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MAJOR DISEASE OUTBREAK RESPONSE

Why the delay? Perspectives of national and local actors on progress toward locally led outbreak readiness and response

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Contents

Introduction

Locally led outbreak readiness and response is not new. Local actors have always played a critical role in preparing for and responding to disease outbreaks. National and subnational non-governmental organizations (NGOs), civil society organizations (CSOs), community-based organizations (CBOs), and faith-based organizations (FBOs) are often well positioned to support affected and at-risk communities by leveraging their knowledge and local networks.

Recent disease outbreaks in humanitarian settings (such as COVID-19, Ebola in the Democratic Republic of Congo (DRC), and cholera in Syria) have highlighted the long-standing need for international actors to better recognize and appreciate the value of local actors and their existing capacities and to foster collaboration to support local leadership and strengthen skills and resources.[1,2] The need for donors, UN agencies, and international organizations to shift leadership, authority, and decision-making power to national and local actors is well documented, as is the need for the humanitarian landscape to shift from competition to collaboration. The #ShiftThePower movement[3,4] and growing demands for the decolonization of aid have accelerated and amplified this discourse. However, commitments such as the Grand Bargain[5] have not been fully realized. For example, there has been no tangible increase in direct funding to local actors, although signatories remain committed to the policy and practice changes implied in the original vision.[6] Similarly, the Pledge for Change[7] was intended to galvanize action,[8,9] but progress has remained slow.[10,11] Yet there are signs of a renewed commitment to localization by global actors, including efforts by the Directorate-General for European Civil Protection and Humanitarian Aid Operations (DG ECHO) to systematically translate Grand Bargain commitments into action through its policy framework, advocacy, and programming.[12]

Existing outbreak coordination mechanisms can often affect the ability of local and subnational actors to engage effectively in outbreak response and to have influence and decision-making power. In contrast to the global humanitarian cluster system, response coordination for infectious disease outbreaks varies, and there is no consistent approach across countries and outbreaks. A country's national ministry of health (MoH) or relevant health agency usually leads the overall response. It may receive technical and operational support from the World Health Organization (WHO), depending on the size and scope of the epidemic, the capacity of the national government, the epidemiology of the disease, and the setting and context of the epidemic. In addition, the MoH or other relevant health agencies

Mwanza community members receive a COVID-19 vaccine

may delegate activities to other UN agencies, government agencies, or NGOs.[13] If there is a pre-existing humanitarian response and the cluster system has been activated, WHO will usually take the lead in linking the health cluster to the outbreak coordination mechanism, such as an emergency operations center (EOC) or a nationally led specialist coordination taskforce. In 2020, local and national NGOs held only 11% of co-chair positions in the cluster system and only 6% of humanitarian country team membership positions.[14]

During major disease outbreaks, including those classified as public health emergencies of international concern (PHEIC), multiple challenges impede international, national, and local organizations from meaningfully engaging in the response. For example, decision-makers, including UN agencies and national authorities, often have limited knowledge of the role that international non-governmental organizations (INGOs)/ NGOs and local organizations can play and the contributions they can make. In addition, when there is an international surge in response to large outbreaks, national and local organizations can be overshadowed. This leads to their exclusion from important structures responsible for coordinating response efforts, communication, and resources.

Negotiating the complex networks of actors within outbreak coordination and management systems is an additional challenge for local actors working in countries that are in protracted humanitarian crises (also supported by multiple—and often different—global actors). While there are differences in how local actors engage in humanitarian response and in disease outbreak readiness and response, it can be difficult to differentiate between localization efforts in each response context, as the challenges faced by local actors are largely the same. Barriers to localization are often magnified when responding to a disease outbreak, but they remain persistent in the complex humanitarian environment with which local actors engage every day.

As humanitarian needs, including those specific to disease outbreaks, continue to grow, donor funding to meet these needs is not keeping pace. The 2022 Global Humanitarian Overview (GHO) requirements reached $51.7 billion by the end of the year to assist 326 million people in need of humanitarian aid.[15] Despite record funding levels in absolute terms, the funding received against the 2022 GHO requirements amounted to $25.9 billion, or 50%. This shortfall has catastrophic consequences for at-risk and affected populations and directly impacts locally led action.

The Global Health Cluster reported that 62% of health cluster countries received less than 20% of the funding needed to provide life-saving health services to affected populations in 2022.[16] Recent outbreak-specific response appeals, such as the 2022–2023 Sudan Ebolavirus disease outbreak in Uganda and ongoing COVID-19 plans

Nurse Hamda, reminds families of the eight steps of hand washing, in order to prevent the spread of COVID19

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Healthcare workers at a Save the Children-supported facility in Congo

in humanitarian settings, also remain underfunded. Insufficient funding for outbreak response means that allocations to local actors are often not prioritized, limiting their ability to respond rapidly and effectively. Where funding is available, it is disproportionately allocated to international actors. Funding for local actors remains a fraction of overall aid funding (between 1.2% and 3.3% in 2018–2021) and far below the Grand Bargain target of 25%.[17] This prevents local actors from occupying leadership positions and perpetuates reliance on international actors.[18,19]

About this paper: scope and structure

This paper centers on the **perspectives of national and local organizations** working in humanitarian settings, specifically highlighting their recommendations for enabling locally led action during infectious disease outbreaks. The paper consolidates local perspectives on what needs to happen to accelerate change for effective and meaningful locally led action in preparing for and responding to major disease outbreaks in humanitarian settings and to better respond to the holistic needs of affected populations. The findings will provide a foundation for dialogue and future cooperation between local and global actors to move towards concrete action, accelerate power shifts, and overcome localization inertia.

The intended audience is primarily global humanitarian actors, including international NGOs, UN agencies, and donors. However, the key actions outlined should be of interest and use to all those involved in planning, coordinating, and implementing outbreak readiness and response, including national health authorities, national non-governmental actors, and local actors, including NGOs, CSOs, FBOs, and CBOs, who may also use the paper for their own advocacy purposes.

The paper draws on evidence from a literature review, consultations with global humanitarian actors (i.e., donors, UN agencies, international NGOs, a global network of CSOs), and key informant interviews with local/subnational and national actors in four countries: DRC, South Sudan, Syria, and Yemen.[i] These countries were selected because they are humanitarian settings with complex and protracted crises and have experienced or are at risk of major disease outbreaks. Annex 1 provides a brief overview of the humanitarian context and recent outbreak situations in each of these four countries, highlighting the complexity within which local actors are working. Annex 2 summarizes the methods and approach used to develop the paper and the working definitions for local/subnational, national, and global actors.

Key themes were identified from the three sources (literature review, consultations, and key informant interviews). The preliminary findings were presented at three validation sessions to gather additional insights and reflections and to discuss ways to accelerate effective localization in outbreak readiness and response in humanitarian settings.

The paper is structured around four Key Actions, developed and framed according to the priorities articulated by local/subnational and national actors (see Box 1). Each Key Action is addressed in turn, synthesizing the perspectives expressed by the actors consulted and concluding with bullet points outlining *what needs to happen*. These bullet

i The perspectives of government ministries of health (MoHs) and national (public) health institutions were beyond the scope of this paper. It should be noted that these actors are key decision-makers and implementers in disease outbreaks, and further research may be warranted to understand their priorities regarding localization in readiness and response.

points are based on the priorities articulated by local, subnational, and national actors preparing for and responding to disease outbreaks. They are intended to prompt collective action and shared responsibility and are not recommendations directed at any particular actor.

Box 1. Four Key Actions for Locally Led Outbreak Response

Key Action 1

Commit to *localization* as a process that places locally led action at the center of disease outbreak readiness and response.

Key Action 2

Redesign humanitarian architecture and emergency coordination mechanisms to prioritize locally led action in disease outbreaks.

Key Action 3

Recognize and support effective outbreak readiness and response initiated by local actors.

Key Action 4

Trust local organizations to define their technical and organizational needs and capacities and leverage knowledge and skills sharing between actors in different geographic contexts.

