



AFRICAN INSTITUTE FOR HEALTH & DEVELOPMENT

"Working with communities for better lives through evidence-based programming"



IUHPE - UIPES

INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION
UNION INTERNATIONALE DE PROMOTION DE LA SANTÉ ET D'ÉDUCATION POUR LA SANTÉ
UNIÓN INTERNACIONAL DE PROMOCIÓN DE LA SALUD Y EDUCACIÓN PARA LA SALUD

PROJECT REPORT

COVID-19 RESPONSE FOR KISII COUNTY, KENYA



November 01, 2021

Acknowledgements

This report on Covid-19 Health Promotion in Kisii, Kenya was prepared by the African Institute for Health and Development (AIHD) in partnership with Kisii County. The team is indebted to a number of people who contributed to the project design, planning, implementation, evaluation and preparation of the report.

First, we recognize with appreciation the financial support from of Vital Strategies through the International Union of Health Promotion and Education (IUHPE) and the technical support received from the Project Coordination Team under the leadership of Liane Comeau. A special mention goes to the project team from AIHD and Kisii County that included: Dr. Mary Amuyunzu-Nyamongo (AIHD); Alice Sinkeet (AIHD); Clare Amuyunzu (AIHD); Judy Akuma; Metrine Kwamboka (AIHD); Dr Richard Onkware (Kisii County) and Beatrice Bosibori (Kisii County).

We also appreciate all the research assistants from Kitutu Central Ward who worked tirelessly under sometimes harsh conditions to collect primary data. We would also like to thank the data manager Mr. Milton Adier Bwibo, for data processing and analysis. A special mention goes to the community members for their active participation throughout the project period; without which, this project would not have been a success.

It is not possible to mention everyone, but we acknowledge the contributions of all who made the project a success.

Table of Contents

| | |
|--|-----|
| Acknowledgements..... | i |
| Acronyms and Abbreviations..... | iii |
| 1. Introduction..... | iv |
| 2. Executive Summary..... | v |
| 3. BACKGROUND..... | 1 |
| 3.1 Introduction..... | 1 |
| 3.2 Project Aim, Objectives and Rationale..... | 1 |
| 4. PLANNING PHASE..... | 2 |
| 4.1 Selection and training of CORPs..... | 5 |
| 4.2 Identification of Risk Groups..... | 5 |
| 5. PROJECT IMPLEMENTATION PHASE..... | 6 |
| 6. ENDLINE EVALUATION..... | 9 |
| 6.1 Methods..... | 9 |
| 6.2. Endline Study Results..... | 10 |
| 6.2.1 Socio-demographic characteristics..... | 11 |
| 6.2.3 Sources of information on Covid-19..... | 13 |
| 6.2.4 Covid Management, Attitudes and Prevention Practises in the Community..... | 14 |
| 6.2.5 Vaccine uptake..... | 16 |
| 6.2.6 General effects of Covid-19..... | 18 |
| 6.2.7 Synthesis of Findings using the RE-AIM Framework..... | 19 |
| 7.1 Lessons Learnt..... | 23 |
| 7.2 Use and dissemination of project results..... | 23 |
| 7.3 Conclusion..... | 23 |
| 7.4 Recommendations..... | 24 |
| 8. REFERENCES..... | 2 |
| 9. ANNEXES..... | 3 |
| Annex 1. Household and Community Endline Evaluation Questionnaire..... | 3 |
| Annex 2. Household and Community Baseline Assessment Questionnaire..... | 10 |
| Annex 3: KII Guide..... | 16 |
| Annex 4: Best buys in COVID-19 preparedness and response in Africa..... | 18 |
| Annex 5: CORPs RCCE training manual..... | 20 |
| Annex 6: Project Photos..... | 25 |

Acronyms and Abbreviations

| | | |
|------------|---|--|
| AIHD | - | African Institute for Health and Development |
| APDK | - | Association for the Physically Disabled Kenya |
| SBCC | - | Social Behavior Change Communication |
| CHPO | - | County Health Promotion Officer |
| CORPs | - | Community Own Resource Persons |
| Covid-19 | - | Corona Virus Disease 2019 |
| FGDs | - | Focus Group Discussions |
| HBC | - | Home Based Care |
| HPOs | - | Health Promotion Officers |
| IFRC | - | International Federation of Red Cross and Red Crescent Societies |
| IUHPE | - | International Union for Health Promotion and Education |
| KIIs | - | Key Informant Interviews |
| MOH | - | Ministry of Health |
| NGO | - | Non-Governmental Organizations |
| ODK | - | Open Data Kit |
| PAs | - | Public Address System |
| PWDs | - | Persons with Disabilities |
| RAs | - | Research Assistant |
| RCCE | - | Risk Communication and Community Engagement |
| SARS-CoV-2 | - | Severe Acute Respiratory Syndrome-Covid-19 – 2 |
| SCHMT | - | Sub-County Health Management Team |
| SGBV | - | Sexual and Gender Based Violence |
| SPSS | - | Statistical Package for Social Sciences |
| UNICEF | - | United Nations International Children's Emergency Fund |
| WASH | - | Water Sanitation and Health |
| WHO | - | World Health Organization |

1. Introduction

| | |
|--|--|
| Country/Project Title | Covid-19 Health Promotion in Kisii County, Kenya |
| Geographical Areas of intervention | Kitutu Central ward, Kisii County, |
| Project Timeframe | July 2021 to October 2021 |
| Project Lead (name & contact details) | Dr. Mary Amuyunzu-Nyamongo Email: mnyamongo@aihdnt.org Cell phone: (254) 722 850 401 |
| Organization | African Institute for Health and Development (AIHD) |
| Project Team Members | AIHD Kisii County |
| Organizational Partners | N/A |
| Date of Final Report | 31/10/2021 |

2. Executive Summary

Background: 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. The aim of the project was to implement health promotion strategies in Covid-19 response to stop and control the spread the disease and promote vaccine uptake. The implementation of the project was based on health promotion principles geared towards empowering individuals and communities to make informed decisions to equitably stop and control the spread of the disease, while protecting people’s basic needs and their physical and mental health. The project was implemented from July 2021 to October 2021. This project pursued the following objectives to: (i) engage local communities and key stakeholders in the Covid-19 response and empower them to reduce its spread; (ii) 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; (iii) ensure that community level implementation is informed by best available knowledge, research and resources on effective risk community and community engagement; and (iv) create community coalitions to coordinate local responses adapted to the needs of local communities.

Project planning: A series of planning meetings and consultations were held among the lead teams who included the County Director of Public Health, County Health Promotion Officer (CHPO) and AIHD project staff. During these meetings, Kitutu Central ward which is the most affected by the Covid-19 pandemic was selected. The Sub-County was also chosen because of its populous, high transit and peri-urban setting with proximity to major markets and busy bus termini in the county as well as due to the risk population characteristics, it also has the highest number of Covid-19 cases; 1339 (51.3 %) of the total cases in Kisii county (MoH SITREP, 2021).

Baseline Evaluation: The baseline aimed to generate evidence that would guide the implementation of the project and inform the design and focus areas; highlight gaps that need to be addressed during community engagement sessions as well as help compare behavior among different target groups. Specifically, the study aimed 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.

A cross-sectional study design was used to collect data through both qualitative and quantitative tools, from the target population. Quantitative data were collected using a questionnaire (249 respondents randomly sampled from the community as per project target locations) and observation checklist. Qualitative data were collected by conducting Focus group discussions (FGDs) and Key informant interviews (KIIs); participants were selected purposefully from the influencers and risk groups in the community.

Key baseline findings: It was clear from the baseline study that despite the MoH emphasizing on adherence to Covid-19 preventive measures and high awareness levels at the community

level (94%, n=249), people had lowered their guard. Notably, less than 50% of the study population (n=249) put on their masks properly while the rest had no masks, or they were worn improperly/were in their pockets at the time of interaction. Moreover, it emerged from the study findings that attitudes, perceptions, myths, misinformation and misconceptions were key barriers in adherence to the prevention measures and vaccine uptake, which was low (12.9%, n=249). Although the health seeking behaviour was good (94%, n=249), it was clear that the RCCE strategy would go a long way to impart knowledge and increase awareness on vaccine uptake and preventive measures.

Implementation: 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 Kumi*¹ 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).

Endline assessment: The project team undertook an endline evaluation in the project sites in October 2021. The evaluation team adhered to the MoH guidelines on controlling the spread of the virus. The evaluation involved a total of 255 participants who were randomly selected from the project intervention sites. The study aimed to determine the results of the Covid-19 health promotion interventions. Specifically, the evaluation sought to: i) assess progress in the achievement of the project objectives; ii) identify and document the lessons learnt in the implementation of the project; and iii) make appropriate recommendations. Furthermore, the evaluation questions investigated the following aspects: relevance, effectiveness, efficiency, sustainability, impact, coherence, and appropriateness of the project. It should however be noted that the timeframe between the baseline and endline was too short to capture the effects of the project.

The endline evaluation, similar to the baseline, used both quantitative and qualitative tools. A short questionnaire was uploaded on Open Data Kit (ODK) where data were collected regarding knowledge, attitude, practices, health seeking behaviour, relevance, effectiveness, efficiency, and sustainability of the project in the targeted study site. Qualitative data were collected by conducting community conversations and Key informant interviews (KIIs). The participants were selected purposefully from the influencers and risk groups in the community.

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.

Key endline study findings: The following are the key findings of the study:

- i. *Covid-19 awareness:* Majority (83.1%, n=255) of the respondents cited that one can contract it through contact with infected persons, touching of contaminated surfaces (62%), droplets from infected people (56.5%) and airborne disease (18%). Only a small percentage (1.6%) of the people interviewed said they did not know how it is transmitted. This is an improvement from the baseline findings where most of the respondents (75%, n=249) cited that one can contract it through contact with infected persons, touching of contaminated surfaces (49%) and droplets from infected people (53%), 19% reporting that it's an airborne disease. Only a small percentage (3%) of the people interviewed said they did not know how it is transmitted.
- ii. *Sources of information on Covid-19:* Majority of the respondents (91%, n=255) said their main source of information on Covid-19 was through the media with the most preferred media being radio (87.8%, n=255), TV (59.6%) and social media (18.4%). Other sources of information mentioned included healthcare providers (16.9%), CORPs (4.7%), chiefs (3.1%), family members and friends (2.7%) and website (0.4%). The results corroborate with those from the baseline where 94% (n=249) of the respondents cited the media as their main source of information on Covid-19.
- iii. *Covid management, attitudes, perceptions and prevention practises in the community:* In case of a suspected case, a high percentage (79.6% n=255) of the respondents mentioned they would go to the hospital, (25.1%) would quarantine oneself, (15.3%) would seek advice from a knowledgeable person, (8.2%) will buy medicine in pharmacy and a paltry (1.6%) said they would go to a traditional healer. This is a clear indication that community members are now changing their attitudes/perceptions towards Covid-19.
Furthermore, when asked about the barriers to adherence to prevention measures, slightly more than half (55.7%, n=255), cited financial constraints followed by attitudes and perceptions (51.4%), incorrect knowledge on the disease (44.7 %), stress (13.3%) and alcoholism (0.4%). Notably, during the baseline, the major barriers to adoption of preventive measures were attitudes and perceptions (52%), incorrect knowledge about the disease (32.5%) and financial constraints (31.3%).
- iv. *Vaccine uptake:* On the uptake of the Covid-19 vaccine, it is evident that almost two-fifths of the respondents (38.4%, n=255) had received the vaccine. This is an improvement from the baseline results where 12.9% (n=249) of the respondents had received the vaccine. Almost two-thirds of the respondents (61.1%, n=255) were willing to receive the vaccine while 38.9% were unwilling. For those who had not been vaccinated and were unwilling to take the Covid-19 vaccine, more than half of them (52.5%, n=61) mentioned fear of the side effects as the main reason hindering vaccine uptake, followed by no trust in the vaccine (23%, n=61) as well as stigma associated with Covid-19 (21.3%, n=61)
- v. *General effects of Covid-19:* Participants in the study were asked to state how Covid-19 had affected them. Majority (73.3%, n=255) cited no income, and more than half (57.3%) reported job loss. A small percentage (5.5%) said they are no longer in school while the 'other category' accounted for less than 15%. The findings confirm the baseline results that showed (55%, n=249) of the respondents reported loss of income as the major effect of Covid-19.

Synthesis of data findings using the RE-AIM 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.

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.

Recommendations: Based on the project implementation the following recommendations are made:

- i. The County should build on the results to sustain and scale-up the gains made including the partnership with CORPs to mobilize communities for health actions;
- ii. There is a need for an elaborate partnership agreement among partners to ensure that communities are effectively mobilized and supported for health action;
- iii. Invest in increased advocacy and outreach to boost vaccine uptake at the grassroots;
- iv. The County, in collaboration with partners, should support continuous community involvement in the Covid-19 interventions, which would engender community ownership and facilitate the development of community driven strategies. This would also enhance ownership and sustainability of such efforts;
- v. The National and County Governments, through the MoH, should prioritize health promotion and establish strong relationships with key stakeholders, gatekeepers, influencers in implementing behavior change communication;
- vi. Both County and National Governments and other stakeholders work through the CORPs, people with disabilities and other influencers as change agents in the delivery of health messages in their communities; and
- vii. There is a need for the National Government to support the establishment of a health promotion national structure to harness and build the health promotion capacities at the national, county, sub-county and community levels.

3. BACKGROUND

3.1 Introduction

The International Union for Health Promotion and Education (IUHPE) was invited by the World Health Organization (WHO) and Vital Strategies to develop health promotion and education actions, to support ongoing response to the Covid-19 pandemic in the African continent in line with the Best Buys identified by Vital Strategies and partners. This was with the recognition that countries in the WHO African Region are the least prepared for infectious disease threats with an average readiness score of 39 out of 100, according to robust external assessments (see Annex 4 for documentation on best buys shared by vital strategies). Weak health systems, which face a huge burden of disease, underfunding and lack of human resources contribute to this problem. The participating countries in this project are Kenya, South Africa, Zambia, Zimbabwe, and India. The AIHD, in partnership with Kisii County, developed health promotion and education actions, to support ongoing response to the Covid-19 pandemic using the Risk Communication and Community Engagement (RCCE) planning tool.

Situation Analysis: In December 2019, a novel coronavirus, SARS-CoV-2, was identified as the cause of an outbreak of viral pneumonia in Wuhan, China. The disease, later named Coronavirus Disease 2019 (Covid-19), subsequently spread globally. The disease has rapidly evolved in Kenya since it was first reported on the 13th March 2020. As of 27th October 2021, 252,938 persons tested positive for Covid-19 with 246,505 recoveries and 5,266 Covid-19 related deaths. In terms of vaccination a total of 4,084,297 (5.5% of the population) adults have been vaccinated countrywide; 3,576,875 (first dose) and 1,507,422 (second dose) (MoH Kenya, 2021).

