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

MALAWI

A CASE STUDY ON CHOLERA AND COVID-19

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LIST OF ACRONYMS

ACPC Area Civil Protection Committee
CEA Community Engagement and Accountability
CPC Civil Protection Committee
DCPC District Civil Protection Committee
GAVI Global Alliance of Vaccines
HQ Headquarters
HSA Health Surveillance Assistant
IFRC International Federation of Red Cross and Red Crescent Societies
MRCS Malawi Red Cross Society
NGO Non-Governmental Organization
OCHA UN Office for the Coordination of Humanitarian Affairs
ODK Open Data Kit
ORS Oral Rehydration Solution
PASSA Participatory Approach to Safe Shelter
UN United Nations
VCPC Village Civil Protection Committee
WASH Water, Sanitation and Hygiene
WFP World Food Programme
WHO World Health Organization
WPV1 Wild Poliovirus type 1

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 on 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 Red Cross Red Crescent programmes and community health systems during public health emergencies. Based on initial discussions between the IFRC and National Societies, five countries were selected to document a variety of community engagement and accountability practices with communities across the world: Guinea, Georgia, Guatemala, Indonesia and Malawi. This document presents the results of the research in Malawi.

Community engagement and accountability 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 community 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 have been largely under-researched within the Movement. We need to collect evidence that proves the importance of investing in community engagement and accountability and to provide better guidelines to track and measure the impact of our interventions.

Information and conclusions in this case study are based on primary and secondary data collected in two geographical areas covered by Malawi Red Cross Society (MRCS): Blantyre and Chikwawa. This is complemented by secondary data consisting mainly of a desk review of documents provided by MRCS (reviewed during the pre-fieldwork phase and listed in Annex 1) and quantitative data from the feedback system. In addition to the documentation, the research team conducted a set of semi-structured interviews with MRCS personnel and Government representatives, along with focus group discussions with MRCS volunteers and community members. Data collection tools are described in Annex 3.

OBJECTIVE

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 public health emergencies such as COVID-19 and cholera.

In line with the proposed methodology, the research seeks to answer the following 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 the National Society response activities and ensuring communities are heard during an outbreak?

To answer to these two questions, this research focuses on both the effectiveness and impact of

community-centred activities. Based on the presented findings, the case study ends with a set of conclusions and recommendations that will serve as a basis to identify what are the key community engagement and accountability approaches that have been more impactful, effective and appropriate in the particular context of this case study, and eventually, across the five countries considered in the global research.

METHODOLOGY

This work takes a primarily qualitative approach to understanding the impact of community engagement practices. Qualitative research allows for a better understanding of those practices by referring to real-life experiences that describe how National Society approaches have contributed to enhance the health system as well as community resilience and behavioural practices during health emergencies. The methodology is based on a desk review and an analysis of opinions and perceptions of implementing teams and the communities they worked with.

Information and conclusions presented in this case study are based on both primary and secondary data collected in two geographical areas covered by MRCS: Blantyre and Chikwawa.

Fieldwork was conducted in both regions between **28 November and 2 December 2022**. Some final semi-structured interviews were conducted remotely through Microsoft Teams in January 2023.

Data collection consisted mostly of semi-structured interviews (one-on-one) and focus group discussions (all male, all female, mixed gender) with community members, MRCS personnel and Government representatives both at the central and at the district level, as demonstrated in Annex 2.

Some considerations around 'impact'

This study is not a quantitative impact analysis. It explores qualitative and narrative aspects 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.

1 KEY FINDINGS

Overall, this research highlights five positive impacts of community engagement.

1. **Partnership with communities increases the willingness to get vaccinated and improves acceptance of public health measures.** Working with existing community groups, such as village civil protection committees, local chiefs, youth and physically impaired groups, strengthens community capacity, ownership and resilience to public health emergencies.

2. **Community feedback facilitates data-driven decision making.** This addresses the fear of going to hospitals, boosting confidence and uptake of vaccines during COVID-19 and improving the correct usage of water treatment to prevent cholera.

3. **Legitimacy and social recognition of influential community members increases access to and trust towards MRCS volunteers.** Communities were more inclined to get vaccinated after seeing their local chiefs receiving the vaccine first. Thanks to trusted community chiefs, MRCS was also able to overcome initial hostility and resistance, reaching the rest of the community effectively.

