



PUTTING COMMUNITIES FIRST: THE LEGACY OF USAID'S APC PROJECT

Sky Woll:

Good morning and afternoon! My name is Sky Woll, and I'm here supporting APC. Before we begin, I'd like to do some quick housekeeping and review the Adobe Connect environment for today's webinar.

Within the webinar environment, please make use of the Q&A box on the bottom right side of your screen to share your thoughts, ask your questions, or ask for help with sound during the presentation. The questions you ask are only visible to you, our presenters, and technical support. If you are experiencing difficulties, our technical support will respond to your question privately. We will collect your questions for our speakers and will save them for the discussion period at the end of the webinar.

It is great that we are able to connect people from so many places today, but your experience may vary based on your internet connection and your computer equipment. I will briefly go over a few troubleshooting steps in case you have technology challenges today.

Please use the Q&A box to ask 'APC Tech' for assistance. If the troubleshooting steps are not successful, please rest assured, the webinar is being recorded and you will receive an email with a link to the recording following today's event. Also, questions that don't get answered during the Q&A sessions will get answered and sent by email with all participants. Now, I'm gonna hand it over to Liz Creel, our project director. Thank you.



Liz Creel:

Greetings and welcome to today's webinar, Putting Communities First: The Legacy of APC. My name is Liz Creel and I am the project director for Advancing Partners & Communities (also known as APC) and I'll be serving as the moderator. During this webinar, we will watch a short video on the project and then have four speakers discuss the impact, results, and lessons learned from APC's main health areas. We will save 15 minutes at the end of the webinar to answer any of your questions. And just in time for the holidays, we're excited to share APC's final report, which will be available on APC's website—www.advancingpartners.org—by Christmas. Please add it to your holiday reading list!

To get us started, I'd like to introduce Marguerite (Maggie) Farrell from USAID, the current agreement officer's representative for APC. Maggie is a health officer in USAID's Global Health Bureau, Office of Population and Reproductive Health. She has worked in global health for more than 30 years, most recently as the Zika team leader in the Office of Infectious Disease. She has lived and worked in Ecuador, the Philippines, and Spain, and has been a community and union organizer with low-income, senior, and immigrant populations in the U.S.

Maggie Farrell:

Good morning and afternoon! My name is Maggie Farrell, the USAID Agreement Officer's Representative, or AOR, for the Advancing Partners & Communities project (APC). I am excited to introduce APC's final webinar on the project's lessons learned from 2012–2019 and thoughts about the way forward.

Before I begin, I'd like my USAID colleagues, the APC team from JSI and FHI 360, along with many partners in multiple countries, for their efforts to advance community health.

As background, APC is a seven-year USAID-funded community health project that has strengthened health services in more than 40 countries—from the most remote communities to national ministries of health—with a particular focus on voluntary family planning, infectious disease prevention, including HIV and post-Ebola response in West Africa.

We have also supported vulnerable populations – from people with disabilities in Laos to women and their families in Haiti seeking financial services to become more self-reliant and free from poverty.

Since 2012, APC has served as a flexible, multidisciplinary vehicle with more than 55 funding streams from USAID's Bureau for Global Health, other Washington bureaus, and numerous Missions. This flexibility has brought in different technical sectors that have helped inform one another, create a more comprehensive approach that has strengthened health services more broadly and provided support for countries on their journey to self-reliance.

We launched this project at a time when attention to the critical role of community health was increasing. So, while APC has worked at multiple levels of the health system, community health has been a significant focus of our work.

APC's programs spanned the breadth of health systems from advocacy and policy change at the highest levels of government to training sessions with community health workers that enabled users of family planning to obtain contraceptives in their communities. We had many partners – non-governmental organizations, faith-based organizations, other private sector actors, national and local governments, and a wide range of communities.

APC was also a grants management and capacity-building project. Over the past seven years, APC gave out more than 110 grants to NGOs of different sizes and levels of maturity, to help build their organizational and technical capacity and mobilize their own funding.

And now, I will turn things over to Liz, our moderator. I wanted to note a few things about Liz. Over the past 25 years, she has worked in family planning, reproductive, maternal, newborn, and child health, and environmental health. Prior to joining APC, she she a multidisciplinary communications team in support of USAID's Global Health Bureau, and managed public policy, advocacy, and communications efforts for several NGOs working in MNCH and the humanitarian sector. She was a senior technical officer for family planning and population issues for the Population Reference Bureau, and a project manager for the U.S. EPA on global efforts to avert ozone depletion and climate change.

Liz Creel: Thank you, Maggie. Before I introduce our speakers, we'd like to show a quick video about APC that highlights the importance of community health.

Video Speaker 1: Community health affects the stability of nations and the prosperity of families. Access to health services and voluntary family planning allows women and men to take control of their health, and this has far-reaching benefits.

Community health workers are an important part of a strong health system. They can reach remote and underserved people to convey important health information and link families to the formal health system.

They can mitigate infectious disease outbreaks, reduce discrimination of marginalized people, and collect data to inform health policy decisions.

The fabric of community health is woven from the strands of families, local volunteers, faith-based organizations, nongovernmental organizations, and government institutions. All of whom play part in supporting a population's health.

