WORKING PAPER

Improving The Response To Covid-19: Lessons From The Humanitarian Sector Around Communication, Community Engagement And Participation

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Improving The Response To COVID-19: Lessons From The Humanitarian Sector Around Communication, Community Engagement And Participation

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Introduction[1]

AS THE WORLD GRAPPLES WITH SUCCESSIVE WAVES of the COVID-19 coronavirus, what lessons can we learn from other health emergencies and humanitarian crises to develop a more effective and accountable response to the pandemic? This paper outlines some of the learning gained in the humanitarian aid sector in accountability around two-way communication, community engagement, and the participation of vulnerable people, and how this can be applied to support this current response.

COVID-19 showed that even countries with strong economies and well-established health and social protection networks struggled to cope with the pandemic. The failure of governments to engage with and communicate effectively with communities and find means for them to participate actively in the response has had devastating – and avoidable – consequences. This impact has been disproportionately felt by the most vulnerable and marginalised people, who often felt they were being overlooked; while official information was in competition with misinformation and rumours, often circulating within communities the authorities had not been able to listen to, or had not known about. So, as the world grapples with further successive waves of the COVID-19 coronavirus, could there be lessons in building a more responsive approach to COVID-19 by learning from other health emergencies and humanitarian crises?

Are there lessons that can help address these shortcomings exposed by the pandemic? If we reframe the health response to the COVID-19 pandemic as a humanitarian relief operation, but on a global scale, it is possible to see how all countries, including those in the West, can draw lessons from nations that already have experience of confronting such humanitarian crises. Nations in the midst of ongoing humanitarian aid programmes related to the Ebola response, refugee relief operations or malnutrition or reconstruction work when the pandemic started had strategies and plans for dealing with a crisis already in place. They were ready to pivot these tools and communicate and engage their own populations to work together to tackle this health emergency. The same could not be said for many Western nations who were not ready in this way. By contrast, countries that have tackled humanitarian crises with few resources and multiple constraints have gained hard-won lessons that helped to facilitate a better response to COVID-19, often using community engagement methods, techniques and systems developed with funding from the very nations now in need of this experience.[2]

This paper distils the learning gained in the humanitarian aid sector which may help to mitigate or even go some way towards solving some of the challenges in working with communities in the COVID-19 response. Key to these lessons from a humanitarian perspective is the question of who should the response measures to the COVID-19 pandemic be answerable to? This question of accountability has been clearly answered in humanitarian settings: it is those people who most need the help, rather than those who administer or pay for the programmes.

With this in mind, this paper argues that it is possible to build a new foundation for the planning of pandemic responses that puts people first. It's possible that, had more countries treated the pandemic like a complex humanitarian crisis and applied good practice in communication, community engagement and accountability, more could have been done to reduce the spread and impact of the virus.

Here then are eight key areas where the global pandemic response can be seen to be falling short, along with the lessons from the humanitarian sector to help remedy them. These lessons may also help to minimise the impact of future health emergencies and humanitarian crises in all countries

summary of lessons learned

lesson one
Put people and principles at the centre of COVID-19 decision-making, not politics.

lesson two
Reframe discussions about responsibility in a pandemic so that those who are considered vulnerable are a priority rather than an afterthought.

lesson three
Prepare ways to share sophisticated information quickly in complex, but predictable emergencies so that knowledge, trust, and resources in the population can be leveraged when it happens.

lesson four
Have communication channels and cooperation plans for all governmental and non-governmental authorities and organisations so that the response is coordinated and understandable to the community.

lesson five
Find ways for people to get involved and have a meaningful say in the response: make this the cornerstone of any COVID-19 communication plan.

lesson six
Work to re-engage communities as participating partners; have mechanisms to leverage local and volunteer groups to maximise their knowledge expertise to increase the effectiveness of the COVID-19 response.

lesson seven
Move to more participatory, two-way communications and feedback with vulnerable communities; find out what channels they really use, not just what we want them to use.

lesson eight
Empower local agencies and communities to take a lead role in the response, so they can truly supplement the response and take charge at a local level.

1. The need to prioritise people and principles over politics

There is no room for partisan or nationalistic politics during a global pandemic. Yet this is precisely what has happened in many countries. The pandemic has become politicised, with people-centred and evidence-based decisions on handling the crisis taking a backseat to partisan politics. Where partisan politicisation has taken place, the basic facts about COVID-19 are in question. Examples include assigning blame for the pandemic to political rivals, questioning the scientific evidence for political gain, communicating false or misleading information about the impact of the pandemic, and giving unrealistic and overly optimistic timelines on how and when the virus will be contained and controlled.[3]

More importantly, this politicisation is seen in decisions and actions that prioritise other considerations such as political image, partisan advantage, or factionalism rather than directly addressing the disproportionate impact the virus has had on the community. Rather than the pandemic becoming a rallying point for a coherent, coordinated and unified national and international effort that engages everybody as a partner or stakeholder, the effectiveness of the response has become diluted by political manoeuvring which has created divisions, distrust and confusion; these amplify the negative effects of the response instead of minimising them.

In a politicised environment, only those who can generate political impact are heard and engaged with, while those without political leverage, often the most vulnerable in society, are overlooked and potentially subject to discrimination and stigmatisation. If anything, the pandemic has demonstrated, once again, that those who are not heard because of age, disabilities, race, ethnicity, sex and gender roles face an increase in their vulnerability in a crisis – not least because of contributing factors such as economic uncertainty, underlying health issues (many poverty-related), and a lack of access to services and assistance. With few available assets or positive coping mechanisms, the added challenges of lockdowns, physical distancing and other preventive measures means COVID-19 is now exposing those marginal to society to even greater risks.[4]

While humanitarian crises are not exempt from politicisation, humanitarian actors are guided by a set of Fundamental Principles that put the prevention and alleviation of human suffering above all else. These principles call for humanitarian actors to work as neutral and impartial actors, independent from political or other interests. The aim is to provide assistance fairly and equitably to all those affected without discrimination in proportion to people's needs; regardless of ethnicity, status or political or religious beliefs. The focus is on responding to a crisis in ways that attempt to meet the needs as holistically as possible while minimising negative impacts and harm. It is not about assigning blame or passing off responsibilities to different parties.

lesson one
Put people and principles at the centre of COVID-19 decision-making, not politics.

