



CHAMPIONS:

Communities in Pandemic Preparedness and Response

Lessons Learned from the COPPER CE Project



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Activists' Coalition on TB – Asia-Pacific (ACT! AP)
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October 2025

*Communities in Pandemic Preparedness and Response Project - Community Engagement



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ACRONYMS

ACHIEVE - Action for Health Initiatives

ACOMIN - Civil Society for Malaria Control, Immunisation, and Nutrition

BNPB - National Disaster Agency for Disaster Countermeasure

CELG - Community Engagement and Leadership in Epidemic Governance

CFR - Case Fatality Rates

CISMAT-SL

CLM - Community-Led Monitoring

COSCA - Collectif des Organisations de la Société Civile de l'Adamaoua

CS - civil society

CSO - civil society organisation

DPH - Director of Public Health

EOC - emergency operations centre

FIS - For Impacts in Social Health

HTM - HIV, TB and malaria

IHR - International Health Regulations (2005)

JIP - Jaringan Indonesia Positif

JHF - Janna Health Foundation

JEE - Joint External Evaluation

KHANA - Khmer HIV/AIDS NGO Alliance

KRCS - Kenya Red Cross Society

KVP - key and vulnerable populations

NAPHS - National Action Plan for Health Security

NEPHWAN - Network of People living with HIV/AIDS in Nigeria

NGO - nongovernment organisation

ORS - oral rehydration salts

PPR - pandemic preparedness and response

ROOHCAM - National One Health Civil Society Network

SPA - Service Provision Assessment

SPAR - States Parties Self-Assessment Annual Reporting

TB - tuberculosis

VHSG - village health support group

WASH - water, sanitation, and hygiene

YOUNETPO - Youth Network for Positive Change



BACKGROUND

As the world stepped out of the shadow of the COVID-19 pandemic, many countries boosted their capacities to act as more diseases continue to pose a similar threat, leaving national health responses mechanisms eager to be ready to work in partnership with civil society and communities for a better pandemic response.

The Global Fund's Communities in Pandemic Preparedness and Response Project- Community Engagement (COPPER CE) Strategic Initiative was aimed at increasing participation of key vulnerable populations, key populations and last-mile populations in pandemic prevention preparedness and response (PPR). This report provides an overview of the experience of implementers from eight countries–, five from Africa: Cameroon, Kenya, Liberia, Nigeria, Sierra Leone, and three from Asia-Pacific: Cambodia, Indonesia, Philippines.

The COPPER CE project was envisioned to meet the challenges identified under the preceding project Community Engagement in Pandemic Governance (CELG), which had sought to assess and develop community engagement strategies and approaches to enable marginalised and most vulnerable populations to influence COVID-19 and PPR decisions at the country-level.

These challenges were:

- Many communities had limited access to information and are not included in PPR decision-making fora
- There was an absence of systematic PPR capacity development strategies and plans for most vulnerable and marginalised communities
- There was weak consultation and coordination with civil society in the development and oversight of PPR policies and programs
- There continued to be stigma and discrimination against most vulnerable and marginalised communities

At the same time, the World Health Organisation has also required countries to adopt assessment systems for measuring a country's readiness to deal with health emergencies, using instruments that such as the mandatory States Parties Self-Assessment Annual Reporting (SPAR) and the non-mandatory Joint External Evaluation (JEE). These assessments enable countries to identify gaps in their health systems and map out their preparedness and response. In countries involved in this report, the civil society organisations have been keen to work with national and public health systems but have limited understanding of these regulatory mechanisms, prompting the need for better understanding of these mechanisms to be able to participate in national level initiatives.

Objectives of the COPPER CE

Build knowledge and capacity of communities on PPR

- Ensure communities have access to accurate and timely information, tools, and resources on PPR.
- Strengthen capacity of communities at national level and facilitate their engagement in country level PPR decision-making fora.

Support meaningful community engagement in PPR governance

- Support meaningful community engagement from governance to implementation and oversight including national level multistakeholder PPR processes and mechanisms, CCMs, national intergovernmental JEEs and SPAR platforms

Support coordination, evidence generation and use

- Enhance coordination and networking both within the traditional HIV, tuberculosis and malaria communities and in partnership with PPR actors to create a shared PPR vision that integrates health equity, human rights, and gender equality in agile and responsive systems for health.

To meet these goals, the COPPER CE implementers worked to:

- Provide most impacted communities with tools and resources to ensure strengthened knowledge and capacity to engage in PPR decision making
- Generate and use evidence to identify and articulate community PPR priorities that address human rights and gender related violations in pandemic strategies and planning
- Strengthen national community coordination platforms to engage in PPR and influence national PPR decision making and oversight
- Build multisectoral public, private partnerships and platforms that support community engagement in PPR

The first phase, CELG, was implemented from March 2024 to April 2025, and the second phase, COPPER CE was initiated for April to December 2025. This report covers the learnings gained from the second phase.



For more information about the COPPER CE Project, please visit the page <https://copper.apcaso.org/>

COUNTRY COMPILATION OF LESSONS LEARNED:

AFRICA



CAMEROON

Gaining a major role

Civil society organisations and marginalised communities were mainly excluded from national level PPR processes. To support the integration of CSOs in the JEE, NAPHS, and other PPR processes they conducted a mapping of key PPR processes, held capacity building on PPR planning, and developed a PPR National Advocacy Plan, creating an agenda for constituency consultations. They have since become part of key national PPR processes through their efforts.

Cameroon's experience of dealing with the COVID-19 pandemic crucially revealed the need to strengthen the resilience of health systems to effectively protect the most vulnerable populations and preserve lives. There is also an urgent need to systematically integrate community priorities into pandemic preparedness and response (PPR) mechanisms, including within existing strategic and operational frameworks such as the Joint External Evaluation (JEE), the National Action Plan for Health Security (NAPHS), and responses to epidemics such as Mpox.



For Impacts in Social Health (FIS) mapped out the challenges that remain, including the absence of a formal community participation framework, insufficient coordination among key actors, and the fragmented and unsystematic integration of human rights and gender considerations into the planning and implementation of PPR strategies. These gaps compromised the ability to fully mobilise communities and ensure an inclusive, equitable, and sustainable response to health threats.

Cameroon has several of policy documents for national emergency health plans and procedures for pandemic preparedness and response including six main strategic documents: the National Strategic Plan for Integrated Disease Surveillance and Response, the National Multi-Hazard Preparedness and Response Plan for Public Health Emergencies, the National Action Plan for Health Security, a document prioritising zoonotic diseases for intersectoral engagement for identifying zoonotic diseases such as rabies, anthrax, avian flu, Ebola, Marburg virus disease,

and bovine tuberculosis, and finally the concepts and operations of the Public Health Emergency Operations Coordination Center. Unfortunately, these main documents share a common challenge regarding community engagement: **neither the community nor civil society were sufficiently included during their development and planning.**

FIS and their partners brought together civil society and organisations involved in PPR, including those working in human rights, gender-based violence, blood transfusion, provision of health care services to HIV and AIDS patients, tuberculosis patients, malaria services and other marginalised groups such as albinos, the elderly, and people with disabilities, among others. These groups have formed an informal network of PPR advocates which included key national human, animal, and environmental health related civil society networks. Their initial meeting was to come together to **discuss national progress in community engagement** that was generated through desk studies, focus groups involving over 60 CSO representatives, and an online survey.



Group discussions during the community review of PRP processes and mechanisms, 29 – 30 January 2025

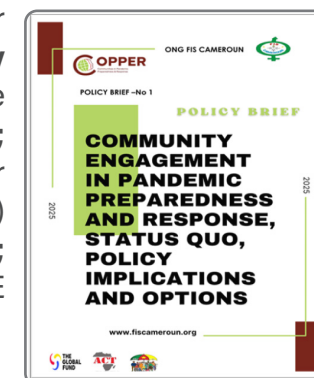
The group conducted several **capacity building of CSOs and community actors on PPR plans**, processes and strategies, with particular emphasis on NAPHS and JEE, community monitoring, and advocacy. These trainings include a workshop for over 30 CSOs on PPR,



An Advocacy Plan Update Workshop, April 3-4, 2025 in Yaoundé, was held to validate the national advocacy agenda, integrate new recommendations, and strengthen medium- and long-term community engagement in preparedness and response to epidemics Cameroon.

