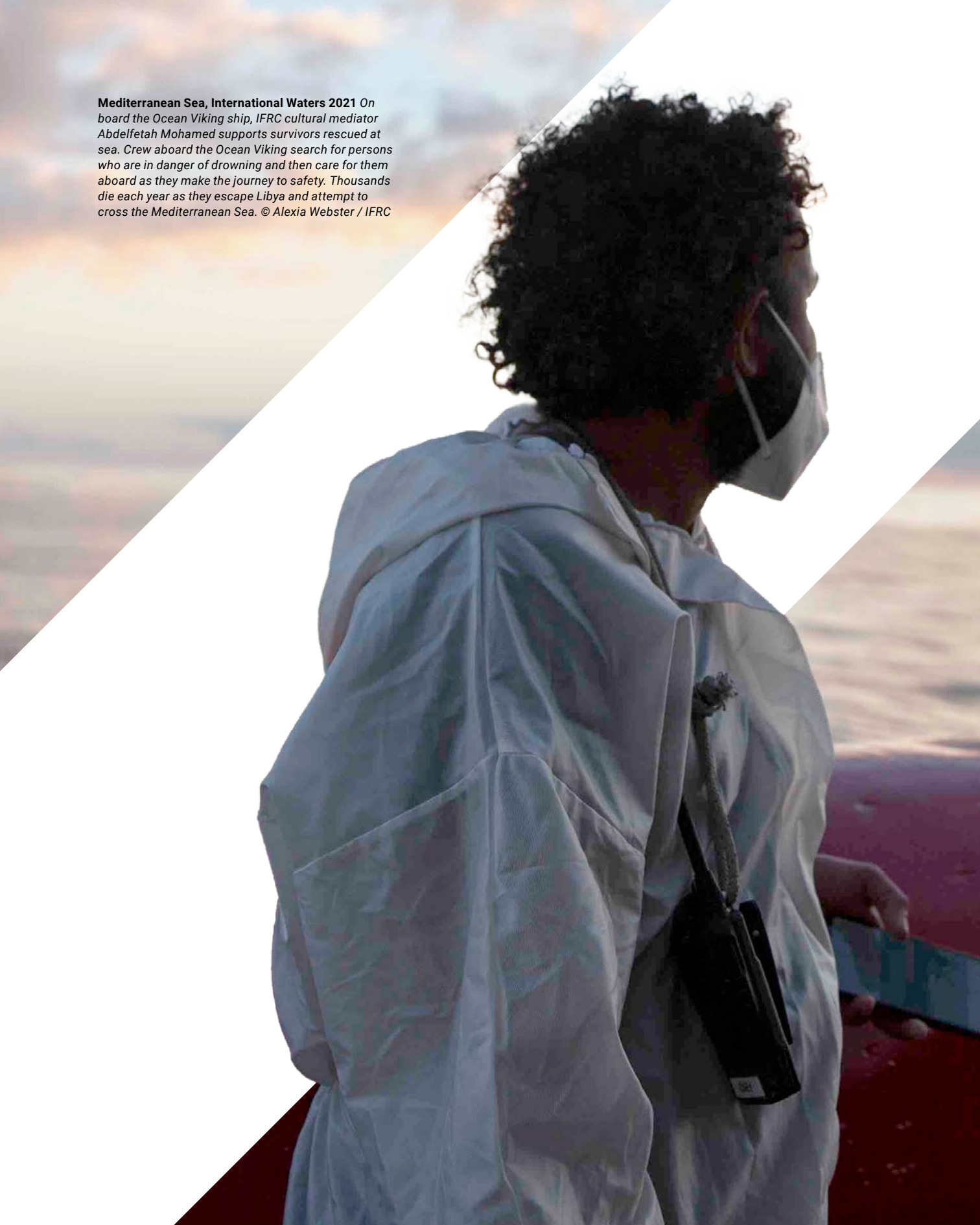
