Project Zika Response in Ecuador and Peru

International workshop "Community mobilization in response to emergencies and epidemics: learning from the fight against zika"

WORKSHOP SYSTEMATIZATION

Quito, 4 – 6 june 2019

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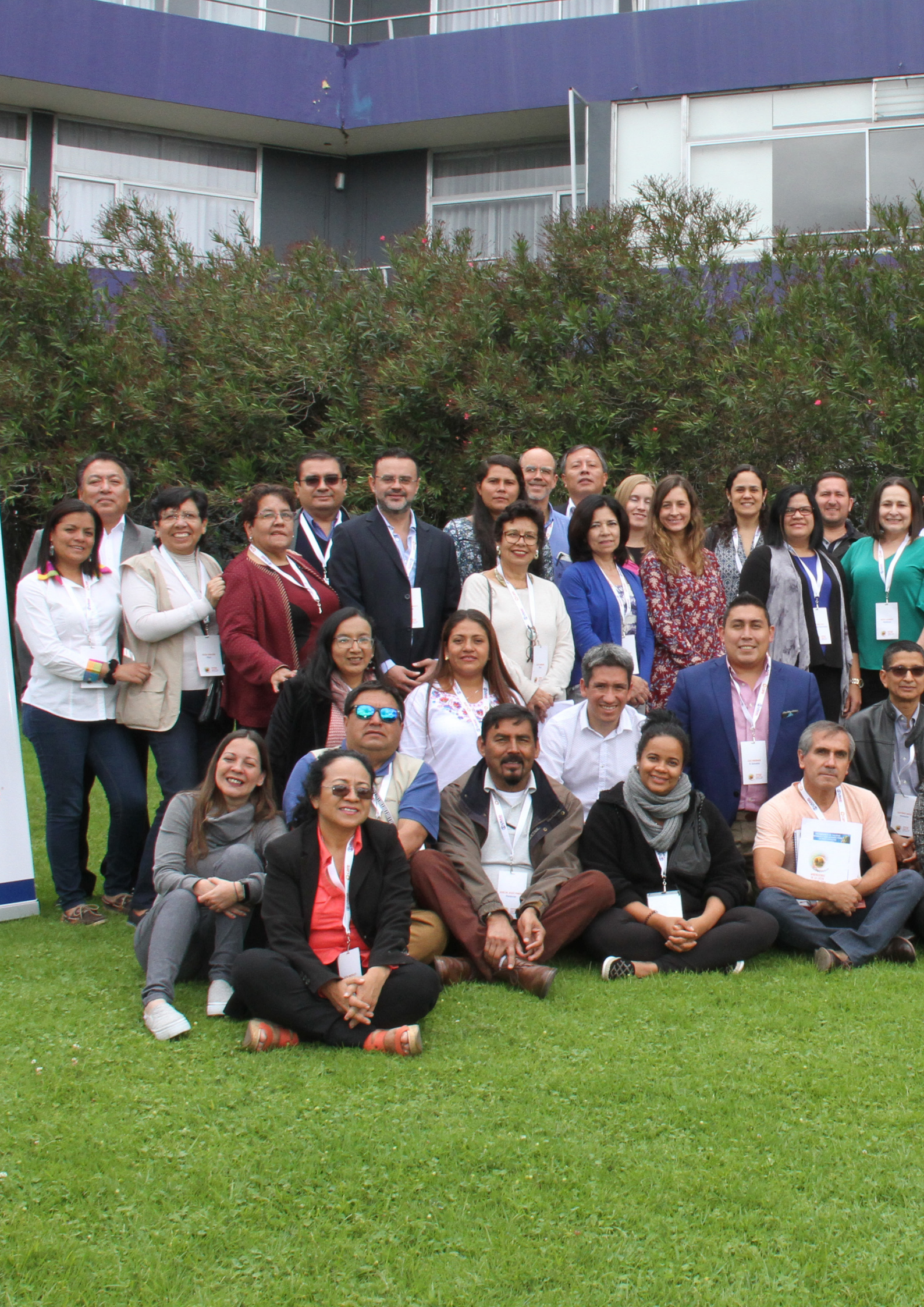

Project Zika Response in Ecuador and Peru
International workshop
"Community mobilization in response to emergencies and epidemics: learning from the fight against zika"

Workshop systematization

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PRESENTATION

CARE, the executing organization of the Ecuador-Peru Binational Project, “Together Against Zika”, in coordination with the United States Agency for International Development (USAID), organized the international workshop “Mobilization of the community in response to emergencies and epidemics: Learning from the fight against Zika”, which took place in Quito - Ecuador, from June 4 to 6, 2019.

Participants in the workshop were delegates from USAID partner organizations that execute projects aimed at promoting community participation in response to the Zika emergency in several countries in Latin America and the Caribbean. Additional participants were representatives of national counterpart organizations of the projects in the different countries, including delegates from the Ministries of Health, Education, Social Inclusion and / or Development, at national, sub-national or local level; representatives of local governments, such as Municipalities; of educational institutions; delegates of monitors, promoters and community brigades; and delegates from the United Nations’ agencies such as UNICEF and PAHO.

The methodology of the workshop sought to allow participants to exchange experiences, knowledge, and lessons-learned through individual and group reflection, motivated by conferences, panels and group work. Four were the main axes of the workshop:

1. Community mobilization in the response to public health emergencies;
2. Community epidemiological surveillance for the prevention and response of public health problems: learning from the response against Zika;
3. Challenges and good practices of social and behavioral change (CSC) in the promotion of Zika preventive practices; and,
4. Good practices to promote the sustainability and institutionalization of community mobilization experiences at the local, national and regional levels.

In addition, we reflected on quality assurance in community prevention interventions of Zika.

The gender approach and people with disability inclusion were topics that were incorporated into the discussion, especially regarding the sexual transmission of the Zika virus, protection and care during pregnancy, the risk for girls and boys who are infected during pregnancy due to the consequences of the congenital syndrome associated with Zika, especially microcephaly; and the sexual division of work at home.

CARE Ecuador presents in this document the main results of the systematization of the international workshop, with the purpose of contributing to the debate on community mobilization in response to public health emergencies, recovering the lessons learned in the response to the epidemic caused by Zika virus, through 7 projects, executed by different organizations, with the support of USAID, in 13 countries of Latin America and the Caribbean.

In addition, we believe that the lessons -learned from the experiences developed in the response to Zika are contributions to the reflection and debates about the importance of community mobilization and empowerment in the prevention and response to public health problems and health emergencies.

Alexandra Moncada
Country Director
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1. INTRODUCTION

The Zika epidemic had a rapid and specific evolution in the Latin American and Caribbean region. From March 2015, when a large outbreak of exanthematous disease was reported in Brazil, until November 2016, when the World Health Organization (WHO) considered that the event was no longer a Public Health Emergency of International Interest (ESPII) .

In 2016, the United States Agency for International Development (USAID) in 2016, allocated resources and called for proposals to support the response to the Zika epidemic with community participation and mobilization, vector control, strengthening health services and research, among other topics.

USAID approved and funded 7 projects that were implemented in 13 countries in Latin America and the Caribbean. The projects aimed at strengthening the capacity to reduce, through community participation and mobilization, the potential for future outbreaks of infectious diseases. These included three lines of work: 1. Vector control and management 2. Social behavior change communication, and 3. Community-based monitoring and surveillance.

For USAID, controlling the outbreak of the Zika virus, a rapidly evolving public health emergency, required working on community commitment and strengthening community processes to address the existing threat. From here comes the effort to support these processes in Latin America and the Caribbean (USAID, 2016).

USAID facilitated the exchange of knowledge and experiences between community mobilization projects in the response to Zika through meetings, workshops, and virtual meetings where the executing organizations presented their lessons learned and good practices noted.

In June 2019, USAID and CARE International, the Bi-National Project Together Against Zika executing organization in Ecuador and Peru, organized, convened and executed the international workshop called “Community mobilization in response to emergencies and epidemics: learning from the fight against Zika ”, which was held in Quito-Ecuador, on June 4, 5 and 6, 2019.

The main objective of the workshop was to establish a space to analyze and capitalize on the results of the experiences promoted by USAID with implementing partners in the region, related to community mobilization, the management of quantitative and qualitative information, and the sustainability of their interventions. In addition, the event sought to identify the experiences that could be replicated in various contexts at local, national and regional levels.

The workshop's thematic axes were the following:

- Community mobilization in response to public health emergencies.
- Community epidemiological surveillance for the prevention and response of public health problems: learning from the response against Zika.
- Challenges and good practices of social and behavioral change in the promotion of Zika preventive practices.
- Good practices to promote the sustainability and institutionalization of community mobilization experiences at local, national and regional levels.

Other issues also reviewed were: Quality assurance in emergency interventions, gender focus and inclusion of disabilities in the fight against Zika.

Conferences, panels with expositions, and working group sessions were produced within each of these four thematic axes.

1.1. Systematization Methodology

The methodology, tools and systematization of the international workshop meant a joint work between the team in charge of systematization, the CARE's technical team of the specific to the Bi-National Project Together Against Zika, USAID advisors, and members of other organizations working with USAID in the response to Zika: Johns Hopkins Center for Communication Programs (Health–K4H and Breakthrough Action–BA Programs) and Population Council (Breakthrough Research–BR Program).

Systematization Process

The systematization was developed in two stages:

Stage I: Consolidation of Information

The information gathered for each thematic axis was consolidated. In this process, the systematization team identified the content presented in conferences, panels, and working groups, regarding good practices, lessons learned, and challenges.

Stage II: Systematization

In this stage, a conceptual framework of reference (elaborated from the review of specific bibliography) was delivered for each thematic axis. Then, the document containing the consolidated information of the workshop was analyzed, in order to

elaborate a synthesis with the most relevant content of good practices and lessons learned. Finally, recommendations were made to strengthen each of the axes against epidemics and other public health problems.

In this document each axis is located, with the following structure:

A **conceptual framework** developed from a bibliographic revision and various reflections held during the workshop, aiming to understand the approach given to each topic.

The conceptual framework highlights the main theoretical elements to understand the meaning of each topic, based on the revised bibliography, as well as the contributions collected at different moments of reflection held during the international workshop.

