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Strengthening community health system responding to COVID-19

Although the vaccination against COVID-19 has become widespread in some countries, many countries have been struggling to control it.

It is urgently needed to assure the reliable and well-functioning health system with people in every community.

We introduce here two articles about AHI alumni's efforts, one from GO and another from NGO, to strengthen the local/ community health system, so as to make it genuinely accessible and trustworthy for the people.

Health functionaries waited a whole day, but no one turned up for vaccination in Pratapgarh district, Rajasthan, India

(Note: Edited version of excerpt from The Hindu, Jun. 27, 2021 article authored by Chhaya Pachauli and Anant Bhan)

Tackling vaccine hesitancy challenge in rural India, Ms. Chhaya Pachauli, Prayas, India, ILDC 2019

Ms. C. Pachauli

"They send 'black' vaccines for us while people in the cities are being given 'white' vaccines!",
"The vaccines are to kill us as we are poor".

These statements certainly have much deeper connotations attached to them than just 'safety concerns. In rural India concerns about COVID-19 vaccines are now increasingly commonplace. People voice their concern about what will happen to them if they get vaccinated and have doubts that the government is sending inferior quality vaccines to them. Vaccination sessions in local health centers often see very few or no takers.

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A few weeks ago, villagers in Barabanki (UP) jumped into a river to escape from COVID-19 vaccinators. Efforts by local health authorities to create awareness are of little avail. There are contrasting dimensions to COVID-19 vaccine rollout: one where people are enthusiastically accepting it and the other of resistance. There are many diverse factors at play in this, which may go beyond the health concerns and have more to do with socio-anthropological aspects of health-seeking behavior.

Historical discrimination on tribal community

Meeting with community members and stakeholders in Kalakhet village of Pratapgarh district

These individuals, and the communities they belong to, are probably not really challenging medical science, or questioning vaccine trial results, adequacy or inadequacy of evidence. Rather, they seem to indicate deep-seated fears and belief in conspiracies, the fear of perhaps being discriminated and deceived and of being omitted from societal benefits. Parts of rural Rajasthan, where we have seen high vaccine refusal rates, are also often poorly resourced, and often tribal. Communities in this region here have believed that the widespread poverty and the general backwardness that they had been pushed into is a result of historically institutionalized discrimination imposed on them by those in power. They believe that they have been systematically alienated of their land rights, forest rights and kept deprived of basic education and health care. All of this has led to a state of despondency and, more than that, a very strong feeling of distrust and resentment against government institutions and those in power. Such contexts cannot be ignored while we try to understand what might be fueling the extreme fear and resistance around COVID-19 vaccine.

Strengthening public health system

Orientation of front-line health workers at Primary Health Center in Pratapgarh district.

Responses to vaccines must also be discussed and analyzed in conjunction with and in comparison, to uptake of other health care services by a particular population. Addressing vaccine hesitancy in rural India would first of all require health systems to be honest and transparent. Create awareness, let people know how vaccines work, how they help prevent a disease, what are the probable side effects and how they can be managed. Health authorities need to be comfortable about people raising questions, while providing them answers as best as possible.

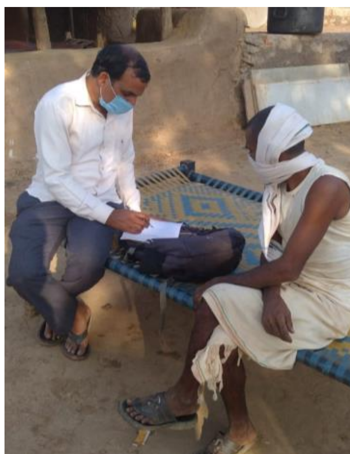
Sustained and meaningful efforts need to be made to build trust, gain confidence of communities and meet their expectations. This would also require seeing them as equals, treating them with dignity and acknowledging their fears. To do this, governments and the health functionaries will need to break out of their conventional notions and beliefs around people's healthcare-seeking behaviors and understand and address their fears and apprehensions. They will also need to rethink and after their communication strategies and move beyond ceremonial awareness drives and campaigns to interventions that are truly engaging and which make the communities feel important and valued.

Even more crucial is to engage communities in planning, execution and monitoring of health care services at all levels. Create fora where they can freely convey what they want and how they want it to be delivered, where they can share how they feel about government policies, programmes or services and where they can hold people and systems accountable for gaps without the fear of being subjugated. Also, governments at both Union and State level must commit to investing more on health care and prioritizing primary health care services. Quality health services in all aspects, and not just in sporadic efforts such as pandemic vaccination campaigns, should be delivered.

