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RESEARCH ON THE IMPACT OF COMMUNITY ENGAGEMENT AND ACCOUNTABILITY APPROACHES IN PUBLIC HEALTH EMERGENCIES

INDONESIA

A CASE STUDY ON COVID-19

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Address: Chemin des Crêts 17, Petit-Saconnex, 1209 Geneva, Switzerland
Postal address: P.O. Box 303, 1211 Geneva 19, Switzerland
T +41 (0)22 730 42 22 | **F** +41 (0)22 730 42 00 | **E** secretariat@ifrc.org | **W** ifrc.org

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Research lead: Monica Posada (IFRC)

Author: Magdalena Isaurralde (PlanEval)

Design: Hadley Kincade

Illustrations: Nikolett Zsilovics

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ACRONYMS

CEA	Community engagement and accountability
CBS	Community-based surveillance
CP3	Community Epidemic and Pandemic Preparedness Program
CBAT	Communitybased action team
PMI	Palang Merah Indonesia (Indonesia Red Cross Society)

INTRODUCTION

This case study was conducted as part of research commissioned by the International Federation of Red Cross and Red Crescent Societies (IFRC) on the impact of community engagement and accountability in public health emergencies. The overall objective of the research is to identify, understand and document how community engagement and accountability approaches have changed, impacted and/or influenced National Societies' programmes and community-health systems during public health emergencies. The research has been conducted in five different countries: Guinea, Georgia, Guatemala, Indonesia and Malawi. Based on initial discussions between the IFRC and National Societies, these five sites were selected to document a variety of community engagement and accountability practices within various communities across the world and during the response of different public health emergencies.

Community Engagement is a way of working that recognizes and values all community members as equal partners, whose diverse needs, priorities, and preferences guide everything we do. We achieve this by integrating meaningful community participation, open and honest communication, and mechanisms to listen to and act on feedback and data, within our programmes and operations. Evidence, experience, and common sense tells us when we truly engage communities and they play an active role in designing and managing programmes and operations, the outcomes are more effective, sustainable, and of a higher quality.

Nevertheless, the impact of community engagement and accountability approaches has been largely under-researched within the Movement. There is a clear need to collect the evidence that proves the importance of community engagement and accountability investments, to strengthen its Theory of Change, and to pave the ground for a future impact measurement frame work which will allow better guidelines to track and measure impact of community engagement interventions.

This document presents a case study on community engagement practices during COVID-19 by the Indonesia Red Cross Society (Palang Merah Indonesia or PMI). Since some community engagement and accountability activities were developed in the context of endemic diseases, our case study includes, to a lesser extent, qualitative data of community engagement approaches in other recurrent diseases, particularly tuberculosis.

OBJECTIVES

The objective of the research is to identify, understand and document how community engagement and accountability approaches have changed, impacted and/or influenced Red Cross Red Crescent programmes and community-health systems during COVID-19.

The evaluation seeks to answer two fundamental questions:

1. Are community-led interventions contributing to a better uptake of public health measures and strengthening community-health systems during an outbreak?
2. Are community feedback systems informing Red Cross Red Crescent National Societies response activities and ensuring communities are heard during an outbreak?

To answer these two questions, this research focuses on both the effectiveness and impact of community engagement and accountability activities. The conclusions will serve as a basis for defining key community engagement and accountability determinants across the five countries in the study.

METHODOLOGY

This case study employed semi-structured qualitative methods and observations, facilitated by PlanEval researchers and supported by IFRC and PMI. The interviews and group discussions were conducted in a conversational style, allowing participants to express their thoughts, opinions, and experiences around their role during outbreaks. All interviews were conducted in local language (Indonesian Bahasa) thanks to the support of a local interpreter. All conversations were transcribed using Verbatim and translated into English to analyse the data. Annex 1 provides an overview of the data collection process and geolocations. To triangulate the data, the approach relies on primary quantitative data from local community feedback systems as well as primary quantitative data from epidemiological indicators and behavioural surveys when available.

The qualitative component was structured along three lines.

1. Individual interviews with PMI staff and volunteers

For the qualitative component, the research team conducted semi-structured interviews with the personnel in charge of the interventions. The purpose of these interviews was to understand how community engagement and accountability fit into related field activities. The interview guide for this section was adapted according to:

- The context of COVID-19 and other emergencies
- The nature and impact of community engagement and accountability practices with the community
- Local partnerships with community-based groups, health and administrative structures and inter-agency coordination.

This component was conducted both remotely and on-site.

2. Focus group discussions with communities

This research was an opportunity to assess community needs, priorities, autonomous solutions and concerns. To evaluate the effectiveness of the intervention, the research team conducted focus group discussions with the community on the dedicated sites to analyse the effectiveness of the interventions vis-à-vis local needs and priorities.

In addition to the semi-structured interviews and focus groups with the community, the research team spoke with village chiefs and other community representatives, such as *kaders*. These exchanges are not part of the formal data collection process, as they are informal exchanges that provide insights on the functioning of local structures, etc.

3. Desk review

The desk review included articles, brochures and working documents from IFRC and PMI Indonesia, which allowed us to triangulate with testimonies recovered in the field. The desk review also allowed the possibility of comparing the approach taken during different epidemics and/or in different regions of the country.

Some considerations about "impact"

This study does not encompass a quantitative impact analysis. Instead, its objective is to provide a qualitative and narrative exploration of how community engagement practices and their outcomes are observed and interpreted by the various participants involved in the study. We acknowledge that effective interventions depend on the harmonization and congruence of multiple factors, including structural, cultural, institutional, and economic determinants. Consequently, the evidence of impact collected in this study should, in certain instances, be considered as a contributing element rather than a sole and isolated catalyst for change.

Study limitations

There were several obstacles identified during the field work. The following paragraphs provide a brief explanation of the major challenges and how they were resolved during the data collection.

- **Enthusiasm from the community**

The field work generated a lot of enthusiasm from the communities, resulting in great curiosity and presence during the discussion groups. This caused some disturbances in the discussion venues, especially at Lawen and Tanah Baru. To mitigate the risk of outside influence, the research team attempted to define the meeting space with the support of the local PMI branch.

- **Facilitation by national office staff**

The facilitation by local PMI branches may have introduced some bias, as the assessment objectives were introduced by individuals who were familiar with local communities. To address this and to avoid complacent responses, the research team asked PMI staff to limit their participation in the discussions.

- **Difficulties in accessing remote areas sites leading to discard one site.**

Although the logistics were planned ahead to reach some mountainous villages of Central Java, there was a risk of cancellation due to weather conditions. Despite these anticipated efforts, the second site in Banjarnegara was discarded due to landslide risks, with no possibility of replacing it.

1 KEY FINDINGS

Overall, this research highlights the positive impacts of community engagement, partnership with community structures, data-driven decision-making, and context-specific approaches in risk reduction adherence and treatment uptake behaviors during public health emergencies:

1. Community engagement approaches conducted in active participation with community-based groups had a positive impact in vaccination acceptance especially in hard-to-reach areas. Women play a significant role in strengthening solidarity ties within the community and between the community and institutions to reinforce inclusion of the most vulnerable.
2. Fostering the autonomy of communities in co-planning and decision-making processes generated more resilient and well-prepared communities responding to the COVID-19 pandemic. This was especially impactful in the way communities decided and planned the cash distribution criteria and self-organization.
3. Trust and proximity with community influencers enables the contextualization and appropriateness of the response to local norms, customs, and linguistic diversity, resulting in higher understanding and uptake of risk reduction measures related to COVID-19 and tuberculosis.
4. PMI's investments in understanding and supporting existing capacities of community-based groups increased their social recognition and trust among other community members. It also impacted in sustaining and strengthening the self-efficacy and readiness of community-health systems.
5. Data-driven decision-making generated tailored approaches to bring vaccines to those with mobility restrictions and shaped successful vaccine rollout efforts to larger population.

