



# COVID-19 IN THE AMERICAS: LISTENING TO THE MOST VULNERABLE

**Community perceptions from migrants, refugees,  
host communities and indigenous populations**



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## **COVID-19 in the Americas: Listening to the most vulnerable**

Community perceptions from migrants, refugees,  
host communities and indigenous populations

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- **Bolivia:** Country report written by the Bolivian Red Cross.
- **Brazil:** Country report written by Luana Galdino and Rozana Ribeiro from the Brazilian Red Cross, with contributions from Observatorio Humanitario.
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# BACKGROUND



Latin America was declared by the World Health Organisation (WHO) as the epicentre of the COVID-19 pandemic in May 2020. By December 2021, date at which results were compiled, Latin America and the Caribbean include four of the 15 countries worldwide with the highest number of COVID-19 deaths ([WHO 14/12/2021, PAHO 3/12/2021](#)).

Most governments in the region acted quickly when the virus was first identified in February 2020, adopting border closures, and implementing public health measures such as restrictions on movements and gatherings, quarantines, school closures and distance learning<sup>1</sup>. In view of the various challenges in accessing services, countries in Latin America and the Caribbean declared a state of emergency in March 2020 with national quarantines<sup>2</sup>. The capacities of health systems were increased by governments in order to face the sanitary crisis and enable health care access ([OECD 11/11/2021](#)). The rapid containment response reduced the infection rate. However, different socio-economic factors heightened the effect of the sanitary crisis in the region. According to the OECD, 60% of the population of the region was working in the informal economy and 20% of Latin America's urban population was living in slums, informal settlements or precarious housing, leading to difficulties in implementing social distancing and to major socio-economic impacts ([OECD 11/11/2021, OXFAM 31/03/2020](#)). Moreover, the COVID-19 pandemic largely impacted the country's economy, causing the worst recession the region has ever known and reducing households' income and purchasing power.

Inequalities within the populations grew deeper, particularly for the migrant population in Central and South America and the Caribbean, estimated to be nearly 15 million in 2020 ([IOM 2021](#)). In February 2021, Colombia announced it would provide 10-year temporary protection status to approximately 1.7 million Venezuelans migrants who entered the country before 31 January 2021, facilitating access to the public healthcare system and to COVID-19 vaccines. Most countries in the region have since included refugees and other displaced people in their vaccination rollouts, but challenges remain for people seeking asylum and irregular or undocumented migrants ([IFRC 2021](#)).

Despite the major socio-economic impact of the crisis, countries of the region were slow in reversing the restrictions adopted. For instance, Bolivia lifted quarantine measures in May 2020 based on an official classification of the country's contagion level and Argentina also adopted a gradual plan for the reopening of schools and businesses based on a geographical map of contagion rates. By August 2021, only Mexico, Costa Rica, Colombia, and the Dominican Republic kept their borders open without restrictions. Argentina only fully reopened its borders in November 2021 ([R4V 2021](#)).

By December 2021, all five Variants of Concern (VOC) of the virus have been identified in the Americas and all countries in Latin America and the Caribbean have started vaccinating their populations. Full vaccination is covered for 69% of the region's population, including 68% of the population in Argentina, 66% in Brazil, 63% in Panama, 50% in Colombia, 47% in Trinidad and Tobago, 38% in Nicaragua, 36% in Bolivia, 23% in Guatemala and 18 % in Jamaica ([PAHO 2021](#)).

<sup>1</sup> Dashboard presented by CEPAL with details on the measures adopted by all countries in Latin America and the Caribbean : [COVID-19 | Comisión Económica para América Latina y el Caribe \(cepal.org\)](#)

<sup>2</sup> All measures adopted by the governments in response to the COVID-19 pandemic can be found per country on the UNDP website: <https://www.latinamerica.undp.org/content/rblac/en/home/coronavirus.html>

# EXECUTIVE SUMMARY



**This research from the IFRC brings the voices and experiences of people and communities from nine countries in Latin America and the Caribbean. The findings reveal the myriad of impacts that the COVID-19 pandemic has had on the most vulnerable and hard to reach populations. Migrants, host community populations, Red Cross volunteers as well as indigenous peoples share their individual perceptions about the challenges they have faced over the course of the pandemic.**

The Americas Region has experienced its worst recession on record over the past few years, driven by some of the world's highest COVID-19 mortality rates and long-lasting government restrictions that have crippled economies and pushed those with precarious livelihoods to the brink of survival. This, in combination with low trust in government decision makers and a slow and uneven rollout of vaccinations across the region has increased instability. The pandemic has affected everyone, and those with low or unstable incomes, lack of access to or awareness of services and those more prone to distrust in decision makers, have encountered the most dramatic consequences. Listening to these stories is necessary to understand their challenges and coordinate efforts and respond to the ones most in need.

This report summarizes the findings and offers hands-on recommendations around the impact and usefulness of health information, the trust, awareness and access of COVID-19 vaccines, and the socio-economic impact of the pandemic.

A dashboard presenting main results and allowing readers to explore findings is available [here](#).

## **1. Access to health messages and the impact of health messages**

### **Most people receive sufficient and adequate information**

Participants around the whole region say that they receive a vast amount of COVID-19 related information and that it is relevant to their situation. There are age differences that are important to consider. Younger

persons (18–29) use social media and active web-based research to access information. The elderly (above 70) prefer a more direct contact to receive information.

### **Information gaps relates to treatment, testing and mental health support**

Despite the abundance of information, there are some important gaps related to patient care, knowledge of COVID-19 treatments, vaccines and testing. Also, the responses show a lack of information on mental

health. Indigenous peoples report having received less information overall, especially on prevention measures, isolation measures and risks and complications if getting sick



Left: **Bolivia** A Bolivian Red Cross volunteer conducting a perception survey with a community member on the impacts of COVID-19. © Bolivian Red Cross  
Middle: **Brazil** Brazilian Red Cross volunteers in Amazonas state are doing everything they can to support people. © Brazilian Red Cross

## Health professionals, health authorities and Red Cross mentioned among the preferred sources of information

Health information is generally acquired through traditional media (TV, Radio), social media and in communication with family and friends. However, the most trusted sources are health professionals, ministries of health, Red Cross volunteers and UN agencies. The responses also show an importance to understand who the members in a particular community trust the most.

Public health messages on mass media may work to get the information through to a wide audience but may not be the most trusted and effective means to be heard and considered for action for the elderly.

## 2. Covid-19 vaccine awareness and perceptions

### High level of acceptance across countries

The participants in all countries express a general willingness to take the COVID-19 vaccine. Only two out

of ten of the people asked would refuse to take it, except in Jamaica where the number reaches five out of ten.

### Migrants and indigenous populations report higher constraints in accessing vaccination services.

Most of the participants know where to get vaccinated against COVID-19 and describe the service as easily accessible. However, 25 per cent say that the distance, long waiting lines, inconvenient opening times, and inadequate services, make the access “not easy at

all”. Importantly, half of the migrants and indigenous populations report high constraints. Participants in Colombia report having made the journey to the vaccination sites, only to be turned away without being vaccinated.



Right: **Jamaica** A Jamaican Red Cross volunteer conducts a survey with a Maroon community member about the socio-economic impact of COVID-19  
© Chrysanthis Dixon / Jamaica Red Cross

## Indigenous participants report greater issues with the distance and opening times

Although respondents from indigenous communities' express willingness to get the vaccine, at the time of the survey no one from these communities had been

vaccinated. Compared to the other participants, people from the indigenous communities say that they have greater problems with both distance and opening times.

## 3. Trust in covid-19 vaccines

### Trust in health care providers is generally high

The participants generally express trust in health care providers in charge of the COVID-19 vaccine as well as in the vaccine itself. It is still important to consider that large differences persist between countries. The level of trust respondents expressed in the vaccine appear to be related to the level of trust they rated health care

providers. **Migrants express fear of side effects and concerns over safety.**

The interviewed migrants are generally more reluctant to take the COVID-19 vaccine. They express fear of side effects and concerns over safety.

### Trust and willingness to take the vaccine not necessarily related

It is interesting to note that though 80 per cent of the participants in the survey say that they would agree or have agreed to take the COVID-19 vaccine, their trust in the vaccine differs with only 24 per cent of respondents having high trust in the vaccine and 64 per cent having little to moderate trust. This indicates that willingness to take

the vaccine is not necessarily related to trust but is rather connected to the situation and needs of the individual (i.e if vaccination is required in relation to work permits or fear of side effects during the journey to another country if they have decided to remain unvaccinated).

## 4. SOCIO-ECONOMIC IMPACT OF COVID-19

### Health and socio-economic impact are the main worries in communities

Seventy-seven per cent of the interviewed persons express worries over the health impacts of the virus, but also over the very acute social and economic impact that the restrictions have brought to their communities. Pregnant and lactating women have expressed the highest concern in general. The participants share

that their main health-related fears are the loss of loved ones and getting the infection. They also share important concerns around the social aspects brought by the restrictions, for example isolation and closure of schools. Indigenous groups are particularly troubled by social isolation and not being able to pay their dept.

### The pandemic widely affected economies and housing conditions, with the bigger toll on the most vulnerable.

Up to 74 per cent of the participants say that they have a changed economic situation as a direct result of the COVID-19 restrictions. Reduced income and the loss of jobs in combination with increased living costs are illustrations of this. In Colombia, almost half of the migrants coming from Venezuela who participated in the study say that it's impossible to get hold of essential products, such as food and medicine and that they are

unable to pay rent. Some migrant respondents report that they have been exposed to evictions. They also say that it sometimes is impossible to get heath care. Indigenous respondents suffer severe socio-economic impacts. Eighty seven percent report a reduced income, increased living costs and the inability to get basic healthcare.

### Rising trust in humanitarian actors, in a context of distrust in decision makers.

Before the pandemic the populations in the region already reported a rather low trust in the intentions of decision makers 'to do what is right'. During the pandemic, this trust has decreased to a third. On the other end, the levels of trust in humanitarian actors have risen. Indeed, humanitarian actors emerge as the second most trusted group 'to do what is right' after scientists. More than half of respondents don't trust decision makers and 77 percent trust humanitarian actors. This makes humanitarian actors well placed to take an active role in engaging and acting within communities.

Based on the discussions with the vulnerable populations in Latin America, the IFRC gathered the following hands-on recommendations

1. Trust should not be taken for granted.
2. Address information gaps.
3. Use appropriate information channels.
4. Provide psychosocial support services and grief support when necessary.
5. Coordinate with partners to advocate for vaccine equity.

