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UNION INTERNATIONALE DE PROMOTION DE LA SANTÉ ET D'ÉDUCATION POUR LA SANTÉ
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Report to Vital Strategies:
Phase 2 of Project to support the COVID-19 response in the African region and India: Enabling healthy and resilient communities

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Acronyms and Abbreviations

AIHD	-	African Institute for Health and Development
CORPs	-	Community Own Resource Persons
COVID-19	-	Coronavirus Disease 2019
IEC	-	Information, Education and Communication
IUHPE	-	International Union for Health Promotion and Education
PTA	-	Parent-Teacher Association
RCCE	-	Risk Communication and Community Engagement
RE-AIM	-	Reach, Effectiveness, Adoption, Implementation, Maintenance
SOP	-	Standing Operating Procedure
UNICEF	-	United Nations Children's Emergency Fund
WHO	-	World Health Organization

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Introduction

Phase 1 of the project by IUHPE and partners to support the response to COVID-19 from a health promotion perspective began in June 2020 and ended in March 2021. The four countries involved were South Africa, Kenya, Zimbabwe and Zambia. A report was presented to Vital Strategies in April 2021, along with a request for an extension of the project due to subsequent waves of the COVID-19 pandemic in Africa and other regions of the world. A proposal including an additional partner, the Voluntary Health Association of India, was submitted and funding for an additional six months was granted.

In May 2021, Phase 2 of the project was launched and continued through October 2021 (see Table 1 for a complete timeline). The projects in South Africa and Kenya continued or adapted their Risk Communication and Community Engagement (RCCE) interventions according to need in targeted regions, and our Indian partner carried out a range of interventions in one province. The school-focused pilot projects in Zimbabwe and Zambia wrapped up and activities shifted to dissemination efforts to share findings with a range of stakeholders. Table 2 shows how funds were distributed to all project partners.

For all projects involved in Phase 1, the same Country Leads remained in charge of the projects during Phase 2. The Project Management Group (PMG) was composed of:

- Professor Margaret Barry, Chair (IUHPE President)
- Dr. Mary Amuyunzu-Nyamongo (Kenya)
- Professor Hans Onya (South Africa)
- Professor Davison Munodawafa (Zimbabwe)
- Professor Oliver Mweemba (Zambia)
- Bhavna B Mukhopadhyay, Chief Executive of the Voluntary Health Association of India
- Dr. Nancepreet Kaur, Programme Manager at VHAI (India)
- Francis Namisi, Senior Lecturer at Department of Health Systems Management and Development, AMREF International University (Kenya)
- Dr. Erma Manoncourt, IUHPE VP for Membership
- Graham Robertson, IUHPE Immediate Past President
- Pofessor. Louise Potvin, IUHPE Executive Board member
- Professor Stephan Van den Broucke, IUHPE VP for Scientific Affairs
- Dr. Liane Comeau, IUHPE Executive Director
- Dr. Ana Gherghel, IUHPE Head of Scientific Affairs

The PMG ensured that the project progressed as planned and provided input as required. The Country Leads reported directly to this group, as it was determined that given the experience acquired in Phase 1, a Project Coordinator and a separate Project Working Group were no longer required for Phase 2.

Table 1: IUHPE Phase 2 COVID-19 Response in Africa & India 2021 – Project Timeline

Project Overview	Description of work	Completion date
Project Management Meeting	Kick-off Meeting with Project Partners and IUHPE Project Management Group	26 April 2021
Project Milestone	Set up project agreements and contracts	May 2021
Deliverable	Intervention Planning Templates completed by Kenya, South Africa and India Country Leads Dissemination activities planned – Zimbabwe & Zambia	Mid-May 2021
Project Management Meeting	Update on intervention plans - Kenya, South Africa and India Review Monitoring and Evaluation plans Dissemination plan delivered in Zimbabwe and Zambia	End of May 2020
Project Milestone	*Implementation of Community Interventions* Phase 2 interventions implemented in Kenya, South Africa and India. Monitoring & Evaluation underway - Phase 2 baseline indicators being collected.	May/June 2021
Project Management Meeting	Updates on intervention delivery - Kenya, South Africa and India Phase 2 monitoring and evaluation plans **Updates on** dissemination plans delivered in Zimbabwe and Zambia	End of June 2021 **AND End of July 2021**
Project Management Meeting	Review progress on interventions and training. Dissemination outputs from Zambia and Zimbabwe – Guide book/Policy Briefs	**Early September** 2021
Deliverable	Zambia and Zimbabwe dissemination reports completed	End of **September** 2021
Project Management Meeting	Meeting to review progress and project monitoring and evaluation updates	End of **September** 2021
Project Management Meeting	Draft Final Reports from Country Leads	Mid-**October** 2021
Deliverable	**Final Country Reports including project monitoring & evaluation** **Feedback to funders**	**End of October 2021**