Effective practices or good practices: is an approach or strategy that is perceived and / or demonstrated to be successful in achieving its objective. The description includes details about the implementation, the key components that led to success and the explanation of why it is considered an effective practice (example: it has data that demonstrates its success) or if it is perceived as effective (example: through experience) (K4H).

Lessons learned: this section presents key observations or knowledge drawn from an experience. Lessons learned can focus on successful action or what needs to be done - differently - next time, in order to propel improvement in achieving objectives. The lessons learned should be documented and taken into account to inform similar types of work to be held in the future. (K4H).

The **recommendations** are made taking into account good practices and lessons learned, previously identified, together with the recommendations proposed by the workshop participants.

2

SYSTEMATIZATION RESULTS

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2. SYSTEMATIZATION RESULTS

2.1 Community mobilization in response to public health emergencies

2.1.1 Conceptual framework

During the Zika outbreak emergency, it was determined that community empowerment is key in prevention and response actions for Zika and other diseases transmitted by Aedes Aegypti, and, in general, in prevention and response to various public health problems (WHO, ZIKA Estrategic Response Plan. Revised for July 2016-December 2017, 2016).

Within this frame, the following concepts were incorporated:

The community is a specific group of people who often live in a defined geographical area, share the same culture, values and norms, and are organized in a social structure according to the type of relationships that the community has developed throughout time. The members of a community acquire their personal and social identity by sharing common beliefs, values, and norms that the community has developed in the past and that can be modified in the future. Its members are aware of their identity as a group and share common needs and the commitment to meet them. (WHO, 1998).

Community mobilization is a process through which the community itself stimulates action. It is planned, carried out and evaluated by individuals, groups and organizations of the community - in a participatory and sustained way - to improve health, hygiene and, in general, to improve the general standard of living in the community. It refers to a group of people who have transcended their differences to meet on equal terms in order to facilitate a participatory decision-making process. In other words, it can be seen as a process that initiates a dialogue between community members to determine who, what and how problems are resolved. This process provides a way for everyone to participate in decisions that affect their lives. (UNAIDS, 1997).

Empowerment for health is conceived as a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, raise their concerns, design strategies for participation in decision-making and carry out political, social and cultural actions to meet their needs. Through this process, people perceive a closer relationship between their goals and how to achieve them and, a correspondence between their efforts and the results they obtain.

A distinction is made between the empowerment for the health of the individual and that of the community. Empowerment for individual health refers primarily to the individual's ability to make decisions and exercise control over his personal life. The empowerment for community health means that various individuals act collectively in order to achieve greater influence and control over the determinants of health and quality of life of their community; a major objective of community action for Health. (WHO, 1998).

2.1.2. Good practices

2.1.2.1. Enhance the capacities of the community and community teams through the exchange of knowledge and different training activities

Community leaders, teachers, promoters, volunteers, or brigades were the main actors, trained by the technicians of the project's implementing partners institutions, or of public institutions such as ministries of health. The training was carried out, mainly, through face-to-face workshops, experience exchange sessions, and home visits.

The topics were defined based on the knowledge needs identified, being the most recurrent: the stages of vector development, the ways of virus transmission, Zika's symptoms and signs, the risk factors for congenital syndrome, and the actions of prevention. These topics were complemented with other significant issues, for example: leadership, communication, and coordination with public or private entities.

The training allowed to communicate the scientific and specialized knowledge to the actors of the community, and influenced to maintain an active, diligent and articulating role. In addition, it made possible to organize and carry out dissemination and prevention actions.

2.1.2.2. Promote the training and participation of adolescents, girls and boys as key actors in raising awareness and prevention in the family

The awareness building and training processes aimed at children and adolescents were mainly developed within the educational units. In some cases, project technicians trained teachers; subsequently, they were responsible for replicating the contents with adolescents and children. In other cases, the training was carried out for adolescents, and were they who assumed the role of facilitators with their peers and with children. The training topics were: training tools, Aedes aegypti hatchery control, and Zika prevention.

For training, guides (or manuals) and edu-communicative material were produced, based on key messages that respect the reality and cultural identity of the target population. Many of these materials incorporated a gender approach.

Training children and adolescents was valued as positive because they are actors who, when become informed on some new knowledge and internalize it, are permeable to incorporate behavior changes and to become motivated to actively participate in knowledge dissemination and prevention actions of Zika. Additionally, they play a role of "educators" within their families and communities because they can be diligent communicators and thus influence knowledge, promote the adoption of prevention practices, and warn about the need for behavior changes.

> "Girls and boys can have a positive impact on their family environment, which is why the participation of schoolchildren and teachers was promoted. This work was carried out with recreational methodologies that facilitated learning "(Maria Espinoza, Peru, Panel: Community Mobilization in urban and rural contexts)

2.1.2.3. Organize “Care Groups” for caregivers and families with children affected by Zika virus

The “care groups” are territorially organized groups that accompany and develop prevention activities. This groups consolidate and act at different times, depending on the situation that has to be faced.

A care group is defined as:

> “A group of 10 to 15 volunteers, community-based health educators, who meet regularly with project staff for training and supervision. Each volunteer is responsible for regularly visiting 10 to 15 of their neighbors, sharing their knowledge and facilitating behavior change at household level. These groups create a multiplier effect when reaching each beneficiary household with communication messages to change interpersonal behavior. They also provide the structure for a community health information system (...) ”(Group work).

In Nicaragua, for example, the project implemented by SSI / AMOS considered that working with care groups was a good practice for two reason: first, because its conformation contributed to greater coverage accompaniment of the affected families, and, second, because those who made the accompaniment are recognized by the community. It is important that who accompanies a “care group” be informed and sensitized on the subject, because only then they can motivate learning in other actors.

The members of the care group actively participated in the reading of different health situations and in the dialogue with the family and the community. By involving deeply in the project’s implementation process, care-group members generated close ties, and protection attitudes with members of the community and with educators (community facilitators) who became their colleagues. Thus, the care group was consolidated as a space for learning, socialization and care.

2.1.2.4. Promote inter-sectorial coordination to enhance the synergistic performance of institutions

Inter-sectorial coordination was a practice developed at different project’s levels in order to promote the articulated work of different public, private, social and community organizations, aiming at deploying multiple actions in which each organization or institution, from its roles, competences and functions, contributes to face and respond to problems or demands related to the control and prevention of Zika.

Another favorable element identified, regarding partnered work, was the intersectorality that involved working in a coordinated and synergistic way, strengthening institutions’ capabilities and their actions in response to the Zika emergency. The inter-institutional coordination incorporated the participation of the community and community agents, through the participatory construction of action plans whose execution is subject to systematic monitoring and evaluation.

Among the activities carried out by the projects to enhance inter-sectorial coordination, some significant strategies were identified: the creation and / or strengthening of inter-sectorial tables or multi-sectorial committees, the development of inter-sectorial plans and, coordination with local governments.

In inter-sectorial work, better guarantees can be found for the sustainability of control and prevention actions of Zika, and communication aimed at achieving behavior change, given that institutions have developed their own knowledge and skills that have led them to empower themselves with the response program.

2.1.2.5. Strengthen institutional capacities to promote community mobilization

The role of institutions such as the Ministries of Health, Education and local governments was essential to encourage and motivate the community mobilization necessary for the implementation of prevention actions. In order to strengthen this role, various training workshops and training activities were developed, each appropriate to the territories and contexts. Also tools and methodologies were designed and implemented specifically for training purposes.

This practice allowed institutions to understand the community-based approach to Zika prevention. In addition, as it contributed to establishing trust and credibility among these institutions toward the project, greater support and participation in the action plans was achieved. For example, the ministries of Health officially recognized the entomological surveillance done by the community using *ovitraps* as a significant prevention effort.

2.1.2.6. Getting to know the reality from a multidisciplinary approach

The experiences presented by the different projects identified as a good practice were: the knowledge of the local reality from a multidisciplinary perspective that incorporates the communicational, the epidemiological, the cultural and the economic.

The multidisciplinary work made it possible to carry out an integral reading of the reality of the territories and of the behaviors of their inhabitants regarding the Aedes Agepty mosquito issue. This permitted to acknowledge that -in each community- there were particular economic, social and cultural aspects that needed to be taken into account for a proper intervention. With this information, the institutions adjusted and adapted their strategies to work on those aspects identified as unfavorable for prevention, such as the difficulty of using insect repellent due to its cost and, the non-acceptance of the use of condoms due to conceptions related to sexuality and gender.

Performing the analysis of the ZIKA virus situation with the participation of community actors and institutions, allowed to have a comprehensive view of the problem of Zika in the context of the emergency, in which it is difficult to practice studies in depth. The information collected from the analysis permanently fed the project design, and the adaptation of the action strategies contributed to generate empathy and commitment of the community and the institutional actors of the territory with the proposals oriented to work in response to Zika.

2.1.3. Lessons learned

2.1.3.1. Strategies and actions must be adapted to the context of each territory

The knowledge of each community in which the project is going to act is key to adapt the intervention's strategies and actions to its social, political, cultural and economic dynamics and contexts. For example, urban and rural territories are radically different, therefore, particular strategies must be design for each case. The same happens when considering the level of organization a particular community has: some communities are organized and have a leadership that represents collective interests, while some communities experience the opposite. Therefore the intervention parameters in the communities cannot be homogenized.

2.1.3.2. Community participation is a must in order to improve results

To achieve better results in the control and prevention of Zika, community participation and empowerment is key. Participation must take place throughout the intervention process, from the analysis of reality, design, planning, to the execution of communication, and vector control actions, as well as monitoring and evaluation. It is necessary to have methodologies and tools to ensure that the institutional and community actors know about the subject, that they are committed to and participate in the mobilization of the community.

It should be added that this lesson learned is also relevant to other thematic axes, such as sustainability. This raises the need for all community actors to participate, for example, in the construction and transfer of techniques and tools for action.

2.1.3.3. Volunteers must be recognized and legitimized by their own communities

The role of volunteers is essential to promote community participation and mobilization. In order for them to do it in the best way, they must be people from the same community, who know their territory, their neighbors, their culture, and their customs. They must be people who enjoy the trust of the community and who have legitimacy and credibility to promote defined actions in their communities.

These actors must be accompanied by those who manage the project, as well as by the public institutions with which they are linked. This accompaniment task allows these actors to build their role as volunteers from learning by doing, which means that the volunteer is done builds itself from the practice itself. Thus, the practice becomes a pedagogical source.

