

WORLD DISASTERS REPORT 2022  
**TRUST, EQUITY AND LOCAL ACTION**

Lessons from the COVID-19 pandemic to avert the next global crisis

To ensure that we do not repeat the same mistakes, the critical lessons from this pandemic must be embedded into national laws, policies, budgets and actions.

The *World Disasters Report 2022* is a contribution to this effort and calls for greater investment in domestic and local preparedness: preparedness to prevent, detect early and respond quickly to future outbreaks and other shocks and stresses.

The report underscores the importance of preparedness based on the principles of trust, equity, and local action.

**Trust**, because pandemic countermeasures, including vaccines, public health information and isolation measures, will not be accepted unless there is trust.

**Equity**, because pandemics thrive on and aggravate inequity and cannot be controlled until access to services and critical products, including vaccines, is guaranteed in law and available in practice.

**Local action**, because pandemics begin and end in communities, and because governments need to leverage and support local action to build resilience, trust and agile health systems.

Most importantly, the report recommends several practical approaches and programmes that show how these principles can be addressed through community prevention and preparedness, stronger community health systems, protection and support of frontline responders, legal preparedness, and better use of local data.

We have a historic opportunity to strengthen disease outbreak preparedness in the coming years by putting local communities at the centre. All of us – governments, the international community, and partners – have a critical role to ensure that opportunities are not squandered. The IFRC network commits, in line with our mandate, to stand by governments and communities to support this process in law and in action.



*Jagan Chapagain*  
**IFRC Secretary  
General**



# EXECUTIVE SUMMARY

## LEARNING FROM COVID-19 TO BETTER HANDLE FUTURE DISASTERS

### COVID-19 is a disaster without recent parallels

**The coronavirus pandemic has been the biggest disaster in living memory, by almost any measure.** Over 6.5 million people are confirmed to have died in less than 3 years – or about 1 in 1,000 people by the most conservative estimates (WHO, no date) – an order of magnitude larger than that of any recorded earthquake, drought or hurricane. Industries and entire economies have been devastated: the International Monetary Fund has estimated that the pandemic will cost the global economy US\$13.8 trillion by the end of 2024 (Gopinath, 2022). The socioeconomic impacts of the pandemic, meanwhile, are also enormous.

**Furthermore, the pandemic's indirect impacts have touched the lives of virtually every community on the planet.** No disaster in recent decades has had such sweeping impacts. This means that everyone now has some exposure to disaster management, or mismanagement, because we have all endured the pandemic and its consequences.

Figure E.1: The death toll from COVID-19 (2020–present) compared to the most severe disasters of the 21st century to date



Source: EM-DAT, no date; WHO, no date; ReliefWeb, no date; Dawood et al, 2012.

**On the other hand, not everyone has suffered equally.** In many cases, the pandemic aggravated existing inequities and mistrust, both between and within countries. Sadly, in some cases, the health countermeasures taken to respond to it sometimes had a similar effect, particularly when they ignored or impeded local and community action, rather than leveraging it for greater preparedness.

# We weren't prepared, and we need to be

This report focuses on preparedness: both the ways preparedness ahead of COVID-19 was inadequate, and how to prepare more effectively for future public health emergencies. We must now prepare our societies for the next public health emergency. Being truly prepared therefore means being ready to prevent, respond and recover, and to learn lessons for next time. In other words, preparedness is an ongoing, continuous process.

**Many countries were unprepared for COVID-19.** Some did not have a plan for a disease outbreak of this magnitude. Others had allowed key elements of their preparedness to lapse – for example, cutting spare bed capacity in hospitals in the name of efficiency, leaving healthcare systems unable to handle the surge in COVID-19 patients. Crucially, many countries had not invested enough in preparedness at the local level and were not able to leverage the local preparedness that did exist. Those countries most successful in combating the spread of COVID-19 had built resilient healthcare systems and social safety nets, and they had learned the lessons of previous coronavirus outbreaks like severe acute respiratory syndrome (SARS) in 2003. These countries still had to adapt and still found aspects of the pandemic difficult, but they had a cushion that others did not.

**As of the time of writing, all countries remain dangerously unprepared for future outbreaks.**

Despite the COVID-19 pandemic showing the world the importance of being prepared, countries are not ready for another public health emergency. For example, the 2021 *Global Health Security Index* – while an imperfect preparedness analysis tool – analysed 195 countries on six categories of preparedness for health emergencies, including detection, response and societal norms. It concluded that none are ready for future epidemics and pandemics (Bell and Nuzzo, 2021). Rated out of 100 on their preparedness, not one country scored above 80. Worse, the global average was just 38.9, almost exactly the same as the last assessment in 2019, indicating there has been no real improvement in health emergency preparedness.

