Increasing resilience to diseases and epidemics: a CARE learning review

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List of Acronyms

CAAP	Community Adaptation Action Plan
CARE	Cooperative for Assistance and Relief Everywhere
CBA	Community-based Adaptation
CBS	Community-based Surveillance
CCA	Climate Change Adaptation
CHW	Community Health Worker
CIS	Climate Information Services
COVID-19	Coronavirus disease
CSA	Climate Smart Agriculture
CVCA	Climate Vulnerability and Capacity Analysis
DRM	Disaster Risk Management
FGD	Focus Group Discussion
IGA	Income Generation Activity
IPC	Infection Prevention and Control
IRM	Integrated Risk Management
KII	Key Informant Interview
MEL	Monitoring, Evaluation and Learning
NRM	Natural Resources Management
PIIRS	Project and Programme Information and Impact Reporting System
PSP	Participatory Scenario Planning
SGBV	Sexual and Gender-based Violence
SRHR	Sexual Reproductive and Health Rights
SuPER	Sustainable, productive, equitable and resilient
VDC	Village Development Committee
VESA	Village Economic and Savings Associations
VSLA	Village Savings and Loans Association
WASH	Water, Sanitation and Hygiene

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Introduction

The COVID-19 pandemic is testing the resilience of communities CARE works with on an unprecedented scale, with complex interrelated primary and secondary impacts on populations across the globe. It is highlighting the urgent need to support communities to mitigate, respond and recover from public health related crises, as well as from other prevalent shocks and stresses such as those related to climate change. And it lays bare the injustice of pervasive inequity and an expanding wealth gap, with poor and vulnerable communities disproportionally bearing the brunt of the devastation. A radical system overhaul is urgently needed to build fair and equitable societies. Increasing resilience will be key to this effort and in successfully managing future disease and epidemic shocks.

Increasing resilience is a key approach in CARE's 2020 Program Strategy and plays an important role in CARE's 2030 Vision. When communities are resilient, the chances of moving out of poverty in the face of worsening shocks and an uncertain future climate are greatly enhanced (CARE, 2016). This resilience focus cuts across CARE's four key programme outcome areas: living-saving assistance through humanitarian action; exercise of sexual reproductive and maternal health rights for women and girls; increased food and nutrition security and climate change resilience; and greater women's access and control over economic resources. With this approach, CARE supports poor people to strengthen their capacity to absorb and adapt to shocks and manage growing risks whilst building enabling environments for pro-poor social and policy change. CARE's programmes also work to address the underlying causes of vulnerabilities and build capacity to transform in response to new threats and opportunities, such as COVID-19 and other diseases. In addition to building critical community assets and capacities, a vital part of increasing resilience to disease and epidemics is working with governments and communities to strengthen health services, systems, structures and policies that support people, especially the most vulnerable, in the face of epidemic and disease shocks.

Purpose of Learning Review

The communities with whom CARE works have long faced a variety of shocks and stresses. But, perhaps now more than ever, it is important to understand 'what works' in order to inform replication and innovation of further action for increasing resilience against disease and epidemics. This learning review has been commissioned by CARE's Climate Change and Resilience Platform (CCRP) and CARE Nederland to contribute to this effort. It examines different types of CARE's programming that has increased resilience across diverse contexts. It draws out key transferable experiences, lessons, and good practices of effective support to communities, civil society, and governments to manage the multiple impacts of disease and epidemic shocks. Framed within CARE's 'Increasing Resilience Framework', the review also provides practical guidance to support CARE country teams as they consider their resilience strategies for the current pandemic, and future disease outbreaks and epidemics.

Methodology

For CARE, resilience goes beyond the ability to recover from shocks and includes addressing the underlying contextual conditions that make people vulnerable in the first place. Furthermore, increasing resilience is not an outcome that can be achieved within a specific time frame, but an ongoing process. CARE's Increasing Resilience Framework (see Figure 1) identifies the following required components and conditions that support resilience:

- People's **capacities and assets** to manage shocks and stresses are built and supported. These are shocks and stresses that affect groups of households, communities, regions, or entire countries. Please see the table below and Figure 2 for core categories.
- The **drivers of risk** are reduced. Please see Figure 3 for common types of risk drivers.
- The final component is about an **enabling environment.** The actions above are supported by an enabling natural and social environment that allows individuals and communities to reduce their vulnerability. Individuals and communities can only strengthen their resilience to shocks, stresses and uncertainties if the formal and informal rules, plans, policies and/or legislation and natural environment allow them to reduce their vulnerability; build and act upon their capacities; increase and strengthen their assets; and directly address risk drivers.

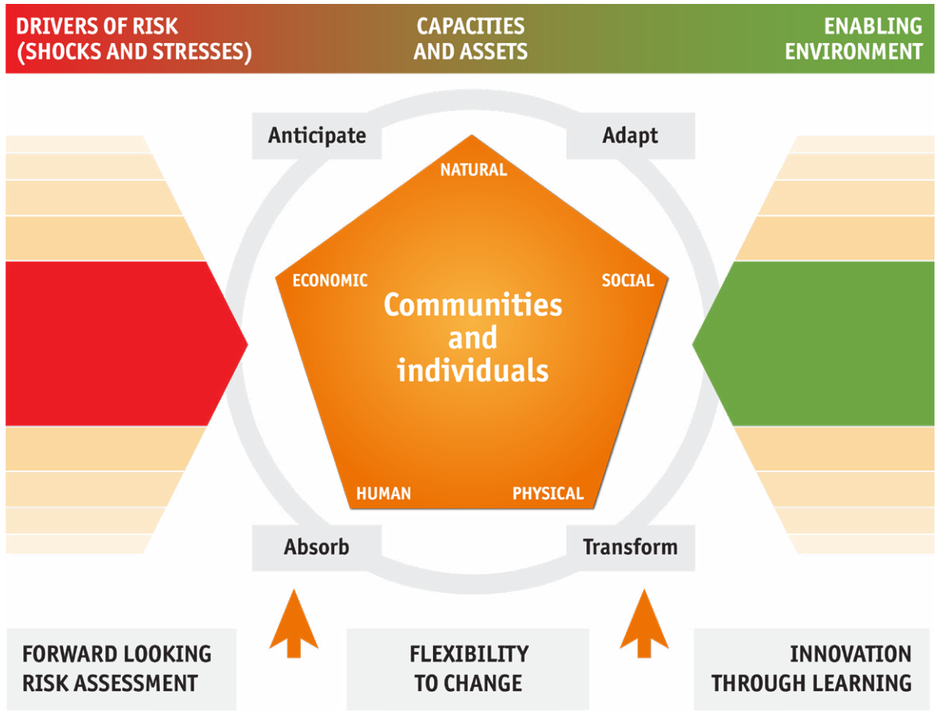

Figure 1: CARE's Increasing Resilience Framework

Assets	Capacities
Human potential: e.g. skills, knowledge, education, health, family size, and individual motivation.	**Anticipate risks:** foresee and therefore reduce the impact of hazards that are likely to occur and be ready for unexpected events through prevention, preparedness, and planning.
Social capital: e.g. extended family, community cohesion, voice, and political influence.	**Absorb shocks:** accommodate the immediate impact shock and stress have on their lives, wellbeing, and livelihoods, by making changes in their usual practices and behaviours using available skills and resources, and by managing adverse conditions.
Economic resources: e.g. market access, savings, insurance mechanisms, livestock, and productive assets.	**Adapt to evolving conditions:** adjust their behaviours, practices, lifestyles, and livelihood strategies in response to changed circumstances and conditions under multiple, complex and at times changing risks.
Physical capital: e.g. tools, premises, infrastructure, and productive land.	**Transform:** influence the enabling environment and drivers of risk to create individual and systemic changes on behaviours, local governance and decision-making structures, economics, and policies and legislation.
Natural resources: e.g. forests, common pastures, water, soil, and environmental resources.	

