

ARCHITECTS OF **RESILIENCE**

A stand-alone compendium of evidence on how community engagement and community-led monitoring shift marginalised voices from the margins to the centre of pandemic preparedness and response.



Introduction



(Photo credit: Shutterstock.com)

The COVID-19 pandemic reshaped the global health landscape and exposed a hard truth, resilience is impossible when people remain invisible. This compendium brings together ten case studies from the Global Fund's Communities in Pandemic Preparedness and Response initiative, COPPER, illustrating a clear shift from communities as passive recipients of policy to central actors in pandemic preparedness and response. Across Africa and Southeast Asia, these stories show how trust, connectivity and credible evidence transformed isolation into collaboration and marginalised voices into decision-making power.

At the heart of COPPER is the deliberate fusion of Community Engagement and Community-Led Monitoring. Community Engagement builds the social pathways, confidence and collective voice required for communities to participate meaningfully in preparedness and response, while Community-Led Monitoring provides the technical tools, data and rigour needed to convert lived experience into actionable evidence. Together, CE and CLM create a balanced accountability system that strengthens pandemic preparedness and response beyond clinical readiness by addressing social vulnerability, gender inequality and human rights.

From the digital rebirth of community monitoring in Kenya and Malawi, where mobile platforms and real-time dashboards inform government decisions, to innovative media strategies countering misinformation in Liberia, COPPER shows how technical assistance and regional knowledge hubs can localise complex concepts for diverse populations. Comparable innovations are evident in Southeast Asia, including the Philippines, Indonesia and Cambodia, where community actors are embedded in preparedness and response structures and contribute to joint reviews, protocols and oversight.

The compendium also reflects on persistent challenges. Domestic resource mobilisation remains uneven, political will is fragile, and long-standing commitments such as the Abuja Declaration are still not fully honoured. Yet these case studies demonstrate that when communities are trusted, resourced and connected, they become the architects of their own protection. COPPER offers proof of impact alongside practical lessons and innovations pointing towards a safer, more equitable approach to pandemic preparedness and response.

Table of Contents

Case Study 1 Knowledge in Action: How Regional Bodies Amplify Community Voices in Pandemic Preparedness and Response (PPR), including Last-Mile Communities' voices in PPR spaces	2
Case Study 2 Prepared but Unprotected: The Price of Ignoring Gender, Rights, and Equity in Health Security	5
Case Study 3 From Confusion to Connectivity: The Digital Rebirth of Community Pandemic Preparedness and Response	8
Case Study 4 How Technical Support Mentorship Sparked a Revolution and put Communities in Charge of Health Accountability	11
Case Study 5 From the Margins to the Table: How the Excluded Became Part of the Pandemic Preparedness	14
Case Study 6 Time for African nations to honor the Abuja Declaration and fund their pandemic preparedness	17
Case Study 7 From Fear to Facts: Liberia's Media Revolution in Pandemic Preparedness and Response	20
Case Study 8 In their Words: Localising Pandemic Preparedness and Response literacy for Every Voice and Every Community	23
Case Study 9 Integrated Community Engagement & Community-Led Monitoring where Communities Thrive and Change is Measurable	26
Case Study 10 Knowledge Sharing for Continuous Learning – The COPPER Knowledge Hub	29

CASE STUDY 1

Knowledge in Action:

How Regional Bodies Amplify Community Voices in Pandemic Preparedness and Response (PPR), including Last-Mile Communities' voices in PPR spaces



ACT Africa regional learning and advocacy meeting. (Photo credit: ACT Africa)

Context

The COVID-19 pandemic turned the world upside down, leaving communities vulnerable and unprepared. By May 30, 2021, the World Health Organization¹ placed the reported death toll at more than 3.4 million deaths worldwide. Suddenly, the phrase “new normal” became part of everyone’s daily vocabulary.

In the midst of the devastation, there was no time to pause, and communities needed to act fast. The Global Fund’s Communities in Pandemic Preparedness and Response (COPPER) project stepped in. Designed to equip communities with the knowledge, tools, and networks to prepare for future pandemics, COPPER focused on those often left on the margins. From building pandemic preparedness literacy to influencing national policy, COPPER enabled communities to engage with leaders, influence health policies, and ensure their voices were heard—turning data and experience into action for safer, more resilient health systems.

PPR Literacy

Activists Coalition on TB Asia Pacific (ACT AP)/APCASO and Africa Coalition On Tuberculosis (ACT Africa) became catalysts for pandemic preparedness and response literacy across select African and Asia-Pacific countries, creating a regional Knowledge Hub² that turned complex technical frameworks into practical tools communities could use. Through webinars, lesson briefs, toolkits, and country presentations, the Hub became a peer-learning space where communities moved from understanding to action.

Modules covered PPR 101, Joint External Evaluations (JEEs), National Action Plans for Health Security (NAPHS), and One Health processes, often in local languages to ensure lived experiences shaped learning and built confidence for decision-making. Pre- and post-training assessments showed dramatic gains: over 80% of participants scored above 80% after training.

Small pilots demonstrated growing influence; commune councilors in Cambodia spoke up in preparedness discussions, youth coalitions in the Philippines shaped local advocacy using evidence, and faith-based and civil society networks in Nigeria translated knowledge into concrete policy asks.

¹ <https://www.who.int/data/stories/the-true-death-toll-of-covid-19-estimating-global-excess-mortality>

² <https://copper.apcaso.org/>

Coalition Building

Once communities mastered pandemic preparedness and response literacy, they joined forces across networks; HIV, TB, malaria, women's groups, youth, and marginalized populations, to speak with one collective voice at local and national tables. The Knowledge Hub showcased stories and country presentations, highlighting how diverse networks came together to share learning and coordinate action.

COPPER expanded on earlier efforts to unite HIV, TB, malaria, women's, youth, disability, and human rights groups under a single Asia-Pacific platform. In Indonesia, community groups partnered with the National Disaster Management Authority to produce policy briefs that linked local priorities to national disaster governance.



6,000
volunteers
trained

Malawi trained over 6,000 volunteers and established Community Rapid Response Teams—demonstrating how coalitions can operationalize PPR actions at scale.



**Advocacy with
Global Fund
Grant Cycle 8**

In **Cambodia**, coalitions aligned advocacy with the upcoming Global Fund Grant Cycle 8, positioning themselves to shape national planning.



**Influence
policy changes
and programs**

In the **Philippines**, coalitions went further, embedding pandemic-sensitive social protection into policy and influencing the Department of Education's comprehensive sexuality education programs.

Technical Assistance

As coalitions matured, they turned to targeted technical assistance (TA) to make sense of JEEs, Resilient and Sustainable Systems for Health (RSSH) modules, and national planning processes. The Knowledge Hub curated webinars and resources, guiding country teams to analyze policies, interpret platforms, and identify practical next steps.

By strengthening understanding and building capacity, TA empowered communities to lead advocacy, contribute to policy briefs, and act on evidence, without creating dependency. Communities gained confidence, skills, and the insight needed to turn learning into meaningful influence.



**Practical
PPR toolkit
created**

In **Indonesia** communities initially struggled to navigate PPR mechanisms like JEEs and Self-Assessment Annual Reporting (SPAR). Tailored TA led to the creation of a practical PPR toolkit, boosting knowledge and enabling structured engagement with authorities.

Turning Data into Action

Armed with data literacy and technical support, community coalitions transformed Community-Led Monitoring (CLM) dashboards into actionable advocacy agendas. The Knowledge Hub provided toolkits and lesson briefs to guide communities in translating raw data into clear policy asks and operational recommendations.