**Furthermore, true preparedness means being ready for multiple hazards, not just one.** One of the biggest surprises of the COVID-19 pandemic was that many countries that were seemingly well prepared for a disease outbreak struggled to cope with the coronavirus. It also goes beyond pathogens: societies that prepare well for disease outbreaks but neglect to prepare for extreme weather events will still find themselves vulnerable if a hurricane strikes. Societies can only become resilient by developing disaster frameworks that can handle multiple types of hazard, which can occur simultaneously.

**We need to start preparing now, because our world is becoming increasingly hazardous.** In 2021, 378 disasters were recorded – not including disease outbreaks – which is higher than the 20-year average of 337 disasters per year. Many countries had to respond to hazards like hurricanes and floods while also dealing with COVID-19. Much of the increase in hazards is driven by a rise in climate- and weather-related disasters. Alongside this, the 21st century has seen a wave of disease outbreaks, of which COVID-19 is just one, albeit the largest. This increasingly hazard-prone world demands a global effort to help communities develop preparedness, to reduce the burden of suffering and mortality.

# Trust, equity and local action are key to preparedness

**Preparedness is only effective if founded on trust, equity and local action.** In the wake of COVID-19, many reports and analyses have highlighted the importance of preparedness for future disease outbreaks, and for disasters generally (see Introduction). However, after reviewing these global evaluations (for example Sachs et al, 2022; IPPPR, 2021) and IFRC's internal learnings (for example Johnston, 2022; IFRC, 2021), we identified three key elements of preparedness that are largely being neglected in the recommendations of other reports, despite being essential for success. These elements are **trust, equity and local action**. The IFRC highlights the importance of trust, equity and local action throughout this report. They are the common threads running through our recommendations. The COVID-19 pandemic, as well as long experience with other crises, has taught us that neglecting these factors has enormous social, economic, physical and mental costs.

**TRUST** *Preparedness means building trust. Indeed, trust is one of the best predictors of a successful response to any emergency.* At every stage of the disaster management process – most crucially prior to an emergency – it is essential to build trust throughout communities and societies, something the COVID-19 pandemic made abundantly clear. When people trusted public health messages, they were willing to comply with public health measures that sometimes separated them from their families for months at a time in order to slow the spread of the disease and save lives (see Chapter 2). Similarly, it was only possible to vaccinate millions of people in record time when most of them trusted that the vaccines were safe and effective, or at least better than the alternative. But the reverse is also true: when trust is fragile or lacking, public health becomes political and individualized. In the past years we have learned that the pandemic both fed on and fueled political, economic and personal tensions, impairing our ability to respond.

**EQUITY** *Preparedness must include provisions for greater equity, because public health emergencies both thrive on and aggravate existing inequities.* Major hazards like disease outbreaks and extreme weather events have extremely inequitable impacts, causing the most harm to those who are already poor, dispossessed or otherwise vulnerable. This is often compounded by inequitable preparedness frameworks, which fail to assist those who need help the most. In a pandemic, this approach is self-defeating: so long as the disease is spreading in one sector of the population, it can still return in a more contagious or dangerous form. But it is also corrosive to society if some groups are left to suffer the long-term impacts of a disaster. If a society isn't helping everyone, it isn't truly prepared. It is therefore essential to bolster social protection programmes, foster inclusion, and achieve universal health coverage.

**LOCAL ACTION** *Preparedness must be local, because action at the community level is an essential component of any effective hazard response.* From disease surveillance to earthquake shelters, local actors are on the front line, meaning they are well placed to achieve real change (see Chapter 2). Local actors like our National Society volunteers form a bridge between authorities and communities, and they are well placed to observe decision making at all levels. Local action harnesses the collective knowledge and actions of a community; for example, people often know their neighbours and are conscious of the most vulnerable. Working closely with communities also allows responders to identify their true wants and needs, and to understand why they are reluctant to adopt health measures such as vaccination. In contrast, top-down government action, imposed without engagement with communities, may fail to reach marginalized groups or to serve the specific needs of each community. This is fatal because diseases spread

at the weakest links in the chain, so a lack of community surveillance allows them to infect ever more people. Instead, local action makes use of the bonds of trust that exist between local businesses, organizations and communities. The IFRC's experience with community health systems, including preparedness and community engagement, illustrates the vital importance of working at the local level and how effective community-based interventions were often the most effective during the COVID-19 pandemic.