To assess and reflect on how well resilience is integrated into their projects, CARE teams are encouraged to use CARE's Resilience Marker tool. The data is collected, compared and tracked across 80+ member and country offices using the Project and Programme Information and Impact Reporting System (PIIRS). This review used the Increasing Resilience framework as the lens to review the PIIRS database from 2018 and 2019. Approximately 2,000 projects returned, and were then filtered using the following criteria:

- Score of 3 (good) or 4 (excellent) on the Resilience Marker.
- Identified diseases and epidemics as one of 3 top shocks or stresses in their context.
- Had accessible evaluation and learning material on CARE's central online repository.

Over 200 projects met these criteria, which we filtered further by choosing projects that:

- Addressed health-related shocks and stresses directly, first.
- Next, those that worked on comprehensive set of resilience building interventions across a range of sectors.
- Together, resulted in a fairly representative balance of countries and regions.

In line with the time and resources available for the review, the final selection was: 13 projects/programmes for document review and a further 13 projects to be reviewed less intensively. On this sample, we conducted a document review and remote Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) with CARE staff directly involved in the programming to share their experiences, learning and recommendations.
It is important to note a few limitations in this process. As this is not a formal research study or evaluation, the methodology and rigour are more restricted. The Resilience Marker is a self-reported tool; therefore, the quality and depth of information varies across programming, and there is a risk of bias. Many of the projects/initiatives had already ended, which may affect the accuracy of information recalled, and limit the information available about how communities are affected by or resilient to COVID-19. This also limited the amount that could be accessed on the current status of many communities in facing the pandemic. Time and resources limited the number of staff engaged directly. Notwithstanding these limitations, this report offers a wide breadth and depth of valuable knowledge and insights from evaluations and direct staff accounts on resilience building in different contexts.

Overview of Sampled Programming

Number of projects/programmes	26
Countries of programming	19: Afghanistan, Bangladesh, Ecuador, Ethiopia, India, Indonesia, Iraq, Kenya, Laos, Malawi, Peru, Philippines, Sierra Leone, Somalia, Thailand, Uganda, Yemen, Zambia, Zimbabwe
Number of evaluations, learning and assessment reports reviewed	34
Number of staff interviewed in FGDs and KIIs	17
Date range of programme implementation	2010-2020
Number of people reached based on PIIRS reported figures	Directly: Women and girls +5,550,000; men and boys +5,000,000 Indirectly: +10,500,000 people Total: +21,000,000 women, men, girls, and boys reached
Key sectors of programming	Health, Sexual and Reproductive Health and Rights (SRHR), Food Security, Livelihoods, Nutrition, WASH, Disaster Risk Management (DRM), Climate Change Adaptation (CCA), and humanitarian response
Main approaches and tools used for resilience building[1]	**Health:** Health System Strengthening, Community-based Surveillance (CBS), Community Health Workers (CHW), SRHR services/family planning, SGBV prevention, referrals, and management **WASH:** constructing and rehabilitating WASH infrastructure, Water User/management Committees, participatory health and hygiene education **Financial inclusion, livelihoods, and Economic Empowerment:** Village Savings and Loans Associations (VSLAs), Income Generation Activities (IGAs), Value Chain Development, Graduation Models **Climate Resilient food security and nutrition:** SuPER food systems (sustainable, productive, equitable and resilient), Climate Smart Agriculture (CSA), Farmer to Farmer and Farmer Field Schools, seed banks, cash/voucher transfers, and Community Animal Health Workers **CCA/DRM:** Community-based adaptation, Climate Vulnerability and Capacity Analysis (CVCA), Participatory Scenario Planning (PSP), Community Adaptation Action Plans (CAAPs), Integrated Risk Management (IRM), Natural Resource Management (NRM), community DRM/NRM committees **Inclusive governance:** Community Scorecards, support to community governance structures (e.g. Village Development Committees) **Gender equality and equity:** Rapid Gender Analysis, Gender Dialogues, Gender Action Plans, Social Analysis and Action, Social Change Agents.

[1] Some of these approaches overlap sectors but are only listed once.

Shocks, stresses, and drivers of risk across the sample

As discussed, all sampled projects had identified diseases and epidemics as one of the key **shocks and stresses** in their contexts. However, meteorological shocks and stresses (particularly drought and floods), were by far the most common, followed by economic and social ones, which were each identified on a similar scale. Conflict and fragility were also highlighted as drivers of risk, shocks, and stresses, but are more nuanced as they are specific and varied, based on contextual political and social power dynamics.

Climate change and climate-induced hazards were identified as a leading stress for all sampled programmes. This is perhaps to be expected given that much of CARE's programming takes place in agricultural and pastoral rural settings where the primary and secondary impacts of climate change are inherently connected to community livelihoods. Resilience to climate change calls for a range of multi-sector interventions. The sampled programmes all covered more than one sector while many covered several, with gender and disaster risk management (DRM) featuring strongly as both cross-cutting and stand-alone interventions.

Poor governance and institutions, limited access to basic services, and social norms and barriers were also commonly identified as interlinked drivers of risk in all programmes based on the documents reviewed, KIIs and FGDs. The remaining drivers: lack of control over resources, environmental degradation, and conflict and market failure, also appear but are more context specific and fluid. It is important to note that these common drivers of risk identified in the sample go beyond the context of disease and epidemic shocks and stresses and apply to others as well.

Categories of Shocks and Stresses

Geophysical
Earthquake, tsunami, volcano

Meteorological
Drought, floods, cyclones

Political & conflict
War, coup, political unrest, corruption

Economical
Price increase, currency shocks, market collapse

Diseases & Epidemics
HIV, Ebola, crop and livestock diseases

Social
Demographic change, migration, exclusion, (gender) discrimination

Technological
Toxic spill, infrastructure collapse, large scale power outage

Figure 2: Shocks and stresses in CARE's Increasing Resilience Framework

CARE commonly encounters the following drivers of risk:

- Climate change
- Poor governance and institutions
- Lack of control over resources
- Limited access to basic services
- Environmental degradation
- Conflict
- Market failure
- Social norms and barriers

Figure 3: Drivers of risk in CARE's Increasing Resilience Framework

Key Findings: 10 good practices and 10 lessons for increasing resilience in the face of disease and epidemics

To draw a comprehensive picture of what it takes to increase resilience in the face of epidemics and diseases, the identified lessons and good practices should be interrogated and understood alongside each other. It is relevant to note that many sampled projects struck a balance between implementation of interventions on the ground and other efforts such as advocacy to influence social and gender norms change, address risks and build enabling environments for social, environmental and economic transformation. CARE recognizes that, *"The enabling environment and drivers of risk are often the two ends of a continuum as some factors can simultaneously be sources of risk or opportunity."* (CARE, 2016)

Good Practice 1:

Increasing resilience in the face of disease and epidemics requires multi-sector integrated interventions that are sensitive to the context

Programmes that address both health service supply and demand are more effective in addressing public health crises and increasing resilience to disease and epidemics in the long-term.

The review confirms the need for and success of **integrated interventions that work on a range of capacities and assets and are tailored to the operating context.** This is not a new learning for CARE, and staff emphasised that programme design must start with understanding the context and identifying drivers of risk. Accordingly, the vast majority of the reviewed projects are comprised of different interventions that worked to address a variety of drivers of risk in order to support livelihoods, food security, nutrition and WASH, whilst also embedding cross-cutting elements of gender, social norms change and DRM.

The evidence confirmed that CARE's programming is also strong in establishing and supporting robust community structures and linkages across the health system to build an **enabling environment** that can be sustained and acted upon by communities in the long-term **(transformative capacity)**. CARE's programmes also add value through training health sector staff and community volunteers **(human potential).** These elements are key to increasing resilience to disease and epidemics and contribute to increasing the **demand** for health services by promoting health seeking behaviour and links to health services at the community level.

