are engaging with people in a follow-up action, with recommendations, or even learning in two* *directions. There isn't necessarily any dialogue. We have the tendency to think mobilization and awareness raising is sufficient. It's how we see it*".

This trend persisted when interviewees staff working at mission coordination level. Medical staff working at coordination described CE in the mission as "*paternalistic"* and getting communities to do what MSF thought was best or "*just sit under the tree and take the medicine* [MSF] *tells you to*".

In interviews with staff working on HIV, there was a tendency for those working in the health facilities at secondary and tertiary levels to focus overly on CE as a process of education, and communities as passive recipients, while those focusing on operations, advocacy, or health promotion tended to frame communities as more active, and spoke about attempting to enable patients by including them in the project. Nonetheless, the objectives of both groups when discussing empowerment was to increase adherence to treatment, and increase peer support of patients on ARV treatment. For example, staff described working with adolescent groups and church groups in order to improve adherence to treatment and decrease stigmatization, respectively. The process involved the identification of groups and capacity-building on health topics. Peer educators were also described as part of CE with adolescents. The objective of increase adherence to treatment through education and social support was described.

One outlier in DRC was the definition of CE of those who had worked in Ebola emergencies. In this case, CE engagement was described as a priority of the intervention, consisting of enabling communities to understand and partake in decision-making of Ebola interventions. This perspective of CE in Ebola was often attributed by interviewees as a consequence of learning from the attacks in North Kivu during the 2018-2020 Ebola Outbreak.

4.1.2.6.2 In the Venezuela Mission

Interestingly, in the Venezuela mission in both projects all staff framed this process as one of co-decision making, collaboration, and relationship building. The objective of community engagement was access, as in other missions, but also equally framed as an ethical necessity that communities be included in solving issues related to their own health.

When discussing this, participants explained this disposition was encouraged by two overarching factors. First, the historical dimensions of the country, in which community leaders and groups played an active role in the governance of their physical locale, in addition to a public health perspectives most medical staff mentioned training in. Second, that it was an approach that was made necessary given the organization's position in the country. Comparatively, the presence of INGOs and humanitarian actors remains quite low in Venezuela. As such, involving communities in decision-making was framed as needed both to be known and to establish ties at local level, in case relationship at macro level are tense or turbulent.

4.1.2.7 Differences Between Health Programs

4.1.2.7.1 In Emergency Interventions

In emergency interventions, two perspectives emerged from the interviews on CE during emergency interventions. The first group stated that CE was something that could be done effectively in emergencies. They described building connections and dialoguing with communities was easier in emergencies because the need was acute, and the demand for services and the need were usually agreed upon. This group gave examples of CE including communities in participative mapping, rapid assessments to tailor health messages, and mobilizing to implement some of MSF activities. The second group consisted of interviewees who said that time was too short in emergencies to engage with communities, and that this was why it was not done or prioritized.

4.1.2.7.2 In HIV Interventions

Often when interviewing medical staff in HIV interventions they acknowledged a discordance between the ideal view of CE as a process to promote empowerment relative to the actual focus of CE on education or community mobilization. Many of these staff expressed frustrations of not being able to go "*further*" in community engagement. For example, an operational coordinator working on HIV for two decades described that the MSF had become "*lost*". He described that previously CE in HIV was listening to communities and facilitating the construction of solutions together, whereas now it focused highly on education and adherence. Another medical staff working on community-based activities in HIV, described how they felt MSF's position towards patients had become less oriented towards empowering patients and enabling them, rather focusing on providing high quality curative medical care.

4.1.2.7.3 In NCD Interventions

More than other health programs, interviewees working on NCD particularly focused CE as a process to facilitate understanding other medical actors and social organizations in their zone of intervention. This was described as necessary in order to not duplicate activities, and facilitate the referral of patients. As one social worker illustrated, "*if at the clinical we tell the woman who has diabetes she must eat good food, she may say I cannot pay good food. MSF does not provide the food. So we have to know the community to know where I can counsel her to go seek support for this*".

4.2 What is the Process of Community Engagement at MSF

4.2.1 As Stated in MSF Documentation

Strategic Orientations state that CE is "*to include communities in collaborative approach to decision-making*" and "*systematically including communities throughout the project cycle*" (pg. 18). The community engagement 2020-2023 strategy lists specific points on engaging communities that must be considered at each phase of the project cycle (42,56). This CE throughout the project cycle (see figure 1) is labeled as "non-optional". Key moments and actions are:

- **Exploratory mission** - leaders and social representatives must be informed about who MSF is and purpose. Parts of the exploratory mission reports should be shared and discussed with communities' leaders. Anthropological assessments are recommended.
- **Project proposal** – pertinent discussions with communities should be included in the proposal sent for validation
- **Project implementation ongoing -** community should be regularly updated on MSFs activities, encouraging feedback on quality and effectiveness. Cultural briefings on communities required for international staff
- **Project closure** - communities should be informed why the project is closing Ideally a project closure committee has been formed with key stakeholders
- **Project evaluation** - Communities should be given space to share their feedback. MSF should share evaluation report with communities.

4.2.2 Perception from the Interviewees

Interviewees defined CE as process throughout the project lifecycle, highlighting that for all project types it was a process that needed to start when planning an intervention, throughout project implementation, until closure. However, in illustrations given by interviewees at project level, CE was rarely a continual process, and consisted rather of punctual involvement of communities at various moments throughout the project lifecycle.

During exploratory missions and project initiation, communities were included in needs assessments with the objective to understand the context and needs and support MSF's design of the project. Interviewees described communities inclusion in FGD or meetings to assess beliefs, practices, and understand social dynamics, and meetings held with key leaders and other health organizations. There were very few examples of communities partaking in decision-making at needs assessments, or supporting the design of the program and solutions to the identified problem.

During implementation of a project, interviewees described liaising with local or regional level representatives of MOH or other health organizations as part of the process of CE. Interviewees often described meetings conducted to keep other organizations abreast of MSF's activities or to coordinate with them. In this way, as one coordinator in DRC stated "*there is always community engagement because we are working alongside the ministry of health and partners. But community engagement is more than this. It's rather a state of mind and way of working*."

During implementation there were also examples of capacity-building of community groups during project implementation. Examples consisted of identifying focal points or volunteers in communities of interest for the project. These volunteers were usually selected jointly, between communities and MSF. These focal points were trained in health topics related to the project. They were then asked to disseminate health messages and talks in their own communities. In some cases they were asked to participate in activities organized by MSF. However, when describing the process of CE, and working with community groups or health volunteers, a paramedical manager said, "*Uhh not a proper one* [type of CE]. *I would call it more community participation. You know, they can come and listen to a health talk, but there is no dialogue or shared decision-making*".

Throughout implementation there were also feedback mechanisms were also described as part of the process of CE. Examples given included asking community members to partake in satisfaction surveys at hospitals or clinics, as well as feedback and rumours collected by HP teams. In these examples, most follow-up actions that were described related to correcting incorrect beliefs of communities, rather than responding to feedback. As one epidemiologist detailed, "*we collect feedback and rumours, and we plot these geographically across communities. Like this HP teams know where to go to give health talks and correct beliefs*". Regarding collecting feedback, as one medical staff working in NCDs described:

> "*I find it great that we want to hear from them inside the clinic* […] *I find it a bit patronizing. You know, we don't involve them in the rollout of the activities, and in what is perceived as the main needs. And we decide it for them. And I don't know... I feel like it's patronizing. Because they are already accessing free services. And then we want to hear from them... I mean it's very unlikely that they are going to complain*."