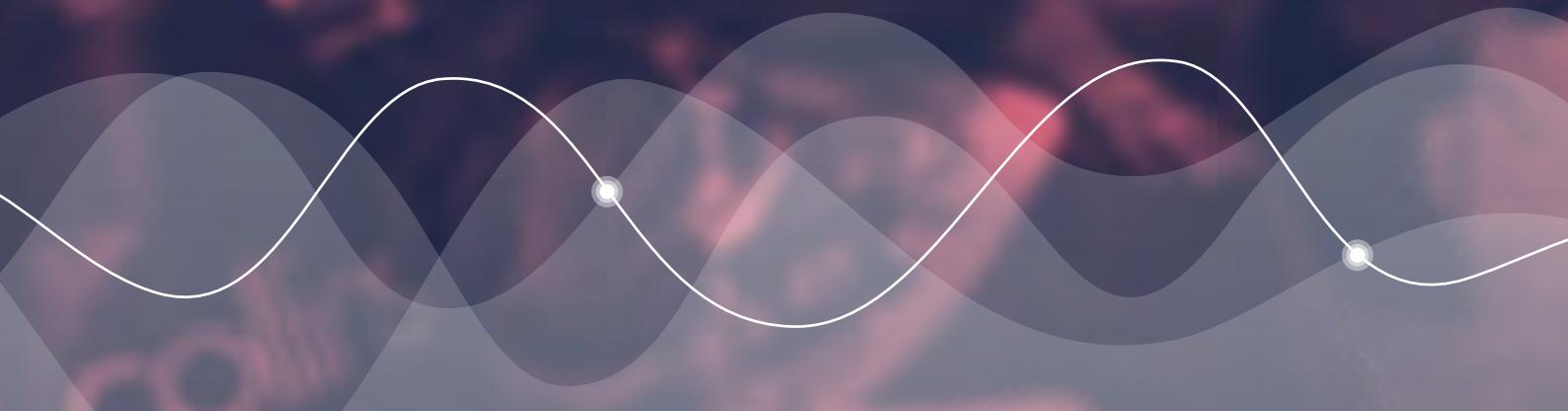
6. Highlight the benefits of the vaccine and address misinformation.
7. Efforts need to be put in maintaining or improving the way communities are approached.
8. Prioritize communication with pregnant and lactating women.
9. Assist households economically affected by the COVID-19 pandemic.
10. Identify the priority needs of vulnerable households.
11. Create local partnerships to support people's economic recovery with a development perspective



Nicaragua Red Cross volunteers support the elderly to be well informed and to dispel doubts around COVID-19 vaccines. They also assist with access to vaccination centers.

© Nicaragua Red Cross

# METHODOLOGY



**Survey sample.** In total, 7743 individuals were interviewed across nine countries. Thirty six percent were male and 61% female, 44% were displaced and 44% were residents. Most interviewees were between 18 and 29 years (30%), 30 and 39 (27%), 40 and 49 (20%), 50 and 59 (12%). Interviewees between 16 and 17 years and between 70 and 79 only represented 4% of the sample while participants over 80 years old represented less than 0,5%. Indigenous people were interviewed in Colombia, Guatemala and Panama and represented nearly 12% of the total survey sample.

**Limitations.** Several limitations must be taken into consideration when reading the findings presented in this report.

All nine countries assessed used a different sample size, Nicaragua having the smallest sample (117) while Colombia reached 2077 interviewees. This had an impact on the comparisons drawn between countries as the smallest samples offer limited representativity.

Similarly, the number of participants per age group varied considerably, thus impacting the comparability.

For instance, only 34 persons over 80 years (0,4% of total participants) and only 123 persons between 16 and 17 years (1,6%) were interviewed. A similar issue can be noted regarding the 153 pregnant and lactating women included in the total sample (2%).

The samples used at the country level did not necessarily cover migrants, refugees, and asylum seekers. For example, the survey in Bolivia included almost exclusively participants from the host community with less than two percent migrant interviewees. Similarly in Brazil, Guatemala and Jamaica, very few migrants were assessed (11% in Brazil and less than 3% in Guatemala and Jamaica). Indigenous people were only covered in the studies done in Colombia, Guatemala, and Panama. The findings for this particular group should therefore only be applicable for these three countries.

As a result of these limitations, comparisons between countries, population groups, age intervals or socio-economic profiles are indicative only and should not be generalized for the entire population in the surveyed countries.



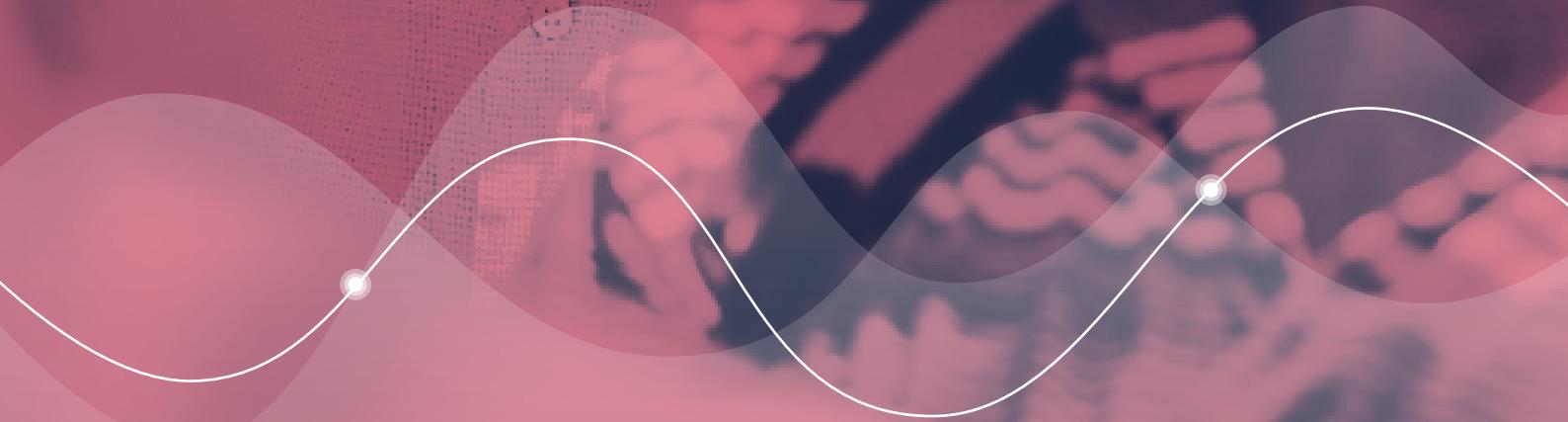
<b>Country</b>	<b>Sample</b>	<b>Date of data collection</b>	<b>Target population</b>	<b>Geographical areas</b>
<b>Argentina</b>	<b>1039</b>	15 June–12 July 2021	Migrants from all groups of age over 18, both males and females. 82% migrants (64% from Venezuela, 7% from Bolivia, 7% from Paraguay, 7% from Peru, 4% from Colombia, 4% from Chile); 5% IDPs; 4% residents; 9% no answer	All provinces across the country were sampled, with more than half of respondents residing in the two largest cities, Buenos Aires (33%) and Córdoba (23%).
<b>Bolivia</b>	<b>1704</b>	23–29 August 2021	People between 18 to 40 years of age 98% residents; 2% displaced (1% from Peru)	Urban areas in 9 departments of La Paz, Santa Cruz, Potosí, Cochabamba, Tarija, Chuquisaca, Oruro, Beni and Pando
<b>Brazil</b>	<b>625</b>	22–23 July 2021	Elderly people, migrants, and people with low income, from all groups of age over 16. 89% residents; 11% displaced (5% from Haiti, 1% from Venezuela, 1% from Bolivia)	States of Rio de Janeiro, São Paulo, and Paraná, covering the South-East and South regions of the country
<b>Colombia</b>	<b>2077</b>	22 June–3 July 2021	People over 18 years old. Most interviewees are originally from Venezuela (71%). 66% migrants; 20% residents; 7% IDPs; 7% no answer 72% from Venezuela, 2% from Ecuador	Most interviewees are living in Arauca state.
<b>Guatemala</b>	<b>391</b>	1–27 September 2021	47% migrants, 38% IDPs; 1% residents; 4% other; 10% no answer 81% maya, 18% mestizo	Survey was conducted in the departments of Guatemala, Escuintla, Santa Rosa, Solola, Quetzaltenango, Suchitepéquez, Retalhuleu, San Marcos, Huehuetenango, Quiché, Baja Verapaz, Alta Verapaz, Petén, Izabal and Chiquimula.
<b>Jamaica</b>	<b>259</b>	27 July–6 August 2021	85% residents; 2% displaced; 10% no answer; 2% other	Community of Charles Town (Maroons settlement).
<b>Nicaragua</b>	<b>117</b>	29 July–11 August 2021	Beneficiaries from the Managua Psychosocial Support Centre of the Nicaraguan Red Cross. 96% residents; 4% displaced	All assessed populations come from Managua, Masaya, Estelí and Matagalpa, León and Granada departments.
<b>Panama</b>	<b>929</b>	10 September–7 October 2021	Indigenous community leaders. 44% residents; 43% displaced; 13% no answer	The survey was conducted among indigenous communities of Embera Comarca and inhabitants from the cities of Chitré and Arraijan.
<b>Trinidad and Tobago</b>	<b>602</b>	14 July–30 September 2021	Citizens of Trinidad and Tobago (69%) and migrants from Venezuela (29%). 69% residents; 29% displaced (27% from Venezuela); 2% no answer	Respondents lived across the country: Icacos, Port of Spain, Tobago

*“The reality is that most of the migrants I know  
that have taken the vaccine did it not by choice but  
because of work. Right now, they are closing the doors  
to persons that don’t have the vaccination card.  
There are many questions around the secondary  
effects but some of us have no choice.”*

*— Interview with a male migrant in Trinidad and Tobago*



# MAIN FINDINGS



The findings presented in this section are derived from the systematic comparison of results between countries, age groups, education level, gender and displacement status. Significant differences are reported below as well as the absence of differences when relevant.

