Global Fund Thematic Review on Community Health.

Synthesis report

June 2020

Executive Summary

Background

This report describes the results of the Thematic Review of Global Fund Community Health Investments. The report draws on in-depth reviews conducted in Democratic Republic of Congo, Ghana, Liberia, Mali and Mozambique. The Thematic Review was commissioned by the Global Fund to Fight AIDS, Tuberculosis and Malaria in September 2019 and conducted by the Dakar-based NGO ENDA Santé.

The review aims to strengthen understanding of the Global Fund's current investments in community health care and how they contribute to scaling-up effective interventions for HIV, TB and malaria, in selected countries. Specifically, the review is aimed at identifying and documenting successes and challenges in the planning, implementation and monitoring of community health care, including:

a. Assessing partnership and linkages between health facilities and communities for strengthening referrals and retention in care;
b. Assessing the quality of community health care delivery;
c. Assessing how community-based care data is gathered, reported and used for programmatic decision-making;
d. Generating information and evidence that could be used by the Global Fund to take successful community-based implementation practices to scale.

Unlike a programme evaluation, this Thematic Review focuses on identifying and describing the best examples of effective community practice, and sites were selected accordingly based on strong performance. The results should therefore be understood as reflecting the most effective approaches that have potential for scale up rather than as an overall appraisal of Global Fund investments and performance.

This synthesis report accompanies the detailed Thematic Review reports for each country, as well as the Key Lessons Briefs for each country which highlight some of the most notable findings and which are companion pieces to this overall synthesis, providing additional details and examples.

Main Findings

What is the focus of Global Fund investments in community health? How are they designed and how do they align with national health policies and frameworks?

Global Fund-supported community interventions in the five countries follow a similar pattern. Community malaria interventions tend to be well integrated into national health systems, since they are often delivered by a formal cadre of community health workers – even if the specific name given to this cadre is different in each country. Community health workers (CHW) involved in malaria are on the whole involved in delivering a range of health interventions, focused primarily on childhood illnesses and in some cases maternal health. community malaria interventions tend to be well-integrated with broader health efforts; and the cadres are recognised as a key component of the health system in national health strategies in all of the

countries. However, in many cases the TB and HIV interventions are not effectively integrated into standard CHW roles.

The limited integration of HIV and TB community interventions into mainstream community health strategies is related to the unique characteristics of these two diseases, both in terms of the population groups that are most affected and in terms of the related social determinants that affect vulnerability and access to services of those affected. As a result, community interventions for HIV and TB are highly targeted and incorporate not only direct prevention and treatment related interventions (such as community based testing and treatment, treatment adherence support) but also interventions that address stigma, discrimination, human rights violations and gender inequalities. In most cases they are delivered by specialist "peer" cadres – people living with HIV, representatives of specific affected groups such as key populations, mothers living with HIV, young people and adolescents, and people who have recovered after TB treatment. The unique experiences and motivations of these cadres are part of what makes them effective in community health programming.

All of the countries included in the Thematic Review have seen an increase in Global Fund support to interventions aimed at reducing human rights barriers, stigma, discrimination and gender inequality. In addition this category of community programmes includes support to community-led social accountability interventions such as community based monitoring and advocacy.

The level of alignment with national policies varies. CHW cadres are well recognised in national health strategies. While this is not the case for population specific peer cadres, they are more likely to be aligned in disease strategies. Advocacy and accountability interventions, as well as interventions designed to reduce human rights related barriers, are less evidently part of health policies and frameworks. However, health and disease programme decision-makers on the whole recognise their value.

What role have Global Fund-supported community health programmes played in improving access to services, case finding and retention in care?

Fieldwork revealed consistent positive feedback on these interventions from managers, health care providers, community cadres and service users on the roles played by community health programmes. The overarching finding to emerge from all five countries included in the Thematic Review is that a diverse range of community programmes can combine effectively with formal health care provision to significantly improve results. This is achieved either by providing alternative venues or methods to deliver services (such as community-based testing and drug delivery) or by providing complementary services (such as tracing people lost to follow up, adherence support and community based monitoring).

Success factors included:

- ✓ The development of close collaboration and mutual respect between community cadres and health care providers, from local through to national levels.
- ✓ An openness to providing different parallel options for accessing testing and treatment, recognising that different community groups and different individuals access services in different ways.

- ✓ The integration of interventions aimed at addressing broader barriers and needs of the population, helping improve engagement with services.
- ✓ The creation of programming environments that enable community cadres to be innovative and responsive to needs rather than overly rigid frameworks.
- ✓ Investment in community mechanisms to promote programme accountability.
- ✓ The provision of reliable, effective support to the formal health sector to complete the overall service provision landscape.

How have Global Fund investments enabled referrals, linkages and partnerships between communities and health facilities?

Effective community health responses are strongly reliant on effective collaboration with the formal health sector. Partnerships and referral systems are rendered more effective by the establishment of a strong sense of teamwork, shared responsibility and accountability for results. These features were commonly identified in effective examples of community health responses seen through the Thematic Review. This collaboration to be clearly incorporated into the design of Global Fund grants in a number of ways:

- ✓ Joint planning between community and health care practitioners.
- ✓ Development of collaboration through specific efforts to develop relationships between community and health facilities such as involvement of clinicians in the recruitment and training of community cadres, ensuring cadres report information on their activities to clinicians.
- ✓ Training of health care workers and managers on human rights and the establishment of programmes to reduce stigma and discrimination in healthcare settings.

In addition, community cadres reported that due to denial and self-stigma, some people living with HIV and TB still try to avoid treatment. Cadres therefore need to look beyond formal referral tools to trace individuals who are in this situation.

How do Global Fund investments support data-driven decision-making at the community level?

The Thematic Review found that within community programmes data has traditionally been associated with reporting on activities undertaken with less emphasis on local data usage. Tools and systems for reporting have been developed and strengthened over time with better integration within national reporting systems. Activity reporting from community cadres is also increasingly linked to activities conducted in health facilities, allowing better tracking of completed referrals and follow up of patients. However the use of data for real-time strategic decision-making at local level was on the whole limited.

On the other hand, ample evidence was found of community and health sector workers using data effectively to improve the quality and timeliness of their day-to-day work. This indicates a strong level of understanding of the principle of using data not just for reporting but to enhance decision-making in discussions with many community cadres and local health care workers. It is reinforced when there is a strong culture of teamwork between these cadres.

The big shift in the data landscape in recent years has been the growth in community-based monitoring for social accountability, which is increasingly supported through Global Fund grants. The countries included in the Thematic Review all have some form of community-based monitoring, funded either through a Global Fund country grant or through a multi-country community treatment observatory grant funded between 2017-2019. Where local monitoring is established it can form the basis for dialogue between the population, community based organisations, health care providers and local decision-makers, and it was acknowledged during the Thematic Review that this can shorten feedback loops and speed up local problem-solving. A challenge remains in ensuring the data they generate is effectively valid and representative when aggregated at national level.

How do Global investments contribute to the quality of community health care delivery?

Availability and use of standard packages for community interventions

The Thematic review found evidence across all five countries that community programmes are delivering standard packages. There are considerable variations in the content of those packages depending on the specific role of the cadre and whether or not they focus on a disease area or key population group.

The advent of relatively new roles for community cadres such as adherence support, active case finding or paralegal support mean that in some cases the packages are defined at the programme level by Global Fund Principal Recipients or Sub-Recipients, but have not yet become established within national guidelines.

It is noteworthy that given the recognition of the importance of teamwork between community cadres and health care providers, packages increasingly reflect not just the roles of individual cadres but the combined roles of these teams. This can contribute to the development of shared responsibility and accountability.

There is a tension between the principle of polyvalence – in other words of community cadres being tasked to address multiple health conditions for any member of the population – and specialisation, which is typical in particular in HIV and TB programmes. In countries with weak health systems there is an understandable interest in developing of a uniform, polyvalent cadre that can address a wide range of needs. However, the Review found that there is a risk in this being done at the expense of specialised cadres, since inherent in the success of some of the Global Fund supported programmes is the fact that specific cadres are working on issues that they have direct experience of, and in stigmatised communities that they are themselves part of. A hybrid combination of generalist/polyvalent alongside specialised community cadres and programmes appears to be most effective at meeting a wide range of needs.

System design and support: training, commodities, tools, reports, coordination, supervision and support

Standardisation of systems for recruitment, training, and supervision of community cadres is evident. Stand-out examples of recruitment and training of community cadres were those that involved community members and health care professionals in the process since this established a strong basis for teamwork and partnership. A strong partnership between community and health service implementers in the recruitment and training of community cadres provides the basis for effective planning and supervision of work on the ground.

Collaborative planning between community and health care staff, as well as regular monitoring and supervision from lead implementing organisations also help to ensure standards are adhered to. The review observed that when this approach is in place it allows for more decentralised decision-making and autonomy in how work is conducted at the local level, allowing adaptations to specific circumstances and events.

Sustainability of the system including retention of community cadres

The increasing recognition of community programmes and their links with health service delivery in national frameworks and policies, and the strong reliance of health facilities on them suggests a high level of commitment to sustaining them. However, these interventions and programmes are on the whole funded on a project basis rather than as core elements of the health system. Some of the cadres and community interventions that have been more recently introduced through Global Fund support such as peer paralegals and other population-specific cadres are likely to take some time to be fully recognised as part of the health system and therefore become prioritised for sustained support. In addition many of the important community cadres, for instance those focused on human rights, are unlikely to be incorporated into health systems funding. Sustained financing of community interventions therefore needs to consider not just financing for health interventions but financing structural and broader social and rights-based interventions that have been supported by the Global Fund.