During the consultations, subnational and national actors shared examples of efficient and effective outbreak readiness and response that were locally initiated, led by local actors, and used existing capacity and resources. Five *local insights* are presented throughout the paper to provide recent examples of locally led action in outbreak response (see Box 2). Each local insight was developed and written in collaboration with the local actor(s) concerned. Collectively, the local insights demonstrate the potential impact that local actors can have and highlight lessons learned from the localization approaches implemented.

Box 2. Local Insights

1. Locally led response to the COVID-19 outbreak in Syria.
2. Promoting locally led disease outbreak readiness and response through local advocacy in Yemen.
3. A locally led response to a cholera outbreak based on community engagement in Yemen.
4. A fully locally led rapid outbreak response, leveraging locally available resources in South Sudan.
5. Supporting the MoH to compile its own data and analytics to inform local outbreak response in the DRC.

Key Action 1

Commit to *localization* as a process that places locally led action at the center of disease outbreak readiness and response

This Key Action directly addresses local/subnational and national actors' interpretations of localization. Local/subnational and national actors emphasized the use of the preferred term locally led action to mean an approach or process, a shift in both mindset and structures toward locally driven outbreak readiness and response. They stressed that localization should not be seen as an end result or an outcome in itself. Instead, they emphasized the need for less centralized funding mechanisms and operations, more inclusion, greater power and capacity to lead, and more use of existing capacities, resources, and systems. Local/subnational and national actors saw these factors as critical to achieving genuine locally led action. When discussing interpretations and operational definitions of localization in outbreak readiness and response, participants often focused on localization efforts within the broader humanitarian sector as the context for localization in outbreak response.

Lack of clarity in the definition of *localization*

There is a lack of clarity and agreement on the definition of localization, and there is no definition specific to localization in disease outbreak readiness and response. This implies that different actors operating at different levels may interpret localization differently. We need to recognize these varying perspectives, as potentially conflicting priorities may influence both the impetus for and the localization process.

The Organization for Economic Cooperation and Development (OECD) defines localization as a process: ***"Localizing the humanitarian response is a process of recognizing, respecting and strengthening the leadership by local authorities and the capacity of local civil society in humanitarian action, in order to better address the needs of affected populations and to prepare national actors for future humanitarian responses."***[20]

The actors consulted for this paper echoed the lack of consensus around the term, suggesting that different agencies and stakeholders often tailor definitions of localization to their own scope of work and approach and can vary across and within operational settings and countries. National and subnational/local actors referred to localization as a locally led response and response processes that emerge from the local context. Although many of the issues raised are also relevant to preparedness and readiness, all the national and subnational/local actors consulted focused on localization in relation to response rather than readiness or recovery.

Local/subnational actors consulted emphasized that localization means that local actors have the power and capacity to lead and implement outbreak responses with international support only when and where needed and requested and that international actors should promote local insights and knowledge.

National actors consulted discussed equitable partnerships with equitable pay for international and national/local actors, strengthening organizational capacity, and the need for response processes to emerge from the local context. They also highlighted the need to support national governments to lead decision making and suggested that decisions should be made at the intersection of government and civil society.

Global actors consulted described changing how they support local actors, adapting policies and programs, and ensuring that local actors have the necessary resources and capacity to support their communities. Some international actors also highlighted community engagement and community feedback mechanisms as key aspects of locally led action, particularly during major disease outbreaks, when rumors and mistrust of global actors (and the origin of an outbreak) often circulate.

Despite the fraught terminology, the local/subnational, national, and global actors consulted agreed that key components include creating improved and less centralized funding mechanisms; building inclusive coordination mechanisms that are more accessible to local actors; and recognizing, leveraging, and strengthening existing local capacities, resources, and systems. The paper discusses each of these key components in more detail in Key Actions 2, 3, and 4.

"It means to empower local actors to take the lead, make their own decisions and not be fund- driven, and to be able to do their interventions more quickly and effectively, to sustain themselves, and to have more space for decision-making."

(Subnational actor, Syria)

Rejecting the term *localization*

The inherent tension between who is a local actor and who is not, however defined, perpetuates the power imbalance between "us" and "them."[21] The use of the term *localization* often suggests that it is an outcome or result in itself and implies that international organizations are the instigators or "doers" of localization.

There is therefore a growing tendency to problematize or reject the term altogether, with critics arguing that it avoids tackling overarching systemic issues, such as racism and colonial legacies, and by its very nature obscures and undermines the work that local actors are already doing. Many local/subnational and national actors consulted emphasized that they preferred the terms *locally led* and *locally driven* action as more appropriate and fit for purpose.

"I deliberately don't want to use the word localization because I think it is inherently problematic. I deliberately don't use the word, which is pejorative. ...It is uncomfortable; it implies that what we are working to do is to translate something that is fundamentally international to something that is local; the reality is that what really counts is already here."

(National actor, Syria)

Decentralization is not localization

The drive for localization has led many international organizations to decentralize their operations through local branches, national partners, or affiliates whilst simultaneously requiring local organizations to adopt the standards,

Monowara Khanan, an assistant community medial officer, assesses Redwan

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processes, and procedures of their international counterparts.[22,23] The affiliated organization then has access to the larger pool of resources, capacity, and funding available to the INGO.[18,22] However, this can create new hierarchies of local organizations and raise the question of whether local organizations affiliated with an international organization continue to be "local."

Similarly, the practice of registering the country office of a large INGO as a national organization places it in direct competition with local actors but with the advantage of having access to international technical and funding support.[22–24] While such organizations often employ national staff as country office directors, it is unclear whether this represents any kind of power shift if the system itself has not changed. Some INGOs have explicitly denounced such practices and have been careful not to conflate them with localization efforts within the humanitarian sector.[25] Global actors should be clear about their approach to localization and report transparently on changes at different levels (i.e., global, regional, national, and local) in the process.

This *internationalization of local organizations* (rather than transforming the international humanitarian system into a locally driven) can be interpreted as expansionist and neocolonial. Local actors, by definition, do not need to localize—they are *already* local. The Pledge for Change, a mutual commitment between Adeso and various INGOs, has chosen to focus on non-competition between local organizations and INGO-affiliated locally registered organizations rather than focusing energy on attempting to seek consensus around evolving definitions of who is local, national, or global.[7]

"When we talk about shifting power, are we serious about it? Are we willing to do it? We need brave decisions to be made."

(National actor, Syria)

What needs to happen

- There needs to be a broad commitment to localization as a constructive process that puts locally led action at the center of disease outbreak readiness and response. Localization should not be seen as an end result in itself.
- Global actors (INGOs, UN agencies, and donors) must clarify their approach to *localization* in general and in relation to outbreak readiness and response in particular. Find opportunities to share knowledge about the changes (positive and negative, intended and unintended).
- There needs to be recognition that *internationalizing local organizations* does not equate to *localization*. Expansionist organizational and business models that maintain decision-making power in high-income countries must be challenged.

Key Action 2

Redesign humanitarian architecture and emergency coordination mechanisms to prioritize locally led action in disease outbreaks

This Key Action emerged from the ongoing frustration expressed by local/subnational and national actors regarding their lack of decision-making power, limited access to flexible and long-term funding, and lack of voice and agency in existing humanitarian and outbreak coordination mechanisms. Actors at all levels shared positive examples detailing greater involvement of local actors in coordination mechanisms and decision-making processes, as well as new funding modalities. However, it was recognized that these were small, often isolated examples within both the complex humanitarian system and outbreak response coordination. Local/subnational and national actors felt that the ultimate goal should be to transform the entire system to be truly locally driven.

Transform humanitarian architecture and the concentration of power

Many national and subnational/local actors consulted framed their discussions on localization in terms of their experiences of working in a humanitarian setting against the backdrop of emerging threats, including disease outbreaks.

There was acknowledgement among those consulted that the current humanitarian architecture is a product of colonialism, with decision-making and financial power largely held by donors, UN agencies, and INGOs.

Local/subnational and national actors highlighted that while localization is increasingly visible in organizational frameworks and guidelines, the rhetoric implies a reluctance to challenge the status quo. There was frustration among the local/subnational and national actors consulted that this mindset persists.