In all countries involved, resurgences of COVID-19 infections and restrictions on movements and activities delayed some interventions or caused adjustments in the way the interventions or dissemination activities were delivered. For this reason, the timeline of the project was extended to October 2021, with the funder's permission (as opposed to September as initially planned). This shows that challenges to reducing the spread of COVID-19 remain, and that the pandemic continues to impact people's lives, nearly two years after its onset.

This brief summary presents the objectives, activities and results for each region. The Details of each partner's project, including information on methods and data collection, are included in the appendices.

Table 2: Distributions of funds to project partners

Item	Tasks	Resource Type	Cost in USD
Administration and project support	Administrating overall grant and financial reporting to funder; technical support to scientific and communications activities	IUHPE Secretariat Staff	5 900 $
Country-level budget (upscaling of current RCCE interventions in South Africa)	Includes Human resources; Materials; Logistics; Admin costs	As required within each country budget	25 000 $
Country-level budget (upscaling of RCCE interventions in Kenya)	« «	« «	25 000 $
Country-level budget (Initiating RCCE interventions in India)	« «	« «	25 000 $
School-based projects in Zambia and Zimbabwe through the end of the school year (5K each)	« «	« «	10 000 $
Subtotal			90 900 $
Overhead- 10% of total cost (non-labour costs to IUHPE International Secretariat and Management and Working Groups-material, communications and logistical costs)			9 090 $
Total amount requested			**99 990 $**

Summaries of Projects – Objectives, Activities and Results

Main interventions sites in South Africa, Kenya and India

All three sites where RCCE interventions were maintained or initiated in Phase 2 made use of the RE-AIM monitoring and evaluation framework:

- **Reach** - How many community members accept the use of the project RCCE strategies for COVID-19 vaccination uptake and actual number of vaccination administered?
- **Effectiveness** - What are the effects of the phase 2 interventions on protective behaviours in reducing COVID-19 transmission rates, both positive and negative?
- **Adoption** - What is the level of uptake and institutionalization of RCCE measures for COVID-19 by community members and healthcare workers?
- **Implementation** - What is the extent to which RCCE measures and vaccination for COVID-19 are implemented as intended in the local community?
- **Maintenance** - What is the extent to which RCCE measures for COVID-19 are sustained over time?

In South Africa, Limpopo province was targeted as in Phase 1, but there was an important push to vaccinate as vaccines became available, in response to the fact that South Africa is the African continent's worst-hit country by coronavirus, accounting for around 43 percent of the continent's diagnosed coronavirus infections. The number of people in South Africa who have tested positive for coronavirus has reached a total of 2.91M COVID – 19 cases and 88 317 deaths since the start of the pandemic. The project objectives were:

- To examine the content and design of materials used in Phase 1 of the South Africa interventions, in light of new research evidence and relevant theory and guidance, in order to identify and improve sub-optimal elements and aspects.
- To increase the knowledge and skills of community health workers trained in Phase 1 who will be involved in implementation of COVID-19 vaccination in order to ensure safe and effective administration.
- To address misinformation, misconceptions, myths and stigma as well as COVID-19 vaccine mistrust.
- To evaluate Phase 2 activities through a combination of quantitative and qualitative research approaches.