## ACCESS TO AND IMPACT OF HEALTH INFORMATION

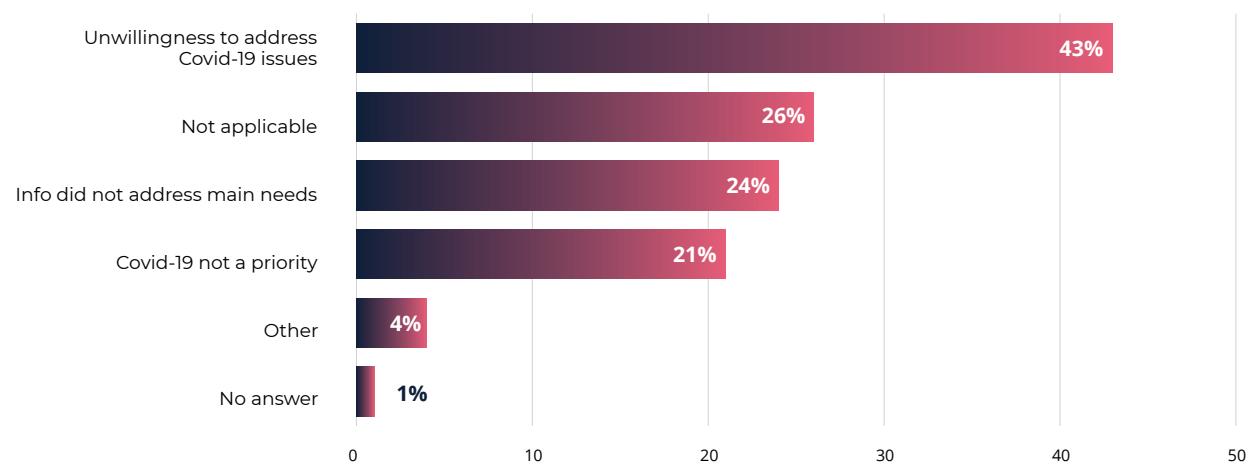
**Nearly all the surveyed populations received information about COVID-19 and believe it was applicable to their context.**

Ninety one percent of the assessed population reported receiving information with no major discrepancies between men and women nor between residents and migrants. The largest number of people who reported not receiving information on COVID-19 were under 18 (16–17) and over 60 years. Moreover, the percentage of people receiving information on COVID-19 decreased as the age rose over 60: 88% of participants from 60 to 69 years; 86% of participants from 70 to 79 years; 79% of participants over 80 years. Similarly, 20% of the participants over 80 years reported receiving inapplicable information while only 10% of other age groups reported this. Participants with no educational background or with only primary education had slightly less access to information about COVID-19 (10% under the regional average) compared to respondents with university background.

**The majority of respondents reported that the received information was relevant to their context.**

Ninety one percent of respondents reported that the information received was relevant to their context, with no major discrepancies between groups. Three main reasons were mentioned to explain irrelevance: the lack of willingness at the community level to address COVID-19 related issues (43%); the perception that the information received by sources did not address the main needs of the interviewees (24%) and the belief that the pandemic was not a priority (21%). Indigenous respondents showed very different results from the other participants as 60% of them reported that there was an unwillingness to address COVID-19 issues (against 43% of other respondents) while only 10% of them believed that COVID-19 was not a priority (against 21% of non-indigenous respondents) and none of them reported that the information did not address their main needs.

**Figure 1.** Why was the information you received not applicable or realistic in your context?



Participants with a university background had a higher belief that the information received on COVID-19 did not address the main needs (31% of them against 42% of participants with lower education levels). Likewise for residents compared to migrants (31% against 14%).

The unwillingness at the community level to abide COVID-19 related measures has been more frequently reported in Colombia (93%) but much less in Brazil (35%), Argentina (26%) and Jamaica (7%). The lack of appropriateness of the information to the people's main needs was more frequently reported in Trinidad and Tobago (42%), Nicaragua (33%), Bolivia (30%) and Argentina (28%). Last but not least, the perception that the COVID-19 was not a priority was most frequently reported in Nicaragua (56%), Jamaica (33%), Brazil (25%), Argentina (24%) and Bolivia (24%). In the Red Cross Red Crescent (RCRC) report on COVID-19 response for migrants in Colombia, the authors highlighted that even though most information received by migrants was seen as useful, the information providers frequently lacked a sociocultural adapted communication (IFRC 2021).

Ninety seven percent of respondents in Colombia reported receiving applicable information. Guatemala had the lowest scores – even though relatively high – with 86% of the assessed population reported having received information and 72% of them reported that the information was applicable to their context. The results generally demonstrate effective and successful communication campaigns in countries, with a need to develop further or strengthen existing communication strategies for specific population segments, particularly under for persons under 18-years and over 60 years

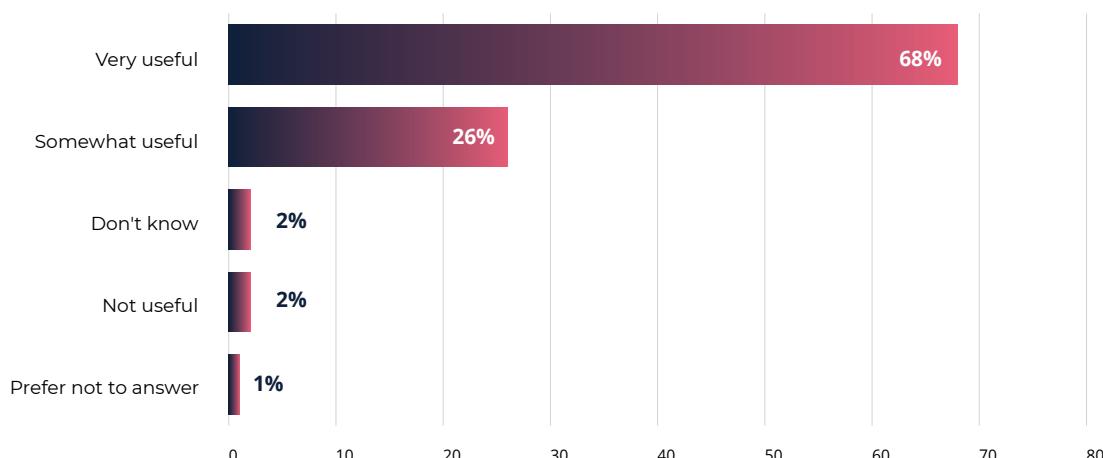
### **The information received about COVID-19 was mostly described as useful or very useful.**

Overall, 94% of the respondents found the information useful and among these, 68% found it very useful. There were no major discrepancies between men and women on that matter (less than two per cent difference) nor according to education level or residency status. However, results differed by age groups, notably between participants aged 16 or 17, over 80 years and the rest of the participants. Indeed, 84% of under 18 year old respondents reported the information received as very useful compared to 57% only of over 80 year old respondents.

Nicaragua and Brazil were the two countries where the highest proportion of respondents reported that the received information was very useful (respectively 89% and 87% of the assessed population). Other countries had similar satisfaction rates, except in Argentina and Guatemala where only 55% and 60% of respondents found the information very useful.

The few participants who reported that the information received was not useful (2%) mentioned four main rationale: the information was not based on facts (18%); the information was not applicable given their economic situation (10%); the information did not help them understand how to stay safe from COVID-19 and how to protect others (8%), and the information was not shared in a language they could understand (5%).

**Figure 2.** How useful was the information you received about COVID-19?





**Panama** While conducting the perception surveys, volunteers from the Panamanian Red Cross provided information on the importance of the correct use of masks and the COVID-19 vaccination. © Panama Red Cross

**Most of the information received by respondents included details on the virus symptoms and transmission routes as well as the governmental response. However, very few respondents reported having received information on patient care, highlighting a potential awareness gap. Information on testing was also lacking except in Brazil, Trinidad and Tobago and Jamaica.**

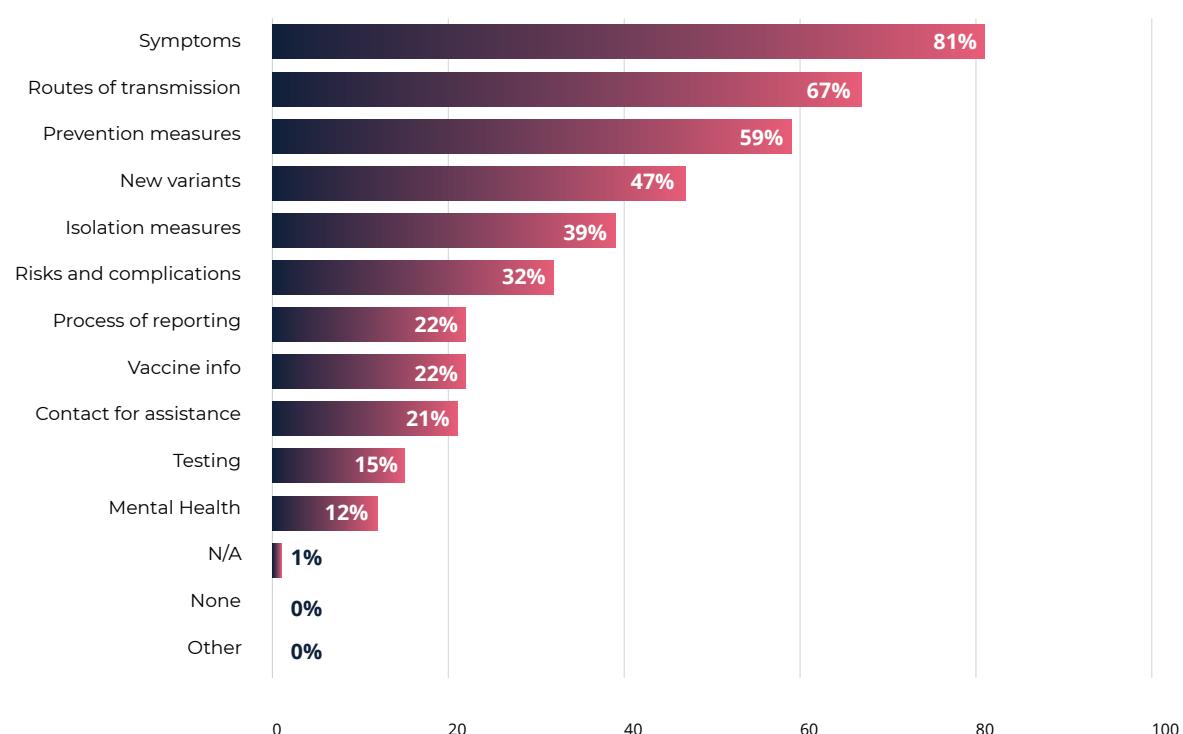
According to the survey, the COVID-19 related information that was received by the participants included mostly indications on COVID-19 symptoms (81%); transmission routes (67%); prevention measures recommended by governments (hand hygiene, use of masks, social distancing etc.) (59%); the new variants (47%) and isolation measures (39%). Mental health, however, was mentioned by only 12% of respondents while a 2020 WHO survey indicated that the pandemic had increased the demand for mental health support ([WHO 2020](#)). While the risks and complications from COVID-19 only appeared as the sixth most received information (mentioned by 32% of respondents), it was listed as one of the main types of information by interviewees in Trinidad and Tobago (81%), in Bolivia (45%), in Panama (43%) and in Brazil (41%). In the latter country, information on testing was said to be received by 40% of respondents. Testing was also heavily mentioned by interviewees in Trinidad and Tobago (66%) and in Jamaica (37%) while in all the other countries, this information type was cited by less than ten percent of interviewees. In Nicaragua, vaccine related information (types of vaccines, modality, safety,

eligibility criteria, registration, etc.) was reported as one of the main types of information received through different channels (38%) while it was only reported by 21% of respondents at the regional level. In Colombia, 1% of the respondents declared having received no information, most of the participants who responded this way were migrants. No major discrepancies in the results were revealed across gender, education level, residency status or age groups. *However, indigenous participants reported having received less information on prevention measures (41%), isolation measures (24%) and risks and complications (19%) than the rest of the respondents.*