The UN's new Emergency Relief Coordinator's Flagship Initiative, currently being piloted in four countries (Colombia, Niger, the Philippines, and a region of South Sudan), aims to "*reinvent the way the [humanitarian] system runs at country level*," moving towards a less bureaucratic and more agile way of working and transforming intractable structural problems and power imbalances.[26] This, together with the priorities outlined in the new UN Office for the Coordination of Humanitarian Affairs (OCHA) strategic plan (2023–26),[26] is an important call to action for global stakeholders. Less clear, however, is the extent to which these transformative ambitions are on the agenda of local organizations.[27]

"The biggest barrier to localization—we don't want it. There is a very strongly rooted colonial and control aspect to humanitarian response, and the whole system comes from countries that are not exposed to Ebola, cholera, measles, etc. Telling countries how and what should be done and making guidelines and responses and strategies—this is not local, full stop."

(National actor, DRC)

Michelle*, Ebola community health worker, DRC

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Create new funding modalities

Although outbreak response coordination mechanisms vary by country and outbreak event, the national MoH or other relevant national agencies usually lead the overall response. In this context, locally led action can be challenged by limited resources, particularly when a response is largely funded by international donors.[ii]

Global, national, and subnational/local actors all identified funding issues as critical. The global actors consulted highlighted that funding allocations to local actors do not meet agreed commitments (e.g., the Grand Bargain), and actors at all levels confirmed that significant changes in funding modalities are needed to effectively and efficiently resource locally led response efforts. Local actors emphasized their frustration at being "overlooked" in favor of INGOs, and some national actors consulted suggested that decision-making is tied to resources, with those holding more resources having more influence over decisions.

Moreover, the funding available to local actors is insufficient to enable them to respond rapidly and effectively to crises, including outbreaks.[23,28–33]

Humanitarian and outbreak response funding also tends to be short-term. This affects smaller local NGOs, which may not have access to diversified funding streams or unrestricted or institutional funding to fill gaps. Actors consulted at all levels emphasized that short-term funding negatively impacts local actors: it prevents them from retaining staff, maintaining organizational capacity, and deploying rapidly in the event of an outbreak. These entrenched financial barriers are also recognized in much of the recent humanitarian literature.[33–36]

Consulted actors also highlighted that funding is often conditional on donor priorities, further reducing the decision-making capacity of local/subnational and national actors.[23,37] The recent Grand Bargain signatory meeting (June 2023) included multi-agency discussions on more realistic funding mechanisms.[38] Advocacy by other major donors for more direct funding and equal partnerships[38,39] signals a shift in the right direction, but operationalization of concrete action at the local level is still needed.

ii It was acknowledged that with limited (or no) preparedness, emergency funding will never be sufficient to respond to a crisis, especially a sudden-onset crisis or disease outbreak. While some national and subnational/local actors highlighted that underinvestment in their organizations prevented them from hiring staff and strengthening capacities that could help them better prepare for the next outbreak, none of those consulted specifically discussed the preparedness funding landscape as such.

"Local organizations don't sufficiently have a voice. When an outbreak happens, you need to respond, but if you don't have pre-positioned funding. ...You have staff capacity and experience, but it's only those who have the funds who can respond. The funds are in the hands of international partners; we don't have direct access to donor funding, and anyway, that does not cover indirect costs."

(Subnational actor, DRC)

Dedicate space for local actors in humanitarian and outbreak coordination mechanisms and decision-making

Actors consulted at all levels highlighted that both humanitarian and disease outbreak coordination mechanisms are complex and exclusive. This is also widely acknowledged in the existing literature.[40–43] A recent global mapping by the Inter-Agency Standing Committee (IASC) found that local and national organizations are present in 80% of humanitarian country teams but account for only 9% of their leadership.[18,19]

Some subnational/local actors consulted participated in humanitarian cluster meetings and in disease outbreak coordination structures (i.e., pillar and cross-pillar technical working groups). Still, their role was often limited to information sharing, and they were not involved in decision-making. Smaller organizations and those working with vulnerable populations, as well as unregistered CBOs, were described as often being sidelined in coordination structures, thus exacerbating inequalities in partnerships. This may be partly due to limited resources, pre-existing relationships, and unfamiliarity with coordination mechanisms, but their lack of representation is problematic.

Some actors suggested that language (when meetings are held only in dominant international languages such as English, French, or Arabic) and the use of jargon are also barriers to participation. Internet connectivity, transportation, funding, and time were also mentioned as obstacles to participation, and it is known that such issues can be exacerbated by public health measures such as movement restrictions and social distancing. In general, it was felt that there is limited space for local/subnational, national, and global actors to coalesce to discuss shared challenges and work collaboratively towards solutions.

Many local/subnational and national actors consulted shared frustrations about their lack of voice, lack of access to decision-making platforms, and restricted agency. However, perceptions of progress in including local actors in decision-making varied by country and by organization, with actors in Syria and Yemen reporting greater inclusion than their counterparts in the DRC and South Sudan.

It was therefore encouraging that a number of actors consulted who were working in larger and established subnational and national NGOs shared positive examples of participation in both humanitarian and disease outbreak coordination structures, including leading outbreak-specific task teams. National and subnational actors in South Sudan described platforms such as the locally led South Sudan NGO Forum, which was established to actively coordinate humanitarian response efforts with international organizations, including outbreak response, and in Syria, the Assistance Coordination Unit worked with local health authorities to lead the COVID-19 preparedness and outbreak task force in the northwest of the country (see Local Insight 1).

What needs to happen

- Redesigning the international humanitarian system to be more locally driven must be a collective priority. While new global initiatives have transformative ambitions, they may continue to represent global rather than local priorities.
- Both humanitarian and outbreak coordination structures and decision-making processes need to be made accessible and inclusive. More agile ways of working need to be adopted, and structural barriers and power imbalances must be overcome to ensure the representation and inclusion of a wider range of local/subnational actors in decision-making.
- Funding models for both humanitarian and outbreak response need to be reconfigured to provide local actors with access to flexible/unrestricted, long-term, and direct funding, as well as funding that strengthens longer-term organizational capacity and sustainability. Donors should commit funds for anticipatory action so national and subnational/local actors can better predict and prepare for crises, including major disease outbreaks.

Local Insight 1: Locally-led response to the COVID-19 outbreak

Country: Syria
Partnerships: Assistance Coordination Unit (ACU) with local authorities in North Syria
Response: COVID-19 outbreak (2021)

"The taskforce for preparedness and outbreak in northwest Syria is a great example of us, as a local actor, contributing to decision-making and shaping response strategies. We are leading it, and this will enable us to extend our robust experience at the subnational level to other areas."

(Subnational actor, Syria)

"The preparedness for the COVID-19 outbreak was a pilot experience for us, shifting dependence on the humanitarian relief/support from UN agencies to local authorities or funds."

(Subnational actor, Syria)

Locally led action: The ACU operates in an area of northern Syria that is only accessible from Turkey; there are no government authorities present, and UN agencies from Damascus cannot access the area. As the ACU, we leveraged our unique position and ongoing presence in the area to advocate for urgent action by local health authorities and to mobilize local capacity during the COVID-19 outbreak. As a result of our advocacy, facilities operating within the Early Warning Alert and Response Network (EWARN) received donations of supplies and equipment (e.g., swabs and viral transport media [VTM] for testing, laboratory equipment, polymerase chain reaction [PCR] kits, and personal protective equipment [PPE]) from local health authorities funded by Turkish agencies. With our support, the locally led response allowed facilities in the area to establish a PCR laboratory, expand their EWARN team to respond to the outbreak, and deploy public health officers during the response. ACU began working in the area in 2021, and we relied entirely on our own organization's funds until we received funds from the US Bureau for Humanitarian Assistance (BHA) in October 2022. The PCR lab is still operational and supported by a BHA-funded project.