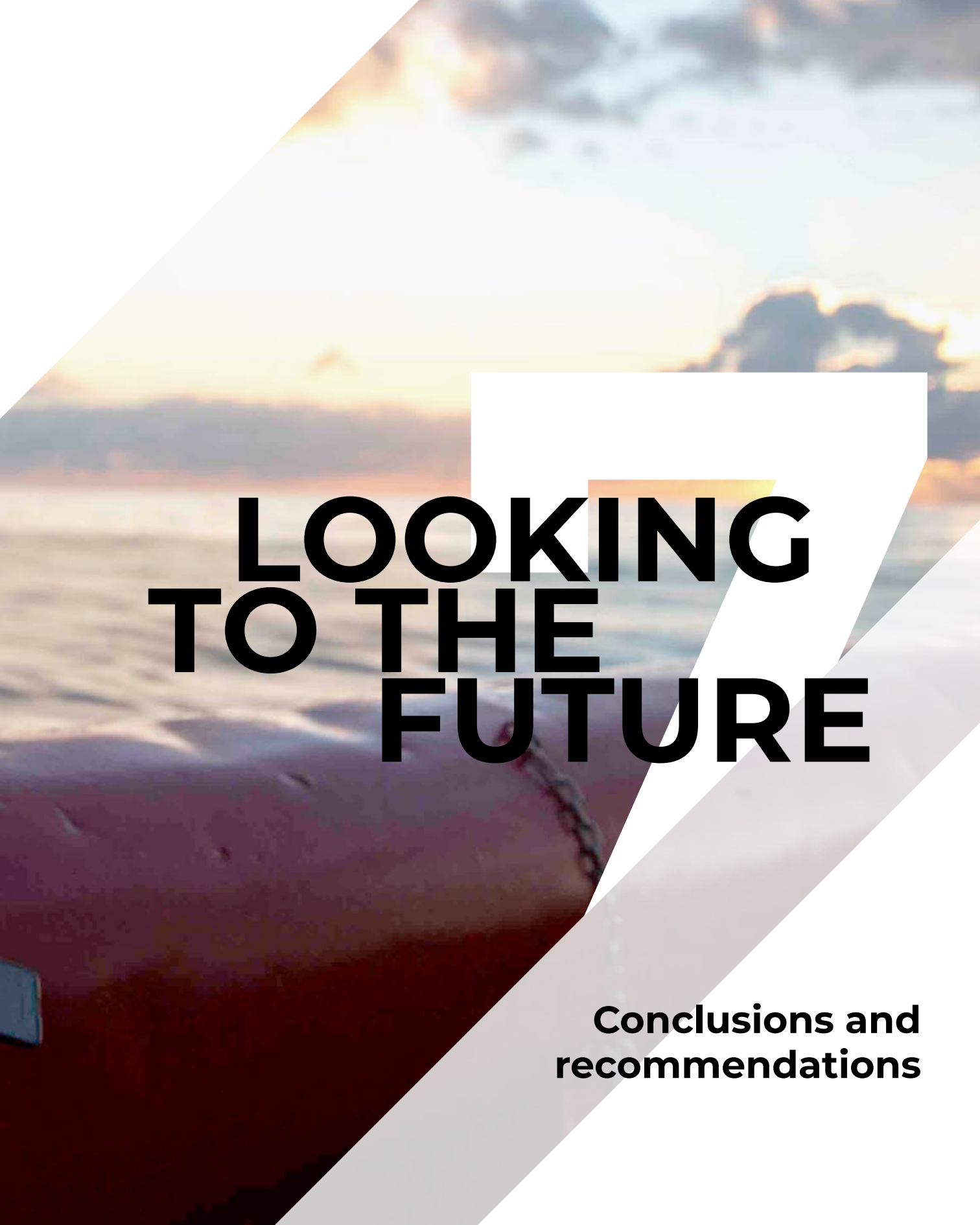


