LESSONS OF INCLUSION IN PANDEMIC GOVERNANCE

Community Engagement in Pandemic Governance (CELG)

AFRICA COALITION ON TUBERCULOSIS

ACT! ACTIVISTS' COALITION ON TB ASIA-PACIFIC

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Published by APCASO Foundation
With support from the Global Fund

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ISBN (E-book): 978-616-94502-1-4

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ACKNOWLEDGMENTS

This publication was made possible thanks to the efforts of Rachel Otu-Amponsah of the **Africa Coalition on Tuberculosis (ACT-Africa)**, and **Activists' Coalition of Asia-Pacific (ACT! AP) & APCASO**, whose community engagement strategic initiatives have been the foundation of this work on Community Engagement and Leadership in Pandemic Governance (CELG), now referred to as Community Engagement in Pandemic Preparedness and Response (COPPER). More importantly, the work and lessons learned presented here were conducted tirelessly by our partners in the 8 countries where COPPER was implemented: FIS Cameroon, Stop TB Partnership Kenya, ADPP Mozambique, Janna Health Foundation Kenya, CISMAT Sierra Leone, KHANA Cambodia, Jarangan Indonesia Positif (JIP), and Action for Health Initiatives (ACHIEVE), Philippines. This project was also supported with funding from the **Global Fund to Fight AIDS, Tuberculosis, and Malaria.**

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Activists' Coalition on TB – Asia-Pacific (ACT! AP) hosted by APCASO
ACT-Africa

May 2024

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Acronyms

AMIMO	Mozambican Miners Association
CBO	Community-Based Organisation
CELG	Community Engagement and Leadership in Epidemic Governance
CLM	community-led monitoring
CSO	civil society organisation
FGD	focus group discussion
ICH	Innovations for Community Health
IDP	internally displaced population
KVP	key and vulnerable population
LMP	last-mile population
NGO	nongovernment organisation
NTP	national TB program
PASTB	Philippine Alliance to Stop TB
PPPR	pandemic prevention, preparedness, and response
PCV	patient care volunteers
PSG	peer support group
PWD	people with disability
SSI	sub-sub-implementer
SSR	sub-subrecipient
TB	tuberculosis
TB HEALS	TB Health Education and Livelihood Support Community
VHSG	village health support group

Background

The COVID-19 pandemic has accentuated inequity and unequal access to health services especially life-saving services and commodities to TB. COVID-19 related lockdowns all over the world has increased both TB incidence and TB-related deaths in 2021, which has set back the TB response for 5 to 8 years[1]. Countries like India, for instance, would incur additional TB-related deaths of 40,685 between 2020 to 2025 before national TB response would return to normal. Similarly, Kenya would incur an additional 1,157 deaths before returning to normal. Further, pandemics such as COVID-19 have exposed the heightened level of inequity among what is considered as last-mile populations (LMPs). These populations are categorically defined as those who are not only poorest of the poor but are also people who continue to be underserved and excluded, where development needs are greatest, and where resources are most scarce.

In TB, several populations are considered last-mile due to their condition, situation, susceptibility, and increased risk to contracting TB. These are slum dwellers, people with disabilities, internally displaced populations, refugees, migrants, people in closed settings (such as prisoners), and tricycle drivers. Their increased risk to TB and their overall situation to TB has further exacerbated during the COVID-19 pandemic with an increased number of incidence and/or risk. In 2020 in Indonesia, for instance, as many as 222 cases of TB among the 116,358 incarcerated people in correctional institutes were detected in 5 provinces.

Focused effort is needed to further understand the risks and vulnerabilities of these last-mile populations in the context of TB. Thus, in 2023, the Global Fund implemented the project, the Community Engagement in Pandemic Governance (CELG), that aimed to reach identified LMPs, build their capacities in advocacy and leadership, include them in existing TB efforts, and eventually influence COVID-19 and pandemic decision-making at country level.

Community Engagement in Pandemic Governance (CELG)

The CELG project sought to develop and test community engagement strategies and approaches that enable LMPs as part of TB networks to influence COVID-19 and PPPR decisions at the country-level. Its activities can be summarised into two:

- Conduct community engagement assessments and mapping out LMP organisations, TB community-led organisations and civil society, and existing (if any) COVID-19 or PPPR processes and platforms at the country level wherein LMP can engage.
- Develop a costed community engagement plan that identifies the strategies that will build and strengthen the engagement of LMPs in the TB and COVID-19 decision-making processes

1 https://stoptb.org/assets/documents/news/Modeling%20Report_1%20May%202020_FINAL.pdf

Eight countries undertook the community engagement assessments, namely Cameroon, Kenya, Mozambique, Nigeria and Sierra Leone in Africa; and Cambodia, Indonesia, and the Philippines in Asia-Pacific. Each country was designated with a specific LMP, defined by each country's context of their extreme vulnerability to TB and COVID-19. During data gathering, surveys, focus groups, and individual interviews were conducted among LMPs themselves as well as among service providers. Results in the assessment highlighted the vulnerabilities of LMPs to TB, COVID-19, and other pandemic threats because of their living conditions and overall situation, high risk of infection, and the little to no access to information and care both during COVID-19 and to TB. LMP identified aspects of their marginalisation, discrimination, and economic adversity that supersede health threats in their situations. In many cases, these vulnerabilities become limiting factors in their capacity to mobilise and engage as a community, as for example when they had to prioritise going to work over attending meetings and training, or when they are too remotely located that even the logistics of coming together already presents significant challenges.

One marker of vulnerability for LMPs is the scarcity of existing data on TB prevalence or even general health risks among some populations. With the lack of prioritising these populations in public health care planning, the health situation of LMPs remains unseen and unrecorded. Public and available data are either anecdotal or outdated, which could not be utilised to design health programmes that would specifically cater to the needs of these populations. Hence, these assessment has enabled and initiated data gathering on these groups that could become a basis of further attention on their situation.