4. **Taking time to understand the community needs and context led to a more relevant and impactful response.** Culturally appropriate language and the use of public gatherings such as weddings, funerals and sport events impacted in the adoption of positive hygiene practices such as washing hands regularly, also the intend to continue practicing them beyond the outbreak.

5. **Meaningful community participation is not always well understood by communities or responders, and often only happens at a late stage.**

2 COUNTRY CONTEXT

Malawi is ranked 174 out of 189 countries on the Human Development Index and has a poverty rate of 51.5%. The country's economy is heavily dependent on agriculture, which makes it particularly vulnerable to the effects of climate change and natural disasters. Like many other sub-Saharan countries, Malawi faces numerous healthcare challenges. This study focuses on community engagement and accountability during two recent outbreaks in the country: COVID-19 and cholera.

COVID-19

The Malawian president declared a state of national disaster on 20 March 2020, a few days before the first COVID-19 case was confirmed (1 April 2020). The country faced three main peaks in the number of confirmed cases: in January 2021, July 2021 and December 2021. Since then, the number of cases has remained relatively low. Between March 2020 and April 2023 there have been 88,625 confirmed cases of COVID-19 (with 2,686 deaths) reported to the World Health Organization (WHO). The highest peak, in January 2021, reached 6,656 confirmed cases in one week.

At the national level, a *COVID-19 Preparedness and Response Plan* was set up under the guidance of the Department of Disaster Management Affairs and Ministry of Health. The plan was organized in sectoral clusters, composed of Government ministries and departments, UN agencies, NGOs, MRCS and other humanitarian actors. Each sectoral cluster was charged with providing policy direction in their own area of focus and all clusters provided information to a central committee in charge of major decisions. Other measures taken by the Government of Malawi in response to the pandemic included an international travel ban, school closures at all levels, cancellation of public events, decongesting workplaces and public transport, mandatory face covering and a testing policy for symptomatic people.

The COVID-19 vaccination campaign was launched in March 2021, with vaccine doses provided by the COVAX facility, a global initiative led by the World Health Organization (WHO), Gavi, and the Coalition for Epidemic Preparedness Innovations (CEPI) to ensure equitable access to COVID-19 vaccines for countries around the world. The vaccination plan is being rolled out in a phased approach, starting with healthcare workers and other priority groups. According to the WHO, the vaccine roll-out encountered challenges at several levels, resulting in low uptake. WHO reported that vaccine hesitancy was initially high due to misinformation, disinformation and lack of general knowledge about the COVID-19 vaccines. Moreover, the country faced delays in vaccine supply, which led to a vaccine stockout at the peak of the third wave. UNICEF, the World Bank, WHO and other development partners provided support to the Government to increase vaccine uptake through expanding vaccination sites, ensuring effective use of available stocks, pacing delivery of new vaccine stocks, mobilizing communities to address doubts and misinformation and training health workers.

As of 19 April 2023, a total of 27 persons (per 100 population) were vaccinated with at least one dose, according to WHO.

Cholera

Cholera is an endemic disease in Malawi with seasonal outbreaks during the wet season. The disease is particularly present in the southern region of the country, which is more prone to flooding during the rainy season due to its low-lying and flat landscape.

In 2022, a first outbreak was declared in March, following the passage of Tropical Storm Ana in January. The outbreak was initially declared in two districts (Nsjanje and Machinga) and quickly spread to five other districts: Balaka, Blantyre, Chikwawa, Mulanje, Neno. By 7 November 2022, the outbreak had spread to 27 districts, with a total of 6,253 recorded cholera cases and 188 deaths. According to information from WHO and UNICEF, the outbreak has, at the time of writing, been controlled in four districts. Out of the 6,253 reported cases, 5,867 people have recovered and 198 are currently in the treatment centres.

A *National Cholera Response Plan* was implemented by the Government, with support from WHO, UNICEF and MRCS. As part of the outbreak response, WHO facilitated the procurement of cholera vaccines through the Global Alliance of Vaccines (GAVI). Additionally, WHO, UNICEF, MRCS and partners are supporting the Ministry of Health through:

- provision of clinical care at dedicated treatment centres
- training of health care workers
- improvement of water treatment systems
- distribution of essential supplies
- awareness raising on hygiene practices and prevention methods.