The project interventions focused on five rural autonomous communities in the Capricorn District, where COVID-19 cases were high, with a focus on settings with limited resources. In line with the objectives of this project, the following activities were completed:

- Created a secondary vaccination site at the University of Limpopo to the referral hospital in Mankweng in order to ease the burden of vaccination at the hospital and retrained key Health Workers on implementation of COVID-19 vaccination.
- Dialogue with community leaders on vaccines and vaccination up-take including mistrust, misconceptions/disinformation.
- Conducted capacity building workshop of community coalitions groups.
- Identified barriers, enablers, and key lessons from the literature review and participants' experiences through semi-structured interviews.
- Carried out systematic training to change culture-specific norms, attitudes and beliefs, addressing misinformation and vaccine mistrust (booster).
- Collected second follow-up data for monitoring and evaluation purposes.

This allowed the project interventions to address barriers and enablers in the local communities and to change culture-specific norms, attitudes and beliefs to address misinformation about the COVID-19 vaccine. These interventions were evaluated using mixed (quantitative and qualitative) methods.

Among the main results, the vaccination clinic resulted in 13,336 adults being fully vaccinated, as of September 28th 2021. Information leaflets were distributed to support this effort. Uptake was lower than expected among (21,000 students are enrolled at the university), due in part to misinformation.

Surveys of approximately 500 households in the targeted communities, following the interventions with community leaders and workers, showed changes in knowledge of coronavirus, including signs and symptoms, prevention measures and misinformation, myths and misconceptions as well as stigmatisation. Attitudes towards adherence to COVID – 19 protocols also changed significantly. Regarding practices/behaviours among community and family in performing measures such as hand washing, sanitising of hands (when there is no water and soap), social distancing, avoiding gathering or crowds, the observed effect of the intervention was improved significantly at second follow-up. This might be because of the severity of the third wave, which was dominated by the Delta variant and many more deaths and infections occurred.

The vaccination clinic and the interventions in the communities supported the adoption, implementation and maintenance of a range of activities and practices. The clinic's work is expected to continue beyond October 2021, and capacity building efforts in the local communities ensured the continued involvement of local actors.

It can be concluded that there are several advantages to employing local health workers in vaccination campaigns. Building on existing trust and rapport, local health workers can engage with communities, discuss key information about the campaign, monitor vaccine acceptance levels and respond to rumours as they arise. It is important to build trust at the community level and to ensure that training is fit for purpose.

In Phase 2 of this project, only indigenes from the Capricorn District were recruited, who are staff of the local University (University of Limpopo) and field workers (CHWs) from the very community they were assigned to. All communication was in the local language and practical/relevant examples were used. Responses to questions and concerns regarding COVID-19 and the vaccines were exhaustive and convincingly addressed. The contents of the interventions were tailor-made. Vaccination rollout by the Department of Health needs to replicate this example.

In **Kenya**, the African Institute for Health and Development (AIHD) and Kisii County implemented a health promotion project in Kitutu Central ward in Kitutu Chache South Sub-County, Kisii County. Kitutu Central ward is the most affected by the Covid-19 pandemic. The Sub-County was also chosen because of its populous, high transit and peri-urban setting with proximity to major markets and busy bus terminals and the presence of at-risk populations. The aim of the project was to implement health promotion strategies in the Covid-19 response to stop and control the spread the disease and promote vaccine uptake. The project objectives were to:

- engage local communities and key stakeholders in the Covid-19 response and empower them to reduce its spread;
- enable local communities to protect themselves, their families and communities by taking effective behavioural action to stop the spread of the virus in their community;
- ensure that community level implementation is informed by best available knowledge, research and resources on effective risk community and community engagement;
- create community coalitions to coordinate local responses adapted to the needs of local communities.

Planning was done through meetings and consultations including the County Director of Public Health, County Health Promotion Officer (CHPO) and AIHD project staff. A baseline evaluation was done to i) determine the knowledge,

awareness and understanding of Covid-19 in the intervention communities; ii) assess sources of information and health support services at the community level; iii) examine the adherence to Covid-19 preventive measures by communities; iv) understand the barriers, rumors, misinformation, fear and stigma associated with Covid-19; v) examine the effects/impacts of Covid-19 to the community; and vi) understand how the community is addressing /responding to Covid-19 to curb its spread. Quantitative (questionnaires) and qualitative (focus groups and key informant interviews) methods were used.