3.2 Project Aim, Objectives and Rationale

Aim: The project aimed to engage with key stakeholders in planning, designing, and implementing a range of RCCE interventions, based on health promotion principles: empower individuals and communities to make informed decision stop and control the spread of the disease within communities equitably while protecting people’s basic needs and their physical and mental health.

Objectives: Considering the efforts of National and County Governments, the MoH, health implementing partners and other actors, as well as international partners such as World Health Organization (WHO), United Nations Children’s Fund (UNICEF), International Federation of Red Cross (IFRC), World Bank and much larger Non-Governmental Organizations (NGOs) operating in the country such as CARE International and World Vision in addressing the pandemic, this project pursued the following objectives:

- i. To engage local communities and key stakeholders in the Covid-19 response and empower them to reduce the spread;
- ii. To enable local communities to protect themselves, their families, and communities by embracing effective behavioural action to stop and control further spread of Covid-19 in their communities;
- iii. To ensure that community level implementation is informed by best available knowledge, research and resources on effective RCCE; and

- iv. To create community coalitions to coordinate local responses adapted to the needs of local communities.

Rationale: The project focused on communication in crisis and the concrete ways in which this can be supported over a period of time from a health promotion perspective. Central to this non-medical health promotion approach to the Covid-19 crisis was the need to increase people's control over their health. This would require enabling individuals and communities to acquire the knowledge, skills, and efficacy to take preventive behavioural actions and access support and services that would protect and promote their health in the face of the pandemic.

4. PLANNING PHASE

The selection of the project implementation site, Kisii Central ward in Kitutu Chache South Sub-County, was informed by consultations and deliberations between the lead teams (Kisii County and AIHD). The design of the project was informed by the risk population characteristics and needs. The ward is a populous, high transit, peri-urban setting with major markets, busy bus termini in the county and has the highest number of Covid-19 cases; 1339 (51.3 %) of the total cases in Kisii county (MoH SITREP, 2021). It is also inhabited by a group of marginalized community – the Nubians.

Inception meetings were held in the month of July 2021 with the County Health Management Team (CHMT) and Sub-County Health Management Team (SCHMT) where AIHD introduced the project, its objectives and designed a workplan for implementing the project in the community. During the deliberations, the County head of disease surveillance presented the County Covid- 19 situation report for the month of July 2021. Moreover, risk groups were identified to be: (i) the youth since they believe the disease is for the elderly; (ii) public transport operators (*boda-boda*² riders, *matatu*³ crew) due to their contact time with high numbers of different passengers along the routes they ply; (iii) market vendors due to high turnover and heightened transit within the market and congestion due to limited space; and (iv) the *Nubian* community because they are a marginalized community and have a high poverty index. The project team members had specific roles to play on the project as illustrated in Table 1

² Bicycles and motorcycle taxis commonly found in East Africa.

³ A minibus or similar vehicle used as a taxi

Table 1: Terms of Reference for the Project team

| Category | Members | Role |
|--|--|---|
| County lead person | County Director of Public Health | Liaison: Kisii County/ Partner |
| | County Coordinator Head of Health Promotion | -Support supervision and Coordination -Onwards transmission of progress and reports upwards |
| Sub-County Coordinators and Supervisors | Sub County Medical Officer - Health Sub County Health Promotion Officers and Community Health Strategy Service Coordinators | -Support Supervision during implementation of the project -Supervising the Community Own Resource Persons (CORPs) during stipulated activities -Sharing activity reports -Documenting concerns and needs felt in the various communities |
| Technical and financial support | AIHD | -Country Liaison with international partners/donors -Facilitation of project implementation |

Source: AIHD, 2021

Baseline Evaluation: The baseline aimed to generate evidence that would guide the implementation of the project and inform the design and focus areas of the project; highlight gaps that need to be addressed during community engagement sessions as well as help compare behavior among different target groups. Specifically, the study aimed 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 the Covid-19 preventive measures by communities; iv) understand the barriers, rumors, misinformation, fear and stigma associated with Covid-19; v) examine the effects/impact of Covid-19 to the community; and vi) understand how the community is addressing /responding to Covid-19 to curb its spread.

A cross sectional study design was used to collect data using both qualitative and quantitative tools from the target population for the baseline assessment. Quantitative data were collected using a questionnaire (249 respondents randomly sampled from the community as per project target locations) and observation checklist. Qualitative data were collected by conducting focus group discussions (FGDs) and key informant interviews (KIIs). Participants for FGDs and KIIs were selected purposefully from the influencers and risk groups in the community.

The key baseline assessment findings included:

- i. *Sources of information:* Majority of the respondents (94%, n=249) said their main source of information on Covid-19 was through the media with the most preferred media being radio, Tv and social media (90.8%). Other sources of information mentioned included health care providers (2%), family members (1.2%), community leaders (0.4%), religious leaders (2%) and workplace (0.4%)
- ii. *Knowledge on Covid-19:* Majority (78% n=249) of the respondents were aware of the pandemic, its origin, symptoms and prevention measures. The most common form of preventive measure being practiced in the community was wearing of masks at 90%, handwashing (88%) and keeping social distance at 51%. On whether they had seen

Covid-19 awareness done in the community in the past three months, a high percentage of the respondent (78%) of them said they had seen awareness being conducted in their respective villages with the remaining 22% saying that they had not seen any form of awareness.

- iii. *Attitudes, perceptions, stigma and barriers to adoption of Covid-19 measures:* Majority (83%, n=249) of the respondents acknowledged the severity of the disease with a small proportion (11%) of respondents comparing it to harmless influenza. The community perceived the elderly (85%) as the high-risk population as well as people with comorbidities (41.8%) and children under 5 years (22.9%). It was evident from the results that families with covid -19 deaths and recoveries were the most stigmatized at 47% and 35% respectively; followed by people who had travelled into the country from perceived high-risk areas 26.1%, foreigners at 23.9% and healthcare workers at 16%. The major barriers to adoption of preventive measures were attitudes and perceptions (52%), incorrect knowledge about the disease (32.5%) and financial constraints (31.3%).
- iv. *Psychosocial effects of Covid-19:* Participants in the study were asked to state their general wellbeing since the start of Covid-19. Almost half (48%) of the respondents expressed fear and anxiety, 43% were stressed and 9% lived their normal lives. The major fear regarding Covid-19 was dying from the disease 55%, fear of being infected 36% and fear of being isolated at 6%. Most people (55%) lost their main source of income as they closed their businesses because of the pandemic while 27% said they had lost their jobs.
- v. *Management and testing of Covid-19:* Only a small percentage (10%) of those interviewed had been tested for Covid-19 with 92% saying they would go to hospital if they tested positive for the disease. Moreover, 65.1% mentioned using concoction, (22.9%) mentioned treatment with conventional medicine and 5.2% using traditional medicine. When asked about self-medication, a majority (76.7%) said no to self-medication while 23.3% said they would self-medicate.
- vi. *Covid-19 vaccination uptake among the respondents:* There was a low uptake of the Covid-19 vaccine with only 12.9 % of the respondents having received the jab while 58% of the respondents said they were willing to be vaccinated and 42% said they will not get the vaccine. Some of the reasons cited against uptake of the vaccine included fear and stigma associated with Covid-19 (20.7%), fear of side effects (56.5%), lack of trust in the vaccine (25%) and lack of information on the vaccine (31.5%).
- vii. *Health seeking behaviour in relation to Covid-19:* A majority (94%) of the study participants said they would go to hospital should they become sick during the pandemic period. The other 6% shared the following reasons against going to the health care facilities in case they fell sick: fear of being asked to test for Covid-19 before treatment, fear of health care providers who could be infected, fear of being isolated or quarantined, lack of medicine and lack of trust in the healthcare providers.

It was clear from the baseline study that despite the MOH emphasizing on adherence to Covid-19 preventive measures, people had lowered their guard. It was observed during the baseline assessment that less than 50% of the study population put on their masks properly while the rest had no masks, or they were worn improperly/are in their pockets. People had a lot of misinformation's and misconceptions due to absence of correct information in the

community. It was evident that the RCCE strategy will go a long way to impart knowledge and increase awareness on preventive measures.

4.1 Selection and training of CORPs

Through a consultative process between the SCHMT, influencers were selected based on their perceived level of positive influence, acceptability, and the respect they commanded within their groups. They included the youth leaders, religious leaders, transport sector representatives, market vendors representatives, and the Nubian community leaders. The identified CORPs were empowered through training, commissioned as change agents, and encouraged to continue community conversations at individual, family, community, workplace and within other social spaces.



Figure 1: Consultative meeting with key stakeholders
(Photo by AIHD)

A training manual for the community (see Annex 5) was used. The training adopted plenary presentations facilitated by the health promotion team and group discussions. At the end of the training, the CORPs:

- Had a clear understanding of the Sub-County RCCE plan and their role in supporting its implementation;
- Identified the key audiences and the influencers in the communities;
- Could define and prioritize key RCCE objectives;
- Identified the myths, misconceptions, rumours and misinformation in their communities;
- Identified the most at-risk individuals in their jurisdictions;
- Developed workable action plans to be implemented in their respective areas, which were refined by the health promotion team; and
- Were well informed on types of vaccines available in the country, vaccine importance, eligibility criteria and side effects. Misinformation causing hesitancy was also demystified.

4.2 Identification of Risk Groups

Greater interactions with more people without following the laid down prevention measures puts an individual at greater risk of contracting the disease. The identification of risk groups was informed by evidence generated from the Kisii Covid-19 data, whereby priority was given to the cohorts reporting high numbers of new infections and the patterns in distribution. Further considerations were made from analyzing the social settings, occupation, socialization, or behavioral characteristics in relation to the Covid-19 prevention guidelines. The high-risk groups identified were the youth, public transport (*boda boda* riders, matatu crew), market vendors and the *Nubians*.

5. PROJECT IMPLEMENTATION PHASE

The project employed a multi-strategy approach through advocacy, community engagement, social mobilization, community preferred media and social media.

5.1 Advocacy: this is a powerful tool for negotiation with high level influencers and decision makers to disseminate information for intended action, persuade for support, commitment and build synergy when rallying for action (Kaldy, 2021). As such, an entry advocacy meeting was held in the APDK hall in Kisii County. This meeting brought together several stakeholders and opinion leaders including Sub-County Health Management Team (SCHMT), Sub-County Administrator, Officer Commanding Police Station, Ward Administrator, Area Chiefs, Village Leaders, representatives from the transport sector, business community, youths, people with disability and the Clergy.



Figure 2: Stakeholder's meeting (Photo by AIHD)

The aim of the meeting was to introduce the objectives of the project, gain entry into the ward and advocate for active participation and support of the activities. The consultative meeting resulted in the development of an action plan and selection of CORPs. The stakeholders observed that most community members had regressed on prevention and control of Covid-19 resulting in soaring cases. Moreover, resolutions on how the community could be empowered to accept vaccination and sustain preventive behavior change geared towards prevention of Covid-19 were explored and agreed upon.

5.2 Capacity building: This involved selection and training of 25 CORPS for 2 days. The CORPs were selected based on their representation and level of influence among the risk groups in the community. This selection was facilitated by key stakeholders and opinion leaders in the ward such as the local administration, County and SCHMT and local leaders. The CORPs were inclusive of PWDs, youth (both male and female), the clergy, leaders from transport sector (*matatu crew and boda boda*), leaders from the market vendors, *Nubians*, among others. Health promotion officers and community health service officers and other key healthcare providers came up with a training manual that was used during the training. Capacity building for the CORPs aimed at achieving shared understanding of strategies, approaches, activities, and key messages to be disseminated during the implementation.



Figure 3: CORPs Training (Photo by AIHD)

The following approaches were used during the training: lectures, group discussions and presentations, demonstrations, and role plays. The aim of the training was to equip the CORPs

with the correct information package and empower them to have various conversations with their peers at the community level (Progovac et al., 2020). The participants were introduced to Covid-19 including definition, modes of transmission, signs, and symptoms, prevention, and vaccination. Other topics covered included identification of various risk groups and analyzing their unique characteristics; documentation of rumors, myths, misconceptions, misinformation and discussing on how to demystify them; types of vaccines available, vaccine importance and side effects, vaccine misinformation; map and identify sites to carry out the implementation and allocation of designated groups to sites to be visited on each day during the implementation period. During the training, majority of participants confessed to understanding what Covid-19 was and could explain the key symptoms.

5.3 Social Behavior Change Communication (SBCC): Use of SBCC ensures tailor made approaches to address specific target groups or audiences using more sustainable, and acceptable approaches to improve attitudes, thus enabling people to initiate and sustain positive behavior. It provides an opportunity to disseminate intended information, interrogate present behavior, or trigger self-evaluation at an individual and the social aspects, while weighing the risks and consequences as opposed to the benefits of embracing the desired positive behavior being promoted (Glanz & Rimer, 2005; Glanz & Bishop, 2010; HC3, 2014). In this regard, tailor-made messages were designed and disseminated to each of the target audience addressing the present behavior, the desired behavior and a rallying call for individual and collective call to action. Activities used for this approach, carried out by the CORPs, included interpersonal communication and small group conversations done with peers at workplaces, social settings and at community and household levels.

5.4 Branding and identification of implementation teams: Branding during an activity or



Figure 4: Branded CORPs and facilitators (Photo by AIHD)

event helps to draw recognition in the vicinity, exhibits shared values and meaningful coexistence of all players of an organized group. During awareness creation activities for the project, such as roads walks, the implementation team donned branded reflector jackets and sashes which had a unifying message **“#Social Mobilizers #Changeagents”** a statement that

drew attention with people wanting to know what the group members were doing. Furthermore, the walks also made a significant statement to the onlookers/standbys, pedestrians and motorists driving along the roads.

5.5 Media: Media has a crucial role in communication and is widely trusted as a source of credible information because it can reach a wide variety of audience. The project used media as a key strategy to enhance communication through available preferred and previously used



Figure 5: County HPO addressing the media after the road show launch.(Photo by AIHD)

channels in the community. As a result, community radio stations such as Egesa FM, Minto FM, TV stations such as Getembe and K24 TV <https://youtu.be/8TvRDbxsOVc> were selected and used by HPOs where they addressed key issues on Covid-19. Approximately 450,000 people were reached during live discussions on Covid-19 issues (as assessed by the media stations).