Authorities and decision makers everywhere should use and apply humanitarian principles as the lens through which to guide the design and management of COVID-19 responses, with a particular focus on applying the principles of humanity and impartiality. Responses should consider the diverse needs of different vulnerable groups in the population. They should prioritise assistance in proportion to needs, delivered in ways that are fair, accessible, equitable and inclusive for these groups. The need to do this must be placed above all other considerations.

It is abundantly clear that accountability towards people and communities most affected by the pandemic is woefully absent in the responses, including in many of the high-income countries hit hardest by the pandemic, such as the US, UK, Italy, Spain and others.

Key to this principled humanitarian approach is **engaging** with different stakeholder groups to understand their views and perspectives on the crisis and its effects on them. This is linked to **communicating** with the same stakeholders on how humanitarian organisations work and what behaviour can be expected from them and the rights and entitlements of the people they aim to assist. It emphasises their right to access life-saving information and to participate in decision making as well as providing safe, accessible and inclusive ways for them to provide their feedback on those decisions.

Humanitarian actors have learned after many costly mistakes that any population affected by a crisis is not homogenous and a simplistic "one size fits all" approach simply does not work. There are always people and groups within the affected populations that are more vulnerable and who are at-risk of greater negative impacts. Aid actors are increasingly attuned to recognising the multidimensional impacts of a crisis on different groups in the population and designing more comprehensive interventions which are targeted and adapted to address the priority needs of the affected people. This contrasts with the approach taken in many countries where responses to the pandemic seems to be limited to addressing the health and economic impacts mainly at the macro level, and not considering the human cost for vulnerable people and communities.

This people-centred approach in humanitarian responses has been essential to building relationships of trust with vulnerable people and to ensuring resources are used efficiently and effectively to address their needs and priorities. Governments and decision-makers everywhere could learn from this and apply these humanitarian principles to the way their responses to COVID-19 are designed and managed, starting from the premise that political interests should not have any influence over principled, evidence-based decision making when it comes to providing for communities.

2. The most vulnerable people in society felt they were not being heard during the COVID-19 response, and that they were overlooked by new systems being put in place.

The humanitarian system uses the word "accountability" to define who the response is answerable to. This definition of accountability is not about defining financial or legal responsibilities or even determining who has ultimately responsibility for the successes or failures of the response. Rather, the concept of accountability in humanitarian work draws upon the principles and benchmarks established by humanitarian organisations and UN agencies to put the rights, dignity and interests of the people who need the most help at the centre of the decision-making processes. In other words, under this definition, to be accountable aid organisations must plan and act as though they are answerable to the most vulnerable people they serve.

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Accountability in this context includes the responsibility to work with affected people to find ways to improve the quality of the coronavirus response today, while also leaving people and communities in a better situation, ready to confront the humanitarian challenges of tomorrow. This requires participation, engagement and communication with vulnerable people and communities to ensure crisis response actors know what their immediate needs are and what can help strengthen their resilience and coping mechanisms for future shocks.

Seen in this light, it is abundantly clear that accountability towards people and communities most affected by the pandemic is woefully absent in the responses, including in many of the high-income countries hit hardest by the pandemic, such as the US, UK, Italy, Spain and others. Direct participation of people in decisions that affect them is largely absent, and strategies to engage with communities are often top-down and instrumentalised to serve government or institutional goals. Communication efforts often fail to meet the basic information needs of vulnerable people or seek out ways to listen to their feedback and concerns. It does not use feedback to more effectively address the effects of the pandemic, which can affect people in a multitude of ways, many of which may not be foreseeable and are unlikely to be anticipated by authorities and governments.

Together, this adds up to an accountability gap where the people most vulnerable and most affected by the impacts of COVID-19 are not receiving the support and assistance they need. They have little recourse to exercise many of their basic rights: the right to access relevant, appropriate and quality assistance in line with their own priority needs; the right for clear, accurate and reliable information to help them take better-informed decisions; the right to participate and to be involved in decisions that affect them; the right to accessible and inclusive mechanisms that hold decision-makers to account for their management of the response.

The humanitarian sector has had a poor record when it comes to its own performance and accountability towards people affected by crises; people's rights to safeguarding are not always upheld and relationships are not always based on trust, transparency and mutual respect. However, by openly acknowledging these shortcomings the humanitarian sector has made significant progress in embedding accountability to affected people in its organisational policies, procedures, and practices.

Examples include the wide adoption and endorsement in the aid sector of the Core Humanitarian Standard (CHS), which sets out nine commitments outlining what vulnerable people can and should expect from aid organisations – a blueprint to hold them to account. While much more needs to be done, this approach to accountability could serve as an example to any institution or organisation involved in responding to the COVID-19 pandemic, and it will put the focus back where it belongs: improving results and protecting the rights of those most affected by the pandemic.

lesson two

Reframe discussions about responsibility in a pandemic so that those who are considered vulnerable are a priority rather than an afterthought.

Authorities and decision-makers everywhere should reframe who they answer to so that their focus is primarily on their responsibilities towards the people and communities who are most vulnerable and at-risk from the impact of the pandemic. They should establish mechanisms to integrate people-centred approaches to participation, communications and feedback into COVID-19 assistance programmes, and they should follow standards such as those established by the Core Humanitarian Standard.

The world was ill-prepared for COVID-19, despite years of warnings that a global health pandemic was likely to occur sooner rather than later. This lack of preparedness is no surprise as disaster risk reduction, prevention and preparedness measures are consistently underfunded and often ignored by policymakers.

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3. Lack of preparation on how to communicate complex information in a predictable emergency such as a pandemic

The world was ill-prepared for COVID-19, despite years of warnings that a global health pandemic was likely to occur sooner rather than later. This lack of preparedness is no surprise as disaster risk reduction, prevention and preparedness measures are consistently underfunded and often ignored by policymakers. It is true that the scale and scope of this pandemic are staggering, but the gaps in preparedness were essentially the same kinds of preparedness gaps as identified in the 2008 Avian Flu outbreak in Asia. Despite this, little action was taken.[5] Even in situations where there was some degree of preparedness, without the key element of knowing how the community and society will react to these measures their effectiveness could not be gauged.