Learning: The COVID-19 task force established by WHO was initially responsible for funding COVID-19-related activities in northwestern Syria. However, due to a lack of funding and the fragility of the cross-border resolution with Turkey, WHO re-oriented the taskforce as the Surveillance and Outbreak Preparedness and Response (SOPR). WHO delegated responsibility for funding the outbreak response to international organizations and directed the SOPR to collaborate with local authorities to maximize the response. This approach, shifting away from dependence on UN agencies for humanitarian support and disease outbreak response, highlights the effectiveness of channeling funds directly to local organizations for them to lead the response.

Key Action 3

Recognize and support effective outbreak readiness and response initiated by local actors

This Key Action calls for greater recognition of the essential role of local/subnational and national partners in disease outbreak readiness and response and for greater visibility of their work. It was clear from local/subnational and national actors' experiences that efficient and effective outbreak response is initiated locally by local actors, but it was less evident that global actors recognized and supported these actions. Local actors were frustrated that their outbreak response work was not recognized or considered important by international actors; they also insisted that local solutions to outbreaks must be developed and supported. This Key Action also serves as a reminder that while equitable partnerships are emerging in the context of outbreak readiness and response and local skills, knowledge, and relationships are being leveraged, the rate of progress in changing attitudes, shifting power, and strengthening mutual trust and respect is too slow.

Nurture equitable partnerships that give visibility to the work of local actors

Many INGOs have strengthened their partnership principles, and some long-term equitable partnerships with shared goals and visions were identified by the local/subnational, national, and global actors consulted. Donor governments, such as the United States and the European Union, are promoting equitable partnerships with local responders. For example, USAID has committed that by 2030, 50% of all its programming will "*place local communities in the lead*" to set priorities, co-design projects, drive implementation, and evaluate program impact.[18,39,44] A similar shift is occurring at the country level. A group of subnational actors in Yemen, for example, reported that by developing a consortium of local partners focused on local advocacy, they helped push INGOs and UN agencies to consider localization, and large grants now come with donor requirements for INGOs to partner with local actors (see Local Insight 2).

Despite some positive progress, unequal partnerships persist, and local actors continue to operate as sub-contractors.[iii] The reliance on subcontracting means that local organizations are not fully recognized in response efforts, that INGOs and UN agencies retain decision-making power, and that there is little direct investment in the subcontracted organizations themselves.[40] Further, actors consulted stressed that donor regulations, including onerous due diligence, reporting requirements, and inflexible partner selection criteria, favor international or, in some cases, large national NGOs. Local actors resent the lack of visibility, recognition and respect afforded their work. Often, the logos of international organizations or donors are prominently displayed, while the identities of local partners remain obscured.

iii Subcontracting refers to the outsourcing of specific tasks or services by a global organization or agency. This often involves delegating aspects of the work to local or national organizations called subcontractors or implementing partners. Subcontractor relationships tend to be more transactional, while partnerships tend to be more egalitarian, prioritising collaboration, trust, and shared decision-making.

"Before support starts reaching our villages, we [local actors] are the first to respond to an outbreak, but our work is not being considered. I wish my work was acknowledged and considered as helping to make changes."

(Subnational actor, DRC)

Leverage local skills, knowledge, and community relationships for an effective locally led outbreak response

Actors consulted at all levels agreed there are clear advantages to involving local actors in outbreak readiness and response. Local actors have great knowledge of the context and the affected or at-risk populations, and being familiar with or part of the community means that local actors better readily understand their needs, priorities, cultures, traditions, beliefs, and languages. As such, local/subnational actors are often trusted and accepted by the population and, depending on the context, potentially by other stakeholders, including government and non-state actors. Local actors are well positioned to effectively engage and mobilize communities in ways that international actors cannot. This is exemplified by a local NGO in Yemen that developed a robust community-led response to the recent cholera outbreak (see Local Insight 3). Strong community relationships are essential for effective locally led outbreak response and could be improved by learning from community engagement and examples of sensitization "good practices" in other sectors.

National and local actors also noted that local actors have greater access to difficult-to-reach places, such as active conflict zones, and can adapt to challenging circumstances. For example, if a community is displaced, local actors who are part of the community will often have access to the population due to their proximity, existing community acceptance, and ongoing or routine engagement. They also have access to or can source local information in a timely manner.

"It is about recognizing that cultures are different; ways of working are different; ways of addressing community health are different; and the solution needs to be developed by the local leadership here in the country and in the context itself. It is not about solutions being provided and adapted to the context."

(National actor, DRC)

Mpartoke, 41, prepares a measles vaccine during a campaign supported by Save the Children's Emergency Health Unit

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Asma* with Shafak's mobile health clinic team in the camp she lives in, in Idlib, North West Syria

Locally led outbreak responses can be more sustainable, efficient, and equitable

Those consulted highlighted that because local/subnational actors have an ongoing presence in the country (unlike many INGOs), they can be agile in moving from readiness to response if they have pre-positioned funding and supplies. Thus, their actions have the potential to be more sustainable and effective. Locally led responses can also be cost-effective,[31,45] leveraging available resources for maximum impact, which is emphasized by the local/subnational and national actors consulted in South Sudan based on their own recent experiences (see Local Insight 4 below). While efficiencies are possible, this does not mean that a locally led response should be seen as a cheaper option; rather, it requires a system-wide commitment that local actors are equitably engaged, resourced, and remunerated. Indeed, given the need to strengthen the longer-term capacity for sustainability, the short-term costs may in fact be greater.

Trust, accountability, and responsibility are the cornerstones of an effective, locally led response

Although the COVID-19 pandemic was perceived as a catalyst for change with a rapid increase in locally led responses, there is little evidence that it changed the power dynamics or interactions between international, local/subnational, and national actors in the longer term.[22,28,29]

In addition to the perception that local/subnational and national actors generally lack capacity and skills compared to global actors, there was a sense among the actors consulted that local/subnational and national actors are more likely to be perceived as untrustworthy, corrupt, unethical, and not neutral. Actors consulted did not volunteer first-hand accounts of experiencing such behavior; rather, it was seen as a backdrop to all interactions, a component of the "them" and "us" mentality that perpetuates systemic power imbalances. Such positioning is also evident in the recent commentary on localization and humanitarian reform, and the broader literature is replete with examples of local actors being (often implicitly) considered inferior to global actors.[22,28,36,46,47]

Power dynamics persist at all levels. Within a country, some of the control and decision-making issues described between global actors and national actors are also evident among government, national, and subnational/local actors. Some actors described in-country competition for resources and technical support, while others suggested that constraints were politically motivated. A number of local/subnational and national actors also highlighted government-led restrictions on civic space and limitations on the amount of funding local and national actors could receive from international donors.

It was felt that international organizations require local actors to adhere to the principles of neutrality and impartiality as part of their partnership selection criteria. At the same time, many international NGOs also struggle to uphold these principles themselves.[28] Similarly, the international community consistently demands high levels of trust while failing to demonstrably trust local actors (e.g., by questioning their accountability and refusing to provide direct funding), despite emphasizing the need to acknowledge common threats and pursue collective action.

What needs to happen

- There needs to be greater recognition that local/subnational and national actors play an essential role not only as first responders but also in the readiness, response, and recovery phases of disease outbreaks and humanitarian crises. Global actors need to acknowledge, respect, and give greater visibility to the work of local/subnational and national actors.
- Changing attitudes and shifting power dynamics between global and national, subnational/local actors require mutual trust and respect. Global actors need to relinquish control, and local actors must act with agency.
- Global actors need to commit to partnership models that are equitable, collaborative, and based on shared decision-making.
- Due diligence processes need to be simplified, and reporting requirements made realistic. Bureaucracy and administrative processes should not be a barrier to participation. Global actors, including donors, UN agencies, and INGOs, need to ease compliance burdens on local partners.
- Leveraging local skills, knowledge, and relationships can draw on good practices in community engagement, community-centered approaches, and community health worker systems. These are well established in the public health and development sectors and must be invested more broadly in disease outbreak response and the humanitarian sector.

