2016 CLA CASE COMPETITION

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Case Story

This Case Story was submitted to the 2016 CLA Case Competition. The competition was open to individuals and organizations affiliated with USAID and gave participants an opportunity to promote their work and contribute to good practice that advances our understanding of collaborating, learning, and adapting in action.

The Kavango Treatment Initiative: Catalyzing Local Action to Achieve the UNAIDS 90-90-90 Targets

Stephanie Posner

Pact Namibia

Ministry of Health Officer collaborating with members of two NGOs. Pact / Gina Figueira.

What is the general context in which the story takes place?

Thanks to an aggressive public health effort, roughly 143,000 Namibian people living with HIV were receiving antiretroviral therapy (ART) by the end of FY 2015, putting the ambitious UNAIDS 90-90-90 targets within the country's reach. Remaining gaps are localized: ART service data from 2014 suggest that Kavango Region had the second-highest HIV treatment gap, at almost 50 percent. Mandated to coordinate the local response, the Regional AIDS Coordinating Committee (RACOC) struggled to lead strategic and collaborative action in the region.

In late 2013, Pact initiated the Namibian Institutional Strengthening project, supported by the U.S President's Emergency Plan for AIDS Relief (PEPFAR) through USAID. The primary aim was to build the capacity of local actors to support an evolving national response to HIV and AIDS, in light of the country's transition to a predominantly domestically financed program. Subsequent iterations of PEPFAR directed this overall goal toward regional and district-level coordination and systems support, with a specific focus on ART treatment.

Through active engagement of governmental and nongovernmental implementers in the region, the project team mobilized local political leaders, decision makers from the Ministry of Health and Social

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Services (MOHSS), NGOs, and people living with HIV to form the Kavango Treatment Initiative (KTI), a rapid response team designed to collectively tackle the most pressing HIV challenges in Rundu, the region's largest health district. The KTI was highly valued by local participants and resulted in rapid actions taken within and across governmental and nongovernmental actors.

What was the main challenge or opportunity you were addressing with this CLA approach or activity?

With multiple local resources available for the HIV epidemic, the Namibian Institutional Strengthening project's challenge was to promote more effective collaboration and improved leadership among local actors, particularly in government, with the result of tapping into local human and financial resources to address key HIV priorities. Across the government response, multiple coordination groups were set up to support the HIV response, including the RACOCs, typical of most southern African HIV programs. Some RACOCs were better at sharing information; all were excellent in organizing national events such as World AIDS Day and Tuberculosis Day. Although there was information sharing, there was absolutely no joint reflection and learning and, as a result, no coordinated responses. There was limited engagement of MOHSS as a key player (they saw no value), and none of the 13 RACOCs were effective in producing any real collaboration among members.

The RACOCs were not the only coordination bodies experiencing this challenge. Various strategies (e.g., the Combination Prevention Strategy) called for regional tasks teams, yet good implementation of these local coordination groups and task teams always remained a challenge. It appeared that government did not really know how to support implementation of good coordination, other than providing budgets.

In addition, data were required for good local coordination. HIV-related data are abundant in Namibia, but not really "available" in easy-to-access formats for regional and local data, nor presented for people with varying capacity for analysis.

The purpose of the KTI element of the project was to develop an effective coordination body (task team) under the auspices of the RACOC and build experience such that collaboration bodies could learn to be more effective at the coordination function.

Although the region's 50 percent ART treatment gap was USAID's (and PEPFAR's) primary concern, there was very real and ethical resistance from MOHSS to add more patients on treatment without first addressing adherence. The KTI needed to bridge these closely related but subtly different goals to get alignment among the members.

Describe the CLA approach or activity, explaining how the activity integrated collaborating, learning, adapting culture, processes, and/or resources as applicable.

Convening six times over a six-month period, the KTI, under the auspices of the Kavango RACOC brought together local implementers from different sectors. Providing a platform for open interaction toward clear and shared goals, KTI members tackled a host of issues that were crucial for meeting the MOHSS HIV and AIDS service delivery targets as well as the 90-90-90 goals. Carefully presented, locally available data were critical to each meeting. In-depth analysis of the data included examining local service mapping, analyzing patient data, triangulating pharmaceutical data, and jointly analyzing published data compiled in extensive local factsheets and an electronic dashboard. Although qualitative and quantitative data for joint action were important to this KTI activity, the area for CLA learning focuses more specifically on the "people" aspect:

- **Bringing the right people together:** KTI members were very carefully selected and consisted of highly motivated and committed people from the health sector, NGOs, other ministries, and people living with HIV and AIDS in the region. Members were identified through a series of processes, including multiple interviews during an assessment, nomination, and a social network analysis.