2 UNDERSTANDING THE LOCAL STRUCTURES

Communities and community-based groups are complex constructs that encompass various definitions and present numerous ways of understanding their nature and dynamics. Community-based groups often emerge organically from within the community and actively engage in activities and initiatives that address shared concerns or promote collective well-being.

The notion of communities is often based on the false assumption of existing social cohesion and homogeneity. However, communities and community-based groups encompass diverse individuals with different backgrounds, perspectives, and interests. Understanding and navigating this diversity can be fundamental, as it requires recognizing and addressing the varying needs, priorities, and power dynamics within the community. When a disaster hits or a new outbreak is declared, those community-based groups are the ones who will most probably activated to provide quick and efficient support to their peers.

In Indonesia, the research team observed a highly structured local environment of community-based groups.

Puskesmas: the Indonesian health system relies on decentralized health structures, the *Puskesmas*. These are overseen by the Indonesian Ministry of Health and provide health care for the population on a sub-district level. *Puskesmas* are responsible for implementing health programmes to prevent and treat tuberculosis, detect and control dengue outbreaks, respond to the COVID-19 pandemic and promote immunization. However, *puskesmas* lack the personnel necessary to implement such initiatives. To overcome this obstacle, the *puskesmas* establish a cooperative relationship with the *kelurahan*, the local authority responsible for governing village affairs. The chiefs of *Kelurahan* are in close contact with the *rukun warga* leaders to seek the appointment or offer volunteer service to their local community.

Kelurahan: The *puskesmas* work with the *kelurahan* ((urban administration unit), but also with smaller administrative divisions such as the *rukun warga* (abbreviated RW, literally 'pillar of residents') and *rukun tetangga* (abbreviated RT, literally 'pillar of neighbours'). The limited resources available for the implementation of health programmes encourages local cooperation. Thus, *puskesmas* coordinate with *kelurahan* to follow up on public health directives on dengue prevention campaigns, tuberculosis and routine vaccination campaigns.

Kaders: Kader is a village representative from the government assigned by the primary health center or village office. In some instances, PMI volunteers are also *Kader* in their villages. Usually community leaders and representatives of women or youth's groups are *Kaders*. Their role is to coordinate with the entire village's community regarding any social issues (health, economic, political) that needs attention.

Community-based action team (CBAT) is a community network trained and working closely with PMI. CBATs are community disaster-preparedness agents acting in the community to increase resilience. CBAT are also crucial in supporting public health response and making the bridge with the communities. Members represent a variety of groups, including women, youth, the elderly, religious groups and people who have disabilities.

3 FINDINGS

3.1

Community participation: a driving force in the uptake of risk reduction measures during new outbreaks

When identifying positive effects of community participation, both communities and volunteers report positive changes in the prevention of COVID-19. It was also mentioned during focus group discussions that much of the community participation was achieved through personal contact and one-on-one interaction. **This is important to highlight because it reveals that participation in the research sites is seen mainly as a way of a 'being part' of specific activities or being reached door-to-door, rather than being actively engaged in all phases of the response.**

As described below, it appears that the role of Community Based Action Teams (CBATs) was a driving force in the adoption of preventive measures during COVID-19 and also during endemic health diseases such as tuberculosis (TB). As we have seen in the previous section, CBATs are defined as a community local responders who are trained and working closely with PMI. They are normally seen as community disaster-preparedness agents but progressively active in supporting outbreaks and other disease control activities, serving as the main bridge with the rest of communities. As PMI supervisors in Bogor indicate, health promotion campaigns and hygiene protocols led by CBATs were effective and, contributed to change people's behaviour, especially regarding the use of masks and hand washing. This is confirmed by focus group discussions in Tanah Baru, where communities that did not consider COVID-19 relevant in the early stages of the pandemic began to adopt hand washing, social distancing and mask-wearing after CBATs carried out awareness activities at social events or mass gatherings, with locally adapted strategies.

> **"So, we work together with the puskesmas and kaders, we bring like some kind of loudspeaker, we bring pamphlet, banner and poster, we also have like sing, easy-to-remember song so for people to wash their hands and so on. So we practice the health protocols or give information about the health protocols, put mask, washing hands and so on. So people in the area provide or distribute mask as well."**
>
> ***— CBAT Member, Tanah Sareal***

It results clear from the research that CBAT's intermediation is crucial in establishing sustainable links with communities as they appear to be trusted and embody good reputation based on the consistency of their work during different health and environmental crises.

According to interviews with communities and PMI staff in Tanah Sareal and Tanah Baru, the work carried out with community-based surveillance to promptly detect and treat TB was a major step in building bonds of trust with the population. As TB is a disease transmitted by airborne microdroplets, community volunteers explained that some of the prevention advice for tuberculosis helped to inform about COVID-19 and transmission routes were more easily understood. The same applied to the public health recommendations around self-isolation at household level to avoid family clusters.

Furthermore, they state that early detection of TB facilitated access to treatment, especially for high-risk patients. The Tanah Sareal evidence shows that individual behaviours are gradually adapted to prevention, isolation and detection and that communities are able to replicate health practices more easily as they encounter new diseases. The work that the community action teams provided to be better informed and prepared to contain tuberculosis served as a precedent for COVID-19 pandemic, increasing the chances of healthy practices to be instituted in a faster and trusted manner.

> **"Every time people get treatment for TB, I always recommend them to ask their family members to come along, or the cadres that are working in their area so that they can remind this patient and motivate this patient, because TB treatment is quite long, for six months."**
>
> ***— Member of Puskesmas in Tanah Sareal***

Synergic participation of community chiefs, health centers and community action teams fostered acceptance of COVID-19 vaccination.

One of the major observations of this research is the important role that community-based groups played to generate greater acceptance of vaccination in rural areas that were initially reluctant to accept the vaccine. The village of Lawen illustrates how the coordination established between the health centre, the volunteers and the local authorities led to greater vaccination acceptance. In Lawen the research team found that the accompaniment of the CBATs through door-to-door visits was a fundamental step to promote community participation and to gather the concerns and suggestions of the community during the vaccination campaign. Due to this thorough work, the Lawen community's predisposition to vaccination was significantly modified, leading to a vaccination rate close to national levels.

According to the local PMI branch, before the CBATs started sensitization on vaccine importance in Lawen, the population's' willingness to be vaccinated was low. Within the requests and perceptions of the local population, the CBATs observed a certain reluctance to travel to the vaccination centres, which are sometimes several hours away by road. In consultation with PMI, the they suggested to advocate for the vaccination centres to be moved closer to the most isolated villages. The vaccination campaign has helped people who live off the transport routes to find an easy solution and combine the trip to the market with vaccination.

