Yemen 2020 *Rana Yonis is one of seven volunteers at COVID-19 Care Center in Aden, Yemen, where she has been volunteering since August 2020. She has been volunteering in different organizations since 2011. "I got into volunteering because I saw my neighborhood suffer. I thought I have to do something to help. So I joined the Red Crescent." © Anette Selmer-Andresen / NorCross*

2 ENGAGE COMMUNITIES AND LOCAL ACTORS

By integrating local actors and communities into systems, societies can boost their preparedness

Contents

INTRODUCTION

The experience of the COVID-19 pandemic reinforced that local actors and communities need to be at the centre of epidemic and pandemic prevention, preparedness and response. While governments have the primary responsibility for responding to needs and coordinating the response, local actors and communities have essential roles to play.

Communities have many roles, including but not limited to: voicing needs and concerns, contributing local knowledge, problem analysis and co-construction of solutions. Community voices are key because health services and disaster management systems must be relevant, contextually appropriate and co-owned by communities. Many of this report's messages and recommendations are ultimately based on lessons learned from communities.

Meanwhile, recognized and trained local actors, by virtue of their proximity and pre-existing access to communities, can perform frontline tasks such as preparedness, community-based surveillance, strengthening health literacy, and supporting the extension of basic health services to the most vulnerable. Local actors have a very significant role in building trust, strengthening equal access to health and community health systems, and enabling early and effective action – all essential elements of disease control.

Definitions

Disease prevention: Actions designed to avoid the emergence of a disease in the first place (primary prevention); to detect and respond early once the disease manifests (secondary prevention); or to reduce the further spread of the disease at further stages (tertiary prevention) (WHO, no date).

Disease outbreak preparedness: The capability of the public health and health care systems, communities and individuals, to prevent, respond to, and recover from health emergencies. Preparedness is not a steady state; it requires continuous improvement. It also includes the practice of improving the health and resiliency of communities (Nelson, 2007).

Community-based surveillance: The systematic detection and reporting of events of public health significance within a community by community members (IFRC, no date a).

Bangladesh 2021 *Bangladesh Red Crescent volunteers helping an elderly woman named Majeda Khatun who has been recently released from Satkhira Sadar Hospital after getting admitted with COVID-19 symptoms. © Mir Hossen Roney*

2.1 WHAT WE SAW
COMMUNITIES THAT NEEDED HELP OFTEN DID NOT GET IT

Again and again during the COVID-19 pandemic people did not receive the help they needed. In a number of other cases, they have rejected public health advice when offered. In this chapter, we explore some of these problems and how they could have been averted had we paid more attention to local actors and communities, and the role they play in community health systems. In the final section we draw on some positive examples of good practice during the pandemic, which point the way to better preparedness at the community level.

One of the most obvious barriers was restrictions on movement for both domestic and international relief personnel. At the domestic level, these were imposed by many governments to slow the spread of the coronavirus. As noted in Chapter 1, such measures can be important public health tools if used in a balanced way. However, they were often applied with incomplete deliberation as to who might be needed to respond and therefore to be included in the risk calculus for (necessarily) narrow exemptions. This made it harder for some types of frontline responders, including trained and supervised volunteers from our National Societies, to visit those who needed their help. In the strictest regimes, face-to-face contact with anyone outside of one's immediate household became almost impossible. For many people, especially those living in poverty, these restrictions on movement made it hard to put food on the table; a problem many National Red Cross and Red Crescent Societies stepped in to address (see Box 2.1) (for more on socioeconomic impacts, see Chapter 4). The global shortage of personal protective equipment (PPE) like face masks in the first half of 2020 aggravated this problem. Without PPE, health workers could not safely attend to vulnerable and infected people (Burki, 2020). Many had to do without, thus risking their own health and ability to contribute to the COVID-19 response (WHO, 2020).

At the international level, many countries failed to nuance entry requirements to find particular solutions for international relief personnel. Of course they, like anyone, could have been carriers of disease but systems were not ready with bespoke protective solutions to fast-track this group. As a result, those countries received little or no international assistance – and had to rely solely on their own systems (UN OHRLLS, no date).

In some cases, this meant local actors were able to take a lead role. For example, in April 2020 Tropical Cyclone Harold struck Vanuatu and Fiji. In both countries, National Red Cross and Red Crescent Societies were well established and able to take the lead. Their decentralized networks performed assessments, distribution, coordination and community liaison. There was a shift in the power dynamics between national and international IFRC network actors during this response. More emphasis was placed on local leadership and national government partnerships. This shift was enabled by long-standing capacity development programmes that invested in key staff, disaster preparedness programmes, and assets such as pre-positioned relief supplies (Australian Red Cross, 2020).

However, in many countries the local response was less effective, due in part to a lack of investment in local capacity both before and during the crisis. Community health systems – and the local actors and communities that run them – were bypassed or not supported to do their jobs as they should. This left national health systems to respond to every need, everywhere.

Some of this has been discussed in Chapter 1. There was an overall lack of investment in community preparedness and prevention, so communities and local actors did not have the resources and expertise they needed to respond to outbreaks. A key failure of preparedness was the limited capacity for community-based surveillance, which is known to be an effective way of detecting new disease outbreaks quickly, but which had been under-resourced. There was also a lack of clear mechanisms for local actors to coordinate with local authorities and national health systems.