However, health crises and indeed health services in the long-term also require substantial quantities of **supply of physical capital,** such as infrastructure, equipment, and drugs. This is beyond CARE's capacity to deliver alone, however, any disease and epidemic response and long-term resilience to these shocks must ensure strong and sustainable supply side support for health systems and services. While many of the sample projects aimed to address this need within the resources available, physical capital gaps in health services were identified as an impediment to both the response phase and long-term resilience to disease and epidemic shocks and stresses.

Examples:

CARE's work in the **Sierra Leone Ebola epidemic** was extremely successful in fostering effective **Community Based Surveillance** (CBS) structures and establishing links between communities and health services. CBS is a means for communities to contain and prevent the spread of a disease through contact tracing, alerts, and linkages with health services. The **Community Health Workers** (CHW) and its network play an active role in CBS and were found to be extremely effective in this Ebola project. The **Enhancing Capacity and Resilience of Health Systems (ECRHS) Phase 1 Evaluation** found that CHWs, *"actively engaged in identifying recommended CBS priority diseases and events in their communities and reporting them through the appropriate reporting channel…CHWs observed to have particularly strengthened the Integrated Disease Surveillance and Response (IDSR) system. The link between the CBS systems and the IDSR has consolidated their existence, and disease surveillance and reporting were observed to have consistently improved."*

CARE also provided essential supplies and equipment, especially for Family Planning, but there remained a large unmet need, with only 9.5% of Public Health Units (PHUs) having all supplies and equipment needed to provide routine services at the end of the project. The **ECRHS Phase 1 final evaluation** highlighted the *"need for health service quality improvements and maintenance as well as provision of drugs and family planning commodities…to make the supply chain more functional from the national level to the last mile."* The expectations for INGO programming, such as CARE's, is high given the need, yet limited budgets are insufficient to provide all required materials. ECRHS project staff explained that *"Our budget increased in Phase 2, but at same time we increased geographical scope, so (supply of stocks) is still a problem. Now we are trying to prioritise, and facilities are at different levels of need…historically the government hasn't had the budget for supplies, so 90% comes from partners and NGOs."* More sustainable supply chains and resources for government and community health services is a key need for increasing resilience to disease and epidemics.

This also applies to programming outside of public health crises. For instance, in **Promoting Resilient Livelihoods Project (RESET II)** in Ethiopia, the project trained health professionals in a range of health and nutrition practices and treatments and provided medical stocks, which expanded health coverage (supply) and increased community access (demand). The midterm review found that, *"By improving basic services (health and WASH), animal health and pasture, agricultural production and income, DRR approaches, contingency plans and information, the project was able to meet the complexity of poverty alleviation and has directly contributed to individuals being more prepared, resilient and less at risk now and will continue to do so. As a direct result of the project, the health facilities had above 50% of the medical supplies required in the national guidelines compared to below 50% [at baseline], because of this health offices provided additional services to 378,720 people (51% women)."*

Lesson 1:

Comprehensive multi-sector programmes yield results for increasing long-term resilience to disease and epidemics, while it is also essential to address both demand and supply side needs, especially physical capital. Such programmes facilitate positive health outcomes for improved health status and practices of households, strengthening community capacity to absorb future disease and epidemic shocks. CARE's provision of training on Infection Prevention Control (IPC), basic health services, data management support and facilitating CBS structures and linkages support increased human potential, resulting in improved health outcomes. These interventions also contribute to an enabling environment with improved health system preparedness and planning, and therefore build adaptive capacity of these systems to effectively respond to new risks and conditions. However, equally important are physical capital of infrastructure and sustainable medical supply chains and stocks. This is a critical factor in mitigating and managing public health crises, the lack of which severely limit health systems and services to absorb disease and epidemic shocks and increase resilience in the long-term.

Good Practice 2:

Successful financial and livelihoods interventions lead to an increase in uptake of medical services

This increases resilience to disease and epidemics, and better health practices and outcomes.

Economic resources are clearly linked to resilience. Findings show that **increased economic resources** (such as income, savings, insurance, and access to credit or loans) support both **anticipatory and absorptive capacity**, by enabling households to better **prepare for future disease and epidemic shocks** and maintain improved health practices overall. Increased economic resources can make essentials affordable and accessible, such as basic medical services and medication; a more diverse and nutritious family diet; and clean water. This improves both health and decreases the risk factors for disease transmission. Secondary adverse economic effects of a disease or epidemic shock will impact households less if they have more financial stability and economic resources, such as medical insurance.

Examples:

Kenya's PROFIT Graduation Programme targeted vulnerable women and youth to build sustainable livelihoods through asset transfer in the form of cash grants or in-kind goods to support their businesses, a monthly stipend for 6 months, and free health insurance for 18 months. It also provided technical training in business skills, financial literacy, and asset management; life skills training in maternal and child health, WASH, HIV/AIDS, alcohol and drug abuse and gender empowerment; continuous mentorship; and consumption and savings support. Interestingly, **health emerged as a major area of impact** as found in the final evaluation. *"Graduates acted on lessons learned about prevention and treatment of health issues…Confidence in the largely female sample grew the most with respect to obtaining financial services and seeking medical treatment, while mothers felt they had a better grasp of their family's nutritional needs as well as knowing how to manage household resources to provide for them…the impacts of health, business, and financial training, market linkages across value chains, and the success of savings groups and business savings training, will continue to provide the basis for income generation and resilience in the face of shocks throughout PROFIT participants' lifetimes."*

A **positive correlation between economic resources and health services access** was also found in other projects, including the **Bangladesh Shomoshti Project.** The final evaluation determined that the income of project beneficiaries increased by 39% while the project also worked to increase households use of social services, including health. The midterm review found that 92% of the respondents were using at least two social services as compared to 57% at baseline. Furthermore 86% of households interviewed had visited a community clinic at least once and among them, 91% also accessed health services from community clinics in the last six months.

This linkage is also demonstrated by the success of Village Savings and Loans Associations (VSLAs)[2]. Several informants and evaluations recognised that **funds saved in VSLAs enable households to invest in their families' health** overall, and to access pooled funds in health crises. As one staff KI for the **Enhancing Community Resilience Project (ECRP) in Malawi** explained, *"Since our project tried to build capacity of beneficiaries financially, and for food security and nutrition, once they improve this, they are supported to be resistant to diseases because they will have money for food and increase their nutrition and health immunity. Plus, with VSLA savings, they are more able to go to hospitals in illness… Empowered households have more money and food now, so it's easier for them to bounce back more easily than households which do not."*

Lesson 2:

There are important reinforcing links between targeted health interventions with training on health practices such as nutrition, breastfeeding and safe water use, and interventions that support livelihoods and financial inclusion. Improved livelihoods and financial household status in turn improve the ability of households to access health services and follow health and nutrition advice received through training and awareness raising. Their increased economic resources enable them to absorb and adapt to disease and epidemic shocks and stresses, thus increasing long-term resilience to them.