Recommendations

How can local health care providers and community actors achieve greater impact?

Build strong partnerships and mutual accountability between community actors and health facilities

There are a number of strategies that can be used to build this: joint planning between community and health facility implementers; attaching community cadres or programmes to specific health facilities; involving health facility workers in the recruitment and training of community cadres and involving community representatives in training facility workers on issues such as stigma. Providing status to community programmes, and explicitly recognising their contribution also helps to build their credibility. Actively engaging users of services in planning, review and feedback activities can also strengthen this partnership.

Use locally generated data to shape activities

Systematising basic data analysis at local level, and involving community and health care workers in this, will be an important improvement. Data and insights generated from local level community-based monitoring can also play a role in informing local decision-making with real-time data.

Link HIV and tuberculosis services, and address broader health needs

Linking TB and HIV is a good starting point and has been shown to be feasible in the countries reviewed; malaria services can also be linked in a relatively straightforward way. It is also feasible to go further and increase the scope of services towards a more universal or holistic approach. Achieving effective linkages involves establishing strong communication between different service providers and community cadres; joint or cross training on different health topics; and joint planning.

Link community HIV and tuberculosis support with empowerment, human rights and accountability efforts

Ensuring complementary services or interventions are co-located – for instance, embedding or linking peer paralegals within clinical and community care teams, further helps to strengthen overall impact. Accountability efforts such as community-based monitoring and local consultative committees are also showing an important contribution and should be considered part of a comprehensive community programme.

Encourage flexibility and responsiveness by community cadres

Resourcefulness and adaptability can be encouraged by ensuring that funding guidelines and systems allow for flexibility and autonomy at the local level, albeit within the scope of quality standards; and by celebrating and promoting good examples of flexible service provision.

Engaging with other community resources beyond the official community cadres

Community involvement in health is not just limited to identified "cadres" such as community health workers or peer educators. Community programmes and clinicians can work with broader community support networks and can also include community led service provision such as ART distribution sites, outreach testing, and drop-in centres for key populations.

How can the Global Fund and national actors better support community health programmes to achieve greater impact?

Foster local ownership and encourage local adaptation

The Global Fund and national actors can ensure that local planning and adaptation takes place by avoiding overly rigid activity planning at the central level and focusing on achievement of results over time. Facilitating the sharing of experiences between locations for instance through training, communication and exchanges can also support this process.

Provide a range of different options for obtaining services

When different options are available they help meet the needs of a wider range, because each addresses different barriers. It allows for a more person-centred approach and makes it more likely that ambitious programme targets can be reached.

Invest in capacity for strategic local data use

This should include building the basic skills of local level actors in collating, triangulating and interpreting data from different sources, including both regular reporting and community-based monitoring. It should also involve building an understanding of data and local monitoring as tools for local action rather than merely reporting requirements.

Supporting and testing innovations while maintaining continuity of effective approaches

While funders such as the Global Fund are well placed to support and nurture innovation and scale up, national programmes can take these innovations once they have been proven to be effective and embed them into national approaches. This provides a stronger basis for sustainability. This process should be systematised by both the Global Fund and national actors.

Support the development of community movements and programmes

Investment can be used to mobilise communities to work at greater scale. The Global Fund and implementers should also consider trialling other less structured models such as convening cadres from different communities at regional and national level to encourage linkages, lesson

sharing and representation without necessarily relying on formal structures. Support to community-based monitoring and social accountability efforts is also an important way to develop community movements and ownership.

Invest in enabling environments

Doing this effectively requires working beyond the health sector, engaging in particular with human rights organisations and government departments responsible for human rights, justice and law enforcement.

Maintain efforts to resolve overall health systems challenges

It was noted repeatedly that the success of community health programmes depends to a large extent on having effective service provision within health facilities. This is particularly the case in programmes aimed at strengthening case finding and access to and retention in care since it is essential that community services are able to refer to facilities that have the skills, equipment and commodities necessary to complete the loop.

Build capacity of community cadres and other community programmes

Training packages, including refresher training and supportive supervision, be provided consistently rather than cut down or delivered in a shortened version due to funding constraints.

Enable linkages between disease programmes where feasible and appropriate

The linkage and integration of services related to different health problems or diseases should also be encouraged by funders and other national actors by, for instance, aligning planning timelines and incentivising collaboration between implementers specialising in different programmes or with different populations.

What lessons from this review might be transferable to other health programmes?

Building relationships between health professionals and the communities they serve

Promoting the positive experiences from HIV, TB and malaria within health facilities and health administrations may help generate interest and skills in engaging with communities in other important health domains such as maternal and child health, or as is particularly germane at the time of writing, major new health emergencies and pandemic threats.

Strengthening ownership and accountability and empowerment in relation to health

Community empowerment, accountability and human rights interventions increase the confidence of people to demand better health services and to be treated correctly and with respect. Community based monitoring for social accountability approaches can be expanded to observe a broad range of health issues, and indeed as the Thematic Review found, they already are since community members or service users, when asked to feed back on the quality or other aspects of health services, do not by and large limit themselves to commenting on services related to specific diseases or programmes. Community social accountability efforts may in fact provide a strong basis for integration of different health programmes and a platform for the development of universal health coverage.

Build capacity in good practices while encouraging local innovation

The principle of testing new approaches and establishing them into national systems once they have been proven to be effective is valid across different health domains. Programming frameworks should provide quality standards without stifling local adaptation, which is the

hallmark of effective community health programming – this is applicable not just for HIV, TB and malaria but across health domains including new pandemic threats such as Covid-19.

Provide a blend of health service options to achieve the maximum impact

"One size fits all" approaches are attractive from the perspective of standardisation, management and funding. However, no single service delivery model will meet the needs of all of the population. Specific health problems, or specificities within population groups will always mean that there will be a need for differentiation and creativity. Alongside core "mainstream" programming models, decision-makers should therefore allow and encourage differentiated approaches that engage with, involve and meet the needs of specific community groups.

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Acknowledgements

The ENDA Santé team could not have conducted this Thematic Review without the active contributions of actors involved in community health programmes in Democratic Republic of Congo, Ghana, Liberia, Mali and Mozambique. From community through to management level, participants in the review generously gave up their time, both during their busy working days and out of hours, to voluntarily respond to our questions and discuss their successes and challenges. While for confidentiality reasons not all participants are named in this report, we are grateful to all.

We also thank Global Fund Country Team Members who provided valuable orientation on the scope of the review and back up logistical support, as well as Gavin Reid of the CRG department and Lize Aloo and Isabelle Yersin of the MECA team.

The conclusions and opinions in this report are those of the ENDA Santé Team, and are based on the data collected and the analysis of that information.

About this report

This report provides a general synthesis of the overall findings of the Thematic Review on Community Health in five countries. Detailed examples and descriptions of the Global Fund's investments in the 5 countries can be found in the country reports which are available from the Global Fund. In addition, a *Key Lessons Brief* summarising the high-level good practices is available for each country. This general synthesis report should be read alongside these *Key Lessons Briefs* as they provide critical additional context and examples that illustrate the overall synthesis conclusions.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
CHA	Community Health Assistant
CHP	Community Health Promoter
CHSS	Community Health Services Supervisors
CHV	Community Health Volunteer
CHW	Community Health Worker
CTO	Community Treatment Observatory
CTW	Community Tuberculosis Worker
DIC	Drop-in Centre
DRC	Democratic Republic of Congo
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
iCCM	Integrated Community Case Management
LTFU	Lost to follow up
MOH	Ministry of Health
MSM	Men who have sex with men
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission of HIV
RFP	Request for Proposals
TB	Tuberculosis
UIC	Unique Identification Code

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1. Introduction

1.1 Context and objectives of the Thematic Review

ENDA Santé was commissioned by the Global Fund to Fight AIDS, Tuberculosis and Malaria to conduct a Thematic Review of its investments in Community Health Care. The review objectives as stated in the initial Request for Proposals are as follows:

"…to better understand how Global Fund's current investments in community health care contribute to scaling-up effective interventions for HIV, TB and malaria, in selected countries. Specifically, the review is aimed at identifying and documenting successes and challenges in the planning, implementation and monitoring of community health care, including:

a. Assessing partnership and linkages between health facilities and communities for strengthening referrals and retention in care;
b. Assessing the quality of community health care delivery;
c. Assessing how community-based care data is gathered, reported and used for programmatic decision-making;
d. Generating information and evidence that could be used by Global Fund to take successful community-based implementation practices to scale." (1)

The review was initially intended to be conducted in 8 countries, with three countries to be covered through a desk review and the remaining five through a combination of desk review and a country visit. Due to delays and clashes with Global Fund funding request deadlines, the review was subsequently reduced to cover only the 5 in-depth countries: Democratic Republic of Congo, Ghana, Liberia, Mali and Mozambique.

1.2 Review Approach and Focus

Following award of the contract, the ENDA Santé team worked with Global Fund stakeholders to refine the scope of the Thematic Review, agreeing key principles, developing an overall framework and agreeing focus areas for the countries included in the review. These are described in detail in the Inception Report (2). To summarise, the key agreed principles were that the review should be:

- *User-focused*, in other words that programme implementers at country level should participate actively in the process, both in data collection and in the cocreation and validation of recommendations.
- *Positive deviance based*, aimed at identifying the ways in which community interventions contribute to results. This approach calls for purposive sampling in order to focus the review on examples of programmes that best illustrate effective – or ineffective – approaches that can be replicated, rather than a random sampling approach which would be appropriate for a formal programme evaluation.