5.6 Community Mobilization and engagement

The following strategies were used for community mobilization and engagement:

- i. **Road walks:** These were held during project implementation and brought together SCHMT, CORPs, administrative officers, opinion leaders and influencers from the two sublocations. The intention of the walks was to pull crowds and create awareness to the targeted audiences on risk factors that could lead to an increase in the spread of Covid-19. At the end of the road walk, people converged in a central place where they were sensitized on Covid-19.
- ii. **Use of Public Address System (PAS):** A PAS is an electronic system comprising microphones, amplifiers, loudspeakers, and related equipment (Barbera, & Zeitzoff, 2018). The messages disseminated during this period focused on Covid-19 prevention and control measures, emergency operation centre services, demystifying inappropriate information, vaccination, among others. The PAs helped in mobilizing the community as the loud instruments could amplify the sound to reach areas where the vehicle could not.
- iii. **Community conversations:** This strategy was used to engage the community members on Covid-19 prevention and control at the community level. Misinformation, myths, rumors, and misconceptions were addressed during these conversations. Additionally, this strategy allowed demonstrations of appropriate ways of wearing masks and proper hand washing techniques. The CORPs and the team leads were branded in sashes and reflector jackets for ease of identification during the community engagement forums.
- iv. **Social Networks:** A social network is a group of individuals (such as friends, acquaintances, and coworkers) connected by interpersonal relationships (Kim, & Hastak, 2018). Social networks ensure messages are passed on to several people

through the various platforms. This strategy was key during the implementation period since it helped the project team to work with key influencers who were proposed by the community members, among them being risk target population as presented earlier. All of them were empowered with key Covid-19 prevention messages as change agents within their communities. The use of social networks helped the project team to reach the marginalised migrant community (Nubians) since the influencers were well known within their communities. It also helped in the identification of different social behaviours among different target groups.

6. ENDLINE EVALUATION

The project team undertook an end of project evaluation whose overall purpose was to assess progress in the achievement of the project objectives, identify and document the lessons learnt in the implementation of the project and make appropriate recommendations. Triangulation of data was undertaken to improve validity of the results. Secondary data related to the project was used to fill information gaps from primary sources. The main objective of the evaluation was to determine the results of the Covid-19 Health Promotion interventions. Specifically, the evaluation sought to: i) assess progress in the achievement of the project objectives, ii) identify and document the lessons learnt in the implementation of the project, and iii) make appropriate recommendations. Furthermore, the evaluation questions investigated the following aspects: relevance, effectiveness, efficiency, sustainability, impact, coherence, and appropriateness of the project.

6.1 Methods

6.1.1 Assessment design: The assessment utilized a cross-sectional study design conducted using both qualitative and quantitative tools. Quantitative data were collected using a questionnaire, while qualitative data were collected by conducting KIIs and community forums. The sample of respondents for the quantitative data was arrived at by utilizing multi-stage sampling design. Stratification was done as per project target locations (Kitutu central ward) while systematic sampling was employed in the selection of the study subjects in the community. A total of 255 respondents were selected for quantitative endline assessment. The respondents were people aged 18 years and above who had resided in the area for more than 12 months and had agreed to take part in the survey. Participants for the qualitative data collection were selected purposefully from the influencers and risk groups in the community; 6 KIIs (influencers) and two (2) community forums/conversations (with boda boda riders and market vendors) were conducted.

6.1.2 Assessment site and team: The assessment was done in the project site. The assessment team comprised of Kisii CHMT, research assistants (RAs) and supervisors supported technically by the team from AIHD.

6.1.3 Data collection tools: The assessment utilized a range of tools and study techniques as outlined below.

i) Quantitative data: The data were collected through questionnaires prepared in open data kit (ODK) and uploaded on to smart phones for near real time transmission of the results. The data collected focused on the following indicators: sociodemographic information, Covid-19

knowledge, attitudes, practices, health seeking behavior, project relevance, effectiveness, efficiency and sustainability in the targeted study site.

ii) Qualitative data: KIIs were conducted at the same time as the collection of quantitative data. A total of six (6) KIIs were conducted with the risk groups, community influencers and frontline health care workers who were purposively selected to take part in the interviews. They were recorded after seeking permission from the respondent. Community conversations/forums were held with risk populations where information on knowledge, adherence to MoH guidelines, vaccine uptake, misinformation, myths, rumors, and misconceptions on Covid-19 were discussed.

6.1.4 Recruitment and training of research assistants (RAs): A total of 6 RAs were selected from the target community and underwent a two-day training to acquire knowledge on how to collect data from the study area. The training also included pre-test of the data collection tools. After the training they were deployed. Data collection was undertaken from 18th to 21st October 2021.

6.1.5 Data Processing and Analysis: Quantitative data were transferred near real time during data collection and analysed using the statistical package for social sciences (SPSS) and excel. Content analysis was used for qualitative data with emergent themes recorded in an Excel matrix. Frequencies and cross-tabulations were produced to provide a general description of the respondents' characteristics. Detailed analysis was based on the objectives and presented in the form of text, tables, and graphs.

6.1.6 Ethical considerations: The study team aimed at meeting ethical standards and to create conditions that would produce quality data. The assessment team upheld the following standards/ethics throughout the assignment:

- i. Great care was taken to provide honest and clear information about the objectives of the assessment and how the results would be used. The principle of informed consent was applied in all areas of the assessment.
- ii. All team members and RAs were briefed to ensure respect, protection and promotion of the rights of the study participants.
- iii. The principle of anonymity and confidentiality was applied in the sense that none of the quotes reported would be identifiable to the respondents. The participants were also assured of their liberty not to participate in any activity they might find uncomfortable.
- iv. The assessment team sought ethical approval from the African Medical Research Foundation (AMREF) Ethics and Scientific Review Committee (ESRC), National Commission for Science Technology and Innovation (NACOSTI) and adhered to the MoH guidelines on controlling the spread of the virus. The findings of the studies will inform program implementation, interventions and provide a baseline for scale-up to other counties or countries.

6.2. Endline Study Results

This chapter presents the findings of the endline evaluation study. The results are presented in text, graphs and tables for ease of comprehension and interpretation. This section is structured alongside the study themes based on Covid-19 awareness, sources of information,

attitude, practices, health seeking behavior, vaccine uptake, relevance, effectiveness, efficiency and sustainability of the project in the targeted study site.

6.2.1 Socio-demographic characteristics

A total of 255 respondents were interviewed: 129 in Township and 126 in Mwamosioma sub-locations. The data indicated that slightly more than half (53.7%, n=255) of the respondents were female while 46.3% were male. From the respondents interviewed, it emerged that 14.9% (n=255) were aged between 18-24 years, 20% were aged between 25-29, and 23.5% were aged 50+ years while the rest of the age categories accounted for less than 15%. When asked about their level of education, it was clear that a high number of the respondents (45.1%, n=255) had attained *secondary level* of education, followed by primary level at 23.1%), *tertiary/technical college* at 20.0% and *no education* at 5.5%. A small percentage (6.3%) of the respondents reported to have attained *university level* of education.

In terms of primary occupation, about a quarter (21.7%, n=249) of those who were interviewed engaged in *small-scale enterprises*, followed by *agricultural activities* (21.4%), *no work* 14.6%, *homemaker/housewife* (11.7%) and *day worker* at (10.1%). Those who reported *students*, *private employment*, *civil servant/Government official* and *pension/retired* accounted for (8.3%), (5.8%), (1.8%) and (1.6%), respectively. Regarding marital status, majority (69.4%, n=255) were married, 24.3% were single, 5.5% widowed, 6.4% separated and 0.4% divorced. Majority of the respondents (90.2%, n=255) had lived in the study area for more than six months. Table 2 presents a summary on the socio-demographic characteristics across the two study sublocations.

Table 2: Sociodemographic characteristics of respondents

| Sociodemographic characteristic | | N=255 | Percentage (%) |
|---------------------------------|------------------|-------|----------------|
| Sub location | Township | 129 | 50.6 |
| | Mwamosioma | 126 | 49.4 |
| Sex | Male | 118 | 46.3 |
| | Female | 137 | 53.7 |
| Age | Mean | 38.81 | |
| | SD | 14.90 | |
| | Min | 18 | |
| | Max | 90 | |
| | 18 – 24 | 38 | 14.9 |
| | 25 – 29 | 51 | 20.0 |
| | 30 – 34 | 34 | 13.3 |
| | 35 – 39 | 28 | 11.0 |
| | 40 – 44 | 19 | 7.5 |
| | 45 – 49 | 25 | 9.8 |
| 50+ | 60 | 23.5 | |
| Marital status | Married | 177 | 69.4 |
| | Single | 62 | 24.3 |
| | Widowed | 14 | 5.5 |
| | Separated | 1 | 0.4 |
| | Divorced | 1 | 0.4 |
| Level of Education Completed | No education | 14 | 5.5 |
| | Primary school | 59 | 23.1 |
| | Secondary school | 115 | 45.1 |

| | | | |
|--|--|-----|------|
| | Tertiary college/technical college | 51 | 20.0 |
| | University | 16 | 6.3 |
| Current Occupation | Homemaker / housewife | 27 | 10.6 |
| | Agricultural activities (e.g. farming, fishing) | 56 | 22.0 |
| | Day worker (e.g. factory, construction) | 27 | 10.6 |
| | Small scale enterprise (e.g. kiosk owner, market stall etc.) | 53 | 20.8 |
| | Student | 15 | 5.9 |
| | Private employment (e.g. bank, business etc.) | 20 | 7.8 |
| | Civil servant / government official | 17 | 6.7 |
| | No work | 35 | 13.7 |
| | Pension/ retired | 4 | 1.6 |
| | Others are: watchman | 1 | 0.4 |
| Presence of disability | Yes | 11 | 4.3 |
| Type of disability | Mobility/physical impairments | 7 | 2.7 |
| | Visual impairment | 4 | 1.6 |
| Duration lived or worked in the location | Less than a month | 3 | 1.2 |
| | 1-3 months | 10 | 3.9 |
| | 4-6 months | 12 | 4.7 |
| | Over 6 months | 230 | 90.2 |

Source: (AIHD) Endline Assessment, 2021

6.2.2 Covid-19 Awareness

The respondents were aware of Covid-19 disease and the ways in which it is transmitted. Majority (83.1%, n=255) cited that one can contract it through contact with infected persons, touching of contaminated surfaces (62%), droplets from infected people (56.5%) and airborne disease (18%). Only a small percentage (1.6%) of the people interviewed said they did not know how it is transmitted. Moreover, the study participants were aware of the symptoms of Covid-19.

In terms of how the disease is manifested, it emerged that 85.5%, n=255 of them reported that the disease is manifested through cough, fever (80%), headache (73.3%), difficulty in breathing (58.4%), shortness of breath (40.8%), loss of taste and smell (23.5%) and body ache and muscle ache (23.1%). However, a few (0.4%) of the respondents said they did not know the symptoms of Covid-19. This is an improvement from the baseline findings where most of the respondents (75%, n=249) cited that one can contract the disease through contact with infected persons, touching of contaminated surfaces (49%) and droplets from infected people (53%), 19% saying that it's an airborne disease. Only a small percentage (3%) of the people interviewed said they did not know how it is transmitted. Table 3 gives a summary of the knowledge on Covid-19 transmission routes and symptoms.

Table 3: Covid-19 transmission routes and symptoms

| | | Township (n=129) | Mwamosioma (n=126) | Total (N=255) |
|-----------------------------|--|------------------|--------------------|---------------|
| COVID-19 transmission means | Contact with infected people | 77.5 | 88.9 | 83.1 |
| | Touching contaminated objects/surfaces | 51.9 | 72.2 | 62.0 |
| | Sexual intercourse | 0.0 | 0.8 | 0.4 |

| | | | | |
|----------------------|---------------------------------|------|------|------|
| | Blood transfusion | 0.8 | 1.6 | 1.2 |
| | Droplets from infected people | 57.4 | 55.6 | 56.5 |
| | Airborne | 16.3 | 19.8 | 18.0 |
| | Mosquito bites | 0.0 | 0.0 | 0.0 |
| | Eating contaminated food | 0.0 | 0.8 | 0.4 |
| | Drinking unclean water | 0.0 | 0.8 | 0.4 |
| | Don't know | 3.1 | 0.0 | 1.6 |
| | Other (Kissing and handwashing) | 0.8 | 1.6 | 1.2 |
| Symptoms of covid-19 | Fever | 77.5 | 82.5 | 80.0 |
| | Cough | 82.9 | 88.1 | 85.5 |
| | Headache | 71.3 | 76.2 | 73.7 |
| | Shortness of breath | 34.9 | 46.8 | 40.8 |
| | Difficulty in breathing | 54.3 | 62.7 | 58.4 |
| | Loss of taste and smell | 21.7 | 25.4 | 23.5 |
| | Body and muscle ache, | 20.2 | 26.2 | 23.1 |
| | Diarrhoea | 4.7 | 2.4 | 3.5 |
| | Don't know | 0.8 | 0.0 | 0.4 |

Source: (AIHD) Endline Assessment, 2021

From the KIIs conducted, it was established that most of the community members were aware of Covid-19. Regarding adherence to MoH guidelines, it emerged that there was laxity as noted by key informants interviewed:

“People should learn to embrace that Covid-19 is with us and they should take the necessary precautions.” (KII – Infection Prevention and Control head).

“As much as cases are slowly coming down, we should continue to adhere to MoH guidelines...we are not out of the woods yet” (KII – Health care provider).

“Community members should keep in mind that it is not business as usual ...this disease is still with us” (KII – local leader).

6.2.3 Sources of information on Covid-19

A majority of the respondents (91%, n=255) said their main source of information on Covid-19 was through the media with the most preferred media being radio (87.8%, n=255), TV (59.6%) and social media (18.4%). Other sources of information mentioned included health care providers (16.9%), CORPs (4.7%), chiefs (3.1%), family members and friends (2.7%) and website (0.4%) as shown in Table 4.

Table 4: Community main/preferred sources of information on Covid-19

| | | Township (n=129) | Mwamosioma (n=126) | Total (N=255) |
|---|--|------------------|--------------------|---------------|
| Source of the information on Covid-19 virus | TV | 71.3 | 74.6 | 72.9 |
| | Radio | 88.4 | 93.7 | 91.0 |
| | Social media (blogs, twitter, WhatsApp, Facebook etc.) | 38.8 | 29.4 | 34.1 |
| | CORPs (community leaders and influencers) | 7.8 | 7.1 | 7.5 |
| | Websites | 2.3 | 4.0 | 3.1 |
| | Family and friends | 10.1 | 14.3 | 12.2 |
| | Chiefs | 4.7 | 1.6 | 3.1 |
| | Mobile phones | 10.1 | 13.5 | 11.8 |
| | Health workers | 21.7 | 23.8 | 22.7 |

| | | | | |
|--|--|------|------|------|
| The preferred source for getting information on Covid-19 | TV | 63.6 | 55.6 | 59.6 |
| | Radio | 84.5 | 91.3 | 87.8 |
| | Social media (blogs, twitter, WhatsApp, Facebook etc.) | 19.4 | 17.5 | 18.4 |
| | CORPs (community leaders and influencers) | 3.1 | 6.3 | 4.7 |
| | Websites | 0.0 | 1.6 | 0.8 |
| | Family and friends | 2.3 | 3.2 | 2.7 |
| | Chiefs | 3.9 | 2.4 | 3.1 |
| | Mobile phones | 4.7 | 1.6 | 3.1 |
| | Health workers | 14.7 | 19.0 | 16.9 |

Source: (AIHD) Endline Assessment, 2021

6.2.4 Covid Management, Attitudes and Prevention Practises in the Community

When asked what they would do in case they suspected to have contracted Covid-19, a high percentage (79.6% n=255) of the respondents mentioned they would go to the hospital, (25.1%) would quarantine oneself, (15.3%) would seek advice from a knowledgeable person, (8.2) would buy medicine in pharmacy and (1.6%) would go to a traditional healer.