On top of this, three linked problems hampered community responses to COVID-19.

First, there was a lack of access to local health services. In many communities, particularly those that did not have an on-site health centre, people who became ill from COVID-19 or other diseases had no one to turn to. In other communities, the local health services became overwhelmed by the huge demand for COVID-19 assistance. As a result, they had to temporarily abandon other needs such as elective surgery, maternal and newborn infant care, routine vaccination, and management of chronic illnesses (Núñez et al, 2021).

Second, many communities have extremely limited access to health education and information (Royston et al, 2020). Many people did not know how to protect themselves and others from the coronavirus. Information provided by social media or state news was not necessarily trusted. People often did not understand the rationale behind public health measures. Some still do not. In many countries, governments gave contradictory advice. Meanwhile, oversimplified beliefs often took hold: for instance, that COVID-19 is only dangerous to the elderly and clinically vulnerable (King's College London, 2020) or, in Zimbabwe, that "COVID-19 does not kill black people" (Erlach et al, 2021). This was compounded by the mass spread of misinformation and disinformation.

Finally, and very much tied to the two previous issues, there was often a lack of trust in health services and other authorities. Multiple studies suggest that **trust** was one of the best predictors of a country's success or failure in handling the COVID-19 pandemic. A 2022 study compared rates of infection and death in 177 countries. Some of the variation in infections and deaths could be explained by obvious factors like the countries' age profiles, COVID-19 being more dangerous to older people. However, one of the strongest correlations was with measures of trust in the government, and of interpersonal trust. Higher levels of trust were associated with lower infection rates and with higher uptake of COVID-19 vaccines where these were available. The study is observational and does not prove causation. However, if increased trust did contribute to the lower infection rates, potentially due to higher compliance with recommended behavioural changes, it implies that trust is truly powerful. Based on this hypothesis, the researchers estimated that if all countries had the same level of trust in government as Denmark, global infections would have been 12.9% lower. Similarly, if all nations had Danish levels of interpersonal trust, infections would have been 40.3% lower (COVID-19 National Preparedness Collaborators, 2022).

Determinants of trust are very complex, and this report cannot hope to address them all. One factor is that governments are seen as having largely failed to tackle crises like COVID-19 and climate change, so some now view them as discredited (Edelman, 2022). This pervasive mistrust is compounded by the fact that vulnerable and marginalized communities are often the least trusting of governments and authorities, which they often view as sources of demands rather than providers of needed services (Bavel et al, 2020). It is these vulnerable and marginalized people who are most at risk from major hazards like COVID-19, yet their social position and experience of historical mistreatment also makes them prone to distrust authorities and organizations that might help them.

These many problems can all be tied back to one central failing: a lack of local capacities. People tend to trust individuals with whom they are familiar, as evidenced by the trust often shown to general practitioners or 'family doctors' who people know for many years (Salisbury, 2021). Unfortunately, many communities did not have the support, funding and prior training they needed to handle COVID-19. They did not have personnel with the necessary training and expertise, and they did not know with whom to coordinate. They also had little exposure to health systems or access to the equipment and other resources they needed.

Guyana 2021 *Melissa Lewis talks about staying safe and healthy during COVID-19, while the Guyana Red Cross team delivers hygiene kits to rivering communities. These communities are impacted by COVID-19, and it is difficult to access cleaning and hygiene items because of distances and lockdown measures. © Angela Hill / IFRC*

BOX 2.1 / CASE STUDY
FOOD AND HYGIENE FOR THE VULNERABLE

From the beginning of the COVID-19 pandemic, the Turkish Red Crescent delivered food and hygiene kits to vulnerable people. By April 2020, it had delivered over 30,600 food boxes and 35,800 hygiene boxes (Paksoy, 2020). Almost 10,000 staff and volunteers were involved.

The volunteers focused especially on those who were not able to leave their homes due to the protective measures and health concerns. These included the elderly and financially vulnerable. The Turkish Red Crescent also delivered meals three times a day to people who were quarantined and thus unable to leave their houses (TRC, 2020).

Türkiye 2020 *Providing support during Ramadan. Red Crescent volunteers across the country helped to provide three meals a day to vulnerable people, totalling more than 3.4 million individual meals. More than 53,000 Turkish Red Crescent volunteers and staff provided critical support to communities during the COVID-19 pandemic. © Turkish Red Crescent*

2.2 WHAT WE LEARNED
COMMUNITIES AND LOCAL ACTORS WERE NEGLECTED

Many of the failures of the COVID-19 response can be attributed to a lack of engagement with local actors and communities, in all phases of the public health emergency management cycle. Many of the problems that have arisen during the COVID-19 pandemic are the result of top-down interventions and over-centralized command and control measures by governments that lacked community engagement and presence or the coordinated assistance of local response actors (Loewenson et al, 2021). Another factor, tied to this one, was a frequent failure to include people who are not part of the formal health sector in decision making. This, de facto, excludes communities and many local actors. Conversely, successful responses to COVID-19 relied on local actors and communities.

In this report, we use the Grand Bargain's definition of **local actors**: "organizations engaged in relief at the local/community level that are headquartered and operating in their own aid recipient country and which are not affiliated to an international NGO" (IASC, 2018). Local actors may be part of a federation, network confederation or alliance, provided they maintain independent fundraising and governance (IFRC, no date b). They have some formal training and are organized into a structure for supervision. In contrast, we define a **community** as simply all the people living in a specified region.