Many interviewees stated that CE during project closure consisted of informing the communities that MSF was closing and finding a suitable partner to take over some activities. However, most had not been involved in project closures outside of emergency interventions.

4.2.2.1 Differences Between Missions

4.2.2.1.1 In DRC Mission

In the DRC mission particularly strong examples of including MOH partners and leaders at the local, regional (health area), and national level throughout the project. For the PUC project this was illustrated through their system of sentinels, both community leaders and local and regional health staff across the country who send alerts to the teams to signal urgent health needs before the PUC confirmed the needs and if they would intervene. In the HIV project this meant working with other large INGOs, as well as coaching and mentoring ministry of health staff at secondary and tertiary health facilities.

However, in interviews staff in both projects highlighted that co-decision-making with communities, throughout the project was limited, and the realization that CE was important came too late in the project lifecycle, and was integrated as an afterthought. As one coordinator explained, "*we come a bit too late to the realization community engagement is important. Maybe it's because it's difficult to understand. At the start when we open [a project] we think only of the hospital."* Similarly, a staff member involved in the 2018-2020 Ebola Outbreak response in North Kivu said, "*we only realize* *community engagement is important when we get burnt, like in North Kivu with Ebola. Then we say 'oh man, maybe we missed something*'."

4.2.2.1.2 In Lebanon Mission

The most significant difference in the Lebanon mission interviews was the focus in interviews on redefining community needs and project closures. This may be because at the time of the interviews the project in South Beirut was closing its NCD cohort after 7 years. Interviewees focused on the lack of CE and the negative impact it was having on the patients and communities while the NCD project component was closing.

As one manager mentioned, "[the project] *was closing because MSF had a calendar*". Another staff, speaking on her negative impression of the closure without community involvement said, "*how did it end up the way it is today? I still fail to understand. But my guess is that community engagement was not one of the priorities at the beginning*." Another medical staff described being embarrassed as a medical professional, and "*want*[ing] *to throw myself out a window*", when she arrived and she saw patients were only being informed of the closure and sent home with three months' supply of medication without including communities in the closure. Other medical staff explained how the project team was now attempting to map and network with other local NGOs that could provide medication and care, while trying to identify patients who had been discharged to check whether they had found other sources of medication or care. Many expressed how the realization of CE during project closure had come too late.

4.2.2.1.3 In Venezuela Mission

In Venezuela there was more inclusion of communities in the proposals of activities, and more collaboration from needs assessment through implementation. In the project in Anzoátegui, for example, a medical staff described how MSF ran their clinic, and supported several others, but further activities were only organized and planned when communities approached MSF to ask for support or expressed needs. In the illustrations from this context, staff specifically mentioned their indirect support of other healthcare workers and health clinics, allowing these other actors to identify needs and determine how MSF could support them.

4.3 Who is Involved in the Process of Community Engagement in MSF

4.3.1 In Communities

When discussing what a ‘community’ was and how who was involved in community engagement was determined, there was an overall awareness that community consisted of both geographical, as well as social and cultural boundaries. Staff working directly in communities (e.g. health promoters, outreach nurses, social workers, mental health professionals) detailed this further, and described community as something that could be defined by an outsider, as well as by those within a given community, and that most people belonged to several ‘communities’ at one moment. However, when discussing the process of community engagement most participants reverted to speaking about “beneficiaries” and “target population”.

Much of the documentation in MSF on challenges and barriers to community engagement in previous interventions, such as the West Africa 2014-16 Ebola outbreak, underlines the challenge of engaging with non-formal community representatives, or capturing the diversity of groups and organizations in the process of engagement. Perhaps surprisingly then, most participants described an array of different organizations (for example, civil society, CBOs, religious groups, adolescent clubs, women groups) that should be considered beyond health, government, or official leaders, and stressed the importance of seeking to include informal power holders within different communities.

Although key populations, such as sex workers, women, elderly, and minors were flagged as important communities to include, potential harms of community engagement exacerbating existing power structures, or marginalizing the already vulnerable were not a prominent topic when speaking about who is invited to participate. Worries that current approaches and ways of working were not capturing the most vulnerable, or the excluded emerged in several interviews with staff working in PHC or HIV in the DRC and Venezuela missions. As an interviewee shared, *“Another risk* [of not understanding communities around you]*is to completely disregard the needs of particular groups in the communities. And very often it can be the most vulnerable groups inside vulnerable groups*”. In the DRC missions, this was described that when analyzing security incidents violent responses came from groups where no contact had been established or maintained. In Venezuela, worries of representativeness focused on doubts that MSF was able to pierce through the power dynamics existing in communities prior to the organizations arrival, and move beyond these gatekeepers to access and engage with those that may be the most vulnerable.

4.3.2 Within MSF

Discussions on the process community engagement also broached who within MSF teams was most involved or responsible for this. Two types of groups emerged; those that considered community engagement a transversal way of working across all job profiles, not only at project level, but by all institutional level and those that framed community engagement as an activity carried out by health promotion or outreach teams. In fact, many non-medical or operational profile staff asked why they were being included or asked to comment on community engagement, as they weren't medical staff nor HP. This is contrary to documentation that stipulates that community engagement is an embedded way of working for all staff and teams.

Another common theme that emerged in interviews with national staff, was that international staff participation in the associative was diminishing, and that national staff were a "forgotten bridge" between MSF and communities, as a national PMR explained it. A national logistician shared that in his experience lack of recognition in the history of communities and places was linked to internationals staff difficulty in engaging with communities in their work, and their tendency to impose their ways of thinking and working on national teams, whose experience, at times, felt disregarded and at worst that historical traumas were being replicated.

4.4 Challenges with CE at MSF

When asked about CE in their work at MSF, in every interview people stated that while there was some level engagement, it needed to be improved. Through the discussion of how it should be improved, interviewees often highlighted challenges to CE in MSF's work. Themes that emerged through interviews were lack of resources and prioritization, lack of understanding and guidance, issues in decision-making and power, as well as biomedical approaches to health. These are described in the subsections below.

4.4.1 Resources & Prioritization

Across all institutional levels interviewees described an asynchrony between the organization's purported value of the essential nature of community engagement, and the prioritization of resources dedicated to this end. One participant, working between headquarters and project level, frustratingly shared:

“*I don't feel that the sincere willingness* [for CE] *is there. They may say 'yes, yes' because it is the right time to say, 'yes, yes, we need to involve' and so on. But the commitment of this willingness, I don't see so much on every level. Because if you really are committed and you put it in your prospects, you put resources on that, you put resources to make it happen*.”

Similarly, at project and mission level coordinators expressed a desire to do more in terms of engaging communities throughout the project cycle, moving being consultation. However, they often stated they were confronted by a lack of human resources to cover the extra time it took to invest in CE. As one participant remarked, “*I feel that MSF thinks community engagement can be done without any material resources or investment. Like all the HP needs are posters for community engagement.*”

Particularly in settings where resources were limited, for example reduced budget, lack of gasoline or transport, many staff felt that the first activities reduced were those done with communities rather than curative care activities. Some project staff expressed frustration that the headquarters position was to promote dialogue and collaboration with communities, but there was an expectation that this could be done without extra resources. In contrast, interviewees at headquarters level often said CE was done because project teams spent too much time behind computers or desks, or that they lacked the imagination or perspective to engage with communities, and did not understand the value of “*drinking tea*” with communities.