> **"Many people from the neighbouring regency come here to get vaccinated, and we hold events and campaigns because we have a market here and they come here rather than go to the city. And every afternoon we visit the other villages to promote hand washing and wearing masks."**
>
> ***— Head of the Village, Lawen***

Combined with the proximity of vaccination centres, the intervention of village chiefs, *kaders* and CBATs was key in promoting vaccine uptake and thus narrowing the gap between local statistics and the national percentage of the population having received one or two doses. PMI surveyed 1,051 individuals in Lawen in October 2021. The survey found that 1,031 individuals (98.1%) had received at least one dose and 20 individuals (1.9%) had received two. Approximately one month later, 66% of the surveyed population had received two doses.

Moreover, the CBATs who chose to be vaccinated in the first cohort had a considerable effect on persuading those who were reluctant to be vaccinated. As such, **this notion of exemplarity** appears in the testimony of the CBATs in Lawen. This group describes that during the vaccination campaign, appearing healthy after the vaccine made the safety of the vaccine 'visible' to the rest of the population.

I wasn't really aware of all the infections that can be transmitted through breathing. But thanks to the CBATs' teaching, I realized that it's helpful to use a mask, especially when there are a lot of people in a room.

— Member of the Tanah Baru community

> **"It is (was) important for the community to talk to CBAT and see how, having been vaccinated, they were healthy and working."**
>
> ***— PMI, CBAT supervisor***

Traditional community gatherings were identified as an effective community participation mechanism during the COVID-19 vaccination campaign. The organization of social events such as sporting, musical, or school events, or simply PMI volunteers' presence in relevant community meeting centres brought the community closer to PMI activities while legitimizing the role of CBATs in promoting health practices. **These events offered a way to ensure that communities understood the key social measures to prevent COVID-19 during an entertainment moment based on cultural preferences for the community**.

For example, taking advantage of the fact that the CBAT group in Lawen was formed around an association of young musicians, COVID-19 vaccination campaigns were designed around concerts in the village and recreation activities at schools.

> **"They used the language [which is] used by the community. For example, in schools, in my school, the way they campaign about washing hands they use songs, dance, so it is more interesting for the children to learn. It's in Indonesian, Bahasa Indonesia (…) After CBAT campaigned to schools, now they understand how to live healthy, so they wash their hands regularly. So, the campaign given by CBAT was also interesting, less boring, so the children received well the campaign. There were some games and children were also given some prizes."**
>
> ***— Member of CBAT, Banjarnegara***

3.2

Communities are seen as catalysts of social inclusion during epidemics

The autonomy of communities in planning and implementing health promotion activities is one of the dimensions studied in this research. Rural and peri-urban communities in this research described mechanisms of co-decision, co-implementation, and planning carried out in the communities and jointly with the Community Based Action Teams (CBATs) volunteers and local health centres (puskesmas). the data from the different key informants suggests that co-planning can take the form of finding solutions on how to help the most vulnerable groups.

An example of community-led solutions that emerged from this research was the initiative of designing local fundraising campaigns through CBATs, kaders and heads of villages, and providing advice to patients and their families on how to use the funds. This was reported to be a common local initiative in Bogor (Tanah Baru) and Banjarnegara (Lawen). Community groups were also involved in selecting criteria for assigning and distributing the funds as well to accompany and advise family households on the best way to use the cash grant. Within this scenario, each community was free to carry out the activities they wanted, according to their own needs. The unique design of the Community Cash Grants system empowered the community to allocate funds, rather than individual families or households. As a result, the process required intensive assistance and two-way communication with the community, carried out by the main communities in coordination with PMI. .

Across the three sites,the researchers observed that **one of the main ways of self-organization is reaching the most disadvantaged is to promote and ensure risk reduction and protection measures are taken**. Community's

redistribution of monetary aid, the regular interaction with those that live in remote areas as well as helping others with transportation when people are far from health centres can be other examples of social solidarity.

> **During the cash transfer program, PMI supports community-led initiatives such as the communal kitchens, and also, we have *jaga tangga*. *Jaga tangga* is the actualization of community engagement. When we see our neighbours having difficulties in finding food, we need to support them, at least we report to the village authorities. When someone is infected with COVID then the neighbours would assist with providing food initially… in the beginning of COVID it was still scary, people came to me and provided support. They provided things that I need so I didn't need to go outside at all.**
>
> ***— National Staff interviewed in Banjar***

In Lawen, hard-to-reach communities expressed that in the early stages of the pandemic, they lacked knowledge about COVID-19 and its treatment, and they faced difficulties in accessing the healthcare centres, due to the long distances from their villages. In response, village chiefs and other community volunteers supported by PMI, took the initiative to bring COVID-19 hygiene promotion information to the most isolated groups. Moreover, they mobilized themselves to provide transportation to those individuals that could not access vaccination centres by themselves, offering their own vehicles or motorcycles. **These situations have reinforced the perception among community members that when they need assistance, they can turn to the CBATs to address their demands.**

> **"When a community member knocks at my door in the middle of the night to ask me for help, without knowing me, without knowing my name, I know that I am useful to others."**
>
> ***— Women's association and Kader member, Tanah Baru***

The joint work of PMI, village chiefs, *Pukesmas*, *kaders* and CBATs on developing hygiene and health protocols, as well as accelerating vaccination campaigns, was indicated as essential. Therefore, **local structures played a crucial role in crafting their solutions to promote health care, including vaccines uptake** especially for the most disadvantaged. It is important to note that these mechanisms are coordinated with the health structures and local and regional government, acting in a synergistic way. Issues that require collective mobilization, such as the vaccination campaign, **are subject to a concerted effort among local actors**.

> **"When the law for accelerating vaccination was introduced, we worked together with CBATs and PMI, because we could not do everything on our own. So, puskesmas, as the implementing agency, would move to the community and to prepare for the venue and equipment, we worked together with CBATs and other sectors including village and sub-district offices."**
>
> ***— Puskesmas agent, Lawen***

3.3

Trust and proximity of PMI with community influencers allows appropriateness and contextualization of the response

The research team focused on understanding the mechanisms to propose a communication that is not only adapted to linguistic diversity, but also to the norms and customs of the populations concerned. In Indonesia, **the contextualization and adaptation of health promotion and communication is guaranteed by the role of the key influencers in the community**.

Interviews with PMI highlighted that, in most cases, these influencers were the heads of the CBAT teams in each village, who were trained technically before implementing COVID-19 response activities. PMI also selected other profiles, based on rapid assessments and perception surveys conducted in the design phase, to include vulnerable or under-represented groups. In these assessments, the community recommended village chiefs, *kaders* and Pemberdayaan Kesejahteraaan Keluarga (PKK, which translates as 'family welfare association in village' – led by women) as having a positive influence in their community. These selected influencers are also members of CBAT in their villages. Other key and trusted profiles (such as village headman, cultural leaders and local government representatives) were identified. PMI could address community doubts and complaints and convey relevant messages through those influencers. This made it possible for PMI to communicate with the community even when volunteers were unable to visit due to pandemic restrictions.

Creative and locally appropriate use of communication channels and languages was used to engage with communities. PMI team members highlighted their use of radio programmes, SMS, social media and helplines to convey accurate information, as well as respond to community concerns and queries. Social media worked for certain sectors of the community, but excluded those without access to internet and devices, those with low literacy or who were unfamiliar with digital communication. In this context, radio allowed more inclusive two-way communications, generating more interactive instances where PMI could share information. This allowed communication efforts to be focus on addressing the information gaps that were identified. Another advantage of using radio as a communication channel is its broad territorial reach.

