



# EVERYONE COUNTS COVID-19

*Nobody is safe until everybody is safe*

January 2023

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**Contact us:**

Requests for commercial reproduction should be directed to the IFRC Secretariat:

**Address:** Chemin des Crêts 17, Petit-Saconnex, 1209 Geneva, Switzerland

**Postal address:** P.O. Box 303, 1211 Geneva 19, Switzerland

**T** +41 (0)22 730 42 22 | **F** +41 (0)22 730 42 00 | **E** [secretariat@ifrc.org](mailto:secretariat@ifrc.org) | **W** [ifrc.org](https://www.ifrc.org)

# CONTENTS

	<b>Abbreviations</b>	<b>7</b>
	<b>Foreword</b>	<b>8</b>
<b>1</b>	<b>Context</b> The pandemic from the perspective of National Societies	<b>11</b>
	<b>How did the pandemic develop over time? What did that mean for National Societies?</b>	<b>12</b>
	<b>The course of the pandemic</b>	<b>13</b>
	Did almost every country experience an extreme peak?	15
	<b>How did governments respond across the world?</b>	<b>18</b>
<b>2</b>	<b>The IFRC network's COVID-19 response</b>	<b>23</b>
	<b>How did National Societies respond to the pandemic?</b>	<b>24</b>
	<b>Keeping track of all the data: about the COVID-19 Indicator Tracking Tool</b>	<b>32</b>
	Overview of the indicators, priorities and pillars	32
	<b>How can this mass of data be usefully aggregated?</b>	<b>38</b>
	Achievement indexes	38
	The DNA of the response: every National Society had a different response	41
	"Personal best": do most National Societies report high scores on at least some indicators?	43
	<b>Did National Societies manage to respond in a sustainable way?</b>	<b>44</b>

<b>3</b>	<b>Unity or isolation in the face of a global crisis</b> An open and collaborative network	<b>49</b>
	<b>National Society collaboration with government and local authorities</b>	<b>50</b>
	<b>Examples of National Societies whose response complemented their government's response</b>	<b>53</b>
	<b>Collaboration between National Societies</b>	<b>55</b>
	GO data: field reports	55
	Financial flows based on financial tracking	58
	Did National Societies rely on old or new partnerships during the pandemic?	60
<b>4</b>	<b>Preparedness and prior experience</b> How did they help in COVID times?	<b>65</b>
	<b>How did National Societies' prior experience help them to respond quickly and at scale during the pandemic?</b>	<b>66</b>
	How does performance on the COVID-19 indicator tracking achievement indexes relate to comparable pre-COVID-19 achievements?	68
	Preparedness resulting from specific preparedness programmes	70
	Did National Societies with prior experience of emergencies achieve more under COVID-19?	74
	<b>National preparedness: country risk profiles</b>	<b>74</b>
	<b>Exploring the risk index further</b>	<b>76</b>
<b>5</b>	<b>The real extent of the pandemic</b>	<b>81</b>
	<b>Estimated excess deaths</b>	<b>82</b>
	<b>Demographics: how severe was the pandemic in different regions, allowing for demographics?</b>	<b>87</b>
	Indirect mortality	88



<b>6</b>	<b>On the front line</b> The stories of the volunteers	<b>93</b>
	<b>COVID-19 stories from volunteers</b>	<b>94</b>
	<b>Findings</b>	<b>96</b>
	Overall top-level map	96
	Volunteering in the pandemic: overcoming fear, turning challenges into growth	97
	Why volunteer?	98
	What volunteers did	99
	How National Society action led to volunteer capacity	100
<b>7</b>	<b>Vaccinations</b>	<b>103</b>
	<b>How is the work of National Societies to support vaccinations being scaled up?</b>	<b>105</b>
	<b>How does the work of National Societies complement the work of their governments?</b>	<b>108</b>
	<b>How did the IFRC counteract under-reporting of vaccination achievements? Predictive modelling of vaccinations</b>	<b>109</b>
	Results of the estimation	109
<b>8</b>	<b>What did we learn and what comes next?</b>	<b>113</b>
	<b>Which are the lessons that we have learned?</b>	<b>114</b>
	Innovating	114
	Improving equity	114
	Building resilience locally	115
	Leveraging the unique added value of the Red Cross and Red Crescent	115
	<b>Conclusion</b>	<b>116</b>
<b>9</b>	<b>Appendixes</b>	<b>119</b>

# FIGURES

<b>Figure 1-1</b> The sudden peaks of the pandemic	<b>14</b>
<b>Figure 1-2</b> The sudden peaks of the pandemic: example of Italy	<b>15</b>
<b>Figure 1-3</b> Stringency of individual governments' COVID-19 policies over time	<b>19</b>
<b>Figure 2-1</b> Overview of priorities, pillars and indicators	<b>35</b>
<b>Figure 2-2</b> Achievements on different people reached indicators	<b>36</b>
<b>Figure 2-3</b> Staff and volunteers	<b>37</b>
<b>Figure 2-4</b> Health facilities	<b>37</b>
<b>Figure 2-5</b> The DNA of the response	<b>41</b>
<b>Figure 2-6</b> Achievement in different priorities compared across the pandemic	<b>42</b>
<b>Figure 2-7</b> Almost all National Societies reported high numbers for at least some indicators	<b>43</b>
<b>Figure 2-8</b> Strengthening National Societies – achievements.	<b>45</b>
<b>Figure 3-1</b> The role and activities of the National Society are expressly included in the national government's main plan(s) for COVID-19 response/recovery.	<b>51</b>
<b>Figure 3-2</b> The National Society peer support network in action: Support within and between regions	<b>57</b>
<b>Figure 3-3</b> Financial Support between regions	<b>59</b>
<b>Figure 3-4</b> International support links between National Societies during Covid partly built upon existing links	<b>60</b>
<b>Figure 3-5</b> Existing and new partnerships	<b>62</b>
<b>Figure 4-1</b> Correlations between achievements on relevant FDRS Key Performance Indicators 2019 and on COVID-19 tracking priorities during the pandemic	<b>69</b>
<b>Figure 4-2</b> Correlations between achievements on relevant FDRS Key Performance Indicators 2019 and on selected Covid-19 tracking priorities during the pandemic	<b>71</b>
<b>Figure 4-3</b> Officially reported deaths	<b>75</b>
<b>Figure 4-4</b> Estimated excess deaths and reported deaths	<b>77</b>
<b>Figure 5-1</b> Total deaths	<b>83</b>
<b>Figure 5-2</b> Total deaths per 1000, comparing officially reported deaths with estimated excess deaths	<b>85</b>
<b>Figure 5-3</b> Excess deaths	<b>86</b>
<b>Figure 5-4</b> Total estimated excess deaths per 1000, if all countries had the same age profile	<b>87</b>
<b>Figure 6-1</b> Volunteers' stories map	<b>96</b>
<b>Figure 6-2</b> Challenges that volunteers faced	<b>97</b>
<b>Figure 6-3</b> Detail of the map	<b>98</b>
<b>Figure 6-4</b> Detail of the map	<b>100</b>
<b>Figure 6-5</b> Detail of the map	<b>100</b>
<b>Figure 7-1</b> Achievements on three vaccination indicators	<b>105</b>
<b>Figure 7-2</b> Developments on vaccinations independently of National Societies	<b>106</b>
<b>Figure 7-3</b> Progress made by National Societies on vaccinations during the second half of the pandemic	<b>107</b>
<b>Figure 7-4</b> Steps to construct the global estimate of the number of individuals the National Society has supported to get vaccinated against COVID-19	<b>110</b>
<b>Figure 9-1</b> Correlations between overall performance on all FDRS Key Performance Indicators	<b>131</b>

# ABBREVIATIONS

<b>CBS</b>	Community-based surveillance	<b>MENA</b>	Middle East and North Africa
<b>CEA</b>	Community Engagement and Accountability	<b>MHPSS</b>	Mental health and psychosocial support
<b>CHF</b>	Swiss francs	<b>NS</b>	National Society
<b>DREF</b>	Disaster Response Emergency Fund	<b>PER</b>	Preparedness for Effective Response
<b>DRR</b>	Disaster risk reduction	<b>PNS</b>	Participating National Society
<b>EMS</b>	Emergency Medical Services	<b>PPE</b>	Personal protective equipment
<b>FDRS</b>	Federation-wide Databank and Reporting System	<b>RCCE</b>	Risk communication and community engagement
<b>IARP</b>	Innovative Approaches for Response Preparedness	<b>RPII</b>	Response Preparedness Phase II
<b>ICRC</b>	International Committee of the Red Cross	<b>SAI</b>	Supplementary immunization activity
<b>IFR</b>	Infection fatality rate	<b>WASH</b>	Water, sanitation and hygiene
<b>IFRC</b>	International Federation of Red Cross and Red Crescent Societies	<b>WHO</b>	World Health Organization
<b>IPC</b>	Infection prevention and control		

# FOREWORD

The Covid-19 pandemic has overturned the lives of people and communities at an unprecedented level and scale. Since the pandemic began, National Red Cross and Red Crescent Societies throughout the world have scaled up efforts to deliver assistance, communicate risks, and engage communities with the support of IFRC's global COVID-19 Emergency Appeal which has allocated nearly 400 million CHF in support of National Societies with a total Federation-wide expenditure of 2.12 billion CHF.

Immunization has played a large role in improving the lives and livelihoods of many people. Almost three years into the pandemic, National Societies have trained over 1.9 million staff and volunteers on COVID-19 vaccine introduction, supported a total of 14,500 health facilities, and more than 123.9 million individuals to get vaccinated against the virus. Yet, millions of people are still waiting to receive vaccinations and are still in need of humanitarian assistance to recover from the impact of the pandemic.

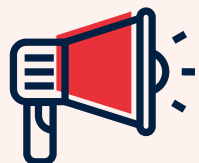
In the Everyone Counts COVID-19, we share the findings and learnings from the collective activities of at least 180 National Societies. The report highlights the fundamental strengths of the IFRC network, our ability to be innovative and quick to adapt to new operational contexts, while sustaining the trust of communities. Our focus on building on equity and global resilience helped the communities we partnered with face this global challenge.

The Everyone Counts COVID-19 is an important collection of lessons from our National Societies. It focuses on the solidarity between them and their collaboration with local authorities. Both existing and novel partnerships were leveraged and formed across the network, within and across regions. Many National Societies were included in their country's national plan for COVID-19 response, highlighting once more their local capacity as strong auxiliaries in support of governments across the world. Collectively, National Societies have demonstrated the strength of our network and the power of mobilizing local communities, supporting each other under unprecedented conditions to make sure that, together, we can make everyone count.

As we continue to minimize the impact of the COVID-19 pandemic on communities, we are scaling up preparedness efforts for future outbreaks. Nobody is safe until everybody is safe, which is why our work to ensure equitable access to resources and knowledge globally, must continue.

*Jagan Chapagain*  
**Secretary General**

## Health



Risk communication and community engagement for health and hygiene promotion activities

**1.1B**

people reached



Individuals supported by National Societies to get vaccinated against COVID-19

**123.9M**



Staff and volunteers trained on COVID-19 vaccine introduction

**1.9M**



Health facilities supported

**14.5K**

## Socio-economic



Food and other in-kind assistance

**87.7M**

people reached



Cash and voucher assistance

**6.1M**

people reached



Community feedback mechanism

**1.8M**

comments collected



Staff and volunteers trained on community engagement and accountability

**412.8K**

## Strengthening National Societies



Community preparedness, response, and disaster risk reduction measures

**170.8M**

people reached



National Societies included in government plans

**152**

**Total income**  
**CHF 2.36B**

**Total expenditure**  
**CHF 2.12B**





1

## CONTEXT

THE PANDEMIC FROM  
THE PERSPECTIVE OF  
NATIONAL SOCIETIES

## KEY QUESTIONS

▶ **How did the pandemic develop over time?**

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▶ **How did governments respond across the world?**

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▶ **What did that mean for National Societies?**

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## How did the pandemic develop over time? What did that mean for National Societies?

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The coronavirus pandemic presented unprecedented challenges to individuals, families, communities, health systems, economies and governments across the globe. As a result, health authorities and their auxiliaries had to respond to people's information needs while developing novel ways to counter the spread of the disease through a variety of activities, often on a nationwide scale. News of the spread of the pandemic across the planet meant that people became very quickly aware of its impact on people in other countries. To support individuals, families, communities, health systems, economies and governments in dealing with the pandemic, the IFRC launched its first ever global Emergency Appeal. For many National Societies, this was their first experience of receiving Emergency Appeal funding themselves rather than mobilizing help for other National Societies.

In this introductory chapter, we will focus on two defining aspects of the pandemic: the overall course of the pandemic and the response of individual governments across different regions of the world. Although these two factors were often beyond the control of National Societies, they had a significant impact on the activities carried out.



## What was it like to be responding in the first weeks of the pandemic? The case of the Red Cross Society of China<sup>1</sup>

On 11 February 2020, the number of confirmed cases globally was over 43,000, with over 1,000 deaths reported, almost all in mainland China. The Red Cross Society of China (RCSC) rapidly activated up to 1.8 million volunteers to support the response across the country. The National Society joined the Chinese government's response, providing support to help meet the huge and sudden demand for medical items. In addition to providing cash donations, the RCSC and its branches across the country – including its city branch in the epicentre of the pandemic in Wuhan – coordinated domestic and international offers of consumable medical equipment. This included, among other things, gowns, masks and disinfectant. Assistance was also provided to transport personal protective equipment (PPE) in coordination with the relevant authorities.

The outbreak was accompanied from the very start by a massive “info-demic”, making it hard for people to find trustworthy sources and evidence-based guidance to rely on during the rapidly evolving situation. The RCSC promptly filled the gap by disseminating information on disease prevention and health education. Innovative ways of communication were used, including the massive use of social media. Other activities carried out by RCSC branches included providing psychosocial support services, psychological first aid and health care, transferring patients to health-care facilities by ambulance and distributing relief items.

## The course of the pandemic

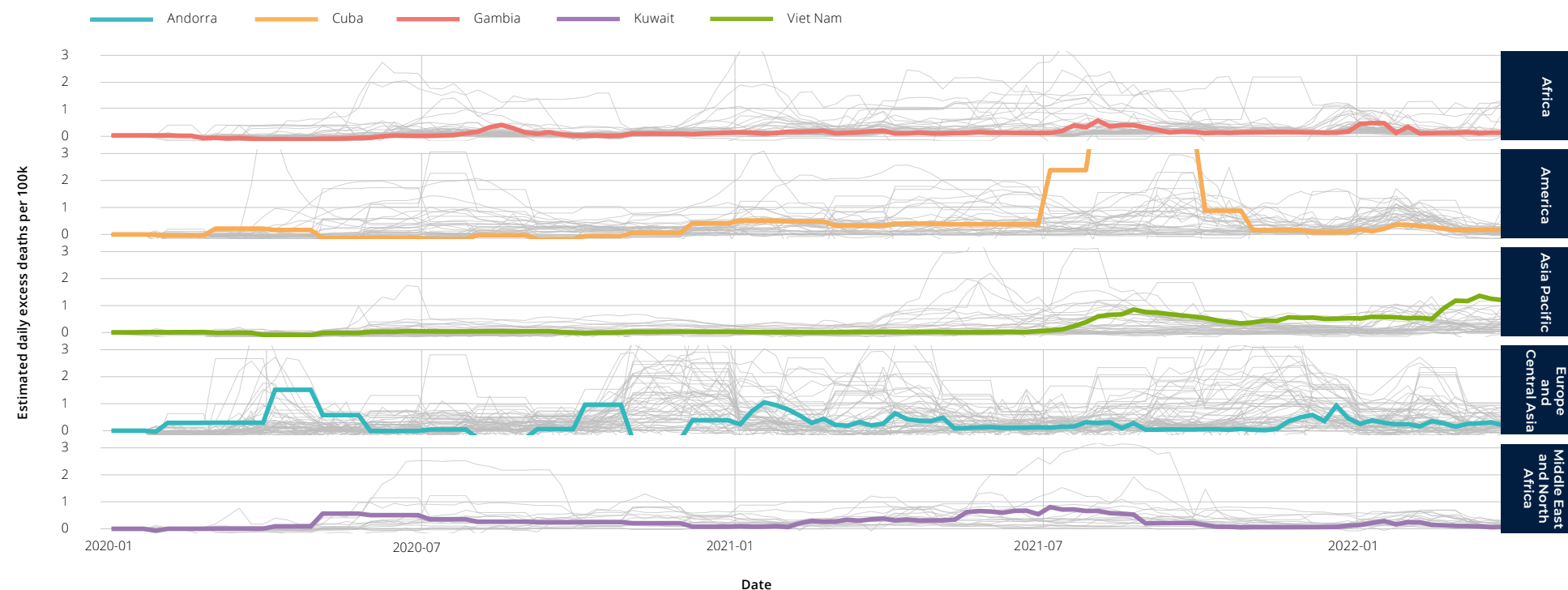
Reporting on the overall progress and magnitude of the pandemic requires the use of indicators that are (1) as accurate as possible, (2) widely available across different countries and for the entire course of the pandemic and (3) not subject to systematic biases towards under- or over-reporting. The indicator that meets these requirements and that will therefore be used in this section (and in the rest of the report, except where otherwise stated) is *estimated excess deaths* – per day, per month, per quarter and in total. We have chosen this over two other commonly used indicators, namely *officially reported deaths* and *reported cases*. The reasoning behind this decision is further explained in Chapter 5.

Figure 1–1 shows a grey line for every country with a National Red Cross or Red Crescent Society, charting the bewildering “ups and downs” of the pandemic. A typical country from each region has been picked out and highlighted with a thicker coloured line. As only a few lines in each region have peaks that are much higher than 300,000, the y-axis is cut off at that point, making it easier to focus on the details.

**China 2020** On the frontline in Wuhan, volunteer emergency medical teams transported critically ill patients to and between hospitals. To help both patients and health-care professionals, Red Cross purchased and deployed specialized ambulances to Wuhan.  
© Red Cross Society of China / IFRC



<sup>1</sup> <https://adore.ifrc.org/Download.aspx?FileId=289577>

**Figure 1-1** The sudden peaks of the pandemic

**Figure 1-1.** Estimated daily excess deaths per 100,000 people due to COVID-19. A typical country from each region has been picked out (country whose death toll is closest to the regional median) and highlighted with a thicker coloured line. Dataset: *Excess-deaths*.<sup>2</sup>

## KEY FINDINGS

- The fainter lines in this figure representing individual countries show that rates in many of them often soared and dipped.
- Many countries, especially in Europe and Central Asia, experienced at least one extreme and sudden peak

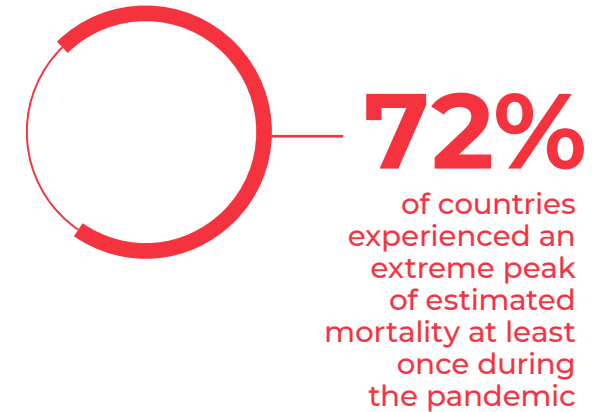
<sup>2</sup> The caption for each figure in this report also refers to a specific dataset, listed in the Appendix.

## Did almost every country experience an extreme peak?

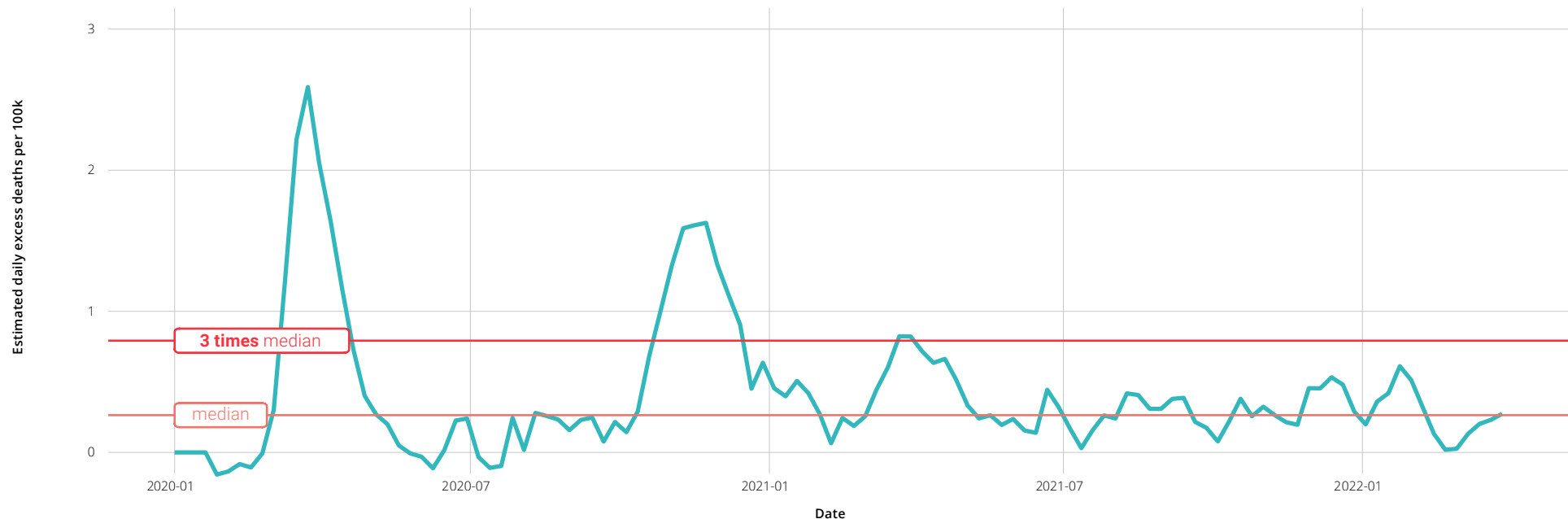
An “extreme peak” can be defined as when the estimated rate of excess deaths per day was significantly higher than the median rate for the same country over the entire duration of the pandemic. As there is no obvious way to define “significantly higher”, we have (somewhat arbitrarily) decided to define it as a daily death toll more than three times the median for that country.

The percentage of countries that experienced an extreme peak of estimated mortality at least once during the pandemic was 72%. One of these was Italy which experienced three extreme peaks. Its first peak led the first wave of the pandemic as it spread across the world.

Figure 1–2 illustrates this example, highlighting the median and three times the median with red lines.



**Figure 1–2** The sudden peaks of the pandemic: example of Italy



**Figure 1–2.** Estimated daily deaths per 100,000 people due to COVID-19 in Italy. Dataset: Excess-deaths.

## What was it like to be in one of the countries that experienced a very extreme peak?

### The case of the Jamaica Red Cross<sup>3</sup>

The rapid onset of COVID-19 and the steep rise of the infection curve had the potential to cause havoc, especially at the beginning of the pandemic when little was known about the disease and its spread. Several countries experienced extreme peaks of over 64 times the national median for the pandemic, including the island of Jamaica.

In January 2022, Jamaica saw a surge in COVID-19 cases. In response to this surge, the Jamaica Red Cross focused efforts on providing assistance to the Government of Jamaica in reaching its goal of vaccinating 65% of the Jamaican population by March 2022. To improve the low uptake of vaccines, the National Society provided additional support to the national vaccination programme by conducting the following activities:

- 1,429 people were transported to vaccination sites, and volunteers also helped to register people at the sites;
- 1,400 care packages were distributed at vaccination sites to encourage continued safety measures after vaccination;
- a robust risk communication campaign was launched to assist in reducing vaccine hesitancy and anti-vaccine sentiment and included the production and dissemination of:
  - » posters, floor stickers and t-shirts with COVID-19 messages;
  - » radio infomercials on popular radio networks;
  - » rental of five digital billboards in four major towns that will display COVID-19 messages until 2023.

## What was it like to be in a country with a relatively constant high level of cases?

### The case of the Libyan Red Crescent<sup>4</sup>

Alongside those countries that had to face extreme peaks of infections and deaths, others, such as Libya, would experience more stable, but still high, levels of cases throughout much of the pandemic.

Despite sustained movement restrictions and internet connectivity challenges, the Libyan Red Crescent (LRC) addressed ongoing needs by providing refresher and new web-based training to its volunteers and staff.

Yet the major challenge faced by the LRC during this response was ongoing and intensified conflict in the country, which prevented free and easy movement by staff and volunteers to implement the required activities. The continued destruction of health facilities and insecurity in large parts of the country hindered an efficient and optimized response. In spite of this, the LRC has been able to serve as a first responder and an active partner to the public authorities, providing relevant and timely support throughout the past two years. During the initial phase, the response focused heavily on distributing hygiene kits and food, providing mental health and psychosocial support (MHPSS), conducting large-scale information campaigns aimed at vulnerable communities and setting up mobile service points for migrants.

As soon as vaccines became available, the LRC partnered with the Libyan National Centre for Disease Control to support the rollout of COVID-19 vaccination, with a focus on community engagement and logistical support. More than 600 volunteers went out and about in their communities to engage with local people and answer their questions about vaccines. Volunteers helped with vaccine registration and data entry, and several LRC health clinics in the south of the country were used as vaccination centres.

3 [https://prddsgofilestorage.blob.core.windows.net/api/event-featured-documents/file/MDR000050U25\\_24\\_month\\_report.pdf](https://prddsgofilestorage.blob.core.windows.net/api/event-featured-documents/file/MDR000050U25_24_month_report.pdf)

4 <https://www.ifrc.org/article/world-immunization-week-going-last-mile-keep-communities-safe-covid-19>





**Jamaica 2021** A perception survey in Jamaica was conducted while the people of the community were carrying out their daily activities.  
© Chrysanthia Dixon / Jamaica Red Cross



**Philippines 2020** *Beause of lockdown, many people choose to return to the provinces. The increasing COVID-19 cases prompted local governments to suspend travel, stranding people at sea ports and airports. The Philippine Red Cross assisted locally stranded individuals with food, hygiene kits, testing and life-saving information to protect them from the disease. Philippine Red Cross also created child-friendly spaces for kids to play and learn proper handwashing.*  
© Philippine Red Cross

## How did governments respond across the world?

In their role as auxiliaries to their government, National Societies needed to shape their response activities in accordance with the government support in place, but how can we get a complete picture of the different ways in which governments responded across the world? It is incredibly difficult to make an accurate and unbiased assessment of the day-to-day performance of governments throughout the pandemic, but we can at least assess their public policies. Oxford University's Stringency Index<sup>5</sup> systematically collects information on common policy responses undertaken by governments to address the pandemic. This information is aggregated into 20 indicators which are divided into three categories:

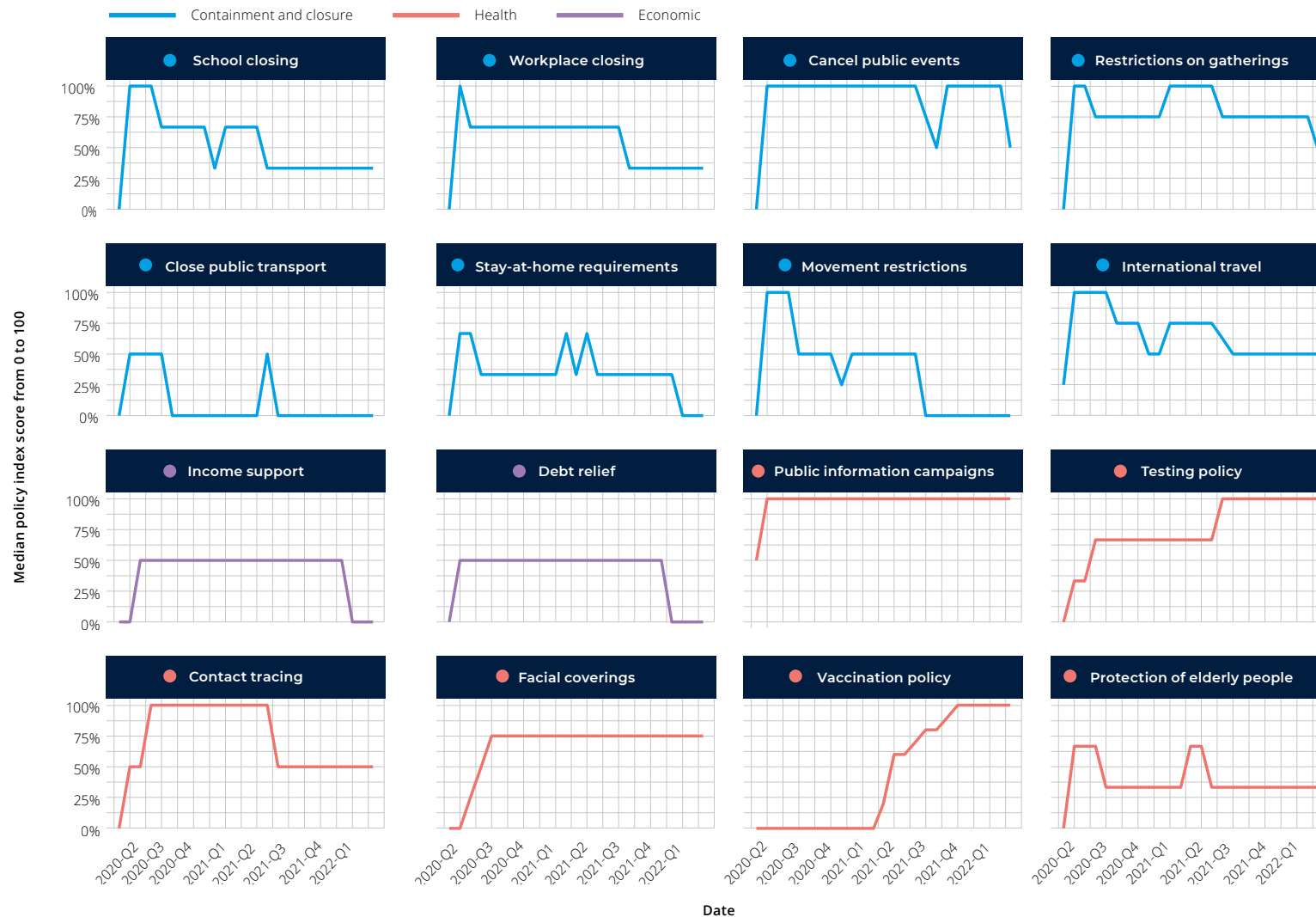
- **Containment**, which covers “lockdown” restrictions and closures, with eight policy indicators including school and workplace closures, cancellation of public events, restrictions on gathering size and stay-at-home requirements;
- **Health**, with eight indicators including COVID-19 testing policy, contact tracing, emergency investment in health care, investment in vaccines, facial coverings, public information campaign and, most recently, vaccination policy;
- **Economic** support, which includes measures such as income support and debt relief.

Each indicator is represented by a percentage score from 0 to 100 reflecting the level of government action throughout the pandemic, 0 being the lowest possible score and 100 the highest. Figure 1–3 shows the median Stringency Index score of all countries at different points in time. It is important to note that these figures refer to government policy and not the degree of implementation. Even so, it is a good indication of the context in which National Societies operated.

5 See Appendix to Chapter 1.



**Figure 1–3** Stringency of individual governments' COVID-19 policies over time



#### KEY FINDINGS

- On average, countries were scoring quite highly on most of these policy indexes at least at some point in the pandemic.
- On average, governments were assessed as responding strongly on public information.
- They might have seemed slow at the time, but government responses were generally very quick.
- Health policies generally became quite stringent early on and remained so for most of the pandemic, although contact tracing became less important in 2021 and governments were less able to prioritize support for elderly people.
- Economic support was weaker on average than the other policy responses.
- Vaccination policy starts at the beginning of 2021 and increases rapidly from that point on.

**Figure 1–3.** Stringency of government policies over time. Dataset: Oxford-policy.



**Tunisia 2021** Tunisian Red Crescent volunteers respond to COVID-19. They do shopping for people who are confined, such as the elderly and people at risk. They also use bicycles for distributions of items that aren't heavy, such as vouchers. Being mobile allows them to travel to different places safely to raise awareness about prevention measures. © Tunisian Red Crescent



## KEY MESSAGES

- ▶ Some National Societies were faced with extreme peaks of infections and deaths, while many others had to deal with a constantly high level of exposure.
- ▶ Governments across the world responded with an array of more or less stringent policies to cope with the pandemic, providing the background against which National Societies shaped their own response.
- ▶ Vaccination campaigns became an important part of the response in the second half of the pandemic (see Chapter 7).





2

**THE IFRC  
NETWORK'S  
COVID-19  
RESPONSE**

## KEY QUESTIONS

- ▶ **How did National Societies respond to the pandemic?**

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- ▶ **What were the main elements of the response?**

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- ▶ **How can we compare the speed and size of the response across indicators, priorities and National Societies?**

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## How did National Societies respond to the pandemic?