**Influence
policy
changes**

In **Indonesia**, CLM-driven advocacy influenced policies such as extended ARV prescriptions and decentralised HIV services, showing how community evidence translated into service adjustments.



Five PPR indicators integrated into national pandemic preparedness mechanisms

In the **Philippines**, five PPR indicators were integrated into national pandemic preparedness mechanisms, tracked alongside HIV and TB indicators. HIV community groups began addressing system-level pandemic resilience.



Scaled CLM

Kenya linked community data to decision-making and scaled CLM to more counties.

Stepping into the Decision-Making Room

Communities moved from the sidelines to the center of pandemic preparedness and response (PPR) platforms. Equipped with advocacy briefs and CLM evidence, coalition leaders joined technical working groups, local task forces, provincial health offices, CCMs, and emergency operations centers, forums where critical health decisions are made.



Community voices

In **Kenya**, a country partner attending a Joint External Evaluation (JEE) noticed community voices were missing. Today, they lead efforts to ensure inclusion in future meetings, forging a strong partnership with the National Public Health Institute (NPHI). Across other countries, coalitions presented evidence, negotiated practical solutions, and shaped multi-sectoral discussions.

The Knowledge Hub captured these experiences through country case studies and webinars, showing how communities brought data-driven insights into national and local decision-making, turning participation into influence.

Shaping Policy from the Ground Up

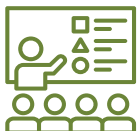
The COPPER journey translated into real-world policy impact. Communities helped expand service delivery, integrate PPR indicators into national CLM systems, and ensure their priorities were reflected in grant and planning cycles.

Across countries, training empowered participants to engage meaningfully in national policy processes and community representatives contributed to revising the One Health Governance Manual and validating the Community Representation Guide.



87 community members trained on GESI and NAPHS.

One training in **Nigeria** equipped 87 community members to understand national processes around Gender Equality and Social Inclusion (GESI) and the development of National Action Plans for Health Security (NAPHS).



In **Liberia** evidence from community engagement informed mechanisms for pandemic preparedness. Their recommendations, such as having local networks support outbreak tracking and data sharing, were incorporated into the final One Health Manual (C19RM Compendium, 2022).

COPPER also emphasized defining "community" locally, ensuring marginalized populations had a seat at the table. This approach reached nomads in **Nigeria**, internal migrants in **Sierra Leone**, people with disabilities in **Kenya**, and slum dwellers elsewhere, demonstrating that when communities are empowered, their voices can shape lasting, inclusive health systems.

The COPPER journey shows that when communities are equipped with knowledge, supported by TA, and given validated platforms to present evidence, they move from being passive beneficiaries to active policy influencers.

CASE STUDY 2

Prepared but Unprotected:

The Price of Ignoring Gender, Rights, and Equity in Health Security



COPPER PPR engagement in Adamawa State, Nigeria. (Photo credit: Janna Health Foundation)

Context

When the world went into lockdown during the Corona Virus Disease 2019 (COVID-19), another crisis quietly unfolded behind closed doors. Gender-based violence rose sharply, earning the name “the twin pandemic.” Women and girls, already burdened by inequality, were trapped with their abusers and cut off from support.

The pandemic revealed a stark truth: health emergencies don’t happen in isolation. They expose deep cracks, poverty, displacement, and gender inequality. True preparedness isn’t only about vaccines or hospital beds; it is about learning, protecting dignity and safety. Real resilience depends on health systems that uphold equity, gender equality, and human rights, where no one is invisible.

The Global Fund recognised this early. Its 2023 - 2028 strategy places health equity, gender equality, and human rights at the center of pandemic preparedness. Communities, especially women and marginalized key and vulnerable populations, have been supported to lead, engage, and shape responses. Communities in Pandemic Preparedness and Response (COPPER) Community Engagement (CE) facilitated structured participation of marginalized groups in national decision-making, while Community-Led Monitoring (CLM) mechanisms captured community experiences, monitored inclusion, reported violence, and flagged gaps, creating accountability that strengthens preparedness on the ground.

Building on lessons from the COVID-19 Response Mechanism (C19RM), countries began translating these approaches into action. Community groups, civil society and women's networks participated in the National Action Plans for Health Security (NAPHS), and also contributed in the Joint External Evaluations (JEEs), helping weave gender and human rights into national health security plans. The Pandemic Preparedness Response (PPR) Scorecard provided a shared tool that will track progress, close gaps, and ensure governments remain accountable to the most vulnerable.

A partner working closely with the Global Fund explained that health equity, gender equality, and human rights are inseparable in community work.

“We emphasise community engagement because once communities have identified their needs, those needs inherently address gender, human rights, and health equity issues. We developed a PPR scorecard that specifically measures the inclusion of health equity, gender equality, and human rights in the NAPHS process,” they said.

The PPR Training Resources and Handbook for Strengthened Communities, compiled by Regional Partners, strongly advocates mainstreaming gender in pandemic preparedness, including equal participation of women in decision-making and use of sex-disaggregated data to inform targeted interventions.

Nigeria: From Isolation to Inclusion:

Before COPPER CE and CLM, Nigeria's pandemic preparedness largely overlooked the most vulnerable: people affected by TB or People living with HIV, nomads, Internally Displaced People, women, persons with disabilities, and religious minorities. Nearly 70% of nomadic populations remained unvaccinated to COVID-19.

Janna Health Foundation (JHF) secured seats for communities in key decision-making spaces, from Emergency Operations Centres to One Health platforms and NAPHS Committees. The CLM mechanism strengthened this by monitoring service delivery, identifying gaps in inclusion, and generating community evidence for advocacy. Using the PPR Scorecard, JHF tracked gender and equity gaps, influencing more inclusive plans. Challenges remain in sustaining engagement and translating inclusion into budgeted action, but Nigeria demonstrates that combining policy engagement and community monitoring, builds trust and resilience for all.



Sierra Leone: Building Inclusive Governance:

Sierra Leone strengthened community leadership and integrated equity, gender equality, and human rights into national PPR frameworks. Over 70 CSOs formed a PPR coalition representing people living with HIV and TB affected communities, female sex workers, men who have sex with men, and persons with disabilities.

CE equipped communities to engage in JEEs, SPAR, and NAPHS consultations. The coalition influenced responses during the Mpox outbreak, demonstrating credibility and collaboration with authorities. Remaining gaps include mobilising resources and reaching populations with limited education. Sierra Leone illustrates how CE alone can embed rights-based, gender-responsive, and equitable pandemic preparedness while highlighting areas for continuous improvement.



50 community leaders trained, **50%** representation of youth, women's groups.

Cameroon: Strengthening Community Voice

Cameroon made progress in integrating equity, gender, and human rights into PPR policies, though full institutionalisation is ongoing. CE trained 50 community leaders, with 50% representation of youth, women's groups, key populations, and human rights organisations.

Through Collectif des Organisations de la Société Civile de l'Adamaoua (COSCA) Santé, civil society engaged national platforms, including JEEs and Universal Health and Preparedness Review High-Level Missions. While full integration into NAPHS is pending, CE strengthened mobilisation, awareness, and advocacy. Government commitment to gender and rights-based approaches remains inconsistent, but Cameroon demonstrates that structured community engagement can elevate inclusion and accountability in PPR governance.



Task forces in **4 cities** ensured representation of marginalised groups and former inmates.

Indonesia: Embedding Rights and Equity

In 2024, COPPER advanced equity, gender, and human rights in Indonesia. Task forces in Jakarta, Bandung, Bogor, and Bali ensured representation of marginalised groups, including people living with HIV, TB, malaria, and former inmates.