Since Indonesia has great linguistic and cultural diversity, PMI local branches are key in considering linguistic particularities in the way they engage communities locally. In Central Java, for example, the research team observed efforts by PMI to adapt the translation of messages into Javanese to ensure fluid communication with the people of Lawen and other villages. CBATs in Lawen also expressed to PMI the need to adapt the messages to local languages for certain messages, particularly around the vaccination campaign, following rumours about vaccine side effects, fears about needle use and risks to at-risk individuals.

In Lawen, before adapting the messages, the PMI team and CBATs conducted a small survey to gather feedback, capture rumours and suggestions, and gather information on the medical condition of the population. In response to the suggestions collected in the survey, PMI proposed providing information in different Javanese dialects and creative communication channels, such as children's songs.

> **"They used the language used by the community. For example, in schools, in my school, the way they campaign about washing hands they use songs, dance, so it is more interesting for the children to learn. It's in Indonesian, Bahasa Indonesia."**
>
> ***— Member of CBAT, Banjarnegara***

> **"When medical terminology is used, it is necessary to translate it into simple language, explaining the meaning of the words. For this, we worked together with members of the puskesmas to help us find the words."**
>
> ***— PMI volunteer***

However, the medical terminology used when informing about risks and protection measures around not only COVID-19, but also TB, was sometimes misunderstood by the communities. In Bogor, the research observed efforts to popularize medical terminology, which can be perceived as attempts to communicate appropriately and sensitively to local needs and fears.

In Tanah Baru, the community emphasized that the language used by the volunteers is clear and understandable, which facilitates the incorporation of information into daily life, and promotes a positive impact on personal habits to avoid COVID-19 and TB transmissions. In Tanah Sareal, however, even when using the necessary translations and languages, sometimes the community expressed doubts or resistance. In these cases, collaboration with Pukesmas and other health workers allowed reinforcement of messages to relay in other forums such as during face-to-face or community-awareness sessions.

Identifying the needs and suggestions of vulnerable communities was also key in adapting the response. PMI conducted COVID-19 perception surveys and post-emergency assessments targeting various groups in the community, including women and older people. The majority of respondents participated in an online survey that was distributed through PMI's social media platforms and WhatsApp groups. To ensure their participation, PMI held focus group discussions with vulnerable populations, such as older people, to gain a deeper understanding of their needs. Radio programmes, telephone calls and chat applications made it possible to gather information on concerns and needs in an intimate and direct way. A perception survey was also conducted, and activities were planned based on the results. The distribution of disinfectant sprays is an example of actions taken in response to locally identified needs.

3.4

Communities feel listened to and perceive their visions are incorporated into PMI response

One of the questions guiding this research is whether community feedback improves and informs PMI actions and ensures accountability to the community. In this regard, one of the aspects analyzed is the extent to which community feedback allows for the collection of community suggestions, opinions, complaints and recommendations.

In the three sites observed, communities feel listened to and perceive that their visions are incorporated into the PMI response, which improves their willingness to participate and continue to provide insights. In this regard, the active role and trust of the volunteers were crucial, as they accompanied the most vulnerable people in the community in a personalized way, reinforcing communities' trust in PMI and community volunteers.

> ***Interviewer: "Do you feel that your opinion is valued by PMI?"***
>
> **"Yes, very much. During vaccination, there were some people with disabilities. And the community asked PMI to pick them up, those with disabilities. They were very happy to do that. ... Secondly, not all community members have means of transportation. They were having difficulties to come to the vaccination site, and PMI provided the vehicles. So, they pick those who do not have vehicles to come to the vaccination site."**
>
> ***— Community member in Lawen, Banjarnegara***

The communities reported having discussed concrete proposals during the implementation of the response, such as setting up hand-washing points.

> **"Once, at the start of COVID, we needed places to wash our hands. We suggested for places to wash hands in public areas. And then PMI facilitated and setup some places where people can wash their hands in the area. (Also) in prayer sites (mosques) during COVID we needed to keep our distance, so PMI arranged the distance, they gave marking on the floor so that it is not too close one another, the congregation."**
>
> ***— Community member in Lawen, Banjarnegara***

The research found that communities provide feedback through different channels, such as door-to-door visits, surveys, community meetings, or digital channels (WhatsApp groups). Since not all members of the community have a mobile phone, door-to-door visits or volunteers' presence in public spaces and community events, such as school or sports activities, stood out as the most efficient way to collect feedback. This type of contact has been prioritized and turned out to be more effective. It was also an effective means of collecting additional information about vulnerabilities, health and vaccination, and of addressing fears and rumours through accurate information and concrete examples/statistics on deaths caused by COVID-19.

Communities acknowledged the appropriate use of languages and strategies to manage the effects of misinformation. In general, through interactions with the PMI branches in Bogor and Banjarnegara, we observed that PMI was committed to collecting community data to address critical questions, doubts and specific needs of families. One of most recurrent trends was the lack of transportation for hard to reach communities, mobility restrictions to access

medical centers and the need of economic support to face the pandemic.

Having noted this, it appears **that the treatment of certain questions and doubts from the communities was sometimes informal**. Indeed, in discussions with CBAT supervisors, it has been reported that feedback is sometimes transmitted verbally to be resolved immediately, for instance when communities ask about the symptoms of COVID-19 or TB. This means feedback is sometimes not properly logged, therefore not systematically recorded and tracked over time. According to conversations with the national PMI staff, **the feedback collection system is still being standardized, with data being collected separately for regular programmes and for actions that depend on specific programmes such as the the Community Epidemic and Pandemic Preparedness Programme (CP3).** This process of standardization which will eventually provide a more robust and interconnected feedback system, is currently underway, and as the following section shows, PMI has a rich and informative database to support its actions.

Feedback data made it possible to monitor the state of opinion during the pandemic. From discussions with the national staff and the branch in Bogor, we observed that the PMI attaches great importance to the regular and centralized collection of feedback, as well as to its processing. The PMI team centralizes data in a standardized framework that is shared by the IFRC and dedicates resources to data analysis. This process does not exclude exchanges with the branches to clarify the data incorporated into the centralized system (questions, suggestions from the populations or others). Agents have informal mechanisms for clarifying queries and finding appropriate solutions.

> **"Whenever we have feedback that we cannot answer or respond to by ourselves, we coordinate with our colleagues, mostly from the Head of Department and then Disaster or… any department we got into the feedback, so we have a WhatsApp group inside of the PMI and then we put the feedback in the WhatsApp group and then all colleagues will help to answer or give the result back to us. And then after that, once we have the response, we put it in the logbook, and also respond back to the community. For example, in social media, when we have comments, they have feedback through comments and whenever we can respond as soon as possible, we respond within one day and then if we still have to coordinate with our colleagues to get the response, probably within three days we should get the response back to the community and also DM, Direct Messages, to community who give feedback."**
>
> ***— PMI staff member, Headquarters, Jakarta***

The strength of PMI's feedback-collection system is measured by the number of answers provided to queries. An analysis of the organization's shared datasets shows that approximately 1,800 responses were included over a two-year period.

