



National Guidelines for Community-Led Representation in Pandemic Preparedness and Response

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Abbreviations

AMR	Antimicrobial Resistance
CDC	Centers for Disease Control and Prevention
CBO	Community-Based Organization
CHC	Community Health Committee
CHP	Community Health Promoter
CHMT	County Health Management Team
CHU	Community Health Unit
CIDP	County Integrated Development Plan
CLM	Community-Led Monitoring
COHU	County One Health Unit
CSO	Civil Society Organization
DHIS2	District Health Information System 2
EANNASO	Eastern Africa National Networks of AIDS Service Organisations
EBS	Event-Based Surveillance
EOC	Emergency Operations Centre
eCHIS	Electronic Community Health Information System
FAO	Food and Agriculture Organization
GHSA	Global Health Security Agenda
HENNET	Health NGOs Network
IHR	International Health Regulations
IDSR	Integrated Disease Surveillance and Response
JEE	Joint External Evaluation
KEMRI	Kenya Medical Research Institute
MEL	Monitoring, Evaluation, and Learning
MoH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NAPHS	National Action Plan for Health Security
NEPHAK	Network of People Living with HIV and AIDS in Kenya
NPHI	National Public Health Institute
PHEOC	Public Health Emergency Operations Centre
PHC	Primary Health Care
PPR	Pandemic Preparedness and Response
RCCE	Risk Communication and Community Engagement
SOP	Standard Operating Procedure
SPAR	State Party Annual Reporting
TB	Tuberculosis
ToR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization
ZDU	Zoonotic Disease Unit

1. Introduction

1.1. Rationale and Global Lessons

The COVID-19 pandemic was an unprecedented global event that exposed significant weaknesses in health system resilience, coordination, and equity. Despite technological advancements and international coordination mechanisms, many countries struggled to implement responses that were inclusive, locally adaptive, and trusted by their populations. A central lesson emerging from global reviews—including the *Independent Panel for Pandemic Preparedness and Response’s Background Paper on Community Involvement*—is that effective pandemic preparedness and response (PPR) cannot succeed without active, meaningful, and institutionalized community participation.

Globally, communities proved to be the first line of defense in both detection and mitigation. Local organizations mobilized rapidly to bridge information gaps, distribute essential supplies, and sustain community trust at a time when formal systems were overwhelmed. This experience demonstrated that when community voices are absent from planning and decision-making, public health measures tend to be less responsive, less trusted, and less effective. Conversely, when communities are empowered as co-creators of solutions, they bring local intelligence, social networks, and behavioral insights that enhance both the efficiency and legitimacy of public health interventions.

Evidence from diverse contexts reinforces this conclusion. In Oman, as reported in *Frontiers in Public Health (2020)*, structured community engagement was formalized through local health committees and religious councils. This participatory approach increased compliance with infection control measures, improved coordination between government and citizens, and enhanced collective ownership of risk communication. The Oman experience demonstrates that institutionalizing participation—rather than treating it as ad hoc consultation—builds trust and sustains public cooperation during crises.

In Kenya, similar patterns were observed during the COVID-19 pandemic. The *COVID Collaborative Kenya Case Study (Joint Learning Network, 2022)* documented how existing community networks—particularly those linked to Community Health Units (CHUs), faith-based organizations, and civil society coalitions—played an instrumental role in mobilizing resources, countering misinformation, and ensuring service continuity for vulnerable populations. By leveraging trusted local structures such as community health promoters (CHPs) and community health committees (CHCs), Kenya was able to mount locally tailored interventions that complemented national guidance. This community-based mobilization fostered accountability between citizens and government and helped sustain essential health services under restrictive conditions.

The global and Kenyan experiences collectively highlight that community involvement is not merely a moral imperative but a strategic necessity. It enhances resilience, promotes equitable service delivery, and ensures that pandemic response measures are socially acceptable and contextually appropriate. However, these same experiences also exposed systemic weaknesses—fragmented engagement structures, short-term donor funding, and limited representation of marginalized populations such as key and vulnerable groups. Many countries, including Kenya, lack formal frameworks defining how communities should be represented within national PPR governance mechanisms.

This Technical Guidance Note therefore arises from the recognition that Kenya must move beyond project-based, episodic engagement toward structured, institutionalized community-led representation. By embedding communities within the decision-making architecture of health security, the country will strengthen its ability to anticipate, prevent, and respond to emerging threats in a way that is inclusive, coordinated, and sustainable.

1.2. Purpose and Scope

The purpose of this Technical Guidance Note is to provide a nationally contextualized framework for integrating community-led representation into Kenya's Pandemic Preparedness and Response (PPR) systems. It aims to operationalize the principle that communities are equal partners in governance—capable of shaping policy, influencing resource allocation, and holding decision-makers accountable for outcomes.

Specifically, this guidance note seeks to:

- Define governance and institutional arrangements that formally embed community representation at national, county, and community levels within the PPR architecture.
- Establish selection criteria and terms of reference for community representatives to ensure inclusivity, legitimacy, and accountability.
- Outline capacity-building mechanisms to strengthen the technical, organizational, and leadership competencies of community and civil society actors involved in PPR.
- Recommend sustainable financing mechanisms to support community engagement, coordination, and feedback structures at all levels.
- Provide a framework for two-way communication and feedback, ensuring community-generated data and perspectives inform surveillance, policy decisions, and emergency response actions.

The scope of these guidelines extends across Kenya's multi-level governance system—from the Ministry of Health and the National Public Health Institute (NPHI) at the national level, through County Governments and their respective Emergency Operations Centres (EOCs), to Community Health Units and Committees at the grassroots. It also encompasses engagement with civil society networks, key population groups, youth movements, and faith-based organizations, ensuring a whole-of-society approach to health security.

Ultimately, this guidance provides a foundation for institutionalizing community leadership within Kenya's PPR ecosystem, aligning with global standards such as the International Health Regulations (IHR 2005), the Africa CDC Framework for Community Health Systems, and the Global Health Security Agenda (GHSA). Through this process, Kenya aims to build a resilient, inclusive, and people-centered health security system—one that recognizes communities not as beneficiaries of preparedness, but as co-architects of a safer future.