4.4.2 Understanding & Guidance

Often lack of CE was framed by office-based staff as a lack of understanding of the importance of CE at project or mission level. Mission and project staff did not express a perceived lack of understanding in community engagement. They did, however, highlight that attempting to work with such an approach was highly person-dependent, based on individual values, management style, and perception of health, whether biomedical or biosocial focused. Many identified a lack of support on organizational values, staff attitudes, support framework to best incorporate CE process in projects, particularly on if consultation was sufficient for CE. Some coordinators specified that they understood there could not be a manual for community engagement, but that minimum standards across all MSF projects to ensure that teams were engaging with communities sufficiently. In turn many national staff expressed that international staff's lack of recognition of the history, and at times trauma, of where they were working, negatively impacted their capacity to forge sincere links and understandings with the communities in which they were working.

4.4.3 Decision-Making & Power

A major impediment that was highlighted in discussions with staff working at project and mission level was decision-making and power sharing within the organization. As one interviewee summarized:

"I would say [CE] *happens, but not in this ideal way.* […] *I don't know if it's related to the mission itself or MSF's, let's say, way of validating and planning activities.* […]*The fact that there are all of these, let's say, different layers of decision making […] sometimes the final decision is being made too far or the time is not allowed to take enough into consideration the communities"*

Discussions often circled back to how, even with a willingness to share decision-making with communities on paper, in reality there wasn't the freedom to co-manage programs with communities. A participant who had worked for a considerable time for another large INGO sardonically commented that before she thought the financial independence of MSF would mean projects and strategies were less planned around external priorities, and more based on communities' needs. Through her experience she observed that organizational strategic priorities and decision-making mechanisms considerably diminished the ability to collaborate with and adapt to communities. Another coordinator describing the same, defined it as the organization's inability to be humble and "*bend the knee in front of communities".*

Other interviews commented that individuals in coordination roles for MSF did not always wish to relinquish their decision-making power, which made sincere CE challenging. Interviewees commented that lack of power-sharing in the process of CE at MSF resulted in tokenism. Several participants described the relationship between communities and MSF as patronizing, or that while collaboration existed in punctual activities, MSF generally stayed closed "*in its corner*" in terms of decision-making. As one medical doctor described communities are "*expected to sit under a tree, listen to information, then take their medicine*".

MSF's way of perceiving and working with communities was also framed as perpetuating an already uneven power balance between the organization and communities. As one person illustrated it:

“ [MSF] *can't come into a community and say 'well I engage with you but when I no longer need you I’ll do my thing'. Or ‘I'll ask you what you think, but whatever you think, I'll do whatever I want.’ Or ‘I'm going to ask you to help me make sure we're safe. But on the other hand, when it comes to decisions, for your own health and protection, there, I'm not going to get involved’. It’s always unequal relationships. People felt really used. And that was what it was during Ebola”*

4.4.4 Biomedical Approaches

A final theme that emerged when participants discussed challenges was the overly biomedical approach MSF has. Many interviewees commented on the choice of MSF to invest inside health facilities, on advanced care or highly technical and innovative treatments, rather than to focus on what empowerment and change could happen through communities.

Participants also said that MSF’s strict adherence to their protocols and procedures, and that these should be carried out by MSF staff, while contributing to quality of care, also precluded the possibility to give communities the chance to build capacity. This approach was also described as limiting what was considered ‘knowledge’. This was particularly cited in regards to response to emergencies and Ebola. An interviewee with experience in Ebola over several decades described how in her earlier experiences MSF followed best medical practices, but remained flexible and adapted to local histories and dynamics, and that now with the explosive growth of the organization, particularly following the 2014-16 West Africa Ebola Outbreak, the organization was dominated by protocols that removed the person from the patient, and removed the patient from their context.

4.5 Evaluation of CE at MSF

4.5.1 As Stated in Documentation

Guidance on evaluating CE existed in the form of checklist of questions in the Operational Quality Framework. Here essential questions to ask communities before, during, and after project implementation were described (61-64). Questions focused mainly on if communities, synonymously described as stakeholders or target populations in the same document, had been involved at different steps in the project cycle, and if the communities needs were understood. Questions included: *“Did you involve the communities and key actors in the mapping exercise? Do you know the dynamics within the communities and between key stakeholders?”, or “have you identified the risks of negative impact on the* *short and long term of the intervention and did you involve the target population* […]*?".* There was also guidance on measuring community activities, including feedback, and rumours, as well as training activities in the HP Knowledge Base, however, this was not explicitly tied to evaluating CE.

Description of evaluation and monitoring of CE was found mostly in medical and HP strategies and reported using project logistic frameworks in quarterly monitoring report, and annual reviews (48,65-67). In the majority of cases, across all health programs and missions CE evaluation was placed under the HP department's objectives and activities. Objectives included "empowerment", engaging vulnerable groups, or involvement of communities in activities. It was as monitored through number of meetings with community-based groups, number of activities conducted by community volunteers, changes in health literacy, or qualitative reports on rumours in communities (51,57,60).

4.5.2 Perception from Interviewees

When speaking how CE was measured, there was a strong division of those that thought it was really not something that could be evaluated or monitored, and those that thought it could and should. In the former, many stipulated that it was something that the quality of could only be felt or observed when working in health programs. In the latter, there was assertion that any measurement of CE must include a qualitative approach, and not just quantitative measures, and it was necessary to evaluation and monitor.

In several interviews staff spoke about the attempt of medical teams to better evaluate CE. Interviewees described HP teams as the responsible team for this, working with epidemiologists, and medical staff to apply information collected during community-based activities to track both the impact of activities, and report on needs. In most examples, the information collected focused on number of meetings with different community groups, quantity of trainings conducted, health education sessions (number of participants and topic), knowledge on health topics, health behaviour. This data collected was then primarily used to measure reported change of behaviour in prevention and health seeking.

Some interviewees working in HP teams mentioned feedback monitoring database. In these databases interviewees reported collecting feedback, questions, and rumours, classifying them, and noting follow-up actions taken. However, in reporting documents the data mentioned in the interviews pertaining to feedback from patients were absent. Satisfaction surveys in hospital and clinic settings were mentioned as an activity conducted routinely as a way to measure impact of CE, but similarly were not something that was found in the operational monitoring or evaluation reports.

Chapter 5: Discussion

In this chapter we discuss the implications and relevance of the major findings of our study. Namely, discordance in how communities are perceived in CE, the tensions in the objectives of CE between utilitarian and empowerment frames, as well as two of the chief challenges of a medical INGO integrating CE; power issues and biomedical approaches to health. This section will support and inform the recommendations that follow.

5.1 Challenges in Understanding & Objectives of Community Engagement

5.1.1 Perception & Role of Communities

The definition of CE expressed both in MSF documentation and by interviewees was described as a process occurring throughout the project cycle that entailed listening to communities, understanding them, and including them in the health intervention. However, in interviews there were strong division in how communities were perceived in the process of CE.

