World Health Organization

Community assets and civil society outreach in critical times

An initiative to engage civil society organizations in the COVID-19 response

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Bangladesh – Association of Development Agencies in Bangladesh
Burkina Faso – Burkinabe Red Cross
Ecuador – Fundación Pachamama and Confederation of Indigenous Nationalities in the Ecuadorian Amazon
Guatemala – Guatemalan Association for Persons with Disabilities - Manuel Tot; and Latin American Network of Non-Governmental Organizations of Persons with Disabilities and their Families

India – DISHA Foundation
Iraq – Heevie
Israel – Mosaica
Kenya – Organisation of African Youth
Lebanon and Yemen – MENAHRA
Mali – Association of Deans of Medical Faculties of French-speaking African countries
Nepal – National Federation of the Disabled - Nepal
North Macedonia – Association for Emancipation, Solidarity and Equality of Women
Serbia – IDEAS
Sri Lanka – Foundation for Health Promotion and Alcohol and Drug Information Centre
The Philippines – Families Choice for Health and Development

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Abbreviations

ADAB	Association of Development Agencies in Bangladesh
ADIC	Alcohol and Drug Information Centre
AGPD-Manuel Tot	Guatemalan Association for Persons with Disabilities
AHC	attacks on health care
CADMEF	Association of Deans of Medical Faculties of French-speaking African Countries
CBO	community-based organization
CONFENIAE	The Confederation of Indigenous Nationalities in the Ecuadorian Amazon
CORUS	Centre des Opérations pour la Réponse aux Urgences Sanitaires
COVID-19	coronavirus disease 2019
CSO	civil society organization
EPP	emergency preparedness plan
ESE	Association for Emancipation, Solidarity and Equality of Women
FHP	Foundation for Health Promotion
FM	frequency modulation
IDP	internally displaced person
IPC	infection prevention and control
MENAHRA	Middle East and North Africa Harm Reduction Association
NFDN	National Federation of the Disabled – Nepal
NMS	Nairobi Metropolitan Services
OAY	Organisation of African Youth
PLHIV	people living with HIV
PWUD	people who use drugs
RIADIS	Red Latinoamericana de Organizaciones de Personas con Discapacidad y sus Familias
RT-PCR	reverse transcription- polymerase chain reaction
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2

Introduction

In 2020–2021, with the support of the COVID-19 Solidarity Response Fund, the World Health Organization (WHO) provided direct financial and technical support to 54 grassroots civil society organizations (CSO) in 40 countries, serving over 80 million people in situations of vulnerability, including migrants, refugees, internally displaced persons, persons with disabilities, older persons, youth groups, women and children in distress, hard-to-reach indigenous communities, hidden social and ethnic minorities, informal workers and front-line care providers.

Connecting communities to services and fostering participatory governance, the CSO Engagement Initiative sought to mitigate the impact of the COVID-19 pandemic on the most vulnerable.

This initiative was designed, planned and implemented under the leadership of the WHO Country Readiness Strengthening Department. Guided by the commitment to the 3Es (enable, empower, engage), the Initiative called on partners to create an enabling environment for empowering communities with a strong voice to engage in decision-making and shared accountability for building resilience to emergencies beyond COVID-19.

Pursuing its Triple Billion targets *(1)*, WHO is committed to engaging community stakeholders toward making health central to the agenda of equity and inclusion and toward strengthening resilience of health systems and communities.

This collection of best practice experiences is a testimony to the life-changing impact of the support provided to the grassroots organizations by WHO and COVID-19 Solidarity Response Fund.

Best practice experiences

WHO AFRICAN REGION

Burkina Faso – Protecting health workers from attacks

As part of the whole-of-society response to COVID-19 in Burkina Faso, the Operations Centre for Health Emergencies (CORUS), WHO Country Office for Burkina Faso, Health Cluster, and Burkinabe Red Cross joined efforts to facilitate access to basic health services for internally displaced persons in the complex humanitarian settings of the country's Boucle du Mouhoun, Sahel and Centre Nord regions. A total of 3 236 973 people live in these areas and are served by 289 health centres.

These health centres are the only source of health-related information and medical help for communities. It was essential to train community relays who could reach these centres with COVID-19 information and help them to maintain the trust of local people in public health and social measures. It was also critical to safeguard the health centres from attacks by violent armed groups.

In view of persistent and increasing attacks on health care (AHC), the Burkinabe Red Cross trained 39 volunteers and security focal points in Dori and Kaya cities on methods to reduce risks for health

COVID-19 awareness sessions with community relays, Burkina Faso, 2021. © WHO African Region

care workers and improve access to care for people in remote communities. From June to September 2021, with the help of the WHO monitoring tool for health attacks *(2)*, the Burkinabé Red Cross was able to report over 20 attacks on health workers including murder, kidnapping, hostage-taking, ambulance-jacking, arson at health structures and theft of medical products. These incidents led to 36 health facilities being closed or put out of operation, leaving people in the target areas with no medical help.

Previously unreported, this evidence was for the first time made available to CORUS: AHC has now been recognized by the government as a high-impact event preventing access to care. As a result, the Ministry of Health has integrated AHC programmes into its national response plan and is now leading operational research on the impact of AHC. This work has led to policy discussion on the need for new laws to protect health care workers. WHO and the Ministry of Health have jointly developed communication materials to support the Burkinabé Red Cross in its training programme for security focal points in the target areas. This training programme is currently being scaled up nationally.

COVID-19 awareness sessions with youth, Kenya, 2021. © WHO African Region

The Burkinabe experience has been shared with Nigerian CSOs which, working in similar humanitarian settings, will be able to benefit from and adapt the training materials for local use.

The Burkinabe experience shows that appealing to local organizations to take part in protecting health care facilities and personnel from attacks is a critical measure to strengthen community ownership of health services. Efforts should be made by health authorities in similar settings across the world to establish and sustain partnerships with local CSOs.