The project employed a multi-strategy approach through advocacy with the influencers, community engagement with the risk groups, social mobilization, community media and social media. The community engagement activities in the form of road shows, television and radio spots, and community conversations were carried out through Community Own Resource Persons (CORPs) and gatekeepers given their influence, understanding and cohesiveness of their respective communities. The gatekeepers and CORPS included the ward administrators, the Nyumba Kumi1 elders, religious leaders, chiefs, women and youth leaders and persons with disabilities. To avert possible risk of escalating new infections or further community transmission of Covid-19, the community engagement activities promoted positive behavior change thus enabling people to initiate, sustain and maintain desirable behavior outcomes, an interactive process of Social Behavior Change Communication (SBCC).

An endline assessment similar to the baseline evaluation was carried out. Findings are summarized here according to the RE-AIM monitoring and evaluation framework:

Reach: The findings revealed that the project activities were in line with the National Government and County strategic response to the Covid-19 pandemic and that the community members were sensitized majorly through community conversations. Community members mentioned that the project contributed to their understanding of the disease and their required prevention efforts.

Effectiveness/impact: The evaluation revealed that the project had increased knowledge of the target communities on Covid-19 and capacity building. From the evaluation results, the respondents mentioned sources of information that were employed by the project during implementation as their main sources of information on Covid-19. In addition, slightly more than one-tenth (31%, n=255) of the community members mentioned that they had participated in awareness meetings or dialogues at their workplaces, which included the bus terminus, business stalls, the markets, the motorcycle stages and at home (Nubian community) among others; all of which were the sites targeted by the project.

Adoption: coherence and appropriateness: The evaluation established that consultations were undertaken with different stakeholders during the project planning stage. A baseline assessment was undertaken among vulnerable communities to assess their knowledge on Covid-19. The findings informed the development of the implementation plan using the RCCE strategy. Regular monitoring of the project ensured creation of synergies with other health actors, enhanced quality implementation, timely achievement of project objectives, thereby ensuring that evidence-based health promotion activities were proposed and implemented.

Efficiency: In terms of implementation timelines, the evaluation results established that the project was implemented within the planned timelines. Comparing the results of the project vis-à-vis the amount of funds invested, there was value for money. The evaluation established that competitive bidding was used for selection of project goods and services. It should be however noted that the implementation period of 2 months was too short to be conclusive about the efficiency of implementation.

[1] a Swahili phrase meaning ten households, though not literally. The concept is aimed at bringing Kenyans together in clusters defined by physical locations, felt needs and the pursuit of a common ideal of a safe, sustainable and prosperous neighborhood.

Maintenance and Sustainability: The project empowered the CORPs and healthcare workers, as a sustainable intervention towards the prevention of Covid-19. Locally available resources were utilized through identification and training of CORPs on different aspects of Covid-19. These CORPs actively took lead in the implementation of project activities. Through the project's capacity enhancement activities, the targeted communities and project locations will continue to benefit beyond the funding period. The likelihood that the community will continue to practice what they had learnt from the project even after the close of the project was adjudged as good at the point of evaluation.

Conclusion: The project provided an avenue for delivery of effective RCCE to the communities, while ensuring their participation and achievement of sustainable practices that contributed to the prevention of Covid-19 infection and transmission among the targeted communities. The implementation of the project presented an opportunity to explore the use of health promotion principles in the fight against the pandemic. The training and facilitation of CORPs as change agents is illustrative of the need for projects to use local resource persons in awareness and behavior change communication. The fact that these people reside in the community and have numerous opportunities to pass health messages (in churches, markets and during social events) makes the investment worthwhile. The evaluation shows that apart from perceptions and attitudes, there are real barriers to behavior change that cannot be wished away. The balancing poor people must make between staying at home and seeking employment is real. For the youth, the choice could be as simple as he/she buys a mask and goes hungry. Such challenges need to be considered in control measures so as those people found to be unable to manage are supported in concrete ways.