This distinction means the two groups have different roles. For example, in a health emergency, local actors may provide services like basic health assistance, logistics and building health literacy (Garcini et al, 2022), while communities provide input (including co-designing programmes) and feedback.

In practice, local actors and communities are not entirely distinct. Local actors often belong to communities or are close to them, and their value derives in part from that proximity: they can act as gatekeepers to communities. Similarly, communities and community groups often take a highly active role and should not be considered as passive recipients of aid (see Box 2.2).

In the following two sections, we explore in turn how local actors and communities have been neglected and under-used during the COVID-19 pandemic.

BOX 2.2 / CASE STUDY
INDIGENOUS RESILIENCE TO COVID-19 IN CANADA

When the COVID-19 pandemic hit, indigenous leaders in Canada drew on lessons they had learned from the 2009 H1N1 influenza pandemic to develop strategies to protect their communities.

Key indigenous health actors proposed and implemented strategies to mitigate the risks of COVID-19 and document its impact. Culturally appropriate mitigation and treatment strategies were developed and implemented. Indigenous healthcare providers developed and disseminated public health messaging through webinars and videos. Where possible, indigenous case counts, mortality and vaccination rates for on-reserve indigenous populations were tracked.

At the community level, many innovative responses were in evidence. Leaders, acting as sovereign authorities, closed their borders. In some cases, they did so ahead of regional, provincial or territorial orders – and left them closed after those external restrictions had been lifted. Rural and remote communities transformed public buildings into isolation centres for those with COVID-19, or in some cases as alternative housing for elders to protect them and ensure their needs were met.

Existing emergency plans were adapted to respond to the needs presented by the pandemic. Continuation of cultural practices through social media enabled people to connect despite social distancing and lockdowns. Leaders exchanged knowledge with each other related to successful confinement and mitigation practices. They also sought to put in place strategies to ensure their communities experienced as little interruption in accessing health programmes and services as possible.

Many indigenous communities continued to endure structural inequalities stemming from historical colonisation. These include insufficient housing options leading to overcrowding, lack of access to clean water, and mistrust of a healthcare system where they have experienced discrimination and racism. These inequalities resulted in disproportionate numbers of H1N1 cases. Until they are addressed and resolved, indigenous communities will be impeded in their efforts to fully implement pandemic public health measures. Nevertheless, the indigenous response to COVID-19 was boosted by strong leadership, cohesive communities, historical memory of lessons learned, sharing of knowledge, and continued resilience.

2.2.1 Local actors were not integrated into policy frameworks

In many countries, local actors were neglected by the leaders of the COVID-19 response (IPPPR, 2021a). They found themselves acting in semi-isolation from health systems and other responders. Legal and policy frameworks used to prepare for and respond to the coronavirus did not integrate local actors. This made it difficult for them to work in tandem with health systems and other responders. National Red Cross and Red Crescent Societies have reported that, when coordination with authorities was close, this was a significant enabler to their response. They were able to scale up the most relevant services, which were complementary to those provided by public authorities and other agencies (Johnston, 2022). However, many other local actors do not have such established relationships with governments and public authorities, and were therefore unable to coordinate with them.

This lack of policy integration fed down into practical difficulties. Prior to the emergence of COVID-19, many countries had not conducted joint exercises between public authorities and local actors. When the pandemic began, local actors attempted to step in, but despite their best efforts the result was often confusion (IPPPR, 2021b). In many cases, local actors did not have access to PPE such as face masks. As mentioned in section 2.1, they often did not have authorization to move around to carry out their tasks, and they found that authorization was unclear, with ill-defined rules. They were not trained to perform their tasks, nor was financial support available.

A key role of local actors is to complement overburdened health systems. When waves of COVID-19 patients began flooding hospitals, local actors like community health workers and volunteers could in theory have taken on additional responsibilities, thus freeing up medical professionals to deal with the most urgent and critical cases. However, where countries did not have policies or systems in place to enable this, the capacities of local actors could not be used to their full potential (Sachs et al, 2022).

These problems are not new. Local actors like community health workers have long been undervalued and underfunded. Many local actors face difficulties accessing international support, which is an issue exemplified by the failure to fund local women's rights organizations during the pandemic, despite the increase in violence against women (IRC, 2021). As a result, the pandemic took a heavy toll (Lotta et al, 2022). Even in New Zealand, where the coronavirus was well controlled for many months, community health workers reported major impacts on their wellbeing. A survey published in 2022 found they faced "significant risks to personal and professional relationships", "considerable stress and anxiety" and "personal isolation and loneliness as a result of lockdown restrictions". The researchers recommended that community health workers' "crucial role" should be acknowledged and that they be supplied with PPE, improved remuneration including time off, and regular counselling and support (Holroyd et al, 2022).

