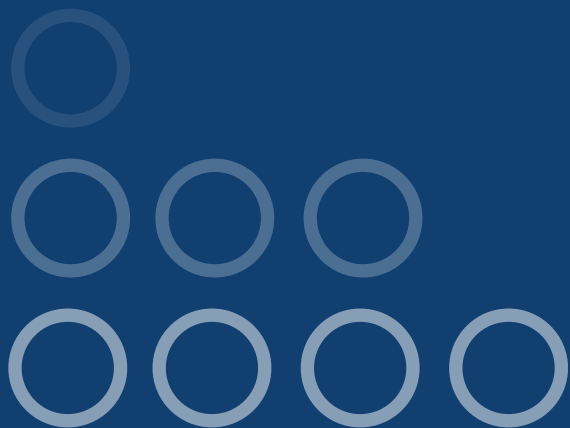


PUTTING PEOPLE

AT THE CENTER



OF PANDEMIC PREPAREDNESS



FRIENDS
OF THE GLOBAL FIGHT

AGAINST AIDS,
TUBERCULOSIS
AND MALARIA

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EXECUTIVE SUMMARY

The world is not prepared for the next pandemic threat, and underinvestment in human capacity and social supports is a major part of the reason. Even as COVID-19 cases and deaths have declined, the risk persists that new, more dangerous SARS-CoV-2 variants will emerge. Other threats, like a menacing new pathogen, may also be on the horizon. To protect the world from health emergencies that might be even more serious than COVID-19, we do not have a moment to lose.

Over the last half-century, the world has mobilized to respond to several major pandemics, including HIV/AIDS, COVID-19, SARS, tuberculosis and malaria. These experiences have generated important lessons about what works – and what doesn't work – in controlling a pandemic. This is especially the case for the HIV/AIDS response, which has adapted approaches to maximize public health impact over the last four decades. In working to build robust pandemic prevention, preparedness and response (PPR), we must put into practice what we know to be effective. We know, for example, that during a pandemic the world must pull together and coordinate its efforts, avoiding nakedly nationalistic approaches, prioritizing equity and leaving no country or community behind. The best way to prepare for future pandemics is to build robust, resilient, people-centered health systems that can address current health problems while having the ability to pivot in the event of a new emergency.

Technical solutions on their own, while essential, will not fully prepare us for future pandemics. In responding to pandemics, *people* are the key variable. The very best diagnostics and vaccines in the world will not be effective unless we have a well-prepared health workforce that can deliver them, and unless people have sufficient access to – and trust in – their health system. Likewise, state-of-the-art surveillance can identify where public health interventions are needed, but these interventions will achieve their desired result only if people are willing and able to abide by recommended prevention methods.

This report focuses on two sets of people who are critical to PPR:

- The people who need and use health services and who will be asked to adhere to guidance for prevention, care and treatment; and
- The people who deliver health services and inform communities on appropriate responses during health emergencies.

Putting people at the center of PPR means devising responses that are designed for people with diverse needs and perspectives. This requires building strong, responsive health systems; crafting social protection programs to mitigate the harms associated with pandemics and incentivizing everyone to adhere to public health guidelines; grounding PPR in human rights and equity; and meaningfully including civil society in PPR and broader health governance in order to increase trust and ensure that responses meet the needs of all communities.

In responding to pandemics, *people* are the key variable.

The reality is that health workers are the single most important component in any health system.

While COVID-19 has focused attention on the need to strengthen health systems, there is one pillar of health systems – *the health workforce* – that sometimes attracts insufficient attention in planning for PPR. In particular, international donors, who frequently lead the way in procuring commodities and strengthening laboratories and supply chain systems, often leave it to resource-limited countries to educate, train, deploy and retain their health workers. At the same time, many high-income countries are offering inducements to health workers in low- and middle-income countries to migrate to where they can earn higher salaries and enjoy better working conditions.

The reality is that health workers – including community health workers, doctors, nurses, midwives, and public health staff – are the single most important component in any health system. Countries can't respond effectively to a pandemic without a well-prepared, motivated work force, as it is health workers who are on the frontline when a health emergency strikes. And if a country can't respond to a health emergency, the well-being of its neighbors and the entire world is potentially jeopardized.