In India, the COVID-19 pandemic experienced a phase of rapid spread. At the onset of this project, 31st May 2021, India had the second highest number of COVID-19 cases in the world with a cumulative total of 29 million confirmed cases and 351,000 deaths. An innovative community-based health promotion programme was implemented with the objective of building the capacity and resilience of local underserved communities and health systems and developing a sustainable roadmap for COVID-19 prevention. This programme focused on underserved communities in the state of Odisha, which has 32.59% of its population below the poverty line. This programme is based on a Risk Communication and Community Engagement (RCCE) model of WHO, UNICEF and IRC, that has been adapted by IUHPE and partners in Africa. The objectives were to :

- build the capacity of the local communities on COVID-19 response and empower them to mitigate its impact facilitate positive behaviour change on COVID-19 prevention and management
- create peer educator networks and community coalitions for knowledge sharing and to coordinate local responses adapted to the needs of local communities
- strengthen the ongoing government programmes catering to the needs of the vulnerable population
- develop a sustainable roadmap for effective management and prevention of COVID-19/future outbreak.

RCCE Activities in 70 villages were developed to address the following issues: barriers including myths, misinformation on COVID-19 and vaccination among the local communities; low access to reliable and authentic information on COVID-19 prevention and control; lack of community awareness on available public services and programmes on COVID-19; poor coordination and feedback mechanisms, low community involvement in COVID-19 response.

The activities included training to strengthen capacity of a range of local actors, e.g., peer educator networks, pre-existing COVID-19 teams, community coalitions and committee, frontline workers. They were provided with reliable and updated information on COVID-19 prevention and management including preventive measures; stigma and discrimination, management of mild cases in home isolation; services and Government programmes on COVID-19; easy access to government health facilities and services. These groups motivated and ensured that their community members are availing of COVID-19 vaccination services in a timely way. They facilitated monitoring of the COVID-19 situation in their community and reporting to the local health authorities. Communication strategies and channels were tailored to the

health literacy and local languages of the community groups. Actions were coordinated with government departments to avoid duplication of efforts.

A baseline evaluation was carried out at the start of the project, and an endline evaluation was also completed in September-October 2021. This involved data collection in 20 villages, using mixed methods including focus groups with health workers and local community members (over 120 participants at both measurement times), Rapid Assessment Quantitative Close-Ended Questionnaires of knowledge, behaviour and practices of the population (400 participants at both measurement times), and a Community Transect to observe the community's behaviours in maintaining physical distancing in the marketplaces, mask wearing, and handwashing with soap and water.

Key findings are presented in line with the elements of RE-AIM monitoring and evaluation framework:

Reach: The project interventions have reached more than 32,134 people (8033 families) living in 70 villages of District Ganjam, Odisha (India). The majority of the people belonged to vulnerable families/groups (households below the poverty line). As per the evaluation findings, the project activities were well aligned with the Government of India and State Government's guidelines and strategic plan on COVID-19 Prevention and Control. A total of 528 participants took part in the evaluation study. Responses from the local community members and groups confirmed that the project has significantly contributed to COVID-19 prevention and control in their area, particularly in overcoming the fear and stigma related to the virus, improving vaccination coverage and access to the handwashing.

Effectiveness: The local communities described the COVID-19 Information Centers as one of the authentic and reliable sources of information. These centers were set up at the village level by the project and are managed by trained peer educators and community volunteers. As per the evaluation results, there were significant changes in knowledge of coronavirus (signs and symptoms, prevention measures and misinformation, myths and misconceptions, COVID-19 vaccination). Attitudes towards adherence to COVID – 19 protocols such as proper usage of mask, avoiding crowded places also changed significantly. Practices/behaviours among the community and family members on measures such as hand washing were observed to have increased over the months of the project implementation. The communities have been observed using the handwashing facilities created at the public places.

Efficiency: As per the implementation plan and timelines, the results established that the project was mostly implemented within the planned timelines. However, there were some activities which were delayed such as the endline evaluation that was earlier planned for September 2021 but was completed in October 2021 due to lockdown in the month of May and June 2021. The project has overachieved on some of the targets, for example 30,000 populations to be reached (target) vs 32,134 population actually reached. Comparing the results of the project vis-à-vis the amount of funds invested, it has yielded remarkable results, particularly in terms of population coverage as well as creating a pool of trained peer educators and community volunteers on the ground.