Malawi Red Cross Society volunteers disinfect a cholera treatment centre in Blantyre

Source: MRC

3 FINDINGS

Community engagement and accountability approaches that had a positive impact on public health responses in Malawi:

3.1

Engaging communities built trust, which increased their willingness to get vaccinated

Achieving sufficient vaccination rates in Malawi has been challenging, particularly in communities where there are fears and hesitancy surrounding immunization.

This research shows that through their community feedback mechanism, MRCS identified the underlying reasons why people were not getting vaccinated. They then addressed these through stronger community engagement and practical changes to how vaccines were delivered. For example, door-to-door conversations and working through trusted leaders was found to build trust and acceptance, which led to more community members being willing to get vaccinated. The effectiveness of these one-to-one conversations was one of the most appreciated and effective ways of encouraging healthy practices, while also helping to maintain trusting relationships between the affected population and MRCS volunteers.

"The volunteers would visit us in our houses frequently. So many people were scared to go vaccinate, then many people started warming up to it and went to vaccinate."

— Community member, Chikwawa

Vaccine demand was also increased by engaging community leaders to set an example for their community members by getting vaccinated themselves first:

"Our leaders were encouraging us go and vaccinate, because they were the first to vaccinate, for us to follow their good example."

— MRCS Volunteer, Blantyre

Community feedback also helped MRCS understand the practical barriers faced by elderly people, or those with disabilities, in accessing vaccination centres. To address this, MRCS established mobile teams to vaccinate people in their own homes, which improved inclusivity and accessibility, particularly for people with limited mobility:

"Definitely in terms of vaccination, they could receive the vaccine where they were. For the elderly, most of them were not able to walk and they didn't have a reachable facility. For disabled people, they did not have wheelchairs. It was necessary to make sure to collaborate and to provide these people with the vaccine. They were in a prioritized group. First were the elderly, then the disabled, than people with chronic illnesses, et cetera."

— MRCS staff, feedback mechanism

Community member helping Red Cross staff

Source: MRC

3.2

Community engagement approaches strengthened community capacity and ownership, building long-term resilience to future public health emergencies

MRCS' commitment to working in partnership with existing community structures and groups had many positive impacts, including strengthening the capacity and ownership of community groups, which led to better uptake of public health measures by community members and improved resilience to future public health emergencies. For example, MRCS supported the village civil protection committees (VCPC) by training their members on preventive and curative healthcare measures. MRCS also provided the VCPCs with ongoing technical support to help them monitor COVID-19 and cholera outbreaks and develop monthly contingency plans and by providing funding and materials to conduct activities included in their plans. The research shows these efforts led to a strong sense of ownership and empowered community members. This was evidenced through both MRCS volunteers and active community members reporting they felt heard, engaged, and proud to see how their efforts were helping change people's behaviours.

The committees and volunteers also reported going on to plan and implement their own activities, following support from MRCS. For example, youth groups organized drama presentations in public places, such as markets, and community members mobilized themselves to introduce a law aimed at encouraging sustainable waste management practices.

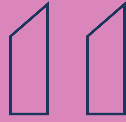
"... we have a youth drama group that walks around, and they perform in the markets and teach people about cholera. People are attracted when they see a gathering and there is laughter, so they come and listen to the message."

— Member of the Village Civil Protection Committee, Blantyre

Empowering community structures and groups also led to greater acceptance of public health measures by community members, as information and guidance was being shared by known, trusted and influential members of the community, such as local chiefs, religious and youth leaders and committee members. These groups have significant capacity to communicate and engage with others and by empowering them to lead response activities, MRCS also helped enhance the community's trust in them and the information they shared. Interviews showed that MRCS' training and support helped committee members gain self-confidence and credibility within their communities:

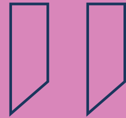
"As you know, Blantyre has been heavily hit by cholera. So, after the first outbreak, the Red Cross trained us on prevention and how to handle the awareness campaign in the villages. That is why we are very thankful to the Red Cross because now the people believe us and the chiefs know that when the VCPC calls for a gathering, people come."

— Member of the Village Civil Protection Committee, Blantyre



I was explaining to people here this morning that I got all my three vaccines, you can see I am healthy, and I do not have any problems. Right after that, that man and that man got vaccinated. I show them my vaccination card and tell them that I am fine.