Local Insight 2: Promoting locally led disease outbreak readiness and response through local advocacy

Country: Yemen

Partnerships: Abs Development Organization for Woman and Child (ADO), SOUL for Development, and Tamdeen Youth Foundation (TYF), with Building Foundation for Development, Life Makers Meeting Place Organization, Medical Mercy Foundation, Sustainable Development Foundation, Yemeni Development Network for NGOs, and Field Medical Foundation

Response: Disease outbreak response in general (2019–present)

"They [the international actors] cannot succeed without us, and we cannot succeed without them; we have to work together."

(Subnational actor, Yemen)

Locally led action: Yemen is a country at high risk of disease outbreaks that could exacerbate its health crisis. Previously, INGOs operating in Yemen implemented projects directly without engaging local actors. As local/subnational actors, we became increasingly frustrated with this arrangement and began advocating for localization directly with the humanitarian coordinator, local authorities, and UN agencies. By emphasizing the value of local actors in outbreak response and the challenges we faced in participating in coordination mechanisms and working in partnership with INGOs, our local advocacy prompted INGOs and UN agencies to re-consider their approach to localization.

To ensure that our advocacy efforts were coordinated, nine local NGOs in Yemen (including ADO, TYF, and SOUL for development) formed a consortium in 2019, with technical, logistical, and capacity support from Oxfam, CARE, ICVA, and other INGOs. One of the initial objectives of the consortium was to jointly develop a "localization initiative," launched in August 2021, and has since grown to include 100 local NGOs, CSOs, and CBOs. Fifteen local actors (NGOs, CSOs, and CBOs) sit on the steering committee of this initiative. Since its launch, key outcomes have included engaging local actors and connecting them to international networks (e.g., NEAR, ICVA, and Charter for Change); holding regular meetings with local and international actors to discuss localization; and developing a draft localization strategy in consultation with national authorities, local NGOs, and INGOs. The consortium has developed a performance measurement framework for the localization strategy and completed a baseline assessment in 2022 that was locally led in partnership with ICVA and HAG and in consultation with NEAR.

Yemen is the first country in the MENA region to measure progress in localization. The nine local actors that make up the consortium are responsible for its financial sustainability—a dedicated fund is allocated annually from our own budgets to cover running costs. The members recently developed a roadmap to strengthen the consortium's governance and expand its reach. To ensure continuity, we are recruiting a consortium coordinator and planning to apply for funding for multi-sectoral projects.

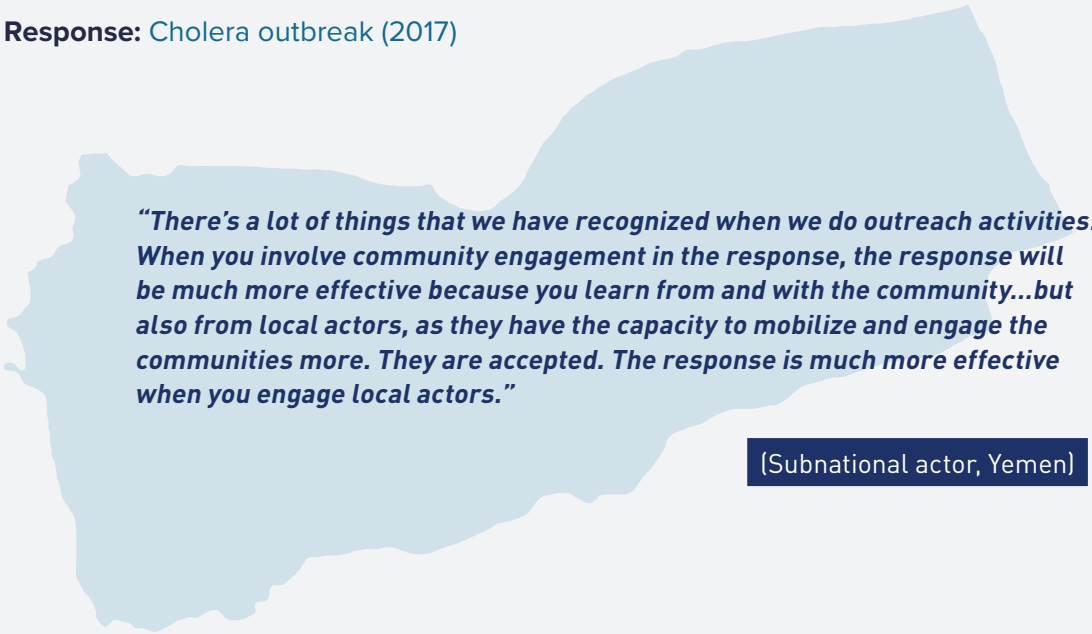
Learning: Through the consortium, local actors continue to advocate for change around coordination, partnerships, funding, and the importance of localization. Our voices have been heard by the humanitarian coordinator, UN agencies, and local authorities, who now stipulate that large relief, development, and disease outbreak grants should involve local NGOs.

Local Insight 3: Robust, locally led response to a cholera outbreak based on community engagement

Country: Yemen

Partnerships: bs Development Organization for Woman and Child (ADO) with affected communities

Response: Cholera outbreak (2017)



"There's a lot of things that we have recognized when we do outreach activities. When you involve community engagement in the response, the response will be much more effective because you learn from and with the community...but also from local actors, as they have the capacity to mobilize and engage the communities more. They are accepted. The response is much more effective when you engage local actors."

(Subnational actor, Yemen)

Locally led action: Abs Development Organization for Woman and Child (ADO) is a well-established humanitarian and development NGO in Yemen that adopts a strong needs-based approach to reach the most vulnerable women, children, displaced persons, and host communities in rural areas on the coast of Tihama. We have developed a trusted working relationship with the community, which has helped us play a significant role in responding to the recent cholera outbreak. After initially responding to the outbreak by operating a diarrhea treatment center (DTC) to support the surveillance and management of cholera cases, we realized that this was not having an impact on the number of cases, which remained persistently high. Instead, we changed course and adopted a community-centered approach, establishing a local committee. We identified the source of the outbreak by engaging the committee in focus group discussions with community members and leaders, combined with water quality and contamination analyses. We then implemented an integrated approach, providing clean water sources and water management and working in partnership with the community to raise awareness, rehabilitate water sources, and dig wells to provide clean water. ADO's strong relationship with the community helped us effectively mobilize and engage community members.

Learning: This was an integrated, locally led, and community-centered approach that provided a solution to persistent cholera cases in the community. It demonstrates the importance of local actors mobilizing communities and local capacity in disease outbreak response. During the response to the cholera outbreak, several projects were facilitated through funding support from international actors, including OCHA, Oxfam, ZOA International, and Diakonie Katastrophenhilfe (DKH).

Key Action 4

Trust local organizations to define their technical and organizational needs and capacities, and leverage knowledge and skills sharing between actors in different geographic contexts

This action responds to concerns raised by national and subnational actors that local capacities are not always recognized and utilized in disease outbreak readiness and response and that capacity strengthening provided by global actors is based on perceived needs rather than the actual needs of national and local actors. Some global actors recognized the value of sharing skills and knowledge across geographic contexts, but it was acknowledged that this is not the norm. Many local/subnational and national actors felt that response efforts were more effective when their experience in managing previous disease outbreaks was recognized and used alongside or instead of international expertise.

Recognize and leverage local capacity

Actors consulted at all levels emphasized that local actors have the capacity to respond to disease outbreaks, especially if they have experience with previous public health emergencies. They often begin to respond before the surge of international actors, and they can immediately engage communities and mobilize human resources.

As highlighted above, several limitations to locally led action in disease outbreaks in humanitarian contexts were raised by those consulted, and it was acknowledged that where resilience to shocks is low, and the setting is underprepared, it may not be feasible for local actors to rapidly surge a response across all activated response pillars. However, national and subnational/local actors advised that when local skills, knowledge, and relationships are recognized and valued, it is easier to identify what additional support may be needed from international actors, who can then make a strategic contribution rather than duplicating or even replacing existing activities or structures. This was underscored by a local actor in South Sudan who described how their sustained local presence during a recent meningitis outbreak led them to leverage MoH funding to launch a rapid response and allocate budgets to priority areas (Local Insight 4).