2.2.2 A lack of engagement with communities

Health systems and other actors have repeatedly failed to engage with communities during the COVID-19 pandemic. Community engagement is known to be essential to effective health and disaster responses (Corbin et al, 2021). This is partially why the Risk Communication and Community Engagement (RCCE) Collective Service was established by the IFRC, United Nations Children's Fund (UNICEF) and World Health Organization (WHO) (RCCE, no date), and why the humanitarian community pledged to a major transformation of practice, a 'participation revolution', in the 2016 Grand Bargain (Grand Bargain, no date). However, historically it has often been done either partially or not at all (IFRC, 2019). This pattern has been repeated in the COVID-19 response.

When it comes to the 'risk communication' aspect of community engagement, responders have often failed to establish genuine two-way dialogues with communities. Centrally designed and rather anonymous messages have been pumped out about everything from wearing face masks and social distancing to vaccination. Such public information – while valuable – is only one-way and impersonal, and it can therefore easily miss core fears or misperceptions among communities. Furthermore, when feedback has been elicited from communities it has often been dismissed or ignored (McKay et al, 2022).

There has been similar neglect of the 'programme design' element of community engagement. The idea that communities should play an active role in designing the health services they receive goes back at least to the Alma-Ata Declaration of 1978, which includes a proviso that "The people have a right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO, no date). But this has not been carried through in the subsequent four decades. As recently as 2020, an Organization for Economic Cooperation and Development (OECD) report identified multiple gaps in primary healthcare, one of which was a need for "broader roles for patients". The OECD called for genuine engagement of patients and community members (OECD, 2020). Similar arguments have been put forward by the WHO's Independent Panel for Pandemic Preparedness and Response (IPPPR, 2021a).

Instead, governments responding to the COVID-19 pandemic often resorted to coercion. Public health orders were backed up with the full force of criminal law, and law enforcement and security forces were deployed to enforce them. The predictable result was social and political resistance and the exacerbation of communities' distrust of government and health systems (and vice versa) (Loewenson et al, 2021).

2.3 WHAT WE NEED TO DO ENGAGE WITH COMMUNITIES AND LOCAL ACTORS AT ALL STAGES

Health systems strengthening, in particular community health systems strengthening, is fundamental to preparing societies for future disease outbreaks. Communities and local actors both have key roles to play in this. This is true in low- to middle-income countries, where national health services are often less comprehensive. But it is also true in far richer countries (WHO, 2022c). There, a shortage of health personnel has contributed to a delegation of certain tasks to qualified nurses or carers. There has also been a shift towards a more people-centered approach to health (as embodied by the public health approach) and a strengthening of primary healthcare.

2.3.1 Invest in local actors to help manage outbreaks and other hazards

Local actors can play multiple roles in disease outbreaks and other emergencies. Their activities can reduce the risk of major outbreaks and improve outcomes when such outbreaks do occur. A key challenge is to bolster community health systems. Such systems provide a vital link between health systems and the communities they serve, especially remote and marginalized ones.

One crucial group of local actors is community health workers (CHWs) – often including trained and supervised volunteers – who provided essential support during the COVID-19 pandemic. This ranged from contact tracing and screening to preparedness and prevention training, health education, at-home non-medical care, basic primary care and referrals. They have also done so in previous disease outbreaks (Bhaumik et al, 2020). Contact tracing, for instance, is a pillar of infectious disease control: it entails identifying and notifying people who have been in contact with an infected person so that they can take precautions to protect themselves and others (IFRC, 2020a). Contact tracing is often best done by local actors who are embedded in their communities (IFRC, 2021a). They have local knowledge that enables them to swiftly and correctly identify likely contacts, and they can be better placed to address fears about what tracing will entail. For this reason, public health experts called for significant investment in CHWs early in the pandemic (Ballard et al, 2020). It is time for those calls to be heeded.

Community-based surveillance is one way in which local actors can support the detection of health risks and early action within their communities where outbreaks start. Many countries' health systems run early warning systems to alert them to disease outbreaks, but these systems often struggle to reach everyone – for instance, if people are unable to access health facilities. Community-based surveillance is a way to bridge this gap. Local volunteers are trained to spot signs and symptoms of diseases with epidemic potential. Because they work in the communities they are from, they are more likely to be **trusted** than outsiders. If they become aware that someone is ill, they can support the community to take immediate

protective action and alert a supervisor, who can in turn trigger a response from the health system (see Box 2.3). Community-based surveillance thus helps protect vulnerable people and communities who might otherwise fall through the gaps. It also helps to protect society as a whole by enabling early detection and rapid responses to outbreaks. All public health emergencies start small, with a mere handful of cases – but left unchecked they can balloon into a global crisis, as COVID-19 did.

Community-based surveillance is one of the pillars of IFRC's successful **Community Epidemic and Pandemic Preparedness Programme** (CP3) (IFRC, no date c). This has been running since 2017. It uses funding from the US Agency for International Development (USAID) to help communities to prevent, detect and respond rapidly to disease threats. It is currently active in seven countries. CP3 takes a 'One Health' approach, helping communities to detect disease outbreaks in both humans and animals to reduce the threat of zoonotic spill-over. Community-based surveillance is one of the pillars of CP3, alongside more traditional epidemic and preparedness activities (see Chapter 1).

