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THE IMPACT OF COMMUNITY ENGAGEMENT ON PUBLIC HEALTH OUTCOMES

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AT A GLANCE

This report presents findings from research on how community engagement and accountability (CEA) strategies enhance health and humanitarian programmes. Conducted by Plan Eval and commissioned by IFRC, the study took place in Georgia, Guatemala, Guinea, Indonesia and Malawi, examining how CEA efforts impacted public health outcomes, particularly during the COVID-19 pandemic and other disease outbreaks such as Ebola and cholera.

Findings demonstrate that CEA significantly reshapes community dynamics, strengthening trust, improving response effectiveness and fostering more resilient health systems. The research identified six key characteristics of effective CEA:

1. **Active community participation:** Engaging communities early and continuously increased trust and improved health behaviours.
2. **Empowerment and ownership:** Community-led decision making led to improved public health outcomes and stronger response efforts.
3. **Inclusion and accessibility:** Addressing linguistic, cultural and geographic barriers ensured broader participation and engagement.
4. **Two-way communication:** Establishing feedback mechanisms reduced misinformation and helped adapt response strategies.
5. **Localization and adaptability:** Tailoring CEA approaches to local contexts enhanced effectiveness and sustainability.
6. **Coordination with local leaders:** Leveraging existing networks strengthened approaches and boosted credibility.

To build on these insights, IFRC should refine its CEA evidence collection processes, systematically integrate community feedback into programme design and implementation, and strengthen monitoring frameworks to measure long-term impact.

2

OBJECTIVES AND METHODOLOGY

The research sought to determine how CEA approaches influenced IFRC programmes and community health systems, particularly during COVID-19. Key questions included:

1. How do community-led actions improve public health measure uptake and strengthen health systems during outbreaks?
2. How do community feedback systems shape National Societies' actions and ensure community voices are heard?

Qualitative data was collected through interviews, focus groups, and document reviews with diverse stakeholders, including vulnerable groups. Data was coded on the deep.io platform to analyze trends across three domains:

- CEA actions
- impact
- issues and affected populations.

Comparative analysis by Georgetown University assessed how CEA strategies adapted to cultural, social, and political contexts, and their correlation with health outcomes, including morbidity, mortality and compliance with health guidelines. The research also contributed to developing a framework to monitor and track CEA's impact on humanitarian and health programming. The analysis also examined how well CEA activities ensured that community voices were heard and integrated into decision-making processes, and how they impacted operational adjustments during public health emergencies.

3

COMMUNITY ENGAGEMENT AND ACCOUNTABILITY EXPERIENCES IN FIVE COUNTRIES

3.1. Georgia

The following subsections outline our findings in Georgia. A more detailed case study is available as a standalone document.

3.1.1. Overview of the CEA approach during COVID-19

The Red Cross Society of Georgia's COVID-19 response built on pre-pandemic partnerships with local governments, local institutions like "community houses", and formal and informal local leaders. Those partnerships had been established during a prior diabetes screening initiative conducted in rural areas with the World Diabetes Foundation. During the pandemic, the National Society worked with those same local leaders to gain community trust in COVID-19 initiatives. Their strategy included working through community houses and mobile health units to distribute supplies and vaccines in urban and remote areas, conduct door-to-door campaigns and encourage participation in COVID-19 awareness and prevention activities.

Partnerships with local community members, such as health professionals, teachers, village representatives and local religious leaders, facilitated two-way communication. Local leaders identified gaps in youth education, and local community members created extra-curricular tutoring programmes to meet this need. Community members also organized knitting drives to provide for vulnerable community members.

Youth volunteers, in particular, were active agents of the National Society's activities. Continued capacity building improved their ability to expand their volunteer networks and create new networks and associations.

Local representatives shared information with National Society staff about community needs. This included information to improve aid distribution programmes, address rumours around vaccine costs, the delivery of masks and first aid training, and develop a wider range of communication channels. This facilitated trust between communities and the National Society.

3.1.2. CEA challenges during COVID-19

The inclusion of ethnic and linguistic minorities was a challenge to CEA actions. There was insufficient representation of ethnic and linguistic minorities (Azerbaijani and Armenian) among National Society staff and volunteers. This inhibited community access, understanding of community needs, and participation in ethnic Azerbaijani and Armenian villages and villages in remote and mountainous areas. This issue was eventually addressed by coordinating with Azerbaijani and Armenian National Societies to obtain written materials in local languages.

3.1.3. Positive outcomes attributed to CEA actions

Our research in Georgia suggests that:

- Active and regular participation by the community with the National Society increased and sustained health behaviours.
- Community-led initiatives helped vulnerable community members.
- Public-private partnerships enabled greater recognition of the National Society and enhanced vaccine acceptance.
- Training provided by the National Society for community leaders resulted in increased community participation.
- Local volunteers enhanced trust in the National Society.
- The implementation of a national telephone hotline gave citizens a direct communication channel with the National Society.

3.2. Guatemala

The following subsections outline our findings in Guatemala. A more detailed case study is available as a standalone document.

3.2.1. Overview of the CEA approach during COVID-19

The Guatemalan Red Cross' COVID-19 response built on partnerships with the Ministry of Health, local community councils, community leaders, women's leaders, Indigenous mayors and village health commissions.

Community-based activities centred on schools, which are a hub of social and communal life. This increased information distribution, decreased misinformation and increased vaccine uptake among youth. In rural areas, cooperation between the National Society and local community development council (COCODES) was essential for community trust and participation.