Targeted trainings and dialogues equipped stakeholders with advocacy skills and rights-based knowledge, feeding into JEEs and NAPHS consultations. CLM captured real-time community data to track inclusion and guide advocacy. Digital tools, social media campaigns (#COPPER_Indonesia), and the PPR Scorecard enhanced visibility and accountability. Challenges remain in reaching stigmatized groups, but Indonesia demonstrates that combining structured engagement, evidence-driven monitoring, and advocacy can embed equity, rights, and gender into PPR policies, offering a model for inclusive pandemic preparedness.

CASE STUDY 3

From Confusion to Connectivity: The Digital Rebirth of Community Pandemic Preparedness and Response



COPPER workshop in the Democratic Republic of Congo.

Innovation doesn't always come from wealth; it often emerges from urgency, resilience, and imagination. Some of the African countries, including Malawi, the Democratic Republic of Congo (DRC), Liberia, Sierra Leone, and Burkina Faso, have turned the devastating impact of pandemics like Ebola and COVID-19 into digital innovation.

Across communities, smart tools now link Pandemic Preparedness Response (PPR) to Community Led Monitoring (CLM), giving citizens a voice, guiding government decisions, and demonstrating that local insight, paired with technology, can drive faster and smarter responses.



Malawi offers a striking example. In 2024, the country embedded PPR into CLM through CommCare, mobilising 6 000 volunteers to feed real-time data into national systems that support 12 rapid response teams. That data has strengthened system responsiveness and accountability; when communities flagged missing test kits or stock-outs, supply issues were replaced quickly and ministries began acting faster once CLM metrics appeared on national dashboards. Innovations that include drone drug deliveries, dashboards in local languages, and volunteer-led validation sessions, turned everyday observations (from clinic wait times to sanitation gaps) into actionable evidence used in county planning and national PPR guidance, so decisions are now directly informed by community voices.

Kenya emerged as a leader in Africa's digital health innovation. Known as "Silicon Savannah," the country integrated PPR as a fourth pillar in its national health monitoring mechanism using the I-Monitor platform. Community data collectors and peer monitors now gather real-time evidence on specific PPR indicators, including stock-outs of ARVs and malaria commodities, disruptions to outreach services, clinic wait times, and other barriers to service access; stigma, discrimination, confidentiality breaches and police harassment affecting key and vulnerable populations; and the functionality of surveillance systems, availability of PPE, and timelines of emergency referrals. This information, drawn from 25 counties, feeds into digital dashboards that enable rapid reporting and issue resolution, and drive actions such as rapid redistribution of medical commodities, the restoration of disrupted outreach services, and the incorporation of CLM data into quarterly country planning by county health teams. Kenya plans to further integrate CLM into its national digital health system, supported by 37 community networks representing key and vulnerable populations.



"Community members are key actors in the health system, they're our super users," notes a CLM implementer, referring to community monitors who consistently use digital tools to gather high quality data, spot issues early and support others in the field.

Other countries have applied similar digital strategies with notable results:



6 PPR indicators embedded in nationwide systems

Burkina Faso: Communauté Les Monitoring- Observatoire des Comportements et des Activités de Santé (CLM-OCASi) now spans 70 districts, embedding six PPR indicators into nationwide systems, including monitoring of infection prevention measures, stock levels of essential medicines, availability of isolation spaces, health worker training on emergency response, reporting timeliness, and

community awareness of outbreak protocols. Digital dashboards empower 180 actors to collect, analyse, and visualise data, enabling community organizations to contribute to national reporting, coordinate with the Ministry of Health and One Health Secretariat, and influence advocacy actions such as improved resource allocation and preparedness planning.



16 districts linked through WhatsApp forums and in-person CLM meetings.

Sierra Leone: The COPPER project links 16 districts through WhatsApp forums and in-person CLM meetings, connecting youth, women, people living with HIV, TB survivors, and persons with disabilities to PPR processes such as real time community surveillance and rapid response activation. This inclusive system guides advocacy, policy input, and Mpox responses despite resource constraints.



87 community members trained on health security frameworks

Liberia: Digital tools connect youth and vulnerable groups to national PPR processes, offering access to training, policy briefs, and updates. Eighty-seven (87) community members have been trained on health security frameworks such as the Joint External Evaluation (JEE) and National Action Plan for Health Security (NAPHS).



PPR indicators integrated using a digital platform for real-time data, analysis, and advocacy.

DRC: Union Congolaise des Organisations des Personnes vivant avec VIH (UCOP+) integrates PPR indicators such as monitoring of emerging pandemics, readiness of health facilities, stock availability for HIV, TB and malaria treatments into CLM for HIV, TB, and malaria, supported by a digital platform for real-time data visualization, actor training and

integrated analysis for advocacy. Quarterly technical coordination meetings with civil society actors and the integration of HIV, TB and malaria CLM activities into a unified vision strengthen coordination, while dedicated Ministry of Health focal point ensures government recognition and facilitates institutional support. Concrete results include improved joint advocacy actions to address systematic dysfunctions, alignment of multiple actors around shared PPR priorities, and evidence of policy influence through the Ministry of Health formally acknowledging and supporting CLM, enabling community-generated data to directly inform national preparedness and response decisions.

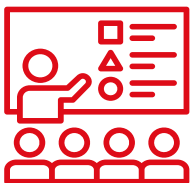


25 COPPER CE organisations turned communities into pandemic watchdogs.

Philippines: Twenty-five (25) COPPER CE organisations turned communities into pandemic watchdogs. Peer education, training, and digital tools enabled ~500 members to flag healthcare and livelihood gaps. Community-led campaigns, like the Tricycle Drivers' manifesto on World TB Day, engaged over 50 agencies and NGOs, turning local voices into national policy action.



(Photo credit: ACHIEVE, Philippines)



Key learnings:

Sustaining community engagement and community-led monitoring in PPR requires continuous learning through refresher trainings, surveys and webinars, which keep coalitions and communities active and informed. Digital tools have proven particularly valuable, enhancing collaboration, knowledge sharing, and advocacy, while supporting the adoption of PPR structures at national and sub-national levels. Despite challenges that include uneven access to smartphones, the integration of digital innovations can amplify voices and bring pandemic preparedness to the communities.

Across these contexts, one lesson is clear: embedding PPR into CLM mechanisms transforms communities into active health system actors. With the right digital tools and local ownership, even resource-constrained countries can build agile, data-driven, and responsive health systems that learn and act in real time. Importantly, investing in digital tools to support CLM (including PPR) facilitates faster and easier data collection, consolidation, and analysis, and such digitalization can be achieved without high costs by using free-to-use platforms, not just expensive solutions.



CASE STUDY 4

How Technical Support Mentorship Sparked a Revolution and put Communities in Charge of Health Accountability



Communities engaged in PPR activities in Cambodia. (Photo credit: KHANA)

Behind every successful Community-Led Monitoring (CLM) and Community Engagement (CE) programme is a steady hand behind the scenes that shapes the foundations long before implementation begins. Technical Assistance teams act as both architects and engineers, designing the programme model, theory of change and implementation blueprint; building monitoring frameworks and success indicators; and ensuring alignment with national priorities. They translate vision into technical specifications, develop data and quality-control systems, and integrate the digital tools and SOPs that make the model workable, scalable and safe.

Yet despite carrying the structural weight, TAs rarely seek the spotlight. Their success is measured in seeing local champions, ministries and implementing partners take centre stage, and excel through systems they helped design.

