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Navigating fear and care: The lived experiences of community-based health actors in the Philippines during the COVID-19 pandemic

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ABSTRACT

The activities of community-based health actors are widely recognized as critical to pandemic response; yet, there exists a lack of clarity concerning who is included in this ecosystem of actors and how these actors experience the complexity of delivering community-level care in the context of a public health emergency. The objectives of this study were (1) to characterize the lived experiences of community-based health actors during the COVID-19 pandemic in the Philippines; and (2) to identify opportunities for further supporting these critical actors in the health workforce. Virtual semi-structured interviews were conducted (January–February 2021) with 28 workers employed by a Philippines-based non-governmental organization (NGO) to explore their lived experiences during the COVID-19 pandemic. Data were analyzed thematically using a hybrid inductive-deductive coding process, informed by Tronto's conceptualization of an ethic of care. Lived experiences among study participants were shaped by discourses of fear and care, and the interaction between these two affects. Participants reported everyday experiences of fear: NGO workers' fears of contracting and transmitting COVID-19 to others; perceived fear among community members where they worked; and fears around COVID-19 testing, recognizing the personal and social implications (e.g. stigma) of a positive test. Amid fear, participants had everyday experiences of care: care was a powerful motivator to continue their work; they felt supported by a caring organization that implemented safety protocols and provided material supports to those in quarantine; and they engaged in self-care practices. These findings contribute to understanding the ecosystem of actors involved in community-based health care and engagement efforts and the challenges they encounter in their work, particularly in a pandemic context. We highlight implications for civil society organizations charged with protecting the mental and physical well-being of their workers and describe how these actions can contribute to local health systems strengthening.

1. Introduction

The COVID-19 pandemic has challenged health systems worldwide and exacerbated pre-existing gaps within health service delivery. Increased community engagement, vis-à-vis extending health services into local communities, has been called for as a means of strengthening health systems, particularly in resource-constrained settings (Gilmore et al., 2020; Haldane et al., 2021a; World Health Organization [WHO], 2021). Throughout the COVID-19 pandemic, non-governmental organizations (NGOs) and other civil society actors have played crucial roles

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in many low- and middle-income countries (LMICs). These non-state actors have provided an array of community-based functions to bolster government-led emergency response efforts, such as coordinating humanitarian relief, communicating public health messaging within local jurisdictions, and supporting illness prevention and case management in communities (Cai et al., 2021; Dodd et al., 2021a; Osuteye et al., 2021). This community-based work has filled critical gaps in state capacity at a time when resources are stretched thin and has helped to address the direct and indirect health consequences of the COVID-19 pandemic.

Community health workers have been widely recognized as integral members of the health workforce during the COVID-19 pandemic, especially in many LMICs (Ballard et al., 2020; Bhaumik et al., 2020; Palafox et al., 2021; Wells et al., 2021). Their community-based activities, such as providing basic disease screening at the household level, delivering health education, and assisting individuals with navigating local health and social supports amid the pandemic (Dodd et al., 2021b; Mallari et al., 2020; Scott et al., 2018), have contributed to more resilient and responsive health systems (Nanda et al., 2020; Peretz et al., 2020; Rahman et al., 2021). Beyond community health workers, however, is a more complex, dynamic network of, what we refer to as, community-based health actors addressing similar health system needs. This ecosystem of community-based health actors, which includes frontline staff employed by NGOs, offers services and supports that are often complementary, adjacent to, or overlapping with formal health systems. Importantly, this ecosystem of community-based health actors often shares a commitment to protect and enhance the health and well-being of communities in resource-constrained settings.

This ecosystem of community-based health actors includes individuals in paid or voluntary roles within NGOs. Although NGOs are structured differently, many medium to large organizations share a similar workforce composition: frontline workers delivering services in addition to individuals in management or supervisory roles. Workers across these varied roles are often uniquely positioned in localized crisis response as both employees and individuals embedded within the communities where they work. As such, these workers are required to navigate complex roles as intermediaries between the communities where they work and live, and formal institutional structures associated with their organizations.

While it is evident that community engagement or embeddedness is critical to pandemic response, especially in resource-constrained settings, the lived experiences of community-based health actors who have provided health education, promotion, referrals, and services during the COVID-19 pandemic are not well understood. Further, there is limited understanding of how community-based health actors who do not hold the job title of 'community health worker' have experienced and navigated the COVID-19 pandemic. To address these gaps, the objectives of this study were (1) to characterize the lived experiences of community-based health actors in the early-to mid-stages of the COVID-19 pandemic in the Philippines, given their proximity to communities where they live and work; and (2) to identify how these lived experiences might inform opportunities to further support these critical actors in the health workforce, particularly in the context of pandemic response. By so doing, we aim to expand understanding of who is actually involved in community health engagement efforts and the challenges they encounter in this work – an inquiry with implications for organizations charged with protecting the mental and physical well-being of their workers.