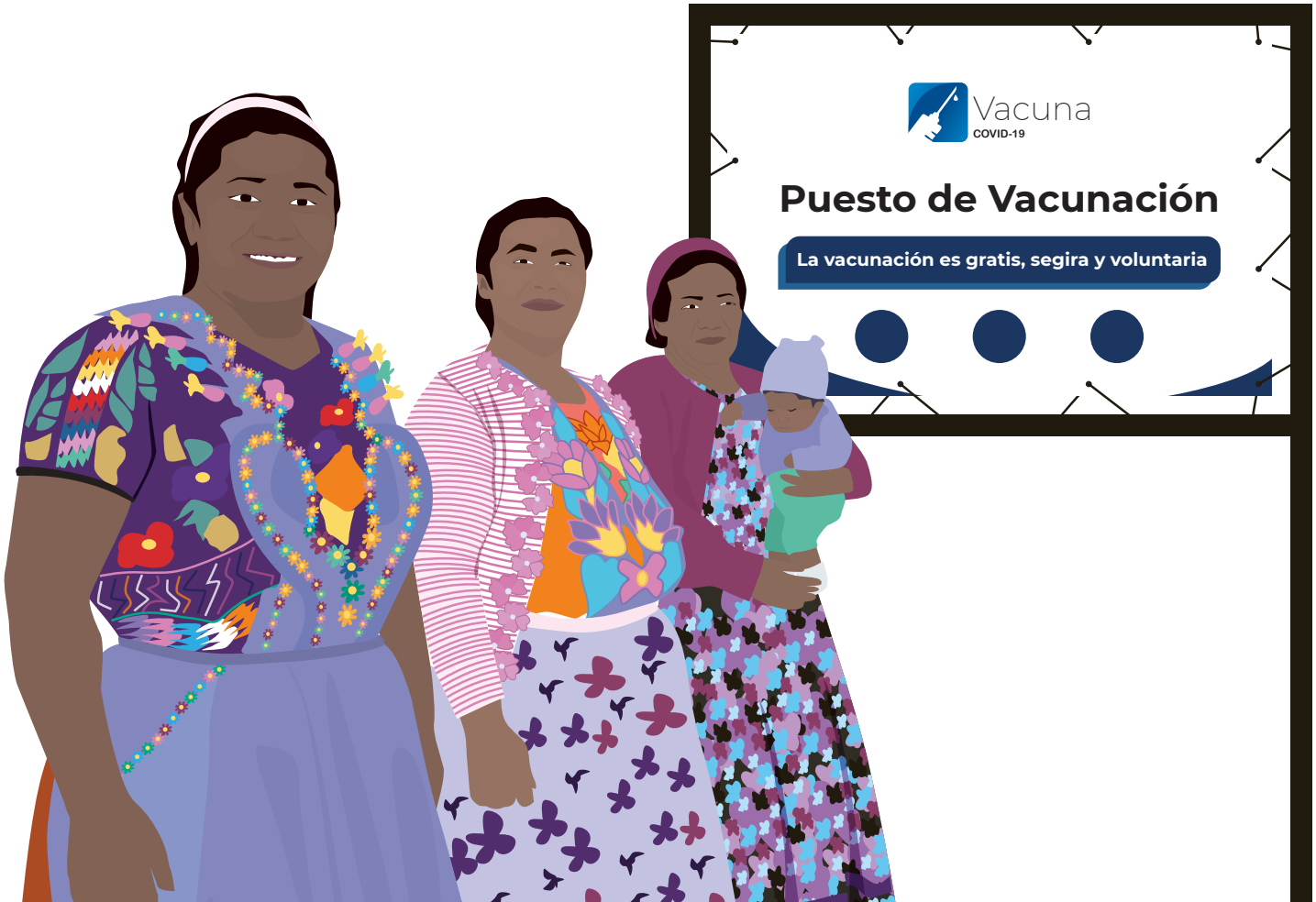
3.2.2. CEA challenges during COVID-19

There was a lot of documentation on barriers to CEA impact in Guatemala. Community participation was affected by local power and gender dynamics, including internal political and social divisions and gender hierarchical structures that restricted participation. The vulnerability of the Izabal-Puerto Barrios community to natural disasters overwhelmed community prioritization of COVID-19 issues. Linguistic and cultural diversity exceeded the National Society's ability to communicate with subpopulations.

3.2.3. Positive outcomes attributed to CEA actions

Our research in Guatemala suggests that:

- Community participation contributed to risk reduction practices in different communities.
- Coordination with local community structures was essential for CEA success.
- Local knowledge about the context was important for CEA approaches.
- Internal power dynamics in the community could impact CEA outcomes.
- Women and ancestral medicine practitioners played a key role in vaccine promotion.



3.3. Guinea

The following subsections outline our findings in Guinea. A more detailed case study is available as a standalone document.

3.3.1. Overview of the CEA approach during COVID-19

The Red Cross Society of Guinea's COVID-19 response built on concurrent Lassa fever and Ebola virus disease (EVD) epidemic responses. The National Society's experience during the Lassa fever epidemic of 2021 and EVD epidemics of 2014–2016 and 2021 informed its COVID-19 response. During the EVD response of 2014–2016, Guinea communities were at the epicentre of a disease outbreak that was characterized by deep mistrust of external responders, community-based reluctance and resistance, and violence towards external responders. Since then, relationships with local communities have improved as responders have expanded and sustained the capacity of local communities to lead disease response efforts – including safe and dignified burials – and created and sustained opportunities for two-way communication for both disease preparedness and response (surveillance, contact tracing) and community engagement and accountability.

During the COVID-19 response, long-term investment in CEA infrastructure seems to have paid off. The National Society was able to leverage existing relationships with community leaders and stakeholders, including local community chiefs, community organizations and traditional societies like Zowo women's and men's societies. The National Society also worked through affiliate groups engaging in "peer outreach" to identify people living with disabilities, people who are far from health centres, prisoners and other members of vulnerable and marginalized populations. These organizations served as focal points for the distribution of information translated into local languages. Local communities, in turn, made targeted recommendations to localize the Ebola and COVID-19 responses to improve local health systems' capacity for contact tracing, safe and dignified burials, surveillance and community education, disease prevention and vaccine distribution.

3.3.2. CEA challenges during COVID-19

We identified several barriers to CEA actions, including that NGOs engaged with local governments rather than local organizations, there was a lack of training for volunteers in how to use the community feedback system, language around response systems was unclear, and there was a lack of response to community feedback.

3.3.3. Positive outcomes attributed to CEA actions

Our research in Guinea suggests that:

- Lessons learned from the response to Ebola epidemics have strengthened trust between response stakeholders and communities, leading to a more inclusive response.
- Community-based volunteers played a key role in promoting risk reduction practices and vaccine uptake.
- When National Society volunteers and local community members gain meaningful disease-prevention skills, training and local capacities, local communities are more empowered and confident in disease outbreak response.
- Adapting CEA approaches to local contexts increased vaccine acceptance and uptake.
- Community feedback mechanisms like training, radio broadcasts in local languages, and engagement with community customs strengthened COVID-19 vaccine acceptance.

3.4.Indonesia

The following subsections outline our findings in Indonesia. A more detailed case study is available as a standalone document.