While in MSF documentation, communities were framed as active actors in the process of CE, in interviews two different patterns emerged. The first in which communities were viewed passively and the second in which they were viewed as active contributors to the process of engagement. This tension in how communities are viewed is consistent with previous literature, in which two frames of of 'community' in CE have been highlighted. The first frame relates more to the passive view of communities, and has been described as *operational* or epidemiological, focusing for disease control. In this frame, as highlighted by Manderson and Espino, there is a focus on the 'target area' and a greater importance given to the geographical element of community in order to understand and control the spread of infectious disease (27,68). Rifkin has highlighted that challenges in giving a standard definition of 'communities' or 'participation' has resulted in a tendency to use this epidemiological frame of communities, and this leads to the perception that "*participation* [is] *the response of a group to take up advice and activities that have been proven to deliver better health*" (69, p.32).

The second frame is more social and active in nature and is often described using Zakus & Lysack's work. In this frame communities are seen as a blend of the geographical locale and social characteristics, including shared beliefs, interests and concerns, as well as values (2). In examining these two frames, the operational/epidemiological versus the social, Brunton and colleagues found that when communities are classified by others outside their own group, communities tend to be seen more passive as “populations” rather than “communities” (28). As our results indicate that MSF tends to identify communities from the outside, this could explain the organizations dominant framing of communities passive in the “target population”.

The passive frame of communities that emerged in our findings is also consistent with Massé paradigm of the perception of communities in health interventions as a *cruche vide* (empty vessel, my translation) (70). In the *cruche vide* conceptualization, community members are empty vessels that must be filled with correct or true information. We see this in multiple interviews, particularly in DRC, in which CE is framed as a process to educate, correct understandings, and beliefs, in which the communities themselves are the passive objects receiving.

Beyond, the operational versus social frame of community, or perceiving them as *cruche vide,* the tendency to frame communities passively at MSF may also be explained by reflecting how humanitarian organizations conceptualize communities and patients relative to their work. As work by Didier Fassin has highlighted in humanitarian interventions, “*however local people consider themselves, this construction as the victim is viewed by humanitarian organizations as both necessary, since it identifies the target of the intervention, and sufficient in that the perspective of the populations is never required*” (71, p.232). Ticktin has furthered this idea in her work on humanitarians’ perspectives of health and citizens, and notes that humanitarians’ worldview requires them to consider communities as passive in their suffering, which then leaves little to no room to consider these people and groups as equals (72). This humanitarian framing of communities as passive groups in has been documented by Malkki. In her work she finds that humanitarian actors and organizations “*dehistorize*” and depolitize communities, stripping them of the historical, cultural, and socio-political aspects, as they become those that just need aid, rather than those that may be able to participate and engage in the construction of solutions (73).

In MSF documentation, quality of care was highlighted as one of the objectives of CE. In interviews the process of CE was described in two ways; either a process of listening, learning and adapting care, where there is a collaborative approach to decision-making, or a process in which communities are convinced an intervention is acceptable, with the objective of fostering “*buy-in*”, as one interviewee described it. Instrumentalizing CE for “*buy-in*”, is consistent with what has been outlined in studies examining CE in health research (74-76). In the first perspective, communities form an active part of the relationship and can influence what care is provided and how. In the second perspective CE is to convince a passive community that the program and care provided is acceptable. Quality of care has been defined by van Olmen and colleagues as ""effectiveness, efficiency, safety, patient-centeredness (giving information, shared decision making, combining a biomedical, psychological, and social perspective), integrated and comprehensive (addressing the needs for curative care, prevention and health promotion), continuity within and beyond a single episode of disease (dimension of time), and continuity beyond the visits to one specific health institute" (77). Given how, at MSF, communities and individuals tended to be viewed passively, stripped of their socio-political and historical context, perceived as entities to be persuaded that care is responsive rather than contribute to the balance of supply and demand of care, it remains how questionable that CE could lead to improved quality of care at MSF.

5.1.2 Contrasting Paradigms - Utilitarian versus Empowerment

Findings also highlight a discordance between objectives of CE at MSF. This was found when comparing MSF documentation to interviewees perspectives, and also between the perspectives of MSF staff as expressed in their interviews. Documentation focuses on community engagement objective foster quality of care, accountability, while empower communities to share collaboratively in decision-making, whereas data collected in the interviews predominantly detailed CE as an objective for on disease control, making interventions responsive, or facilitating access and acceptance of the organization.

We could classify these differences of the rationale of CE in MSF into the two paradigms on how CE improves health intervention (utilitarian inclination) or community engagement (social justice inclination) (28,78). In her work Rifkin describes these frames as the "target-oriented" versus the "empowerment" frame (79). The first frame has its roots in the biomedical perspective of health and views participation to improve health. In this frame the aim of CE is to understand behaviour so that professionals may manipulate it, and to get communities accept a particular intervention by health professionals (79). The second paradigm sees empowerment as an objective itself of CE. In this mindset the assumption is that unequal health is due to unequal health resources and that, in line with work done by Freire, engagement will allow people to take control over resources and decisions in their lives, thereby creating a catalyst for social change, and improvements in health equity and health(28,80). Rationale or objective of CE is essential to understand, as it affects the the approach, process, and evaluation of CE that follow.

Several frameworks exist that conceptualize CE as a continuum of power sharing and role of the communities relative to the professionals. These include Arnstein ladder, which describes the degrees to which power is shared by those who have power and those who do not (35). Also, Rifkin's framework also looks at the extent to which communities decide and contribute across elements of health programs relative to professionals, describing participation as narrow or wide on a five-point scale, across 5 factors (4,9), as well as Draper and colleagues work, that has built off of Rifkin's (37). They propose that these interactions between professionals and communities exist along a continuum, moving from least (information sharing, mobilization) to most empowering (empowerment). These frameworks highlight that CE is a continuum, with weak or narrow engagement at one end, and wider or stronger empowerment at the other.

Placing our findings against the aforementioned paradigms, and looking through the lens of the frameworks above, we can say that there is a contradiction between MSF documentation, and between interviewees conceptualization of the rationale of CE at MSF. Documentation describes elements associated with the empowerment frame, while interviewees gave examples that demonstrated that MSF generally uses CE in a more target-oriented or utilitarian paradigm in their health programs, focusing on their own goals, such on access, acceptance, and making care relevant. Furthermore, while the process of CE was detailed in MSF documentation as one of shared decision-making and embedding operations in communities' realities, examples from interviews showed that this rarely went beyond collaboration, and that usually communities at most were involved in activities or parts of the program, as determined by MSF.

Tensions between these two paradigms, and their ideological underpinnings, have been documented in literature as a challenge in incorporating CE in health programs (81). Lack of theoretical underpinning, and lack of definition of the ideology, and rationale of engagement have been highlighted as one reason for failure or co-option of CE (31,82). Consequently, we could posit that the observed diverging rationales and ambiguity in objectives of CE at MSF could present a challenge to effectively engaging with communities. Without clear understanding the rationale of CE in a health program, the change process, and how this can be assessed will remain problematic. Other studies have advocated that to improve the approaches taken in CE rather than juxtaposing the empowerment and utilitarian paradigms, they be considered complimentary and holistically, as “and/both” rather than an “either-or” relationship (79).