JEE and NAPHS processes, advocacy development, a workshop for over 50 members of National One Health Civil Society Network (ROOHCAM) on pandemic fund proposal and the role of CSOs. They then **developed an advocacy plan** which was presented to all key CSOs for amendment, ownership and adherence.

They also developed knowledge products for **building civil society capacity on community engagement in PPR**: a) a country profile on pandemic preparedness and response; b) a guidance note on Country Capacity for Community Engagement and Policy Options; c) a Human Rights and Equity Assessment Report; and d) a community-led review report on JEE and NAPHS processes and MPOX response.



To further support engagement, they developed PPR planning guides, including a constituency consultation agenda, a roadmap for integrating CSOs and communities into the PRP, and an advocacy strategy with the aim of improving results-based PRP planning.



As an outcome of their strengthened capacity, the CSOs **advocated for participation in several PPR processes** and subsequently enabled the inclusion of 45 civil society representatives in the Universal Health and Preparedness Review in 2024. The PPR advocates, specifically ROOHCAM members, also participated in the Pandemic Fund Proposal submission and integration of community engagement priorities and the submission of the third pandemic fund proposal from March to June 2025, as well as in the State Party Annual Review planned for early 2026.

ROOHCAM also strengthened their collaboration through the close partnership with Coalition des organisations de la société civile du Cameroun pour la santé (COSCA - Santé), CSOs Coalition for Health Financing and Universal Health Coverage in Cameroon (COFIS CSU), Global Civil Society for Malaria Elimination (CS4ME), and CSO Platform for Vaccination and Health System Strengthening in Cameroon (PROVARESSC) and other civil society health organisations and vulnerable groups. This collaboration led to the induction of new members and the adoption of a unified PPR advocacy strategy among civil society actors.

Meetings among various civil society multiple meetings and workshops allowed for fruitful collaboration, communication and data sharing between several Cameroonian civil society coalitions.



Lessons Learned

- Civil society organisations are involved in several PPR activities at country and international level, however their inclusion and participation in PPR is not structured hence it is non-systematic and sometimes figurative.
- There is a need to build capacities of CSOs on PPR processes, strategic planning, advocacy, communication and resource mobilisation.
- Advocacy is a vital component of CSO activity planning and implementation
- CSOs have resources with a majority of it sourced from international donor organisations

KENYA

Mobilising the champions

A severe cholera outbreak was reported in Kisumu and Migori counties in February 2025, causing the local authorities to close a large public market. Stop TB Partnership Kenya and their partners within the health community mobilised and trained community PPR Champions to enhance hygiene awareness, improve sanitation, and support early detection and referral to health services, effectively reducing cholera transmission and fatalities. Similarly, a community-led PPR to an Mpox outbreak also relied on social media and localised communication channels to reduce and manage spread of infection.

Even after COVID-19, Kenya has faced health crises that require urgent response at the community level. For many Kenyans in the rural areas, this health response comes in the form of a local **community health promoter** (CHP), one of the many who are tasked by the county health programmes as well as the various civil society actors providing health services.



These CHPs are assigned into community units, where they oversee a number of households within a given locality whom they would observe, conduct health checks and report family health issues, not just TB, HIV, and malaria, but also the well-being of the children and all other aspects pertaining to health for a particular family. As of 2025, there are currently 107,000 CHPs in Kenya, forming a first line of community health care.¹

Closing the market

Cholera spread through the counties of Kisumu and Migori in February 2025, and by April, there were 97 cases as well as 6 fatalities². The local public health officials identified the Kibuye public market in Kisumu as a possible health risk, due to the open-air nature of the market where

¹ Built from the Ground Up: How 107,000 Community Health Promoters Are Changing the Face of Primary Health Care in Kenya <https://newsroom.amref.org/blog/2025/06/built-from-the-ground-up-how-107000-community-health-promoters-are-changing-the-face-of-health-care-in-kenya/>

² Cholera: Deadly Disease Recently Reported in Kenya Explained, Prevention and Preparedness <https://news.digital/newsflash/cholera-deadly-disease-recently-reported-in-kenya-explained-prevention-and-preparedness/>

thousands of people congregate daily, and where there is a notable lack of water supply, toilets and hygiene facilities.

In response to the escalating crisis, health authorities, supported by organisations such as the Kenya Red Cross Society (KRCs) and local community alliances, activated emergency response measures. A key component of this response was the engagement of **community health promoters as PPR Champions** who played a pivotal role in community-level interventions. The champions had previously been trained under the COPPER CE support on pandemics and emergencies and how to respond. Together with the CHPs, the champions also included youth leaders and local elders who have a degree of influence in the community and are well-trusted to bridge the health services and the people. The effectiveness of the interventions depended on the champions' ability to build trust within their communities, communicate in local languages, and tailor messages to specific cultural contexts. Their presence at the grassroots level allowed for real-time monitoring of community health and immediate reporting of new cases.

Under the COPPER CE intervention, the PPR champions were mobilised from the TB, HIV, and malaria-affected communities and the CHPs. Stop TB Partnership Kenya and their partners provided training on identifying cholera symptoms, prevention, and treatment. The PPR champions strengthened their knowledge of the appropriate disease response, and they conducted door-to-door visits and group discussions where they engaged families and small groups, providing practical demonstrations and information on cholera prevention. These champions conducted sensitizations among the villages, at learning institutions, as well as at the workplaces. They offered crucial health messages on signs and symptoms of cholera, the importance of seeking immediate medical attention for diarrhoea and vomiting, and reporting to health facilities for treatment. They also promoted safe water practices, especially the importance of boiling or treating drinking water using purification tablets

such as aqua tabs and chlorine granules. They emphasised the need for proper handwashing where they demonstrated correct handwashing techniques with soap and clean water, especially after using the toilet and before preparing food. They provided home-based care including basic administering/delivery of oral rehydration salts (ORS) for home-based management of cholera.

Moreover, the champions assisted in community surveillance and assisted rapid response teams in active case finding and monitoring their health status to break the chain of transmission. For Kisumu county, the PPR Champions optimised using communication platforms such as WhatsApp to do case reporting and gather disease surveillance data, which could then be easily shared with the local public health authorities for action. Meanwhile in the neighbouring Migori county, they used an



Kibuye market [photo screenshot from video <https://www.youtube.com/watch?v=8LoKHStOqDs>]

existing mobile application named M-Dharura (from the Kiswahili word for emergency) for case finding and disease surveillance. Further, the champions acted as the bridge to healthcare connecting the underserved populations to formal healthcare services, making referrals to clinics and following up with patients to ensure recovery and adherence to treatment. In this way, the champions engendered community empowerment and ensured communities actively participated in their health management; they ensured a wider access to health by reaching marginalised groups.

At the county level, the PPR champions conducted advocacy for improved sanitation especially in settings where large numbers of people congregate, such as the Kibuye market and at bus stations, to reduce further risks of transmission. By April 2025, the local authority had already decided to close the Kibuye market, with the aim of upgrading the facilities and addressing the hygiene issues present. The larger community around



STP-K conducted a workshop to disseminate PPR assessment and receive feedback on the national pandemic scorecard in February 2025. Discussions covered early detection and surveillance, equity and inclusion, community engagement and risk communication and, strengthening health systems.

Kibuye, and the traders at the market were initially resistant to the closure of the market, but through the intervention of the community health promoters and the PPR champions, they were informed on the benefits of improving the sanitation and hygiene facilities and accepted the closure. These interventions brought significant results for the Kisumu and Migori counties where the PPR champions were engaged. They promoted a heightened community knowledge of cholera transmission, its symptoms, and modes of prevention. The community sensitisation campaigns greatly increased people's understanding that cholera is spread through contaminated water and food, particularly fecal contamination. The community learned basic prevention methods, such as handwashing with soap and water treatment. They also brought about behaviour change focusing on specific behaviours such as boiling or treating drinking water, proper food handling, and safe disposal of human waste.

People in the community raised a demand for improved sanitation facilities especially at Kibuye Market, and the construction of more public toilets and running water that are freely accessible to the community. Furthermore, communities are mobilising to clean-up exercises, clearing drainage systems, and proper waste disposal to help reduce environmental contamination and potential breeding grounds for pathogens that cause disease.

Communities were more empowered to improve early case detection and referral through the M-Dharura app and other communication channels being used at the county level. Timely referral to health facilities has encouraged community members to seek immediate medical attention at health facilities.