2. Core Concepts and Evidence Base

2.1. Definitions and Concepts

Understanding the conceptual foundations of community engagement and representation is essential to institutionalizing these practices within Kenya's Pandemic Preparedness and Response (PPR) architecture. The following definitions are grounded in global literature and contextualized to the Kenyan health system.

Community

In the context of health security, *community* refers to groups of people linked by geography, identity, shared experiences, or social interests who interact regularly and possess collective capacities to influence their environment. Communities are not homogenous; they encompass rural and urban populations, faith-based groups, key and vulnerable populations (such as people living with HIV, TB survivors, and persons with disabilities), youth, women's organizations, and other social formations. Recognizing this diversity ensures that PPR interventions are tailored to different realities and leave no one behind.

Community Engagement

Community engagement is defined as a *process of developing partnerships and shared decision-making between communities and institutions to identify priorities, design interventions, and evaluate outcomes*. According to the Independent Panel's *Background Paper on Community Involvement (2021)*, meaningful engagement is characterized by mutual trust, transparency, and sustained dialogue. It extends beyond consultation to include empowerment—enabling communities to set agendas, co-create solutions, and participate in governance.

In pandemic contexts, engagement means involving communities throughout the preparedness continuum—risk assessment, surveillance, emergency planning, communication, and recovery. It transforms communities from recipients of information into active agents of resilience.

Representation

Representation refers to *structured, legitimate, and sustained participation* of community actors in formal decision-making and coordination mechanisms, such as technical working groups (TWGs), Emergency Operations Centres (EOCs), County Health Management Teams (CHMTs), and One Health platforms. Representation must be institutionalized through clear mandates, selection criteria, and terms of reference to ensure continuity, accountability, and influence on policy decisions.

Community Resilience

Community resilience refers to the ability of communities to anticipate, absorb, adapt, and recover from public health emergencies. This resilience is strengthened through trust, local leadership, social cohesion, and resource mobilization capacities. Community engagement and representation are foundational to resilience—when communities are empowered to act collectively, their ability to prevent and respond to crises improves dramatically.

Equity and Inclusivity

Effective engagement requires equitable inclusion of marginalized and high-risk groups whose voices are often excluded from formal systems. Incorporating their lived experiences into planning ensures that preparedness measures are socially just, contextually relevant, and aligned with Kenya's constitutional principle of participatory governance.

2.2. Evidence from COVID-19 and Beyond

Global and national evidence clearly demonstrates that community engagement and representation are *indispensable pillars* of pandemic preparedness and response. Studies from multiple countries—including those reviewed by the Independent Panel, *Frontiers in Public Health*, and the *Joint Learning Network (JLN)*—offer concrete lessons on why and how communities must be at the center of health security systems.

a) Building Trust and Legitimacy

The Independent Panel's review of global responses to COVID-19 found that *trust was the single most important determinant of compliance with public health measures*. In countries where communities were informed, respected, and engaged in planning—such as Viet Nam, Senegal, and New Zealand—citizens were more likely to follow guidelines, participate in surveillance, and support vaccination campaigns. Conversely, top-down approaches that sidelined community voices led to resistance, misinformation, and reduced adherence to containment measures.

In Kenya, early community-led risk communication initiatives, including those led by the Kenya Red Cross, faith-based organizations, and community health volunteers, helped counter rumors and mobilize support for government guidelines. These efforts demonstrated that community trust is earned through consistent engagement and visible feedback loops.

b) Empowering Community Networks

The *Frontiers in Public Health (2020)* study on Oman illustrated that formalizing community participation within local governance structures led to stronger ownership of interventions. Community taskforces—comprising local leaders, women's representatives, and religious scholars—served as bridges between technical authorities and the population. This structure promoted co-creation of culturally sensitive messaging and improved compliance.

Similarly, in Kenya, Community Health Units (CHUs) and Community Health Promoters (CHPs) served as key conduits between national health policies and household realities. During COVID-19, these networks were instrumental in monitoring symptoms, facilitating contact tracing, and identifying vulnerable households in need of social support. The *JLN Kenya Case Study (2022)* found that these grassroots structures not only enhanced surveillance but also strengthened accountability and transparency in the response process.

c) Adaptive Governance and Learning

The Joint Learning Network's case study emphasizes that adaptive governance—the ability to continuously learn, adapt, and integrate community feedback—was essential to Kenya's success in implementing locally relevant interventions. The *COVID Collaborative* model brought together national and county actors, civil society, and community representatives to co-create and share innovations. This learning-oriented model of collaboration fostered a culture of continuous improvement and responsiveness to emerging needs.

d) Institutionalizing Engagement Structures

Both global and national evidence converge on a critical finding: community engagement must be institutionalized rather than ad hoc. Temporary or donor-driven initiatives, while valuable, often dissolve after crises, eroding the continuity of community participation. The Independent Panel advocates for

embedding community representation in national and local PPR frameworks—ensuring that engagement is mandated, financed, and measured as part of health system performance.

In Kenya, this means aligning engagement with the Community Health Policy (2020–2030), the National Action Plan for Health Security (NAPHS), and the emerging NPHI Framework, all of which recognize communities as core partners in surveillance and response.

e) Equity, Gender, and Inclusion

Evidence also highlights persistent inequities in participation. The Independent Panel and the *Lancet* reviews on gender and COVID-19 revealed that women, youth, and marginalized populations were disproportionately affected but underrepresented in decision-making. Addressing these gaps requires deliberate inclusion measures—such as gender quotas, capacity-building programs for youth leaders, and engagement of key population networks.

Kenya’s vibrant civil society ecosystem, including organizations such as Stop TB Partnership Kenya, NEPHAK, WACI Health, and EANNASO, provides a strong foundation for advancing inclusive engagement that integrates voices from key and vulnerable populations into formal PPR decision-making spaces.

3. Governance Architecture for Community Representation

Kenya’s governance system for health security operates within a devolved framework in which responsibilities are shared between the national government and county governments, as established by the Constitution of Kenya (2010). Within this structure, effective community engagement in Pandemic Preparedness and Response (PPR) requires a clearly defined architecture that connects community voices to both technical and policy decision-making platforms.

This section outlines how representation should function across three levels — national, county/sub-national, and community — to ensure that community perspectives are consistently integrated into health security governance, planning, and implementation.

3.1. National Level Structures

At the national level, community representation must be institutionalized within existing coordination frameworks that oversee health emergencies, preparedness planning, and multi-sectoral collaboration.