5.1.3 Sustainability as an Objective of Community Engagement

Sustainability has been defined as the continuation of services and benefits of a program or intervention over time after withdrawal of support or funding (37,83). While sustainability is not explicitly mentioned in institutional documents as an objective of CE, it was described as such in interviews, although ambiguity existed around the concept of sustainability. Some described ownership and sustainability being fostered through health education and knowledge sharing. Others described sustainability through ownership occurring through power-sharing and collaboration with communities across the project, as well as capacity building activities.

In development studies, engagement has been previously defined as both a means to help excluded groups overcome exclusion, while also facilitating ways for them to solve the problems that they face (84). It is in this sense, through the inclusion of marginalized groups, and the involvement of communities in designing solutions to the problems they have identified, that sustainability can be achieved (74). Contrary to this, in our findings there was a paucity of examples at MSF of communities being involved in decision-making or responsible for program elements. This is in line with findings of Mubyazi that in most LMIC contexts decisions are made by elites, and community engagement largely consists of informing on decisions that will be implemented (29).

While the literature on CE defines sustainability as one of the possible benefits (7,37,85), this is only possible when CE consists of empowerment in health programs, rather than simply mobilizing or getting communities to do what has been decided by professionals (32). In our findings there were very few examples of empowerment outside of information provision as power. As such, it remains questionable if sustainability is a possible outcome of CE at MSF if decision-making, as well as identification of solutions remains the hands of MSF.

5.1.4 Accountability as an Objective of Community Engagement

Accountability is an essential element of functioning health systems (77). It has been defined as not only a supplying of information on actions taken, but also a dialogue between actors regarding the reason or justification of choices, it is not just informing what is done, but also if it's done and why it's done in that way (86). As previously mentioned, INGOs, including MSF, make up for a considerable amount of program spending in health systems in LMIC. Like public institutions, INGOs also have the responsibility to be accountable to both patients and the communities with whom they are working (87). Previously research has highlighted that social accountability is often lacking in INGO (88). Our findings confirm that this holds true for MSF.

In MSF documentation being answerable and accountable to both patients and communities was highlighted as an objective of community engagement. In the documentation the need for two-way dialogue, transparency on actions and their consequences, as well as feedback mechanisms to allow communities to questions and be involved in these decisions affecting them are detailed. In interviews however, there was little indication that this was perceived as an objective for community engagement. Moreover, in MSF programs, examples from interviews highlight that two-way dialogue on decision-making was limited, communities were more often informed of decisions and actions taken, rather than permitted to dialogue on these decisions. Similarly, there was little evidence of feedback from communities influencing actions of the organization. While more specific research would be needed on the accountability mechanisms between MSF and communities, particularly the social accountability of the organization towards communities, our findings point that accountability towards communities is rarely achieved through community engagement, and that this responsibility is lacking in MSF operations.

5.2 Challenges in Community Engagement

5.2.1 Power & Decision Making

Through the interviews conducted with staff at MSF our findings largely demonstrate that although collaborative decision-making with communities is in organizational policies, the reality is that power remains with the organization. Through the project cycle, in needs assessment, project design, implementation, monitoring and closure, power is not shared. This was also stressed by multiple interviewees as a key challenge in CE at MSF. This was associated with the hierarchical level within the organization validated decision, as well as the nature of the organization and the extent that they are able and willing to share power with communities.

This finding is consistent with critiques of the inherent difficulties of large international institutions integrating CE or participatory approaches. Inequity in distribution of power has been one of the critiques against international institutions co-opting an emancipatory and bottom-up process of community engagement (89). Further analyses have underlined that CE as a participatory approach is at odds with international institutions wish to maintain existing power structures (90). More specifically, large international institutions, given their structure and organization, tend to transform what should be a participative and inclusive process into a top-down, standardized, and bureaucratic one (91).

Interviewees also highlighted that in health programs, MSF controls how decisions are made and what information counts in this decision-making, and that as such sharing power with communities is problematic, which negatively impacts CE. This challenge of power sharing in CE is consistent with previous work highlights that when power on what knowledge counts, and who decides continues to be held by external INGOs, communities are often unwilling to engage, even when offered the possibility (92). Likewise, other work has found that if CE is sincerely to foster empowerment, and not just tokenism, then the knowledge of the people being included should be the driving force to empowerment. Pratt and colleagues have found that these power disparities between health professionals and communities negatively impact “deliberative dialogue”, thereby affecting the potential of CE to contribute to health programs (74). Taking the above into consideration we could posit that the lack of power-sharing of MSF, on information and decision, may not only discourage communities from participating sincerely, but also foster tokenism and shrink the possibility for dialogue. This then would impede the process of CE.

As outlined by Peter Redfield, when and where MSF works, it imposes its way of decision-making, its structure, and how power is shared on communities (93,94) . This also can be seen in our findings. Clearly, across missions and health programs included in our case study, MSF decided who, when, where and how engagement should happen. As such, while there may be space for engagement, it is controlled and decided on by the organization. In this sense space for engagement is restricted (95). Providing the opportunity to engage does not always mean a group or individual has the power to engage. On the contrary, engagement processes may actually reinforce existing forms of exclusions or power dynamics within communities, creating challenges in representation and inclusive dialogue (7,95,96). Local problems cannot simply be solved by engagement at the micro level, but must also consider other levels where inequalities of power may be reproduced or generated (97). This includes examining distribution of power within MSF and how this affects possibilities and quality of CE.

This reflection on power within and outside the organization, particularly relative to relationships with communities, is absent in MSF's work on community engagement. Reflections on lack of consideration of power in CE have been documented in previous research (31,98). Our findings on power and CE at MSF are in line with previous research and also highlights the need for more attention on governance and power relations in order to facilitate equitable health systems and improved health outcomes for groups who are already marginalized.

5.2.2 Biomedical Approaches to Health

MSF biomedical focus was another challenge flagged by interviewees to engaging with communities. This was linked to the perception that MSF focused mostly on what was going within health facilities, both in terms of curative care and investments inside facilities, rather than that which is outside. It was also tied to the organizations control on what knowledge and expertise was valued.

MSF is a medical humanitarian organization. As such, its primary focus is that of saving lives (21,99). Previous work has found that humanitarian organizations are primarily concerned with bare life or *bio,* rather than the political and social participation of individuals and communities (100,101). MSF's approach to lives has also been called *minimal biopolitics* by Redfield (94). However, CE, as a complex social process, the recognition of political and historical dynamics of groups is essential. This tendency of humanitarian organization to focus on the biological side of life, rather than the social, may explain the critique made that biomedical approaches to health in MSF impede integrating community engagement as an approach.

Not only could the nature of MSF as organization affect CE, but it could also affect the way the organization conceptualizes health problems, as well as solutions. As outlined by Paul Farmer, how health problems are framed, biomedically or taking a biosocial approach, will affect how resources are shunted and how interventions are designed (102). Biomedical approaches often overlook social dynamics, power structures, and as such overestimate the possible positive effects of biomedical focused interventions (103). Moreover, a purely biomedical focus does not recognize the social element of ill health (104).

Ignoring these social forces, whether poverty, racism, coloniality, ignores that health outcomes will be shaped by these factors and not just curative treatment, health education, or individual agency (105).