Later in the pandemic, as vaccines became more widely available, local volunteers became crucial to vaccination programmes (WHO and UNICEF, 2021). Vaccine confidence and acceptance issues have been a significant challenge in many countries. The distribution of vaccines requires government expertise and coordination, but localized effort and community engagement are essential to understand access and acceptance barriers and ensure maximum uptake. Even once approved COVID-19 vaccines were proven to be highly safe and effective and made available to the people in need, people still felt hesitant to take them. This was due to distrust of the service providers or social norms like popular distrust of vaccines, which hinder their capacity to use the service (WHO SAGEI, 2022). Rumours and concerns have taken root in some communities, especially vulnerable groups who often have **limited trust** in the authorities. In some cases, this has led to violent attacks on COVID-19-related infrastructure and personnel (IFRC, 2021b).

Centralized awareness campaigns can only do so much about these highly specific forms of vaccine hesitancy. Moreover, people are more likely to **trust people** they know than organizations that may be perceived as faceless: for instance, family-owned businesses are trusted more than any other kind (Edelman, 2022). Instead, community engagement by local actors is necessary. Some local actors have had success in tackling vaccine hesitancy by engaging closely with communities, using community feedback mechanisms and perceptions surveys to find out what they believe and fear. When collected and processed at a regional or central level, this can help public health authorities to develop tailored engagement strategies and thus change people's perceptions. For example, the Georgia Red Cross collected information on people's perceptions of the COVID-19 vaccines in order to systematically identify their reasons for hesitancy. Likewise, the Ukrainian Red Cross conducted one-to-one meetings and small group conversations to convey information about vaccines. Volunteers underlined that vaccination was voluntary and advised people to consult their doctors if they had health concerns (IFRC on Medium, 2021).

Community-level programmes have the additional benefit of creating **networks of trust**. These can be harnessed for more effective disaster responses, and for other humanitarian and development work. Such trust-building exercises are essential for the Global Health Security Agenda. One commentary noted that "the time to start engaging with communities is not in the middle of a health emergency", because such times are chaotic and outside actors are often regarded as suspect (Natoli et al, 2020). Instead, it is crucial to start engaging with communities during 'normal' times. This allows time to build trust and relationships, ready for when a crisis hits (see Box 2.4).

BOX 2.3 / CASE STUDY
COMMUNITY PREPAREDNESS IN INDONESIA HELPS TO STOP DENGUE OUTBREAK

As well as being vulnerable to diseases like influenza that affect most countries, Indonesia also has a number of endemic diseases like dengue fever. To prevent disease outbreaks from spreading, the government established an early warning system in primary health centres to help detect and treat potential outbreaks in communities.

For this to work, community members must report their health status to these clinics. However, many people do not – sometimes because they cannot, sometimes because they are unwilling, and sometimes because their symptoms seem too mild to be worth reporting. Community-based surveillance reduces this problem by detecting possible cases quickly and, through trusted intermediaries, bringing them to the attention of health systems. It extends the reach of the national surveillance system, enabling faster reporting and response and potentially fewer cases and fewer deaths.

In one case, volunteers in Sobokerto village heard reports of a child experiencing fever, joint pain and red spots. These are classic dengue symptoms. The volunteers investigated and alerted their supervisor the same day through WhatsApp. From there, they coordinated with the local village head. The suspected case was ultimately confirmed as dengue and the child received the needed medical support and recovered. The volunteers conducted household visits to look for signs and symptoms of dengue, but no further cases were found.

The volunteers also discovered that residents did not know about all potential mosquito breeding sites. In response, they provided health promotion information and mobilized a community to clean such sites (Resolve to Save Lives, 2022). As a result, the community became more resilient to dengue and other mosquito-borne diseases (IFRC, 2021d).

Local actors also have key roles to play in **health literacy**. People with high levels of health literacy can be thought of as possessing a 'social vaccine', which enables them to adopt good practices and to encourage others to do the same (Okan et al, 2022). Health literacy is not simply about knowledge – though that is essential – but is also about having the skills and motivation to both learn and apply that knowledge (Sørensen et al, 2012). Again, local actors' strong connections to the communities they serve make them ideal promoters of health literacy. People are more likely to trust information and advice when it comes from a known and trusted source, particularly if they feel alienated from their governments (see Box 2.5). For the same reason, local actors are often ideally placed to manage **community engagement** (see section 2.3.2).

During crises, some local actors can aid health services by **task shifting**. CHWs can be trained in certain routine healthcare tasks, such as screening of signs and symptoms for diseases like COVID-19 or administering routine childhood vaccinations. The CHWs can then step in to perform tasks that would normally be conducted by more extensively trained professionals (IFRC, 2020b). There are, of course, risks whenever medical interventions are carried out by people without formal medical credentials. However, the balance of risks is particularly attractive for task shifting when healthcare systems become overwhelmed and 'regular' healthcare staff cannot perform routine tasks, or they are simply unavailable in particular locations. This is because foregoing any care if it cannot be provided by the most highly qualified people brings its own risks: for example, conditions that were under control may flare up if left unattended, necessitating emergency treatment.

With CHWs, the only healthcare available in many communities, task shifting was essential during the pandemic. For their part, the local branches of many National Red Cross and Red Crescent Societies assisted with identifying suspected cases of COVID-19 in communities, including in some cases performing diagnostic testing (IFRC, 2021c). Positive cases could then be directed to the professional healthcare system. This simultaneously relieved the healthcare system by removing the need to conduct screening, and it ensured as many people as possible received healthcare when they got COVID-19. Similarly, many National Red Cross and Red Crescent Societies set up telephone hotlines to provide mental health and psychosocial support during the pandemic. In 2020 alone, the Ecuadorian Red Cross provided mental health and psychosocial support services to 8,677 people (IFRC Psychosocial Centre, 2020).