3.4.1. Overview of the CEA approach during COVID-19

The Indonesian Red Cross Society (Palang Merah Indonesia, or PMI) built on existing tuberculosis initiatives to respond to the COVID-19 pandemic. PMI prioritized community engagement, including partnering with women and community-based groups to expand COVID-19 vaccine acceptance and uptake in hard-to-reach areas, and improving risk reduction and treatment measures for tuberculosis. The National Society adapted materials and activities to local norms, customs and languages to improve contextualization and appropriateness and deployed a range of two-way communication strategies. Community leaders provided feedback to about local communities' needs and concerns and helped the National Society to adapt their approaches to ensure participation and reach.

3.4.2. CEA challenges during COVID-19

Geographical isolation in remote areas like Banjarnegara poses significant challenges to community engagement. Residents often struggle to attend meetings, access vital information, and participate in decision-making processes—especially during the rainy season, when many homes become inaccessible. Limited communication channels further exacerbate these difficulties, hindering their ability to stay informed and involved. To overcome these barriers, innovative approaches such as radio broadcasts and partnerships with local volunteers were employed. These efforts ensured the delivery of culturally appropriate information, enabling community members to receive and act on essential messages despite the constraints.

3.4.3. Positive outcomes attributed to CEA actions

Our research in Indonesia suggests that:

- Community-led solutions enabled access to health for the most vulnerable.
- The participation of communities was a driving force in the adoption of preventive measures during COVID-19.
- Local social events offered a way to communicate key public social measures to prevent COVID-19, based on the cultural preferences of the community.
- Trust is seen as a reciprocal path, rooted in a mutual understanding between communities and the National Society.
- In various contexts, women contributed to strengthening solidarity ties, not only with the community, but between the community and institutions.

3.5. Malawi

The following subsections outline our findings in Malawi. A more detailed case study is available as a standalone document.

3.5.1. Overview of the CEA approach during COVID-19

The Malawi Red Cross Society integrated its CEA activities to respond to two concurrent disease outbreaks: COVID-19, and a cholera outbreak that is ongoing. The National Society worked with existing community groups, including village civil protection committees, local chiefs, youth and physically impaired community groups to strengthen community capacity and local ownership. The most effective strategy was one-to-one conversations through household and community visits. Community feedback drove decision making. By partnering with local leaders, the National Society increased access and trust, reduced rumours and misinformation, and leveraged local leaders as role models for vaccine uptake.

3.5.2. CEA challenges during COVID-19

Challenges to good community engagement and accountability systems included responding and acting on community feedback, a lack of early and meaningful community participation, and barriers to reaching people in remote areas.

3.5.3. Positive outcomes attributed to CEA actions

Our research in Malawi suggests that:

- Engaging communities led to increased trust.
- Cooperation between the National Society and community groups led to positive risk reduction and increased vaccine and treatment uptake.
- Distribution of accurate information by the National Society empowered local actors.
- Active and regular participation with the National Society increased and sustained health behaviour.
- Community feedback helped the National Society improve its response and meet the needs of communities.

4

KEY CHARACTERISTICS OF EFFECTIVE COMMUNITY ENGAGEMENT

Our analysis showed that CEA approaches were locally adapted across all five countries.

Actions included:

- coordinating with local partners
- engaging trusted community influencers
- developing and sustaining two-way communication systems and community feedback mechanisms
- sharing understandable information
- building on local capacity
- encouraging participation using locally appropriate measures.

Adaptations to suit the local context explain many of the differences between actions implemented in the five countries. However, variations in terminology made comparison and differentiation difficult. For example, a "hard-to-reach" community in Indonesia might lack access to healthcare because of geography and terrain issues, while a "hard-to-reach" population in Guatemala or Georgia might lack access to CEA resources because of migrant, ethnic, or Indigenous status and language preferences.

"Local structures" might refer to local administrative governments, local village chiefs, female-led volunteer networks or rural healthcare delivery systems, each with different purposes, sources of power, resources, authority and institutional capacities.

The cross-analysis of CEA actions across the five case study countries reveals five key characteristics:

- active participation by communities
- empowerment and ownership of affected communities
- inclusion of diverse community groups in decision making
- two-way communication
- adaptability and localization of response operations.

4.1. Active participation

Participation faced significant challenges during the COVID-19 pandemic due to measures like social distancing, mandatory masking and restrictions on gatherings, which limited traditional forms of community interaction. The way participation was approached and implemented varied widely depending on the context. For instance, in countries like Malawi and Guatemala, participation was not clearly defined and often became an afterthought, introduced late in the design and implementation of response programmes.

In contrast, Guinea offered a compelling example of participation being deeply embedded in local community engagement efforts. There, community involvement was a central pillar of the outbreak response, contributing significantly to its success. This level of engagement highlighted the transformative potential of active participation as a driver of behaviour change, facilitating improved vaccine uptake, disease prevention and the adoption of protective measures, such as masking and hygiene practices.

In Indonesia, the combination of door-to-door visits and the visible presence of volunteers in public spaces emerged as the most effective strategies for gathering community feedback and fostering meaningful engagement. Similarly, in both Indonesia and Malawi, participation in community education events and vaccination campaigns played a critical role in encouraging trust and uptake of health practices and recommendations. Meanwhile, in Georgia, innovative approaches such as public-private partnerships, including the highly successful COVID-19 vaccine "marathon", significantly enhanced the dissemination of vaccine information and boosted vaccination rates. These efforts demonstrated how increased participation could lead to better communication, stronger support for public health measures, and more sustainable behaviour change.

In both Guinea and Georgia, communities showed an increasing desire to actively participate in the technical aspects of response efforts, signalling a shift towards greater community ownership. This deeper involvement helped build trust in the response measures, creating a more collaborative and effective environment for addressing the challenges posed by the pandemic

4.2. Empowerment and ownership

Empowerment and ownership are two terms that remain subjective and context specific. "Empowerment" often refers to actions communities take independently to address their own conditions, while "ownership" relates to their capacity to make critical decisions early in the programme cycle or take the lead in decision making. Alternatively, it may also involve their engagement with local leaders.

