Identifying and Prioritizing Community Engagement Activities to Strengthen Global Health Security

GHPC Kenya Workshop Proceedings

Sarah Paige

Senior Advisor, Global Health Security Agenda

CORE Group

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Introduction:

CORE Group is a not-for-profit membership organization that convenes global community health professionals to share knowledge, evidence, and best practices, and then translates these into the real world with a direct impact. The Global Health Practitioner Conference (GHPC) is CORE Group's flagship annual conference. GHPC Kenya is CORE Group's first regional conference on community health.

GHPC Kenya was held from 14-16 October 2019 at the Safari Park Hotel in Nairobi, Kenya. Over 250 individuals attended the conference from 21 different countries. The attendees represented a diverse set of community health stakeholders. Participants included Ministry officials, community health workers, private sector, policy and program technical specialists, UN, youth, and media.

Prior to the conference itself, CORE Group created opportunities for pre-conference workshops and site visits. One of the workshops was entitled *Identifying and Prioritizing Community Engagement Activities to Strengthen Global Health Security*. The purpose of the workshop was to leverage the community engagement expertise that participants bring to GHPC to generate indicators, benchmarks, and/or examples of activities that promote the role of communities in global health security programming and planning.

Workshop Preparation

CORE Group hosted weekly meetings from August through September 2019 to prepare for the pre-conference workshop. The working group was comprised of eight individuals, including content and training experts from the US, Kenya, and Ethiopia. The team met weekly to discuss resources, materials, teaching methods, presentations, and desired outcomes. Five of the working group members led the development of slide decks for use at the workshop. One deck was dedicated to briefing participants on the status of global health security, a second deck provided in-depth content that is building the evidence and capacity for stronger community engagement approaches for outbreak preparedness and response. A third deck provided instructions for the three group work sessions that were based on content in the *WHO Benchmarks for International Health*

Workshop Abstract

The **Global Health Security Agenda (GHSA)** was launched in February 2014 to advance a world safe from infectious disease threats, to bring together nations from all over the world to make new, concrete commitments, and to elevate the International Health Regulations (2005) as a national leaders-level priority. Global health security practitioners and policy makers acknowledge the need for an inclusive, community-led approach to strengthen a nation's capacity to prevent, detect, and respond to infectious disease. However, missing from the health security toolkit is a clear path to do just that.

Part of **CORE Group's *2019 Regional Global Health Practitioner Conference (GHPC): Leverage, Link & Learn for Community Health***, this session bridges the experience of community-based organizations alongside global and national health security planners and policymakers to share best practices in community engagement that will strengthen health security from local to national levels and beyond.

Regulations (2005) (IHR) Capacities. Additional content experts joined the workshop to support facilitation and note-taking during the group work exercises.

In addition to the workshop planning meetings, CORE Group sought informal consultations with high-level stakeholders. The purpose of these conversations was to share information about the planned workshop and seek feedback regarding concerns or opportunities related to the process of identifying and compiling promising community engagement strategies to promote the role of communities in global health security programming.   Input was collected from WHO, UNICEF, Anthrologica, Resolve to Save Lives, Georgetown University Center for Global Health Science and Security and used to guide the materials presented and the output.

A description of the workshop is provided in Attachment A. Here we present the ideas generated by the workshop. In some instances participants proposed new Benchmarks, or new activities and indicators. The next step is to improve upon these ideas for new Benchmarks, activities and indicators through further discussion.

Outcomes by a subset of WHO Benchmarks

Despite the fact workshop participants were new to global health security architecture, terminology, and frameworks, facilitators were able to work with participants to identify potential contributions to WHO Benchmarking document; develop new community-focused indicators to support the WHO Benchmarks; and recommend proven community engagement strategies that could be repurposed for health security priorities. The participants proposed new Benchmarks and identified many community-focused indicators for activities that could be implemented to support capacity building efforts among five Technical Areas of the Joint External Evaluation. The five Technical Areas were selected from across the three categories of the Joint External Evaluation of prevention, detection, and response.