Task shifting needs to be urgently expanded in the future. This is due to the ongoing global shortage of healthcare workers. The WHO estimates that the global health workforce in 2022 is 15 million smaller than it needs to be. This is an improvement on 2016, when the shortfall was 18 million, but it is still a significant deficit (WHO, 2022b). Furthermore, health professionals often prefer to live in urban areas, so rural and remote areas are typically underserved. Task shifting ameliorates this by using non-professional and semi-professional CHWs. The CHWs can both carry out essential healthcare activities and act as a bridge between local people and the national healthcare system.

Furthermore, local actors can play similar roles in all other kinds of disaster, not just health emergencies. Indeed, the services required are often similar. Whether a community is experiencing an influenza outbreak or an earthquake, basic health services are still essential, as is the provision of accurate information about what to do.

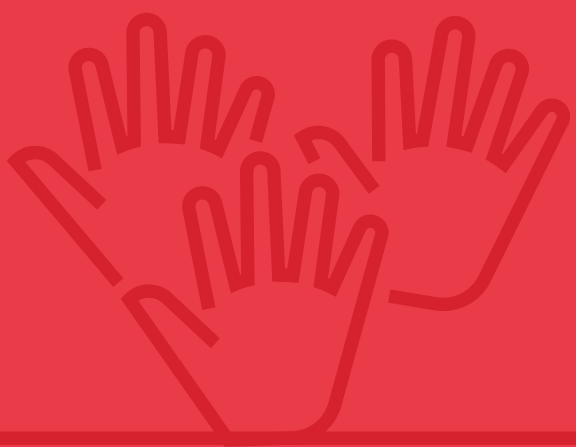
BOX 2.4: WORKING WITH COMMUNITIES IN URBAN ENVIRONMENTS

Responding to disasters in cities poses challenges not encountered in rural environments. These difficulties have been laid bare during the COVID-19 pandemic. A 2021 report by the German Red Cross explored how National Societies responded to COVID-19 in cities and found many experienced difficulties (German Red Cross, 2021). For example, more people in cities were **distrustful** of the government and other authorities compared to rural areas. This was partly driven by the large numbers of migrants and refugees in cities; these groups are often wary of the authorities. National Societies that had a pre-existing presence in the cities were more trusted.

Compared to rural areas where everyone knows everyone, cities are anonymous. People might live there because they can go unnoticed. These marginalized people are often among the most vulnerable – yet their very anonymity in urban areas means it is difficult for humanitarians and other actors to find and help them. The solution is for humanitarians and other disaster risk managers to build up a strong presence in urban communities long before disasters occur. This will build **trust** and enable the identification of vulnerable people (PrepareCenter.org, no date).

Malaysia 2021 *The Malaysian Red Crescent Society worked together with the state of Pahang health department and the local communities to vaccinate migrants in the district of Cameron Highlands. The collaboration between the Ministry of Health and Protect Health Corporation Sdn Bhd (ProtectHealth) was the first of its kind to be led entirely by a humanitarian organization. The Malaysian Red Crescent Society successfully vaccinated more than 7,000 migrants from at least 10 different ethnic groups in Kuala Lumpur, Selangor and Sabah. © Nazir Sufari*

> **Local volunteers are trained to spot signs and symptoms of diseases with epidemic potential. Because they work in the communities they are from, they are more likely to be trusted than outsiders.**



Local actors can only achieve all this with sustained capacity and infrastructure investment. This enables local teams to retain members, resources and knowledge, and to engage in local coordination mechanisms. Instead of bursts of short-term funding during crises, such programmes require stable, long-term support. They also require access to overheads to strengthen institutional capacity (see Chapter 3).

Some donors are now seeking to address this issue. One is the European Commission's Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO). DG ECHO has partnered with IFRC on a new Pilot Programmatic Partnership (PPP), which offers strategic, flexible, longer term and predictable funding for National Societies engaged in preparedness work (IFRC, no date d). The scheme will help communities to prepare for epidemics and other disasters. The launch of the Financial Intermediary Fund for Pandemic Prevention, Preparedness and Response, hosted by the World Bank, also recognizes the need for more consistent, flexible funding (WHO, 2022a). However, how much of this funding will flow to local actors and programmes is still to be decided by its board. A third ambitious initiative is Africa Frontline First, which has set a target of deploying 200,000 CHWs in 10 countries by 2030 (Africa Frontline First, no date).

Finally, local actors need to be integrated into wider health and governmental systems. As well as financing, they must be supported institutionally through governance and coordination mechanisms. The auxiliary role accorded to National Red Cross and Red Crescent Societies is one example of a mechanism by which local actors can be integrated and work closely with the government and health system. It is "a specific and distinctive partnership, entailing mutual responsibilities and benefits, based on international and national laws, in which the national public authorities and the National Society agree on the areas in which the National Society supplements or substitutes public humanitarian services" (IFRC, no date e). During the COVID-19 pandemic, states could have made more use of mechanisms such as the auxiliary role that allow them to be assisted by local actors in emergencies. Again, preparedness is key: these coordination mechanisms will be most effective if they are set up in advance of future emergencies.