When asked about the barriers to adherence to prevention measures, a majority cited financial constraints (55.7%, n=255), followed by poor attitudes and perceptions (51.4%), incorrect knowledge on the disease (44.7%), stress (13.3%) and alcoholism (0.4%). In terms of practicing social distance, more than a third (34.5%, n=255) of the respondents reported that they always practice social distance, 20.8% never practice, 20.4% practise sometimes, 17.3% rarely practise while 7.1% practise often, as shown in Table 5.

Table 5: Summary results on Covid management in the community

| | | Township (n=129) | Mwamosioma (n=126) | Total (N=255) |
|--|---|------------------|--------------------|---------------|
| If there is a suspected case of COVID-19, what is done | Go to hospital | 76.7 | 82.5 | 79.6 |
| | Buy medicine in pharmacy | 7.0 | 9.5 | 8.2 |
| | Go to traditional healer | 1.6 | 1.6 | 1.6 |
| | Quarantine oneself | 25.6 | 24.6 | 25.1 |
| | Seek advice from a knowledgeable person | 15.5 | 15.1 | 15.3 |
| The barriers to adhering to Covid-19 prevention measures | Financial constraints | 54.3 | 57.1 | 55.7 |
| | Incorrect knowledge on the disease | 45.7 | 43.7 | 44.7 |
| | Stress | 10.9 | 15.9 | 13.3 |
| | Attitudes and perceptions | 51.2 | 51.6 | 51.4 |
| | Other: Alcoholism | 0.0 | 0.8 | 0.4 |
| Level of community practicing social distancing while visiting shops, marketplaces or when on public transport | Always | 33.3 | 35.7 | 34.5 |
| | Often | 9.3 | 4.8 | 7.1 |
| | Sometimes | 14.7 | 26.2 | 20.4 |
| | Rarely | 18.6 | 15.9 | 17.3 |
| | Never | 24.0 | 17.5 | 20.8 |

Source: (AIHD) Endline Assessment, 2021

Attitudes and perceptions greatly impact the adherence to the Covid-19 prevention measures. In terms of the attitude of the respondents on Covid-19, the score was above average as follows; I believe any of us can get Covid-19 and Covid-19 is a dangerous disease (mean, 3.6), after I know of a case of someone with COVID-19 in my community I feel

worried/scared (mean, 3.5), our community can prevent transmission of Covid-19 and I am worried I can get and transmit the virus to my family (mean, 3.4), a mask can prevent transmission of Corona Virus (mean, 3.2) and Covid -19 is a harmless disease (mean, 2.7) as presented in Table 6.

Table 6 Summary results of attitudes and perceptions in the community

| | Min | Max | Mean | SD |
|--|-----|-----|------|-----|
| I believe any of us can get COVID-19 | 1 | 4 | 3.6 | 0.6 |
| Our community can prevent transmission of COVID-19 | 0 | 4 | 3.4 | 0.7 |
| I am worried I can get and transmit the virus to my family | 0 | 4 | 3.4 | 0.7 |
| A mask can prevent transmission of Corona Virus | 0 | 4 | 3.2 | 0.8 |
| Covid -19 is a harmless disease | 0 | 4 | 2.7 | 1.3 |
| COVID-19 is a dangerous disease | 0 | 4 | 3.6 | 0.7 |
| After I know of a case of someone with COVID-19 in my community, I feel worried/scared | 2 | 4 | 3.5 | 0.6 |
| The government's call for COVID-19 preventive efforts are important for my community | 0 | 4 | 3.4 | 0.8 |

The interpretation: The mean score of above 2 is above average, the closer it is to 4 the better and closer is it to 0 the worst attitudes towards Covid-19 virus: Source: (AIHD) Endline Assessment, 2021

Moreover, the study participants understood Covid-19 preventive measures and they mentioned their main practises to ensure the disease was prevented, this is scored as follows: I follow and adhere to government curfew requirements (mean, 3.5); I wash hands with soap and water and I wear masks correctly (mean, 3.3); I maintain social/physical distancing when in crowded areas and I use alcohol-based hand sanitizer in the absence of soap and water for hand hygiene (mean, 2.8 and 2.6 respectively); I disinfect objects and work surfaces and if I suspect I have COVID-19 I will take herbs or traditional medicine (mean, 2.5 and 2.0 respectively) as depicted in Table 7.

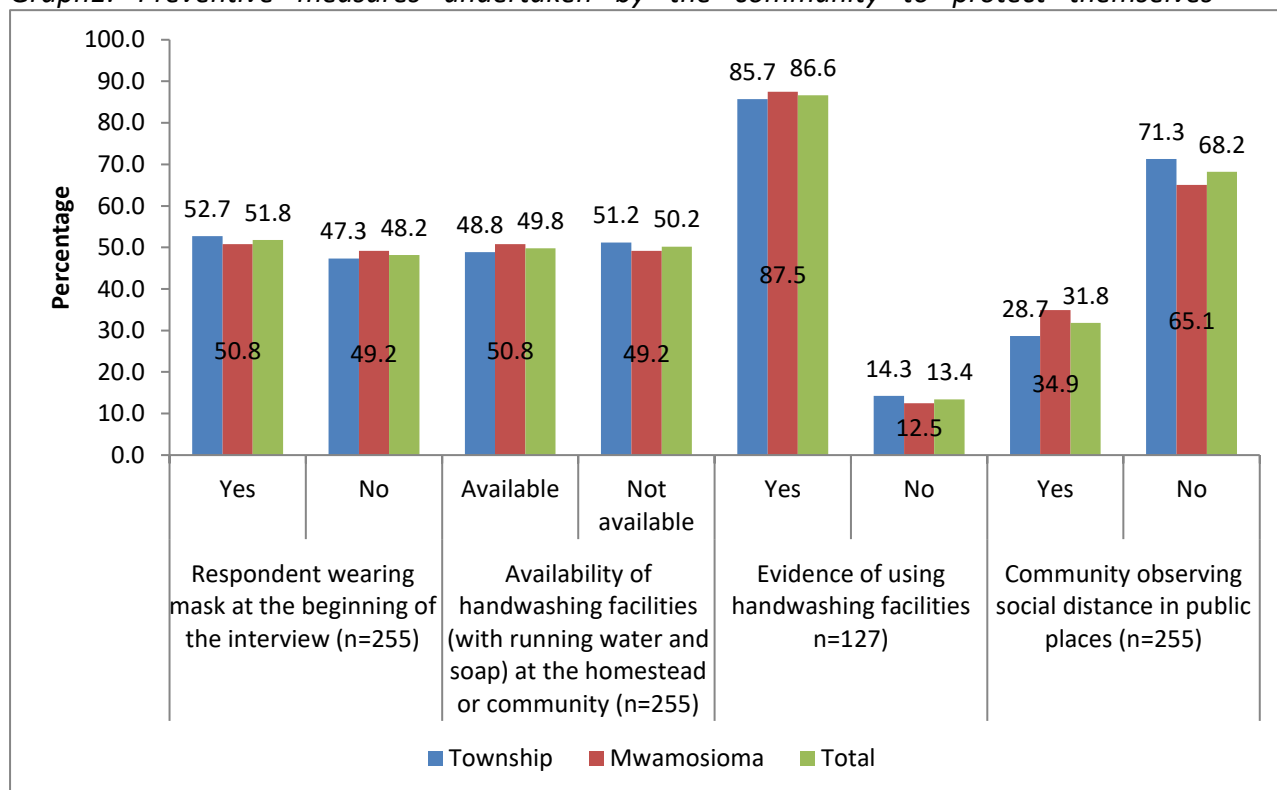
Table 7: Summary results on prevention practice statements

| | Min | Max | Mean | SD |
|--|-----|-----|------|-----|
| I wash hands with soap and water | 1 | 4 | 3.3 | 0.8 |
| I wear masks correctly (covering mouth and nose) | 1 | 4 | 3.3 | 0.8 |
| I maintain social/physical distancing when in crowded areas | 0 | 4 | 2.8 | 1.2 |
| I use alcohol-based hand sanitizer in the absence of soap and water for hand hygiene | 0 | 4 | 2.6 | 1.2 |
| If I suspect I have COVID-19, I will take herbs or traditional medicine | 0 | 4 | 2.0 | 1.7 |
| I disinfect objects and work surfaces | 0 | 4 | 2.5 | 1.4 |
| I follow and adhere to government curfew requirements | 1 | 4 | 3.5 | 0.7 |

The interpretation: The mean score of above 2 is above average, the closer it is to 4 the better and closer is it to 0 the worst attitudes towards Covid-19 virus: Source: (AIHD) Endline Assessment, 2021

Observation findings: An observation section in the questionnaire was used to measure adherence to the Covid-19 prevention measures among the respondents. The following is what was observed: slightly more than half (51.8%, n=255) of the respondents wore masks during the interview, 49.8% (n=255) of the respondents had handwashing facilities (with 86.6%, n=127 evidence of use), while 50.2% of the respondents had no handwashing facilities. More than two-thirds of the respondents (68.2 %, n=255) did not observe social distance while 31.8 kept the 1.5 metre distance as depicted in Graph 1.

Graph1: Preventive measures undertaken by the community to protect themselves



Source: (AIHD) Endline Assessment, 2021

Moreover, during community conversations, the following ways were mentioned by the respondents on how they would protect themselves from Covid-19. A youth leader echoed:

“By practicing regular handwashing, wearing masks correctly and practising social distancing in the youth meetings” (KII, Youth leader).

A transport sector representative mentioned:

“By placing handwashing facilities in various bus/matatu stops to promote handwashing and wearing masks correctly” (KII, Boda boda rider).

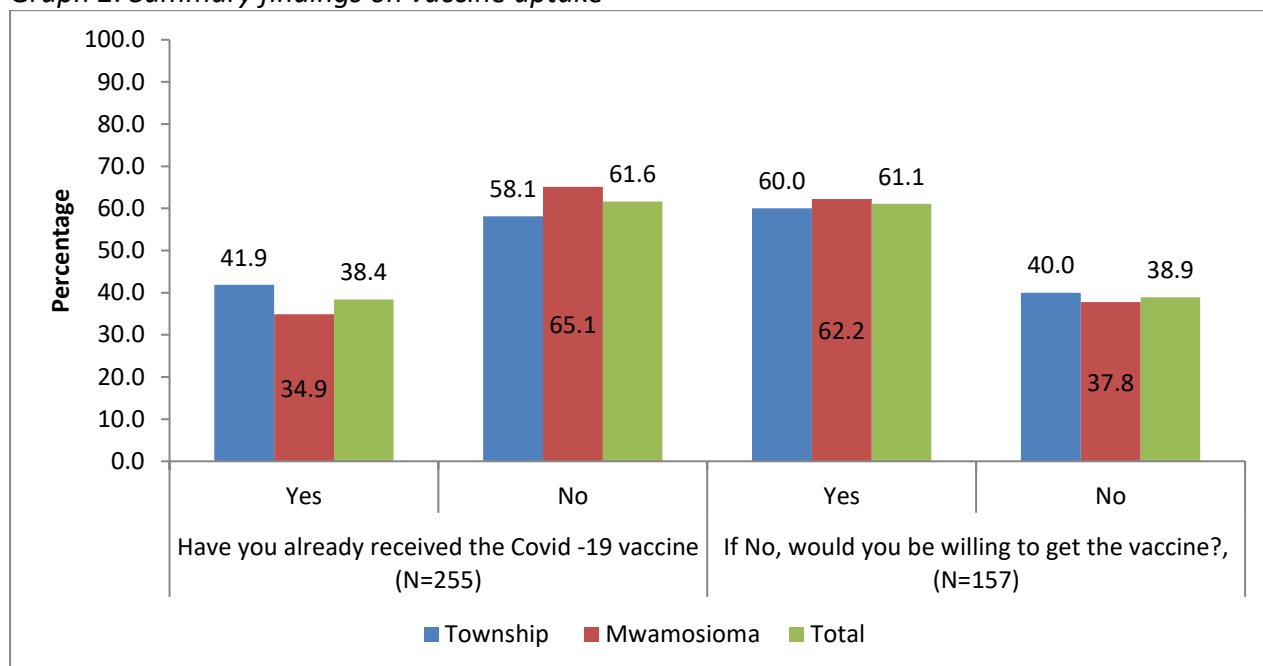
Yet another respondent stated:

“By placing hand water facilities at the entrance of the church to allow for handwashing, providing free masks to the members of the church and sanitizing the microphone often” (KII, Religious leader).

6.2.5 Vaccine uptake

On the uptake of the Covid-19 vaccine, it is evident that about two-thirds (61.6%, n=255) had not received the vaccine while (38.4%) had been vaccinated, which was an increase from the baseline results (12.9%, n=249). Almost two-thirds of the respondents (61.1%, n=255) were willing to receive the vaccine while 38.9% were unwilling as illustrated in Graph 2.

Graph 2: Summary findings on vaccine uptake



Source: (AIHD) Endline Assessment, 2021

Nevertheless, for those who had not been vaccinated and were unwilling to take the covid-19 vaccine, slightly more than half of them (52.5%, n=61) mentioned fear of the side effects as the main reason hindering vaccine uptake, followed by no trust in the vaccine (23%, n=61) as well as stigma associated with Covid-19 (21.3%, n=61) as summarized in Table 8.

Table 8: Summary findings on reasons for vaccine hesitancy

| | Township (n=30) | Mwamosioma (n=31) | Total (n=61) |
|--|-----------------|-------------------|--------------|
| Normally, I am scared of injections | 10.0 | 19.4 | 14.8 |
| Fear and stigma associated with Covid-19 | 23.3 | 19.4 | 21.3 |
| I have a pre-existing condition such as diabetes, hypertension, HIV/AIDS, etc. | 13.3 | 9.7 | 11.5 |
| I fear the side effects | 43.3 | 61.3 | 52.5 |
| It's against my beliefs (cultural/religious beliefs) | 0.0 | 3.2 | 1.6 |
| I do not have trust in the vaccine | 13.3 | 32.3 | 23.0 |
| I do not have adequate information about this vaccine | 10.0 | 16.1 | 13.1 |
| Others: Still giving birth and who will provide or work for me | 3.3 | 3.2 | 3.3 |

Source: (AIHD) Endline Assessment, 2021

The same sentiments were echoed during qualitative inquiries thus:

“The youths believe they are immune and therefore think that the vaccine is not necessary. The male gender believe it will affect them sexually and they fear the side effects of the vaccine such as blood clotting” (KII- youth leader).