1) **IHR Coordination, Communication and Advocacy, and Reporting**. This area is limited to national level indicators given its link to policy and advocacy, but the participants argued there is a role for community engagement. Therefore, the participants recommended including a new Benchmark within this technical area.

Establish a mechanism for ensuring issues that are relevant to community needs, priorities, and capacities are included in national multisectoral coordination meetings, and the results of those meetings are fed back to the community

This new Benchmark could be measured through the following indicators:

- Number of village/unit health committees that are aware of the IHR coordination mechanisms
- Proportion of village/unit health committees that regularly discuss IHR/health security

- Number of monthly multisectoral coordination meetings that include community representatives
- Number of best practices for community engagement shared by community members that are subsequently included in National Action Plan for Health Security
- Resource mobilization through bottom up budgeting (yes/no)
- Number of collaborative or joint monitoring visits that include village/unit, Ward, District, Region, National level focal points for health security/IHR

2) **Antimicrobial Resistance (AMR)** Participants developed several indicators that addressed multiple streams of work within the Technical Area of AMR. For example,

Multisectoral coordination for AMR indicators:

- Proportion of private sector engaged in One Health platform at community level
- Number of community members engaged in the participatory approach
- Number of communities with AMR action plans in local languages for local engagement
- Number of relevant sectors involved in implementing AMR action plans

AMR Surveillance indicators:

- Number of public and private health facilities testing before treating with antibiotics Proportion of community health workers trained to use guidelines for prescribing antibiotics at the community level
- Level of antimicrobial resistance within priority pathogens

Optimal use of antimicrobial medicines in human and animal health indicators:

- Proportion of community members purchasing antibiotics in licensed/registered pharmaceutical shops/kiosks
- Proportion of shop owners providing antibiotics without prescriptions
- Proportion of community members requiring antibiotics referred to healthcare provider
- Proportion of vets, farmers educated on antibiotics

When reviewing the Benchmarks associated with "Infection Prevention and Control (IPC) for AMR", participants identified the need for clear IPC recommendations at community and household level and proposed the following:

Establish community-level infection prevention and control guidelines that account for local environmental, social, ecological, and livelihood contexts, resources and capacity

And identified indicators to reflect that Benchmark

- Proportion of community members practicing optimal hand-washing behaviors
- Number of activities implemented with locally available resources

- Community IPC guidelines adopted by village/block health committee (yes/no)

Participants recommended the participation of Water, Sanitation, and Hygiene colleagues for technical assistance and guidance.

3) **Surveillance**. Participants recommended two Benchmarks that explicitly highlight the role of community:

Develop a legal/policy framework with strategic plan and finance strategy for community-based surveillance that is flexible and adaptable

Ensure community-based surveillance system is a component of the government system starting at the lowest administrative level and feeding data up to central level

A corresponding set of indicators was proposed:
- Percentage of specified target diseases, syndromes, and/or conditions reported by the community-based surveillance system OR
- Does the community report according to the standards/thresholds set within the national surveillance structures and system?
- Number or proportion of people who are able to report an event within the community (but outside the formal health system)
- Number of multisectoral community health committees established that include surveillance in their organizational scope
- Timeliness of reporting health events within the community up to the surveillance system
- Proportion of reports coming from multisectoral surveillance teams

4) **Emergency Response Operations**. The following community-focused Benchmarks were developed and recommended by participants to ensure a functional emergency response coordination.

Identify, train, resource, and roster multisectoral community level response teams for rapid deployment

Ensure community health workers/community volunteers are trained and engaged to share messages and to convey basic surveillance information (links to surveillance and RCCE technical areas) and to listen and address community priorities

Establish a mechanism for identifying and utilizing local knowledge of affected communities (ie, identify physical and cultural barriers to access; operate through trusted sources of information)

Ensure the EOC has capacity and motivation to establish a direct channel of data exchange from the community to the EOC for decision making and feedback during emergency response

Conduct simulations with a focus on information and feedback flow from the EOC back down to volunteers/community level for action in the community

Involve community representatives/religious/traditional leaders in the development of plans and SOPs at the EOC level, especially at sub-national EOCs.