**Embracing trust, equity and local action will enable society to better handle future disease outbreaks and other hazards.** In the following chapters we address six key activities – all of which contribute to building preparedness. They are:

**1. Strengthening prevention and preparedness at the local level.** Our experience indicates that countries that prepared more for disease outbreaks handled COVID-19 – and sometimes multiple overlapping emergencies – better.

**2. Leveraging the roles and capacities of communities and local actors through integrated community health systems.** In many countries the capacities of local actors like community health workers were not used to their full potential, hampering the COVID-19 response. This happened because these local actors were not supported or coordinated with the wider health system. Similarly, communities were not sufficiently involved in the design of programmes, so responses did not necessarily meet their needs.

**3. Building global solidarity mechanisms** to ensure that pandemic response products reach all communities. Many communities have not had sufficient access to pandemic response products like vaccines. This was partly a failure of international distribution and partly lack of capacity in domestic programmes like community engagement and logistics. The situation was exacerbated by an ongoing failure to give more humanitarian funding directly to local actors.

**4. Protecting communities against the socioeconomic impacts of public health emergencies.** Many governments rapidly strengthened their social protection systems to cover more people and offer more effective and rapid assistance, often in the form of cash transfers. However, a number are now treating this as a temporary measure and scaling back their efforts, leaving people again unprotected. Furthermore, there are many barriers preventing communities from accessing essential services.

**5. Collecting local data and harnessing it to take action.** The pandemic has been both a triumph and failure of data collection, analysis and use. 'Traditional' epidemiological data like virus genotyping has been gathered and shared with remarkable speed. However, the pandemic has also seen a continued failure to collect more and better social and economic data in order to better understand people's beliefs, needs, vulnerabilities and capacities.

**6. Strengthening legal preparedness for public health emergencies.** Legal frameworks create an enabling environment for all the other actions. However, many countries' public health emergency laws were outdated, ill-adapted, or did not align with other emergency frameworks. There are also gaps at the international level. This contributed to chaotic responses in many countries. Our public health emergency laws need to be updated and reviewed so that future disease outbreaks can be handled more effectively.

**Based on these findings, we have developed a set of overall recommendations.**



## **The consequences of poor decisions and recommendations to address them**

The findings and recommendations made throughout this report have addressed what we see as gaps in the COVID-19 response to date. Moreover, as we head into negotiations on the International Health Regulations and on a new pandemic agreement at the World Health Assembly, and as we observe the direction that some domestic authorities are taking at home, we see areas of serious concern. If left unaddressed, these issues could lead us to either repeat the mistakes of the past, or aggravate existing inequities and tensions.

In the next three sections, we address our key concerns about trust, equity and local action – and how to resolve them. Finally, we present three measurable targets for the next three years.

## Trust

**Top-down social control measures** like lockdowns and vaccine passports, when implemented without trust and transparency, **often lead to polarization and create resistance to public health measures.**

Moreover, **a narrow focus on increasing communication campaigns and countering misinformation will not build trust. It may even backfire** in situations of political and social unrest, or discrimination.

Trust can only be built through:

- **Proximity:** People trust people they know, such as local actors.
- **Education:** People trust what they understand, via health literacy programmes.
- **Listening:** People trust those who listen to them and act on their concerns, such as trained community engagement specialists who gather feedback and analyse it.
- **Access to services:** People trust those who address their needs, including their basic health and social protection needs.
- **Ownership:** People trust measures they feel ownership of and are consulted on.

Just as importantly, **building trust is a process that cannot wait until a crisis occurs.**

### *We urge governments to promote:*



**Community ownership of emergency preparedness plans:** Design, implement and monitor whole-of-society and whole-of-government preparedness plans that leverage the capacities and knowledge of local actors and communities to prevent, detect and respond early to disease outbreaks and public health emergencies.

**Active listening and community engagement:** Create or scale up meaningful, two-way community feedback mechanisms that record community concerns, needs and suggestions, and collect and analyse them to adapt public health measures when possible and as needed.

**Access to services and education through stronger community health systems:** Invest in or strengthen **community health systems.** These include all the actors, infrastructures and services that promote community health, ranging from information and services to emergency preparedness and programmes addressing the determinants of health. They include water and sanitation systems and strong mental health and psychosocial support.

## Equity

**Developing the supply side of pandemic response products, without addressing the demand side, undermines access and uptake of these products by countries and communities**, especially the most vulnerable and hard to reach.