As such, one of the most critical aspects of being prepared is knowing the best way to communicate with the affected communities so that information flows both ways. It is vital that those implementing and designing policies know what the trusted and preferred communication channels are for any given population, and also what potential mechanisms exist for people to participate in prevention and response activities. This preparedness work includes mapping the different barriers and obstacles in accessing needed information, services and assistance and the existing capacities that could be mobilised to support this. This kind of baseline analysis is often part of the needs assessment and planning process of humanitarian response. But too often this data and available analysis is ignored or forgotten in a new emergency, leading to time delays, duplication of effort and an ineffective intervention.

Many parts of society tried to alert authorities to problems linked to the lack of preplanning, but they found few routes to do so beyond siloed social media. Preparedness measures failed in a long list of key areas: care for the elderly and other vulnerable groups, provision for children's education under confinement, and timely financial support for people facing job losses or economic hardships. In terms of social protection there were few prepared provisions for psychosocial support and measures to prevent gender-based violence.

Apart from medical and physical aid, many countries were also unprepared legally with no clear legal frameworks to establish the limits and extent of emergency powers, to clarify roles and responsibilities, and how to protect individual and collective rights. Even when such legal frameworks did exist there was often a huge gap in public perceptions around the legitimacy of such laws and regulations.

More attention to preparation for better information sharing could have helped mitigate a lot of this. Had there been more early public, community and stakeholder engagement in defining the legal framework to support an effective crisis response with better transparency and communication around its aims and purposes, then governments may have had more success in gaining greater acceptance of the temporary limits on individual rights for the collective good. Instead, as seen in many countries, there were legal challenges and public protests against these laws once they were announced because of numerous gaps and questions in the hastily written rules which could have been answered earlier.

To help avoid this, the CDAC Network and partners have been working with governments and aid agencies to establish national platforms to pre-prepare for and coordinate communication and community engagement prior to a crisis. These national platforms are in place in high-risk countries for natural disasters like Bangladesh, Fiji and Vanuatu, and they have proven to be extremely useful in compiling this data. They also build trust and working relationships between different local, national, and international actors. Similar examples are also to be found in regional disaster risk reduction platforms in Central America which bring together different stakeholders to regularly share knowledge and learning and plan coordination before a crisis occurs.[6]

In addition, the CDAC Network with partners like WHO, the IFRC and UNICEF are building a resource library of community engagement tools and key messages that can be accessed by aid providers for use in different emergencies. This includes an extensive database of COVID-19 and other related health prevention and promotion messaging. It also contains tools to support the mapping of vulnerable groups, the trusted and preferred engagement and communication channels used by the community, their information needs, and plans to gather feedback on their views on both the effectiveness of programmes and their relationship with aid providers.[7]

lesson three

Prepare ways to share sophisticated information quickly in complex, but predictable emergencies so that knowledge, trust, and resources in the population can be leveraged when it happens.

Authorities and decision makers *everywhere* need to invest in long-term community participation, community engagement and communication strategies to improve the quality and effectiveness of the current COVID-19 crisis response. They need to know ahead of time what people's preferred communication methods and channels are. Data on vulnerable people and communities' existing capacities, needs and preferences around communication and engagement needs to be documented, disseminated, and updated regularly as part of preparedness, risk reduction and contingency planning for future crises. The response can be made more answerable to the people it serves, especially the most vulnerable overlooked members of the community, if prepared for.

These are examples of preparedness that all countries could use to adapt and replicate to support their own preparedness efforts. It may seem unlikely that high-income countries will acknowledge the learning and experiences coming from countries with fewer resources and capacities, but such countries often have much more experience in dealing with humanitarian and health emergencies on a regular basis.

4. Competing systems hinder cooperation, and create confusion among populations

A striking feature of the response in many of the hardest hit high-income countries is the lack of effective coordination and collaboration between different authorities, civil society, and other actors. Part of this is due to the politicisation of the response, with arguments over competing jurisdictions and competencies, and playing the "blame game" to deflect criticism for the poor performance of some authorities to other actors. Another factor may be inexperience around coordination of a major national-level emergency. Whatever the reasons, the effects are devastating.

In Spain, the failure to coordinate between federal and state authorities, even on the bare minimum of defining who does what, when and where has exacerbated the prevalence of coronavirus: creating a macabre "Dance of Death" in the words of the Economist.[8] Even Canada, which has generally received high marks for the level of collaboration and coordination between federal and provincial health authorities, has found it difficult to elaborate common guidelines on such simple measures as requiring children to wear face masks in schools.[9]

Humanitarian actors have long recognised the benefits of establishing cooperation and coordination measures as a first step in a crisis, especially in terms of the potential to minimise gaps in humanitarian responses and simplifying communication. These measures include establishing formal coordination mechanisms to bring together multiple actors around specific programme areas, such as provision of health services. By working together, different authorities can undertake joint assessments and consult with vulnerable groups on their needs and preferences. A unified approach is much better at positively engaging different communities as they see a single point of authority for the different needs rather than competing interests, this is particularly important when discussing the engagement and communication aspect.

Thanks to the work of organisations like the CDAC Network, more and more crisis responses are establishing collective platforms for communication and feedback, so that people's views and opinions can be aggregated from multiple organisations and analysed to provide a shared evidence base for a more people-centred decision-making process by all authorities and organisations linked to a pandemic response. Indeed, it is becoming a standard procedure for aid organisations to establish feedback and complaints mechanisms for all projects and programmes as part of their overall accountability to affected people.[10]

lesson four

Have communication channels and cooperation plans for all governmental and non-governmental authorities and organisations so that the response is coordinated and understandable to the community.

Authorities and decision-makers everywhere, local, regional, national and international, should establish and strengthen common collective platforms to coordinate efforts to communicate and consult with each other to collect and analyse feedback and inputs on the quality and effectiveness of responses. All organisations need to know how to use this information to support a coordinated people-centred decision-making process that does not confuse people by giving out conflicting information or conflicting policies.