Our research identified several examples of empowerment and ownership. For example, in Malawi, sustained engagement on COVID-19 and cholera saw local committees initiate public education efforts like drama presentations and establish new laws promoting sustainable management of health protection waste. In Indonesia, communities actively participated in cash-distribution programmes by co-planning and making key decisions early. This resulted in initiatives such as communal kitchens, local fundraising and cash grant distribution, improving outreach to marginalized groups. In Georgia, people who initially lacked confidence to volunteer for CEA became advocates after receiving training. They then used their social connections to build trust in their communities. As this trust grew, community members felt empowered to take responsibility for the well-being of others. With increased confidence, they raised important issues like gaps in vaccine access and COVID-19 information, helping to improve local health services. Volunteer networks based in "community-based houses" addressed local needs during COVID-19 by launching youth education and community support initiatives. Similarly, in Guinea, volunteers requested training to take charge of public health responses.

A significant issue for CEA approaches is the timing of community engagement in the programme cycle and how much power communities hold throughout CEA activities. In many cases, CEA activities occurred during the implementation phase, with few opportunities for community input during initial programme design. As a result, two-way feedback mechanisms were crucial for course correction and ensuring community ownership.

4.3. Inclusion

CEA is an effective way to promote inclusion across local populations. In all countries, CEA activities expanded access for geographically isolated communities, people living with disabilities, youth, women, ethnic and linguistic minorities and vulnerable households.

In Georgia, the translation of COVID-19 materials improved information access and trust among ethnic Azerbaijani and Armenian communities. Youth-led voluntarism in the Red Cross Society of Georgia empowered youth networks, broadening outreach efforts. In Indonesia, mobile clinics reached remote populations and people with disabilities, while women-led volunteer networks enhanced women's leadership roles. In Malawi, mobile clinics and house-to-house vaccine campaigns improved access for people with disabilities, and school-based programmes delivered health information to children. The Guatemalan Red Cross and the Ministry of Health expanded vaccination access in rural areas, used sign-language translators for people with language-based disabilities, and launched a multilingual initiative targeting the LGBTQI+ population to provide hygiene kits and promote violence prevention, reducing stigma and discrimination.

Our analysis suggests that inclusion is crucial for CEA's success. Efforts to engage marginalized and hard-to-reach populations, including ethnic minorities and people with disabilities, were most successful when localized approaches were tailored to the specific needs of each community. Whether through translation of materials, community-driven initiatives, or adaptations in communication strategies, inclusion expanded the reach and effectiveness of health programmes.

4.4. Two-way feedback

Two-way feedback is essential for improving aid effectiveness and reducing misinformation. Our research revealed an expanding range of communication mediums being used by National Societies. They included radio programmes, SMS, social media, helplines, community events, drama at markets (Malawi), theatrical and musical performances (Georgia and Indonesia), face-to-face communication, WhatsApp groups and surveys. This diversity of communication channels highlights the complexity in evaluating CEA's impact across different contexts. Local adaptations, such as songs and WhatsApp messages, were tailored to cultural trends and folklore to enhance community engagement.

In Malawi, community feedback directed the National Society to collaborate with local religious leaders on COVID-19, increasing public acceptance of health programmes. Feedback also helped identify issues, such as improper use of chlorine in pit latrines, leading to targeted information campaigns and demonstrations. Reports from communities about shortages of buckets and masks prompted additional resource distributions.

More research is required to identify which communication strategies have the greatest impact and how to maintain face-to-face communication as a priority in evolving two-way communication environments during response efforts.

4.5. Adaptability and localization

In all five countries, the National Societies used creative approaches to localize CEA activities. In Guatemala and Guinea, the National Societies worked with local religious and ancestral leaders to strengthen COVID-19 outreach and trust. Local leaders played a crucial role in the success of CEA initiatives by lending their credibility to National Society partners, acting as role models for vaccine uptake, facilitating access to marginalized communities, and identifying gaps in implementation. In Indonesia, Guatemala and Malawi, community leaders who were vaccinated early encouraged others to follow by demonstrating their health after vaccination. However, in some countries like Georgia and Guatemala, collaboration between National Societies and local governments led to a merging of roles, sometimes creating mistrust.

Localization efforts varied widely across countries. A minimum requirement for localization was translating CEA materials into local languages, such as Azerbaijani and Armenian in Georgia, Mayan in Guatemala, Javanese in Indonesia, and Sena in Malawi.

Geography and physical distance challenged the effectiveness of CEA activities. In Indonesia, community leaders adapted health system activities by moving COVID-19 hygiene promotion to hard-to-reach areas and securing transportation for people with disabilities. In Guatemala, municipalities adjusted healthcare service delivery hours to better meet local needs. In Malawi, mobile and door-to-door vaccination campaigns increased access for persons with disabilities, though CEA efforts still struggled to reach remote populations.

4.6. Building on local capacity

In most communities, well-established health systems, government and community organizations provided leadership in partnership with the IFRC.

National Societies in Indonesia, Georgia and Guatemala strengthened the potential for local engagement by leveraging these pre-existing networks and infrastructures. Building on these systems reinforced local autonomy, empowerment and decision making, fostering trust between National Societies and communities.

In Guatemala, the coordination between the Guatemalan Red Cross and the Ministry of Health during vaccination campaigns through community sweeps was particularly valued.

Guinea's experience shows that there is no one-size-fits-all approach to building local capacity. Experience during earlier Ebola and Lassa fever outbreaks showed that relying on government officials instead of local leaders was counterproductive for CEA. There was a need to transfer skills and responsibilities for surveillance, contact tracing and dignified burials from responders to local communities.

National Societies worked with local communities to strengthen their capacity to respond to health emergencies. This trust building, capacity building and system strengthening promoted local ownership. In Indonesia, COVID-19 messaging built on previous tuberculosis awareness campaigns, encouraging National Society volunteers to lead in informal disease surveillance. In Malawi, the National Society worked with village civil protection committees to support local communities in developing contingency plans and securing resources for COVID-19 and cholera.

5

COMMUNITY ENGAGEMENT IMPACTS ON PUBLIC HEALTH EMERGENCIES

Public health emergencies reveal cross-sectoral key outcomes of national, local and community actors' community engagement approaches. Our research shows five consistent outcomes:

1. building trust
2. improving vaccine access and uptake
3. promoting behaviour change and disease prevention
4. responding to misinformation
5. enhancing aid effectiveness.