BOX 2.5 / CASE STUDY
REDUCING VACCINE HESITANCY IN THE SYRIAN ARAB REPUBLIC

The Syrian Arab Red Crescent has been listening to people's concerns about the COVID-19 vaccines in order to understand why they are hesitant to take it – and then help them to overcome their fears (IFRC, no date f).

In one instance, a community circulated a rumour about a judge dying after receiving the COVID-19 vaccine. The judge had previously declared that he would take the vaccine, but he passed away before receiving it. After his death, the community rejected the vaccine, assuming it was the main reason for his death.

The Syrian Arab Red Crescent's Community Based Health and First Aid (CBHFA) team urged the judge's family to help dispel rumours. First, all the judge's family members received and advocated for the vaccine. Second, the CBHFA team held group meetings and invited a judge's family member to confirm that the vaccine was not the reason behind the judge's death. Following these sessions, people's trust in the COVID-19 vaccine grew, and most community members rushed to get the vaccine.

On another occasion, during a focus group discussion with five women, one of the women said that the COVID-19 vaccine paralyzed her sister. The other women believed her. However, during the discussion, it became clear that the woman's sister had multiple health issues that contributed to her illness and paralysis. After understanding her medical history, and following ongoing discussions with the Syrian Arab Red Crescent CBHFA team, the women received their first dose of the vaccine.

Syria 2021 *Throughout 2021 and 2022, Syrian Arab Red Crescent has been working to ramp up the vaccination rates in different areas of Syria. For example, volunteers are conducting vaccine awareness home-to-home visits in Hama and Sweida, the are providing training sessions for volunteers in Deir ez-Zor and many other locations -and they are conducting awareness sessions in Lattakia and other locations. © Syrian Arab Red Crescent*

2.3.2 Engage communities in all phases of the public health emergency management cycle

Communities must be active participants in all phases of health and disaster management. Too often they have been treated as passive recipients of assistance. This is not only patronising; it is also ineffective. The most impactful forms of response are those developed collaboratively in the full knowledge of each community's needs, vulnerabilities, beliefs and capacities (IFRC, 2021e). A 2022 review of COVID-19 responses in 177 countries concluded that: "Efforts to improve pandemic preparedness and response for the next pandemic might benefit from greater investment in risk communication and community engagement strategies to boost the confidence that individuals have in public health guidance" (COVID-19 National Preparedness Collaborators, 2022).

Crucially, local leadership enables better communication and feedback. When healthcare and disaster teams work closely with communities, they have an opportunity to find out critical information such as who is most at risk, what they need to manage that risk, their level of health literacy, and who they are prepared to trust (see Box 2.6). This information enables more appropriate preparation and response. It is particularly important to focus on marginalized and vulnerable communities, which need greater engagement efforts to meet their information needs. Community engagement and accountability is thus at the heart of preparedness (see Chapter 1 for more on preparedness and Chapter 5 for more on community feedback data).

IFRC has identified five guiding principles that underpin people-centered community systems (IFRC, no date g). They are based on extensive experience of public health responses, including but not limited to COVID-19. Successful community health systems must be:

1. **Community led.** Health programmes are more effective if they are managed, governed and implemented by communities themselves. People are more likely to take action in their communities if they can lead on all aspects, from assessing their own needs to implementation of the programme and evaluating its results (WHO, 2021). For example, in the Democratic Republic of the Congo, Red Cross volunteers worked with communities to develop messages in support of measles vaccinations. They held participatory workshops, which were attended by community health partners, community health workers, religious and traditional leaders, and local administrative and health authorities. The aim was to co-create solutions to outbreaks. Volunteers collated rumours and feedback, which were used to develop key engagement strategies. Key messages were then adopted by health authorities, fostering commitment to amplify them widely (IFRC, 2022a).

2. **Informed by data**. To maintain trust, we must listen, respond and act on what communities are telling us. It is essential to understand how they perceive the disease and the response. Responders must also determine the key drivers of community behaviour, plus their questions, suggestions and capacities. Social data, including community feedback data, is just as important as epidemiological data (see Chapter 5 for more on data collection and analysis). For example, the IFRC undertook community research into people's experiences of the pandemic, including vaccine acceptance, across Latin America and the Caribbean. Researchers interviewed 7,743 people in nine countries. Levels of vaccine acceptance were generally high: only two out of ten people asked would refuse it, except in Jamaica where five out of ten would.

However, there were access issues. Migrants and indigenous populations reported higher constraints due to distance, long waiting times, inconvenient opening times and inadequate services (IFRC, 2022b).

3. **Accountable.** Health systems must be accountable, transparent and responsive to the voices, priorities and needs of people and communities. Communities must be able to participate in the governance of the health system, planning of health interventions and approaches, and in the delivery and oversight of services. Such widespread community participation in monitoring and evaluation makes programmes more sustainable and enables better use of resources. To achieve it, governments must invest in boosting communities' capacities, for example their health literacy, including knowledge of health rights. One instance of good practice enabled HIV patients to assess the delivery of their treatments. The programme ran from 2017 to 2019 in 11 countries in West and Central Africa. Respondents reported that it often took many weeks to get their viral load test results. However, as the project went on and the feedback was absorbed, this and other indicators improved (The Global Fund, 2020).