The recommendations from these country-level assessments were utilised to guide the development of community engagement plans. A number of consultations were conducted among LMPs as well as dialogues with government representatives and other decision makers to develop these costed plans that seek to focus on six areas of community engagement: (i) information and knowledge-sharing; (ii) consultations; (iii) collaboration; (iv) empowerment; (v) participation; and (vi) community leadership. Each country's costed community engagement plans sought to improve the inclusion of LMP in the TB and COVID-19 programming and policy-making, and improve their participation in the decision-making processes. Succeeding activities were conducted by country implementers based on these plans, and these will be presented in the succeeding sessions.

To consolidate the learning and to share them among country implementers, a regional CELG Knowledge Hub was also established. The Hub is currently hosting a website, **https://celg.apcaso.org**, which holds a repository of various reports and tools that were produced by its country implementers. The Hub also hosted a series of LESSONS webinars, which aimed to provide an orientation about pandemics among country implementers, and learn among each other's implementation of community engagement plans. The Hub also tried to facilitate discussions among the eight country implementers to further expand the understanding about community engagement of LMP in the context of pandemics.

The next section will highlight each country's community engagement plans and related activities, and share the lessons that country implementers have learned throughout the implementation process of their engagement plan activities.

Country Compilation of Lessons Learned: AFRICA

CAMEROON

Nine out of 10 **internally displaced populations (IDPs)** in Cameroon are unaware of any network or organisations responsible for TB and COVID-19 programming in their country. This shows that these populations have been excluded in existing health programming. Results in the community engagement assessment shows that stigma, discrimination, and poverty hinder the engagement of IDP and raise their issues in health-related decision-making processes.

Community Engagement Plan Implementation

During the period, different approaches have been implemented as part of the country engagement plan. This were (a) information and mobilisation, (b) consultation and involvement, and (c) collaboration and empowerment of IDPs.

IDPs and other stakeholders including government, NTP, and international and national NGO participated in an orientation workshop to launch the process of adoption and implementation of tools for engaging LMP and community structures in the

response to TB, COVID-19 and other pandemics (CELG). This community-oriented process contributed to informing and mobilising IDPs to participate in addressing short-term concerns with strong external support from partners.

IDPs were involved as early as the development of the community engagement assessment report, which already aimed to build the interest of IDP and recognise the importance of their engagement and voice in designing the assessment about them. Recommendations of this report aimed to contribute towards improving access to TB and COVID-19 services.

FIS Cameroon, CELG's country implementer, conducted several activities under this approach. This included (a) production of a 13-minute documentary that highlighted collaborative activities between IDP support groups and social infrastructure to improve support and access of IDP to TB and COVID-19 services; (b) building the capacity and empowerment of 3 groups of IDPs; and (c) strengthening the Pandemic Prevention, Preparedness, and Response (PPPR) multisectoral platform with strong participation of IDP representatives together with TB-led community organisations and civil society organisations, government representatives, national and international organisations, and WHO country offices and other UN organisations. Through these activities, IDPs are empowered to develop systems for self-governance, establish and implement priorities, and develop sustainable mechanisms for health promotion with external partner's network.

Lessons Learned

FIS Cameroon identified several lessons throughout the implementation of the community engagement plans. This includes (a) strong situational analysis, (b) participation of IDPs during the implementation, and (c) alignment with national efforts.

First, a strong situational analysis serves a sturdy foundation on the kind and level of interventions that can be included in the community engagement plan. The situational analysis report that was developed in Cameroon contributed to the country's strong understanding of the national policies and guidelines. One key recommendation of the report shows that the involvement of communities is mandatory in most of the decision-making process and body.

Second, the participation of a diversity of LMPs should be ensured and prioritised throughout the duration of the implementation of the community engagement plan. In Cameroon, while the target population was IDP, FIS Cameroon made sure to have an equitable representation of men, women, and adolescent girls and boys. This contributed to providing additional sense of realities of experiences among IDPs as well as an increased level of empowerment among these different population segments. Third, the situational analysis that were conducted contributed towards decision makers becoming more aware of the situation of IDPs at country level, including ongoing efforts. This has helped find alignments in the activities that will be identified in the community engagement plan. In Cameroon, this process meant aligning with existing activities of the Ministry of Public Health's Disease Control Directorate of Epidemics and Pandemics. A succeeding national plan for preparation and response to epidemics and pandemics of respiratory pathogens was validated in late 2023.

Challenges

Some ongoing challenges still remain to be addressed, such as:

a. **Access to information and a lack of accountability** on the part of public bodies responsible for implementing state policies. The priorities of IDPs are more oriented towards subsistence.
b. **IDPs have limited participation** mainly due to discrimination, poverty, ignorance, lack of communication, and language barriers.
c. **Limited participation of other partners** such as other ministerial departments in charge of social issues and finance. The participation of major United Nations agents was also a handicap in the process.

Despite this, two key facilitating factors played towards the success of the implementation of the community engagement plan in Cameroon. The first is the **leadership of the Ministry of Health**. At the start of the process, FIS Cameroon organised several meetings with the different directorates of the Ministry of Health and the national Tuberculosis Control Program. This made it possible to strengthen the leadership of the Ministry of Public Health throughout the process. Towards the end of the project, the Ministry of Public Health has: (i) contributed to improving the research protocol and facilitated obtaining administrative authorization for research as well as documentary research; (ii) invited other administrations to various pandemic and epidemic-related meetings; and (iii) ensured alignment with ongoing efforts at the national level.

The second facilitating factor was the **orientation among all stakeholders** that was conducted at the onset of the project. Through this orientation workshop, an evaluation workshop was developed to guide the implementation of the community engagement plan for IDPs; and a set of protocol and tools for assessing the engagement of LMPs and community structures in the response to TB, COVID-19 and other pandemics were developed among main parties and integrated amendments. A steering committee of national stakeholders were also setup that will be in charge with technical support and supervision of the entire evaluation. This has showed a strong commitment of the national government in the implementation of the community engagement plan beyond the CELG project in Cameroon.