Strengthening local organizations, formed by and for the people they serve, creates local leadership and fuels the innovation and learning that leads to self-reliance. Since 2012, APC the Advancing Partners and Communities Project, has worked with communities and partners in more than 40 countries to improve the overall health of communities. To achieve this goal, APC provided global leadership for community-based programming and helped hundreds of local organizations conduct more effective health programs.

Video Speaker 1: It takes into consideration our current needs and activities to build our capacity. It's a flexible and adaptable strategy, and we have truly appreciated their support.

Video Speaker 2: Now, each year there will be a line in the budget for community health

Mashoudou Mari: Our village community health aide also often raises awareness on different topics, including family planning. That is what motivated me to ask my wife to adopt family planning – because I am convinced of its benefits for us.

- Video Speaker 3: Every day, if I may say so, we save lives and that is important. Today, mothers are happy, children are healthy and the mortality rate has dropped.
- William: Now, this morning I can see bright. I can see whatever with my right eye. I am very, very, very happy. I don't know what to express to this team that came because they have done well for us.
- Video Speaker 4: After renovation, everything good. I have light at any time of the day. Then the water, at any time I need water, I will get water. The changes, the difference, is great. And I enjoy my work now.
- Desiree Edghill: To watch people not wanting to come to an NGO because they're fearful that someone might think that they're HIV positive, to now watching people coming to get tested, coming with their partners and not being fearful, the youngest to the oldest. I think for me that's a great achievement.
- Sally Rajigadoo: My husband tried to kill me, like, three times, strangle me, poison me, hold my mouth and throw the poison in. Well, actually, I would get raped every night, so that's, like, a normal thing. I just got fed up with the pressure. And there was a lady from United Bricklayers, and she told me, she said, "I have somewhere I can take you. Come with me." And they prayed with me and they talked with me, and I shared from the beginning to the end of my story. It was like a burden come off of me, like a weight. When I walked out of Bricklayers that day, I was a different person.
- DS: I am so glad to come and play sport with PWD in my province, because sport helps us keep healthy, regardless if we are disabled or not.
- Video Speaker 5: I'm so glad to have access to Braille books, it is more comfortable to read and study.
- Video Speaker 1: With support from APC, community health programs around the world are more resilient, and families in thousands of communities can live healthier lives.
- Liz Creel: Now that you've seen APC in action, I'd like to turn things over to our presenters, who can share more results and stories across the project. Our first speaker, Nancy Pendarvis Harris, will talk about our community-based family planning programs.
- Nancy is a senior advisor to APC and a vice president at JSI. Her work experience includes long-term assignments in Kenya,

Madagascar, Nicaragua, Nigeria, the Republic of Georgia, and Tanzania. She has managed large centrally funded and bilateral USAID projects, and has helped bring reproductive health care to crisis settings. Although Nancy works extensively on policy and health systems issues, the foundation of her professional values is community-level work. Nancy was recently honored with a Lifetime Achievement Award from American Public Health Association in November.

Nancy Harris:

Thank you, Liz. APC supported a surprising array of community-based family planning program activities. We focused on filling learning, policy, and programmatic gaps and on increasing access to services at the community level. Our successes included being in 22 countries, training and supporting over 17,000 community health workers, building capacity and sustainable among 23 non-governmental organizations. Communities are the bedrock of successful health systems.

Too often, however, communities plus the structures that serve them, are not sufficiently integrated into the formal health system. This leads to gaps, inefficiencies, and it erodes trust. APC worked to change this. APC applied tools and approaches such as human-centered design to increase the voice of communities in program design.

We worked with young people, especially young women, to advance their agency and participation in family planning. Our work added to the evidence that faith networks across a spectrum of religions fulfill the promise that faith groups are key partners in reaching the hardest to reach. We reached isolated, left-behind communities through integrated approaches such as population health environment, and integrated maternal neonatal child health.

Our programs mobilize the private sector and local resources, such as mayors, to advocate for services and contribute to ongoing financing. We also demonstrated that clients are willing to pay for family planning products and convenient services. In fact, we increased commitment to family planning in virtually every community where APC worked. Finally, we advanced task shifting and expanded access to new methods through new service delivery channels. Together, APC's activities provide a useful road map going forward for a health systems approach to community-based family planning, youth-oriented services, and gender equality. We have selected two examples from APC.

The first example is APC's work on injectable contraceptives, specifically DMPA. Many of us know it as Sayana Press. We funded complementary activities in four countries. This work helped redefine how DMPA-SC can be provided as part of a package of community-based family planning services. In Benin, we undertook policy advocacy from top government leaders to community and faith leaders to enable provision of injectable by community health workers. This – then we worked hand in hand with the Beninois government and partners to extend services in 10 districts of the country.

Results showed that the new method delivered by CHWs is popular. Ugandan grantees also undertook similar efforts, also with high acceptability. In Malawi, APC undertook well-designed studies to demonstrate the safety, effectiveness, and acceptability of self-injection. A jury publication on the research was influential across the community of practice. APC piloted self-injection through private providers in Zambia.

This demonstrated the effectiveness of a new training approach utilizing e-learning as well as clients' willingness to pay for the product. It turns out, for many clients, convenience matters as much as cost. APC's practical experiences and documentation provide a useful road map for expansion of Sayana Press throughout Africa. It has proven – it has been a game changer, and is a forerunner of new wave of self-care family planning methods.

For our second example, we travelled to the extremely poor, ecologically fragile island of Madagascar. Here, we built on previous experience in integrated population health environment to improve the scale – and scale up this important approach, standardize documentation, and to solidify country commitment.