- **Fostering open dialogue and trust and enthusiasm:** KTI members came from different backgrounds and professional levels in their organizations. Yet, in the meetings all contributions were equally valued, which increased members' readiness to contribute and share perspectives. Innovative and intentional facilitation approaches were applied, such as carefully convened and facilitated panel discussions, "stakeholder shoes" facilitation technique, and "learning journeys" that produced experiential learning with direct personal and valued impact on participants. These approaches contributed substantially to fostering open interaction, trust, needed dialogue, and idea exchanges between healthcare providers and people living with HIV and AIDS. It also focused attention on shared objectives and freed participants to think about solutions creatively and collaboratively. Sensitive data could be shared and discussed without fear of repercussions. The whole experience created enthusiasm among participants and led a key MOHSS participant to conclude, "I never want to miss a KTI."

Were there any special considerations during implementation (e.g., necessary resources, implementation challenges or obstacles, and enabling factors)?

In interviews during closeout, members cited multiple reasons for the KTI's success. Highlights are as follows:

- The KTI initially focused on having members jointly develop their own specific and locally relevant priorities, based on data.
- The KTI engaged members deeply in all processes (i.e., was very intentionally participatory).
- This included collecting or compiling needed local data through "data deep dives" to better understand the issues and assisting the KTI to prepare information in easy-to-understand formats and presentations. Deep dive topics were selected based on priorities.

- The KTI focused very intentionally on good facilitation to provide a space that fostered trusting relationships, increased respect among members, promoted greater willingness to listen, and ultimately helped members feel ownership over the KTI.
- The KTI enabled open debate and discussion, even on difficult topics, resulting in joint ownership of the issues, collaborative solutions, catalyzed action, and (importantly) shared successes.
- Fostering local ownership and local solutions: The KTI enabled people to make local suggestions and improvements to existing systems. Members often found that they felt empowered to effect change themselves — taking action using their own local resources, sometimes within themselves. As the regional coordinator of a local NGO said, "Through the KTI … we realized we have all the solutions with us." In a limited period and mostly drawing on local human and financial resources, multiple actions were taken between meetings, particularly by the MOHSS — actions that even went far beyond the steps identified at each meeting. Empowered, KTI members truly "ran with it."

In general, for the results that were produced and the local human resources that were catalyzed into action with their own financial resources, relatively few resources were required to inspire these actions. The project spent about $1 million during the six months of KTI work, not all of which went to support the KTI, which was in a region quite far from head office, which was situated in the capital (thus, much went toward travel).

It was a challenge to keep track of all the changes that the KTI was rapidly producing. For example, "catalyzed" actions included:

- Actions taken to organize and implement recognized needed training
- Needed equipment immediately sourced and put in place by MOHSS
- ART pharmaceutical system challenges tackled and small changes made, resulting in dramatic systems improvements stemming from ideas in meetings
- Clinical mentors recognizing interpretation errors that NGOs were making and following up with a meeting and clarifying "tool" that dramatically improved referrals

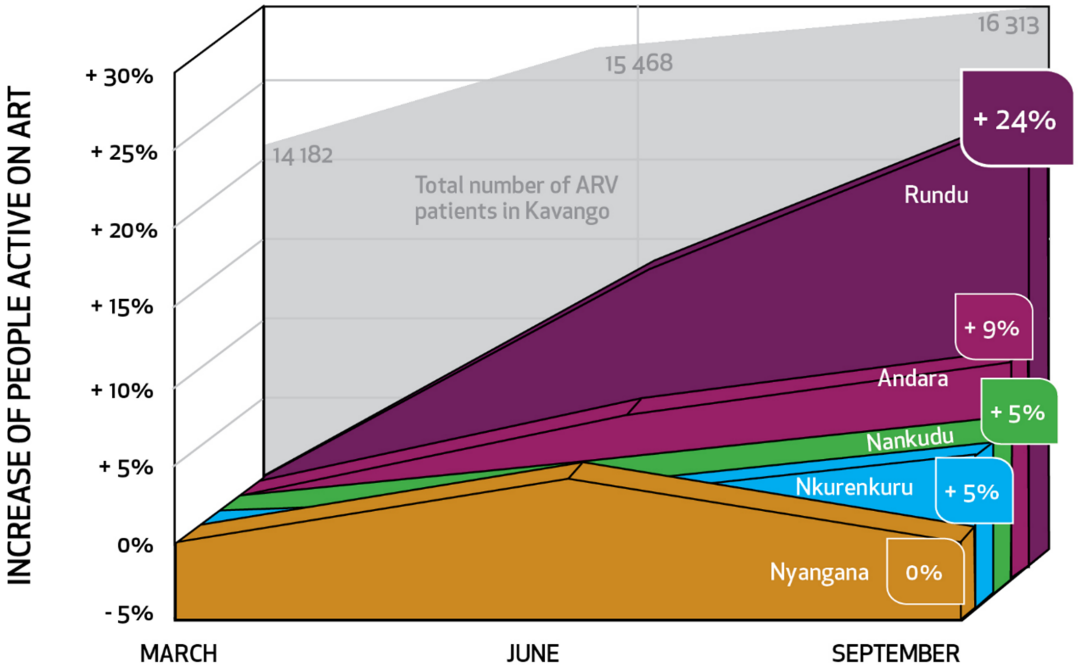
A number of other examples can be cited. In addition to attempting to gather the actions that were taken, we sought to understand the changes that people were personally experiencing. Most had to be collected through qualitative means (feedback presentations, follow-up interviews, or even "checkouts," in which members expressed how the approaches affected them, including their emotions). These types of personal changes among members — which were meaningful to us as implementers and often could not be anticipated (in terms of results) — are rarely measured or valued in performance monitoring plans or even theories of change. Yet, these very personal changes and expressions were key markers of effective collaborative work and collective success. **We believe that there is much to learn about these personal changes as process indicators.**