[2] A Village Saving and Loans Association is a Savings Group that is a self-managed group of 15-25 individual members from within a community who meet regularly (weekly, biweekly, or monthly) to save their money in a safe space, access small loans and obtain emergency insurance. Members can take out loans to cover expenses such as school fees and medical bills without selling productive assets, or they can use the loans to invest in income generating activities to raise household income. As a result, VSLA members experience significant improvements in household health and wellbeing, and an overall improved quality of life. The VSLA prototype was introduced by CARE in Niger in 1991. For more information, please see: https://care.org/our-work/education-and-work/microsavings/vsla-101/

Good Practice 3:

Building financial and productive capital quickly is an important element for engagement and retention of communities in more long-term resilience investments

Increasing resilience is a multifaceted and complex ambition. In many of the sampled programmes, results were built over several months, or even years. Communities can be hesitant to engage or remain in activities that don't deliver quick rewards of asset and capacity building results, or that require an investment of their limited resources (despite potential long-term gains). The evaluative documents reviewed **highly recommend ensuring a balance of interventions with "quick wins", especially monetary ones, with those that cost communities' time and energy over the long-term.**

Examples:

Where the Rain Falls III (WtRF) in Bangladesh, India and Thailand: *"The importance of financial capital to building resilience and adaptive capacity is well known. Several recent evaluations of adaptive capacity have suggested that a minimum household income must first exist in order for beneficiaries to be taken on risk, innovate, and practice flexible-forward thinking decision-making. Ensuring 'quick wins' activities from project start-up that…build household or community financial capital in a short period of time… will secure their interest and incentivize their active engagement in community-based adaptation planning processes… to improve the sustainability of outcomes of the project and increase the resilience of livelihoods and food production systems, long-term planning must complement the short-term need for demonstrable results."*

ECRP in Malawi: *"Interventions with short term benefits or returns register a higher adoption rate than those with benefits realised in a long term: those with immediate benefits attracted most participation… The relevance of this lesson lies on the provision of immediate practical solutions to needs of households."*

Related to this, **providing a range of options** for uptake that communities can select from based on their means and risk thresholds is also key. The **Promoting Climate Resilience Project in Laos** final evaluation noted that, *"Providing a diverse array of climate change adaptation options allows farmers to select strategies which they feel most comfortable in adopting and which they are able to secure the greatest benefits from their labour."*

This finding also highlights one of the reasons that VSLAs[3] are attractive to communities and are often sustainable in the long-term - they provide economic resources that households can see more tangible gains quickly with several options for Income Generation Activities (IGAs). However, **VSLAs are also an entry point to several different interventions that require more time but also work to build assets** - such as changing maladaptive social norms and increasing VSLA members' voice and influence **(social capital)** or promoting healthy hygiene and nutrition practices **(human potential)**. These assets work together to decrease drivers of risk and **build transformative capacity** through which VSLAs become strong community structures for increasing resilience in several ways. As also cited in **ECRP Malawi**, *"A strong consensus exists [that] VSL as an entry point to participation proved to be an effective tool to enhance adoption of other interventions, such as low carbon stove. The short-term economic benefits…were practically important in responding to many household needs, indicating that sustainability would likely be achieved. It is a preferred intervention because it is more practical, efficient, effective and very appealing to the households."*

Lesson 3:

It is important for programmes to balance interventions between those that require long-term investment to yield gains for resilience and others that can produce "quick wins", in order to prevent participant attrition and increase the potential for sustainability. While this is relevant to all programmes that seek to increase resilience, it is important to consider in the context of supporting communities in the face of disease and epidemics as well.

[3] Please note that VSLA is used as a general term in this report that covers other iterations used across different programmes in CARE such as Village Economic and Social Association (VESAs) in Ethiopia, Village Saving and Lending (VSL) in Malawi and Self-Help Groups (SHGs) in Bangladesh and India.

Good Practice 4:

Addressing SRHR and SGBV is essential for increasing resilience and positive health outcomes in public health crisis responses

CARE recognises the **interconnected links between Public Health Crises, SRHR and SGBV** and addresses them in its resilience and health programming, leading to better health outcomes overall. This emphasis also supports an **enabling environment for increasing resilience to disease and epidemics** by building recognition that sexual health, rights, and protection are fundamental to long-term community health. In public health crises, there is often a rise in SGBV as identified in CARE's recent Global COVID-19 Rapid Gender Analysis. SRHR is also often adversely impacted because women have reduced access to delivery units and proper ante and postnatal care, while health systems are focusing on an epidemic. Ensuring that SGBV and SRHR services are maintained, and needs and gaps addressed, reduces related medical ailments, deaths, and complications. It can also increase health-seeking behaviour and trust in the health system, which can in turn build **transformative capacity of communities** to work effectively with health sector providers for a **more enabling health sector environment.** When proper investments in SGBV and SRHR services are made, this also supports communities **to better anticipate risks, absorb shocks and stresses, and adapt** to address pressing health and protection needs, especially for women and children, who are often underserved and disproportionately affected by the adverse consequences of diseases and epidemics. This is illustrated in the examples below.

Examples:

Both of CARE's **Zika and Ebola epidemic response projects** recognised the secondary negative health impacts linked to SRHR and took preventative action. For example, *"The Ebola crisis had broader impact on maternal and reproductive health services- raising widespread concerns of women dying at home from complications of pregnancy and childbirth. The crisis particularly had impact on pregnant women since health facilities were overwhelmed with Ebola patients and health workers were afraid to treat women experiencing bleeding/haemorrhaging associated to pregnancy complications."* By including specific activities and resources for family planning (contraceptives and advice), HIV counselling and testing, maternity ward improvements, **CARE's Sierra Leone ECRHS project** supported overall health system stabilisation and better health seeking behaviour by communities. The SRHR focus was upscaled in Phase II due to its high relevance for both women's and community health, according to the ECRHS Phase 1 final evaluation.

"The Ebola crisis had broader impact on maternal and reproductive health services, raising widespread concerns of women dying at home from complications of pregnancy and childbirth. The crisis particularly had impact on pregnant women since health facilities were overwhelmed with Ebola patients … Investing in rehabilitation of maternity wards and relevant functional equipment provision and installations will increase access to safe delivery service which encourages better health seeking behaviour by community members as result of safer deliveries at facilities…[with CARE's intervention] there was a marked increase in PHUs offering basic health services [including family planning] and HIV counselling and testing…an important finding on efforts made to stabilise the health system." This was also especially **important as it helped communities build their trust in the health system,** *"PHUs offering routine health services with restoration of trust in the health system (by increasing demands for services)- which serves as an achieved outcome of efforts made towards health system strengthening."*

In the bi-national **Zika Response in Ecuador and Peru,** gender was mainstreamed into all material and messages for men and women. Targeted activities were developed for groups of men, covering the Zika transmission routes, especially sexual transmission, and the use of condoms as a preventive measure. SGBV was also included due to the high rate of SGBV in communities. Youth and children were targeted through teachers and schools using specially developed teaching guides and educational materials. Adolescent knowledge on Zika prevention and control increased by 109% from the baseline, including on SRHR issues. As one staff explained, *"The project had a central topic on preventing Zika, but community also decided on other topics such as prevention of sexual exploitation and abuse, protection of pregnant and lactating women and SGBV."*

Lesson 4:

SRHR and SGBV integration in response to disease outbreaks and epidemics supports communities to **anticipate, absorb and adapt to health shocks and build assets of human potential and physical capital** for improved community health outcomes especially for women and children. These combined capacities, assets and outcomes also work to support longer-term resilience to disease and epidemics.

Good Practice 5:

Gender-sensitive and inclusive WASH is critical for public health crisis response and recovery as well as increasing resilience to epidemics and diseases

An important element in WASH interventions is a focus on gender mainstreaming and inclusivity for ensuring widespread access and sustainability.

Examples:

The **Sierra Leone ECRHS Phase I** evaluation found *"Outstanding' performance on WASH access and behaviours with targets exceeded"* although it also noted a big difference between access in urban and rural areas, underscoring the need for a more inclusive approach. A staff KI explained that *"Water [wells and sanitation facilities] – allows handwashing for communities which is very important. An important connection between the wells and the maternal delivery areas and sanitary health facilities – now they have running water."* Also, risk minimising behaviour was found to be relatively higher for water hygiene (89.8%) and handwashing (67.7%), with a large proportion of households continuing to adopt these practices.