Mediterranean Sea, International Waters 2021 *On board the Ocean Viking ship, IFRC cultural mediator Abdelfetah Mohamed supports survivors rescued at sea. Crew aboard the Ocean Viking search for persons who are in danger of drowning and then care for them aboard as they make the journey to safety. Thousands die each year as they escape Libya and attempt to cross the Mediterranean Sea. © Alexia Webster / IFRC*



LOOKING TO THE FUTURE

Conclusions and recommendations

CONCLUSIONS

The ability to prevent, detect and respond early to public health emergencies alongside other shocks and stresses is a humanitarian, social and economic necessity for two reasons. The first is that these shocks and stresses, including extreme weather events, are growing more frequent and intense, and our ability to merely respond to them is limited. The second is that the conditions for the spread of contagious disease outbreaks, including population growth, unplanned urbanization, international travel and commerce, will continue to grow for the foreseeable future. We simply cannot afford to wait anymore. We must invest in much stronger preparedness systems. By doing so, we will be investing in our future.

However, while the data indicates there has been some progress in the area of disaster risk reduction, in that fewer hazards appear to become emergencies, the same cannot be said about epidemic and pandemic prevention and preparedness. Technological and epidemiological advances are there, but strong preparedness systems, including health systems strengthening, are found to be severely lacking. To be sure, humanity was not prepared for the COVID-19 pandemic. Moreover, even the most advanced preparedness systems often neglect the role and added value of local actors and communities, an aspect of response that the fight against HIV clearly demonstrated.

Governments and other actors must now take action to ensure we are prepared for the next health emergency.

As we have explained in this report, preparedness is not a phase of the response and should not be confused with readiness. It is a process and a set of actors, skills, infrastructure and procedures that are needed for a society to more effectively and rapidly prevent, detect and respond to public health outbreaks, epidemics and pandemics. It is worth singling out some of the aspects of preparedness that are frequently missing:

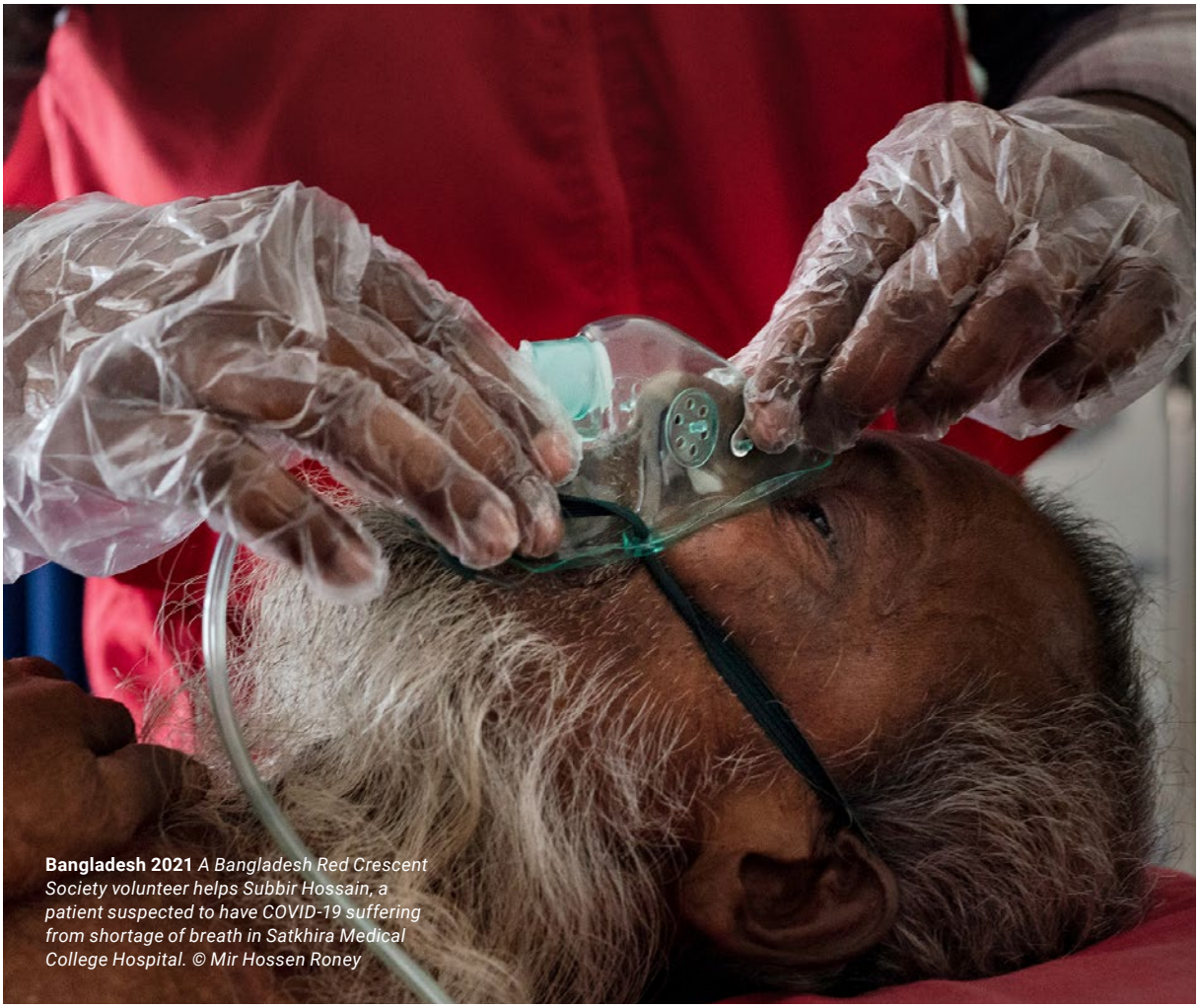
- Preparedness must go beyond the availability of medical products, services and information and focus more on accessibility. This will allow us to deliver the products, services and information to the communities that most need them, and to encourage their uptake.
- Preparedness goes beyond the ability of governments to apply a standard set of operating procedures in the event of a health emergency. Rather, it must begin with the needs, vulnerabilities and strengths of communities, for it is at this level that diseases will first be detected and controlled.
- Preparedness goes beyond our ability to face a single threat; at a time where a range of hazards and risks are growing increasingly frequent and interlinked, we must be prepared for a multitude of risks. At the local level, this frequently entails a set of basic and common procedures, together with greater risk awareness and more accessible, localized services.
- FInally, epidemics and pandemics have impacts that go beyond physical health: among others, they affect livelihoods, mental health, education and violence. Preparedness means having systems and policies in place to tackle all of these impacts.

