Aidspan

Independent observer of the Global Fund

CONTINUITY OF HIV, TB AND MALARIA SERVICES IN CHALLENGING OPERATIONAL ENVIRONMENTS

The RAME, Réseau d'Accès aux Médicaments Essentiels (Access to Essential Medicines Network), commissioned a study in 2019 on community organizations' good practices, opportunities, and limitations in ensuring continuity of care in challenging operational environments (COEs). Five countries, classified as COEs by the Global Fund, were selected to participate in the study: Central African Republic, Chad, Guinea, Mali, and Niger. RAME is the Francophone Africa platform of the Global Fund's Strategic Initiative on Communities, Gender and Rights and has called on the Initiative and the Global Fund to finance this study.

The study's main objective was to document good practices and community responses in order to report on the capacities and potential of community actors to deliver health services to the most vulnerable populations using Global Fund grants.

An interview with the coordinator of the study, Hugues Traoré and with Simon Kabore, the executive director of the RAME, allows us to look at the main conclusions of this study and how the results will be used.

GFO: What methodology did you use to carry out this study?

The study was built in three stages, with one coordinator per country. The relevant civil society organizations (CSOs) were involved in the process, as the aim was to collectively identify good practices and opportunities that could be adapted and applied in other countries.

We first carried out a review of the literature and documents available in each country, particularly those

defining essential community care strategies and packages in national policy documents regarding community health, HIV, tuberculosis (TB), malaria, and sexual and reproductive health. We then interviewed key informants (representatives of community-based organizations, staff or representatives of health facilities, representatives of national disease control programs, and technical and financial partners) and beneficiaries in order to identify the best practices.

GFO: How do challenging operating environments differ from others in terms of the use of community responses?

Most COEs are affected by political instability. Regions in conflict can leave many displaced people and refugees without shelter and needing care – sometimes in dangerous conditions. Similarly, some regions become dangerous for health center staff, which limits, and sometimes even prohibits, the provision of services. In unstable countries with fragile judicial systems, good governance and respect for human rights are often more difficult to enforce.

In these countries, where people are working with fewer resources and in a state of emergency, it is necessary to go back to basics. This means being flexible with certain processes, allowing implementing partners to work differently. Some will say that this becomes cheap medicine, but this is not the case: can we say, for example, that war medicine is cheap? Certainly not – not only does it save many lives, but it has advanced knowledge and medicine in general.

If we want to work effectively in the COEs, and build on community interventions and systems already at work, we have to accept a level of programmatic and financial detail that is not possible elsewhere. Many local initiatives are not standardized, yet they work and can be used as a model for other regions or countries. Why not subsidize micro-projects? It is possible to carry out activities at a low cost in COEs: with 150,000 CFA francs (€152), we can supply patients in several villages with antiretroviral drugs, thanks to community transport circuits with secure conditions. Even if the results do not live up to expectations, the financial loss is insignificant. Sometimes there is no alternative and one has to accept the risk, which is ultimately more operational than financial.

GFO: You have focused on several effective practices implemented by CSOs. Can you cite some of them?

It is interesting to note the community involvement in the transport of samples (whole blood, plasma, Dry Blood Samples) from the sites to the reference laboratories and the delivery of results from the laboratories to the sites. The Réseau Malien des Associations des personnes vivant avec le VIH (RMAP+) initiated this intervention, which has recruited members of the network to transport samples every day (except for the regional capital of Koulikoro, which is provided with samples twice a week). This initiative has made the biological sampling circuit functional, and there has been a 21 percent increase in viral load coverage, from 12 percent in 2014 to 33 percent in 2018.

L’École des Maris (EdM), set up by SongES in Niger, is an interesting example of men’s involvement in the reproductive health of the women in their community. The EdM intervention focuses on training and strengthening the knowledge of a core group of husbands on the importance of promoting and using reproductive health services. These men will act as role models in their homes and communities to induce a change in knowledge, behavior and attitudes, sowing the seeds for a change in gender roles and reproductive health. This strategy has been successful in supporting husbands in the use of family planning, assisted childbirth, and antenatal care.

Observatories of access to care (watchdogs), such as those implemented in Burkina Faso, Guinea or Niger, are essential mechanisms for mobilizing citizens for their health. Thanks to these mechanisms, we can observe the progress made in terms of educating the population on their right to health, and their knowledge of the main health dangers and increases in the reporting of health system dysfunctions. Some

observatories no longer limit themselves to access to HIV/TB/malaria care but have added components concerning human rights and reproductive health.