Yet another key informant opined that:

“Some people believe vaccine is a way in which government acquires funds from the developed countries” (KII - Healthcare worker).

A religious leader noted that:

“There is media misinformation about the vaccine especially social media platforms such as Facebook...religious beliefs is another big hindrance ...some religious leaders advice their congregation not to take the vaccine” (KII, Religious leader).

Moreover, to boost vaccine uptake the following suggestions were made during the conversations:

“Social mobilization should be conducted often, and vaccination should be conducted in public places such as markets and terminus to capture many people” (KII, youth leader)

Another study participant noted that:

“The Government should go to the grassroot level by using the various leaders in the community to encourage members to get vaccinated...since the campaigns have begun, politicians should advice their supporters during their campaign meetings to get vaccinated” (KII, Health care worker).

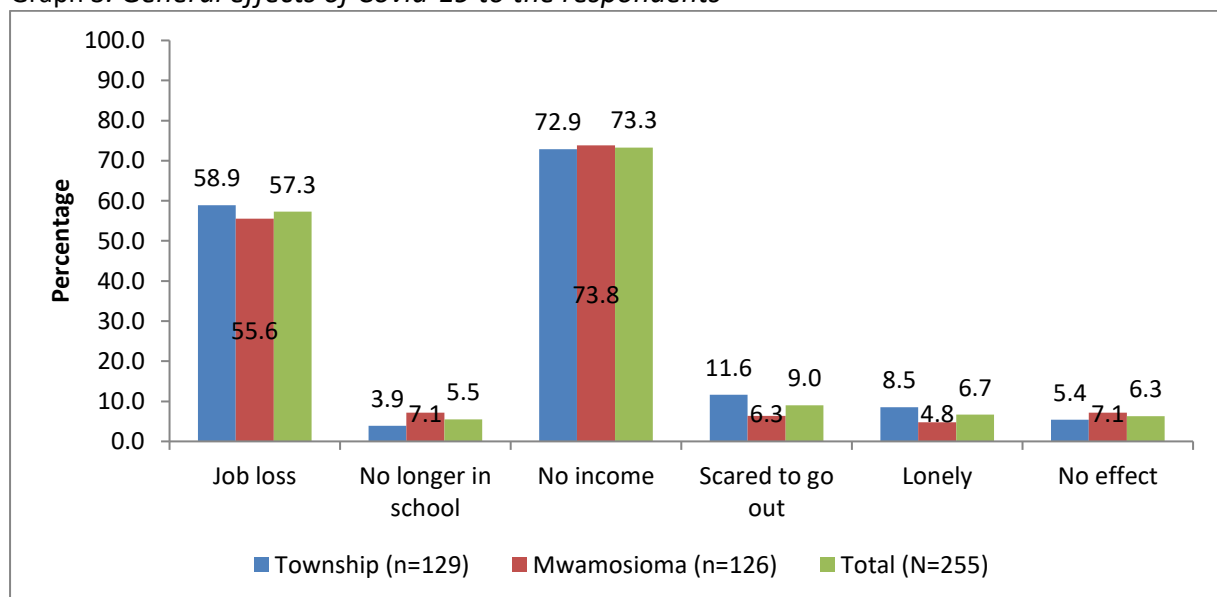
Yet another informant opined that:

“Those who have been vaccinated to encourage others to take the vaccination and the government should give more education on Covid -19 vaccine and the various types being given out” (KII, transport sector representative).

6.2.6 General effects of Covid-19

Participants in the study were asked to state how Covid-19 had affected them. Majority (73.3%, n=255) cited no income, and more than half (57.3%, n=255) expressed job loss, 5.5%, (n=255) said they were no longer in school while the rest accounted for less than 15% as shown in Graph 3.

Graph 3: General effects of Covid-19 to the respondents



Source: (AIHD) Endline Assessment, 2021

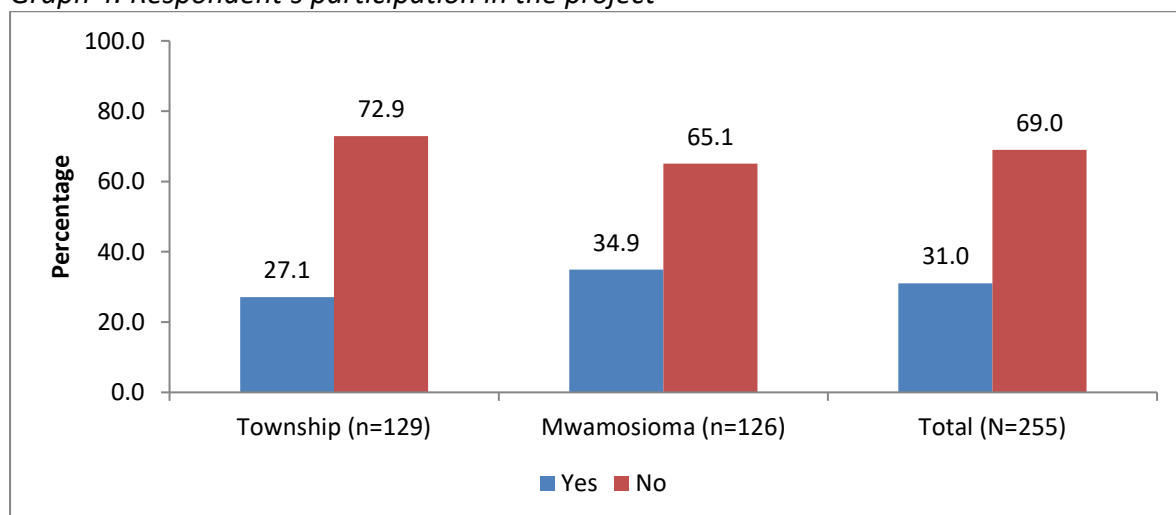
6.2.7 Synthesis of Findings using the RE-AIM Framework

Project Reach: The findings revealed that the project activities were in line with the National Government and Kisii County strategic direction concerning the response of the Covid-19 pandemic. The project was found to be aligned with the needs identified by the communities. Furthermore, the activities conducted under the project were aligned to the Kisii County Health Promotion objectives. In addition, the project complemented the County efforts of boosting vaccine uptake and preventing the transmission of Covid-19 among vulnerable populations in the county by establishing efficient and effective community-based awareness raising methods. The evaluation assessed relevance in terms of community perspective. The discussions held with the community representatives during the implementation and monitoring activities revealed that the project activities implemented addressed a felt community need. During the evaluation, community members mentioned that the project contributed to their understanding of the disease, and their prevention efforts. Approximately 450,000 people were reached during live discussions on Covid-19 issues (as assessed by the local media stations).

Project Effectiveness: The survey assessed knowledge of Covid-19 by collecting data on awareness of the disease. All participants in the survey had heard about Covid-19. Notably, 7.5% of the respondents who had heard about Covid-19 mentioned CORPS among their main source of information. Based on these findings, it was notable that the project activities may have influenced community knowledge levels on Covid-19.

The respondents were asked if they had participated in a health promotion project on Covid-19 in the last 6 months. Over two-thirds (69%, n=255) mentioned that they had not, while (31%, n=255) mentioned they had participated in a project as shown in Graph 4.

Graph 4: Respondent's participation in the project



Source: (AIHD) Endline Assessment, 2021

The respondents who had participated in the health promotion project on Covid-19 (31%, n=255) mentioned that they had been talked to at their workplace which included the bus stage, matatu terminus, their business stalls, the market, the *boda boda* stage among others; all which are locations which the Covid-19 Health Promotion project had targeted. Other

locations mentioned were the church, health facilities and at home. During the KIIs, participants were asked about the role they played in the project. A key informant noted that:
“Encouraging people to get the vaccine in hospitals and to follow the preventive measures that have been set aside by the MoH” (KII, Youth leader).

Yet another participant reported:

“Training of the CORPS chosen, giving them key messages on infection, prevention and control of Covid and participating in the Roadshows” (KII, Healthcare worker).

Another study participant observed that:

“I participated during the road show and it was well receivedwe created awareness on the importance of adhering to MoH guidelines” (Boda boda rider).

Project Impact: The evaluation study revealed that although the Government through the MoH was key in creating awareness countrywide, the project had made a difference in terms of increasing knowledge and understanding of the target communities on Covid-19.

Some of the respondents attributed their understanding of the disease on the interaction and information they had received from the CORPs who had been trained by the project. Compared with baseline data, there was some improvement in terms of understanding of the disease. It should be noted that during project implementation other social mobilization were taking place in the county and country which could also have contributed to the reported increase.

Capacity building was a core activity for the project. A total of 25 CORPs were trained under the project and were involved in implementation of the project activities. Through the training and involvement of the community resource persons, the targeted project locations capacity in terms of response to Covid-19 was improved. The evaluation revealed that the resource persons continued to engage the community in different dimensions concerning the disease. Additionally, the involvement of the HPOs, Sub-County Administrator and CORPs contributed to improved knowledge on health promotion and exposure to health promotion strategies and interventions as mentioned during qualitative inquiries include:

“The Covid-19 awareness level and vaccination numbers among the youth have increased, people especially the youth have started adhering to the Covid-19 preventive measures and have changed their attitude towards Covid 19” (KII- Youth leader).

Another respondent noted that:

“The community members were given information on how they should prevent themselves from getting Covid-19, many people have volunteered to be vaccinated and a lot of myths and misconceptions on the vaccines have been demystified” (KII, Healthcare worker).

During the evaluation, respondents were asked how information on Covid-19 added value in prevention and control of the disease. Majority, (91.1%, n=79) of the study participants reported that the project increased their knowledge, (82.3%, n=79) mentioned it enhanced

vaccination, (64.6%, n=79) said it improved adherence to MoH prevention measures and improved health seeking behavior (40.5%, n=79) as shown in Table 9.

Table 9: Summary findings on Covid-19 value addition in the community

| | | Township (n=35) | Mwamosioma (n=44) | Total (n=79) |
|--|--|--------------------|----------------------|-----------------|
| Type of information on COVID-19 received | Washing/sanitizing of hands | 100.0 | 100.0 | 100.0 |
| | The need to physically and social distance | 88.6 | 95.5 | 92.4 |
| | Proper wearing of masks | 74.3 | 81.8 | 78.5 |
| | Seeking healthcare when sick | 48.6 | 56.8 | 53.2 |
| | Covid-19 vaccination | 74.3 | 61.4 | 67.1 |
| How the information on COVID-19 added value in prevention and control of the disease | Heightened adherence to MoH guidelines | 62.9 | 65.9 | 64.6 |
| | Increase in knowledge on the disease | 85.7 | 95.5 | 91.1 |
| | Enhanced vaccination acceptance | 85.7 | 79.5 | 82.3 |
| | Improved health seeking behavior | 51.4 | 31.8 | 40.5 |
| To what extent have you and your households benefited from the information? | A little extent | 20.0 | 6.8 | 12.7 |
| | Moderate extent | 25.7 | 38.6 | 32.9 |
| | Greater extent | 54.3 | 54.5 | 54.4 |

Source: (AIHD) Endline Assessment, 2021

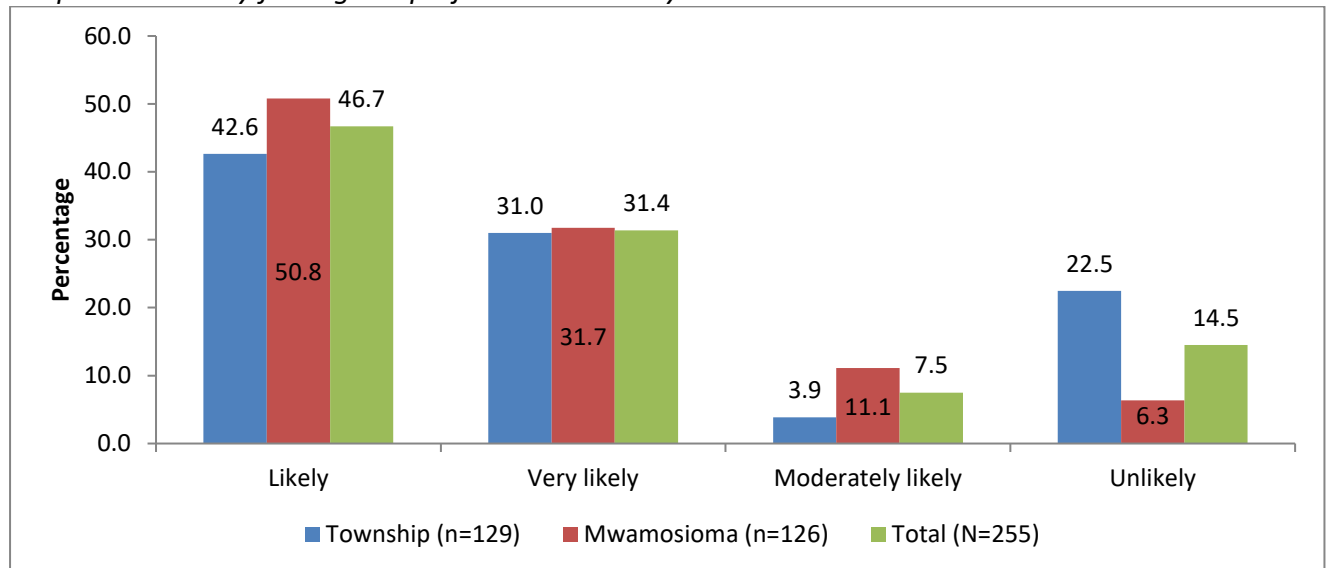
Project Adoption: Coherence and Appropriateness: The evaluation revealed that during the project design stage, consultations were held between different stakeholders. The baseline assessment results informed the design of the project and ensured that the project fitted with other Covid-19 activities or interventions undertaken by the County. The baseline also informed the development of the implementation plan, where existing Health Promotion Strategies and interventions were used, while referencing to the Kisii Covid-19 RCCE strategy. The consultations and regular review and monitoring of the project ensured avoidance of duplication by the County or other health actors. By undertaking the baseline assessment, the project implementers and other stakeholders ensured that evidence-based health promotion activities were proposed and implemented.

Project Efficiency: In terms of implementation timelines, the study established that the project was implemented within the planned timelines. Comparing the results of the project vis-à-vis the amount of resources invested, there was value for money. The evaluation established that competitive bidding was used for selection and purchase of project goods and services.

Project Maintenance and Sustainability: The project sought to invest resources and skills in community members, as a sustainable intervention towards greater empowerment in prevention of Covid-19. The evaluation revealed that the project enhanced the participation of community members through different approaches in prevention of Covid-19. The project utilized locally available resources, it identified resource persons from the target locations and trained them on different aspects of Covid-19. These resource persons were involved and actively took lead in implementation of the project activities. Through the project's capacity enhancement activities, the targeted communities and project locations will continue to benefit beyond the funding period. The fact that the project was implemented by Kisii health team, there is already internal capacity to enhance and scale up the best practices. As

presented in Graph 5, it is evident that the project achievements will continue after the project life.