Zimbabwe's Putting Women and Girls at the Centre of WASH and Health (ANCP WASH) Phase 2 Project, yielded a range of outcomes to increase resilience, including high water access (from 69 to 94%); sanitation improvement; increased awareness through participatory health and hygiene education; and embedded community capacity to manage WASH. The project evaluation found that, *"The best strategy for being responsive to the women and girl needs was to make them part of the structures in key decision making processes for WASH. Woman made up 70% of sanitation action groups which were driving the implementation of sanitation and hygiene programmes in their villages whilst girls made up to 75% of the club members at schools....were trained to be sensitive to girls needs in the planning and implementation of school developments resulting in construction and equipping of girl friendly latrines."* This also extended to traditionally male activities of operations and maintenance with communities agreeing that *"women builders and pump mechanics are able to perform as well as their male counterparts given appropriate resources and support."*

In **Zambia's Food and Nutrition Security and Enhanced Resilience (FANSER) Project,** there were positive gains in health, nutrition, hygiene of sanitation made for communities by targeting women on relevant knowledge, attitudes, behaviours and practices, resulting in an improved change in community WASH attitudes and awareness. However, water access remained a critical gap that the project evaluation recommended be addressed by the government, given the **important link between water and absorptive and adaptive capacity.**

Lesson 5:

Water supply and associated hygiene and sanitation infrastructure and practices (combining assets of **human potential, physical capital and natural resources**) that put gender and inclusivity at the centre are key to increasing resilience to health-related shocks and stresses, by **building both absorptive and adaptive capacity.**

Good Practice 6:

Both cross-cutting and direct gender interventions are critical for increasing resilience in the face of disease and epidemics

The evidence base highlighted CARE's focus on empowering women and working towards gender transformative impacts, although not all interventions were equally strong in this regard. CARE's resilience work often offers gender expertise and technical support for local civil society partners as well as international consortium members. Advocacy for gender equality and women's voice is a core part of programming, to support more gender equitable social norms and practices around DRM, WASH, food security and livelihoods. This advocacy brings community level evidence to powerholders and policy makers in national, regional and global fora, in order to influence the enabling environment, **to ensure that all people are able to act to build their assets, use their capacities and address their drivers of risk.**

Several approaches were identified as useful in the evidence base. These included targeted activities to challenge harmful and discriminatory social norms in order to influence the enabling environment and build **transformative capacity** - such as Gender Dialogues, Gender Action Plans, Social Change Agents, Social Analysis and Action. Other examples of targeting women in Farmer Field Schools and VSLAs worked to build **social capital, economic assets and human potential.** This is reflected in the following examples.

Examples:

In **WtRF III in Bangladesh, India and Thailand,** Gender Action Plans and Gender Dialogues were linked with more equitable household labour distribution, reportedly increasing from 22% to 67% in just one year. One staff KI explained the benefit of these combined interventions, *"The gender aspect was really critical... should always be central because of women's huge role in family, household and community and they are so active in sharing the knowledge...I really saw that women were speaking to me, and they were explaining the benefit of the [climate-smart] adaptive techniques – it's a game changer for them."*

Shouhardo III in Bangladesh focused heavily on women's empowerment and participation, with the final evaluation observing *"a general increase in the absorptive, adaptive, and transformative capacities, including significant changes in resilience capacities... women's participation, women's decision-making power and control over cash income."* The findings also noted better household recovery from shocks and more access to health and nutrition services at the community level.

In **Ethiopia's Grad I Programme,** the final evaluation found positive results linked to resilience through the gender approaches. *"Women reported economic empowerment, increased confidence, increased mobility, and better relationships with husbands and neighbours. Village Economic and Social Associations [VESAs] create and strengthen social ties, especially for women who previously had nowhere to go and little to discuss with each other. Women's VESA leadership has a positive spill-over effect on other members, and VESA participation by women improves their immediate living situation with either husbands or children."*

Lesson 6:

Gender equity and the redefinition of gender roles and norms, are necessary for increasing resilience to a variety of shocks and stresses, including disease and epidemics. Without a gender-equitable **enabling environment,** where all people are equally able and empowered to act to **address their drivers of risk,** resilience cannot be realised. Programmes that prioritise both mainstreamed *and* stand-alone gender activities are perceived as more successful in achieving long-term resilience.

Good Practice 7:

Multi-stakeholder participation and linkages between government services and communities play a vital role in building all types of capacities whilst creating enabling environments for successful health interventions and increasing resilience to epidemics and diseases overall

Resilience building requires a range of different stakeholders across sectors and ownership of communities and government. CARE often facilitates multi-stakeholder action and important linkages both **vertically, between grassroots structures and increasingly higher levels of governance, and horizontally, across different sectors and themes.** CARE uses its privileged positions on high-level national and regional forums for advocacy to support an **enabling environment,** through more effective budgeting, planning and policy implementation. Several evaluations and KIIs recognised this as an important success factor for results in the programmes reviewed and an area in which CARE can often support the most, especially with limited budgets and resources. For example, coordination, planning and advocacy support to meet the Health and WASH supply needs such as medicine, safe potable water, latrines, and environmental sanitation infrastructure as well as training of health staff and volunteers **(physical capital and human potential).** CARE also helps connect actors and coordinate solutions all the way from the community level stakeholders to national powerholders and policymakers, to raise the voice of communities and their rights for inclusive basic services **(social capital).** Through this process, communities are able to act on their **transformative capacity** to influence decision makers on issues that matter to their development and wellbeing. One staff from CARE's global Partners for Resilience programme[4] explains the importance of this connecting role. *"Communities are our faces in government meetings, and they can make a change. Empowering them is very crucial for us and working through them and explaining how government laws, policies and systems relate to their lives and experiences... unpack the facts and policy links and why it matters to them and their lives – like the effects of Climate Change and disasters."*

[4] See the acknowledgements page for more information on the Partners for Resilience Programme.

Examples:

In **Sierra Leone**, the final evaluation for **ECRHS Phase 1** found that CARE's role in the CHW network made an important difference as a connecting force. *"A long-term disconnect initially observed between the health system and communities... The CHW network was... the most effective community-based surveillance structure and has established well connected link with primary health unit and district health management teams particularly noted to have played key role in containing and preventing the spread of communicable diseases in their communities."* Staff KIIs also reinforced this *"because the health system strengthening strategy was not just one aspect but integrated components from national to district to community level. It was horizontal across the sectors, and vertical between levels of government. The participatory approach was key - participation of different stakeholders at different levels."*

The importance of multi-stakeholder participation and linkages was also reinforced in the **bi-national Zika response in Peru and Ecuador**. Staff KIIs highlighted the involvement of communities at all levels up to the national government, as well as improved information flows – from low level volunteers up to academic research; linkages between municipalities to prevent transmission; and municipalities linking with communities for behaviour change and mobilisation.

This applies to other resilience programming as well. For example **Kenya's PROFIT** final evaluation notes that, *"CARE's role ...provided participants a) knowledge about how to navigate the local healthcare and financial services scene, b) introduction to local key players who can provide support, and c) supported entry into a bureaucracy few community members felt they knew about. In short, they provided an essential connection between government services and the public who could most benefit from them."*

Lesson 7:

Facilitating multi-stakeholder participation and vertical and horizontal linkages builds both social capital and human potential. When such conditions are present within programming, all the types of capacities for increasing resilience are supported - **anticipatory, absorptive, adaptive, and transformative**. These also work to create a more enabling environment for long-term resilience to disease and epidemics.

Case Study: Established Community Health Workers and Surveillance System in CARE's Sierra Leone Ebola response are now supporting communities to effectively respond to Covid-19.

Innovative use of Community Health Workers (CHWs) in the Ebola response in Sierra Leone (ECHRS) has significantly helped communities, and the health system, to build **absorptive capacity** and **adaptive capacity** to deal with shocks, including COVID-19.