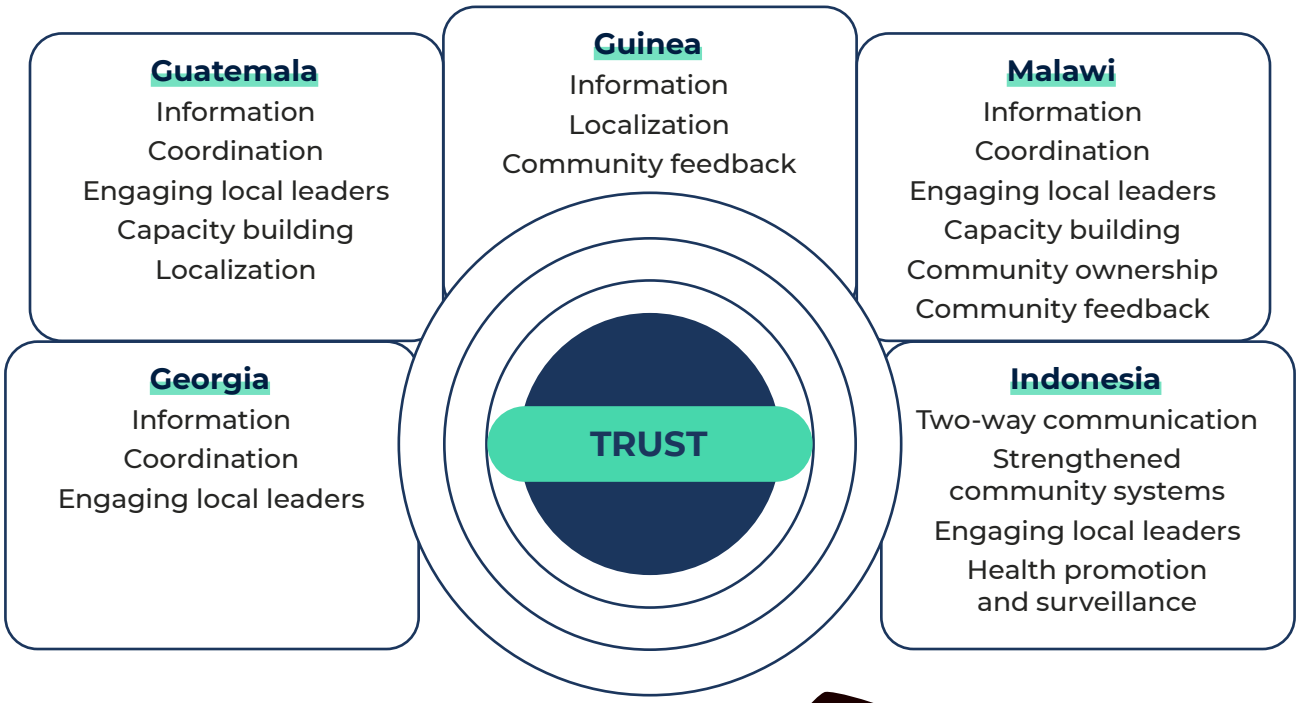
These cross-cutting outcomes align with the central challenges faced during public health emergencies and reflect the broader aspirations of community engagement work. Our analysis (see the 5 case studies) identified specific CEA actions that are most strongly tied to these outcomes. There are clear patterns and actionable insights to be drawn about the link between CEA inputs and their measurable impacts in these critical areas.

5.1. Building trust

Figure 1 summarizes the CEA actions that appear to have strengthened trust in each of the five countries.

The actions consistently involve improving the information environment, coordinating with local stakeholders, engaging local leaders and localizing information. This is achieved through appropriate communication channels, translation into local languages, and door-to-door outreach efforts.

Figure 1: CEA impacts on trust

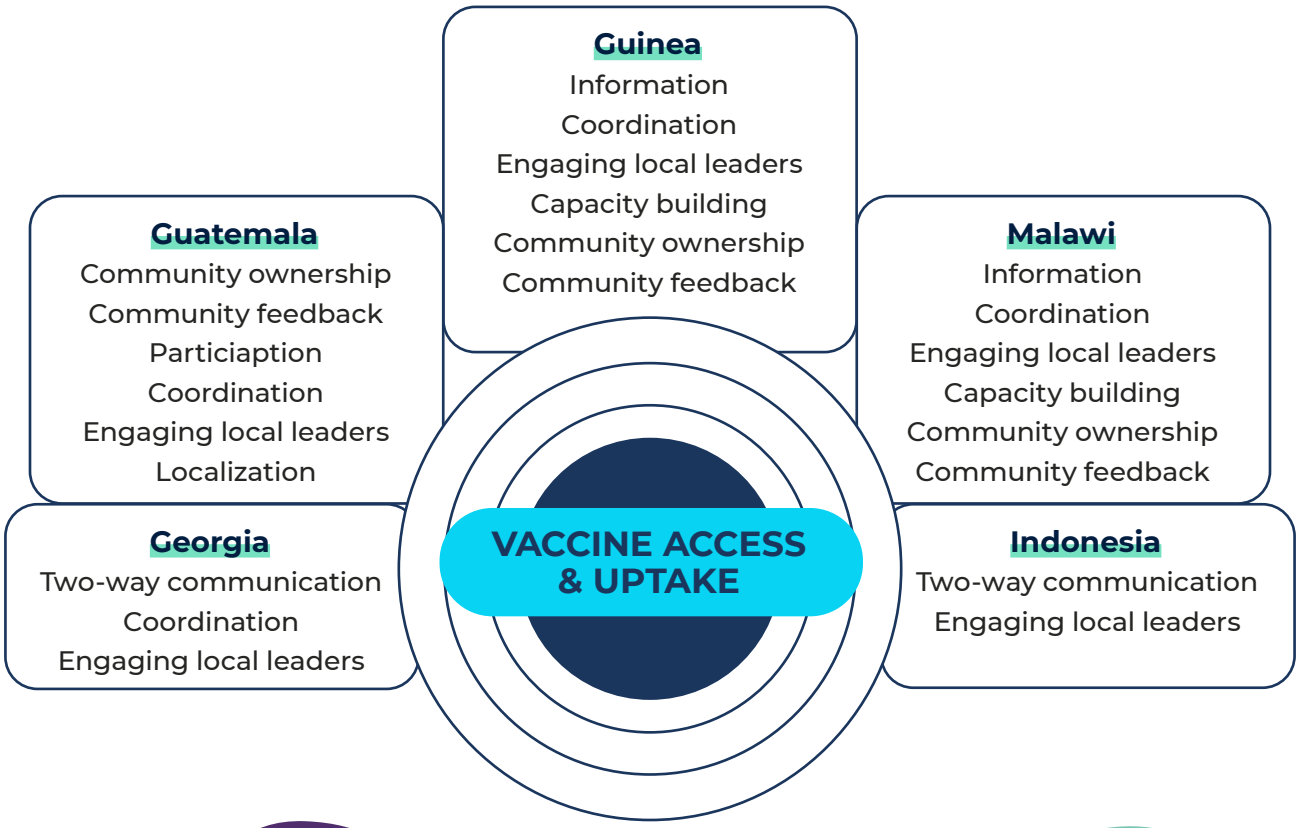


5.2. Improving vaccine access and uptake

As shown in Figure 2, community ownership was a key driver of vaccine access and uptake in three countries, while community feedback and two-way communication were critical in all five countries.