2. Methods

2.1. Theoretical approach: an ethic of care

This research was guided by an ethic of care, which is a theoretical approach that conceptualizes the act of caring as central to justice and links care work to particular moral attributes (e.g., 'care giving' aligns with the moral attribute of competence; 'caring with' aligns with respect and solidarity) (Tronto, 1993). This approach can be used to characterize the work of civil society actors in relation to distinct, yet interrelated, modes of care. For example, previous research has linked the care work of NGOs to Fisher and Tronto's (1990) typology of care to help delineate the NGO role in civil society as that of caring *for*, *about*, and *with* communities (Collins, 2015). More specifically, caring *for* involves the hands-on responsibilities associated with physical caregiving; caring *about* is concerned with an emotional attentiveness to the needs of others; and caring *with* involves a collective responsibility and mobilization for care work (Tronto, 2013). This ethic may take on different, or heightened, meaning in dynamic pandemic situations in which community-based health actors experience ongoing uncertainty and evolving degrees of risk – whether physical or social (Thorpe, 2020) – in their care work. As such, an ethic of care is a useful theoretical approach within which to examine lived experiences of community-based health actors in this dynamic context of risk, as well as how the community embeddedness of these actors shapes their orientation toward care work.

2.2. Study context and location

This study was part of a broader qualitative project investigating how a mid-size NGO in the Philippines has worked with staff to continue their community-based poverty alleviation work during the COVID-19 pandemic. International Care Ministries (ICM) is a faith-based NGO that aims to support ultra-poor households in the Philippines through providing community-level health education, experiential learning opportunities, and resource provision (Luu et al., 2022). ICM operates programs across twelve regional bases in the Visayas and Mindanao islands and employs approximately 500 fulltime staff at various levels of work and management (*see Appendix A in the Supplmentary File for a summary of ICM's organizational structure and associated staff roles*). *Transform* is ICM's flagship program that involves a network of NGO workers who provide training and support to rural communities within *barangays* (the smallest political subdivision in the Philippines) in the following areas: health (tuberculosis screening; antenatal and newborn support; basic treatment for diarrhea and skin diseases), sustainable livelihoods (microloans; savings groups), education (parent-coaching), and values (building of social networks; personal support).

The health component of *Transform* is delivered by health trainers. Many of these individuals have formal health training (e.g., midwives, nurses), and receive further training through their role in health education and promotion, along with the provision of basic public health and primary healthcare support to communities. Health trainers often work closely with government-funded *barangay* health workers in roles that are connected and interrelated, yet distinct (Dodd et al., 2021b). For example, health trainers may identify individuals suspected of tuberculosis infection through ICM's active case finding program, and refer the individual to a local health facility for testing and support provided by *barangay* health workers (Lau et al., 2020b).

2.3. COVID-19 adaptations

During the early stages of the COVID-19 pandemic (March–October 2020), ICM temporarily paused the *Transform* program. Once the initial wave of COVID-19 case numbers decreased in communities where they work, the program resumed. ICM, in collaboration with researchers from the University of Toronto (Canada) and University of Waterloo (Canada), co-developed context-specific COVID-19 guidelines, which drew on up-to-date guidance from several national and multi-lateral organizations including the World Health Organization (Haldane et al., 2021b). These guidelines, in addition to ICM's own organizational protocols, included the use of personal protective equipment (PPE), infection prevention and control training, and also required staff to adhere to local public health restrictions in their respective jurisdictions. Additionally, ICM implemented a universal program to ensure all staff

were regularly tested for COVID-19. This decision aligned with government mandates and was initiated by ICM to enable community-based work to continue safely, recognizing the heightened impact that COVID-19 transmission could have in the resource-constrained communities within which they work.

2.4. Participant recruitment

A list of ICM regional bases was used to sample bases according to geographic diversity and variation in terms of the availability of COVID-19 testing. Within selected bases, study participants were purposively sampled according to their respective organizational roles and responsibilities. This sampling approach was used to account for the ways in which organizational roles could influence risk of COVID-19 exposure, the connection to ICM's testing mandate, and broader lived experiences of the COVID-19 pandemic (Table 1). We aimed to recruit a sufficient number of individuals to ensure a broad representation of participant roles and geographic locations. Participants were contacted by email or in-person and invited to an interview. Recruitment of participants continued until no new experiences and themes were discussed among interviewees. All participants received information about the study and provided informed oral consent and gave permission for their interview to be audio-recorded using the Zoom© videoconference platform. Research ethics approval for this study was obtained from the University of Waterloo (Ref #42061), University of Toronto (Ref #20291), and De La Salle Medical and Health Sciences Institute (Ref #2020-14-06-A).