— Religious leader, Chikwawa



"[the trainings] have helped to change all of us, myself as well as people in the village because if I am not informed, I will tell my people the wrong information but the expertise from the Red Cross has made me to know what is right and I tell the people in the village, and they have changed. So, this has helped me and the people in the village."

— Member of the Village Civil Protection Committee, Blantyre

Community groups and committees interviewed had a clear sense of ownership and a desire to do more to help their community. For example, committee members in Blantyre who have not yet been trained on cholera prevention and response, expressed their keenness to receive this training.

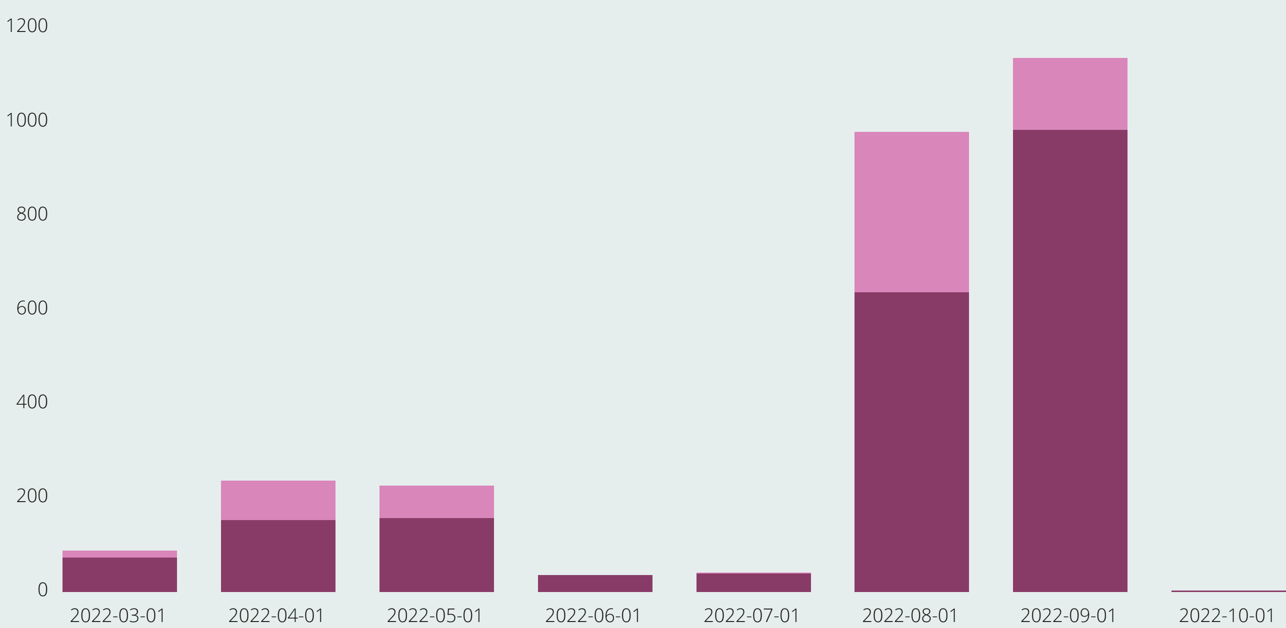
3.3

Community feedback mechanisms facilitated data-driven decision making

The research found that community feedback was highly valuable to MRCS and helped them to adapt their public health and community engagement activities based on the barriers, preferences, rumours and beliefs present in communities. These adaptations are increasing the impact and accountability of MRCS public health responses, including increasing vaccination rates, improving health behaviours and reducing the effects of rumours and misinformation.