More than 2000 CHWs were trained from 400 communities. CHWs were trained to monitor, report, and respond to public health issues. They were highly visible to communities, playing a key role in containing and preventing the spread of communicable diseases. This **capacity building** of people has led to consistently improved disease surveillance and reporting, using standard reporting procedures and referral systems. It created communication links between community and district, where there were none, and better linkages with the health system managing the epidemic.

Many of the CHWs have continued to participate in the disease surveillance and reporting system beyond the programme, now using their strengthened **human potential** and **social capital** to work on the new COVID-19 challenge.

The ECHRS programme, has contributed to a national scale-up of, and new policy on CHWs, that aims to strengthen the **adaptive capacity** of the health system nationally. The quality of health service delivery is however limited by an overreliance on volunteers and needs huge financial investment in the health workforce.

Good Practice 8:

Building strong, replicable community structures and community engagement for health and resilience is one of CARE's main value-additions

The evidence repeatedly highlighted CARE's strength in building and supporting **community structures as a key entry point into all forms of capacity and asset building.** Where possible, CARE links with established community and government structures, and creates new ones where there are gaps. Most notably with its work around VSLAs, but also DRM and CCA approaches including Climate Vulnerability and Capacity Assessments (CVCAs), Participatory Scenario Planning (PSPs) and Community Adaptation Action Plans (CAAPs). These processes often establish or support community level groups (DRM committee, or equivalent) to lead them; these structures are a key vehicle for increasing resilience and sustainability. They also enable CARE to facilitate linkages between the communities and higher levels. This provides a route for communities to claim their rights and demand accountability from power-holders – **fostering inclusive governance, a key aspect of an enabling environment for increased resilience.**

Examples:

The **Partners for Resilience Programme** is a strong example of how CARE works with community structures to **build and action transformative capacity.** It has supported community groups to voice their rights to assets and basic services for community resilience, and successfully influenced government plans and budgets, thus facilitating a more **enabling environment.**

For example, in **Partners for Resilience in Indonesia,** CARE and its partners work to strengthen Village Development Committees (VDCs) and include Integrated Risk Management (IRM) into their plans. They then advocate for these to be included in district level 5-year mid-term plans and budgets. This has resulted in concrete support to communities' gender sensitive DRM activities such as sustainable agriculture practices of providing climate resilient commodity seeds; rain harvesting infrastructure during drought; and drip irrigation innovations for improved water resource use. As one programme staff explained, *"Through advocacy, it's a good entry point and a strategic way in ensuring the sustainability and scalability of programming because once integrated risk management is in the policy and budgets, it is mandatory for village government to implement the programme."*

Similarly, in **Partners for Resilience in Uganda,** CARE is also working with community environment and wetland committees to build awareness of and advocate IRM needs. This has contributed to the response to crop pests such as desert locust infestations. CARE helped mobilise communities to discuss response, prevention, and planning with district authorities, and to successfully demand national government support. CARE has also supported VSLAs for a decade, which have created opportunities for communities to build a range of assets and capacities. Members have opened businesses, improved their houses and land, and are better meeting their household needs. Partners for Resilience has also successfully linked some VSLAs with district level government funding programmes. For example, several of them accessed a Presidential programme that supports livelihoods enhancements.

The evidence base highlighted many other examples of the significance of community structures that CARE supports in increasing resilience overall and also to disease and epidemic shocks.

- *"The VSLA approach can be one of the economic coping mechanisms, where there are no formal financial institutions particularly at the time of emergency conditions such as delivery, sickness and drought. VSLAs serve as an entry point to promote hygiene and sanitation and promote WASH related non-transmittable disease prevention. Members are constructing improved latrine for their households and mobilizing their neighbours to do the same," (SWEEP Ethiopia Final Evaluation).*

  "As a result of the program, individuals and communities are more aware of public services rights and entitlements, have better access to service providers and have stronger capacities to negotiate for services… members of the different groups established by the program received similar messages on basic services and governance which reinforced awareness [and demand for services]," (Shouhardo III Bangladesh Final Evaluation).

- *"The training of communities in DRM, Early Warning systems, climate change, and participation in local and national DRR fora…reduced vulnerability of households to climatic risks and disasters ..Existence of vibrant VCPC and VDC in the communities and community participation were key factors for the success…VSL was found to have a dual function, with short term recovery aided by the ability to have immediate access to money for food and other essentials," (ECRP Malawi lessons learnt report)*

The evidence base also highlighted that community engagement benefits from creative approaches tailored to specific groups and contexts, as found in the **Zika Response** (see 'Case Study' on page 28). Similarly, the role of youth as champions for resilience and health outcomes was highlighted in several programmes; however, engaging youth successfully requires targeted strategies to meet their needs and interests. For example, **ECRP Malawi** found that, *"Involvement of youths improved collaboration with government stakeholders and agencies and had facilitated relationships with stakeholders through forum meetings and advocacy work…Enthusiasm of the youth coupled with their literacy levels is adding value…Recruited youths were trained and in-turn transferred the skills to the communities, (DRR, VSL, CCA)…For resilience of vulnerable communities, long-term commitment in youth participation is often necessary. Careful analysis is needed to discern best way to secure youth participation for the long-term success."*

Findings also emphasised that where possible, structures such as VSLA, as well as **community engagement and mobilisation should be both replicable and encourage replication.** The more structures are replicated, the stronger they become, and their impact increased. Replication of community engagement and cascading of messaging also **increases the likelihood of sustainable healthy practices, and equitable social norms.**

For example, the **WTRF III final evaluation** explained that the programme started with 40 initial Farmer Field Schools of 25 farmers each, the programme multiplied impact across 20 communities. Each farmer provided demonstrations and successfully transferred climate smart agriculture to 3 households each, turning a core group 3,600 into 6,500 more households. Also, the 3 target districts provided new resilient variety of seeds to these farmers who multiplied them for distribution to poor farm households and also kept some for a seed bank as a community asset in the long-term. The **SWEEP Ethiopia** mid-term review found that *"Because of such exemplary achievements [of VSLAs], new VSLAs are being replicated just by observing the SWEEP supported VSLAs in the nearby villages."*

While the evidence supports several positive practices and results around community structures, there is also learning that indicates **over-reliance on volunteers is unsustainable due to a lack of incentives, motivation and high expectations and workloads placed upon them.** This was raised across the evaluations, presenting a risk despite the positive impact. This reinforces the need for systematic recognition of these structures and volunteers while also prioritising different types of incentives such as in-kind resources (farming inputs, transport support, etc). Overuse of volunteers as a replacement for under-funded government services is ill-advised.

Lesson 8:

Community structures and linkages are essential to increasing resilience in the face of disease and epidemics, amongst other shocks and stresses. However, **tailored, and creative approaches for different groups, including ensuring recognition** for their services, are required for their optimal effectiveness, especially in the absence of monetary incentives. It is also important to **recognise the limits to using volunteers, including ensuring reasonable workloads and expectations.** Volunteers should be used with caution to ensure that they do not create a disincentive for investment in essential government health services, and risk undermining the enabling environment.

Case Study: CARE's innovations for creative community engagement successfully helped to increase awareness and safe practices during the Zika epidemic in Peru and Ecuador.

The Zika response in Ecuador and Peru "Juntos ante el Zika" project was designed to strengthen community, local and national capacities to respond (anticipate, absorb, and adapt) to the outbreak, and behaviour change was recognised as key to the lasting impact of the programme. Innovative approaches to community engagement were used to maximise disease awareness and sharing of prevention messages.

In Ecuador, a government ministry trained 280,000 households using risk songs to convey prevention messaging. They encouraged different household members then to adapt these into new songs, music, poems, and games that suited to their cultural context.