The PHE integration activity in Madagascar, under the USAID Community Capacity for Health program, supported the government and partner-NGOs in 4,855 villages in seven regions. This effort addressed health and environment needs by revitalizing cross-sector collaboration and invigorating national interest in integrating PHE work. It worked closely with the 40-member PHE and NGO network, and an interministerial PG working group of four agencies to share best practices and results. They strengthened innovated PHE models, and it prepared them for replication in new sites.

In all, more than 5,600 community health volunteers were trained and deployed in family planning service delivery in target bio-diversity areas. Messages on PHE reached nearly 5 million people. A third of this information came from community health volunteers. This project, along with other working PHEs, advanced evidence that integrated PHE is an effective strategy for environmental hotspots and that these approaches can be scaled up.

I wanted to close from a quote from a visionary youth faith leader who attended our recent Voice of Experience Faith-Based Family Planning Reflection in Kenya. The group work illustrated the enthusiasm and solid commitment of the faith community, especially the importance of reaching out to young people. Speaking about family planning, he observed with gusto, "Family planning must be part of everything we do." Amen to that.

Liz Creel:

Thank you, Nancy for the compelling presentation of APC's work in CBFP and highlighting some key successes in task shifting, introduction of injectable contraceptives, integrated programming and work with faith entities.

Just a reminder to everyone to please be sure to type questions for our speakers in the Q&A box.

Now, I would like to introduce our second speaker, Walter Proper, who will talk about our HIV and AIDS programs with key populations. Walter is the director of field support for APC at JSI. He has worked extensively in family planning and reproductive health, HIV, TB, malaria, and essential medicine systems improvement. Prior to APC, Walter was the country director of JSI Zambia, and before that, regional director of JSI's Center for Health Logistics. His experience includes more than 25 years as a senior manager and supervisor of multicultural teams.

Walter Proper:

Thank you, Liz. So, through PEPFAR-funded technical assistance and support, APC built capacity within public and private organizations in 15 countries to provide quality HIV prevention, care, and treatment services.

So, first, it's good to understand that APC support came through three different funding streams: field support, the local capacity initiative, and social contracting. Let's begin with field support. This support funded our three APC country offices and their grantees in Botswana, the Dominican Republic, and Guyana. And the

mandate was to improve the access and quality of HIV services to high-risk, vulnerable, and hard to reach populations.

In DR and Guyana, with concentrated epidemics, the focus was on key populations: men who have sex with men, commercial sex workers, and transgender people.

In Botswana, with a generalized epidemic, the focus was on adolescent girls and young women. All three countries focused on strengthening both public and private sector HIV services and successfully adapted a broad range of strategies to close the gaps across the HIV treatment cascade, to reach the UN AIDS 90-90-90 2020 target.

In Botswana, through the Cookie Jar Facebook chat group, APC helped support young women with sexual and reproductive health information and referrals to integrated services. APC worked diligently to integrate HIV services into sexual health services for this population.

The work in the Dominican Republic included new strategies to reach key populations by employing cyber educators, very millennial-like, to engage MSMs and transgender individuals on dating apps. Not only were more men who have sex with men reached, but those who were reached were the highest risk, and would not have been reached otherwise. And then therefore, they had a higher HIV yield, which means more HIV positives than those reached through more traditional methods of community outreach and referrals.

As with much of the PEPFAR world, there was a focus on increasing HIV yield through index testing; this is through partner notification, involuntary partner referral of sexual partners of people living with HIV/AIDS. An example of this effectiveness of index testing is the Dominican Republic in FY 18. We found that the traditional non-indexed testing strategies, those self-referrals and outreach methods, had a yield of 4.1. With facility-based index testing, the project achieved 26.3% yield among sexual partners of newly diagnosed individuals.

The Dominican Republic is also interesting in that there was a focus on working with the Haitian migrant population. PUR navigators who were native Creole speakers were essential to serving this population. APC developed a very successful model for HIV outreach, linkage, and retention for this priority population.

In addition to outreach and testing activities, APC worked to improve management and quality of services in DR by building the capacity of health providers and introduce clinical sites to new methodologies and tools. For both the NGO and the public sector health facilities, APC provided training in clinical, psychological, social, and program management. As part of the improvements at the clinical sites, APC established the quality improvement collaborative at all PEPFAR supported sites. This was a process to identify root causes for gaps in services and unmet targets, to test and measure and adjust improvement interventions, and then adopt best practices based on proven interventions.

Based on its success, the National Health Service officially adopted the QIC model to expand the Treatment for All strategy to all government HIV clinics. A key lesson learned across the three offices was that it was critical to go to the community either through employing peers or community health workers, to reach these vulnerable populations. And more detailed on this can be found in the APC's final report.

The second PEPFAR stream came through what was called the Local Capacity Initiative. With a mandate to strengthen sustainability of national HIV/AIDS response through increased advocacy capacity of local nongovernmental organizations. APC provided technical assistance to the USAID and CDC directly funded grantees in 13 countries and in one region, Asia.

Early on in the initiative, we discovered that in order to elevate these NGOs' CSOs ability to advocate, we first had to help them in other areas as well. Therefore, we provide assistance to strengthen their organizational and financial management structures, specifically auditing, accounting systems, as well as data collection, and data visualization for advocacy. So, we have many great country examples, but I'll choose only one.