Kenya – Kisumu and Nairobi youth fighting the pandemic

With 70% of the sub-Saharan African population aged under 30 (3), Africa is the youngest continent in the world. Youth engagement has been critical in the COVID-19 response, from compliance with COVID-19 public health and social measures to youth leader support for national efforts to mitigate the pandemic's impact on communities in vulnerable settings.


WHO Regional Office for Africa
Engaging the Youth in COVID-19 Prevention & Control - Kisumu County
We are not safe yet: Elimika. Wajibika . Chukua Hatua
We are not safe yet: Elimika. Wajibika . Chukua Hatua

WHO partnered with the Organisation of African Youth (OAY) *(4)* to reach the most vulnerable groups in the peri-urban areas of Kisumu, Kenya's third-largest city. With the support of WHO Regional Office for Africa and WHO Kenya Country Office, OAY became an active member of the COVID-19 Task Force in Kisumu and got swift COVID-19 response actions off the ground in the Manyatta and Obunga communities.

Manyatta and Obunga are the poorest slums of Kisumu, and face challenges such as poor sanitation, insecurity, unemployment, poor roads and difficult access to health services. From July to September 2021, OAY held COVID-19 information campaigns among women's and youth groups and trained a total of 1000 local women and youth leaders in COVID-19 risk communication. Together with other local organizations and youth leaders, OAY distributed masks and hand sanitizers to people living in overcrowded households, families with older persons, and persons with disabilities.

Informed about COVID-19 risks, Elizabeth Gwaro, the leader of Manyatta Development, a women's community-based organization in Manyatta, turned for support to the Kibos Sugar Company, a producer of ethanol and hand sanitizers in Kisumu. Having explained to the company managers the importance of hand hygiene among those with limited access to soap and water in overpopulated and poverty-stricken peri-urban areas of Kisumu, Elizabeth received a donation of 20 litres of hand sanitizer. Together with a group of young women, Elizabeth repackaged the sanitizer into small bottles and distributed them in Manyatta, Kondele Ward, Nyalenda and Obunga in Railways Ward, as well as in the slums of Kisumu. The women of Manyatta Development seized the opportunity of this distribution campaign to inform communities about COVID-19 prevention, protection and control measures, including COVID-19 vaccination.

OAY established a joint committee with the Great Lake University and Kibos Sugar Company to distribute hand sanitizers in Manyatta and Obunga and to organize health promotion days in schools. OAY trained 40 Youth Champions to promote compliance with COVID-19 public health and social measures and to mobilize communities to access vaccination in Kisumu.

In Nairobi, OAY worked hand in hand with the Nairobi Metropolitan Services (NMS) to raise awareness about COVID-19 prevention and control in Kamiti Prison Remand Centre for boys and girls in Roysambu subcounty. In August 2021, OAY visited the centre five times and talked to 50 girls and 206 boys about the basics of COVID-19 – how it spreads, signs and symptoms, variants, potential mortality – and the importance of prevention, protection and control measures. In view of the obvious difficulty of complying with physical distancing and mask wearing in the facility, OAY talked with the Superintendent about the need for strict adherence

Left photo: COVID-19 awareness sessions with youth, Kenya, 2021. © WHO African Region

to COVID-19 protocols advised by the Ministry of Health.

This collaborative work between OAY and NMS stimulated the services to liaise regularly with their respective institutions and to call on the government to step up its daily TV and radio reminders to the public to follow COVID-19 protocols. In December 2021, following a joint NMS/OAY advocacy campaign, NMS organized a vaccination drive at Kamiti prison where 525 prisoners were able to receive their first dose of COVID-19 vaccine.

OAY continues to spread the message that it ought to be the role of administration and management in structured institutions to make sure that infection prevention and control (IPC) protocols are observed and sustainable IPC measures in place.

With WHO support, OAY has not only improved health-related awareness among communities in situations of vulnerability but also inspired youth and women's community-based organizations to network with local partners in order to improve community life.

Mali – Protecting health workers against the COVID-19 pandemic

Health care workers are on the front line of the COVID-19 pandemic. They are at high risk of infection and seven times more likely to come down with severe COVID-19 than other workers *(5)*. In resource-limited countries, the situation is even more difficult in health facilities due to the lack of staff, training, and necessary equipment. Effective IPC measures can reduce the risk and spread of COVID-19 among health care workers and safeguard uninterrupted patient care.

WHO partnered with CADMEF, the Association of Deans of Medical Faculties of French-speaking African countries, and supported the Faculty of Medicine and Dentistry of the University of Sciences, Techniques and Technologies of Bamako, Mali, to develop IPC protocols for health workers.

With the technical input from WHO Regional Office for Africa and WHO Mali Country Office, CADMEF Mali carried out a cross-sectional survey among 500 medical and paramedical health care workers in five university teaching hospitals of Bamako in November and December 2021, a period corresponding to the fourth wave of COVID-19 in Mali. CADMEF interviewed workers on the risks of COVID-19 and their IPC-related knowledge and practices using a WHO survey tool *(6)*. Survey findings indicated that nearly half (48.2%) had direct contact with patients diagnosed with COVID-19, 10% reported a positive RT-PCR test to SARS-CoV-2, and 8.2% declared a history of COVID-19 symptoms. Nearly half (49.6%) were vaccinated against COVID-19 but 22.4% expressed vaccine hesitancy. Roughly half (48.0%) were not aware of WHO-recommended multimodal hand hygiene *(7)* and only 8.8% regularly used personal protective equipment. None of the nonmedical personnel in the sample had been trained on health

Workshop on developing IPC for healthcare workers, Bamako, Mali, 2022. © WHO African Region

care-associated infection risk, IPC or use of personal protective equipment. This survey highlighted the low compliance of personnel with IPC and high risk of potential health care-associated infections in health facilities. It also emphasized the need to scale up training on IPC measures and develop an effective IPC implementation strategy with a focus on nonclinical staff in order to minimize the transmission risk of SARS-CoV-2 and other health care-associated infections in health facilities.

Using these results as a template, CADMEF developed a ten-module IPC course for health workers and is pressing for national authorities to institutionalize the IPC course in the medical faculty curriculum and in every technical hygiene committee in health facilities across Mali.