5. People were told what to do by central authorities with no way to give feedback, causing frustration

When it comes to health emergencies, there is still a strong tendency to revert to top-down medically driven interventions shaped by government authorities and medical experts with little direct participation by people and communities in their design. This "life-saving" model, however, was initially necessary in the case of COVID-19; when uncertainty about the nature of the virus and mortality rates required a strong technical focus on "flattening the curve" through physical distancing, mandatory mask use and lock-down measures.

But more than six months into the pandemic the shortcomings of this approach are evident, particularly in higher-income countries with high COVID-19 prevalence. Lessons around community participation from previous and ongoing health emergencies, such as Zika, cholera, and Ebola, underline that an effective response requires taking more participatory approaches that involve the community as a whole. These crises show that applying a strict medical perspective is not enough. They must be complemented with a broader multidisciplinary approach drawing on social science to engage with communities to understand the socio-economic and other determinants of health at the local level and working jointly with them to find the most appropriate strategies to improve people's health and resilience.[11]

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When it comes to health emergencies, there is still a strong tendency to revert to top-down medically driven interventions shaped by government authorities and medical experts with little direct participation by people and communities in their design.

Compare this to agreed humanitarian standards which enshrine participation in a response by the community. Not so long ago, a group of some of the largest government donors and aid organisations signed the Grand Bargain, pledging to transform aid so it can better support accountability to vulnerable and crisis-affected people. The "Participation Revolution" is a core component of the Grand Bargain, committing all parties to seek and support more active participation by vulnerable and crisis-affected people in all phases of the design, implementation and management of humanitarian response. The right of vulnerable and crisis-affected people to participate in decisions that affect them has been continually emphasised in numerous policies promoting good practices in humanitarian action, such as the Red Cross Red Crescent and NGO Code of Conduct or the Sphere Standards.

There are similar parallels in the development and health sectors such as the 1976 Alma-Ata Declaration which asserts "People have a right and duty to participate individually and collectively in the planning and implementation of their health care."[12] More recently, the Sustainable Development Goals (SDGs) reiterate the importance of participation and call on governments and other stakeholders to "Ensure responsive, inclusive, participatory and representative decision-making at all levels."[13] The Grand Bargain reaffirms these commitments and reinforces the responsibility of institutional actors and government donors to prioritise participation as a means to improve the effectiveness of humanitarian interventions for vulnerable people.

Though implementation is uneven, humanitarian responses are increasingly incorporating mechanisms to ensure that people have a voice but – generally speaking – not a vote in decisions that affect them. This includes consulting with vulnerable local communities to define aid priorities within the design of projects and to give a degree of participation in decision-making.

A case in point is how the humanitarian sector has learned from the response to various Ebola outbreaks in Africa. The initial responses failed to fully understand the social dynamics, cultural practices and beliefs that shaped people´s views of the disease, including the long-standing mistrust of governments and aid organisations. The results were that the first interventions were not as effective as they could have been. Only by engaging with communities did aid actors learn how to adapt their responses to better address the needs and concerns of those affected and effectively deal with the outbreak. Humanitarians also learned that what works in one context does not necessarily apply in another. The response strategies needed to be adapted by the participation of communities in the design of the implementation of all interventions so as to ensure they could better address people's needs and priorities which can then improve the "technical" health outcomes.[14]

With COVID-19, countries that were already responding to existing humanitarian crises (or those with experience in dealing with previous crises) may have been in a better position to incorporate mechanisms for participation into their responses. In these cases, governments and aid actors were

able to draw on the experience gained by working together and leverage relationships with vulnerable people and communities to facilitate a degree of participation on how to best adapt their activities to the new COVID-19 reality. They could consult with communities on physical distancing measures or use alternative communication channels to facilitate feedback and provide opinions on any new issues that now affected them.

By contrast, this commitment to participation seems to be notably absent with many of the Grand Bargain signatories, including by the US and some of the hardest-hit European nations. In these countries, there were few systematic approaches to establish mechanisms for people to participate in decision-making processes by the authorities. Instead, the emphasis has been on government authorities taking the lead on the response. Official participation seems to be mostly limited to following the instructions set out by the authorities rather than mobilising people to actively contribute their own ideas on supporting the response to the pandemic.

In the absence of any clear national strategies for participation it has largely fallen to existing volunteer and community groups and civil society organisations to take on the role of filling the many gaps in meeting the needs of the most vulnerable people in the population. These expressions of solidarity have seen community groups sew masks for front-line health workers and organise donations to foodbanks. Businesses have individually participated by donating supplies and materials to support the response.

The lack of a structured and coordinated way for people to participate and productively engage is a missed opportunity to leverage the knowledge, resources and capacities of civil society and local communities to support a more effective and comprehensive response. Even the UK, which initially stood out with its call for a million volunteers to support the National Health Service, found it difficult to channel the overwhelmingly positive public response into any meaningful contribution to the government-led response, leaving many people frustrated.[15] In fact, it could be argued that the failure to find effective participation strategies or mechanisms in many high-income countries could be a contributing factor behind the increasing number of public protests against restrictions on movement or the use of face masks in Germany, Spain, the USA, and others.

Without trusted and functional mechanisms for people to engage in an open dialogue with health authorities and those in positions of power and participate in decisions that affect them, it is easy to understand how this can lead to frustration, mistrust and conflict. In this case, the impulse for participation can be misdirected away from containing the virus to more counterproductive activities.

lesson five:
Find ways for people to get involved and have a meaningful say in the response: make this the cornerstone of any COVID-19 communication plan.

Authorities and decision makers everywhere need to integrate measures to facilitate the greater participation of vulnerable people in the design, delivery, management, monitoring and evaluation of COVID-19 responses. Participation measures should include safe, accessible, equitable and inclusive opportunities to express views and opinions on the best approaches to address their needs and priorities and take an active role in decisions that affect their lives.

6. Where there were opportunities to participate in the COVID-19 response it was only on terms designed by the authorities, which may exclude minorities in society

Humanitarian organisations and donors are in agreement that the participation of vulnerable people in a crisis is a powerful means to improving both the accountability and the effectiveness of the response, especially as what is needed can frequently outmatch the funding available. The question is then, how to facilitate that participation?

Participation at the level of having a meaningful impact on outcomes in a large-scale crisis is rarely spontaneous or organic, especially by the most vulnerable and marginalised in society. Aid organisations employ community engagement strategies to organise and coordinate their interactions with communities so they can help channel participation towards achieving a goal.