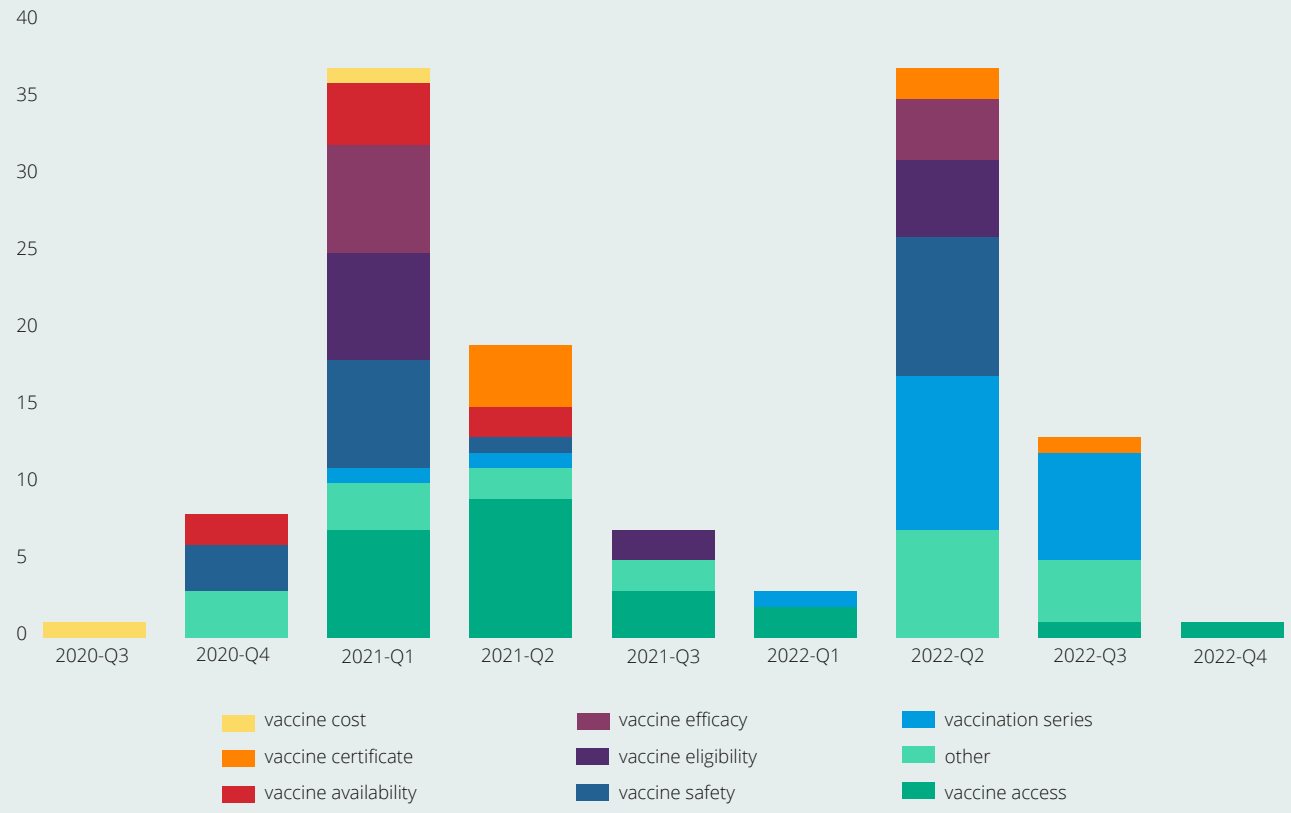
Analysis of feedback data shows that the majority of queries from communities are questions. This was also noted in the interviews conducted with local PMI branches, leading PMI managers to support the training of local PMI agents (KSRs) and CBATs to provide well-founded answers to the questions posed by communities.

When looking at the link between the feedback collection system and the response to COVID-19, it is possible to establish that the feedback data made it possible to monitor the state of opinion during the pandemic. This is reflected in the strong initial trend – COVID-19 makes up for the majority of the feedback at the beginning of 2020 – towards a certain decline in interest following vaccination (late 2021/early 2022). The questions asked by the communities also express the evolution of the pandemic. While questions related to preventive measures, transmission and evolution of the disease were over-represented in early 2020, this trend has decreased, suggesting the positive contribution of PMI in addressing the most relevant and consistent queries.

Community feedback on COVID-19 vaccines enabled PMI to address key topics and issues as the immunization campaigns were implemented. Figure 16 indicates two peak periods for feedback. The first coincides with the beginning of the vaccination campaign in 2021. At this point, questions emerged about vaccine safety, efficacy, availability, access to vaccines, and eligibility criteria. The second peak occurs in the second quarter of 2022, when the booster campaign was launched.

Figure 17 shows examples of quotes from the database. They demonstrate that communities inquire about the location of the vaccine centres, the closest health facilities, etc. Questions about eligibility criteria and priority populations are also reported, along with questions on side effects, among others.

Figure 1: Feedback about COVID-19 vaccine



Source: Plan Eval

Finally, **community-led feedback mechanisms has been a key priority for PMI during the recent period**. One innovative approach was the organization of a podcast competition in collaboration with local universities. Other ideas include relating to communities and engaging in dialogue with them about PMI actions. At the internal management level, PMI developed monthly reports that enabled it to adjust the programme according to community input and address their needs. For example, when PMI received a request from the community to modify COVID-19 disinfection schedules in the Jakarta region, it was moved to off-peak hours.

Figure 2: Examples of community feedback on vaccines (2021)

Safety
Are there any side effects from the vaccine?
Got the Sinovac vaccine, the side effect is so far, it's just sore on the arm that was injected. I hope it doesn't have any other effects. How do we know that this Covid vaccine is safe?
The AstraZeneca vaccine has been approved in Indonesia. Is the sharing mechanism the same as Sinovac? And they say it can cause blood clots. Really?
Was there any outreach before the people were vaccinated, going directly to the community to explain that this vaccine is safe?
Efficacy
Can the current Covid vaccine be effective against the new Covid virus variant? Can this vaccine prevent the mutated Covid virus?
Can you still get Covid if you have been vaccinated?
For vaccines that are already available (Sinovac & AZ}, are they compatible with this 8117variant? How effective is the covid-19 vaccine protecting us from transmission?
Availability
I heard the news that 1t is said that the Indonesian vaccine can be used next year. Is that right? Who is the target for later? Will it be paid? Is there a Covid vaccine that people can choose from?
When will civil society get the vaccine? How distribution and registration mechanism? Will an independent covid vaccine be provided later? Will it be paid later?
Access
At pm1 tea can you vaccinate? what's the host?
Who have taken vaccines at pm , what time do you usually come? Let me get the queue early can you provide the covid19 vaccine?
Does anyone know how to get a vaccine from PMI? Do you have to register first or just come? Info please
Does PMI still have a quota? If you want a vaccine at PMI, come right away or can you register online?
Eligibility
If there is no vaccine for the elderly, then how can we protect our grandparents to be immune to COVID-19.
The doctor wants to ask how for people who have high blood pressure but want to be vaccinated, what is the procedure like? Want to ask. Who will be prioritized to get the vaccine? Thank you
Who will be given priority to get the vaccine?
Will a COVID 19 vaccine be available for children?