2.1.3.4. Groups and organizations should be promoted around common goals and interests

In several projects, groups of pregnant women were formed aiming to be trained on Zika prevention actions and the risks of Congenital Syndrome. In some experiences, participants also addressed other issues related to pregnancy and turned the groups into supportive spaces.

With adolescents or young people, awareness building and training in Zika control and prevention actions was made possible by addressing to their demands for support to organize and have a space to learn about sexuality or violence prevention issues.

This shows that people organize when there are common interests and, organizational spaces respond to their needs and concerns of useful knowledge for their daily lives. In case of another epidemiological emergency response event, it should be analyzed where the point of common interest for the population lays and how to insert it into (or associate it with) the primary subject that calls for project action.

2.1.3.5. Planning should be promoted to mitigate the impact of patronage practices that hinder working with the community

From the opinions gathered in several working groups, it was mentioned that the client practices of the authorities or leaders, especially at the local and community level, hinder the work sustained with the community because they limit their empowerment and co-responsibility by making it a passive recipient of gifts and favors. Political patronage also hinders the implementation of public policies that guarantee rights. As indicated, interventions must consider the risk of client practices occurring and define actions to mitigate their impact. The strengthening of gathering groups between actors, such as volunteers, pregnant women, "care-group" members, is one of the strategies that could contribute to this objective because they constitute spaces for learning, planning, and decision-making. We must strengthen these spaces from and with the actors, that is, making them their protagonists.

2.1.3.6. Community mobilization in-emergency differs from the one that would be implemented in medium and long term

Community mobilization in the medium and long term is necessary. However, since we are addressing an emergency, time is limited, therefore it is necessary to capitalize on the learning, as well as on the existing community integration spaces, and the articulations that from here are built with the health authorities and other institutions that work in surveillance and response in public health.

In emergency interventions it is very complex to include community mobilization, because it is not always possible to locate leaders, or organize the community. However, looking for and knowing the organizational structures that existed before the emergency facilitates the path. (Group work. Facilitator Dr. Josefina Coloma. Topic: *Reflection on the interventions of the CBSS, which could be reproduced and extended in other public health problems and emergencies*).

2.1.3.7. The analysis of social determinants must be included in the definition of health programs

In some worktables it was suggested that health programs, in order to to face emergencies, turn into vertical structures. That is to say, they do not allow the recognition of the dynamics of the community, of their knowledge and abilities, and therefore limit and hinder their active

participation before, during and after an emergency. It was suggested that it is necessary to consider the complexity of different contexts, the interaction of social determinants of health and how these realities interact with the community.

2.1.3.8. Projects must have clearly defined community mobilization indicators set from the beginning, to measure the participation processes in addition to the number of participants

In the reflection groups it was pointed out that the community mobilization indicators must be precise, must have clear definitions to avoid multiple interpretations, and must be defined from the beginning of a project or program. Also, it is necessary to develop the capacities of the project teams in reading and analyzing the indicators.

2.1.4. Recommendations

2.1.4.1. Generate evidence on the processes developed and their results through systematizing the experiences developed by the projects to promote community participation and mobilization for the control and prevention of Zika

The systematization should analyze the experiences in particular contexts, such as the presence of violence or climate change, and provide guidance to promote community participation and mobilization for Zika control and prevention in emergencies.

2.1.4.2. Strengthen the relationship with the health authority

To cope with an epidemic such as Zika, programs based on community mobilization and participation must, from the beginning, be linked to the competent local and national health authorities, as well as to the general local authorities, in accordance with regulations and the competences established in each country. This suggestion was made in the need to recognize and improve the work of the community; for example, incorporating into their system of references those made by community agents.

In addition, to ensure the sustainability of promotion and prevention programs with community participation, it is necessary to influence the definition of public policies, laws, ordinances and technical standards as necessary.

2.1.4.3. Activate the role of local governments

The health competencies of the municipalities differ between countries; however, there are similarities between the competences related to services that directly affect the health of the population, among them: territorial planning, provision of drinking water and sewerage, solid waste management, risk management, inter-institutional articulation in the territories, and the strengthening of community participation. These competencies, given they are directly related to the living conditions of the population, constitute an opportunity to work, with community mobilization, on the prevention of diseases such as Zika.

In health emergencies, it is necessary to strengthen an active role of local governments, in promote an adequate performance of these competencies.

It is necessary, among other actions, to influence the institutionalization, by local governments, of prevention and control programs based on community participation and mobilization. This can be achieved through the formulation of local regulations, training of institutional personnel and allocation of resources for prevention.

Additionally, it is necessary to strengthen the knowledge of community actors about the competencies of local governments in responding to public health problems, including emergencies.

2.1.4.5. Listen to people in order to respond to the priorities identified by the community

The big challenge is to listen to people and respond to the priorities identified by the community. Community participation must be understood as a process that is built permanently and systematically. The starting point is to recognize that the community has capacities and strengths - not only - needs and weaknesses. A participatory process will allow the same community to identify their problems, prioritize them and be part of the decisions for the solution. Therefore, focusing on the problem-solving capacity that communities have is essential to succeed with community participation and mobilization.

2.1.4.6. Implement monitoring and evaluation systems with indicators that can be applied in the context of an epidemic or public health emergency and in post-epidemic intervention processes

The monitoring and evaluation system should be designed, if possible, from the beginning of the program or project, and with the participation of institutional and community actors. It must incorporate outcome and impact indicators with clear and specific definitions and their means of verification.

Where possible, technology should be used to develop friendly systems that allow the community actors themselves to enter, read and analyze the data collected, before transferring the information to the health authority. The training of institutional and community actors in the use of indicators, should not be neglected, nor the participation of the actors in the monitoring and evaluation of the actions of the program or project.

2.1.4.7. Strengthen community capacities

The strengthening of communities' capacities must always be nourished by the basic principles of respect for the values, knowledge, culture and decisions of the community. The contribution of community leadership is essential to the entire process and cannot be left exclusively to technical staff.

Once these basic principles have been observed, different paths can be proposed to strengthen community capacities: leadership training, gender equality, development of community organizations, social communication for behavior change and others. (Increase of community capacity and community empowerment to promote health. Helena Restrepo. PAHO / WHO. Fifth World Conference on Health Promotion. Mexico City, June 2000).

It is necessary to design, develop and implement a capacity building process for health volunteers that includes not only relevant issues of health surveillance, community mobilization and leadership, social and behavioral change and others that are considered important, but also that includes mechanisms to officially recognize the community members' abilities; for example, certification by both academic bodies and ministries or secretariats of health. The best incentive for community members is to be offered the opportunity to work for the solution of problems and conditions that negatively affect their daily lives. Making the capacity building programs of health volunteers have incentive or motivational plans, will ensure their sustainability over time. Finally, this process should seek to link volunteers to health institutions.

On the other hand, as community capacities are strengthened, through participatory processes, it is also necessary, in order to promote coordinated work, to develop capacities in other key institutional actors, such as officials of education, and health and local government institutions. It is recommended that, as a result of information, communication and / or education processes, these officials be sensitized and trained in what community work means, its importance and relevance in health surveillance.

This awareness building and training will not only allow the recognition of volunteers, brigades, monitors, etc., of their solidarity organizations such as health committees, situational rooms, inter-sectorial tables, but it will also allow to legitimately include this collectives as important elements for the implementation of CBSS, thus guaranteeing a strong link between the community and its structures with the health authorities.

Before considering the capacity development processes of community actors such as volunteers, monitors, brigades, etc., clear criteria should be proposed and discussed to define the profile of the volunteer in different contexts. In addition, it is important to ensure that the community participates in the selection process to ensure its legitimacy and acceptance by its neighbors and organizations.

2.2. Community-based Epidemiological Surveillance (CBSS) for the prevention and response of public health problems: learning from the response against Zika

2.2.1. Conceptual framework

Public health surveillance is an essential function associated with state and citizen responsibility for health protection, consisting of the systematic and constant process of collecting, analyzing, interpreting and disseminating specific health-related data, for use in the planning, execution and evaluation of public health practice "(PAHO Colombia Knowledge Center, 2012, p.6).

Surveillance therefore allows timely actions to improve the living conditions of individuals and the community.

Community-based epidemiological surveillance (CBSS) is defined as:

> "Strategy of the Public Health Surveillance System aimed at the identification, analysis and dissemination of knowledge associated with events, risk factors and / or determinants that, based on the information collected, analyzed or built, are likely to affect the health and quality of life of organized populations as a community". PAHO, Ministry of Health and Social Protection. Proposal for the operation of the community-based public health surveillance strategy. Colombia. Bogota, 2014. Page 16.

The CBSS favors the generation of a set of capacities in the population that aim at the construction or strengthening of an active citizenship in health, manifested by a progressive increase of their knowledge on the subject, social and citizen participation, the exercise of social control and the awareness of co-responsibility and solidarity towards health and quality of life.

The CBSS involves citizen participation in the collection, organization and analysis of data and information on a health situation. In this way, inputs are configured so that the community identifies actions in response to the health status found. In emergency situations, where the affected territory may be extensive or vulnerable to other events, the population is nervous and distrustful, with very little capacity to act; while health personnel are almost always insufficient to respond to the emergency. In these circumstances, CBSS can be very important.

The CBSS is not an alternate system; it is a support or a complement from the community structure to government public health surveillance systems. In the CBSS, the community identifies the risks and the alternative solutions, becoming an active social actor in its own transformation and health maintenance. http://cruzroja-zika.org/vigilancia-basada-en-comunidad/

Given the CBSS in recognition of the capacities and knowledge of the community, three fundamental pillars for its implementation can be described:

1. Contribute to strengthening community capacities: training and community organization in surveillance and diseases public health interest, specifically the collection of information and notification about community health.
2. Promote social mobilization: facilitate spaces for community integration, articulating them with health authorities and other institutions that work in surveillance and response in public health.
3. Support communities and health authorities: Sensitive, simple and reliable community support systems, linked to feedback and health authority's response. http://cruzroja-zika.org/vigilancia-basada-en-comunidad/

Working in CBSS demands that the State and other institutional allies, public and private, recognize that the community is the bearer of knowledge and skills that allow it to take on challenges in the face of health situations.