Kenya

Interventions in Kenya focused on people with disabilities (PWDs). From the community engagement assessment report that was conducted, it was found that common forms of disabilities intersect with other existing diseases, such as chronic respiratory diseases, cancer, diabetes, malnutrition, HIV and AIDS, other infectious diseases, and injuries such as those from road accidents, falls, land mines, and violence. Results of the assessment also show that PWDs systematically face economic and social disadvantages due to poor access to many social services. They also face stigma and and discrimination, which perpetuate the lack of access to health care services. These challenges contribute to unhealthy lifestyle and poor mental health, creating a cycle of poor health. At the decision-making level, PWDs are often left out even in inclusion policies in national governance frameworks. Lack of facilitative programs and materials further exacerbate the exclusion of PWDs and hinder their participation. Such materials include braille, interpreters for the deaf, transport for persons with limited mobility, among other rehabilitative facilities.

Community Engagement Plan Implementation

The Community Engagement Plan of Kenya focused on addressing a myriad of challenges of inclusion among PWDs while at the same time, addressing the broader social issues that hinder PWDs' access to health services. Interventions to respond to self-stigma and stigma from the community were also identified. Healthcare workers that attend to PWDs were also provided through the community engagement plan.

Lessons Learned

Several lessons were identified throughout the implementation of the community engagement plan. A major lesson was the **creation of partnerships**. Creating partnership for emergency preparedness specifically tailored to PWDs is crucial for ensuring their safety and well-being during crises. This created increased inclusion of PWDs in programming and planning for emergency preparedness and leveraged existing networks for enhanced response. Increasing the amount and coordination of disability research and routinely including PWDs in general health research help close the knowledge gap on effective interventions. Active collaboration across agencies in planning health disparities research, including funding, monitoring, and dissemination of findings have also increased the inclusion of PWDs. During the duration of the implementation of the community engagement, PWDs engaged with government agencies, NGOs, disability advocacy groups, healthcare providers, educational institutions, international organisations and donors, media and communication channels, local government authorities, and technology and innovation partners.

Another significant lesson is the need to r**ecognise the diverse needs of PWDs.** Disabilities can vary greatly in type and severity, and everyone may have unique requirements during a disaster that needs to be assessed so that interventions are tailored. Understanding and addressing these diverse needs is crucial. This includes understanding their cultural context and situation, and take into consideration their cultural beliefs, attitudes, and practices that may influence individuals' perception and response towards disasters. This would also encourage pandemic preparedness plans to be flexible and adaptive to accommodate the changing needs of PWDs.

Engaging PWDs in the planning process is also essential. Throughout this process, PWDs offered valuable insights into their own needs and could contribute to the development of more inclusive pandemic preparedness plans. Inclusion ensures that no one is left behind and that plans cater to the needs of the entire community. Learning from their experiences and coping strategies could also inspire new approaches to disaster preparedness that benefit the entire community. At the same time, working with PWDs on pandemic preparedness can empower them to take an active role in their own safety and resilience. Providing them with the necessary knowledge, skills, and resources enables greater independence and self-determination during emergencies. Engaging PWDs also mean building strong partnerships with disability advocacy organisations and community groups. These partnerships help to amplify the voices of people with disabilities, advocate for their needs, and ensure that their perspectives are incorporated into pandemic preparedness efforts. These also increase collaboration among activists that advocate the needs of PWDs.

Challenges

Our country implementer in Kenya faced several challenges during the conduct of the various community engagement plan activities. Apart from the broader challenges of stigma and discrimination and limited access to social services including education and health among PWD, the lack of representation in decision-making process has hindered the ability to advocate for their rights, participate in community planning, and influence policies and programs that affect their lives. Likewise, the lack of awareness and sensitivity among community members about the rights and needs of people with disabilities have contributed to the misunderstandings, patronising attitudes, and reluctance to include PWDs in community initiatives. Many communities in Kenya also lack adequate infrastructure and services to accommodate the needs of PWDs. Inaccessible buildings, transportation, public spaces, and communication channels hinder their ability to fully participate in community activities and access essential services. PWDs living in rural and remote areas face additional challenges related to geographical isolation. Limited access to transportation, healthcare, and support services can exacerbate social isolation and restrict opportunities for community engagement.

Mozambique

The community engagement assessment report in Mozambique shows that there is a low level of awareness about TB and COVID-19 services among miners in Mozambique, with only 1 in every 10 miners know organisations that provide TB and COVID-19 related services among their groups. This is similar to the results with regards to community participation, wherein only 2 in every 10 have engaged as TB patient care volunteers (PCV) based on focus groups discussions (FGDs). Three in every 10 miners interviewed also perceived that their government played a significant role in TB and pandemic response, while 6 in every 10 indicated their government's presence at the local or sub-national level.

Results of the community engagement assessment were used to develop the community engagement plan among miners as well as ex-miners, government representatives, NGOs, and CSOs working with miners, TB, and pandemics. Mozambique's community engagement plan focused on the six elements of the plan, namely (i) information, (ii) consultation, (iii) collaboration, (iv) empowerment, (v) participation, and (vi) leadership.

Community Engagement Plan Implementation

Key activities from the community engagement plan of the country are detailed below:

1. **Appointment of a district government focal point to respond to the issues of miners and ex-miners.** During the advocacy meetings conducted with the government at the district level, one focal point was selected to monitor and follow up on all the issues concerning miners and ex-miners. The focal point will work directly with the Mozambican Miners Association (AMIMO), the health directorate, community leaders, and other organisations working with miners and ex-miners to understand the problems and barriers faced by these target groups regarding TB, COVID-19, and broader PPPR involvement and services. In addition, the focal point will work with AMIMO to explore other areas such as investments (entrepreneurship support) and land ownership documents to support miners who return home from the mines to be reintegrated into the community and have a closer follow-up with health issues.
2. **Created a platform on which government and miners and ex-miners meet regularly.** The district administrator focal point created a government platform to regularly meet with miners and ex-miners at the district level. For these meetings, the government focal point for miners and ex-miners will prepare the agenda with issues to be discussed based on the challenges and barriers reported at the community-led monitoring (CLM) platform of the miners and ex-miners as well as with the issues reported by the community leaders. Meetings were conducted thrice a year.
3. **Mapping of all miners and ex-miners in Manjacaze district.** The focal point together with AMIMO and the community leaders mapped the miners and ex-miners in the Manjacaze district and report the total number to the district government for succeeding advocacy meetings last week of March. The mapping aims to know the total number of miners and ex-miners in each administrative post to compare with the total number of ex-miners who visit the occupational health center in the district.
4. **Miners and ex-miners are included in community committees at the community level (administrative post) and the district level (district government).** A total of 6 ex-miners were included in the community health committees (5) and the natural disasters management committee (1) at the district level. The miners were selected by AMIMO and proposed to the community leaders and the district government.
5. **Miners are organised as small groups at the community level.** To ease the coordination and participation of miners and ex-miners in the existing committees, AMIMO was recommended to work with the community leaders to organise all the miners and ex-miners in small groups/associations at the community level. This aims to involve all miners and ex-miners without leaving anyone behind and eases the efforts of AMIMO and the district health directorate to follow up and screen all ex-miners and their families and their participation on community committees.
6. **Dissemination of TB, silicosis, and covid-19 information**: 176 miners (family members) and ex-miners of three (3) administrative posts (Manjacaze-sede, Chibondzane, and Macuacua) were trained in 3 days on TB, silicosis, PPPR and on advocacy skills.

Lessons Learned

ADPP identified a number of lessons and recommendations throughout the implementation of their community engagement plan. One major lesson was the **need to establish a TB network for better coordination among the organisations working with miners and ex-miners in TB, COVID-19, and PPPR programs.** AMIMO together with Kenguelekeze and ADPP called for a meeting with organisations mapped during the mapping exercise including NTP to discuss the need to revitalize or create a new TB network to respond to the weak coordination and consultation between various actors implementing TB programs and working with miners and ex-miners.

Based on AMIMO's experience in implementing OneImpact CLM, it has proven to be a useful platform for community engagement, including with ex-miners. Therefore, **CLM platforms should be used and expanded as a platform for LMP to voice concerns that can be shared and addressed.** The barriers reported through the CLM gave a voice to LMP that can be used as evidence to inform the design of different programs targeting LMP by different donors, and to advocate for the revision of policies and programs to include miners and ex-miners in decision-making on TB, COVID-19, and PPPR. AMIMO and Kenguelekeze will continue to implement CLM to engage mine workers and ex-miners through the CLM process and hereby improve the TB and PPPR response.

The **appointment of a district government focal point for LMP issues showed to be an effective way to facilitate the inclusion of miners and ex-miners** in various community committees, including the government natural disaster and management community at the district level. There is also a need to involve all local TB, COVID-19, and PPPR stakeholders at all levels and to develop an action plan with sufficient resources to improve coverage of TB, COVID-19, and PPPR activities among miners and ex-miners.

Lastly, miners and ex-miners need to be **included in the community structures for TB, COVID, and PPPR.** This would ensure their active role in voicing the barriers they face and are be actively involved in the implementation of initiatives related to PPPR and promote inclusivity and diverse perspectives. This must also be accompanied with education and empowerment interventions to build and strengthen LMP's skills.

Challenges

The implementation of the community engagement plan in Mozambique was not without challenges. Primarily, the lengthy process by the Ministry of Health in approving the bioethics committee protocol led to the delayed conduct of the community engagement assessment, which further delayed the succeeding activities including the development of the community engagement plan. Bureaucracy also played a role in identifying needed government informants during the data gathering process. Low literacy, language barriers, and limited knowledge about TB and COVID-19 among miners and ex-miners also impeded the timely implementation of the community engagement plan in the country.

Nigeria

The community engagement assessment in Nigeria focused on the involvement of nomads and internally displaced populations (IDPs) in the country, understanding their vulnerabilities to TB, COVID-19, and pandemic prevention, preparedness, and response (PPPR).

Key findings indicate limited community engagement at national and sub-national levels, with challenges such as inadequate representation, lack of feedback mechanisms, and cultural barriers affecting the participation of women and girls. Despite this, successful initiatives have been implemented to include the formation of Steering Committee, survivor associations, and CSO coalition for TB, raising awareness to the needs of nomads and IDPs. Findings also emphasise the need for improved community understanding of PPPR, active participation of LMP representatives in decision-making bodies, and investment in capacity building for effective engagement. Recommendations included tailored education targeting LMP, strengthened partnerships, gender-sensitive involvement, and the establishment of feedback mechanisms between civil society representatives.

Community Engagement Plan Implementation

Nigeria's community engagement plan focuses on the involvement of communities and civil society in all stages of the PPPR processes, with a goal to ensure that communities and civil society are effectively engaged in country-level processes and mechanisms related to PPPR, emphasising the integration of health equity, human rights, and gender equality. The plan in Nigeria has three objectives, namely:

1. Strengthen the capacity of communities and civil society at the national and sub-national levels to engage in PPPR processes;
2. Enhance coordination and networking to create a shared PPPR vision integrating health equity, human rights, and gender equality; and
3. Support meaningful community engagement in PPPR governance, implementation, and oversight.

Lessons Learned

Based on the implementation of their community engagement plan activities, three key lessons were identified:

1. The project underscores the **pivotal role of community engagement** in TB care and prevention among nomads and IDPs. Actively involving them enhances the effectiveness of the TB programming and breeds local ownership and sustainability of interventions.
2. **Establishing robust partnerships** with government entities, community leaders, academicians, and NGOs is a critical lesson. These collaborations contribute diverse perspectives, resources, and support, fostering a holistic approach to TB care and prevention.
3. The importance of **cultural sensitivity** emerges as a key facilitator in the implementation of the community engagement plan activities. Adapting interventions to local contexts, using culturally relevant terminologies, and involving community leaders contribute to greater acceptance and success.