MRCS collects feedback during door-to-door visits and during community activities. Feedback is logged in a paper form and then loaded into an online system. Feedback data is then analyzed at headquarters, with the analysis shared back with local staff and volunteers. The research found this clear and structured process for collecting feedback has helped to ensure it is understood,

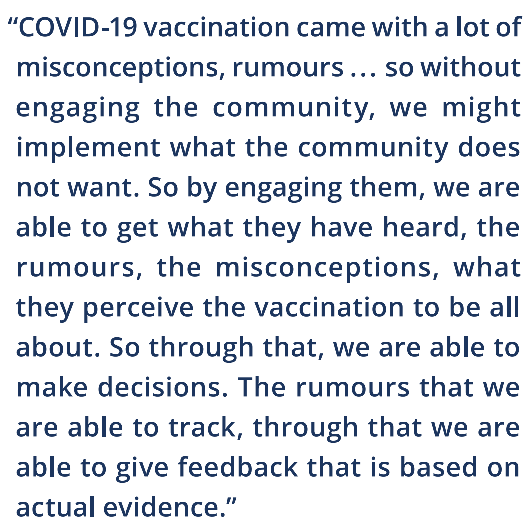
Figure 1: Community feedback responses



Source: Plan Eval

analyzed, acted on and responded to. From March to October, 2,700 feedback comments were recorded, most of which related to COVID-19 vaccination (see Figure 1).

Feedback data analyzed by the National Society was used to identify the main barriers to vaccination, which included rumours, fear and religious restrictions, sometimes driven by information shared by religious leaders themselves. An MRCS officer in Blantyre explained how knowing this information has been particularly important for the COVID-19 vaccination campaign, where understanding beliefs and misperceptions at community level has helped them design more effective vaccination efforts:



"COVID-19 vaccination came with a lot of misconceptions, rumours ... so without engaging the community, we might implement what the community does not want. So by engaging them, we are able to get what they have heard, the rumours, the misconceptions, what they perceive the vaccination to be all about. So through that, we are able to make decisions. The rumours that we are able to track, through that we are able to give feedback that is based on actual evidence."

— MRCS staff, Blantyre

This data also directed MRCS to engage more with religious leaders by training them on COVID-19 and ensuring they can actively share accurate information with their members, which led to religious leaders becoming advocates for vaccination as opposed to a barrier:The community feedback mechanism has also informed changes and improvements in health response activities, including identifying practices at community level that could undermine safe practices or even lead to an increase in infection rates. For example:

- The introduction of door-to-door vaccinations for COVID-19 helped address the fear that some people had to go to hospital and get vaccinated. By providing the vaccination service to people's doorstep, it eliminated the need for them to go to the hospital and face the risk of contracting the disease. This intervention not only ensured that the community got vaccinated, but also increased their confidence in the vaccine.
- Community feedback identified that chlorine, used in pit latrines to prevent cholera, was not always used correctly. MRCS responded by scaling up information and demonstrations on how to use chlorine properly and effectively. By doing this, people were empowered to take responsibility for their health and prevent the spread of cholera in their community.
- MRCS provided buckets and masks after communities reported they were facing challenges following public health measures. By providing the necessary materials, the community was able to implement and adhere to the recommended health practices, such as handwashing and mask-wearing.
- Greater involvement of village chiefs and religious leaders to help tackle fears of vaccination by leveraging the influence and trust that community members have in these leaders.
- Targeting parents and parent associations to encourage COVID-19 vaccination of children was an effective way to ensure that children were protected. Parents play a significant role in the health of their children and are more likely to support vaccination efforts if they are well informed and involved. Issues MRCS could not respond to were referred to other stakeholders. For example, when requests to drill boreholes fell outside of the scope of the project, this was referred to Government and to MRCS partners at headquarters who may have the capacity to respond.

3.4

Community engagement improved the access and acceptance of MRCS volunteers in the community

In public health responses, rumours and beliefs are often a roadblock to behaviour change and adopting safe practices. This can lead to resistance and even violence at community level against those who are promoting public health measures, including MRCS. Several MRCS volunteers reported that they often faced hostility from community members, especially when encouraging people to get vaccinated. However, strong community engagement approaches and relations with community leaders, meant MRCS was able to identify trusted and influential figures in the community. Seeking and securing the support and endorsement of these local leaders proved essential to reaching the rest of the community:

Religuous leader who received the COVID-19 vaccine

Source: MRC

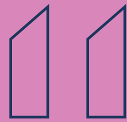
> "[the support from leaders] helped us a lot because at first when we were in contact with community, some people would cast us out, calling us satanic and chase us after seeing our t-shirts. This was mostly due to the rumours going around but after the leaders talked to them, people started talking to us and accepted the information then told their friends as well."
>
> *— MRCS volunteer, Chikwawa*

3.5

Understanding the community needs and context led to a more relevant and impactful response

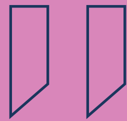
MRCS' understanding of and adaptation to the needs and context at the community level increased community understanding and uptake of health measures. For example, MRCS used culturally-based gatherings to share health information, including weddings, funerals, football matches or school events. During these events, local chiefs, volunteers, committee members and local health workers would also address the questions and concerns shared by community members. MRCS also mobilized youth groups as part of the response. With 34% of the Malawian population aged between 10 and 24 years,[1] the youth are seen as an important and influential target group during public health responses. As reported by several MRCS officers, young people have their own communication style, which means youth are often more effective at engaging their fellow youth.