2.2.2. Good practices

2.2.2.1. Community-based epidemiological surveillance (CBSS) is based on the participation and appropriation of community actors

Community-based epidemiological surveillance is based on the active participation of actors in different spaces and community networks. It democratizes access to information, contributes to the analysis of reality, to the generation of community capacities, and enhances commitments for action against epidemics or health problems.

> "There is agreement on the importance of community participation to address these problems, and the implementation of the CBSS strategy is a powerful tool to generate community mobilization and the empowerment of the population for health care and promotion." (Dr. Josefina Coloma, Introductory conference. Community epidemiological surveillance. Lessons learned and results found) ".

For the implementation of the surveillance model, 100% of the homes in the project intervention area were scanned and sectorized. Care groups were structured and cascade training began. Community facilitators were trained to form care groups, each group consisting of 10 to 12 brigaders who received training with the responsibility of promoting healthy behaviors and prevention of ZIKA. Each person had to visit 10 homes, which allowed to cover the total population of the area of influence of the project. (David Parajón - SSI Nicaragua PANEL 1. Topic: Community epidemiological surveillance. Lessons learned and results found in the experiences of CBSS implementation) (Community Based Surveillance Systems: emphasis on inter-institutional linkages).

2.2.2.2. The participation of community actors in Zika virus control and prevention actions is strengthened through their participation in the construction of messages, communication materials and community actors training

Health promoters and community volunteers should be part of the construction and validation of messages and communication and training materials. For example: home visit guides, verification and control guides of ovitraps, among others, since it helps to strengthen their knowledge and develop their self-esteem, personal confidence and their commitment to community action, participation and mobilization.

> In El Salvador, a experience with 200 communities and 184 schools, three fundamental components were the basis to develop the CBSS system: 1. Awareness and information to the community, through friendly and appropriate communication material for local realities. 2. Training for volunteers, following a curriculum developed, which included among the following topics: spokesmanship, communication, and management of communication tools. In addition, edu-communication materials were prepared for volunteers whch included information on generating community capacities in leadership, communication and community organization. And, 3. Identification and notification of cases by applying the training provided and use of protocols and guides. (Luis Andrade. El Salvador. Panel: Contrast the lessons learned and the results in CBSS's experiences with the local reality).

2.2.2.3. Coordination with the Ministries of Health and Education has had a multiplier effect

The projects established coordination mechanisms with educational units, with educational authorities of the territorial level, and with officials of the Ministry of Health, creating training spaces, information analysis and institutional coordination that helped strengthen the community's role in the CBSS.

In the CBSS implementation process, teachers and students became facilitators and transmitters of information in the educational units, as well as in their families and with their community. The participation of school children and adolescents emerged as a great strength in the project given that they became replicators in their homes and communities. (Group No. 2. Facilitator: Arturo Sánchez. Topic: Reflection on CBSS interventions that could be reproduced and expanded into other public health problems and emergencies).

2.2.2.4. The platforms and computer networks allow to have information in real time and take appropriate actions for control and attention

The computer platforms, developed with simple language and easy-to-apply tools, are easy to use by community actors and ensure their participation in the generation of information that allows decision-making by both the community and the health authorities.

In Nicaragua, the "Dengue Chat" was created: a WhatsApp group to give real-time warning about positive hatcheries and to allow timely action. It is a tool that also allows the data to return to the community, which is important because it activates the community. (Dr. Josefina Coloma. Introductory conference: Community epidemiological surveillance. Lessons learned and results found in the experiences of implementing Community-Based Surveillance Systems: emphasis on inter-institutional linkages).

2.2.3. Lessons learned

2.2.3.1. The strategy "Socializing evidence, planning alternatives" (SEPA) must be used in the implementation of the CBSS.

This strategy was implemented under the methodological approach of participatory action research. SEPA strengthens community capacities because the generation of evidence is carried out with the participation of family and community members. In addition, the use of SEPA contributes to making the key messages addressed to families, and in general to the community, appropriate to their needs and realities.

The evidence that supported the key messages in the communication material used in the community came from the analysis performed both in entomological studies and in knowledge attitudes and practices (CAP), which were analyzed jointly with the community using the SEPA strategy. (Dr. David Parajon. Panel. Community Epidemiological Surveillance. Lessons learned and results found in the experiences of implementing CBSS).

2.2.3.2. A horizontal relationship must be maintained between health personnel and community actors and within communities, in order to promote communication and participation

Health personnel should maintain a horizontal relationship with members of the community who have been sensitized, trained and informed. In turn, this group must maintain a horizontal relationship with the other members of the community that have not yet been trained. This horizontal relationship will have a multiplier effect on the transmission of information and knowledge to other neighbors. These partipating community members, who are called doers, play a key role in community communication and participation.

The notion of "doers" is an innovative conception regarding community participation and role. Doers are people from the community, neighbors who are sensitized and informed, capable to take actions for vector control and prevention, but also promoters of a multiplier effect as information transmitters to neighbors. Doers are more likely to talk to their families at two points and three times more likely to talk to neighbors. (David Parajón-SSI Nicaragua. Panel: Community epidemiological surveillance. Lessons learned and results found in the experiences of implementing Community-Based Surveillance Systems. Emphasis on inter-institutional linkages).

The surveillance actions carried out by the community actors - volunteers - to verify whether the people or the family implemented the "good practices" should be done with a perspective of accompaniment - and not of supervision - and have a maximum periodicity of 15 days to achieve better monitoring and impact. Home visits constitute a fundamental tool both to build conditions for social and behavioralchange and for CBSS with community participation and mobilization.

> In the home visit, a respectful, informed and evidence-based dialogue must be established to learn by doing. Evidence of the presence of larvae and adult mosquitoes in the house should be sought together, to reflect upon the actions that can be taken, and to finally establish agreements that compromise participation. The volunteer or technician who makes the visit must maintain an attitude of accompaniment, and not of supervision, in front of the family. (Dr. Josefina Coloma. Introductory Conference. Community-Based Epidemiological Surveillance).

2.2.3.3. Collective work between technicians and the community should be promoted to develop and strengthen community capacities in leadership, communication and community organization

Developing the capacities of the community must be the result of a team work between health, communication and community development technicians together with the community. The content of educational-communicational materials must be aligned with the key messages that promote leadership, communication and community organization. Its content must be concrete and written with clear and precise language.

The sensitization and information to the community for the development of their capacities, through friendly communication material adapted to local realities, allowed the identification of community volunteers, later trained in leadership in order to articulate Zika prevention and control community committees. This was achieved by taking advantage of the collective work of communication and health technicians, and with the contributions of people from the community. (Dr. Luis Andrade. El Salvador. Panel. Contrast the lessons learned and the results in CBSS' experiences with the local reality).

2.2.3.4. The implementation of the CBSS must be carried out in coordination and articulation with the health authority, for example, with the Ministries or Secretariats of Health

Coordination and articulation at the national level, with the Ministries or Secretariats of Health, especially when the administration and competencies are centralized in these institutions, is essential for the implementation of the Community-Based Epidemiological Surveillance proposals at different levels of government.

Coordination and articulation with the Ministry of Public Health, at all levels, enabled the implementation of the CBSS. Intervention areas were selected, and agreement was reched on strengthening the use of the reference / counter reference system. In addition, this coordination helped to connect the population with the health-care system. (Dr. Luis Andrade. El Salvador. Panel. Contrast the lessons learned and the results in CBSS' experiences with the local reality).

2.2.2.5. The CBSS helps strengthen community structures to respond to health problems such as Zika

The creation and / or strengthening of community spaces or structures, such as the situation rooms, or the Zika prevention and control committees, facilitated the comprehensive analysis of the information collected by the CBSS community actors. In these spaces, epidemiological surveillance, communication and sustainability strategies were articulated to boost community mobilization and articulation with the health sector.

In Guatemala, an important strategy to boost community participation and the implementation of preventive actions was the creation of the community situation rooms, where the information collected from the ovitrap readings and the identification of probable cases was presented and analyzed. This allowed to operate actively for the elimination of hatcheries and for referral of probable cases to the health units. In addition, the communication messages were reviewed and those that achieved better acceptance and promoted behavior change were prioritized. (Dr. Arturo Sánchez. Guatemala. Panel: Face the lessons learned and the results in the experiences of CBSS and inter-institutional coordination).

In El Salvador, the Zika community prevention and control committees organized surveillance and notification of probable cases. (Dr. Luis Andrade. El Salvador).

2.2.3.6. Community-based epidemiological surveillance and control systems must be linked to the Ministry of Health or governing body

The CBSS registration system must be linked to the health sector systems, so as to allow the referral of probable cases for their attention and to facilitate prevention actions, etc.

The registration and control systems of the CBSS should be linked to the institutions, through common protocols and tools that allow greater effectiveness in prevention actions, as well as in the response of attention to suspected disease cases . Dr. Arturo Sánchez. Guatemala. Panel. (Contrast the lessons learned and the results in CBSS' experiences with the local reality).

2.2.4. Recommendations

2.2.4.1. The CBSS must have an integral and interdisciplinary character

To understand the integral and interdisciplinary nature of health surveillance interventions, such as CBSS, it is important to know and discuss the social determinants of health. It is recommended to strengthen the capacities of local governments and other local institutions to discuss the determinants of health.

Coordination with local governments contributes to more comprehensive interventions, better relationships to improve environmental conditions and to stimulate articulation and intersectoral interventions.

2.2.4.2. Promote social mobilization of communities

The production of information from the community, through its volunteers, monitors or brigade members, accounts for the health situation. The analysis of this situation, where problems are identified, prioritized and possible solutions to them proposed, are elements that can and should generate an important social mobilization of the community and its organizations. In turn, this mobilization must open spaces in which the institutions listen to the needs and proposals of the community, and only then provide answers.

In the spaces of participation for people and their communities, such us health committees, intersectoral tables, and situation rooms, reflection, decision-making and mobilization of the same community are promoted. In addition, these spaces are a source of production of information necessary for decision-making by health authorities or other govern bodies, whose competences are linked to the prevention and control of diseases caused by arboviruses.

A trigger for social mobilization is undoubtedly the transfer of technologies, methodologies and tools that help the community make sound decisions and improve their practices and behaviors. It is recommended that all interventions ensure that the capacities to face future emergencies

through community mobilization are installed and developed in the communities. And it is also recommended to position this working model with health authorities and local governments.