Ensure communities are involved and consulted about community level response plans

Maintain capacities of volunteers and community level responders through refresher trainings and investment

Corresponding indicators are

- Proportion of reporting and data gathering materials available at community level
- Number of trained community-level rapid response teams
  - (Identify optimal population-level coverage)
- Proportion of community stakeholders involved in planning and coordination
- Register of trained community volunteers (i.e., surge support) (yes/no)

5) **Medical Counter Measures and Personnel Deployment.** Participants identified the following indicators to measure progress towards the goal of a functional system for activating medical counter measures.

- Proportion of people at the community level trained on protective measures
- Number of medical and non-medical supplies within communities and are readily available (e.g. chlorine, ORS, gloves)

 Operational Considerations
Workshop participants were tasked with identifying the essential components of effective community engagement approaches and the operational needs for successful implementation. Foundational to each example was the discussion of *trust*, *local participation*, and *partnership*. The importance of trust cannot be over-emphasized. The 'best practices' provided by participants leveraged existing sources of trust within target communities and to simultaneously were designed to steward and strengthen trust between community members and implementers. Two in-depth examples are included in Attachment C. These components are a reinforced by the UNICEF Community Engagement Standards, which describe a much more comprehensive and validated set of principles to use to guide the development and implementation of community engagement approaches (Attachment D).

International Rescue Committee is implementing community-based surveillance using lessons from polio to conduct Ebola surveillance in Uganda. The teams conduct regular community dialogues where questions are asked: "what would you do if…" and the

community provides insights. IRC also works with key informants in the community to strengthen surveillance and expand their network of trusted sources. They also engage schoolteachers, traditional healers, shop owners – to distribute and engage community members on what to do. Using community-based key informants is economical and allows for the collection of rumors and subsequent adaptation of messaging. When this approach was implemented for polio surveillance, detection rates for onset of fever and paralysis increased from 60% to 80%. Because the strategy worked it is now being utilized for Ebola surveillance.

However, all the work presented in this report requires operational considerations. Participants reflected on the broader elements required for effective implementation. For example, participants agreed that political buy-in, human resources, financial resources, feedback systems, evidence and reports, community coordination mechanisms, commitment, shared leadership, gender/youth/disability considerations, local champions, and locally informed monitoring and evaluation mechanisms are needed for successful implementation of community engagement activities.

<u>Summary</u>

Given the current state of realization and desire to improve the way communities are integrated into outbreak preparedness and response structures, the opportunity to tap into a cohort of community engagement experts to inform outbreak preparedness and response capacities was of significant value. We were able to gain insight and guidance from experts to re-imagine the WHO Benchmarks for IHR capacities from a community perspective. The conversations that took place during the group work were rich and informative. We unfortunately did not have a chance for meaningful follow up during the workshop itself. This report reflects only a small fraction of the significant work that took place. We expect these conversations to continue, and that this report is a spark towards the development of a compendium of community engagement approaches and interventions that are oriented towards the health security community across all scales.

Proposed Next Steps

This document is being shared back to participants and to those individuals who were consulted in the workshop development phase. As part of that dissemination, we are seeking feedback on how the information may be used within their respective organizations, and if there is a way to further enhance linkages between the community work and health security programming at national level. Further discussions are necessary among a broader audience, including UNICEF, GOARN, Africa CDC, and at national and subnational levels, to continue refining the Benchmarks proposed at the workshop and the utility of the corresponding indicators.

Attachment A - The Workshop

The workshop was originally capped at 50 participants, however, all interested participants were permitted to join the workshop, therefore the attendance reached as high as 80 participants at one point. A sign-in sheet captured names, organizational affiliation, email address, and permission to follow-up. A total of 65 individuals from 40 different organizations signed in.