WHO Regional Office for Africa continues to assist CADMEF to publicize the IPC modules throughout the CADMEF regional network as a key tool for health care worker protection in emergencies.

WHO Regional Office for Africa is committed to protecting health care workers and ensuring the continuity of quality care for all patients in need. The CSO Engagement Initiative has proven that a national medical community can collect quality data using WHO tools and develop evidence-informed programmes to mitigate the impact of COVID-19 and other pandemics on health facilities.

WHO REGION OF THE AMERICAS

Ecuador – Indigenous communities at the forefront of responding to the pandemic

Ecuador is a multi-ethnic country of wide cultural diversity: there are 18 indigenous nationalities and 14 traditional indigenous villages spread across the country. In many cases, especially in the Amazon region, these communities can be reached only by river or air: this factor, along with other socioeconomic realities, makes access to health services difficult and accordingly renders these populations highly vulnerable to public health threats such as COVID-19.

WHO Regional Office for the Americas/Pan American Health Organization (PAHO) supported two local CSOs, Fundación Pachamama and CONFENIAE *(8)*, to reduce the pandemic's impact on indigenous communities. Through jointly planned interventions, PAHO/WHO Country Office for Ecuador helped both CSOs to scale up their community assistance programmes.

Fundación Pachamama works to empower indigenous women and amplify their voices in order to improve the maternal, infant and reproductive health of indigenous nations in the Ecuadorian Amazon.

Guided by PAHO/WHO Regional Office for the Americas and PAHO/WHO Country Office for Ecuador, Fundación Pachamama planned a comprehensive, community-based action in Achuar and Shuar communities to abate the pandemic's impact, flagging up ways to maintain essential health services in remote communities. Stressing the need

Right photo: Workshop on producing artisanal soaps from medicinal herbs and oils, Macuma, Morona Santiago province, Ecuador, 2021. © WHO Region of the Americas.


Trogata

for compliance with COVID-19 public health measures in these remote communities would have been futile due to the fact that adequate hygiene and health services are not accessible. Fundación Pachamama organized a series of workshops to train local women in health promotion and methods of producing artisanal soap. Community health workers from neighbouring communities came together at these workshops in Achuar and Shuar, where they were trained not only on COVID-19 awareness but also on safe deliveries to prevent maternal and neonatal deaths in their communities. At the same time, 400 childbirth kits were distributed to support safe and healthy childbirth. Shuar men were invited to attend later workshops on domestic and gender-based violence. The news that local men were becoming allies for women's and family health was welcomed by all the indigenous communities. A total of 223 women and men benefited from these workshops.

This WHO/CSO collaboration has not only helped to improve health-related awareness in communities but has also convinced local women to become agents of change. Their new roles extend from working as trained midwives to supervising local soap production and generating a source of sustainable income for the communities in Achuar and Shuar.

CONFENIAE represents 11 indigenous nationalities of the Ecuadorian Amazon via 23 affiliate organizations, reaching over 200 indigenous communities of around 100 000 people.

To ensure that COVID-19 information got to hard-to-reach communities, PAHO/WHO supported CONFENIAE in expanding the FM radio frequency of its indigenous radio station "La Voz de la CONFENIAE" – the only radio broadcast reaching the indigenous communities in the native languages of the Amazonian region. PAHO/WHO also supported CONFENIAE to develop radio production plans. A total of 30 radio scripts were co-written for 7 local radio networks affiliated with CONFENIAE to disseminate culturally relevant messages on COVID-19, including encouraging people to trust immunization. Through this joint work, CONFENIAE has become not just a beneficiary but also an important local partner and amplifier of the national response to the pandemic.

In addition, as part of the PAHO/WHO risk communication campaign, PAHO/WHO and CONFENIAE provided mental health support to schoolchildren and their families to cope with fears that might have affected the children during the pandemic. The book *My Hero is You*, designed by the Inter-Agency Standing Committee *(9)*, was translated by PAHO/WHO into the local language, and 600 copies of *Naatka Muruitme (10)* were distributed to children in the indigenous communities of Ecuador.

Supporting local CSOs in community-based interventions reduces the disproportionate vulnerabilities of remote communities and inspires indigenous community health workers to provide the whole range of essential health services during a pandemic.

The overarching hope is that by broadening the skills of community health workers – with improved access to culturally sensitive information, inclusive community-centred interventions and ongoing support for essential health services – will ultimately reduce morbidity and mortality in these isolated communities and strengthen resilience among Amazon's indigenous communities to emergencies.

Guatemala – Nothing about us without us: getting persons with disabilities involved in health emergencies

In Guatemala, CSO support focused on including persons with disabilities and their families in humanitarian response plans and inclusive risk management for emergencies and disasters with the motto "Nothing about us without us" *(11)*.

Persons with disabilities have been adversely and disproportionately impacted by the COVID-19 crisis in the Americas. Around 15% of the global population live with a disability condition, the Region of the Americas alone claiming around 9.44% *(12)*. The prevalence of persons with disabilities living in conditions of poverty and extreme poverty in Guatemala stands at 10.38%.

The COVID-19 pandemic laid bare many things: the invisibility of persons with disabilities, widening exclusion gaps and the worsening lack of inclusive humanitarian actions, including access to health. Moreover, in 2020, Guatemala had to cope with not only the COVID-19 pandemic: it was further impacted by two devastating natural disasters, hurricanes Eta and Iota. In an emergency situation, persons with disabilities are two to four times more likely to die.

Guided by WHO Regional Office for the Americas, PAHO/WHO Country Offices in Guatemala and Ecuador signed a multicountry coordination agreement with the regional CSO RIADIS *(13)* and the local CSO partner in Guatemala, the Guatemalan Association for Persons with Disabilities (AGPD)-Manuel Tot. Including the specific conditions affecting persons with disabilities in health registries was central to the CSO action plan: it focused on a human rights approach within the national health system, universal accessibility of health services and involvement of persons with disabilities in drawing up inclusive programmes, policies, plans and projects.