Currently, national leadership in PPR is anchored in the Ministry of Health (MoH) through the National Public Health Institute (NPHI) and supported by the Public Health Emergency Operations Centre (PHEOC), the IHR Inter-Ministerial Coordination Committee (IMCC), and various Technical Working Groups (TWGs).

a) National Public Health Institute (NPHI)

The Kenya NPHI should host a Community Engagement and Accountability Unit (CEAU) that acts as the national coordination hub for all matters related to community participation in health security.

This unit will:

- Serve as the technical liaison between communities, civil society, and national emergency structures (PHEOC, IMCC, TWGs).
- Coordinate the integration of community-generated evidence (from CLM, CHUs, and CSOs) into national surveillance and policy reports.
- Manage the national roster of community representatives, ensuring diverse representation (gender, age, marginalized groups, regional balance).
- Develop and update national guidelines, SOPs, and standards on community engagement in PPR.
- Facilitate periodic national learning exchanges and after-action reviews involving community actors.

b) IHR Inter-Ministerial Coordination Committee (IMCC)

The IMCC provides strategic oversight for IHR core capacities and ensures coordination across sectors (health, agriculture, environment, interior, and finance).

To strengthen inclusivity:

- Civil society and community representatives should be incorporated as observers or advisory members, providing grassroots perspectives on preparedness priorities, equity, and accountability.
- These representatives should be drawn from national community networks (e.g., Stop TB Partnership Kenya, HENNET, NEPHAK) and key population coalitions.
- The IMCC should adopt a standing agenda item on community engagement, with progress tracked through regular updates from NPHI's CEAU.

c) Risk Communication and Community Engagement (RCCE) Coordination

The RCCE Sub-Pillar, under the national PHEOC, should be formally recognized as a cross-cutting function with dedicated budgetary support and a defined organizational structure.

Its key functions include:

- Coordinating public communication, community dialogues, and social listening during health emergencies.
- Managing a national RCCE strategy that links national communication with county-level feedback.
- Ensuring that community representatives and civil society partners are embedded within emergency communication planning teams.
- Leading post-event evaluations to document lessons on community trust and engagement.

3.2. County and Sub-National Structures

Kenya's 47 county governments are at the frontline of public health service delivery and emergency response. The success of national frameworks depends on institutionalizing community representation at county level, where decisions about planning, resource allocation, and coordination directly affect community outcomes.

a) County Emergency Operations Centres (EOCs)

Each county EOC should serve as the operational hub for preparedness and response, linking surveillance, logistics, communication, and coordination. Community engagement at this level should be formalized through:

- Inclusion of Community Health Committee (CHC) representatives and civil society organizations (CSOs) in EOC planning and simulation exercises.
- Designation of a County Community Engagement Focal Person responsible for coordinating input from CHUs, CBOs, and faith-based groups.
- Mechanisms for communities to submit feedback and reports to the County EOC during and after emergencies, ensuring bottom-up information flow.

b) County One Health Units (COHUs)

COHUs operationalize the One Health approach, linking human, animal, and environmental health surveillance.

To enhance community participation:

- Each COHU should include representatives from farmer cooperatives, water resource user associations, indigenous community groups, and local environmental networks.
- Community actors should be engaged in zoonotic surveillance, joint outbreak investigations, and participatory disease mapping.
- COHUs should collaborate with local academic and veterinary institutions to promote public education and behavior change on zoonotic risk reduction.

c) County Health Management Teams (CHMTs)

CHMTs oversee county health planning, budgeting, and coordination of community health services.

They should:

- Ensure that community structures (CHCs and CHUs) are linked to county decision-making through representation in annual health sector reviews and emergency planning sessions.
- Institutionalize quarterly consultative meetings with CSOs and CBOs to align local priorities with county and national PPR frameworks.
- Incorporate community engagement indicators into county performance contracts and health scorecards.

3.3. Community-Level Structures

At the grassroots, community health governance structures serve as the foundation for all engagement efforts. Kenya's Community Health Strategy (2020–2025) defines these entities as the operational base for health promotion, surveillance, and accountability.

a) Community Health Units (CHUs)

CHUs are the lowest administrative unit in the health system and comprise a network of Community Health Promoters (CHPs) who deliver household-level health services and collect health data.

Their role in PPR includes:

- Conducting community-based disease surveillance and early warning.
- Disseminating public health messages and countering misinformation.
- Mobilizing communities for preventive measures such as vaccination or vector control.
- Reporting alerts to the County EOC through digital tools like eCHIS or mobile platforms.

b) Community Health Committees (CHCs)

CHCs are elected governance bodies representing the interests of households served by a CHU. They play a critical role in linking the community to the formal health system.

Their functions should include:

- **Coordinating community dialogues** on preparedness priorities and ensuring local ownership of interventions.
- **Selecting and mentoring community representatives** to participate in county and national coordination forums.
- **Monitoring service delivery and response quality** during outbreaks and providing feedback to CHMTs.
- **Facilitating local accountability** through public barazas, health scorecards, and feedback loops.

c) Community-Based Organizations and Local Networks

Beyond formal CHUs and CHCs, Kenya has a rich ecosystem of civil society organizations, faith-based institutions, youth groups, and key population networks. These groups contribute to social mobilization, advocacy, and behavioral change communication. They should be formally recognized as part of the PPR ecosystem and included in:

- County stakeholder databases and emergency rosters.
- Public health outreach campaigns and RCCE activities.
- Participatory monitoring initiatives and community-led accountability platforms.

d) Linkages Between Levels

A strong governance architecture requires functional vertical linkages connecting communities to counties and the national level.

- CHCs and CSOs should channel community feedback to County EOCs and CHMTs.
- County structures should, in turn, synthesize this input and share it with the NPHI’s Community Engagement and Accountability Unit.
- The NPHI should maintain a national feedback repository to ensure that local insights inform national PPR policy and planning.

Summary of the Governance Architecture

Level	Key Structures	Community Representation Mechanisms	Primary Functions
National	NPHI, IMCC, PHEOC, TWGs	CSOs, community reps in advisory roles, RCCE Unit	Policy formulation, coordination, oversight
County	County EOCs, COHUs, CHMTs	CHC and CSO participation, focal persons for engagement	Implementation, simulation, and response
Community	CHUs, CHCs, CBOs, faith/youth networks	Elected or nominated local representatives	Surveillance, mobilization, accountability

Effective governance for community representation in PPR requires clearly defined roles, vertical linkages, and dedicated coordination mechanisms across all levels of the health system. Embedding communities into Kenya’s existing structures—rather than creating parallel systems—ensures sustainability, ownership, and coherence in pandemic preparedness and response.