4 ENABLERS OF EFFECTIVE COMMUNITY ENGAGEMENT APPROACHES

4.1

Mutual trust

The support of local structures and especially of those people who play an influent role in their community, either because of their political or organizational responsibility (the case of heads of villages or community leaders), or because of their socially founded legitimacy (the case of the CBATs), is crucial to support the work of PMI during emergencies.

These figures maintain strong bonds of mutual trust with their community peers and with PMI. Whether it is by reporting emergencies, providing assistance or adopting new health and care habits, community-based groups seems to be perceived as reliable figures to trust and follow when an emergency or disaster appears.

> **"When we become volunteers we get the knowledge that cannot be learn in university or even graduate school"**
>
> ***— Member of the Tanah Baru community***

As far as COVID-19 is concerned, **pre-existing capacities are also especially important when it comes to giving a quick and effective response in a new and unforeseen context**. In Lawen, many activities that had been carried out around health promotion were adapted to COVID-19 when the pandemic was declared.

In Banjarnegara, the legitimacy of CBATs' work is originally related to their role during disasters, rather than to their work on health. The majority of them started assisting their own community and neighbouring villages during earthquakes and landslides. At this point, the CBATs valued the experience they obtained thanks to the approach of PMI during other emergencies. They highlighted that through the pandemic and together with PMI, they learned how to better organize themselves.

4.2

Empowered community-based structures

Community participation in the village is supported by a strong community organization in which the village (*kelurahan*) chiefs, health centre (*puskesmas*) representatives, and other local groups such as the CBATs, women's groups, and *kaders* work synergistically.

Initial introductory exchanges held with the heads of *kelurahan* for each of the three sites visited confirmed that the role of PMI and community volunteers working with the Red Cross is an important component of the institutional approach to public health. Some examples of how decisions are discussed, communicated and articulated at the local level were found in Banjarnegara.

The support of local structures and especially of those people who play relevant roles in the community, either because of their political/organizational responsibility at the local level (in the case of the heads of villages), or because of their socially founded legitimacy (in the case of the CBATs), was crucial for the implementation of the COVID-19 response and, more generally, in support of public health. These figures maintain strong bonds of trust and a sense of closeness, which is what drives people to get involved in the response, whether it's by relaying requests, reporting emergencies, disseminating information, providing assistance or adopting new health and care habits. In this sense, CBAT volunteers are perceived with great trust and closeness by the community they are part of.

The organizational structures already in place allow for greater interconnectedness of actions with the Red Cross, as there are already spaces in the community where collective issues are discussed and decisions are made together, and where health is a part of the collective discussion. These characteristics are observed in all three sites, as village leaders are used to discussing issues of collective interest at RW and *kelurahan* levels. Community members, representatives of local groups, and public health workers participate in these forums with their respective expertise.

A form of organization of community issues that are deliberated regularly allows for concerted decisions. This local public space appears to be a place of consultation that allows different issues, including health issues, to be put on the agenda.

> **"Usually, we have meetings at the village level. There's a meeting called Musrembangdes (an abbreviation of Musyawarah Perencanaan Pembangunan Desa, which translates as Village Development Planning Meeting), so it's like a town hall meeting, we invite everyone from all walks of life. In the Musrembangdes we discuss about the development of the village, and then village funding, and then community work."**
>
> ***— CBAT member, Lawen***

4.3

Legitimacy and social recognition of communities

As emergency response agents, CBATs recognize that the legitimacy of their work is largely tied to rebuilding roads and other infrastructure following events such as the landslides that are common in this region. **The training provided by PMI is perceived as an institutional support to their work. They describe it as a "new umbrella under which they can work with the community."**

As far as COVID-19 is concerned, pre-existing capacities are also especially important when it comes to giving a quick and effective response in a new and unforeseen context. In Lawen, many activities that had been carried out around health promotion were adapted to COVID-19 when the pandemic was declared. At this point, the CBATs value the experience they obtained thanks to the approach of PMI during other emergencies. Pre-existing capacities are crucial for prompt responses in novel situations. Lawen adapted health promotion activities to address COVID-19 challenges. Expertise from PMI's prior emergencies is invaluable to CBATs, notably enhancing their outbreak response organization.

For the vast majority of women interviewed in Tanah Baru, working with PMI and the community legitimized their role and enhanced community recognition.

Many women take a long-term trajectory when it comes to serving the community. During their involvement with PMI, CBAT women received professional education and training, which allowed them to develop assistance in actions that they considered fundamental for the community. As reported during focus groups in Tanah Baru, CBATs belong simultaneously to women's associations that have been performing community work for more than 20 or 30 years. Some of them assist with emergency and epidemic control and surveillance programmes, such as dengue, malaria and AIDS as well as with disaster risk reduction. The knowledge received from PMI contributes to consolidating autonomy and professionalization of CBAT women who believe that their work would not be possible without collaboration with agencies such as the Red Cross,

which puts them in a position of power and relevance. Furthermore, they position themselves in the role of identifying and connecting with other community-based organizations that can expand the humanitarian work force.

When discussing their personal reasons for carrying out these tasks, women emphasize that their motivation is based on the possibility of incorporating knowledge to collaborate with agencies that carry out social assistance work in the areas where they live.

> **"Aside from puskesmas, we are involved with PMI, so we are more confident, we can tell the community that we are PMI volunteers [and] can help the community [to] do the early detection so [the] disease doesn't spread too fast or too wide, so we can minimize [it]. So this is handled [in the] right away."**
>
> ***— Woman Member of the CBAT in Tanah Baru***

4.4

Regular face to face or remote community interaction

In the early stages of the pandemic, face-to-face exchanges and mass gatherings have had to be limited, and implementation has had to adapt to these conditions, as well as the new needs and priorities in the context of the pandemic. Keeping regular interaction with communities was proven to be fundamental to maintain risk reduction measures as well as keeping feedback systems alive.

The use of well known communication channels such as radio programmes, SMS, social media, and helplines in order to convey accurate information, as well as respond to community concerns was indeed effective. Social media however, worked for certain sectors of the community, but excluded those without access to Internet and devices, low literacy or unfamiliarity with digital communication.

Although this research did not find any community interlocutor who referring to the above mentioned channels, it is still relevant to mention the contribution and value of them to keep communities informed and engaged.

Secondary data and interviews with IFRC mentioned how PMI set up a monthly interactive radio show called PMI Cegah COVID-19 (literally translated as PMI COVID-19 prevention), also available in Zoom platform. Using the most salient trends from their community feedback data, an expert on that topic would be invited to answer in an immediate and comprehensive manner, people's questions about the pandemic. Some of the questions tracked and monitored through the radio show have been provided by PMI to this research: "There were some of my friends who informed me that after being vaccinated and the rapid test turned out to be positive for covid 19. So how does the vaccine actually work?" (Male, DKI Jakarta) or "Can you still get Covid if you have been vaccinated?" (Female, DKI Jakarta).

The active engagement and appreciation of the radio initiative by the audience was a reason to extend the programme until December 2022.

In addition to this, they focusd on community demands, which allows for a tailor-made implementation that was highly effective at promoting community participation in the emergency response to COVID-19. Face to face contact, however, based on the conversations with communities, is perceived as being pleasant and reassuring, compared to other channels. Furthermore, this type of contact, which offers greater intimacy and closeness, allows for the communication of relevant information and the collection of feedback.