Graph 5: Summary findings on project sustainability



Source: (AIHD) Endline Assessment, 2021

Further, study participants were asked about the likelihood that they would continue to practice what they had learnt from the project even after the close of the project. A key informant noted that:

“I will encourage people to get vaccinated and in church I will encourage members to social distance and follow all the MoH guidelines to prevent spread of Covid- 19” (KII, religious leader).

The same sentiments were echoed by another study participant, thus:

“We will continue to put into practice what the medical people told us during campaigns ...wearing of masks, washing of hands, avoiding shaking of hands ...” (Market vendor).

Partnership

The presence of the AIHD as the main partner for this project helped the County Government and specifically the HPO to penetrate the community. The AIHD provided necessary resources that helped in mapping of stakeholders for this project and training of the CORPs. Additionally, the project provided necessary resources for implementation of the activities including facilitation and branding for the CORPs and team leads for purposes of creating awareness. Lastly, the project supported monitoring and evaluation (M&E) activities. The importance and strength of this partnership is that they supported the project from inception, implementation and till completion of the project. The experience between the partners has set the pace for other partners to embrace RCCE activities in the country to combat Covid-19. It is therefore, expected that the MoH at the County level will continue supporting the project sustainability of the existing expertise at the County and community levels.

It is notable that the AIHD has a partnership with the County on Non-Communicable Diseases. The experiences gained during the implementation of this project and the contacts made will

be utilized in accelerating the implementation of the project. It is also anticipated that the HPO and the other healthcare workers now appreciate the health promotion principles better and will use the same approaches with other partners.

7. LESSONS LEARNT, CONCLUSION AND RECOMMENDATIONS

7.1 Lessons Learnt

- i. The success of any initiative depends on the effort put in capacity building. The participation and involvement of the CHMT, SCHMT, CORPS, the community, the media and other relevant stakeholders in the project will contribute to the ownership and sustainability of this initiative.
- ii. The communities can provide solutions to their own problems, they only need to be empowered with knowledge to make decisions to protect themselves, their families, and the entire community.
- iii. PWDs can be used as a change agents to foster inclusion and acceptability in the community.
- iv. The community responds positively when influencers practice correctly what they are asking the risk groups to do. All CORPs and health promotion officers adhered to the guidelines on prevention and control of Covid-19.
- v. Flexibility during project implementation is key given the complexities and dynamics of the current environment in which we operate in.
- vi. Future programming should involve the community members for project ownership and sustainability.

7.2 Use and dissemination of project results

The project results will be used to inform future programs and policy makers on best practices. There was dissemination of the research findings to IUHPE, other implementing partners and key stakeholders. The partners presented the results in reader friendly forms and popular versions for ease of access by many people in the community. For effective follow-up, the project had invested resources and skills in community members, as a sustainable intervention towards greater empowerment in prevention of Covid-19. This approach focused on ensuring community members understand how to continue caring for themselves even after the project completion.

7.3 Conclusion

The Covid-19 Health Promotion project provided an avenue for delivery of effective RCCE to communities in Kisii County, while ensuring their participation and achievement of sustainable practices (including increased control in taking measures and vaccine uptake) that contributed to the prevention of Covid-19 infection and transmission among the targeted communities. The evaluation findings provide evidence of the results attributable to the project. 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 showed 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.

7.4 Recommendations

- i. The County should build on the results to sustain and scale-up the gains made including the partnership with CORPs to mobilize communities for health actions;
- ii. There is a need for an elaborate partnership agreement among partners to ensure that communities are effectively mobilized and supported for health action;
- iii. Invest in increased advocacy and outreach to boost vaccine uptake at the grassroots;
- iv. The County, in collaboration with partners, should support continuous community involvement in the Covid-19 interventions, which would engender community ownership and facilitate the development of community driven strategies. This would also enhance ownership and sustainability of such efforts;
- v. The National and County Governments, through the MoH, should prioritize health promotion and establish strong relationships with key stakeholders, gatekeepers, influencers in implementing behavior change communication;
- vi. Both County and National Governments and other stakeholders work through the CORPs, people with disabilities and other influencers as change agents in the delivery of health messages in their communities; and
- vii. There is a need for the National Government to support the establishment of a health promotion national structure to harness and build the health promotion capacities at the national, county, sub-county and community levels.

8. REFERENCES

- Barberá, P., & Zeitzoff, T. (2018). The new public address system: why do world leaders adopt social media?. *International Studies Quarterly*, 62(1), 121-130.
- Hahn, R. A., & Truman, B. I. (2015) Education Improves Public Health and Promotes Health Equity. *Int J Health Serv*, 45(4), 657–678.
- Kaldy, J. (2021). Leadership, Advocacy, and Communication in Crisis: COVID-19 and Beyond. *Caring for the Ages*, 22(1), 16.
- Kim, J., & Hastak, M. (2018). Social network analysis: Characteristics of online social networks after a disaster. *International Journal of Information Management*, 38(1), 86-96.
- KNBS (census report,2019)
- Njuguna, J. (2019). Progress in sanitation among poor households in Kenya: evidence from demographic and health surveys. *BMC public health*, 19(1), 1-8.
- Progovac, A. M., Cortés, D. E., Chambers, V., Adams, L. B., Jean-Claude, S., Willison, C. E., ... & Cook, B. L. (2020). Addressing Major Health Disparities Related to Coronavirus for People With Behavioral Health Conditions Requires Strength-Based Capacity Building and Intentional Community Partnership. *World medical & health policy*, 12(3), 242-255.
- Waisbord S. Where Do We Go Next? Behavioural and Social Change for Child Survival. *Journal of Health Communication*, vol. 19 (sup 1), 2014, pp. 216–222, doi:10.1080/10810730.2014.933288
- WHO, UNICEF, IRC. Risk Communication and Community Engagement (RCCE) Action Plan Guidance COVID-19 Preparedness and Response. 16 March 2020. Available from: [https://www.who.int/publications-detail/risk-communication-and-community-engagement-\(rcce\)-action-plan-guidance](https://www.who.int/publications-detail/risk-communication-and-community-engagement-(rcce)-action-plan-guidance)
- World Health Organization (WHO). Communicating Risk in Public Health Emergencies. A WHO Guideline for Emergency Risk Communication (ERC) policy and practice. Geneva: WHO; 2017. Available from: <https://www.who.int/risk-communication/guidance/download/en/>
- World Health Organization (WHO). Risk communication and community engagement preparedness and readiness framework: Ebola response in the Democratic Republic of Congo in North Kivu. Geneva: World Health Organization; 2018. Available from: <https://apps.who.int/iris/handle/10665/275389>

9. ANNEXES

Annex 1. Household and Community Endline Evaluation Questionnaire

Endline Assessment

Risk Communication and Community Engagement (RCCE) Strategy in Kisii County, Kenya

Questionnaire for community members

| |
|--------------------------|
| Identification |
| IDENTIFICATION NUMBER: |
| INTERVIEW DATE: |
| INTERVIEWER NAME: |
| START TIME OF INTERVIEW: |

Notes to enumerators:

- Do not read the answers unless directed to in the question instructions.
- Responses that are numbered (1, 2, 3...) mean that only one response is allowed.
- Responses that are lettered (a, b, c...) mean that more than one response is allowed

Introduction

Good morning/afternoon. My name is..... I am from Kisii County, Health Services Department. We are conducting a study to determine the effectiveness of the Risk Communication and Community Engagement (RCCE) strategy. You have been selected to participate in this discussion because you are a member of this community and because your views are important. I therefore kindly request you to share your honest opinion on the issues we will be discussing.

Your participation in this discussion is voluntary and you are free not to discuss any issue you feel uncomfortable with, and this will not affect you in any way. The information you provide shall be kept in confidence and will only be used for the purposes of this study. This discussion will last approximately 30 minutes.

Do you have any questions or comments before we proceed?

Interviewer: (If any question/comment, please first address them before proceeding with the interview).

Consent:

Consent given:

1. Yes ()
2. No [STOP INTERVIEW]

Section 1: Socio - Demographic information

1. Geographic identifiers **(To be pre-filled)**

- a) County: _____
- b) Sub-County _____
- c) Ward: _____
- d) Location: _____
- e) Village: _____

2. Gender **(Select one)**

1. Male
2. Female
3. Intersex

3. How old are you (years)? _____ **(numeric)**

4. Marital status **(Select one)**

1. Married
2. Single
3. Widowed
4. Separated
5. Divorced
6. Other, specify _____

5. What is the highest level of formal education you have completed? **(Select one)**

1. No education
2. Primary school
3. Secondary school
4. Tertiary college / technical college
5. University
6. Other, specify: _____

6. What is your current occupation? **(Select one)**

1. Homemaker / housewife
2. Agricultural activities (e.g. farming, fishing)
3. Day worker (e.g. factory, construction)
4. Small scale enterprise (e.g. kiosk owner, market stall etc.)
5. Student
6. Private employment (e.g. bank, business etc.)
7. Civil servant / government official
8. No work
9. Pension/ retired
10. Other (specify): _____

7. Any physical disability? **(Select one)**

1. Yes
2. No (SKIP to Q9)

8. If yes, specify type of disability **(Select one)**

- a) Mobility/physical impairments
- b) Visual impairment
- c) Hearing impairment
- d) Speech
- e) Mental impairment
- f) Self-care
- g) Other Specify

9. How long have you lived or worked in this location? **(Select one)**

- 1. Less than a month
- 2. 1-3 months
- 3. 4-6 months
- 4. Over 6 months

Section 2: General Information on Covid-19

10. Have you heard about COVID-19? **(Select one)**

- 1. Yes
- 2. No

11. If yes, what was the source of the information TV? **(More than one response is possible)**

- a) Radio
- b) Social media (blogs, twitter, WhatsApp, Facebook etc.)
- c) CORPs (community leaders and influencers)
- d) Websites
- e) Family and friends
- f) Chiefs
- g) Mobile phones
- h) Health workers
- i) Others (specify): _____

12. What is your preferred source for getting information on Covid-19? **(More than one response is possible)**

- j) TV
- k) Radio
- l) Social media (blogs, twitter, WhatsApp, Facebook etc.)
- m) CORPs (community leaders and influencers)
- n) Websites
- o) Family and friends
- p) Chiefs
- q) Mobile phones
- r) Health workers
- s) Others (specify): _____

13. How has COVID-19- 19 affected you or any member of your household? **(More than one response is possible)**

- a) Job loss

- b) No longer in school
- c) No income
- d) Scared to go out
- e) Lonely
- f) No effect
- g) Other, specify: _____

14. How is COVID-19 transmitted? **(More than one response is possible)**

- a) Contact with infected people.
- b) Touching contaminated objects/surfaces
- c) Sexual intercourse
- d) Blood transfusion
- e) Droplets from infected people
- f) Airborne
- g) Mosquito bites
- h) Eating contaminated food
- i) Drinking unclean water
- j) Don't know
- k) Other (specify): _____

15. What are the symptoms of covid-19 that you are aware of? **(More than one response is possible)**

- a) Fever
- b) Cough
- c) Headache
- d) Shortness of breath
- e) Difficulty in breathing
- f) Loss of taste and smell
- g) Body and muscle ache,
- h) Diarrhoea
- i) Don't know
- j) Other (specify): _____

16. If there is a suspected case of COVID-19, what would you do? **(Select one)**

1. Go to hospital
2. Buy medicine in pharmacy
3. Go to traditional healer
4. Quarantine oneself
5. Seek advice from a knowledgeable person

17. What are the barriers to adhering to Covid-19 prevention measures? **(More than one response is possible)**

- a) Financial constraints
- b) Incorrect knowledge on the disease
- c) Stress
- d) Attitudes and perceptions
- e) Other, specify: _____

18. Do people in your community practice social distancing while visiting shops, marketplaces or when on public transport? **(Select one)**

- 1. Always
- 2. Often
- 3. Sometimes
- 4. Rarely
- 5. Never

19. Have you already received the Covid -19 vaccine that is being given by government? **(Select one)**

- 1. Yes (SKIP to Q22)
- 2. No

20. If No, would you be willing to get the vaccine? **(Select one)**

- 1. Yes
- 2. No

21. If No, what is hindering you from accepting the vaccine? **(More than one response is possible)**

- a) Normally, I am scared of injections
- b) Fear and stigma associated with Covid-19
- c) I have a pre-existing condition such as diabetes, hypertension, HIV/AIDS, etc.
- d) I fear the side effects
- e) It's against my beliefs (cultural/religious beliefs)
- f) I do not have trust in the vaccine
- g) I do not have adequate information about this vaccine
- h) I do not qualify for it (am not under the target group)
- i) Other, specify_____

22. COVID-19 Attitude Statements: **For each of the following statements, score as follows:**

- 1. Strongly Agree
- 2. Agree
- 3. Neutral
- 4. Disagree
- 5. Strongly Disagree

| No. | Statement (Read the statements to the Respondent) | Score |
|-----|--|-------|
| a) | I believe any of us can get COVID-19 | |
| b) | Our community can prevent transmission of COVID-19 | |
| c) | I am worried I can get and transmit the virus to my family | |
| d) | A mask can prevent transmission of Corona Virus | |
| e) | Covid -19 is a harmless disease | |
| f) | COVID-19 is a dangerous disease | |
| g) | After I know of a case of someone with COVID-19 in my community, I feel worried/scared | |
| h) | The government's call for COVID-19 preventive efforts are important for my community | |

23. COVID-19 Practice Statements: **For each of the following statements, score as follows as measures taken by the respondent to prevent getting Covid-19**

- 1. Always
- 2. Often
- 3. Sometimes
- 4. Rarely
- 5. Never

| No. | Statement (Read the statements Respondent) | Score |
|-----|---|-------|
| 1. | I wash hands with soap and water | |
| 1. | I wear masks correctly (covering mouth and nose) | |
| 1. | I maintain social/physical distancing when in crowded areas | |
| 1. | I use alcohol-based hand sanitizer in the absence of soap and water for hand hygiene | |
| 1. | If I suspect I have COVID-19, I will take herbs or traditional medicine | |
| 1. | I sensitize my work colleagues, friends, family, and other people around me on protecting themselves from COVID-19? | |
| 1. | I disinfect objects and work surfaces | |
| 1. | I follow and adhere to government curfew requirements | |

Section 3: Measures undertaken by community to protect themselves, their families and Community (Interviewer's observation – record as observed)

24. Respondent wearing mask at the beginning of the interview **(Select one)**
1. Yes
 2. No
25. Observe availability of handwashing facilities (with running water and soap) at the homestead or community where the data collection is being done **(Select one)**
1. Available
 2. Not available (SKIP to Q27)
26. If available, is there evidence of use **(Select one)**
1. Yes
 2. No
27. Community observing social distance in public places?
1. Yes
 2. No

Section 4: Community and Key Stakeholder Engagement and Empowerment in the COVID -19 Response and Prevention

Assessing Relevance, Efficiency, Effectiveness and Sustainability of the Project

28. In the past one 6 months, did you or any member of your household participate in a project, implemented by the County, on prevention and control of Covid-19?
1. Yes
 2. No (SKIP to Q32)
29. What type of information on COVID-19 did you receive? **(More than one response is possible)**
- a) Washing/sanitizing of hands
 - b) The need to physically and social distance
 - c) Proper wearing of masks
 - d) Seeking healthcare when sick
 - e) Covid-19 vaccination
 - f) Others (specify): _____
30. How has the information on COVID-19 added value in prevention and control of the disease?
- a) Heightened adherence to MoH guidelines
 - b) Increase in knowledge on the disease
 - c) Enhanced vaccination acceptance

- d) Improved health seeking behaviour
- e) Other, specify: _____

31. To what extent have you and your households benefited from the information? **(Select one)**

- 1. A little extent
- 2. Moderate extent
- 3. Greater extent
- 4. Not at all

32. What is the likelihood that you will continue to practice what you learnt from this project even after the close of the project? **(Select one)**

- 1. Likely
- 2. Very likely
- 3. Moderately likely
- 4. Unlikely

Any further comments/suggestions

Take GPS coordinates

| |
|---|
| END TIME OF INTERVIEW : _____ |
| RESULT OF INTERVIEW: COMPLETE: _____ |
| INCOMPLETE: _____ REASON: _____ |
| INTERVIEW NOTES: (add a section here) |

Thank you for your cooperation

Annex 2. Household and Community Baseline Assessment Questionnaire

Covid-19 questionnaire for community members

| |
|--------------------------|
| Identification |
| IDENTIFICATION NUMBER: |
| INTERVIEW DATE: |
| INTERVIEWER NAME: |
| START TIME OF INTERVIEW: |

Notes to enumerators:

- Do not read the answers unless directed to in the question instructions.
- Responses that are numbered (1,2,3...) mean that more than one response is allowed
- Responses that are lettered (a,b,c...) mean that only one response is allowed.