The transfer of methodologies and technologies is achieved when the institutions, together with the communities, systematize their learning, best practices, lessons learned, and challenges. As a product of systematization, manuals, guides, protocols, etc., should be developed, with clear examples of the experience, to make them available to all the actors involved, both institutional and community.

2.2.4.3. Support communities and health authorities to develop support systems that allow them to easily link

It is recommended to establish monitoring and evaluation systems with indicators that allow measuring compliance with the objectives and results of the CBS systems and the validity and relevance of these systems in public policy.

It is necessary to support the communities and the health authorities so that they have systems that ensure that the data produced by the community agents is of quality and triggers timely feedback, both from community organizations and from the Ministry and Secretariats of Public Health, plus other institutions responsible for surveillance and response in public health.

It is recommended that any in intervention, whether in emergency or long-term situations, the joint information system be implemented since the beggining, involving institutional actors together with community actors. This would allow the data collection instruments to become real support for both parties, and guarantee a feedback to the authorities' response and to the construction of public policies.

These information systems - defined together - must have simple, sensitive and reliable mechanisms to generate evidence of the disease at community and local level, and regarding its cost. These evidences will contribute to the institutionalization of the CBSS and to the generation of a local public policy that guarantees its sustainability. In most of the experiences shared during the international meeting, it was mentioned that the systems provide information for the formulation of public policies adapted to the reality of each country.

In the same way, these mechanisms must support the integration of data produced by the community into the health surveillance system and demonstrate this data's valdity as a complement to the other institutionalized registration systems. This will reinforce the social mobilization necessary to ensure community empowerment.

It is necessary to link academic sectors, such as universities, in the generation of evidence of the impact of CBSS on the health of the population, which ensures immediate and appropriate responses from health authorities.

2.3. Communication for Social and behavioral Change (CBSC)

2.3.1. Conceptual Framework

USAID defines social and behavioral change as the following:

"Activities or interventions that seek to change health search behaviors and the social norms that enable them. Such interventions may be based on a number of different disciplines, including communication for behavior and social change, marketing, advocacy, behavior economics, or person-centered design. "

In an emergency context, it is essential to prioritize the behaviors that need to be changed or modified urgently and it is these that should guide the design of CBSC strategies. Breakthrough Action and Breakthrough Research, working with USAID and in consultation with the implementing partners in the Zika response (with community mobilization), developed a matrix of Zika prevention behaviors, taking into account the supporting evidence and its feasibility. Seven behaviors delineated in three categories are defined:

Table of behavior categories for social change

Category	Behavior
Personal protection	• Use mosquito repellent (DEET, Picaridine, IR3535 and lemon eucalyptus oil only), following the indications of each product during pregnancy to reduce the risk of Zika transmission by mosquito bites. • Use the condom during pregnancy to prevent Zika sexual transmission.
Vector control within the house and the community	• Regularly eliminate standing water accumulated inside and outside the house, and in areas of community use. • Cover the water storage containers, rarely used, at all times with a tightly fitting lid, taking care that the lid does not deform or touch the water. • Brush the walls of water storage containers, often used, to remove eggs from mosquitoes.
Appropriate behaviors	• Attend prenatal control consultations to monitor pregnancy and learn about the risk of contracting Zika and how to prevent it. • Seek advice from a trained provider about modern family planning methods, in case you do not plan to get pregnant.

Source: *Zika Prevention Behaviors Matrix. Breakthrough Action and Breakthrough Research, 2018.* **Prepared by:** *Systematization team.*

The CBSC definitions establish the common denominators of this communicational approach in the following terms:

To this systematic, strategic character, sustained in models of behavior change and organized through multiple channels and media, it is important to add one more feature that completes the characterization of the approach:

> "...It is an **interactive process with communities** to develop appropriate **messages and approaches**, to develop positive behaviors, **promote and sustain** the change in individual, community and society behavior" (FHI, 2002).

Therefore, the CBSC requires the active participation of those who will - certainly- be the individual and collective subjects of the change towards positive behaviors and, consequently, of social and cultural changes. The more articulated and integrated the set of lines of action is, the more power the implementation has to modify behaviors and social habits.

The Pan American Health Organization (PAHO) states that:

> "... To achieve these behavior changes, it is important to **analyze** in depth the **behaviors that are intended to be modified**, which in turn suggests what **means of communication** should be used to promote them. In addition, the **epidemiological moment** (or inter-epidemic interval) at which the corresponding messages would be transmitted should be considered" Pan American Health Organization, 2017, p.21)

Here PAHO refers to three key aspects: 1. The identification of the behaviors that are to be generated 2. The means and messages that will be used and 3. The epidemiological moment in which the messages will be disseminated. To achieve the changes sought through the CBSC, some conditions are considered necessary:

- Adaptation of content to the context in which it will work.
- Construction and reiteration of messages based on the prioritization of established behaviors.
- Incorporation of different key actors to promote responses to Zika.

2.3.2. Good practices

2.3.2.1. To achieve behavior change, work must be based on the knowledge of reality as the basis for communication action.

The knowledge of the local reality, of the culture and of people perception about Zika must be the basis for motivating behavior change. Home visits, workshops, fairs and other spaces of interpersonal communication are decisive actions to influence behavior change.

It should focus, in terms of territories and public, behaviors to be modified to better identify: the language, media and communication resources that will be used to reach people with information on what to do to ensure control and prevention of Zika.

It should focus, in terms of territories and public, in behaviors to be modified, to better identify: the language, media and communication resources that will be used to reach people with information on what to do to ensure Zika control and prevention.

The communicative process includes training of community actors on technical-scientific knowledge. In this process, the training content must be transmitted and reiterated considering: respect for culture, respect for knowledge and commitment to the abilities of people to process information, capabilities to rebuild and incorporate new knowledge.

2.3.2.2 Interpersonal communication is vital to influence knowledge, and attitude and behavior change

The participation of each subject as an individual, as part of a group or as a communication agent requires the development of interpersonal communication skills and also of knowledge on the specific culture and territory. Volunteers, brigades, and monitors, have enormous potential to influence - at home and in the community - to produce knowledge and in attitudes and practices modification for Zika control and prevention, especially if they are native to the territory were the intervention develops.

The implementation of communicative actions contributes to the empowerment of people, who when assuming the role of voluntary agents, discover their communicative talents, thus becoming "community communicators" - one of the pillars of social communication for behavior change - able to sustain long-term actions and assume similar tasks in front of other community needs.

2.3.2.3. The population must participate in the construction communication products, especially when it comes to promoting change of specific behaviors in order to achieve long term cultural adjustments

In the experience of Nicaragua on the construction of key messages, the SEPA methodology (Socialization of evidence for participatory action) was implemented. This methodology starts from the generation of evidence with community participation, which allows to identify behaviors and risk factors that constitute the main input to build key messages adapted to local needs and reality.

The construction of messages and communicative products must be carried out on the basis of attitudes, practices, behaviors and motivations' analysis for people's behavior change in relation to the subject, in our case, response to Zika's emergency. The next step is to include the population, through consultations, in the definition of written, oral, and / or graphic language to be used in communications.

The experience in Ecuador on the "Inclusion of men in the actions of prevention and control of the Zika virus" was based on the results of the CAP studies, as well as on the participation of men in the communication design aimed at promoting the elimination of mosquito breeding sites and the prevention of Zika virus' sexual transmission.

In communication actions for social and behavioral change it is important to define differentiated strategies and forms according to age and culture, to include them in Zika prevention and control actions. The experiences developed with adolescents were based on listening and valuing their life projects, as well as training, so that they were motivated to assume, in turn, the role of trainers, a task that empowered them in their educational, family and community spaces.

2.3.2.4. Educational and communicational actions must be articulated with those of community participation, in order to generate favorable conditions for changing attitudes and behaviors.

To influence social and behavioral change, strategies must be developed, which articulate educational (learning) and communicational (information and dissemination) actions with participation and mobilization actions.

Volunteers must reach individuals and families with information and knowledge about the actions they should take to protect themselves from mosquito bites, to eliminate their hatcheries, and other issues of interest to the community. The volunteer who performs the home visit should know about the subject, handle the key messages and the communication material that he will use.

2.3.3. Lessons learned

2.3.3.1. Without the participation of the individuals and the community, a change in attitude and behavior is not possible

Community participation is the pillar of any communication strategy for social and behavioral change. The experiences demonstrated the importance of mapping key actors both individuals and institutions, identifying their roles and building alliances with these actors. In addition, networks and organized spaces already existing in the communities must be recognized because they are key to enhancing participation, as well as the construction of plans from and with the community. Finally, for the action of the projects, partnering with community leaders who know the mobilization mechanisms in their territories is fundamental. (Opinion expressed during the group exchange on lessons learned).

Putting these lessons learned on participation into practice ensures:

- The knowledge of the context and, therefore, relevance in the communication strategy.
- The construction of appropriate messages, in the appropriate language and, disseminated through the appropriate means.
- The empowerment of the protagonists of change, that is, the people.
- The mobilization of capacities and resources already existing in the community, around a common objective.
- The permanence in the time and, therefore, generation of changes in the long term.
- The social and cultural sustainability.

For that,

- Supporting and strengthening, permanently, the groups of volunteers and brigade members to develop multiple capacities, in communication, in field research and in participatory methodologies, is a key to overcoming several of the challenges that arise. (Opinion expressed during the group exchange on lessons learned).
- Strengthening the capacities of community actors, of all ages and, especially, of young people is also a factor of sustainable transformation that also impacts on the modification of cultural patterns.

- Generate recreational edu-communicative spaces that help break taboos; design and implement peer education spaces, completely horizontal; as well as listen and identify the needs of knowledge and life projects; are lessons learned in sustainable work with teenagers. (Zika Project CARE Ecuador).

2.3.3.2. The selection and prioritization of behaviors that need to be modify guides the dissemination of information to build new knowledge, to transform into behaviors

Prioritizing the behaviors that the implementation seeks to change, allows the construction of limited and necessary messages; these have to be clear, concrete, culturally relevant: considering written language, sound and image; and they have to be repeated through different media and communication actions.

The prioritization of behaviors to modify, based on evidence and feasibility, facilitates the observation of the impact that the communication strategy, articulated to the set of project strategies, effectively has on the behaviors of the populations.