Through integrated support to both CLM and CE, Technical Assistance (TA) helped local organisations transform fragmented efforts into coordinated systems of accountability, preparedness and action. TAs strengthened community literacy on Pandemic Preparedness Response (PPR), expanded digital and advocacy capacities, and provided mentorship and training that moved communities from participation to leadership. Working across 12 countries, they guided partners through governance frameworks such as the International Health Regulations (IHR), Joint External Evaluations (JEE) and National Action Plans for Health Security (NAPHS), while adapting to cultural contexts and varying CLM maturity. In doing so, TAs created the enabling conditions for ownership, cross-country learning and real-time improvement.

The Global Fund and its partners - including Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO), Pan African Treatment Access Movement (PATAM) and CLAW Consortia/L'Organisation de Développement et de Lutte contre la Pauvreté (Odelpa) and have supported countries across Africa and Asia to expand CLM's scope beyond the traditional diseases.

A TA supporting CLM implementation across Eastern and Southern Africa reflected on the impact of this role:

“Through COPPER CLM, we were able to guide countries to build momentum among communities, civil society and activist leaders, and made inroads with pandemic preparedness and response. We are strengthening their capacity to engage meaningfully and laying the groundwork for more resilient and sustainable health systems.”

Today, CLM programmes integrate pandemic preparedness, human rights, gender, and budget monitoring, ensuring that community priorities remain central as global health threats become more complex.

Tailored TA Rollouts: Lessons from the Field

A Global Fund regional partner summarized the role of a TA as being time sensitive.

“TA has been valuable, especially when aligned with local needs. Despite initial challenges such as the TA's need not being clearly identified from the start, the key was that training and TA were need-based and time-sensitive. Faster TA responses were essential for sustaining activities and long-term impact.”

Each country demonstrates how adaptive TA bridges the gap between global frameworks and local realities.



In **Sierra Leone**, the Civil Society Movement Against Tuberculosis (CISMAT) led a comprehensive capacity-building initiative, training people living with HIV and TB, female sex workers, and persons with disabilities to participate in national oversight mechanisms. Their coalition of more than 70 CSOs now engages government stakeholders to advocate for human rights and equitable healthcare access, marking a new era of community participation in health security.



Similarly, Khmer HIV/AIDS NGO Alliance (KHANA) in **Cambodia** strengthened civil society's understanding of PPR through provincial workshops, user-friendly guides, and interactive tools. Collaboration among HIV, TB, and malaria networks showed that with the right support, local actors can drive integrated monitoring even in resource-limited settings.



In **Nigeria**, the Janna Health Foundation (JHF) integrated marginalised groups, including people living with HIV, internally displaced persons, and religious minorities, into state-level PPR platforms. Their advocacy prompted the Adamawa State Ministry of Health to open Emergency Operations Centre meetings to community groups, transforming skeptical communities into trusted partners in disease surveillance and response.



In the **Philippines**, Action for Health Initiatives (ACHIEVE) transformed communities from having little understanding of PPR into active advocates. Through peer education and advocacy workshops, women's groups, transport workers, and people living with HIV and TB developed manifestos demanding access to healthcare, livelihood security, and protection from gender-based violence, clear examples of how community literacy evolves into advocacy.



In **Malawi and Kenya** AMREF Health Africa, tailored TA and cross-country learning drove systemic integration. Kenya's AMREF Health Africa expanded CLM from three pilot counties in 2015 to 25, adding PPR as a fourth pillar in the national framework. Supported by COPPER, 37 networks collected real-time data through digital platforms, feeding evidence into county and national decision-making. Inspired by Kenya, ActionAid Malawi trained 6 000 volunteers and created Community Rapid Response Teams across 12 districts to monitor PPR indicators and advocate for local solutions. These models proved that when TA is structured yet flexible, it produces scalable systems of community accountability.

Learning Across Borders:

Cross-country exchanges have become an integral part of CLM-PPR integration. Through Communities of Practice and peer-learning platforms, countries share lessons on digital tools, advocacy scorecards, and engagement strategies. These exchanges have inspired CLM innovations such as multi-disease CLM dashboards for real-time decision-making.

The diversity of experiences, from Cambodia's grassroots learning circles to Nigeria's faith-based coalitions, highlights the adaptability of the CLM model. What unites them is the conviction that communities must not only be consulted but must lead in building resilient, equitable health systems.

Sustaining the Gains: Sustaining CLM-PPR integration depends on institutional recognition, domestic financing, and continued community ownership. Governments such as those in Kenya and Malawi are embedding CLM indicators in national monitoring systems, while community coalitions safeguard the independence and inclusivity that make CLM so effective.

While the momentum is undeniable, challenges remain. These include translating data into policy reform, ensuring equitable funding, and protecting community monitors in politically sensitive environments. Across COPPER-supported countries, community-led monitoring has evolved from an accountability tool into a transformative governance model for pandemic preparedness.

CASE STUDY 5

From the Margins to the Table:

How the Excluded Became Part of the Pandemic Preparedness



PPR Champions in Cambodia, (Photo credit: Khana)

Context

When pandemics strike, it is grassroots communities who feel the impact first, and they hold the keys to practical solutions. Yet, pandemic preparedness has long been shaped almost entirely by government-led processes, leaving those who carry the heaviest burden of pandemics and epidemics on the margins.

With the introduction of the Global Fund's Communities in Pandemic Preparedness and Response (COPPER) during the Coronavirus Disease COVID-19, a selection of countries in Africa and the Asia Pacific region began to shift this dynamic. Marginalised and vulnerable groups in these pilot countries, from People Living with HIV and TB affected communities, to women, key populations, youth, and migrant workers, People with Disabilities, Slum Dwellers, Refugees and internally displaced communities have stepped up as leaders where their voices were once absent, shaping decisions that protect everyone. Through the COPPER initiative, they are finding space at the table, turning lived experience into powerful guidance for pandemic preparedness and response (PPR), and slowly helping to build preparedness and response plans that truly protect everyone. While their involvement is still emerging, they are proving that inclusivity isn't just fair, it's smart.



One Kenyan interviewee reflected, “We managed to secure representation of people with disabilities in the Kenya Coordinating Mechanism and technical working groups. It’s a breakthrough.”

Advocacy by Stop TB Kenya and the Kenya Union of the Blind, which disseminates TB and pandemic information in Braille, turned sidelined voices into active participants, proving that empowered communities (including the vulnerable and marginalised) strengthen pandemic preparedness for everyone. This was demonstrated in February 2025, when Stop TB Partnership Kenya mobilised and trained community PPR Champions during a cholera outbreak in Kisumu and Migori. The champions raised hygiene awareness, improved sanitation, and supported early detection and referral; actions that reduced transmission and fatalities and helped bridge the gap between preparedness planning and effective outbreak response.

Country Examples



Voices long unheard in **Nigeria** are now shaping state-level pandemic response. Civil society groups successfully advocated for the inclusion of people living with TB and HIV, displaced persons, and religious minorities in Emergency Operations Centers (EOC) in Adamawa and Gombe States. Their presence has enhanced early detection of TB outbreaks, improved rapid sharing of information, and built public trust. EOC meetings are now open to grassroots groups, linking communities with public health systems to respond not only to pandemics but also to health threats such as cholera and diphtheria.