Community engagement, however, can be used as a catchphrase, which disguises the use of participation and communication to serve the objectives of the aid organisation itself rather than the desired needs of vulnerable and affected people. Relationships between aid organisations and vulnerable groups are rarely an equal partnership with equitable distributions of power, resources and shared risks and responsibilities for outcomes. Used like this, community engagement does not empower marginalised people and groups to fully participate in the design and management of a project.

But this does not always have to be the case. The US Centre for Disease Control (CDC), best known for its technical role in orienting epidemic responses, has also been a long-standing champion of community engagement as a means for health authorities, civil society organisations, and communities to work together to find solutions to public health issues facing vulnerable groups. The CDC's 1997 community engagement guiding principles are still relevant today. It states the need to invest time to get to know the community and its formal and informal networks and structures; recognise diversity and existing vulnerabilities, capacities and social and power dynamics within the community; to establish relationships of trust and enable two-way communication between authorities, external actors and the community.

Two principles in the CDC guide are particularly important and powerful reminders to any external organisation wanting to work with communities:

"Remember and accept that collective self-determination is the responsibility and right of all people in a community. No external entity should assume it can bestow on a community the power to act in its own self-interest."

"Organizations that wish to engage a community as well as individuals seeking to effect change must be prepared to release control of actions or interventions to the community and be flexible enough to meet its changing needs"

Despite the CDC's cautions, many community engagement strategies still tend to be designed in a top-down, paternalistic (or even, some would argue, neo-colonial) manner, especially when dealing with public health issues such as social and behaviour change communications. Aid organisations predominantly work through local authorities, community leaders and formal channels at the expense of using informal networks and channels with more direct interactions with the most vulnerable in a population. Groups that may already face significant barriers and obstacles due to language, gender roles, stigma or other discrimination may be inadvertently left out of engagement strategies that rely primarily on formal channels. The importance of local knowledge, capacities and resources are often overlooked, with a reliance on technical expertise instead of seeing affected people as experts on their own lived experiences, preferences, and priorities.

There are signs of progress though. Aid organisations today are placing more emphasis on mapping people´s trusted and preferred means for communication and participation and using this to define engagement strategies better aligned to people's priorities. This includes providing opportunities for jointly defining response objectives and establishing how participation in decision making will be safe, equitable and inclusive based on people's and communities' own preferences and using existing formal and informal networks and structures.

lesson six:
Work to re-engage communities as participating partners; have mechanisms to leverage local and volunteer groups to maximise their knowledge expertise to increase the effectiveness of the COVID-19 response.

Authorities and decision makers everywhere need to develop effective community engagement strategies to structure their interactions and relationships with communities. These strategies should look at vulnerable people and communities as equal partners, not as "targets" or "beneficiaries", and respect their preferences around how they want to participate and engage with external actors. This also requires recognising the knowledge, capacities, and resources that communities can bring to the table when designing and implementing responses.

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Community engagement can be used as a catchphrase, which disguises the use of participation and communication to serve the objectives of the aid organisation itself rather than the desired needs of vulnerable and affected people.

For the COVID-19 response, humanitarian actors engaged in existing crisis responses were quick to establish risk communication and community engagement coordination groups as a core component of the overall response plans. The aim was to provide a consistent and coherent approach to engage with communities around COVID-19 and develop content and messages to integrate into different programmes to reach different audiences with key messages. While community engagement may have been initially instrumentalised to quickly reach communities with risk communication messages, as the response continues this gradually shifts towards more active involvement of communities in activities. Engagement strategies can then make better use of local knowledge, capacities, and resources to adapt informational content to changes in the context of both the needs and preferences of vulnerable groups.

For example, many aid actors working with refugees and displaced persons in camp settings have leveraged their existing programming and relationships with vulnerable communities to integrate COVID-19 measures into activities. Health messaging was adapted to the new context in consultation with communities. Other activities such as water and sanitation, food distribution, or education were adapted to work with local water management committees or health promotion networks. These relationships made it easier to give a greater role to communities in participating in the design and implementation of projects. Participation here is still a work in progress though, as full participation in decision-making processes is still often channelled through government health authorities and international partners.

All this is reflected in the recently updated COVID-19 Global Response Risk Communication & Community Engagement (RCCE) Strategy developed by the World Health Organisation (WHO) and other key aid organisations. The strategy recognises the need to move towards more participatory, two-way communication approaches and to give more space for vulnerable and affected groups to engage more actively with authorities and aid providers. The revised strategy calls on governments and aid organisations to work more closely with civil society and vulnerable people and groups and to consider measures to strengthen local capacities to deal with the pandemic.

The collaborative work to develop this strategy is a positive example of how cooperation among national and international health authorities, aid actors and other stakeholders can lead to a more coherent global approach to community engagement that can be adapted to local contexts. Despite the clear value of these guidelines however, they are not likely to be referenced or used outside of

stressed countries with humanitarian crises. This is unfortunate, as it is the domestic response of some of the hardest-hit high-income countries where they are needed most. In these countries the disengagement and disconnect between authorities and communities is stark. What is missing is a coherent strategy to work with and through community-level structures and formal and informal networks to tackle the pandemic together.

7. An uncoordinated reliance on traditional communication techniques was quickly overwhelmed by the mass of sudden information and misinformation about COVID-19

The WHO and several key aid organisations have warned that COVID-19 is just as much of an "infodemic" as a health pandemic, and with good reason. With hundreds of articles, reports, guidelines, and media stories published each day on the coronavirus, it is difficult to make sense of the overwhelming amount of information – and misinformation – available on the coronavirus. COVID-19 is also the first pandemic where traditional sources and channels of information, such as government-issued bulletins, press conferences and mainstream news media have been supplanted by the internet and social media. Now more than ever, people around the world have access to news and information from different sources; many of which do not have the same layers of checks and balances to ensure the accuracy and reliability of information provided by traditional news media outlets.[16]

Despite this, government and health authorities in many countries continue to rely on traditional news conferences, press releases and policy statements to communicate their COVID-19 responses. What is worse, on many occasions the information provided by authorities has been inconsistent, uncoordinated, and contradictory. This provides the perfect ingredients for creating confusion and doubt amongst populations, and it undermines efforts to prevent or contain the community transmission of the virus.