There is an urgent need to increase the number of doctors, nurses, midwives and other health workers, especially in low- and middle-income countries. It is also critical to support and empower health workers, providing them with the tools and professional respect they need to thrive. In particular, women account for 70% of the global health workforce, and too often their needs are neglected within health systems, which continue to be led mostly by men. Retaining women in the health workforce requires concerted efforts to close the gender pay gap, elevating the status and decision-making authority of women within health care systems, and ensuring that women have opportunities for professional advancement.

In addition, recruiting, training and effectively integrating a “field force” of millions of community health workers in the coming years will pay extraordinary dividends, not only in addressing current health priorities but also in building robust preparedness against future pandemics.

The international community must invest now in making PPR work for people – for those who need health services and those who deliver them. COVID-19 has taught us that inclusive approaches are more effective and sustainable than top-down approaches that do not take full account of

people's needs and desires. We must do better in buttressing our preparedness for future pandemics, and through a people-centered approach we can.



Photo: A health worker tests village residents for malaria in Bosaum, Battambang province, Cambodia. The Global Fund/Quinn Mattingly.

What is pandemic preparedness?

In this “age of pandemics”¹, preventing and preparing for future health emergencies is now a major global priority. Member states of the World Health Organization are developing a new pandemic convention or agreement², and international donors have come together to create a new Pandemic Fund at the World Bank.³

But exactly what *is* pandemic preparedness and response (PPR)? What needs to be in place to prevent future health emergencies from spiraling out of control? What tools do societies need to identify emerging health threats before they become a crisis, and to rapidly curb the spread of infection and minimize the harm to human health and well-being?

Friends of the Global Fight Against AIDS, TB and Malaria (Friends) set out to understand new and diverse perspectives on these questions. Friends hosted a virtual convening of leading global health experts and civil society partners from around the world; co-sponsored a dialogue among global civil society at a global health conference⁴; and interviewed key informants, with a specific focus on stakeholders from low-and middle-income countries. Friends reviewed the scientific literature on the response to COVID-19 – identifying what worked and what didn’t – as well as the considerable and growing literature on optimal approaches to PPR for the future.

Several important findings emerged. Much of the discourse on PPR has focused on technical issues – surveillance and laboratory systems⁵; mechanisms for sharing and using data to drive public health decision-making; and ensuring access to diagnostics, treatments, vaccines and other prevention tools. Two clear priorities are building robust manufacturing capacity in low- and middle-income countries to reduce reliance on manufacturing in high-income countries in responding to future health emergencies^{6,7}; and mobilizing essential financing for robust, sustainable health systems.⁸

These technical issues are critical to future success. But even the most technically sound approaches will not prevent or respond effectively to future pandemics unless they work for *people*. This report explores how to place people at the center of PPR.

We focus on two sets of people who are essential to PPR. The first are those who need health services and who will need to be engaged in efforts to mitigate the spread of future pandemics. Addressing the needs of the people who need and use health services demands that we build trust in health systems, strengthen community-led capacity, and ensure that health systems meet the needs of the most vulnerable and marginalized populations. Countries must be prepared to mitigate

Even the most technically sound approaches will not prevent or respond effectively to future pandemics unless they work for *people*.

human suffering due to the economic and social fall-out from pandemic control efforts and engage civil society as partners and leaders in PPR planning and execution.

The second key set of people are the health workers whose job it is to deliver the health services needed in a health emergency. The people who deliver health services are the most important component of the health system. Health workers are on the front lines in the event of a crisis, diagnosing new infections, treating those who fall sick, administering vaccines, answering the questions of anxious patients and triaging cases to avoid the collapse of local health systems. International donors often consider funding and outfitting the health workforce a national responsibility, but many low- and middle-income countries, especially those in debt distress, lack the resources to recruit, train and strategically deploy new health workers or to provide current health workers with the tools they need. Meanwhile, the World Health Organization has warned of an accelerating rate of migration of health workers from low- and middle-income countries to high-income countries, where they can earn higher salaries and enjoy better working conditions, in part thanks to inducements provided by high-income countries, such as cash bonuses and waived visa requirements.⁹ Unless we bolster the health workforce, and strengthen the global management of health worker migration, we are likely to be unprepared for the next health emergency.¹⁰

Photo: Dr. Zolelwa Sifumba of South Africa leads the fight against multidrug-resistant tuberculosis in her community. The Global Fund/ Joubert Loots.