PPR Champions in Cambodia. (Photo credit: Khana)

Cambodian communities vividly demonstrate the power of local action. COPPER CE equipped groups with locally adapted PPR training manuals, conducted community mapping to identify marginalised populations, and supported the integration of PPR considerations into Commune Investment Plans. One of the contributions was the strengthening of community-level early warning and surveillance practices, where village malaria workers, long-standing monitors of local outbreaks, now report emerging diseases to Village Health Support Groups, which in turn channel information to national health authorities. Khmer HIV/AIDS NGO Alliance’s (KHANA) training across six provinces has created a network of empowered PPR practitioners ready to take initiative, reinforcing that true preparedness starts at the community level.



In **Indonesia**, former prisoners joined prison and health authorities, and civil society in multi-stakeholder workshops, proving that those most affected by stigma and are least visible in society and national systems are slowly participating. By sharing lived experiences and participating in joint plan-ning, they ensured task forces considered equity and strengthened local capacity, opening up the process to be collaborative and inclusive.



TODA drivers in the Philippines.. (Photo credit: Achieve.)

Metro Manila's tricycle drivers and indigenous communities in the **Philippines** also found their voice through COPPER. Tricycle Operators and Drivers Association (TODA) associations advocated for pandemic-sensitive social protection, while gender-based violence emerged as a key concern. Action for Health Initiatives (ACHIEVE) trained 51 peer educators, each reaching at least 10 community members, spreading PPR knowledge to 500 people.



Two engaging brochures in Filipino supported the sessions, helping communities understand their role in PPR and actively hold government agencies accountable. The coalition demonstrated that even the most vulnerable can drive meaningful change when given tools, knowledge, and a platform to act.

These achievements did not come without challenges. Many communities initially lacked knowledge of pandemic preparedness, and marginalised groups were often overlooked in decision-making. Success relied on deliberate strategies: training peer educators, producing accessible materials, and following representation guidelines to include women, people with disabilities, and indigenous populations. Persistence, trust-building, and structured advocacy allowed communities to move from the margins to active partners, shaping policies, influencing responses, and ensuring no voice is left unheard.

When everyone is included, resilient health systems are built, and communities become the architects of their own protection, proving that empowering marginalised groups is not just a moral imperative, but a strategic necessity for a stronger and inclusive pandemic preparedness.

Validation in Numbers



51
PPR platform members



120
community health workers

Cambodia: 51 PPR platform members and 120 community health workers trained across six provinces.



51
peer educators trained

Philippines: 51 peer educators trained, each reaching at least 10 community members (~500 people); two locally developed brochures in Filipino to support community understanding of PPR.

Philippines TODA Advocacy: Pandemic-sensitive social protection packages and gender-based violence included as priority issues.

CASE STUDY 6

Time for African nations to honor the Abuja Declaration and fund their pandemic preparedness.



NGO For Impacts in Social Health (ONG-FIS Cameroon) press conference.

Context

The freeze in global health funding¹ has dealt a severe blow to community organisations, which for years have strengthened national health systems. Some were forced to close doors, leaving millions without support or hope. The shock is a stark reminder that no nation can outsource its resilience. Funding uncertainty leaves vulnerable populations exposed, highlighting the urgent need for self-reliant, homegrown solutions.

As the Communities in Pandemic Preparedness and Response (COPPER) project nears its conclusion and the Global Fund's Grant Cycle 8 begins, communities and civil society face a pressing fear that years of progress in pandemic preparedness and response (PPR) could unravel. Memories of Coronavirus Disease (COVID-19) vaccine inequity, when wealthier nations stockpiled doses while poorer countries scrambled, are still vivid². Without sustained domestic investment, the hard-won gains in community inclusion, preparedness, and health security risk slipping away.

Domestic resource mobilisation is a lifeline. By investing local resources into building health systems, and strengthening accountability, countries embed PPR into national priorities, and ensure funds are tracked and used effectively. Governments that finance their own preparedness and response take ownership of long-term solutions rather than relying on donor-driven, short-term fixes.

¹ Kyobutungi, C., 2025, *Healthcare in Africa on brink of crisis as US exits WHO and USAID freezes funds: health scholar explains why*, The Conversation, 10 February. Available at: <https://theconversation.com/healthcare-in-africa-on-brink-of-crisis-as-us-exits-who-and-usaid-freezes-funds-health-scholar-explains-why-248906> (accessed 6 Dec. 2025).

² Reuters 2021, 'Rich nations stockpiling a billion more Covid 19 shots than needed: report', Reuters, 19 February. Available at: <https://www.reuters.com/business/healthcare-pharmaceuticals/rich-nations-stockpiling-billion-more-covid-19-shots-than-needed-report-2021-02-19/> (accessed 6 Dec. 2025).

COPPER's community engagement work is proving the power of local action. Communities that were once mere recipients of aid are now watchdogs and advocates, trained to read budgets, track spending, and demand accountability. This shift towards homegrown financing is already taking shape. Liberia, Sierra Leone, Malawi and Cameroon are pioneering domestic resource mobilisation, showing that true preparedness begins at home, where communities safeguard not only funds but their futures.



Action Aid Malawi joins a March on Resource mobilization (Photo credit: Action Aid Malawi Facebook)

Country Examples



Liberia's COPPER Community Engagement (CE) implementor is turning advocacy into tangible domestic financing. By engaging champions in the House of Representatives and Senate, communities have proposed levies on fuel imports to fund health emergencies, now under consideration in the 2026 budget. Eighty trained communities and civil society members monitor spending across 15 county Emergency Operations Centers, ensuring PPR financing is transparent, sustainable, and community driven.



Malawi's COPPER-supported Community-Led Monitoring (CLM) platform translates community advocacy into domestic funding. ActionAid Malawi trained 6,000 volunteers to integrate PPR into HIV, TB, and malaria monitoring mechanisms, enabling communities to identify service gaps. This advocacy secured USD 1.2 million for volunteer training in event-based surveillance.



Newspaper article on PPR activities in Malawi. (Photo credit: Action Aid Malawi Facebook)

A country implementer from Malawi emphasized: “We realized that communities were rarely involved in pandemic planning. COVID-19 showed us we couldn’t leave them out. The government has fully embraced it. Communities are now part of the solution, not just beneficiaries.”

Community Rapid Response Teams now operate in 12 districts, and CLM integration into government systems by November 2025 will strengthen accountability and locally owned health security.



COPPER CE in Sierra Leone, led by Civil Society Movement Against Tuberculosis (CISMAT), is advancing domestic financing for PPR. The PPR community Coalition, representing all 16 districts and vulnerable groups, has developed advocacy agendas targeting the Ministry of Health, WHO, and parliamentarians. Ahead of the 2026 budget cycle, coalition members are engaging legislators to embed community priorities into national health security plans, promoting accountability and long-term sustainability.



Cameroon's marginalised communities and civil society are beginning to mobilise domestic resources for PPR. Networks such as National One Health Civil Society Network (ROOHCAM) and Collectif des Organisations de la Société Civile de l'Adamaoua (COSCA) Santé trained over 80 Civil Society Organisations on PPR planning, Joint External Evaluation's (JEE), National Action Plan for Health Security (NAPHS), and advocacy, enabling the submission of priorities for the third Pandemic Fund proposal (March - June 2025). These efforts lay the groundwork for structured community participation and future locally-driven financing.



In Kenya, COPPER CE has embedded CLM as a tool for domestic resource mobilisation, with community health promoters and 37 networks collecting real-time data across 25 counties to inform government decision-making. Communities and civil society use advocacy plans and existing monitoring tools, such as the Human Rights scorecard and NGO-led disease scorecards, to guide spending and capture PPR-related outcomes. While a dedicated PPR spending scorecard is still in development, these tools provide a clear, accountable way to track resources, strengthen pandemic preparedness, and ensure community contributions are factored into national health strategies.