It follows then that if MSF takes a biomedical perspective as the causes of health issues, CE focus will be on ensuring health positive behaviour, adherence, as well as health seeking behaviour, which our findings demonstrate. As recent research showed, health literacy and effective community outreach are unlikely to be effect unless also considering structural and social elements to ill health(106). A dominant biomedical approach is not conducive in acknowledging the importance of social determinants of health, nor that engagement in health problems and design of solutions, can empower individuals to overcome inequities in health. There are possibilities to *re-socialize* health, and examples of tackling social and biological causes of ill health with communities have been documented (107). However, given MSF history and values, adopting a more biosocial approach may be impossible.

5.3 Study Limitations

There are several limitations that may impact the findings of this research:

I. Communities in project and mission were not included in the sample. As such we could not triangulate what is represented through interviews with staff with what in what is happening in the communities concerned. I attempt to mitigate this by asking national staff respondents for their perspectives as members of local communities.

II. Having worked at MSF, my insider position and history with the organization may have affected the way interviewees responded to her questions, as well as my interpretation of results. This could have made respondents more open with me. However, even with the guarantee of anonymity, they could have equally felt that the quality of their work was being assessed and as such withheld. I engaged in a process reflexivity throughout the study to mitigate any possible bias.

III. The missions selected do not represent all missions nor all contexts, and the projects selected do not represent all missions in one project. Similarly, I focused solely on the work in only one of several Operational Centres of MSF. Approaches may vary across different OC.

IV. While my review of MSF documentation was facilitated by colleagues and peers in the organization, and consisted of searching the organization's various database to find all relevant policy, strategic, and technical documents, I cannot say it is exhaustive. The organization and its employees produce a large amount of documentation and at times they are kept in personal files or lost.

Chapter 6: Recommendations

Following the results and discussions we would propose the following recommendations to MSF. These recommendations may also be used by other INGOs working in health attempting to integrate communities meaningfully into their work.

I. With the diversity of contexts and communities, one standard rationale of CE **should not** be recommended for all of MSF. Nonetheless, there needs to be a concerted effort to ensure the objectives of community engagement are understood and defined prior to setting up a project, and are checked throughout the process of the project. As such, the recommendation should be not only to ensure an theoretical underpinning and clearly defined rationale, but consider both paradigms of empowerment *and* target-oriented to achieve objectives of health programs. In this way the process of CE can becomes more holistic and capable in considering complex interactions of communities and health. Without defining the rationale of CE the organization tension between perceived objectives will result in the organization remaining at information sharing, or mobilization in community engagement.

II. If CE is to contribute to medical interventions, and support disease control and quality of care, there will need to be a concerted effort on viewing communities as active participants in this process instead of passive objectives. Space in decision-making process needs to be made for community involvement, and sharing of power must be made a priority in projects. Regularly assessing and analyzing community capabilities, including all social systems and collective resources they possess, has been proposed as a suggestion to improve communities' place in CE as active participants and contributors (108). To encourage this the organization should consider working with communities in programs to evaluate their capacities, and if and how they can contribute to particular interventions. This should be done systematically.

III. Further operational research should be conducted. This research should include an ethnographic approach, replicating the themes in this study's interviews, but also incorporating communities as participants in the sampling. This would mediate the limitation of this study and the exclusion of communities from the study population.

IV. Changing the way MSF engages with communities will require a change management approach and should consider theories on organizational change. The findings from this study could be applied to frameworks such as the Multipolar Performance Framework (MPF), in order to identify specific areas of misalignment and bottlenecks in the organization, feedback loops and unintended consequences of current practices. Subsequently, this could help the organization better steer change in the appropriate direction.

V. While not sufficient alone to bring change, training on CE at all levels of the organization should be conducted to reduce the gap in understanding between what is written in MSF documentation and what is understood by employees at different levels. A support framework should be put in place, and coaching available on how to incorporate this approach. The existing mentoring and on-boarding programs could be entry points for these trainings and support.

VI. Resources, including finances and HR must be consistently allocated to CE in every project and mission.

VII. Monitoring and evaluation systems for CE need to be revised. Current systems do not evaluate processes of CE, nor are there any attempts to measure power sharing, or ownership of communities. Monitoring needs to move beyond behaviour change. Perspectives of communities should be regularly included in monitoring and evaluation.

I would also recommend further research on this topic, both to with the goal of expanding on this initial exploratory research, and to improve on it given the limitations detailed above. First, intrigued by the proposition of Van Belle, Rifkin, and Marchal (89), I would recommend taking the results of this initial study and leveraging them to conduct a realist evaluation of community engagement in an MSF program. Using this initial exploratory research framing community engagement from the perspective of program designers and implementers, to construct a program theory, which could then be used to assess and compare across sites within one mission. Second, I would recommend conducting a similar study with another medical humanitarian organization including CE in their programs. This would allow a point of comparison between organizations. Third, in the future, I would recommend looking further into the interactions of humanitarian interventions, community engagement, and coloniality, and the impact context on community engagement. A further subject that bears attention at MSF is the organization’s accountability towards communities.

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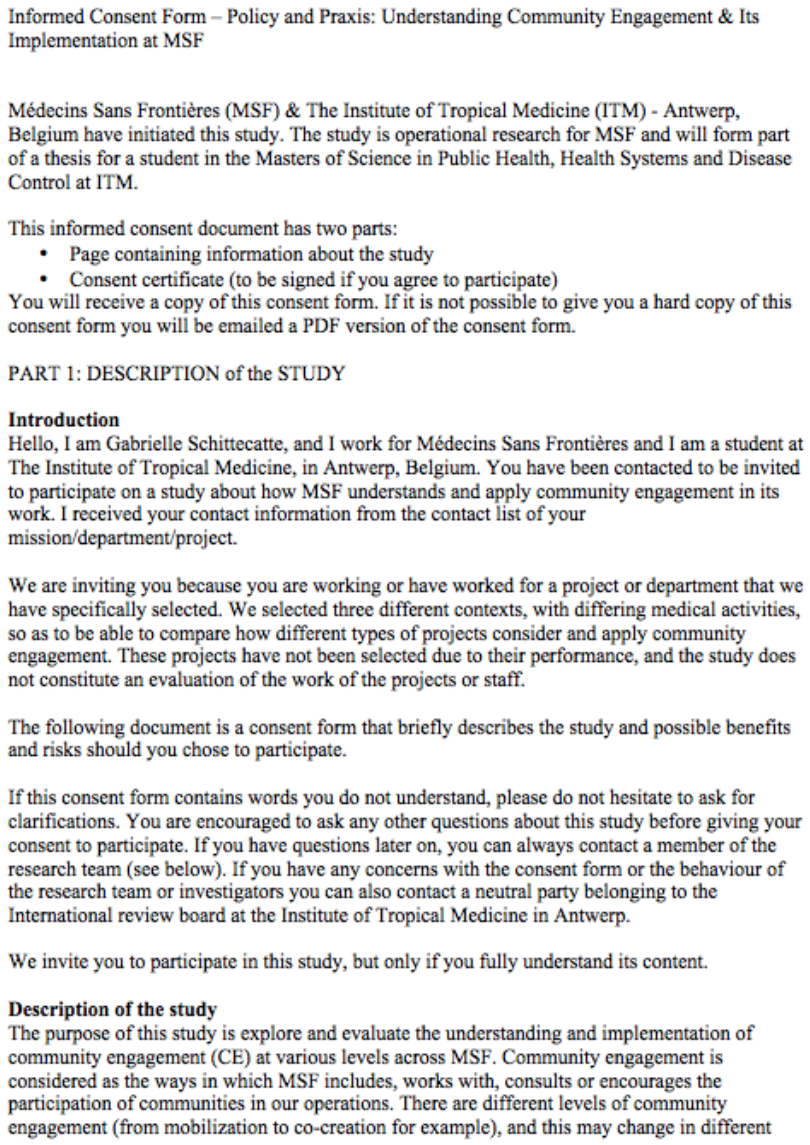
Annexes

Annex I Informed Consent Sheet



Informed Consent Form – Policy and Praxis: Understanding Community Engagement & Its Implementation at MSF

Médecins Sans Frontières (MSF) & The Institute of Tropical Medicine (ITM) - Antwerp, Belgium have initiated this study. The study is operational research for MSF and will form part of a thesis for a student in the Masters of Science in Public Health, Health Systems and Disease Control at ITM.