And finally, there was a considerable reduction in Case Fatality Rates (CFR) that was facilitated by early detection and referral out of engaging communities in the response.

Communications as a way to fight Mpox

When Kenya saw an increase in cases of Mpox³, especially in the coastal areas around Mombasa, Stop TB Partnership Kenya and their PPR champions made a concerted effort to address the disease proliferation at points of transmission or 'hotspots'. Utilising community-specific channels such as WhatsApp, local radio broadcasts, and local languages helped disseminate vital health information quickly to the community.

One of the most vulnerable groups were sex workers, whose access to health care was extremely limited due to the stigma they face. Sex workers groups used WhatsApp to share symptoms, health facility locations, and service availability within their hotspots, facilitating quick response and reducing transmission. They organised for health care services to be provided at their hotspots. This response minimized continued transmission among the sex workers. Eventually, the transmission was managed well enough that the National Public Health Institute did not have to restrict movement in and out of the county.

Local radio stations broadcasting in Kiswahili and local dialects helped reach coastal communities effectively, overcoming language barriers and speaking more directly to their audience. They also asked local champions and survivors to share their stories and give practical advice, such as on sanitation and homemade oral rehydration solutions, to encourage health seeking behaviour without having to face stigma. Lastly, local chiefs, who are influential in their communities, organised monthly meetings with residents to discuss health updates and encourage reporting of infection cases, while PPR champions supported them to promote One Health awareness.

³ <https://www.ghanawebbers.com/GhanaHomePage/africa/How-truck-drivers-sex-workers-drive-Mpox-across-borders-2073278>



Lessons Learned

For Stop TB Partnership Kenya and their partners, their experience in responding to these disease outbreaks from the perspective of PPR have brought them a better understanding of the specific needs of communities. They share the lessons learned from these two cases:

- Targeted interventions are key to reducing further transmissions and therefore identifying hotspots played a key role in hygiene campaigns to reduce risk of disease re-emergence
- Community dialogues and local communication are helpful avenues, especially in the rural communities, to be able to facilitate passing of information and sharing feedback from the communities.
- Sustainable water, sanitation, and hygiene (WASH) infrastructure is critical beyond emergency responses; targeted hygiene interventions and hotspot identification are essential to control outbreaks, highlighting ongoing challenges due to inadequate water and sanitation investments in high-risk areas.
- Communities need sustainable WASH infrastructure that is responsive to the day to day demands and needs and not just a response during emergencies and disease outbreaks. There is limited investments on WASH programs in the high prone areas to pave way for universal access to safe water and sanitation.

LIBERIA

Institutionalising PPR in national policies

COPPER CE advocates in Liberia strengthened pandemic preparedness and response through multi-stakeholder coalitions, policy advocacy, and community engagement. They worked to make PPR integrated into existing health responses through holistic health approaches, found allies among legislators who could help them set up sustainable financing for PPR, and built the capacity of their communities to ensure robust civil society participation in national health systems.

With support from the COPPER CE project, **Youth Network for Positive Change (YOUNETPO)** formed a **PPR coordination platform** involving civil society organisations (CSOs), communities, and government agencies. This coalition included CSOs, slum dwellers, disease survivors, persons with disability among others. The coalition now forms the core of community engagement in PPR meetings. Some eighty (80) civil society members of the coalition were trained in pandemic preparedness processes, specifically the Joint External Evaluations (JEE), State Party



Annual Reports (SPAR), and National Action for Public Health Plans (NAPHs) to make them ready for their engagement roles.

With their greater strength and unity, the coalition started as observers, but slowly, they became partners and contributors to policy. At the local level, there are now community members who coordinate within the 15 Emergency Operation Centers (EOCs) in each county. Then there is the KP technical working group at the National AIDS Commission, the PPR coordination platform hosted at the National Public Health Institute, and finally there is the One Health Platform in which civil society now holds defined roles in national health governance as when the One Health Governance Manual was drafted, CSOs participated in its review and validation. The One Health Manual has been submitted to the office of the Vice President and will be launched soon.

What helped advance their advocacy was through choosing **PPR champions**, who serve as allies in the legislature and government

agencies such as the Ministry of Health, National Public Health Institute, and National Disaster Management Unit. These champions have promoted civil society representation in key PPR decision-making processes. Moreover, the champions have supported crucial policy demands being proposed by CSOs.

The first is for **securing alternative financing for health and epidemic response**, without needing for another epidemic to emerge for the government to begin looking for resources. These alternative financing could be similar to how Liberia finances its National Road Fund from levies on gasoline imports, and could be set aside to enable the government to be able to respond immediately to emergencies. The policy has been taken up in the House of Representative and the Senate in discussions for the 2026 budget, a promising outlook for the CSO initiative. The other policy they are seeking to advance is a National Primary Health Care Policy ensuring adequate implementation and empowering communities to advance policy.

OnemoreimportantstepYOUNETPOtookininstitutionalising PPR was through promoting its ideas through broadcast media, radio, and television that reached audiences in all 15 counties of Liberia. They were able to bring in experts to speak on PPR topics on media, and the broadcasts drew responses from the audience, including COVID-19 survivors and community health practitioners who also affirmed the need for a better government health response to pandemics. These audience responses have served as input into the PPR coalition's policy advocacy efforts.



Representatives of PLHIV, media, persons with disability, slum dwellers, survivors network members, and other KVPs across Bong, Nimba, Grand Gedeh, Grand Kru, Maryland, River Gee and Sinoe Counties participated in a Regional Pandemic Preparedness and Response (PPR) Training held on October 2024.



Representatives of civil society organisations to reviewed and validated a policy brief and shadow report developed around Primary Health Care in Liberia, September 2025



YOUNETPO held a High Level Pandemic Preparedness and Response (PPR) Engagement meeting on August 2025 to share a policy brief and a shadow report to rally the support of key stakeholders including members of the Liberian Legislature specifically the House and Senate committees on health, the Ministry of Health, PPR platforms, local authorities among others.

In attendance were Hon. Julie Fartomah-Wiah - House Chairperson on Health, Hon. George Paygar- Assistant Minister for Policy and Planning, Ministry of Health, Dr. Gorbee Logan-Technical Assistant, Office of the Chief Medical Officer, Mr. William E. Walker Jr; Head of Secretariat, Liberia Coordinating Mechanism (LCM/CCM), representatives of the National Disaster Management Agency, the National TB and Leprosy Program of Liberia and civil society organisations.



Lessons Learned:

- Early engagement, the strategic use of media, and partnership with government stakeholders are essential for building inclusive and impactful PPR systems. However, there is still a need for continuous engagement at all levels and follow ups with CS and communities to assess the impact of their participation in these different PPR platforms. Sustainable progress requires continuous investment in community capacity and more **consistent feedback loops between national platforms and grassroots actors**.
- There is a need to **advocate with constituents and representatives** to be able to ensure that the commitments that were made during the dialogues are being implemented. It is not just about getting the commitment, but these should be followed up to ensure that they have the will to be able to live up to that commitment.



NIGERIA

Building community engagement and bridging to break misinformation

In Nigeria, civil society under the COPPER CE project worked to make community voices, especially those of the most vulnerable populations, included in national health platforms. They facilitated the inclusion of people living with TB, people living with HIV, internally displaced persons, and representatives from religious minorities into structures such as the Emergency Operations Centres in Adamawa State and Gombe State. Their inclusion has enabled these groups to be part of interventions related to pandemic response in these regions. One community, the Tsangaya School in Gombe State, has already gained from inclusion and equity, utilising communications to access health services that used to be out of their reach.

Nigeria has diverse cultures, languages and ethnicities, many of which have experienced displacement, conflict and exclusion from state services particularly during health crises such as COVID-19 and



Ebola. **Janna Health Foundation (JHF)** and their partners recognised that key community groups including women, persons with disability, people living with HIV, people living with tuberculosis, as well as various religious and traditional institutions were not adequately integrated into state-level PPR platforms despite having felt the most impact of the pandemic.

This lack of inclusion hinders the effective dissemination of accurate health information, the early detection of disease outbreaks, and the mobilisation of community-led responses during health emergencies. One indicator of exclusion JHF cited is that 70% of key vulnerable populations were not vaccinated even after the COVID-19 pandemic. Further, there is no representation of these groups in the JEE, SPAR and NAPHS processes.