In order to meet these criteria, preparedness must be underpinned by **trust, equity and local action**. These are mentioned in other assessments of the COVID-19 pandemic response, but they have been under-emphasised and under-analysed. A fuller understanding of all three will enable greater preparedness.

Trust At every stage of the disaster management process, it is crucial to build trust in and with communities. The value of trust is now broadly accepted, but global discussions have not given enough attention to how trust is built. There is a tendency to assume that trust is achieved by communicating more or countering misinformation; for example, that governments should provide more or better information to people. In fact, building trust is far more complex; it requires genuine two-way communication and coordination. Communities must be included in all phases of preparedness, including co-designing measures and programmes, and their concerns must be taken into account. This will have three tangible benefits: communities will 1) know their concerns and priorities matter, 2) meet and be familiar with responders far in advance of a crisis, and 3) understand better and be more receptive to difficult decisions, such as public health measures.

Equity Public health emergencies and other disasters both thrive on and aggravate existing inequities, particularly if preparedness frameworks and policies are not inclusive and co-designed with local actors and communities. Equity is now at the centre of global health policy discussions. However, it is often discussed only in terms of people's access to pandemic response products like vaccines. This is critical, but too narrow. We must ensure equal access to the full range of essential health countermeasures, which includes medical countermeasures as well as access to key health services. Equal access to health countermeasures requires proximity, affordability, legal access, and the willingness to trust these countermeasures. First, we propose this be achieved by strengthening community health systems, prioritizing the most vulnerable in legal and policy frameworks and ensuring access to health countermeasures regardless of legal status. Second, in order for shocks and stresses not to aggravate existing inequities, we believe that strengthening social protection systems in advance of a crisis is key. Third, we must make more rapid progress towards a needs-based allocation of humanitarian funding, and one that supports local infrastructure and capacity.