Aiming to focus the efforts on the key behaviors, that have the greatest potential to reduce Zika transmission risk - including intrauterine -, Breakthrough ACTION and Breakthrough RESEARCH, with USAID and the implementing partners developed the "Matrix of behaviors with the greatest Zika prevention potential"

https://www.zikacommunicationnetwork.org/sites/default/files/resource_files/Zika-Prevention-Behavior-Matrix-spanish.pdf

2.3.3.3. The communication strategy outlined in an emergency moment not necessarily works when the peak of the emergency passes, or when the emergency is not perceived as such by individuals and communities

A lesson learned was that a specific issue such as Zika should be inserted into the set of problems and major concerns of the communities. If the perception of risk falls or is non-existent, the problem is dealt within the framework of broader and more comprehensive actions that respond to other problems that are more important for these communities. Addressing the major problems and concerns of the communities and, in that context, the work around Zika, is key to the CBSC and to community mobilization.

The common denominator was that no community understood the risk of Zika and thus the concerns that mobilized them were others. Therefore, working with the community from the knowledge of its broader problems and linking them to Zika was a key. (Project CAZ Communicative Action against Zika, in the Dominican Republic).

Communication strategies must be planned to intervene at the time the emergency is at its highest peak. However, the strategy must also consider what will be done when the emergency passes and the risk remains. That is why we talk about strategies and - not only – about communication actions.

2.3.3.4. Messages to raise risk perception should be based on evidence

The evidence must be included in the communication narrative that is built. It is essential to raise the risk perception, as this is the catalyst for action and behavior change.

Another aspect of particular relevance is the ability to adapt strategies and segment audiences as evidence is obtained. These two factors have called for methodological flexibility, identification of opportunities in different contexts, and the search for new solutions that have usually led to good practices. (Breakthrough ACTION).

A communication strategy for behavior change should be based on clear evidence and have the ability to change over time as new evidence is recorded. The permanent attention to the evidences that arise from the processes and the adaptive capacity of the communication strategy to these evidences, gives the communication narrative the possibility of going hand in hand with the community dynamics. Therefore, when enhancing the processes' communication approach, their mobilizing potential increases.

2.3.4. Recommendations

2.3.4.1. Communication is a strategic line of work in social and behavioral change and should be considered from the beginning in the interventions / projects to be executed

It is important to include communication from the beginning as a strategic line in the projects to be executed. In this way, the communication is articulated - in a coherent way - to all the components of the project, enhancing its support capacity and its transforming action.

The design of the communication strategy must contemplate, know and respond, at least, the following aspects:

- Cultural relevance within a social and political context.
- The precision and rigor in the messages built.
- The language, images and communication resources close to the codes and daily life of the communities.
- Knowledge and use of the opportunities and communication flows already existing in the communities.
- The key actors that influence community dynamics must be part of the design, execution and evaluation of communication actions.
- Flexibility in the implementation of the strategy, so that it can respond in a timely manner to changes in context and the evidence that occurs throughout the process.

In the strategy design and throughout the implementation, actions that point to the three levels of change must be ensured, that is, the staff, the group and the community; all of them necessary from the perspective of the sustainability.

2.3.4.1. CCSC strategies must be designed and executed taking into account two key moments: the emergency and the "post" emergency

In a context of emergency, the following is recommended:

- Conduct rapid diagnoses to identify the perception of risk in the strategy's different levels of intervention: personal, group and community. These diagnoses must allow identifying knowledge, attitudes and practices existing in relation to Zika virus control and prevention.
- Elaborate messages, use communicational supports, and develop communicative actions aiming to raise the risk perception.
- Deploy materials and actions in the appropriate time, that is, at the peak of the emergency.

In the post-emergency context, it is recommended to identify, through participatory mapping, the following aspects:

a) Actors that CSBC strategy considers, for example: the health, education and other sectors that play decisive roles in the territories, either because of its decision-making capacity, or because of its direct relationship with the population;
b) Effective information flows and communication circuits in the community;
c) Key cultural patterns that can act for or against the change in behaviors sought.

2.3.4.2. The communication strategy for the CSBC must be adapted to the context of the intervention and the changes that may occur

The communication strategy must not be static but adapted to the changes in the context, and must employ as reference the definition of behaviors that need to be modified in order to achieve a specific objective.

There are some sources of information that provide evidence to supports behavioral changes sought. For example: the systematization of communication, participation, mobilization actions; the results of the CAP studies, together with evidence-based analysis and available evidence; and the evidence available in the media. Starting from evidence, including it in the messages and modifying the strategy based on it, ensures opportunities to perform accurate communicative action with poignant content.

2.3.4.3. The articulation between communication, participation and community mobilization helps to generate better conditions for the sustainability of actions aimed at to social and behavioral change

Communication by itself can hardly produces behavioral changes. However, if it is articulated, in the project's strategy, joint to the lines of participation and mobilization, it will constitute a catalyst for the necessary cultural transformation processes that Zika virus control and prevention demand.

2.4. Sustainability

2.4.1. Conceptual framework

Within the framework of the health emergency, USAID support was aimed at strengthening the role of community participation and local systems to improve and expand existing efforts for an effective response to a rapidly evolving epidemic caused by the virus. Zika in the Latin America / Caribbean region (LAC). (USAID. APS-OAA-15-000004). Therefore, sustainability was not a condition for interventions, unlike what is expected with development programs.

The sustainability of the strategies and actions developed by health emergency projects should seek to strengthen the role and participation of local and community actors. Consequently, sustainability actions should improve and expand the efforts of local institutions and systems in an effective response, in this case, to the epidemic caused by the Zika virus in the Latin America / Caribbean region (LAC).

https://www.mcsprogram.org/wp-content/uploads/2015/03/Viable-Integrated-Community-Health-Platform-Brief.pdf

Sustainability implies the "need for continuous support from certain actors whose power, participation and / or contributions are essential for an initiative (or strategy) to be maintained over time". (Mokate, 2001)

During the international workshop, the sustainability and institutionalization of the interventions was analyzed. The main focus of the analysis was to determine to which level the actions developed and the results obtained created conditions to reduce the problems related to the control and prevention of ZIKA, and to ensure that the strategies and actions promoted have continuity after the completion of the projects.

This prompted to identify, in the context of the action against the Zika epidemic, who are the actors at different government levels (national, regional, local level), and what are the competences, functions, roles, technical capacities and economic factors that can assure the continuity of the community mobilization strategy (for epidemiological surveillance and behavioral changes) after the projects culmination.

2.4.2. Good practices

2.4.2.1. The strengthening of existing community participation spaces should be promoted through strengthening the community's relationship with local governments and with the health care authority, at its different levels of attention.

The existing participation spaces are strengthened with the empowerment of the community. As a result of efforts in coordination with the authorities or institutions responsible for health, the community participates in the design and implementation of plans for Zika control and prevention.

It is necessary to promote the transfer of knowledge of the community to the public health institution or authority, in order for the community collective experience can serve as input in the generation of public policy instruments.

2.4.3. Lessons learned

2.4.3.1. The participation of local actors in the context of current public policies or legal frameworks should be promoted and strengthened

It is necessary that each territory have public policies or legal frameworks that encourage community participation. This ensures having responsible institutions, with assigned financial and technical resources; this guarantees to generate knowledge, participation and mobilization of communities in response to epidemics in emergency contexts.

If there is no work at the political level by promoting ordinances, it is difficult to work on sustainability. As long as there are no laws that normalize the processes, it is difficult for the community and the health authorities to sustain prevention and control actions on the individual will to change and maintain habits. It is necessary to assert influence at the political level: in the education and health sector, aiming to acquire commitments. Politically, health and education secretaries must joint efforts for interventions to become normalized (Sustainability theme: Group work).

2.4.4. Recommendations

The sustainability of strategies and actions driven by programs or projects, in response to epidemics, that are developed in an emergency context, must be thought of in two periods: First, to consolidate the planned actions during the emergency; second, to extend in time intervention actions once the project is finished.

2.4.4.1. In the context of the emergency, strengthening local systems, governmental (municipalities, districts, etc.), health, and community systems, contributes to sustainability

From the group reflections some recommendations were given to strengthen local systems in face of future emergency:

- Promote the initial dialogue with health and community authorities to socialize the proposal and seek participatory decision-making spaces during the intervention, because it will facilitate the consolidation of actions and processes.
- Identify organizational structures of community life, inter-sectorial health committees and others, and involve them in the response to the epidemic, so that they become actors in pedagogical mediation processes that facilitate in their communities the learning and adoption of preventive practices.
- Information and knowledge are resources to raise awareness and empower local actors and systems. Local systems must have information that allows the population to have greater knowledge of their reality and improve the quality of their decisions.
- The home visit is highly valued in all group reflections, as a strategy that builds trust and keeps community actors informed.

2.5. Other subjects

2.5.1. Quality assurance in emergency interventions

In health, quality assurance process has been developed mainly to guarantee quality of care in health services.

An essential public health function is to guarantee and improve the quality of individual and collective health services (PAHO); however, there is little evidence of quality assurance and control in community-based health actions.

Quality control is the verification of compliance with quality standards –previously– defined to guarantee the planned product. It is a reactive procedure that is applied to a finished product. Quality assurance is proactive, preventive, and seeks to avoid failures or defects in the product. (J. Chang. USAID).

It is required to work within the framework of a Quality System and have a standard operating procedures for each relevant activity carried out with or by the community.

Although not all projects worked on the quality assurance of community-based interventions, those that did contributed elements to be considered in response to future epidemics.

2.5.1.2. Good practices

2.5.1.2.1. The control and improvement of the quality of community interventions in response to Zika

In the activities that were carried out with the participation of the community, protocols, checklists, and other tools were applyied to contributed to assure the proper quality in these activities. These also made possible to identify problems in the activities' execution, and make adjustments for the improvement of their quality.

Quality assurance was implemented in some CBSS experiences developed in Central America and Peru. In one case, it contributed to the work of community volunteers employing ovitramps, producing valid data; in another, it allowed to discover and correct problems in the training of volunteers in the use of flipcharts during home visits.

Protocols were developed for the training of volunteers and to verify the egg-count in ovitraps. With the use of the protocol, the results of the work carried out by the volunteers were compared with the mosquito egg-count performed by experts. (Julie Niemczura. ZICORE Guatemala and El Salvador. Panel. Quality Assuranse and Control).