Not enough attention has been given to identifying the varying information needs of different groups of the population and the trusted information sources and communication channels they prefer. This has meant that many vulnerable groups were left without access to critical information about the pandemic and the response.[17]

In countries where the pandemic was politicised, health information and guidance has been questioned or ignored, while mixed messages were used to justify decisions which may contribute to increased community transmissions of the virus, such as the use (or non-use) of face masks. Much of this communication was couched in terms of an either/or choice between individual health and protecting the economy. While decision makers need to make difficult decisions on how to best allocate finite resources there was little transparency around those decisions or the rationale behind them. There was no compelling case by these governments to unite individuals, civil society, and businesses around a common cause.

Countries that fared well in the early response, such as Canada or New Zealand, stand out as exceptions. These governments were able to effectively and convincingly communicate the gravity of the situation based on the available medical and scientific evidence and reinforce the message that the response required the full efforts of all people for the common good. Politicians often took a backseat to health authorities when updating the public on the coronavirus status and preventive measures. Information and messaging were generally clear, consistent, and largely independent from political interests. In the best cases, spokespersons were empathetic with the hardships and suffering caused by the pandemic and response measures, and were transparent about the uncertainty about the evolution, prevention and treatment of the virus, further reinforcing trust and confidence in the content of the messages.[18]

By contrast, the official communication strategies in some of the hardest-hit countries were slow to adapt their content and channels to meet the changing information needs and communication preferences of different groups in the population. As the pandemic continued to progress, information overload, message fatigue, complacency, and a false sense of the real risks of infection prevailed.

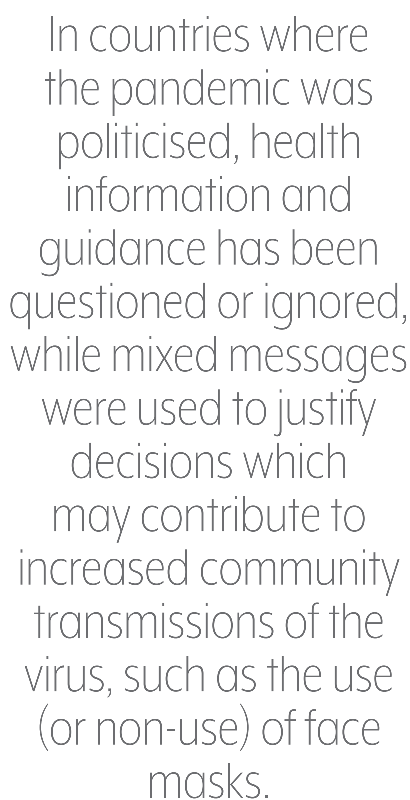
lesson seven:

Move to more participatory, two-way communications and feedback with vulnerable communities; find out what channels they really use, not just what we want them to use.

Authorities and decision makers need to move away from an over-reliance on top-down communication to more participatory, two-way communication. Organisations and communities need to have prepared ways to listen and learn from each other on how to meet information needs and priorities, and track and address rumours and misinformation. Priority communication channels and information needs to be available to help reduce the stigma and discrimination of the most vulnerable and affected groups in the population.

At the same time, the proliferation of alternative communication channels, such as those of social media, led to a corresponding proliferation of rumours, misinformation and falsehoods that directly undermined key health messages around COVID-19 and eroded trust and confidence in public health authorities. All this points to a missed opportunity to leverage the multiple channels available to provide information, and to engage with different groups in the population to take a more timely and more aggressive stance on combatting misinformation and rumours.

Alternatively, aid actors working in humanitarian crises were quick to recognise the importance of a coherent approach to COVID-19 communication. As noted earlier, risk communication and community engagement working groups were formed and integrated into existing coordination mechanisms. One of the first tasks was to map existing trusted and preferred information sources and communication channels. This is becoming a standard operating procedure in almost any humanitarian crisis and serves to identify the most appropriate mix of communication channels to ensure key messages around the crisis and its response reach different vulnerable groups and that they are relevant, appropriate, accessible and understandable. This also sets the foundation for a more transparent two-way communication between aid providers and vulnerable communities.



As an example, prior to COVID-19, aid actors successfully mobilised a mix of alternative communication channels to ensure vulnerable groups have access to life-saving information in different emergency settings. For example, in Central America the IFRC and the National Red Cross and Red Crescent Societies, UNICEF, UNHCR and others successfully used a combination of traditional print media, telephone hotlines, and social media platforms to reach vulnerable groups such as migrants or families at risk of Zika and other infectious diseases.[19] Similarly, in West Africa, a combination of different social media tracking and analysis tools have helped understand the issues and topics of concern to vulnerable people and used this to adapt their communication strategies. These experiences are now being used to shape and inform COVID-19 communication, particularly in the use of social media to access populations where face-to-face communication is impossible due to restrictions on movement.[20]

In some regards, it was easy to adapt to the new situation by just adjusting pre-existing health information campaigns used in previous and current emergencies such as the importance of handwashing in cholera prevention. The ongoing relationships with aid providers and repeated exposure to health and behaviour change messages may have also been a factor to explain the relative success at providing different vulnerable groups with clear, relevant, and appropriate prevention messages. By contrast, high-income countries rarely reinforce basic health messages like the importance of handwashing in public health information campaigns. This, along with contradictory, mixed messages, and the politicisation of the pandemic and the response may have undermined the adoption of healthy behaviours and led to complacency around prevention measures when the outbreak emerged.

Another lesson from the humanitarian sector is that integrating a variety of safe, inclusive, and accessible mechanisms for people to provide feedback, inputs, or complaints about the response has multiple benefits in terms of the effectiveness and accountability of interventions. Feedback can help identify gaps, risks, and issues around both the quality of assistance and the relationship between aid workers and communities, which then can enable adjustments to improve responses. Feedback mechanisms can also help to build a relationship of trust and transparency with aid organisations, provided the feedback is acted upon and that aid actors “close the feedback loop” by reporting back to the community on how their feedback and complaints have been addressed.