National Society responses have taken the form of a multitude of activities which can be grouped into 23 pillars across three operational priorities:

1

**HEALTH:** Sustaining health and water, sanitation, and hygiene (WASH))

2

**SOCIO-ECONOMIC:** Addressing the socio-economic impact

3

**STRENGTHENING NATIONAL SOCIETIES:** Strengthening National Red Cross and Red Crescent Societies

Many National Societies, especially those with experience responding to epidemics, were familiar with some of these kinds of activities. However, nearly all National Societies were also required to develop and implement some activities which were completely new to them rapidly and at scale. This was a challenge across the globe.

On pages 25–31 we present each of the pillars with examples of what they mean in practice.

### Infection prevention, hygiene promotion and WASH (community level)

**Slovakia – April 2022:** A Slovak Red Cross volunteer gives a COVID-19 test to a refugee from Ukraine living in the temporary shelter at Camp Zilina. © Marko Kokic/IFRC



### Infection prevention, hygiene Health: Mental health and psychosocial support services (MHPSS)

**The Maldives – June 2021:** Maldivian Red Crescent volunteers provide mental health and psychosocial support via free telephone hotlines to people feeling isolated and lonely or suffering from mental health issues. © Maldivian Red Crescent



### Risk communication, community engagement, and health and hygiene promotion

**Indonesia – July 2020:** The Indonesian Red Cross Society continuously carries out campaigns on health protocols and promotes their implementation daily in the community. © IFRC/Indonesian Red Cross Society



### Isolation and clinical case management for COVID-19 cases

**Afghanistan – May 2021:** Staff at the Afghan Red Crescent Society's COVID-19 hospital in Kabul joined the pandemic response to provide surveillance, screening and referral systems in areas that are unsafe and hard to reach. © Meer Abdullah/Afghan Red Crescent Society







**Infection prevention, hygiene  
promotion and WASH  
(community level)**

*Haiti – September 2021 The Haiti Red Cross Society  
and the IFRC run hygiene promotion activities with  
local communities in Les Cayes, Haiti. © Adriano  
Valentini / IFRC*

## Community-based surveillance (CBS)

**Somaliland – 2020 CBS and the [Nyss platform](#) contribute to preventing, identifying and responding to disease outbreaks through early warning and early response.**  
© Norwegian Red Cross



## Maintaining access to essential health services (community health)

**Afghanistan – October 2021: An Afghan Red Crescent Mobile Health Team visits a community outside Kandahar.**  
© Meer Abdullah/Afghan Red Crescent Society



## Maintaining access to essential health services (clinical and paramedical)

**Haiti – September 2021: A Finnish Red Cross medical doctor visits a child suffering from stomach pain in the newly opened Outpatient Department of the field hospital run by the Finnish Red Cross and the Canadian Red Cross in Parc Larco.** © IFRC



## Ambulance services for COVID-19 cases

**Italy – March 2020: Italian Red Cross volunteer preparing for an ambulance shift in Florence.** © Michele Squillantini/Italian Red Cross



### Support for immunization

**Iran – September 2021:** Iranian Red Crescent volunteers support people affected by the pandemic with medical care, awareness-raising activities and vaccinations and assist with other tasks at vaccination centres. © Iranian Red Crescent



### Shelter and urban settlements

**Bahamas – July 2020:** A family affected by Hurricane Dorian in 2019 receive prolonged rental assistance from the Red Cross during COVID-19 emergency. © Holly Baker/American Red Cross

## SOCIO-ECONOMIC

### Management of the dead

**Guinea – March 2021:** Red Cross Society of Guinea volunteers on their way to the hospital morgue to take a swab from someone who might have passed away from Ebola during the COVID-19 pandemic in N'Zérékoré, Guinea. © Naomi Nolte/IFRC



### Infection prevention and control and WASH

**Senegal – April 2021:** Hygiene volunteers from the Senegalese Red Cross Society, trained on infection prevention and control, clean and disinfect the wards of the COVID-19 treatment centre at Dalal Jamm Hospital in Dakar, Senegal. © Adams Sie/IFRC





### Livelihoods and household economic security

**Philippines** – August 2020 The Philippine Red Cross provides cash assistance to the families most affected by COVID-19 in Mandaluyong City.  
© France Noguera / IFRC

### Community engagement and accountability, including community feedback mechanisms

**Brazil** – August 2021: Brazilian Red Cross volunteers conduct perception research on COVID-19 among people living in extreme poverty, migrants and the elderly to better understand how to improve services and serve the needs of these population groups  
© Brazilian Red Cross



### Social care, cohesion and support to vulnerable groups

**Greece** – March 2020: Hellenic Red Cross volunteers help homeless people with first aid and information on COVID-19 infection prevention. © Hellenic Red Cross



### Support to volunteers

**Myanmar** – April 2021: The Myanmar Red Cross Society trains its volunteers on how to wear PPE properly, ensuring that they are protected while saving lives.  
© Myanmar Red Cross Society



### National Society readiness

**Laos** – August 2021: The Lao Red Cross prepares its teams by conducting disaster response training amidst the COVID-19 pandemic. © Lao Red Cross



## STRENGTHENING NATIONAL SOCIETIES





### National Society sustainability

**Georgia** – April 2020 The Georgia Red Cross Society, together with hypermarket “Goodwill,” has launched a charity campaign to help vulnerable lonely elderly people and socially vulnerable families affected by COVID-19. © Georgia Red Cross Society

## Keeping track of all the data: about the COVID-19 Indicator Tracking Tool

The role of the IFRC is to coordinate, monitor and facilitate information exchange between National Societies. How did this extraordinary response impact the way it keeps track? As the crisis affected countries all over the world, it was clear from the onset that a Federation-wide approach would be necessary. This prompted the use of the Federation-wide Databank and Reporting System (FDRS) platform to coordinate this task. The FDRS is a team within the IFRC dedicated to providing an overview of all National Societies through a yearly data collection exercise. Alongside its existing tracking system, a separate but similar process was established to track those indicators most relevant to the COVID-19 activities of National Societies. The resulting *COVID-19 Indicator Tracking Data* would become the major source of information on the activities of nearly all National Societies across the world and is therefore used extensively in this report. Here, we present an outline of the system used to collect this data.

The *COVID-19 Indicator Tracking System* is built around 44<sup>6</sup> indicators that are grouped into the 23 pillars referred to above. These, in turn, are divided into three operational priorities: Health, Socio-economic and Strengthening National Societies. The pillars group together indicators which reflect similar kinds of activities. This means that one National Society reporting on more indicators than another is not necessarily conducting more activities, but may be capturing different aspects of the same activities. In other words:

- the number of *pillars* reported is a reflection of a National Society's breadth of activities (the number of different activities);
- the number of *indicators* reported is a reflection of both a National Society's breadth of activities and the level of detail that it reports.

### Overview of the indicators, priorities and pillars<sup>7</sup>

Table 2–1 gives an overview of the priorities, the pillars under each one and the indicators for each pillar.

In some parts of this report, the indicators concerning vaccination are kept separate from the rest of the Health priority in a subset called Health (vaccinations). This decision was made because they are significantly different from the other indicators included in that priority (vaccination activities started much later) and National Society achievements on vaccinations are not very closely related to achievements on the other Health indicators.

### How the system was adapted

During the pandemic, the indicators sometimes had to be adapted to adjust to the new situation. Some indicators were dropped, some merged and others added along the way, and some definitions were improved. For example, indicators on COVID-19 vaccinations were added as these became available. In addition, the feedback mechanisms implemented led to the adaptation of some of the details of the indicators to provide more clarity to National Societies. These were not, however, substantial adjustments and therefore do not affect the comparability of the data over time.

For the purposes of this report, time-based data (in particular COVID-19 Indicator Tracking Data) is usually grouped into quarters (three-month periods).<sup>8</sup>

COVID-19 indicator tracking in this report covers the period from the second quarter of 2020 to the first quarter of 2022.

<sup>6</sup> This number changed slightly over time.

<sup>7</sup> Indicators, priorities and pillars are defined in the Federation-wide Emergency Appeal Revision <https://adore.ifrc.org/Download.aspx?FileId=308535>

<sup>8</sup> This classification allows better comparison with different datasets. In the case of COVID-19 Indicator Tracking Data, the data was actually submitted in a reporting tool in six "rounds", initially every three months and from the fifth round, every four months.



## National Societies were able to report on increasing numbers of indicators

The new COVID-19 Indicator Tracking System was another new data collection exercise for National Societies, who required some time to adapt to it. As time went on, National Societies reported on more and more different kinds of activities. By the start of 2021, National Societies were implementing and reporting on an average of around 16 different indicators per quarter.

By the third quarter of 2020, nearly 130 National Societies were reporting achievements in the Health priority.

## Achievements: numbers for each main type of indicator

Now we turn to the *content* of this reporting on how National Societies responded to the pandemic. We will look at the total achievements of National Societies over the course of the pandemic (latest figures end of first quarter of 2022) for:

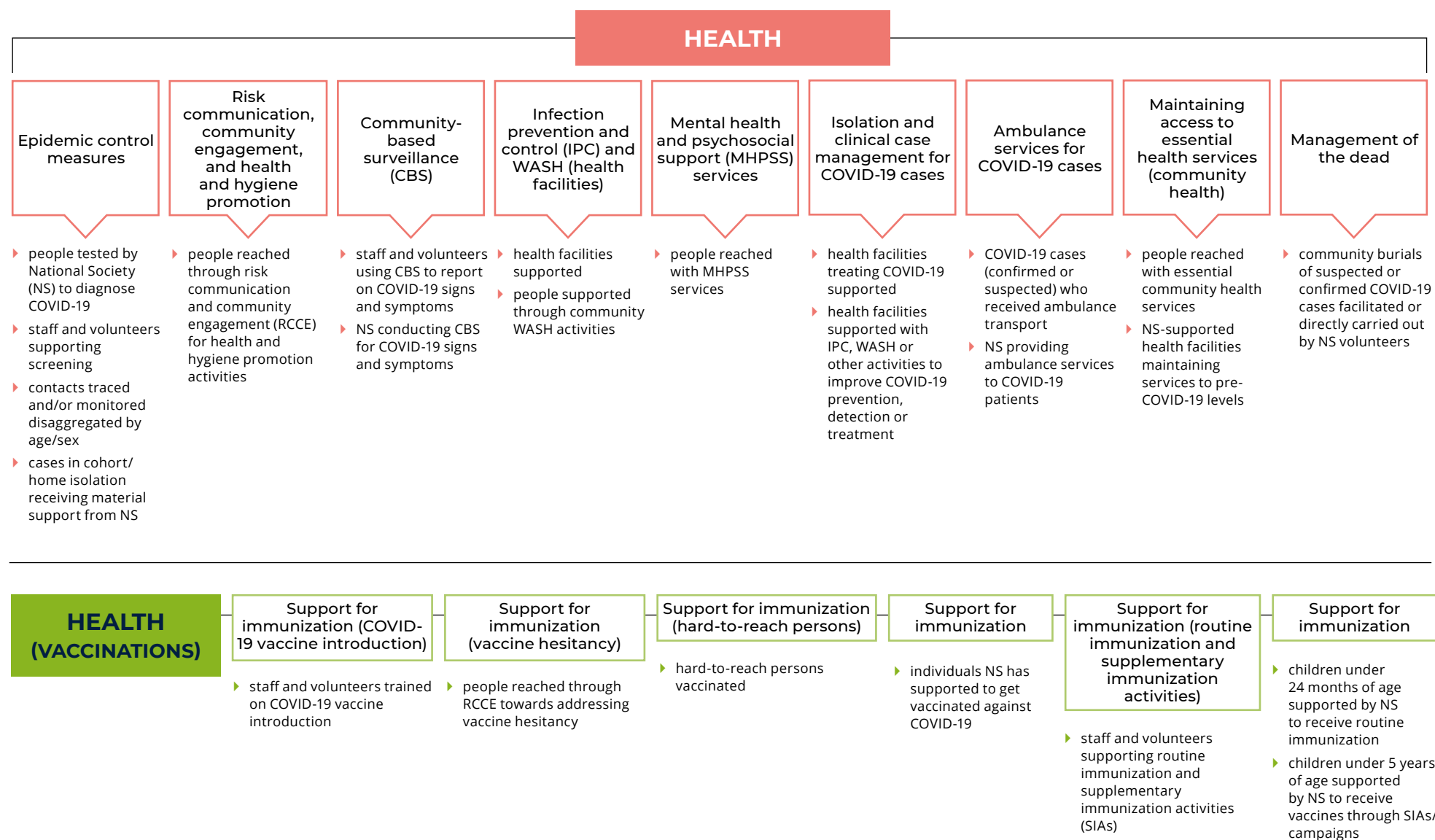
- people reached;
- health facilities supported;
- support to staff and volunteers.

Nearly all these indicators are cumulative. For example, the indicator “number of people reached with MHPSS services” for the Somali Red Crescent Society, submitted in September 2021, counts all the people reached by that National Society with MHPSS over the entire duration of the pandemic up to September 2021.

The beeswarm plots on the following pages (Figure 2–2, 2–3 and 2–4), so named because they resemble swarms of bees, show the values for each individual National Society as a coloured point, grouped into rows that correspond to the indicators listed on the left. As many National Societies may have similar scores, in which case the points overlap one another, the points are sometimes moved slightly so that they are all visible. While the blue line near the centre of each swarm marks the median score for that indicator, the label at the right-hand edge of each swarm shows the total score for all National Societies.



**Mongolia 2022** Mongolian Red Cross volunteers work in the kitchen of the health service in Tuv province to provide meals to patients. Mongolian Red Cross has worked closely with government health departments to help provide important services to affected communities while the country grappled with the COVID-19 pandemic. © IFRC

**Figure 2-1** Overview of priorities, pillars and indicators

## SOCIO-ECONOMIC

Livelihoods and household economic security

- ▶ people reached with conditional and unconditional cash and voucher assistance
- ▶ people reached with food and other in-kind assistance
- ▶ people supported with skills development for livelihoods/economic activities

Shelter and urban settlements

- ▶ people reached with safe and adequate shelter and settlements under the circumstances of COVID-19

Community engagement and accountability, including community feedback mechanisms

- ▶ community feedback reports produced
- ▶ community feedback comments collected
- ▶ NS staff and volunteers trained on community engagement and accountability

Social care, cohesion and support to vulnerable groups

- ▶ branches including an analysis of the specific needs of marginalized groups in their assessments
- ▶ people reached by programmes addressing exclusion
- ▶ people reached by programmes addressing violence
- ▶ people reached by programmes addressing education-related needs

## STRENGTHENING NATIONAL SOCIETIES

NS readiness

- ▶ people reached through pandemic-proof community preparedness, response and disaster risk reduction (DRR) measures
- ▶ the role and activities of the NS are expressly included in the national government's main plan(s) for COVID-19 response/recovery
- ▶ the NS has developed contingency plans for COVID-19 response and other concomitant emergencies

NS sustainability

- ▶ % of core organizational budget that is funded
- ▶ new streams for unrestricted income
- ▶ unrestricted financial reserves for more than 3 months
- ▶ the NS has adapted its business continuity plan for COVID-19 or developed a new one

Support to volunteers

- ▶ volunteers have access to the personal protective equipment (PPE) necessary to safely fulfil their duties
- ▶ volunteers are provided with insurance that covers accidents, illness and death benefits for their families, including private, organizational (e.g. solidarity funds) or public coverage from authorities



**Malaysia 2021** Volunteers of Malaysian Red Crescent provided vaccination assistance to over 150 people at a local church. As part of the ongoing vaccination effort, the MRCS has also assisted the inoculation of the bedridden, physically disabled and Orang Asli. © Malaysian Red Crescent

**Figure 2–2** Achievements on different people reached indicators

Each service is reported separately, which means that the same people may be reached by multiple activities. Figures should not be summed up across indicators to avoid double counting. The same applies throughout this report where “people reached” indicators are reported.

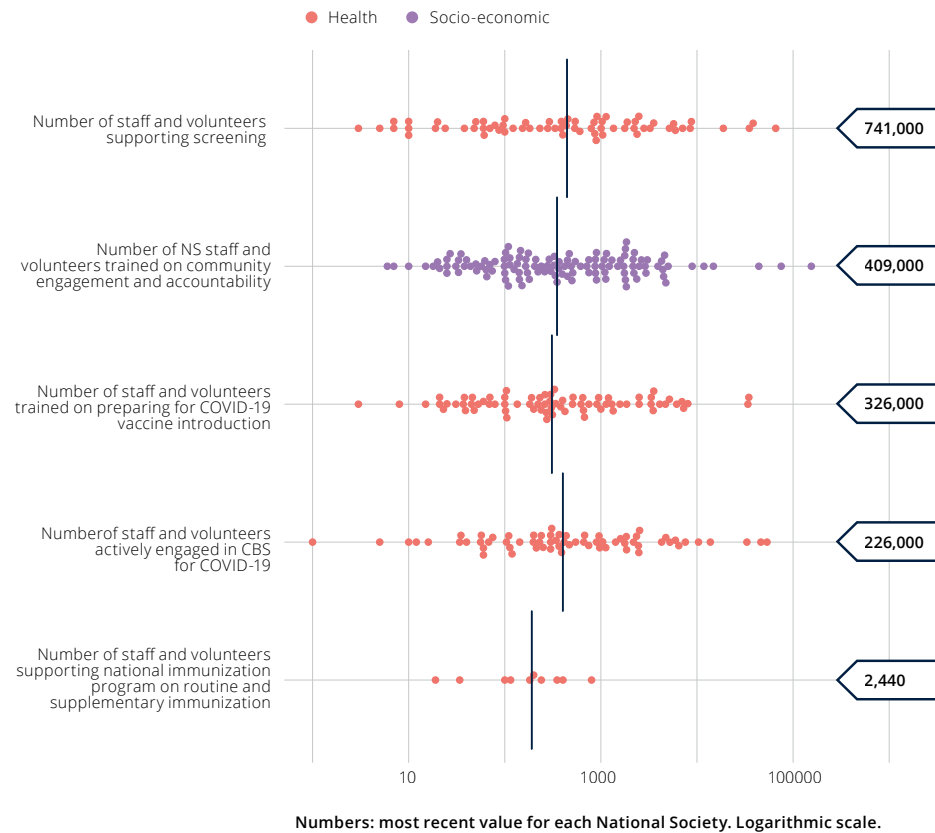
#### KEY FINDINGS

- National Societies reported achievements on 17 different “people reached” indicators.
- For nearly all these indicators, over a million people were reached globally.
- The largest number was for people reached through RCCE: around 978 million people.



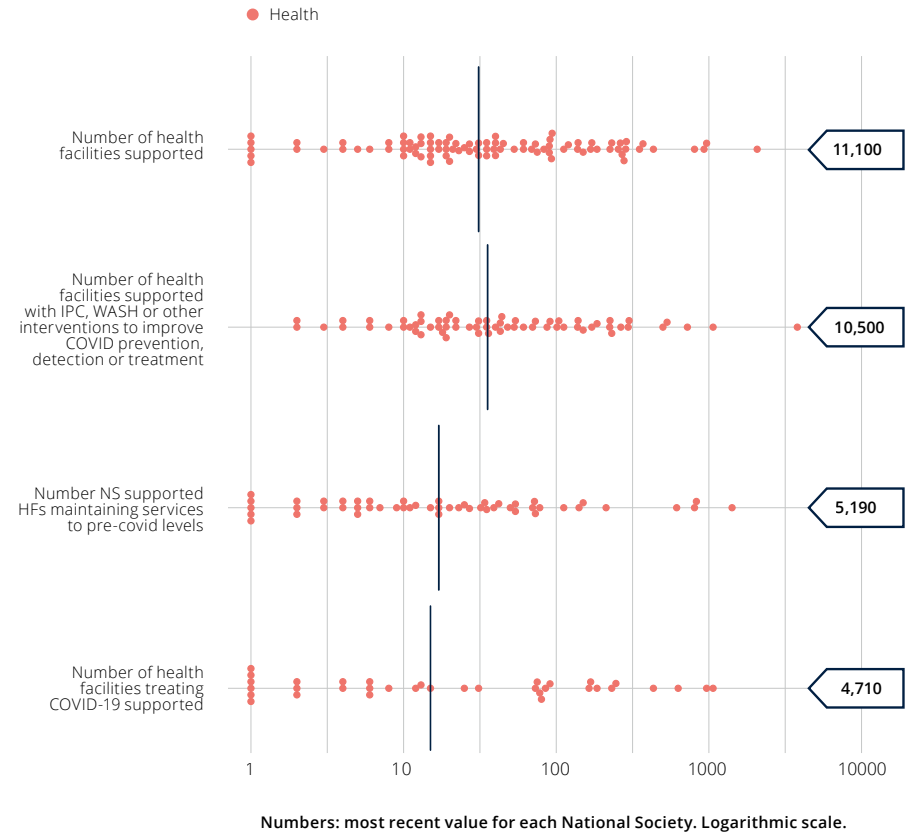
**Figure 2–2.** Beeswarm plot of achievements on different “people reached” indicators (total figures up to first quarter of 2022). This figure shows the number of people each National Society has reached throughout the pandemic (in a logarithmic scale on the x-axis) for the various indicators (on the y-axis). The logarithmic scale helps to “spread out” smaller numbers as otherwise it would be difficult to separate the values at the lower end of the scale. Dataset: CI-tracking.



**Figure 2–3 Staff and volunteers****KEY FINDINGS**

- Over three-quarters of a million staff and volunteers were involved in screening COVID-19 cases.
- Over a third of a million staff and volunteers were trained on RCCE and COVID-19 vaccine introduction.

**Figure 2–3.** Beeswarm plot of achievements on different “staff and volunteers” indicators (total figures up to first quarter of 2022). Dataset: CI-tracking.

**Figure 2–4 Health facilities****KEY FINDINGS**

- Over 10,000 health facilities were supported globally.

**Figure 2–4.** Beeswarm plot of achievements on different “health facilities” indicators (total figures up to first quarter of 2022). Dataset: CI-tracking.

## How can this mass of data be usefully aggregated?

We have seen that National Societies collectively provided an enormous amount of data to the FDRS COVID-19 Indicator Tracking System. How can we combine all this information to get a more accurate picture of how National Societies responded in such a way that we can see, for example, how progress on Strengthening National Societies compared to progress on numbers of people reached? This can be difficult for the following reasons:

- There are enormous differences between the populations of the countries in which the different National Societies work, so that a figure of 10,000 people reached in a small country has a completely different meaning to the same indicator value in a large country with a population in the hundreds of millions.
- Even when correcting for population, most indicators are still not evenly spread. There will be a few National Societies with much bigger numbers so that much of the information about the differences between National Societies with smaller numbers is lost.
- The indicators are hard to compare. While some indicators just require binary (“yes/no”) answers, numbers reported for other indicators may climb into the millions, for example, the number of people reached with messaging.

### Achievement indexes

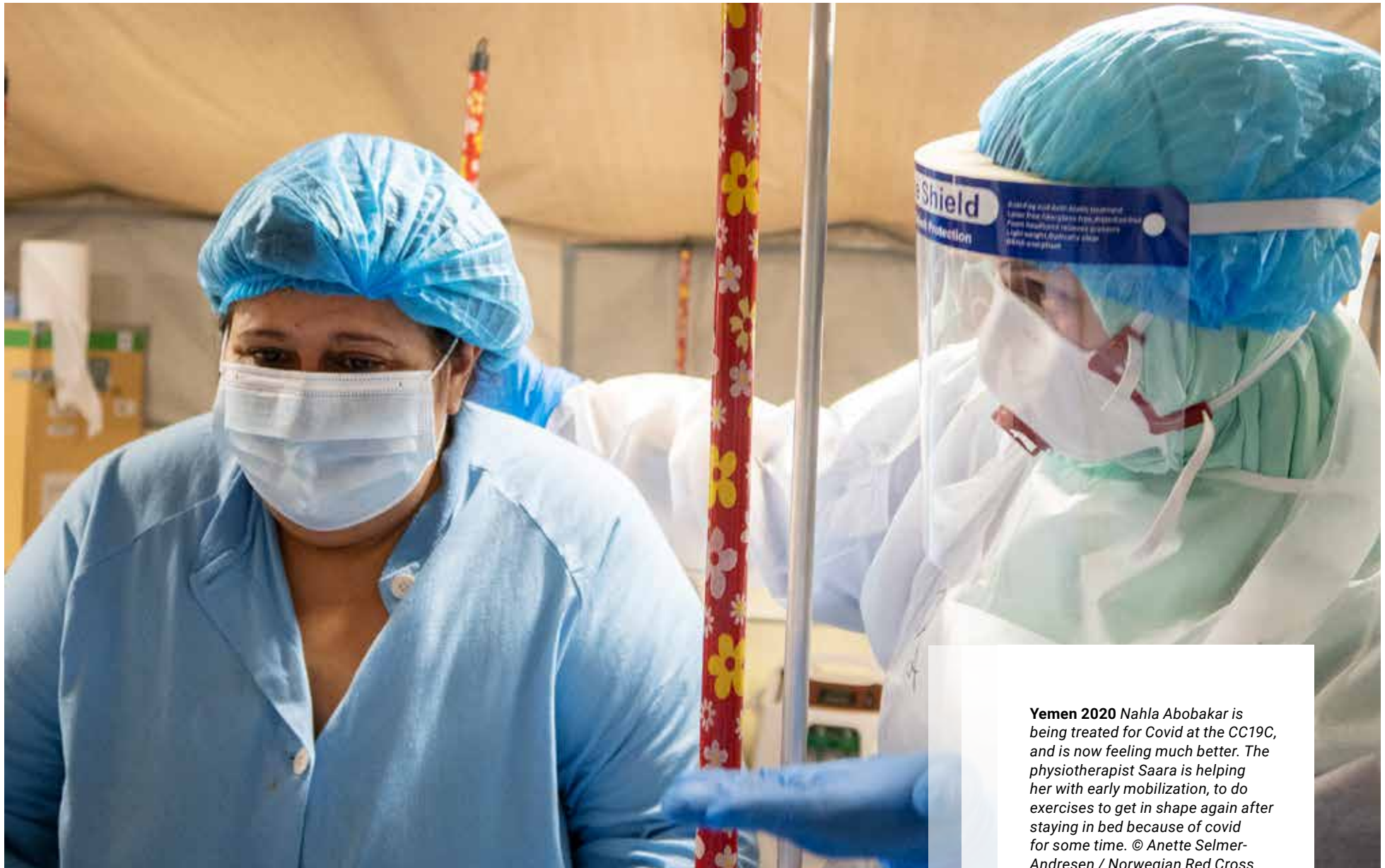
To overcome these difficulties, we decided to create a National Society *achievement index* for each indicator, and for the pillars and priorities, we created aggregate achievement indexes too. These indexes are created as follows:

For each indicator, we take the values for a National Society over all the quarters<sup>9</sup> and:

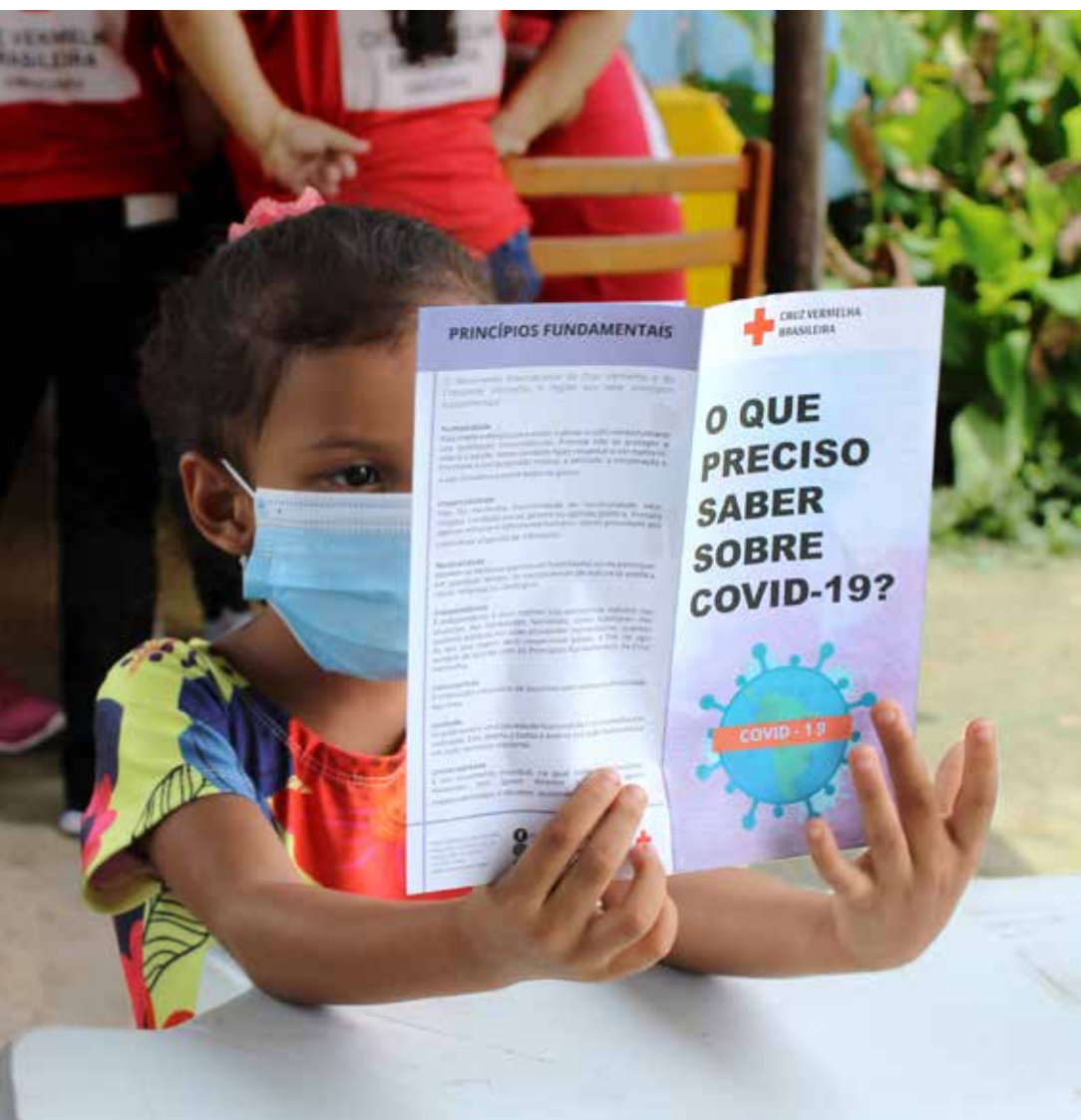
- 1. Unify:** convert all binary indicators to numbers (0 or 1).
- 2. Take proportions:** for most indicators, convert the numbers into a proportional number by dividing them by the total population to correct for population size. This is not, however, necessary for some of the indicators, such as the binary indicators.
- 3. Rank:** put all the resulting numbers over all the quarters for all the National Societies in order to get a “rank” for each number, counting from 1 upwards.
- 4. Standardize:** standardize the rank scores, assigning 100 to the top value and 0 to the lowest value. So, if a National Society has an achievement index of 100 on the indicator for RCCE for the first quarter of 2021, it means that in that quarter, the National Society achieved the highest (or joint highest) number (adjusted for population, where appropriate) ever reported for this indicator over the entire duration of the pandemic. A score of 50 means the National Society reported a roughly average number.

<sup>9</sup> Sometimes a National Society may report more than one value for an indicator in a given quarter (three-month period) or no value at all. So, for each indicator and for each National Society, we calculate a unique score for each quarter as follows:

- if the National Society had more than one score in that quarter, we assigned the last of the scores;
- if the National Society had not reported in that quarter but had reported in a previous quarter, we took the score from the previous quarter.



**Yemen 2020** Nahla Abobakar is being treated for Covid at the CC19C, and is now feeling much better. The physiotherapist Saara is helping her with early mobilization, to do exercises to get in shape again after staying in bed because of covid for some time. © Anette Selmer-Andresen / Norwegian Red Cross



**Brazil 2020** Brazilian Red Cross volunteers in Amazonas state are doing everything they can to support people, including distributing food baskets, rapid tests, PPE, hygiene kits, prevention kits, masks, sanitizer, and providing access to safe drinking water, psychosocial support, and other types of assistance. © Brazilian Red Cross

These indexes are convenient because:

- they can be compared between National Societies since they are constructed to be proportional to population;
- they can be compared between indicators, pillars, etc.;
- they can be compared across different points in time and therefore be used to display changes over time;
- they have an intuitive meaning: a maximum score of 100 means that the achievement was the best or joint best of all the scores obtained by all National Societies throughout the pandemic; a score of 0 means the achievement was the lowest or joint lowest of all the National Societies throughout the pandemic.<sup>10</sup>

These indicator-specific indexes for each National Society are useful on their own, but can be combined to establish what are called aggregate indexes, for example, by combining values across the Health priority to assess a National Society's achievements across all the indicators that are part of this priority.