4. Representation Framework

The establishment of a structured representation framework is fundamental to ensuring that communities, civil society, and other grassroots actors are not only consulted but also formally embedded within decision-making processes across all levels of Kenya’s health security system. Meaningful representation fosters legitimacy, inclusivity, and accountability, enabling communities to contribute to the design, implementation, and evaluation of Pandemic Preparedness and Response (PPR) strategies.

4.1. Selection Criteria and Equity Considerations

Effective and legitimate community representation depends on transparent, participatory, and inclusive selection processes. The process should be grounded in principles of trust, diversity, accountability, and gender equality.

a) Selection Principles

1. **Community Legitimacy:** Representatives should be selected through open and participatory processes facilitated by **Community Health Committees (CHCs)** or **recognized community coalitions**. Their selection must reflect the trust and confidence of the communities they represent.
2. **Transparency and Fairness:** The process should be guided by clear criteria, publicly communicated to all stakeholders, and verified by the local CHC or relevant community networks.
3. **Competence and Commitment:** Representatives should demonstrate a proven track record in community mobilization, health promotion, advocacy, or leadership in civil society or faith-based initiatives. They must also be willing to allocate time to engage consistently in coordination processes.
4. **Inclusivity and Diversity:** Representation should be equitable and inclusive, reflecting Kenya’s social and demographic diversity. This includes:
 - **Gender parity** – At least 50% of representatives should be women.
 - **Youth inclusion** – A minimum of one youth (18–30 years) per delegation to ensure intergenerational leadership.
 - **Marginalized groups** – Representation of key populations, persons with disabilities, and communities living in informal settlements or remote areas.
 - **Geographical diversity** – Representatives should be drawn from all regions and counties to ensure national coverage and perspective balance.
5. **Rotational Representation:** To promote broad participation, terms should allow for periodic rotation of representatives while maintaining institutional memory through mentoring and documentation.

b) Validation and Endorsement

Each representative's legitimacy should be formally endorsed by the CHC or community-based organization that nominated them. Endorsement should be documented through:

- A signed letter of appointment from the CHC or county health department.
- Verification by the County Health Management Team (CHMT) or the County Department of Health (CDOH) to ensure compliance with national standards.

This formal recognition process will prevent duplication, ensure continuity, and enhance accountability.

4.2. Roles and Responsibilities

Community representatives play different but complementary roles across the national, county, and community levels. These roles should be clearly articulated in **Terms of Reference (ToRs)** and aligned with existing health governance structures.

a) National Level

At the national level, community representatives contribute to policy formulation, advocacy, and strategic oversight. Their responsibilities include:

- Providing community perspectives in national technical working groups, PHEOC taskforces, and IHR coordination meetings.
- Advocating for inclusive policies, equitable resource allocation, and community-led accountability mechanisms.
- Contributing to national assessments such as Joint External Evaluations (JEE) and State Party Annual Reporting (SPAR) by validating data from community perspectives.
- Supporting development and review of national RCCE strategies, PPR policies, and guidelines for community engagement.

Representatives at this level should also engage with the National Public Health Institute (NPHI) to ensure that community intelligence informs surveillance and preparedness planning.

b) County Level

At the county level, representatives serve as the link between policy and practice, ensuring community needs and realities shape implementation. Their key responsibilities include:

- Participating in County Emergency Operations Centres (EOCs), One Health Units (COHUs), and health sector planning forums.
- Contributing to emergency preparedness plans, including simulation exercises and response coordination.
- Supporting risk communication by co-developing culturally sensitive messages for local dissemination.
- Facilitating community data sharing, ensuring that local surveillance findings and CLM reports reach county authorities.

- Advocating for the inclusion of community engagement line items in county health budgets.

By occupying these spaces, community representatives strengthen the vertical linkages between counties and the national level, ensuring bottom-up feedback in decision-making.

c) Community Level

At the grassroots level, community representatives act as facilitators, educators, and mobilizers. They play a frontline role in sustaining preparedness and resilience. Their core responsibilities include:

- Leading health promotion and risk communication within households and community forums.
- Facilitating community-based surveillance, including identification of unusual events and early warning reporting to CHPs and CHMTs.
- Organizing community dialogues on outbreak preparedness, vaccination uptake, and infection prevention practices.
- Monitoring service quality and documenting lessons from response efforts.
- Building social cohesion and trust by bridging the gap between authorities and citizens.

In doing so, community representatives ensure that preparedness and response interventions remain people-centered, contextually appropriate, and grounded in local realities.

4.3. Terms, Accountability, and Incentives

Formalizing representation requires clear Terms of Reference (ToRs) and robust accountability mechanisms to maintain transparency, performance, and trust between communities and institutions.

a) Terms of Reference (ToRs)

Each representative should operate under a formal ToR that outlines:

- Roles and responsibilities across planning, coordination, and reporting.
- Duration of engagement, typically two years, renewable based on performance and community endorsement.
- Expected deliverables, such as participation in meetings, submission of reports, and facilitation of community feedback sessions.
- Code of conduct, covering ethics, confidentiality, and respect for diversity.
- Conflict of interest disclosure to prevent bias or misrepresentation.

The ToRs should be standardized at the national level but adaptable to county and community contexts.

b) Accountability Mechanisms

Accountability is bidirectional — representatives are accountable both to their communities and to the institutions they engage with. Mechanisms include:

- Regular reporting: Representatives must provide periodic updates (e.g., quarterly) to the CHCs or CBOs that nominated them, summarizing key decisions and outcomes.
- Public feedback forums: Communities should have platforms—such as barazas, town halls, or digital channels—to evaluate representative performance.
- Performance reviews: County Departments of Health, in collaboration with CHCs, should conduct annual reviews assessing representatives’ contribution to PPR engagement.
- Documentation and transparency: All engagement activities and outcomes should be recorded and archived within the county health information system for accountability and learning.

c) Incentives and Support

While community representation should not be driven by material gain, appropriate facilitation is essential for sustainability and fairness.