With PAHO/WHO technical guidance, barriers faced by persons with disabilities in accessing health services during COVID-19 were analysed in depth[1]. This led to the disability variable being

1 Reports developed with PAHO/WHO Guatemala included: analysis of legislation on disability in Guatemala; Narrative Report on the Report on the situational analysis of the approach to care for persons with disabilities in the context of COVID- 19; Mapping of the care for persons with disabilities in health services in the context of COVID-19, & the mapping of actors; and directory of organizations of persons with disabilities working in risk management.

Workshop on the application of the INGRID-H methodology, Guatemala, 2021.
© WHO Region of the Americas

included in the national health care records and PAHO/WHO's evaluation-action tool *Disability Inclusion in Hospital Disaster Risk Management (INGRID-H) (14)* being rolled out in six hospitals in Guatemala.

In order to address the problem of disability inclusion in emergency risk management, PAHO/WHO strengthened several alliances between CSOs representing persons with disabilities and key national stakeholders, and supported participatory governance mechanisms – the National Coalition on Inclusive Risk Management[2] and the National Technical Roundtable for Strengthening the Inclusion of persons with disabilities in Health Risk Management – led by the

2 National Coalition was a temporary coalition that included partners such as the Ministry of Health, 77 members of CSOs representing PWDs and a range of public institutions and relevant development actors related to disabilities, Health Management and Humanitarian Aid.

Discussion on inclusive policies for persons with disabilities, Guatemala, 2021.
© WHO Region of the Americas

Ministry of Health, CSOs and key stakeholders[3]. This national roundtable was the first of its kind in Guatemala on health and risk management, and a Ministerial Agreement has been approved to ensure its continuity and sustainability.

Changing the approach to disability will allow persons with disabilities to become involved in shaping inclusive programmes, plans and projects so that this target group can access quality health services appropriate to their particular needs. This country project is one of the lessons learned by the Region of Americas on how to improve disability inclusion within health systems and strengthen community resilience to emergencies.

3 Included the important participation of the National Coordination for Disaster Reduction (CONFRED) and the National Council for the Care of Persons with Disabilities (CONADI).

WHO SOUTH-EAST ASIA REGION

Bangladesh – Harnessing collective strengths for a wider reach

From April to September 2021, about 2.3 million people in 90 wards of three major city corporations[4] in Bangladesh were reached by the WHO initiative on engaging CSOs in the COVID-19 response in partnership with the Association of Development Agencies in Bangladesh (ADAB) *(15)*, the country's largest coordinating body of local community-based (CBO) and civil society organizations.

With technical support from WHO Country Office for Bangladesh, ADAB commissioned 33 CBOs to step up adherence to public health measures in Chattogram, Dhaka North, and Dhaka South – the areas with the highest number of COVID-19 cases. All 33 CBOs were trusted sources for their communities and had strong relationship with local governments.

"In this project, we have given emphasis on engaging small and local CBOs. Small-scale, local organizations are agile and well-targeted, and are highly cost-efficient. They have their commitment to their community, a good understanding of local reality and local needs. They are effective in negotiating with local government. They can design projects based on homegrown experience and can operate programmes at low cost and require less administrative formalities. And they can participate anytime in social

4 City corporations govern major cities and metropolitan areas in Bangladesh.

COVID-19 awareness miking, Dhaka South City Corporation, Bangladesh, 2021. © WHO South-East Asia Region

development activities. That was a key factor of success in our community engagement activities," explained Dr. Jashim Uddin, Director of ADAB, when he outlined the association's considerations when selecting local CBOs for this project.

When designing its COVID-19 response programme, ADAB organized individual discussions and group meetings with the 33 selected CBOs to consult on the response strategy. Suggestions were first obtained from the CBOs before planning the

type and frequency of activities. Plans were then coordinated with WHO Country Office for Bangladesh to ensure that they were technically aligned with WHO guidelines and the government's COVID-19 policies.

To implement the co-developed plans, ADAB briefed local imams and COVID-19 prevention messages were routinely disseminated through mosque miking. ADAB also negotiated with transport authorities to promote preventative measures, and hundreds of bus and bike mikings were made in the most crowded areas every day. Most importantly, local female ward councils became active negotiators with local authorities on improving access of their communities to preventative measures including the availability of masks, soap, hand sanitizers, and vaccines.

By harnessing local partnerships, this CSO initiative in Bangladesh was able to combine collective strength, resources and reach in getting the most out of the project.

India – How a COVID-19 response partnership is developing migrant health traction in CSO work

The outcomes of the most recent collaboration between the Government, WHO Country Office for India and DISHA Foundation *(16)* will support the CBOs and CSOs in India to include migrant health in their work.

Data collection and registration of workers, India, 2021. © WHO South-East Asia Region

Awareness campaign at bricklike manufacturing unit, Shirdi, India, 2021. © WHO South-East Asia Region

In January 2021, as part of its COVID-19 response and under the global WHO initiative to engage CSOs in the COVID-19 response, WHO Country Office for India partnered with DISHA Foundation, a national CSO aiming to alleviate the lives of people from marginalized groups, including migrant workers, persons with disabilities and those in prison. This joint WHO/DISHA Foundation work focused on addressing the needs of internal migrants who had moved to the cities from various parts of the country for employment.

WHO supported the organization in developing its COVID-19-related programme on migrant health, which included:

- ensuring that internal migrant workers continue to have access to essential health services by partnering with community health centres;
- improving access of 12 000 migrant workers to COVID-19 vaccines by encouraging them to register and bringing vaccination sites closer to where they work; and
- providing internal migrant workers with timely COVID-19-related information and messages tailored to their contexts by advancing peer support and leveraging digital technology.

Throughout all these activities, WHO provided technical support and facilitated coordination among national and local authorities.

"The COVID-19 pandemic has highlighted the importance of ensuring no one is left behind in our goal to ensure health for all. With the whole country putting its best foot forward in the fight against the pandemic, the migrant project has helped build a model through which the needs of vulnerable communities can be adequately addressed," said Dr. Anjali Borhade, Director of DISHA Foundation.