Introduction

Good morning/afternoon. My name is..... I am from Kisii County. We are conducting a study to determine the effectiveness of the Risk Communication and Community Engagement (RCCE) strategy. You have been selected to participate in this discussion because you are a member of this community and because your views are important. I therefore kindly request you to share your honest opinion on the issues we will be discussing.

Your participation in this discussion is voluntary and you are free not to discuss any issue you feel uncomfortable with, and this will not affect you in any way. The information you provide shall be kept in confidence and will only be used for the purposes of this study. This discussion will last approximately 30 minutes.

Do you have any questions or comments before we proceed?

Interviewer: (If any question/comment, please first address them before proceeding with the interview).

Consent:

Consent form signed:

3. Yes ()
4. No [STOP INTERVIEW]

Section 1: Sociodemographic information

2. Geographic identifiers (To be pre-filled)

1. County: _____
2. Sub-County _____
3. Ward: _____
4. Location: _____
5. Village: _____

2. Gender **(Circle one)**
 - a) Male
 - b) Female
 - c) Intersex
3. How old are you (years)? _____ **(numeric)**
4. Marital status **(Circle one)**
 - a) Married
 - b) Single
 - c) Widowed
 - d) Separated
 - e) Divorced
 - f) Other, specify _____
5. What is the highest level of formal education you have completed? **(Circle one)**
 - a) No education
 - b) Primary school
 - c) Secondary school
 - d) Tertiary college / technical college
 - e) University
 - f) Other, specify _____
6. What is your current occupation? **(Circle one)**
 - a) Homemaker / housewife
 - b) Agricultural activities (e.g. farming, fishing)
 - c) Day worker (e.g. factory, construction)
 - d) Small scale enterprise (e.g. kiosk owner, market stall etc.)
 - e) Student
 - f) Private employment (e.g. bank, business etc.)
 - g) Civil servant / government official
 - h) No work
 - i) Pension/ retired
 - j) Other (specify): _____

Section 2: Covid-19 awareness

1. Have you heard about Covid-19? **(Tick one)**

Yes ()

No ()
 2. Have you heard/seen Covid-19 awareness done in your area (workplace, home, or community in the last 3 months)? **(Tick one)**

Yes ()

No ()
- If Yes, what type of information on COVID-19 did you receive? **(Circle all you know)**
- a) Washing hands
 - b) The need to physically and social distance
 - c) Use of masks
 - d) Seeking healthcare
 - e) Any other.

If any other, please explain _____

3. How is covid-19 transmitted? **(Circle all you know)**

1. Contact with infected people.
2. Touching contaminated objects/surfaces
3. Sexual intercourse
4. Blood transfusion
5. Droplets from infected people
6. Airborne
7. Mosquito bites
8. Eating contaminated food
9. Drinking unclean water
10. Don't know

4. What are the symptoms of covid-19 that you are aware of? **(Circle all you know)**

1. Fever
2. Cough
3. Headache
4. Shortness of breath
5. Difficulty in breathing
6. Loss of taste and smell
7. Body and muscle ache,
8. Diarrhoea
9. Don't know
10. Other.....

5. Have you or your family members had covid-19 disease confirmed by a laboratory test? **(Tick one)**

Yes ()

No ()

If yes what did you or they do? **(Select one)**

- a) Go to hospital
- b) Buy medicine in pharmacy
- c) Go to traditional healer
- d) Quarantine oneself
- e) Seek advice from a knowledgeable person

6. What preventive measures do you and your family take to stop the spread of and contracting covid-19? **(Circle all actions you take)**

1. Wash hands regularly using soap and water
2. Wearing mask in public places
3. Using disinfectants at home to clean surfaces
4. Using hand sanitizer
5. Avoid touching the face
6. Covering mouth and nose with tissue paper when sneezing
7. Coughing inside of an elbow
8. Avoiding close contact with anyone who has a fever and cough
9. Avoiding going out when having flu-like symptoms or sick
10. Don't know

Section 3: Sources of information

1. What is your main source of information on covid-19? **(Circle one)**

1. Media- radio, T.V, posters, social media, SMS, brochures.
2. Health care providers
3. Family members
4. Community leaders
5. Religious leaders
6. Community health volunteers
7. Peers
8. Other, specify _____

2. Which is your most preferred and trusted source of information on covid-19? **(Circle one)**

1. Media- radio, T.V, posters, social media, SMS, brochures.
2. Health care providers
3. Family members
4. Community leaders
5. Religious leaders
6. Community health volunteers
7. Peers
8. Other, specify _____

Section 4: Attitudes on covid-19

1. What is your perception on covid-19? **(Circle one)**

- a) It is a dangerous disease
- b) It is just like flu
- c) It is a harmless disease
- d) Other, specify _____

2. Who do you think is at highest risk to get the coronavirus? **(Circle all you know)**

1. Children under 5 years old
2. Adolescents up to 15 years
3. The youth
4. Adults
5. The elderly
6. Pregnant women
7. Health workers
8. People with co-morbidities i.e. diabetes, high blood pressure, heart disease etc.

3. Do you think you are likely to become sick with the new coronavirus? **(Tick one)**

- Yes ()
No ()

4. Do you think it is important to take preventive measures to prevent the spread of coronavirus in your community? **(Tick one)**

- Yes ()
No ()

5. Do you think the coronavirus disease is generating stigma? **(Tick one)**

- Yes ()
No ()

To whom? **(Circle all you know)**

1. Health care workers
2. Covid-19 positive recoveries
3. Family with covid-19 death
4. Foreigners e.g. Chinese
5. People who have travelled back into the country or from high-risk areas
6. Other, specify _____

6. What are the barriers to adoption of covid-19 prevention measures? **(Circle all you know)**

1. Financial constraints
2. Incorrect knowledge on the disease
3. Stress
4. Attitudes and perceptions
5. Other, specify _____

Section 5: Psychosocial effect of covid-19

1. What has been your general wellbeing since covid-19 started? **(Circle one)**

- a) Fear and anxiety
- b) Normal
- c) Stressed
- d) Other, specify _____

2. What is your main fear about COVID-19? **(Circle one)**

- a) Being infected
- b) Being in isolation
- c) Dying from the disease
- d) Stigma in the community
- e) None

3. What effect has COVID-19 had on you as an individual? **(Circle one)**

- a) Lost my job
- b) I am no longer in school
- c) No income in business
- d) I am scared to go out
- e) Lonely
- f) Other (specify): _____

4. If you had pain/or felt sick, would you go to a healthcare facility? **(Tick one)**

- Yes ()
No ()

If No, why? **(Circle one)**

- a) Fear of being asked to test for Covid-19 before treatment
- b) Fear of health care providers who could be infected
- c) Fear to be isolated or quarantined

5. In your view, why are people avoiding going to healthcare facilities in this area? **(Circle all you know)**

1. They will be tested for COVID-19
2. There are no medicines

3. They may get infected while waiting to be served
4. They do not trust the health providers (they could be infected)
5. I do not know
6. Other, specify _____

Section 6: Management of covid-19

1. What is the recommended treatment for covid-19 in the community? **(Circle one)**
 - a) Conventional Medicine
 - b) Concoction (boiled mixture of lemon, ginger, garlic and honey)
 - c) Traditional/herbal medicine
 - d) None

2. Would you self-medicate if you test positive? **(Tick one)**
Yes ()
No ()
If yes, what factors would encourage this? **(Circle all you know)**
 1. Lack of knowledge on the harm of un-prescribed medication
 2. Need for faster recovery
 3. Fear of hospitals
 4. Fear of being isolated from the family
 5. Other, specify _____

3. What do you think are the harmful effects of self-medication? **(Circle all you know)**
 1. Overdose
 2. Kidney problems
 3. Liver damage
 4. Death
 5. Other, specify _____

4. Have you already received the Covid -19 vaccine that is being given by government? (Select only one)
 1. Yes ()
 2. No ()

5. Would you be willing to get the vaccine? (Select only one)
 1. Yes ()
 2. No ()

6. If No, what would hinder you from accepting the vaccine? **(More than one response is possible)**
 - a) Normally, I am scared of injections
 - b) Fear and stigma associated with Covid-19
 - c) I have a pre-existing condition such as diabetes, hypertension, HIV/AIDS, etc.
 - d) I fear the side effects
 - e) It's against my beliefs (cultural/religious beliefs)
 - f) I do not have trust in the vaccine
 - g) I do not have adequate information about this vaccine
 - h) Other, specify _____

Take a GPRS point
Thank you for your participation!

Annex 3: KII Guide

Key Informant Interview (KII) Guide for Healthcare providers, Community leaders, Programme Implementers, Policy Makers, Among Others

County _____
Sub-county: _____
Venue of the interview: _____
Date of the interview: _____
Name of the interviewer: _____
Name of the respondent: _____
Name of organization if applicable): _____
Length of stay in the organization (if applicable): _____
Designation of respondent: _____
Start time: _____ End time: _____

Introduction

Good morning/afternoon. My name is..... I am from Kisii County, Health Services Department. We are conducting a study to determine the effectiveness of the Risk Communication and Community Engagement (RCCE) strategy. You have been selected to participate in this discussion because you are a member of this community and because your views are important. I therefore kindly request you to share your honest opinion on the issues we will be discussing.

Your participation in this discussion is voluntary and you are free not to discuss any issue you feel uncomfortable with, and this will not affect you in any way. The information you provide shall be kept in confidence and will only be used for the purposes of this study. This discussion will last approximately 30 minutes.

Do you have any questions or comments before we proceed?

Interviewer: (If any question/comment, please first address them before proceeding with the interview).

Ice breaker

What are the general challenges facing this community? **Probe on;** *health, water, education, security, poverty, etc.*

Key Issues for Discussion

1. About his/her position and role in Covid-19 response project

Tell me about yourself and your role in this community:

- How long have you held your current role?
- What was your role in the Covid-19 health promotion project and RCCE strategy implementation?
- What challenges did you face during implementation?

2. Project Relevance, Impact and Sustainability

- i. How would you describe the project implementation in relation to the RCCE strategy and COVID-19 response priorities? **Probe on:** *RCCE objectives prioritised and met, RCCE plan compliments the Community needs.*
- ii. In your view, to what extent was the project relevant to the needs and priorities of the community? **Probe on:** *importance of the project on behaviour change in individuals, family and targeted risk population etc.*

- iii. Among the target beneficiaries who participated in the project implementation process what strategies were used to identify and engage community members? **Probe on:** *participation of community members, representation of risk groups in the project implementation activities etc.*
- iv. In which ways has the project-built capacity among the targeted groups? **Probe for** community coalitions formed
- v. To what extent did the project produce results (intended and unintended, positive, and negative)? **Probe on:** *reduction in cases of Covid-19 being reported, adherence to MoH protocols, reduction in stigma, fear, misconception on COVID -19 etc.*
- vi. What are the measures in place to ensure the project continues after the end of the funding? **Probe on:** *partnerships/collaboration with key partners, sense of ownership, goodwill by the county government, resource allocation, capacity building etc.*

3. Covid-19 vaccination

- i. How would you describe is the uptake of the Covid 19 vaccine in the community since the onset of the project? **Probe on:** *availability of vaccines, numbers vaccinated, refusals, hesitancy, misconception/fear/stigma etc.*
- ii. In your view, what are some of the reasons for vaccine hesitancy and refusal in the community? **Probe on:** *fear/stigma/misconceptions, cultural, structural barriers, access, knowledge etc.*
- iii. What can be done to increase vaccine acceptance in this community? **Probe on:** *vaccine drive measures such as awareness creation/education, community participation, making them more accessible etc.*

4. Recommendations

In your opinion what are the three (3) recommendations for improvement of future health interventions in your community, especially on health promotion?

THANK THE RESPONDENT

Annex 4: Best buys in COVID-19 preparedness and response in Africa

Countries in the WHO African Region are the least prepared for infectious disease threats, with an average Ready Score of 39 out of 100 according to robust external assessments. As the COVID-19 pandemic spreads to the region, several critical activities should be implemented to fill country gaps, mitigate disease spread and save lives. These include:



Establish a rapid response fund to support timely detection and control activities. Many countries have systematic delays in deploying rapid response teams due to a lack of easily accessible funding to support the rapid deployment of trained response teams. This includes funds to mobilize a team, procure the necessary supplies and equipment, and transport the team to the field. This activity will establish a rapid response fund easily accessible by the Ministry of Health to support timely outbreak investigations.