NGO involvement for building trust

In the tribal villages where Prayas had been working, most of the population have come to outrightly reject vaccines. While a large part of vaccine hesitancy has been fueled by misinformation doing the rounds on different social/digital media platforms, a lot is also due to the words of mouth rumors of severe illnesses or deaths post vaccination which are mostly coincidental but people tend to associate them with vaccines.

Prayas team has been working relentlessly to address the various fears and mis-conceptions around COVID-19 vaccines that prevail in the communities. It has been holding commu-nity meetings, door to door home visits to sensitize people on the significance of vaccines.



A Prayas team member talks with a villager

Apart from this, Prayas has been organizing workshops with community influencers of the community where vaccine hesitancy is prevalent such as Panchayati Raj Institution members, traditional faith healers, religious leaders, etc. Many of them themselves were vaccine hesitant. Through the workshops we tried to provide them a scientific understanding of how vaccines would work and why they are crucial in our fight against the pandemic. We also tried to cater to the various misconceptions and fears around vaccines that they had in their minds and tried to remove myths by giving them examples which they can easily relate to.

The workshops are thus a tool to build their confidence on the vaccines and to equip them with facts and arguments which they can further use to dispel myths and rumors that exist in their communities. Many of the participants conveyed that their perspective on vaccines has drastically changed, many said that they are now ready to get vaccinated themselves and that they would also motivate people to go for it. However, some with more rigid mindsets continue to stick to their own perspectives. Our team members continue to engage with them even after the workshops. Given the credibility they have in their communities, their words carry a lot of weight and people tend to rely on them for advice and decision making on vaccination.

Thus, we have to engage intensively with the local communities, identify populations where the hesitancy is acute and rampant, take help of commu-nity leaders whose voices matter and engage them in planning and execution of vaccination sessions.

Meeting with community influencers in Chittorgarh, Rajasthan

Community Isolation System in Thailand,

Mr. Preeda Taearak, ILDC 1988, Mr. Techid Chawbangpom, ILDC 2012,
Ms. Khanitta Saeiew, ILDC 2019, Ms. Nanoot Mathurapote,
National Health Commission Office (NHCO), Thailand

Mr. P.Taearak *Mr. T. Chawbangpom* *Ms. K.Saeiew* *Ms. N. Mathurapote*

Situation of slum area in Bangkok, Thailand

Thailand was the first country outside China to report the COVID-19 case in January 2020. Last year, Thailand efficiently managed COVID-19 prevention and control. The government provided screening, treatment and quarantine sites for Thai and non-Thai people, while people complied with government measures.

The whole of society supported the government to fight against COVID-19, for example, organizing home visit by health volunteers to explain correct information on COVID-19 prevention and awareness, producing fabric face masks and alcohol gels by themselves and sharing to people in need, setting up community kitchens and distributing food to affected people and etc. In September 2020, it marked the first 100 days that Thailand had no new confirmed cases from local transmission.

A man sitting in front of his house (Thairath newspaper)

Until the end of 2020, the COVID-19 situation has altered. The second wave of COVID-19 started at the shrimp central market in Samut Sakhon province near Bangkok, followed by the third wave in April 2021 starting at an entertaining venue in Bangkok. From there, the virus transmission has spread to slum area nearby and further to construction worker sites. Since then, the number of confirmed cases has risen. As of July 13, 2021, the cumulative total of COVID-19 patients in Bangkok was 101,575 people, while number of patients in Thailand was 353,712.

The COVID-19 transmission in slum areas has sparked a high concern to all responsible organizations such as NGO networks, academic institution and Government. It is difficult to control the transmission of the virus in such densely populated areas. The poor living condition in slum areas make the situation deteriorated. In Patana Mai Community of Klong Toei sub-district, 13 people live together with one toilet. In another slum area, Supot Uthit community of Sala Thammasop Sub-district in Thawiwatthana district, 38 people or 19% of total population were infected COVID-19.

On top of COVID-19 rapid spread, the number of complete vaccinations in Thailand is still limited. As of July 12, 2021, only 4.83% of population received two doses of vaccines and 14.28% received one dose. The situation is then worrying that the health care system might be collapsed sooner or later.