A key finding from our work is that the world shouldn't reinvent the wheel when thinking about preparing for future pandemics. In part due to a more than five-fold increase over the last two decades in official development assistance for health¹¹, substantial health infrastructure has been built in low- and middle-income countries. Even though the bulk of official health assistance is focused on specific diseases and health conditions, the infrastructure established through these investments proved pivotal in accelerating and strengthening national responses to COVID-19.^{12, 13} Indeed, strengthening the response to current infectious disease threats is an excellent way to build the infrastructure and hone the skills required to respond to future health emergencies. Taking on board lessons learned from responding to previous health emergencies can help identify how best to leverage existing systems for PPR and avoid creating new health silos.

This report uses two lenses to understand the central characteristics of PPR. First, we identify key characteristics of a resilient, optimally prepared, people-centered health system. Second, we note key actions that are needed to place people at the center of PPR.

Key principles to guide PPR efforts

Over the last half-century, the world has responded to several major pandemics – including, HIV/AIDS, malaria, tuberculosis and COVID-19. Experiences in responding to these ongoing pandemics underscore the importance of adhering to a set of basic principles in fighting pandemic diseases.

Unless the needs of marginalized, underserved populations are taken into account in early planning, serious inequities are inevitable.



Imperatives of global solidarity and shared responsibility must guide PPR.

In contrast to the badly delayed but ultimately historic worldwide mobilization to advance towards universal HIV treatment access, COVID-19 showed a world much less willing to share the burden of coping with the worst global disease outbreak in a century. The lack of global solidarity in the case of COVID-19 led to unconscionable, persistent shortages in access to COVID-19 tests, treatments and vaccines in low-income countries.¹⁴ Shortsighted, nationalistic approaches can't be repeated for future pandemics, which may be even more severe than COVID-19. In a pandemic, no one is safe anywhere unless everyone is safe everywhere. Supporting the needs of countries where health systems are weak is not solely a matter of altruism, but also of self-interest.



We must plan for equity from the very outset of PPR.

Unless the needs of marginalized, underserved populations are taken into account in early planning, serious inequities are inevitable.^{15, 16, 17} In countries from all regions and income levels, low-income households, racial/ethnic minorities, marginalized populations and rural dwellers experienced diminished access to COVID-19 vaccines.^{18, 19}

The best way to prepare for future pandemics is to more effectively respond to existing health problems. Rather than try to activate key health system functions once a crisis emerges or isolate preparedness units and functions from the rest of the health system, the more promising strategy is to build these essential functions into ongoing practice.²⁰ PPR efforts should proactively support win-win and optimally cost-effective scenarios – building robust pandemic preparedness while addressing current, ongoing health challenges.

To prepare health systems for future pandemics, we should focus now on bringing as many people into the health system as possible.



Building strong, resilient health systems is an essential pathway to PPR.

Primary health care is the key to an effective pandemic response. To prepare health systems for future pandemics, we should focus now on bringing as many people into the health system as possible, building strong and durable provider-patient relationships and ensuring that

patients receive good-quality care that addresses their needs. This requires major new investments to bolster essential health systems capacity, including a special focus on the health workforce. The shortage of health workers was the single largest cause of disrupted health services during the pandemic and the single most important barrier to delivering vaccines and other life-saving tools to combat COVID-19.²¹



PPR efforts demand strong political processes and accountability.

Every country should have in place a National Action Plan for PPR that clearly specifies roles, responsibilities, lines of authority and coordinating mechanisms. At all levels – global, regional and national – PPR planning should include clear timelines, programmatic milestones and regular, transparent reporting of progress.



PPR governance must be inclusive and transparent.

Experience with HIV, TB and malaria underscores the benefits of including civil society and community voices at all levels of health governance, including planning, program design, monitoring and accountability, and strategic adaptation.²² This must include the professional associations and unions that represent health workers. The inclusion of civil society and diverse stakeholders, while ensuring gender equity in representation in PPR governance, ensures that PPR strategies resonate with communities and helps broaden trust in and support for PPR measures.



Communities are central players in PPR and must be adequately resourced and fully integrated into PPR efforts.