Janna Health Foundation conducted an advocacy visit to the Adamawa State Ministry of Health, January 2025

Misinformation

Exclusion also breeds misinformation around diseases, and this undermines public adherence to preventive measures. The absence of structured involvement from key grassroots organisations left a critical gap in locally trusted communication channels, making it difficult to counter false narratives being propagated in the community and ensure timely community action.⁴ Other evidence from studies in Nigeria has shown that communities with limited participation in public health planning are more vulnerable to misinformation. Such gaps in community engagement not only delay the detection of emerging outbreaks but also erode public trust in official health advisories, thereby complicating overall outbreak responses.⁵ One specific example of this is that during

⁴ World Health Organization. Adamawa State Government partners with WHO to increase COVID-19 risk messaging in readiness for third wave. 2 August 2021. Available from: <https://www.afro.who.int/news/adamawa-state-government-partners-who-increase-covid-19-risk-messaging-readiness-third-wave>

⁵ World Health Organization. Working with the media in Nigeria's COVID-19 fight. 3 December 2020. Available from: <https://www.afro.who.int/news/working-media-nigerias-covid-19-fight>

the Ebola outbreaks in 2014, many people believed bathing in salt boiled in water prevented transmission, even leading to shortages of salt in shops. The public health officials had to correct this misinformation first to be able to address this public health threat.

Building linkages

To counter misinformation and exclusion in pandemic preparedness and response, JHF advocated for influential community groups such as Network of People living with HIV/AIDS in Nigeria (NEPWHAN), the TB Network, Civil Society for Malaria Control, Immunization, and Nutrition (ACOMIN), and representatives from religious and traditional institutions to be incorporated into state-level PPR platforms. They visited the Adamawa State Ministry of Health in January 2025 and made a compelling case for inclusion by presenting evidence to show that **robust community engagement led to better health outcomes and effective risk communication**, and that inclusion of local voices would: **enhance the**

rapid and accurate dissemination of health information, strengthen early detection and reporting of outbreaks; build public trust and counteract misinformation by leveraging local trusted institutions. A media team from the local radio station was present to document and broadcast the initiative to ensure that key health messages would also reach a wider audience.

As a result of this advocacy initiative, the Director of Public Health (DPH) announced that all Emergency Operations Center (EOC) meetings would now be open to community groups, enabling grassroots voices to inform response strategies. The EOCs are at the forefront of pandemic response in each state, they conduct disease surveillance and are responsible for coordinating outbreak response activities in the country.

The DPH also tasked the state epidemiologist to work closely with the advocacy team to integrate community groups into state-level platforms including the One Health Coordination platform. This enabled communities to be quickly responsive to emerging threats and strengthened overall public health interventions.

Lastly, the advocacy visit fostered a more robust partnership between the Adamawa State Ministry of Health and key grassroots organisations. This collaboration not only enhanced the flow of accurate health information but also built mutual trust, an essential component in countering misinformation, as seen in previous media-driven public health campaigns.

The state public health system has developed information sharing and have increasingly relied on the community groups for gathering epidemiological data. The platform has linked the community and the public health sector, not only in pandemic preparedness but also developing responses to health threats such as diphtheria and cholera.



JHF reported that community trust grew when the leaders of the Tsangaya schools were directly involved.

Communicating disease without stigma

A similar advocacy initiative was done in Gombe state, where the inclusion of an underserved community in the state's public health department outreach has enabled a stronger disease surveillance for this community.

The Tsangaya Schools are religious schools with boarding facilities to accommodate students from nearby villages – they live in communal housing and sometimes have crowded conditions. Due to stigma and discrimination, they often lack access to public services as well as access to health care.⁶ During COVID-19 pandemic, these communities became at high risk for infection and were even forced to shut down temporarily as local health officials tried to deal with pandemic prevention in their states.

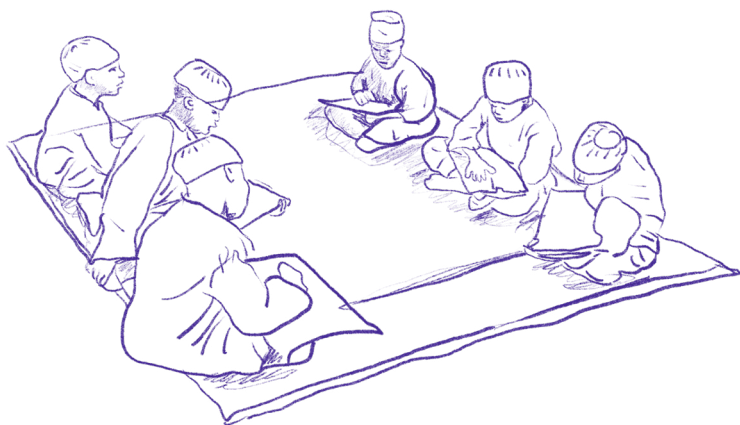
⁶ Tsangaya, The Traditional Islamic Education System in Northern Nigeria <https://www.scribd.com/document/794782214/Tsangaya-The-Traditional-Islamic-Education-System-in-Northern-Nigeria>



Under the COPPER CE project, JHF and their partners went into the Tsangaya schools and shared information on infectious diseases and their transmissions, prevention measures, and how to access treatment; they gave orientations on disease surveillance and reporting; they discussed the importance of sanitation and hygiene. The leaders of the Tsangaya Schools became part of public health coordination meetings, and they developed their own mode of disease surveillance and reporting, facilitated by social media and communications tools such as WhatsApp.

When an outbreak of Buruli ulcer was reported in one Tsangaya school, the school leaders shared their cases on the apps and allowed them to reach out to the local public health officials who could then provide the appropriate medical and treatment. In this way, treatment was made available to the school residents without stigma or discrimination, while a sustainable relationship was established between the schools and public health services in the county.

JHF plans to replicate this advocacy model in other states in the North-east region of Nigeria, promoting community inclusion in PPR efforts across the region. They will also provide training and support to community groups to enhance their ability to contribute effectively to PPR platforms, building a foundation for community-led PPR advocacy that is well integrated with national public health systems.



Lessons Learned:

- **Community engagement is essential:** actively involving local groups such as NEPWHAN, TB Network, ACOMIN, and religious and traditional leaders not only enriched the decision-making process but also bolstered the timely dissemination of accurate information. This inclusion empowers communities to take ownership of public health interventions and increases overall resilience.
- **Trust-building mitigates misinformation:** by integrating grassroots organisations into formal health platforms, the state can more effectively counter misinformation. When trusted local voices participated in the response, they served as vital channels to debunk false narratives and encourage adherence to preventive measures.
- **Collaborative advocacy drives structural change:** the advocacy visit demonstrated that strategic engagement with state health authorities can yield tangible policy changes, such as opening EOC meetings to community groups and establishing integrated communication channels. These changes create a more responsive and inclusive public health framework.
- **Sustained partnerships are key:** the collaboration between government entities, community leaders, and media partners is vital. Such partnerships ensured that accurate, evidence-based messages reach even the most vulnerable populations, ultimately improving early outbreak detection and response.

SIERRA LEONE

From Exclusion to Partnership

Previously excluded communities in Sierra Leone have empowered themselves to participate meaningfully in pandemic preparedness and response, leading to more inclusive policies and stronger community engagement in health security.

In Sierra Leone, **Civil Society Movement Against Tuberculosis-Sierra Leone** (CISMAT-SL) and their partners worked on strengthening community engagement in pandemic preparedness and response (PPR), with the goal of empowering affected communities and civil society organizations (CSOs) to actively participate in national health security decision-making processes.

After Ebola ravaged Sierra Leone in 2014, the country set up emergency pandemic systems to be able to handle health crises. These systems include the National Emergency Response Committee, which is the public health agency designated to work with partners, WHO, and the Ministry of Health on the joint external evaluation processes. And then



there is the National Action Plan for Health Security (NAPHS) which was implemented for the period 2018 to 2022 to “enable Sierra Leone to prevent the likelihood and reduce the consequences of disease outbreaks and other public health hazards; build national capacities for early detection and effective response systems to public health emergencies and other events of public health threats”⁷ Also because of their experience dealing with Ebola, Sierra Leone displayed leadership by being the first African country to conduct a second Joint External Evaluation (JEE) and the third globally to use the latest JEE evaluation tool, improving its health sector scores significantly. A review of the NAPHS was undertaken in 2025 as it reached the end of its implementation period.