1 World Population Dashboard. Malawi. UNFPA. Available online: https://www.unfpa.org/data/world-population/MW



When cholera and COVID-19 broke out, we as the VCPC here in Chilomoni worked hand in hand with the Red Cross because there were some problems in the areas that we couldn't handle on our own like all the expertise they gave and the awareness in schools and markets as well as different roads. On our own it would have been too much because we did not have many materials; but the Red Cross helped us to reach out to the people

— Member of the Village Civil Protection Committee, Blantyre



"After talking with the community leaders, we went further and we talked to different groups of people: young people, women, people with disabilities, et cetera. We were making sure that we have talked to all those groups. Each group had their preferences. Young people said they preferred quiz sessions, for example. Whatever we do as the Red Cross, we make sure that we talk with people."

— *MRCS staff, Blantyre*

Health information and guidance developed at headquarters was shaped by issues raised through community feedback, and then adapted and translated into local languages by staff at the branch level. The research shows this led to health information being well understood by community members:

"Here, there are many languages. Some speak Sena, some speak Mang'anja, some speak Nyungwe in Chikwawa. Whenever [the youth/MRCS volunteers] go to the place where there are Sena, they speak Sena, so they can understand. Whenever they go to the area of Chapananga, they have to adopt the language for easy understanding."

— *MRCS staff, Chikwawa*

The study also found that when information is shared by members of the community through multiple channels and events, it is more likely to reach a wider audience, including those with reduced mobility, older people and people with disabilities. For example, MRCS uses interactive theatre, WhatsApp and memorable radio jingles adapted to folklore and cultural trends to share information and answer community questions. The WhatsApp channel was reported by community members as an easy-to-use and effective tool, allowing for timely two-way communication between all those involved in the MRCS response.

Listening and responding to the needs expressed at community level was also crucial to sustain the promoted changes, as expressed in the following comments from community members:

"The Red Cross came and asked us what we need and how we can fight this disease. We told them of our needs for the job to be easier like protective wear. They brought us masks, sanitizers, hand washing buckets and other stuff that we needed to give to school children and use in our homes because we are leaders that give the community messages that they gave us to tell the people in the area like there is COVID-19 and there is now a vaccine."

— *Member of the Village Civil Protection Committee, Blantyre*

Community engagement sessions for Cholera in Malawi

Source: MRC

4

ENABLERS OF EFFECTIVE COMMUNITY ENGAGEMENT APPROACHES

Based on the findings, the research team identified several enablers that supported the effectiveness of MRCS' community engagement and accountability approaches. These include:

4.1

A willingness to hand over power to community structures

MRCS' success in empowering community structures and groups to lead their own response activities required a willingness and commitment from MRCS to hand over control of decision making and resources to other organizations. A strong understanding of and commitment to participation, community engagement and community-led solutions at all levels of MRCS was a critical enabler of this approach. Trust is seen as a reciprocal path and rooted in a mutual understanding between communities and the MRCS. The progressive social recognition and leading initiatives of community groups can be interpreted as a mutual reliance on the way of serving and engaging their own communities.

Volunteers from Nkhata Bay district help prepare chlorination

Source: MRC

4.2

Strong community connections and coordination

Overall, the interviews indicate that MRCS' strong community relations led to effective collaboration between the Red Cross, local structures and community members. This created a positive perception of MRCS' work, enhancing legitimacy of the organization, with possible positive influence beyond the COVID-19 and cholera response. During early stages of the pandemic for instance, MRCS interacted with their existing network of local leaders, village chiefs and the health surveillance ssistants (HSAs) to activate a coordinated support. An example is how HSAs interacted with MRCS to address some of the questions they were unable to address and vice versa: MRCS volunteers supported HSAs in their door-to-door COVID-19 vaccinations campaigns.