**S**ome caveats on achievement indexes: the indexes for individual indicators only reflect what has been reported against those specific indicators. It is, of course, possible for an individual National Society to have low achievement indexes even though it has been carrying out excellent work because it is not captured well or at all by the individual indicators or simply because it has not been reported consistently. Aggregate achievement indexes for the pillars and priorities reflect the total number of different indicators reported as well as the ranks on each indicator. A higher score obtained by a given National Society for a particular priority can mean a higher achievement index on the same indicators (e.g. more people reached), but it can also mean that the National Society is reporting more indicators for that priority.

<sup>10</sup> A missing score means the National Society did not report that indicator at all – this is relevant only for “point-in-time” indicators, for example, whether the National Society has unrestricted financial reserves for more than three months.



## The DNA of the response: every National Society had a different response

The figure 2-5 shows the aggregate achievement index for each indicator for each National Society, where each grey-bordered box represents one National Society. Within each box, each stripe represents the overall achievement index<sup>11</sup> for a single indicator.

The graph emphasizes how different every National Society is as each one carried out a different set of activities and had high achievement indexes on at least some indicators. We challenge the reader to find two National Societies with the same pattern of achievement!

### KEY FINDINGS

- Every National Society had its own particular pattern of responses, with its own specific strengths.

Health ●  
Health (vaccinations) ●  
Strengthening National Societies ●  
Socio-economic ●

11 The sum of the achievement indexes for the indicator for each quarter, rescaled again so 0 is the lowest value and 100 is the highest.

**Figure 2-5** The DNA of the response



**Figure 2-5.** The diversity of responses. Each vertical stripe represents one indicator. The main colour of each stripe corresponds to the priority. The intensity of the colour shows the achievement index for that indicator. Dataset: CI-tracking

**Figure 2–6** Achievement in different priorities compared across the pandemic

In Figure 2–6, we use the composite achievement indexes for each priority to compare achievements across regions throughout the pandemic. These are calculated as the averages per region of each National Society's rescaled total achievement indexes. For each priority, the numbers on the y-axis reflect the total achievement rescaled: 100 is always the highest (relative to population size) total for any National Society in any quarter.



**Figure 2–6.** Achievement indexes of National Societies over the pandemic by priority. Lines are not shown when there are less than three National Societies reporting in a given region. Dataset: CI-tracking.

## KEY FINDINGS

- Overall, the achievements in the different priorities were relatively similar when compared across regions.
- Achievement in Health was particularly high in MENA and Africa.
- Achievement in most priorities, especially Health, gradually increased as the pandemic progressed.
- Achievement in Strengthening National Societies accelerated quickly but has started to drop off again in most regions (some of the Strengthening National Societies indicators are time-based and so are more likely to show a drop).
- Achievement was particularly high in Asia Pacific and MENA, especially in 2021, although it dropped a little in MENA towards the end of the year.
- In the Socio-economic priority, the medians are mostly well below 50. This is because there were a few National Societies that scored very highly across all the constituent indicators, whereas the majority scored well only on one or two of the indicators in this priority. These high-scoring National Societies also tended to very quickly start reaching high scores early in 2021.

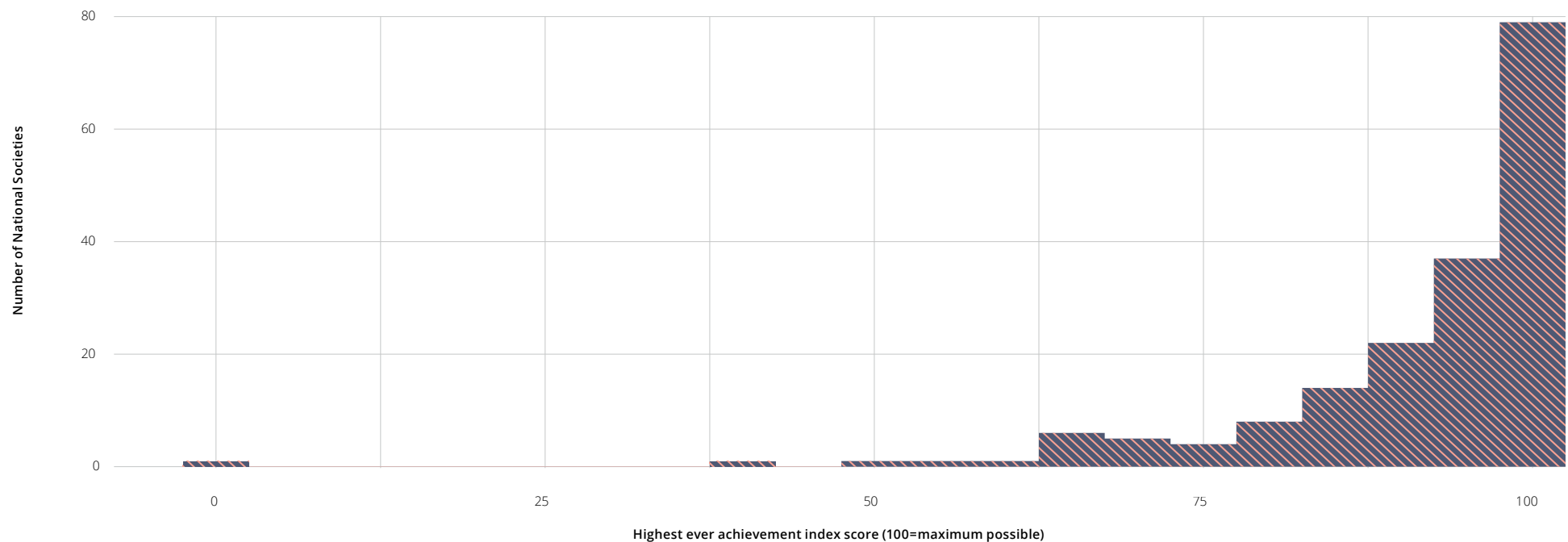
## “Personal best”: do most National Societies report high scores on at least some indicators?

Are there are just a few National Societies that perform well on nearly all the indicators nearly all the time or do individual National Societies tend to have their own particular strengths and achieve high numbers over time on specific indicators? Figure 2-7 provides the answer. It shows how many National Societies achieved a high achievement score during the pandemic on at least one indicator (from 0 to 100)."

### KEY FINDINGS

- Over 60 different National Societies had, at some point in the pandemic, an achievement index score of between 96 and 100 on at least one indicator, meaning that their achievement on this indicator was the best, or nearly the best, ever recorded by any National Society at any point in the pandemic, and nearly all reporting National Societies had at least one achievement index score of 75 or more on at least one indicator.

**Figure 2-7** Almost all National Societies reported high numbers for at least some indicators



**Figure 2-7.** The “personal best” achievement score for each National Society on any indicator over the pandemic, excluding binary indicators. Dataset: CI-tracking.

## Did National Societies manage to respond in a sustainable way?

The pandemic and the response to it placed a considerable strain on National Societies.



Within the IFRC Secretariat, there was a strong commitment to business continuity and staff health, with personnel dedicated to these technical roles for COVID-19, at global and regional level. This included 24/7 support for all Secretariat staff and offices, and many staff felt they and their families were well informed and supported to manage the risks of COVID-19.<sup>12</sup>

**IFRC Evaluation Report**

How did National Societies stand up to the strain? Strengthening National Societies was monitored with COVID-19 tracking indicators. The Strengthening National Societies pillar includes activities on:

- support to volunteers;
- National Society readiness;
- National Society sustainability.

As most of these indicators are in a binary (yes/no) format, Figure 2–8 presents them together.

It shows the percentages of the National Societies in each region for achievement of the indicators listed in the labels. The red area shows the National Societies reporting that they have reached this achievement, the darker grey area shows the National Societies reporting that the achievement had not been reached and the light grey area represents the National Societies that did not report anything.

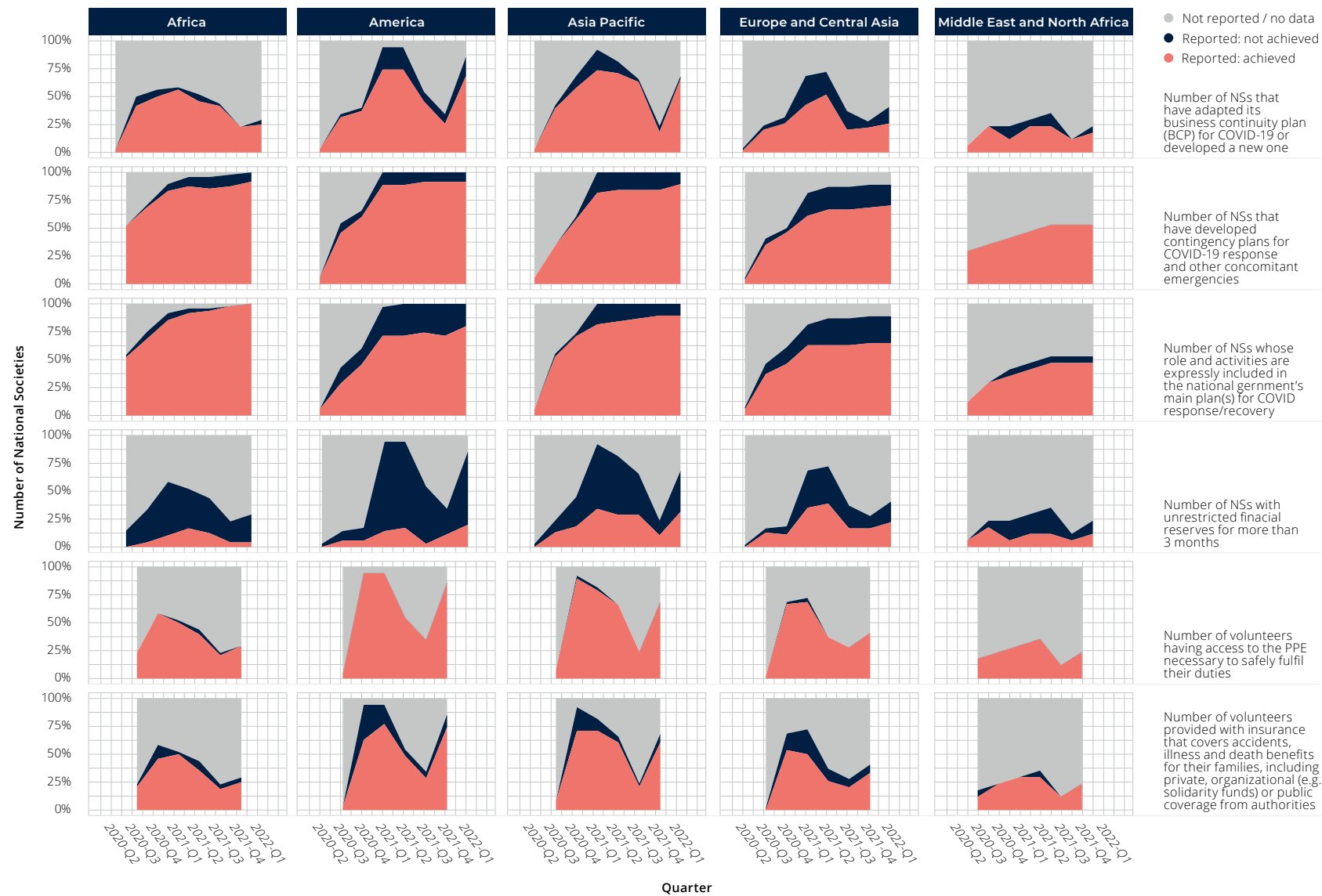
Achievements may be difficult to capture when a proportion of National Societies have not always been able to report on particular indicators. This lack of data might mean that the National Society has nothing to report, but it could also be that the National Society had achievements to report but did not do so.



**El Salvador 2020** The Salvadorean Red Cross Society delivered hygiene kits, educational material kits and teaching guides to three schools in Aguilares and three in Guazapa. The actions are being carried out as part of the emergency response to COVID-19. © Salvadorean Red Cross Society

<sup>12</sup> IFRC (2022), *Evaluation Report: IFRC-wide response to the COVID-19 pandemic*, p. 13.



**Figure 2–8** Strengthening National Societies – achievements**KEY FINDINGS**

- The percentage of National Societies with these achievements is particularly high in Africa, the Americas and Asia Pacific.
- The first data points involve fewer National Societies as they started to work towards these achievements.
- Few National Societies report that they have unrestricted financial reserves for more than three months.

**Figure 2–8.** Strengthening National Societies (binary, yes/no indicators only). Dataset: CI-tracking.



**Madagascar 2020** Hand washing facilities were set up by the Malagasy Red Cross Society in many neighbourhoods.  
© iAko Randrianarivelo / IFRC

## KEY MESSAGES

- ▶ National Societies responded to the pandemic with a very broad range of activities. Most National Societies had to implement new activities or carry out familiar ones on an unprecedented scale.
- ▶ The IFRC FDRS team introduced a COVID-19 Indicator Tracking Tool, and most National Societies started reporting on it almost immediately. By the third quarter of 2020, nearly 130 National Societies were reporting achievements in the Health priority.
- ▶ National Societies reported achievements on 17 different “people reached” indicators.
- ▶ On nearly all these indicators, over a million people were reached globally.
- ▶ The largest number was for people reached through RCCE: around 978 million people.
- ▶ Over three-quarters of a million staff and volunteers were involved in screening COVID-19 cases.
- ▶ Over a third of a million staff and volunteers were trained on RCCE.
- ▶ Each National Society carried out a different set of activities and had high achievement indexes on at least some indicators.
- ▶ In spite of the best efforts of National Societies and the IFRC Secretariat, the pandemic presented a challenge to National Society sustainability. Although many National Societies had relevant contingency plans, few report that they have unrestricted financial reserves for more than three months.







3

**UNITY OR ISOLATION  
IN THE FACE OF A  
GLOBAL CRISIS**

AN OPEN AND  
COLLABORATIVE  
NETWORK

## KEY QUESTIONS

- ▶ **To what extent were National Societies included in their government's response and recovery planning and in health-care systems? Did the support offered by National Societies reflect and complement their government's response?**

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- ▶ **Were different National Societies within the IFRC network able to support one another?**

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- ▶ **At the start of the pandemic, did National Societies turn to existing partners for support or did they find new partners?**

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- ▶ **How many partnerships were there?**

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- ▶ **How much financial support was provided?**

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- ▶ **To what extent were partnerships formed across regions and within regions?**

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## National Society collaboration with government and local authorities

The pandemic started just months after the 33rd International Conference of the Red Cross and Red Crescent in 2019. During the conference, a resolution was passed, entitled "Time to act: Tackling epidemics and pandemics together" which "encourages States and components of the Movement to strengthen cooperation and coordination and [calls] for National Societies to use their auxiliary role to support efforts in community-centered disease prevention, control, preparedness and response". Was this resolution put into practice when the pandemic hit?

To answer this question, we use one of the indicators of progress in the pillar National Society readiness, included in Operational Priority 3 as part of the COVID-19 Indicator Tracking Data the IFRC has collected: *the role and activities of the National Society are expressly included in the national government's main plan(s) for COVID-19 response/recovery*.

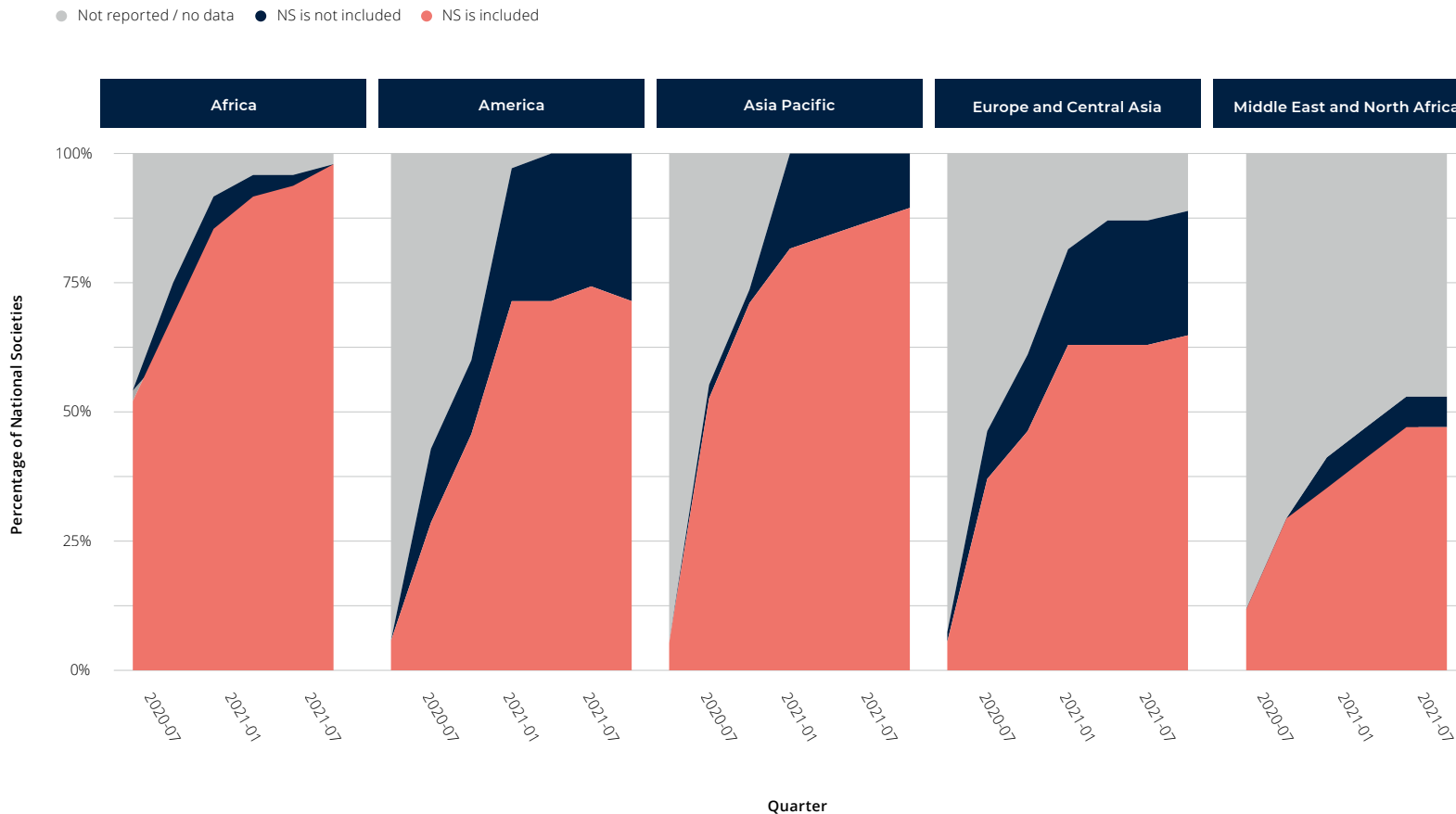
Figure 3–1 shows the evolution over time of the responses provided by National Societies.<sup>13</sup>

The COVID-19 Evaluation<sup>14</sup> confirmed the importance of the role of National Societies alongside national governments and called for further targeted support to be provided to National Societies "to consolidate their roles as auxiliaries to government in the humanitarian field and providing further guidance on how to navigate the complexities that arise. This should also include having focal points to support dialogue with governments." The Evaluation also recommends "[e]ngaging with donors, humanitarian and development partners, using the experience and evidence of this pandemic response, to demonstrate the value of investing in National Society preparedness and sustainability both for the remainder of this response and in future programmes and operations, and to develop a clear vision and strategy in this regard".

13 For the purposes of this report, the few "I don't know" responses have been coded as missing data, appearing in the category "not reported/no data".

14 IFRC (2022), *Evaluation Report: IFRC-wide response to the COVID-19 pandemic*, p. 18.

**Figure 3–1** The role and activities of the National Society are expressly included in the national government’s main plan(s) for COVID-19 response/recovery



**Figure 3–1.** The role and activities of the National Societies are expressly included in the government’s main plan(s) for COVID-19 response/recovery, over time. Dataset: CI-tracking.

#### KEY FINDINGS

- Across all regions, the role of National Societies has steadily increased during the pandemic as more and more of them would expressly be included in government’s plan for the response to COVID-19.
- National Societies in the Africa region have proportionally been included most in government’s plans all throughout the pandemic, with over 50% of them already included by the end of June 2020.
- In the Americas, Asia Pacific, and Europe and Central Asia, the highest proportion of National Societies explicitly mentioned not to be included in government’s plans, especially during later phases of the pandemic.

This next example from Sierra Leone shows what this can look like in practice and also highlights how previous experience of dealing with an epidemic was useful for some National Societies in responding to COVID-19.



**Sierra Leone 2021** Sierra Leone Red Cross Society communications team operates the “Radio in a Box” that allow the Red Cross to take their health messages to remote and isolated communities within Sierra Leone and to get important feedback from them. © Victor Lacken / IFRC

## What was it like for National Societies having strong partnerships with national and local authorities?

### The case of the Sierra Leone Red Cross<sup>15</sup>

In 2014, Sierra Leone was struck by a deadly Ebola outbreak, which took the lives of thousands of people over the following years. The country has learned the immense value of having a robust multi-hazard national disaster management preparedness plan that enables all key partners to act quickly in the vital early stages of an outbreak. This plan was codified into an extensive framework for government, the private sector, non-profits and the Sierra Leone Red Cross to collectively prepare for and respond to hazard emergencies. As a result, when Sierra Leone’s first case of COVID-19 was identified in Freetown, all these partners were already planning and deciding what activities would be most relevant in the subsequent response.

The Red Cross worked alongside the government’s National Coronavirus Emergency Centre, using its extensive network of volunteers to provide information to communities about the disease. In cities, they conducted a radio and television campaign. In rural areas, they had to use more innovative communications techniques, for example, what they call a “radio-in-the-box” system, which involves identifying a strategic location in the community and setting up a loudspeaker to deliver messages, a method first pioneered during the Ebola outbreak. This allowed them to get the messages to people they would not have been able to reach through traditional communications methods.

A National Society being part of the national disaster management preparedness plan before an epidemic or pandemic occurs allows for quicker mobilization and action as the specific services and expectations are clearly articulated and the auxiliary role is recognized.

15 [https://www.ifrc.org/sites/default/files/2022-03/Preparedness\\_COVID\\_SuccessStory\\_Sierra%20Leone\\_EN.pdf](https://www.ifrc.org/sites/default/files/2022-03/Preparedness_COVID_SuccessStory_Sierra%20Leone_EN.pdf)



## Examples of National Societies whose response complemented their government's response

It is important to realize that not all governments around the world were able to provide health and socio-economic support to their populations in the way they might have wanted to. We compared the Oxford University's Stringency Index on government COVID-19-policy (discussed in Chapter 1) with the National Society achievement indexes (explained in Chapter 2) to identify National Societies that were able to fulfil their auxiliary role by supporting their national government, which was unable to offer support to its citizens. Here is an example of such National Society.



**Lesotho 2021** Lesotho Red Cross Society and UNICEF Lesotho Risk Communication and Community Engagement (RCCE) Awareness Campaign being conducted in Sani pass, Lesotho.  
© Lesotho Red Cross Society

### How did National Societies cooperate with other agencies to prevent COVID-19 transmission?

#### The case of the Lesotho Red Cross Society<sup>16</sup>

In a good example of cooperation with other agencies, the Lesotho Red Cross Society teamed up with UNICEF Lesotho and WHO to conduct an RCCE project from August 2020 to March 2021. The project aimed to strengthen community-level risk communication, coordination and structures and critical WASH services and supplies to respond to and control COVID-19 infections. The campaign covered public places, such as bus stops, reaching villages through a convoy that toured around the district town and nearby communities. The campaign also worked through church leaders and traditional healers to reach as many communities as possible.

According to the Divisional Secretary of Qacha's Nek, Thabo Motautona, the idea for this mobile campaign stemmed from one of the COVID-19 protocols in place in Lesotho. This protocol, which mandates spending no more than an hour where 50 people or more are gathered in one place to reduce infections, would play a central role in the campaign. "When going around these communities, we made a few stops where people seemed to have gathered without observing proper COVID-19 precautions, such as wearing masks and keeping a safe distance from other people, and reminded them about the risks," explains Motautona. "During these stops, we asked people questions about coronavirus and handed out masks and lanyards with key messages about the pandemic, such as 'wear a mask' and 'wash your hands regularly.'"

<sup>16</sup> <https://www.redcross.org.ls/unicef-lrcs-go-from-pillar-to-post-to-pass-the-covid19-awareness/>

## How did National Societies support each other during the COVID-19 crisis?

### The case of the Palestine Red Crescent Society<sup>17</sup>

This story from Palestine in September 2020 is a good example of cooperation between National Societies.

In cooperation with the Directorate-General for European Civil Protection and Humanitarian Aid Operations, the Danish Red Cross and the Spanish Red Cross, the Palestine Red Crescent Society (PRCS) launched the *Response and Preparedness to the COVID-19 Crisis in Palestine* project. The activities aimed to control the spread of the virus, curbing its direct and indirect effects, reduce COVID-19 mortality and enhance the safety, mental health and social wellbeing of disadvantaged groups.

The project focused on emergency medical services (EMS), primary health care, community information and awareness, community action, psychosocial support, reducing the social stigma associated with COVID-19 and dispelling rumours about the disease. PPE and a state-of-the-art ambulance with a separation between the driver's cabin and the patient compartment were purchased with the funds provided. Primary health-care clinics throughout the West Bank received support, medicine, medical supplies and equipment to reduce the pressure on public health systems. The project promoted the National Society's community awareness campaigns via videos and spots on its website and social media accounts as well as through its branches in Palestine and among the diaspora. Key messages about the virus and its prevention, the need to comply with quarantine rules and the provision of mental support to the population were disseminated.

According to Randa Bani Odeh, Head of the PRCS Projects Department, "the project is in line with the Society's objectives, mainly in terms of providing emergency medical services and enhancing community awareness, with a view to building resilience and quality response to emergencies and to the COVID-19 pandemic in particular".

Speaking on behalf of the Danish Red Cross and the Spanish Red Cross, Alfredo Melgarejo, Country Coordinator for the Danish Red Cross, said: "We are delighted with this partnership with EU Humanitarian Aid to support the PRCS's Emergency Response Plan. This commitment confirms the confidence of international partners in the capacity and reliability of the PRCS as a leading humanitarian actor in the Palestinian context in general and particularly in the current situation, where the PRCS EMS system and health facilities and the highly engaged community and psychosocial field teams are a crucial factor in the national response to the ongoing COVID-19-pandemic."



**Palestine 2021** Palestine Red Crescent volunteers visits families who have been put to home quarantine due to the exposure or infection to the coronavirus. ©Palestine Red Crescent Society

<sup>17</sup> <https://reliefweb.int/report/occupied-palestinian-territory/palestine-red-crescent-society-launches-response-and>

## Collaboration between National Societies

One of the strengths of the International Red Cross and Red Crescent Movement is solidarity across National Societies thanks to its peer-to-peer network of National Societies, as highlighted in previous FDRS *Everyone Counts*

reports. Were National Societies able to leverage existing National Society contacts when facing COVID-19 or were all National Societies too preoccupied with their own response?

### GO data: field reports

There are different sources of data on collaboration and partnerships between National Societies.

We will first look at the IFRC GO database of around 3,000 field reports from 2020 and 2021<sup>18</sup>. These reports give status updates on activities in ongoing emergencies, such as tropical storms, droughts and other types of crises. The reports are submitted either by the implementing National Society or by an international partner. While some reports include activities related to COVID-19, others only contain separate activities. Although the reports do not cover all the activities conducted by National Societies, the selection of projects they include provides numerous examples of their local and international reach.

For an idea of the type of information included in the reports, see the excerpt below describing an example of international support for a project conducted by the Pakistan Red Crescent Society (PRCS) from a report submitted in April 2021.

*“PRCS, through the COVID-19 response, has reached over 32 million people across 54 districts, through the distribution of PPE and family hygiene kits, provision of cash and food assistance, the establishment of Corona Care Hospital for screening and its conversion into mass vaccination centre, rehabilitation/installation of WASH infrastructures, community-level awareness and mass media campaign...”*

- *German Red Cross supported PRCS in the provision of food packs (dry ration) to approximately 3400 HH [households], Hygiene Kits to 1800 HH, unconditional cash grant to 10000 HH, and other support in terms of health services including provision of testing kits, PPE, etc...*
- *Norwegian Red Cross provided support to PRCS in the Health sector, provision of Hygiene kits and support in CEA activities.*
- *Turkish Red Crescent provided support to Corona Care Hospital with 210 pieces of medical aid including 50 pcs of 47-litre oxygen cylinders, 50 oxygen flow meters, 10 oxygen pressure regulators and 100 special oxygen masks for ensuring treatment of patients struggling with the COVID-19 virus. Turkish Red Crescent distributed 1,000 food parcels in Islamabad, Karor, Rawalpindi, and Faisalabad. ICRC provided food (dry ration) to 1550 households along with support to volunteers engaged in the COVID-19 response.”*

<sup>18</sup> <https://go.ifrc.org/reports/all>. Appendix to the chapter 3.





**Guatemala 2021** CEA sessions in the community within the framework of the creation of participatory videos. © Hermanos Corallo

## Details of the analysis

There is so much data of this kind in the GO Field Reports that we used computer-assisted text analysis tools to process it. See Appendix to Chapter 3.

International collaborations were mentioned a total of 584 times in 303 different reports; many reports provided information on multiple collaborations.

Of these 303 reports, 168 mentioned collaboration with just one other partner National Society (PNS), with the remainder referring to collaboration involving more than one PNS.

Altogether, 182<sup>19</sup> completely different combinations of PNSs and National Societies were mentioned, which means that many partnerships are mentioned multiple times, either because the same collaboration is reported more than once during the pandemic or because several activities were conducted under the partnership.

## GO Field Reports: numbers of partnerships across regions

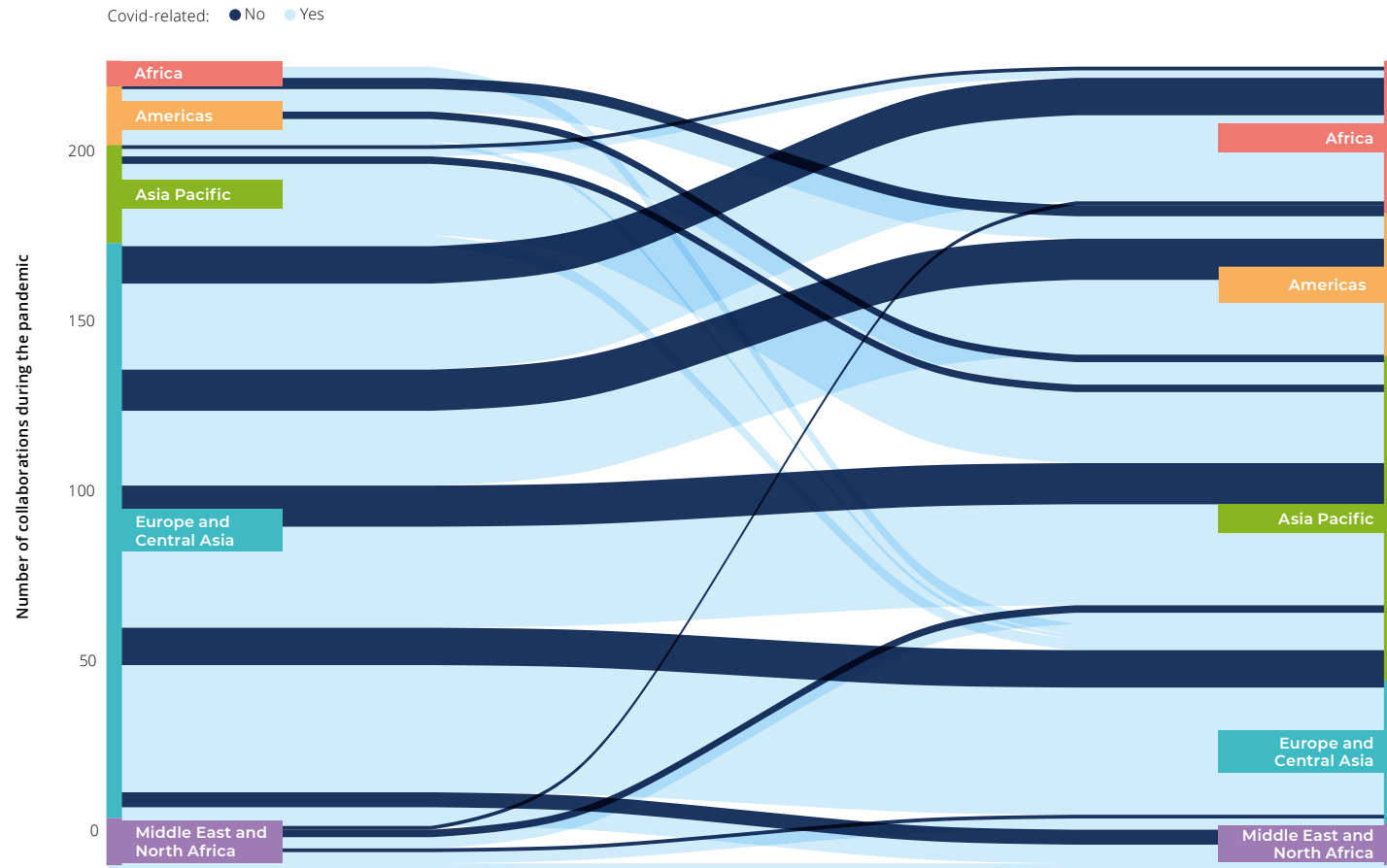
During the COVID-19 crisis, a variety of new partnerships were formed and existing ones maintained between National Societies both within and across regions.