5 IDENTIFIED BARRIERS

5.1

Isolation and characteristics of the territory

In Banjarnegara, due to the frequent occurrence of climatic events, as well as the physical characteristics of the territory, the research team observed that it was more difficult for certain populations to participate in collective events such as community talks. Indeed, as shown in Figure 9, many houses are built in areas that are not easily accessible during the rainy season.

Banjarnegara provides an example of how the physical distance and limited access to resources, information, and communication channels can impede community members' ability to engage and contribute effectively. Overcoming these challenges during COVID-19 required tailored approaches that considered the specific context of the isolated territory, such as utilizing alternative communication methods like radio or identifying and collaborating with local volunteers providing culturally appropriate information. However, addressing the challenges of isolation and recognizing the unique characteristics of the territory, still requires further efforts to promote inclusive and constant community participation to ensure that the voices and needs of all community members are considered in the COVID-19 response and beyond.

5.2

Retention of community volunteers

A major obstacle to community participation is the long-term commitment of volunteers. According to the Community Epidemic and Pandemic Preparedness Program (CP3) report, 73% of the volunteers trained in community based surveillance among other community preparedness approaches are still working, however, there is an important concern about the absence of any remuneration in support of this work. This presents unique challenges in retaining and motivating volunteers, although the non-monetary approach can also lead to a stronger sustainability model, ensuring that the programme can continue after initial funding has ceased.

PMI has taken steps to ensure the stability of the volunteer base, but this is still a major concern and methods of compensation and capacity building for volunteers should be considered.

> **"Time, that's the most difficult challenge that we have. Because we also have our day job, especially door-to-door visit, we need to adjust our time with the community members we're going to visit. So, the challenge is to split the time between becoming volunteer and bringing bread for the family. When we become volunteer, we bring our own pocket money from home."**
>
> ***— CBAT member, Lawen, Banjarnegara***

This risk is perhaps more important for women volunteers, since they are heavily involved in helping others, so-called 'care activities', which are cumulative with the work they do in their homes. Although the CBAT women, especially in Tanah Baru, pointed out the importance and qualitative leap of the work carried out jointly with PMI, they also emphasized their presence in numerous work groups and the time demands that this requires.

5.3

Assessing participation in the various phases of programming

The discussions with the communities reveal the various ways in which individuals are involved in PMI initiatives. However, it is not possible to ascertain whether this involves making decisions and handling significant concerns about various stages of current projects, including planning, design and evaluation. Participation is sometimes mentioned in reference to mere attendance at events, without evidence of a deeper involvement in policy implementation, co-creation or decision making. Assessing whether the conditions exist for integrating the community into various stages of programming requires further exploration.

5.4

Community feedback reporting

Based on the research, it appears that the treatment of certain questions and doubts from the communities was sometimes informal as a way to respond in an immediate manner to population's doubts. Although interviews suggested that PMI volunteers and community action teams tried to ensure that questions were answered in a timely and fast manner, this resulted in a less consistent way of logging, tracking and monitoring community input in a way that could influence decision-making processes. Another challenge identified during interviews with PMI staff is how the different operational and programmatic areas working on prevention, detection and response of public health diseases, are currently operating with its own community feedback systems and collection methods. This suggests a gap in unified feedback collection and reporting. Moreover, as seen during COVID-19 response, communities interest and attention over the course of the pandemic may wane over time. Maintaining community interest, trust and motivation to provide feedback throughout a public health response requires ongoing efforts, innovative strategies, and recognizing the value of community feedback in shaping effective interventions.

"Every time there's anyone who got sick even in the middle of the night, sometimes they knock on my door. And I was asking myself what's so special about me? How come they trust me so much while actually, I am no one, nothing. I am not a doctor or anything. But the committee always comes to me and I think, they really need me. I feel satisfied because I can help the community. (...) So, I can help the community especially those that are underprivileged. How could they pay this many million for the hospital? So I'm satisfied, I can help the community."

— Community-Based Action Team, Tanah Baru

6 CONCLUSIONS

Findings from the study indicate that community engagement and accountability has a positive impact on public health outcomes and should be continued and reinforced. Overall, the study has identified elements an inclusive community engagement and accountability approach that considers groups that are usually under-represented in the policy and programme cycle (design, implementation and monitoring). These actions of solidarity undoubtedly contribute not only to the sustainability of health-appropriate practices, but also to the economic autonomy of families and patients. They especially strengthen those who fulfil caregiving roles, frequently assigned to women.

1

Community-led solutions enabled access to health for the most vulnerable. Rural and peri-urban communities in Indonesia describe in some cases, mechanisms of co-decision and co-implementation, carried out in the communities and jointly with CBAT volunteers and local health centres (Puskesmas). In most cases in this research, community ownership is seen as the opportunity of inclusion and social cohesion which means agreeing how to ensure access to health care to the most vulnerable. These actions of solidarity undoubtedly contribute not only to the sustainability of health-appropriate practices, but also to the economic autonomy of families and patients. They especially strengthen those who fulfil caregiving roles, frequently assigned to women. Moving the vaccination centre closer to the communities with mobility barriers and co-designing their own cash grants criteria and implementation are the most salient examples of community-based solutions that address local needs and aspirations.

2

The participation of communities was a driving force in the adoption of preventive measures during COVID-19. The sustained trust, legitimacy and local coordination among communities, PMI, local governments and health centers contributed to change people's behavior, especially regarding the use of masks, vaccines uptake and health seeking behaviors. Community participation remains anchored in local structures and relies on voluntary work. However, for hard-to-reach communities, participation is not frequent due to geographic isolation. Accessing remote areas can create barriers to the frequency of engagement and decision-making of remote communities. Participation is interpreted in different ways by community individuals, CBATs and PMI which means participation can take different forms. Besides the above mentioned community based groups and volunteers, this research has not identified evidence about other community members that have actively participated in decision-making process or that have been engaged in the differentt stages of a response.

3

Local social events offered a way to communicate key public social measures to prevent COVID-19, based on cultural preferences of the community. As part of the COVID-19 vaccination process, door-to-door visits by CBATs provided an opportunity to speak with each household in detail and to explain the importance of vaccination. The identification of key community members who promote good practices and link programmes with the communities was key to understand and uptake public health social measures messages during COVID-19.

4

Trust is seen as a reciprocal path and rooted in a mutual understanding between communities and the Red Cross. The role of the CBATs in anchoring trust between the Red Cross and communities impacted positively in changing behaviours especially regarding health care seeking, or accelerating demand for COVID-19 vaccines. The progressive social recognition of community-based volunteers supported by PMI can be interpreted as a mutual reliance on the way of serving and engaging communities. As providers of adequate and accurate information, CBATs helped people to remain calm in contexts of emergency and uncertainty and played an exemplary role in vaccinating themselves to encourage other community peers to follow the same path. In this regard, the active role and trust of the volunteers were crucial, as they accompanied the most vulnerable people in the community in a personalized way, reinforced communities' trust in PMI and community volunteers.

5

Communities feel listened to and perceive their visions are incorporated into PMI response. The research concludes that community formal and informal feedback helps PMI tailor its response to meet communities' needs which maintains their willingness to participate and continue to provide insights. However, systematization of community data seems still not standardized and programme siloed.