Recommended support measures include:

- **Modest stipends** to cover opportunity costs associated with participation (aligned with government per diem and engagement policies).
- **Logistical support**, including transport reimbursement, communication airtime, and access to documentation materials.
- **Capacity-building incentives**, such as training opportunities, certification, and participation in national exchange forums.
- **Recognition mechanisms**, such as awards or certificates for outstanding community leadership.

Ethical facilitation ensures that representation remains inclusive, equitable, and sustainable, particularly for volunteers from marginalized or low-income backgrounds.

Summary of the Representation Framework

Level	Selection Source	Core Roles	Accountability Mechanisms	Facilitation
National	National CSOs, Networks, CHC-endorsed leaders	Policy advocacy, TWG participation, RCCE strategy development	Reports to networks and NPHI	Stipends, travel support
County	CHCs, County CSOs, Faith & Youth Networks	EOC participation, planning, risk communication	Reports to CHMT and CHCs	Transport, capacity-building
Community	CHCs, CBOs, informal groups	Surveillance, mobilization, feedback, awareness	Reports to CHU and CDOH	Recognition, mentoring

In summary, a well-structured representation framework provides the foundation for a whole-of-society approach to health security. It ensures that communities are not peripheral participants but equal partners, shaping Kenya’s capacity to anticipate, prevent, and respond to public health threats.

5. Capacity Development

5.1. Overview

Building a resilient, community-driven Pandemic Preparedness and Response (PPR) system in Kenya requires more than the inclusion of communities in meetings and consultations. It demands that community actors have the knowledge, technical competence, and organizational capability to engage meaningfully in health security processes. Communities must be able to interpret and use health information, participate in surveillance and coordination, influence policies, and hold health institutions accountable for service delivery and preparedness outcomes.

Capacity development therefore goes beyond short-term training interventions. It involves a systematic and continuous process that strengthens individual skills, institutional capabilities, and collective confidence within communities to function as equal partners in Kenya's public health system. The objective is to establish a comprehensive national capacity development system that ensures every community representative, whether at national, county, or grassroots level, is equipped to contribute effectively to pandemic preparedness and response.

5.2. National Training Framework

To achieve structured and sustainable capacity building, Kenya should develop a National Community Capacity Development Framework coordinated by the National Public Health Institute (NPHI) in partnership with the Ministry of Health (MoH). This framework will guide the planning, delivery, and evaluation of all community-level training related to preparedness and response, ensuring consistency, quality, and accountability across the country.

The framework should define the core competencies that every community representative must possess. These include an understanding of the national PPR architecture, basic epidemiology and outbreak detection, the One Health approach, and familiarity with the main surveillance systems such as eCHIS, IDSR, and DHIS2. It should also address policy awareness, including the International Health Regulations (IHR 2005) and Kenya's National Action Plan for Health Security (NAPHS).

In addition to technical competencies, the training should strengthen soft skills such as communication, leadership, and advocacy. Modules should also integrate cross-cutting areas including gender equality, youth engagement, social inclusion, and governance to ensure that representatives are equipped to advocate for the rights and needs of all population groups, especially marginalized communities.

The framework should align with existing national tools such as the Community Health Services Training Manual and the Risk Communication and Community Engagement (RCCE) Guidelines. Its implementation should be overseen by a National Community Capacity Development Committee housed within the NPHI. The committee should draw members from academia, civil society, county governments, and partner organizations to ensure inclusivity, relevance, and continuous improvement.

The establishment of this framework will harmonize community training across the country, promote standardization, and ensure that all actors working in the PPR system share a common understanding of roles, responsibilities, and coordination mechanisms.

5.3. Training of Trainers (ToT) Model

To sustain capacity building over time, a Training of Trainers (ToT) model should be adopted. The ToT approach enables knowledge to be cascaded from national experts to county facilitators and eventually to community leaders. It builds local ownership of the training process and ensures that capacity development continues even after external projects or donor support have ended.

At the national level, the first group of trainers should be drawn from established institutions such as the Kenya Medical Research Institute (KEMRI), the University of Nairobi, and Moi University. These institutions can support curriculum development, deliver advanced modules, and co-certify participants together with the MoH and NPHI. Civil society and technical coalitions including the Stop TB Partnership Kenya, HENNET, and EANNASO should serve as regional resource partners, providing field experience and ensuring community representation in the training process.

At the county level, the County Health Management Teams (CHMTs) will coordinate cascade trainings that target Community Health Committees (CHCs), Community Health Promoters (CHPs), local faith-based organizations, and civil society groups. These county-level trainers will adapt the curriculum to local realities and ensure that training is continuous, inclusive, and linked to county health priorities and budgets.

The ToT approach will help each county maintain a pool of trained facilitators capable of providing refresher courses, orienting new representatives, and supporting continuous capacity strengthening for community leaders involved in PPR. This decentralized system will ensure sustainability, consistency, and equity across all 47 counties.

5.4. Certification and Continuous Learning

To professionalize community representation within the national PPR architecture, participants who complete the prescribed training modules should receive formal certification endorsed by the MoH and NPHI. Certification will validate their competencies and give them the legitimacy to participate in formal structures such as Technical Working Groups, Emergency Operations Centres, and county coordination platforms.

The certification process should combine theory and practice, including assessments based on participation in outbreak simulation exercises, contributions to community surveillance activities, or engagement in advocacy initiatives. Certified participants should be registered in a National Register of Certified Community Representatives maintained by the NPHI. This register will help track qualified individuals, support deployment during emergencies, and avoid duplication in representation.

Capacity development should not be a one-time process. It should be continuous and adaptive to emerging health threats, evolving technology, and new policy priorities. The NPHI, together with academic institutions and regional partners such as EANNASO and the Africa CDC, should establish systems for continuous professional development. These could include online refresher courses, self-paced e-learning modules, and annual peer learning exchanges where community leaders from different counties share lessons and best practices.

Mentorship and coaching programs should also be developed, pairing newly trained community representatives with experienced leaders and technical experts. This will help sustain institutional memory, enhance leadership skills, and build long-term confidence among grassroots actors.

5.5. Expected Outcomes and Impact

The implementation of this capacity development strategy is expected to transform community participation into an integral component of Kenya's public health system. Through structured training and certification, communities will be better equipped to support surveillance, communication, and governance functions within the PPR framework.