Prior to the COPPER CE project, key and vulnerable populations—including people affected by TB and HIV, men who have sex with

⁷ Sierra Leone launches a comprehensive five-year national action plan for health security in compliance with international health regulations <https://www.preventionweb.net/news/sierra-leone-launches-comprehensive-five-year-national-action-plan-health-security-compliance>

men, female sex workers, and people with disabilities — **were largely excluded from national discussions on pandemic preparedness and response**. CISMAT noted that this exclusion was marked by a lack of knowledge of the JEE and SPAR processes as well as of structured mechanisms that would allow these groups to contribute to health security planning and response efforts.

Further, while the JEE framework already emphasises community and civil society involvement, in practice, these groups have been largely excluded from decision-making and implementation. Because of this exclusion, issues such as gender dynamics, human rights, and climate justice are not adequately addressed. Historically, national PPR processes have **overlooked the unique needs, perspectives, and capacities of marginalised groups** such as women, youth, persons with disabilities, and other vulnerable communities. This exclusion has often resulted in strategies that fail to address the realities faced by these groups during disease outbreaks. By bringing these voices to the table, the project aimed to create more equitable and effective health security frameworks.

To address these gaps, CISMAT conducted community mapping exercises, held training on PPR concepts, and eventually established a PPR Civil Society Coalition, bringing together representatives from all 16 districts in Sierra Leone and from various diverse key affected populations. Members of the coalition gained knowledge on gender and human right dynamics in PPR, equipping them to take an active role in planning and response activities.

Growing inclusion, growing influence

The coalition organizes regular meetings, develops advocacy agendas and briefs, and engages with national stakeholders such as the Ministry of Health and the World Health Organisation. Communication and coordination are facilitated through both in-person meetings and a dedicated WhatsApp forum.

The coalition's efforts have led to significant policy influence, most notably the inclusion of gender, human rights, and community roles in



National Consultative and Advocacy Meeting on Pandemic Preparedness and Response (PPR) with National Stakeholders and CSOs, October 2024

the formulation of responses against Mpox. The coalition also played a crucial role in ensuring that community voices were included in response strategies and that communication was adapted to local languages. Community-driven communication strategies have also helped address misinformation and improve adherence to public health measures. Community members now participate in both national and district-level meetings, contributing to the planning and implementation of health security measures.

Overall, the project has brought about a transformative shift from exclusion to active, informed participation of communities and CSOs in PPR processes. The development and use of **advocacy tools, such as a community engagement agenda and policy briefs**, have been particularly impactful, serving as guides for ongoing engagement and policy influence. Community members report increased involvement and representation in decision-making from local to national level.

As the COPPER CE project is nearing its conclusion, the knowledge and structures established are expected to sustain ongoing community engagement in health security. In essence, the COPPER CE project by CISMAT has empowered previously excluded communities in Sierra Leone to participate meaningfully in pandemic preparedness and response, resulting in more inclusive policies and stronger community engagement in health security.

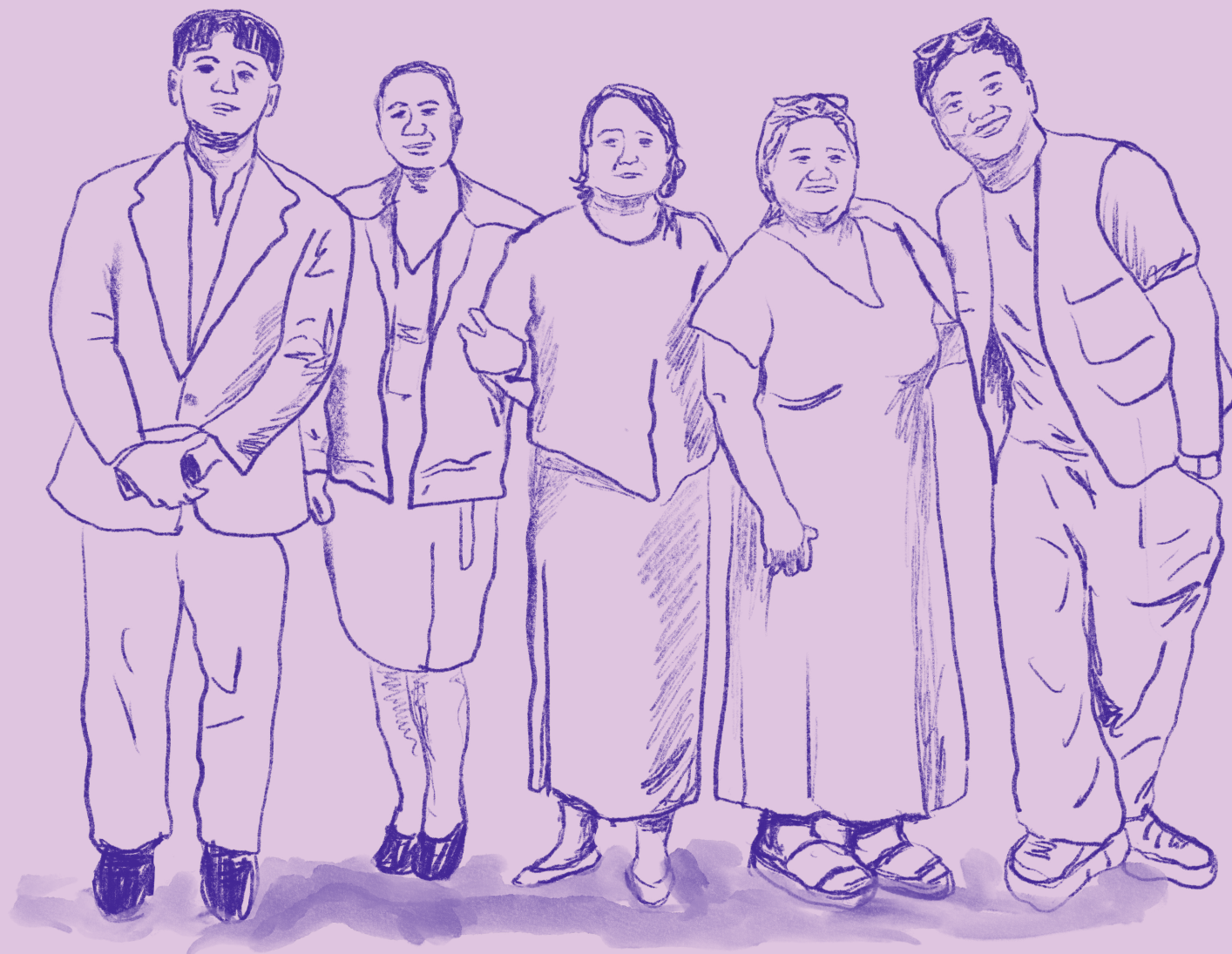


Lessons Learned:

- **The value of inclusivity:** engaging diverse groups, including women, youth, persons with disabilities, and marginalized communities, enriched the planning process by bringing in varied perspectives and addressing the unique needs of different populations.
- **Importance of capacity building:** empowering communities through targeted training improved their confidence and ability to contribute meaningfully to PPR processes. However, the depth of understanding varied, highlighting the need for ongoing education and support.
- **Advocacy as a catalyst for change:** persistent advocacy efforts by the PPR CS Coalition proved essential in influencing policymakers to embrace more inclusive approaches. Collaboration between stakeholders was significantly improved by having a unified coalition voice.
- **Challenges of sustained engagement:** while the initiatives succeeded in engaging diverse groups initially, maintaining their involvement required continuous resources, communication, and adaptability to evolving community needs.
- **Alignment with national frameworks:** Integrating local-level insights into national policies proved impactful but highlighted gaps in existing frameworks that need to be addressed for sustained inclusion and action.

COUNTRY COMPILATION OF LESSONS LEARNED:

ASIA-PACIFIC



CAMBODIA

Knowledge strengthens communities



In Cambodia, the country's civil society and community health practitioners boosted their engagement and capacity by developing their knowledge and understanding of PPR concepts and international health regulations and standards. Since becoming knowledgeable in PPR, they have formed an engagement platform and have become an integral part of public health consultations on PPR policy as well as contributing to sustainability of PPR initiatives.

While civil society engagement in PPR has been an ongoing work among HIV, TB and malaria (HTM) responses in Cambodia, they acknowledged that the International Health Regulations (IHR) is still a new concept for the communities and CSOs. This limits their engagement in policymaking around PPR and they find that policies do not necessarily reflect the expertise and experience of long-standing disease response.