In Peru, communities were recognised by a prestigious University, showcased at a fair, and publicised across Latin America. Many of the most innovative ideas came directly from the communities, as acknowledged by a high-level panel of academia, health, and government actors.

The conclusion was that effective behaviour change must be led by the communities themselves. The commitment and assets (social capacity and human potential) to do this can be utilised and further built by engaging communities in interesting and dynamic ways, and by recognising community efforts. Neither example used monetary incentives, but care was taken to understand what would inspire participation, commitment and ultimately behaviour change.

Good Practice 9:

Accessible, sustainable communication channels enhance preparedness, early warning, and ongoing access to critical information, thus building anticipatory and adaptive capacity

CARE embeds advisory mechanisms in much of its programming, which prove beneficial for resilience building and action. These are linked to the community structures discussed earlier, and often designed to support community agriculture and livelihoods in the form of market updates and Climate Information Services (CIS), however health related communications were also noted in the evidence base.

As CIS such as weather advisories are often sent via mobile phones, they can continue beyond the project and support agriculture cycles planning and livestock fattening and destocking, to support yields and sale of productive assets at the optimal time. Several staff interviewed highlighted these as one of the most sustainable interventions in the long-term. Even if not all households have mobile access, households actively share the information with one another and at meetings. However, non-technological means to share messages are also still highly relevant in many contexts, often facilitated through the community structures CARE supports. The following examples highlight the significance of these communication channels.

Examples:
In **Zimbabwe's ENSURE Project**, market information was found to be mostly received through community meetings (40.2%), farmer to farmer (36.3%), telecommunications (16.0%), eco-farmer (14.5%), and electronic media (13.5%).

In **ECRP in Malawi**, Village Civil Protection Committees are the most important actor in immediate flood responses for information and medical advice.

The **Zika Response** utilized different technological means to communicate health messages, including a CBS app in Peru, which was found to be inexpensive, agile, and highly portable. The final evaluation highlights the positive *"experience of community-based vector control, supported by technological and communications innovations,"* while, *"digital communication channels are one of the most effective strategies to reach young people, where there is greater replicability of messaging."*

Staff from **WtRF III in Bangladesh** explained that *"The project linked with agro-climate service providers and registered HHs on the list to send alerts and weather info which meant they could take more anticipatory decision making to prepare before floods arrive...through mobile alerts - many had access to this - not 100% but the neighbours would share info and that's how it spread. They are continuing now."*

Lesson 9:

Establishing different communication channels for weather and health alerts is often cost-effective and efficient, providing a high return on investment for anticipatory and adaptive capacity and asset protection. Providing health, disease and epidemic messaging through established channels, such as CIS, which CARE often facilitates with meteorological agencies, government line ministries and community structures such as DRM committees, should be explored more in CARE's public health crisis responses.

Good Practice 10:

Adaptive Management is key to increasing resilience. This requires flexible project plans, budgets, and risk-financing, such as crisis modifiers

Adaptive approaches are increasingly used in humanitarian and development programmes to ensure that activities continue to contribute to development and resilience goals, even in a shifting context. The evidence from this sample reinforces the **need to be agile** in contexts facing ongoing and multiple shocks and stresses. This is particularly important in rapidly changing or unknown situations, such as the emergence of new diseases with a limited evidence base, as society is experiencing with COVID-19.

Flexibility and continuous monitoring with real-time feedback loops were highlighted by some evaluations and staff informants as a key element of success. These provided the information and flexibility to change strategies and interventions when necessary to respond to the immediate or new situation, in order to protect and enhance progress towards the programme goals. This was the case for **both advocacy and community-based interventions.** The examples below show the benefit of this approach **when building and protecting assets** (ECRAS Zimbabwe) and when **building capacities and strengthening the enabling environment** (Zika Response and PfR Indonesia).

Examples:
The **Zika Response** project staff explained that *"The openness and flexibility of donor was very valuable – they were monitoring, listening and exchanging info regularly and open to changes and adaptations to make it viable in both countries."*

Staff from the **ECRAS project in Zimbabwe** reinforced a *"Need for adaptive management informed by evidence from implementation - if one approach doesn't work then you can adjust. This process is dynamic and requires documentation and key combinations to make it a success. And use of high frequency monitoring approach. We can see the complex interactions between the indicators. We look for example at livestock tracking distance that usually increases in dry season and we can look at the pasture condition to make inferences and activate crisis modifiers."* ECRAS is part of a larger country wide resilience building fund under which several other consortiums operate; CARE's consortium produced the strongest results on several indicators in the recent fund-wide external outcome monitoring survey.

Due to the flexible and evolving nature of **Partners for Resilience**, the programme was able to pivot in 2020 to provide direct response to the COVID-19 pandemic. In Indonesia for example, CARE re-budgeted to distribute Personal Protective Equipment and strengthened community taskforces for response and efforts on GBV prevention by creating and distributing training and IEC materials and reactivating complaint mechanisms for GBV at the district, sub-district and village levels. Additionally, staff observed that the community structures such as VSLA and DRM communities that the programme supported over the past decade are helping their communities to **absorb and adapt** to the COVID-19 impacts. Also, they are being used as entry points to raise awareness and promote safe practices to reduce disease transmission.

Lesson 10:

Adaptive management can increase resilience to epidemics and diseases and protect development gains. Techniques such as adaptive MEL should be used to ensure programmes meet their resilience goals, even in a shifting context.

Case Study: CARE's use of flexible risk-financing in crises to protect resilience gains

The crisis modifier is a risk-financing mechanism that has been used in several programmes to respond quickly to new or anticipated humanitarian needs, in order to protect development gains. The **ECRAS project in Zimbabwe**, has used the crisis modifier five times so far to protect households **(and assets)** from emerging crises while continuing its core work of building **capacities to absorb, adapt to and reduce risk. In Ethiopia, the GRAD I** project succeeded in increasing food security and resilience by helping households to cope with shocks. A crisis-level drought that hit some areas threatened to overwhelm these incremental improvements. Using the crisis modifier, funding was rapidly made available for animal feed, seeds, and additional finance that **protected assets** and proved central to household survival.

"Because there was no rain, we could not produce anything, but then we got the seed and we survived." Households then reported a "good harvest" that enabled them to feed their children."
- GRAD I beneficiary

These types of **flexible risk-financing approaches should be routinely built into the design and delivery of resilience programmes,** as in these two cases. As well as donor support through NGOs, Government multi-year risk financing should be built into disaster risk planning and budgets at all levels - from community to national government. This would build the capacity of the system to **absorb shocks** and **adapt to** changing circumstances. Such an adaptive management approach with risk-financing also works to increase **transformative capacity** at all levels because communities able to play a more active role in programming based on real-time evidence and are more protected from regression into a previous state of lower resilience, allowing for more focus and efforts to be put towards their development.

Concluding remarks and recommendations

This review unearthed **ample evidence of increased assets and capacities** of the communities participating in the sample projects, and a range of positive results, good practices, and lessons for increasing resilience to shocks and stresses. One could speculate several plausible ways that these communities are faring better because of the different assets and capacities developed as a result of CARE's programming. However, the **evidence base does not provide a firm conclusion about exactly how this has contributed to the ability of these communities to respond to COVID-19 in real-time or their future exposure to disease and epidemics,** due to several practical limitations.

Firstly, and perhaps most importantly, most of the communities in closed projects are not being tracked by CARE anymore. While there are a few examples that can be found globally (mostly in CARE's VSLA programming), a **general lack of systematic post-ex evaluations** and continuous monitoring means that staff cannot provide reliable evidence in this regard.