Trust local actors to define their capacity-strengthening needs

Local/subnational and national actors consulted explained that local capacities are not always recognized or assessed and that capacity strengthening is usually provided according to external (international) criteria and based on perceived or assumed needs rather than being fully aligned with the actual needs of local actors. International organizations' capacity-strengthening efforts are often vertical, focusing on short-term technical skills related to an immediate outbreak response (or donor priorities) rather than on more horizontal, systems-based, and sustainable organizational and leadership strengthening.

Dr Omnia conducts health screening in a religious school in Khartoum state, Sudan

National and subnational/local actors consulted agreed that global support can be positive if it is demand-driven and collaborative.

Although more research is needed,[18,19] emerging evidence suggests that supporting locally led responses and strengthening capacity where and when needed can contribute to more sustainable disease outbreak readiness and response, more self-sufficient local organizations, and more sustainable national health systems. In addition, readiness and response actions are more effective when lessons learned from previous outbreaks are incorporated and local actors have access to and ownership of local data. National actors in the DRC shared their recent experience of shifting the dynamics of operational data collection, analysis, and use in outbreak response by supporting the generation of data from within a unit in the MoH and returning data ownership to local actors (see Local Insight 5).

Local/subnational and national actors consulted viewed capacity strengthening as largely unidirectional, from global to national and subnational actors, and they emphasized that multidirectional learning across geographic contexts may actually be more effective. One global actor consulted described *capacity sharing* as a more appropriate term than *capacity strengthening*, and a national actor in Syria stressed that the *most effective* work they had done was to act as a facilitator to help organizations learn from each other rather than from INGOs.

Value and use local clinical expertise in disease outbreak and response

Actors consulted at all levels suggested that there is also resistance to shifting decision-making responsibilities to local actors in the context of disease outbreak readiness and response because of the specialized clinical expertise required. While local/subnational and national actors in the DRC and Yemen highlighted that specialized clinical expertise may be lacking at the local level, making it necessary to source from international organizations and agencies (either at the national, regional, or global level), they also emphasized that experience gained during previous disease outbreaks can shift this balance. For example, local actors in the DRC were able to manage recent Ebola outbreaks (including the introduction of novel vaccines) using skills they had acquired during previous outbreaks. Indeed, the actors consulted in Syria suggested that local clinical expertise was often greater than visiting international staff unaccustomed to working in the Syrian context, challenging perspectives on who "the experts" were.

"During the 12th and 13th Ebola outbreaks, local health teams responded on the basis of the skills they had acquired during the management of the previous long outbreaks. They know how to communicate with people, how to communicate in the local language, and…it was cheaper than importing expertise."

(National actor, DRC)

What needs to happen

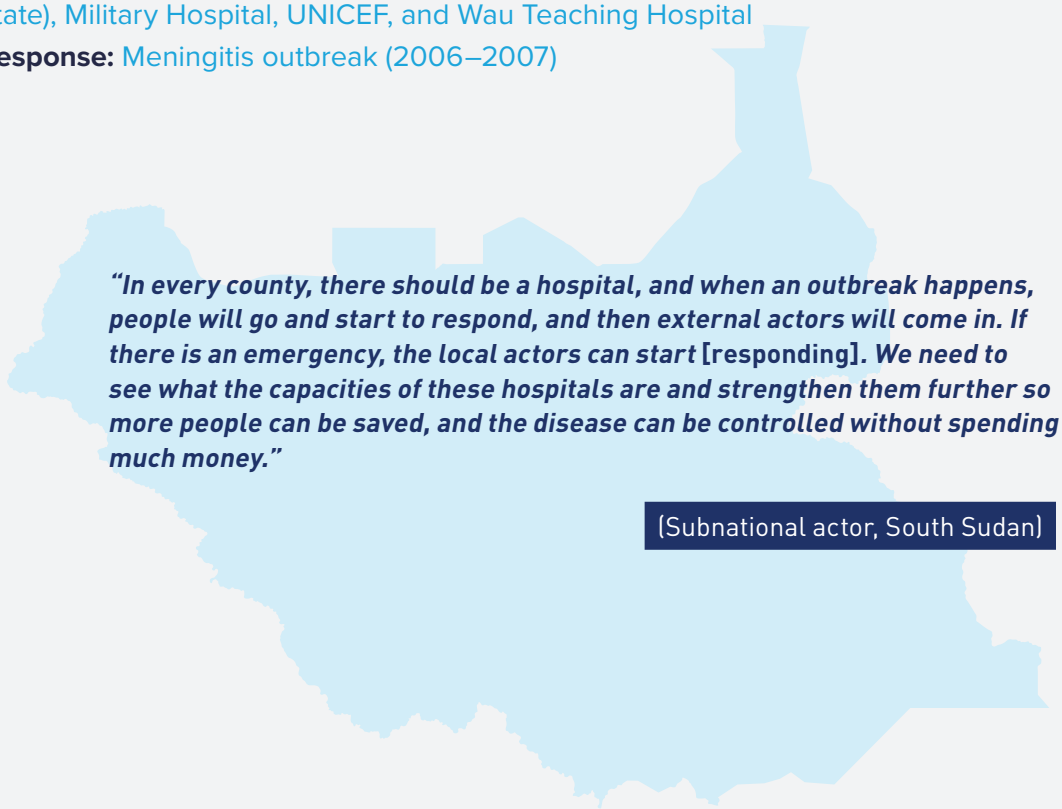
- Global actors need to be guided by local actors on how, where, and when they can best add value to disease outbreak readiness and response rather than duplicating or even replacing existing mechanisms and structures. Support provided by global actors should be demand-driven and reflect changing needs over time and across the different phases of preparedness, response, and recovery.
- Investments by donors, UN agencies, and INGOs in capacity strengthening for disease outbreak readiness and response should be based on and fully aligned with the actual needs of national, subnational/local actors and build on lessons learned from previous responses. It should be systems-based and include sustainable organizational and leadership strengthening, as well as the transfer of technical skills.
- Capacity sharing needs to be multidirectional, involving diverse actors from a range of disciplines and across geographical contexts. Global actors must be willing to learn from national, subnational/local actors whose expertise they should value and trust.

Local Insight 4: Fully locally led rapid outbreak response, leveraging locally available resources

Country: South Sudan

Partnerships: Mary Help Association in partnership with the MoH (Western Bahr El Ghazal State), Military Hospital, UNICEF, and Wau Teaching Hospital

Response: Meningitis outbreak (2006–2007)



"In every county, there should be a hospital, and when an outbreak happens, people will go and start to respond, and then external actors will come in. If there is an emergency, the local actors can start* [responding]*. We need to see what the capacities of these hospitals are and strengthen them further so more people can be saved, and the disease can be controlled without spending much money."

(Subnational actor, South Sudan)

Locally led action: Mary Help Association is a local NGO that operates a 150-bed hospital in the Wau region, runs a nursing and midwifery college with 370 students and provides accommodation for nurses. During health emergencies, the association treats patients and provides primary care until INGOs respond. In 2006 and 2007, there were three meningitis outbreaks in the Wau region, and only a few health actors (including UNICEF and the MoH) were present when the first cases were reported to the medical authorities. Because of the Mary Help Association's long-standing presence in the area, we were one of the few local actors invited to meet with the director general of the MoH, the director general of the military hospital, UNICEF, and the honorable minister of health to discuss the response plan. Together with the MoH, UNICEF, and the military hospital, the association trained 30 students from the Wau Teaching Hospital in meningitis case management, supervised case management, and administered meningitis vaccines (provided by UNICEF and MSF). As part of our response to the meningitis outbreak, The Mary Help Association converted a local school (without electricity) into a temporary hospital and began treating patients with the support of local authorities.

Learning: Nearly 1,000 patients were treated, and there were no meningitis deaths in the temporary hospital. Mary Help Association leveraged our strong relationships with affected communities and existing leadership structures to launch a rapid response. By receiving funds directly from the MoH, the Mary Help Association was able to allocate the budget where it was most needed. During the recent measles outbreak, our experience from previous disease outbreaks allowed us to quickly set up an isolation center, train nurses, manage an isolation ward, and report cases to the MoH.

