The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Community Systems Strengthening Framework

Revised edition, February 2014

Acronyms & Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
CBO	Community-based organization
CSO	Civil society organization
CSS	Community systems strengthening
DOTS	Directly Observed Treatment, Short-Course. The basic package that underpins the Stop TB strategy.
FBO	Faith-based organization
HIV	Human immunodeficiency virus
HSS	Health systems strengthening
LLIN	Long-lasting insecticidal net
IPT	Intermittent preventive treatment of malaria during pregnancy
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
NGO	Nongovernmental organization
OGAC	Office of the Global AIDS Coordinator (U.S. government)
PMTCT	Prevention of mother-to-child transmission (of HIV)
SDA	Service delivery area
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations Global Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Preface to the 2014 Edition of the CSS Framework

2014 sees the launch of a new funding model, developed by the Global Fund with the aim of increasing the impact of its investments. The new funding model has implications for how countries apply for funding, for how much funding they can access, and for the types of programs that they can include in grants funded by the Global Fund.

As part of the development of the funding model, the Global Fund has also revised the guidance for investments in AIDS, tuberculosis, malaria and health systems strengthening (HSS), and has produced "Measurement Frameworks" for each of these. Each Framework is broken down into Modules – which are broad program areas – and each Module is broken down into Interventions. One of the main principles guiding the definition of Modules and Interventions is that they should be clearly differentiated from each other – so as to avoid duplications and confusion that often happened in the previous funding approach.

Community Systems Strengthening – CSS – appears as a Module under each disease Measurement Framework (AIDS, tuberculosis and malaria). CSS also appears in the HSS Framework, although it is integrated across the HSS modules rather than as a standalone module. Guidance on how to apply for CSS funding using the new Modular approach is provided in the CSS Information note on this page:

http://www.theglobalfund.org/en/fundingmodel/support/infonotes/.

The CSS Module is based on the CSS Framework which was first developed in 2010. A review of the "core components" and "service delivery areas" of the CSS Framework was conducted in 2013, during which CSS experts were consulted about how best to reframe CSS in the Modular approach. This also provided an opportunity to rectify some aspects which had been shown to be confusing and unclear during previous funding rounds.

The development of the CSS Module did not entail a revision of the CSS Framework itself, and the Framework remains the core reference document for actors interested in developing CSS programs. However, recognizing that the "Service Delivery Areas" contained in the Framework are no longer consistent with the new CSS Module, this edition of the Framework has been produced to clarify the relationship between the Framework and the Module.

In revising the Framework for the current edition, we have taken care not to change the scope of CSS and the range of community sector activities that were defined when the Framework was first developed. However, it is also important to note that not all of the activities described in the Framework are strategic priorities for Global Fund investments under the New Funding Model. As such, while the Framework should remain the principle reference for developing and defining community sector action on health at a country level, applicants for Global Fund funding should use the Framework in conjunction with the Global Fund's Information and Strategic Investment guidance notes, which spell out in detail the interventions and activities which are eligible for Global Fund funding.

Foreword

The concept of community involvement in improving health outcomes is not a new one. It has its roots in the action that communities have always taken to protect and support their members. Modern approaches to community health care are reflected in the Alma Ata Declaration of 1978,[1] the more recent work of WHO on the social determinants of health[2] and the relaunch of the primary health care concept in 2008.[3] These laid the foundations for much of the work that has been done, highlighting the role of communities in increasing the reach and impact of health systems, for example in TB, malaria and HIV care and prevention.[4,5,6] It has become increasingly clear that community support for health and social welfare has unique advantages in its close connections with communities, its ability to communicate through people's own culture and language and to articulate the needs of communities, and its ability to mobilize the many resources that community members can bring to the processes of policymaking and decision-making and to service delivery.

Further progress is now needed to bring community actors and systems into full partnership with national health and social welfare systems and in particular to ensure that their work for health is better understood and properly funded. Achieving this goal is vital for making progress toward the goals of universal access to health care and realizing the rights of everyone to achieve the highest attainable standards of health, no matter who they are or where they live. The Community Systems Strengthening (CSS) Framework is a contribution toward this goal.