Local action Preparedness, while fundamentally a responsibility of governments, cannot be designed and implemented from the top. Local actors and communities, who are at the frontline of the response, should not only inform prevention and preparedness efforts but also co-design them. Unfortunately, we often fail to leverage their knowledge, training and capabilities. It is necessary to devise ways to include local actors and communities in health systems and disaster risk management programmes. Community health systems enable this by creating a bridge between communities and health authorities. To do so, they must be funded, supported and coordinated with national health systems (noting that a range of legal options to do this exist).



Bangladesh 2021 *A Bangladesh Red Crescent Society volunteer helps Subbir Hossain, a patient suspected to have COVID-19 suffering from shortage of breath in Satkhira Medical College Hospital. © Mir Hossen Roney*

The consequences of poor decisions and recommendations to address them

The findings and recommendations made throughout this report have addressed what we see as gaps in the COVID-19 response to date. Moreover, as we head into negotiations on the International Health Regulations and on a new pandemic agreement at the World Health Assembly, and as we observe the direction that some domestic authorities are taking at home, we see areas of serious concern. If left unaddressed, these issues could lead us to either repeat the mistakes of the past or aggravate existing inequities and tensions.

In the next three sections, we address our key concerns about trust, equity and local action, and how to resolve them. Finally, we present three measurable targets for the next three years.

Trust

Top-down social control measures like lockdowns and vaccine passports, when implemented without trust and transparency, **often lead to polarization and create resistance to public health measures**.

Moreover, **a narrow focus on increasing communication campaigns and countering mis-information will not build trust. It may even backfire** in situations of political and social unrest, or discrimination.

Trust can only be built through:

- **Proximity:** People trust people they know, such as local actors.
- **Education:** People trust what they understand, via health literacy programmes.
- **Listening:** People trust those who listen to them and act on their concerns, such as trained community engagement specialists who gather feedback and analyse it.
- **Access to services:** People trust those who address their needs, including their basic health and social protection needs.
- **Ownership:** People trust measures they feel ownership of and are consulted on.

Just as importantly, **building trust is a process that cannot wait until a crisis occurs**.

We urge governments to promote:

Community ownership of emergency preparedness plans: Design, implement and monitor **whole-of-society and whole-of-government preparedness plans** that leverage the capacities and knowledge of local actors and communities to prevent, detect and respond early to disease outbreaks and public health emergencies.

Active listening and community engagement: Create or scale up **meaningful, two-way community feedback mechanisms** that record community concerns, needs and suggestions, and collect and analyse them to adapt public health measures when possible and as needed.

Access to services and education through stronger community health systems: Invest in or strengthen **community health systems**. These include all the actors, infrastructures and services that promote community health, ranging from information and services to emergency preparedness and programmes addressing the determinants of health. They include water and sanitation systems, and strong mental health and psychosocial support.

Equity

Developing the supply side of pandemic response products, without addressing the demand side, undermines access and uptake of these products by countries and communities, especially the most vulnerable and hard to reach.

The international community and domestic authorities should promote:

Domestic capacities to distribute pandemic response products, including through local actors: Invest in domestic capacity to store, transport and distribute these products through better funding, training, advance notice and the necessary laws/policies to facilitate the movement and distribution of the goods. The contributions of local actors to this process are critical given their access to isolated and marginalized areas, and to disaster- and conflict-affected areas.

More flexible, predictable humanitarian funding: Where government capacities need to be complemented by international humanitarian organizations or recognized local actors, reform humanitarian funding to make it more equitable, predictable, flexible and accessible to local actors.

Community confidence and interest in pandemic response products: Invest in meaningful community engagement programmes to promote community uptake of these products. Such programmes should be complemented by transparent information on the timing, method and location of the distribution, as well as on the choice of product.

Equitable and fair distribution of indemnification and liability risk, including for humanitarian organizations, and limitations on how long manufacturers can be exempted from purchasing indemnification and liability insurance for new products.