*The international community and domestic authorities should promote:*



**Domestic capacities to distribute pandemic response products, including through local actors:** Invest in domestic capacity to store, transport and distribute these products through better funding, training, advance notice and the necessary laws/policies to facilitate the movement and distribution of the goods. The contributions of local actors to this process are critical given their access to isolated and marginalized areas, and to disaster- and conflict-affected areas.

**More flexible, predictable humanitarian funding:** Where government capacities need to be complemented by international humanitarian organizations or recognized local actors, reform humanitarian funding to make it more equitable, predictable, flexible and accessible to local actors.

**Community confidence and interest in pandemic response products:** Invest in meaningful community engagement programmes to promote community uptake of these products. Such programmes should be complemented by transparent information on the timing, method and location of the distribution, as well as on the choice of product.

**Equitable and fair distribution of indemnification and liability risk,** including for humanitarian organizations, and limitations on how long manufacturers can be exempted from purchasing indemnification and liability insurance for new products.

**Development and production of pandemic response products that are less expensive, easier to store and administer and just as effective:** Such products are essential for countries that do not have the capacity to purchase, store or administer more expensive and complex products.

**Limiting discussion of equity to the question of equitable access to pandemic response products is short-sighted.** There are many other concrete and critical measures that can help address inequities in pandemic preparedness, by addressing the drivers of disease outbreaks and their differentiated impacts.

***The international community and domestic authorities should promote:***



**Equitable access to information:** This includes domestic obligations to create early warning/early action systems for their populations.

**Equitable access to domestic health and social protection services:** This must include: guaranteeing rights to basic health countermeasures and social safety nets, regardless of legal status; strengthening social protection systems before a crisis occurs, including through joint vulnerability assessments; and increasing local access to health services through community health systems.

**Equitable and needs-based access to humanitarian assistance:** This should include reducing the use of earmarked humanitarian funding to allow for more flexible, needs-based assistance across countries and time. Such flexibility is essential because of the considerable variations in how disease outbreaks evolve.

**Greater emphasis on multi-hazard prevention (primary, secondary and tertiary) and preparedness:** This will help to mitigate or avoid the impacts that epidemics and pandemics have on the most vulnerable. It will also address the possibility of compounded shocks and stresses, such as economic or social shocks, earthquakes, weather- and climate-related events, and conflicts.

## Local action

While domestic authorities will always have the primary responsibility to manage public health emergencies, **overly centralized and medicalized approaches to pandemic prevention, preparedness and response cannot address the local complexities of emergency management.** These complexities include: a variety of risk factors and drivers of disease; the unpredictable social, economic and physical/mental effects of a disease; and people's attitudes to public health measures and risk.

Moreover, **a failure to include other actors, and to leverage and support local knowledge and capacities, can rapidly lead to overwhelmed government services and systems.**

### *Domestic authorities can address this by:*



**Recognizing and integrating recognized and trained local actors into domestic emergency and health systems:** This includes the design, implementation and monitoring of **multi-hazard national emergency preparedness plans and legal frameworks** and recognizing their **contributions to health systems strengthening, especially community health systems** (in this case, we refer to approaches such as task shifting – the transfer of non-medical but health-related tasks to trained local actors).

**Providing trained and recognized local actors with the legal protections and facilities they will need to carry out their tasks:** This includes priority access to personal protective equipment and pandemic response products; exemptions from movement of goods and personnel as public health warrants; and the financial support, training and oversight that they need to meet quality, living and safety standards.

**Working with communities** to design, implement and monitor **domestic emergency preparedness plans** for prevention, early action and response.

# Measurable objectives for the next three years

The next pandemic could be just around the corner: if the experience of COVID-19 won't quicken our steps toward preparedness, what will? Governments can take concrete action immediately by following this three-point plan.

1

By the end of 2023, every country should have **updated pandemic preparedness plans** and should have reviewed the relevant legislation to see if it too needs updating.

- Plans should include **concrete measures** to strengthen equity, trust, and local action.
- Legislative reviews should bear in mind, among other things, the **need for a holistic approach** to crisis response, clarity of roles and responsibilities, and the needs of recognized local actors for personal protective equipment and appropriate exemptions from movement restrictions.

2

By 2024, **adopt a new treaty and revised International Health Regulations**, which include concrete and measurable obligations to:

- **Strengthen** equity and trust.
- **Promote** better domestic and international legal governance of pandemics.
- **Invest in and support** the range of services and inputs that can be provided by recognized local actors and/or communities.

3

By 2025, **increase domestic health finance by 1% of GDP** and **global health finance by at least US\$15 billion per year** (G20, 2021; WHO, 2019).

- A much greater proportion of global financing for both public health and humanitarian action must also flow to **the local and community level**.
- Global financing should be **more predictable and flexible** to allow for more effective and needs-based action.