Coordination played a major role in vaccine access and uptake in all countries except Indonesia, as many health systems adapted to improve vaccine availability by bringing campaigns closer to hard-to-reach areas. Engaging community leaders also emerged as a crucial factor, with their advocacy and role-modelling efforts significantly promoting vaccines within local populations.

Figure 2: CEA impacts on vaccine access and uptake

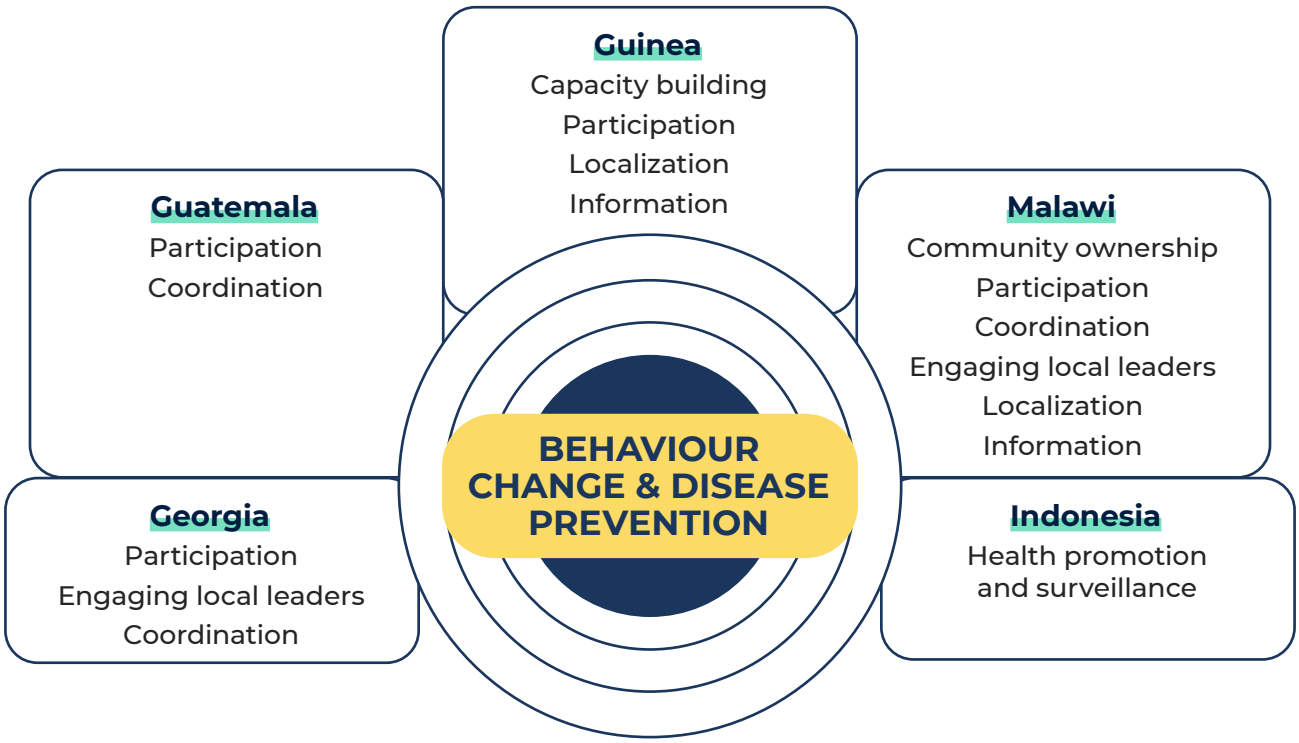


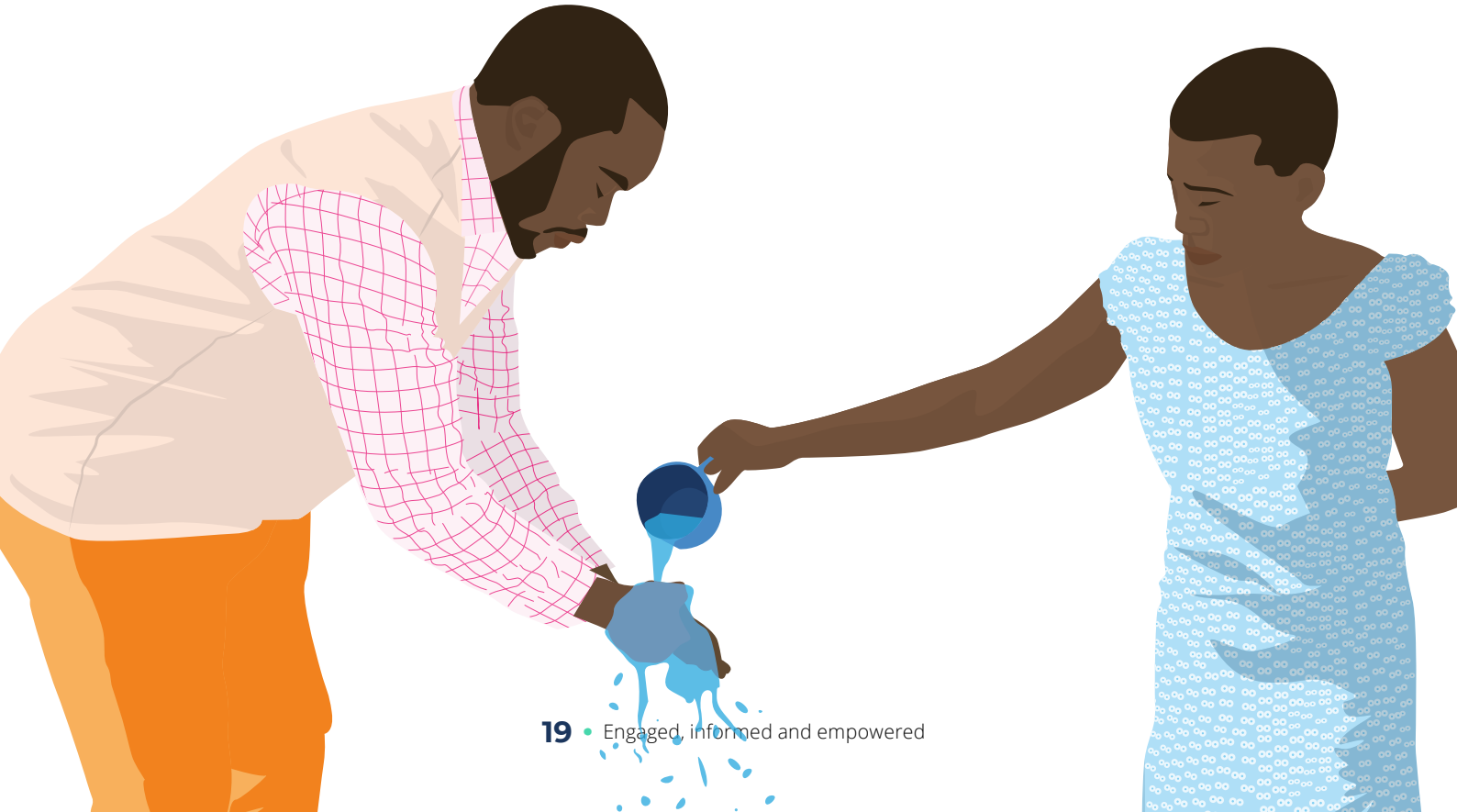
5.1. Behaviour change and disease prevention