This informed consent document has two parts:

- Page containing information about the study
- Consent certificate (to be signed if you agree to participate)

You will receive a copy of this consent form. If it is not possible to give you a hard copy of this consent form you will be emailed a PDF version of the consent form.

PART 1: DESCRIPTION of the STUDY

Introduction
Hello, I am Gabrielle Schittecatte, and I work for Médecins Sans Frontières and I am a student at The Institute of Tropical Medicine, in Antwerp, Belgium. You have been contacted to be invited to participate on a study about how MSF understands and apply community engagement in its work. I received your contact information from the contact list of your mission/department/project.

We are inviting you because you are working or have worked for a project or department that we have specifically selected. We selected three different contexts, with differing medical activities, so as to be able to compare how different types of projects consider and apply community engagement. These projects have not been selected due to their performance, and the study does not constitute an evaluation of the work of the projects or staff.

The following document is a consent form that briefly describes the study and possible benefits and risks should you chose to participate.

If this consent form contains words you do not understand, please do not hesitate to ask for clarifications. You are encouraged to ask any other questions about this study before giving your consent to participate. If you have questions later on, you can always contact a member of the research team (see below). If you have any concerns with the consent form or the behaviour of the research team or investigators you can also contact a neutral party belonging to the International review board at the Institute of Tropical Medicine in Antwerp.

We invite you to participate in this study, but only if you fully understand its content.

Description of the study
The purpose of this study is explore and evaluate the understanding and implementation of community engagement (CE) at various levels across MSF. Community engagement is considered as the ways in which MSF includes, works with, consults or encourages the participation of communities in our operations. There are different levels of community engagement (from mobilization to co-creation for example), and this may change in different

settings and across time. Communities can both be defined geographically, or by shared traits (e.g. a community of a certain village or neighbourhood or a community of expecting mothers). Our objective in this study, and why we are proposing you to participate, is to support MSF improving the way it engages with an includes communities in its responses, particularly in outbreaks, so as to increase the quality of care, both of which are part of MSF's strategic objectives.

The interview, in which we are asking you to take part, will consist of us asking you some questions, and will take about 45-60 minutes. If you consent, we would also contact you after the data collection and analysis is completed in order to share our findings with you and receive your feedback, should you wish to provide it.

Selection of the participants
As mentioned above, we would like you to propose to participate in this study because you work in or with one of the missions or projects we have chosen to include in our research. Individuals at project, coordination, and headquarters have been included in the sample. Individuals from project to coordination level have been purposefully selected in 2-3 projects across 3 missions. The operational units responsible for these missions have also been selected, as have individuals in the medical department. There will be approximately 75 participants.

Participation
The participation is voluntary; you are free to decide if you participate or not. This study and your participation are not evaluation of you or your work for MSF. Participating will not effect in any way the evaluation of your work or your commitment to MSF.

Risks
There is no overt risk linked to participating in this study. However, the interview may provoke reflections that are upsetting or difficult to process in regards to the work you do with MSF. You are free to decide to stop participating at any moment, and an MSF psychological support unit is available to be called should you need.

Advantages
The interview process will provide you with a space to discuss CE and its role in MSF and in your work. The interview collected will be analysed to support the process of CE in MSF's operations, and as such you will be able to use your experiences and reflections to contribute to the critique, and evolution of CE at MSF. The interview will also allow you a moment to reflect and discuss CE and reflect on what this means for your work, relative to MSFs *Strategic Orientations.*

Confidentiality
We will not share any information that you give us with any other people outside our research team. The collected information will be kept confidential. Your interview will in anonymized, and all identifying information will be removed for the analysis. Interview details will not be shared with any member of your team nor your manager or coordinator. Only the Principal Investigator will have access to your audio-recordings. However, the risk of being identified by opinions or ideas shared cannot be removed entirely. Completely anonymity cannot be

Politique et praxis: comprendre l'engagement communautaire et sa mise en œuvre à MSF

Médecins Sans Frontières (MSF) et l'Institut de Médecine Tropicale (ITM) - Anvers, Belgique ont lancé cette étude. L'étude est une recherche opérationnelle pour MSF et fera partie d'une thèse pour un étudiant de la maîtrise ès sciences en santé publique, systèmes de santé et contrôle des maladies à l'ITM.

Ce document de consentement éclairé comprend deux parties:

- Page contenant des informations sur l'étude
- Certificat de consentement (à signer si vous acceptez de participer)

Vous recevrez une copie de ce formulaire de consentement. S'il n'est pas possible de vous donner une copie papier de ce formulaire de consentement, vous recevrez par courriel une version PDF du formulaire de consentement.

PARTIE 1: DESCRIPTION DE L'ÉTUDE

Introduction

Bonjour, je suis Gabrielle Schittecatte, je travaille pour Médecins Sans Frontières et je suis étudiante à l'Institut de Médecine Tropicale, à Anvers, Belgique. Je vous contacte pour vous inviter à participer à une étude sur la manière dont MSF comprend et applique l'engagement communautaire dans son travail. J'ai reçu vos coordonnées de la liste de contacts de votre mission / département / projet.

Nous vous invitons parce que vous travaillez ou avez travaillé pour un projet ou un département que nous avons spécifiquement sélectionné. Nous avons sélectionné trois contextes différents, avec des activités médicales différentes, afin de pouvoir comparer la manière dont différents types de projets considèrent et appliquent l'engagement communautaire. Ces projets n'ont pas été sélectionnés en raison de leurs performances et l'étude ne constitue pas une évaluation du travail des projets ou du personnel.

Le document suivant est un formulaire de consentement qui décrit brièvement l'étude et les avantages et risques possibles si vous choisissez de participer.

Si ce formulaire de consentement contient des mots que vous ne comprenez pas, n'hésitez pas à demander des éclaircissements. Vous êtes encouragé/e à poser toute autre question sur cette étude avant de donner votre consentement à participer. Si vous avez des questions plus tard, vous pourrez toujours contacter un membre de l'équipe de recherche (voir ci-dessous). Si vous avez des doutes concernant le formulaire de consentement ou le comportement de l'équipe de recherche ou des enquêteurs, vous pourrez également contacter une partie neutre appartenant au comité d'examen international de l'Institut de Médecine Tropicale d'Anvers.

Nous vous invitons à participer à cette étude, mais uniquement si vous en comprenez parfaitement le contenu.