Community response to COVID-19

National Health Commission Office (NHCO), which is a government organization, established in 2007 with an objective of developing healthy public policies through collaboration and synergy from various sectors and stakeholders particularly civil societies and communities. Health charter has been promoted for each community to discuss and get involved in the solving the problems.

In 2020, NHCO encouraged communities throughout the country including Bangkok to discuss among themselves on how to handle COVID-19 in their communities. The output of the discussion is the development of the social measures against COVID-19 initiated by community members. It aims to supplement the government measures, which are too generic or hard to comply with such as a lockdown measure.

Providing goods to community members in Klong Teoi slum area

NHCO organized training on developing community health charter and invited local leaders. Then local leaders facilitate a community health charter process in their area with a support of NHCO. Various community members, such as village headman, community committee members and village health volunteers participated in discussion of the development process. They had experiences of coping with social issues such as air pollution and housing in the slum area. They discussed on the roles and functions of each stakeholder in response to COVID-19, for example;

- Community leader/ president / a village headman: provide a special infectious waste disposal site for the community, collect information of people who traveling to another province, provide prevention COVID-19 information and encourage community members to clean their house especially doorknobs and sink.
- Police station: provide necessary equipment to prevent COVID-19 for community volunteer such as a disposal mask, alcohol gel.
- Public health office: provide necessary information on prevent COVID-19 to community leader.
- Temple/mosque: provide alcohol gel or soap for people, give a sermon on preventing COVID-19 and emotional and mental care.
- a community health volunteer: collect information of vulnerable group such as elderly people, bed ridden and children.

The development of the health charter gives an opportunity for both community members and local government to discuss on how to handle with the outbreak. That leads to understanding the expectation of both sides and trust-based collaboration.

Responding to the dramatic change of situation due to COVID-19 from 2020-2021, NHCO has focused on engaging communities to set up a community isolation system for COVID-19 prevention and control. Many organizations such as Thawiwatthana District Office under Bangkok Metropolitan Administration (BMA) covering Supot Uthit community slum area, and Health and Society Institute, which has a research area in a Klongtoei slum area, contacted NHCO for advice and collaboration with its wider network. These organizations supported communities to set up a community isolation system in a slum area.

A Community Isolation System

The system can be categorized as listed below.

1) Bubble and seal
This system applies for a small community. It closes the community and requests community members to quarantine or stay within a community for 14 days, except patients to go to hospitals. Food, vaccines, medical supplies and survival packages are provided at the community. The community opens again when everyone in the community tests COVID-19 negative.

2) Community control
This system is for bigger community and sets up 3 centers, namely, a waiting center for patients to go to hospitals, a quarantine center for high-risk contact person, and a rehabilitation center for recovered patients to stay 14 days before returning home. All centers are located in the community. A government hall or a temple can be used for these centers.

3) Data and communication
This system applies to both big and small communities for collecting data on health and negative impacts from COVID-19 such as job loss. The data is used for providing assistance and sharing information. Doctors and health volunteers use this data to follow up symptoms or find hospitals for patients. NGOs or volunteers can know who are in need for food and survival package in time.

NHCO has developed a guideline on the community isolation system for any communities to be able to apply and set up the system by themselves. Communities which adopted this system has a good relationship among local government, community and external partner. When community needs help from those partners they will directly contact them. We also found some community leaders try to share their experiences on coping with this crisis to others communities and try to set up their micro system when third wave of COVID-19 coming. Community sense of ownership and sustainability is more ensured.

Lessons learned

Community people raising their fists as a symbol of solidarity to fight against COVID-19

As working on COVID-19 response for almost two years, NHCO draws the following lessons.

Community strength with a good leader helps communities to ensure safety from COVID-19 or at least mitigate the negative impacts from COVID-19. During the time of emergency, the government has to prioritize their assistance to vulnerable communities. If a community is strong, it helps community members assist one another and even helps other communities.