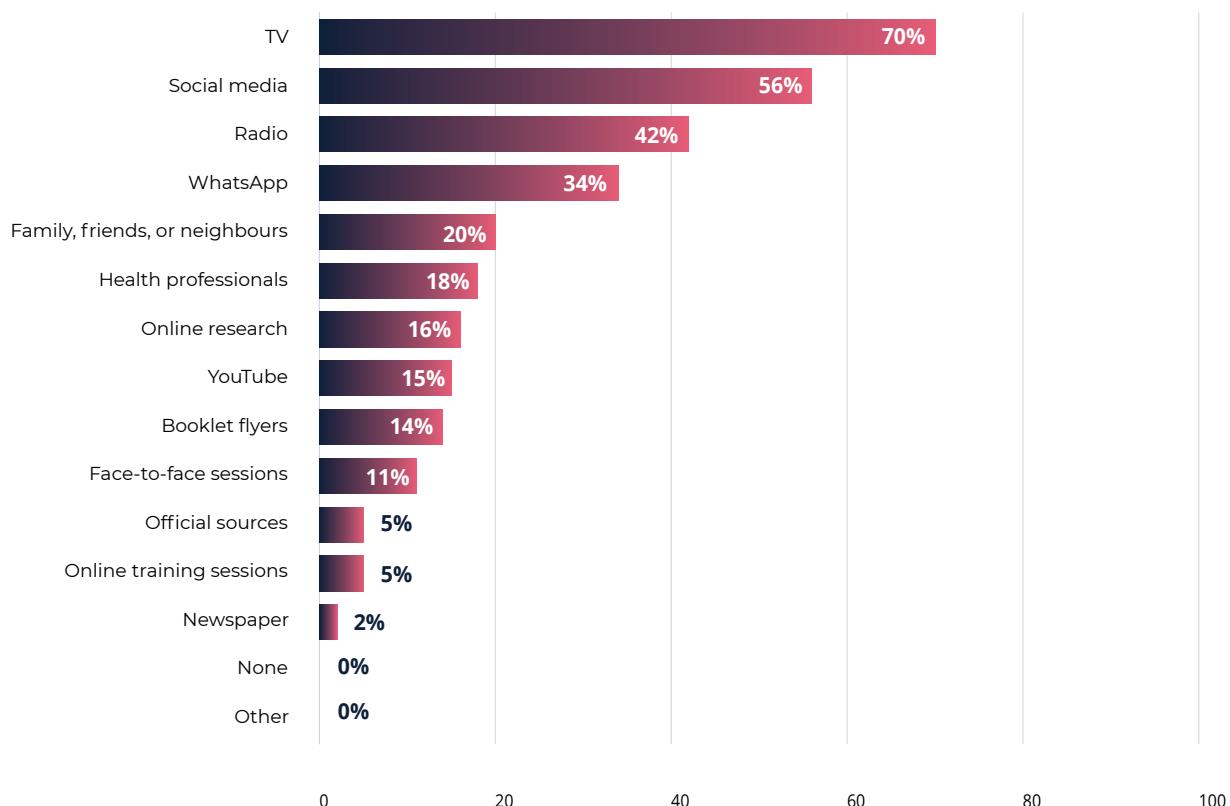
**Respondents reported similar communication means on COVID-19, usually a combination of media and personal contacts.**

Seventy percent of respondents obtained information from television, ( 56%) from social media, (42%) from radio, (34%) from WhatsApp (20%) and from contact with family/friends/ neighbors. Though these channels did not appear in the exact same order for each age group assessed, the five top information sources are similar across all age groups except for the 18–29 year old respondents who more frequently reported using online research (WHO, RCRC, CDC, MoPH, etc.) compared to personal contact with family/friends/neighbors. Social media were less used by participants over 60 years, only 22% of this age group cited this source against about half or more of participants in each of the other age groups. The same outcome could be seen for WhatsApp

**Figure 3.** What kind of information have you received about COVID-19?



**Figure 4.** How do you usually access information about COVID-19?



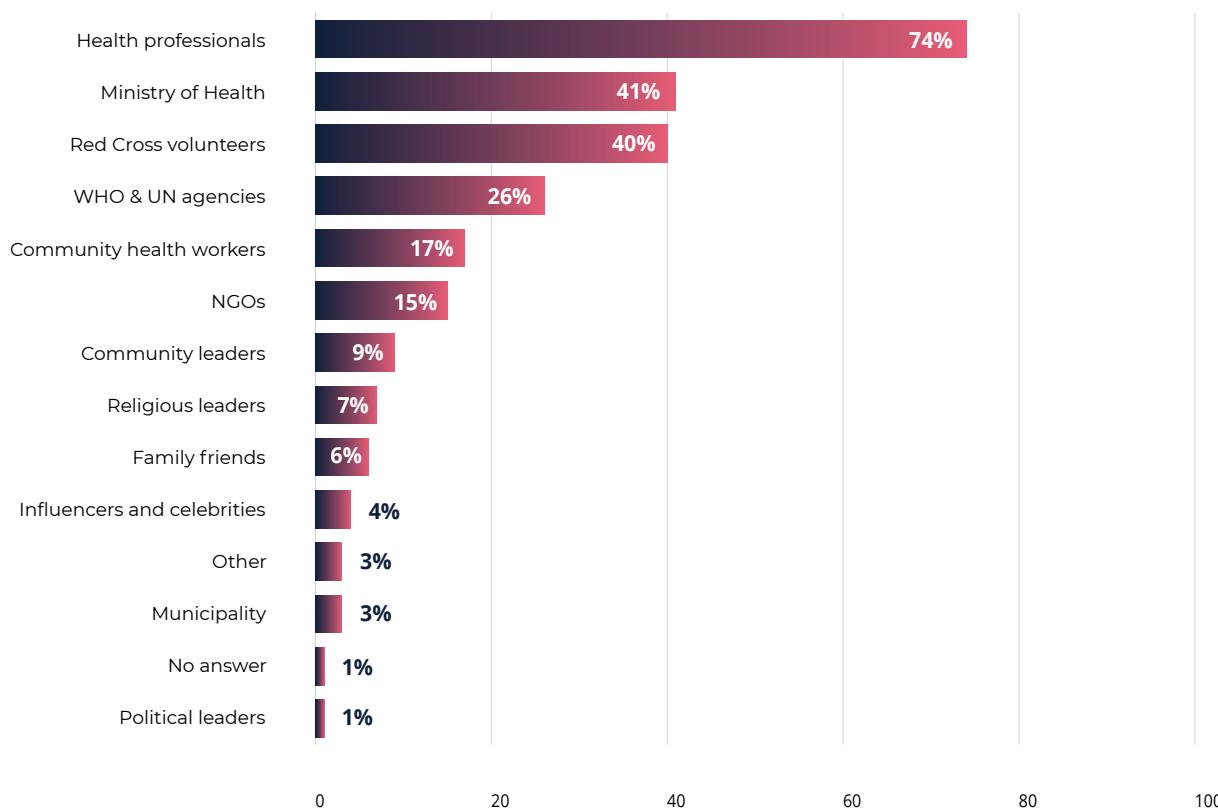
with a much lower score for respondents over 60 (15% against 30 to 40% in other age groups) and for YouTube (5% against 17% to 18% in other age groups). Regarding disaggregation per education level, it appeared that participants with no formal education were less likely than more educated groups to report radio as their main information source (65%) while they represented the education-related group that reported using social media the least (28% against between 42% and 70% in other groups). Indigenous respondents had very similar favorite communication channels with a higher use of the radio (62% against 39% for the other participants) and WhatsApp (42% against 33%), as well as a lower use of online research (6% against 17%).

At the national level, face-to-face awareness sessions were seen as one of the preferred channels (12%) in Jamaica. In Brazil, online research (WHO, RCRC, CDC, MoPH, etc.) also appeared to be highly used to get information (22%). In Nicaragua, personal contact with health professionals (31%) and the use of booklets and flyers (25%) were reported as the third and fourth channels preferred respectively, however, the number of respondents for this question was very limited and this result should be seen as indicative.

Overall, participants relied mostly on information from official authorities and from humanitarian / development actors.

The five most preferred information sources were health professionals (74%), ministries of health (41%), Red Cross volunteers (40%), WHO and UN agencies (26%) and community health workers (17%). There were no major discrepancies in the results between men and women nor between migrants, indigenous people, and residents, however, respondents over 60 years of age were less inclined to rely on WHO and UN agencies as information sources (17% only vs. about 30% for all other age-groups). Likewise, participants with university background were more inclined to use the UN agencies as information sources than other participants (36% against less than 20% of respondents with lower educational background). Religious and community leaders were more frequently reported as information sources by respondents in Jamaica (respectively 19% and 27%), though the survey was only conducted in one community and the results must therefore only be seen as indicative.

**Figure 5.** Who do you refer to the most to get trustworthy or reliable information about COVID-19?





**Guatemala** In San Luis Palo Grande, IFRC's regional Community Engagement and Accountability team and the Guatemalan Red Cross developed a participatory video process.  
© Hermanos Corallo

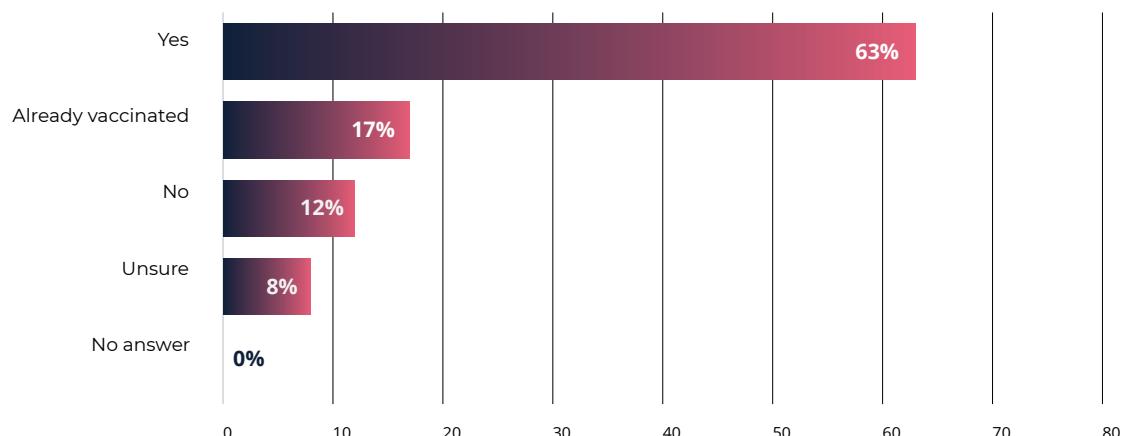
# COVID-19 VACCINE AWARENESS AND PERCEPTION

Only 17% of respondents had been vaccinated at the time this survey was implemented. The highest vaccination rates were found in Bolivia, Brazil and Trinidad and Tobago. The general acceptance of the COVID-19 vaccine was relatively high with only two people out of ten who would refuse vaccination.