Description de l'étude

Le but de cette étude est d'explorer et d'évaluer la compréhension et la mise en œuvre de l'engagement communautaire (CE) à différents niveaux dans MSF. L'engagement communautaire est compris comme étant la manière dont MSF inclut, travaille avec, consulte, ou encourage la participation des communautés à ses opérations. Il existe différents niveaux d'engagement communautaire (de la mobilisation à la cocréation par exemple), et cela peut changer dans différents contextes et au fil du temps. Les communautés peuvent à la fois être définies géographiquement ou par des traits communs (par exemple, une communauté d'un certain village ou quartier ou une communauté de femmes enceintes).

Notre objectif dans cette étude, et pourquoi nous vous proposons de participer, est d'aider MSF à améliorer sa manière de s'engager avec et d'inclure les communautés dans ses réponses, en particulier en cas d'épidémie, afin d'améliorer la qualité des soins, qui font tous deux partie des objectifs stratégiques de MSF.

Sélection des participants

Comme nous avons mentionné ci-dessus, nous aimerions que vous accepteriez de participer à cette étude parce que vous travaillez dans ou avec l'une des missions ou projets que nous avons choisi d'inclure dans nos recherches. Des personnes travaillant au projet, à la coordination, et au siège ont été incluses dans l'échantillon. Des individus du niveau projet au niveau coordination ont été sélectionnés à dessein dans 2-3 projets répartis sur 3 missions. Les unités opérationnelles chargées de ces missions ont également été sélectionnées, ainsi que des personnes du service médical. Il y aura environ 75 participants.

Participation

La participation est volontaire; vous êtes libre de décider si vous participez ou non. Cette étude et votre participation ne sont pas une évaluation de vous ou de votre travail pour MSF. La participation n'affectera en aucune manière l'évaluation de votre travail ou votre engagement envers MSF.

Des risques

Il n'y a pas de risque manifeste lié à la participation à cette étude. Cependant, l'entretien peut provoquer des réflexions bouleversantes ou difficiles à appréhender par rapport au travail que vous faites avec MSF. Vous êtes libre de décider d'arrêter de participer à tout moment, et une unité de soutien psychologique MSF est disponible pour être appelée si vous en avez besoin.

Avantages

Le processus d'entretien vous fournira un espace pour discuter de la CE et de son rôle au sein de MSF et dans votre travail. L'entretien recueilli sera analysé pour soutenir le processus de CE dans les opérations de MSF, et en tant que tel, vous pourrez utiliser vos expériences et réflexions pour contribuer à la critique et à l'évolution de l'EC à MSF. L'entretien vous permettra également de réfléchir et de discuter de CE et de réfléchir à ce que cela signifie pour votre travail, par rapport aux orientations stratégiques de MSF.

Confidentialité

Nous ne partagerons aucune information que vous nous communiquez avec d'autres personnes extérieures à notre équipe de recherche. Les informations collectées resteront confidentielles. Votre entretien sera anonymisé et toutes les informations d'identification seront supprimées pour l'analyse. Les détails de l'entrevue ne seront partagés avec aucun membre de votre équipe, ni votre manager ou coordinateur. Seul la chercheuse principal aura accès à vos enregistrements audio. Cependant, le risque d'être identifié par des opinions ou des idées partagées ne peut être entièrement supprimé. L'anonymat complet ne peut pas être garanti car vous pourrez peut-être être identifié/e en fonction de ce que vous partagez lors de votre entretien. Pour réduire les chances d'identification après votre entretien, nous vous enverrons la transcription de votre entretien

Diffusion des résultats

Nous vous recontacterons après l'analyse des données pour partager nos résultats avec vous et recevoir vos commentaires sur ces résultats.

Droit de refuser

Vous n'êtes pas obligé de participer à cette étude, vous êtes libre de refuser. Cela ne vous affectera en aucun cas. Le refus de participer n'a aucun effet sur votre emploi chez MSF.

Contact

Pour toute question, préoccupation ou commentaire avant et / ou après l'entretien, veuillez contacter la chercheuse principale Gabrielle Schittecatte; gabrielle.schittecatte@msf.org; (téléphone ou Whatsapp) +32474 42 41 31

En cas de faute de la chercheuse ou de l'équipe de recherche, veuillez contacter Raffaella Ravinetto du Comité d'examen institutionnel à irb@itg.be.

PARTIE II: LE CERTIFICAT DE CONSENTEMENT

Je confirme avoir été informé de cette étude. Les informations m'ont été lues et expliquées et j'ai compris le but et le processus. J'ai eu l'occasion de poser des questions auxquelles on a répondu à ma satisfaction. J'accepte volontairement de participer à cette étude.

Nom du participant / témoin: ________________________________

Signature du participant / témoin: ________________________________

Date: ___/___/___

Formulario de consentimiento informado: política y praxis: comprensión de la participación comunitaria y su implementación en MSF

Médecins Sans Frontières (MSF) y el Instituto de Medicina Tropical (ITM) - Amberes, Bélgica han iniciado este estudio. El estudio es una investigación operativa para MSF y formará parte de una tesis para un estudiante de la Maestría en Ciencias en Salud Pública, Sistemas de Salud y Control de Enfermedades en ITM.

Este documento de consentimiento informado tiene dos partes:
- Página que contiene información sobre el estudio
- Certificado de consentimiento (debe ser firmado si acepta participar)

Recibirá una copia de este formulario de consentimiento, si no es posible darle una copia impresa de este formulario de consentimiento, se le enviará por correo electrónico una versión en PDF del formulario de consentimiento.

PARTE 1: DESCRIPCIÓN DEL ESTUDIO

Introducción

Estimado Lector/a, soy Gabrielle Schittecatte, trabajo con Médecins Sans Frontières y soy estudiante en el Instituto de Medicina Tropical, en Amberes, Bélgica. Se le ha contactado para ser invitado a participar en un estudio sobre cómo MSF entiende y aplica la participación de la comunidad en su trabajo, cabe mencionar que obtuve información sobre usted utilizando la lista de contactos de su misión / departamento / proyecto.

Te invitamos porque estás trabajando o has trabajado para un proyecto o departamento que hemos seleccionado específicamente. Seleccionamos tres contextos diferentes, con diferentes actividades médicas, esto con el fin de poder analizar ¿Cómo? diferentes tipos de proyectos consideran y aplican el compromiso de la comunidad. Estos proyectos no han sido seleccionados por su desempeño y el estudio no constituye una evaluación del trabajo de los proyectos o del personal.

El siguiente documento es un formulario de consentimiento que describe brevemente el estudio y los posibles beneficios y riesgos en caso de que decida participar.

Si este formulario de consentimiento contiene palabras que no comprende, no dude en pedir aclaraciones. Se le anima a hacer cualquier otra pregunta sobre este estudio antes de dar su consentimiento para participar. Si tiene preguntas más adelante, siempre puede comunicarse con un miembro del equipo de investigación (ver más abajo).
Si tiene alguna inquietud sobre el formulario de consentimiento o el comportamiento del equipo de investigación o de los investigadores, también puede comunicarse con una parte neutral que pertenezca a la junta de revisión internacional del Instituto de Medicina Tropical en Amberes.

Lo invitamos a participar en este estudio, pero solo si comprende completamente su contenido.

Descripción del estudio

El propósito de este estudio es explorar y evaluar la comprensión e implementación de la participación comunitaria (CE) en varios niveles en MSF. La participación de la comunidad se