# POLICY BRIEF

April 2017

# Clinic - CBO Collaboration ($C^3$) Programme

## Linking health facilities and communities for improved PMTCT and paediatric HIV outcomes

### BACKGROUND

The Global Plan was responsible for extraordinary gains, evidenced by a 60% reduction in new paediatric HIV infections in 21 of the highest-burden countries in sub-Saharan Africa[1]. While this is exceptional progress, work remains to be done. The newly established super-fast-track framework[2] and Sustainable Development Goals, together with global guidance on Universal Test and Treat (UTT) will require unprecedented rapid scale-up, and implementation of new ways of delivering services. Providing access to prevention and treatment to all pregnant women, children and adolescents will require a shift away from intensive, individualised care to that of an expanded public health approach, which is characterised by decentralisation, simplification, task-shifting and extended community-based service delivery.

At the forefront of global efforts leading up to 2020 and beyond will be the role of community. Delivering on the Three Frees will require an immediate, accelerated approach. Without a bold and empowered community response, the health system, operating in isolation, will not succeed in breaking down many of the barriers preventing access and retention in programmes. To reach and sustain record numbers of pregnant women, children and adolescents in care, clinics and the communities they serve must partner with each other. Together, clinics and communities must sensitize communities to increase uptake, link children and families into care, combat stigma and discrimination, monitor programme quality and build stronger local health systems.

There is however limited evidence and guidance available on how the pivotal role of community structures can be supported to accelerate and expand responsive services. What is clear is that for the contribution of community to be amplified, it must be linked in to the health system. Community strategies are infinitely more powerful when actioned through jointly established clinic-community partnerships and implementation plans. Despite this, clinics and community-based organisations (CBOs) tend to operate in isolation, relying primarily on informal arrangements that do not provide the needed structure or mechanisms to facilitate and coordinate meaningful and sustainable engagement.

**The $C^3$ Programme is a partnership between PATA and the Positive Action for Children Fund to build 36 clinic-community partnerships across 9 focus countries. The 3-year programme uses a localised model to learn global lessons.**

Within this context, the C³ Programme was conceptualised and drew upon linking the Paediatric-Adolescent Treatment Africa (PATA) clinic network and Positive Action for Children Fund (PACF) CBO network in clinic-community collaborative partnerships across sub-Saharan Africa, the world's most affected region.

## OBJECTIVES

1. To improve PMTCT and paediatric HIV service delivery
2. To engage communities in PMTCT and paediatric HIV service delivery and link clinical services and communities in health partnerships
3. To identify and disseminate challenges, lessons learned and best practices for clinic-CBO collaboration

## METHODOLOGY

C³ initiated 36 clinic-community partnerships across nine focus countries (Ethiopia, Nigeria, Malawi, Zambia, Uganda, DRC, Cameroon, Kenya and Zimbabwe) over a three-year period. The programme set out to develop, incubate and disseminate clinic-community implementation models and partnership strategies, as well as provide recommendations for effective clinic-CBO collaboration. C³ used a localised model – establishing four clinic-community partnerships per country – to gather and learn lessons. Partnerships were supported and received several forms of capacity-building, including partnership initiation forums, small grants, monthly conference calls, materials and tools, and email contact and trouble shooting. During the implementation period, we facilitated local C³ review meetings and undertook 20 site visits across eight countries. Lastly, the PATA-PACF 2016 Continental Summit, held in December 2016 in Entebbe, Uganda convened 104 representatives from the C³ partnerships to collectively pause, reflect and refine the programme's key learnings.

As the programme progressed, the key domains within which clinics and CBOs can most effectively operate and collaborate in addressing the leaky cascade emerged.

