

Triaging Community Feedback: A Participatory Approach

This briefing provides guidance on how to facilitate a participatory workshop with community members to:

- 1) discuss how they share and receive information during health emergencies and humanitarian crises;
- 2) understand which channels and sources of information participants (mis) trust and why;
- 3) to prioritise the importance of different concerns and worries they might have and to collectively determine which are the most urgent to address; and
- 4) to discuss and identify locally led, trusted solutions to addressing urgent feedback.



Health emergencies and humanitarian crises are often accompanied by heightened concerns and anxiety amongst the population, whether about the disease or the nature and consequences of emergency response measures. This can exacerbate community tensions or fuel feelings of mistrust towards national governments and external partners. In an environment where trust is weakened, these concerns may manifest themselves as misinformation or rumours or other forms of unverified information that can negatively impact the effectiveness of response efforts.

This problem is accentuated by phenomena such as increasing access to the internet and the growth of social media, and practitioners increasingly speak of an ‘infodemic’ surrounding health emergencies—that is the rapid circulation of large amounts of information, including misleading and false news.^{1,2} We also know however, from research in health emergencies, that circulating rumours or concerns rarely signal simply a misunderstanding or a failure to access ‘correct’ information.³ Rather, these narratives often express deep-seated patterns of mistrust in institutions and

organisations delivering emergency responses as well as histories of exclusion and marginalisation.^{4,5} Conversely, our research shows that the trustworthiness of information is determined by the characteristics of those delivering the message—for example their perceived honesty and accountability as well as their social proximity.

In recent years, we have seen the growth and development of robust Risk Communication and Community Engagement (RCCE) approaches that have increased the inclusion of the perspectives and experiences of people directly affected by crisis in the planning and delivery of emergency responses.⁶ Such efforts have also led to the proliferation of toolkits and strategies developed to collect community opinions and feedback during emergencies. This reflects a growing consensus that emergency responses cannot be successful if they do not manage to win and maintain the trust of affected populations. Attempts to track community opinions, experiences and feedback aim to identify social and political dynamics that may be relevant to the organisation of a response, trace the potentially undetected spread of disease within communities, gather feedback on ongoing operations and identify concerns and misinformation.* These inputs are collected through a large range of methods including rigorous programmes of social science research, social listening

by community mobilisers, the establishment of toll-free phone lines and text messaging services, and the scraping of social media data. There is also significant ongoing innovation in how such data are analysed and displayed, for example through interactive dashboards to be connected with programmatic goals. As RCCE practitioners face this often overwhelming amount of data, a challenge remains in terms of how to act on it, and particularly, on which information to prioritise for action.

Despite growing attention on the potential dangers of ‘infodemics’, for example, there are still several untested assumptions that underpin the sector’s engagement with misinformation, rumours and concerns. These include the relationship between concerns that people may express, on the one hand, and behaviour on the other, as well as the extent to which misinformation circulating online reflect real-world concerns. From a data point or a trend in the data that shows that a certain piece of information is circulating (virtually or within communities), we cannot necessarily deduce that this is believed by those who share it or that it will meaningfully or solely influence their health-seeking or disease prevention behaviour during an emergency. For example, the introduction of novel vaccines is often accompanied by doubts and mistrust, and there tends to be an assumption amongst implementers of vaccination campaigns that these reflect unwillingness to be vaccinated. This is however not always borne out by vaccination data across different contexts, and qualitative research has shown that people often take these vaccines *despite* their concerns.⁷ An overinterpretation of the significance of certain concerns because they emerge from social listening data can, furthermore, erode relationships with communities if groups or individuals feel blamed for being ‘resistant’ or ‘hesitant’ simply for asking valid questions or voicing genuine worries. Similarly, this can lead to underestimating other problems that are contributing to potential difficulties with uptake, such as access. An additional challenge is that analysis of social listening data* does not always differentiate between what is immediately actionable and what might be longer-term considerations. For example, if we identify narratives of mistrust in government, rooted in longer political histories, leading to doubts being cast on the delivery of an emergency programme, what can an RCCE practitioner do in the short term? In these instances, it is important to be able to differentiate short-term operational opportunities from long-term, structural recommendations that require situating rumours and concerns in broader approaches to building trust in institutions and state-building. Ignoring the longer-term need to re-establish confidence between government and citizens, for example, will result in cyclical challenges with crisis response, but expecting to address it over the course of a single emergency response is also not realistic.