Community action proved pivotal in the response to COVID-19^{23, 24}, just as it has in the case of HIV.²⁵ To optimize community contributions during a health crisis, community-led systems for advocacy, service delivery and service monitoring must already be in place, provided with sufficient resources and fully integrated as trusted partners in national and sub-national health systems.



Building trust within societies will pay critical dividends in the event of a health emergency.

During COVID-19, high levels of trust in government as well as inter-personal trust were associated with lower COVID-19 incidence and mortality.²⁶ A step that all countries can take to address the lack of trust is to ensure that all national PPR plans include clear community engagement and health education strategies.²⁷ This will increase the likelihood that in the event of a national health emergency, more people will hear from those they do, in fact, trust.

Putting people at the center of PPR: Meeting the needs of people in an emergency

As COVID-19 has painfully underscored, the ultimate test of PPR is our ability to minimize the harmful effects of a pandemic on people. In addition to causing an estimated 14.9 million deaths worldwide as of the end of 2021²⁸ and leaving an estimated 65 million with lasting, often disabling health problems²⁹ COVID-19 vastly increased the number of people living in poverty and food insecurity³⁰ and contributed to marked increases in gender-based and intimate-partner violence.³¹

Social protection systems play a key role in mitigating human suffering during a pandemic

By the end of April 2020, 4.4 billion people, or more than half the world's population, were living in settings with partial or complete lockdown.³² Designed to slow the spread of COVID-19, these lockdowns also caused immense difficulties, especially in households living in or near poverty. People who are already at the point of desperation when a health emergency strikes may be less likely to heed public health decrees if doing so means falling further into poverty. And for many people, including those living in informal settlements, social distancing or regular handwashing during COVID-19 was simply not feasible.

The response to COVID-19 highlighted underlying weaknesses in national social protection systems, especially in low- and middle-income countries. Currently, roughly half the world's population is wholly unprotected by any social protection benefit, meaning that billions are left to fend for themselves on a daily basis, with potentially dire consequences during a health emergency.³³ Moreover, where welfare services ostensibly exist, national schemes often either exclude altogether or discriminate against marginalized groups, such as sex workers in most countries.³⁴

National governments should work to steadily strengthen the reach and meaningfulness of social protection systems before another emergency strikes. As they expand and strengthen their social protection systems, countries should also enact enforceable rules to ensure that all communities, including the most marginalized, are covered by welfare programs. Donors should consider ways to encourage national governments to expand social protections in the interest of pandemic preparedness, including through incentives in debt relief packages and new concessionary loans from international and regional development banks.





Human rights and equity are pivotal to effective PPR

When health emergencies arise, panic often ensues, leading many people to look for scapegoats. Although international human rights instruments clearly spell out countries' responsibilities to treat everyone with dignity and respect, COVID-19 was associated with substantial human rights violations.³⁵ People were vulnerable to disease, compounded by being blamed or persecuted—a double indignity. Women, LGBT people and political activists were often the targets of violence and abuse during COVID-19.^{36, 37, 38} Experiences during COVID-19 mirrored the epidemic of stigma that has accompanied the HIV pandemic.

When people's lives are threatened and their rights violated during a pandemic response, they are unlikely to trust governmental authority or seek the health services they need. Not only are violations of human rights morally wrong, but a climate of impunity for human rights violations also diminishes the trust and social solidarity that societies need to respond effectively to a health emergency. Learning from COVID-19, human rights must be a cornerstone of PPR at global, regional and country levels. Countries should ensure that mechanisms are in place to respond to human rights abuses when they arise, including clear mechanisms for redress and well-resourced community advocacy and accountability systems.³⁹ During the acute phase of COVID-19, violence, intimidation and harassment of health workers surged.⁴⁰

Inclusive governance builds strong public support for PPR

When COVID-19 hit, communities were on the frontline of the response in countries both rich and poor.⁴¹ Communities know their own needs, understand best how to reach the most vulnerable and marginalized, and serve as incubators of innovation during a health crisis. Recognizing the unique added value of communities to pandemic responses, there has been a clear trend over the last quarter-century to include civil society as integral partners in the governance of global health initiatives.⁴² Likewise, civil society is also playing an increasing role in country-level health governance, including through participation in Country Coordinating Mechanisms for the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as in national health assemblies in some countries.⁴³

When an emergency such as COVID-19 hits, all of society is needed to respond. Inclusive health governance helps build broad support for health initiatives, facilitates trust between communities and public health authorities, and ensures that responses meet the needs of all people. Concerted efforts are needed to strengthen civil society engagement in health governance at the global level – including at the World Health Organization, which currently has no formal civil society involvement in governance decisions. Countries should take steps to ensure that health decision-making processes include robust, meaningful participation by civil society and affected communities.⁴⁴ This inclusive governance must also include professional associations and unions that represent the health workforce – both as an essential part of civil society and as invaluable sources of information and perspectives for PPR response planning.