Under the COPPER CE project, **Khmer HIV/AIDS NGO Alliance (KHANA)** and their partners in HTM response had already formed

the **National Pandemic Preparedness, Prevention and Response (PPPR) Platform** that could unite various CSOs and communities into engaging with the government on this issue. However, they assessed the PPR situation in Cambodia and found that despite increasing awareness of PPR and the importance of community engagement in PPR among the civil society representatives at the national levels and community health workers at the sub-national and community levels, there were still gaps. The community health workers (CHWs), such as outreach workers, community action workers, peer support groups, and other community representatives from HIV, TB, and malaria, still lacked a clear understanding of PPR concepts and frameworks due to the highly technical concepts, language barriers, and previously limited involvement in such processes.

Further, they also found a low level of understanding among communities and CSOs regarding the international health regulatory processes: the Joint External Evaluation (JEEs) and State Parties Self-Assessment

Report (SPAR) which measure a country's PPR capacity. These public health instruments have only been newly introduced to communities and CSOs were also communicated in technical language and only focused on the policymaking bodies.

To address these gaps, KHANA organised **in-person training sessions on PPR concepts and frameworks** among PPR platform members and the community health workers across six key provinces: Phnom Penh, Kampong Cham, Takeo, Preah Vihear, Battambang, Siem Reap. The training sessions were designed for knowledge sharing as well as an engaging space for participants to air their own viewpoints and insights of how PPR can be adopted among their constituents and KVPs.

They also developed a user-friendly **PPR Guide for Communities**, in which they translated all training materials into Khmer, and incorporated interactive teaching tools such as pre- and post-tests to reinforce learning. The aim was to simplify technical contents and build lasting community capacity. In addition, the PPR promotional materials were designed and printed to support the field outreach activities. The PPPR outreach activities were carried out in 13 provinces and led by the PPPR platform members, aimed at increasing PPPR knowledge and understanding of the targeted KVPs

Meanwhile, for the CSOs, they introduced the JEE and SPAR processes and the role that communities and key vulnerable populations play in reporting such as documenting best practices and meeting the indicators, including the clinical aspects, that contribute to the National Action Plan on Health Security (NAPHS).

These capacity building initiatives were well-supported by the Department of Communicable Disease Control under the Ministry of Health, with resource persons coming in to bring their expertise and national perspective and leading the discussions of adapting JEE and SPAR in the Cambodian context.

Strengthened Collaboration

As a result of these capacity-building initiatives, KHANA were able to measure a meaningful increase in the understanding of PPR among community health workers. The training not only built capacity and knowledge but also **empowered them to take a more proactive role in supporting their communities** during health crises. The training further highlighted the importance of **information sharing, joint planning, and coordinated action** to improve the effectiveness of pandemic response efforts. These initiatives are outlined in the PPR Advocacy Roadmap that maps out the roles and relationships of public and civil society health workers at every level, making it an important tool for collaboration among various actors and stakeholders.



PPPR promotional materials were distributed widely by the PPPR platform members among their respective programs (HIV, TB, and malaria). These materials were designed to convey key messages regarding the vulnerabilities of communities during a pandemic, core principles for community practice, and fostering an understanding of community resilience and educating key target populations through small group sharing sessions and one-to-one outreach activities.

One practical example of coordination and integration now exists at the local level, where village malaria workers have been monitoring cases of the disease for decades and have contributed to a palpable decline in infection. Malaria response organisations have slowly expanded the role of village malaria workers to become part of PPR where they are able to report emerging diseases to the village health support groups (VHSGs), who in turn can relay disease transmission to subnational, provincial and national health authorities for action. Meanwhile, the National AIDS Authority is establishing provincial AIDS committees, district AIDS committees, and community AIDS committees, which will each have a representative from the community health workers who are already trained in PPR. Community teams working within HIV and TB response will also be integrated in the same manner, creating a potential network of PPR practitioners.

In addition, these workshops enhanced coordination between the Ministry of Health, CSOs, and community members, laying the foundation for stronger collaboration. The CSOs within the PPR platform began to be invited to the Ministry of Health quarterly meetings where they are able to chart a workplan, report on the project's implementation, as well provide feedback on the implementation of other members.

For the implementers, meaningful community engagement was not just about delivering information, it was about creating spaces for dialogues, building local ownership, and supporting people to take action in ways that work for them.

Sustainability

There is a sense of deep commitment that has developed among the members of the PPPR Platform, where they see themselves looking at having to sustain the initiatives despite the project coming to an end in 2025. The Cambodian Country Coordinating Mechanism (CCM)



The Pandemic Preparedness, Prevention and Response (PPPR) Platform, conducted their 2nd Quarterly Platform Meeting on July 2025 to review and discuss the progress updates of the platform with regard to the PPPR capacity building, outreach activities, advocacy and coordination. This meeting also identified key priorities about the RSSH-PPR for the upcoming Global Fund Grant Cycle 8 (GC8) 2027-2029.

acknowledges that **integrating PPR into existing systems for disease response, especially for HIV, TB, and malaria is a path towards sustainability**. While new diseases such as avian influenza are emerging in the region and threatening to become epidemics, the PPPR platform can bring in their experiences in disease surveillance and reporting into PPR practices being developed by the public health sector.

The national health agencies have also requested Platform members to develop a training manual on unknown diseases, in which they can prepare for emerging diseases that could potentially lead to outbreak or pandemics. They are taking on this responsibility as a full partnership and as a learning opportunity for collaborating on PPR.



Lessons Learned:

Capacity building

- Continuous education and skill development in areas such as Joint External Evaluation (JEE), Service Provision Assessment Report (SPAR), and pandemic preparedness and response (PPR) advocacy enable communities and CSOs to move from limited knowledge to active engagement within their communities
- Making technical concepts accessible to everyone is essential especially at the community level. When the PPR training sessions and materials are presented in plain language, in local dialects, and in a way that reflects people's lived experiences, **engagement increases significantly**. Many participants expressed that this was the first time they felt truly included in conversations about pandemic preparedness.
- By conducting training directly in the provinces, they removed barriers and built trust with local actors. This also gave them better insight into the unique needs of each community, which will help them tailor future activities more effectively.
- However, **a one-time training is not enough**. While post-test results showed improved knowledge among 74.3% of participants, many of them requested ongoing support and follow-up to help apply what they learned. There is a need for sustained engagement and the need to continue investing in community-led preparedness beyond initial awareness efforts.

Coordination and Collaboration:

- These capacity building efforts further highlighted the importance of strong coordination between local governments (e.g., the Ministry of Health), CSOs, and communities to achieve shared public health goals.
- The **creation of a PPPR platform** or collective, while informal in structure, allows CSOs and community networks to come together to discuss priorities and share knowledge regarding pandemics. This approach has been recognised as effective by both donors and government bodies, enhancing CSO representation in policymaking bodies.
- **Producing resources** such as the PPR roadmap and community engagement guides clarified roles and competencies for CSOs and communities at national and subnational levels. These tools facilitated collaboration with government entities and have been appreciated for producing tangible results in pandemic response activities.



INDONESIA

Collaborating for contingencies



Pandemic preparedness and response (PPR) advocates in Indonesia worked to foster inclusive, multi-stakeholder collaboration at national and local levels, through activities aimed to bridge national policy with community-driven actions and strengthening coordination and capacity among diverse actors across the country. They also worked to bring more inclusive community involvement in PPR to address the disproportionate impact of pandemics on marginalised groups including persons deprived of liberty, focusing on empowering affected communities and integrating their voices into national and local health systems to enhance equity and effectiveness in PPR efforts.

In Indonesia, particularly in Bandung, Bali, Bogor, and Jakarta, gaps in coordination and limited capacity among local task forces posed a significant challenge to effective community engagement in pandemic prevention, preparedness, and response PPR.

Jaringan Indonesia Positif (JIP) and their partners implemented a series of coordination and collaboration workshops to **strengthen the capacity of local task forces** in Bandung, Bali, Bogor, and Jakarta. Members of these task forces include the community of HIV and TB civil society groups, the provincial health office and community health centres, as well as the prison authority and former prisoners themselves. JIP made sure to include the prisons because they have found that people deprived of liberty as well as formerly incarcerated persons have been among the most vulnerable during the pandemic, and their inclusion in these task forces ensure that their voices are part of the discussions on PPR.