2.5. Data collection

Between January and February 2021, semi-structured interviews were conducted with 28 NGO workers located across five different bases. Interviews were conducted virtually over Zoom© videoconference by at least two research team members and lasted an average of 37 min (range: 29–64 min) in duration. When needed, interviews also included a multilingual research team member so that participants were free to respond in English, Tagalog, Hiligaynon, or Cebuano, as preferred. Interviews focused broadly on NGO workers' experiences throughout the pandemic. As participants expressed particular interest in sharing their experiences of fear and care, interviews tended to evolve around and expand on these themes. Audio-recordings were translated into English, as necessary, and transcribed in full. A multilingual research team member closely reviewed the transcripts of interviews not conducted in English for accuracy.

Table 1
Participant characteristics of non-governmental organization (NGO) workers (n = 28).

Participant Characteristics	Female	Male	Total
Location			
Bacolod	3	2	5
Cebu	2	3	5
General Santos	4	2	6
Iloilo	4	2	6
Koronadal	3	3	6
NGO worker role			
Area head	2	2	4
Branch head	3	2	5
Health coordinator	6	0	6
Health trainer	3	2	5
Livelihood coordinator	2	0	2
Livelihood trainer	0	3	3
Pastor coordinator	0	3	3
TOTAL	16	12	28

2.6. Data analysis

In total, four research team members met regularly throughout data collection to share observations and identify emergent themes across interviews. This form of roundtable peer debriefing among interviewers enhanced data validity and analytical rigour (Creswell and Miller, 2000). Data were analyzed thematically by two research team members, using a hybrid inductive-deductive coding process (Fereday and Muir-Cochrane, 2006). The deductive approach was informed by Tronto's (1993) conceptualization of an ethic of care. *QSR NVivo 12*© software was used to assist with organization and retrieval of codes and participant quotations. A codebook was developed iteratively, then re-applied to all transcripts (DeCuir-Gunby et al., 2011).

3. Results

In describing their lived experiences during pandemic response, NGO workers recounted fear and care narratives, with a focus on how they navigated day-to-day tasks and activities associated with their role in the NGO. Thus, results were organized into two major themes: everyday experiences of fear and everyday experiences of care. A third major theme was identified that highlighted the interactions between fear and care affects.

3.1. Everyday experiences of fear

Experiences of fear featured prominently across interviews with NGO workers. Key subthemes identified through our analysis of everyday experiences of fear included how fear shaped experiences of work, how NGO workers navigated community-level fears in their community-based outreach work, and how fears surrounding COVID-19 testing played out among NGO workers.

3.1.1. NGO workers' fears: "I always think of the safety of the staff"

NGO workers shared their experiences of fear, including their own fears as well as their perceptions of the fear of others (e.g., community members, community leaders, and program participants) over the first nine months of the pandemic. A common expression among interviewees was that "we cannot see our enemy", highlighting concerns around the 'unknowns' of contracting or transmitting COVID-19. NGO workers emphasized personal fears around contracting the virus, recognizing the potential implications for their physical and emotional health, particularly for those with underlying health conditions. Respondents also articulated anxieties around spreading the virus to family members, home communities, and communities where the *Transform* program operated. Some respondents specifically discussed fears around being asymptomatic carriers and unknowingly putting others at risk of infection. One respondent shared how fears surrounding COVID-19 were integrated with their other sentiments toward NGO work:

> It's not really comfortable at work because of the nervousness. The eagerness for work is there, your love for your work is there, the excitement for work is there, but the nervousness that you will get infected or you will be the one to infect, you cannot really stop that (PS015).

Notably, seven interviewees did test positive for COVID-19 at some point during the pandemic. Many of them indicated panicking upon hearing the test result, fearing for their lives, and fearing for their families. In addition to personal fears around contracting and spreading COVID-19, respondents in supervisory positions experienced anxieties due to their responsibilities in overseeing staff teams. In these leadership roles, ICM's area and branch heads had to weigh the need for ongoing programming with the health risks posed to staff members and program communities. An area head shared their experience of balancing these priorities:

> I always think of the safety of the staff. […] Honestly, I could compromise the program, but not the safety of the staff, which I really prioritize. […] Those high-risk staff, I told them to be extra careful. […] There was fear initially, but they assured me that it's okay. There is one high-risk staff who went to the community wearing a gown, face shield and all. Staff also have their own initiatives for how to protect themselves, because they understand that we really have to do our job (PS012).