Sixty three percent of the assessed population would agree to get the COVID-19 vaccine if it was available and recommended. Only 12% would not take the vaccine and 8% were unsure of what they would do. There were no major discrepancies between men and women, between migrants and residents nor between age groups or based on education level. **However, a notable difference could be drawn between indigenous people (from Colombia, Guatemala and Panama) and the other participants. Results showed that no interviewees from the indigenous groups had received the vaccine against COVID-19 yet, unlike 19% of the other participants. The Guatemalan Red Cross underlines the historical lack of access to health services for indigenous populations and migrants, which could partly explain this response gap.** Though indigenous respondents were slightly more prone to vaccination with 75% of them being in favor of getting the vaccine.

At the country level, Nicaragua, Panama, Colombia, and Argentina showed high levels of vaccine acceptance with over 70% of respondents willing to be vaccinated. Bolivia, Brazil and Trinidad and Tobago also showed very high acceptance levels with over 80% of respondents willing to be vaccinated or having received the vaccine already at the time of the study, with respectively 41%, 35% and 58% of the respondents already having been vaccinated against COVID-19. This high rate in Trinidad and Tobago can be explained by the inclusion of refugees and migrants in the vaccination plan, done mainly through drive-through vaccination sites and without the need for an appointment ([UNHCR 2021](#)).

**Figure 6.** If a COVID-19 vaccine were available and recommended to you, would you get it?



Bolivia, Brazil, and Nicaragua showed a very high level of acceptance of the vaccine with over 85% of the population of each country believing their acquaintances would get the vaccine. On the other hand, 41% of respondents in Jamaica believed their acquaintances would not take the vaccine.

While 80% of the respondents had already gotten or would surely agree to get the COVID-19 vaccine, 76% believed that their acquaintances would get it too. However, 12% did not think so. There was no major discrepancies between men and women, migrants and residents nor between age groups or based on education level.

82% of the respondents knew where to get vaccinated while 18% did not have this information. There were no major discrepancies between men and women, migrants, and residents nor between age groups and education levels.

Several countries showed impressive results in this regard. Bolivia, Guatemala, Panama, Trinidad and Tobago, Nicaragua and Brazil all reached scores higher than 90% with regard to respondents knowing where to get vaccinated for COVID-19. Argentina had a very low score in comparison with only 64% of the participants having this information.

**"You have to make an appointment online and then go by taxi or bus. It is a difficult process because there is no translator, most speak English... It is difficult because there is no transportation."**

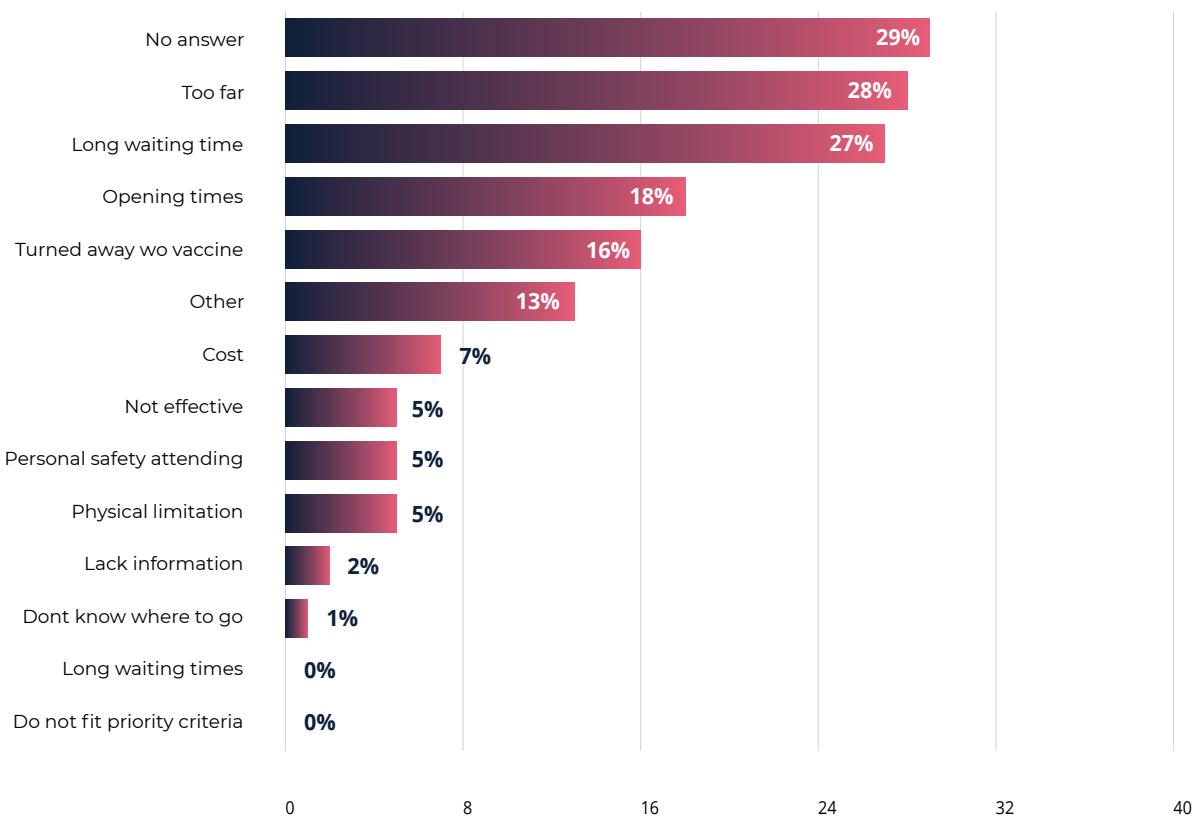
— Interview with a female migrant in Trinidad and Tobago

Overall, 61% of all the **respondents had received a vaccine (other than COVID-19) during adulthood** while 33% had not. There were no major discrepancies across gender, residency status or education level, however, participants over 60 years were more likely to report having received vaccines (over 70%) as well as pregnant/lactating women (81%). High differences existed between countries with examples such as Brazil and Panama showing high percentages of vaccinated adults (both 87%) while Jamaica, Colombia, Guatemala and Argentina reported lower figures (respectively 26%, 48% and 51%).

**Most of the respondents knew where to get vaccinated against COVID-19 and described the service as easily accessible. However, migrants and indigenous populations reported higher constraints in accessing vaccination services.**

At the regional level, 73% of interviewees believed that it is easy to access vaccination services, including 33% who perceived vaccination services as very easy to get to and 19% moderately easy. On the other hand, 25% of the participants reported the access as not easy at all, due to the distance (28%), to long waiting lines (27%), to inconvenient opening times (18%) and, finally, to inadequate services (being turned away without vaccination, 16%). Moreover, half of the migrants faced difficulties in accessing vaccination services. In Colombia, for example, *more than half of migrants, refugees and asylum seekers surveyed in this study, especially the youngest ones, expressed that vaccination centers were too far. Another common barrier reported among migrants in Colombia was that they were "sent back home without vaccines" which could be linked to how migrants perceived the treatment received at the vaccination centers.*

**Figure 7.** What makes it hard for you to get a vaccine?



There were no major discrepancies between men and women. The same barriers to vaccination appeared across age groups, with the exception of respondents over 80 years who mentioned physical limitations as the main barrier. Participants over 60 were less inclined to suffer from long waiting lines and opening times compared to other age groups but mentioned physical limitations (14%) more frequently. Participants with university background seemed to suffer less from distance to health services than respondents from groups with lower education level (17% against 41% of participants with primary education, 27% with secondary education and 38% without formal education). ***Indigenous participants reported greater issues with the distance (42%) than the other participants (33%), as well as with opening times (26% against 17%).*** Being turned away without vaccination was another main barrier reported by this group (23% against 15% for the other participants).

At the country level, most respondents in Brazil (88%) and Panama (69%) perceived access to vaccination services to be very easy. On the contrary, 54% of respondents in Colombia - mostly migrants (reported by 63% of migrants against 29% residents)- perceived access as not easy at all, mainly due to distance and long waiting lines. Even though access to healthcare was legally required to be given to migrants in case of emergencies, IFRC indicated that long waiting times and other challenges restrict migrant's access in Colombia. Moreover, increased demand has hindered access to already limited health services in border areas (IFRC 2021, R4V 2020). In Jamaica and in Trinidad and Tobago, personal safety was the first and second main barriers mentioned by interviewees. In Argentina, while over half of the participants believed the vaccination services were only a little easy to not at all easy to access, the main barrier mentioned was the lack of effectiveness of services.

# TRUST IN COVID-19 VACCINES

**Respondents generally trusted health care providers in charge of the COVID-19 vaccine as well as the vaccine itself (safety, efficacy, relevance to beliefs). It is still important to consider that large differences persist between countries. For instance, 62 per cent of respondents in Brazil reported high trust in the vaccine compared to 27 per cent in Panama. Trust in healthcare providers and trust in vaccine efficacy were appear to be related. For example, in Brazil, more than 80 per cent of participants with very high trust in vaccines agreed that they also had very high trust in healthcare workers, and at the other end of the scale, in Guatemala, 78 per cent of those with no trust in the vaccine also agreed they held no trust at all in health care.**

The surveyed population reported moderate trust (35%) and very high trust (29%) in healthcare providers in charge of COVID-19 vaccines. Twenty four percent reported little trust and 12%no trust at all. There were no major discrepancies between men and women, migrants, and residents nor between age groups or based on education level. It is however important to consider that large differences persist between countries.

While levels of trust in healthcare provider were fairly low in Jamaica and Panama. Approximately 25% of the surveyed population stated that they had no trust at all in healthcare professionals in charge of vaccination. The opposite was observed in Brazil where 69% of the surveyed population have/would have very high trust in healthcare providers.

Interestingly, while 80% of respondents would agree or had already agreed to take the COVID-19 vaccine, their trust in the vaccine itself differed. **Indeed, only 24% of interviewees had high trust in the vaccine and 34% had moderate trust, 28% had little trust and 14% had no trust at all in the vaccine.** There were no major discrepancies between men and women, however participants between 60 and 79 years were the age group with the highest level of trust in the vaccine (more than 30%). It must be noted that the age groups 70–79 and over 80 also showed a higher distrust in the vaccine (respectively 29% and 35%), showing a high polarization of opinion in this age group. No major differences were found based on the education level of participants nor between

residents and migrants. In Colombia, for instance, where more than half of the surveyed population were migrants from Venezuela, level of confidence in the COVID-19 vaccine was low and fear of vaccines being unsafe was one of the most reported reasons. Based on the national report from this survey, the vaccination rollout process was sometimes associated with the Colombian and Venezuelan governments, which generated mistrust in the interviewees.

Secondary sources indicate that unclear communication can heighten vaccine hesitancy due to an overload of information and a lack of trust in information providers. By March 2021, only one third of the countries in the world had a specific strategy against vaccine hesitancy. Studies also show that migrants can be more reluctant to vaccines. For instance, migrants interviewed by the Turkish Red Crescent Society reported that they are in good health and thus do not need the vaccine. Fear of long-term side effects and concerns about safety can also cause reluctance. In Colombia for instance, vaccine hesitancy among migrants was mainly due to fear of side effects that could reduce the ability to work (IFRC 2021).