The coordination and collaboration workshops involved multi-stakeholder discussions, experience sharing, and joint planning sessions with government representatives, community leaders, health workers, and civil society organisations. Additionally, they also conducted a national-level consultative meeting in the first quarter of 2025 to foster multi-stakeholder engagement in pandemic preparedness and response



National dialogue for developing a multi-stakeholder joint advocacy agenda and policy recommendation document, opening space for discussion on the involvement of former prisoners and the HIV, TB, and Malaria communities in the National Health Insurance system, and developing a PPR follow-up plan that serves as a joint reference for multi-stakeholder implementation, August 2024.



efforts in Indonesia. This meeting brought together stakeholders from the public sector (including various ministries), the private sector, and community-based organisations across disciplines to align strategies, share best practices, and promote inclusive approaches for stronger and more coordinated pandemic preparedness and response.

These workshops focused on strengthening the coordination capacity of district-level task forces through knowledge exchange, intersectoral dialogue, and training on inclusive, community-led implementation strategies. By the 2nd quarter of 2025, each locality had developed a draft action plan that clearly outlined stakeholder roles and incorporated mechanisms for meaningful community engagement. Follow-up activities were initiated to support implementation and promote learning across districts. This approach proved to be both innovative and impactful, as it effectively bridged national-level strategy with localised, community-driven action.

In addition, the initiative identified a key need to support ongoing learning and awareness, so they developed a digital platform for risk mapping and sharing accessible, community-informed knowledge products. The website, <https://pandemicresponse.id/> has resources in Bahasa Indonesia and English. JIP chose the digital format for their resources because it is more efficient and cheaper to produce and share than printed resources, and they are counting on the broad connectivity among their networks to make this knowledge available widely. They have coordinated with the National Agency for Disaster Countermeasure (BNPB) and the Ministry of Health, to be able to connect the websites of these three agencies with the pandemic response website as inter-related support mechanisms for PPR.

Beyond the collaboration on knowledge resources, the task forces collaborate with the National Disaster Agency because apart from responding to natural disasters such as flooding, earthquakes and

volcanic eruptions, it was the main agency that handled the pandemic response during COVID-19. JIP and their partners have begun working together with the provincial and city disaster agencies **to make a contingency plan in case of a pandemic or disaster** in their areas. This collaboration brings in the community voices in disaster and pandemic response at both local and national level.

One looming threat will be testing this response as Indonesia is facing rising cases of acute respiratory infections from the human metapneumovirus, caused by extreme heat, pollution and forest fires exacerbated by climate change.⁸ In disaster areas, people who have to stay in evacuation centres have become prone to these infections, while those in urban areas who have pre-existing conditions, as well as infants, children and the elderly become even more vulnerable.

With extensive coordination and collaboration at local and national level, the communities have become an intrinsic part of PPR efforts in Indonesia, and have planned to focus on securing sustained funding and promoting policy reforms that embed inclusivity and responsiveness into the national PPR framework.



⁸ Indonesia's Health Ministry Warns of Rising Acute Respiratory Infections Amid Heat and Pollution <https://indonesiasentinel.com/indonesias-health-ministry-warns-of-rising-acute-respiratory-infections-amid-heat-and-pollution/>



Lessons Learned:

- One key lesson was the importance of integrating national-level policy direction with localized, community-driven action. **Engaging a wide range of stakeholders**—including government institutions, private sector actors, and community-based organizations—proved essential for developing contextually relevant and widely supported strategies.
- Local task forces are more effective when **equipped not only with technical knowledge but also with tools for collaboration** and community outreach.
- A major challenge encountered was the varying levels of capacity and coordination readiness across districts. This required flexible facilitation and tailored approaches to ensure meaningful participation.
- There is a critical need for **ongoing support mechanisms**, such as digital platforms and accessible knowledge products, to sustain learning and engagement beyond one-off workshops.
- The process reinforced that continuous communication, follow-up, and adaptation are essential for building trust, ownership, and long-term resilience in PPR systems.

PHILIPPINES

Manifestos for health, justice and rights



Populations most affected by pandemics developed their capacities in pandemic preparedness and response, and crafted advocacy agendas that reflected their urgent and diverse concerns. These messages highlight human rights, gender equality, access to healthcare and livelihoods, and form the core of their demands for government and relevant private institutions to include and prioritise the vulnerable sectors of the community.

In the Philippines, communities most affected by the recent pandemic such as people affected by TB and HIV, members of public transport groups, women's groups, migrant workers groups, youth organisations, and indigenous peoples' organisations have very limited knowledge when it comes to pandemic preparedness and response. **Action for Health Initiatives (ACHIEVE)** brought in these groups to form a COPPER Coalition Philippines that would lead the advocacy for PPR.

At the beginning, their inadequate knowledge of PPR prevented them from engaging substantially in processes as well as developing focused advocacy messages and demands for holding government agencies accountable and responsive to health threats. To build their capacities for more meaningful engagement, ACHIEVE and their partners conducted capacity building among these key vulnerable populations through **peer education sessions**, specifically on the basic concepts of PPR in the context of human rights and the roles of the community in PPR. The implementers trained **51 peer educators**, who in turn reached at least 10 of their constituencies, thus ensuring that PPR knowledge reached as much as 500 persons among the key populations. The peer educators held these sessions with their respective constituencies in their specific localities. These learning sessions were supported by producing two brochures on the topic of PPR and on the roles of the community in PPR. The materials were written in Filipino and presented in an engaging way for more people to understand the concepts more easily.

The peer education sessions provided coalition members space to bring up unique challenges during the COVID-19 pandemic. For women's groups, they highlighted the increase in gender-based violence in the long lockdown period; for many workers' groups, it was the loss of livelihoods even as the government failed to implement safety measures for frontline workers; for the people living with HIV and TB, access to medicine and healthcare was severely compromised.

ACHIEVE reported that communities they work with transformed from being zero information on PPR to active participants in shaping advocacy and engagement in PPR. The next step in their engagement was an advocacy workshop so that the coalition members could craft an advocacy agenda.

A manifesto of health and livelihood

Through advocacy workshops, Coalition members not only deepened their understanding on PPR but also developed concrete advocacy messages targeting local and national government decisionmakers. As critical community issues related to PPR emerged, they saw the need to express these issues and to urge the government and relevant private institutions to include and prioritise the vulnerable sectors of the community, as well as the last-mile populations. Because the COPPER Coalition Philippines has members from different sectors and with different priorities when it comes to PPR issues, the Coalition developed an advocacy agenda based on the priorities of the members. These priority issues include access to healthcare, sustainable livelihoods, security, and protection from gender-based violence.

One key and vulnerable population very much affected by the COVID-19 pandemic were the tricycle drivers of Metro Manila, whose livelihoods were severely interrupted as the country imposed strict lockdowns and



The COPPER Philippines Coalition held an Advocacy Plan Meeting and COPPER Project Work Plan Review on September 2025

curtailed movement in the urban areas. Among themselves they were already very vulnerable to tuberculosis, and the loss of livelihoods meant they could not support themselves and their families. Government aid programmes during the pandemic could not replace the prolonged loss of income.

As these tricycle drivers were organised in local community associations, they were able to identify their priority issues in relation to health care and economic justice. They developed a **manifesto that expressed their demands** for sustainable livelihood programmes and for fair and timely aid distribution during pandemics. They also wanted to be involved in collective action and partnerships on health initiatives as well as clear and timely sharing of health information. Through their manifesto, the tricycle drivers aimed to express how pandemics present not only health challenges but economic challenges as well, requiring a holistic response from the government.



Space to be heard

The communities' engagement has shifted toward collective action, as seen in their participation in the stakeholder commitment meeting, where they directly voiced their concerns and call to actions. During the stakeholders' commitment meeting attended by key partners, the Coalition showcased the advocacy messages they had created. This provided member organisations an opportunity to engage with stakeholders and explore potential partnerships during the event, which was held on World TB Day March 2025. The gathering was attended by stakeholders and partners from national and local government health agencies, non-governmental organisations such as the Philippine Red Cross, UNAIDS, and civil society members of the COPPER Coalition. It served as a platform to reaffirm collective commitments, mobilise investments, and drive meaningful action toward TB elimination, and to gather key stakeholders for their commitment on PPR issues.