The workshop was kicked-off by welcoming remarks from Lisa Hilmi, the Executive Director at CORE Group. That was followed by a presentation on The Global Health Security Landscape and a presentation on Community Engagement and Outbreak Preparedness and Response.

After the presentations, participants were tasked with three assignments to be completed in small groups. Group size ranged from 8-14 members. Each group had a group work facilitator and a note-taker. The facilitator was pre-identified and had expertise either in GHSA or Community Engagement, or both. The note-taker was identified at the time of the assignment. The note-taker's role was crucial, since the goal of the workshop was to identify and curate a set of proven community engagement strategies that could be redeployed in support of health security programming. Unfortunately, the note-takers did not receive adequate training or orientation, so the information that was collected during the group work activities was variable.

> Lessons Learned: In the future, we need to figure out another way to capture the information gleaned at tables that doesn't fall upon one person taking notes. We might need to consider a maximum number of workshop attendees so that all are able to actively participate. Finally, we learned to communicate with pending attendees frequently to encourage them to complete 'pre-work'.

The first assignment was to share best examples of community engagement interventions, models, or strategies from their organization or experience. All participants who had registered in advance of the workshop received an email requesting them to use a template to complete the assignment so that they would have an example ready to share with the group, and that we could use in the workshop report. Only two participants completed the assignment in advance (Attachment C).

The second assignment for group work was to repurpose the examples provided to fit within the global health security technical areas. Selections of the WHO Benchmarking document were assigned to the tables, with a table facilitator responsible for leading the small group through the exercise. This activity was followed by a third assignment, which challenged groups to then consider the operational components needed to implement the intervention as part of a global health security program.

Overall, community engagement activities shared in the first and second group work assignments repeatedly emphasized the role of **trust, familiarity, and collaboration or partnership.** A few examples highlighted the concept of empowerment and actualized the

concept through interventions that informed community members of their rights, and reframed health and quality health service delivery as a right.

The results from the third assignment were very thoughtful and immediately relevant to the global health security Benchmarking document. The groups were assigned chunks of the Benchmarking document for different technical areas, and generated indicators and operational needs for those areas. This content is included in the main body of the report.

Attachment B:

Examples of Best Practices in Community Engagement from Workshop Participants

ORGANIZATION	PERSON SUBMITTING	CONTACT INFO
Kenya Red Cross Society	Naomi Ngaruiya	ngaruiya.naomi@redcross.or.ke
Activity	Indicators (qualitative or quantitative)	Operational requirements
I. Through the support of IFRC and USAID, Kenya Red Cross Society is working in 4 counties (*Narok, Bomet, Tharakanithi and West Poko*t) whose major socioeconomic activities are animal farming. The organization has since trained **723** Community Health volunteers (**CHVs**) on Epidemic Control for Volunteers (**ECV**) module together with Community Based Health First Aid (**CBHFA**)aimed at enhancing community knowledge /basic concepts on the common epidemics which include zoonoses and Human diseases. This has been followed by further training of **263 C**HVs on community Based Surveillance **(CBS)** from the above aimed at strengthening the ability to monitor disease trends and health status thus an early warning system for effective response or action. Armed with knowledge and skills, the trained CHVs have since intensified house hold visits to communicate on good healthy practices, organized community group sessions, community dialogues and also targeting influential local leaders with epidemics preparedness information for priority diseases. At the community level, a group of CBS volunteers are linked to a supervisor (*veterinary officer or public health officer*) who is fully trained on CBS. During the routine activities of House hold visits, CBS volunteers are able to send alert messages through an M-health platform	Justification of the intervention success; 1. There is observable risk behaviour reduction in the target communities. E.g sampled households are able to explain the risks of eating carcasses of dead animals unlike before when the behavior was more rampant. 2. Epidemic disease Case finding and reporting is a notch higher as opposed to one year ago when the community morbidities and mortalities associated with zoonotics passed un noticed. These alerts have eventually resorted to improved resources allocation and routine animals' vaccinations with	The Community Epidemics and Pandemic Preparedness Program has been a pilot project in the four counties. Community based surveillance as the words state is by itself a preventive, and detective weapon culminating to effective and timely response. To achieve these objectives key inputs are required which are: 1. Well predefined curriculum which is able to integrate both animal and person epidemic causing diseases. This was formulated by both KRCS and county partners drawn from Vets and PHOs 2. Formulation of CBS protocol which was also done by both partners which clearly stipulates the how, the who and when. 3. The intervention is resource intensive since strong surveillance systems are needed which includes: Communication structures, report tools, response tools, training