Another area head disclosed a sense of inadequacy in managing a staff team during the pandemic, acknowledging that their lack of expertise in medical fields made it difficult to feel confident in the decisions they made on behalf of their team. Many respondents, whether staff members or area and branch heads, shared that their fears ran highest in the early days of the pandemic, when they had little information about COVID-19. As information about the virus was uncovered and shared, and as organizational protocols were established within ICM, NGO workers indicated that many of their anxieties were assuaged.

3.1.2. Navigating community fears: "They don't want the COVID virus to enter their premises"

NGO workers encountered fear among community members, leaders, and program participants when they visited, or attempted to visit, program communities. Respondents shared that, in some regions, community members and leaders were concerned about urban-to-rural spread and were therefore hesitant to welcome NGO workers at all. In these contexts, community gatekeepers played a critical role in determining whether ICM workers could enter the community or not. An area head talked about navigating these restrictions in their region:

> [The community was] very strict … the *barangay* captain refused us … we went to the mayor so that the community would accept us. Their *barangay* officials were really the ones who guard and they really blocked the passageways going to their community. That's how afraid they are of COVID. That's how they protect their place from COVID. They don't want the COVID virus to enter their premises (PS001).

This experience highlights how ICM workers often needed to navigate layers of local bureaucracy, including power dynamics between mayors and *barangay* captains (with mayors often overseeing multiple *barangays*). Across geographic settings, respondents shared similar experiences with *barangay* captains, checkpoint authorities, and community leaders such as mayors, though the stringency of restrictions varied across communities. Where community gatekeepers were hesitant, but not in opposition to allowing NGO workers entry, respondents described pursuing additional measures to assure community leaders of the organization's compliance with safety requirements. For example, for some *barangays*, NGO workers had to obtain letters of permission to enter, show swab test results, and reassure checkpoint officials that they would strictly adhere to local and organizational protocols while present in the community. Overall, respondents interpreted the restrictions implemented by community gatekeepers as being driven by a combination of fear and responsibility for community safety.

In some communities, NGO workers encountered hesitancy among community members to engage in ICM programming. Of note, hesitancy among community members appeared to be exacerbated in contexts where an NGO worker had tested positive for COVID-19. Across regions, respondents explained that they respected each person's decision regarding whether or not to participate in ICM's programming during the pandemic; however, they encouraged participation by explaining the nature of COVID-19 infections and detailing the safety precautions in place within the program. In some communities, NGO workers found that individuals were not afraid of COVID-19 and had no interest in following safety protocols: these communities were often found in more remote areas, where the virus had not reached or had not had a substantial impact. In these communities, NGO workers incorporated COVID-related education into their regular programming to emphasize the physical risks and potential impact of the virus. One respondent described their experiences with different levels of fear in communities:

> In my five communities, there is one that is afraid of us because they know where we are from; that we're from the city. There are participants who don't want to face us because they are afraid of the virus. I also have a community which is okay if we visit them, and they are happy we do that because we bring food supplies that could help them. They also appreciate what we teach so that they will also be equipped (PS004).

3.1.3. Fears around COVID-19 testing: "[If] you test positive, everyone will be affected"

COVID-19 testing was a trigger for fear among both NGO workers and community members. While workers recognized that their results from ICM's testing program provided 'knowns' regarding COVID-19 status, and a negative result would offer reassurance in their professional and personal lives, the anticipated repercussions of a positive result were powerful stressors. In addition to direct health implications associated with contracting or spreading COVID-19, respondents identified concerns associated with secondary outcomes, including both economic losses and social repercussions for individuals placed in quarantine. A branch head discussed their fears around the impacts of a positive test:

> Actually, I was also one of those hesitant to have the swab test because [if] you test positive, everyone will be affected. To me, I have an elderly mother and my sibling has a young child. We're staying at the same house. So, if I tested positive, all of the people in our compound will be affected. All of us will be quarantined. That was my worry. That was also the feeling of other staff, if they test positive […] because we cannot deny the fact that there are many people living in one house like us, we are very crowded (PS013).

While ICM provided economic and social support to staff members who were placed in quarantine, NGO workers recognized that other people in their communities did not have the same support networks, and they feared being the source of these repercussions for others.

NGO workers identified other fears that had circulated among staff regarding COVID-19 testing: that the swab would be painful, cause nosebleeds, damage vital organs, or trigger allergies. These fears were largely mitigated after ICM's first round of swab testing. However, respondents described associated fears surrounding COVID-19 testing that circulated more broadly in their communities, particularly through social media. Specifically, NGO workers shared the perception that, regardless of test results, public knowledge of their participation in testing would trigger fears among other community members. Anticipating stigma and discrimination, some respondents chose to conceal from others that they had been tested for COVID-19.