Together with WHO, DISHA Foundation developed capacity-building tools, including a standardized training module to boost CBO and CSO capacities for integrating migrant health in their work on the ground. "The training manual being developed through the project will be an important resource for CSOs to create sustainable support to address migrants' needs. Building capacities of CSOs working with migrant workers will be crucial to ensure targeted interventions to address the needs of the migrant communities", said Dr. Muniraju SB, Deputy Advisor, Aayog National Institution for Transforming India.

Once approved by the Government, the training module will be made available nationwide – still in partnership with WHO and DISHA Foundation – as part of the general effort to promote migrant health in the agenda of CBOs and CSOs. India is a country with many local nonprofit organizations working on development. While only a handful of them currently cover migrant health in their respective programmes, it is likely that, as CBO and CSO capacities increase, many of them will realize the importance of addressing this issue, while becoming more capable of and confident about supporting it.

"WHO, through its strategic engagement with civil society partners, supports efforts to enhance health outcomes among the most vulnerable communities. Strengthening such interventions plays a pivotal role in building community readiness and resilience to help reduce the impact of COVID-19 pandemic and other health emergencies among the people at risk", said Dr. Roderico Ofrin, WHO Representative to India.

Nepal – Nothing about us without us: advancing a disability-inclusive emergency response

In March 2021, WHO partnered with the National Federation of the Disabled - Nepal (NFDN), an umbrella organization of persons with disabilities in the country, to advance disability-inclusive preparedness for and response to the COVID-19 pandemic *(17)*. In collaboration with the Ministry of Health and Population, WHO and NDFN launched the campaign: "Yes we can", A disability-inclusive COVID-19 response.

"Yes we can" started with 61 virtual district help-desks that provided life-saving guidance and information to persons with disabilities, including COVID-19 preventative measures and, where necessary, isolation and quarantine instructions and/

A mental health activist discusses with female community health volunteers on early identification of people in distress, unity Nepal, 2021. © WHO South-East Asia Region

or referrals to COVID-19 health facilities. These help-desks also coordinated tele-rehabilitation sessions between experts and persons with disabilities to ensure that essential rehabilitation-related services were maintained amid the restrictions triggered by the pandemic.

The pandemic had a grave impact on the psychosocial well-being of women and girls with disabilities, especially those in situations of gender-based violence. NFDN trained twelve women in Lumbini province as peer counsellors to help manage the sensitive issue of gender-based violence. These

women are now key facilitators, intervening in a timely manner in cases of gender-based violence involving persons with disabilities and their families.

"Yes we can" ensured that facilities and health care workers are adequately equipped to provide appropriate treatment and care to persons with disabilities who develop COVID-19. NFDN trained frontline COVID-19 nurses and paramedics, while the COVID-19 Unified Central Hospital, a reference facility for COVID-19, was assessed for disability inclusion by a team of persons with disabilities. Using the results of this assessment, WHO and partners advocated for and supported the hospital in addressing gaps to ensure a disability-inclusive COVID-19 facility that will serve as a standard for all other unified COVID-19 facilities across the country.

As part of its data-driven advocacy, "Yes we can" collected information from 21 COVID-19 facilities on whether assistive devices and other basic amenities, including water, sanitation and hygiene were available for persons with disabilities, and shared it with the authorities. Similarly, data on almost 1 500 households of persons with disabilities not suitable for home quarantine/isolation were shared with the municipal authorities so that members of such households could be prioritized for institutional quarantine or isolation.

NFDN and partners prioritized the vaccination of 90 000 persons with severe disabilities (43% of registered persons with severe disabilities in the country). Transportation to vaccination facilities was arranged by municipalities and local entrepreneurs. The vaccination registration system developed for this purpose allowed accurate data to be recorded on persons with disabilities.

Most importantly, "Yes we can" continued to enhance the disability-inclusive three-tier health system model for emergencies that emerged from the experience of previous disasters, including the 2015 Nepal earthquake. Previous disasters highlighted the importance of having a separate injury rehabilitation subcluster during emergencies. The systems and processes that have been developed and expanded are applicable not only for large-scale disasters but for small- and medium-scale emergencies, and should be sustained at all times.

WHO and NFDN have also developed guidance on managing children with disabilities in COVID-19 facilities and are working together with the government on guidelines to allow persons with disabilities to take part in emergency preparedness and response.

The Nepal experience can be applied to similar low- and middle-income country contexts. An enabling environment that allows persons with disabilities to become involved and show initiative in line with the "nothing about us without us" principle will ensure that no one is indeed left behind.

Started as a pilot initiative in the city of Pokhara in Gandaki Province – more than a hundred miles from the capital, Kathmandu – "Yes we can" has been scaled up to all 77 districts of all seven provinces of Nepal.

Door-to-door visits to support the elderly, Sri Lanka, 2021. © WHO South-East Asia Region

Sri Lanka – Community-powered solutions for COVID-19 prevention

When individuals, families and communities are engaged and empowered to do their bit in the COVID-19 response, it is not only about their taking control of their own health. More importantly, it is about letting them take ownership of the problem, as well as potential solutions to it. These were among the most important lessons learned from WHO's partnership with the Foundation for Health Promotion (FHP) and Alcohol and Drug Information Centre (ADIC) *(18)*.

Both organizations focused on promoting COVID-19 protective measures among target communities in Sri Lanka, resulting not only in

increased compliance with public health measures but also helping to set up an innovative contact-tracing scheme through a family-run community COVID-19 calendar.

The community COVID-19 calendar provides support in monitoring a person's risk of contracting COVID-19. The initiative was started by the FHP as an individual family checklist for households. The idea was then developed into a community COVID-19 calendar, which allowed communities to identify high-risk spots, activities, etc. The same idea was adopted in workplaces. The calendar contains a checklist that measures a person's possible exposure to COVID-19. For example, in households using the COVID-19 calendar, if one member of the family spends time outside without practicing protective measures, this person will be marked in the calendar as being at "high risk" while the rest of the family will be marked as being at "moderate risk."