The expected outcomes include the establishment of a skilled, confident, and empowered community workforce that actively contributes to disease prevention and preparedness. Stronger coordination between national, county, and community structures will enhance accountability, improve data quality, and ensure that community intelligence informs national decision-making.

Over time, the professionalization of community roles will also strengthen public trust in the health system, reinforce collaboration between government and civil society, and institutionalize community-driven health governance as a pillar of Kenya's national health security strategy.

By investing in sustained capacity development, Kenya will build not only stronger institutions but also empowered communities capable of leading and sustaining health security interventions beyond the life of any single project or emergency.

6. Resource Mobilization and Sustainability

Sustainable financing is essential to maintain long-term community engagement in PPR. Without predictable resources, community participation risks remaining ad hoc and donor-dependent.

6.1. Dedicated Budget Lines

Both the national government and county governments should establish dedicated budget lines for community engagement in PPR within their annual health budgets. These allocations will cover:

- Support for community representation at coordination meetings and TWGs.
- Facilitation for surveillance, communication, and outreach activities.
- Capacity-building, logistics, and feedback mechanisms.

This financial commitment will signal institutional recognition of community engagement as a core function of PPR.

6.2. Integration into UHC and County Planning Instruments

Community engagement activities should be mainstreamed within broader development and health system frameworks, including:

- Universal Health Coverage (UHC) implementation plans, linking health security to primary healthcare and service delivery.
- County Integrated Development Plans (CIDPs) and County Health Sector Strategic and Investment Plans, ensuring resource alignment with long-term planning and monitoring frameworks.

6.3. Partner and Private Sector Collaboration

Strategic partnerships can expand resource availability and innovation in community systems strengthening.

- Development partners (e.g., WHO, CDC, USAID, Global Fund) can support digital tools, data systems, and joint training initiatives.
- Private sector entities—including telecom companies, logistics providers, and pharmaceutical distributors—can contribute through public-private partnerships (PPPs) supporting mobile-based reporting systems, emergency transport, and community logistics.
- Corporate Social Responsibility (CSR) programs should be leveraged to fund local preparedness efforts, particularly for marginalized or high-risk counties.

By integrating diverse financing sources, Kenya can ensure sustainable, multi-actor investment in community resilience and pandemic readiness.

7. Information Systems, Feedback, and Communication

Reliable, timely, and transparent information exchange between communities and health authorities forms the backbone of an effective Pandemic Preparedness and Response (PPR) system. Communities are often the first to detect unusual health events, but their reports only translate into action if robust systems exist to channel, analyze, and respond to that information. A well-functioning feedback and communication structure ensures that communities are not merely data providers, but informed participants who understand how their contributions influence decision-making and resource allocation.

Effective information systems strengthen surveillance, improve coordination, and enhance trust. They also serve as accountability mechanisms, allowing communities to track government responses to emerging threats and verify that their input translates into tangible outcomes.

7.1. Strengthening Community Reporting Systems

Kenya has made important progress in digitizing community-level health data through systems such as the electronic Community Health Information System (eCHIS), which enables Community Health Promoters (CHPs) to record, transmit, and track data from households. However, integration between these community-level tools and national surveillance systems remains incomplete. Strengthening the connectivity between eCHIS and national platforms will significantly enhance early detection and response.

The Integrated Disease Surveillance and Response (IDSR) and the District Health Information System 2 (DHIS2) should be configured to receive and analyze data directly from eCHIS and community monitors in real time. This linkage will allow community-generated alerts on symptoms, mortality, environmental hazards, or zoonotic events to automatically populate national dashboards used by the Ministry of Health, the National

Public Health Institute (NPHI), and the Public Health Emergency Operations Centre (PHEOC). In turn, national actors can send automated feedback or verification requests back to CHPs and community focal points, creating a two-way data exchange loop that supports rapid action and mutual accountability.

Standardization is key to this integration. The Ministry of Health, working through NPHI and County Health Departments, should develop uniform reporting templates, indicators, and digital tools that align with the IDSR framework and Kenya's Health Sector Strategic Plan. These tools should be complemented by training for CHPs, community monitors, and county surveillance officers to ensure accuracy, completeness, and consistency of data across counties.

To address gaps in areas with limited connectivity, offline and low-technology reporting options such as SMS-based alerts or paper-to-digital upload mechanisms should be supported. Mobile network partnerships could enable communities to submit alerts free of charge using shortcodes, especially during outbreaks.

Strengthening these systems will transform community health actors into an active surveillance force, improve data triangulation between health and environmental sectors under the One Health approach, and enhance Kenya's compliance with the International Health Regulations (IHR 2005) core capacity requirements.

7.2. Two-Way Communication and Feedback Loops

An effective information system is not defined solely by how well data flows upward — it must also ensure that information flows back to the people who provide it. Communities must be kept informed about what happens to their reports, how government institutions have responded, and what outcomes have been achieved. This two-way communication is central to building public trust, sustaining participation, and reinforcing the legitimacy of the PPR system.

County Emergency Operations Centres (EOCs) should establish structured communication protocols to ensure that feedback is routinely shared with Community Health Committees (CHCs) and other community governance structures. Each report or alert submitted through eCHIS or other platforms should trigger an acknowledgement notification confirming receipt and next steps. Where possible, this feedback should be delivered directly to CHPs and CHCs via SMS, mobile applications, or WhatsApp groups that have been approved by the County Health Departments.

Periodic updates should be provided to communities, summarizing response actions taken, containment measures, and lessons learned. This can be achieved through regular community meetings, barazas, town halls, or CHC forums, where health officials share progress updates and receive community feedback.

For broader reach, community radio, local language bulletins, and faith-based communication networks should be leveraged to disseminate updates and reinforce preventive messages. Local radio programs can provide weekly summaries of public health alerts, interviews with county surveillance officers, and testimonials from community responders.

Feedback mechanisms must also be inclusive and accessible. Information should be translated into local languages and simplified formats to reach people with low literacy levels, while ensuring accessibility for persons with disabilities. Tailored communication

materials should be designed for marginalized populations such as nomadic communities, slum dwellers, and people living in remote areas.

By institutionalizing two-way communication, Kenya's health system will foster transparency and accountability, demonstrating that communities' efforts and vigilance are recognized and valued. This, in turn, will strengthen cooperation during future health emergencies.