The COPPER Coalition Philippines, coordinated by Action for Health Initiatives (ACHIEVE), is advancing domestic PPR financing through community advocacy. Vulnerable groups, including people affected by TB and HIV, public transport workers, women, youth, and Indigenous communities, co-developed an advocacy agenda and manifesto, presented to government agencies and partners during World TB Day 2025. Early commitments signal potential government and private funding, supported by 51 trained peer educators reaching over 500 community members.

With COPPER CLM and CE coming to an end, there is fear that hard-won gains in pandemic preparedness could be lost, yet countries like Cambodia, Kenya and Nigeria are some of the nations that are taking proactive steps, embedding PPR financing into national health budgets, integrating CLM into mainstream healthcare, and securing funding for community engagement at national levels.

CASE STUDY 7

From Fear to Facts:

Liberia's Media Revolution in Pandemic Preparedness and Response



Leo Tia engages the media on COPPER in Liberia (Photo credit: YOUNETPO)

When Ebola struck Liberia in 2014, fear spread faster than the virus. Misinformation, mistrust, and rumors cost about 2700 lives and silenced communities. When COVID-19 arrived, once again, fear and mistrust, fueled by the spread of fake news, caused untold harm as fear gripped communities.

Today, Liberia is rewriting that story. Through the Communities in Pandemic Preparedness and Response (COPPER) Community Engagement (CE) Project, funded by the Global Fund and led regionally by regional partner Africa Coalition On Tuberculosis (ACT Africa), with Youth Network for Positive Change (YOUNETPO) as the country partner, communities are reclaiming their voices, rebuilding trust, and influencing the agenda for the nation's health future.

While this case study centers on Liberia's transformation following an epidemic and a pandemic, it reflects a broader movement across COPPER countries to rebuild trust through credible, community-led communication and stronger relationships with the media.

Media as an important partner in PPR

When Liberia was hit by the Ebola epidemic in 2014, harmful misinformation spread rapidly across digital, social and even traditional media, costing lives as people trust falsehoods over credible health advice. The pattern repeated during COVID-19 in 2020. Liberia was not alone; neighboring Sierra Leone faced the same wave of dangerous rumours and misleading reports that caused fear and confusion.

When the COPPER project began in July 2024 in Liberia, implemented by a youth-led organisation, there was a deliberate push to ensure credible information flows across digital and traditional media, strengthened by ongoing engagement with journalists and media partners. YOUNETPO also focused on strengthening their own digital platforms, ensuring that the 87 community members, including people living with HIV, malaria, and TB affected communities, slum dwellers, women, youth, and persons with disabilities, who had never heard of Pandemic Preparedness and Response (PPR), had direct access to credible information, at all times. The project started by mapping key platforms, from Emergency Operations Centers (EOCs) at the county level to the National Public Health Institute and connecting them to community structures. “These are the groups most affected when crises hit,” says Leo Tia, the organisation’s Executive Director.

For the first time, communities took charge of the narrative, closing communication gaps and limiting opportunities for rumors to spread. They co-created a National PPR Advocacy Agenda, identifying their priorities, which include improving risk communication systems and voicing them directly to policymakers and participated in developing and validating key frameworks such as the One Health Governance Manual. Digital tools, such as a chat room, a WhatsApp channel with real-time updates and social media platforms and their website, helped communities stay connected, share updates, and raise issues.



“Information is very important. When you don’t have information, it makes it difficult to even understand, act, or make decisions. An informed population makes good decisions, and it has helped in shaping the advocacy,” explains Tia.

In Sierra Leone, Civil Society Movement Against Tuberculosis (CISMAT-SL) partnered with community radio stations that broadcast in local languages to share credible information on COPPER, on Mpox and cholera during an outbreak. The same approach was also applied by Kenya’s county implementor Stop TB Partnership Kenya during a recent outbreak of diseases, while Nigeria’s Janna Health Foundation used jingles in Hausa and Fulfude to reach nomadic communities in Internally Displaced People (IDP) camps. They also arranged slots for religious leaders to communicate COPPER programmes to their constituencies.

In Liberia, Tia is confident that his communities will not be left behind in future emergencies.



“The COPPER CE project had a significant impact,” says Tia. “If there is a future health emergency, Liberia is now in a stronger position to ensure past mistakes, where communities were left behind, won’t happen again. They are in the room developing policy briefs, giving input, and shaping final PPR policies and strategies.”



CASE STUDY 8

In their Words:

Localising Pandemic Preparedness and Response literacy for Every Voice and Every Community



Communities engaging in COPPER PPR activities in Adamawa State, Nigeria. (Photo credit: Janna Health Foundation)

Context

Nelson Mandela once said, “If you talk to a man in a language he understands, that goes to his head. If you talk to him in his language, that goes to his heart.” This spirit sits at the center of Community Engagement in Pandemic Preparedness and Response (COPPER) approach to community empowerment. In several implementing countries, country implementing partners have gone beyond the expected to ensure that no one is left behind in understanding Pandemic Preparedness and Response (PPR). Faced with a complex, technical new field, they chose to translate, adapt, simplify and re-frame PPR literacy materials into the languages people speak at home and in villages. In doing so, they affirmed something powerful: vulnerable communities deserve information that honors their lived realities and invites them into the decisions that shape their futures.

Across COPPER Community Engagement (CE) and Community-Led Monitoring (CLM) activities, communities and civil society took content from Global Fund’s regional partners, Africa Coalition on Tuberculosis (ACT Africa)¹ and ACT AP/APCASO², Knowledge Hub and transformed it into accessible, culturally grounded learning tools. They hosted sessions in local languages, produced audio explainers for people with low literacy, created visual storyboards for remote communities, and used local radio to reach women, migrants, young people, and people living with HIV, TB and malaria affected communities.

¹ <https://copper.actafrique.org/>

² <https://copper.actafrique.org/>

In Kenya, the Stop TB Partnership (Kenya) the lead country implementer ensured that visually impaired community members were not left behind by translating key PPR literacy materials and resources into Braille, widening access to PPR literacy for all. By bringing PPR concepts into local languages and familiar communication channels, communities and civil society opened space for vulnerable and marginalized groups to ask questions, challenge assumptions, understand risks and articulate their own priorities. These efforts ensured that community members who had long felt excluded were able to fully engage with the technical language of preparedness and be part of the decision-making chain.

Building on the foundation laid by Global Fund's regional partners who curate and deliver timely, well-researched PPR literacy content through The COPPER Knowledge Hubs, local communities and civil society have taken this work even further. While the regional partners ensure that communities across the implementing countries receive accurate tools, frameworks and guidance on PPR, national implementors have adapted these resources into local languages and formats that resonate with their audiences. Community manuals, simplified guides, short videos and thematic learning sessions have been reworked to reflect cultural nuances and everyday realities. This intentional localisation is doing more than improving understanding, it is opening doors. Communities that once found Joint External Evaluation's (JEE), National Action Plan for Health Security (NAPHS), One Health and disaster management discussions and national coordinating platforms inaccessible are now equipped with the language and clarity to participate meaningfully in these processes.

These seemingly simple acts, rewriting a training guide and running a radio dialogue in mother tongue, triggered meaningful shifts at both national and sub national levels, boosting confidence and ensuring enriched participation in stakeholder forums, validation workshops and policy consultations. National structures such as Emergency Operations Centre's (EOC), One Health platforms, National Public Health Institutes (NPHI) and Health Ministries are beginning to recognise that genuine participation starts with accessible information. The lesson is clear, localisation is not a courtesy, but a catalyst. It builds trust, strengthens ownership and improves data quality and participation in preparation for future health emergencies.