MRCS also worked closely with Government representatives, community committees such as the VCPC, local chiefs, religious and youth leaders, as well as community volunteers, who acted as facilitators in mobilizing and engaging community members in preventive and curative healthcare measures, both in regard to the COVID-19 pandemic and to the cholera outbreak.

> **"Us, the chiefs, and our friends (VCPC and PASA) work together. When they get a message, they pass it to us. When we have questions that we do not have answers to, we tell them and they send it to the Red Cross and they get back to us. They use the phone."**

> ***— Local leader, Blantyre***

5 IDENTIFIED BARRIERS

The implementation of community engagement and accountability approaches in Malawi faced a number of challenges. Addressing them will improve the impact of interventions and strengthen community resilience.

5.1

Challenges in 'closing the loop'

The research identified that community feedback is not always consistently responded to or acted upon. There are positive examples of feedback being responded to quickly, particularly through the WhatsApp line:

> **"When the Malawi Red Cross has been sent the complaint, they respond in time and we are happy. If the Red Cross does not have answers, they go and ask others and tell us they will answer us in such a period of time."**
>
> *— Member of the Village Civil Protection Committee, Blantyre*

However, examples were also shared by MRCS volunteers of not receving information or updates on feedback they had compiled and sent to headquarters:

> **"Since we started volunteering and sending our things to Lilongwe, we have never received anything. We just do our job, compile the data and send it to headquarters, but we haven't heard anything."**
>
> MRCS volunteer, Blantyre

If local staff and volunteers are not provided with updates on actions taken and responses to feedback, this limits their ability to provide an onward response to the community and close the feedback loop. Over time, this could damage community trust in the feedback mechanism. This challenge was identified during an interview with one MRCS staff:

> **"I think we really need to work on improving the feedback system. I think we are better at receiving feedback, but then there are some gaps in terms of responding to those feedbacks and acting on them. It doesn't make any sense if we can only receive feedback and not do something with it. The essence of receiving is that the feedback helps to make some adjustments.... It's about resources as well, for prioritizing the activity."**
>
> *— MRCS staff, feedback mechanism*

To address this, MRCS is investigating if feedback data can be analyzed at the district level instead of at headquarters, which would help to speed up the process of closing the feedback loop with volunteers and communities.

5.2

Meaningful community participation is not always well understood by communities or responders, and often only happens at a late stage

This study observed diverse perspectives and understandings of what constitutes meaningful participation. Community engagement recognizes the importance of truly engaging

communities as active decision makers in designing and managing programmes and operations in a locally and appropriate way. However, during interviews conducted for this study, participation was frequently understood as community members taking part in health-promotion activities, exchanging information during community dialogues, and having door-to-door interactions with MRCS volunteers. Community members beyond those in leadership roles rarely discussed participation in terms of co-designing solutions and sharing decision-making power with MRCS and other responders.

While some community members, such as community chiefs, were involved in the design of community engagement strategies from the start of the response, there was little evidence of their involvement in the design of the public health response. This only occurred at a later stage, during implementation. This limitation was identified by an MRCS staff member:

> **"One of the things that we are missing in terms of programme or project design, we don't really engage the communities in terms of providing the input. Mostly we engage them along the way. For example, we have had several COVID-19 vaccination programmes or projects, we got the feedback from those projects, instead of engaging some of the community members in designing these projects, we would not do that. We mostly engaged them along the implementation."**
>
> ***— MRCS staff, Feedback mechanism***

Involving different segments of the community in the design of the response from an early stage could have helped improve its effectiveness. For example, if religious leaders had been involved in the design phase of COVID-19 vaccination campaigns, there could have been less resistance from this group and vaccination rates would have been higher from the outset of campaigns.

5.3

Barriers to reaching people living in remote areas limits inclusive participation

Some community members live in remote and isolated areas. The lack of public transportation has made it difficult for mobilized volunteers to reach out to those people. As a result, some community members could not be meaningfully engaged in the response. Even if research indicated that mobile vaccination units were an efficient way of reaching physically impaired population or older people, the need to engage more regularly the most remote areas remains. Community engagement efforts can result in better understanding of the barriers and possibilities to further liaise with focal points from the remote areas, who can serve as two-way information facilitators for the MRCS, increasing the chances to contain outbreaks.