Large differences existed in relation to the level of trust in the vaccine between countries. For instance, 62% of respondents in Brazil reported a very high trust in the vaccine compared to 27% in Panama and 38% in Jamaica reported having no trust at all in the vaccine at the time of the survey.



**Peru** Thanks to the support of Red Cross staff members, indigenous communities of Peru receive vaccines administrated by the National Ministry of Health.  
© Sebastián Castañeda / Peruvian Red Cross / Reuters / ICRC

# COVID-19 SOCIOECONOMIC IMPACTS

**The surveyed population expressed high worry regarding the COVID-19 pandemic. Seventy seven percent** of the assessed population reported high concern. There were no major discrepancies between men and women (less than five percentage points). However, pregnant and lactating women seemed to be more concerned with the situation as 86% of them answered positively to the question "Is there anything that worries you in relation to the coronavirus?". Small differences were found in respondents between 40 and 70 years who had the highest concern level about COVID-19 (over 78%), and for respondents over 70 years old who had the lowest concern level (70% and under). Interestingly, residents were more prone to express concern than migrants (80% against 73%). No significant differences were found based on the education level of participants.

Nicaragua hosted the population with the most worries over COVID-19 according to this study, with 93% of the interviewees feeling concerned. However, populations in Argentina and Jamaica appeared to be slightly less worried with 59% and 52% respectively of the assessed population who reported feeling concerned.

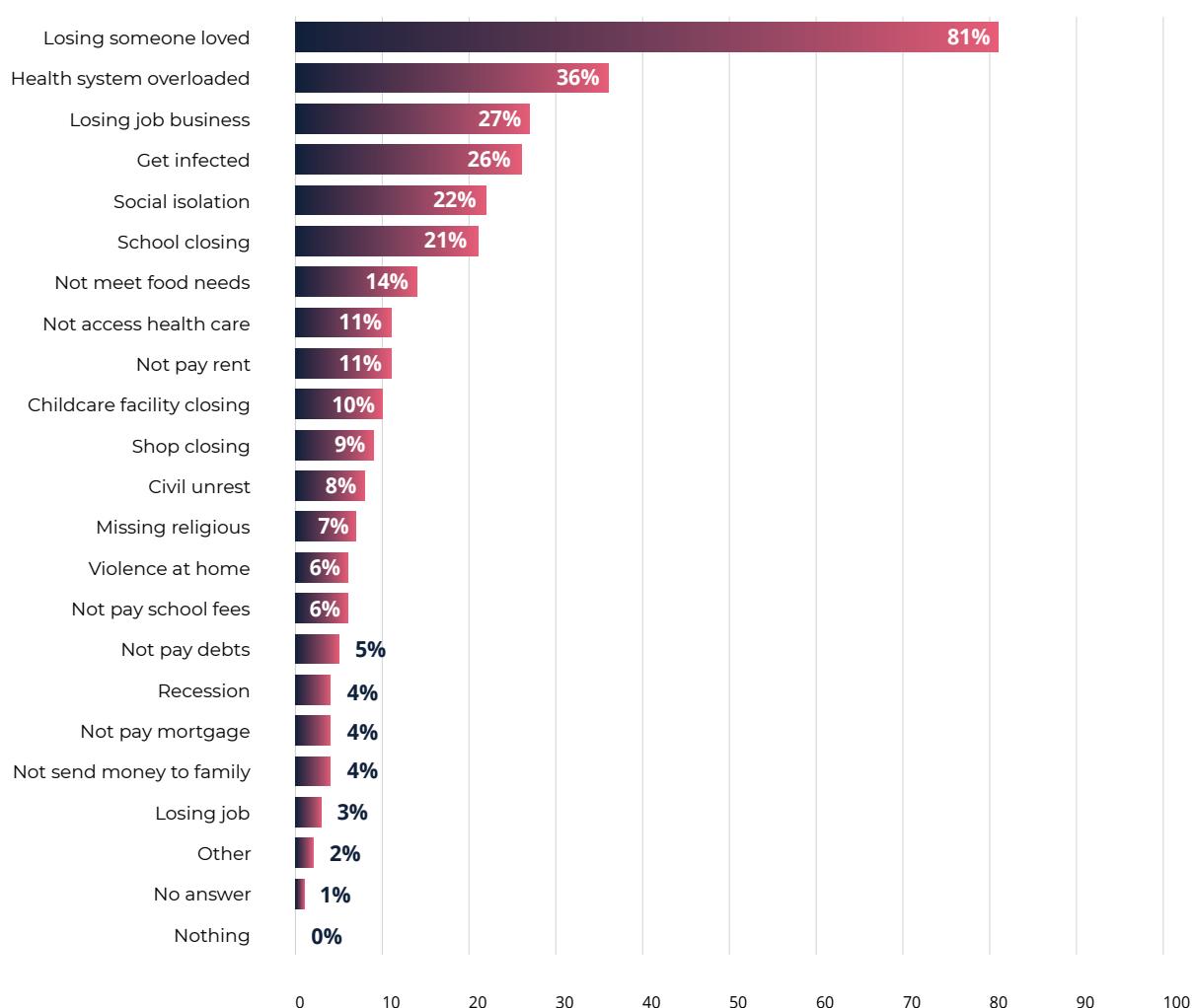
The main worries reported by the populations are the fear of losing someone beloved (81%); of seeing the health system overloaded (36%); of losing one's job or business (27%); of being socially isolated (22%) and of seeing schools being closed (21%).

There were no major discrepancies between men and women nor between migrants and residents or between age groups, even though the position of the main concerns may vary slightly between groups. No differences were found based on the participants' education level. **A significant difference can however be noted as indigenous participants expressed higher concern regarding social isolation (32%) than the other participants (20%). The inability to pay debts was another important concern for this group (17%) while it was barely expressed by the rest of the interviewees (3%).** The three least reported worries were to not be able to send money to one's family in the country of origin; not being able to pay one's mortgage and recession (e.g., business closing).

**Panama** Migrants from Haiti staying at Lajas Blancas Migrant Reception Station participate in a conversation with members of the IFRC and the Panamanian Red Cross to identify principal needs and level of satisfaction with the humanitarian services offered by the International Movement in this region. © Panama Red Cross



**Figure 8.** What worries you most in relation to the coronavirus?



Across countries, results were similar, with the fear of losing a beloved person, seeing the health system overloaded and losing jobs or businesses, as the most reported worries. In Argentina, not being able to pay rent and shop closing came in forth and fifth place (respectively 29% and 26%). In Brazil, schools being closed was also a major worry (33%) as well as not being able to meet food needs (30%). The fear of not accessing health care didn't appear as a critical issue for respondents in Brazil (only 5% mentioned it). On the contrary, it was reported as the third most important worry in Bolivia (22%) and as the fourth in Nicaragua (33%). Not meeting food needs was an important concern in many countries: Nicaragua (44%), Trinidad and Tobago (37%), Brazil (30%) and Argentina (24%).

In Colombia, almost half of the migrants coming from Venezuela that participated in the study reported the impossibility of acquiring first class products needed such as food and medicine, and not having been able

to pay their rent. In some cases, migrants reported that they have been exposed to evictions and to the impossibility of getting health care provision.

**Before the pandemic, the economic situation in the assessed countries was considered generally good by respondents, except in Argentina and Nicaragua. National economies was reported as widely affected by the pandemic, with significant impacts on respondents' livelihoods and housing conditions.**

Overall, 44% of the respondents in the region believed that their economic situation prior to COVID-19 was good, 34% that it was adequate, 11% that it was excellent and 8 per cent that it was poor. There were no major discrepancies between men and women, residents, and migrants, between age groups nor based on education level.

***"Last year I had covid and for this reason I lost my job.***

***In the company for which I worked they decided to fire***

***me because I was infected with covid, I fulfilled the***

***isolation for 21 days and even so in the company they***

***fired me for fear of catching it. Losing my job affected my***

***life, since getting a job in these times is very difficult and***

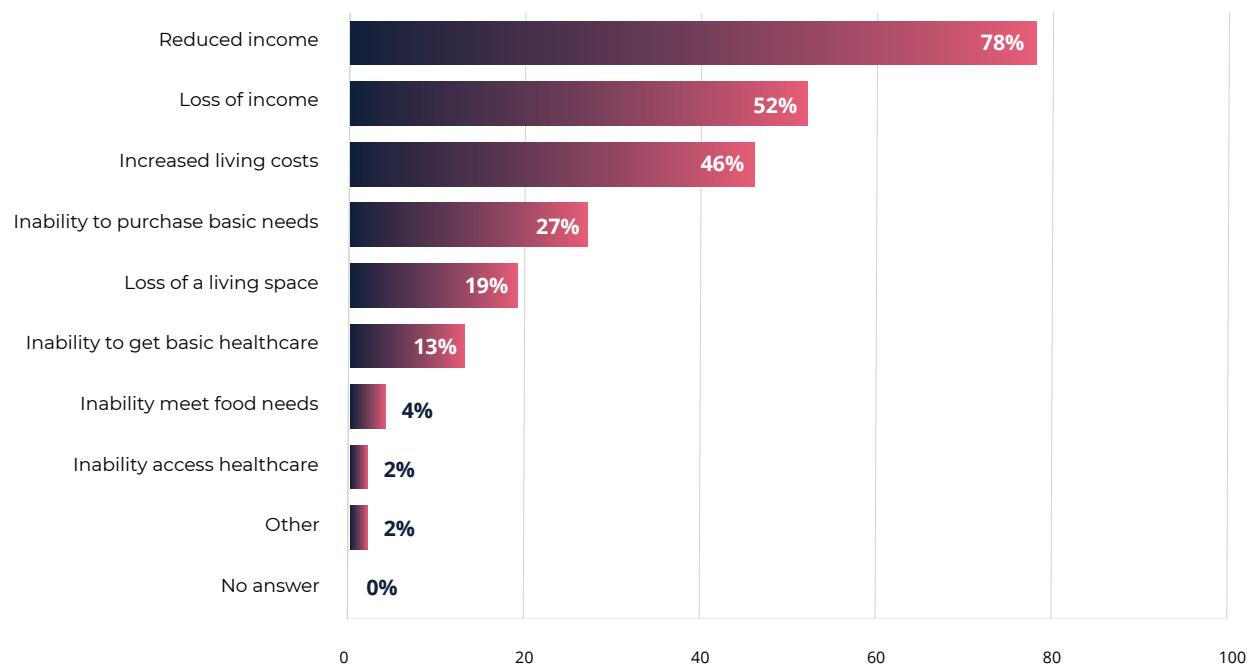
***that was the livelihood in my home. The life of a migrant***

***is not easy and in recent years even less."***

— Interview with a female migrant in Argentina



**Figure 9.** How has COVID-19 has affected your economic situation?



Interviewees in Brazil reported a very positive perception of their economic situation before COVID-19 with 40% of the assessed population perceiving it as excellent, 49% as good and only 3% as poor. In Guatemala, Jamaica, Panama, Trinidad and Tobago, Bolivia and Colombia, most people considered their past economic situation as adequate to good (about 80% in each country). In Argentina and Nicaragua, however, the past economic situation was perceived mostly as adequate by 47% and 56% respectively of the respondents and poor by 26% and 23% of the respondents.