Figure 3–2 provides an overview of the number of international partnerships, as mentioned in the field reports, showing the unique partnership flows between regions. A large proportion of these partnerships are related to a COVID-19 response activity, as indicated by the flows colour-coded according to the legend. Supporting National Societies are displayed on the left, and receiving National Societies on the right.

<sup>19</sup> This means that if National Society X mentions a collaboration with National Society Y in March and October of the same year, it is difficult to be sure if these are substantially similar or substantially different activities. For the purposes of this analysis, they are treated as separate collaborations, and no attempt is made to determine whether there are separate activities or whether the same activity is referred to at different times.



**Figure 3–2** The National Society peer support network in action: Support within and between regions



#### KEY FINDINGS

- The most numerous type of international collaboration involved a National Society in Europe and Central Asia assisting another in the same region.
- Across all regions, partnerships that include COVID-19 response activities far outweigh non-COVID-19 collaborations, except in MENA where the proportion of COVID-19 and non-COVID-19 collaborations is more similar.
- Apart from Europe and Central Asia, the only region with significant numbers of collaborations within the same region was Asia Pacific.
- National Societies in Asia Pacific focused the majority of their support on other National Societies within the region.
- MENA received the largest proportion of non-COVID-19 collaborations, which were all with partners in Europe and Central Asia.

**Figure 3–2.** International partnerships mentioned in the GO Field Reports. Dataset: GO-field-reports.



**Bangladesh 2021** The Bangladesh Red Crescent Society (BDRCS) and its Red Cross Red Crescent partners are running 14 health facilities inside the camps and adjoining area, supporting people living in camps and local communities. The BDRCS, with support of IFRC and PNSs, is operating a Severe Acute Respiratory Infection -Isolation and Treatment Centre in the camp that offers support for both communities. © Ibrahim Mollik / IFRC

## Financial flows based on financial tracking

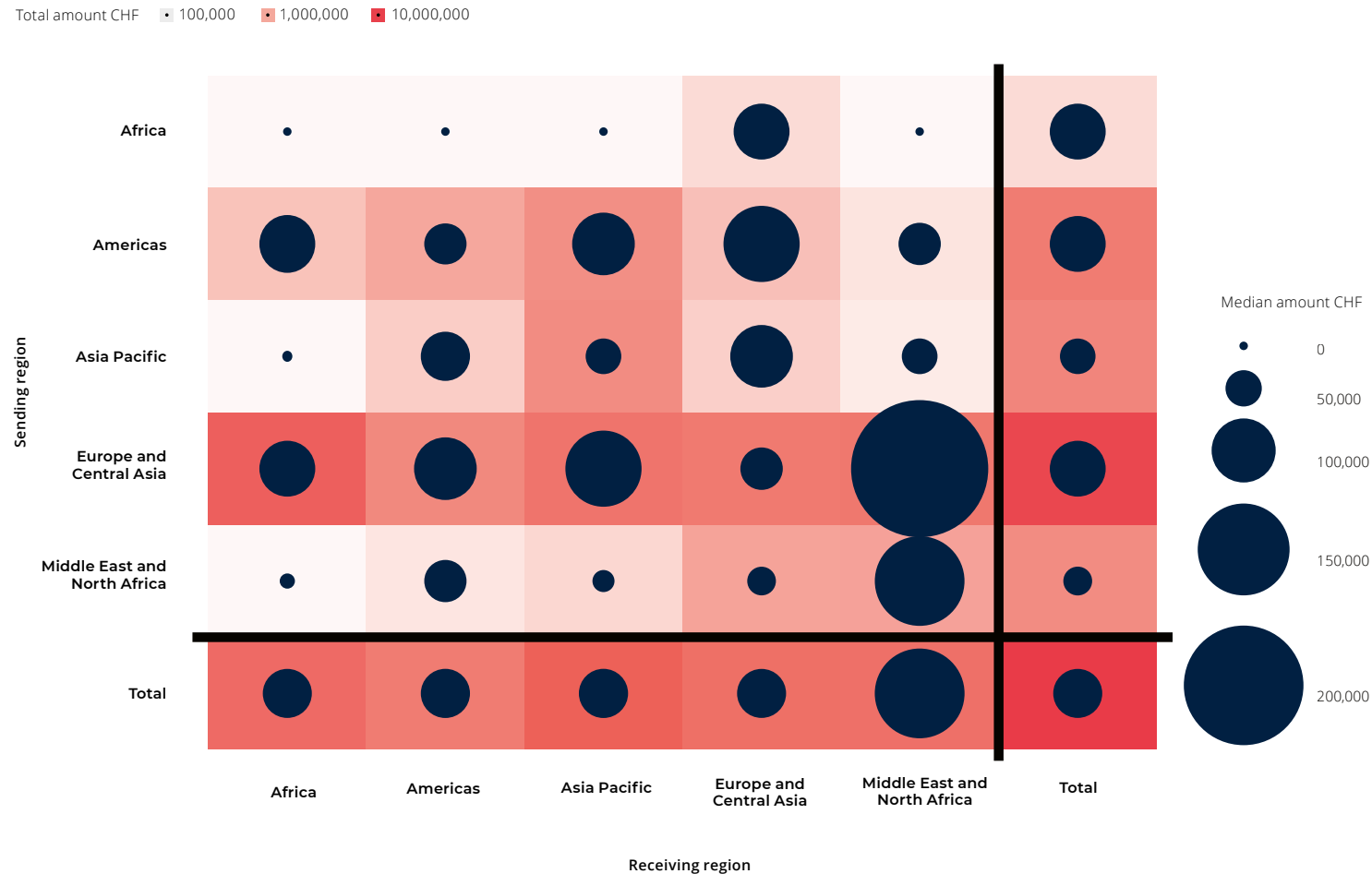
We have looked for evidence of many different kinds of partnerships in the GO Field Reports which cover all kinds of collaboration. One of the main types of mutual support between National Societies is financial support. Data on financial transfers during the pandemic provides another rich source of information about collaboration.

Figure 3-3 is a heatmap showing financial transactions between National Societies, disaggregated by sending and receiving regions: Cells with larger total amounts are shown in a darker red; larger median amounts are represented by big blue circles. For example, the cell near the bottom right showing transactions from Europe and Central Asia to MENA has a very large circle but only a medium red background. This means that while the total amount of funds transferred was fairly large, the median amount was very large and there were relatively few transactions.

Total number of unique combinations of sending and receiving National Societies in the COVID-19 financial database between 1 May 2020 and 31 December 2021: **481**

Approximate total value of financial transactions between National Societies in the COVID-19 financial database between 1 May 2020 and 31 December 2021: **CHF 89,700,000**

Transfers from other National Societies were not the only source of National Society income. The IFRC Secretariat, through its Global COVID-19 Emergency Appeal, was able to allocate – as at 20 April 2022 – around CHF 327 million to 163 countries in support of National Societies.

**Figure 3–3** Financial Support between regions**KEY FINDINGS**

- The median size of transfers differs substantially depending on sending and recipient regions.
- There were relatively few financial partnerships with recipients in MENA, but amounts were typically relatively large, in particular, those from Europe and Central Asia and from MENA itself.
- National Societies in Asia Pacific and Africa received large total amounts of transfers, although in Asia Pacific quite a large part was from other National Societies in the same region, whereas National Societies in Africa received the largest amounts from outside the region.
- Europe and Central Asia was a predominant donor region except in Asia Pacific, which received many internal transfers as well as support from the Americas; transfers from the Americas to Asia Pacific also tended to be quite large.

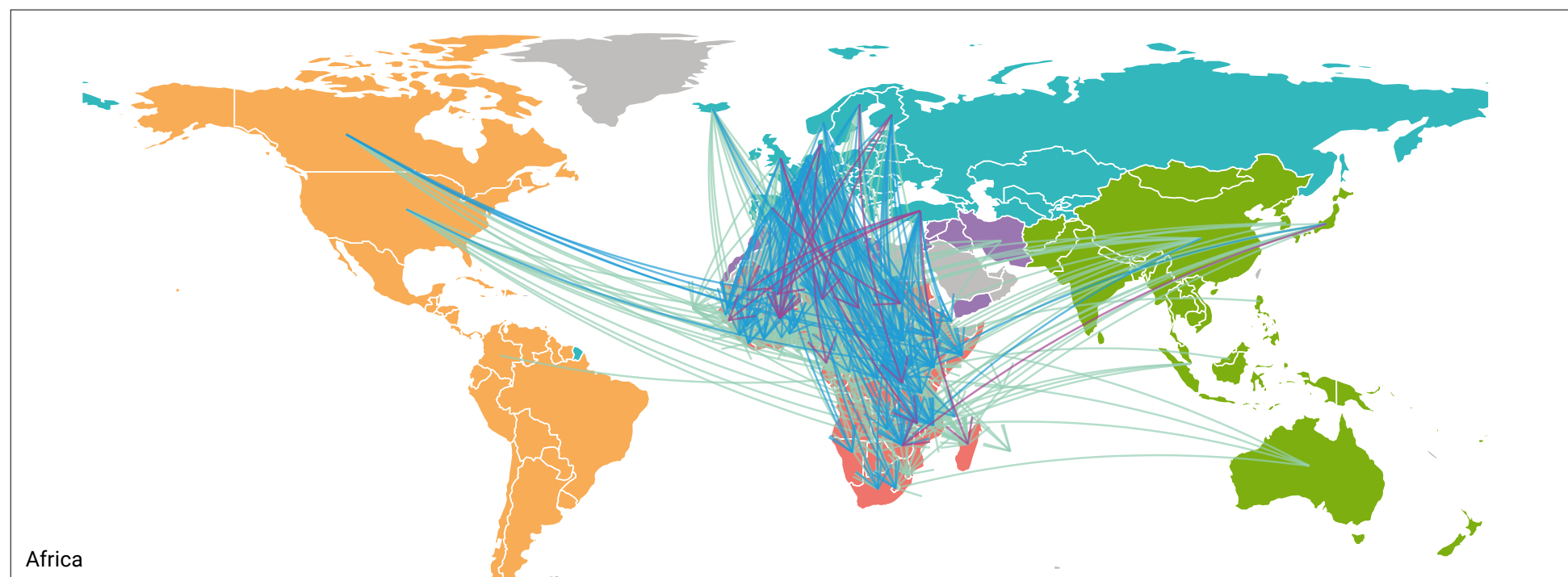
**Figure 3–3.** Total and median amounts of financial support transactions between National Societies in different regions during the pandemic. The background colour of the rectangles indicates total amounts, and the size of the circles indicates the median amounts. Dataset: COVID-financial.

## Did National Societies rely on old or new partnerships during the pandemic?

Can we get a more precise answer to the question of whether National Societies tended to turn to partners they had already worked with before the pandemic or preferred to form new partnerships? We can try to answer this question by comparing the data on financial transactions during the pandemic with the long history of collaborations recorded in the FDRS from 2017 until just before the start of the pandemic at the end of 2019.

For each receiving region, figure 3–4 shows that many existing international partnerships were leveraged during the pandemic (blue arrows), and other new ones were formed (purple arrows).

**Figure 3–4** International support links between National Societies during Covid partly built upon existing links

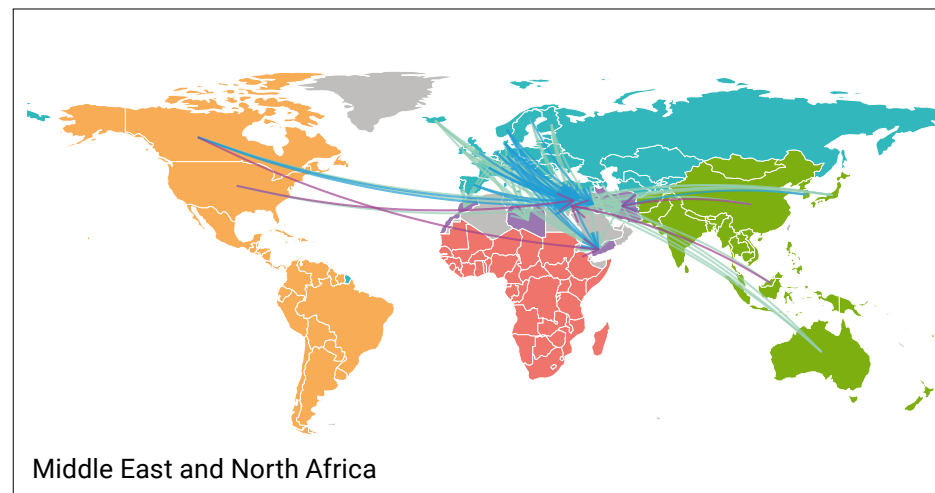
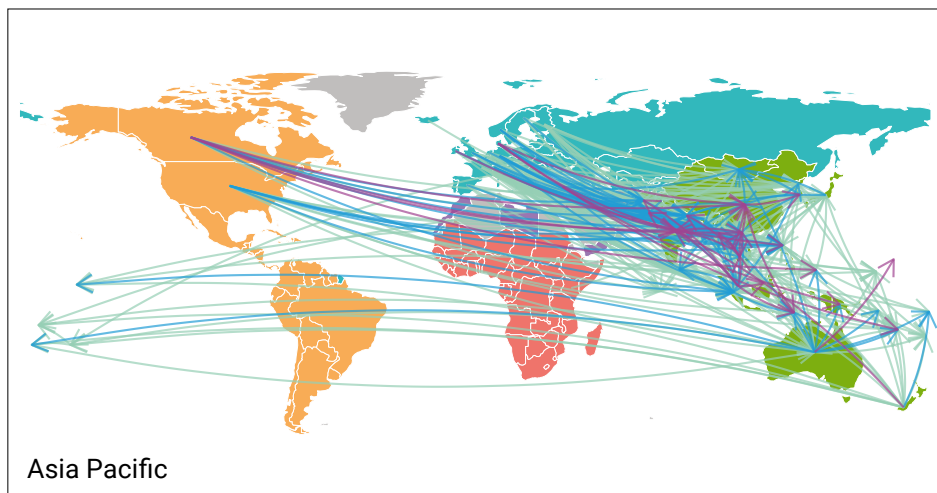
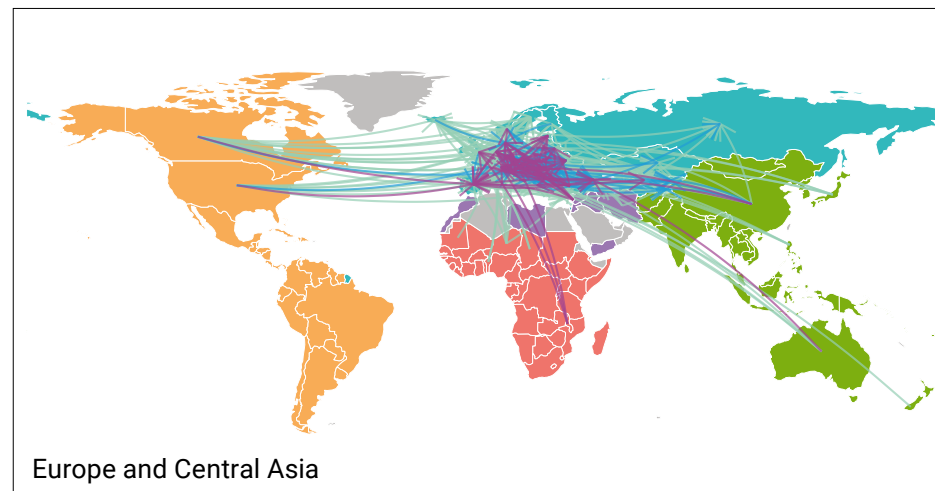
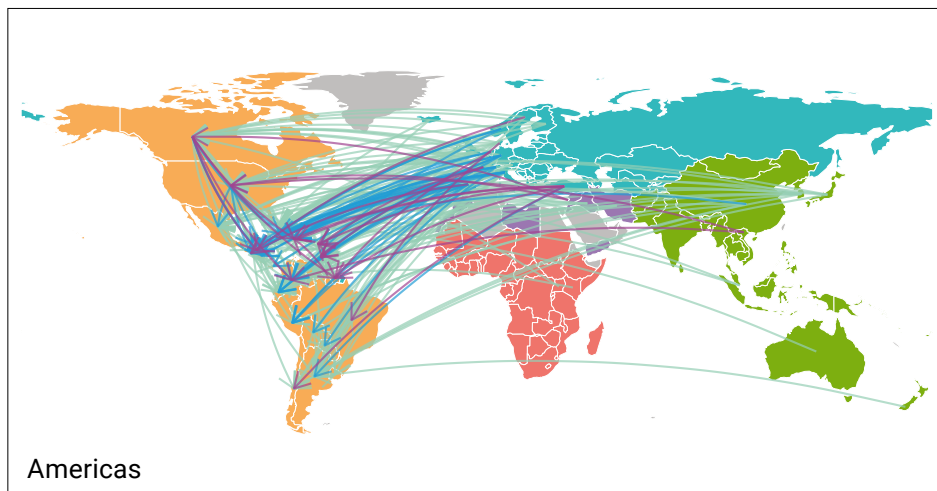


**Figure 3–4.** International support links between National Societies during COVID-19. Each small map shows the financial flows received by each region. Blue arrows indicate existing links before the pandemic that were also activated during the pandemic, purple arrows are new links and light green arrows are existing links not used for the COVID-19 response. Dataset: FDRS-partnerships-2017-19 & Dataset: COVID-financial.



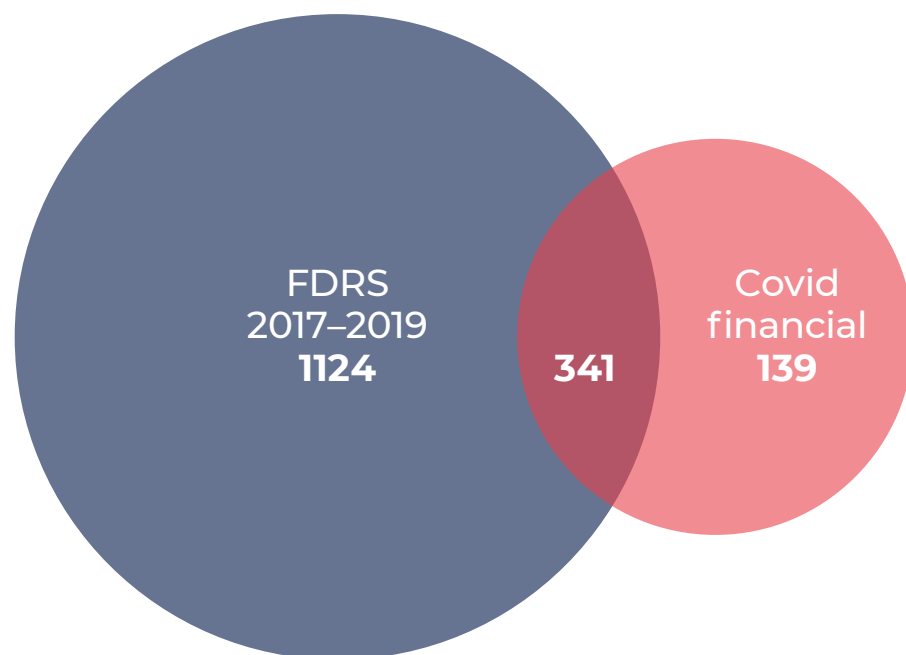
**KEY FINDINGS**

- About 30% of financial partnerships between National Societies during the pandemic were new and not reported previously in the FDRS.



The overlap between these two types of partnerships can be seen more clearly in the Venn diagram shown in Figure 3–5. For example, if a National Society in one country is assisted financially by the National Society in another country and there is a record of the transaction in the COVID-19 financial data, but there is no record of any cooperation up to the end of 2019 in the FDRS database, this would appear in the right-hand part of the figure. The overlap between the two circles represents those partnerships that are recorded in both FDRS data and financial data.

**Figure 3–5** Existing and new partnerships



**Figure 3–5.** The overlap between previous partnerships recorded in the FDRS data 2017–2019 and financial partnerships during the pandemic up to the end of 2021. Dataset: FDRS-partnerships-2017-19 & Dataset: COVID-financial



## KEY MESSAGES

- ▶ Around three-quarters of National Societies were included in their government's response and recovery planning, and there is plenty of evidence of their contribution to national pandemic preparedness plans and policies.
- ▶ In many cases, National Societies were well integrated into their government's response and were often able to provide services additional and complementary to those already offered by the government.
- ▶ Different data sources confirm the enormous diversity of the different ways in which National Societies supported one another during the pandemic.
- ▶ The total value of financial transactions between National Societies in the COVID-19 financial database between 1 May 2020 and 31 December 2021 was around CHF 89 million.
- ▶ The IFRC Secretariat, through its Global COVID-19 Emergency Appeal, was able to allocate – as at 20 April 2022 – around CHF 327 million to 163 countries in support of National Societies.







4

# **PREPAREDNESS AND PRIOR EXPERIENCE**

HOW DID THEY HELP  
IN COVID TIMES?

## KEY QUESTIONS

- ▶ **What helps a country or a National Society to respond successfully to a pandemic?**

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- ▶ **Are there specific factors which help or is a pandemic like COVID-19 so inherently unpredictable that everything comes as a surprise?**

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- ▶ **In particular, did National Societies' prior experience in delivering support to their country's population help them to respond quickly and at scale during the pandemic?**

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- ▶ **Did assessments of countries' preparedness for epidemics conducted before the arrival of COVID-19 predict how severely they were hit by it?**

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## How did National Societies' prior experience help them to respond quickly and at scale during the pandemic?

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It seems very likely, on the face of it, that National Societies with relevant past experience were able to respond better to the pandemic. However, it is challenging to provide the evidence behind this statement. How do we define a successful National Society response?

The achievement indexes presented in Chapter 2 give us a unified way of capturing the numbers and other achievements that National Societies reported to the COVID-19 Indicator Tracking System. Using the indexes, we can, for example, determine how much a particular National Society achieved relative to other National Societies on a particular indicator, pillar or priority, either in a particular quarter or over the whole pandemic. These indexes do not really tell us about the quality of response, but they can at least tell us something about "how much" was achieved, relativized to population size where appropriate. Another problem is that although we can identify some independent variables, such as "prior experience of epidemics", there are many other relevant factors which might be affecting the relationship between experience and response. For example, certain National Societies with experience in responding to epidemics might also have had more prior support from the IFRC or they might have larger numbers of better-trained volunteers.

We can at least check the correlations between possible causes and effects and see if they are *consistent* with our hypotheses. We can then review additional qualitative information by looking at narrative evidence: are there plausible, well-documented stories about how preparedness helped?

A first example from Somaliland illustrates how previous technical experience helped with the response.

## How did prior technical experience help National Societies with COVID-19 vaccine rollout?

### The case of the Somali Red Crescent Society<sup>20</sup>

Often community members are the first to become aware of health concerns but are not able to quickly pass this information on to local health authorities. Community-based surveillance empowers local volunteers to report on health risks of concern, allowing for quicker responses and stopping disease outbreaks before they become large-scale epidemics. Since 2018, the Somali Red Crescent Society (SRCS), with the support of the Norwegian Red Cross and the Canadian Red Cross, has been using CBS.

During routine activities, volunteers provide health education, raise awareness about disease prevention and carry out health promotion. When someone in the community is found to be sick and showing signs and symptoms of a health risk of concern, volunteers use basic mobile phones to report it by means of a simple SMS code to the CBS platform Nyss<sup>21</sup>, a software tool designed by the Norwegian Red Cross in collaboration with the Belgian Red Cross and the IFRC specifically for CBS. The Nyss platform sends a reply to the volunteer with health messaging they can use to engage with the individual or family who may be affected. It also collects and analyses the data sent from all the reports submitted by CBS volunteers and triggers an alert to SRCS staff. After supervisors have cross-checked the alerts, Nyss can automatically notify the health authorities who can then take further steps, including case investigation and other health responses, as needed.

In late March 2020, a SRCS CBS volunteer was conducting house-to-house visits when she met a man who had recently travelled abroad and was exhibiting COVID-19 symptoms. Following public health guidance, she remained at a safe distance, wore PPE and used her mobile phone to report the health risk. Within two hours, a rapid response team from the Ministry of Health arrived at the individual's home, tested him for COVID-19 and advised him to quarantine. Within a few days, it was confirmed that his test result was positive and he became the first official case of COVID-19 in Somaliland.

<sup>20</sup> [https://www.ifrc.org/sites/default/files/2022-04/Preparedness\\_COVID\\_SuccessStory\\_Somaliland\\_EN%20%281%29.pdf](https://www.ifrc.org/sites/default/files/2022-04/Preparedness_COVID_SuccessStory_Somaliland_EN%20%281%29.pdf)

<sup>21</sup> <https://www.cbsrc.org/what-is-nyss>



**Somaliland 2020** Naima Aden Umar, the SRCS volunteer who identified the 1st confirmed COVID-19 case in Somaliland on 26 March 2020, through Community Based Surveillance run by Somali Red Crescent Society.  
© Somali Red Crescent Society

## How does performance on the COVID-19 indicator tracking achievement indexes relate to comparable pre-COVID-19 achievements?

For this analysis, we take the achievement index data from COVID-19 tracking and compare it with FDRS data from 2019 for each of the FDRS Key Performance Indicators for each National Society. The FDRS 2019 data is taken as a direct measure of pre-COVID-19 achievements. Did National Societies reporting achievements at scale, such as number of people reached, also report substantial achievements on the COVID-19 achievement indexes?<sup>22</sup>

Results show that, overall, National Societies with high achievements in 2019 (breadth and depth of operations) also had high achievement indexes for the pandemic (breadth and depth of operations).

For example, the National Societies' achievement index on the COVID-19 tracking priority Health (excluding vaccination indicators) is well predicted by their FDRS 2019 achievement index for people reached in health programming.

These results are not surprising, but it is still good to see them confirmed by the data. As specified above, we have not proved that National Society strengths in 2019 are causally related to high achievement during COVID-19, but the results are consistent with that hypothesis.

So, why is this analysis valuable? With the FDRS, the IFRC is providing valuable data about all member National Societies, going back to 2012. This important dataset helps the IFRC and partners predict future National Society engagement and response and allows for better planning. While COVID-19 was an unprecedented pandemic, many National Societies were familiar with the key response activities needed to curb it and support communities.

In Figure 4–1, we look at the same data in a little more detail, with more specific COVID-19 tracking pillars (rather than top-level priorities) on the vertical axis. Only pillars with particularly high correlations are shown.

A summary of all the relationships between COVID-19 tracking pillars and FDRS scores is given in Appendix to Chapter 4.

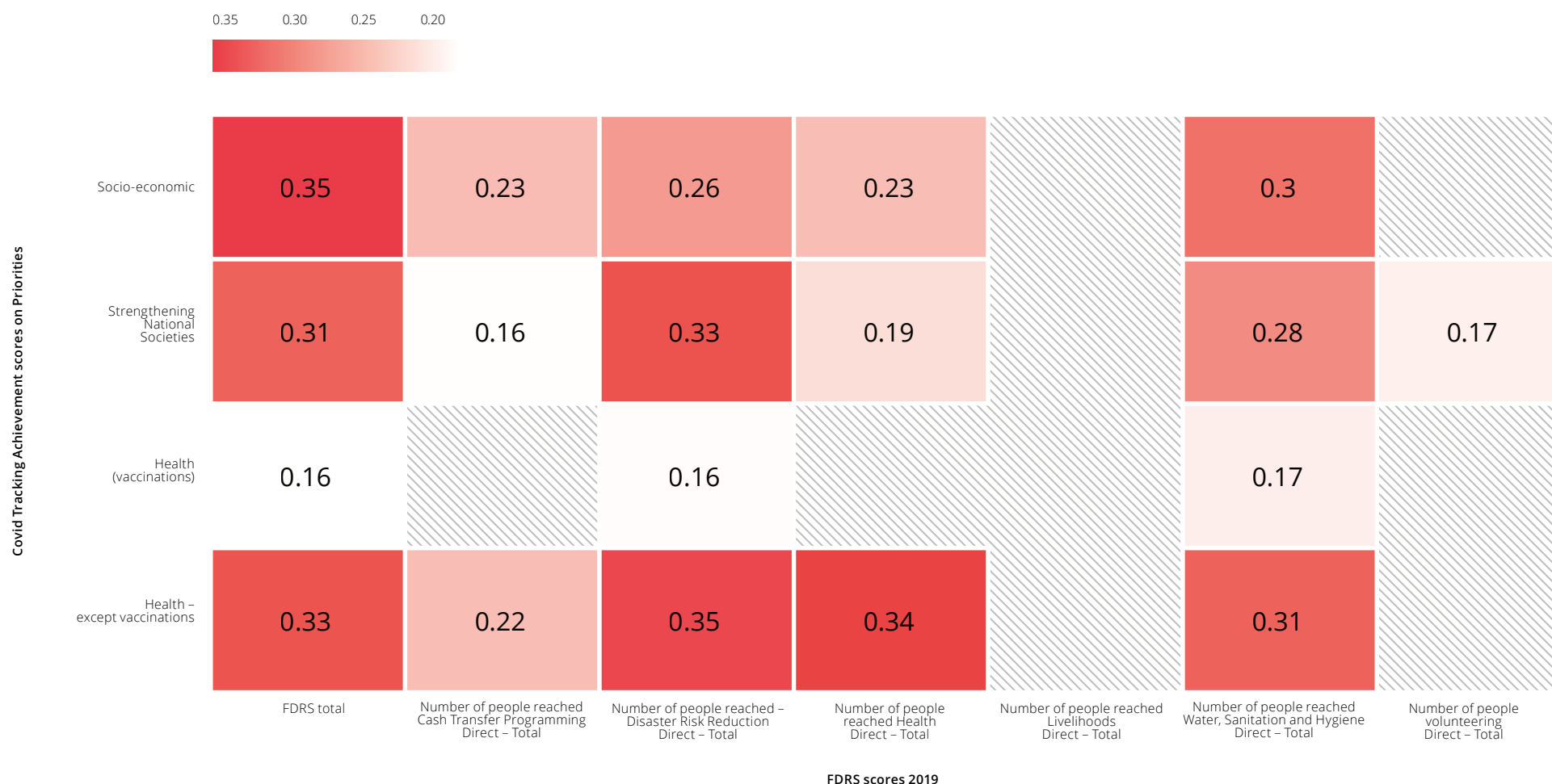
### KEY FINDINGS

- FDRS Key Performance Indicators 2019 well predicts the Covid Tracking Achievement score. National Societies that scored high in FDRS Key Performance Indicators of 2019 also had high achievement indexes for the COVID-19 tracking priorities during the pandemic.
- Performance on the COVID-19 tracking priority “Health” is well predicted by FDRS 2019 performance in many areas.

<sup>22</sup> See Appendix to Chapter 4.



**Figure 4–1** Correlations between achievements on relevant FDRS Key Performance Indicators 2019 and on COVID-19 tracking priorities during the pandemic



**Figure 4–1.** Correlations between overall achievements on relevant FDRS Key Performance Indicators 2019 and on COVID-19 tracking priorities during the pandemic. Correlations in the grey squares are not statistically significant and are therefore not shown. Dataset: CI-tracking & Dataset: FDRS-achievements-2019.

## Preparedness resulting from specific preparedness programmes<sup>23</sup>

As the humanitarian landscape evolves, local actors face greater challenges, but also opportunities, in dealing with the effects of climate change, epidemics and complex emergencies, among other crises. To meet these challenges and seize opportunities, the IFRC's National Society Preparedness for Effective Response (PER) approach supports National Societies to systematically strengthen ways of working and ensure their humanitarian services are more efficient, timely, appropriate, well-coordinated and effective. The approach recognizes that response is, first and foremost, locally led, that improving capacity requires National Society ownership, commitment and political will and that National Societies are in charge of their own development.

It is a continuous and flexible approach that enables National Societies to assess, measure and analyse strengths and gaps in their preparedness, anticipatory action and response mechanism and, ultimately, take the necessary action to improve these areas. The PER mechanism outlines a common organizational structure for any National Society. It allows for a standard language to be used to discuss, prioritize and invest in the core components of National Society preparedness and supports continuous learning. It is designed to eventually measure changes in National Society response capacity over a period of time. There are several projects and programmes contributing to National Society preparedness and response capacity for multiple hazards and others focusing on epidemic preparedness. Most importantly, these efforts complement each other as National Societies and local actors continue to face overlapping disasters and crises.

Over recent years, the IFRC has been tracking changes in National Societies that have been engaged in more structured preparedness programmes,

and positive change has been demonstrated by those National Societies. At the same time, additional efforts in capturing learnings from DREF-supported operations and COVID-19 response learnings<sup>24</sup>, using the PER mechanism, can support operations managers and National Society leaders in identifying preparedness priorities based on the evidence collected and response experiences through these sources of information.