These efforts demonstrate that inclusion should not be an afterthought but should lie at the heart of national PPR Platform vision. When information reaches everyone, communities move from the margins to the center of preparedness.

Country Adaptations:

Kenya

Stop TB Partnership Kenya has tailored PPR literacy efforts to local needs through several unique adaptations:

- **Accessible formats:** The PPR literacy toolkit was adapted for accessibility, including the development of Braille resources in partnership with the Kenya Union of the Blind. A PPR-specific Braille toolkit is also planned to strengthen inclusive learning.
- **Targeted training:** Training-of-trainers (ToTs) equipped local actors to cascade PPR knowledge to community networks and health workers. Virtual sessions were adjusted based on participant feedback to improve clarity and engagement.
- **Responsive curriculum updates:** Community questions, confusion, and language needs prompted Civil Society Organisations (CSO) to refine the curriculum, offer interpretation in local languages, and introduce structured feedback mechanisms to ensure that PPR literacy materials remain contextually relevant.



Cambodia

Community feedback showed that technical language and top-down delivery limited understanding of PPR concepts. In response, Khmer HIV/AIDS NGO Alliance (KHANA) and partners introduced several context-specific adaptations:

- **User-friendly materials:** A simplified PPR Guide in Khmer was developed, translating complex concepts from the International Health Regulations (IHR), JEE, States Parties Self-Assessment Annual Reporting (SPAR), and National Action Plan for Health Security (NAPHS) frameworks into accessible, community-level language.
- **Interactive learning:** Role plays, discussion sessions, and pre-/post-tests improved engagement and comprehension, with post-training knowledge scores reaching 74.3%.
- **Localised delivery:** In-person trainings across six provinces enabled facilitators to tailor examples and explanations to local realities, making PPR learning more relevant and accessible to communities.



Indonesia

Community feedback underscored the need to translate technical PPR concepts into practical, locally meaningful guidance. JIP and partners introduced several adaptations:

- **Digital access:** Jaringan Indonesia Positif (JIP) created <https://pandemicresponse.id> in Bahasa and English, providing risk maps and community-informed resources for broad, easy access.
- **Cost-effective learning:** Digital materials reduced costs, improved efficiency, and allowed rapid sharing, increasing community engagement with PPR content.
- **Localised action planning:** Community task forces collaborated with provincial and city disaster management agencies to co-develop contingency plans, turning PPR literacy into practical, context-specific preparedness actions.



Lessons

Communities must be at the center of pandemic preparedness and response, shaping PPR training materials and resources, interventions, and advocacy strategies.



Local adaptation of training materials through translation, accessible formats, and culturally relevant examples, is essential for building skills and knowledge for meaningful engagement.

Structured feedback loops ensure that communities not only receive information but actively contribute to influence policy and monitor implementation.

Gender and human rights considerations must be integrated into all literacy and engagement activities to address differentiated needs. populations.

Philippines

ACHIEVE and partners adapted PPR literacy to be relatable and accessible, avoiding technical jargon. Localised materials: Two brochures in Filipino explained PPR basics and community roles. Connecting to lived experiences: Communities linked PPR to gender-based violence, livelihood loss, and healthcare access, highlighting economic justice, social protection, and rights. Peer-to-peer training: 51 peer educators reached around 500 people across TB/HIV groups, tricycle drivers, women's organisations, and youth, making sessions interactive, relatable, and meaningful.



CASE STUDY 9

Integrated Community Engagement & Community-Led Monitoring where Communities Thrive and Change is Measurable



(Photo credit: Shutterstock.com)

Context

Much like the Yin and Yang philosophy, where two contrasting forces come together to create balance and harmony, the integration of Community Engagement (CE) and Community-Led Monitoring (CLM) has been described as a complementary pairing. Each brings something the other cannot offer alone: CE opens doors, builds coalitions, and strengthens voices, while CLM brings the evidence, structure, and accountability needed to turn that voice into influence. Together, they form a balanced system that helps communities lead with confidence and shape the health responses that affect their lives.

CLM has given communities the tools to turn lived experience into evidence and influence. Digital platforms have democratised data collection, allowing groups who were once ignored to gather timely information, demand accountability and follow up on responses. With these skills, communities now track service quality, pinpoint gaps and push for concrete change at facility and system levels.

As one facilitator put it, “Communities stopped being spectators; they became system actors.”

CE has equipped the most vulnerable communities with knowledge, tools and confidence to shape national health security - moving them from passive recipients to active participants. Through training, mentorship and user-friendly handbooks, CE demystifies complex processes such as Joint External Evaluations (JEE), States Parties Self-Assessment Annual Reporting (SPAR) and National Action Plan for Health Security (NAPHS), opening real pathways for communities to influence policy. Its most notable innovation is a Pandemic Preparedness Response¹ (PPR) scorecard that checks whether health equity, gender equality and human rights are embedded in PPR plans; the scorecard surfaces gaps, helps communities design action plans and feeds those priorities into national advocacy.

¹

<https://www.who.int/news/item/20-05-2025-world-health-assembly-adopts-historic-pandemic-agreement-to-make-the-world-more-equitable-and-safer-from-future-pandemics>

A Global Fund partner summarised the scorecard's purpose: *"We developed a PPR scorecard that measures how health equity, gender equality, and human rights are included in the JEE and NAPHS process. It highlights gaps and challenges, supports communities to create action plans, and feeds into wider advocacy so they can push their priorities into national pandemic policies and strategies."*

Insights and Lessons Learned - When CE and CLM work together, communities thrive. CLM strengthens and sustains the gains made through CE, ensuring that engagement becomes continuous rather than episodic. This combined approach has already shown promise in countries such as the Philippines, Nigeria and Kenya, where the two mechanisms were implemented alongside each other and deepen community influence.

The integration of COPPER CE and CLM leads to influential participation of communities in structures. CE opens the doors to national platforms, but CLM equips communities with the evidence needed to participate with authority. This shifts discussions from opinion to proof, strengthening accountability and transforming decision-making spaces into forums where communities can negotiate, challenge and shape outcomes. The result is not only stronger partnerships, but a clearer balance of power where community voices genuinely guide policy and programme decisions.

With CLM linking facility, district and national levels, CE's capacity building, targeted training and policy analysis ensure that marginalised groups, particularly women, young people and persons with disabilities, can participate meaningfully. CLM supplies the evidence they need; CE gives them the skills and pathways to use it, expanding equity, strengthening voice and improving health outcomes.

Communities Leading the Way



Philippines: - In Metro Manila, tricycle drivers, women's groups, youth, migrants, and Indigenous communities initially had limited pandemic preparedness and response knowledge. Action for Health Initiatives (ACHIEVE)² combined CLM and CE to build capacity: 51 peer educators reached 500 community members. CLM revealed disrupted access to medicines, livelihoods, and safety concerns. CE workshops translated these insights into advocacy manifestos prioritising healthcare, pandemic-resilient education, economic support, and protection from gender-based violence. By World TB Day 2025, communities presented evidence-backed agendas to government officials and NGOs, showing how integrated CE-CLM translates lived experience into policy influence.



Nigeria - In Adamawa and Gombe States, historically excluded populations, including people living with HIV and affected by TB, persons with disabilities, displaced populations, and religious minorities faced barriers to information and services. The Janna Health Foundation used CLM to document gaps in vaccination coverage and misinformation, while CE enabled advocacy for inclusion. Community groups gained access to Emergency Operations Centre meetings, reported outbreaks, and accessed care without stigma. The result: strengthened trust, improved outbreak response, and institutionalised community participation.