Cost: USD \$50,000 per country



Pandemic non-pharmaceutical interventions (NPIs) impact assessment. NPIs are an essential part of pandemic containment and mitigation, especially in the absence of available treatments and vaccines. NPIs include disruptive measures like school, market and church closures, and cancellation of mass gatherings. These can have significant intended consequences. This activity will use rapid polling of urban centers to understand the impact of NPIs. This data will guide decision-making on which policies to implement and how to limit negative impacts on communities. **Cost:** USD \$80,000 per country



Communications in a crisis. In a pandemic, risk communication is a core pillar of the overall response. Social media monitoring, rumor management and the effective prevention and management of misinformation are all key components of a communications strategy that supports disease control and adapts to the evolving situation in a crisis. This activity will support implementation of this comprehensive approach to better engage and adapt to community needs. **Cost:** \$250,000 per country



Infection prevention and control. Meticulous infection prevention and control is essential during all phases of a pandemic response. Healthcare workers must be adequately trained and equipped to protect themselves and their patients. This activity will expand infection prevention and control training to the most vulnerable healthcare workers on the frontline, including nurses and midwives. **Cost:** \$200,000-400,000 per country (workforce size dependent)



Functional laboratory network. Major gaps existing in laboratory specimen referral and transport systems, and the laboratory information systems that track specimens and capture testing results. This activity will support countries to develop functional laboratory networks that can transport specimens from anywhere in the country for advanced diagnostics. **Cost:** \$200,000 per country

Embedded support to global and regional organizations. Large organizations such as the World Bank, Global Fund and World Health Organization Regional Office for Africa have different mandates and linkages to global health security. To better leverage their funds to



support preparedness for current and future health threats, this activity will embed experienced technical advisors at each institution. **Cost:** \$600,000.



Annex 5: CORPs RCCE training manual

1. Participation coverage and meeting venue requirements

The sensitization forums will bring together the CORPs; these include leaders and/or representatives of the following groups in the community: People Living with Disabilities (PLWD), women, youth, transport industry (Buses and motorcycles), community elders, religious Leaders,

The meetings should be organized at ward level to achieve wider participation. Ensure the venue arrangement meets the required control and prevention measures such as: limiting the number of participants, arrange the seats 1-2 meters apart, provide water and soap, and/or alcohol-based sanitizer for participants to regularly wash their hands.

2. Approach/Delivery:

- ▶ The sessions should minimize on presentations and encourage discussions with the aim to:
 - Listen to what the participant's key concerns and questions are
 - Generate priority areas/issues and localized communication approaches
 - Identify channels they can use to pass key messages that are sustainable in their setting.
 - Generate content for engaging community members
- ▶ Use simple language and words – avoid using acronyms and technical terms
- ▶ Give practical advice – what can they actualize within their context
- ▶ Use easy to understand illustrations

3. Content

Session 1: Basic Information on COVID-19

Background

- ▶ Begin the session by asking them what they already know, and what they wish to know about COVID-19. Ask questions such as: what have you heard about this new coronavirus disease (COVID-19)? What information would you like to know about the new coronavirus?
- ▶ Find out their understanding of asymptomatic and symptomatic cases, and seek their input in explaining these terms in an easy to understand language for their respective communities
- ▶ Based on their responses, provide an overview of COVID-19 highlighting what it is, its severity level, how someone can get infected with the virus, and what they can do to protect themselves. Share some trend data even if just to mention there is an increase generally in Kenya and region-specific where available for the hot spots (*link this to increase in susceptibility which is increased likelihood of contracting the disease since there are more people who are infected in their communities with some not showing any symptoms*). This may play a role in raising the perception of risk at individual as well as collectively at community level.

Prevention and control

- ▶ Explain briefly what the government is doing to curb the spread of the virus through contact tracing, quarantining and self-isolation. Explain these terms using simple language and that these actions are crucial to minimizing the spread.
- ▶ Emphasize proper/correct and consistent use/application of protective and preventive measures. Focus more on **why** people need to undertake certain measures and **how** they can be done correctly
- ▶ Explain about vulnerable groups - those most at risk while emphasizing that anyone can get infected.

- ▶ Find out what they know about the signs and symptoms of COVID-19, and whether they know what to do if someone in their family or community gets sick with symptoms similar to those of COVID 19.
- ▶ Explain **home-based care**: who needs it, and how can it be done safely, and what role they (CORPs) can play in this
 - ▶ Find out what they know about referral and management of suspected and confirmed cases. Explain the procedures

Safety: Infection Prevention and Control (IPC)

- ▶ Find out what the CORPs have been doing to keep themselves and their families safe. What kind of PPEs do they use? What challenges do they face in this? Discuss the necessary precautions to take during implementation

Note: Participation of the IPC focal person is key to address any issues that arise

Myths, Misinformation and Stigma

- ▶ Find out the common myths about COVID-19 in the community, and whether community members practice hand washing, wearing masks and social distancing and **why** they do or don't practice these measures
- ▶ Explain why myths and rumors occur during an outbreak and emphasize the importance of providing accurate information about the virus. Emphasize that as community leaders and community health workers what they say is trusted. Highlight how they can build and maintain the trust
- ▶ Address the misinformation that has resulted or may lead to stigma towards certain groups/individuals within their community.

Risk Factors & Barriers at community level (Presentation to trigger discussion)

- What do they see as general barriers (e.g. other social economic barriers – though this might not be address through communication they can think community solutions;
- What are the facilitators / opportunities at their 'community'?

Session 2: Target Audiences, Communication and Engagement Channels

- ▶ Engage participants in a dialogue about the **information needs** of the different groups they represent
- ▶ Jointly **identify the key messages** for the various groups and how they can be reached without breaking the IPC regulations. Establish what means of communication they prefer or are comfortable with, the languages they prefer use and the role they want to play.
- ▶ **Identify the challenges** they are likely to face in reaching the groups and how to address them. Emphasize the need to **build on the existing channels of communication** and expanding them to reach each group in the community
- ▶ Do an exercise where the participants map out areas in the community where people are most at risk of contracting the virus and where they are least likely to get infected. Come up with ways of reducing the risks while continuing with essential activities
- ▶ Encourage them to **collaborate** with those who are **more influential in their communities** in passing the information to the target groups. Engage them in identifying some of individuals or networks that would be more influential

- ▶ Emphasize the importance of **2-way communication** – be open to listen to the concerns, fears, myths and misinformation being raised by community members. Keep addressing them accordingly and consult where need be.

Session 3: RCCE Action Plans

- ▶ Working in groups (based on localities represented) participants will develop the priority RCCE interventions they will undertake, who will they target, the key messages for each target groups, the channels to be utilized and the timelines
- ▶ Encourage the participants to be SMART in developing the action plans
- ▶ Agree on how they will report their activities – present the reporting tool and identify the focal point for receiving the reports, and how often (***this may not apply to CHVs who already have a standard tool for reporting their activities and care should be observed not to burden them with another***).
- ▶ How they will be reviewing progress – beyond reporting. E.g. how regularly with they meet to review progress and emerging issues
- ▶ Explore best feedback mechanism from community upwards

Session 4: Covid 19 vaccine

The participants informed that there are currently five types of COVID VACCINE namely;

- ▶ AstraZeneca / Oxford vaccine - **COVISHIELD™, VAXZEVRIA™**
- ▶ –Moderna
- ▶ –Sinopharm
- ▶ –Johnson & Johnsons (**Janssen Covid 19 Vaccine**)
- ▶ –Pfizer/BioNTech

In Kisii the vaccines available are ASTRAZENECA AND MODERNA in specific facilities.

Importance of the COVID 19 vaccine

- ▶ COVID-19 vaccination will help protect you from getting COVID-19 disease
- ▶ All COVID-19 vaccines currently available have been shown to be highly effective at preventing the disease
- ▶ Based on what we know about vaccines for other diseases and early data from clinical trials, COVID-19 vaccine protects from getting severe COVID-19 disease
- ▶ Getting vaccinated protects people around you, particularly people at increased risk for severe illness from the disease
- ▶ COVID-19 vaccination is a safer way to help build protection
- ▶ Getting COVID-19 may offer some natural protection, known as immunity
- ▶ COVID-19 vaccination will help protect you by creating an antibody (immune system) response
COVID-19 vaccination will be an important additional tool to help stop the pandemic
- ▶ Wearing masks and social distancing help reduce your chance of being exposed to the virus or spreading it to others, but these measures are not enough
- ▶ Vaccines will work with your immune system so it will be ready to fight the virus if you are exposed.
- ▶ Stopping a pandemic requires using all the tools we have available, COVID vaccine is an additional tool in stopping the effect of the pandemic

Side effects of the vaccine

Members informed that the vaccine may cause some mild side effects which include; Headache, nausea fatigue vomiting decreased appetite injection related tenderness and pain, abdominal pain, excessive sweating, muscle pains, chills fever.

Members informed that each person's body will react differently and others will not experience any side effect at all therefore they should encourage members to go for the vaccine since among the myths and rumors that exist none has been confirmed to be true.

Members informed on the eligibility criteria Age ≥ 18 years

- ▶ Provide verbal consent
- ▶ Persons who have previously had SARS-CoV-2 infection
- ▶ –Vaccination may be offered regardless of a person's history of symptomatic or asymptomatic SARS-CoV-2 infection (14 days after infection)

key messages on Vaccination

participants taken through the following key messages;

1. ALL COVID-19 vaccines are safe for use by adults, breastfeeding mothers and as per current WHO guidelines, can also be used by pregnant women upon recommendation by a qualified physician.
2. All vaccines are effective in preventing severe disease, hospitalization and death due to COVID-19. The best vaccine is the one offered to you.
3. High risk groups will be prioritized for vaccination. These are: individuals 50 years and above; Frontline workers not reached in phase 1 (Health care workers, Uniformed officers, Teaching and non-teaching staff); Persons above 18 years living with chronic illness (e.g. high blood pressure, HIV, depression, diabetes, renal failure and others)
4. The vaccines will be available **FREE** of charge in all government approved vaccination sites in your county. For more information, visit your nearest Health Facility. You can also find information at: <https://www.health.go.ke/>
5. Individuals can **PRE-REGISTER** for COVID-19 vaccination at the nearest health facility. Carry your ID card and ensure your details are correctly captured. Pre-registration can also be done through the MoH portal <https://portal.health.go.ke>.
6. The Government appeals to youths to support parents and members of the community who may need help with the pre-registration.
7. After vaccination, you might experience some side effects that include – pain at injection site, headache, fever, fatigue, muscle pain, chills, diarrhoea, and nausea. These are normal and will usually go away. Remember to report any side effects after vaccination: **Call Tel. 0795 743049, report to the nearest Health Facility or to Pharmacy and Poisons Board @ <https://pv.pharmacyboardkenya.org>**
8. To be fully vaccinated, make sure you complete your dosage as required. Taking different types of Vaccines is **NOT** recommended.
9. Remember even after one is fully vaccinated, they can still get infected or infect others with COVID-19 virus.
10. It is very **IMPORTANT** to continue observing the other COVID-19 preventive measures even after you have been vaccinated. These are **[1] Wear Face Mask [2] Keep Social Distance and [3] Regularly Wash Your Hands or Sanitize.**
11. After being fully vaccinated you can obtain and print your COVID-19 certificate from <https://portal.health.go.ke>

Messages for different risk groups

Key Messages for the Youths

1. Wash your hands frequently with soap and running water or with an alcohol-based sanitizer.

- After coughing or sneezing
 - When caring for the sick
 - Before, during, and after you prepare food
 - Before eating
 - After toilet use
 - When hands are visibly dirty
 - After handling animals or animal waste
2. Wear face masks whenever in public.
 3. Maintain social distancing to protect yourself and others from getting sick.
 - Maintain at least a 2-meter distance between yourself and anyone who is coughing or sneezing.
 - Avoid close contact with anyone when you are experiencing cough and fever.
 4. Avoid touching your eyes, nose, and mouth with your hands.
 5. Practice respiratory hygiene.
 - Cover your mouth and nose with your bent elbow or tissue when you cough or sneeze. Then dispose of the used tissue immediately.
 - Clean hands with alcohol-based hand sanitizer or soap and running water after coughing or sneezing and when caring for the sick.
 6. Clean and disinfect frequently touched objects and surfaces regularly.
 7. Stay home if you have fever, cough, and difficulty breathing, and seek medical care early.
 - Stay home if you feel unwell if you have a fever, cough, and difficulty breathing, or have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with the ongoing spread of COVID-19. Follow the directions of your local health authority in seeking medical care.
 8. Stay informed and follow the advice given by your healthcare provider.
 - Stay informed on the latest developments about COVID-19.
 - Follow the advice given by your national and local public health authorities.
 9. Encourage all youths above the age of 18 to go for vaccination.

Key Messages for Market vendors and Customers

1. Maintain at least a 2-meter distance from others and practice no-contact greetings.
2. Wear a clean face mask whenever you are out in the public.
3. Wash your hands frequently or use hand sanitizer.
4. You and your customers to enhance hand hygiene. Wash your hands and encourage your customers to wash their hands at entry and exit from the market.
5. Disinfect surfaces such as beverages sold in markets, plates for foods, cups, shared utensils, cash, and other items after purchasing.
6. Ensure customers have limited time at the market.
7. Encourage older customers especially with underlying conditions to stay at home or send someone to shop for them.
8. Discourage customer food sampling.
9. Wash your hands after attending to your customers or touching food.
10. Discourage customers from touching food products.
11. Encourage the market vendors and their customers to go for the covid 19 vaccine.

Key Messages for BodaBoda Riders

1. Ensure you and your customers wear face masks every time.

2. Ensure you have a hand sanitizer or wash your hands after handling cash or carrying a client.
3. Ensure you change your clothes and clean-up immediately after returning home and before interacting with the family.
4. Encourage your friends to wear face masks and wash their hands frequently with soap and running water after interacting with cash or their clients.
5. Encourage your friends to go for vaccination

Key Messages for Matatu crew and passengers

1. Ensure all passengers wear a mask properly before entry and during the journey.
2. Advise your customers to sanitize or wash their hands with soap and running water before entry.
3. Sanitize or wash your hands with soap and running water after handling cash or interacting with your customers (wash at the end of every trip).
4. Encourage social distancing in the matatu and avoid carrying excess passengers
5. Disinfect or wash your matatu properly with soap and water every day after work.
6. If you feel unwell (cough, sneezing, difficult breathing) stay at home and seek treatment before returning to work.
7. Encourage all the matatu crew and their passengers to go for vaccination

Annex 6: Project Photos



Figure 1: CORPs and Facilitators during training (Photo by AIHD)



Figure 2: Stakeholder's meeting (Photo by AIHD)



Figure 3: SCHMT Planning Meeting (Photo by AIHD)



Figure 4: Training of RAs (Photo by AIHD)



Figure 5: Community sensitisation by CORPs including PWDs (Photo by AIHD)



Figure 6: Media briefing by the County HPO. (Photo by AIHD)



Figure 7: Flag off of the road walk by the County Director of Public Health (Photo by AIHD)



Figure 8: A CORP sensitizing bodaboda sector (Photo by AIHD)



Figure 9: A CORP expounding on the myths and misconceptions (Photo by AIHD)