for event based reporting from the community to the supervisors who actions and follow up in case of a pending epidemic outbreak.	data justification (need based planning). 3. Community engagement through community dialogues has had a ripple effect as the trained ECV/CBS trained male volunteers have since formed small sub surveillance committees in their estates/villages to vigil on any mischief incase an animal dies and someone decides to slaughter overnight and sell to innocent community members.	materials, investigation resources as well as regular monitoring and mentorship. 4. Long term sustainability approaches will require multiharzard contingency planning for more coordinated response as opposed to silos where different stakeholders respond to epidemics differently.
II. Schools' preparedness for early detection and early action through campaigns and information sharing. To complete the cycle of community epidemic and pandemic preparedness, schoolteachers have been trained on ECV and CBS package as well and further encouraged to form health clubs in their schools. School health clubs have become the best platform for learners to acquired epidemics prevention, preparedness and response knowledge which they further cascade down to their parents during holidays thus there is constant preventive education in the target community.	3.Since the teachers were trained on ECV and CBS two animal bite cases have been identified from schools, coordinated and treated effectively. Most schools had no sanitary facilities which was indicative of higher chances of epidemic conditions like cholera. But soon after the 4 days training the teachers ensured that sanitation facilities were immediately installed.	IEC materials for learning institutions on epidemics/pandemics and if possible to input the school curriculum as a long term measure.

Figure 1; Hand sanitation facilities installed in one of the project area schools to avert acute diarrhoea cases e.g. Cholera

Figure 2:Dialogue meeting held at one of the community units Narok County where two persons had been affected by anthrax ….Community dialogue is a key aspect towards achieving GHSA

Figure 3; Epidemics prevention sessions in schools…a key aspect towards strengthening capacities to prevent ,detect and respond to infectious diseases.

Figure 4; Community maps by community health volunteers showing epidemic diseases hot spots...an indication of effective preparedness since communities have become aware of the risks….key aspect towards advancing GHSA

ORGANIZATION	PERSON SUBMITTING	CONTACT INFO
Wote Youth Development Projects	Peter Owiti	pngola@yahoo.com +254728300521
Activity	Indicators (qualitative or quantitative)	Operational requirements
Community based TB active case finding TB and referral system where trained community health volunteers(CHVs) and Facility linkage assistants (FLA) follow up of all new smear positive clients for active case finding. Two community health volunteers are stationed at the high volume facility of Makueni level 4 facility where all inpatients are sensitized on TB ,they monitor coughs at the waiting bay and invite any client that has any of the symptoms like 1). Cough of any duration 2).Previous Contact with TB patient 3).Night sweat 4). Loss of weight 5). Fever 6). Fatigue and short of breath All those who answer yes to 1 & or 2 are invited to produce sputum escorted to lab for Genexpert test and if positive is enrolled for treatment Other community health volunteers (CHVs) attached to each facility are given contacts of all new TB patients within their jurisdiction after consent by the patients to follow then at home and screen all family members and if there are	*We know this is a successful project because* 1. *Case detection increased (15 %)* 2. *Increased enrolment in IPT uptake for underage children* 3. *Improved tracking of those lost to follow-up at laboratory and clinic since they are all escorted (0)* 4. *Improved linkage between outpatient clinicians and laboratory department (100 %)* 5. *Improved treatment outcomes (deaths below 5%)* 6. *All the 60,000 clients that visit facility are every month are sensitized on TB.* 7. *Improved Infection Prevention and control and cascade of care as all patients are visited at home*	*This project is at cohort stage . To be successful we are learning that we need* 1. *Scale up facility linkage assistants from 2 facilities to 8 other high volume facilities* 2. *Improve welfare of community health volunteers and facility linkage assistants from 8.5 dollars per referral and 2 dollars per day for FLA to improve e retention .* 3. *Clear Standards of Practice regarding how much volunteers could do so that they do not put themselves at risk OF exposure to the bacteria and continuous checkup for LTB* 4. *Continuous training to update CHVs on new technologies and information like lam tests and 3HP and human rights* 5. *Help the CHVs to be a registered body with legal settings and certification to improve their CV*