Challenges

One major challenge in the conduct of the community engagement plan was the limited representation of CSOs and LMP representatives in national-level coordinating structures for TB, OVID-19, and PPPR. This was mainly due to the lack of awareness of LMP among other stakeholders coupled with the lack of awareness on TB, COVID-19, and PPPR among nomads and IDPs that hinder their lack of access to prevention, treatment, and care services. Janna Health Foundation, country implementer for CELG in the country, recommended strengthening community engagement, including investing in capacity building for LMP representatives, promoting gender-sensitive involvement, and enhancing partnership and coordination between sub-national authorities and stakeholders would help improve this major challenge. There was also a proposal to establish feedback mechanisms between CSO representatives and LMPs, design tailored communication strategies for LMPs, and support training of health workers and community volunteers to improve TB case notification.

Sierra Leone

CISMAT, our CELG partner in Sierra Leone, targeted persons living with disabilities (PWDs) and slum dwellers as their LMP given that this population had the least level of access to health services and COVID-19 and TB interventions. Conducted across 8 districts in Sierra Leone, the community engagement assessment found that PWDs are associated with beggars, those who use assistance (such as wheelchairs), and those that are visually impaired. They are also exposed to chronic illnesses and sexual violence, particularly young girls with disabilities who are vulnerable to unwanted and unsupported pregnancies. They also faced socioeconomic issues, such as unemployment due to low level of literacy.

It was also found through the assessments that most people with disabilities fall in conflict with the law during the pandemic response to COVID-19 and Ebola. People with disabilities were criminalised for not wearing masks, which they could not afford.

Community Engagement Plan Implementation

The costed community engagement plan mainly conducted a number of regional advocacy meetings that aimed to propose engagement mechanisms for PWD and slum communities in the TB and COVID-19 responses. Key government entities, namely the National TB program, the NARCOVEC, former COVID-19 response departments, and the local administrative councils have been targeted for these regional advocacy meetings. Likewise, partnerships among PWD networks, such as the Network of Organisations of PWD, and the Sierra Leone Disability Union (SLUDI) were involved to coordinate with their respective members.

Lessons Learned

Two major lessons were learned during the engagement of PWD and slum communities in Sierra Leone. The first is with regards to allocation for incentives as part of encouraging the engagement of LMP; the second is around needs-based planning.

During the mobilisation of PWD and slum communities, CISMAT faced issues of settling food and daily subsistence allowance, which apparently was needed to sustain the engagement of the LMP. Extra budgeting is needed not only for the LMP themselves, but also for the caregivers assisting PWD to ensure that they assisted throughout their engagement. Some of them would hesitate to attend community meetings because no social or economic benefit were secured for their caregivers, which eventually deter their PWD clients to attend their mobilisation activities.

CISMAT also learned the importance of designing their advocacy activities based on the needs of the PWD and the slum communities. However, their disabilities and their needs vary greatly in type and severity, hence understanding their diverse needs is critical. This can be addressed by including as many diverse LMP as possible, representing their realities, aspirations, and needs.

Challenges

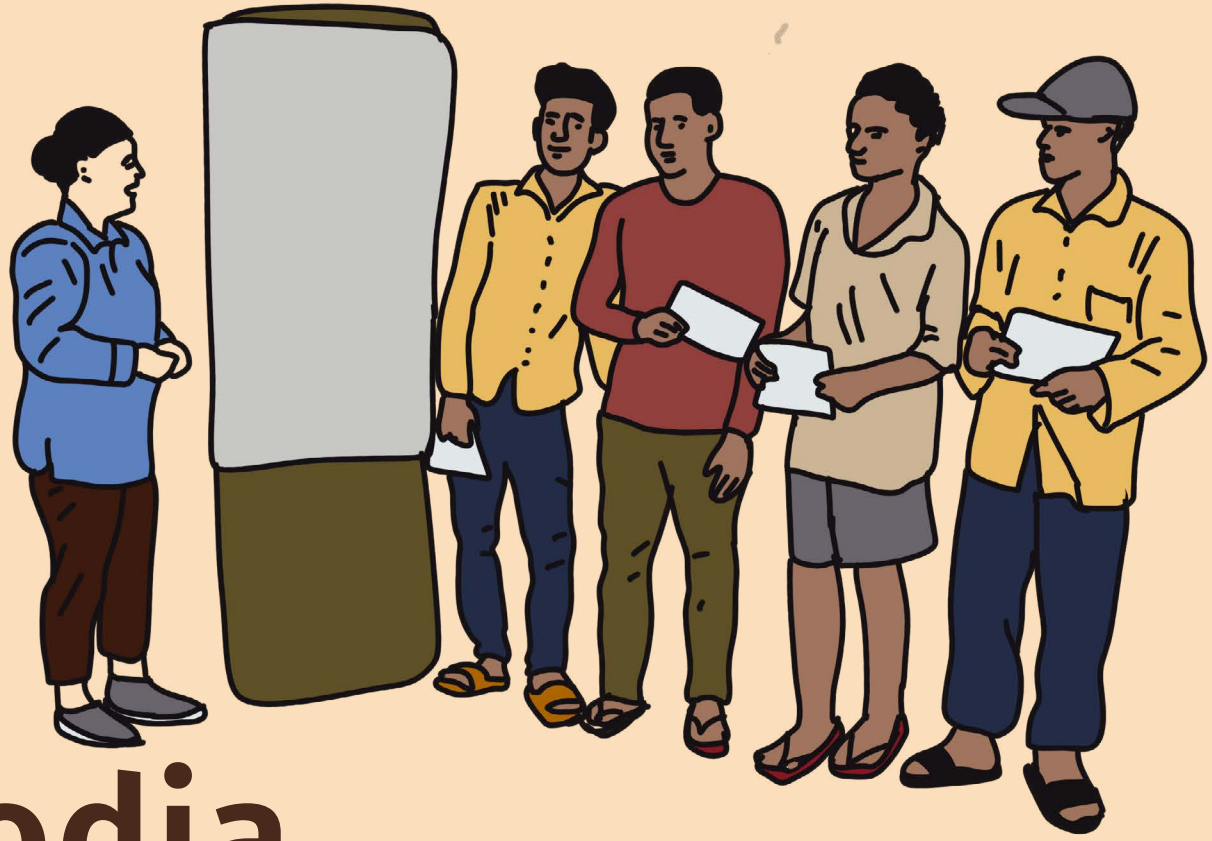
Some of the challenges that CISMAT encountered during the implementation were mainly around outreach of LMP and slum dwellers and providing information and education about TB and COVID-19 to where they are located. Many sites where activities were conducted do not have appropriate transportation and infrastructure, which make it difficult to reach PWD and slum dwellers.