PER is a cyclical approach that enables a National Society to systematically assess, measure and analyse the strengths and weaknesses of its response system in order to take remedial actions. It would be interesting to be able to see if levels of preparedness predict performance on COVID-19 tracking. So far, 84 National Societies have engaged in the PER process, with 20 of those having completed more than two cycles. The PER approach provides valuable process data, which in time should become an important dataset showing progress in preparedness.

The COVID-19 Evaluation<sup>25</sup> found narrative evidence that “those National Societies already engaged in specific preparedness programs prior to the pandemic (such as the Community Epidemic and Pandemic Preparedness Program (CP3), Response Preparedness II and other bilateral projects that were applying the Preparedness for Effective Response (PER) Approach) were able to respond more effectively”.

A related initiative is the Response Preparedness Programme implemented since 2012 by the Netherlands Red Cross to support several National Societies from the Africa and MENA regions in strengthening their response capacities and improving their anticipatory and emergency planning mechanisms.<sup>26</sup> There is very strong narrative evidence from this programme that investing in preparedness improved the COVID-19 response.

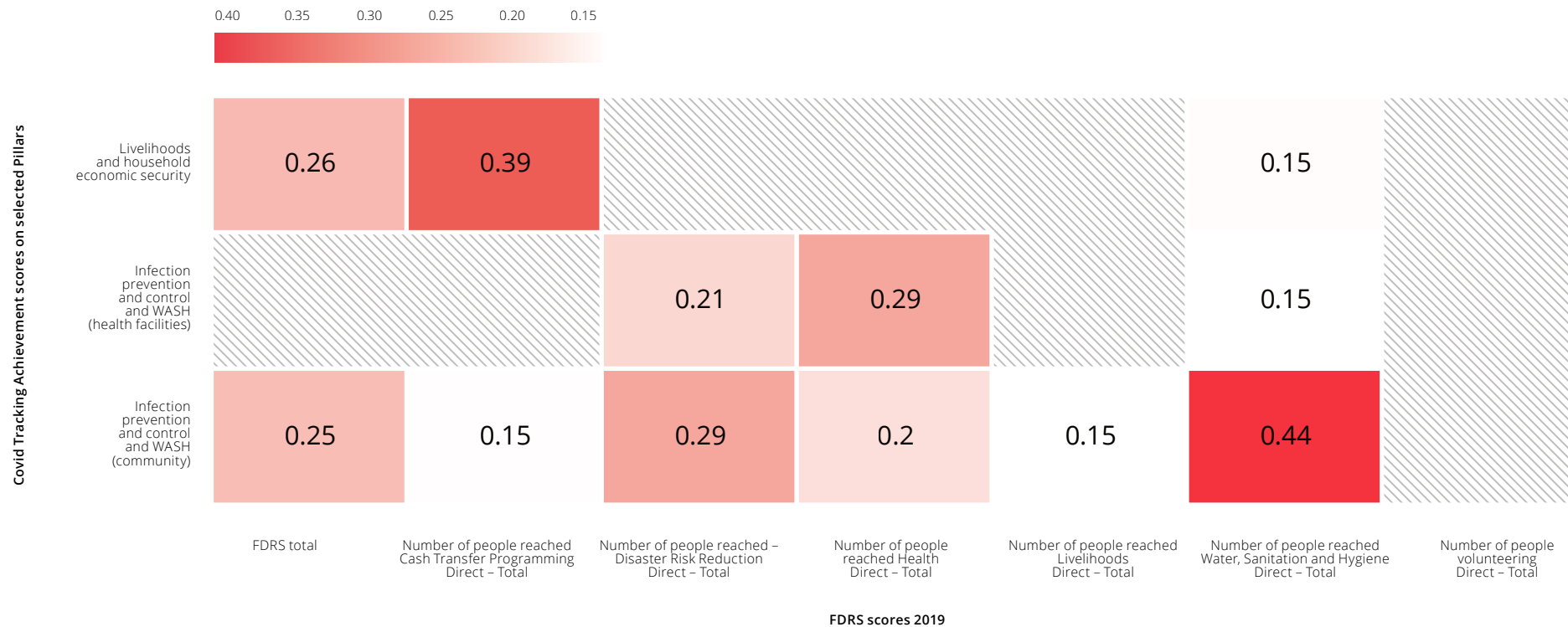
23 More information about how the IFRC is monitoring progress in the National Society response mechanism globally and regionally can be found here: <https://go.ifrc.org/preparedness#global-performance>.

24 <https://app.powerbi.com/view?r=eyJrIjo1YjRkY2I3ZWQtdmZBjNS00ODI3LTlhYTktZDM3YzZiNGM0MWM1IiwidCI6ImEyYjUzYmU1LTczNGUtNGU2Yy1hYjBkLWQxODRmNjBmZDkxNyIsImMiOiJh9&pageName=ReportSectionfa0be9512521e929ae4a>

25 IFRC (2022), *Evaluation Report: IFRC-wide response to the COVID-19 pandemic*.

26 Netherlands Red Cross: Response Preparedness Programmes. <https://www.rodekruis.nl/nieuwsbericht/iati/global-disaster-response-tools-for-the-red-cross/>

**Figure 4–2** Correlations between achievements on relevant FDRS Key Performance Indicators 2019 and on selected Covid-19 tracking priorities during the pandemic



### KEY FINDINGS

- The correlations largely confirm our substantive expectations, for example, performance on the COVID-19 tracking pillar “Livelihoods and household economic security” is well predicted by FDRS 2019 performance in cash transfer programming.

**Figure 4–2.** Correlations between overall achievements on selected FDRS Key Performance Indicators 2019 and on selected COVID-19 tracking pillars during the pandemic. Correlations in the grey squares are not statistically significant and are therefore not shown. Dataset: CI-tracking & Dataset: FDRS-achievements-2019.



**Kenya, 2020** Dr. Asha Mohammed (right) during door-to-door Corona Virus hand sanitizer distribution in Manyatta, an informal settlement of Kisumu County. Kenya Red Cross Society has been responding to the COVID-19 crisis across the country, including in informal settlements and slum areas. © John Bundi / Kenya Red Cross Society



Over the years, the Response Preparedness Programmes – Response Preparedness Phase II (RPPII) and Innovative Approaches for Response Preparedness (IARP) – initiated by the Netherlands Red Cross and implemented in the Central African Republic, Ethiopia, Kenya, Lebanon, Mali, Uganda and Zambia, have built or reinforced strong foundations enabling the National Societies of these countries to activate their preparedness and response mechanisms faster than ever to face an unprecedented crisis such as the one caused by the COVID-19 pandemic. These mechanisms are not only faster, they are also of much higher quality, especially in the areas of risk analysis and mapping, community engagement and internal and external coordination. Clear proof of this is the speed at which the National Societies developed their COVID-19 response plans, the quality of those plans, the enhanced collaboration with their respective governments (a crucial component of epidemic response) and their remarkable use of data which enabled them to carry out a much more accurate risk analysis to target the areas and communities most at risk of spreading the disease (another key aspect of epidemic control).<sup>27</sup>

An important finding from these reflections was that National Societies were able to develop their COVID-19 response plans “in record time (within just a few days, as opposed to weeks or months in the past)”. The fact that the outline of the National Societies’ response to epidemics had already been identified was crucial, even though COVID-19 and the response to it are unprecedented and quite different from the types of epidemics envisaged in the original plans.

### How did National Societies use lessons learned from Response Preparedness Programmes to draft COVID-19 response plans? **The case of the Zambia Red Cross Society**<sup>28</sup>

The Zambia Red Cross Society (ZRCS) used many of the lessons learned from RPPII to develop its COVID-19 response plan. The knowledge it gained during the Contingency Planning training helped it develop its COVID-19 response plan in record time, and it was the first National Society in the southern Africa subregion to prepare such a plan. The IFRC cluster support team asked if they could share it with other National Societies in the region, which then used it as a reference. All ZRCS departments were involved in the development of this plan, which was not the case before RPPII. All the colleagues worked very smoothly together, as they all knew what they had to do. Before RPPII they would not have known where to start. Moreover, the ZRCS was among the first National Societies in the region to develop its business continuity plan and RCCE plans. They informed the Disaster Relief Emergency Fund (DREF) application and the subsequent COVID-19 Emergency Appeal which were quickly submitted and approved.



**Zambia 2020** Zambia Red Cross Society carried out social mobilisation activities for campaign to improve immunisation coverage in the country. © Zambia Red Cross Society

<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

## Did National Societies with prior experience of emergencies achieve more under COVID-19?

We delved further into the relationship between preparedness and responsiveness by looking at DREFs and Emergency Appeals from 2016 to 2019 for each National Society. We imported the database and formed a score, adding 1 for each DREF and 2 for each Emergency Appeal. We also formed a similar score just for DREFs and Emergency Appeals classified as being for epidemics.

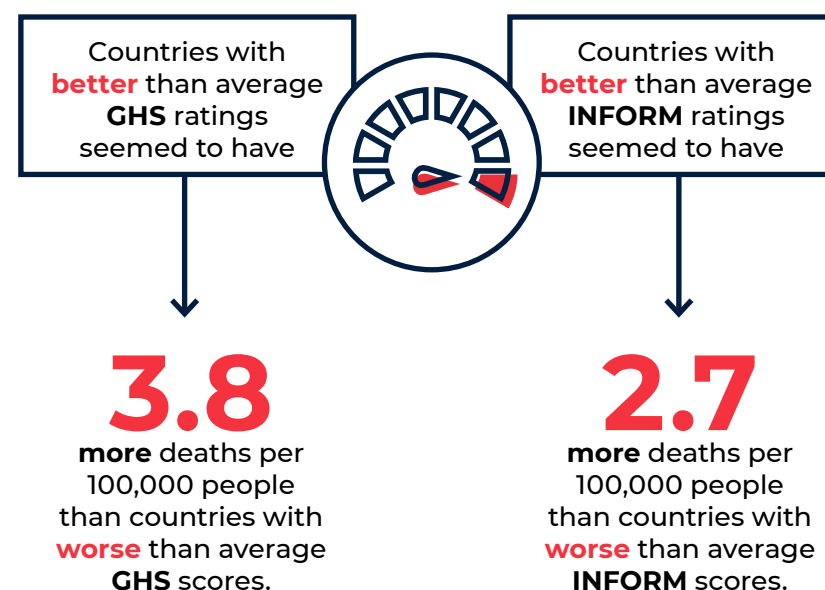
While there are no significant correlations<sup>29</sup> between National Society achievements on the COVID-19 tracking indicators and the overall “Emergencies

experience” scale, there are two significant correlations<sup>30</sup> with the “Epidemic emergencies experience” scale: National Societies with prior experience of epidemic emergencies also had higher achievements on the CBS and Management of the dead pillars in the COVID-19 tracking achievement indexes. These are not very strong correlations, but they are in the expected direction and give some support to the fundamental idea that prior experience makes a difference.

## National preparedness: country risk profiles

There have been several recent attempts to assess the preparedness of different countries for emergencies and epidemics by panels of renowned experts using modern risk and vulnerability models and a wealth of data. These models are important not only because of the actual risk scores calculated, but also because of the debate they encourage about what factors really matter in preparing for humanitarian emergencies. Were these models able to predict the complex combination of factors which determined how countries fared under COVID-19?

We will look at two such risk indexes, INFORM and the Global Health Security (GHS) Index.<sup>31</sup>



<sup>29</sup> At  $p < 0.01$

<sup>30</sup> At  $p < 0.01$

<sup>31</sup> The GHS Index (<https://www.ghsindex.org>) is the result of collaboration between the Nuclear Threat Initiative and the Johns Hopkins Center for Health Security and was developed with Economist Impact. It measures the capacities of 195 countries to prepare for epidemics and pandemics. See *Appendix to Chapter 4*.

Were these two indexes able to predict how badly different countries were hit by COVID-19? This question has already been asked, with surprising, almost paradoxical, answers.<sup>32</sup>

However, this paradoxical connection between the assessments of risk and COVID-19 outcomes is likely to be mostly or completely spurious: countries assessed as higher risk tend, on average, to have less capacity to report COVID-19 deaths accurately<sup>33</sup> as discussed in Chapter 5. If we explore the relationship between risk indexes and *estimated excess deaths* rather than *officially reported deaths*, as recommended in Chapter 5, these relationships disappear – overall, there is no longer any strong and consistent relationship between risk and outcome.<sup>34</sup>

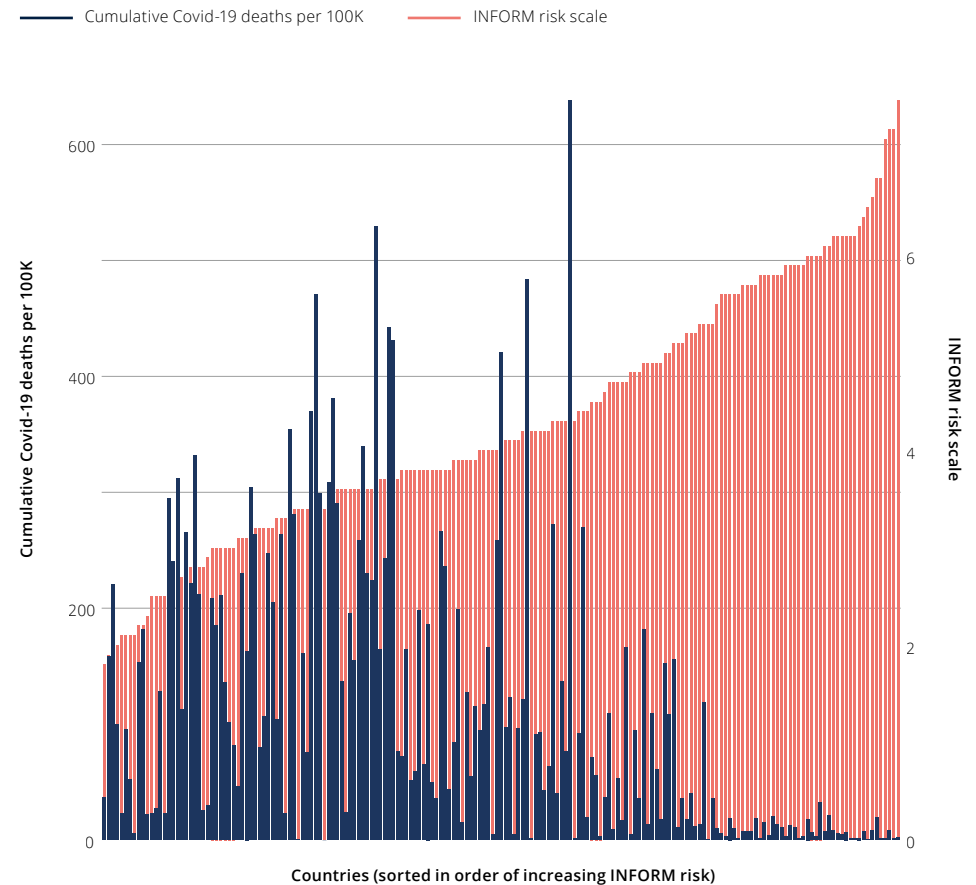
The important message seems to be that the COVID-19 pandemic affected countries in ways that even experts using state-of-the-art methods found it very hard to predict. Most likely the factors that they considered are all relevant, but the pandemic presented health systems (and governments and societies) with complex, changing combinations of both familiar and new factors that affected outcomes in surprising ways which changed even from week to week.

32 E.J. Abbey, B.A.A. Khalifa, M.O. Oduwale, S.K. Ayeh, R.D. Nudotor, E.L. Salia, *et al.* (2020), “The Global Health Security Index is not predictive of coronavirus pandemic responses among Organization for Economic Cooperation and Development countries”, *PLoS ONE* 15(10): e0239398. <https://doi.org/10.1371/journal.pone.0239398>. Our analysis here updates this approach.

33 See Chapter 5.

34 Overall, the correlations disappear, but a few weak ones remain, both in expected and “paradoxical” directions. In particular, there is a weak but significant positive (expected) correlation between estimated excess deaths per 100,000 people and the INFORM Vulnerability subscale, and there is still a weak but significant negative (paradoxical) correlation between estimated excess deaths per 100,000 and the INFORM Hazard subscale. There are also weak but negative correlations between estimated excess deaths per 100,000 and two of the six GHS subscales (as higher scores on the GHS scales are desirable, a negative correlation is to be expected, whereas a negative correlation with the INFORM scales is paradoxical).

**Figure 4–3** Officially reported deaths



**Figure 4–3.** Number of officially reported deaths per 100,000 people compared to overall INFORM risk scores. Each country has one red column for the risk score and one blue column for the cumulative number of reported deaths. The countries (on the x-axis) are sorted according to increasing risk. Dataset: INFORM-risk.

## Exploring the risk index further



Italy 2020 During a shift on the Italian Red Cross ambulance in Florence. © Michele Squillantini

Even this finding that there is no strong overall connection between risk indexes and outcomes is surprising. How did these two indexes not manage to correctly predict COVID-19 outcomes?

Figure 4-4 shows the correlation between the INFORM risk index on the horizontal axis and deaths per 100,000 on the vertical axis, broken down by region. The final column shows the results for all the regions. Each point is one National Society.

The top row of the chart shows correlations with *estimated excess deaths* (which we believe to be a much more accurate and useful figure) and officially reported deaths, shown on the bottom row. We can see that, in the bottom right graph, there does indeed seem to be a strong negative relationship between risk and mortality, the effect which we called “paradoxical” above. In the top right plot, which shows *estimated excess deaths*, there still appears to be a weak negative relationship, but in fact this is not significant, as we explained above.

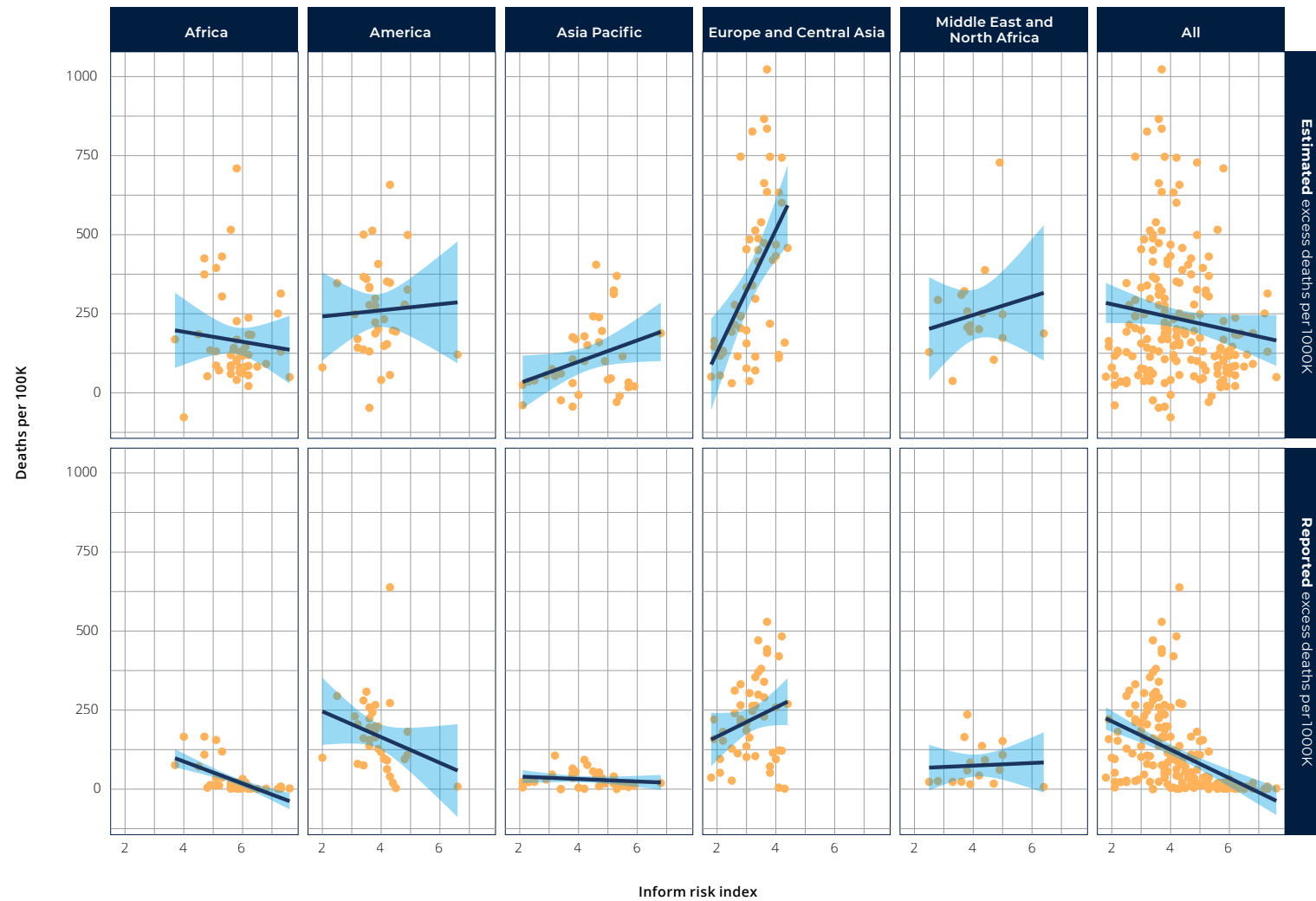
However, if we look at the separate correlations for the individual regions, on the top row, we can see that, for all regions except Africa, there seems to be a positive relationship that reinforces the hypothesis that risk indexes predict mortality. There seems to be an especially strong relationship in Europe and Central Asia and also in the Americas. It therefore seems that, in each specific regional context, the expected positive relationship between the risk index and mortality does indeed hold, except in Africa.<sup>35</sup> In fact, the *combination* of the risk index and region provides a good model for predicting estimated excess mortality per head of population,<sup>36</sup> accounting for 30% of the variability.

<sup>35</sup> This can be seen as an example of Simpson’s Paradox ([https://en.wikipedia.org/wiki/Simpson%27s\\_paradox](https://en.wikipedia.org/wiki/Simpson%27s_paradox)). As the context provided by each region is likely to be causally relevant, we can probably conclude that the regional correlations, rather than the overall correlation, are closer to the truth.

<sup>36</sup> A linear model predicting estimated excess mortality on the basis of the INFORM risk score, region and their interaction has an adjusted R-squared of 0.31; a model which does not include the interaction term has an adjusted R-squared of 0.23.



**Figure 4–4** Estimated excess deaths and reported deaths



**Figure 4–4.** Estimated excess deaths (top) and reported deaths (bottom) per 100,000 compared to overall INFORM risk score, broken down by region. Dataset: INFORM-risk & Dataset: Excess-deaths.



**Netherlands 2020** A group of students offered to help and signed up for Ready2Help. Ready2Help is the Netherlands Red Cross network for people who want to provide additional help in times of emergency. The group went to the shops to do groceries for people who couldn't shop for their own groceries.  
© Lieke Vermeulen

## KEY MESSAGES

- ▶ There is significant plausible narrative evidence that National Societies' preparedness and prior experience helped them respond to COVID-19.
- ▶ National Societies with more substantial breadth and depth of achievements in their operations in 2019, as recorded by the FDRS Key Performance Indicators, also had more substantial breadth and depth of achievements during the pandemic, as recorded by the COVID-19 tracking indicators. A plausible explanation is simply that National Societies with the sort of experience, resources and logistics required to respond well in pre-pandemic operations were also well-placed to respond at scale in the pandemic.
- ▶ National Societies with prior experience of epidemic emergencies also had higher achievements on the CBS and Management of the dead pillars in the COVID-19 tracking achievement indexes.
- ▶ Expert ratings of countries' preparedness for epidemics conducted before the arrival of COVID-19 did, to some extent, predict how severely they were hit by it, as long as we use estimated excess mortality as an outcome measure and take regional context into account.







**5**

**THE REAL EXTENT  
OF THE PANDEMIC**

## KEY QUESTIONS

In earlier chapters, we used estimated excess deaths rather than, for example, officially reported deaths, as our main measure of the extent of the pandemic. In this chapter, we go into this issue in a little more detail, asking:

- ▶ **What indicator should we use to report how the pandemic affected different regions and countries?**
- ▶ **What can we learn from the problems we encounter when trying to answer this question?**

## Estimated excess deaths

Most data on deaths, cases and hospitalizations comes from official sources in each country, but it can be incomplete and perhaps inaccurate. Data on deaths due to COVID-19 is affected by many factors, including:

- differing definitions of what death due to COVID-19 actually means; for example, if someone has a heart attack and dies, but also had COVID-19, is this to be recorded as a COVID-19 death?
- the ability of health institutions to report this data, for example, due to:
  - » lack of testing;
  - » uncertainty about people who die at home.

There are alternative ways to measure the impact of the pandemic, for example, the number of confirmed cases or the number of people in hospital or, in particular, in intensive care with confirmed or suspected COVID-19. However, these are just as sensitive to case definitions and ability to test and report.

Officially reported deaths is probably the most commonly used statistic, but if we want to get a precise picture across the IFRC network and across the globe, we have to be very careful that our data is accurate and, in particular, that it is not treating countries differently, especially if we expect some countries to be systematically less able to report deaths accurately than others.

One way to avoid some of these problems is to look at *excess* deaths in the pandemic period: how many more people died than we might expect for the same period, given what we otherwise know about deaths in the same months in previous years? This method has the particular advantage that it also takes into account deaths which might be *indirectly* due to the pandemic, for example, because people cannot reach health facilities for treatment for other medical problems. When we use this statistic, we have to be aware that we are not just reporting deaths that were *directly* due to COVID-19.

Many countries publish excess death figures as well as deaths directly attributable to COVID-19, but many others do not, so the problem of systematic bias remains. Several teams have used models to estimate excess deaths and give a more accurate picture. WHO published such a model in March 2022.<sup>37</sup> In this report, we use estimated excess deaths data from a similar but earlier model created by the *Economist* magazine<sup>38</sup> as our main measure of the extent of the pandemic, using data up to the end of the first quarter of 2022, country by country and over time. This figure for “(estimated) excess deaths” uses governments’ official excess death numbers whenever and wherever they are available, and the model’s estimates in all other cases. For many countries, there are no official excess death estimates at all, and so for these countries the model is used to estimate excess deaths for the whole pandemic. For some other countries, official excess deaths estimates are only available for some periods during the pandemic, in which case the model is used to produce data for the remainder of the pandemic. For consistency, we always refer to these figures as “estimated excess deaths” even though, for some countries and for some periods in other countries, the numbers come from official sources.

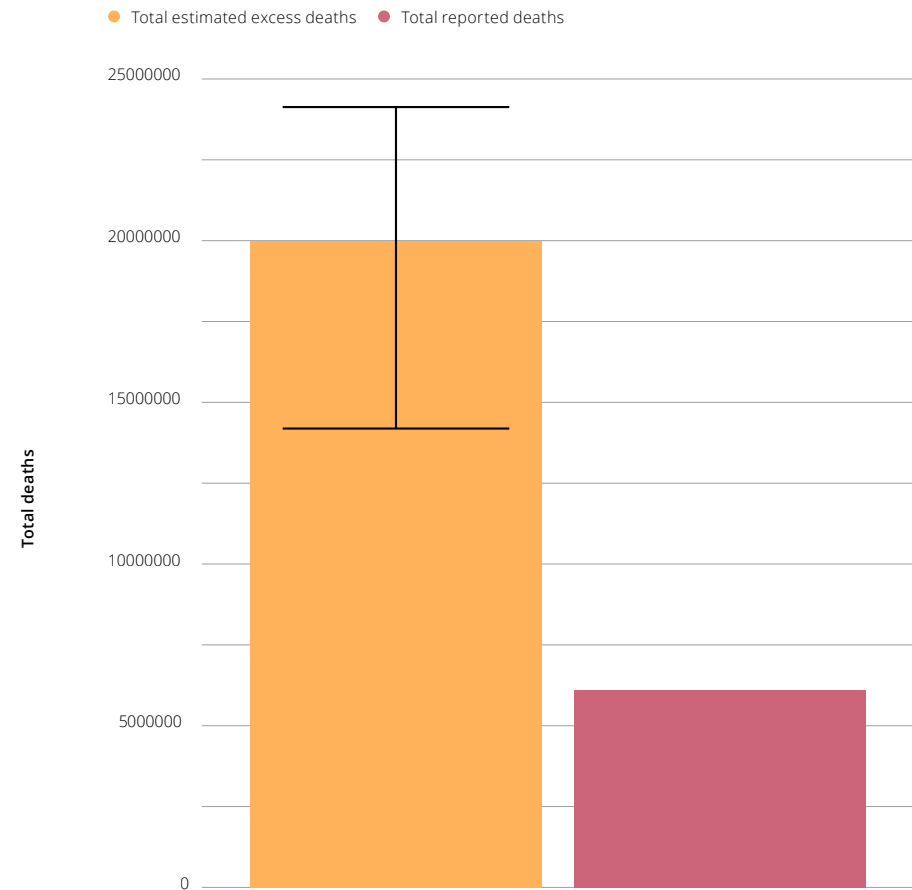
What the model actually does is take official excess death estimates where they are available and compare them with a database of 121 relevant indicators (population, mobile phone use, life expectancy, amount of international travel, etc.). The model tries to find a way to combine the information from the other indicators to predict the official excess death estimates, which it does quite well, as can be seen below. Then, the same model is used to predict excess deaths wherever official excess death indicators are missing.

**T**he estimates provided by this model have quite wide “confidence intervals” (see Figure 5–1). Elsewhere in this report, we do not explicitly mention this uncertainty, but it is always there.

37 <https://www.who.int/publications/m/item/methods-for-estimating-the-excess-mortality-associated-with-the-covid-19-pandemic>

38 <https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates>

**Figure 5–1** Total deaths



**Figure 5–1.** Total reported deaths versus total estimated excess deaths. The error bar shows the 95% confidence interval – we can be 95% sure that the true figure lies between these limits. Dataset: Excess-deaths.

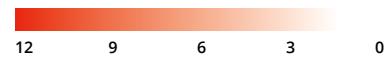


**Bangladesh 2021** Bangladesh Red Crescent Society volunteers helping an elderly woman named Majeda Khatun who has been recently released from Satkhira Sadar Hospital after getting admitted with COVID19 symptoms. © Mir Hossen Roney

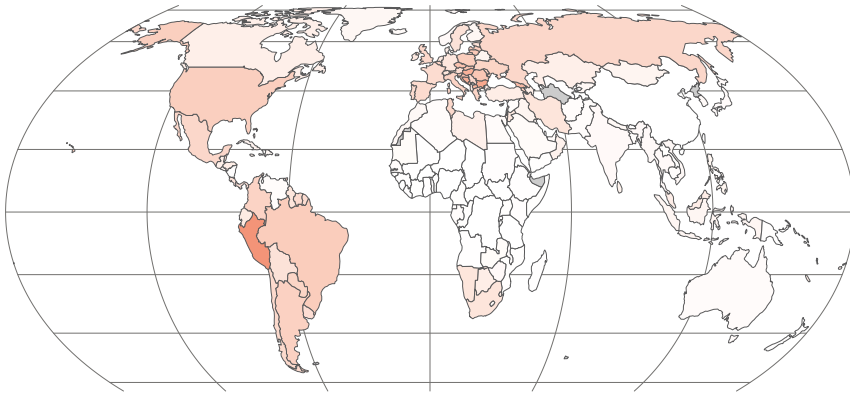


**Figure 5–2** Total deaths per 1000, comparing officially reported deaths with estimated excess deaths

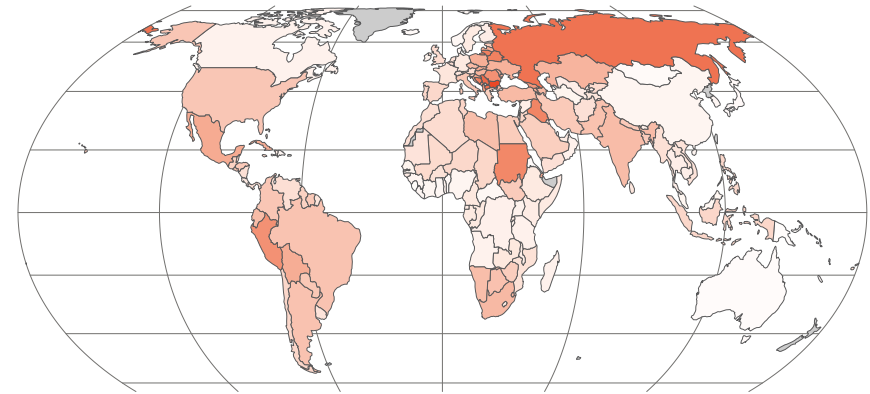
Deaths per 1000



Total deaths per 1000 – official figures



Total deaths per 1000 – estimated excesses



**Figure 5–2.** Map of total COVID-19 deaths, comparing official figures with estimated excess deaths. Dataset: Excess-deaths.