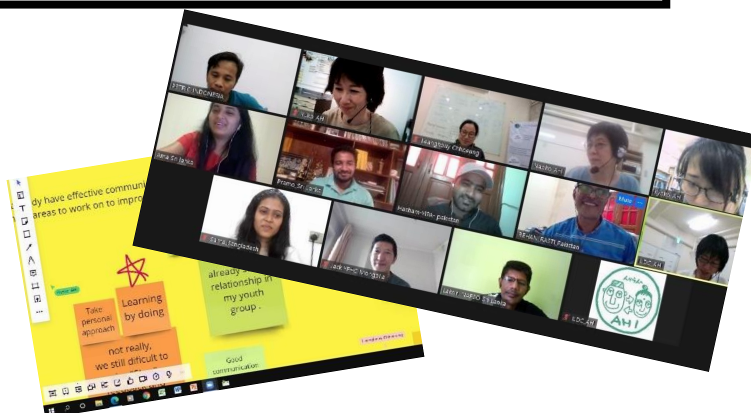
Problem solving in a systematic manner is vital. When NHCO together with the networks designed the community isolation system, a working mechanism, resources, manpower (government officers and volunteers), data and communication system should be designed in a right way.

Long term investment in building trust-based collaboration with multi-sectors and stakeholders is valuable. This investment blossoms when crisis happens. Without long term investment in this matter, collaboration during crisis hardly occur and may be worse leading to conflict. NHCO builds trust-based collaboration through provide a neutral platform such as health assembly or health charter where various sectors and stakeholders come to discuss problems, find solutions and take actions together for more than a decade.

ILDC 2021online course

Yuko OKUMA, AHI

The Part-1 of International Course on Leadership for Community Health and Development (ILDC) 2021 was held on June 14-26. AHI continued online communication with expected participants for almost a year. Nine participants from 6 countries have started the course. ILDC2021 has three phases. The Part-2 is on July 26-August 7 and the Part-3 on September 13-18. Intervals of each part can provide the participants chances to immediately apply what they learn in the training to their own activities.



Taking ownership of the course

The participants spent first few days discussing the course objectives based on the factors of which they would like to make change and the rules for making those objectives actionable through the course. They also discussed the roles they should take for the effective discussion, such as, moderator, time keeper, caption keeper and operator of Miro (online whiteboard tool). Especially, captioning was important not only for the participant with hearing disability, but for others who were not confident in communication in English.

Learning by questioning

The participants discussed in small groups in most of the time. At first, the discussion was not very active and few questions were raised. Then, a participant from Mongolia asked, “Why no questions? Do you guys understand everything?” It was kind of challenging to other participants to make aware of importance of questioning for group learning. Since then, most of participants started to actively be involved in the discussion.

Reflection for improvement

Through the daily evaluation and reflection, the participants recognized especially on the points to be improved in terms of their participation. We kept those findings on Miro, (just like on the wall of AHI training room), so that the participants can reflect anytime. Day by day, each participant has tried to listen carefully and asked for help from others when they were not clear. In the last days of Part-1, they said they were more comfortable.

Experiment and prepare for Part-2

Before the Part-2 starting from July 26th, the participants will meet with youth group members either online/ in person to clarify the concerned points such as the issues which the youth members are struggling and their expectation in their activities. Still, it is not easy for every participant to have the best learning environment in this COVID-19 situation. Considering every condition, AHI walks together with the participants to maximize their learnings until the end of the course.

Voice from a participant

Ms. Shah Rahnuma Binte Jalal Sarna, Centre for Disability in Development (CDD), Bangladesh, ILDC2021

Ms. S.R.B.J.Sarna

Last year, when I received the confirmation letter of my participation in AHI International training course 2021, I was so excited. Everyone asked me "When are you going to Japan?" Sister Keya, my colleague and also a participant of ILDC2015, told me about the story of her stay at AHI. I had been counting the days while making a list of what to bring for my trip to Japan.

Then, all was gone due to COVID-19 situation!! AHI decided that the training course was to be held online. It was unfortunate. My life has changed in those days. Although I was happy that the course would be held, I was doubtful how much of learning experience the online training course could bring to me.

The Part-1 of the course began on June 14th. Aside from the sessions (5.5 hours per day), we had assignments and preparation. It looked going well. However, some sudden and unwelcomed things happened. Internet disappeared during my presentation, power suddenly cut down during small group work, my laptop got frozen during the question-and-answer session. Especially when it was raining, WiFi was down, and I needed to run onto the rooftop floor with my laptop and umbrella. Some other participants also encountered similar troubles and minimize the disruption.

The Part-1 ended. Through sharing each activity in the small group discussion, I learned that there are common challenges on minorities such as MSM (Men who have sex with men), girls, persons with disabilities. In the Part-2, I would like to know more about how such people with social barriers are tackling their issues in the communities. Now I am ready for any kind of big changes which can occur in my life. I realized that sister Keya was right. This 2-week experience did change my life. My energy levels are very high now!