This difficulty to reach out LMP also made it difficult to implement communication strategies that would convey the needed TB and COVID-19 information. There was a need to leverage multiple channels such as through radio broadcasts, print, and through community meetings.

Similarly, the lack of diverse representatives from LMP in policymaking processes have affected the kind of issues and priorities that were advocated for inclusion in policymaking and programming. A more diverse representation is needed to ensure that the issues that are being raised also represent the diversity of the LMP communities.

Lastly, and most importantly, despite the implementation of the CELG project, the lack of sufficient funding to support other initiatives beyond CELG remains a huge challenge. This tend to affect how LMP engage in the implementation of the community engagement plans under this CELG project.

Country Compilation of Lessons Learned: Asia-Pacific



Cambodia

Internal migrants in Cambodia face vulnerabilities when it comes to TB and other infections due to their work environment and access to healthcare wherever they are located. This became the focus of the CELG project in the country. KHANA, our country partner, focused on internal migrants located in Phnom Penh, Siem Reap, and Sihanouk provinces, wherein their awareness about pandemic prevention-related activities as well as in TB are assessed, including their level of engagement across the TB and pandemic responses. In the community engagement assessment survey that they conducted, it was found that only 3 in every 10 respondents knew of the village health support group (VHSG) and lay counsellors who visited and invited them to participate in community-level meetings wherein discussions on TB are held. Likewise, 50% of the respondents said that they have never had attended any meetings related to TB at all. When it comes to COVID-19, 6 in every 10 respondents had better awareness of COVID-19 preparedness and response that the government had organised.

Community engagement plan implementation

Cambodia's community engagement plan focused on expanding and strengthening meaningful engagement of key and vulnerable populations (KVPs) and LMPs in the TB and PPPR responses. They identified 4 objectives, namely: (1) integrating internal migrant workers and construction workers as part of the LMP in the national TB response; (2) strengthening the capacity of the representatives of TB-affected communities and LMP to empower and enable them to actively participate in the TB and PPPR responses; (3) advancing the TB community and stakeholders' participation in the TB and PPPR response; and (4) addressing the TB community and stakeholders' participation in the TB and PPPR response. The work involved organising a number of advocacy meetings among health ministry stakeholders including the national TB program (NTP) to raise awareness and sensitize high-level government officials and key stakeholders on the need for integration and participation of LMPs in the TB and PPPR response at country level. Advocacy meetings among 41 leaders from LMPs, TB champions and TB community leaders were also conducted to raise awareness about the need to strengthen leadership, advocacy, and community mobilisation for effective integration of LMPs in the existing programs and services.

The CELG team also organised partnership and coordination meetings for the inclusion of LMP in existing TB networks. Through these meetings, 54 members of various TB networks as well as other leaders of key population networks of HIV have welcomed LMP in their respective groups.

To sustain the initial engagements and partnership that were formed, focal points who will be responsible for support the work were assigned. At the same time, KHANA established 24 peer support groups (PSGs) and recruited 388 LMPs from the 3 provinces.

Throughout the implementation of the community engagement plan, KHANA translated the documents into Khmer to increase access of LMP with the documents, and to better understand not only the project but also what the interventions aimed to achieve.

Lessons Learned

Three lessons can be learned from the implementation of the CELG project in Cambodia. These lessons revolve around partnership, timing, and innovation.

Working with strong partnership and engagement of various stakeholders have proven to be an effective measure of success of the CELG project at country level. It was identified at the

beginning that there was a limitation of support and collaboration from local authorities due to security reasons, and construction workers' disinterest in participating due to anticipated loss of productivity and earning. To address this, the NTP, provincial health districts, and village health support groups have been mobilised to participate in the project from the onset. Orientation meetings were conducted to enjoin these stakeholders and increase their interest in the project.

Timing of meetings and mobilisation of LMP needs to be considered. The project team worked in flexible ways to conduct the community consultation meetings among LMPs at night so as not to be in conflict with their timing of work in the morning. The team also engaged with VHSGs and commune councils at the community level to gain access to migrant workers in their domicile and locations.

It was also identified during the entire implementation of the CELG project that there is a low understanding on TB, COVID-19, and PPPR among core members and leaders of TB KVPs and LMP. The community engagement plan that was developed, for instance, appeared foreign when presented at the community level that the CELG team in the country found it arduous to promote, adapt, and implement these interventions. **Strengthening LMP and TB networks' capacity to understand COVID-19 and PPPR, as well as TB, needs to be built and sustained.** Provision of technical and financial assistance needs to be available to improve the engagement and advocate for the inclusion of LMP.

Challenges

Several challenges were identified by our CELG partner in Cambodia during the implementation of the project in Cambodia. First, core members and leaders of TB key and vulnerable population groups and networks as well as LMP have low understanding on TB, COVID-19, and PPPR. This has affected the way some of the activities had to be conducted in the country; ensuring that all civil society and community stakeholders understand these concepts first before committing to support the project activities. Second, despite the support that was provided in the implementation of community engagement plan, resources remain limited to continuously support them. This was particularly relevant in integrating PPPR into existing Global Fund-supported projects, including in the HIV, TB, and malaria grants. Lastly, there is a limited level of partnership and engagement from existing sub-sub implementers (SSIs) and sub-subrecipients (SSRs) to support the implementation of the engagement plan. Most of these implementers and recipients focused on the service delivery aspect of the work, while community-led advocacy and social mobilisation interventions were not being supported. This has affected the level of understanding and support needed in integrating CELG activities across the three disease grants.