The Global Fund to fight AIDS, Tuberculosis and Malaria developed the framework in collaboration with a range of stakeholders, supported by a Technical Working Group that included:

- the Joint United Nations Programme on HIV/AIDS (UNAIDS);
- the World Health Organization (WHO);
- the United Nations Children's Fund (UNICEF);
- the World Bank;
- MEASURE Evaluation;
- the Coalition of the Asia Pacific Regional Networks on HIV/AIDS (7 Sisters);
- the International HIV/AIDS Alliance;
- the United States Agency for International Development (USAID) Office of HIV/AIDS;
- the U.S. Office of the Global AIDS Coordinator (OGAC);
- United Nations Development Programme (UNDP) Burkina Faso;

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[1] Declaration of Alma Ata – International conference on primary health care, 1978. Available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

[2] World Health Organization (WHO). Social determinants of health [Internet]. Geneva: WHO; 2011. Available from: http://www.who.int/social_determinants/en/

[3] WHO. The world health report 2008. Primary health care — Now more than ever. Geneva: WHO; 2008. Available from: http://www.who.int/whr/2008/en/index.html

[4] WHO. Community involvement in tuberculosis care and prevention. Geneva: WHO; 2008. Available from: http://whqlibdoc.who.int/publications/2008/9789241596404_eng.pdf

[5] Roll Back Malaria/WHO. Community involvement in rolling back malaria. Geneva: Roll Back Malaria/WHO; 2002. Available from: http://whqlibdoc.who.int/hq/2002/WHO_CDS_RBM_2002.42.pdf

[6] WHO. Partnership work: the health-service community interface for the prevention, care and treatment of HIV/AIDS. Report of a WHO consultation, 5–6 Dec. 2002, Geneva. Geneva: WHO; 2002. Available from: http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf

- Ministry of Health and Social Welfare Tanzania;
- independent consultants and Global Fund staff.

Finalization of the draft was supported by an extensive international consultation with civil society, using an online questionnaire, interviews and a two-day meeting with key informants.[7]

The framework is primarily aimed at strengthening civil society engagement with the Global Fund, with a focus on HIV, tuberculosis and malaria. However, the framework will also be useful for the broader development approach, working on other health challenges and supporting community engagement in improving health outcomes.

Executive Summary

The goal of community systems strengthening (CSS) is to develop the roles of key affected populations and communities, community organizations and networks, and public- or private-sector actors that work in partnership with civil society at the community level, in the design, delivery, monitoring and evaluation of services and activities aimed at improving health. CSS has a strong focus on capacity building and on human and financial resources, with the aim of enabling communities and community actors to play a full and effective role alongside health and social welfare systems.

The Community Systems Strengthening Framework has been developed in the light of experience and in recognition of the need for increased clarity and understanding of CSS. It is intended to facilitate increased funding and technical support for CSS, particularly (but not only) for community-based organizations and networks. The framework defines the terminology of CSS and discusses the ways in which community systems contribute to improving health outcomes. It provides a systematic approach for understanding the essential components of community systems and for the design, implementation, monitoring and evaluation of interventions to strengthen these components.

Why is community systems strengthening important for health?

Community organizations and networks have a unique ability to interact with affected communities, react quickly to community needs and issues, and engage with affected and vulnerable groups. They provide direct services to communities and advocate for improved programming and policy environments. This enables them to build a community's contribution to health, and to influence the development, reach, implementation and oversight of public systems and policies.

Community systems strengthening initiatives aim to achieve improved outcomes for health interventions dealing with major health challenges, including HIV, tuberculosis and malaria, among many others. An improvement in health outcomes can be greatly enhanced through mobilization of key affected populations and community networks and emphasizing strengthening community-based and community-led systems for prevention, treatment, care and support; advocacy; and the development of an enabling and responsive environment.

[7] Community Systems Strengthening – Civil Society Consultation; International HIV/AIDS Alliance 2010/ICASO.

To have a real impact on health outcomes, however, community organizations and actors must have effective and sustainable systems in place to support their activities and services. This includes a strong focus on capacity building of human and financial resources, with the aim of enabling community actors to play a full and effective role alongside the health, social welfare, legal and political systems. CSS is a means to prioritize adequate and sustainable funding for specific operational activities and services and, most importantly, core funding to ensure organizational stability as a platform for operations and for networking, partnership and coordination with others.