Meanwhile, the strict lockdown / shutdown has been imposed in my working area which makes it difficult for me to visit Cox's Bazar (where my youth group resides) for applying my learnings before Part-2 starts. Now I am trying to contact them via online.

Seventh year of PCLDC under COVID-19

(English translation of Japanese Newsletter for AHI supporters authored by Ms. Kyoko SHIMIZU, AHI)

Participatory Community Leadership Development Course (PCLDC) for Young NGO Workers and Community Leaders in Pakistan is one of the collaborative projects between former participants of ILDC and AHI. Last year, PCLDC was held in Lahore from November 21 to 29, in-between the lockdowns.

The training program has started in 2014 with the enthusiasm of Mr. Hector Nihal, who participated in ILDC 2013 to nurture young leaders in Pakistan. Mr. Hector and his colleagues have provided a venue where Pakistani youth with different regions and cultural backgrounds could gather every year. They applied "participatory approach", in which the participants themselves decide what they learn as well as how they proceed with the training, facilitate the sessions, and learn from each other through sharing.

There are more than 100 youths participated for the course. Moreover, a network named LIFE Alliance has been established among former participants. It has regional groups which would recommend participants for PCLDC from their own areas and follow up with the participants after the course. Some of former participants joined the PCLDC management team, which takes roles of planning, organizing and facilitating.

Participants are discussing in small group

Other participants participated in ILDC after PCLDC (and vice versa). Thus, PCLDC is being conducted by the team of ILDC-PCLDC former participants including Mr. Hector.

In 2020, while many other training programs were held online due to the corona disaster, Mr. Hector proposed AHI on holding the training face-to-face in a right timing. When the lockdown was lifted in early October, he and his team started preparation to implement PCLDC.

Later, Mr. Hector said that he alone would not be able to make a decision to hold PCLDC. He was encouraged by the following comments, such as,
"I want as many as young people possible to have same experience in PCLDC as what I did."
"We feel regret if we cancel this year."
The team members worked together to come up with various ideas to make sure that no one would get infected and every participant could complete the training in good health.

In November, the nine-day training was held with 16 participants, taking all possible measures to prevent infection, such as daily temperature check, wearing masks, hand washing, and thorough social distance. Many of them are leaders of youth groups that the PCLDC graduates work with in their working areas. Young government officers who were involved in the activities of the graduates also joined. Among the action plans which were developed by the participants based on what they learned in the training, there was one in which a regional group of LIFE will hold a mini version of PCLDC in their area. I found that the graduates were trying to increase the number of colleagues with the same values in order to further practice the participatory approach which they experienced in the training.

The situation, including corona pandemic, is still to be uncertain and so will be the future. However, the team members of LIFE are continuing to discuss how to develop the training in the next year and beyond. The LIFE members share the basic value of participatory approach, and they will continue their efforts to let many more young NGO workers experience participatory training, expecting them to practice it in their own field.

Participants and management team of PCLDC 2020

News from friends

Mr. Deepak Kumar Ghimire, SIDS Nepal, Sindhuli, Nepal, ILDC2013

Mr. D.K.Ghimire is distributing goods

World has been facing massive global health pandemic (COVID-19). Nepal is not the exception. In Sindhuli district there are 1342 positive cases have been identified with 22 mortalities till date. In this regard, local government and local administration has locked down from last week to mitigate the spreading portion of this virus and this situation is likely extending more. Local government of Sindhuli has been rigorously combating with recent pandemic however, due to the lack of health safety equipment such as Personal Protective Equipment (PPE), masks, sanitizers, oximeter etc. Their services for present COVID-19 affected peoples is not enough.

Meantime, nationwide and district wise lockdown has subsequently led to suffering every sector such as Education, Employment, daily wages labors, Industries, health and daily livelihood of most vulnerable communities of Sindhuli. In this, regard Sindhuli Integrated Development Service Nepal (SIDS Nepal), Sindhuli has been supporting needy communities, health facilities, Community Based Organizations (CBOs) and most vulnerable families in various ways through its development project interventions in crucial situation of COVID-19.

SIDS Nepal has supported health safety equipment and for local government with partnership of various donor agencies. Now, SIDS Nepal has been collecting demands of local governments regarding the COVID-19 response and providing necessary supports.