After examining the hierarchy of Thematic Review questions included in the RFP, the ENDA Santé team and Global Fund stakeholders agreed to a revised Thematic Review framework as follows:

Strategy and design	Q1: What is the focus of Global Fund investments in community health? How are they designed and how do they align with national health policies and frameworks?		
Contribution of community interventions to outcomes	Q2: What role have Global Fund-supported community health programmes played in improving access to services, case finding and retention in care?		
Mechanisms and implementation	Q3: How have Global Fund investments enabled referrals, linkages and partnerships between communities and health facilities?	Q4: How do Global Fund investments support data-driven decision-making at the community level?	Q5: How do Global investments contribute to the quality of community health care delivery?
Lessons and recommendations	Q6: What practical steps can community organisations, service providers, national stakeholders and Global Fund managers take to strengthen and scale up effective community interventions?		

Figure 1: Thematic Review Framework

The specific focus for each country is described in the table below. Note that the table only includes the 5 countries covered by the in-depth review approach following the decision to deprioritise the 3 countries due to be reviewed by desk review only.

Country	Areas of focus
Democratic Republic of Congo	Community monitoring (including community surveillance and treatment observatories); Community based programming for AGYW. Review focused on Maniema Province.
Ghana	Community programming for HIV and TB, focused on civil society led models that have been adopted by the government.
Liberia	Community programming for HIV, focused on non-formalized cadres. Level of formal CHA engagement in HIV and TB testing and treatment support.
Mali	Community treatment observatories, community case finding, adherence support for HIV, and integration of TB and HIV.
Mozambique	Community HIV programming for MSM and FSW, including community human rights interventions.

Figure 2: Thematic Review focus for each country

A detailed review report and a key lessons brief have been developed for each of the 5 countries.

1.3 About ENDA Santé

ENDA Santé, a member of the Enda Tiers Monde network, is an international non-profit organization based in Senegal since 1978 with a strong track record in supporting the improvement of socio economic and health conditions of communities. In the West and Central African region, ENDA Santé focuses its work in implementing programmes that focus on sexual and reproductive health, HIV/AIDS, TB, Malaria, community health, gender-based violence, and local economic empowerment and development. In all these countries it focuses on building capacity of civil society organizations, empowering community led programs, fostering multilevel partnerships and advocacy with governments, the private sector, civil society, the media and key decision makers.

The ENDA Santé Team for the Thematic Review was made up of senior full-time staff of the organisation and international and national consultants. In addition, deliverables were reviewed for quality by experts from Johns Hopkins University School of Public Health.

2. Methods and conduct of the review

2.1 Positive deviance approach

As noted above, ENDA Santé proposed to adopt a "positive deviance" approach to the Thematic Review. While any programmatic review invariably identifies challenges and barriers, this approach involves emphasising the identification of effective practices that have the potential for scale up or that can provide insights for more effective programming overall. This approach was selected in order to ensure the review identifies tested, practical recommendations. The approach is primarily qualitative, with basic quantitative information being used to frame questions and triangulate conclusions.

2.2 Data collection methods

Data was collected by means of a desk review of key documents and a combination of key informant interviews, focus group discussions and site observations during the country visits.

Desk review

Documents were primarily provided by the Global Fund's Country Teams and supplemented through targeted online searches. An initial desk review was conducted in advance of each country visit, and was updated based on additional documents provided by informants during the visits. While most documents included in the review dealt directly with Global Fund investments in each country, additional sources were included such as multi-country reviews and audit reports and evaluations. Data extracted from these sources were classified according to the different review questions, then compiled with data from other sources before analysis.

Qualitative data collection during country visits

Key informant interviews, focus group discussions and site observations were used to ensure a range of perspectives would be captured.

- *Key informant interviews* were conducted with national level stakeholders such as Ministry of Health and Global Fund programme leads, as well as a small number of service providers working at facility level and community health cadres.
- *Focus Group discussions* were conducted with community cadres and service users.
- *Site observations* involved brief inspections of service delivery sites where community and health facility cadres interact.

Guides for each of the above data collection processes were developed in advance, and tailored to the specific questions of the review in each country. The review team employed flexibility in administering questionnaires and using discussion guides, recognising that not every participant would necessarily have views or information relating to every question.

Each data collection event (interview, focus group discussion, site observation) was attended by 2 team members (4 in some exceptional cases), with one team member leading on conducting the session and the other on note-taking.

No payment was given to review participants. Community cadres and service users were in some cases provided with a modest reimbursement towards travel costs depending on the location of data collection activities.

A team member documented each data collection event (interview, focus group discussion, site observation) by hand. Data from each event was then electronically transcribed and reordered where necessary into a standard template by one team member, and reviewed and supplemented by a second team member before being uploaded into a secure shared drive for analysis.

Liberia was the first country visited for the Thematic Review, and the process in Liberia therefore served as a means of piloting the tools. Approaches were adapted and simplified during the course of data collection and these changes are reflected in the tools used in subsequently visited countries.

Participant consent

As a programme review not seeking any individual health information, formal ethical approval for interviews, focus group discussions and site observations was not required. However in the interests of maintaining ethical standards and transparency, the ENDA Santé team adopted a differentiated approach for ensuring all participants had a clear understanding of the purpose of the review, of the confidential nature of any information or opinion shared by them, and of their right to withdraw from the review at any point:

- Programme managers/national level decision makers were sent a description of the review as part of the request for an interview. Agreement to an interview was deemed to represent consent. The purpose was explained again at the start of the interview given that in many cases additional staff were participating who may not have received the initial invitation.
- For health facility staff, community cadres, and service users a description of the review was provided in English, French or Portuguese (depending on the country) which was either read out by a member of the review team or by a volunteer from among the

participants. The description included information on the purpose, advantages and disadvantages, and rights of participants. In some cases a simplified explanation was given in a local language. Participants were asked to indicate verbally whether they consented to participate before the interview or discussion was commenced.

- For site observations, the team explained the purpose to the activity manager in advance.

Data storage and confidentiality

Electronic transcripts of all data collection activities are stored securely in a shared online folder which only team members can access. Electronic transcripts for interviews with national level decision makers and programme managers contain their names, whereas those for interviews and focus group discussions with health care providers, community cadres and service users do not. Names of those participants are recorded separately on paper sign-in sheets and stored securely at the ENDA Head Office in Dakar along with sign-in sheets for travel reimbursal where relevant.

Co-creation of recommendations

ENDA Santé's proposed approach to the Thematic Review included a commitment to being user-focused in order to ensure relevance and ownership of the findings and recommendations. In order to fulfil this, a meeting of key stakeholders was convened by the relevant Global Fund programme coordinators in each country on the final day of the country visit. The Thematic Review team presented initial insights based on a preliminary review of key findings from data collection. Participants were then invited to discuss and propose how those insights could be applied to improve and scale up effective community programming. These suggestions were captured for inclusion in each country report.

Selection of participants and sites

Given the short period of time available for conducting the review, and the focus on reviewing and describing the most effective practices currently being supported by the Global Fund, the locations of visits were agreed based on a pragmatic approach. Firstly, national level key informants were selected from among the lead decision-makers and implementers of Global Fund investments, as well as other national programme stakeholders. Global Fund implementers then advised the team on options for implementation and community level visits, based on their perceptions of the existence of good practices.

A list of review and data collection tools is provided in Annex 1.

2.3 Data analysis

Country level data analysis

As noted above, desk review and in-country data collection findings were categorised according to the key thematic review questions. They were subsequently compiled so that data from all sources for a given question could be assessed. This first raw data set was used to identify data gaps, either prompting requests for further information by email or further document review. Data for each question was then synthesised and summarised for the report. Demonstrated

effective practices as well as underlying insights as to how these practices emerged were identified for each key area of the review. These were combined with discussions and suggestions made during the co-creation meeting in order to develop specific recommendations for the report.

While the primary aim of the review was not to identify challenges but to focus on effective practice, the most cited challenges were also documented and included under each theme in the report in the interests of fully documenting information shared by review participants.

Following data analysis, detailed reports were developed for each country. These were reviewed firstly by country stakeholders and then by Global Fund country teams and review managers, before being finalised. Country reports are available from the Global Fund on request (3; 4; 5; 6; 7).

Multi-country data analysis

Following completion of the 5 country level reviews, they were analysed jointly in order to draw conclusions, lessons and recommendations for consideration by the Global Fund more generally. This analysis focused primarily on identifying the conditions that have enabled strong and effective community programming, since specific practices are described in the country reports. An effort was made to identify common factors across countries, as well as outliers that may be specific to a given context. This report describes the results of this analysis. It is also accompanied by a "key lessons brief" from each country which provide descriptions of some of the best practices identified in each. These briefs are included in the annexe, as well as being available as a standalone summary of Thematic Review highlights from each country.

2.4 Overview of Thematic Review implementation

The review visits were conducted between November 2019 and February 2020. The table below summarises the data collection processes undertaken during the visit to each country. Detailed schedules are included in the individual country reports.

	Key Informant Interviews	Focus Group Discussions	Site Observations
Democratic Republic of Congo	27	5	6
Ghana	29	9	9
Liberia	31	12	9
Mali	18	11	5
Mozambique	12	5	8

Figure 3: Summary of Thematic Review implementation

A total of 143 people[1] participated in the co-creation meetings across the five countries, representing a range of relevant Ministry of Health Departments, Global Fund implementing organisations, community-based organisations and representatives of community cadres and key populations.