6

In various contexts, women contribute to strengthening solidarity ties, not only with the community, but also between the community and institutions. Thanks to the knowledge generated in the community, community engagement and accountability is strengthening women's networks. The social role of women in the community is reinforced by the interest in strengthening autonomy and providing economic and emotional support to caregivers, the contemplation of specific needs of more vulnerable population groups, and the valuing of knowledge as a way to personal professional development.

7 RECOMMENDATIONS

Although the results indicate that community engagement is a strong contributor to the public health response to COVID-19 in Indonesia, this case study highlights challenges that can be improved in PMI's actions.

Expand the volunteer base to avoid demotivating those who spontaneously contribute to PMI actions. Many volunteers struggle to organize the time to volunteer. Most volunteers have to combine community service work with paid work to maintain their living conditions. Although PMI has retained 73% of the volunteers trained in community-based surveillance, there is a major concern about retention. Engaging a larger group of volunteers in various community activities (priority disease reporting, health promotion, cleaning up vector breeding sites, etc.) and supportive supervision can help address these challenges.

Promoting new ways of participation and co-decision of those living in remote areas. Although strategies are in place to reach the most vulnerable groups, it is difficult to guarantee permanent volunteer support to these groups, especially when the physical conditions of the territory create natural obstacles to engage with PMI volunteers and regularly discuss local solutions during an outbreak. Complementary actions that can help reduce these obstacles are the extension of the base of volunteers trained by PMI in isolated areas, and the promotion of mobile actions, such as the work done by CBATs on motorcycles, or bringing vaccination centres closer to isolated villages.

Continue efforts to consolidate feedback systems. A strong feedback system, consolidated through the mobilization of PMI volunteers, is a driving force in strengthening the response to public health crises. The research team notes that the data collected by PMI in Indonesia is very rich and justifies a capitalization effort from the organization which should go beyond programme silos and continue to work towards institutionalization of a consolidated database and broader coordination from different programmatic sources.

It is recommended to continue sustaining and accompanying the consolidation and capacity strengthening of women's associations as part of CBATs and community influencers. The case of Tanah Baru shows that this example can be replicated and further explored and documented by PMI.

Participation in the research sites is seen mainly as a way of a 'being part' of specific activities or being reached door-to-door, rather than being actively engaged in all phases of the disaster management continuum. It is recommended to assess the possibility of another research to further document and understand participation definitions and its different meanings both for PMI, volunteers and communities, especially the most vulnerable and hard to reach, thus, the less enabled to participate.

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ANNEX 1. DATA COLLECTION

Information and conclusions in this case study are based on primary data collected in two geographical areas covered by the Indonesian Red Cross – Bogor and Banjarnegara. The research team conducted a series of semi-structured interviews with PMI staff remotely and in-country with local branches. Data collection activities in-country were conducted between November 20 and 26, 2022.

Table 1 provides an overview of the semi-structured interviews that were conducted with PMI staff, communities and CBAT network volunteers.

Table 1: Semi-directive interviews and focus group doscussion in country

Data collection instrument	Quantity	Profiles
Key informant interviews at national level	8	**PMI HQ level:** Health Division, CEA Unit, National Society Development (NSD) **PMI Local Branches** **PMI Bogor** Programme Coordinator Disaster and Risk Management, PMI CBAT/KSR coordinator/ Local Health Authorities **PMI Banjarnegara** Programme Coordinator for COVID-19. Coordinator in charge of CBAT. Health Officials (from local *puskesmas*) Local authorities
Focus Group Discussions (FDGs)	6	CBAT members Active community members/ networks/ groups
Bilateral exchanges: No semi-structured interviews in Lawen	3	Head of village, *kaders*, beneficiaries living in the hills.

Source: Plan Eval

The village of Lawen is in the district of Banjarnegara, located in the southwestern part of Central Java province. PMI prioritized the visit to Lawen because of the activity related to the vaccination campaign in a rural area very exposed to disasters, including landslides and sometimes suffering from access problems (damaged roads).

In Bogor, the locations chosen for field work and data collection activities are urban and peri-urban areas with high density and rapidly expanding health issues. In preliminary discussions with PMI, the geographical situation of Bogor (60 km from Jakarta) was highlighted, assuming that observations on the impact of community engagement would prove helpful for similar agglomerations. Two peri-urban sites were chosen on the outskirts of Bogor: Keluran Tanah Sareal and Keluran Tanah Baru.

ANNEX 2. GLOSSARY

Cader/Kader: A person or group of people who are fostered by a management agency in an organization, both civilian and military, who function as 'parties' and or to assist the main duties and functions of the organization. In this context, they are community members who volunteer to assist various social and health programmes including the *Puskesmas*' programmes.

Community-based action team (CBAT): A community network trained and working closely with Palang Merah Indonesia (Indonesia Red Cross Society or PMI). CBATs are community disaster-preparedness agents acting in the community to increase resilience. CBATs are a fundamental part of disaster risk reduction as they collaborate in guiding, promoting, motivating and empowering the community in activities or efforts for disaster preparedness, management of impacts on health, the environment and other social problems. It is a group of community volunteers whose primary responsibility is to act early in the face of a potential risk or threat of disaster, generating the necessary alerts. CBATs are also crucial in supporting public health response and making the bridge with the communities. Members represent a variety of groups, including women, youth, older people, religious groups and people who have disabilities.

Lurah: Head of the village office as a district or city apparatus. His/her duties are to carry out the Government Authority delegated by the *camat* (head of district) according to the characteristics of the area and the needs of the district area and to carry out other Governmental matters based on the provisions of laws and regulations as well as local regional regulations. The *lurah* is a civil servant who is responsible for the *camat*. The position can be held by anyone who meets the requirements and is directly elected by the people through *Pilkades*, similar to a national election.

Kelurahan: Urban village terminology primarily used in small to main cities. It is commonly translated to English as sub-district. The leader of the *kelurahan* is a *lurah*, a civil servant appointed by the district Head.

Posyandu: An abbreviation of *Pos Pelayanan Terpadu,* literally 'Family Planning Service – Integrated Health Post'. A basic health activity organized from, by and for the community, assisted by health workers. *Posyandu* is a community-based health effort. *Posyandu* is a self-help activity from the community in the health sector with the responsibility of the village head. *Posyandu* primarily serves toddlers (immunization, weighing, distribution of vitamins) and the elderly (*Posyandu Lansia*).

Puskesmas: An abbreviation of *Pusat Kesehatan Masyarakat*, literally 'Community-Health Centre'. Government-mandated community-health clinics located across Indonesia. They are overseen by the Indonesian Ministry of Health and provide health care for the population on sub-district level.

Rukun tetangga: Abbreviated to RT, literally 'pillar of neighbours'. Administrative division of a village in Indonesia, under a *rukun warga.* The RT is the lowest administrative division of Indonesia.

Rukun warga: Abbreviated to RW, literally 'pillar of residents'. Administrative division of Indonesia under the village or *kelurahan* or *dusun* . An RW is further divided into *rukun tetangga* (abbreviated to RT).

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network, with 192 National Red Cross and Red Crescent Societies and around 15 million volunteers. Our volunteers are present in communities before, during and after a crisis or disaster. We work in the most hard to reach and complex settings in the world, saving lives and promoting human dignity. We support communities to become stronger and more resilient places where people can live safe and healthy lives, and have opportunities to thrive.