At the regional level, a very large part of the population believed that their economic situation had changed due to the pandemic. Only 19 per cent did not believe their economic situation was altered. Although there were no major discrepancies between men and women, it

appears that interviewees over 70 years were more inclined not to report economic changes (above 30% of respondents for 70–79 age groups and over 80). No differences were found based on the education level of participants nor based on their residency status.

Eighty six percent of respondents in Colombia reported economic changes, making Colombia the country with the highest perception of change among the nine surveyed countries. In contrast, only 59% of respondents in Jamaica and 57% in Argentina reported changes.

Among the socio-economic impacts mentioned by the populations, reduced income (78%), loss of job or household income (52%), increased living costs (46%), inability to purchase basic necessities (food, medicine, etc.) (27%) and loss of housing (19%) were the most

***“In my family we were left without work,***

***as a result of the pandemic, businesses closed.”***

***— Interview with a female resident in Nicaragua***

frequently mentioned changes. The inability to access health care was also one of the main challenges in Nicaragua and in Brazil (37% and 23% respectively). Similarly, the inability to access food necessities was specifically reported in Jamaica (32%) and in Argentina (28%). In its report on the socioeconomic impact of COVID-19, IFRC highlights the fact that globally, '*the most common socioeconomic response activity during the pandemic was around food and in kind assistance*' (IFRC 2021).

Interviewees between 18 and 59 years were more frequently impacted by the loss of income (53%) compared to participants above 60 years (39%). Participants without an education degree or special education reported more frequently difficulties in purchasing basic needs and loss of housing. Residents suffered more from loss of income than migrants (63% against 46%) while 34% of migrants reported loss of housing compared to 11% of residents. Secondary sources however underline the partial or total loss of livelihoods of a large number of migrants on a global scope - especially those working in the informal economy – leading to high levels of stress (R4V 2020).

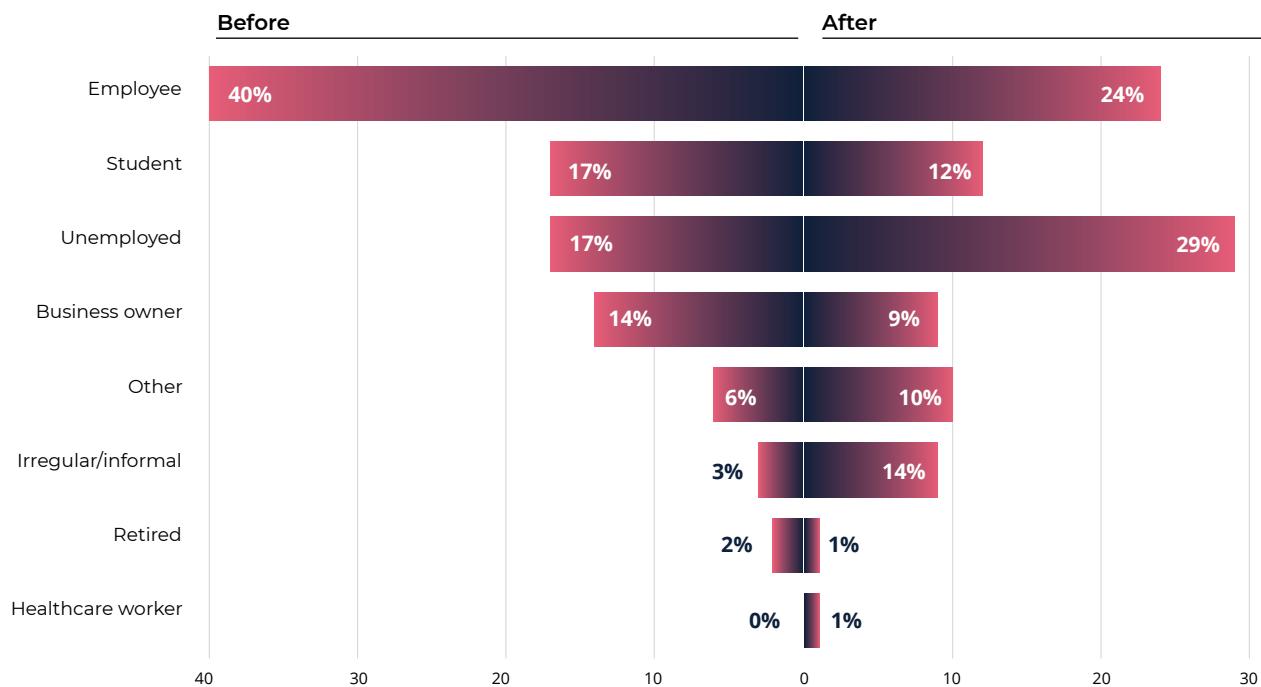
**Indigenous respondents expressed particularly severe socio-economic impacts with 86% of them suffering**

**from reduced income, 61% from a loss of income, 53% from increased living costs and 23% from the inability to get basic healthcare.** . Similarly to the migrants, they also notably suffered from loss of living spaces (33%). The results did not show major discrepancies between men and women in terms of economic impact.

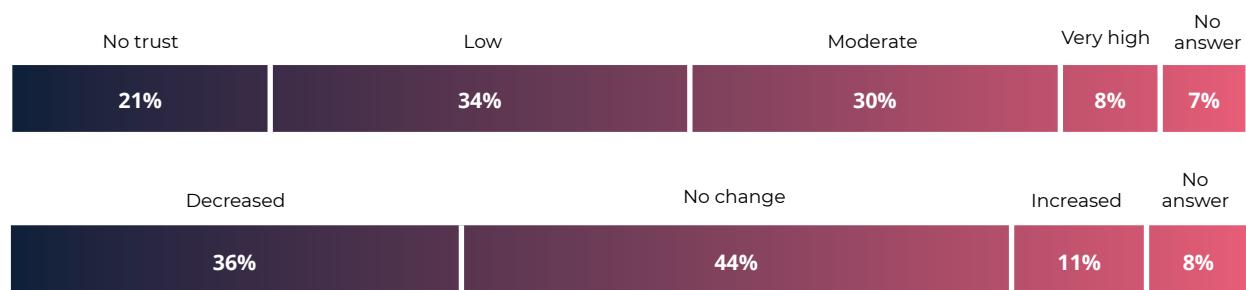
It is interesting to note that in Argentina, while the past economic situation was mainly depicted as adequate and poor, only 57% of the assessed population reported a change since the beginning of the epidemic, which is 17 percentage points lower than at the regional level. According to the people reporting economic changes, the main impacts are reduced income (59%), increased living costs (52%), loss of income (36%) and loss of a living space (19%). Even though no specific differences were noticed between men and women's responses, secondary sources highlight the unequal impact of the pandemic for women who suffer of higher relative job loss at the global level, amongst other effects (IFRC 2021).

The socio-economic impacts of the pandemic were also clearly reflected in the demographic data shared by the participants during the surveys. Indeed, as figures 16 and 17 show, the percentage of employed participants has lowered from 40% to 24% since the pandemic

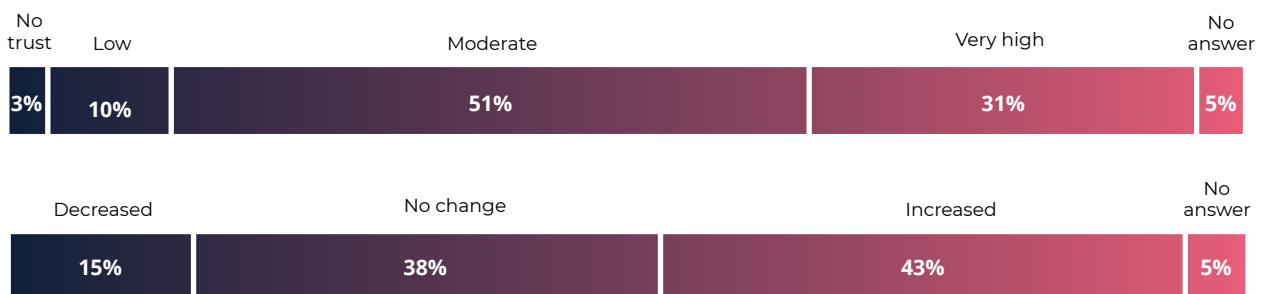
**Figure 10.** Respondents' employment status before the COVID-19 pandemic and in 2021



**Figure 11.** Respondents' level of trust in decision makers before the COVID-19 pandemic and in 2021



**Figure 12.** Respondents' level of trust in humanitarian actors before the COVID-19 pandemic and in 2021



started. These drops affect all countries under study, particularly Nicaragua where unemployment increased from 25% to 62%. Overall, indigenous people seemed to suffer extensively from the loss of jobs with a rise from 14% to 34% of reported unemployment since the pandemic started, as well as a decrease of participants declaring being business owners (12% against 21% before COVID-19). Results also showed an increase of irregular or informal work since the pandemic started, from 2% to 14%.

**Trust levels in decision makers was generally low before the pandemic and has since decreased further for a third of the surveyed population. Government leaders were the least trusted actors 'to do what is right'. On the other hand, the population's levels of trust in humanitarian actors have risen, except in Panama. Humanitarians emerge as the second most trusted actors in terms of doing what is right.**

Before COVID-19 was officially confirmed, the results showed relatively limited trust in decision makers with 34% of the participants expressing low trust, 30%

moderate trust, 21% no trust at all and only 8% a very high trust. These results are supported by Organization for Economic Cooperation and Development (OECD) studies on government trust and reporting that only 51% of the citizens trusted their government in 2020, restricting the potential success of public policies in countries worldwide<sup>3</sup>. The trust in humanitarian actors seemed to be much higher with 51% reporting moderate trust levels, 31% a very high level and only 10% a low level. There were no major discrepancies between men and women nor between age groups. The age groups over 80 years and between 16 and 17 years, reported the highest distrust levels (40% and 28% respectively). Similarly, participants from the age groups over 80 years and of 60–69 years showed the highest trust in humanitarian actors with respectively 57% and 37% of respondents reporting very high trust levels. However, the sample of participants in these age groups (especially 16–17 year olds and over 80 year olds) is small and those results should be seen as indicative only. No major differences were found based on the education level of participants.