2.5 Limitations of the Thematic Review

While there is a good level of confidence in many of the findings of the country-level reviews and of the review overall, the following limitations are acknowledged:

- The initial RFP for the Thematic Review included 8 countries – the 5 described in this report and 3 additional countries to be covered by a desk review. For a variety of reasons (delays, overlaps with the Global Fund cycle, lack of agreement on country focus and approach and the advent of the Covid-19 crisis), the three desk review countries were removed from the review. While the desk review only approach would have only provided limited insights, a consequence of this change is that the review is narrower in terms of the diversity of countries covered.
- The framework of this review required a focus on Global Fund investments. As a result, it was not always possible to observe how community health investments interact with other non-Global Fund supported programmes.
- The timing of the in-country visits coincided with year end and the initiation of the new Global Fund funding request cycle. While this did not affect the ability of most community level actors to engage, many national stakeholders were not able to provide a desirable level of input into the process, in particular in relation to planning and the co-creation meetings.
- While the proposed approach was primarily qualitative, the team had hoped to be able to draw to a greater extent on quantitative results in order to substantiate the sampling of "successful" programme sites. In many cases the community interventions under review had been underway or introduced for less than a year, and as a result validated comprehensive quantitative data was not always available. The team discussed quantitative results with health care providers and community cadres at local level. However, because in most cases these results had not yet been reported to the national level or validated, it was decided not to report them in the country reports.

[1] DRC 36; Liberia 34; Ghana 23; Mali 27; Mozambique 23.

3. Results

3.1 What is the focus of Global Fund investments in community health? How are they designed and how do they align with national health policies and frameworks?

The Global Fund believes that community responses play a range of different roles in responding to major health challenges (8). To understand this range of roles it proposes a framework that provides broad categories of community action, ranging from highly formalised approaches that are part of national health systems, through more independent approaches that are often disease-specific, to programmes that focus on social determinants and social accountability that are conceptually further away from the formal health system (see Figure 4). Furthermore, the Global Fund suggests that in order to maximise the contributions of community responses, interventions across this spectrum should be supported, since each element of the spectrum has an important role to play.

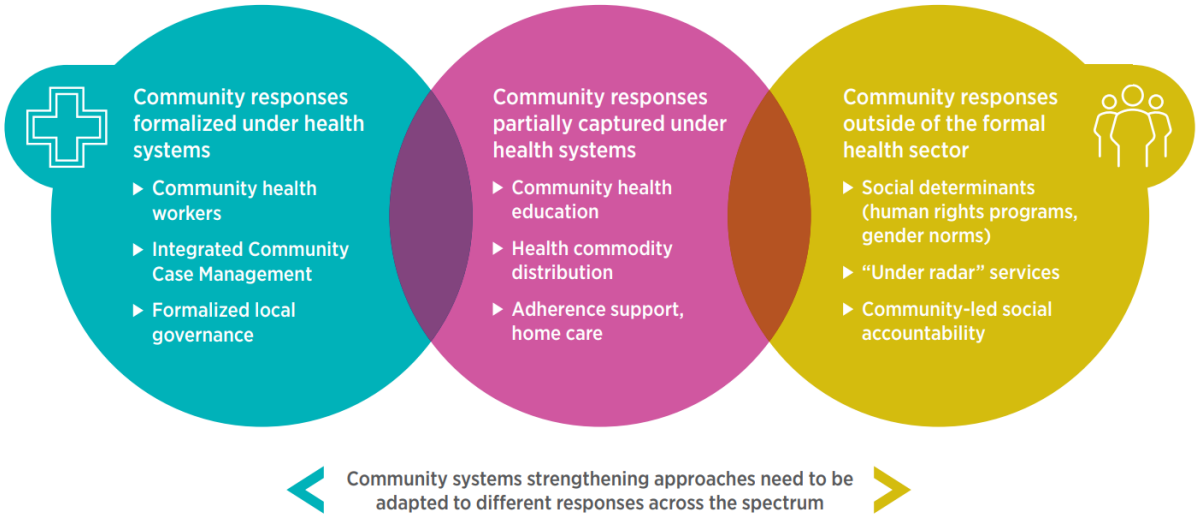

Figure 4: Spectrum of community responses. Source: The Global Fund, Focus on the Crucial Role of Communities (8).

Focus of Global Fund investments in community health in the five countries

This provides a framework for understanding how the Global Fund is investing in community health in the countries participating in this review. The table overleaf summarises the main interventions of each type supported by the Global Fund in each of the countries participating in the Thematic Review. The table below focuses on community programmes that were part of the agreed focus of the Thematic Review and that featured in Global Fund support to these countries during the period under review (2018-2020), though includes minimal details of other Global Fund supported interventions in the interests of completeness. Full country reports should be consulted for more detailed descriptions.

	Community responses formalized under health systems	Community responses partially captured under health systems	Community responses outside of the formal health sector
Democratic Republic of Congo	Malaria - "Relais communautaires au niveau des sites de soins communautaires" or RECOSITES. These are community liaisons focused on integrated management of childhood illnesses and supported by the Global Fund under the malaria programme. - Supervised by lead nurse in each health area; provide treatment for basic malaria cases and referral to health facilities for complicated cases. - "Relais communautaires promotionnels" (RECO) conducting home-based health promotion. - Both types of RECO are volunteers receiving a small motivational stipend.	HIV - Mentor mothers. Women living with HIV reaching pregnant women and women living with HIV to support treatment adherence, and PMTCT. - PODI: community ART distribution by people living with HIV, provides differentiated care for HIV patients and community-based testing. - Global Fund supports community programmes for key populations but not in Maniema province (out of scope of this review). Tuberculosis - TB Relais communautaires (RECO-TB). Sensitisation on TB in community, schools, health facilities, workplaces. Referral to health facilities, active case-finding, treatment adherence support.	HIV - Strengthening / supporting community and key populations groups / associations (capacity building, institutional support, human resources.) Cross cutting - Community-led monitoring: treatment observatory on stockouts, quality, overcharging (not currently covering Maniema province) - Legal support to victims of SGBV; psychosocial support; referral to health facilities. Focused on adolescent girls and young women.
Ghana	Malaria - Community Health Workers: Community-based prevention, treatment and home-based care	HIV - Community investments focus on prevention, care and support for key populations through **peer cadres**, and treatment adherence support and tracing	- HIV and TB community interventions are bolstered by additional community systems strengthening (CSS) investments including strengthening the capacity of TB and HIV affected community

	Community responses formalized under health systems	Community responses partially captured under health systems	Community responses outside of the formal health sector
		cases lost to follow up provided by people living with HIV (Models of Hope). - Interventions recently expanded to reach other subgroups affected by HIV such as pregnant women and adolescents. Tuberculosis - Cured TB patients (TB Champions) conduct active case finding, treatment adherence support and tracing cases lost to follow up under the WAPCAS grant, and NGOs conduct active case finding.	groups to play effective roles in the responses and civil society groups and building social accountability and by human rights investments such as stigma reduction and **peer paralegals**. - Community social accountability through community treatment observatory and other methods such as social accountability monitoring committees (SAMC) are also supported by the Global Fund including through a multi-country grant.
Liberia	Malaria - Support to the national cadre of community health assistants (CHA), involved in delivering integrated community case management for maternal and child health to communities living remotely from health facilities.	HIV and Tuberculosis - The Global Fund supports specific cadres involved in prevention, active case finding, community-based testing, treatment support and tracing people who are lost to follow up. - In the case of HIV the model is based on a peer approach; members of key affected populations – sex workers, men who have sex with men, people living with HIV – are trained and supported to engage with their peers, based on their community connections and ability to gain trust and provide services in a more conducive way.	- Community treatment observatory supported through regional multi-country grant

	Community responses formalized under health systems	Community responses partially captured under health systems	Community responses outside of the formal health sector
		- Community-led drop-in centres staffed with support groups, peer educators and clinicians provide services to key population members. - Active case finding and treatment support for tuberculosis is conducted by trained community members to reduce the pressure on health personnel and to make the most of community knowledge.	
Mali	Malaria - CHW are effectively integrated into the health system, delivering IMCI package as well as referrals to community health centres. TB and HIV - HIV and TB included in principle in the CHW activities but not yet delivered uniformly.	HIV - Peer education packages for key populations - Single-use disposable injection equipment distribution - Stand-alone afternoon/night-time clinic for key populations - Psychosocial support for key populations - HIV testing promotion and community-based testing Tuberculosis - Community active case finding and referral for testing and treatment through volunteer community members.	- Community treatment observatory (through multi-country grant). - Human rights interventions including legal support for victims of SGBV. - Training health care workers and others on stigma, discrimination, gender equality and human rights; advocacy on rights towards authorities and law enforcement.

	Community responses formalized under health systems	Community responses partially captured under health systems	Community responses outside of the formal health sector
Mozambique	Malaria: - Agentes Polivalentes Elementares (community health workers) conduct integrated community case management (ICCM)	HIV: - Case Managers monitor key population members taking antiretroviral treatment, conduct HIV testing - Peer education packages for key populations - Community are and support for key populations and PLWHIV Tuberculosis: - Trained community activists conduct referral to health facilities, active case-finding, treatment adherence support. - Community active case finding and referral for testing and treatment	Human rights: - Legal support for key population (Peer Paralegals) - Literacy regarding Human Rights - Community dialogues to engage and educate community, traditional and religious leaders about HIV, TB, treatment, retention, adherence, access to health care, stigma and discrimination - TB+HIV Community Adherence Support Groups - Malaria training to community structures; schools; community radio sessions

Figure 5: Key community health interventions supported by Global Fund in each country during 2018-2020

As Figure 5 shows, Global Fund-supported community interventions in the five countries follow a similar pattern (in particular when including programmes that were not reviewed in detail as part of this Thematic Review). Community malaria interventions tend to be well integrated into national health systems, since they are often delivered by a formal cadre of community health workers – even if the specific name given to this cadre is different in each country. Community health workers (CHW) involved in malaria are on the whole involved in delivering a range of health interventions, focused primarily on childhood illnesses and in some cases maternal health. The distribution of these cadres is also a matter of national policy – for instance in Liberia the focus is on providing CHA (community health assistant) coverage to people who live remotely from health facilities. Other variations include splitting the roles of these cadres as is the case in DRC where one category focuses on prevention and health promotion and another on curative services.