Development and production of pandemic response products that are less expensive, easier to store and administer and just as effective. Such products are essential for countries that do not have the capacity to purchase, store or administer more expensive and complex products.

Limiting discussions of equity to the question of equitable access to pandemic response products is short sighted. There are many other concrete and critical measures that can help to address inequities in pandemic preparedness by addressing the drivers of disease outbreaks and their differentiated impacts.

The international community and domestic authorities should promote:

Equitable access to information: This includes domestic obligations to create early warning/early action systems for their populations.

Equitable access to domestic health and social protection services: This must include: guaranteeing rights to basic health countermeasures and social safety nets, regardless of legal status; strengthening social protection systems before a crisis occurs, including through joint vulnerability assessments; and increasing local access to health services through community health systems.

Equitable and needs-based access to humanitarian assistance: This should include reducing the use of earmarked humanitarian funding to allow for more flexible, needs-based assistance across countries and time. Such flexibility is essential because of the considerable variations in how disease outbreaks evolve.

Greater emphasis on multi-hazard prevention (primary, secondary and tertiary) and preparedness: This will help to mitigate or avoid the impacts that epidemics and pandemics have on the most vulnerable. It will also address the possibility of compounded shocks and stresses, such as economic or social shocks, earthquakes, weather- and climate-related events, and conflicts.

Local action

While domestic authorities will always have the primary responsibility to manage public health emergencies, **overly centralized and medicalized approaches to pandemic prevention, preparedness and response cannot address the local complexities of emergency management.** These complexities include: a variety of risk factors and drivers of disease; the unpredictable social, economic and physical/mental effects of a disease; and people's attitudes to public health measures and risk.

Moreover, **a failure to include other actors, and to leverage and support local knowledge and capacities, can rapidly lead to overwhelmed government services and systems.**

Domestic authorities can address this by:

Recognizing and integrating recognized and trained local actors into domestic emergency and health systems: This includes the design, implementation and monitoring of **multi-hazard national emergency preparedness plans and legal frameworks,** and recognizing their **contributions to health systems strengthening, especially community health systems** (in this case, we refer to approaches such as task shifting – the transfer of non-medical but health-related tasks to trained local actors).

Providing trained and recognized local actors with the legal protections and facilities they will need to carry out their tasks: This includes priority access to personal protective equipment and pandemic response products; exemptions from movement of goods and personnel as public health warrants; and the financial support, training and oversight that they need to meet quality, living and safety standards.

Working with communities to design, implement and monitor **domestic emergency preparedness plans** for prevention, early action and response.

Measurable objectives for the next three years

The next pandemic could be just around the corner: if the experience of COVID-19 won't quicken our steps toward preparedness, what will? Governments can take concrete action immediately by following this three-point plan.

1. By the end of 2023, every country should have updated **pandemic preparedness plans** and should have reviewed the relevant legislation to see if it too needs updating.

   - Plans should include **concrete measures** to strengthen equity, trust and local action.

   - Legislative reviews should bear in mind, among other things, the **need for a holistic approach** to crisis response, clarity of roles and responsibilities, and the needs of recognized local actors for personal protective equipment and appropriate exemptions from movement restrictions.

2. By 2024, **adopt a new treaty and revised International Health Regulations,** which include concrete and measurable obligations to:

   - **Strengthen** equity and trust.

   - **Promote** better domestic and international legal governance of pandemics.

   - **Invest in and support** the range of services and inputs that can be provided by recognized local actors and/or communities.

3. By 2025, **increase domestic health finance by 1% of GDP** and **global health finance by at least US$15 billion per year** (G20, 2021; WHO, 2019).

   - A much greater proportion of global financing for both public health and humanitarian action must also flow to **the local and community level**.

   - Global financing should be **more predictable and flexible** to allow for more effective and needs-based action.

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Nepal 2022 *A staff member from Nepal Red Cross Society administers the COVID-19 vaccine at the organization's vaccination booth in Kathmandu. © Tsering Lama*