Implementing Community Systems Strengthening

The framework takes a systematic approach to CSS, and focuses on the *core components of community systems*, all of which are considered essential for creating functional, effective community systems and for enabling community organizations and actors to fulfill their role of contributing to health outcomes. These core components are:

1. Enabling environments and advocacy – including community engagement and advocacy for improving the policy, legal and governance environments, and affecting the social determinants of health.

2. Community networks, linkages, partnerships and coordination – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships.

3. Resources and capacity building – including *human resources* with appropriate personal, technical and organizational capacities, *financing* (including operational and core funding) and *material resources* (infrastructure, information and essential medical and other commodities and technologies).

4. Community activities and service delivery – accessible to all who need them, evidence-informed and based on community assessment of resources and needs.

5. Organizational and leadership strengthening – including management, accountability and leadership for organizations and community systems.

6. Monitoring and evaluation and planning – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

This document describes these components in more detail, and maps out how they can be integrated into funding requests submitted under the new funding model.the new funding model

Monitoring and evaluation for CSS also requires a systematic approach. The framework provides guidance on the steps required to build or strengthen a system for CSS interventions. Revised CSS indicators and a revised evaluation appraoch for the new funding model are under development and will be published inin due course. Indicators and M&E guidance associated with the Global Fund's previous model have been removed from this edition of the CSS Framework in order to avoid confusion with the new funding approach. funding approach.

In the context of the Global Fund, applicants are encouraged to consider CSS as an integral part of assessments of needs related to disease programs and health systems, ensuring that they identify those areas where full involvement of the community is needed to improve the scope and quality of service delivery, particularly for areas hardest to reach. A brief description is provided for how CSS can be included within Global Fund proposals. Further guidance can be found within the Global Fund application guidelines: http://www.theglobalfund.org/en/fundingmodel/single/./

The CSS Framework is a major step toward enhancing community engagement and effectiveness in improving health outcomes and increasing their collaboration with, and influence on, the public and private sectors in achieving this goal. Experience with implementation of the framework will help to further improve the definition and scope of CSS, which will continue to be revisited and modified in the light of lessons learned in a variety of communities, countries and contexts.

1. Community Systems Strengthening – A Framework

Key Terms Used in the Framework

This framework is intended to bring clarity and greater understanding to the topic of community systems strengthening. It is therefore essential first to clarify the terminology of CSS. Many of the terms employed in this framework are already in common use but their meanings in various contexts are variable and sometimes imprecise. The following definitions have been adopted for use throughout the framework.

Community systems are community-led structures and mechanisms used by communities through which community members and community-based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Many community systems are small-scale or informal. Others are more extensive – they may be networked between several organizations and involve various subsystems. For example, a large care and support system may have distinct subsystems for comprehensive home-based care, providing nutritional support, counseling, advocacy, legal support, and referrals for access to services and follow-up.

Community systems strengthening (CSS) is an approach that promotes the development of informed, capable and coordinated communities, and community-based organizations, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at the community level, including an enabling and responsive environment in which these contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of community-based organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis, malaria and other major health challenges.

Community is a widely used term that has no single or fixed definition. Broadly, communities are formed by people who are connected to each other in distinct and varied ways. Communities are diverse and dynamic. One person may be part of more than one community. Community members may be connected by living in the same area or by shared experiences, health and other challenges, living situations, culture, religion, identity or values.

Community-based organizations (CBOs) are generally those organizations that have arisen within a community in response to particular needs or challenges and are locally organized by community members. *Nongovernmental organizations (NGOs)* are generally legal entities, for example registered with local or national authorities. They may operate only at the community level or be part of a larger NGO at the national, regional and international levels. Some groups that start out as community-based organizations register as nongovernmental organizations when their programs develop and they need to mobilize resources from partners that will only fund organizations that have legal status.