While the majority of NGO workers did not feel marginalized in their communities due to their NGO work during the pandemic, some individuals who received a positive test result were the subject of rumours and discrimination. For example, a respondent shared that after recovering from the virus, people continued to turn and walk the opposite direction when encountering them on the street (PS005). Another respondent noted that stories of his death were continuing to circulate through his community, despite his full recovery (PS023). An NGO worker from the same community shared particularly harsh encounters with community members, in response to their positive test result:

> The discrimination was the hardest deal for me […]. [Community members] were saying if they saw me go out of the house they would chop my legs off. They were saying I am useless; why did I go out? So I defended myself saying that the time when I went to an area or left the house, I was not positive at that time. […] The sad part was that

they knew you were down, but they didn't care, and no one ever wanted to be positive, not even me (PS025).

This respondent shared plans to move once their contract with ICM ended, because they felt so unwelcome in their community. Experiences of discrimination were particularly evident in this same community, where four out of six interview participants had received positive test results at some point during the pandemic. While some NGO workers had seen improvement in community attitudes through COVID-19-related education, other respondents did not anticipate overcoming these issues until the pandemic ended or vaccination was more widespread. Respondents who received positive test results indicated that the most valuable response to their situation was the care that they received from their co-workers and from ICM more broadly.

3.2. Everyday experiences of care

In addition to fear, experiences of care featured prominently across interviews. Key subthemes identified through our analysis of everyday experiences of care included how NGO workers were motivated to care for and support individuals and communities engaged in ICM programming, how ICM cared for its employees through organization-wide strategies and protocols, and how NGO workers practiced self-care.

3.2.1. Care as motivation: "You no longer think of yourself"

Respondents frequently discussed how care motivated them to continue in their roles, despite the inherent physical and social risks associated with providing essential services during the pandemic. While NGO workers experienced personal fears in the context of the pandemic, their dedication to supporting individuals in resource-constrained communities prevailed over these fears, driving them to return to community-based outreach work when that became possible. A branch head described this transition from fear to care among their team members:

> [During] the first part of this pandemic […] most of my staff, [myself included], we were all worried about our family, our loved ones, the risk [to] our health, our job, and what lies in the future. But we are able to adjust to the current situation, knowing that we need […] to go on. We began to see outward concerns and problems. [We began to see] that, especially in the communities where we are working, there are people [who] need help more than we [do]. And it's a great thing to see that, even in the state of this pandemic, we are able to reach out to families and communities that [are] really in need (PS020).

Recognizing that their program participants experienced various health vulnerabilities at the best of times, NGO workers were particularly concerned about program participants' health and well-being when the COVID-19 pandemic reached the Philippines. For instance, a respondent shared that, when communities first locked down and ICM's community-based outreach work was paused, they worried that recipients of food aid in their program communities would be forced to leave their homes in search of food, thus putting them at risk for infection (PS001). This area head went on to praise their team members for the commitment to returning to work:

> I'm so happy and encouraged by [ICM's field workers] because they conquered their fear of going outside just with all the heart to help other people. The fulfilling [thing] is that, you no longer think of yourself, but your love, your heart towards other people (PS001).

Throughout the interviews, a key factor driving NGO workers' dedication to their work was their personal alignment with the mission and vision of their organization to care for individuals in resource-constrained communities. As one respondent stated: "I [wouldn't] be this compassionate in my work if I [didn't] love it (PS026)!"

3.2.2. A caring organization: "Full support"

NGO workers spoke about ways in which the care provided by ICM helped address their fears around their community-based outreach work. Respondents felt that they received "full support" from ICM throughout the pandemic in the form of a continual salary, good communication from leadership personnel, and overall responsiveness to their needs and concerns. They described being briefed on the nature of COVID-19 transmission, trained in safety protocols, and given PPE and sanitizing supplies to enable compliance with these protocols on the job. In spite of anxieties associated with organizational COVID-19 testing, a respondent expressed gratitude for these care practices:

> I really appreciate ICM for [caring about] the welfare of the staff. When we go to the community, I need to be sure that I cannot infect [community members] and my family. ICM also provides the payment that you will not spend any single peso from your wallet. And that is for safety purposes, both [toward] the community and me (PS017).