² <https://achieve.org.ph>



Kenya - Cholera outbreaks in Kisumu and Migori, alongside Mpox on the coast, tested Kenya's community-led systems. Stop TB Partnership Kenya mobilised PPR Champions, including Community Health Promoters, youth leaders, and elders, trained through COPPER CE. CLM identified hotspots, sanitation gaps, and vulnerable groups; CE transformed this data into action. At Kisumu's Kibuye Market, monitoring revealed hygiene risks; community dialogues enabled temporary market closure and advocacy for improved WASH infrastructure. Champions conducted door-to-door sensitisation, early case detection, and digital reporting via WhatsApp and M-Dharura. Outcomes included behaviour change, reduced fatalities, and stronger community ownership of health.

Cross-Country Implementation Opportunities

When COPPER CE and CLM work in tandem, the potential for impact multiplies. CE partners are actively involved in shaping CLM indicators, ensuring that the measures reflect communities' real priorities and concerns. Insights from CLM are not just numbers; they become advocacy fuel, with CE partners helping to identify key issues that emerge from the data. The collaboration also expands reach: CLM partners can tap into the networks, platforms, and coalitions established by CE actors to share findings and engage decision-makers effectively. Beyond analysis, CE and CLM partners co-design and implement advocacy initiatives, turning evidence into action and fostering a coordinated approach across countries. Together, this partnership strengthens the influence of communities, accelerates responsive policy action, and transforms isolated efforts into a cohesive, high-impact ecosystem.

CASE STUDY 10

Knowledge Sharing for Continuous Learning – The COPPER Knowledge Hub



Knowledge Hub training. (Photo credit: ACT AP/PCASO)

Context

When the world turned inward and people were isolated in their homes during the coronavirus disease COVID-19, communities across Africa and Asia reached out to each other. What began as a crisis of disconnection slowly became a digital movement, one that reimagined what pandemic preparedness and response could look like when led by communities themselves.

Under the Global Fund’s Communities in Pandemic Preparedness & Response (COPPER) initiative, regional partners, Africa Coalition on Tuberculosis (ACT Africa) and Activists Coalition on TB (ACT Asia-Pacific), built something remarkable: the Regional Knowledge Hub¹, a virtual space that connected communities and civil society and leaders across borders. From online webinars and peer mentoring circles, this Hub transformed isolation into collaboration and information into action. Partners learned not just to respond to emergencies but to lead in shaping preparedness. As one participant put it:

“Actionable evidence is about timing and relevance, not just accuracy.”

¹ <https://copper.apcaso.org>



Knowledge Hub. (Photo credit: screenshot of the Knowledge Hub site)

From Information to Influence

The Hub did more than share knowledge; it shifted power. Communities and civil society partners went from sitting on the sidelines to taking an active role in shaping decisions. Technical language, once locked away in policy rooms, became accessible, simplified, and actionable. Technical experts joined the Hub to unpack complex areas such as health equity, Community-Led Monitoring (CLM), and Resilient and Sustainable Systems for Health (RSSH), and to explain how these pillars directly link to pandemic preparedness response (PPR), giving communities the conceptual grounding needed for meaningful engagement. For the first time, communities felt confident taking part in national planning processes like the Joint External Evaluation (JEE) and National Action Plan for Health Security (NAPHS), from the comforts of their homes or offices.

The webinars became lively meeting points where people logged in out of genuine interest. Hosts used interactive icebreakers, and what followed were learning experiences that felt strategic yet full of heart. A regional partner explained how transformative this was:

“The PPR literacy sessions helped partners see exactly where communities were being left out - and what they could do about it.”

This clarity sparked a quiet shift. People realised they had the right not just to attend national processes, but to shape them. Inside the Hub, participants questioned whether projects were designed with communities or merely for them. As one regional lead reflected:

“Sometimes it feels like projects are designed for us, not with us. The real question is, whose reality truly counts?”

The Knowledge Hub soon matured into a true engine of capacity building. For seven months, it became the place people returned to for clarity, confidence, and practical tools. Webinars connected Africa with Asia-Pacific in real time, turning complex ideas into understandable concepts. Thematic sessions covered country implementation progress, CLM tools, engaging National Public Health Institutes, interpreting the Community PPR Scorecard, and navigating global developments such as Pandemic Accord and One Health².

Between sessions, learners explored blogs, manuals, community guides, and short videos, all drawn from lived experiences, not theory. The Hub's expanding library included ready to use PPR toolkits, simplified guides, lesson briefs, and recorded webinars designed to help communities engage consistently beyond live sessions.

This flow of information translated into action as regional partners supported countries to form and strengthen PPR coalitions, bringing together actors who had seldom shared the same table. This include TB, HIV, and malaria networks alongside National Public Health Institutions (NPHI), indigenous communities, migrant groups, former prisoners, and Red Cross volunteers. This resulted in communities and civil society presenting PPR plans to Country Coordinating Mechanisms (CCM) influencing local task forces, aligning CLM work with preparedness, and ensuring marginalised voices became part of national decision-making. In Indonesia, community groups collaborated with the National Disaster Management Authority to conduct policy and technical assessments, producing policy briefs that now inform disaster governance and community participation.

A defining feature of the Hub was real-time exchange. Country implementors, including - Khmer HIV/AIDS NGO Alliance (KHANA) in Cambodia, Janna Health Foundation in Nigeria and Civil Society Movement Against Tuberculosis (CISMAT) in Sierra Leone regularly presented their implementation status, sharing progress, challenges and opportunities. These sessions strengthened solidarity across regions as partners celebrated successes together, unpacked challenges and co-developed practical solutions.

Global and regional PPR partners also contributed insights on key global processes, including the Pandemic Accord negotiations, the Pandemic Fund³, and major health security events, helping communities understand how global decisions shaped national advocacy pathways.

Still, partners understood the realities. Meaningful engagement requires minimal but consistent support. As one African regional partner put it:

“It’s not about creating dependency, but being realistic. Communities still need support to stay engaged.”

To drive sustainability, a domestic resource mobilisation video is now being produced to help countries advocate for these essential costs.

What stands out most is the sense of movement that has grown from the Hub. It has become a place where learning feels enjoyable, where people debate with kindness, share openly, and challenge systems with confidence. It gives communities not only information but a sense of belonging, a reminder that their lived realities matter in PPR.

At its core, the Knowledge Hub reimagines what preparedness looks like when communities are trusted, equipped, and connected. It has given partners across Africa and Asia a seat at the table, the language to participate meaningfully, and the tools to engage with confidence.

² https://www.who.int/health-topics/one-health#tab=tab_1

³ <https://www.thepandemicfund.org>



ACT Africa learning and advocacy meeting. (Photo credit: ACT Africa)

What Worked and What Still Needs Work

The Knowledge Hub proved that communities never lacked capacity, only consistent support. It built trust, improved understanding of governance mechanisms, and inspired peer-to-peer learning across continents.

Yet, the work is not complete. Its short duration revealed the fragility of these gains without institutional backing. Some groups, including migrants, survivors of gender-based violence, and people in detention, remain harder to reach. Shorter training sessions sometimes limited deeper learning, and language barriers reduced participation in some regions.

Still, where content was translated and shared by trusted community leaders, participation soared. Everywhere, the lesson was clear: knowledge only becomes power when it is shared, localised, and sustained.