Community organizations and actors are all those who act at the community level to deliver community-based services and activities, and to promote improved practice and policies. This includes many civil society organizations, groups and individuals that work with communities, particularly community-based organizations, nongovernmental organizations and faith-based organizations (FBOs), and networks or associations of people affected by particular challenges such as HIV, tuberculosis and malaria. Community organizations and actors also include those public- or private-sector actors who work in partnership with civil society to support community-based service delivery, for example local government authorities, community entrepreneurs and cooperatives.

Civil society includes not only community organizations and actors but also other nongovernmental, noncommercial organizations, such as those working on public policies, processes and resource mobilization at national, regional or global levels.

Key populations

As the response to the HIV, tuberculosis and malaria epidemics has matured a common understanding of how each of these diseases impacts particular populations has expanded. Due to a variety of factors both biological and structural, certain populations experience a burden of disease disproportionate to the general population in many settings. Often this disease burden is coupled with decreased access to health services and human rights abuses that stem from societal marginalization and stigma

Developing a common definition of key populations across the spectrum of the three diseases is not possible. However, there are several shared characteristics across diseases and populations that can help clarify who is a key population. For the purposes of this document, key populations are defined as those groups that meet all three of the criteria below:

1. the population experiences increased risk or burden of disease due to a combination of biological, socio-economic and structural factors;

2. access to health services that prevent, diagnose, treat, or care for these diseases is lower than for the general population; and

3. the population experiences human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization

Key populations in the HIV response

Gay, bisexual and other men who have sex with men; transgender people; people who inject drugs; and sex workers are socially marginalized, often criminalized and face a range of human rights abuses that increase their risk of HIV infection. In every country where surveillance data is reliably collected and reported, these populations have higher HIV mortality and/or morbidity when compared to the general adult population. Access to, or uptake of, relevant services is significantly lower for these populations than for other groups.

Key populations in the TB response

Prisoners and incarcerated populations; people living with HIV; migrants and displaced populations are all groups at increased risk for TB infection. These groups experience significant marginalization, human rights abuses, and decreased access to quality services.

Key populations in the malaria response

Knowledge of key populations in the response to malaria is relatively new, compared to the HIV and TB epidemics. Displaced populations and indigenous people in malaria endemic areas are often at greater risk of transmission, may have decreased access to care and services, and are also often marginalized.

Additional factors

The stigma associated with HIV and TB infection in many settings means that often those who have been diagnosed with one of these illnesses experience additional risks for co-infection, marginalization or human rights abuses. For this reason, these populations qualify as key populations under this action plan and should be given unique consideration even when they fall within other key populations.

Similarly, women and girls, including transgender women, experience an increased biological vulnerability to HIV and are disproportionately exposed to violence and other forms of gender oppression that increase HIV risk. This is compounded for women and girls who work as sex workers and/or inject drugs and who may be described as "key affected women". Young people from key populations face increased marginalization as age-related laws and policies can hinder their ability to access HIV-related and other health services.

Other vulnerable populations

In every context there are communities and groups who fall outside of the above definition of "key populations", but experience a greater vulnerability and impact of HIV, tuberculosis and malaria. These may include people whose situations or contexts make them especially vulnerable, or who experience inequality, prejudice, marginalisation and limits on their social, economic, cultural and other rights. Depending on the context this might include groups such as orphans, street children, people with disabilities, mobile workers and other migrants. Some occupations – in particular mining – and contexts may enhance the risk of TB even more by limiting access to healthy environments. Children and pregnant women – in particular women with HIV - are particularly vulnerable to malaria as their immunity is reduced. In many African countries women and girls who are not marginalized – and so would not be defined as "key affected women" – are highly affected by HIV, and must be considered as a vulnerable population.

Depending on the local context, vulnerable populations require focused efforts and resources that address their enhanced needs, even though they do not fall under the general definition of 'key populations' and therefore are not specifically covered by this action plan. Regardless of categorization, the Global Fund's financing model directs resources to priority services where needs are greatest in order to achieve impact.

What Is the Purpose of the CSS Framework?

The CSS Framework is aimed at strengthening community systems to contribute to key national goals and to ensure that people's rights to health are realized. This includes prevention, treatment and care, mitigation of the effects of major diseases, and the creation of supportive and enabling environments in which these systems can function.