Putting people at the center of PPR: Investing in the people who deliver essential health services

The ability of individual countries and the broader global community to respond effectively to a pandemic depends in large measure on the strength and resilience of the health workforce. By one recent estimate, the health workforce represents two-thirds of projected resource needs for PPR.⁴⁵

Without a strong, resilient health workforce, no robust response to a pandemic is possible, much less one that is effective and sustainable. The Biden administration's proposed Global Health Worker Initiative acknowledges this fact, proposing \$20 billion to strengthen the health workforce in low- and middle-income countries.⁴⁶

The need for an intensified focus on health workers is clear, as the global health workforce is in crisis. The world is currently 15 million workers short of the minimum health workforce required, with especially acute shortages in low-income countries, where health worker density (by population) is 6.5-fold lower than in high-income countries.⁴⁷ Many health workers are burned out⁴⁸ – due to the lingering trauma of the COVID-19 crisis⁴⁹ and, especially in developing countries, the understaffed and overburdened clinical settings in which they work.⁵⁰ In low- and middle-income countries, health workers are underpaid, often asked to work in clinics in dire need of refurbishing, and unable to prescribe effective treatment and prevention tools that are readily available in high-income settings.

Expand the health workforce and prepare it to lead on PPR

A sustained, multi-pronged effort, supported with major new resources, is essential to build the health workforce we need to prepare for future pandemics. A key first step is to equip today's health workers with the means and the support they need to identify and respond effectively to a new pandemic. Management Sciences for Health calls for the creation of a "pervasive culture of readiness" in health systems the world over.⁵¹ This will necessitate "trainings, drills, supply maintenance, and ongoing review even during non-event periods" as well as changes in laws and policies to remove centralized constraints and empower local leaders and institutions to respond to health emergencies.⁵²

In addition, sustained efforts are required to expand the health workforce in low- and middle-income countries. Major new investments are needed in the education and training of health workers, with particular attention to countries and regions where health worker shortages are most acute, notably across sub-Saharan Africa.⁵³ Closing the doctor gap in Africa by 2030 will require a three-fold increase in medical school capacity in the region.⁵⁴ Many countries also struggle with acute shortages of nurses⁵⁵



and midwives.⁵⁶ Given the high level of attrition in the health workforce, analyses indicate that investments should aim to generate an “oversupply” of health workers to meet current and future health needs.⁵⁷

One way to reduce health worker attrition and to encourage the grassroots innovation needed to address health emergencies is to make essential investments to empower health workers and improve their working conditions. Comprising 67% of the global health workforce, women provide critical health services to five billion people.⁵⁸ However, many women in the health workforce are insufficiently supported and empowered, as they often make less than their male colleagues and tend to be concentrated in lower-status roles.⁵⁹ Retaining women in the health workforce requires concerted efforts to close the gender pay gap, elevating the status and decision-making authority of women within health care systems, and ensuring that women have opportunities for professional advancement.

At the same time that enhanced investments enable training substantial numbers of new health workers, there is an urgent need to prevent the well-documented “brain drain” of health workers educated in low- and middle-income countries to work in high-income countries, where pay is higher and opportunities for professional advancement are sometimes greater.⁶⁰ Some health workers in low- and middle-income countries are effectively forced to migrate due to poor working conditions and delays in receiving salaries.⁶¹ While acknowledging the right to freedom of movement possessed by health care workers and all other human beings, new investments are needed to mitigate the factors that encourage health worker brain drain – by increasing the pay of health workers in their home countries, improving working conditions and offering meaningful pathways to professional development.^{62, 63} High-income countries that have imported healthcare workers have a responsibility to invest in countries from which they are importing workers, and they should reach bilateral agreements with exporting countries to allow better management of this migration.