# CONCLUSIONS

The COVID-19 pandemic stands out as the most severe disaster to strike humanity for many decades, and certainly in the 21st century. The number of deaths caused by COVID-19 since 2020 outstrips the fatalities from other non-conflict disasters from the last few decades by orders of magnitude.

Nevertheless, other disasters have continued to take place alongside COVID-19. In 2020–2021, Asia-Pacific was the most badly affected region on all measures: number of disasters, number of people affected, and number of deaths.

COVID-19 is also part of an overall trend in increasing hazards and more frequent disasters. The number of disasters occurring per year has increased over the last five decades. The proportion of these disasters caused by climate- and weather-related hazards has increased over the last few decades, based on those recorded in EM-DAT. There has also been an increase in the numbers of disease outbreaks and epidemics over the last 40 years, according to several studies. This increase is not observable in the EM-DAT data, but this is due to the database's limited representation of disease outbreaks. In contrast, the number of disasters caused by geological hazards has stayed broadly constant.

This rise in climate- and weather-related disasters, and in disease outbreaks, means disasters are increasingly overlapping in time and/or space, or occurring in rapid succession. Over the last 60 years there has been an increase in the number of instances of countries experiencing two or more disasters in the same year.

When disasters overlap or occur in rapid succession, they may exacerbate each other's impacts. There is evidence that disasters affect more people if they are closely preceded by another disaster, or if another disaster occurs at the same time in the same country – and especially if it occurs in the same first-level administrative region. Similarly, there are multiple instances where disasters triggered by natural hazards appear to have driven spikes in numbers of COVID-19 cases.

The sobering conclusion is that we now live in a multi-hazard world, in which communities will frequently be confronted with multiple hazards like disease outbreaks, floods and heatwaves. This poses a considerable preparedness challenge.

As a result, communities frequently found themselves trying to respond to an emergency while also dealing with the ongoing threat of the coronavirus. Multiple, overlapping crises cause greater harm. For example, they place increased pressure on public services, including health systems. During the pandemic, first responders have often been unable to reach certain areas due to movement restrictions. People often spend their savings to recover from the first shock, leaving them with no buffer when another shock arrives. Disasters like floods create unsanitary conditions, which favour the spread of pathogens. COVID-19 was an exceptional disaster – but it was also one of many.

## What went wrong: A review of prior reports

The COVID-19 outbreak happened in the 21st century, in a globalised society with access to resources that were almost inconceivable a century ago when the 1918 influenza pandemic took place. For all our knowledge, technology and wealth, humanity was not ready to respond rapidly or efficiently enough to such a public health emergency. Nor were we prepared to deal with the multiple overlapping crises that have compounded the pandemic's impacts.

Multiple reports have examined our response to COVID-19 and how it was impacted by our preparations (or lack of them) for disease outbreaks. These studies offer a wealth of information about the ways governments and the international community prepared themselves for health emergencies, both where those preparations were effective and where they were incomplete or poorly targeted. There are also reams of data on how our health systems, and other public services, performed during the pandemic. In this section we review some of the key reports and their findings. In the following section, we explain how this *World Disasters Report 2022* stands out.

An invaluable overview of lessons learned from the pandemic is provided by the *Lancet* COVID-19 Commission in their report published in September 2022 ([Sachs et al, 2022](#)). The commission describes the death toll as “a massive global failure” and identifies 10 examples of where international cooperation faltered. These included several failures to implement the International Health Regulations (IHR) (2005). Many of the gaps in the response occurred early in the pandemic and were defined by slow or delayed action.

The Independent Panel for Pandemic Preparedness and Response (IPPPR) makes similar points in its major report ([IPPPR, 2021](#)). The IPPPR also focuses on the early phases of the pandemic. They argue that the initial outbreak could have been contained rapidly were it not for a series of mistakes. First and foremost, multiple warnings that the world would face a pandemic were not taken seriously. Preparedness was underfunded and countries did not do enough stress testing. Second, when the initial COVID-19 outbreak was identified and declared a Public Health Emergency of International Concern, too many countries took a ‘wait and see’ approach, instead of moving swiftly to contain the virus and forestall a pandemic. Third, international tensions were allowed to undermine global leadership. Fourth, response funding was too slow, so many countries suffered shortages of essential equipment like diagnostic testing kits. Finally, a failure to take a whole-of-society approach meant the pandemic widened inequalities: disproportionate impacts have been felt by women, vulnerable and marginalized populations like migrants and refugees, and by children whose education has been disrupted or terminated.