In Guinea, the community-based strategy to identify TB patients in pharmacies and informal pharmacies has been a success, with a 16 percent positivity rate. A system of data feedback has been established using the weekly transmission of data by follow-up agents through android phones.

In Chad, nomads have been identified as a vulnerable population due to their distance from health facilities. Nomadic community health workers have been identified and trained on the signs of TB and treatment of the disease, enabling them to raise awareness, identify potential patients and support the patients during their treatment. A total of 50 nomadic health workers in 10 health centers located on the transhumance corridors have been selected to take part in this initiative.

In terms of adapting administrative and financial procedures, there have also been some positive steps: in Mali, in order to pay community health workers and community advisers invested in awareness and advocacy activities in areas far from the big cities, a system of electronic cash transfer through shops/grocery shops has been set up to circumvent the constraint of the zero cash policy. In particular, it has made it possible to pay community-based organizations and cover purchases of small equipment while ensuring the tracing of financial flows, secure cash transfer, and real-time financial management thanks to reliable and verifiable electronic receipts.

GFO: What do the results of this study tell you?

I am convinced that good community practices deal with development in general and are able to adequately respond to challenges. Health systems should take advantage of the pre-existing community systems and dynamics to progress. The health sector can benefit from community practices, but for this to happen we need to have a change in mindset and abandon the idea of an elitist, highly secure system in fragile countries that do not have the resources to guarantee these services. It is clear that in COEs, and in the absence of a formal health system, communities implement unconventional palliative approaches, which are sometimes useful, and sometimes dangerous. Despite the closure of borders in Mali, some transporters travel from Burkina Faso to Mali by motorbike taxi, and continue to supply the population as they seek ways to survive. The neighborhood shopkeeper still supplies sugar and soap, even in remote areas inaccessible to state actors and international organizations. Why not use this same shopkeeper to transfer money from community activities to them, or to make condoms or medicines available, with measures to store them properly?

GFO: You mention actions at the local level, where the impact is minimal and difficult to put forward, while the Global Fund is trying to eliminate the three pandemics. Is this compatible?

Why can’t the Global Fund take all this into account in its grants and use these results to build bottom-up approaches, starting with populations that are resilient? We certainly need socio-anthropologists to better understand the context and the vision of health and disease in these populations, and to implement activities that are meaningful and initiate behavioral change. But we are going down the opposite path – the Global Fund’s country teams bring the discussion back into their sphere of thought and action, without looking at the real problem.

Let’s talk, for example, about the inaccessible areas in Mali, Burkina Faso or the Central African Republic: even in areas where there are conflict and epidemics, there are people who will never leave their villages and can act as a relay. Conversely, among migrants there are always people who raise awareness and take care of the most vulnerable. These people can be hired as basic community health workers in camps for internally displaced people and refugees. Our discussion with the Global Fund teams should focus on how to adapt the response using community levers. This also implies reviewing the logic of the Ministry of

Health based on a structured and standardized decentralization (district management team, nurses, health workers, each with a well-defined role), which, in practice, no longer works in insecure areas.

The problem is the orthodoxy of the Global Fund, which requires extremely precise programmatic planning that does not fit well with community-based initiatives. Imagine, for example, delivering health products by camel in desert areas that are difficult to access because of insecurity. This raises questions such as: how many camels are needed, what roads should they travel, how many products will each animal carry, how often will they travel, what is the investment, what is the impact? It is clear that such precise planning is unrealistic and does not fit with community initiatives. Conversely, community actors are being asked to adapt to a framework that is fundamentally foreign to them.

But let us look at these community approaches with an open mind. Some of them are promising and likely to have a great impact on large territories. The disadvantage comes from the standards imposed by donors. The most interesting solutions in challenging operating environments are those that flow into the environment, operating within the small gaps of this reality.

GFO: What is the next step?

The Global Fund's programs and procedures need to evolve, at least in these fragile contexts, so that people take the initiative. They already decide for themselves in many areas and develop their resilience to different shocks (economic, political, social, climatic). The Global Fund must therefore support these pre-existing dynamics and systems so that health becomes a key issue for these populations.

We are going to try to build on this report; there are lessons to be learned globally, but also in each country. A feedback session was held with the Principal Recipients, the Country Coordinating Mechanisms and the Sub-Recipients in each country involved in the study. The good practices that had been identified were discussed and introduced into the new funding requests.

We also need to be strong enough to challenge and nurture the discussions around the Global Fund's new strategy. The difficulty lies in the balance between the risks taken by the Global Fund (financial but also programmatic) and the need to put the beneficiaries of these grants back at the center of the mechanism.

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