Indonesia

The support to Indonesia under the CELG project focused on the involvement of former and current prisoners in the prevention and control of infectious diseases such as TB, COVID-19, and other infectious diseases. During the community engagement assessment phase that was carried out in 3 provinces, namely DKI Jakarta, West Java, and Bali, several interviews and focus groups were conducted among representatives of CSOs, representatives of correctional institutions, representatives of civil society organisations, and representatives of the prisoners community. Results of the assessment show that both prisoners and ex-prisoners still have low or non-existent level of information about TB, COVID-19, and PPPR activities in the country, despite being part of a community or an organisation (4 in every 10 prisoners interviewed). Consequently, only 7% of the respondents interviewed have heard of a CSO who has been working for TB in the country. Eight out of ten respondents stated that they neither know about the coordination mechanism and network for pandemic preparedness and response that is available in Indonesia, nor were they aware that the LMP (such as themselves) were covered by these networks. In terms of engagement based on the information, consultation, collaboration, empowerment, and participation related to TB, COVID-19, and PPPR activities, most of the former prisoners stated that they did not know about how to engage in the health programme.

Community Engagement Plan Implementation

The implementation of the country engagement plan in Indonesia, which focused on the five components mentioned above, yielded significant outcomes in enhancing community resilience through PPPR. Activities in the community engagement raised awareness, increased access to healthcare, reduced stigma, improved monitoring, built capacities, and integrated programs that were keys to engaging ex-prisoners in the response to TB, COVID-19, and other pandemics in Indonesia. Adequate information that were provided to ex-prisoners also allowed them to understand prevention measures and treatment options. Improved access to health services guaranteed access to needed medical care. Activities related to responding to stigma and discrimination also helped create an inclusive environment. Capacity building also enabled active participation in prevention and health promotion.

Several partnerships were also forged during the implementation of the engagement plan. During this period, country-level partnerships with diverse stakeholders in COVID-19 and PPPR were established. JIP, our country partner in Indonesia, collaborated closely with the Ministry of Health to ensure alignment with national health policies and to optimise resource utilisation. Partnerships with NGOs specialising in public health has also extended the reach and effectiveness of the engagement-related activities. Likewise, the Directorate General of Corrections played a role in ensuring the health and well-being of individuals within correctional facilities by supporting their successful reintegration into society, including their engagement in disease prevention and pandemic response efforts.

Lessons Learned

One of the key lessons learned during the implementation of the community engagement plan was the importance of **tailoring communication strategies to the local context**, recognising the cultural, linguistic, and social intricacies of the community that would increase the impact of information dissemination and would encourage active participation in pandemic-related initiatives. This underscored the importance of using approaches that are sensitive to local and specific conditions for effective engagement, especially in the context that each district in Indonesia has unique and heterogeneous social and cultural characteristics.

Involving ex-prisoners in the design and implementation of interventions is also an important lesson that was learned during this project. Prioritising the active participation of ex-prisoners in decision-making would ensure that interventions are context-appropriate and meet community needs. This lesson underscores the importance of collaborative and participatory approaches for sustainable and impactful pandemic response strategies.

Finally, **flexibility and adaptability** have proven to be critical in community engagement strategies. The dynamic nature of the pandemic and the varying needs of communities require a flexible approach. Remaining responsive to evolving circumstances allows for timely adjustments, ensuring that interventions remain relevant and effective. This lesson underscores the importance of maintaining a flexible mindset and adaptable strategies to meet the challenges.

Challenges

Engaging in the PPPR process poses important challenges, each of which demands practical solutions for successful mitigation. One prominent obstacle is the **communication barrier stemming from language and cultural differences**. To overcome this, a multi-faceted approach was essential: incorporating communication strategies and tailoring them to the wisdom of the ex-prisoners. Involving community leaders helped bridge the gap, ensuring that important information reaches and is understood by ex-prisoners and their communities.

Limited resources, which included financial and information limitations, were another challenge. To address this, strategic resource allocation based on critical needs and high-impact interventions is essential to establish. Seeking partnerships with government and NGOs can help secure additional funding and resources. Implementing sustainable practices, such as ex-prisoners-led initiatives as part of a broader community participation, add resources and expand the reach of interventions.

Finally, **community resistance due to misinformation about ex-prisoners** is a barrier to prevention efforts and collaboration with PPPR efforts. Community engagement campaigns and involving community leaders and health workers can build trust and credibility of ex-prisoners. Utilising diverse communication channels and addressing issues directly help to disseminate accurate information, and to build cooperation between ex-prisoners and the community in the PPPR decision-making.

Philippines

Action for Health Initiatives (ACHIEVE), Inc., CELG country implementer in the Philippines, focused its CELG project towards tricycle drivers. Tricycles are one of the major and cheapest forms of public transportation in the Philippines, plying mostly in streets and inroads in the country. Its extensive reach at the community level in the country exposes its drivers, owners, and operators to vulnerabilities to TB with continuous exposure to smoke, pollution, and other direct risk factors with their passengers and co-drivers. However, results from the community engagement assessment reflected the dearth of information on the prevalence to TB among tricycle drivers.

Tricycle drivers are organised through the Tricycle Operators and Drivers Associations (TODA), which provides franchises to its members to be able to operate legally within their assigned routes. Government health facilities also work directly with TODA to arrange for their registration and other non-health services such as social support among others.

Despite this, based on the mapping survey, 19 respondents from TODA mentioned not having any services being provided to their peers who may have been exposed to TB, including provision of education and information. While 28 of 29 respondents indicated awareness of agencies and implementers that provide COVID-19 related services, only 15 mentioned knowing implementers who can provide TB services.

Community Engagement Plan Implementation

The Philippines' community engagement plan focused mainly on building the awareness capacity and developing peer education skills among TODA members. Around 52 TODA members from 26 TODA groups were trained as peer educators. Eight in every 10 of those who were trained completed the training and have already reached almost 900 other TODA members. They were provided with basic TB and COVID-19 information. During the training, around 20 participants openly discussed their families having experienced TB. Some of them also shared being stigmatised or discriminated because of TB. This showed that the training has had some impact with how TB is regarded among these populations, and how the training enabled them to talk about TB.

As daily wage earners, TODA members find it difficult to miss their work and have shown little interest during the initial stage of the project. Persistently, through the training, TODA members have become involved through invitation efforts and due to the recommendation from TODA leaders who were part of the project's initial activities.