In Guyana, the Local Capacity Initiative supported the creation of the National Coordination Coalition, which now empowers their own member organizations to build their own competencies. They mobilize and diversify their funding sources and advocate for health and human rights and influence policy changes. APC also introduced the use of the scorecard methodology in Guyana as well as in India and Zimbabwe, a toolkit that helps health facilities, communities, senior managers to identify and monitor health goals, and brings together the stakeholders to review and improve the quality of care.

And finally, the National Coordination Coalition, while still small and nascent, currently receives funding through another USAID project, through the Global Fund, and their own government. And the third PEPFAR funding stream was to support social contracting as a mechanism for local organizations individually and as a consortia to negotiate directly for local government funding to provide key populations with focused HIV services. These organizations were able to reach populations and fill gaps that the government could not.

Here, we worked in Guyana and extensively in Kyrgyzstan. In Kyrgyzstan, APC was tasked with building the capacity of the civil society organizations that work with key populations to participate in the republic's social procurement program. The project worked in parallel with the Health Policy Plus project. In addition to conducting several different capacity building workshops, APC's technical assistance including promoting trust and collaboration between the CSOs and the government, including a very successful tour for government and CSO delegates to Croatia, a country further along in terms of social contracting.

In the end, Kyrgyzstan and Guyana CSOs applied for and successfully won local government awards to continue their vital work with key populations in their respective countries.

Thank you. Back to Liz.

Liz Creel:

Thanks, Walter, for sharing different aspects of APC's work with key populations in HIV/AIDS from expanding testing and treatment to capacity building of local organizations and use of social contracting to increase domestic government funding to continue work in the sector.

Now I'd like to shift to our third speaker, Jeff Sanderson, who will share some findings from APC's work in the post-Ebola recovery. Jeff is the team leader for APC's post-Ebola work in West Africa at JSI, which include provision of survivor support services in Guinea, Liberia, and Sierra Leone, as well as numerous other activities related to improvements in infrastructure, training, and other. Jeff has worked at JSI since 2002, holding a number of management, technical, and leadership positions, with a focus on supply chain.

Jeff Sanderson:

Thank you, Liz, for the introduction. As Liz mentioned, I'm gonna try to provide a few highlights from the seven post-Ebola

programs that were supported by APC between 2015-2019. Of these, three were in Sierra Leone, two were in Liberia, and one was in Guinea. The seventh was a regional program focused on best practices and lessons learned in relation to the health needs of Ebola survivors.

So, as some people on the line know, one of the primary reasons for the post-Ebola recovery programs was to rebuild trust in public systems, which had been lost, especially in Sierra Leone and Liberia due to the transmission of the virus from health workers to the general population during the outbreak, and also for the stigma that was associated with this frightening disease. These programs focused on a wide range of support activities, among them physical facility improvements with priority on clean water, sanitation, and hygiene, the strengthening of specialty services for survivors and others, services which were needed to address the various chronic problems that survivors were facing after recovering from the disease, and stigma reduction and clinical care skills for treating survivors, which were important to ensure that survivors received appropriate care and safe treatment.

With that brief overview, I'd like to turn to a discussion of a few of the high-level results from the post-Ebola programs. So, looking at the slide that's on the screen, starting from the top, the six programs rehabilitated or provided equipment to 342 health facilities. We trained more than 8,600 health providers, and as a subset of that almost 1,300 commissions were trained specifically in sub-specialty care including ophthalmology, psychiatry, mental health, rheumatology, and neurology. We helped to build the capacity of three national survivor associations and supported 33 local chapters in counties, districts, and provinces, including local elections and organizational capacity building.

During the period of APC's support, more than 3 million from these three countries utilized. And there were almost 3,000 referrals of survivors to higher-level facilities and 8,000 actual survivor visits to these facilities.

So, just to summarize an important conclusion related to the overall programs, while the focus of more than 50% of these programs was on the Ebola survivor population, the benefits – stronger specialty services, better referral networks, enhanced facilities – were important, obviously, to the general population as well. So, with the time I have remaining, I'd like to focus on the most unique program of the seven. The Sierra Leone program

sought to explore community engagement with the maintenance and preventative maintenance of health facilities.

As background, this program included 70 health posts in three rural districts, all of whom had rehabilitation work under the initial post-Ebola program in Sierra Leone. Our objective was to support and encourage community ownership of these facilities, both in terms of in kind and financial support. With facility assessments and all key decisions managed by a local volunteer facility management committee.

So, turning to the slide that's on the screen, the program included 70 facilities, as I mentioned, and the communities within each facility's service area. And looking at a few of the key results, starting at the top in the dark blue, all 70 of these committees developed what we called Facility Improvement Action Plans, which resulted after a survey of the facility and identifying needs. Sixty-four of the 70 updated their plan monthly and this was during a four-month intervention period with our local partners.

In total, 480 facility staff and community members were trained in topics including bookkeeping, cash management, advocacy, obviously basic carpentry and other repair skills, and the use of the community scorecard to monitor and communicate progress. Sixty of the 70 facilities successfully mobilized private and public resources, meaning cash. And they used 104 different sources or mechanisms to do that, from village savings and loan associations and in some cases they were able to do household taxes, small, small amounts, income generating activities which were supported by the program, and direct contributions from local businesses among others. Average funds raised during this four-month period was about \$400 with three of the facility management committees raising more than \$800 and one raising over \$1000.