## KEY FINDINGS

- Many areas were probably much worse hit than the official figures would suggest.
- Figures for reported deaths recorded by countries in Africa are less than one-tenth of those in most other regions, but when we look at estimated excess deaths, we see that the figures for Africa are similar to those of other regions. So, it is probably not true that Africa “escaped” the pandemic. As the burden of disease is already relatively high in Africa, COVID-19 places an additional burden, especially in the way it interacts with and exacerbates other vulnerabilities, on an already burdened continent.
- Some countries in Central and Eastern Europe had quite high reported deaths but very high estimated excess deaths.

A few countries, such as Australia, have negative excess deaths (in their official figures and therefore also in the model) for some periods of the pandemic, presumably reflecting the fact that public health measures, such as social distancing, were preventing deaths due to other causes, for example, the flu virus.

Whether we look at the total numbers (Figure 5–1) or deaths in individual countries as a proportion of the population (Figure 5–2), the difference between confirmed and estimated actual deaths is horrifying.

One factor that goes a long way to explain these discrepancies is national income. Figure 5–3 shows how many more estimated excess deaths there are, compared to reported deaths, when we compare lowest-income with high-income countries.

Countries with weaker health systems may appear to have escaped lightly, merely because the published mortality and case numbers are more likely to be underestimates. This is supported by the very strong correlation between risk scores (see Chapter 4) and the *difference* between official mortality and estimated excess mortality.

Figure 5–3 Excess deaths

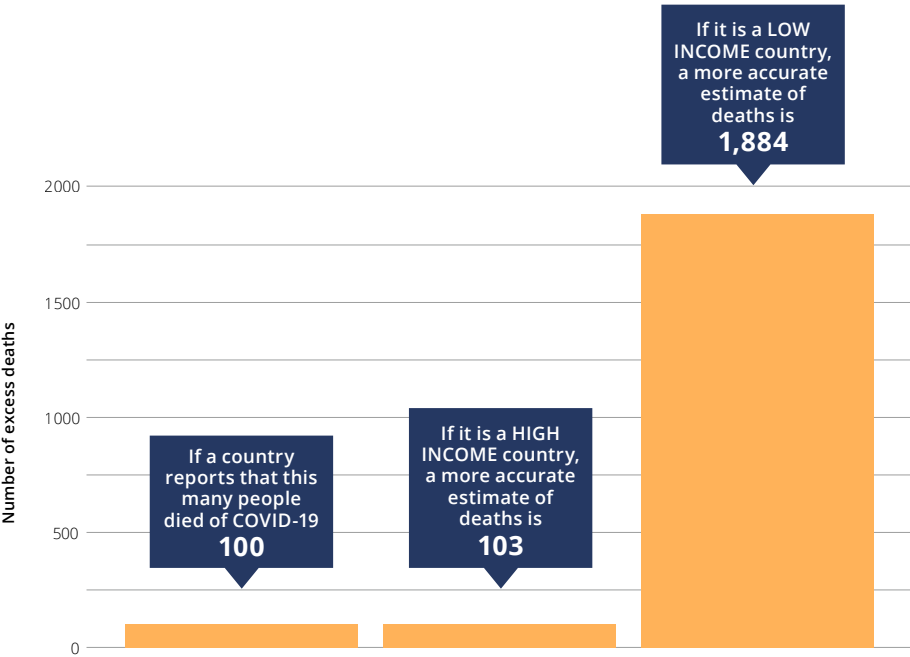


Figure 5–3. How do officially reported deaths compare with excess deaths, by income group. This comparison uses the lowest and highest of the four World Bank income groups, based on the median values as a proportion of population. Dataset: Excess-deaths.



Uganda 2020 In response to COVID-19, Uganda Red Cross Society are working to ensure that burials are carried out in a safe and dignified manner. © Uganda Red Cross Society

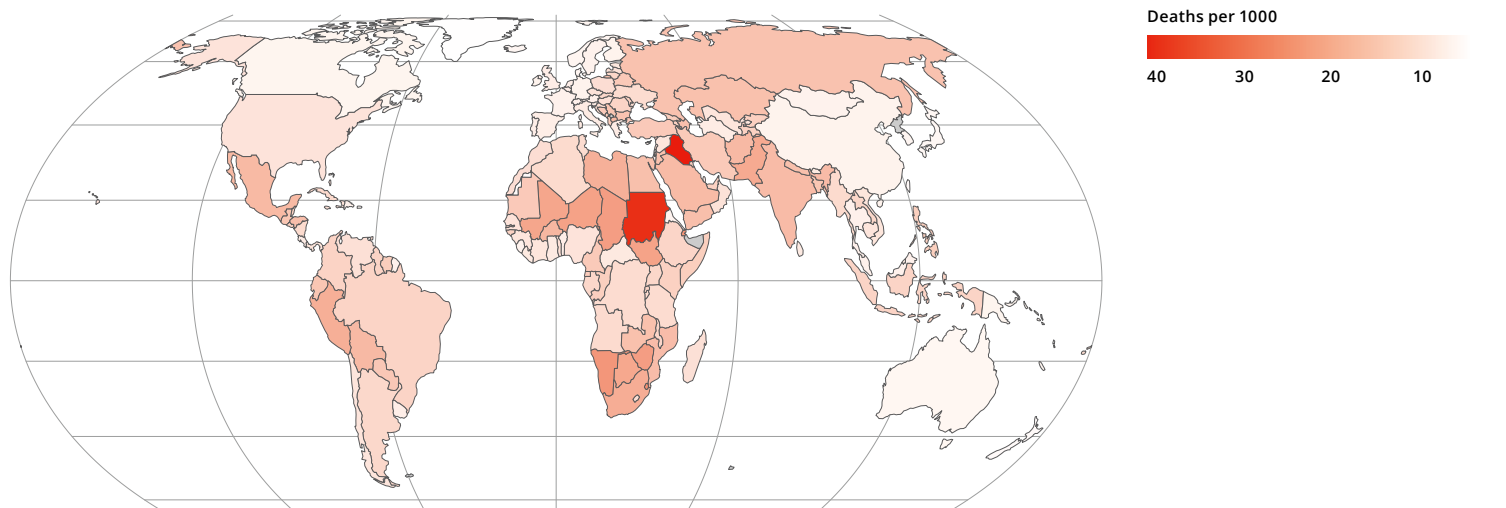
## Demographics: how severe was the pandemic in different regions, allowing for demographics?

People in lower-income countries are, on average, much younger than in higher-income countries, and younger people are much less likely to die of COVID-19. What would mortality figures have looked like if all countries had had populations with the same age profile? Figure 5–4 is one way to answer that question.

Figure 5–4 again shows the estimated excess deaths for each country, but adjusting the excess death figure, using the ratio of its expected demography-adjusted infection fatality rate (IFR), to that of the world median.<sup>39</sup> This

means that countries with a younger population are adjusted upwards, and countries with an older population are adjusted downwards. On the one hand, we should remember that this projection is not real; having a younger population is a real protective factor when considering COVID-19 mortality. However, the impact of the pandemic goes beyond mortality – Figure 5–4 probably also gives a better idea of the relative numbers of cases in different countries and may be relevant to comparisons of other effects of the pandemic, such as the numbers of people with “Long COVID”.

**Figure 5–4** Total estimated excess deaths per 1000, if all countries had the same age profile



**Figure 5–4.** Map of estimated excess deaths if all countries had the same age profile. Dataset: Excess-deaths, including the variable demography-adjusted IFR.

<sup>39</sup> <https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates>

## Indirect mortality

Excess deaths over this time period (whether official or estimated) will certainly include deaths which are not directly due to COVID-19 infections but which are indirect effects of the pandemic (e.g. non-availability of medical personnel) and attempts to mitigate it (e.g. the closure of clinics) or related to the devastating effects of the pandemic on economies due to reductions in exports, tourism,

etc. These effects are likely to be stronger in lower-income countries. For example, according to a Global Fund survey<sup>40</sup> of 32 countries in Africa and Asia, “prenatal care visits dropped by two-thirds between April and September 2020; consultations for children under five dropped by three-quarters”.

## What was it like for National Societies trying to continue other health support during the pandemic?

### The case of the Argentine Red Cross<sup>41</sup>

The work on HIV/AIDS prevention, awareness and stigma reduction is one of the activities established in the Strategic Plan of the Argentine Red Cross (ARC). Volunteers and health promoters from branches across the country play an active part in this area of work through campaigns, touring activities, workshops, talks, communications materials and condom distribution, supplemented by the performance of rapid tests. This work continued during the pandemic.<sup>42</sup>

At the height of the pandemic in Argentina, many people were required to isolate in accordance with government measures. The ARC oversaw the operation of the Tecnópolis Health Park, an isolation centre with capacity for more than 2,000 people. The centre was a temporary isolation space for people between 18 and 50 years old who had been diagnosed with COVID-19 but did not present severe symptoms requiring isolation. The objective was to ensure a place of recovery for patients in the best conditions and prevent other people from becoming infected. This was especially necessary for people unable to comply with isolation measures because they lived in cramped conditions or were homeless and had no place to isolate to avoid infecting other people.

At the centre each day, there were rotations of 100 ARC volunteers who had been trained in all the biosecurity protocols required for their own safety and that of the patients. In addition, every Friday, the ARC volunteers provided HIV and comprehensive sex education courses for people with mild COVID-19 symptoms staying at the Tecnópolis Health Park.

Protection of transgender people and people with HIV is provided by the ARC through two lines of action<sup>43</sup>: delivering food and hygiene kits, in coordination with the Association of Transvestites, Transsexuals and Transgender People of Argentina and the Argentine Federation of Lesbians, Gays, Bisexuals and Trans, and strengthening the livelihoods of trans people through workshops on food security and crafts, in coordination with the school Bachillerato Popular Travesti Trans Mocha Celis. In addition, the ARC maintained its HIV rapid testing facilities open throughout the pandemic, adhering to biosecurity protocols, to ensure people were still able to access this service. The rapid tests are carried out every week, as they have been for the last eight years, and are aimed at the entire community. They are voluntary, free and confidential.

40 The Impact of COVID-19 on HIV, TB and Malaria Services and Systems for Health, [https://www.theglobalfund.org/media/10776/covid-19\\_2020-disruption-impact\\_report\\_en.pdf](https://www.theglobalfund.org/media/10776/covid-19_2020-disruption-impact_report_en.pdf)

41 <https://www.ifrc.org/es/article/covid-19-cruz-roja-argentina-gestiona-un-centro-de-aislamiento-para-2000-personas>

42 Information and figures are for the third quarter of 2020.

43 COVID-19 outbreak: 9-month update, <https://www.alnap.org/system/files/content/resource/files/main/MDR000050U21.pdf>





**Argentina 2020** Argentine Red Cross delivers food kits to communities in the Province of Salta during COVID-19. In this area of the country there is a high incidence of child malnutrition, so in early 2020 the National Government declared a state of emergency. © Argentine Red Cross





**El Salvador 2020** Salvadorean Red Cross Society has delivered humanitarian aid to more than 600 families affected by the storm Amanda. Food and hygiene kits have been delivered. In addition, psychosocial support and hygiene promotion for COVID-19 is provided and medical days are carried out.  
© Salvadorean Red Cross Society

## KEY MESSAGES

- ▶ The IFRC has a duty to analyse data in a way that makes equal sense, as far as possible, for all countries and all National Societies. Only taking into account figures for officially reported deaths means using data that is likely to treat countries in different regions and income groups very differently. That is why, in this report, we have chosen to focus on estimated excess deaths as a measure of the extent and course of the pandemic.
- ▶ In countries where health statistics are less reliable, the pandemic was much worse than official statistics lead us to believe – they are as much an indication of the accuracy of different health statistics systems as they are a reflection of how the pandemic affected different countries. The poorer the country, the more likely it is to have a less effective health statistics system that reports fewer deaths officially.
- ▶ If we take into account the fact that lower-income countries also have more younger people, who are much less likely to die of COVID-19, it is probable that the number of cases per 100,000 people in lower-income countries may actually have been larger than the number of cases in other countries.







6

**ON THE FRONT LINE**

THE STORIES OF  
THE VOLUNTEERS

## KEY QUESTIONS

- ▶ **What was it like for volunteers at the start of the pandemic?**

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- ▶ **How did they deal with the fear and uncertainty around the pandemic and the risks of infection?**

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- ▶ **How much did they rely on pre-existing skills and networks?**

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- ▶ **What can National Societies learn about their volunteers?**

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- ▶ **What motivated them?**

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- ▶ **How could National Societies protect them?**

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One good way to explore these kinds of questions is through narratives – asking people to tell their own stories. We can summarize volunteers’ stories, looking for common themes, feelings and actions and for drivers and consequences of volunteering.

## COVID-19 stories from volunteers

The Solferino Academy is an initiative of the IFRC and its member National Societies that aims to help the Red Cross and Red Crescent network anticipate, understand and adapt to trends and emerging issues. The COVID-19 stories from volunteers were part of a two-step innovation initiative. First in April and May 2020, in the early stages of the pandemic, the Solferino Academy convened Senior Leaders (Secretary Generals, Presidents) and the global network<sup>44</sup> to share lessons and experiences of COVID’s response. Then, invited volunteers around the world to submit their stories. These stories can be viewed and explored at <https://solferinoacademy.com/ourcovidstory/>.

This was not a random sample of IFRC volunteers but rather a snapshot of volunteers who happened to hear about the survey through different channels. Results are therefore not representative of the IFRC’s volunteer network.

The stories were translated into English using Google Translate and were analysed using causal mapping.<sup>45</sup> This is a kind of qualitative data analysis in which analysts are not instructed to look for general themes such as “fear” or “contacted National Society”, as in traditional qualitative data analysis, but to identify passages of text where people talk about how one thing influenced another. For example, Hina Gul from the Pakistan Red Crescent had this to say:

<sup>44</sup> <https://solferinoacademy.com/connecting-our-global-network-during-the-covid-response/>

<sup>45</sup> V.K. Narayanan (2005), “Causal Mapping: An Historical Overview”, in V.K. Narayanan and D.J. Armstrong (eds), *Causal Mapping for Research in Information Technology*, IGI Global, pp. 1–19.

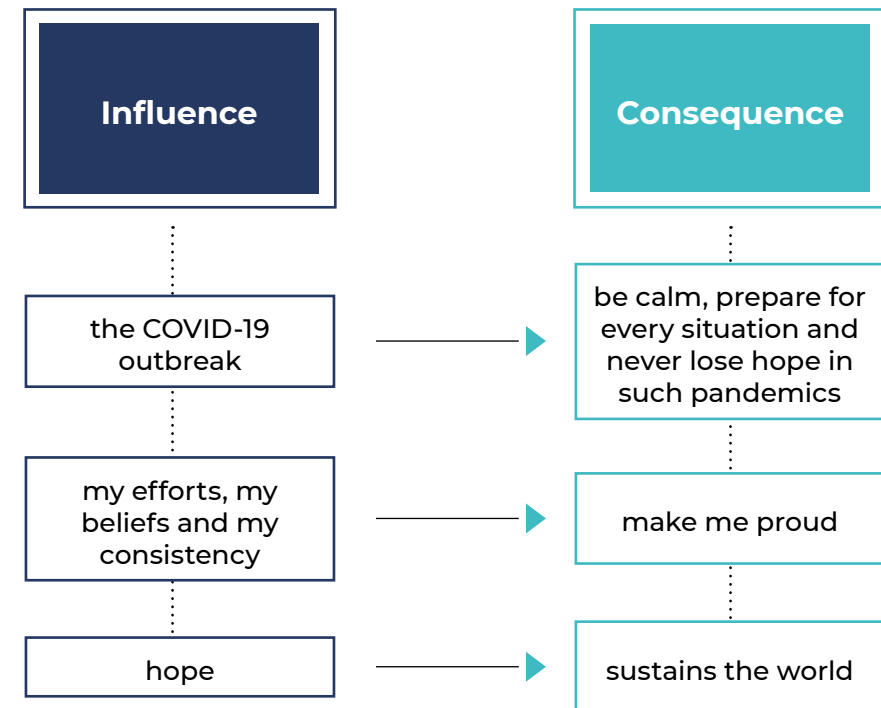


Hi, this is Hina Gul, a volunteer with the Pakistan Red Crescent since 2019. I would like to thank the IFRC for giving me the opportunity to share my own experience in this epidemic situation. The thing I have learned from **the COVID-19 outbreak** is *to be calm, prepare for every situation and never lose hope in such pandemics*. In the context of coronavirus, **my efforts, my beliefs and my consistency** really make me proud ... The role of the media was very disappointing and hard to cope with. Instead of raising awareness and hope, **they terrified people**, which made our job more difficult ... **Hope sustains the world**. One day everything will be fine. The sun will shine again on our souls and give us the opportunity to breathe, innovate and lead.

Hina Gul, Pakistan Red Crescent 11 April 2020

Here we have set in bold the influence and in italics the consequences. We analysed all the stories in this way (see *Appendix to Chapter 6*). In their stories, 188 different people from 53 National Societies made at least one statement which we could code in this way.

Like all qualitative data analysis, this is a subjective process conducted by individual researchers who read all the texts. All the information comes from the text; there is no other data except (in most cases) the volunteer's name and National Society. The volunteers told us what *they believe* influences what in a particular context. These beliefs might not always be accurate (it does not give us reliable information about what *really* influences what), but it is at least useful and interesting to know what the volunteers *think*. This procedure is more like asking a journalist to make a summary of the stories than, say, asking a statistician to count the frequency of different words used. The results are certainly not representative of any particular population, but they help us get an overview of how the volunteers were thinking and what influenced them, especially in terms of motivation and action.



# Findings

What stands out most is the rich information volunteers gave about their motivation and experiences.

## Overall top-level map

This map (figure 6–1) shows an overview of the factors and the relationships between them that were mentioned most frequently by the volunteers. The factors and the links between them feature a number representing the number of times each was mentioned. For example, in all the stories analysed, the causal factor “Volunteer faces challenge” was mentioned ten times; five times as a driver of “Volunteer action” (as shown by the number 5 on the link between them) and five times as a driver of “Volunteer growth”.

As can be seen from the map on the right, the pandemic gave rise to many challenges which affected volunteers but, at the same time, motivated them. Many volunteers mentioned how people’s wellbeing was improved by their actions. However, they spoke most of all about the volunteering itself, the actions carried out by the National Societies and by them, the capacity they needed and developed and their motivation to act (sometimes even how action increased their motivation). Awareness that the challenges of the pandemic were disproportionately affecting others was also a motivation to act for many volunteers. They wrote, in general, about how volunteering was satisfying for them, but also about how the different challenges presented by the pandemic led to their own personal growth, enabling them to appreciate the value of volunteering, the role and importance of the National Society, people’s courage in adversity and so on.

We can zoom in on different parts of the map to see more details.

Figure 6–1 Volunteers’ stories map

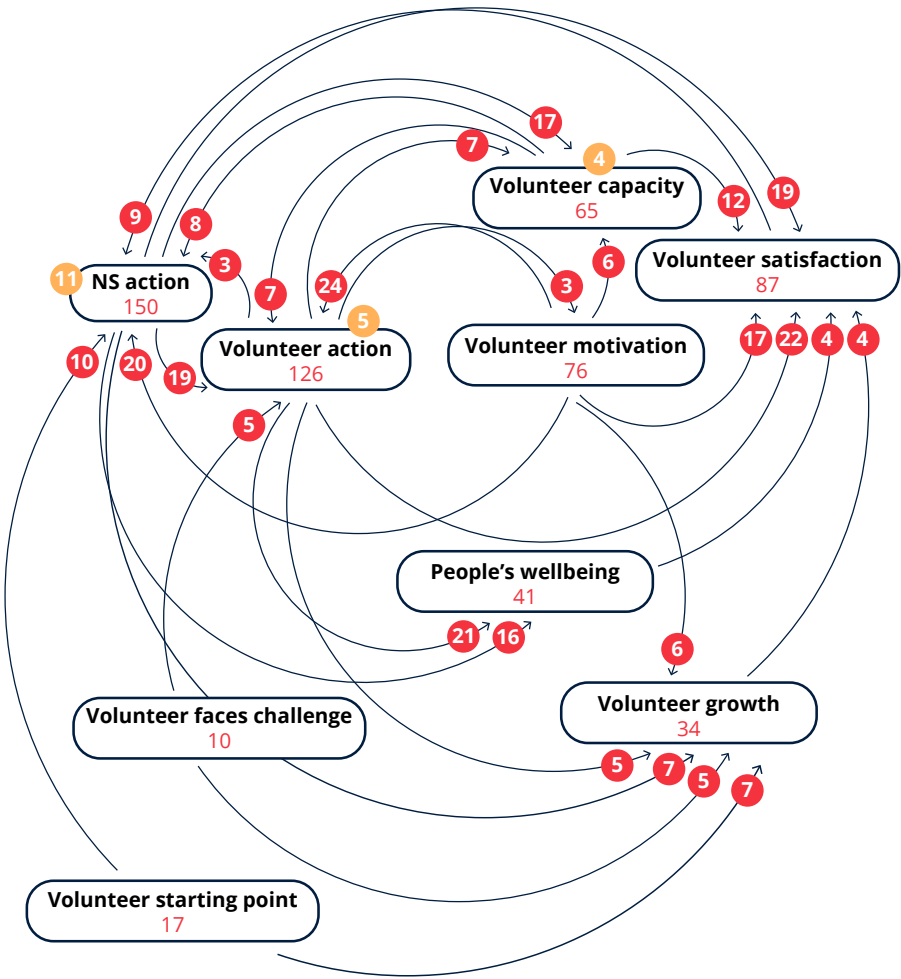
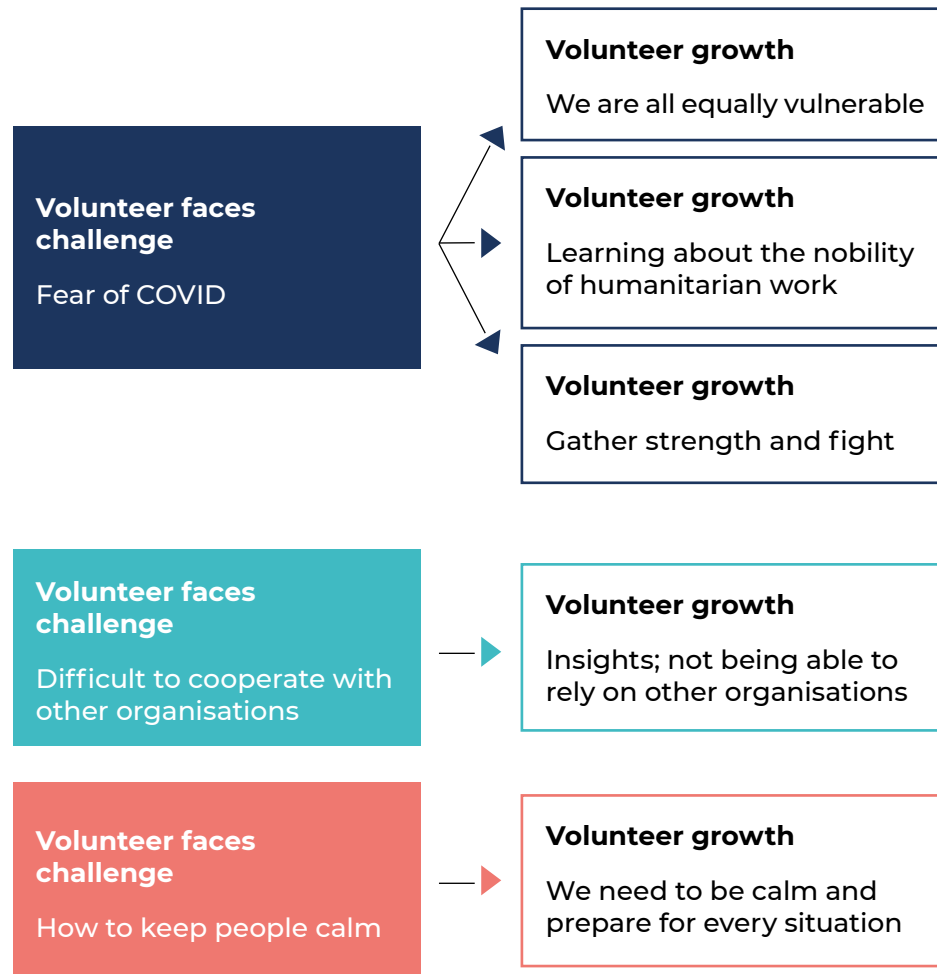


Figure 6–1. The most frequent factors and links in the volunteers’ stories. The numbers on the links and the factors show how often each one was mentioned.



**Figure 6–2** Challenges that volunteers faced



**Figure 6–2.** Zooming in to focus on the different kinds of challenges that volunteers faced and what these challenges led to.

## Volunteering in the pandemic: overcoming fear, turning challenges into growth

The figure 6–2 zooms in on the map to show more detail that is not visible on the overview map about the challenges that volunteers faced.

Volunteering in the pandemic presented many challenges, but volunteers reported that overcoming them provided an opportunity for personal growth. At the beginning of the pandemic, in particular, fears surrounding the uncertainty of how the virus was spread and its severity was a concern for volunteers. Many reported feeling anxious about contracting the virus themselves or exposing their community and loved ones to it. Despite these fears, volunteers believed taking action was the right thing to do and worked to assist and reassure vulnerable people, even when they felt concerned themselves. For many, bravely facing these challenges, with the support of their peers, led to positive experiences and reduced anxiety. Volunteers realized and were proud of their own strength and capacity to help others, despite the hurdles. Supporting people in need opened many volunteers' eyes to the vulnerability of others and increased their respect for those who dedicated their time to humanitarian work.

As a Palestine Red Crescent Society volunteer, it is my duty to provide social and psychological support in order to help people overcome crises that affect them and their children. Volunteering reflects humanity at its best. It also helps us overcome our fears and enhances our awareness, so we are better equipped to fight this pandemic.

**Amal, Palestine Red Crescent Society**

Personally, I think that facing this challenge will help me become a better person and that together, whether we are health-care staff or not, we can contribute to ending COVID-19.

**Alexander, Spanish Red Cross, Disaster Relief**

## Why volunteering?

The figure 6–3 shows another fragment of the main map.

National Societies are lucky to have a range of volunteers from a variety of backgrounds, united in the drive to improve lives and support people most in need. Volunteers reported a range of motivations for starting or continuing volunteering during the pandemic.

Those who had been driven to dedicate their time were clearly concerned by a range of issues, such as homelessness, loneliness, poverty and food insecurity caused or exacerbated by COVID-19. Seeing and understanding these issues moved many volunteers to take action. Furthermore, COVID-19 gave a sense of urgency to many of these issues, which encouraged people to act promptly. Volunteers were sympathetic to those in need of support and stepped in to help in whatever ways they could. These actions led to volunteers understanding the impact acts of kindness could have, which encouraged further action.

In the fight against coronavirus, I am packing food baskets and delivering them to vulnerable people. When I deliver these baskets, it is usually a gloomy picture: old crumbling houses, waste spread around, dirty roads and bad lighting. Nevertheless, what stands out is people's smiles and tears of happiness when they see the much-needed food baskets. You can see they are grateful.

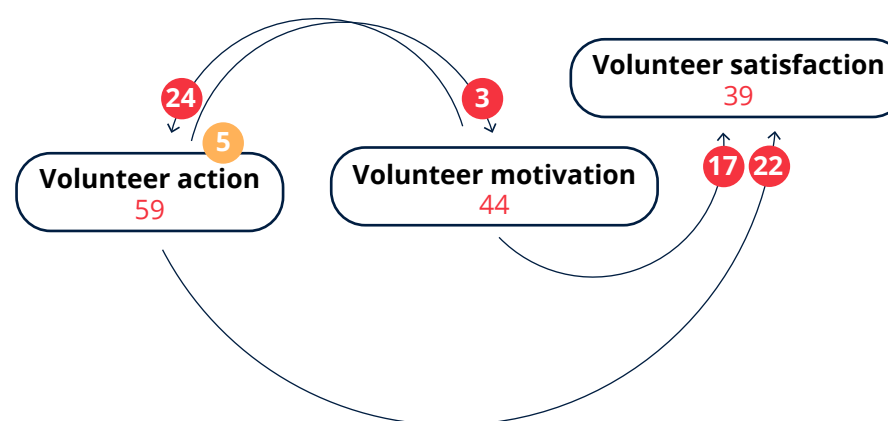
**Jasulan, Kazakh Red Crescent**

Some volunteers recognized that they themselves were in a privileged position and wanted to be able to use this privilege to help those less fortunate.

I think we are often unaware how lucky we are to have a decent home and food to eat. With volunteering, I do not seek recognition or praise; I do it selflessly because I really like being able to help humanity whenever I can... I will speak out and continue working in these difficult times with the people most affected and encourage everyone to become a volunteer as they need us now more than ever.

**Paco, Spanish Red Cross**

**Figure 6–3** Detail of the map



**Figure 6–3.** Zooming in to focus solely on volunteer action, motivation and satisfaction. Note that the frequency numbers on the causal factors usually vary between different views of the same map, as in the previous figure, because they only include the number of times the factor was mentioned within this particular view.

Volunteering also brings a sense of pride and belonging. Seeing the positive impact of their actions gave many individuals a great sense of satisfaction. This was a strong motivation for people to continue devoting their time to such causes. While volunteering with National Societies, people also enjoyed working alongside other people with a shared set of values and a sense of community. This was exemplified by one individual who explained:

I am very proud of the work we do, my colleagues and all the people who make up the Red Cross. After my children and my wife, the best thing that has happened to me in my life is belonging to this organization. Being able to give up your time to help others is very rewarding; it fills you with positive feelings and values that you perhaps did not have before. It is a priceless feeling to help people – when you deliver someone's medication, you can see how grateful they are.

**Felipe, Spanish Red Cross**

Volunteers felt that previous experience, the organization of their peers and the institution of the Red Cross Red Crescent enabled them to act in a confident and effective way despite the challenges involved in volunteering during the pandemic. Belonging to an organization that was prepared and able to offer assistance in such difficult times was a source of pride for many.

Even though the COVID-19 crisis has presented us with many challenges and changed the way in which we operate, the Croatian Red Cross has come up with creative and innovative solutions... Our preparedness, our previous experience and, above all, our determination have helped us overcome these obstacles, as always. The joy we get from volunteering is our reward. No matter how much work it involves, helping society in the hardest times is what makes our lives meaningful, while boosting our collective progress as a society.

**Nika, Croatian Red Cross**

## What volunteers did

Volunteers undertook a range of activities to improve people's wellbeing, such as food distribution, creating programmes and checking-in on vulnerable people. Many of the actions were informed by the needs arising from the pandemic. Many people needed further support, such as those living alone or struggling to get enough food. National Societies were there to provide support with existing services and fill in the gaps where new needs arose, such as calling those in social isolation to ensure they felt as safe and supported as possible. Through social media campaigns, the distribution of leaflets and masks and hand washing demonstrations, volunteers worked hard to keep people safe and informed. Distributing medicine and food was also an important task for volunteers, as vulnerable people lacked access to such items. Raising awareness about how to stay safe was another crucial activity that many volunteers undertook. One respondent described how they saw their role as a Red Cross volunteer:

We are ready to respond and play a supporting role; we are prepared. We disseminate information to help people understand how they can protect themselves. The lockdown has panicked people across the country, and small business owners have lost hope that they will be able to revive their businesses. Homeless people have nothing to eat and seek help from Red Cross volunteers. As volunteers, we are mobilizing resources so that we can buy food for those who are urgently in need of supplies during the lockdown period.

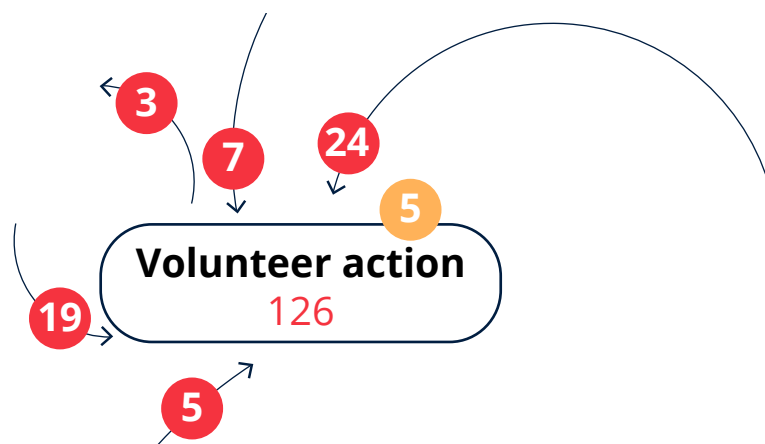
**Thabo, Lesotho Red Cross Society**

Volunteers greatly helped a range of people through difficult times. Many were encouraged by how grateful those they helped were. By providing people with food, hygiene products, masks and medicine, they ensured those in need had access to these vital items. However, it was the verbal support they provided that was most frequently mentioned. By providing reliable information throughout the pandemic and listening to people's concerns, volunteers contributed to reducing loneliness and anxiety.