Another major challenge was not related to the approach necessarily. The program was terminated one year early due to competing PEPFAR priorities. See below.

With your initial challenge/opportunity in mind, what have been the most significant outcomes, results, or impacts of the activity or approach to date?

Within six months and largely through the use of local resources, the KTI's work resulted in significant outcomes:

- **Active ART clients increased by 24 percent (March–September 2015).** During the project period, Rundu District saw the largest increase in active ART clients in the country (see Figure 1 below). This was partly due to the clearing of data backlogs, but may also reflect greater efficiencies in providing treatment to clients. ART retention rates in Rundu were at 100 percent for two consecutive quarters.
- **Increased data accuracy and timeliness for better service delivery.** Collection and sharing of up-to-date client data resulted in tangible improvements in management of client flows and ARV stocks at all treatment sites. Waiting times were reduced, clinical teams could more easily identify treatment defaulters, and, with up-to-date treatment figures for each facility, medical store staff could deliver appropriate amounts of medicines. This led to reductions in stock-outs and ad-hoc replenishments, limiting the risk of losing clients referred elsewhere for medication pick-up.
- **Improved linkages between facility and community-based service providers.** With accurate client data and greater awareness of local NGO service provision, tracing of



Sources: Namibia MOHSS ART PMIS Quarterly Feedback Report for the Periods Mar-June and Jul to Sept 2015

treatment defaulters and referrals to treatment support groups improved. Community-based HIV testing sites increased referrals of HIV-positive clients to the ART program.

- **Mobilization of people living with HIV.** The experience inspired a community member living with HIV to start organizing a much-needed forum for people living with HIV in the region, focused on strengthening the voice of HIV clients.
- **Increased mutual appreciation between people living with HIV and those working in HIV service delivery.** Participation in the KTI sensitized program implementers to the real challenges faced by many ART clients. This led to a fuller acknowledgement of these issues and active work with clients and other community stakeholders toward practical local solutions.

If your project or activity is in the development phase or just recently underway (less than 1 year into implementation), how do you intend to track results and impact? What outcomes do you anticipate?

The Namibian Institutional Strengthening project ended one year early due to PEPFAR decisions that were made while the KTI was starting up (the in-country team did not have time to see the impressive results of the KTI). In addition, the program focus on the region and district levels were lower priority than facility- and site-specific programs. Part of this program was to empower the district level to identify sites and systems for improvement, but this was not in line with PEPFAR's top-down approach of selecting sites directly. (However, it is our understanding that PEPFAR is now reconsidering district-level systems support.)

Although USAID has said that programs like the successful KTI should scale up, they felt their hands were tied. Although the project had planned to scale up to another region with large ART gaps, to apply similar concepts in a second difficult region and learn from scale-up, is was terminated right as the next region was engaged. Unfortunately, the project was not able to scale support to other RACOCs nationally, which would have helped improve their overall coordination capacity based on the lessons learned in Kavango.

What were the most important lessons learned?

- **Many existing approaches and systems still stifle initiative**. Top-down approaches, few opportunities for collective reflection and problem solving, a reliance on outside expertise, and working in programmatic silos hamper creativity and local action.
- **Many solutions can be found within existing systems and using existing resources.** When local implementers clearly understand the challenges and are motivated and empowered to take action, they often find solutions within their organizations or through cooperation.
- **There are too few opportunities for <u>real</u> engagement with people living with HIV.** Even as patient numbers steadily increase, there is little *high-quality dialogue* between providers and clients. As a consequence, the real issues behind lack of service uptake and adherence may not be well understood or sufficiently considered. This hinders the delivery of truly patient-centered services.

- **Adherence issues need to be acknowledged and addressed, even if the health system alone cannot address them.** Food insecurity is a major issue affecting many people living with HIV and their ability to stay on treatment, presenting a challenge to achieving 90-90-90 targets for viral suppression. Cross-sectoral interventions will be needed to deal with poverty's impact on treatment.
- **Community-based programs need to focus on empowerment.** As treatment numbers increase, community programs play important roles in promoting testing, positive health, and dignity, and in tracing treatment defaulters. Local approaches to educate and empower patients to take greater responsibility for their health exist and can complement programs reaching people living with HIV, yet few real examples exist.

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