> **"We did not reach out to everyone because other areas are far away…we are still visiting but reaching out to them is hard due to lack of transport."**
>
> ***— MRCS volunteer, Chikwawa***

CEA Impact Research Focus Group Discussion

Source: MRC

6 CONCLUSIONS

Community-led interventions and participation can promote the uptake of public health measures and strengthening community health systems.

1

Cooperation between RC and community groups led to positive risk reduction and treatment uptake during COVID-19 and cholera outbreaks

Communities perceive Red Cross as a reliable humanitarian organization, which builds on the legitimacy of influential community members. People living in the communities were less resistant to get vaccinated after local chiefs got vaccinated.

2

Community members that built or reinforced their knowledge thanks to MRCS reported feeling more self-confident and legitimate to to help others

When communities take ownership of their health and of the well-being of others, the possibility to outlast the outbreak and strengthen community systems is higher.

3

When actively and regularly engaged with MRCS, members of the community are more likely to incorporate healthy behaviours

Many interviewers reported having adopted positive hygiene behaviours (such as regularly washing hands, properly disposing of sanitary pads and baby diapers, wearing facial masks, going to the hospital at the first sign of symptoms). They have shown the intention of incorporating them definitively in their routine and daily lives.

4

Community feedback is helping MRCS improve its response and meet the needs of the communities

Community feedback has informed the response actors about emerging needs and implementation challenges in the community. The research also showed that MRCS has adapted its strategy to cope with those needs and challenges, despite some difficulties in closing the feedback loop and prioritizing expenses when working on limited resources and budget.

7 RECOMMENDATIONS

Improve transportation options for volunteers to reach hard-to-reach areas

MRCS could explore options to improve transportation options for volunteers, such as providing motorcycles or other means of transportation. This would help to ensure that communication is timely during public health emergencies.

Involve communities in the public health response design from the early stages

MRCS could involve communities in the design of the public health response from the start, rather than only during implementation, as was the case for religious leaders. This would help to ensure that the response is appropriate to the community's needs.

Provide alternative communication channels for volunteers without smartphones

MRCS could provide alternative communication channels, such as SMS or voice calls, for volunteers who do not own smartphones. This would help to ensure that all volunteers can communicate effectively.

Allocate resources for gathering feedback and closing the feedback loop

Resources should be allocated specifically for activities focused on gathering feedback and closing the feedback loop, instead of budgeting only for feedback collection. This would help to ensure that the feedback received is acted upon in a timely manner.

Strengthening capabilities at district level and consider analyzing feedback data at the district level

MRCS could consider analyzing feedback data at the district level, rather than at the central level. This would close the feedback loop more quickly and ensure that timely action is taken based on the feedback received. Doing this will require MRCS to strengthen social science capabilities at the district level to enable agents to effectively process and analyse collected data.

Continue efforts to consolidate feedback systems

A strong feedback system, consolidated through the mobilization of volunteers and agents, is a driving force in strengthening the response to public health crises. The data collected by MRCS in feedback is rich and justifies a capitalization effort from MRCS paving the way to a more consolidated database and broader coordination from different programmatic sources. That may include exploring machine learning ideas around community engagement and accountability feedback.

ANNEX: INTERVIEWEES

	Semi-structured interviews	Focus group discussions
Central level	MRCS personnel: • Head of Planning, Monitoring & Evaluation and Reporting • Feedback Mechanism Team Leader	
District level Blantyre	MRCS personnel: • Blantyre District Coordinator • Blantyre Office staff CDC SLL • Blantyre Office staff Cholera – Swiss Red Cross • Blantyre Office staff BDR Government representatives: • Blantyre District Social Mobilisation Committee representative	Profile of participants: • Female MRCS volunteers • Male MRCS volunteers • Female Committee members • Male Committee members
District level Chikwawa	MRCS personnel: • Chikwawa District Coordinator • Chikwawa Office staff Comrep • Chikwawa Office staff COVID-19 Government representatives: • Chikwawa District Social Mobilisation Committee representatives • Chikwawa Government representative for COVID-19 response	Profile of participants: • Community leaders • Female community members • Male community members • MRCS volunteers

THE FUNDAMENTAL PRINCIPLES OF THE INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

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.