Addressing these challenges will require a complex range of activities, including more sophisticated analytical approaches to distinguish between types of information; establishing relationships between



circulating information and behaviour; and strengthening integration between emergency responses and development programming. There are however more defined, practical interventions that can help us ‘triage’ the concerns and feedback that we identify in our data, and to determine which information needs to be prioritised, how and when to do so. One example is IFRC’s community feedback tool at at: bit.ly/3XgNb8k, which differentiates between ‘operational’ and ‘big picture’ feedback, as well as proposing mechanisms for escalating ‘critical feedback’. It can however be difficult for humanitarian actors to know how and what to prioritise and to ensure that longer-term advocacy continues to inform work beyond the emergency, both of which could undermine trust if communities feel they are not being listened to. Here we propose an additional tool: guidance to facilitate participatory workshops to determine, together with affected communities, the social significance of different types of information, including concerns and misinformation, how to prioritise them and how to identify immediate, medium-term and long-term action to address them. As a long tradition in participatory methods has shown us, a critical starting point for identifying local issues and solutions is to ask people affected by crisis to contribute their perspectives. This is effective for identifying local solutions whilst also helping to build trust. This workshop guidance has been adapted from a methodological approach developed for a study on the relationship between online and offline information pathways in Sierra Leone in Tanzania and a programme of research on evidence, (mis)trust and pandemic preparedness in Sierra Leone.



* See for example IFRC’s community feedback tools at: bit.ly/3XgNb8k.^{8,9} Other examples include Oxfam’s Community Perceptions Tracker at: bit.ly/46WqkIC or Internews’ Rumour Tracking Tool at: bit.ly/3YZ1obg.

* This includes both the use of community mobilisers collecting feedback within communities as well as analyses of social media data.



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Community Feedback Triage Workshop Methodology

Aims of the workshop:

- To encourage community members to discuss how they share and receive information during health emergencies and humanitarian crises
- To understand which channels and sources of information participants (mis)trust and why
- To prioritise the importance of concerns and other types of feedback circulating within affected communities and collectively determine which are the most urgent to address
- To discuss and identify locally led and trusted solutions to addressing urgent feedback

Set up and planning:

- To limit bias, ideally a trusted local partner (e.g., a well-established community-based NGO or CBO) should run/facilitate the workshop
- Facilitators must take care to highlight that this is a safe space for people to voice their concerns, even if these are difficult or impossible to solve. This means listening without judgement, not correcting people, taking note of structural factors, and prompting on how realistic the proposed actions are

Participants:

- In order to have a productive conversation we would suggest having approximately 10–12 participants
- Representatives of different sections of the town/village/neighbourhood
- Make sure that it is not simply people who are 'formal' leaders who are invited, but also those who may have informal authority and be trusted by different groups (e.g., youth influencers, teachers, birth attendants, traditional healers, football coaches, market traders etc)
- Some prior research may be required to understand local dynamics in order to select participants

- Depending on local norms, it may be useful to run several workshops, especially if certain groups of people may feel uncomfortable speaking up in front of others – e.g., by gender, generation or leadership type

Resources needed:

1. Post it notes;
2. Flip charts (one page per concern), pens, refreshments, recorders;
3. Good note takers who can capture the discussions and take pictures of the flipcharts;
4. Stones/beans to be distributed for sorting exercises.

Facilitation:

Discussion should be facilitated in whichever language the community members are most comfortable in. If needed, recordings may be then transcribed and translated.

Time required:

2 hours at least

Note:

This guide uses a cholera outbreak as an example but this can be adapted for any other health emergency.

Introductions and Setting the Scene:

Facilitators will start the workshop by introducing themselves, and asking participants to introduce themselves. Informed consent processes should be carried out to make sure that participants are aware of the aims of the workshop, how their privacy will be protected and how the data will be used. This should be followed by an overview of the workshop and setting of ground rules for the group to work together (e.g., ensuring everyone's confidentiality, respecting everyone's opinion etc).