In the best cases, feedback can help aid actors and health authorities find innovative, locally-generated solutions to problems, such as how best to reach migrant populations, address issues, or how to comply with physical distance restrictions. This is not to suggest that feedback mechanisms have been used consistently and effectively in all humanitarian responses to COVID-19. But in comparison to many of the hardest hit high-income countries, those countries with ongoing humanitarian crises have appeared to fare much better at establishing these mechanisms and using them to support a more effective response.

WFP-FALUME-BACHIR

Petit Lait

WFP-ALICE_RAHMOUN

Aid actors have recognised for some time now the dangers of rumours and misinformation in a crisis situation and were quick to take steps to minimise the potential negative impacts by tackling this head-on. Rumour tracking is regularly included as part of community engagement and communication strategies, with increasing efforts made to understand the social context and factors that allow rumours to spread and become accepted in communities. This is not necessarily the case in countries without as much experience in dealing with rumours in emergency situations. As an example, a recent social media analysis shows how quickly misinformation, rumours and conspiracy theories can travel around the world, with significant impacts on people's trust and confidence with legitimate sources of information.[21]

Another area where humanitarian actors have lessons to offer is dealing with stigma and discrimination of those who are coping with COVID-19. Experiences around HIV/AIDS, Zika and Ebola all helped aid actors understand how stigma and discrimination can further increase vulnerabilities and the impacts of a crisis. This problem is not always visible or evident though. Indirect discrimination also occurs when authorities fail to consider the burden the disease and containment policies may have on the most vulnerable groups, such as the poor. This can be as simple as determining who has access to preventive measures, like access to face masks or soap for handwashing, who gets prioritised for testing, and the kinds of financial assistance needed to meet basic needs. It can also mean recognising and addressing issues around gender-based violence or racially-motivated attacks.

Looking forward, if an effective vaccine is found for COVID-19, governments and public health authorities will still have a massive challenge to deal the alarming level of vaccination hesitancy, where mistrust, misinformation and rumours are leading to a growing number of people who reject vaccinations for common, preventable diseases. This is likely to be compounded by the misinformation and rumours around COVID-19 vaccinations, as well as the significant lost ground on regular vaccination programmes around the world.

All this points to the need to shift away from top-down communication flows to more effective approaches. These include mapping trusted and preferred information sources, working with existing communication channels and consulting with vulnerable people and communities to check that information content and delivery reaches the right people, at the right time, and in the right way. As seen in humanitarian emergencies, this also requires strategies to work with communities to identify specific issues such as rumours, as well as cultural or socio-economic factors that contribute to people adopting, or not adopting, healthy behaviours and practices.

8. Decision making was too centralised, disempowering local agencies with resources to spare and who may also know better where help was most needed

There is considerable debate on what a localised response actually means in practice, particularly when considering the considerable power inequities and resources between local, national and international actors. The COVID-19 pandemic draws out several challenges, dilemmas, and opportunities around how to effectively integrate these local, national and international resources and capacities to support a more effective response, one that allows decision-making to be made more responsive and therefore accountable to those it serves.

This is something humanitarian responses have been reflecting upon for some time. At the World Humanitarian Summit, the UN Secretary-General called for the greater localisation of aid, where local actors are supported as much as possible to lead the response to a crisis with international actors stepping in only when needed to complement local capacities. The localisation agenda is also a core commitment of the Grand Bargain agreement and related initiatives such as the Charter 4 Change. With these principles in mind, COVID-19 was the perfect opportunity to test the aid community's commitment to localisation. In crisis areas the humanitarian response to COVID-19 was able to draw on existing relationships with vulnerable communities developed through these previous programmes. So, with international staff under confinement, and severe restrictions on movements in most countries, the initial response was often led by national governments and, most importantly, by local authorities, with support from national humanitarian organisations, civil society, and local communities themselves. International donors and aid organisations relied on providing remote technical assistance, support, and monitoring. A key advantage was that in many existing crises, this response to COVID-19 was able to draw on existing relationships with vulnerable communities developed through these previous programmes.

MUSE MOHAMMED

lesson eight:
Empower local agencies and communities to take a lead role in the response, so they can truly supplement the response and take charge at a local level.

Authorities and decision makers need to develop strategies to strengthen the role of communities and local actors in the response to expand coverage of prevention, assistance and support to vulnerable and at-risk people and communities. These strategies should acknowledge and prioritise the use of local knowledge, capacities and resources in the response, and commit to transferring decision-making powers and resources to local actors and communities in order to strengthen sustainable capacities to deal with future emergencies and crises.

Like the commitment to participation and community engagement, it is too early to tell if COVID-19 will lead to any substantial changes in terms of investing more longer-term international resources to support local actors and strengthen sustainable community capacity to decrease vulnerabilities at the local level. The global economic downturn and the increasing demands in donor countries to address domestic COVID-19 needs may mean reduced funding overall for humanitarian and development work, and retrench funding channelled through international organisations. But the approach does suggest that localised responses that work with and through community-level actors can be an important means to expand the response and reach more people with life-saving information, support and assistance, as well as laying the foundation for more sustainable capacities and resilience.

Many high-income countries are finding that the emphasis on government-led responses and an over-reliance on specialised medical and technical interventions has come at the expense of investing in quality primary and preventive health care at the community level, as was seen in the SARS and Avian Flu responses previously. This has been a missed opportunity to strengthen the critical role of community engagement in a very cost-effective way prior to, and during, a pandemic response.[22] In many places, local and international NGOs have worked with existing local water management committees, community health promoters and faith-based organisations to mobilise response efforts.[23] These local resources have been critical in supplementing weak national health and social protection systems in many crisis-affected countries. While there are no reliable figures on the economic and social benefits of mobilising local capacities to support the response, the added value can be estimated in billions of dollars; not an insignificant amount in times of severe shortfalls in funding for both domestic and international aid efforts.

Looking at the COVID-19 response, stronger links to communities through effective community engagement and participation strategies might have meant more comprehensive and complementary actions in the response, with more sustainable local capacities to prevent and respond to other situations or emergencies. Meanwhile, countries that face frequent or chronic humanitarian emergencies with few resources and weakened public health systems demonstrate the critical importance of making links to communities to expand the reach, coverage, and effectiveness of their health programmes.[24]

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Conclusions

Participation, community engagement and two-way communication with vulnerable people and communities are essential components of effective and accountable humanitarian action. The COVID-19 pandemic is no different. It is a humanitarian crisis that goes far beyond health and economic statistics; it has touched millions of people and every country in the world.