7.3. Post-Emergency Reflection and Learning

Every public health emergency provides an opportunity to strengthen systems, build relationships, and institutionalize good practices. Post-emergency reflection and learning are therefore essential components of the feedback process, ensuring that experiences from the field inform long-term policy and preparedness improvements.

After major outbreaks or response operations, the Ministry of Health, through NPHI and County Health Departments, should convene After Action Reviews (AARs) and Intra Action Reviews (IARs) that include community representatives, civil society, and frontline health workers. These reviews should analyze what worked well, identify gaps, and recommend corrective actions to enhance community engagement in future responses.

Parallel to the formal AARs, community reflection forums should be organized at the county and sub-county levels. These forums would provide space for CHCs, local leaders, youth networks, and community-based organizations to share lived experiences, document challenges, and propose community-led solutions. Documenting these reflections from the ground ensures that the perspectives of those most affected by emergencies are incorporated into subsequent revisions of national and county preparedness plans.

Findings from these reflection exercises should be compiled into annual Community Engagement Reports, which synthesize lessons, innovations, and recommendations. These reports should be shared publicly through the Ministry of Health's website and summarized through community information channels to maintain transparency.

The knowledge generated should also feed into national learning platforms such as EANNASO's Anglophone Africa Learning Hub, the Kenya Health Security Steering Committee, and Africa CDC's continental knowledge-sharing mechanisms. Over time, Kenya can build a robust repository of community engagement experiences and innovations, positioning itself as a leader in participatory health security governance.

7.4. Expected Outcomes

Strengthening information systems, feedback, and communication mechanisms will result in multiple gains for Kenya's health security architecture. Communities will have improved access to information and greater capacity to act on it, leading to faster outbreak detection and response. The Ministry of Health and NPHI will benefit from a more reliable and inclusive data ecosystem, capable of integrating community intelligence into national decision-making. Most importantly, consistent two-way communication will foster trust, encourage transparency, and transform the relationship between communities and institutions from one of dependency to one of partnership.

Ultimately, these reforms will establish a culture of shared accountability, where community knowledge informs evidence-based policies, and government actions are visibly responsive to the voices of the people.

8. Monitoring, Evaluation, and Learning (MEL)

Monitoring, Evaluation, and Learning (MEL) are essential for ensuring that community engagement in Pandemic Preparedness and Response (PPR) is not only implemented but also measured, analyzed, and continuously improved. A functional MEL system promotes accountability between institutions and communities, helps identify what works and what does not, and ensures that data and lessons from the field inform future strategies. Embedding MEL into Kenya's PPR systems will help connect community-level efforts to national health security outcomes and build a cycle of evidence-based learning and adaptation.

8.1. MEL Framework and Indicators

Kenya should develop a national Monitoring, Evaluation, and Learning framework for community engagement in PPR under the leadership of the Ministry of Health (MoH) and the National Public Health Institute (NPHI). This framework should align with the National Action Plan for Health Security (NAPHS) monitoring mechanisms, the Universal Health Coverage (UHC) framework, and any future PPR monitoring plans.

The MEL framework will serve three main purposes:

1. Track progress in institutionalizing community engagement as an integral component of PPR.
2. Provide evidence to inform decision-making and policy adjustments.
3. Promote transparency and mutual accountability between communities and government institutions.

Key indicators should capture both the quantity and quality of community engagement. They may include:

- Number and frequency of community representatives participating in PPR meetings and technical working groups.
- Proportion of women, youth, key populations, and other marginalized groups represented in decision-making fora.
- Timeliness and responsiveness of feedback provided to community structures following reports or alerts.
- Number of capacity-building activities conducted and participants certified under the national training curriculum.
- Proportion of community-generated data integrated into surveillance and decision-making platforms such as DHIS2 and eCHIS.
- Number of counties with operational community feedback mechanisms such as scorecards or public barazas.
- Regular dissemination of engagement outcomes through county or national health bulletins.

Data should be collected through existing platforms such as DHIS2, the Integrated Disease Surveillance and Response (IDSR) system, and the electronic Community Health

Information System (eCHIS). Counties should report quarterly, while national consolidation and analysis should be done annually.

To ensure accountability, counties should integrate these indicators into their Annual Work Plans (AWPs), and MoH should include them in national Health Sector Performance Reports. An annual report on community engagement in PPR should be published and disseminated to stakeholders, including civil society and development partners.

8.2. Participatory Review Mechanisms

Effective MEL depends on the regular review and reflection of data collected. Kenya should establish an annual participatory review process involving key actors from MoH, NPHI, County Health Departments, civil society networks, development partners, and community representatives.

The review process will involve several steps:

- Data compilation and validation: Counties will collect and verify reports on engagement activities before submission to MoH and NPHI.
- Multi-stakeholder analysis: National and county stakeholders will jointly analyze the performance of community engagement structures, data flow, and feedback mechanisms.
- Identification of gaps and good practices: The review will identify areas requiring improvement, such as financing, representation, and communication. It will also document innovations and success stories that can be scaled up.
- Development of joint action plans: Each review will conclude with a shared plan outlining actions, responsible actors, timelines, and resources needed.

At the county level, semi-annual reflection sessions should be held to assess progress against action plans. Community barazas and dialogue forums should then be used to communicate outcomes to citizens, ensuring transparency and accountability.

Through this participatory approach, Kenya will foster a culture of learning and evidence-based adaptation, making community engagement more responsive and sustainable.

8.3. Knowledge Sharing and Regional Learning

Knowledge generated through the MEL system should be actively shared across national and regional platforms to strengthen collective learning. Kenya's experiences in institutionalizing community engagement in PPR can serve as valuable examples for neighboring countries.

Lessons learned should be disseminated through regional and continental mechanisms such as EANNASO's Anglophone Africa Learning Hub and the Africa CDC Civil Society Engagement Platform. Kenya's MoH and NPHI should share best practices, monitoring tools, and training materials during technical consultations and peer exchange visits.

Domestically, a centralized online repository hosted by NPHI should store training materials, community feedback reports, monitoring data, and engagement tools. This knowledge hub would serve government agencies, civil society, and researchers seeking to strengthen evidence-informed community engagement.