Adoption: The project was implemented in close collaboration with the local health authority and active engagement with the local community groups particularly peer educators, volunteers, women groups, youth clubs, village and community leaders. As per evaluation results, the community groups, particularly the peer educators and volunteers, and government frontline workers have internalised and adopted the concept of RCCE strategy and are actively working with their village communities on project activities.

Implementation: In line with the project objectives, the project has completed all the activities that were planned during the initial stage. This includes formation and capacity building of community groups such as peer educators, Anti COVID-19 squad and others; mass community awareness and BCC activities including miking, wall paintings following health promotion principles; creation of COVID information centres at the village level, and hand washing facilities at the public

places; development, contextualisation and distribution of IEC material such as flipbook, posters, leaflets in the local language (i.e Oriya); and linking the vulnerable families with the social welfare schemes of the Government amongst others. The project has fully achieved the targets set during the planning stage of the project, in some cases, it has overachieved the numbers.

Maintenance or Sustainability: Keeping in view the sustainability of the project activities, the project was closely planned and implemented with the local communities. The project has capacitated and empowered 368 Peer educators, 156 Anti COVID-19 squads, 204 frontline health workers, and 236 other community stakeholders on COVID-19 Prevention and control at the community level, who will continue the work beyond the project period. The active involvement of the local stakeholders and local health authority, particularly government frontline health workers, in the project intervention will ensure the continuity of our efforts on the ground.

In conclusion, every community has strong local health traditions, which are time-tested. These practices need to be kept in mind when planning and implementing the programme. This will ensure that the prevailing strengths of the community are fully utilized and that the local community becomes a natural part of the whole process. The COVID-19 Response Project in India has utilized the existing strengths and resources of the local communities and provided an excellent opportunity to build community ownership for effective prevention and management of COVID-19. It has helped to bridge the missing link between the Government health system and the local communities. It is evident from the evaluation study that the project interventions have yielded significant results and outcomes in a short duration (five months). There are positive change in knowledge, attitude and practices in the local communities on COVID-19 prevention and control based on the comparative analysis of the baseline and endline assessment.

Dissemination efforts in Zimbabwe and Zambia

In both countries, extended school closures and COVID-19-related restrictions on activities were experienced. Phase 2 allowed pilot projects to wrap up and to disseminate results to a range of stakeholders, in order to inform future school-led efforts and school-community collaborations to reduce the spread of COVID-19.

In Zimbabwe, the project aimed to strengthen capacity of schools to implement World Health Organization (WHO) Guidelines for COVID-19 Management and Control adopted by the Government.

Main activities initiated in Phase 1 included a survey on readiness and capacity strengthening workshops for 40 teachers, School Heads and School Health Coordinators. The workshop recommendations raised four (4) key thematic issues, namely, (a) strengthening Community links, (b) addressing compliance fatigue to WHO Guidelines; (c) generating evidence and documenting progress; and (d) integrating COVID-19 issues into the school curriculum.

Survey results revealed several challenges. For example, eighteen percent (18%) of the respondents said they had handwashing stations in schools outside each classroom; and 27% indicated that running water at key points such as toilets was available; and 27% said school had alcohol-based hand sanitizers; while 28% reported having liquid soap. Only 16% reported that their school had enough space to practice social distancing in the classrooms. A total of 18% of the participants reported that their school had enough handwashing stations at their schools. Eleven percent of participants reported that their schools had enough PPEs for both learners and staff. On the training of teachers on COVID-19 prevention and management, a total of 17% of participants reported that there was no COVID-19 prevention and management training done at the school. The Project team gave a donation of 500 reusable cloth masks and 200 liters of hand sanitizer to the two school districts that participated in Phase 1 of this project.

All Government owned schools received the Standard Operating Procedures (SOP) for Management and Control of COVID-19 in Schools. With regards to re-opening of schools, 65% and 60% Church-owned and private schools

respectively felt that they were ready to re-open. Only about 35% of participants from government schools felt that their school were ready to re-open.