Session 1: Information mapping*

Facilitators introduce this session by letting participants know that they will focus their questions on sources of information and what makes us trust information or not. After each question, facilitators should make sure to solicit answers from different participants and ask others to comment on whether they agree or disagree with what others have said and stimulate debate. If possible, ask people for concrete examples and follow up on answers, asking participants to expand and justify them. Prompts in brackets are there to stimulate discussion in case these issues are not brought up by the participants themselves.

- Where do people in this community get information about health?
- Where do you get information about health?
 - Prompts:** *talking to family/friends/neighbours; work; health centre/health worker; church/religious setting; TV; radio; internet, social media, billboards; magazines.*
- What types of information do you trust/not trust and why?
- What makes you trust a piece of information?
 - Potential prompts:** *e.g., the source/person you've heard it from (family member, friend, neighbour, work colleague, health worker, news item, government announcement, particular website etc.); the format it is delivered in (told to you by someone, printed leaflets, radio broadcast, social media post; TV ad etc.); the kind of content (e.g., practical advice on what to do, interesting story that's being shared in the neighbourhood, official advice/health warning etc.).*
- What channels of information do you trust the most and why?—*If a prompt is needed, a channel is the format the information is provided in, for example TV, radio, WhatsApp or social media.*
- What channels of information do you trust the least and why?
- What sources of information do you trust the most and why?—*If a prompt is needed, a source refers to who the information is coming from, for example friends and family, community leader, government official, health care worker or religious leader.*
- What sources of information do you trust the least and why?
- How do you know if what you hear from other people in your community is accurate? How can you check whether it is trustworthy?
- If you needed information about a government health service (e.g., cholera vaccine), where would you go? Have you ever done this? What happened?
- If you wanted the government to do something (e.g., fix sanitation in your neighbourhood) what would you do and who would you approach? Do you feel you would get a response?

Session 2: From information to action

- What helps you make decisions about your health?
 - Prompt if necessary:** *is there someone you speak to or ask for advice? Are there specific services or types of information that help you decide what to do?*
- Health journey:
 - Take a flipchart and draw a road on it
 - Introduce the exercise to participants: this road is a road to health and we want to discuss all the different steps that we would take when we are unwell to get better. Explain that the starting point on the road is the point at which someone feels unwell and that the point at the end of the road is the point at which they have fully recovered.
 - Start labelling each step and asking the group to comment on what some challenges might be at each step.
 - If there is a difference of opinion amongst the group in the steps that they would take, then give participants different coloured pens so that they can draw a new road alongside the one you have drawn on the flip chart. Ask them to mark out their individual steps on the new road. You can create as many different roads on the flip chart as needed. Alternatively, give each participant a separate piece of paper to draw their road and the steps they would take to get better and then discuss the similarities and differences on each road together as a group. If you have a larger group you could ask them to divide into smaller group and draw their roads together.

Ask people, when they explain their steps, to give examples of when they or someone they know had a similar experience. For each step, you might use locally meaningful prompts to stimulate the conversation: e.g., ask local Community Health Worker for advice, seek help from a traditional healer, go to the local pharmacy, go to the hospital etc. Make sure that you reassure participants that there is no right or wrong answer and that there is no judgement attached to anything they say, and that disagreement is not a problem.

 - For each step ask:
 - » How would you make this decision?
 - » What information would you need to make this decision?
 - » Where would you find this information?
 - » Who would help you to make this decision?
 - » What information might put you off going to one health provider over another?
 - » What other factors will influence the decision you make?
 - » What would you do next (and move to the next until, as a group, you reach a final health outcome).

* Note that if partners have already conducted an information ecosystem mapping exercise or a needs assessment with these questions, it may not be necessary to repeat this session—however it may also serve as a useful validation exercise.

Session 3: Emergency specific questions

Here we use questions about cholera as an example, but questions can be adapted to any type of emergency.

- What have you heard about cholera?—*If there is a local term for cholera then use this term instead.*
- What do people say in your community about cholera?—*Emphasise that these can be both things they believe to be true or untrue.*
 - **Prompt if necessary:** *What is cholera? Where does it come from? How can you get cholera? How can you treat cholera?*
- What kind of opinions do people have about cholera?
 - What do people in your community do about these opinions and concerns?—*Props: e.g., they spread these stories, discuss them with others, ask people for advice, dispute these, ask a trusted influential leader to address them.*
 - How do these opinions and concerns affect people's health journeys?—*Ask participants to look back at the health journey map they drew and discuss how these opinions and concerns might change the path, or not, and explain why.*
 - **Prompts:** *do these opinions affect what decisions you make about seeking health? If someone had symptoms of cholera, how might these opinions affect what they or their relatives/friends do about it?*
- What are you doing in response to cholera? What is your community doing in response to cholera?
- Where do you get information about cholera?
- What information do you trust about cholera? Which do you not trust? Why?
- What helps you make decisions when it comes to cholera prevention and treatment? What challenges do you face?