Tools were generated to allow monitoring the competencies of community monitors (volunteers) regarding the registration and management of information, as well as home visits compliance. (Julie Niemczura. ZICORE Guatemala and El Salvador. Panel. Quality Assuranse and Control).

2.5.1.3. Lessons learned

2.5.1.3.1. Ensuring the quality of interventions is key to improve their effectiveness, have greater impact and promote sustainability

The checklists to register the activities' quality are very useful to identify good practices and aspects that should be improved. They also constitute training and learning tool, and when used during the accompaniment of volunteers they must generate immediate feedback for the volunteer. However, they do not determine the compliance of objectives and results, nor do they replace the process and results indicators.

In Honduras, the Quality Benchmark methodology was used, which is a set of quality checklists based on certain standards for process activities: in schools, work with children and adolescents, family visits, installation of ovitraps. The resulting information was stored virtually, and the analysis of the information served to make decisions and improve processes. (Heyhdy Ramos. Honduras. Panel. Quality Assurance and Control).

In Peru, this methodology was adapted and then implemented in the experiences of CBSS. (Rosa Galvan, Peru. Panel. Quality Assurance and Control).

2.5.1.4. Recommendations

Incorporate quality assurance processes into community interventions carried out in response to epidemics or in the prevention of diseases transmitted by Aedes aegyoti. For example, applying the quality assurance approach in the use of ovitraps in community-based entomological surveillance would imply, among other things that the community is known in detail by all the decision-making actors (maps, censuses, previous entomological data, etc.).

Established adequate procedures to carry out all processes: community selection; selection of homes where ovitraps will be placed; decisions on how to communicate with community leaders and homeowners; determination of where to locate ovitraps in the houses; procedures to inspect an ovitrap, to count mosquito eggs, to replace the ovitrap, to report a result, and to verify the results obtained by the volunteers.

Ensure that all people have well-defined roles and know how to perform them (previously trained, supervised, etc.).

Know what are the necessary resources for each process and ensure that they are available each time the process is carried out (and are of the quality established as necessary).

2.5.2. Gender approach in the fight against Zika

The gender concept refers to the "set of social, cultural, political, legal, and economic characteristics socially assigned according to the sex of birth. Gender is the different social meaning of being a woman and a man in a given culture, while sex refers to the genetic and physiological attributes that indicates whether a person is female or male". (CARE, 2013, pp.30). As a socio-cultural construction gender is, it is dynamic and changing.

Incorporating the gender approach allows explaining the social and cultural determinations that affect the naturalization, reproduction, and perpetuation of inequitable relationships: the arbitrary exercise of power, the sexual division of labor, the reification of human beings in an area as sensitive and fundamental as the exercise of sexuality, and its relationship with the prevention of Zika virus risks.

From this perspective, Zika virus posed new challenges: sexual transmission and the risk of congenital syndrome, hence the need to work around sexuality and sexual and reproductive health.

It is important to mention that the incorporation of the gender approach - in most projects - was not planned from the beginning. In several of the experiences, awareness and information strategies initially focused on women of reproductive age were incorporated. Additionally, evidence showed there is a significant need to work with men.

2.5.2.1. Good practices

2.5.2.1.1. Incorporate the gender approach since the project formulation stage

The inclusion of the gender approach is a priority task. To identify more effective prevention strategies and actions against health problems, such as Zika, and to strengthen social mobilization processes, it is necessary to start from the analysis of conceptions and practices associated with gender, exposure to risk factors and processes that deteriorate health such as: gender-based violence, sexual violence, limitations for healthy decision making in the field of sexuality and reproduction, the sexual division of labor, and assigned roles that affect the lives of women and their families.

2.5.2.1.2. Incorporate men in the response to Zika

The interventions identified the need to involve men as active part of the intervention, but there is also need to influence their traditional gender roles. To achieve a better and greater understanding of men about their responsibility in Zika control and prevention, training workshops on sexual and reproductive health and prevention of Zika were held. Also in this regard, messages about men's responsibility for the prevention of virus sexual transmission and the elimination of potential breeding grounds for Aedes aegypti in their homes and in the community were disseminated.

At the beginning it was assumed that providing information only to women or focusing messages towards them would have results. Similarly, at the beginning the focus only on information and no solutions were provided. In the implementation process, and after several visits to the homes, we all realized that it was important to also work with the couples and report on the measures that should be taken for prevention. (Danielle Toppin. Barbados Red Cross. Panel: lessons learned in incorporating the gender and diversity approach in the response to Zika)

2.5.2.1.3. The importance of strengthening women's knowledge and empowerment regarding the exercise of their sexuality and their sexual and reproductive rights should be recognized, as well as recognizing men's roles in addressing these issues.

By incorporating the gender approach in the project activities, it is ensured that the actions are not only for the inclusion of men in awareness and communication talks, but also for the analysis of gender roles in terms of home prevention actions for vector control.
Given these circumstances, in Ecuador, some proposals were made for the prevention of Zika and its consequences:

- Improve women's knowledge about their sexuality and about their sexual and reproductive rights.
- Include men in the activities of prevention and care of hatcheries, and involve them in the prevention of sexual transmission.
- Involve adolescents in the importance of building new masculinities.
- Articulate Zika prevention actions to prevent gender-based violence. (Cecilia Tamayo. CARE, Ecuador).

2.5.2.2. Lessons learned

2.5.2.2.1. The inclusion of the gender approach must be planned from the design of the projects. However, in the absence of this, there must be enough flexibility to promote their inclusion in already planned strategies and activities.

Influencing gender relations requires medium and long-range work. In the context of a health emergency, more precise definitions and clearer scenarios are required from the start, with respect to what aspects of gender will be addressed, considering what is feasible to achieve at the time of the intervention. This implies:

Generating capacity for action - agency - and empowerment of women in the community, requires more time. What can be achieved with the interventions performed is lesser, however, there can be significant improvement if there is a clear aim to work in the gender line. (Cecilia Tamayo. CARE. Ecuador).

2.5.2.2.2. Coordination with health personnel and community midwives to provide information to women and their partners

The message "Healthy mom, healthy baby" had a great impact on families, both in women as in their partners. (Danielle Toppin. Barbados Red Cross. Panel: Lessons learned in incorporating the gender and diversity approach in the response to Zika).

2.5.2.2.3. It is necessary to influence health systems and services to increase men's participation in the prevention and care of pregnancy and their risks.

Generally, health services reinforce traditional gender roles and hold women primarily responsible for the prevention, care and protection of pregnancy and the health of children. Greater impact on health systems and services is required to incorporate actions that involve men, however, it must be recognized that these processes require more time than that planned for the projects.

Influence changes in the work of health services to modify attitudes and practices that traditionally hold women as only responsible for disease prevention and health care.

2.5.2.3. Recommendations

In response to Zika and other public health emergencies, it is necessary to incorporate the gender approach from project formulation, as well as monitoring actions into its implementation. The absence of these conditions in the projects can contribute to reproduce and naturalize the inequality and disadvantage of women.

Performing the gender analysis has special significance in health problems such as Zika, given the sexual transmission possibility of contagion, the risk of associated congenital syndrome and the implications that this has on the lives of women and families. Unequal gender relations have profound limitations for women to make autonomous and healthy decisions about their sexuality and reproduction, moreover in contexts where gender violence is naturalized and gender roles firmly assigned. In this context, gender relations determine that women are primarily responsible for prevention actions within the family and the care of children affected by congenital syndrome.

2.5.3. Inclusion of disabilities in the fight against Zika

Children with some type of disability have the same rights to care from their family as children without disabilities. To ensure compliance with this principle, the United Nations Children's Fund (UNICEF) developed the Essential Components Framework (ECF) "a practical tool for the design, planning and monitoring of multisectoral policies and programs to respond with interventions and early responses to the needs of girls and boys with disabilities and their families " (UNICEF, 2019).

The ECF takes into account:

- The stages of the life cycle and the sectors with which girls and young children with disabilities are most in touch.
- The critical moments and situations that the father or mother and / or caregivers and families go through, as well as the type of support they require.

2.5.3.1. Good practices

2.5.3.1.1. Working on the issue of disabilities requires a comprehensive and inter-sectorial approach. To achieve this, it is necessary to modify the approach of families as recipients of services, towards an approach in which families are partners and a fundamental part of the interventions.

The program implemented by UNICEF in Paraguay achieved the following milestones:

- The theoretical-practical training process developed helped - for the first time - many professionals work with a child with disabilities and their families.
- The conceptual and methodological approach developed allowed us to position disability not as a disease but as a condition of people.
- It was possible to position and show that there is a better impact with early intervention programs.
- The integration of the Child Development Centers (CDI) in Paraguay, early care centers, saw improvement in the development of children and also a greater capacity of response of the mother and the family. (Adriana Balcacer. UNICEF).

2.5.3.2. Lessons learned

Addressing disabilities is an important part of the fight against Zika. Everything about the impact of the disease on health, especially the impacts on the nervous system, has not yet been known. It remains - still - to investigate more on this subject. From UNICEF's experience with a Zika response program, given the disability found in children with neurological syndromes associated with Zika, the following lessons learned are identified.

2.5.3.3. Recommendations

- Consider disability a condition and not a disease.
- Build capacities in services and professionals to address disabilities early and with a comprehensive approach.
- Rethink the purely clinical approach that means having good health, having a mother and a healthy child as a single element. It has to be a holistic, inter-sectorial intervention (relevant not only in the case of ZIKA) in relation to child development and the empowerment of families. (Adriana Balcacer. UNICEF).
- Incorporate families as partners and not as service recipients. Families are the primary caregivers of their children and who have the ability to support them to reach their full potential.