The calendars are designed by local people themselves, so each house or community or workplace has its own unique design. This underscores the fact that the initiative is led and owned by local people – they develop their own tools instead of just being provided with already printed ones. Different colours are used when marking risks, and monitoring in households is usually done by the children. Having children involved in this activity not only increased their motivation amid lockdowns and school closure, but also made the adults more attentive in adhering to the preventative measures.

In line with the DReAM[5] campaign – a joint effort of the Government, WHO and other partners to reinforce adherence to preventative measures – the COVID-19 calendar is used in Trincomalee, Anuradhapura, Colombo, Kurunegala, Monaragala and Matara. The calendar was also adopted by the ADIC communities. It has become widely recognized in the country as an innovative approach to preventing further COVID-19 transmission in communities. "We were helpless and afraid in the beginning. This programme made us become aware and capable. We can protect ourselves and our house now. And we already did it, together," says a community mobilizer.

The community COVID-19 calendar has enabled communities to assess and understand their risks, improve their adherence to preventative measures and monitor their behaviour to protect themselves and their families. The use of this calendar has contributed to strengthening community-based surveillance of the disease, as well as being a shining example of community-led prevention. It underlines the crucial role of communities in making a difference in the fight against the COVID-19: the end of the pandemic is now in the hands of the people themselves.

5 DReAM stands for **D**istancing, **R**espiratory **e**tiquette, **A**septic techniques and **M**ask.

WHO EASTERN MEDITERRANEAN REGION

Iraq – Accessing services in IDP camps

WHO Country Ofice for Iraq partnered with Heevie *(19)* to support activities in Duhok and Sulaymaniyah, two hard-to-reach communities of internally displaced persons (IDPs). The health authorities in Iraq have been stretched by the impact of the pandemic, and providing the necessary management and interventions for hundreds of thousands of IDPs and refugees in the country has put a huge pressure on an already weak health infrastructure.

Heevie stepped in to support the Department of Health in Duhok and Sulaymaniyah and, in consultation with the health authorities and WHO Country Office for Iraq, developed a culturally sensitive COVID-19 training package to help 80 volunteers support their communities. Educational materials were translated and printed in the languages spoken in the communities: Kurdish, Arabic, and the Badini and Sorani dialects. Trained volunteers were able to provide COVID-19 awareness sessions to more than 43 000 individuals in six IDP camps in Shariya, Kabarto 2, Rawanga, Bersivy 1, Mam Rash and Ashti in the governorates of Duhok, Ninewa, and Sulaymaniyah. Masks and hand sanitizers were distributed during the sessions to families in the camps. Supporting vaccine roll-out, Heevie encouraged 1 800 residents to enlist in the preregistration online system for COVID-19 vaccination.

Coordinating its actions with the provincial health departments, Heevie worked with

Door-to-door COVID-19 sensitization visits, Duhok, Iraq, 2021 . © WHO Eastern Mediterrenean Region

management, community leaders, health facility managers, health workers, and other partners at the camps to address the gap between the needs and services provided. Given the limited Internet access for online vaccination registration and the lack of resources and means for IDPs to reach vaccination

centres, Heevie is reviewing whether it might be possible to set up vaccination centres inside camps to provide safer and easier access for vaccination for their populations. These centres could be adapted for long-term routine vaccinations. The CSO engagement prompted a dialogue with national authorities and other stakeholders to discuss challenges faced by IDPs beyond COVID-19.

Lebanon and Yemen – Emergency preparedness plans for harm reduction

WHO and the Middle East and North Africa Harm Reduction Association (MENAHRA) *(20)*, in cooperation with Harm Reduction International, have assisted to marginalized groups of persons who use drugs (PWUD) and people living with HIV (PLHIV). These groups are regularly victims of stigma and discrimination, and reaching out to them made it possible for them to voice their concerns.

Both countries are dealing with a national humanitarian crisis in addition to the COVID-19 pandemic, and the distress experienced by these persistently marginalized groups worsened during COVID-19. WHO supported MENAHRA to develop and validate an emergency preparedness plan (EPP) for harm reduction in both countries. Gaps and challenges identified during an assessment study conducted at an earlier stage with input from PWUD and PLHIV fed into this plan. Validating the EPP was fundamental in both countries in view of the importance of getting all stakeholders on the same page in order to identify gaps and needs and ensure that the EPP for harm reduction was included in national plans for the communities in question. Despite various challenges related to lack of resources and Internet access for online meetings, particularly in Yemen, the EPP for harm reduction was validated. MENAHRA is now a key partner in government planning and decision-making on improving preparedness to future emergencies.

Safeguarding harm reduction services in countries with pre-existing vulnerabilities and/or conflict situations is crucial during emergencies. Governments should recognize that harm reduction services are essential public health services that cannot be suspended in the event of an emergency.

WHO EUROPEAN REGION

Israel – The role of religious leaders in promoting health

The abrupt onset of COVID-19 made it clear that religious communities would face unique challenges in applying preventative measures. Jewish often pray in a quorum of ten, Muslims pray shoulder-to-shoulder. Other faith communities across the world worship together. It was not easy for any of them to accept COVID-19 health measures including preventative activities that did not tally with religious laws, the supreme laws in these communities. The onset of the pandemic, which began a few weeks before the three major religious holidays of Easter, Passover, and Ramadan, was particularly challenging: COVID-19 public health and social measures including vaccination were met with a great deal of fear and suspicion amid a flurry of misinformation and conspiracy theories. Religious leaders had to figure out how to navigate religious laws and customs while upholding human sanctity and dignity.

Dr. Daniel Roth[6] recalled the spread of COVID-19 misinformation in September 2020: "Within 24 hours we managed to gather the most influential Muslim religious leaders in a Zoom meeting together with senior staff from WHO Regional Office for Europe and had them say to their followers 'COVID-19 is real.'

6 Director of Mosaica and lecturer on Religion and Conflict Resolution at the Program for Conflict Resolution, Management and Negotiation at Bar-Ilan University.

A religious leader and a community doctor discussing vaccination, Jerusalem, Israel, 2021.
© WHO European Region

Some also had to say the message [containing misinformation] they gave before was wrong and that they had investigated properly with the top health professionals."