Coalition members held up the messages they had developed from previous workshops:

- "Support community livelihoods during pandemics!"**
- "Engage communities in building resilient systems for health!"**
- "Information saves lives. Ensure access to timely, accurate, and reliable information!"**
- "Protect every child's right to education! Pandemic-proof education and learning systems!"**
- "Zero tolerance for gender-based violence, especially during pandemics!"**
- "Build resilient health systems! Ensure sustainable, comprehensive, accessible and high-quality healthcare at all times."**

Their advocacy messages were acknowledged by the stakeholders present, and received expressions of support, potential partnerships and recommitment to funding and actions.



Lessons Learned:

- PPR is a difficult topic for the communities, considering it is a new and quite technical topic. The implementation saw the need to provide more capacity-building activities with communities on the topic of PPR. Since it is new, more topics should be explored such as the intersection of PPR and disasters (especially those commonly occurring in the Philippines), PPR and community-led monitoring (CLM) integration, as well as the unique vulnerabilities and challenges of people affected by TB and HIV, members of public transport groups, women's groups, youth organizations, and Indigenous peoples.
- To advocate for PPR, there is a need to understand who the key players are and what platforms are available on the topic of PPR. Unfortunately, as the country is also new to this, there are no clear players/leads among agencies, as well as platforms where a national coalition can engage.
- Another challenge for the COPPER Coalition Philippines is that it comprises members from diverse sectors, each with varying issues and priorities concerning PPR. To address these challenges, a workshop was conducted where participants identified obstacles, set specific priority objectives, developed effective strategies, and established the Coalition's advocacy agenda.
- A more in-depth discussion is still needed regarding the issues they wish to address. The commitment expressed by key partners to PPR during the meeting is largely confined to their current roles and responsibilities. Encouraging them to be more open to community engagement and for them to become more responsive to the needs of vulnerable populations will require ongoing advocacy and encouragement from COPPER Coalition members.



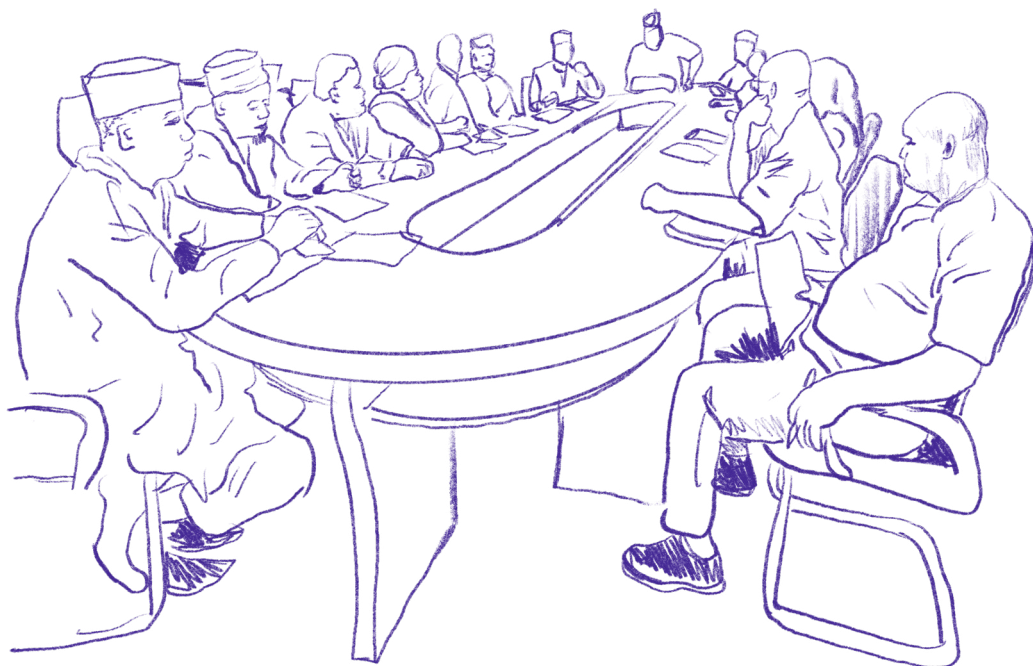
SUMMARY OF LESSONS LEARNED



Building on previous learnings

The learnings shared by the implementers underscore how capacity building, community engagement, inclusivity, and coalition building are foundational for effective pandemic preparedness and response (PPR) systems. In each country's experience, their interventions were already building upon earlier engagement, capacity building and inclusion and have applied previous lessons of how communities can best be strengthened and supported to engage at the different levels of PPR.

These interventions are undertaken by the implementers not in sequential ways, but **synergistically**, to ensure accountability and impact at each step. For example, capacity building does not occur without community engagement, while the choice of whose capacities need to be built must factor in inclusivity and who will be the most impactful partners in advocacy at both local/community and national level.



Capacity building

Firstly, there is capacity building for the frontliners: community health practitioners, village health support groups, nurses and others -- because they are considered first responders in urgent incidences of disease surveillance, reporting and treatment. Then there is capacity building and sensitisation for government agencies, representatives from health ministries and other stakeholders and state actors, which are done with the aim of gaining allies, partners and champions.

Then finally, there is capacity building and education that is central to strengthening communities. Targeted training and ongoing education help civil society organisations (CSOs) and communities move from limited knowledge to active engagement. However, one-time training is insufficient; continuous skill development and support are needed to ensure meaningful participation and confidence.

Inclusion

Meanwhile, inclusivity not only ensures that the voices and perspectives of marginalised and vulnerable groups -- such as grassroots organisations, religious and ethnic minorities, women, youth, sex workers, persons with disabilities, men who have sex with men, -- are heard, it also ensures that they can support each other and find common agendas. Inclusion also ensures that there is a space for everyone to advocate for each other, that trust has already been built and that the engagement is productive.

Partnerships and collaborations

In several countries involved in the COPPER CE project, communities and CSOs found it advantageous to form PPR coalitions, and the establishment of these coalitions opened spaces of collaboration among

civil society and organisations working in HIV, TB, and malaria as well as organisations working and/or representing last-mile populations. The coalitions have been able to articulate the specific advocacies of their community while also contributing to unified positions on PPR.

PPR champions and coalitions learned that collaboration requires commitment and continuous engagement, including regular communication with stakeholders and follow ups through periodic meetings to sustain the momentum of advocacy.

Partnerships with media and local leaders improve inclusivity and impact, with media partners playing a key role in disseminating locally appropriate, accurate, evidence-based messages. Additionally, community dialogues and local communication channels, particularly in rural areas, facilitate the sharing of information and feedback.

Partnerships with stakeholders and government

Strategic and targeted advocacy through partnerships can be impactful. Advocacy with constituents and civil society representatives ensures they can develop a unified position on specific policy, while collaborative advocacy with champions (such as a legislator or a local government official) can bring about policy changes and structural gains. One measure of a productive and meaningful engagement is when interventions gain a response from stakeholders, community and civil society priorities are integrated into policies and are adapted and implemented, and inclusion of civil society and communities in the monitoring and accountability of the implementation of these policies whether at the local level or at the national level.

Challenges and Solutions

Resource mobilisation and sustainability remain significant challenges. CSOs in Liberia and Cambodia cite the importance of sustained funding from international donors, underscoring the need for investment in community capacity, seeking and securing external financial support, developing alternative sources for financing, or finding creative ways of integrating PPR efforts in other existing well-supported projects. Effective coordination and collaboration require aligning local insights with national frameworks such as in Nigeria, which can be impactful but also reveals gaps that need to be addressed. Informal platforms and coalitions facilitate knowledge sharing and advocacy, helping to bridge these gaps.

In Cameroon, CSO participation in PPR was present but lacked structure; they gained a role in national processes through persistent advocacy. Maintaining engagement among diverse groups requires continuous resources and adaptability, as experienced in Cambodia and the Philippines. The technical complexity of PPR and varying levels of readiness across communities called for flexible approaches, particularly in the lessons learned from Indonesia and the Philippines. Trust-building is vital for countering misinformation, with trusted local voices playing a key role in Nigeria.

Finally, the development of tools and resources, such as community engagement guides and PPR roadmaps in Cambodia and Sierra Leone clarify roles and competencies, supporting more structured and effective participation in PPR activities, while accessible knowledge products and digital platforms in Indonesia, are essential for sustaining learning and engagement beyond workshops.



For more information about the COPPER CE Project, please visit the page
[**https://copper.apcaso.org/**](https://copper.apcaso.org/).



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Communities in Pandemic
Preparedness & Response