Local Insight 5: Supporting the MoH to compile their own data and analytics to inform local outbreak response

Country: DRC
Partnerships: Cellule d'Analyse Intégrée (CAI), Integrated Outbreak Analytics (IOA), and the MoH
Response: Disease outbreak response in general (2022–present)

> ***"Integrated outbreak analytics (IOA) is an approach; there is no model or force, and it is not something that is developed at the global level. It is about a local solution that was developed in country with the MoH and partners, and it needs to be replicated in a way that works for each country, context, and MoH. ...We need to stop doing our publications, our PhDs, our careers on the backs of outbreaks and start supporting the MoH and local actors and doing it in a way that is completely adapted to them. We need to stop doing studies for the sake of doing studies."***
>
> (National actor, DRC)

Locally led action: The CAI leads on IOA, an approach developed under the MoH and with multiple partners during the 2018–20 Ebola outbreak.[48] Since 2022, the CAI has been formally established within the MoH. It is supported by a range of partners and donors, including Bluesquare, CDC Atlanta, CDC Africa, ECHO, the UK Foreign Commonwealth Development Office (FCDO), IFRC, MSF-Epicentre, Resolve to Save Lives, Swedish International Development Cooperation (SIDA), UNICEF, WHO, the World Bank, and Wellcome. The CAI is attached to the Institut National de Sante Publique (INSP – National Institute of Public Health) and the Center Operation Urgences Sante Publique (COUSP – Public Health EOC). It is part of the Système d'Information Sanitaire (INFOSAN – health information system) within the MoH and works with national counterparts, including cholera, polio, and measles units and teams.

The CAI supports the public health response by providing integrated analysis to better and more holistically understand outbreak dynamics, inform public health risks and emergencies and their impact on communities, and ensure that the evidence is shared with response actors in near real time to enable them to co-develop effective action. The approach seeks to actively engage the health zone actors in all phases of the work, putting them at the forefront of coordinating with other response actors to co-develop actions to improve public health outcomes.

For example, in 2023, CAI worked with the MoH's cholera unit to integrate an in-depth investigation into its locally managed database and analytics. The resulting evidence showed that cholera risk factors were not only related to water sanitation and hygiene but also had potential associations with displacement, malnutrition, and gender roles, including gender-based violence in cholera-affected households. The results were shared with the *médecins chefs du zone* (MCZ), civil society, as well as NGOs and clusters. Meetings with partners focused on co-developing actions, including agreeing on a timeline, a contact person, and an indicator to demonstrate the completion of the action.

The CAI has demonstrated its critical role in returning data ownership to local health actors, enabling them to use their own data to understand health dynamics. This process creates space to discuss the barriers that lead to recurrent outbreaks (e.g., underlying barriers associated with childbirth at home, lack of fuel for vaccinators to travel to the vaccination sites, limited information on the differences between routine vaccination and vaccine campaigns), identify what can be done at the local level, and determine which actions require external support and/or additional funding.

Learning: The CAI actively engages with partners at all levels and facilitates the reporting and presentation of findings to key response actors at local and national levels, including local health actors, NGOs, CSOs, INGOs, clusters, and ultimately donors, until all the factors contributing to disease transmission dynamics are identified and addressed. In very practical terms, the CAI has changed the approach to operational evidence collection, analysis, and use in public health emergencies by ensuring that data ownership and use rest with local actors.

Conclusion

This paper centers on local actors' perspectives on what is needed to accelerate locally led outbreak readiness and response in humanitarian settings. The four Key Actions presented provide an opportunity for donors, UN agencies, and INGOs to reorient and reconsider their ways of working, their partnership models, and the funding structures needed to deliver on the localization commitments made, for example, in the Grand Bargain and the Pledge for Change, as well as internally within their organizations.

To move beyond rhetoric and tokenistic approaches to localization,[49] global actors must be willing to understand local realities, foster a greater level of trust in local/subnational and national actors, and accept that they have a collective responsibility to actively prioritize rather than inadvertently hinder locally led or locally driven action. The paper serves as a reminder that localization is not just about improving effectiveness or sustainability; it is about solidarity, a premise based on the recognition of interconnectedness and interdependence that has the potential to be transformative and a catalyst for a more collaborative and effective global health infrastructure.[50–52]

Each Local Insight presented in this paper demonstrates different aspects of locally led action in outbreak readiness and response. Together, they illustrate the agency that local actors can have and the outcomes that can be achieved. In giving visibility to these insights, this paper aims to contribute to a growing community of practice on effective, locally led action. Replicating the approaches highlighted by the local insights at scale and/or in other contexts may not be possible or desirable. Locally led action must be based on local contexts, capacities, and needs. However, as local/subnational and national actors repeatedly emphasized, learning from each other's challenges and successes is important.

National and subnational/local actors have clearly articulated *what* needs to happen based on their experience of preparing for and responding to major disease outbreaks in humanitarian settings. There must now be a renewed commitment to make concrete progress on how this can and will happen. This is a collective responsibility—global, national, and subnational/local actors must work together to co-design and implement the actions required to be ready for and respond effectively to disease outbreaks in humanitarian settings.

Hand washing station - measures to prevent the spread of coronavirus in DRC

Annex 1. Brief situation analyses of the humanitarian context and recent disease outbreaks in Yemen, South Sudan, Syria, and the DRC

Yemen

Yemen is experiencing an ongoing, protracted, and complex humanitarian crisis. Eight years of conflict have left the country on the brink of total socioeconomic collapse, with key infrastructure destroyed and health and other services disrupted. The most recent Humanitarian Needs Overview (HNO) analysis estimates that 21.6 million people in Yemen will require humanitarian assistance in 2023;[53] 24% of those in need are women, and 51% are children. There are 4.5 million internally displaced people (IDPs), of whom 3.1 million are in need of assistance. Half of the country's population (17.3 million) is estimated to need food and agricultural assistance; 20.3 million need access to critical health services; and 15.3 million need support to access clean water and meet basic sanitation needs. Recurrent climate-related shocks, such as floods, droughts, reduced water availability, and soil degradation, continue to affect livelihoods and insecurity, which has been exacerbated by the conflict. Together with the lack of access to safe water, sanitation, and hygiene services, these climatic events have left the population highly vulnerable to disease outbreaks, and there have been regular outbreaks of cholera, dengue, malaria, measles, diphtheria, and other vaccine-preventable diseases.[54,55] The world's worst cholera outbreak in 50 years occurred in Yemen between 2016 and 2021, affecting all regions of the country and resulting in over 2.5 million cases and nearly 4,000 deaths.[56] The risk of disease outbreaks is expected to persist due to inadequately equipped and understaffed health facilities, the discontinuation of health programs, continued deficiencies in water and sanitation infrastructure, and the exacerbation of existing vulnerabilities, including seasonal flooding and additional displacement.[53]

Syria

After 12 years of civil war, Syria is experiencing one of the most complex emergencies in the world. The 2023 HNO analysis estimates that 15.3 million people are in need of humanitarian assistance;[57] 21% of those in need are women, and 46% are children. The conflict has decimated public infrastructure, contributed to a worsening economic crisis, and left 6.8 million IDPs by the end of 2022, with 5.3 million in need of assistance. An additional 5.4 million people live as refugees in neighboring countries.[58,59] In February 2023, catastrophic earthquakes and aftershocks struck parts of the northwest of the country, resulting in an estimated 6,000 deaths and more than 12,000 injuries nationwide. The disaster caused extensive damage to homes and infrastructure and affected an estimated 8.8 million people.[59,60] The earthquakes and a devastating drought in 2021 escalated food insecurity.[59,61] Approximately 90% of families in Syria live in poverty. The protracted conflict and multiple natural disasters have led to the collapse of the healthcare system and the depletion of water, sanitation, and hygiene systems, leaving the country highly vulnerable to fast-spreading, waterborne disease outbreaks. At the time of writing, a large-scale cholera outbreak, declared in September 2022, is ongoing. Most cases are concentrated in the northeast of the country, with camp populations particularly affected. As of July 2023, over 150,000 suspected cases and more than 100 deaths have been attributed to the outbreak.[59] Cholera/acute watery diarrhea (AWD), COVID-19, and other recurrent disease outbreaks such as leishmaniasis, measles, meningitis, and malnutrition continue to be leading causes of morbidity and mortality in Syria.[57]