While this may not seem by much by US standards, these were significant amounts in these communities, and in combination with in-kind labor, they were able to address basic repairs and their facilities. So, regarding the facility improvements program, I'd like to end with two conclusions. The community-oriented strategies of this program positively contributed to community and country self-reliance and enhanced community cohesion towards health. Self-reliance and cohesion were strengthened because community members came together to develop local strategies for mobilizing resources, again both cash and in-kind, and for solving the problems that they both identified and

prioritized and in many cases implemented. Thank you.

Liz Creel:

Thank you, Jeff, for sharing an overview of APC's post-Ebola recovery work in Guinea, Liberia and Sierra Leone from support to survivor associations to the important and compelling community-level rehabilitation and renovation of health facilities that were mentioned.

Just another reminder to please be sure to type your questions for our speakers in the Q&A box.

Now, moving on to our fourth and final speaker, Olga Cojocari who will talk about our work with vulnerable populations. As background, Olga is the grants and operations manager for APC at JSI. She has more than 13 years' experience supporting and managing USAID-funded international development programs from headquarters and field offices. Prior to joining the APC team, Olga was grants manager for two civil society strengthening and monitoring programs in Moldova implemented by FHI 360.

Olga Cojocari:

Thank you, Liz. Good morning and afternoon, everyone. Because of APC's design and structure, APC was able to accept funding from a large number of USAID bureaus and missions. With funding from the Democracy, Conflict and Humanitarian Assistance Bureau, the Office of Health, Infectious Diseases, and Nutrition, and the USAID Haiti mission, APC has supported some of the world's most vulnerable populations through grants to organizations that in turn supported several hundred small, local organizations.

Vulnerable populations include children affected by blindness and those separated from their families, people with disabilities, and those suffering from the physical and psychological effects of torture and trauma. People living in conflict, post-conflict environments and prisoners living under extreme conditions.

Despite many international conventions and legal frameworks in support of human rights, there are still many people suffering from marginalization and discrimination and who are most at risk with little access to rehabilitation, counseling, or healthcare. As you can see from this infographic, APC reached around 260,000 people and had a positive impact on their lives.

The results under these areas are impressive and the stories from direct beneficiaries touch hearts. Hearing how people's lives

changed after they received support from the APC project is the best reward for our work. Today I will talk about two programs where APC provided support.

First, is one of APC's largest grants, the Wheelchair Project and the second one is Work with Prisoners. The Accelerating Four Competences for Effective Wheelchair Services and Support Project, shortly called ACCESS, implemented by World Vision demonstrated that addressing inclusion was not only about obtaining an appropriate wheelchair, but also about breaking down societal barriers to inclusion.

The project contributed to strengthening the wheelchair sector and ensuring that people with mobility limitations, especially women and children, could access appropriate products through qualified service providers and enjoy participation in their communities. This was the first time that major organizations across the wheelchair sector partnered together on such a large scale. This project expanded wheelchair service provision in five countries by diversifying the range of available wheelchair products and increasing the management and service capacity of local service organizations, helping them become stronger, independent, and self-reliant.

Yet, the project would not be so successful without doing strong advocacy for policy change for vulnerable populations. In India, government engagement happened at multiple levels. District Handicapped Welfare Officers were trained in World Health Organization's Wheelchair Service Training Package for Managers and were involved in a series of partners of state-level policy and review meetings.

In Kenya, the APC supported sub-project was able to establish a national wheelchair taskforce. The taskforce supported the review of the national action plan and disability policy to ensure that appropriate wheelchair services were included. Collaboration with the host government in Nicaragua resulted in the Ministry of Health drafting policies to integrate the eight steps in wheelchair provision into all wheelchair services. Overall, 93% of wheelchair users showed increased community participation.

Another group of the most marginalized and forgotten populations are prisoners. They live in generally poor conditions and receive little or no consulting and support. Especially in developing countries prisoners are incubators for infectious

diseases like HIV/AIDS and TB which makes working with them so important.

In Haiti, APC funded Health Through Walls, an NGO focused on inmate health to provide comprehensive care to prisoners within some of Haiti's largest prisons, to identify, diagnose, and treat deadly and contagious diseases. Health Through Walls also provided much needed health awareness and education related to HIV/AIDS, TB, and Cholera prevention, care, and treatment. Under the project, all new prisoners were provided with medical exams, TB screening and counseling, and HIV tests.

Overall, 12,426 prisoners were screened for TB and 12,555 prisoners were tested for HIV. Health Through Walls also ensured that prisoners who tested positive received follow-up testing and or treatment. Health Through Walls was able to convince prison management administration to dedicate two small rooms to counsel prisoners with mental health issues and hired a psychiatrist to provide care since there were none on the prison staff.

Overall, APC awarded a large number of sub-grants. More than 110, in a variety of technical areas. For me personally, our work with grantees supporting the most vulnerable populations was most satisfying and rewarding. APC's final report highlights the story of Rosaline, a teenager in search of a better future who made multiple mistakes and ended up in prison. With support from APC's grantee, Rosaline was able to turn her life around and help others in need. Equally heartening is the story of two disabled sisters, Jasmine and Farhanas, from India. Their lives changed dramatically after they received tricycles through the APC supported ACCESS Project. Not only did the sisters become more independent, but the entire family felt a positive change to their overall quality of life. Thank you.