3 <https://www.oecd.org/gov/trust-in-government.htm>



**Jamaica** The perception survey in Jamaica was conducted while the people of the community were carrying out their daily activities. The image shows a local Maroon named "Big Chief" having a conversation with a volunteer while working on a truck in his neighborhood. © Chrysanthis Dixon / Jamaica Red Cross

At the country level, respondents in Brazil expressed an important lack of trust in decision makers with 40% having no trust at all and 47% having low to moderate trust. However, their trust in humanitarian actors was high (59%). A particular gap could be noted between the high trust placed in healthcare providers in Brazil and the low trust in decision makers which has also been underlined by the OECD. Indeed, already in 2018, the OECD reported that Brazil was facing a trust crisis due to corruption, institutional imbalances and constitutional deficiencies ([OECD 2018](#)). The trust in the vaccine and the healthcare providers however can be explained by the late implementation of the vaccination while the country's death toll reached the world third rank, leading the Brazilian population to be eager to get vaccinated ([DW 2021, Vaccine 2021](#)). Similarly, in Colombia, trust in decision makers was relatively limited with 42% of respondents considering it low and 23% reporting no trust. The trust in humanitarian actors was higher with 38% of the interviewees having very high trust and 48% moderate trust.

Regarding the level of trust in decision makers, results show that 44% of the assessed population believed it had not changed since the pandemic while a third expressed a decrease in trust (36%). Only 11% reported an increased trust. The trust towards humanitarian actors had increased for 43% of the respondents while 38% reported no change and 15% mentioned a decline. Trust levels increased mostly for migrants (56% of migrants against 34% of residents) though they already had

higher confidence in humanitarians than residents (37% against 21%). These results can be explained by more frequent and personalized contacts between migrants and humanitarian staff. Brazil and Colombia appeared to have had an important rise in trust in humanitarians (56% and 62% respectively). There were no major discrepancies between men and women nor based on education level. Results for indigenous participants were very similar to the overall scores. While the sampling was low and the results only indicative, most 80 year old respondents and above, reported no change in their trust in humanitarian actors (71%). Interviewees between 70 and 79 years also indicated a positive evolution in terms of trust in decision makers with 18% perceiving an increased trust and only 26% a decreased trust (sample being small, results are indicative).

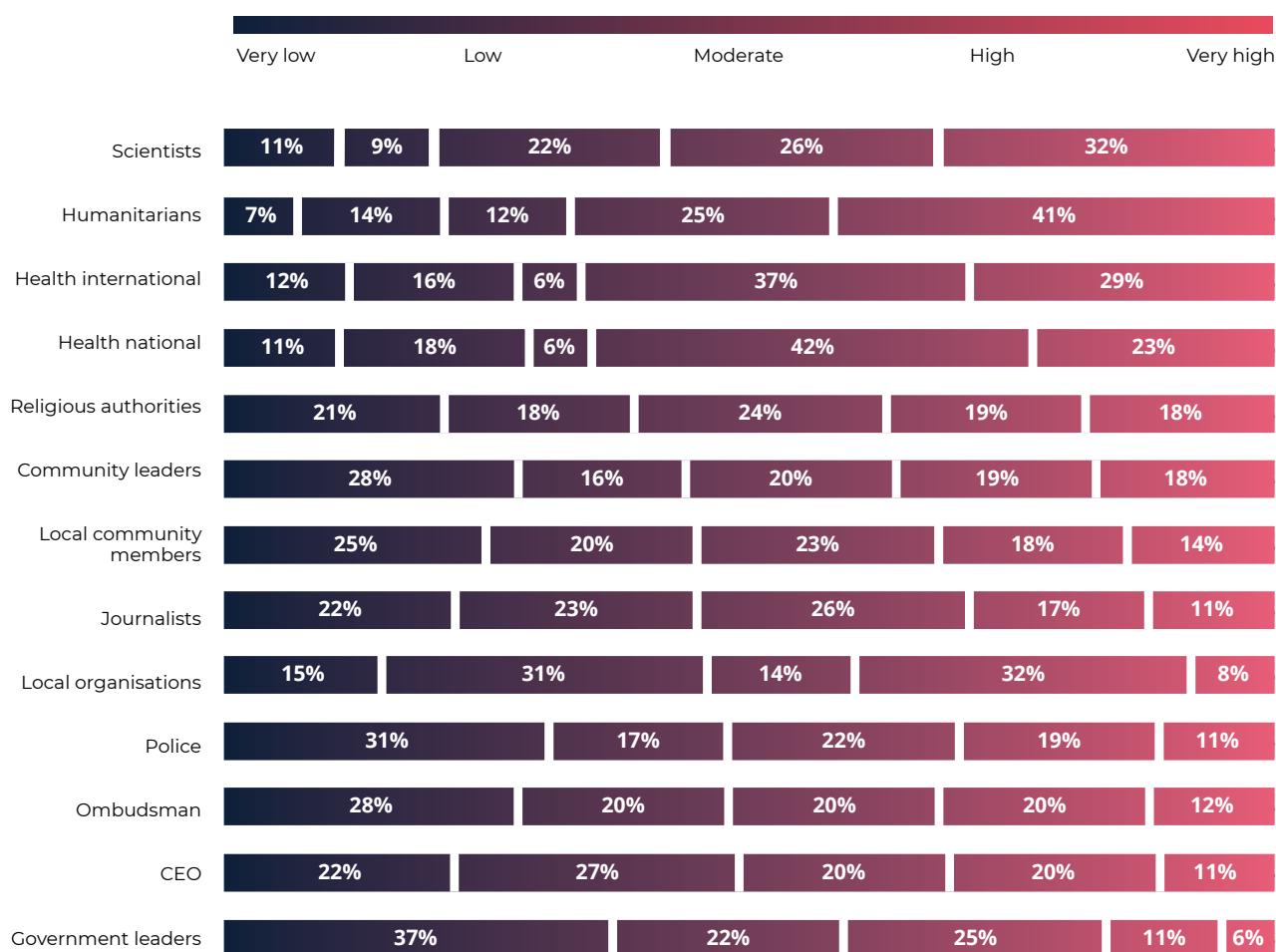
In all the countries assessed, the percentage of people reporting a decrease in their trust in decision makers was higher than the percentage of people who mentioned an increase. Panama, Nicaragua, Bolivia, Argentina, and Jamaica had particularly declining trust levels (over 40 of respondents in each country). While trust in humanitarian actors was generally better, the loss of trust was still higher than the gain in Panama, Nicaragua, and Jamaica. On the other hand, Brazil and Colombia have had an important rise in trust in humanitarians, 56% and 62% respectively.

At the regional level, populations had moderate trust for almost all the categories of actors regarding expectations to do what is right, with a lower score for government leaders (59% of low to very low trust) and higher scores for both scientists (80% of moderate to very high trust) and humanitarians (78% of moderate to very high trust). There were no important discrepancies between men and women except for the level of trust in humanitarians that appeared to be a little higher for women than for men. Regarding age groups, trust in religious leaders and in local community members was higher for participants over 70 years. Furthermore, participants' education levels showed that respondents with tertiary education had a lower trust in humanitarians than respondents with no formal education or only primary education. Migrants declared trusting humanitarian actors more than residents did. On the contrary, the trust in government and in community leaders was slightly higher for residents than for migrants. Regarding indigenous participants, the results showed notably

higher trust than other participants in religious leaders and in local community members. However, they trusted scientists less than the other participants did, with 41% of indigenous participants having stated that they trust them, against 60% of the rest of the interviewees.

There are no major gaps between the countries surveyed. The results show comparable rates and mostly at medium level. However, respondents in Argentina appear to show very low trust in government leaders (8%) but higher trust in local community members (33%) and in scientists (66%). In Brazil, respondents show very high trust in humanitarians (84%) and scientists (71%) and high trust in religious leaders (49%), local community members (60%) and journalists (41%). Similarly, people assessed in Guatemala express relatively high trust in religious leaders (60%), scientists (38%), journalists (36%) and local community members (43%). In Panama, local community members (36%), religious leaders (38%) and scientists (52%) are also perceived as more reliable.

**Figure 13.** Respondents' level of trust in different stakeholders





**Colombia** According to this study, indigenous populations have been severely affected by the socio-economic impacts of the pandemic with many of them suffering from reduced or lost income and the inability to get basic healthcare.  
Courtesy of the Colombian Red Cross

# RECOMMENDATIONS

## Access to health messages and the impact of health messages

1

Leverage frontline health workers and volunteers as key community engagement actors. As the survey results shows humanitarian workers as highly trusted by migrants and indigenous populations, governments, partners and National Red Cross and Red Crescent Societies should accelerate engagement with them and leverage their voice and expertise across communication channels. Provide updated, clear, and comprehensive information on the pandemic evolution in local languages and through culturally appropriate actions.

2

Address information gaps. There is a need to increase information on risks and response to mental health; the importance of testing; vaccination (sites location, side-effects, safety, and registration processes.). Use reassuring and understandable messages in local and native languages and the most trusted actors to engage with communities.

3

Youth and elderly people need tailored engagement strategies. Give transparent, quality information on COVID-19 through internet and social media for 18-29-year-olds, favors direct contact with people above 70 years, particularly through religious and community leaders, which are more trusted by older people.

4

Provide psychosocial support services and grief support when necessary. Such services are also essential in cases where people have lost their livelihoods and have not yet managed to stabilise their economic situation.

## **COVID-19 Vaccines: Overview on vaccine awareness and perceptions of populations**

**5**

Coordinate with partners to advocate for vaccine equity. Engage in dialogue with countries about their national vaccination plans for migrants. Make sure that national vaccination strategies expand to reach remote

areas so that everyone can reach the sites. Help governments with their vaccinations – for example to include drive-through, mobile clinics and other easily accessible settings.

## **Trust in COVID-19 Vaccines**

**6**

Highlight the benefits of the vaccine and address misinformation. Give clear and understandable facts about the benefits of the vaccines and how effective they are against new variants. Include information about side effects and safety.

**7**

Ensure vaccination strategies are community-centred and evidence-driven. Efforts need to be put in maintaining or improving the way communities are approached and engaged. In the specific countries where trust in local authorities is low, ensure to increase community engagement efforts and drive the population towards reliable information and communication from health care providers, humanitarian actors and scientists. Favour direct contact with the trusted actors in countries such as community leaders and religious leaders, etc.



## COVID-19 Socioeconomic Impacts

8

Prioritize communication with pregnant and lactating women. The study shows that they suffer higher anxiety because of the COVID-19 pandemic.

9

Assist households economically affected by the COVID-19 pandemic. Especially indigenous people who have suffered important loss.

10

Identify the priority needs of vulnerable households. Conduct in-depth assessments and identify priority needs of vulnerable households - those unable to purchase necessities such as food and medicine and the ones suffering from the loss of housing and employment.

11

Create local partnerships to support people's economic recovery with a development perspective. Design the rebuilding of livelihoods in a way that support people's economic recovery. A good option is to develop local partnerships with NGOs, the private sector, and governments to approach economic recovery with a developmental vision.



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**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 **14 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.

**For more Community Engagement and Accountability resources:**  
<https://communityengagementhub.org/>