Secondly, the **long-term nature of increasing resilience also means the impacts of many interventions take time to see results** and they will (hopefully) have long-term knock on effects, especially amongst the most sustainable of interventions such as VSLAs, CHWs, embedded DRM plans and budgets as well as the skills and knowledge transfer fostered by CARE's programming. Based on CARE's 2019 learning review on advocacy impact and its efforts in the policy realm, it takes an average of 5 years for communities to see the trickle-down effects of policy in terms of tangible benefits at the community level (Aston, 2019). Therefore, the policy wins and enabling environment that CARE has contributed to related to increasing resilience will continue to be observed for years to come but are presently unknown.

Lastly, as its name suggest, **the Novel Coronavirus is quite unique in its nature and the pandemic is unlike others before it.** Therefore, communities and countries that have often faced other diseases and epidemics, find themselves struggling. As one staff KI aptly expressed, *"COVID has caught us unprepared – it's unprecedented. [We have] a long tradition on working on these vector diseases, but very different with COVID… Two very different diseases and transmission modes so the measures are not adaptable from Zika…We still work with the community monitor volunteers but this is hard because it lasts so long and is so uncertain."*

It is also **challenging to continue supporting communities once projects have closed, highlighting the importance and promise of long-term programmes.** For example, the **Sierra Leone Ebola Programme** is currently in Phase II and has been able **to transition and use existing structures to address this pandemic and other disease outbreaks.** As staff explained *"We trained more than 2,000 CHWs from 400 communities…they are still used today around COVID… the Northern region has more preparedness thanks to the programme. They are better able to identify hazards and shocks and are really ready for COVID…in 2019 they respond to a Lassa fever outbreak within 48 hours. The response is quicker as they are prepared and understand what to do and plans are actually being used."*

While the findings are inconclusive on how communities in the sample are coping with COVID-19, absence of evidence is not evidence of absence. A more rigorous research study could help to answer this question in-depth. However, the learning from CARE's vast experience across the public health sector specifically and for increasing resilience more generally offers plenty of helpful guidance for future interventions.

Recommendations for increasing resilience to epidemics and diseases in CARE's programmes

Having identified 10 good practices and lessons for future programming from this review, it is possible to further interrogate the analysis and draw out overarching recommendations for CARE's work on resilience in the face of disease and epidemics. Certain recommendations are well known to CARE and its programmes should be implementing these as minimum and non-negotiable standards in all types of programming, health or otherwise. These include **localisation, tailoring intervention design to context, inclusive participation, and active multi-stakeholder engagement.** However, it is valuable to elaborate on some of the key lessons for improving programming on a practical level, while also looking at key overarching recommendations for organisational strengthening to support CARE's efforts increasing resilience to disease and epidemics.

Learning from the lessons: 5 key recommendations for improving practice

Resource both supply and demand:

Building capacity through training of service providers and communities is fundamental and can help tip the scales in the favour of healthy behaviours and human potential. However, the need for physical capital, in the form of tangible public health infrastructure, supplies, supply chains, and equipment, is a serious and pressing need for public health crises and long-term resilience to disease and epidemics. This also applies to the critical link between WASH and health outcomes during outbreaks. CARE should continue to work with donors and governments, advocating for more sustainable stocks and supply chains in crises and the long-term.

Continue to ensure gender mainstreaming and stand-alone components within all programmes, but also widen the inclusivity net:

Gender is one of CARE's strengths and value-add, often supporting its partners to improve in this regard. Strengthening other forms of diversity and inclusion to enhance participation of other marginalised groups such as youth and people living with disabilities is strongly encouraged as CARE's continues its efforts to support the most vulnerable increase resilience to disease and epidemic shocks and stresses.

Continue investing time and resources into building and supporting strong community structures and linkages to health services, while finding creative ways to recognise and support their engagement:

The benefits of community structures and CARE's facilitation role in community mobilisation is important and delivers results for both increasing resilience in public health (and other) crises and long-term resilience to diseases and epidemics. These structures also support communities to claim their rights to basic services and demand accountability from powerholders which is an essential part of transformative capacity. Therefore, it is important to highlight their contribution and value wherever possible.

Strategically mobilise and train community volunteers but understand their limits:

While the results of using CHWs for effective CBS and positive health outcomes are well-evidenced, volunteers cannot replace the need for trained and paid staff to play critical public health and DRM functions. Exploring different types of incentives for the long-term engagement of community volunteers is important to plan for during design and also monitor closely during implementation.

Promote and fund adaptive management and the flexibility to change programming in line with evolving risks:

This requires strong encouragement towards both donors *and* staff, since it can be uncomfortable to change course and takes time to adjust to a new modus operandi. Crisis modifiers are key here as well. COVID-19 caught the world unprepared despite resilience building efforts and experience with other types of diseases. We do not know what the next pandemic or epidemic will look like or how it will manifest. Programmes need specific funds set aside to ensure they can resource the adaptations required for new training, materials, messaging, and unforeseen implementation changes, while also protecting resilience gains.

Building on the lessons: 5 key recommendations for organisational strengthening

Apply a systems-thinking approach with a long-term view:

A whole system view is needed in order to sustain results for increasing resilience. The complex and interlinked nature of resilience building requires the involvement of stakeholders at various levels and sectors. Conflicting policies at different levels of governance can be a barrier, therefore programmes should seek to understand and make relevant linkages.

To support an enabling environment for resilience, ensure in-depth understanding of government policy, budgeting, and planning cycles. This will help to align advocacy with policy windows and cycle-dependent opportunities and sustain advocacy efforts beyond project timeframes:

Policy and advocacy is a long-term investment but continued strategic efforts can yield success. In-depth knowledge and long-term partnerships at local and national levels especially, support CARE identify influencing opportunities and hold governments accountable for their commitments. Adaptive management also supports advocacy initiatives to capitalise on emerging opportunities and course correct as required.

Invest organisationally in more resilience understanding and capacity:

CARE has already made significant efforts through integration of resilience into the Programme strategy, the Resilience Marker, the Increasing Resilience guidance, the global CCRP online platform and academy, and the package of practical tools (CVCA, PSPs and CAAPs). However, some staff indicated that they require more support to tackle complex concepts and how to operationalise them, while evaluations cited the high accompaniment and technical support required to make these more user-friendly and relevant at the community level for sustained use. This could mean more technical specialist roles in country teams and project budgets and also continuing to create knowledge products and learning opportunities that are widely accessible and practical.

Monitor, evaluate, learn and improve with continuous transparent documentation of success and failure (and repeat!):

While CARE has made significant investments in MEL over the past decade, yet part of the challenge in understanding what works for resilience and sustainability remains the lack of long-term monitoring and learning in communities where resilience programming takes place. Many informants could not confidently confirm or comment on communities' current status dealing with COVID-19 nor the sustainability of many interventions. While it is challenging to fund MEL once programmes end, it is challenging to gain clear answers without more longitudinal studies and post-ex evaluations, or at the very least, systematically checking in with communities after projects end in order to document the long-term impact of CARE's collective efforts. Furthermore, increasing resilience requires CARE to innovate in the face of new knowledge and learning about emerging risks, which necessitates ongoing MEL throughout and beyond a project.

Seize the opportunity to advocate to overhaul the structures and systems that perpetuate rampant inequity and injustice, as the ultimate driver of risk:

Poor and marginalised people are not disproportionately affected by the pandemic only because communities are not resilient, health systems are weak, and governments are ill-prepared. There is an inexcusable wealth divide and inequity crisis in which some people benefit greatly, others are largely untouched, while far too many suffer excessively due to being part of a system that is designed to fail them. CARE can be a credible, informed, and loud voice to advocate on these issues with its access to several platforms and powerholders.

COVID-19 has spared no country nor community – however, the pandemic has shone a bright light on the startling inequalities within as well as between countries and sparked unprecedented global debate and dialogue. As CARE understands from its programming, change comes in times of crisis. The world is in crisis, and this is an opportunity to overhaul the structures and systems that are the biggest impediment to the resilience of communities and that perpetuate inequity and injustice.

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