As shown in Figure 3, increased participation and coordination with local partners are key drivers in changing behaviour and improving disease-prevention practices.

Localization plays a particularly important role in Guinea and Malawi.

Figure 3: CEA impacts on behaviour change and disease prevention

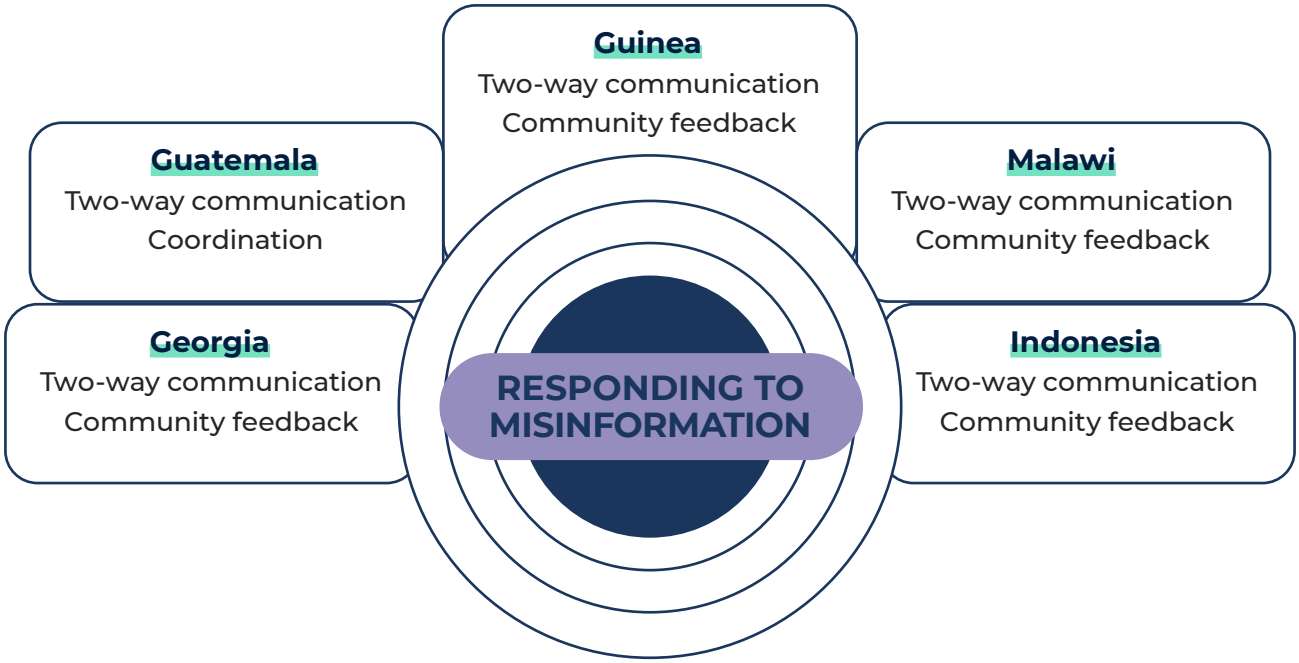




5.2. Responding to misinformation

Figure 4 illustrates how two-way communication and community feedback consistently drive improvements in the ability to address rumours, misinformation and fears at the community level across countries.