Liz Creel:

Thank you, Olga, for sharing these impressive results across a wide variety of programs to benefit vulnerable populations. And for sharing with us the compelling stories that really reflect the effectiveness and importance of capacity building and the efficacy of grant as well.

We're now reaching the wrap up portion of the webinar. As a reminder, I'd like to encourage everyone to check back on the APC website next week for the final report to, read through the full report, and also our lessons learned across our four major areas of

APC, along with 10 major, overarching recommendations. So, rather than going through all of them with you now (you can check the report for the full list), I just wanted to focus on 3-4 that, in my mind, are what I would call “top of mind.”

You’ve heard a lot about the focus of community, and I’d say community, community, community. So, the first recommendation, really, is to “Continue to promote and strengthen harmonization of community health programs within the health system.” Even though there has been, indeed, greater focus placed on community health programs by WHO and others, there continues to be a lack of coordination with little alignment to national strategies, health information systems, and programs.

All of this leads to fractured approaches, weak community ownership and poor integration with the rest of the primary healthcare system. Community health efforts can provide a cost-effective platform for countries pursuing universal healthcare coverage, especially given the potential to meet multiple health needs.

Next, and I think this is one that I feel very strongly about, so I of course needed to mention it but I think we’ve really seen it reflected across APC since the beginning, Increased emphasis on changing social, cultural, and gender norms. Again, while there has been lots of investment in behavior change, norms (both positive and negative) continue to affect people’s ability to receive health services. Take informed and voluntary use of modern contraception and also access to HIV testing and treatment. Community-based interventions can affect behavior change when they consider and integrate approaches that respect the social environment.

Next, and again, this one I think is also very important and I think, given the present, you look at the demographic transition, what’s happening in terms of epidemiology, this trend is right in front of our faces and certainly will become only more important overtime.

Prioritize adolescents, youth, and vulnerable populations. Adolescents and youth are a large proportion of the world’s population with increasingly greater relevance for human development. Involving them in health program development can improve prevention and treatment outcomes. Vulnerable populations, and I’d say across the spectrum, are similarly important.

Development partners must include all segments of these populations in the design and implementation of health solutions for themselves, their families and their communities. Using Human Centered Design, behavioral economics and other social and behavior change approaches can help. It is also important, of course, to develop measurable indicators.

And lastly, given that APC is a grants management grant giving project, of course I need to say something there. I think it's very important to consider the next generation of grant-giving and financing. Under APC, the use of small and medium-sized grants was particularly effective for piloting small-scale efforts, building technical and organizational capacity and facilitating longer term scale up.

In the future, donors should expand the use of grants, certainly and this is happening already of course, to leverage country-led domestic resource mobilization, expand emphasis on the private sector, and that's private sector [inaudible] and ongoing funding as part of holistic approach to financing, and consider other strategies such as social contracting, which Walter mentioned in his presentation blended and results-based financing.

And finally, in closing, I just had a couple of thoughts. APC's legacy of change goes beyond clients, to improvements in health systems and local organizations. The foundation APC leaves behind will enable communities and countries to continue progress toward their health goals, moving the global community closer to meeting the larger Sustainable Development Goals.

And finally, in closing, I would like to thank the dedicated and talented staff from JSI and FHI 360, USAID, and the numerous government ministries and agencies, organizations, and communities that we have worked with since 2012 for their efforts to advance community health. We have done a lot together. As an African proverb says, "If you want to go fast, go alone. If you want to go far, go together."

So, now we will take some time for discussion and to answer your questions. If you haven't done so already, please share your questions for our presenters in the Q&A box. We will try to get to as many questions as we can in the time we have remaining.

So, let's go to our first question. We have one question from Lora Shimp, who has asked, "Given the complexity of urban

communities, could you please provide a couple of examples of how APC has tailored its work to empowering the community in that context?" And I think to respond here I'd like to turn it over to Nancy Harris and to Walter Proper and then I think also – well, I'd like to turn it over to the two of them to respond.

Nancy Harris:

Thank you, Laura. This is an excellent question because community-based family planning in the urban context is quite different from rural models and peri-urban models which we've sort of – we sort of understand now. We understand much less about how to deliver this in urban contexts, how to use community health workers, I think Ethiopia was the first to try to experiment with this. And it hasn't all been successful.

In Benin, early on in the project, we did an urban workshop where we brought together partners and mayors and talked about what could be done in urban areas. And this was our first indication that mayors and people who were close to the communities would be key to making it work in urban communities. We then followed it on by a couple of workshops in which we looked at the context of urban community health workers and how they would work.

And this is still a work in progress, the government was very active with that in the communities and they have been tasked with coming up with guidelines for urban community health workers. It's a big challenge because people work in different places than they live and people commute to work. So, the old models don't work. I think we've had some successes in Benin and elsewhere. But it is the next generation of challenge for community health work.

Walter Proper:

Thanks, Liz. So, for HIV/AIDS clearly a lot of the pandemic is in urban areas, although we worked in rural and urban. So, I would say the first thing is we selected our grantees who are on the ground in these urban centers. They know the communities, they know what's happening there, and they have the outreach. And so, I think in terms of changing our strategy that was really part of it. To get these urban center grantees, to support their work. And that was highly successful with our target populations. Although, again, we still also worked in rural areas.