Dissemination activities in Phase 2 and through November 2021 include the following:

- Presentation of survey results at the COVID-19 Prevention and Management Consultation organized by the Ministry of Primary and Secondary Education in Bulawayo, Zimbabwe;
- Presentation at the COVID-19 Risk Communication and Community Engagement Pillar;
- Guidance document for establishing Schools and Community Links prepared and disseminated widely among School Districts (in progress).
- Executive Summary of the final report of the Zimbabwe COVID-19 in Schools Project (in progress)
- Dissemination workshop on the key findings of the Project attended by teachers and school Heads and National Association of Primary Heads (8 November, 2021)
- Press briefing on the MSU, IUHPE and Vital Strategies collaboration and key findings organized by The Midlands State University (2nd week of November, 2021).

In conclusion, challenges remain for school settings and lessons from Phase 1 remain relevant. There is an urgent need for teachers to be trained on basic COVID-19 prevention and control using approaches as such the *Train-the-Trainer* model. It may also be prudent for government policy to investigate COVID-19 response issues in schools that are not under its jurisdiction, specifically to protect both the teachers and learners in private schools, as well.

In **Zambia**, the project was conducted in Kafue and Chirundu districts. The aim of the project was to strengthen schools' response to the ongoing COVID-19 pandemic. The University of Zambia (UNZA) School of Public health, Department of Health Promotion and Education led the implementation of the project. This was done through capacity building among teachers and Parents Teachers Association (PTA) members in the two districts. Through the use of participatory action research, action plans were developed for implementation within 10 schools in both districts. Throughout the process, data was collected at different phases. In the first phase, a learner needs assessment was conducted to explore knowledge on COVID-19. A situational analysis was then conducted to explore what resources were available to fight COVID-19. At the end of project, post-implementation interviews were conducted to explore experiences in implementing COVID-19 guidelines. This report highlights the dissemination of findings conducted during Phase 2 at both National and district level. It also highlights upcoming deliverables based off this project.

Dissemination at the National level was conducted in July 2021 through a presentation to the National Health Research Authority (NHRA). The main issue raised by attendees was the need to scale up the project to other schools across the country.

In Kafue District, a meeting conducted at the district's Health Office by the District Health Officer in November 2021 was attended by 15 people including head teachers, the district education officials, the district health officials and officials from local council and community development. Participants agreed that the school-based covid prevention approach that involved teachers and the PTA was not only an effective way to improve knowledge on Covid 19 among pupils, teachers and the surrounding communities but also improved capacity for schools to handle similar epidemics in future. The participants wished that the project would be rolled out to other schools where pupils, teachers and parents from supported schools would train other schools to develop actions plans and share lessons learnt. The participants also raised issues about myths and rumours concerning vaccines and the need to tackle vaccine hesitancy.

In Chirundu District, a meeting was officiated in November 2021 by the acting District Commissioner. A total of 16 participants attended the meeting. The included representatives from the district education office, district health office (including the acting district health officer), police department, local government, community development, social

welfare and head teachers reported that the project was a success and helped to transform lives of pupils, teachers and parents through improved capacity to plan for future health threats. The participants raised similar issues from their Kafue counterpart on the need to find resources to roll out the lessons learnt from the project to other schools through peer training. Some argued for the formation or expansion of the school-based anti-aids clubs into COVID-19 or infectious diseases clubs. They also expressed the need for more information on covid 19 vaccines.

Conclusion

Common takeaway messages

Despite the differences across countries/regions, common conclusions emerged:

- Strategies such as RCCE applying Health Promotion principles and methods should continue in the fight against COVID-19. Creating supportive environments will enable rural community dwellers to translate knowledge into action that will result in positive behaviour changes conducive to curbing the spread of coronavirus at the community level.
- Improved government funding to health promotion programming at the community level would help promote health generally and facilitate coordinated responses to other emerging issues in the future.
- Community Health Workers and Community Influencers need to be empowered and skilled, to become leaders and teach neighbouring communities to replicate activities that contribute to reducing the health and socio-economic impacts of COVID-19.
- Coordination with national/regional initiatives and sharing of infrastructure is important to maximize the impact of all efforts.
- Building the capacity of local actors from the community through participatory approaches, including peer educators and community workers, and targeting interventions to communities while being mindful of language and culture, are key to achieving and sustaining results.
- There is general agreement regarding the value of upscaling the interventions deployed across these projects.