Because of this approach, and because malaria is one of a range of illnesses particularly affecting infants, young children and mothers, community malaria interventions tend to be well-integrated with broader health efforts; and the cadres are recognised as a key component of the health system in national health strategies in all of the countries. However, in many cases the TB and HIV interventions are not effectively integrated into standard CHW roles. This can be due to lack of resources or training given that maternal and child health has tended to be the focus of most large-scale CHW programmes. In addition, vulnerability to HIV and TB in many countries is high in specific groups whereas vulnerability to malaria is more generalised among women and children; different diseases therefore require different cadres and targeting approaches.

Some CHWs also address tuberculosis and HIV. TB and HIV prevention are among the modules that Liberia CHA are trained on, and Liberia is also planning to develop a cadre of community health promoters (CHP) who will work with urban populations on a range of health issues including TB and HIV.

The limited integration of HIV and TB community interventions into mainstream community health strategies is also related to the unique characteristics of these two diseases, both in terms of the population groups that are most affected and in terms of the related social determinants that affect vulnerability and access to services of those affected. As a result, community interventions for HIV and TB are highly targeted and incorporate not only direct prevention and treatment related interventions (such as community based testing and treatment, treatment adherence support) but also interventions that address stigma, discrimination, human rights violations and gender inequalities. Moreover, in most cases they are delivered by specialist "peer" cadres – people living with HIV, representatives of specific affected groups such as key populations, mothers living with HIV, young people and adolescents, and people who have recovered after TB treatment. The unique experiences and motivations of these cadres are part of what makes them effective in community health programming. These interventions are primarily categories in the middle column of the table above since while they are often established within each national disease programme they generally sit outside of the recognised formal health sector.

The third category of community interventions sit outside of the health domain, but aim to strengthen access to health services, particularly for excluded or stigmatised groups. Often the

focus is on reducing human rights and gender-related barriers to services, monitoring quality, accessibility, and acceptability of services, and in this regard a degree of independence from the formal health sector is often important.

All of the countries included in the Thematic Review have seen an increase in Global Fund support to interventions aimed at reducing human rights barriers, stigma, discrimination and gender inequality. In addition this category of community programmes includes support to community-led social accountability interventions such as community based monitoring and advocacy.

Alignment with national health frameworks and policies

While a large proportion of community health interventions examined under this Thematic Review is not directly formalized under the respective national health system as Figure 5 shows, this does not mean that they are not aligned with national frameworks and policies. In fact, the review found that most if not all Global Fund-supported community interventions enjoyed some degree of support within national frameworks and policies. Generally this was articulated within specific disease strategies, which allow space for specialist cadres and differentiated service delivery and in some cases specifically describe what these models should look like. Often these guidelines are themselves derived from demonstrated experience of effective community practice within the country itself.

In other cases, the strategy or policy provides an overall framework for the development of diverse types of community intervention depending on the needs of specific groups. While interventions such as community-based monitoring are not always described in national policies or frameworks, these documents almost always include a stated commitment to community participation and accountability; these interventions can therefore be considered to be in alignment with national policy.

At the same time the review revealed that from a policy perspective there can be a tension between formal, national level community health programmes (such as CHW programmes), and disease-specific approaches. As ministries of health seek to scale up access to community health services and expand the range of services they provide, in line with Universal Health Coverage principles, they may perceive a conflict with more "verticalized" or disease specific approaches. One example of this is Liberia where the national policy aims to expand from the current CHA focus (designed to reach populations remote from health facilities), by developing a new CHP cadre which will provide community services to the rest of the population. The intention is that both CHAs and CHPs will be able to provide the HIV and TB services currently provided through programmatic cadres.

The expansion of the roles of community health workers – and their coverage – is desirable. However, this Thematic Review confirmed that a significant added value of the programmatic approach currently in operation for HIV and to an extent TB is that community cadres who are peers of the groups being reached have a unique experience and motivation, access and trust within their respective communities. This often allows them to access and work effectively with the most affected and excluded communities. Close collaboration between community cadres and health care professionals – discussed in more detail in the sections below – is also an important element in ensuring that needs are responded to. A key conclusion of this review is

that a range of different community strategies can and should co-exist in order to ensure the maximum reach and effectiveness.

Having said this there are indications of their importance being recognised: for instance in Mali, community treatment observatories are now included in the national strategic framework for HIV.

3.2 What role have Global Fund-supported community health programmes played in improving access to services, case finding and retention in care?

Thematic review teams visited a large number of sites where community strategies had been introduced or scaled up in the past year. Because they had been underway in many cases for less than a year it was not possible to verify formal quantitative results. However, fieldwork revealed consistent positive feedback on these interventions from managers, health care providers, community cadres and service users.

At one level Global Fund support has helped increase the number of community cadres working on AIDS, tuberculosis and malaria and this in and of itself has contributed to greater coverage of services. However, the overarching finding to emerge from all five countries included in the Thematic Review is that a diverse range of community programmes can combine effectively with formal health care provision to significantly improve results. This is achieved either by providing alternative venues or methods to deliver services (such as community-based testing and drug delivery) or by providing complementary services (such as tracing people lost to follow up, adherence support and community based monitoring). The main factors identified that ensured community health programmes contributed to improved results were as follows:

> *"When people living with HIV are involved, they do everything to help avoid ART stockout because they know that their own lives depend on it".* Peer educator, Mali

- ✓ Implementers have worked to develop close collaboration and mutual respect between community cadres and health care providers, from local through to national levels. Examples of how this has been done include involving health care workers in the selection, training and supervision of community cadres; joint training of health care and community cadres; and creation of forums for joint planning and review. This helps to reinforce the continuum between community and health services. For this to be effective there needs to be a deliberate strategy, for instance whereby decision makers from different sectors or implementing organisations work together to create a collaborative environment and plan and support joint action at the local level
- ✓ An openness to providing different parallel options for accessing testing and treatment, recognising that different community groups and different individuals access services in different ways. This helps to maximise the number of people effectively accessing services. This is the case not only in terms of the variety of locations services can be accessed (e.g. health facility, drop-in centres, community or household), but also in terms of the cadres providing the service. In many cases there were overlaps in the skills and roles of health workforce and community cadres, meaning that they can refer cases between each other

and complement each others' work. The importance of this approach is particularly evident in the case of efforts to make services more accessible to excluded or marginalised populations.

- ✓ The integration of interventions aimed at addressing broader barriers and needs of the population has helped improve engagement with services. Examples include the introduction into programme models of cadres such as peer paralegals to address problems of stigma and discrimination and human rights violations as in Ghana and Mozambique; or the inclusion of support for patient food or transport. The latter example is somewhat rare in programme budgets and is more often self-funded by programme implementers, raising questions about sustainability.
- ✓ Programming environments that enable community cadres to be innovative and responsive to needs: many health care and community cadres described the ways in which they had modified strategies in order to deal with new or emerging challenges. This is most enabled when local health and community cadres have the confidence and are given the flexibility to make adaptations. These examples also showed that there is rarely a "last word" in terms of the most effective strategies since environments are constantly changing. One example of this is the occasional flare-ups of stigma and crackdowns against key populations, which require community health cadres to rapidly react to in order to maintain services and support. Increased use of community based monitoring to report on incidents and rapid response systems are helpful in addressing these situations.

"We started going out to give medicines to patients at home well before the development of the differentiated service delivery modules".

"Some facilities provide treatment to the NGOs to distribute in the community. This happens largely thanks to the openness of the dispensing doctor, without which the drugs would remain in the health facility". Key informant, Mali.

- ✓ Investment in community mechanisms to promote programme accountability is also contributing to improving overall programme performance. The Global Fund has supported some form of community-based monitoring in all of the countries included in the Review. While some have yet to achieve scale or maturity there was acknowledgement from health professionals and decision-makers in particular in Ghana and Mali, of the role these community observatories have played in improving access to services and treatment by providing early alerts and supporting local responses. It was noted in particular that the fact these initiatives conduct advocacy based on credible data enhances their effectiveness.

The review also found that the impact of community health interventions increasing access to services is highly dependent on there being resources available within the health service to provide those services. This is illustrated by the fact that there are often reports of strong performance in HIV testing and onward access to treatment for those testing positive but very poor results in relation to viral suppression, largely because viral load testing is still relatively scarce. Similarly in Tuberculosis programmes, community led active case finding was credited with supporting a significant increase in TB case notification. However this was also helped by the very low level of stockouts of testing reagents in the region under review. Fundamentally, community and health sector interventions need to complement each other rather than be thought of as substitutes.

3.3 How have Global Fund investments enabled referrals, linkages and partnerships between communities and health facilities?

As the previous section notes, effective community health responses are strongly reliant on effective collaboration with the formal health sector. Partnerships and referral systems are

Bringing care to community members

In DRC, the PODI is a community ART distribution site. The Thematic Review team visited the PODI in Kindu, Maniema Province. It provides ART for people living with HIV who are stable on treatment – with a viral load of below 1000 – and who have been referred by health facilities. People living with HIV who use the PODI state that because it is run by other people living with HIV they never face stigma; waiting times are very short and their confidentiality is protected. Health care workers also support the model as it helps free up their caseload and allows them to concentrate on clinically more complicated cases.