Liz Creel:

Thanks to both of you. We have another question that's focused more on the wheelchair service project. So, the question is from Kelly MacDonald, "The work you did with the Wheelchair Service Project is fascinating and definitely needs more attention around

the world. Other than helping those in rural resource settings access wheelchairs, did you help improve wheelchair friendly places?" I think she's citing here, "For instance, facilitating the development of wheelchair ramps?"

Olga Cojocari:

Okay, I'll try to answer this question. So, I agree wholeheartedly that facilitating the development of wheelchair ramps and making buildings and other – the community, I would say, more accessible to people in wheelchairs is very important. However, the main scope of the project – of the access project – was not about renovating buildings and making improvements to roads and things like that. It was more about implementing the eight steps in wheelchair provision, which are referral, assessment, prescription, funding and ordering of a wheelchair, product preparation, fitting and adjustment, and then user training and follow-up, which are very important for the wheelchair users themselves because previously what happened was wheelchairs were donated to people with disabilities without proper measurements and fitting, and this was doing more harm than good to them. So, this was the goal of the project.

Regarding the improvements, it was done indirectly through a mechanism called Citizen Voice in Action which is a mechanism to raise awareness in communities where people with disabilities live and I can cite a few results. Okay so, in Kenya, ramps and accessible toilets were constructed in schools, medical facilities, and government offices. This was also the result of government meetings that I was talking about during my speech. In Nicaragua, they also built wheelchairs – wheelchair ramps in public institutions in two cities. Tipitapa and Malpasillo. And in Romania, they also built 24 ramps to access alleys, built to beneficiaries' home, making one bathroom and one public recreational area accessible. Definitely more needs to be done in that area and I hope that there will be funding and the government will have a vested interest in making community accessible for people with disabilities.

Liz Creel:

Thank you, Olga. We have another question focused on social contracting and the questioner would like to know just if we could describe social contracting a bit more and for that I'm gonna turn that over to Walter to respond.

Walter Proper:

Sure. So, in easy terms, it really is having governments fund their own organizations, and as I said in my presentation it's often for things that the government doesn't do well or is not doing. So

that's really the social contracting concept.

In the case of Kyrgyzstan and Guyana, there was strong support from USAID and the Global Fund together to get governments to move to this arena. Interesting for our work, it's two, kind of, conservative countries and their policies funding organizations for groups that they don't really officially recognize or support. But they recognize them as a health issue and they knew that that was the issue.

So, to really get the governments to understand, and as I said in the presentation, one of the key issues was getting them to talk to each other and trust, because many of these civil society organizations don't trust their government because of the nature of what they're doing. And many of the people they support have been persecuted.

So, it took a while to get both of them to come together to see the outcome that would be the benefit from it and again when Kyrgyzstan, we were, like, one step forward two steps back, two steps forward three steps back, and then the government changed and in the end, it moved and even with the new government change, new people had to be persuaded and brought to the table. But they did and they have successfully moved forward on social contracting.

Guyana actually moved much faster than any of us thought it would move, and moved very fast. The present minister of health, who's a lawyer, at our closing of APC actually announced that this would continue and from what I understand, if she stands up and says, "It will continue," it will continue, so, thanks.

Liz Creel:

And we have several other questions. Another one, what is the most important lesson that APC has learned about community health workers? And I think for this what we can turn it over to all of the speakers to respond. I'll start with Nancy Harris.

Nancy Harris:

Well, we learned a lot of lessons and as you know, when you read the final report, we did a catalog. And so, we did extensive research about community health workers, how many of them, how are they paid, what kinds of training they have and so forth, and the variety is astonishing. But I think one – two lessons, and they're linked, is that in given countries it's important to standardize some things about community health workers: what they can do, of course task shifting, they should be continually

expanding what they can do, and also link them with the health system – particularly the health information system so that all of what they're achieving moves up the system.

I think, and this is a personal opinion based on a lot of the work we did, they do wonderful work and to the extent possible they should be compensated in some countries they compensated, they're formally part of the system and they're considered government employees but in other cases they're totally voluntary. I think at some point they should move toward formal compensation because countries get more out of community health workers and volunteers than practically anyone else in the health system.

Liz Creel: I also thought it would be great if Jeff Sanderson could talk a little bit about the experience on the post-Ebola recovery response in Sierra Leone and the work, really with the facility management committees and some of that focus.

Jeff Sanderson: So, I just would go back first and talk about before post-Ebola, during the crisis, community health workers were dealt with differently in the three countries, but in many cases they were pulled away from their regular jobs, they were involved in case detection, they were involved in monitoring and so forth, and in a crisis situation there are always issues of how much people are getting paid, as Nancy was mentioning and so forth.

And in Sierra Leone in particular it did create some problems because organizations that came in to deal with the crisis, pulling these people away, setting up payment systems, and so forth, when they went back to their jobs post-Ebola, there were many, many, sort of, tensions around what had been a salary level received during the crisis and now going back to a situation where officially in Sierra Leone they get a stipend and don't actually get an official salary. Just to say that it can be complicated as you move from crisis to post.