To tackle misinformation and promote a dialogue with religious leaders and health authorities, WHO Regional Office for Europe supported the conflict resolution centre Mosaica to set up the Kavod/Karama Project[7] to promote the religious value of advancing human dignity and well-being in response to COVID-19. The project spanned religious affiliations, working with representatives from the Jewish, Muslim and Christian sectors to match scientific evidence and religious sensitivities: the aim was to build viable relationships and structures in response to COVID-19 and future health emergencies. WHO organized a dialogue on health promotion between Mosaica and the Israeli Ministry of Health, putting health policy-makers in touch with religious leaders and opening communication channels that can be sustained in the future.

The relationships of trust that Mosaica has built up over time with faith communities set a solid foundation for its work during the pandemic. "Already as far back as February 2020 we were talking to senior Muslim and Jewish religious leaders about closing mosques and synagogues because of COVID-19," recalls Dr Roth. "The difference our cooperation with WHO made is that it has enabled us to expand our capacity and be proactive on COVID-19 rather than just reacting to the crises." COVID-19 prevention campaigns were organized with and by religious leaders ahead of the three biggest holy festivals of the year: during just one of these campaigns, over 12 000 people were vaccinated following a ruling by a Muslim religious leader that promoted vaccination and counteracted misinformation. In another campaign over 80 volunteers were mobilized to encourage people to get vaccinated and accompany older persons to vaccination centres.

"We had true, effective cooperation," said Dr Saleh Bader, a community doctor. "There was a sense of fear among the people here, fear of vaccination as

7 The name Kavod/Karama replicates the Hebrew and Arabic words for dignity.

well. Whenever something was posted on social media, we would post based on medical, religious, and scientific reasoning. Can I provide medical facts? Yes. But then, Sheik Ra'ed[8] backs them up with religious facts."

In its commitment to ensuring a systematic response to COVID-19, WHO supported Mosaica to organize four forums which brought together religious leaders and representatives from the Ministry of Health and WHO. On 14 December 2021, religious leaders serving in the Holy Land endorsed a joint declaration in response to COVID-19 *(21)*. WHO also supported Mosaica to commission an academic research project by Haifa University and Bar-Ilan University on the potential impact of religious leaders in promoting health and meeting public health goals.

The lessons learned from WHO engagement with Mosaica fed into the development of an interim implementation tool for engaging with religious leaders, faith-based organizations and faith communities in the European Region, which will complement the WHO strategy for engaging religious leaders, faith-based organizations and faith communities in health emergencies *(22)*.

The Kavod/Karama project indicated the importance of meaningful collaboration between health authorities and religious leaders. It showed that religious leaders can be highly effective "inside mediators" – able to reconcile science and society. Religious leaders can dispel rumours with messages that are backed up by science and aligned with religion, increase social cohesion and facilitate engagement between health authorities and religious communities. Not only that: the Kavod/Karama project showed how important it is for health authorities to interact with the most influential religious leaders "on the ground", and to develop relationships of trust with them before an emergency occurs. The resulting tools, research and materials, as well as the wider results of the project, were presented at a conference on religious diplomacy in March 2022, shared with other countries, and will continue to enrich WHO's wider community engagement work with CSO networks and influencers.

North Macedonia – Roma communities building resilience to emergencies

In 2021, WHO Regional Office for Europe partnered with the Association for Emancipation, Solidarity and Equality of Women (ESE) *(23)*, a Roma-led CSO, to reduce the impact of COVID-19 on Roma communities in the Suto Orizari, Prilep, Karpos and Gjorce Petrov municipalities.

The Roma population in North Macedonia accounts for 13% of the country's total population. Many Roma live in isolated districts in towns and cities and face high poverty levels, experience deprivation and lack basic amenities such as running water.

8 A senior Islamic scholar.

Roma community board meeting, Gjorce Petrov, North Macedonia, 2021. © WHO European Region

Bringing ESE on board for the joint WHO and Ministry of Health response to COVID-19 led to three Roma community boards being set up. These have become leadership groups: they include informal leaders and influencers from within the Roma communities, as well as representatives from the municipal, health, education, police and social services. Each board has now 10 to 15 members who have been trained on community resilience techniques such as resource mapping and emergency readiness and response.

"The creation of this board was of crucial importance for our community. It allowed a more organized approach for taking action at different stages of a crisis. Also, it improved access to information that, in turn, helped resolve problems faster," said Nezhlan Ismailovska, a member of the Roma community in Prilep.

The boards mapped all resources and assets available in their communities such as those available to the municipality, local ambulance and health services, schools, kindergartens, community groups and other CSOs. They also mapped the needs of Roma communities for emergency preparedness, readiness and response in a survey that involved 2 527 Roma households living in municipalities of around 100 000 people.

With the support of emergency response experts, the boards developed two-year community resilience plans to optimize resources for an ongoing response

Building community resilience plans for Roma households, North Macedonia, 2021. © WHO European Region

to COVID-19 and any future health emergencies with one priority in mind: the most vulnerable should not be left behind. "We learned how to mobilize, organize and deploy our resources where needed," said Ruzha Kostovska, an ambulance doctor and member of the community board in Gjoche Petrov. "Health workers cannot deal with the pandemic on their own. They need to cooperate with communities and get support from other resources available in the municipality."

Aided by WHO and North Macedonia's Institute for Public Health, ESE staff were trained on how to conduct contact tracing. This allowed additional gaps in the system to be identified: a lack of trust in the health system on the part of Roma communities as well as various practical difficulties such as an inability to isolate suspected cases due to overcrowded living conditions. ESE drew up a proposal to support WHO to test the operational contact tracing guide for community engagement in North Macedonia to address these challenges. The hope is that ESE will provide health authorities with firm evidence about how the practical application of these guidance principles can generate trust, increase resilience to future health emergencies and improve uptake of public health and social measures among Roma communities.