PODIs also provide HIV testing in a range of ways – both within the site and in the community, through family testing and contact tracing. The yield – proportion of positive test results – of tests conducted by the PODI is much higher than it is for other testing methods.

In Mali community committees – made up of MSM peer educators and leaders, and people living with HIV - meet monthly with support from the Global Fund grant. This activity allows the project to reach people who would not normally be reached through regular outreach – especially older MSM – and therefore to help more people access HIV testing. It has also helped strengthen referral for ART and broader health care, thanks to the positive role modelling of the participants living with HIV.

rendered more effective by the establishment of a strong sense of teamwork, shared responsibility and accountability for results. These features were commonly identified in effective examples of community health responses seen through the Thematic Review.

The Thematic Review found that it is possible for this collaboration to be clearly incorporated into the design of Global Fund grants. For instance, in Ghana community cadres and health care professionals work as teams both in respect of testing/case finding, and in treatment initiation support. Joint planning takes place between community and health care practitioners, and cadres in many programmes are involved in both testing and treatment work therefore ensuring a stronger linkage between the two.

> *"The street boys and girls take the TB medicine for one or two months and once the cough stops they can stop taking the medicine. Most times, they complain of lack of food. Also due to the level of violence from them, we can ask the community leaders to support us and ensure our safety during awareness sessions. During awareness, community members request for money before they can participate. However, we can tell them the importance and benefits of the sessions".* Community TB worker, Liberia.

Key informants in the review stated that mutual confidence, respect, and collaboration between community cadres and health care workers has not always been the case – in particular when there exists stigma against the communities that the cadres represent. However, improvements have resulted from specific efforts to develop these relationships such as involvement of clinicians in the recruitment and training of community cadres, ensuring cadres report information on their activities to clinicians, joint planning and joint working in the community. In addition, training of health care workers and managers on human rights and the establishment of programmes to reduce stigma and discrimination in healthcare settings were also acknowledged as contributory factors.

Case management, referrals and going the extra mile in Mozambique

Case managers are the main link between communities and health facilities both for HIV and TB – supporting patients to initiate treatment; communicating with peer activists to track contacts and support visits for people on treatment; identifying people lost to follow up and tracing them at community level; planning with peer activists how to deliver psychosocial and adherence support in the community. A version of this cadre exists in all of the countries reviewed, suggesting that it can be generalised.

Peer educators, counsellors, paralegals and case managers have to work far beyond their specific mandates. In particular they are involved in advocacy with community leaders to ensure an enabling environment, and in reacting to challenges that key populations face from time to time. They would not be able to achieve results without doing this.

Linked to this, and as noted in the previous section, effective models are built on health-community teams that assemble a number of related roles. At minimum these include a clinical management specialist, a peer supporter, and increasingly a paralegal resource. While they all have specialities, often these individuals share some of the same skills. This means that they can make up any gaps and ensure personalised support for access to services and adherence, and ensure effective navigation between services. This increasingly includes navigation between services for different health problems such as HIV and TB, with community cadres being well-placed to ensure that service users can access different clinical specialities.

Effective referral systems and tools are also an important aspect for ensuring that service users can effectively navigate and access the services they need. Programmes use referral forms, which clinicians and data managers can subsequently cross-check to ensure that the correct services are delivered. In many cases these forms are also used to monitor the performance of community cadres – for instance, to track the numbers of referrals made by each and often to assess the level of "bonus" or performance payment due to each cadre. The Thematic Review found that while this approach can help ensure a focus on achieving headline results (in relation to case detection, testing and treatment access), it may have the disadvantage of incentivising cadres to take a narrow approach to their community support work. Some community cadres also stated that paper-based referral tools are not conducive to work with stigmatised populations.

> *"Care and support can't happen without the social support side. The doctor has more time to do the consultation and prepare the prescriptions; the peers take care of everything else".* Key informant, Mali.

Many community cadres reported that due to denial and self-stigma, some people living with HIV and TB still try to avoid treatment. Cadres therefore need to look beyond formal referral tools to trace individuals who are in this situation. Other methods are therefore also used to ensure that referrals are effectively completed. Very often, community cadres directly accompany community members to services, using a hands-on approach. Referrals through telephone calls and family mediation are also commonly used. In the PODI treatment centres in DRC, this form of referral is called "référence guidée" and relies on individual accompaniment rather than referral tools. Stable patients are referred from facilities to the PODI using the same approach; similarly, malaria and TB patients are referred by clinicians to community cadres for home-based care and support where appropriate.

"Guided referral" in the context of mobility in Mali

In Mali, Global Fund supported programmes use an approach called "guided referral". The individual – once they have consented to do so – receives referrals and is also provided with direct support either in person or through a phone call, and is supported to attend services by the community cadre accordingly. This system is also used to provide financial support for travel costs or out of pocket health expenditures, thereby reducing barriers to care. Once a referral has been completed and the individual, having tested positive, is initiated in care, funds are transmitted to the individual via mobile money. Because this requires a number of verification steps and payment has to be made by the PR, it is not immediate.

Because the programme works with very mobile populations it has also developed a networked referral system between the different NGOs involved in the implementation – this way they can ensure continuity of services and greater retention of people in care. Where individuals travel to locations not covered by the Global Fund programmes, NGOs have developed systems to refer them on to other partner organisations. In certain cases where an individual is travelling to another country the programme has been able to provide longer prescriptions and provision is made to transmit the medical records to new health care providers, with the consent of the patient.

3.4 How do Global Fund investments support data-driven decision-making at the community level?

The Thematic Review found that within community programmes data has traditionally been associated with reporting on activities undertaken. Tools and systems for reporting have been developed and strengthened over time with better integration within national reporting systems. Activity reporting from community cadres is also increasingly linked to activities conducted in health facilities, allowing better tracking of completed referrals and follow up of patients.

In most cases activity reports from community cadres also provide a basis for payment of stipends or performance bonuses based on the achievement of targets, such as numbers of completed referrals for HIV or TB testing. Methods to improve the reliability of activity reports from community cadres are being introduced. For instance, a nationwide electronic reporting system for key populations, GKPUIS, was recently introduced by the Ghana AIDS Commission which will integrate community and facility reporting and assess referrals through means of unique service user identification codes. The system was being launched at the time of the review making it impossible to assess it; however community cadres were enthusiastic about the prospects of using app-based reporting, not least as it would reduce the barriers and inaccuracies associated with using paper reports.

In terms of data use for decision-making, routine activity reports are often submitted and reviewed at district/province and then national levels – sometimes via both national programme and Global Fund grant channels. As a result the "feedback loop" is quite long – it can be a matter of weeks or months before local teams are provided with supportive supervision to analyse and use the data. Local or district-level forums for periodic (generally quarterly) review of reporting data are established which is a good starting point – the SAMC in Ghana are an example of this. However the use of data for real-time strategic decision-making at local level was on the whole limited.

"Working on paper is not conducive to this community… they don't want their particulars on paper, particularly married MSM. Information on the forms is very sensitive, they mention anal sex – if anyone sees this it puts people at risk."

"…we should use smartphones to collect and send data, it would save time and is confidential. Anyway we use social media to find our clients so everything is online!" MSM peer educator, Liberia.

On the other hand, ample evidence was found of community and health sector workers using data effectively to improve the quality and timeliness of their day-to-day work. Examples were observed of local teams using information on new cases of TB and HIV to target their active case finding and community testing work, and of using information from patient registers to identify and reach individuals who had missed appointments, needed further support or were at risk of loss to follow up. In Ghana for instance community cadres worked with clinicians to do this analysis and agree which team member was best place to conduct follow up. This indicates a strong level of understanding of the principle of using data not just for reporting but to enhance decision-making in discussions with many community cadres and local health care workers. It is reinforced when there is a strong culture of teamwork between these cadres.

The big shift in the data landscape in recent years has been the growth in community-based monitoring for social accountability, which is increasingly supported through Global Fund grants. The countries included in the Thematic Review all have some form of community-based monitoring, funded either through a Global Fund country grant or through a multi-country community treatment observatory grant funded between 2017-2019.

Community treatment observatories

The TB/HIV observatory in **DRC** is managed by a community-based organisation. It allows real time collection of information on barriers to access to care in health facilities, such as stock outs, poor quality, informal payments, stigma and overall satisfaction of service users. The data that is collected forms the basis for direct advocacy towards the local decision-makers. Stock-outs of antiretroviral drugs have reduced significantly in all of the provinces where the observatory is implemented, as has overcharging. Health care facilities have also started to recognise the role of the observatory – when they know that they might be approaching a stock out situation they ask the observatory to help ring the alert with the higher up level.

The observatory has also discovered underlying reasons for some of the behaviours of health care providers – stigmatising attitudes come in part from the fact they are demotivated and not well supported; so the community observatory also intercedes with the authorities to improve the conditions of health personnel.

The Thematic Review team observed the ways in which these community-led interventions are starting to enable more strategic use and interpretation of data. Generally conducted by people living with or affected by the diseases, community-based monitoring provides a starting point for dialogue between service users and service providers (whether in the community or health sector), providing alerts on issues ranging from quality of care, to stockouts, overpayments, and instances of stigma and discrimination or human rights violations. Where local monitoring is established it can form the basis for dialogue between the population, community based organisations, health care providers and local decision-makers, and it was acknowledged during the Thematic Review that this can shorten feedback loops and speed up local problem-solving. However, for this to be effective the information gathered needs to be owned locally and accessible in real time, rather than simply being reported to a central monitoring hub for use at the national or strategic level. In each country there was evidence of good will towards observatories at the local level; in DRC in particular UCOP+ is able to articulate how they have moved from a position where observatories were treated with mistrust to one where health care providers welcome the input as it supports their own requests for additional resources. Similarly in Ghana community based monitoring data is being used in the SAMC committees. A challenge remains in ensuring the data they generate is effectively valid and representative when aggregated at national level.