Photo: With Global Fund support, this clinic at the Kawthaung District hospital in Myanmar offers a wide range of health services focusing on women and children and specializes in treatment to prevent mother-to-child transmission of HIV. The Global Fund / Jonas Gratzner.



To make the health workforce as effective and efficient as possible, we must provide health workers with the tools they need, including expanded access to digital health. In many low- and middle-income settings, health workers are still using paper or flash drives for patient records.⁶⁴ This not only increases the burden on health workers but also makes it more difficult to share information for care coordination or for alerts in the event of a disease outbreak. Helping low- and middle-income countries update their health information systems with state-of-the-art digital tools is an essential part of PPR. Moreover, at all times – but especially during crises – health systems have an obligation to ensure that health workers have access to personal protective equipment and other infection control measures.⁶⁵

Community health workers offer dual benefits – building PPR capacity while addressing existing health challenges

The best way to prepare for future pandemics is to build robust, resilient health systems capable of meeting current health challenges. In this regard, community health workers may well represent the ideal health investment, improving health outcomes in the short term while establishing health systems that are well prepared for future health emergencies.

The value of community-centered health service delivery is well documented. Community health workers prevent a child from dying every three seconds⁶⁶, increasing immunization uptake⁶⁷, intervening to address the needs of children who are malnourished⁶⁸ and helping manage pneumonia⁶⁹, malaria⁷⁰ and other childhood diseases. Community health workers are helping prevent, diagnose and treat non-communicable diseases, such as cancer, diabetes and cardiovascular disease.^{71,72} Due to their ability to reach underserved communities that are not well served by facility-based health services, community health workers have been referred to as the “equity arm” of primary health care.⁷³

Community health workers play a pivotal role in expanding treatment access and improving health outcomes for people living with HIV. Community-driven innovation in the delivery of HIV treatment services, relying on community health workers to distribute medicines, monitor health indicators and promote treatment adherence, is now the standard of care in most high-burden countries.⁷⁴ Tailoring by community health workers of service delivery strategies to address the needs of different groups of patients proved critical to the preservation of HIV treatment services during COVID-19-related national lockdowns.⁷⁵ The President’s Malaria Initiative, funded by the United States, prioritizes the scale-up of community models of care, which depend on community health workers to reach affected households with malaria testing and treatment services.⁷⁶

Given the dual benefits of investments in community health workers – strengthening PPR while addressing current health challenges – financing for the expansion of the community health workforce should look both to PPR-specific mechanisms (such as the Pandemic Fund housed at the World Bank) as well as existing vehicles for financing the health workforce. As 85% of needed PPR investments are in countries that are eligible for support from the Global Fund to Fight AIDS, Tuberculosis and Malaria⁷⁷, efforts to invest in community health worker programs should leverage the grantmaking process of the Global Fund, which in 2022 created a catalytic fund to support community health systems in up to ten African countries.⁷⁸

The best way to prepare for future pandemics is to build robust, resilient health systems capable of meeting current health challenges.



Major new investments are needed to build a global PPR “field force” of health workers

Expanding the traditional health workforce will take time. It takes years to educate and train doctors, nurses, laboratory specialists and other essential health workers. And it will take time to build and promote the incentives that will be needed to ensure that newly educated health workers are willing to work in rural and other underserved communities. This work should begin now.

But building PPR capacity is an immediate priority. Given the threats of potentially catastrophic disease outbreaks, the world doesn’t have years to wait before bolstering our defenses.

A key first step is to invest in multidisciplinary health care workforce teams. This approach, which draws on diverse health worker cadres, has been shown to improve health outcomes, quality of life and psychosocial well-being for a broad array of health conditions.⁷⁹ By putting this approach in place now, health systems can improve the management of existing priority health conditions and strengthen preparedness to address future health emergencies. Another fruitful use of new investments is to improve the working conditions in health care settings – by increasing health worker salaries (especially in low- and middle-income countries), modernizing clinics, transitioning to digital health technologies, and offering new opportunities for continuing education and new pathways for professional advancement.