My phone calls are the last human link. This seems trivial, but it is a vital necessity. As soon as I can, I put a little box of candy that she loves or an article or crossword in her mailbox, but I cannot visit her for obvious safety reasons.

**Rosa, Italian Red Cross**

**Figure 6–4** Detail of the map



**Figure 6–4.** Another fragment of the main map, focusing on volunteer action.

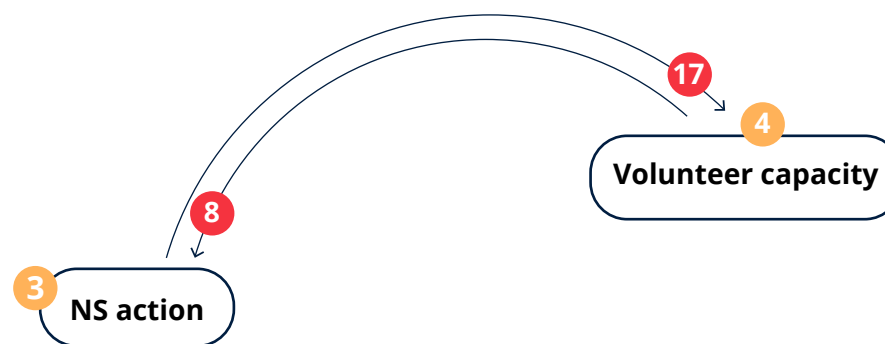
## How National Society action led to volunteer capacity

Volunteers gave many examples of how their skills and ability to help increased over the pandemic, mostly supported by National Societies. This allowed their efforts to be amplified. They also gave examples of how their capacity was able to improve the organization's actions, as shown by the arrow leading into National Society action in the figure below.

Our branch initially called on us [volunteers] and we received training on how the virus spreads, how to avoid being infected, how to train others and how to disseminate messages through all types of media from home. They later called on us to train others, including at markets and other highly frequented areas.

**Maria, Bolivian Red Cross**

**Figure 6–5** Detail of the map



**Figure 6–5.** Another fragment of the main map, focusing on how National Society actions, such as training, influenced volunteer capacity – and vice versa.



## KEY MESSAGES

This chapter illustrates an alternative approach to data collection, engagement and analysis, one which gathers stories rather than numbers and demonstrates “causal mapping”, a relatively new way to combine these kinds of stories. In spite of caveats (the sample of volunteers was not representative, the data deals only with the volunteers’ own perspectives and is not in any way objective, and the synthesis presented here is only one way to summarize the data), the findings give an interesting and plausible perspective on the pandemic through the eyes of volunteers.

- ▶ Volunteers were of course motivated by the way that people’s wellbeing was improved by their actions. However, they spoke most of all about the volunteering itself, the concrete ways in which they were able to help.
- ▶ Awareness that the challenges of the pandemic were disproportionately affecting others was also a motivation to act for many volunteers. They wrote, in general, about how volunteering was satisfying for them, but also about how the different challenges presented by the pandemic led to their own personal growth, enabling them to appreciate the value of volunteering, the role and importance of the National Society and people’s courage in adversity.
- ▶ At the beginning of the pandemic, in particular, many volunteers were afraid because of uncertainty about how the virus was spreading and its severity. Many volunteers reported feeling anxious about contracting the virus themselves or exposing their community and loved ones to it. Despite these fears, volunteers believed taking action was the right thing to do and worked to assist and reassure vulnerable people, even when they felt concerned themselves. For many, bravely facing these challenges, with the support of their peers, led to positive experiences and reduced anxiety. This fear due to uncertainty is one area where National Societies might focus their support for volunteers at the start of crises of this kind.
- ▶ Volunteering also brought a sense of pride and belonging, and volunteers enjoyed working alongside others with a shared set of values and a sense of community.





7

VACCINATIONS

## KEY QUESTIONS

- ▶ **How is the work of National Societies to support vaccinations being scaled up?**

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- ▶ **How does the work of National Societies complement the work of their governments?**

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- ▶ **How did the IFRC use statistical modelling to get a more accurate estimate of the number of people who were supported to get vaccinated?**

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### **Which role did National Societies play in scaling up vaccination work? The case of the Algerian Red Crescent<sup>46</sup>**

The Algerian Red Crescent (ARC) is a key player in the national vaccination campaign in Algeria. Most Algerians were hesitant to get vaccinated against COVID-19 when the Ministry of Health first launched the vaccination campaign. The ARC therefore organized nationwide (online and on-site) public awareness campaigns to combat misinformation and rumours about the vaccine and COVID-19 prevention measures. The National Society has also conducted a perception survey to identify the most common erroneous beliefs held by the public in order to develop effective key messages aimed at diminishing public fears about the COVID-19 vaccine. Additionally, the ARC dedicated 67 centres to assisting the Ministry of Health with the administration of COVID-19 vaccine doses. As a result, more than two million people have already been vaccinated by ARC doctors and nurses both in cities and in remote areas. Many new vaccination centres have recently been set up to reach the national target set by the authorities to have 20 million people vaccinated by the end of 2021. Those who received the second dose of the vaccine were monitored by the ARC on a regular basis for 40 days in order to collect data on potential side effects following vaccination and take action as needed. With the emergence of a new COVID-19 variant called Omicron, the ARC increased its support for the national vaccine rollout campaign and, at the same time, ramped up its public awareness campaigns to encourage even the most hesitant citizens to get vaccinated and to combat misinformation.

<sup>46</sup> [https://prddsgofilestorage.blob.core.windows.net/api/event-featured-documents/file/MDR000050U25\\_24\\_month\\_report.pdf](https://prddsgofilestorage.blob.core.windows.net/api/event-featured-documents/file/MDR000050U25_24_month_report.pdf)



## How is the work of National Societies to support vaccinations being scaled up?

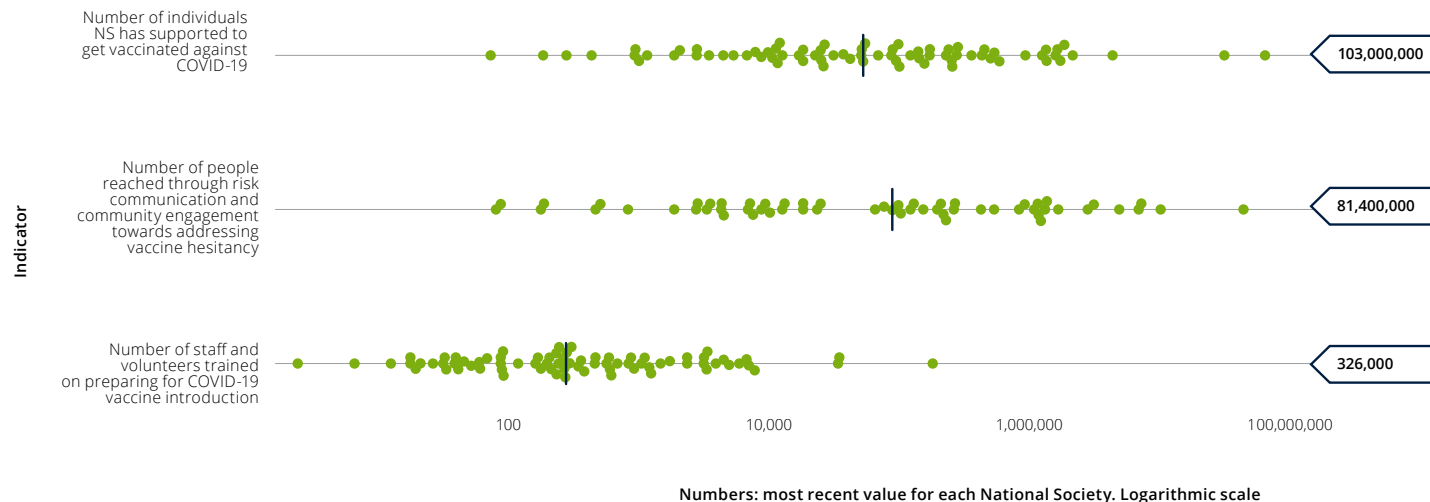
The IFRC's CHF 550 million Emergency Appeal includes CHF 100 million to reach 500 million people via the Immunization Plan<sup>47</sup>, which has five pillars: I) Advocacy, II) Trust, III) Health, IV) Reach and V) Maintain. The IFRC and National Societies have a key role to play in supporting people to get vaccinated, engaging and informing communities, building confidence in vaccines and ensuring that people have access to vaccines.

By the end of the first quarter of 2022, 172 of the 192 National Societies – 90% globally – were supporting or preparing to support COVID-19 vaccination

campaigns<sup>48</sup>, and the COVID-19 Indicator Tracking Database shows that 105 National Societies were reporting positive achievements on at least one indicator of their work supporting their countries' COVID-19 vaccine rollout.

This support comprises direct administration of vaccines, administrative support for country programmes, extending reach particularly to remote areas, information campaigns and promotional and other activities. Figure 7-1 shows total figures for achievements on the three most important indicators.

**Figure 7-1** Achievements on three vaccination indicators



### KEY FINDINGS

- National Societies have reported that over 100 million people have been supported to get vaccinated. This figure is examined again below to add in an estimate of the likely number of people reached but not reported.
- Over 80 million people have been reached through RCCE on vaccine hesitancy.
- Over 320,000 staff and volunteers have received training on COVID-19 vaccines.

**Figure 7-1.** Performance on vaccination indicators during the pandemic: latest cumulative figures and global totals. The dark blue lines mark the median for each indicator. Dataset: CI-tracking.

47 [https://www.ifrc.org/sites/default/files/2021-09/COVID-19%20MDR00005\\_Immunization\\_Annex%20%2811%29.pdf](https://www.ifrc.org/sites/default/files/2021-09/COVID-19%20MDR00005_Immunization_Annex%20%2811%29.pdf)

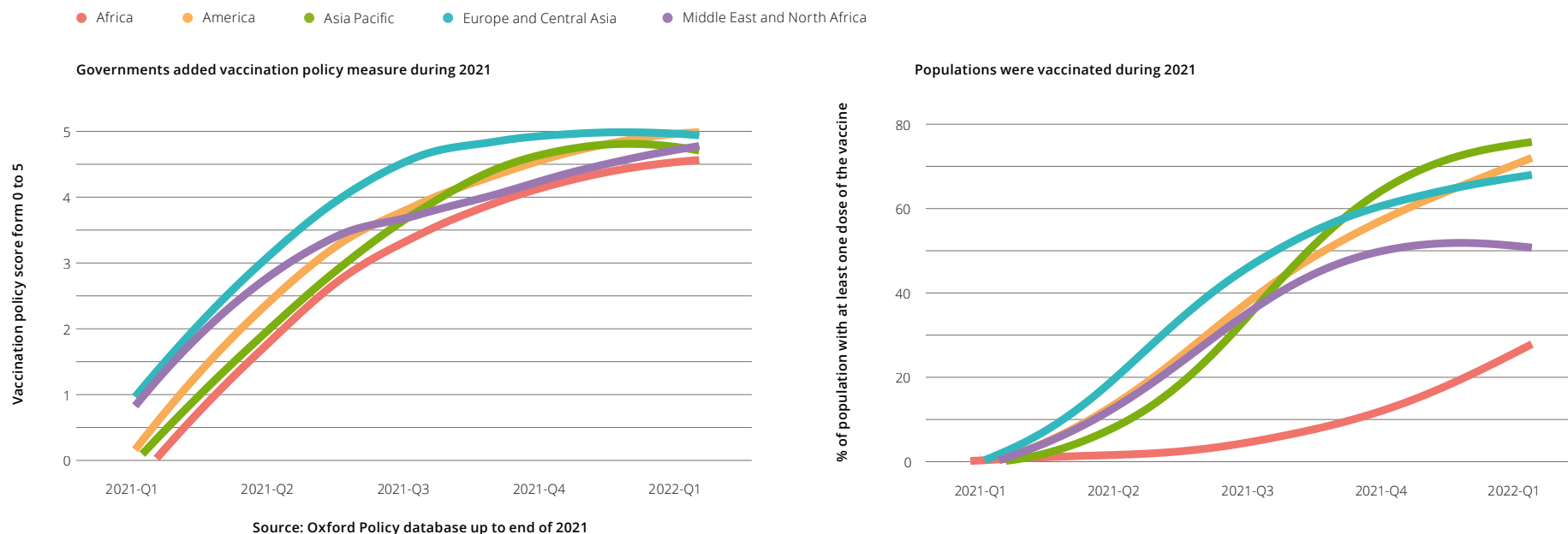
48 Information from the National Society COVID-19 Readiness Assessment Tool.

Instead of presenting totals, the two figures below show developments over time. Figure 7-2 shows developments independently of National Societies, while Figure 7-3 shows progress made by National Societies during the second half of the pandemic on the relevant achievement indexes.

### KEY FINDINGS

- Most governments started adopting vaccination policy measures in the first quarter of 2021.
- Governments across different regions responded in a broadly similar way.
- Vaccination programmes began to be implemented quite swiftly after this.
- Governments' progress in implementing vaccination policy was similar across the regions but Africa lags drastically behind the other regions in terms of the percentage of people with at least one dose of the vaccine.

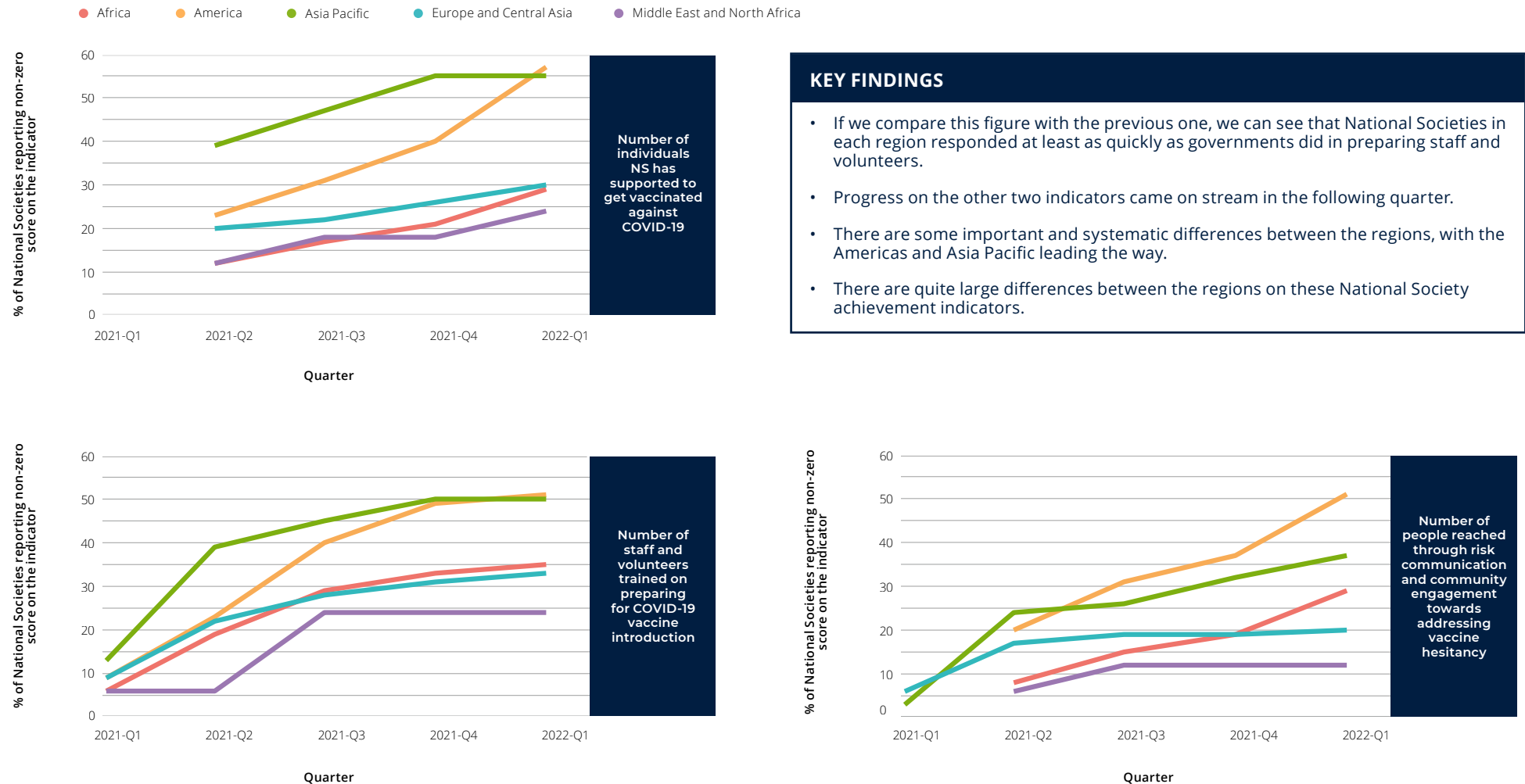
**Figure 7-2** Developments on vaccinations independently of National Societies



**Figure 7-2.** Government policy on vaccinations (left) and numbers of people with at least one dose of the vaccine (right). Lines show smoothed curves fitting the typical values for individual countries.<sup>49</sup> Dataset: Oxford-policy & Dataset: Excess-deaths (additional variables).

<sup>49</sup> The lower curve for the Middle East and North Africa appears to drop slightly in 2022, but this is only because data for some countries was not consistently available.

**Figure 7–3** Progress made by National Societies on vaccinations during the second half of the pandemic



**Figure 7–3.** National Society progress on vaccination indicators over time. Dataset: CI-tracking.

## Which role did National Societies play in complementing governments' efforts?

### The case of Bangladesh Red Crescent Society<sup>50</sup>

Vaccinating an entire population is very challenging, and some governments were less able than others to do this; National Societies were often able to step up to fill some of the gaps.

The Bangladesh Red Crescent Society (BDRCS) handed over four refrigerated vaccine-transportation vans to the Government of Bangladesh with support from the IFRC and USAID on 15 November 2021. Zahid Maleque, Minister of Health and Family Welfare, received the vans. They will be used to strengthen ongoing activities for countrywide COVID-19 vaccination efforts.

Also attending the event were BDRCS Chairman Major General (Rtd.) A.T.M. Abdul Wahab and Vice-Chairman Nur-Ur-Rahman, along with Secretary General Md. Firoz Salah Uddin, Director of Disaster Response Imam Zafor Shikder, Head of IFRC Country Delegation Sanjeev Kumar Kafley and USAID Bangladesh Mission Director Kathryn Stevens.

The BDRCS and the IFRC, together with USAID, are implementing a project called PROVASH with the goal of supporting the Government of Bangladesh in the COVID-19 response and vaccination operations to enhance prevention and reduce transmission in the community. Under this project, the BDRCS and the IFRC will be providing another 14 refrigerated vans to the government health authorities.

**Bangladesh 2021** In Cox's Bazar Vaccinations began in the camps for displaced people, amid a record COVID-19 surge in Bangladesh and a widening global vaccine divide. The vaccination campaign prioritized people aged 55 and over covering 48,000 camp residents.  
© Ibrahim Mollik / IFRC

<sup>50</sup> <https://bdracs.org/bdracs-handed-over-refrigerated-van>

## How does the work of National Societies complement the work of their governments?

In many countries, mainstream vaccination programmes are led by governments, but National Societies take on the important complementary role of making sure that the most vulnerable people are reached, including those affected by conflict, violence and disasters, people in detention, indigenous populations, people living in urban slums and remote rural areas, migrants and individuals without housing.





## How did the IFRC counteract under-reporting of vaccination achievements? Predictive modelling of vaccinations

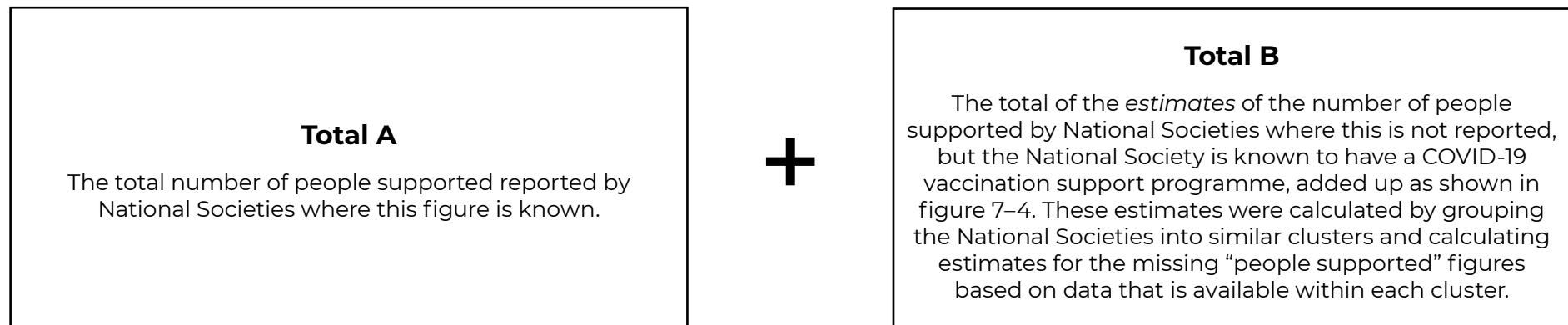
The indicators on the number of people reached under the activities described above are used to present a picture of programme achievements against the pillars. As always, it is important to have figures that are as accurate as possible. However, as usual, this data is not available for every participating National Society, which means that the global figures are an underestimate.

The IFRC Secretariat decided to try to get a better global estimate of one specific and very important indicator: the number of individuals the National Society has supported to get vaccinated against COVID-19 (in this section, we will refer

to this indicator as “people supported”). The way this estimate was calculated is summarized here and explained in more detail in *Appendix to Chapter 7*.

To make this estimate, a mathematical model was built. The basic idea is that the total number of vaccinated people is calculated as the sum of two numbers, Total A and Total B, as follows:

Details of the method are available from [fdrs@ifrc.org](mailto:fdrs@ifrc.org), and an overview is given in Figure 7–4.

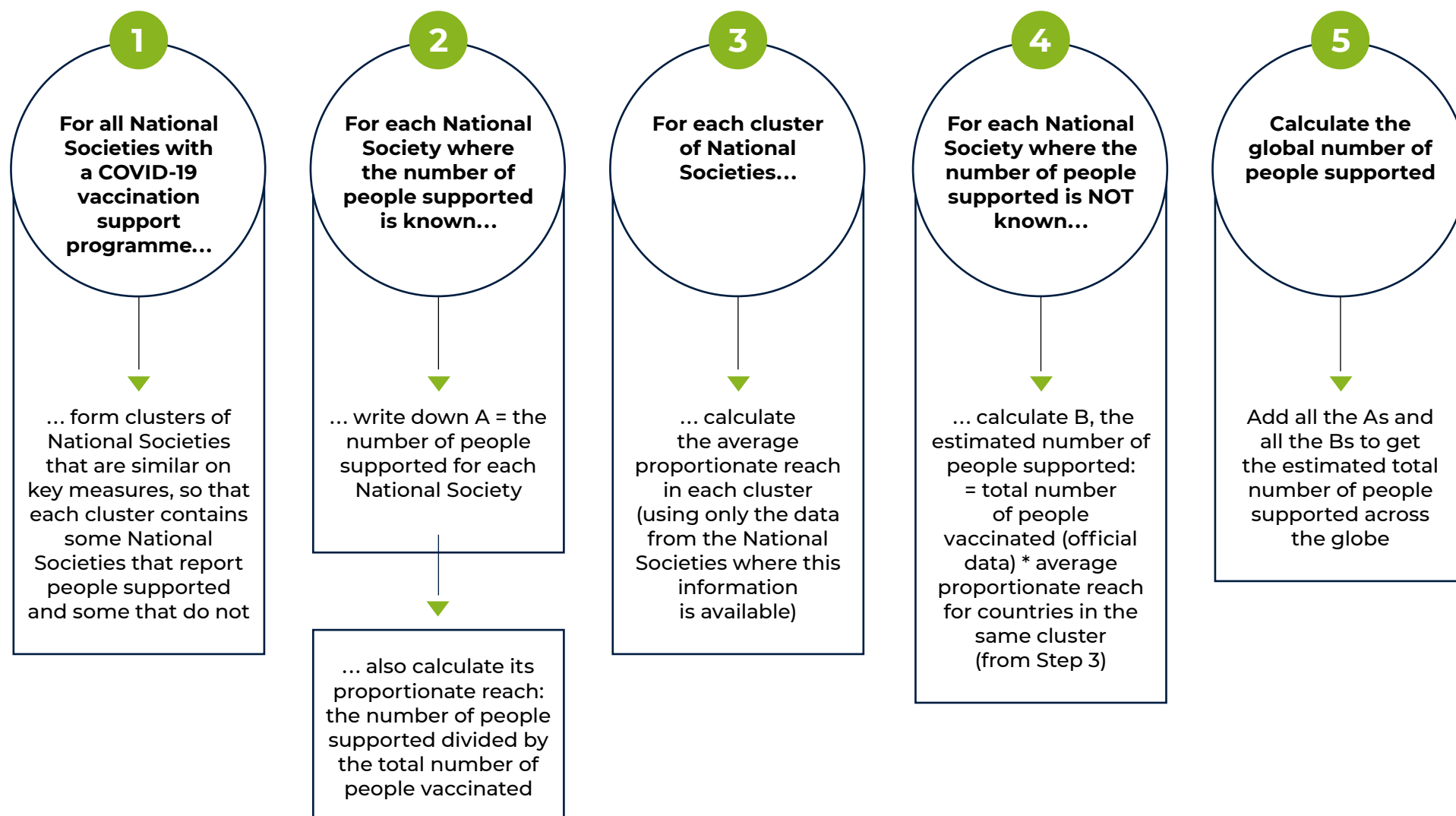


### Results of the estimation

Using data from the 20-month report (based on the model constructed for the 16-month report), the global figure for “people supported” for September 2021 was 207 million, of which 79.3 million (Total A) were actually reported by National Societies and 127.7 (Total B) were extrapolated for the National Societies not reporting.

This model, like all models, comes with caveats (see *Appendix to Chapter 7*). The real figures could differ from the estimated ones quite substantially; nevertheless, as this particular indicator is so critical and with so much of the data missing, an estimate like this is useful in giving a better picture of the contribution National Societies are making to the global vaccination drive.

**Figure 7–4** Steps to construct the global estimate of the number of individuals the National Society has supported to get vaccinated against COVID-19



## KEY MESSAGES

- ▶ Well over half of all National Societies were already active on COVID-19 vaccinations in the first quarter of 2022.
- ▶ Vaccinating an entire population is very challenging, and some governments were less able than others to do this; National Societies were often able to step up to fill some of the gaps.
- ▶ The number of individuals supported by National Societies to get vaccinated against COVID-19 is a particularly important indicator. However, as usual, this data is not available for every participating National Society, which means that the global figures are an underestimate. The IFRC Secretariat used a mathematical model to estimate the global “people supported” figure for September 2021 at 207 million, of which 79.3 million (Total A) were actually reported by National Societies and 127.7 (Total B) were extrapolated for the National Societies not reporting.
- ▶ This model, like all models, comes with caveats (see Appendix to Chapter 7). The real figures could differ from the estimated ones quite substantially. There is no perfect model, and there are other plausible ways to make this kind of estimate which would have arrived at somewhat different figures. Nevertheless, the estimate can help give a better picture of the contributions made globally by National Societies.





8

**WHAT DID WE  
LEARN AND WHAT  
COMES NEXT?**



## Which are the lessons that we have learned?

This report has once again shown how a systematic collection of data, combined with external sources, enables the IFRC to shed new light on the challenges and achievements of our National Societies and populations around the world up to this point in time. What will the future of the pandemic look like? To some, it may seem to be over, while others are faced by new waves of infections or are still struggling with the consequences: loss of family members, loss of

livelihood or indirect effects on health, such as children who have missed out on essential immunization.

To wrap up this report, we will highlight four aspects that will play a major role in our preparedness for the unexpected for the coming months and years.

### Innovating

Digital innovation provides us with tremendous opportunities to enhance our work, become more effective and drive new forms of humanitarian action that are emerging through the rapid advancement of digital technologies. Although we should be mindful of the emerging risks inherent in these technological advancements, digital innovation and transformation will continue to be central to the COVID-19 response.



**Kazakhstan 2021** The Red Crescent of Kazakhstan helps counter misinformation and vaccine hesitancy through a social media chatbot. © Red Crescent of Kazakhstan

### Improving equity

Many of the chapters of this report showed the unequal impact of COVID-19 on different countries and their populations and the different communities within them and unequal access to vaccines and other humanitarian support. These are issues that must remain in focus in the months and years to come.



**Afghanistan 2022** Afghan Red Crescent Society works to improve access to vaccines in remote districts across the country. © IFRC/Meer Abdullah

## Building resilience locally

Our National Societies worked with governments to jointly adapt responses to the unique challenges of each country. This required a combined approach including, among other things, support on public health, sanitation, shelter and economic security. Building local resilience means sustained investment in communities, building comprehensive health care at the community level and “building back better”. The *World Disasters Report* for 2022 consolidates the strong evidence that trust is essential in disaster response, including the response to a pandemic like COVID-19.



**Indonesia 2021** The Indonesian Red Cross Society runs community engagement campaigns through hand washing units, education to healthy practices to prevent the spread of COVID-19.  
© The Indonesian Red Cross Society

## Leveraging the unique added value of the Red Cross and Red Crescent

The IFRC network is the only organization in the world that links global and national resources with grassroots local actors and volunteers in 192 countries. Repeatedly throughout this report, we have seen how National Societies have been able to complement national and local government responses while at the same time leveraging the advantages of being linked to a global network of National Societies and the resources of the IFRC Secretariat.



**Peru 2021** Supporting the national vaccination campaign against COVID-19 of the Health Ministry of Peru for indigenous communities, the Peruvian Red Cross together with the IFRC and the ICRC implements the project “Facilitation of community dialogue and logistic support to the COVID-19 vaccination for hard-to-reach communities” © Reuters / ICRC / Sebastián Castañeda

# CONCLUSION

The *World Disasters Report* for 2022 highlights the central role of relevant, accurate and valid data in preparing for and responding to pandemics. The present edition of *Everyone Counts* can be seen as part of this effort. The experience of the pandemic will inform significant changes across the world in many areas, from global health frameworks and policies to how National Societies recruit and train volunteers. Relevant, accurate and valid data is key to that happening.

The data shows that National Societies experienced the pandemic differently and that governments reacted to it differently. Levels of access to testing, treatment and vaccines by people around the world differed between and within countries. This added to the complexity of the challenge facing National Societies and affected how they had to adapt.

National Societies responded with a very broad range of activities. Most had to implement new activities or carry out familiar ones on an unprecedented scale. Each National Society put together its own unique response based on its particular strengths and unique situation; no two National Societies responded in quite the same way. Every National Society had a high level of achievement on at least some indicators. These diverse efforts are particularly impressive when added together; for example, around 1.1 billion people were reached through RCCE.

In many cases, National Societies were well integrated into their government's response and were often able to provide services additional and complementary to those already offered by governments, especially in relation to vaccination.

Different data sources confirm the enormous diversity of peer support, the different ways in which National Societies supported one another during the pandemic.

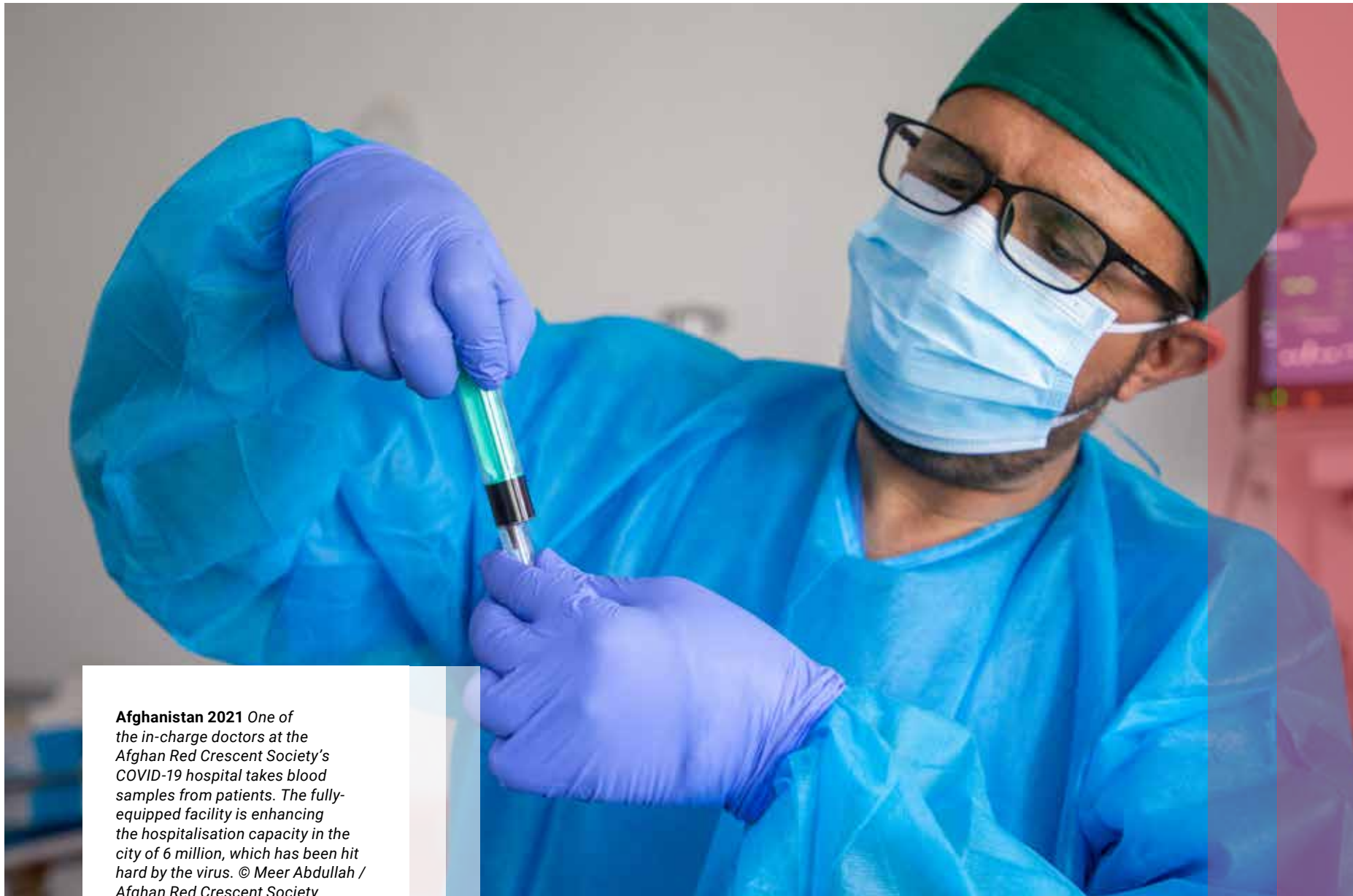
There is also a lot of narrative evidence that National Societies' preparedness and prior experience helped them respond to COVID-19.