3.5 How do Global investments contribute to the quality of community health care delivery?

The Thematic Review request for proposals outlines some specific dimensions of quality to be considered: availability and use of standard packages; system design and support; and sustainability of the system. These headings are used below to structure the overview of findings.

Availability and use of standard packages for community interventions

The Thematic review found evidence across all five countries that community programmes are delivering standard packages. Of course, there are considerable variations in the content of

those packages depending on the specific role of the cadre and whether or not they focus on a disease area or key population group. For some cadres such as community health workers working on IMCI, or peer educators for HIV key populations, the packages have been well defined for a number of years and are endorsed within national policies or guidelines.

The advent of relatively new roles for community cadres such as adherence support, active case finding or paralegal support mean that in some cases the packages are defined at the programme level by Global Fund Principal Recipients or Sub-Recipients, but have not yet become established within national guidelines. This means that standards can vary depending on the implementing organisation.

It is also noteworthy that given the recognition of the importance of teamwork between community cadres and health care providers, packages increasingly reflect not just the roles of individual cadres but the combined roles of these teams. This can contribute to the development of shared responsibility and accountability. However an important challenge resides in the fact that community and health sector components tend to be led by different PRs; coordination therefore needs to be ensured both at local and national levels to ensure that packages are delivered across different cadres as necessary.

The Thematic Review observed a number of instances of services or support being provided through community programmes that were additional to the core service package. These included, for instance, the provision of subsidised diagnostics (e.g. negotiating discounted x-ray fees for people with suspected tuberculosis in Ghana), food assistance or transport costs to support treatment adherence and access to health services. Very often this assistance is provided on a voluntary basis by community-based organisations or health facilities, and occasionally it is funded within a Global Fund grant or by another funder. However there is in general a lack of consistency as to when and how such auxiliary elements are provided in contexts of limited funding.

A final challenge in relation to standard packages is the tension between the principle of polyvalence – in other words of community cadres being tasked to address multiple health conditions for any member of the population – and specialisation, which is typical in particular in HIV and TB programmes. In countries with weak health systems there is an understandable interest in developing of a uniform, polyvalent cadre that can address a wide range of needs; and this approach is underway to an extent in all of the countries covered by this review. However, the Review found that there is a risk in this being done at the expense of specialised cadres, since inherent in the success of some of the Global Fund supported programmes is the fact that specific cadres are working on issues that they have direct experience of, and in stigmatised communities that they are themselves part of. A hybrid combination of generalist/polyvalent alongside specialised community cadres and programmes appears to be most effective at meeting a wide range of needs. This was seen across the countries reviewed where formalised CHWs address general health needs of the overall population and population specific cadres can address the specific needs of highly affected sub populations. At the same time, it was also clear from the review that HIV key population specialist cadres are interested and motivated to expand the range of health problems that they work on, recognising that the populations they work with often require support for health problems other than HIV.

System design and support: training, commodities, tools, reports, coordination, supervision and support

Standardisation of systems for recruitment, training, and supervision of community cadres is evident. As has been noted in previous sections, stand-out examples of recruitment and training of community cadres were those that involved community members and health care professionals in the process since this established a strong basis for teamwork and partnership. In many cases, HIV and TB clinicians identify strong candidates for community roles from among their active or cured patients, and involve them in the programmes in this way. Effective training approaches draw down on nationally agreed training modules which are in turn linked to the guidelines and policies for community programmes. This ensures consistency. However it is apparent that in some cases due to funding constraints, the full content of training modules is not delivered.

> *"People who need care come to see us more than they go to the health centre because they see that we work well. We have never had complaints from those we treated ; training that we receive from the programme allows us to work well"* – Community relais, DRC.

A strong partnership between community and health service implementers in the recruitment and training of community cadres provides the basis for effective planning and supervision of work on the ground. Collaborative planning between community and health care staff, as well as regular monitoring and supervision from lead implementing organisations also help to ensure standards are adhered to. The review observed that when this approach is in place it allows for more decentralised decision-making and autonomy in how work is conducted at the local level, allowing adaptations to specific circumstances and events.

> *"Sometimes during community awareness CTWs encounter risky situations and become afraid. They engage their supervisor to support their safety before continuing".* TB Program Assistant, Liberia.
>
> *"After training they [CHA] initially made mistakes. We put in time to ensure the quality of the treatments". CHA* Supervisor, Liberia.

Many of the community cadres participating in the review talked about the support they received from immediate supervisors, who helped them plan community work, coordinate activities with clinicians, and perhaps most importantly helped resolve problems in the field. All of the community programmes observed had supervisory functions built into their systems. When supervisors from implementing organisations are themselves experienced in community work these skills provide an important additional layer of community intervention and problem-solving.

As well as helping to maintain quality this helps to ensure that expectations and understandings of the roles of different cadres, as well as allowance and incentive mechanisms, are consistent across Global Fund supported programmes.

Within these variations it should be noted that these cadres all adhere to national policy norms – for instance with respect to the role that lay cadres can play in testing and in treatment

support, and the protocols for these. Clinicians interviewed during the review confirmed that they were satisfied with the level of adherence to quality procedures of community cadres.

Sustainability of the system including retention of community cadres

The increasing recognition of community programmes and their links with health service delivery in national frameworks and policies, and the strong reliance of health facilities on them suggests a high level of commitment to sustaining them. However, these interventions and programmes are on the whole funded on a project basis rather than as core elements of the health system. This is particularly the case for disease or population specific cadres (primarily in the area of HIV and TB), although even the generalist/polyvalent cadres (typically CHWs) are also heavily reliant on external funding in most countries.

Some of the cadres and community interventions that have been more recently introduced through Global Fund support such as peer paralegals and other population-specific cadres are likely to take some time to be fully recognised as part of the health system and therefore become prioritised for sustained support. It was notable in the countries reviewed that the more established community interventions had all begun on a less formal or project basis, indicating that it is possible for programmes that are proven to be effective to be integrated into national health systems and scaled up.

On the other hand, peer paralegals, as much as they make an important contribution to achieving health results, may not ever become recognised as health sector assets since their work is primarily in the area of rights and justice. Sustained financing of community interventions therefore needs to consider not just financing for health interventions but financing structural and broader social and rights-based interventions that have been supported by the Global Fund.

Where strong retention of community cadres was observed, a number of contributing factors were cited : strong supervision, regular and transparent payment of allowances and bonuses, and strong partnership and relationships with other cadres and clinical personnel. Conversely, frustrations with the levels and ways in which incentive payments are made, and comparisons with other programmes were cited as reasons for attrition of community cadres.

Availability of commodities associated with prevention, testing and treatment is critical to the quality of community programmes, since they rely on the ability to meet the needs of service users. In some instances cadres reported stock-outs, particularly in relation to condoms and materials required for HIV rapid testing. Similarly the availability of equipment and materials to facilitate work (app-based reporting, torches for outreach, reporting forms, equipment for sputum sampling) was cited as important to the quality of their work. Not having access to these was perceived to have an immediately negative impact on their credibility.

> *"Sometimes when the programme is closed the patients die because of default. Or when we encourage clients to go for treatment and then drugs are not available this can discourage them from going back".* Community TB Worker, Liberia.
>
> *"We did awareness with police and nurses but need more because it is changing shape all the time".* Key Population programme manager, Liberia.

Findings from the Thematic Review suggested that a number of factors need to be considered to ensure retention of community cadres and sustainability of community programmes. They illustrate that sustainability is also about ensuring cadres continue to have the means and motivation to work, including the importance of clinical services to which they are referring patients being fit for purpose. It was also noted that community interventions on the enabling environment, such as efforts to reduce stigma, should be continuous rather than one-off since new personnel are continually arriving, and new events or negative media reports are constantly reviving stigma.

Community based monitoring

Although it is not one of the dimensions of quality improvement identified in the Thematic Review RFP, community-based monitoring is also emerging as a potentially important contributor to improving quality not just of community health programmes but of programmes as a whole. Specifically they can ensure that there is rapid feedback from service users and alerts when there are problems related to provision and stockouts.

4. Discussion and recommendations

4.1 How can local health care providers and community actors achieve greater impact?

The ability of local health care providers and community actors to achieve an impact on health is to a great extent dependent on the conditions under which they work, the operational guidelines that they work under, and their level of autonomy and flexibility to adapt the way they work to respond to specific needs and new situations. Acting on the recommendations in this section therefore requires national decision-makers and funders such as the Global Fund to provide this environment as discussed in the recommendations under section 4.2 below.

Build strong partnerships and mutual accountability between community actors and health facilities

The Review found considerable evidence that results in terms of testing and case finding, effective referrals, and retention in care were enhanced through strong partnerships and mutual accountability between community actors and health facilities. There are a number of strategies that can be used to build this: joint planning between community and health facility implementers; attaching community cadres or programmes to specific health facilities; involving health facility workers in the recruitment and training of community cadres and involving community representatives in training facility workers on issues such as stigma. Providing status to community programmes, and explicitly recognising their contribution also helps to build their credibility. Actively engaging users of services in planning, review and feedback activities can also strengthen this partnership.