ESE used the Photovoice model to document their work and the needs of Roma communities. Together with community board members and other Roma CSOs, ESE presented their policy

recommendations for building resilience to future emergencies within Roma communities at a national conference in Skopje, in September 2021. This event provided a platform for 55 decision-makers and donors and opened a sustainable policy dialogue on the inclusion of Roma communities and their representative organizations in any decisions relating to improvements in their health and well-being.

Including communities when planning interventions that are likely to affect them is a crucial step in empowering community members and activating local resources. In view of its widely acknowledged and life-changing impact on Roma communities in North Macedonia, the CSO Engagement Initiative has led to requests from other countries for expanded support from WHO on community engagement. Evidence accrued by the CSO Engagement Initiative suggests that the cornerstone of building stronger and more resilient communities is inclusion. Participatory approaches to health decisions make an immense contribution to the WHO goal of one billion more people better protected from health emergencies.

Serbia – Civil society building bridges between migrants and health workers

IDEAS, Centre for Research and Social Development *(24)*, works to ensure that the real-life experiences of migrants are taken into account in policy-making. In 2021, WHO Regional Office for Europe partnered with IDEAS to tackle the challenges faced by the migrant communities in Serbia and health workers who treat them in reception, transit and asylum centres.

Aiming to improve the accessibility, quality and cultural sensitivity of health services for migrants, WHO Country Office for Serbia facilitated a dialogue between IDEAS, the Ministry of Health and Ministry of Labour, Employment, Veteran and Social Affairs that has led to development and approval of guidelines on culturally sensitive services for migrants.

Every year, more than 50 000 refugees and migrants pass through Serbia. Many are physically exhausted, traumatized and need medical services and assistance. It is often the case, however, that migrants on the move often prioritize continuing their journey over caring for their health or getting treatment for serious medical conditions. And while health workers try to encourage migrants to look after their health – which recently included complying with protective measures to prevent COVID-19 transmission, report symptoms and get vaccinated – the needs analysis conducted by IDEAS indicates that many migrants do not trust the health services or do not know how to access them.

"I have been here for 4 years now and I am confused," said a 23-year-old Afghan woman.

To address this issue, IDEAS developed a toolkit for health mediators to reduce the negative consequences of language barriers, sociocultural differences and tensions between ethnic groups, and trained 30 medical staff in the reception, transit, and asylum centres that host around 2 000 migrants.

A workshop with migrants, Belgrade, Serbia, 2021. © WHO European Region

Staff received training on communication and cultural skills in assessing COVID-19 symptoms, responding to mental health and other medical problems, and helping migrants access legal and social services. This newly acquired know-how among health mediators has fostered trust in the migrant community and enabled the culturally diverse migrant community to interact with IDEAS and the Ministry of Health to improve the quality and accessibility of health care services.

"If a doctor asks me now to take off my clothes and I am not comfortable, I will say so and ask if there is a health mediator available," said a 16-year-old Pakistani boy.

A further 45 health workers in primary health care facilities were trained on approaches and practices in cultural competence with an emphasis on COVID-19 prevention and control. These training courses gave importance to supporting victims of trauma and violence, including survivors of gender-based violence, unaccompanied and separated children, and persons with addictions.

"I understood cultural competence training as a way of appreciating the context from which migrants are coming and how to better provide services for them," said one of the health workers who took part in the training.

This type of partnership between community, civil society organization and health authorities smooths the way to inclusion and helps to improve access to essential public health services for populations in vulnerable settings. Aiming to sustain the progress made in health mediation efforts, the Ministry of Health has lent its support to health mediators and culturally competent practices in Serbia's migration response project.

WHO WESTERN PACIFIC REGION

The Philippines – Community innovation in contact tracing for vulnerable populations

"This health tracker has been very helpful for us to monitor our family members, especially our children", said Gladys Gapongli, a homemaker and wife of a small-scale miner in Itogon, Benguet, in the northern Philippines. "Now we can know and record if they are ill during this pandemic."

The home health tracker was developed by Families Choice for Health and Development *(25)*, a CSO in the Philippines supported by the WHO global CSO Engagement Initiative of the COVID-19 Solidarity Response Fund.

In 2021, Families Choice conducted COVID-19 and vaccine awareness sessions for indigenous and small-scale gold mining communities in Itogon, Benguet. Gladys's household is one of 400 beneficiaries of the HAAN COVID[9] project.

Unlike those working in established mining companies, small-scale miners in the Philippines have inadequate access to health care and live in hard-to-reach areas. They often come from indigenous populations, live and work in crowded, poorly ventilated conditions, and rarely use the internet or smartphones. Personal protective equipment is not available in these communities.

To ensure that infection cases are detected punctually, Families Choice developed home health trackers: hard-copy logbooks for miners and their

9 In the Ilocano language, "haan" means "no": NO COVID-19.

COVID-19 orientation session for families of mining community, Philippines, 2021. © WHO Western Pacific Region

families to record their daily health status and activities. The health trackers were designed using contact-tracing handbook, developed by WHO Country Office for Philippines, as a model and helped to improve local surveillance data stemming directly from communities. Data from the logbooks fed into expanded contact-tracing efforts undertaken by local authorities. The logbooks also contained information on COVID-19 best practices for preventing and limiting transmission in vulnerable communities: every effort was made to ensure information on public health and social measures was as reliable and up-to-date as possible. Distributing home health trackers is the first step in

COVID-19 orientation session for families of mining community, Philippines, 2021. © WHO Western Pacific Region

developing barangay-level surveillance maps and getting local preparedness and response efforts up and running.

To involve the communities as comprehensively as possible in managing the pandemic response, Families Choice distributed 1 600 face masks, 1 600 face shields and 400 hygiene kits. Together with WHO Country Office for Philippines and the Department of Health, Families Choice developed materials for COVID-19 awareness campaigns to boost COVID-19 vaccine acceptance.

Supported by WHO, Families Choice engaged with local government partners, mining companies, community health workers and local communities to ensure that their efforts were in line with national guidelines.

The work of Families Choice highlights the importance of partnerships with CSOs representing the most vulnerable. It allows them to seize the initiative and include the needs of such communities within national and local health priorities.

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