Session 4: Concerns triage-sorting exercise

4.1

Based on the discussion from the previous session, ask the group to write on separate flipcharts the different opinions/concerns* they have heard in their communities about cholera. Place the flipcharts in a line in the room and ask participants to stand in front of them and familiarise themselves with them. If any participant cannot read, make sure there is a member of the facilitation team ready to help them with the sorting exercise.

4.2

Give each participant an equal amount of stones/beans or any other small object that can be easily sourced. Ask the following question:

- Which of these opinions/concerns have you heard the most?

4.3

Ask participants to place the stones on the flip charts according to the issues they have heard the most to least— i.e. each individual should put the most stones on the issue they heard the most and the least on the one they heard the least. Emphasise that they do not need to rank which concerns them the most yet, just the ones that they hear around their community most frequently. Give each participant time to make changes if necessary. Then ask the group to discuss if they think the ranking is accurate and whether there are any disagreements/surprises over where others placed their stones. Then ask:

- Where did you hear these opinions/concerns?
- What did you think of them? Which of these do you think are true/untrue?
- Do any of these worry you? Why?

Take a picture of the flipcharts before moving on.

4.4

If participants answered that some of the beliefs and concerns do worry them, choose the top 5 opinions/concerns (i.e., those that were heard most often) and clear the flipcharts, giving participants their stones back. Ask them to do the same sorting exercise again but now to answer the following question:

- Which of these worry you the most?

If participants answered that they were not worried about any of the most commonly heard opinions/concerns then skip 4.4 and move to 4.6.

* Note that we deliberately use neutral language here to encourage an open discussion, without passing judgement on different types of information by labelling it misinformation or rumour.

4.5

Once this sorting is complete ask the group to discuss their choices:

- Why do these worry you the most? How might they affect your decisions?
- Are there any disagreements in the group about which concern is the most worrying? Why?

4.6

Ask the participants to sit down again, keeping the flipcharts in view, and ask the following questions:

- If you were working for the cholera response, which concerns would you prioritise (i.e. which would you address first, second, third etc)? Why?
- Which concerns need to be dealt with straight away (e.g., in the next ~1-6 months)?
- Which concerns do you think need to be addressed in the medium term (e.g., in the next ~6-12 months)?
- Which concerns do you think can be dealt with in the longer-term (e.g., in the next 1+ year)?
- Ask the following questions **separately** for the short-term, medium-term, and longer-term concerns:
 - How would you address these issues?
 - Whose responsibility do you think it is to address these issues?
 - What can people in your community do to address these issues? What kind of support would your community need to implement these solutions?—*Keep in mind that people might use this to make requests for specific assistance and look for resources, so it is important to manage expectations.*
 - Why do you think it's difficult to address some of these things? Which ones are most difficult/easiest?
 - Who from your community should be involved in implementing these solutions?

4.7

Explain that the exercise has now concluded and thank participants for their time. Reiterate that the data collected will be anonymously/confidentially shared with agencies and government departments working on the response and used for advocacy purposes. If possible, you may wish to commit to returning to the community in one month to share updates on how the feedback is being/will be acted on. However, only do this if you are certain that you can keep your commitment to hold the meeting. Remember, even if there are no concrete actions taken after one month it is still important to keep the community updated of this.

Disseminating findings and developing actions

After you have completed the workshop, it is important to write up and present your findings to key stakeholders within the response as quickly as possible, so that the findings can shape the response interventions in real time. This might be through a report, a PowerPoint presentation or in an email, for example. Identify internal and external meetings (e.g., RCCE pillar meetings), newsletters or online platforms where your findings can be shared and discussed as widely as possible.

You can use an actions tracker to record agreed action to be taken based on the findings and monitor progress in implementation. The IFRC community feedback action tracker is a useful tool for this and can be accessed [here](#).

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