Use locally generated data to shape activities

There was strong evidence that local health care providers and community programmes – including community cadres – were using data on individual patients or service users to improve clinical practice, follow up and referrals. There was less evidence of strategic data use at local level, for instance to identify patterns in terms of locations of new infections, gender or age or other population-specific differences in referral uptake and retention. In general, such analysis is done further along the reporting chain, for instance at district and national level, and there can therefore be a time-lag in the analysis arriving back at community level and influencing practice. Systematising basic data analysis at local level, and involving community and health care workers in this, will be an important improvement. Data and insights generated from local level community-based monitoring can also play a role in informing local decision-making with real-time data.

Link HIV and tuberculosis services, and address broader health needs

Community programmes for TB and HIV are often highly targeted and specific, working with cadres who have direct experience of the diseases and of the stigmas associated with them. While these characteristics are central to their motivation and effectiveness, these cadres are generally willing to take on additional knowledge so that they can provide broader support to their peers. Linking TB and HIV is a good starting point and has been shown to be feasible in the countries reviewed; malaria services can also be linked in a relatively straightforward way.

It is also feasible to go further and increase the scope of services towards a more universal or holistic approach. In countries with health insurance this can include extending insurance coverage to specific groups vulnerable to TB and HIV so that their broader needs are met. Achieving effective linkages involves establishing strong communication between different service providers and community cadres (since the linkages need to be made not just between community and health sector cadres but also between different clinical specialities); joint or cross training on different health topics; and joint planning.

Link community HIV and tuberculosis support with empowerment, human rights and accountability efforts.

In locations where empowerment and human rights interventions are implemented the review observed an expanded referral pathway which ensures that as well as enhanced access to services, community members can receive advice and legal support when needed. Ensuring complementary services or interventions are co-located – for instance, embedding or linking peer paralegals within clinical and community care teams, further helps to strengthen overall impact.

The Review also noted the value of interventions designed to reduce stigma and protect human rights, in helping strengthen trust with communities and therefore removing barriers to treatment access. Accountability efforts such as community-based monitoring and local consultative committees are also showing an important contribution and should be considered part of a comprehensive community programme.

Encourage flexibility and responsiveness by community cadres

Many of the most notable interventions or approaches observed during the review were developed by community teams working with health care workers, in response to emerging needs. Resourcefulness and adaptability can be encouraged by ensuring that funding guidelines and systems allow for flexibility and autonomy at the local level, albeit within the scope of quality standards; and by celebrating and promoting good examples of flexible service provision.

Engaging with other community resources beyond the official community cadres

Community involvement in health is not just limited to identified "cadres" such as community health workers or peer educators. The review observed the ways in which community programmes and clinicians worked not only with specific cadres but also with broader community support networks – such as community information centres, local leaders, peer groups and families. In addition, community programmes can also include community led service provision such as ART distribution sites, outreach testing, and drop-in centres for key populations.

4.2 How can the Global Fund and national actors better support community health programmes to achieve greater impact?

The standards and systems put in place by the Global Fund and national actors (PRs, SRs and other decision makers) have a considerable impact on the contribution that community health programmes can make. Based on good practices identified during the Thematic Review, the

following key recommendations, many of which are designed to enable the elements outlined in Section 4.1, are proposed.

Foster local ownership and encourage local adaptation.

Many of the good practices identified at community level were enabled by specific investments in local level community engagement and consultation, and joint capacity building of community and health sector workers. The Global Fund and national actors can ensure that local planning and adaptation takes place by avoiding overly rigid activity planning at the central level and focusing on achievement of results over time. Facilitating the sharing of experiences between locations for instance through training, communication and exchanges can also support this process.

Provide a range of different options for obtaining services.

There is often an emphasis, particularly in resource-poor settings, on identifying the single most optimal mode of service delivery – the one that will serve the most people efficiently and to appropriate standards. Decision-makers are often reluctant to allow parallel models as they complicate management and referrals. However, this Review found that when different options are available they help meet the needs of a wider range, because each addresses different barriers. It allows for a more person-centred approach and makes it more likely that ambitious programme targets can be reached.

Invest in capacity for strategic local data use.

In order to support more strategic use of data so as to enhance case finding or support to the populations most at risk of missing out or dropping out of treatment, implementers and the Global Fund should support further capacity building efforts. These would include building the basic skills of local level actors in collating, triangulating and interpreting data from different sources, including both regular reporting and community-based monitoring. This should also involve building an understanding of data and local monitoring as tools for local action rather than merely reporting requirements.

Supporting and testing innovations while maintaining continuity of effective approaches.

The Review covered a range of community programming approaches, some of which were fairly recent while others had been established for some time. However, all community programmes started out as innovations. While funders such as the Global Fund are well placed to support and nurture innovation and scale up, national programmes can take these innovations once they have been proven to be effective and embed them into national approaches. This provides a stronger basis for sustainability. This process should be systematised by both the Global Fund and national actors.

Support the development of community movements and programmes.

The Thematic Review purposively sampled some of the best examples of community health programming in each country in order to identify what is possible, and why. It is apparent that in many cases these programmes are limited in scale by the amount of funding and support available. Investment can be used to mobilise communities to work at greater scale. While the

common approach to this is to support national networking, the Global Fund and implementers should also consider trialling other less structured models such as convening cadres from different communities at regional and national level to encourage linkages, lesson sharing and representation without necessarily relying on formal structures. Support to community-based monitoring and social accountability efforts is also an important way to develop community movements and ownership.

Linked to this, efforts should be made to assess coverage and sufficiency of community cadres in order to effectively estimate and support the models at a scale that will contribute to national level impact. It is likely that the numbers of cadres are insufficient to have an impact on national results. Assessment of workload/caseload among different cadres should be conducted, including an assessment of the numbers in need of but not receiving community support. This will enable planners to estimate and ensure sufficient provision.

Invest in enabling environments.

The Review noted the value of investments in enabling environments, particularly in terms of establishing community consultation, stigma reduction and human rights protection. These contribute to reducing barriers to services and ensure community action is more effective. Doing this effectively requires working beyond the health sector, engaging in particular with human rights organisations and government departments responsible for human rights, justice and law enforcement.

Maintain efforts to resolve overall health systems challenges.

It was noted repeatedly that the success of community health programmes depends to a large extent on having effective service provision within health facilities. This is particularly the case in programmes aimed at strengthening case finding and access to and retention in care since it is essential that community services are able to refer to facilities that have the skills, equipment and commodities necessary to complete the loop. It is very difficult for community health programmes to make a contribution unless these services are available although, as noted above, community actors can play a role in resolving problems that do occur in the health sector through observatory or community based monitoring approaches and advocacy.

Build capacity of community cadres and other community programmes.

In most countries there now exist standard training packages for different community cadres, endorsed by national programmes. Specific funded programmes may also provide additional elements or modules to the training. It is important that training packages, including refresher training and supportive supervision, be provided consistently rather than cut down or delivered in a shortened version due to funding constraints.

Enable linkages between disease programmes where feasible and appropriate.

The linkage and integration of services related to different health problems or diseases is to an extent an operational matter (and is discussed in 4.1 above); however it should also be encouraged by funders and other national actors by, for instance, aligning planning timelines and incentivising collaboration between implementers specialising in different programmes or with different populations.

4.3 What lessons from this review might be transferable to other health programmes?

Despite the Global Fund's focus on AIDS, tuberculosis and malaria, discussions with stakeholders at country level during the Thematic Review suggested that a number of broad lessons and principles emerging from the experience of effective community programmes are likely to be transferable to other health programmes.

Building relationships between health professionals and the communities they serve.

The first broad principle is that of building relationships between health professionals and the communities they serve. Many community members are motivated to help make health systems work more effectively, both through hands on support in facilities and through community outreach work and leadership. Promoting the positive experiences from HIV, TB and malaria within health facilities and health administrations may help generate interest and skills in engaging with communities in other important health domains such as maternal and child health, or as is particularly germane at the time of writing, major new health emergencies and pandemic threats.

Strengthening ownership and accountability and empowerment in relation to health.

Community empowerment, accountability and human rights interventions increase the confidence of people to demand better health services and to be treated correctly and with respect. While interventions supported by the Global Fund deal with specific barriers faced by key populations and people living with HIV, adapting these interventions – alongside community empowerment – may be appropriate to support other population groups in accessing health services. Community based monitoring for social accountability approaches can be expanded to observe a broad range of health issues, and indeed as the Thematic Review found, they already are since community members or service users, when asked to feed back on the quality or other aspects of health services, do not by and large limit themselves to commenting on services related to specific diseases or programmes. Community social accountability efforts may in fact provide a strong basis for integration of different health programmes and a platform for the development of universal health coverage.

Build capacity in good practices while encouraging local innovation.

The principle of testing new approaches and establishing them into national systems once they have been proven to be effective is valid across different health domains. New challenges should be recognised as they emerge and new technologies adopted when they become available. Again this is particularly germane in the context of new pandemic threats. Programming frameworks should provide quality standards without stifling local adaptation, which is the hallmark of effective community health programming – this is applicable not just for HIV, TB and malaria but across health domains.

Provide a blend of health service options to achieve the maximum impact.

"One size fits all" approaches are attractive from the perspective of standardisation, management and funding. However, as the Thematic Review shows, no single service delivery model will meet the needs of all of the population. Specific health problems, or specificities within population groups will always mean that there will be a need for differentiation and creativity. Alongside core "mainstream" programming models, decision-makers should therefore allow and encourage differentiated approaches that engage with, involve and meet the needs of specific community groups.

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Annex 1: List of data collection and review tools

1. Schedule planner
2. Document review instructions
3. Document review template
4. KII and FGD guides
5. Site observation guide
6. KII, FGD, and SO transcript template
7. KII, FGD, and SO data compilation instructions
8. Consent instructions
9. Consent form
10. Co-creation meeting guideline
11. Initial findings presentation