NGO workers indicated that ICM's leadership team also promoted personal care strategies during the pandemic. Area and branch heads discussed ways that they encouraged their staff teams to continue personal hygiene practices and practice self care, such as getting rest and good nutrition. Team leaders described endeavouring to lead by example by being first to receive COVID-19 testing, leading their teams into the field, adhering to organizational protocols, and following their own protocols at home. Through these efforts and encouragement, alongside ongoing emotional and spiritual support, organizational leaders channeled their sense of responsibility for staff well-being into acts of care.

According to respondents, their organization's COVID-19 response not only served to mitigate risk of virus transmission, but also provided a safety net for NGO workers who tested positive for COVID-19. Respondents who had positive COVID-19 test results described receiving food and medical supplies, as well as financial support while in quarantine, mitigating the stress of economic losses. Furthermore, ICM leaders communicated remotely with staff members who had been infected, providing social, emotional, and spiritual support throughout quarantine. This culture of care was evident within staff teams as well, with team members providing prayer and encouragement to one another. Overall, NGO workers believed that their organization, supervisors, and team members cared for, about, and with them – by demonstrating associated care practices of attentiveness, responsibility, and solidarity – and prioritized their personal well-being on and off the job. They also viewed ICM's safety protocols as effective protective mechanisms. In this way, respondents indicated their trust in ICM to provide competent and effective leadership throughout the pandemic.

3.2.3. Self-care practices: "Do everything to protect ourselves"

In addition to organizational protocols and care networks, NGO workers had personal and pragmatic strategies to care for themselves, their families, and their communities throughout the pandemic. Respondents described engaging in hygiene activities prior to entering their home and interacting with other household members. Some stayed in boarding houses or at the local ICM office during the week and only returned to their homes for the weekends or, in one case, practiced social distancing within the home (PS015). Through these measures, respondents felt that they were doing whatever was in their control to keep safe. At the time of interviewing, many respondents expressed confidence in their ability to conduct their community-based outreach work safely. For example, one participant demonstrated assurance in the effectiveness of protocols:

> We know already about COVID-19 and how to protect ourselves, how to protect our families, so maybe there is no more [need to] fear. We just need to put on the protective gear and do what the World Health Organization [says] to do. So, that's it […]. We should keep

ourselves protected [using] the resources that we have. Do everything to protect ourselves and stop worrying, stop fearing (PS022).

At the same time, however, respondents recognized ongoing risks and uncertainties that were beyond their control. In response, respondents consistently cited their Christian faith as a source of comfort and confidence. "Trusting God" thus emerged as a key theme in describing how respondents navigated their NGO work throughout the pandemic. Respondents clearly integrated their personal faith and the faith practices of their organization into their COVID-19 response strategy as a mechanism to maximize their confidence, minimize their fears, and sustain their commitment to providing care during COVID-19.

3.3. Interaction between fear and care affects

Narratives of fear reflected an apparent contradiction: being fearful of the unknown, as well as the known. On the one hand, respondents expressed fear of not knowing whether they were exposed to the virus and potentially transmitting it to others. On the other hand, respondents were fearful of COVID-19 testing and the implications of knowing their test status. Further, respondents experienced an individual psycho-social reaction to a positive test, but also a recognition of the social implications of testing positive. These social implications elicited both fear and care affects: fear of discrimination and stigma associated with a positive test and also fear for personal, family, and community safety, grounded in emotions of care for others. Other community implications of a positive test were also salient in respondents' fear-care narratives. Many respondents reported realizing they were members of a caring organization that would still care for them in quarantine, but also feared they might infect community members in more vulnerable circumstances, who did not have access to those same mechanisms of care and support.

Both fear and care affects were further evident in narratives among respondents and integrated within their lived experiences. In the context of feeling fearful, respondents shared that care was a motivator to continue their work; however, in the context of their care work, fear was still a prominent emotion – particularly understanding the ramifications of testing positive for COVID-19. This interplay of fear and care was especially relevant to how respondents perceived organizational COVID-19 protocols. For instance, many participants identified fear and care as a motivation to adhere to these protocols. This adherence to protocols assuaged fears around transmitting the virus to others and was also viewed as a mechanism for practicing care for one's family and community. Relatedly, individuals noted tangible and intangible ways of navigating fear and care affects. Following evidence-based protocols to prevent virus transmission was a tangible way to cope with fear and practice care for others, while faith was a frequently mentioned intangible coping mechanism for fear and motivation for care work.