Perhaps the most important message concerns equity: the fact that the experiences and situations of different people and communities are very different (and unequal) within and between countries. While some people in some countries might now be thinking that the pandemic is completely over and that it is yesterday's news, this is probably not true for anyone and certainly not for everyone.

**Nobody is safe until everybody is safe.**

**The pandemic is not over and nor is the response.**





**Afghanistan 2021** One of the in-charge doctors at the Afghan Red Crescent Society's COVID-19 hospital takes blood samples from patients. The fully-equipped facility is enhancing the hospitalisation capacity in the city of 6 million, which has been hit hard by the virus. © Meer Abdullah / Afghan Red Crescent Society



**+CIFRC**



**UKaid**  
UNITED KINGDOM AID

Лоиҳаи Андешидани чораҳои зарурӣ бо мақсади пешгирии  
сироятёбӣ аз коронавирус (COVID-19) дар Тоҷикистон.

COVID-19 Response Project in Tajikistan.

**БАСТАИ ХҶРОКА**  
**FOOD PARCEL**





# 9 APPENDIXES

## The data

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### The data repository

All the graphics, tables and calculations in this report were generated by scripts in the computer language R from raw data. The raw data and the scripts could be shared upon request and they are based on data collected until March 2022. Data included in the Foreword at p.8-9 and in the Conclusion p.116 is based on latest figures from the [30-month update](#).

Contact [fdrs@ifrc.org](mailto:fdrs@ifrc.org) for further details.

### Disclaimers and limitations

The analyses in this report are based on different datasets. Each dataset has its own limitations which also apply to these analyses. Readers are referred to the documentation for the different datasets.

In addition, the analyses themselves can introduce additional limitations. For example, when matching datasets by country, countries and territories may sometimes be present in one dataset but not in another. Furthermore, although we did subject the analysis scripts to peer review, we cannot be certain that we have eliminated all errors in coding.

### General limitations which may apply to all databases

Limitations may apply to all the databases, even though efforts have been made within each database to mitigate them. For example:

**Missing data:** data is not available for some indicator variables.

**Standardization:** global datasets are particularly vulnerable to differences between countries in the definitions of variables. When comparing countries or years, there may still be some limitations on the comparability of data due to differences in data collection methodologies, sample sizes, definitions and frequency of reporting.

## Appendix to Chapter 1

### Dataset: Oxford-policy

Short name (shown in figure captions)	Full name	Details	From	To
Oxford-policy	University of Oxford COVID-19 Government Response Tracker (OxCGRT)	Hale <i>et al.</i> (2021), “A global panel database of pandemic policies (Oxford COVID-19 Government Response Tracker)”, <i>Nature Human Behaviour</i> , <a href="https://doi.org/10.1038/s41562-021-01079-8">https://doi.org/10.1038/s41562-021-01079-8</a>  Data: <a href="https://github.com/OxCGRT/covid-policy-tracker/blob/master/data/timeseries/OxCGRT_timeseries_all.xlsx">https://github.com/OxCGRT/covid-policy-tracker/blob/master/data/timeseries/OxCGRT_timeseries_all.xlsx</a>	01 Jan 2020	31 Mar 2022

The COVID-19 Government Response Tracker developed by the University of Oxford (OxCGRT) systematically collects information on common policy responses undertaken by governments to address the pandemic across 20 indicators:

- eight containment and closure policy indicators (e.g. school and workplace closures, cancellation of public events, restrictions on gathering size and stay-at-home requirements);
- four economic policy indicators (e.g. income support to citizens and giving international support);
- eight health system policy indicators (e.g. COVID-19 testing policy, emergency investment in health care, facial coverings, public information campaign and, most recently, vaccination policy).

The data from these indicators is aggregated into a set of four common indexes, reporting a number between 1 and 100 to reflect the level of government action on the topics in question:

- an overall government response index (which records how the response of governments has varied over all indicators in the database, becoming stronger or weaker over the course of the outbreak);
- a containment and health index (which combines “lockdown” restrictions and closures with measures such as testing policy and contact tracing, short-term investment in health care and investment in vaccines);
- an economic support index (which records measures such as income support and debt relief);
- the original Stringency Index (which records the strictness of “lockdown style” policies that primarily restrict people’s behaviour).

## Appendix to Chapter 2

### Dataset: CI-tracking

Short name (shown in figure captions)	Full name	Details	From	To
CI-tracking	COVID-19 Indicator Tracking Data	Provided by IFRC FDRS team	01 Jan 2020	31 Mar 2022

Short name (shown in figure captions)	Full name	Details	Fixed time point
None	World Bank	Population and price level data; exchange rates	2020

How we created the achievement scores from the raw COVID-19 Indicator Tracking Data

What we did is this:

- Each original indicator is scored in a different way, for example, it might count the number of people reached or simply whether an National Society had adopted a certain policy or not.
  - » Converted binary indicators to numbers (0/1).
  - » Divided indicators that count people by the total population in order to be fair to smaller countries.

» For each indicator and for each National Society, we calculated a score for each quarter (3 months).

- If the National Society had more than one score in that quarter, we used the highest of the scores.
- If the National Society had not reported in that quarter but had in a previous quarter, we took the score from the previous quarter.
- Then, for each indicator, we ranked all these scores for all the quarters for all the National Societies and drew up a new standardized rank, giving 100 to the top score and 0 to the lowest.

This is a way to square the circle, to allow combinations of indicators of different types to be incorporated into one score per pillar or priority.

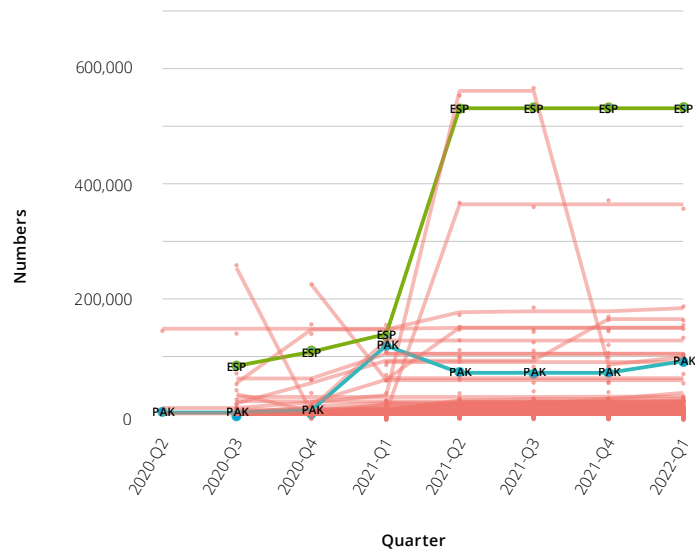
A score of 0 on a given indicator in a given quarter means that the National Society reported the lowest score, and a score of 100 means the National Society achieved the highest ever score over the whole response (relative to population, where relevant) of any National Society on that indicator. A missing score means the National Society did not report on that indicator at all.

These scores have the following advantages:

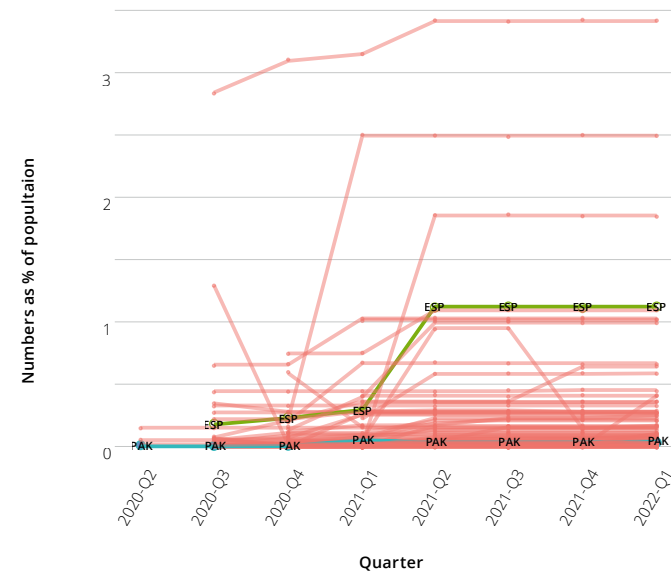
- they can easily be averaged, for example, to combine several indicators within one pillar;
- they can easily be totalled, for example, to sum several indicators within one pillar;
- they can be used to display change over time (because the ranking is based on all-time scores, not quarterly scores).

**Figure 9.1** How do you calculate the achievement score for each Priority for each National Society?

**Panel 1** Example: people reached with cash assistance, one of 44 indicators, raw numbers<sup>51</sup>



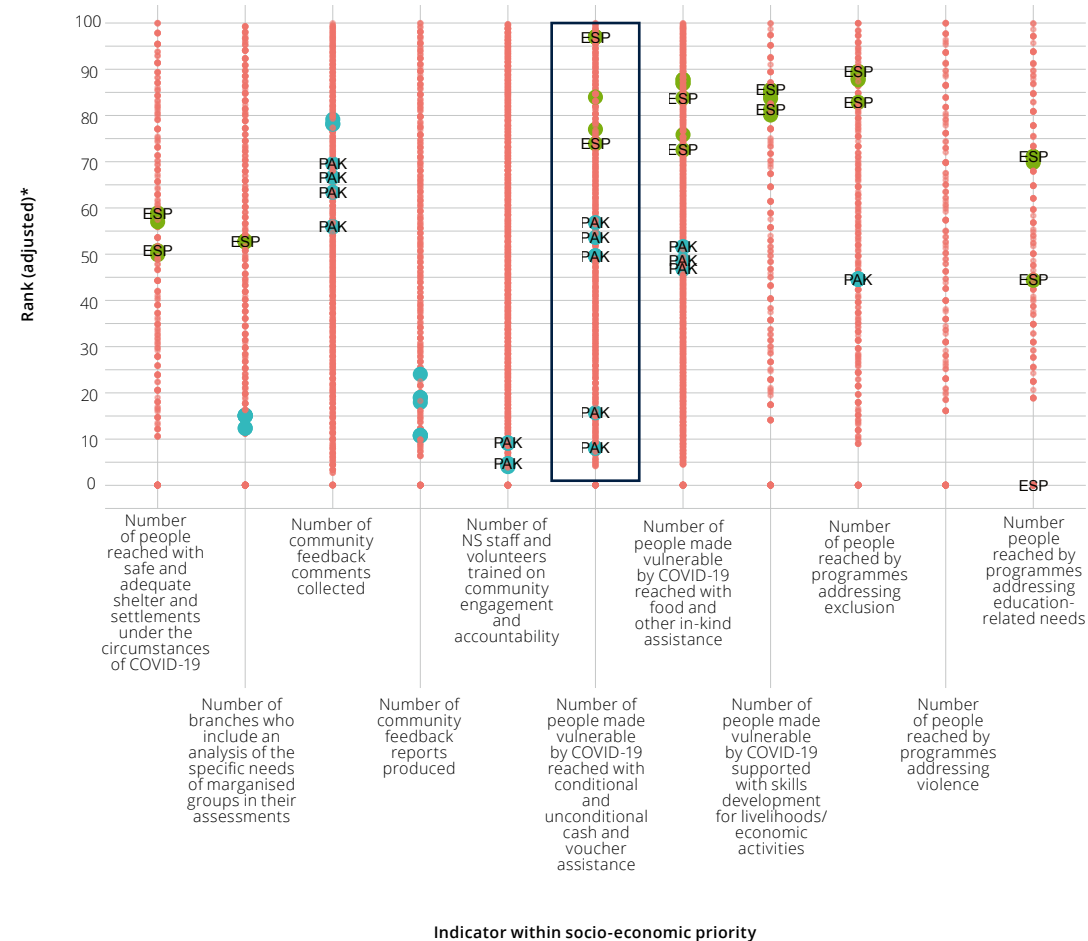
**Panel 2** Calculate population-corrected scores on the same indicator (as % of population)



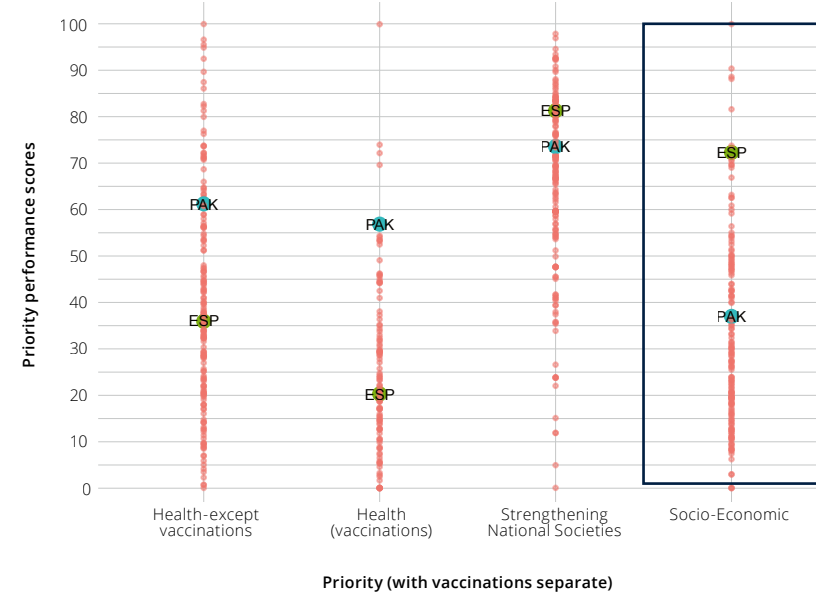
<sup>51</sup> Imputed numbers: if a National Society does not report in one quarter, but does for the previous quarter, the previous quarter is used. Any missing values still remaining are not assumed to be zero but are removed from the dataset.



**Panel 3** Collect together all scores for all time points for the “cash” indicator in panel 2 (blue outline)



**Panel 4** Create and average performance score for each NS, for each priority, ...



The figures illustrate how the performance scores are constructed.

### Panel 1

This panel looks at one indicator as an example: people reached with cash assistance, one of 44 indicators, highlighting two National Societies, Pakistan and Spain, which are shown in blue and green. For each National Society, there is a coloured point corresponding to its raw score on this indicator for each date. The dates (quarters or three-month intervals) are shown along the bottom. There are seven quarters from April 2020 to December 2021.

These raw scores are actually imputed numbers: if a National Society does not report an indicator in one quarter, but did for the previous quarter, then the value for the previous quarter is used. Where a National Society has no valid data for an entire indicator, the missing values are not assumed to be zero; they are removed from the dataset. Where, occasionally, a National Society reports more than once in a quarter, the most recent value is used.

### Panel 2

This panel is essentially the same as panel 1, but it displays figures as percentages of the population, dividing the raw scores by population \* 100. So, the score for Pakistan (with a large population) is relatively lower. Binary (yes/no) indicators and one indicator which is already a percentage are not divided by population in this way.

### Panel 3

Collect together all the ranks for all the time points for the “cash” indicator in panel 3 (blue outline) and condense them into one column alongside all the other indicators in the Socio-economic priority. For each indicator, all the scores in panel 2 over the whole pandemic are then ranked, that is, put in order

of size. Ideally, there would be seven quarters \* 192 National Societies = 1,344 data points in panel 2 (and panel 1), but in practice many are missing. Then, all these scores for this indicator are ranked. To make these ranks more comparable and intuitive, they are converted so that the top score is always 100 and the lowest score is 0. Even where there are fewer National Societies reporting, the ranks are stretched out (rescaled) over the interval from 0 to 100. These ranks are often shared, for example, many National Societies with zero as a raw data score will all get a rank score of 0.

Spain and Pakistan ranked high on this indicator in 2021; many scored lower.

### Panel 4

Collect together the ranks for every time point for every indicator within the Socio-economic priority in panel 4 (grey outline) and take the mean for each National Society to form an average performance score. The averages for the other priorities (with vaccination separate) are formed in the same way.

Also create a total performance score, the sum of the scores, and rescale these again so that 0 is lowest and 100 is highest (the average score is not rescaled).

One particularly interesting approach is to add achievement index values for each indicator within a pillar or priority and then rescale it to give a value between 0 and 100. In the same way, we can also create, for each indicator, pillar and priority, total achievement indexes across the whole pandemic. It should be noted that, although in practice it does not make much of a difference to the findings whether sums or means are used, the choice was made to use sums. This is because sums validate the other indicators and variables in this report slightly better than averages.

## Appendix to Chapter 3

### Dataset: GO-field-reports

Short name (shown in figure captions)	Full name	Details	From	To
GO-field-reports	Field Reports (IFRC GO database) <a href="https://go.ifrc.org/reports/all">https://go.ifrc.org/reports/all</a>	This analysis is based on a “web scraping” of the field reports database which was provided by the Netherlands Red Cross’ 510 team. It was further processed to identify the names of sending and receiving National Societies in the narratives in order to construct a list of technical and other collaborations between National Societies, identifying the National Societies sending and receiving support.	01 Jan 2020	End Jan 2022

The **IFRC GO database** contains around 3,000 field reports from 2020 and 2021. These reports give status updates on activities in ongoing emergencies, such as tropical storms, droughts and other types of emergencies. The reports are submitted either by the implementing National Society or by an international partner. While some reports include activities related to COVID-19, others only contain separate activities. Although the reports do not cover all the activities conducted by National Societies, the selection of projects it includes provides numerous examples of the local and international reach of National Societies.

Two fields (“NS action” and “PNS action”) within these reports are analysed to see if they involve international collaboration with other National Societies. They are treated as “international collaboration” if a National Society other than the reporting National Society is named<sup>52</sup> in the Partner National Society (PNS) or National Society action field; otherwise they are treated as “local”. Any kind of assistance is classified as a “collaboration”, including a simple transfer of funds.

52 Matching against official English, Spanish and French versions of National Society names, with or without “Society”.

## Dataset: FDRS-partnerships-2017-19

Short name (shown in figure captions)	Full name	Details	From	To
FDRS-partnerships 2017–19		List of collaborations between National Societies extracted from the FDRS data for 2017–2019.	01 Jan 2017	31 Dec 2019

## Dataset: COVID-financial

Short name (shown in figure captions)	Full name	Details	From	To
COVID-financial		Information about financial support between National Societies. This (cumulative) data is provided in most cases by both sending and receiving National Societies. To generate overall totals sent within each partnership (from one sending to one receiving National Society), if the sending National Society ever reported, we take the last value reported by them; if not, we take the last value reported by the receiving National Society, converted into CHF where necessary.	01 April 2020	31 Dec 2021

## Appendix to Chapter 4

In order to make the FDRS data up to 2019 comparable with the COVID-19 achievement index, we create FDRS achievement indexes in just the same way as we did for the COVID-19 Indicator Tracking Data (see Chapter 2): we take the original data, divide by the population where appropriate, rank the National Societies and convert these ranks into numbers from 0 to 100, so that for any

given indicator, a score of 100 represents the highest achievement. This gives six relevant FDRS indexes, such as number of people reached with cash transfer programming, and we can also construct a seventh variable, the *total* of all the relevant FDRS indexes, as shown on the horizontal axis of Figure 4-1.

### Dataset: FDRS-achievements-2019

Short name (shown in figure captions)	Full name	Details	Fixed time point
FDRS- achievements-2019	FDRS achievements 2019	Achievements in the FDRS database for National Societies in 2019	2019



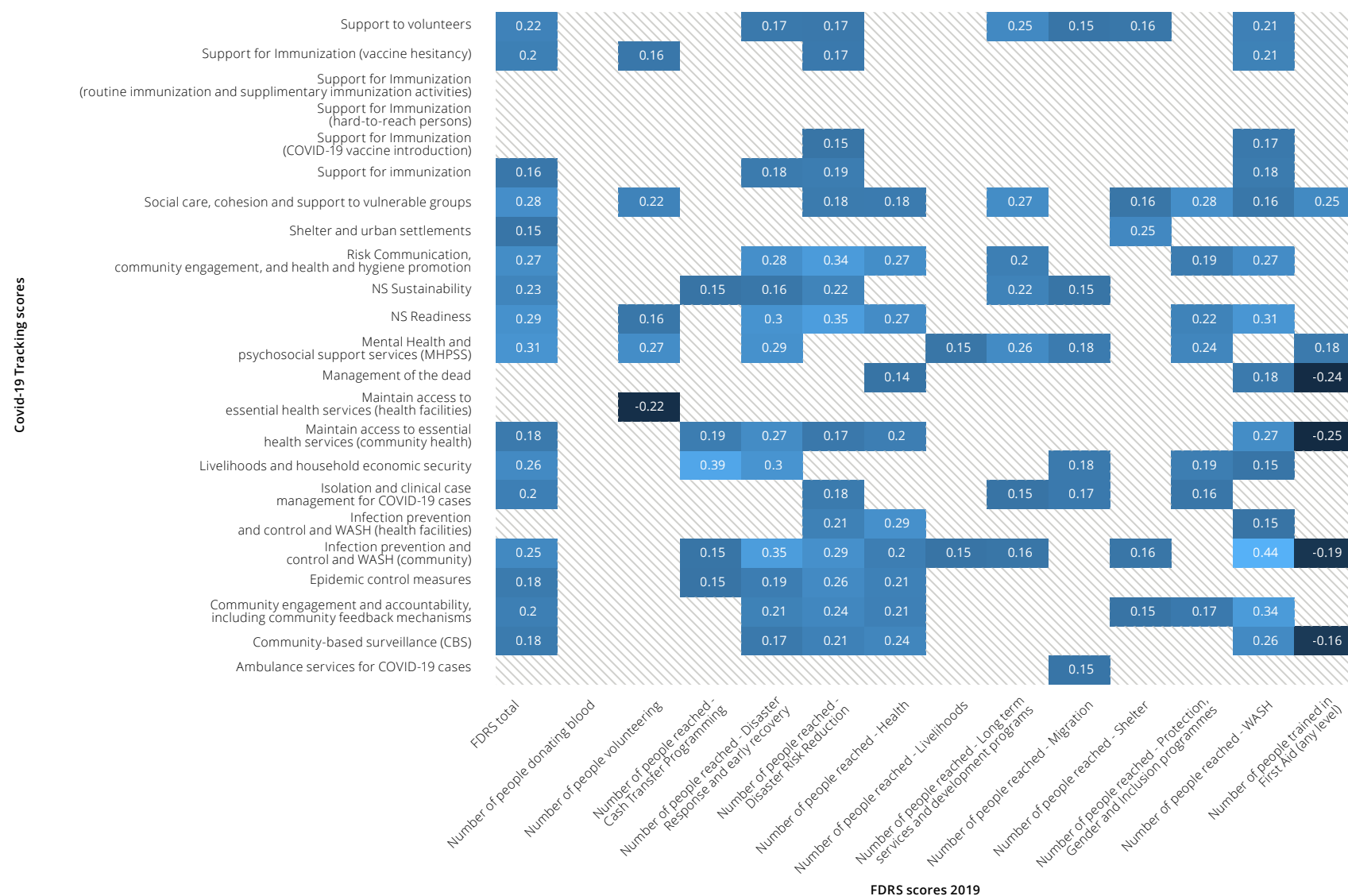
Short name (shown in figure captions)	Full name	Details	From	To
None	PER 2016–19	<p>MASTER PER assessment DATA – Component level 171121.xlsx</p> <p>This dataset provides details of each National Society that completed each stage of the PER process.</p>	01 Jan 2016	31 Dec 2019
None	Appeals 2016–19	<p><a href="https://goadmin.ifrc.org/api/v2/appeal">https://goadmin.ifrc.org/api/v2/appeal</a></p> <p>DREFs and Emergency Appeals from 2016 to 2019 for each National Society. We imported the database and formed a score, adding 1 for each DREF and 2 for each Emergency Appeal. We also formed a similar score just for the DREFs and Emergency Appeals which were classified as being for epidemics.</p>	01 Jan 2016	31 Dec 2019

Short name (shown in figure captions)	Full name	Details	Fixed time point
GHS-risk	The GHS Risk Index	<p><a href="https://www.ghsindex.org/report-model/">https://www.ghsindex.org/report-model/</a> (only 2019 data was used)</p> <p><b>The GHS Index</b> (<a href="https://www.ghsindex.org">https://www.ghsindex.org</a>) is a collaboration between the Nuclear Threat Initiative, the Johns Hopkins Center for Health Security, and Economist Impact. It measures the capacities of 195 countries to prepare for epidemics and pandemics.</p>	2019

## Dataset: INFORM-risk

Short name (shown in figure captions)	Full name	Details	Fixed time point
INFORM-risk	INFORM Risk	<p>INFORM is a collaboration of the Inter-Agency Standing Committee Reference Group on Risk, Early Warning and Preparedness and the European Commission.</p> <p><a href="https://drmkc.jrc.ec.europa.eu/inform-index/">https://drmkc.jrc.ec.europa.eu/inform-index/</a></p>	Various dates in 2019 and 2020

**Figure 9–2** Correlations between overall performance on all FDRS Key Performance Indicators**Figure 9–2.** Correlations between overall performance on all FDRS Key Performance Indicators 2017–2019 and all COVID-19 Tracking Pillars during the pandemic. Correlations in the grey squares are not statistically significant and are therefore not shown.

## Appendix to Chapter 5

### Dataset: Excess-deaths

Short name (shown in figure captions)	Full name	Details	From	To
Excess-deaths	Economist model	<a href="https://github.com/TheEconomist/covid-19-the-economist-global-excess-deaths-model">https://github.com/TheEconomist/covid-19-the-economist-global-excess-deaths-model</a>	01 Jan 2020	31 Mar 2022

Data from a model created by the *Economist* magazine.<sup>53</sup> This figure of “(estimated) excess deaths” uses governments’ official excess death numbers, whenever and wherever they are available, and the model’s estimates in all other cases. The model takes official excess death estimates where they are available and compares them with a database of 121 relevant indicators (population, mobile phone use, life expectancy, amount of international travel, etc.).

Then, the same model is used to predict excess deaths wherever official excess death indicators are missing.

This dataset includes data on reported deaths as well as (estimated) excess deaths over the whole pandemic, together with cumulative totals and the additional variables, such as population, mobility and demography-adjusted IFR, used in the model.

<sup>53</sup> <https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates>

## Appendix to Chapter 6

### Dataset: Causal-mapping

Short name (shown in figure captions)	Full name	Details	Fixed time point
Causal-mapping	Causal mapping of Solferino Academy volunteer stories	In April and May 2020, in the early stages of the pandemic, the Solferino Academy invited volunteers around the world to submit their stories. These stories can be viewed and explored at <a href="https://solferinoacademy.com/ourcovidstory/">https://solferinoacademy.com/ourcovidstory/</a> .	April–May 2020

This was not a random sample of IFRC volunteers but rather a snapshot of volunteers who happened to hear about the survey through different channels. Results are therefore not representative of the IFRC's volunteer network.

The stories were translated into English using Google Translate and were analysed by Steve Powell, Irena Hrkas Rozajac and Hannah Mishan using causal mapping.

While the term “causal mapping” goes back at least to Robert Axelrod,<sup>54</sup> literature on the theory and practice of causal mapping includes a few canonical works as well as book-length interdisciplinary overviews and guides to particular approaches.<sup>55</sup>

As analysts continue with this work, they add to an ever-growing set of “causal factors”, such as “volunteering in COVID-19 situation” and “feeling truly useful”. So, the analyst tries to find common factors mentioned by several of the volunteers – as with ordinary qualitative data analysis.

This approach enables the analyst to look for patterns and trends across the dataset and to understand which narratives of change are common across the set of stories and which are specific to certain individuals or to a particular group of respondents in order to understand how people in general and sub-groups of people see and understand what causes what around them.

This is a type of qualitative data analysis, but rather than just looking for general themes (such as “fear” or “contacted National Society”), as in traditional

54 Robert Axelrod (1976), “The Cognitive Mapping Approach to Decision Making”, in Robert Axelrod (ed.), *Structure of Decision: The Cognitive Maps of Political Elites*.

55 F. Ackermann and C. Eden (2004), “Using Causal mapping: individual and group; traditional and new”, *Systems Modelling: Theory and Practice*, pp. 127–145; A.S. Huff (1990), *Mapping strategic thought*, John Wiley & Sons; M. Laukkanen and P. Eriksson (2013), “New designs and software for cognitive causal mapping”, *Qualitative Research in Organizations and Management: An International Journal*, 8(2), pp. 122–147; V.K. Narayanan (2005), “Causal mapping: An historical overview”, in V.K. Narayanan and D.J. Armstrong (eds), *Causal mapping for research in information technology*, IGI Global, pp. 1–19; A.J. Scavarda, T. Bouzdin-Chameeva, S. Meyer Goldstein et al. (2004), “A review of the causal mapping practice and research literature”, *Second World Conference on Production and Operations Management*, 21 pp.



qualitative data analysis, analysts are instructed to identify passages of text where people talk about how one thing causally influenced another. For example, if a volunteer says...

*Volunteering in this situation made me feel truly useful as I had never felt in any previous volunteering*

... this could be coded as a link from “volunteering in COVID-19 situation” to “feeling truly useful”.

The analysts only code statements related to the volunteers themselves – their thoughts, fears, actions and so on. We code causal claims directly connected to the activity of National Societies and their volunteers. So, we might code a claim about independent volunteering which someone did because it then led them to volunteer for the National Society, but not if it was just a story on its own.

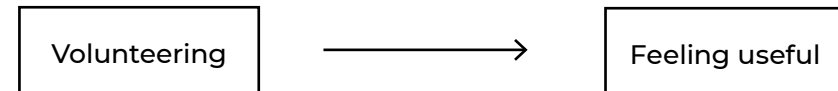
## Hierarchical coding

The analysts applied hierarchical coding to add extra levels of detail to more general factor labels. The different levels of a factor are separated by a semicolon. You can read the semicolon as “in particular” or “specifically”. So, in this example:

*Volunteering in this situation made me feel truly useful as I had never felt in any previous volunteering*

... this could be coded as a link from “volunteering; in COVID-19 situation” to “feeling good; feeling truly useful”. Zooming out to the most general point of view, we can read this as “Volunteering → Feeling good”.

Like all qualitative data analysis, this type of analysis is subjective – it is more like asking a journalist to make a summary of the stories than, say, asking a statistician to count the frequency of different words used. The results are certainly not representative of any particular population.



The point of this is not so much to look at the numbers or to “prove” that something really caused something else, but rather to try to gain an insight into how the volunteers were thinking and what they think influenced what, especially in terms of motivation and action.

The analyst can use these levels to “zoom” in and out to explore and present different views of the data. Maps might be zoomed in to show only the first level of a factor (with all the sublevels nested within it) or zoomed out to present all the levels. Most maps in this report use zoom level 1 to improve map readability.

In some cases, it was hard to distinguish between the causal factor “NS action” and “Volunteer action”. We talk about volunteer action when there is no specific mention of the Red Cross Red Crescent, and we code a passage as “NS action” when there is no specific mention of volunteers or their inputs.

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The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest humanitarian network, with 192 National Red Cross and Red Crescent Societies and around 16.5 million volunteers. Our volunteers are present in communities before, during and after a crisis or disaster. We work in the most hard to reach and complex settings in the world, saving lives and promoting human dignity. We support communities to become stronger and more resilient so people can live safe and healthy lives, and have opportunities to thrive

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