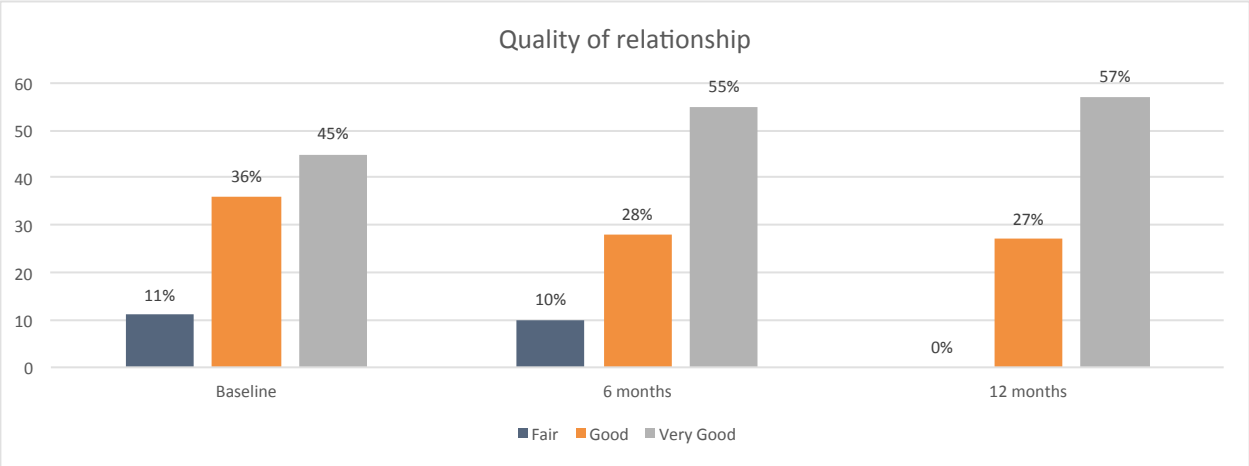
| DOMAIN | STRATEGIES |
|---|---|
| **SERVICE DEMAND MOBILISATION** | Education and awareness<br>Demand creation<br>Community HIV counselling and testing<br>Improved referral systems |
| **COMMUNITY SENSITISATION** | Break down socio-cultural barriers<br>Combat stigma and discrimination<br>Promote male involvement<br>Engage community and religious leaders<br>Campaigns, sporting events, meetings, champions |
| **ACTIVE PATIENT OUTREACH** | Tracking and follow-up<br>Home visits<br>Community case management |
| **TREATMENT, CARE AND SUPPORT** | Peer support groups<br>Peer counselling<br>Food assistance<br>Transport support<br>Income generation |
| **ENABLING FACILITY ENVIRONMENT** | Clinic service times and space<br>Privacy<br>Sensitized health workers |

## RESULTS

Key results showed important improvements in clinic-CBO partnership indicators, as well as an increase in women enrolled in PMTCT services and a reduction in numbers lost to follow-up (LTFU).

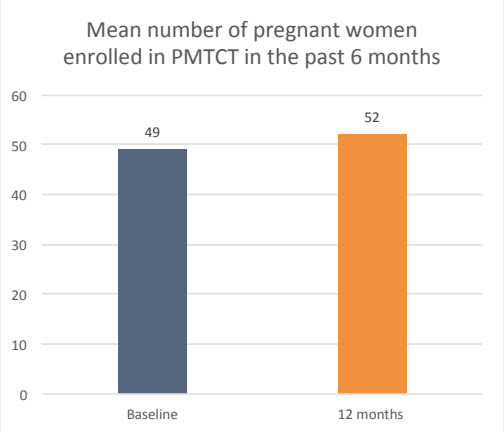
### Improved partnerships relationships

Data from all 36 partnerships showed improved relationships between partners, and improved perception of each other's contribution to PMTCT and/ or paediatric HIV care services.

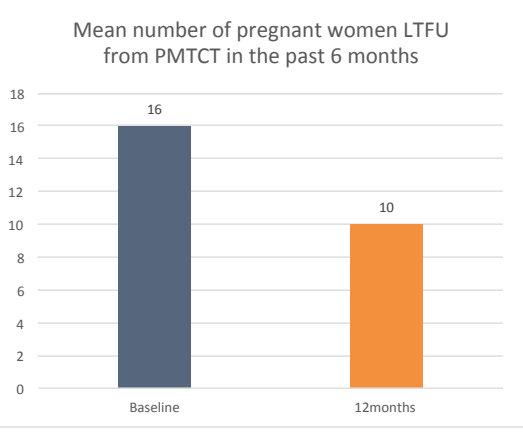



### Improved health outcomes

While data showed improved PMTCT uptake and reduced LTFU, we acknowledge that attributing health outcomes along the PMTCT and paediatric treatment cascade to the C³ intervention was challenging given limited access to standardised and robust facility-level data, which was partly due to our limited and heterogenous sample.




We compared baseline vs 12-month data for the 18 clinics for which we had 12-month patient data and found a 4% increase in the mean number of pregnant women enrolled in the PMTCT programme over the past 6 months (from n=49 to n=51).




We compared baseline vs 12-month data for the 18 clinics for which we had 12-months patient data and found a 38% decrease in the mean number of pregnant women LTFU from the PMTCT programme over the past 6 months (from n=16 to n=10).

## LESSONS LEARNED

These results provide useful lessons and insights into factors which should be taken into consideration when promoting clinic-community collaboration.