We were also involved in Sierra Leone, particularly in helping to roll out a new focus on community health workers in that time, in 2015 to 17 the government had decided to review their informal community health worker program and to try to formalize it in terms of activities, in scope, in training, and trying ultimately to deal with this issue of payment and stipends. They did pretty well on the earlier parts, they still didn't do so well on the payment issue. They – with all the pressure on them from partners to

formalize they still insisted they didn't have the funding to support community health workers' salaries and yet they wanted 15,000 community health workers across the country. So, it moved forward in the new policy with a stipend arrangement and obviously with the goal of the government to have the partners provide that stipend.

So, again it's – I would just conclude by saying in Sierra Leone it's still a complicated situation but they did – what they did do very positively was change the amount of training that community health workers got. Initially they were involved in only a 10-day program that was expanded out to, I believe, 24 days of training but also with practical experience in between different modules. So, they had a five-day module, then they were in the field for a month, then they had another five-day module. So, the training program took quite a bit more time and obviously provided them a lot more skills.

And I think, I'm just gonna say one other thing, I think that's the other important part. In the post-Ebola situation one of the biggest issue was monitoring how status of survivors, how there were different levels of involvement of community health workers, the structures that already existed in the three countries, but what was really important and was provided by our programs was clinical skills to be able to deal with the types of conditions that the survivors presented with but also dealing with the stigma and the issue, how do you address the comfort level of health providers, and particularly community health workers, at that first level of the system to work with survivors? And as you can imagine, given the fear that had been so prevalent in those countries, those trainings and programs were very important.

Liz Creel:

Thank you, Jeff. We have one other question about, "What are some next steps in NGO capacity building?" And again, capacity building was a key – a core focus of the project. This is something that I know we've all thought a lot about. So, for that I'm gonna turn that over to Walter to respond, particularly given all the work in capacity building that was done under the Local Capacity Initiative **[audio cuts out] [01:07:57]** work with key populations and HIV.

Walter Proper:

Thanks, Liz. I mean, I think the learnings is it takes time. And at first, I would say, as I said for even the urban question, there are grantees who are doing fantastic work on the ground. They know their populations, they're from that population often, and they

make things happen. The thing we learned through our assessments, organizational assessments and others and working closely is, they have some really excellent, sometimes, technical people on the ground but they need help in the other areas, just keeping the accounts, and then much less answering donors whether it's the Global Fund or AID.

How to respond to them, how to meet their standards, how to make sure that happens. I think as we give assistance we have to think more than one year, it's just very difficult. One of the things we constantly found, obviously, for all our work, I know it's critical, is M&E. And often if they're lucky enough to get a really sharp M&E person, if that person leaves, it's often another year before they have another person. They're not big enough, large enough to fill that position quickly.

So, one of the things that we tried to push at the end was the redundancy. But if you're a little grantee of six people it's hard to talk to them about redundancy. But that's one of the things I think everyone has to go into, there's great opportunities with these smaller organizations, they're on the ground, but the assistance they need is the full gambit.

And we've been like – where I personally was very involved in Guyana assessing 10 really good NGOs, I would say most of them were very open to understanding what they needed. And it's not just a workshop. They were very clear. I did take that away. "Don't just have us go to a workshop. Have us," – what they would like is the workshop and then a follow-up. "Can someone then come and sit with us and make sure we have a strategic plan that makes sense?" And I think that's the kind of thing when we're looking at assistance and capacity building we have to do. It's not just, we've brought them together, we brought these 40 organizations, we did a workshop and good luck. Now they're saying, "We liked the workshop, but then we want you to come back with us. Can you send someone for a week or two to sit with us and make sure we go through it? We go through it with our board, with all our staff? Because then, in terms of redundancy, everyone has to know it because they're so small. So I leave you with that.

That's a key thing to understand as we build capacity of these little grantees, it takes longer than a year and even if you focused, as we were in LCI was on advocacy, we soon learned we had to take care of the base first in order to get them to advocacy. If you can't collect data in an organized way, it's very hard to advocate much

less move to data visualization. The good news is they do move. These organizations have done it, but again, there's the issue of how small they are and if they lose that person that you've invested in, that's the big issue because they kind of start over again. So, as donors look at this and others look at providing this assistance, it's more than a year and it has to be comprehensive.

Liz Creel: Thank you. Nancy?

Nancy Harris: Well, I'd just like to comment that capacity building is not just for small NGOs. APC worked throughout its history with Christian Connections for International Health, which is 100 partners and some other partners, some of them very large, such as World Vision, some of them medium size. But at the most recent conference there was a strong interest in organizational capacity development using some of the tools that have been developed, a lot for the HIV program and others adapted for governments, and I think there was a feeling that these organizations now their core business, that's providing family planning, providing immunization – other things. But they're aware of the risk of getting direct funding from US government agencies, or from UN, and they really, really want help to make sure that they can do things. So, this is something that the US government can help them develop for their new partners. Make sure that they have the skills and knowledge to administer the programs in a way because it's a big risk if you make mistakes, as Olga will tell you.

Olga Cojocari: Yes. I subscribe to what you have said.

Liz Creel: Well, I think that we're at time. Before we wrap up, I would just like to thank all the participants again for their time and expertise today. Over the next few days, you will be receiving an email with a link to today's recording. And as just a reminder, please check out website around Christmas time for the full, final report. For your viewing pleasure, it's packed with lots of visuals, data, and great content and I'm so proud of this project, I have to say. Thank you all again. And happy holidays to you and yours!

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Duration: 74 minutes