4. Discussion

This study characterized the everyday, lived experiences of community-based health actors in the early-to mid-stages of the COVID-19 pandemic in the Philippines. As our findings indicate, these experiences were grounded in the affects of fear and care, and associated practices. Past research on community-based health actors' experiences of risk and fear has tended to focus on their work in conflict zones and other locations of insecurity (Thorpe, 2020), as well as the position and role of NGOs within contexts of insecurity (Irrera, 2019). Our findings bridge this literature on fear and risk experiences to that of public health crisis response. Specifically, this current study contributes insight into the lived experiences of community-based health actors' fears and navigation of physical and social risk within a pandemic context, in which circumstances of risk can tend to be more dynamic and rapidly evolving. Moreover, research on the COVID-19 pandemic has tended to focus thus far on the care experiences and challenges of primary healthcare workers or 'health and social care workers' embedded within formal health care structures (Nyashanu et al., 2020; Shreffler et al., 2020; Spoorthy, 2020). Our current study provides insight on the lived experiences of other key actors in the health work force, specifically those navigating a unique terrain of embeddedness within communities where they live, work, and hold relationships.

Theoretically, our study stands as a template for further application of an ethic of care in resource-constrained pandemic settings, recognizing that community-based health actors who hold an embedded community role often perform multiple layers of care work (Parvati, 2016). There is a need to understand the nuances of this care work, for which an ethic of care is a helpful lens to examine these practices and experiences of care more thoroughly (Fisher and Tronto, 1990). As our findings illustrate, care ethics may also be a useful tool for examining the link between communities and institutions in pandemic response and delivery of care. This link has been identified as important (Cai et al., 2021; Osuteye et al., 2021), but has not yet been thoroughly examined in relation to public health crisis response.

4.1. Navigating fear and care: individual community-based health actors in social context

The tension between knowing/not knowing expressed among participants in this study can be situated within a psychological model of fear experiences during the COVID-19 pandemic proposed by Schimmenti et al. (2020). Specifically, experiences of community-based health actors map to a "cognitive domain" of the "fear of knowing/not knowing" and also an "interpersonal domain" of "fearing for others/-being fearful of others" (2020: 42). These interpersonal fears are well-founded, as experiences of stigma and social ostracization have been reported among community-based health actors in prior public health crises (Bhaumik et al., 2020), and among health care workers during the COVID-19 pandemic (Bagcchi, 2020; Taylor et al., 2020). As our findings suggest, various forms of self-care, such as pragmatic measures to prevent virus transmission in addition to faith practices, can help mediate the impact of fear experiences among community-based health actors. Similar forms of self-care were identified as significant buffers to the stress experienced by community health workers during the COVID-19 pandemic, as cited in a recent U.S.-based qualitative study (Mayfield-Johnson et al., 2020). Evidently, both fear and care shape experiences of community-based health actors during a public health crisis, a finding that aligns with fear-care interactions among informal caregivers during the Ebola outbreak in West Africa (Park and Akello, 2017), and with the fear experiences of primary health care workers persisting in their care work during the COVID-19 pandemic (Alnazly et al., 2021; Sadang, 2020).

In this current study, it is important to note that the fear-care experiences among community-based health actors were influenced by several additional factors including job description, one's level of responsibility for others' well-being, and geographic location. Importantly, there existed heterogeneity in the fear-care experiences of respondents working across different communities and regions. In part, these differences could be attributed to variations in COVID-19 risk (both real and perceived) during the early stages of the pandemic, in addition to context-specific adaptations and responses (at both the NGO and local government levels) to address COVID-19 risk.

4.2. The role of organizational practices and a 'culture of care' in mitigating health actors' fears

Community-based health actors' narratives point to the value of an organizational culture of care, which was integral to actors' confidence amid the early stages of the COVID-19 pandemic. Organizational-level care practices, such as implementing tangible infection control measures, helped to mitigate fears among community-based health actors, as well as fears within communities directed toward these actors (Haldane et al., 2021b). Moreover, those respondents in supervisory roles

expressed fear for the safety of staff for whom they were responsible; yet, they channeled this fear into tangible expressions of care that assuaged some fears of staff. As evidenced in our results, supports for ill workers, proactive communication, and other organizational expressions of care can contribute to worker well-being and 'better care work' overall. A recent narrative review on the psychological impact of COVID-19 on frontline health workers in LMICs named this organizational culture of care and effective leadership as "organizational resilience", which can buffer worker stress (Deng and Naslund, 2020). While the mental health of primary health care workers has been identified as an important issue during the COVID-19 pandemic (Vizheh et al., 2020), there is a need to extend this concern to other key actors in the health workforce, including those in community-based, community-engaged roles. Thus, an ethic of care at an organizational level can bolster the activities of more frontline community-based health actors, which is of particular relevance in a pandemic context when worker capacity and well-being are paramount to effective response.