The Democratic Republic of the Congo

The DRC, which has suffered the effects of civil war since 1996, is arguably experiencing the most complex and protracted humanitarian crisis in Africa. The Humanitarian Response Plan for the DRC (2023) estimates that 26.4 million people need assistance out of a total population of 109.6 million;[62] 5.7 million are IDPs; and another 1 million have sought asylum in other countries, mostly in Africa. Displacement continues while the country hosts half a million refugees from neighboring countries. The conflict and displacement, subsequent disruption of farming activities, rising prices, climate shocks, and the economic repercussions of COVID-19 and the conflict in Ukraine led to an estimated 26.4 million people being classified as food insecure by the end of 2022, making it the most food insecure country in the world.[63] With minimal access to health care in parts of the country, displacement of health workers, frequent looting of health facilities, and a lack of access to safe water and sanitation, the DRC is at high risk for major disease outbreaks. In recent years, the country has experienced recurrent outbreaks of diseases such as cholera, measles, monkeypox, Ebola virus disease (EVD), meningitis, typhoid, and malaria.[64,65] In the past four years, the DRC has experienced six outbreaks of EVD. Cholera is endemic in parts of the DRC and caused over 300 deaths in 2022. At the time of writing, the risk of the national and regional spread of the current cholera outbreak is considered high due to the fragile context.[66,67] The DRC is expected to continue to experience outbreaks of diseases such as cholera, measles, malaria, EVD, and Mpox, as well as the possibility of outbreaks of bubonic plague.[62]

South Sudan

South Sudan gained independence from Sudan in 2011 after decades of war with Sudan but has since experienced outbreaks of civil war and ongoing sporadic violence. It is estimated that 9.4 million people (76% of the population) will require humanitarian assistance in 2023; 24% of those in need are women; and 54% are children.[68] The protracted conflict, coupled with devastating floods and severe droughts, has led to economic instability, chronic food insecurity, and mass population displacement. By the end of 2022, 2.2 million people had been displaced internally, and more than 2.3 million South Sudanese had sought refuge in neighboring countries. Since October 2018, 613,520 South Sudanese refugees have returned spontaneously and the country is also host to 337,000 refugees and asylum seekers, mostly from neighboring Sudan. The situation has become more fragile due to the renewed conflict in Sudan since April 2023 between the Sudanese Armed Forces and the Rapid Support Forces.[69] Most IDPs, refugees, and returnees live in remote areas that are seasonally inaccessible due to flooding and a lack of basic services. An estimated 9.4 million people (76% of the population) are estimated to be in need of humanitarian assistance.[70–73] Lack of access to health services, low numbers of health workers, and poor water and sanitation contribute to some of the worst health indicators in the world and a high risk of disease outbreaks. Malaria is a leading cause of death, with 95% of the country endemic to the disease. The country also faces sporadic and persistent outbreaks of infectious diseases, including pneumonia, hepatitis A, cholera, diarrheal diseases, EVD, measles, polio, and COVID-19.[74–77]

Annex 2. Summary of methods and approaches used to develop the paper

Overall aim of the paper and key questions

The paper sought to understand the current state of localization, the value of locally led action, and the barriers to achieving it from the perspective of local and national NGOs. It also aimed to identify what needs to happen to accelerate effective and meaningful locally led action in disease outbreak readiness and response.

The research conducted for this paper was designed to answer the following priority questions: From the perspective of local actors and in relation to outbreak readiness and response,

- How is the concept of *localization* understood and/or defined?
- What is the current state of localization?
- What are the barriers to and enablers of localization?
- When does localization work well? What are the advantages of a locally led response?
- What needs to happen to accelerate change?

Methodology

Literature review

A literature review was conducted to determine the extent and type of evidence available on localization in humanitarian settings at risk of major disease outbreaks. An established scoping review methodology was used to guide the search, extraction, and synthesis of the literature.[78] The review included peer-reviewed articles and gray literature relevant to the priority questions. Searches were conducted in six databases in English and French (PubMed, Embase, Scopus, Ovid, Web of Science, and ProQuest), as well as Google Scholar and relevant organizational websites. Additional searches were conducted in Spanish (Google and relevant institutional websites) and Arabic (EBSCO – Al-Masdar, E-marefa, Al-manhal, ResearchGate, and ProQuest). Reference lists were also scanned for relevant literature, and stakeholders consulted for this project shared relevant documents.

After screening and selection using predefined inclusion criteria, 17 peer-reviewed articles and 44 gray literature documents were included in the review. Data were coded and extracted into an MS Excel spreadsheet organized by the priority questions, and coding was updated with inductively derived content from the documents. The coded data were then reviewed and discussed, and key themes were identified from the entire dataset.

The peer-reviewed literature tended to provide country-specific examples of locally led action in outbreak contexts, while the gray literature provided global perspectives, definitions, and conceptualizations of localization, often drawing on evidence from multiple countries or not providing a specific country context. Africa was the most represented continent in the country examples. Just over half of the documents related to localization in outbreak-specific contexts, and of these, the majority related to COVID-19. Ebola, cholera, and polio were also represented.

Consultations with global humanitarian actors

Initial consultations were held with global humanitarian actors to sense-check the paper's approach, identify key topics, and gather additional insights and resources to inform the primary data collection. READY and Anthrologica drew on their networks to identify appropriate individuals and organizations to consult with based on their experience in epidemic and pandemic preparedness and response and familiarity with localization efforts. Nine participants were consulted, including representatives from INGOs, United Nations agencies, donors, and a global network of CSOs.

Key informant interviews with national and subnational actors

Following the initial global-level consultations, interviews were conducted with 21 national and subnational actors to explore country-level perspectives on localization efforts. Topics covered included the extent to which localization is occurring, the barriers and enablers to locally led outbreak readiness and response, and recommended ways forward. READY purposively selected four focal countries to include a range of high-priority humanitarian settings that have experienced or are at risk of major disease outbreaks (e.g., Ebola, COVID-19, SARS, and cholera). The selected countries were the DRC, South Sudan, Syria, and Yemen. Key informants represented national NGOs and subnational NGOs, CSOs, and FBOs (identified from the READY and Anthrologica networks), working on a range of issues, including water, sanitation, and hygiene (WASH); health and risk communication; and community engagement/social behavior change (RCCE/SBC). Where necessary, snowball sampling was used to identify subnational actors from the networks and contacts of those already interviewed.

Data source analysis and triangulation

Data were extracted from the transcripts of the country interviews and initial consultations in an MS Excel matrix using codes based on initial themes from the literature review. The codes were refined as the data extraction progressed. Data extracted from the consultations and interviews were triangulated with the findings from the literature review, and preliminary themes were identified from across the three sources against the priority questions. Preliminary themes were critically analyzed against the priority questions of the paper and refined into key themes. Patterns in the themes within and across countries and by type and level of actor (global, national, and subnational) were highlighted where they existed.

Reflection and stakeholder meetings

Three remote validation and reflection sessions were held with global, national, and local stakeholders to present and validate preliminary findings, gather additional insights and reflections, and discuss ways to accelerate effective localization in outbreak readiness and response in humanitarian settings.

Working definitions used in the paper

Throughout the paper, the following definitions of local and national actors are aligned with those of the IASC:[79]

Local/subnational actor: Local non-governmental actors generally operating in a specific, geographically defined, subnational area of an affected country, without affiliation to an international NGO or CSO. These can include NGOs, CSOs, FBOs, and CBOs.

National actor: National non-governmental actor operating in an affected country where it is headquartered, working at the national level and in multiple subnational areas, but not necessarily affiliated with an international organization (e.g., national NGOs, CSOs, and FBOs).

Global actor: International NGOs, UN agencies, and donors and operating across countries and regions.

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