While it can be concluded from the pilot projects that schools provide an important setting for promoting health and the implementation of school-based activities can serve as a crucial element of community-based health promotion interventions, the findings from Zimbabwe show that schools have faced important challenges in reopening safely. This demonstrates the importance of documenting and understanding these challenges in order to better address them. School-based interventions have the potential to reach the wider community of parents, caregivers and their families and are, therefore an important arm of a health promotion approach to strengthening the community response to COVID-19.

Limitations and Next Steps

As is the case with any intervention, the projects carried out here have some limitations. Many responses were obtained through self-reporting, which poses a risk that respondents report positively (e.g. stating that they took more precautions against COVID-19 than they actually did). Also, measurement samples may not represent the whole population targeted. In addition, the duration of several interventions was short, as was the time between intervention and evaluation.

Additional measures in the future would help assess the sustainability of both the actions on the ground and the duration of their effects. Disruptions to the activities, leading to changes in the project timeline, also occurred and while these are easily explained by the restrictions put in place over time and were necessary to protect the project leaders, their partners, and their participants, they may have impacted the quality of interventions in ways that are difficult to measure.

The COVID-19 pandemic continues to disrupt a range of essential activities, and places marginalized populations at higher risk of its negative health and socioeconomic impacts. In addition, vaccine acceptancy and availability issues support the need for ongoing interventions where risk communication and community engagement provide layers of protection to all.

While it is difficult to measure the true effects of a single project on the spread of COVID-19 in complex and dynamic contexts, it can be concluded that the projects featured here contributed to health and well-being in many ways. Many communities, unfortunately, do not benefit from such support and enhancements to national and local efforts. Project partners have put in place dissemination efforts, and IUHPE hopes to work with them to share the approach and findings across areas in various parts of the world facing comparable circumstances.

This project has contributed to strengthening health promotion capacity and partnerships, both within and across the five participating countries. Project activities have been developed and delivered based on culturally appropriate and evidence-informed approaches, together with supportive project management structures and processes. The development of a South-South collaboration in this second phase is a unique aspect of the project, and although time-limited, it demonstrates the potential of such collaborations in strengthening health promotion capacity in building healthy and resilient communities through employing culturally appropriate processes and outputs. The project interventions and approach adopted set the foundation for addressing other community health issues through fostering community-determined solutions and local capacity building. There is an opportunity to build on this experience and to further develop these interventions in order to consolidate and embed the learning from their implementation.

The following project dissemination joint activities by IUHPE and project partners are being undertaken:

- Peer-review publication for a WHO special issue of the Health Promotion International journal, co-authored by members of the four African project teams and members of the Project Management group: Corbin, H., Manoncourt,E., Oyene,U.E., Hans O., Kwamboka, M. Amuyunzu-Nyamongo, M., Sørensen, K., Bayugo, Y.V., Mweemba, O., Barry, M.M Munodawafa, D., Huda, Q., Moran, T., Omleke, S.A., Spencer-Walters, D., Van den Broucke, S. " A health promotion approach to emergency management: Effective community engagement strategies from five case studies" Health Promotion International (in press). The cases studies featured in the paper include two from the Kenya and South Africa Phase 1 projects, demonstrating the how resilience in local communities can be fostered to help mitigate the impact of emergencies.
- A proposal for a symposium was submitted to the IUHPE 2022 World Conference. The proposal, entitled "Supporting the COVID-19 Response from a Health Promotion Perspective in African and Indian communities", covers the actions across and among all partners as well as discussion about the lessons learned regarding the COVID-19 response and the fostering of South-South collaborations.

ANNEX SECTION – COUNTRY-SPECIFIC EVALUATION REPORTS

A. South Africa (112 pages)
B. Kenya (61 pages)
C. India (71 pages)
D. Zimbabwe (4 pages)
E. Zambia (5 pages)