Partnership

A couple of partnerships were established throughout the implementation of the project. This includes government agencies such as the Quezon City's Health Department and Tricycle Regulation Division. CSOs and CBOs including the Quezon City TODA Federation and Culion Foundation, Inc. CSOs such as Innovation for Community Health, Inc. (ICH)., Breathe-Free PH, and TB Health Education and Livelihood Support Community, Inc., (TB HEALS), who are also members of PASTB, a nationwide network of CSOs and CBOs working on TB, also became project partners of the CELG project in the Philippines.

The partnership with these stakeholders enhanced the engagement of the TODA community in TB Community-Led Monitoring (CLM) which is currently being implemented by PASTB in Quezon City. Though the current TB-CLM in the country is only focused on TB, plans for integration with HIV, as well as pandemic response are part of its long-term plan.

Lessons Learned

Four major lessons transpired during the implementation of the CELG project in the Philippines. These lessons revolved around partnerships; provision of incentives; communications; and importance of sustained skills-building efforts.

First, the visibility of government agencies identified by the TODA community during the snowballing and mapping exercises helped

gain the community's confidence with the project. The presence of representatives from the government, CSOs, and support group members of the PASTB also helped boost the morale of the TODA groups. The TODA community expressed that they felt the stakeholders' support in the pursuit of improving the quality of their life and their readiness to face another health emergency like that of COVID-19.

Providing incentives as part of the improving health-seeking behaviours of TODA members was also identified as a key lesson. The Quezon City Health Department and the Tricycle Regulation Division introduced incentive strategies to improve the health-seeking behaviours of the TODA community to encourage them to undergo chest X-rays and COVID-19 vaccination by providing groceries. This was a response to the request from TODA members of the importance of providing food support or incentives in lieu of them missing their daily work.

Consistent communication is also crucial as part of building trust within the community especially in the context of this project. As daily wage earners, TODA members, especially those who ply the streets, find it difficult to respond to calls or messages, making it challenging to engage in community or health-related activities. To respond to this issue, the CELG team in the Philippines had to meet with the TODA members in their passenger terminals. This has helped build rapport and connection with the members and has significantly increased their participation in the project.

With proper training, suitable materials, sustainable support, and motivation, members of the TODA community can also become effective peer educators and leaders. This is a major learning in the implementation of the CELG project. Addressing TB-related stigma and discrimination has also encouraged some TB survivors to share their experiences more openly.

Challenges

The implementation of the community engagement assessment faced a number of challenges, mainly around mobilisation and low level of knowledge on TB and COVID-19.

Engaging the TODA community in the project proved to be a daunting task as most of them were daily wage earners. Initially, the community expressed their concern about the loss of income they would incur during the project's activities. Realising the importance of community participation, the CELG team decided to offer allowances and incentives, such as T-shirts, rubbing alcohol, and masks to TODA members as an incentive for their involvement.

The CELG team also observed poor engagement in various aspects of TB, COVID-19, and PPPR knowledge and relevant skills such as consultation, collaboration, empowerment, and participation of key and vulnerable populations, including last-mile populations. Consequently, the community identified the need for the right information about TB and COVID-19, and expressed their willingness to learn. They underwent Peer Educators' Training of Trainers, which built their capacity to provide awareness among their peers about TB and COVID-19, making them valuable partners in the fight against the pandemic.

Conclusion and Recommendations

Many lessons learned were identified by our country partners during the implementation of the CELG community engagement plans, which shows the level of innovation engaging LMP has become in the context of PPPR. Most CELG country partners were strongly involved in mobilising and advocating with TB and HIV organisations; working with a relatively new population entails learning and adjusting to be able to respond to the most pressing needs of these populations.

Among these various lessons, three common lessons learned have been identified across the eight countries: (a) diversity; (b) flexibility; and (c) partnership. These three common themes are also this report's recommendations for future engagements with LMP in the context of epidemic and pandemic responses.

1. Protocols to ensure diversity of LMP needs to be defined and in place prior to the initiation of projects such as CELG.

Acknowledging and recognising the diversity of the LMPs that were identified in each country is crucial: from identifying approaches to encourage LMP to participate in the CELG processes, to developing the community engagement plans, and to implementing those plans at the local level. LMP, similar to TB-affected communities, key populations to HIV, and other affected and marginalised populations in the context of any disease, have varying experiences and needs across the life cycle, based on their sexual orientation and gender identity and expression, and citizenship status. In the case of Kenya, the diverse needs, including the types and severity of these needs, have been identified in the situational analyses, which enabled the country team to adapt and be flexible in responding to these needs during the implementation of the community engagement plan.

2. Multistakeholder partnerships need to be established from the onset of the CELG project.

While the implementation of the CELG project needs to be led by key and vulnerable communities and LMP themselves, establishing partnerships with the government and key stakeholders at the onset of the project will offer opportunities to leverage partners' support in the implementation of community engagement plan activities. These partnerships can also provide additional and diverse perspectives as well as resources in fostering holistic approach in responding to the needs of LMPs in the context of PPPR.

3. Governments and relevant stakeholders, including other civil society organisations who are or will be working with LMP, need to be more flexible and adaptive to the realities and needs of LMP to be able to respond to their most pressing needs.

The community engagement plans that were developed during the CELG project responds to the gaps and recommendations that were identified in the community engagement assessment exercises, as well as the discussions that transpired during the presentation and the dialogues among LMPs, government, and other relevant stakeholders. It is necessary, however, that at the very onset of the implementation of the community engagement plans that the results of the analyses reflect the diverse needs of the LMPs. In the experience of our CELG country partners, they needed to introduce additional sustenance allowances to their LMPs and their partners (i.e. caregivers) not only to encourage them in participating in CELG activities but also in lieu of their absence at work. In Cambodia, timing of activities needs to be considered to avoid conflicting with working hours of the construction workers who are their LMP. This level of flexibility also plays a role in employing the needed adjustments as country partners continue to shape and tailor localised communication strategies to local context, recognising cultural, linguistic, and social realities of the LMPs.