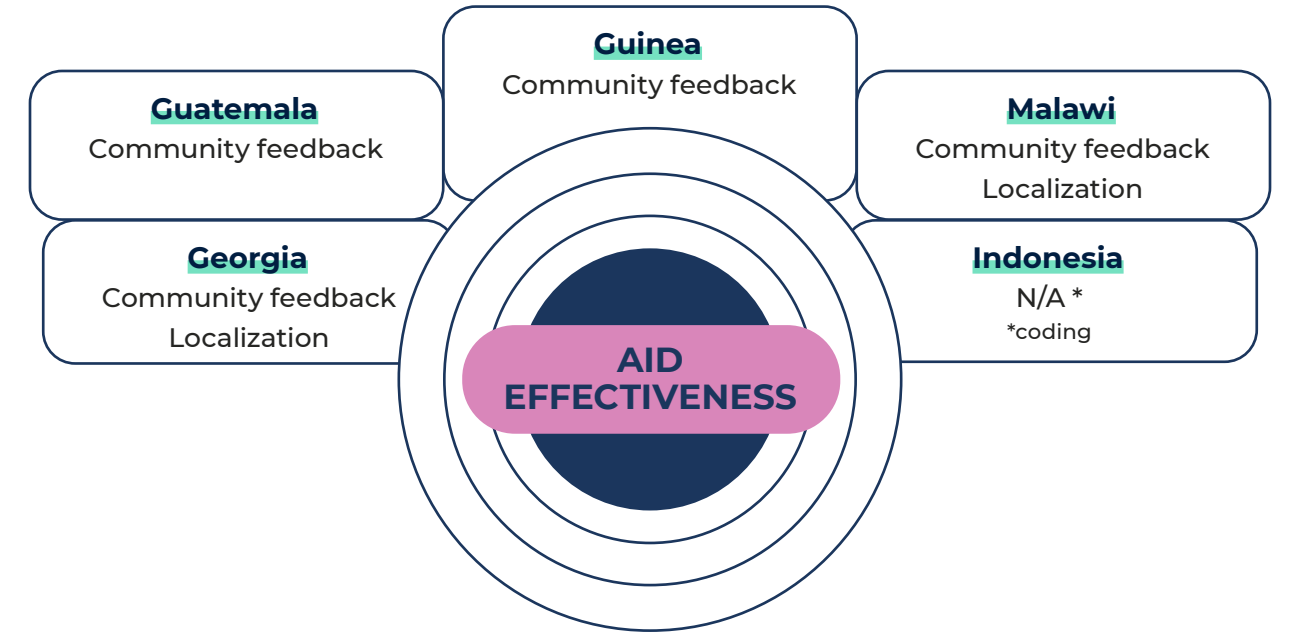
Figure 4: CEA impacts on responding to misinformation



5.3. Aid effectiveness

Figure 5 shows that community feedback was an important driver of aid effectiveness in three out of the five countries.

Figure 5 : CEA Impacts on aid effectiveness



6

CONNECTING COMMUNITY ENGAGEMENT ACTIONS TO MEASURABLE IMPACT

6.1. Available CEA evidence does not currently support impact assessment

Different methods, such as Kobo Toolbox in Georgia and paper-based forms in Malawi, have been used to gather community feedback, reflecting efforts to capture local perspectives and inform course correction and action. However, the approach varies by country and depends on local capacities, making it challenging to systematically analyze trends and compare insights across contexts.

Also, beyond country-level feedback mechanisms, there is a broader need to improve how we assess the overall impact of community engagement approaches and activities. Without structured frameworks for measuring impact, the full contribution of CEA to public health and humanitarian outcomes remains difficult to quantify. For example, in Indonesia, informal data collection limited the ability to draw evidence-based conclusions, reinforcing the need for stronger data systems that move beyond anecdotal information.

Recognizing this gap, efforts are already underway to strengthen how to track and measure impact regularly and over time. The IFRC has developed and is testing[1] a community engagement impact framework that goes beyond assessing CEA's role in public health outcomes, expanding its scope to humanitarian programs and sectors more broadly (see annex 1). This initiative also aims to support a more comprehensive and standardized approach to capturing the influence and contribution of CEA across different agencies.

1 The original five countries research coding framework was revised and validated using a thematic analysis approach to generate a new CEA Impact Analysis Framework which informed this cross-analysis : Revision, which has been validated by researchers, IFRC staff, and National Red Cross Society volunteers and staff. This synthesis report identifies common themes and patterns across the case studies; conducts a comparative framework analysis based on the CEA Impact Analysis Framework.

6.2.Action-Impact pathways

We identified three action–impact pathways in CEA that improve uptake of public health measures and strengthen health systems:

One-way relationship, when a CEA action appears to directly generate a perceptible health outcome. For example, in Guatemala, coordination with the municipality led to **increased trust**.

"A change really occurred more than anything in the rural area. When people saw that there was participation from the municipality as such, let's say from the auxiliary mayors' offices, it was like saying, then what they are doing is fine." (Guatemala)

Sequenced relationship, when a CEA action appears to indirectly generate a perceptible health outcome. For example, in Georgia, building on local capacity led to **programme adaptations** which led to **aid effectiveness** which led to increased **vaccine uptake.**

"The biggest enabler for us, especially in the Kvemo Kartli region, was the diabetes project, which was implemented in 2014. We have quite a close relationship with local medical staff, and with community leaders, especially in Kvemo Kartli, because of the diabetes project, as it was implemented similarly. This project was very similar to the one [mobile units for COVID], except it was focused on diabetes. There was a screening car, the same door-to-door approach for community mobilizations, and that is why these people had trust in us because of that project."

Reciprocal relationship, when a CEA action appears to generate a perceptible health outcome, which leads to an increase in – or repeat of – the initial action, with an associated increase in the scale of the outcome over time. For example, in Malawi, two-way communication led to **increased trust** which led to **vaccine uptake** which generated **more information** which **increased trust** which further **increased vaccine uptake**.

"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."

Because our research was based on qualitative data, we can't show definitive causal links between the actions and the impacts described in our data. However, our analysis of narratives and perceptions contributes to CEA impact assessment. It suggests that there is a positive correlation between CEA actions and improved health outcomes. It builds on the existing evidence base for including CEA in health responses and provides a basis for future qualitative research.

7
CONCLUSION

Examples from five countries highlight how CEA actions improved the uptake of public health measures during public health emergencies and influenced community health systems. Such actions included two-way communication, community feedback, coordination with local leaders and localized approaches.

Our findings emphasize the particular importance of community participation, empowerment and ownership in effective CEA. In each country, communities that were engaged early and actively in the response reported higher trust and cooperation with public health programmes. Moreover, when communities were empowered to make decisions, there was a marked improvement in health outcomes, such as increased vaccine uptake and adherence to preventive measures.

CEA impacts are not limited to changing behaviours; they also reshape social dynamics and relationships, shifting perceptions, attitudes and social connections.

Our analysis also suggests that inclusion is crucial for CEA's success. Efforts to engage marginalized and hard-to-reach populations, including ethnic minorities and people with disabilities, were most successful when localized approaches were tailored to the specific needs of each community. Whether through translation of materials, community-driven initiatives, or adaptations in communication strategies, inclusion expanded the reach and effectiveness of health programmes.

Acknowledgements

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ANNEX 1 : CEA IMPACT FRAMEWORK

The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network, with 191 National Red Cross and Red Crescent Societies and around 16.5 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.