There is a need to conduct thorough, evidence-based evaluations of the COVID-19 pandemic response at all levels and identify what worked well, what didn't, and what those in a position of power could and should have done to minimise the impact. However, at this stage of the pandemic it is clear that too many mistakes have been made; mistakes that could have been avoided or minimised had authorities and decision-makers applied humanitarian principles and good practices to the response.

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Governments and health authorities were unprepared for the scale and scope of the pandemic. The response at all levels – global, national, and local – reveal significant gaps, both around being accountable to affected people, and also the responsibility to ensure their inputs and participation in how best to deal with this global crisis. Communication has been chaotic and uncoordinated, with many examples of politicised and contradictory messages that place the most vulnerable people and communities at risk. Meanwhile, the capacities, resources and knowledge of local people and communities have not been used effectively as part of the overall response.

There is much that can be done **now** to address this accountability gap and improve the quality and effectiveness of the response at all levels. For this, the world has much to learn from the experiences from the humanitarian aid sector and from countries with experience dealing with previous humanitarian crises and health emergencies. These countries often have significantly fewer resources with which to respond yet they show that by engaging and working with vulnerable people and communities, providing opportunities to give feedback, giving an opportunity to participate in decisions that affect them, establishing relationships based on trust, and being open to two-way communication and effective coordination, can all contribute to improving the quality, relevance and effectiveness of the response.

These are lessons that some of the hardest-hit countries by the pandemic, particularly high-income countries with many more resources and well-established health and social protection systems, would do well to draw on. Tried and tested humanitarian principles and good practices should inform their own domestic responses, putting people at the centre of how the response is designed and implemented.

At the same time, the global community must not forget its responsibilities to deal with the needs of millions of people who have simultaneously been affected by both COVID-19 and other humanitarian disasters, conflicts, and emergencies. World leaders need to coordinate better to ensure a more effective and coherent global response to COVID-19 and to put vulnerable people at the centre of what we collectively do to prevent, prepare and respond to all current and future crises. Narrowing the accountability gap should be a priority for us all.

ENDNOTES

1 This paper reflects the views and opinions of the author, and not necessarily those of the CDAC Network or its members.

2 An example of the contrast to the Australian experience of COVID19: *Community engagement in Australia's COVID-19 communications response: learning lessons from the humanitarian sector*, published in Media International Australia: https://journals.sagepub.com/doi/10.1177/1329878X20948289

3 A simple review of the news media in almost any country shows how polarised and politicised the pandemic has become. See for example: https://www.economist.com/europe/2020/10/03/spains-poisonous-politics-have-worsened-the-pandemic-and-the-economy

4 See for example, https://blog.hi.org/wp-content/uploads/2020/06/Study2020_EN_Disability-in-HA-COVID-final-2.pdf

5 See for example https://www.thenewhumanitarian.org/analysis/2020/06/03/coronavirus-pandemic-global-health-aid-history

6 See for examples the experience in Bangladesh at http://www.shongjog.org.bd/news/i/?id=492eb598-e429-428c-843a-f67315afff8e. Other examples can be found at http://www.cdacnetwork.org

7 See the CDAC message library at: http://www.cdacnetwork.org/training-and-tools/message-library/

8 See: https://www.economist.com/europe/2020/10/03/spains-poisonous-politics-have-worsened-the-pandemic-and-the-economy

9 See: https://www.cbc.ca/news/health/coronavirus-canada-schools-1.5679090

10 See for example CDAC's guide on collective services for feedback and engagement: http://www.cdacnetwork.org/policy-and-guidance/guidance/i/?id=cca52f57-4f06-4237-9c18-37b9e8e21a18

11 See for example the "FROM WORDS TO ACTION: Towards a community-centred approach to preparedness and response in health emergencies, for a comprehensive overview of lessons from previous health emergencies. https://apps.who.int/gpmb/assets/thematic_papers/tr-5.pdf

12 WHO Alma-Ata: https://www.who.int/social_determinants/tools/multimedia/alma_ata/en/

13 https://sustainabledevelopment.un.org/topics/information-integrated-decision-making-and-participation

14 See for example: https://www.thenewhumanitarian.org/analysis/2020/06/03/coronavirus-pandemic-global-health-aid-history

15 https://www.theguardian.com/world/2020/may/03/nhs-coronavirus-crisis-volunteers-frustrated-at-lack-of-tasks

16 See for example: https://www.who.int/news-room/detail/23-09-2020-managing-the-covid-19-infodemic-promoting-healthy-behaviours-and-mitigating-the-harm-from-misinformation-and-disinformation and https://covid19.alnap.org

17 See: https://www.thenewhumanitarian.org/news-feature/2020/07/30/coronavirus-immigrant-refugee-language

18 See for example how some Canadian public health officials have become trusted sources of information: https://www.cbc.ca/news/canada/british-columbia/covid-b-c-coronavirus-health-1.5617825https://www.cbc.ca/news/politics/covid-19-conspiracy-theories-1.5672766 and https://www.cbc.ca/news/health/coronavirus-canada-schools-1.5679090

19 See for examples from the Latin America region on community engagement and communication to reach vulnerable groups and populations: http://www.cdacnetwork.org/policy-and-guidance/learning-reviews/i/?id=ad3d74d1-397d-467c-bad1-841a5fe4c131

20 See: https://www.afro.who.int/news/inoculating-against-infodemic-africa

21 See for example: https://washcluster.net/Covid-19-resources

22 See for example: https://www.cbc.ca/news/canada/covid-19-coronavirus-pandemic-countries-response-1.5617898 and https://www.thenewhumanitarian.org/analysis/2020/06/08/coronavirus-transform-humanitarianism-aid

23 See for example: https://washcluster.net/Covid-19-resources

24 The findings of this paper were facilitated by the insights developed in this British Medical Journal article: https://gh.bmj.com/content/4/Suppl_7/e003121.full

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All comments welcome: please send them to info@cdacnetwork.org

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