8.4. Expected Outcomes

The establishment of a robust MEL system will lead to measurable improvements in the quality and effectiveness of community participation in PPR. National and county authorities will have access to data that demonstrates how community input influences decisions and outcomes.

Regular monitoring will help identify weaknesses early, enabling timely corrective action. Annual participatory reviews will promote shared accountability, while structured knowledge sharing will strengthen collaboration across sectors. Over time, the integration of MEL into Kenya's PPR framework will transform community engagement from a peripheral activity into a measurable, evidence-based, and institutionalized component of national health security.

9. Implementation Roadmap

A phased and structured implementation roadmap is essential for ensuring that Kenya's community representation framework for Pandemic Preparedness and Response (PPR) is adopted in a systematic, inclusive, and sustainable manner. The roadmap emphasizes sequencing of activities, coordination among stakeholders, and clear accountability mechanisms. It also recognizes that effective institutionalization of community engagement requires not only policy action but also capacity strengthening, financing, and continuous learning.

The implementation process will unfold in three phases: short-term, medium-term, and long-term, each with distinct objectives, deliverables, and institutional responsibilities.

9.1. Short-Term (0–12 months)

The initial phase focuses on establishing the foundational structures and tools required to operationalize community representation within PPR governance. It will prioritize stakeholder consensus, policy alignment, and pilot implementation to test the practicality of the framework before nationwide scale-up.

Key activities include:

- Validation of the Technical Guidance Note through an inclusive, multi-stakeholder consultation convened by the Ministry of Health (MoH) and the National Public Health Institute (NPHI). This process will engage government representatives, county officials, civil society organizations, development partners, and community leaders to ensure shared ownership and contextual relevance.
- Development of standard Terms of Reference (ToRs) and selection guidelines for community representatives. These ToRs will specify roles, responsibilities, qualifications, reporting structures, and accountability measures, ensuring consistency across counties.
- Implementation of pilot programs in three to five counties, representing diverse epidemiological and socio-geographical settings—such as urban (e.g., Nairobi), rural (e.g., Kakamega), and pastoralist regions (e.g., Garissa or Turkana). The pilots will test mechanisms for community inclusion, data sharing, and feedback

processes within existing PPR structures like Emergency Operations Centres (EOCs) and County One Health Units (COHUs).

- Establishment of a National Coordination Taskforce under MoH and NPHI to oversee pilot implementation, monitor progress, and document lessons. The Taskforce should include representatives from key government departments, county health leadership, civil society networks, and technical partners such as WHO, CDC, and EANNASO.
- Development of a comprehensive implementation toolkit including templates, monitoring tools, and communication materials to guide counties during the rollout phase.

Expected outputs for the short-term phase include a validated guidance note, finalized ToRs, operational pilot counties, and a functional coordination mechanism.

9.2. Medium-Term (1–3 years)

The medium-term phase will build upon the pilot results to scale up implementation across all 47 counties. The focus will shift from piloting and learning to institutionalization, capacity development, and integration of community engagement into formal planning, budgeting, and surveillance systems.

Key activities include:

- Scaling up implementation of the community representation framework to all counties. This includes integrating community representatives within existing coordination structures such as County EOCs, COHUs, and County Health Management Teams (CHMTs). Each county should establish a community engagement focal point responsible for coordination and reporting.
- Embedding community engagement budget lines into county Annual Work Plans (AWPs) and the national Medium-Term Expenditure Framework (MTEF). This step will ensure predictable financing for participation, training, and logistics, reducing dependence on external funding.
- Conducting nationwide and county-level Training of Trainers (ToT) programs targeting community representatives, county health officials, and civil society facilitators. The trainings should use the standardized national curriculum on community engagement in PPR and be anchored by institutions such as KEMRI, the University of Nairobi, and Moi University.
- Strengthening digital feedback and information-sharing platforms. The electronic Community Health Information System (eCHIS) should be linked to the Integrated Disease Surveillance and Response (IDSR) system and the District Health Information System 2 (DHIS2) to ensure real-time data flow between communities and national authorities.
- Expanding partnerships with civil society, private sector actors, and development partners to support digital innovation, logistics, and research on community engagement effectiveness.
- Convening annual review and reflection workshops at national and county levels to assess progress, share lessons, and adapt implementation strategies.

Expected outcomes for this phase include functional community representation in all counties, institutionalized financing, improved data connectivity between systems, and enhanced local capacity for participation and leadership.

9.3. Long-Term (3–5 years)

The long-term phase focuses on full institutionalization, policy integration, and sustainability. It seeks to embed community representation within Kenya's broader health security and governance systems, ensuring that engagement remains a permanent and well-resourced component of national preparedness.

Key activities include:

- Full institutionalization of community representation mechanisms within NPHI, MoH, and county-level PPR coordination structures. This will involve formal recognition of community representatives in organizational charts, planning frameworks, and policy documents.
- Embedding community engagement principles into national health security legislation and policy instruments. For example, revisions to the Public Health Act or related frameworks should mandate representation of community actors in PPR coordination bodies and technical working groups.
- Establishing a National Annual Forum on Community Engagement in PPR, co-hosted by MoH, civil society organizations, and development partners. This forum will serve as a platform for sharing innovations, reviewing progress, and aligning national efforts with regional and global commitments under the International Health Regulations (IHR) and the Africa CDC frameworks.
- Strengthening research and documentation on the impact of community engagement on preparedness outcomes. MoH, NPHI, and academic institutions should collaborate on periodic studies assessing the contribution of community-led approaches to resilience and equity in health security.
- Achieving full operationalization of the framework in all 47 counties, with clear linkages to existing health governance platforms, One Health coordination mechanisms, and emergency response systems.
- Positioning Kenya as a regional leader in inclusive, community-driven health security by sharing best practices with neighboring countries and regional bodies such as the East African Community (EAC) and Africa CDC.

By the end of this phase, community engagement in PPR should be institutionalized as a non-negotiable element of Kenya's health system governance. National and county governments will have the capacity, resources, and accountability systems to sustain community participation beyond individual projects or donor cycles.

In summary, the phased roadmap provides a clear pathway for Kenya to transition from fragmented, project-based participation to a cohesive, institutionalized model of community representation. Through deliberate planning, capacity building, and policy alignment, the country can establish a people-centered, inclusive, and resilient system for pandemic preparedness and response.