4. **Coordinated and collaborative.** Community engagement should be integrated in strategies, policies and procedures. It must also be harmonized within the public health, humanitarian and development responses. Coordination efforts should enable partnerships between local actors, the private sector, states, response partners and communities themselves. For example, to help manage COVID-19 the Eswatini Ministry of Health created a Risk Communication and Community Engagement Technical Working Group. As part of this, a 'dynamic listening group' collects questions, rumours and feedback from multiple sources – including Talkwalker, a social listening tool that monitors what people say about COVID-19 on social media. This creates a real-time picture of people's beliefs and alerts the government to problems; for example, many reported that vaccination centres were too far to travel (IFRC, 2022c).

5. **Inclusive and diverse.** Support should be prioritized to the most vulnerable, marginalized or at-risk groups. Community engagement and accountability approaches must be accessible, culturally appropriate, gender-sensitive and equitably accessible to people with disabilities. As many groups as possible should be represented in local decision making. For example, in the UK, the British Red Cross has a Refugee Support Team that works closely with people seeking asylum. Many of these people faced barriers in accessing health services, so the British Red Cross worked to address this. It produced informational materials in 20 languages, working with people with lived experience to ensure they were relevant. It also supported pop-up vaccination clinics for people outside the health system, for example by raising awareness in advance and helping people book appointments (IFRC, 2022d).

BOX 2.6 / CASE STUDY
IT IS CRUCIAL TO ASK PEOPLE WHAT THEY REALLY NEED

When the COVID-19 outbreak began, the Cameroon Red Cross rapidly began collecting community feedback. Their aim was to find out people's perceptions of the new coronavirus, and what they needed. They collected information through a range of channels, from a hotline and social media sites to focus group discussions and volunteers delivering messages in communities (Cameroon Red Cross, 2021).

The Cameroon Red Cross analysed the feedback in real time to guide its response to COVID-19. They focused on five of the country's most affected regions. The feedback helped them to craft compelling and understandable messages, and to identify the most vulnerable communities.

Based on the surveys, the Cameroon Red Cross translated its messages into over 20 local languages, ensuring that the majority of the affected populations could understand them. They also learned that some people did not believe COVID-19 was real, and devised messages to address this.

The surveys also helped to identify communities that lacked access to safe water. This was crucial because hand washing was one of the main actions people were advised to take to protect themselves – yet many could not do so. Using a geographical analysis of the survey responses, the Cameroon Red Cross identified communities that urgently needed new water points and water storage equipment, and provided these.

Finally, the surveys revealed that many people perceived COVID-19 to be a disease that only affected the elderly. As a result, there was a risk that young people would not adopt safe practices – putting both themselves and their communities in danger. In response, the Cameroon Red Cross worked with a young influencer to engage with younger people about the risks they faced and how to wear a face mask correctly. They also helped to produce talk shows on community radio, as previous analyses had shown these were widely trusted.

KEY RECOMMENDATIONS

Integrate recognized and trained local actors into health systems. This can be done formally or through more collaborative arrangements. Local actors, including community health workers and volunteers, can play key roles in primary healthcare and health systems strengthening at the local level. They can provide certain essential services like community-based preparedness and surveillance, routine vaccinations and task shifting. Depending on their qualifications, some can provide pre-hospital care. Local actors can also act as bridges between health systems and the communities they serve. But in order to do this, they must be integrated into health policy frameworks. Depending on the country's laws, there are a range of options to do this. Health systems must coordinate with local actors, and sustained support (via training, supervision, financing, coordination and legal facilities) must be provided for their activities.

Include local actors in national health emergency preparedness plans for prevention, early action and response. Recognized local actors, whether paid or volunteer, can be thought of as the bridge between national authorities and communities. When adequately trained, supervised and supported, they can provide a wide range of services to help relieve overburdened health systems and increase access to health countermeasures for the hardest to reach, as shown in this report. However, they cannot do this without support and legal facilities to carry out these tasks. The latter may include, as appropriate, prioritization in the distribution of PPE and pandemic response products, exemptions (as appropriate) from restrictions on the movement of goods and personnel, access to physical and mental health services, access to data and information, and so on.

Work with communities to design, implement and monitor health emergency preparedness plans for prevention, early action and response. Community knowledge and buy-in are critical to our ability to design, implement and monitor public health emergency preparedness and response plans. Tangible examples of ways to ensure this include: joint risk and vulnerability assessments, co-design of local and national preparedness measures, joint preparedness exercises, monitoring and evaluation, training for prevention, early detection and response programmes, and regular revision of procedures in view of new threats or lessons learned.

Develop meaningful two-way dialogues with communities about their health needs and concerns. The most effective health interventions are those developed in collaboration with the communities that need them. This means engaging regularly with all communities, especially those that are vulnerable or marginalized. Practitioners must determine what those communities need and want, what their capacities and beliefs are, and their vulnerabilities. Furthermore, it is essential to collect and analyse feedback from those communities, both to develop better health systems and to create lasting relationships of trust. Community partnerships need joint accountability and so must be oriented by evidence. This helps to foster the community trust, civil responsibility and public solidarity needed for health emergency and disaster readiness. Social-behavioural data and community perspectives must drive our work, and community-centred action must become the norm.

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