underage children to enroll them in Isoniazid Preventive therapy (IPT) and also refer any asymptomatic person for further investigation	*and family members trained*	

Attachment C

UNICEF Community Engagement Standards 1-pager

1. Background

With the support of the Bill and Melinda Gates Foundation, UNICEF C4D has developed '**Minimum quality standards and indicators in community engagement**' to provide globally established guidance on the contribution of community engagement in development practice as well as humanitarian action. The objective of the standards is to support implementation of high quality, evidence-based community engagement at scale in development and humanitarian contexts. Modelled on the IASC Minimum Standards, these standards include 16 core minimum standards (see Table 1), with six core standards (principles) driving three key areas of application: Implementation, Coordination and Integration, and Resource Mobilization. It also includes suggested indicators for governments, for implementing agencies (NGOs & CSOs); and tools (checklists and matrices) to support the localized development of indicators.

Part A: Core Community Engagement Standards	Part B: Standards Supporting Implementation
1. Participation	7. Informed Design
2. Empowerment and Ownership	8. Participatory Planning and Preparation
3. Inclusion	9. Managing Activities
4. Two-way communication	10. Monitoring, Evaluation, and Learning
5. Adaptability and Localization	**Part C: Standards Supporting Coordination and Integration**
6. Building on Local Capacity	11. Government Leadership
	12. Partner Coordination
	13. Integration
	Part D: Standards Supporting Resource Mobilization
	14. Human Resources and Organizational Structures
	15. Data Management
	16. Resource Mobilization and Budgeting

These standards resulted from a wide-ranging consultative process from 2018-2019 that built on current practice and research. It included consultations with sector-targeted working groups (emergency health, health and nutrition, WASH), as well as UNICEF country, regional, and headquarters offices. Key collaborators included World Health Organization, Médecins Sans Frontières, European Center for Disease Control, U.S. Centers for Disease Control, members of the CORE Group network, Wellcome Trust, the U.S. Agency for International Development, the Bill and Melinda Gates Foundation, OXFAM, Save the Children, World Vision, CARE, the International Federation of the Red Cross, the London School of Hygiene and Tropical Medicine, MIT, and numerous government representatives.

2. Why have Minimum Standards for Community Engagement?

Community engagement is a technical approach to directly involve local populations in all aspects of decision-making, implementation, and policy. Building on a participatory approach, community engagement strengthens local capacities, community structures, and local ownership to improve transparency, accountability, and optimal resource allocations across diverse settings. Strategically, community engagement sits at the nexus of community systems strengthening, accountability to affected populations, and communications for development (C4D). When done well, community engagement improves the likelihood that communities lead on issues that affect them, access and use services, improve their well-being and build resilience. Community engagement expands the influence of local actors, facilitate the acceptance of information and public education communications, and builds on existing local capacities.

Historically, it has been difficult to scale community engagement due to a lack of consensus around definitions, core criteria, measurement, and local and national contexts. These minimum standards seek to establish a common language for governments, local populations, donors, implementing actors, and policy makers, in order to facilitate the adoption and acceptance of this essential range of practices.

CONTACT US
1901 Pennsylvania Avenue, Suite 902
Washington, DC 20006
202.380.3400
contact@coregroup.org

coregroup

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