4.3. Fear in community-based, pandemic care work: systems-level implications

Community-based health actors play a critical role in public health crises, past and present (Abramowitz et al., 2015; Osuteye et al., 2021). During the COVID-19 pandemic, community engagement has been esteemed as particularly important to infection prevention and control (Gilmore et al., 2020). Our findings expand the definition of who is involved in the ecosystem of community-based health actors doing this health-related engagement to include workers employed by NGOs. In line with Olaniran et al. (2017), who characterize the community health workforce as diverse, we suggest that those doing community health work are, in fact, a complex and dynamic network of actors and organizations with shared goals. Actors perform distinct, yet interrelated, roles and work collaboratively outside of formal health systems to support the health and well-being of communities. Thus, by broadening the definition of who does community-based health work, our study contributes to understandings of what community-based health care and engagement looks like in practice within a pandemic context.

As our findings also suggest, the community embeddedness of this ecosystem of health actors can also present unique challenges in public health crises (Mallari et al., 2020). Being from or living close to the communities where they work creates social risk in the care work of community-based health actors, as they may experience stigma or discrimination in their personal lives due to others' knowledge of their work. Moreover, this positionality influences how actors navigate more personal and community relations. Early in the COVID-19 pandemic, community health workers in some contexts reported a lack of clear guidance as to their specific roles and, further, risked being perceived as the "face of unpopular policies" when engaging with communities in these roles (Lotta et al., 2020:366). They experienced the social challenge of being both 'community member' and 'worker'. Given this distinct positioning from other healthcare workers, more clarity may be required in terms of their health system contribution to pandemic response efforts and, relatedly, strengthened training and support to perform their specific roles. For instance, many community-based health actors already perform active surveillance at the household level for poverty-aligned diseases like tuberculosis or child malnutrition (Lau et al., 2020a, 2020b; Lee et al., 2019). This active surveillance role could be effectively adapted to pandemic response with enhanced training in identifying virus symptoms and referring to appropriate supports. Additional mental and physical health supports may also need to be extended to protect these crucial actors in the health workforce (Pan--European Commission on Health and Sustainable Development, 2021), especially given the potential for social and relational challenges associated with their role.

4.4. Limitations

This study was conducted with a single faith-based NGO in the Philippines. As such, the lived experiences reported by community-based health actors are particular to ICM and the communities with which they work. A non-faith-based organization may implement different organizational care strategies, and employ individuals who draw on different forms of self-care to mitigate their fears, than the faith-based NGO represented in this study. Further research might expand the topic of this study to NGOs in other LMICs and to other organizational contexts to include a more diverse group of respondents and experiences. In addition, this study relied on self-reported accounts of NGO worker experiences. Although efforts were made to build rapport with respondents, social desirability may have shaped some responses shared by respondents. Finally, this study interviewed NGO staff who provide health-related supports adjacent and complementary to, but distinct from, formal health services. Opportunity exists to expand this research to explore the lived experiences of formal healthcare professionals employed by NGOs in health emergency response and how they navigate the intersection of fear and care.

5. Conclusion

Community-based health programs are often regarded as critical to strengthening health systems in the face of emerging complex, global challenges (WHO, 2021). While notably effective in emergency response, there exists a lack of clarity as to how community-based health actors contribute to the functioning of health systems in practice, who is included in this ecosystem of actors, and their experiences of care work. By noting discourses of fear and care, and the interactions between these two affects, this research underscores how community-based health actors continued to provide care while navigating physical and social risks associated with the COVID-19 pandemic. Thus, we contribute to this dialogue an enhanced understanding of the challenges faced in community-based health crisis response and clarify who is involved in these response efforts. Further, we consider what it might look like at organizational and systems levels to equip and support this ecosystem of community-based health actors as they navigate responding to public health emergencies.

Credit roles

Dodd: Conceptualization, formal analysis, funding acquisition, investigation, methodology, project administration, resources, supervision, writing – original draft. **Brubacher:** Writing – original draft. **Kipp:** Conceptualization, investigation, formal analysis, investigation, methodology, writing – review & editing. **Wyngaarden:** Formal analysis, writing – review & editing. **Haldane:** Conceptualization, project administration, investigation, methodology, writing – review & editing. **Ferrolino:** Investigation, writing – review & editing. **Wilson:** Investigation, writing – review & editing. **Servano Jr.:** Investigation, writing – review & editing. **Lau:** Conceptualization, funding acquisition, methodology, project administration, resources, writing – review & editing. **Wei:** Conceptualization, funding acquisition, methodology, project administration, resources, supervision, writing – review & editing.

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Declaration of competing interest

Authors (HF, KW, DS Jr. & LLL) receive renumeration from International Care Ministries (ICM). The authors have been provided

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2022.115222.

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