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Annex: Workshop Agenda

FIRST DAY

Time	Tuesday, 4 June 2019	Speaker/Responsible
08:30-09:00	Participants registration	CARE. Ecuador
09:00-09:30	Inauguration of the international event	Alexandra Monc Annexesada. CARE Geoffrey Schadrack. United States of America Embassy. Jaime Chang. USAID Alfredo Olmedo. Ministry of Public Health of Ecuador.
09:30-09:35	Presentation of the agenda and work methodology	Adriana Muela. CARE
09:35-09:55	Presentation of the participants	Brittany Goetsch. K4Health
Community mobilization in response to epidemics and public health problems: Principles and approaches		
09:55-10:15	**Introductory conference** Minimum quality standards and indicators for community engagement	Speaker: Elizabeth Fox. Global Health Expert: Social and Behavioral Change and Community Mobilization
10:15-10:25	**Forum Q & A**	
10:25-11:10	**Panel 1** Evidence found and lessons learned in community mobilization experiences for the prevention of Zika.	Moderator: Maria Concepción Silva. Red Cross of Nicaragua. Panelists 1. Maria Espinoza. CARE 2. Josefina Coloma. SSI/AMOS 3. Alberto Vasquez. PASMO
11:10-11:30	**Forum** Conclusions and final comments	Moderator: Maria Concepción Silva. Red Cross of Nicaragua.
11:30-11:50	**Recess**	
11:50-12:35	**Work-in-group** Reflection on evidence and lessons learned	Facilitators Group 1: Maria Espinoza. CARE Group 2: Josefina Coloma. SSI/AMOS Group 3: Alberto Vasquez. PASMO Group 5: Arianna Serino. USAID (English speaking group)
12:35-13:35	**Panel 2** Challenges in promoting community mobilization in response to vector-borne diseases: specific strategies to face challenges	Moderator: Gustavo Avila. USAID Panelists 1. Shanika John. Ministry of Health/ Saint Vincent and Grenadines. 2. Julio Ernesto Romero. San Isidro Cabañas Major/El Salvador. 3. Reyna Patricia Vasquez. Community delegate/Honduras 4. Education Delegate/Dominican Republic
13:35-13:50	**Forum** Open forum with speakers	Moderator: Gustavo Avila. USAID
14:00-15:00	**Lunch**	

15:00-15:45	**Work-in-group** Reflection on the challenges found for community mobilization and the strategies implemented.	Facilitators Group 1: Winston Sánchez. Dominican Republic Group 2: Adriana Muela. CARE Group 3: Robert Anguis. CARE Group 5: Jaime Chang. USAID Shanika John. Ministry of Health/ Saint Vincent and the Grenadines (English speaking group)
15:45-16:00	**Plenary Presentation**	Moderator: Gustavo Avila. USAID
16:00-16:30	**Panel 3** Use of indicators to work on community mobilization	Moderator: Julie Gerdes. USAID Panelists 1. Elizabeth Fox. Global Health Expert: Social and Behavioral Change and Community Mobilization 2. Julie Gerdes. USAID 3. Martha Silva. Breakthrough Research
16:30-17:00	**Forum** Open forum with speakers	Facilitator: Julie Gerdes. USAID
17:00-17:30	**Work-in-group** Reflection on the indicators used **Plenary**	Facilitators Group 1: Elizabeth Fox. Global Health Expert: Social and Behavioral Change and Community Mobilization Group 2: Julie Gerdes. USAID Group 3: Martha Silva. Breakthrough Research Group 5: Kristen Alavi. USAID (English speaking group) Arianna Serino. USAI
17:30	**Closing**	Adriana Muela. CARE
18:30	**Cultural event** Zika's Marimbada	Arbor by the pool/lobby 2
08:30-17:30	**Permanent exhibition: Edu-communication materials**	Adriana Muela. CARE

SECOND DAY

Time	Wednesday, 5 June 2019	Speaker/Responsible
08:30-08:35	Work Agenda Presentation	Adriana Muela. CARE
Community epidemiological surveillance for the prevention and response of public health problems: learning from the response against Zika		
08:35-09:10	**Introductory conference** Community epidemiological surveillance. Lessons learned and results found in the experiences of implementing CBSS (Community-Based Surveillance Systems): emphasis on inter-institutional linkage	Speaker: Josefina Coloma. Health Public School, Universidad de California, Berkeley
09:10-09:50	**Panel 4** Face the lessons learned and the results found in CBSS' experiences with the local reality	Moderator: Jose de Jesus Pineda. Global Communities Panelists 1. David Parajon. SSI/AMOS 2. Luis Andrade. CAZ 3. Arturo Sánchez. MCDI
09:50-10:10	**Open forum with speakers** Discussion on the lessons learned and results found in the CBSS and their articulation / incorporation into the national health system.	Moderator: Jose de Jesus Pineda. Global Communities
10:10-11:10	**Work-in-group** Reflection on CBSS interventions that could reproduce and expand on other public health problems and emergencies.	Facilitators Group 1: Josefina Coloma. SSI/AMOS Group 2: Luis Andrade. CAZ Group 3: Arturo Sánchez. MCDI Group 5: Gustavo Avila. USAID (English speaking group)
11:10-11:30	**Recess**	
11:30-12:00	**Panel 5** Quality assurance and control of interventions based on community mobilization to address Zika: results obtained and recommendations for the future.	Moderator: Jaime Chang. USAID Panelists 1. Rosa Galvan. CARE 2. Hehydy Ramos. CAZ 3. Julie Niemzcura. MCDI
12:00-12:20	**Forum** Open forum with speakers.	Moderator: Jaime Chang. USAID
12:20-13:00	**Panel 6** Lessons learned in incorporating gender and diversity approaches in the response to Zika	Moderator: Erin Law. IFRC Panelists 1. Danielle Toppin. IFRC 2. Cecilia Tamayo. CARE 3. Adriana Valcarce. UNICEF LACRO
13:00–13:15	**Forum** Open forum with speakers	Moderator: Erin Law. IFRC
13:15-14:30	**Lunch**	

Challenges and good practices of social and behavioral change (SBC) in the promotion of Zika preventive practices		
14:30-14:38	CCSC as a discipline, its relevance and contribution in the response to Zika.	Speaker: Desiree Luis. Breakthrough Action
14:38-15:10	Challenges, successes and lessons learned in SBC: A look from the perspective of key actors consulted in 6 countries.	Marta Silva Breakthrough Research
15:10-15:15 15:15-16:10	**Introduction Panel 7:** Challenges, solutions and good practices in SBC, at the school, home and community level **Development of Panel 7:** Challenges, solutions and good practices in SBC, at the school, home and community level	Berta Alvarez. Breakthrough Action Moderator: Berta Alvarez. Breakthrough Action Panelists 1. Patricia Vasquez. Global Communities 2. David Parajon. SSI 3. Elkis Santana. CAZ 4. Adriana Muela. CARE
16:10-16:15	**1. Reflection and individual work:** identify other challenges and learning	Desiree Luis. Breakthrough Action
16:15-17:15 17:15-17:20	**2. Reflection and group work:** agreement on SBC challenges and good practices that contributed to the solution to problems faced Final comments	Berta Alvarez. Breakthrough Action Desiree Luis. Breakthrough Action
17:20-17:25	**Closing**	Cecilia Tamayo. CARE
08:30-17:30	**Permanent exhibition: Edu-communication materials**	Adriana Muela. CARE

THIRD DAY

Time	Thursday, 6 June 2019	Speaker/Responsible
08:30-08:40	Work Agenda presentation	Adriana Muela. CARE
Good practices to promote sustainability and institutionalization of experiences of community mobilization at local, national and regional level		
08:40-09:40	**Panel 8** Good practices to promote sustainability and institutionalization of community mobilization experiences at the local, national and regional levels.	Moderator: Rosa Morales. CAZ Panelists 1. Jose Ruben Gomez. Global Communities 2. Alberto Vasquez. PASMO 3. Chantal Braithwaite. IFRC 4. Arturo Sánchez. MCDI
09:40-10:00	**Forum** Open forum with speakers	Moderator: Rosa Morales. CAZ
10:00-11:00	**Work-in-group** Reflection and analysis on good practices for sustainability and institutionalization.	Facilitators Group 1: Jose Ruben Gomez. Global Communities Group 2: Alberto Vasquez. PASMO Group 3: Arturo Sánchez. MCDI Group 5. Chantal Braithwaite. IFRC (English speaking group)
11:00-11:20	**Recess**	
11:20-12:10	**Presentation of work-in-group results**	Moderator: Rosa Morales. CAZ
12:10-13:10	**Next steps. Work-in-group.** Identification of relevant actions to strengthen and institutionalize lessons learned and good practices in the areas of intervention **Plenary**	Facilitator: Arianna Serino. USAID Group 1: Arianna Serino Group 2: Jaime Chang Group 3: Kristen Alavi Group 4: Gustavo Avila Group 5: Julie Gerdes Group 6: Bertha Alvarez
13:10-13:40	**Closing**	Jaime Chang. USAID Cecilia Tamayo. CARE
13:40	**Lunch**	
08:30-14:40	**Permanent exhibition: Edu-communication materials**	Adriana Muela. CARE

Workshop participants

Organization	Country	Participants
Save the Children	Oficina Regional (Panamá)	Loreto Barceló
	El Salvador	Sagrario González
	El Salvador	Luis Andrade
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		José Rubén Gómez
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		Ingrid López
PADF		Nairoby Rivas
MCDI	Oficina Global (Washington)	Julie Niemzcura
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		Cecilia Tamayo
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		Adriana Muela
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		Manuel Vicuña
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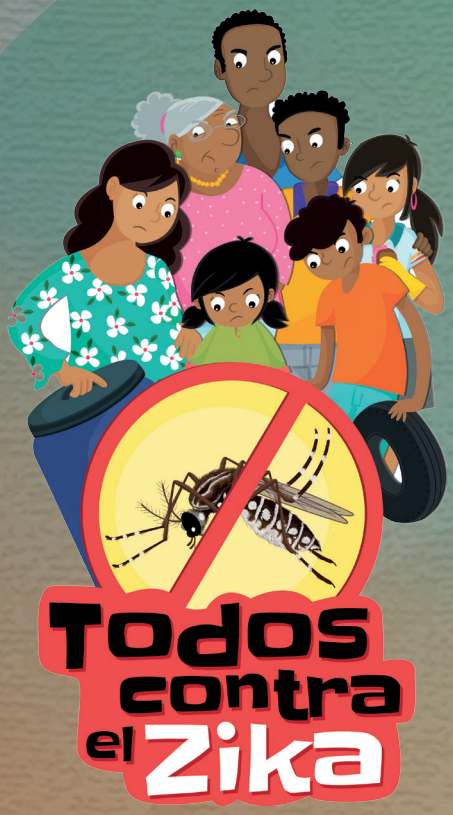

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