| STRUCTURAL ARRANGEMENT | RELATIONSHIP |
|---|---|
| Mutually beneficial joint planning and formalized partnership agreements that articulate a shared purpose and structural arrangement are crucial | Prior to initiation, the best possible partnership matches must be established through systematic mapping |
| Community engagement and clinic-CBO collaboration should be context specific and tailored to each setting, taking cultural, environmental and resource conditions into consideration | Detailed joint planning that engages with data is vital in determining where partnership opportunities exist and establishing priority areas |
| Clear communication strategies, tools, mechanisms and processes that enable regular communication, planning and decision-making must be established at the outset | Formal agreements must identify central drivers and leaders, and provide clear terms of reference that define responsibilities, lines of accountability and the distribution of human and financial resources |
| Checks and balances must be integrated into both clinic and CBO operations, with clearly defined monitoring and evaluation (M&E) indicators and reporting mechanisms. This requires paper or e-trails to jointly monitor services, patient-level outcomes and clinic-CBO partnerships | Regular forums and meetings for dialogue and joint team building must be held to address power differentials, manage conflict, problem solve and share responsibility |
| Involvement of external partners for technical assistance, training and linkage to development opportunities is key. Investment, with district-level facilitation and mentoring support, must be provided to ensure cooperative and well-functioning clinic-CBO partnerships | Integrating clinic-community engagement as a key performance area within both clinic and CBO annual operational plans, with monitored progress, will help to legitimise joint ownership and accountability |
| Clinic-CBO collaboration must be rooted in district planning, resourcing and coordination. This is critical for establishing feasibility at the outset, as well as ongoing sustainability for projects that demonstrate positive outcomes | Partners should utilise existing social capital and inclusion of religious leaders, traditional authorities and key community groups and stakeholders |

The above lessons will form the basis of a C³ toolkit which is under development. The toolkit will serve as a methodology and guide to clinics and CBOs in resource-limited contexts on how to work together and develop linkages that effectively close gaps along the PMTCT and paediatric treatment cascade and lead to improved outcomes for pregnant women, children and adolescents.

## CONCLUSION

C³ Programme outcomes demonstrated that clinic-CBO partnerships are feasible, acceptable, and can result in joint ventures that positively impact services. In addition, if well implemented, clinic-CBO collaboration can be a critical determinant of improved service uptake and retention in care.

While community mobilisation is increasingly endorsed as an effective approach within the HIV response, its impact on measurable outcomes remains poorly defined. This, along with limited access to robust data,

has made challenging our capacity to attribute health outcomes along the PMTCT and paediatric treatment cascade to C³ interventions. To better demonstrate the impact of clinic-CBO collaboration, stronger implementation science approaches should be considered to further explore, develop and document more rigorous clinic-CBO evidence. In response to the recommendations of the Global Plan[3], future clinic-CBO programmes should consider developing better indicators for community engagement in PMTCT and paediatric HIV treatment to increase accountability and as a way of documenting progress. This speaks to the need for centralized data platforms with integrated tools that allow data sharing between implementing partners.

C³ has played a significant role in creating a growing community of practice centred around clinic-CBO collaboration, and has generated rich and diverse insights and learnings that will directly contribute to achieving improved community engagement. One of the biggest lessons learnt has been the need for investing in methodologies that provide structured capacity-building and district coordination. While documented evidence of clinic-CBO linkage remains limited, anecdotal evidence has shown that well planned and supported community responses may have an impact at a level and depth that cannot be approached by most health systems and state mechanisms[4]. Governments must therefore consider incorporating applied community engagement into national AIDS plans, with accompanying budget allocations.

Although most major donors and international development partners are promoting community engagement as an effective fast-track strategy in the HIV response, limited technical guidance and insufficient funding to support this has materialised on the ground. It is anticipated that by 2020, investment in community mobilisation should increase three-fold to 3% of total resources in low – and middle-income countries to assist civil society in representing the interests of communities, and to drive and accelerate the AIDS response[5]. There is therefore a need to advocate for sustained capacity and investment into strengthening clinic-community collaboration, whilst ensuring that such collaboration is regularly monitored and reported against.

### Key programmatic and policy messages

1. International organisations, development partners, governments, and public and private funders must recognize that fiscal commitments and sustainable investments at global, national and local level are key to effective clinic-CBO partnership and services in order to scale up HIV services and support sustainable interventions. Coordination of funding agencies is necessary to support the comprehensive integration of services required to avoid overlaps and duplications.

2. Local governments must in turn direct the increased financing at local level to implement methodologies that provide structured capacity-building and district coordination that strengthen and enhance the capacity of communities, and in particular clinic-CBO partners. This requires the development of integrated real-time health informatics.

3. Clinic-CBO programme implementation must commit to a rigorous research agenda to further explore, develop and document more robust clinic-CBO evidence and develop better indicators for community engagement in PMTCT and paediatric HIV treatment. Investment in innovative and accessible platforms and tools to form part of the feedback loop is necessary to ensure timely dissemination, inform policy and facilitate adoption of best practices.

## References


1. On the fast-track to an AIDS-free generation. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2016.
2. Start free, stay free, AIDS free: A super-fast-strack framework for ending AIDS among children, adolescents and young women by 2020. Geneva: UNAIDS; 2016.
3. Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. Geneva: UNAIDS; 2011.
4. Communities deliver 2015. Geneva: UNAIDS and STOP AIDS ALLIANCE; 2015.
5. Stronger together: From health and community systems to systems for health. Geneva: UNAIDS; 2016.


## For more information:


Paediatric - Adolescent Treatment Africa

Telephone: +27 21 447 9566

Email: info@teampata.org

www.teampata.org