Another health workforce strategy that is immediately actionable is to recruit, train and deploy millions of community health workers across the world. As a review by the African Union found, community health workers “increase uptake of health services, reduce health inequalities, provide a high quality of services and improve overall health outcomes.”⁸⁰ Community health workers are drawn from the communities they serve, and the training they require is shorter than that required for doctors or nurses. Community health workers serve as a vital link between communities and health systems, helping ensure that underserved populations receive the health services they need.

Community health workers have proven especially critical in responding to pandemics and other health emergencies. During the Ebola outbreak in western and central Africa in 2014-2016, which caused 11,325 deaths⁸¹, transmission rates in Liberia only began declining when the government joined with NGOs to deploy community health workers to check households for people who were infected.⁸²

After the regional Ebola outbreak, Guinea proactively assembled and trained 900 community health workers while also strengthening lab capacity. When another Ebola outbreak occurred in Guinea in 2021, community health workers sprang into action as an integral component of a much better prepared public health workforce, educating communities about Ebola transmission and helping affected families conduct burials in ways that were both safe and dignified. Unlike in 2014-2016, when the



rapid spread of Ebola caused experts to fear the disease could become endemic across the region, the 2021 outbreak in the same region was quickly brought under control with only 12 deaths.⁸³ Community health workers also played a key role in responding to the Zika epidemic in 2015, bringing affected households into the health system, educating communities and supporting surveillance efforts.⁸⁴

Community health workers made important contributions to COVID-19 responses across the world.^{85, 86} In sub-Saharan Africa, Africa Centres for Disease Control and Prevention made the recruitment and deployment of tens of thousands of community health workers a pillar of its regional COVID-19 response.⁸⁷ Community health workers educated communities, promoted COVID-19 testing and vaccination, countered misinformation and navigated clients toward testing, treatment and prevention services. One study of four African countries (Kenya, Malawi, Mali and Uganda) found that community health workers succeeded in maintaining continuity of care during COVID-19 lockdowns, in part through proactive household visits and community case management assessments.⁸⁸ Within countries, including here in the U.S., community health workers helped close disparities in access to COVID-19 vaccination.⁸⁹ Experience during COVID-19 underscored the value of community health workers in addressing social and economic factors that increase the vulnerability of underserved communities and diminish their access to health services.⁹⁰

Although the evidence is overwhelming that community health workers improve health service access and health outcomes, especially during crises, the world is largely failing to invest in this essential health worker cadre. Seventy percent of community health workers are women, and half of all community health workers are unpaid.^{91, 92} During COVID-19, many community health workers regularly undertook their essential work without being provided personal protective equipment.^{93, 94} Voluntarism is hardly a sustainable model for the community health workforce, which serves as a linchpin of primary care in many parts of the world.

To be effective, community health workers require intensive training and ongoing supervision.⁹⁵ They must be adequately compensated and have opportunities for professional learning and further advancement.⁹⁶ They also need access to mobile telecommunications tools to enable them to respond rapidly when a problem arises and to serve as the link between communities and health facilities.⁹⁷ Community health workers are optimally effective when they are part of a multi-disciplinary health care team that provides holistic, person-centered care.⁹⁸

Although the evidence is overwhelming that community health workers improve health service access and health outcomes, especially during crises, the world is largely failing to invest in this essential health worker cadre.

Photo: A community health worker advises villagers in Honduras that standing water can be a potential breeding ground for mosquitoes that carry the malaria parasite. The Global Fund/John Rae.



Putting people at the center of PPR: Capturing the “win-win” potential

Even as we grapple with the continuing pandemics of COVID-19 and HIV, new pandemics, driven by pathogens with markedly greater death rates, are highly probable.^{99, 100} We have not a moment to waste in building strong safeguards against future pandemics, averting far higher human and economic costs.

We must seize this window of opportunity to ensure that our efforts to prevent and prepare for future pandemics will work for people. By bolstering the health workforce, strengthening primary health care and taking into account the needs and perspectives of communities, trusted care relationships can already be in place when the world is next required to pivot to address a health emergency. By investing today in strengthening community leadership on health, grounding our approaches in human rights, and building a robust, resilient health workforce, we can realize multiple benefits – improving health outcomes *now* while building the infrastructure and skills we will need to fight future pandemics.



Photo: Mobile clinics such as this one in Kondo District, Tanzania, bring high tech TB testing facilities to the most remote parts of the country. The Global Fund/Vincent Becker.

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