The framework focuses on strengthening community systems for scaled-up, good-quality, sustainable community-based responses. This includes strengthening community groups, organizations and networks, and supporting collaboration with other actors and systems, especially health, social care and protection systems. It addresses the key importance of capacity building to enable delivery of effective, sustainable community responses. CSS will facilitate effective community-based advocacy, creation of demand for equity and good-quality health services, and constructive engagement in health-related governance and oversight.

Communities have unique knowledge and cultural experience concerning their communities, which should be integrated into the development and implementation of community responses. This will ensure that they are shaped by accurate knowledge of what is needed, and based on respect for rights and equity of access. This will further influence social change and healthy behaviors and ensure community engagement at local, national, regional and international levels.

The framework is strongly informed by a renewed sense that community engagement for health is essential for achieving the basic human right to health for all. The Alma Ata Declaration of 1978 was a key starting point, affirming that: "*... health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health*

is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."[8]

More recently, this fundamental principle was reinforced in Millennium Development Goals (2000);[9] the Abuja Declaration on Malaria (2000);[10] the UNGASS Declaration of Commitment on HIV/AIDS (2001);[11] and the Amsterdam Declaration to Stop TB (2000).[12] The 2008 *World Health Report* advocated for renewal of the Alma Ata Declaration, which *"brings balance back to health care, and puts families and communities at the hub of the health system. With an emphasis on local ownership, it honours the resilience and ingenuity of the human spirit and makes space for solutions created by communities, owned by them, and sustained by them."*[13]

Major consultations have addressed the importance of strengthening health service/community partnerships for the scale-up of prevention, care and treatment for HIV, TB, malaria and other diseases. Key aspects addressed within the CSS Framework include collaboration with community organizations in: increasing access and adherence to treatment; development of health service performance assessment guidelines; and the need for joint development of partnership frameworks between communities and health and other services.[14]

The CSS Framework is a flexible tool that can be adapted for use in different contexts and countries. Its use is not limited to the Global Fund or to the three diseases (HIV, TB and malaria) that are the focus of the Global Fund's mandate. Different users will need to assess at an early stage how to use the framework appropriately for different regions, populations, health challenges and contexts. Within the CSS Framework, community systems are regarded as being both complementary to and linked with health systems, both with their own distinct strengths and advantages. The main elements – the core components – of effective community systems are described; illustrative examples of potential activities, interventions and community-level monitoring and evaluation are provided.

The framework also recognizes that major funding gaps exist for key aspects of community action related to health outcomes. It highlights the need to support the development and implementation of systems for policy and advocacy, resource mobilization, and evidence-driven program design and implementation. These actions will enable community action to achieve quality assured, equitable, appropriate delivery of interventions that contribute to improved health outcomes and an enabling sociocultural, legal, economic and political environment.

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[8] Declaration of Alma Ata – International conference on primary health care 1978. Available from: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

[9] The Millennium Development Goals. Available from: http://www.undp.org/mdg/basics.shtml

[10] The Abuja Declaration and Plan of Action. Available from: http://www.rollbackmalaria.org/docs/abuja_declaration_final.htm

[11] Declaration of Commitment on HIV/AIDS. Available from: http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/default.asp

[12] Amsterdam Declaration to Stop TB. Available from: http://www.stoptb.org/assets/documents/events/meetings/amsterdam_conference/decla.pdf

[13] WHO. The world health report 2008. Primary health care — Now more than ever. Geneva: WHO; 2008. Available from: http://www.who.int/whr/2008/en/index.html

[14] WHO. Partnership work: the health-service community interface for the prevention, care and treatment of HIV/AIDS. Report of a WHO consultation, 5–6 Dec. 2002, Geneva. Geneva: WHO; 2002. Available from: http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf

The important roles that community actors can and should play in achieving better health outcomes are emphasized, highlighting the unique advantages of community organizations and networks in their ability to deliver services within communities and with regard to their ability to affect the broader determinants of health that often outweigh any intended impacts through improving health service access and use.[15,16] These determinants affect people's mental and physical health and well-being at many levels. They include, for example, income and social or cultural status; education; physical environment; employment and working conditions; social support networks and welfare services; genetics, personal behavior and coping skills; and gender. Community actors are in a unique position to work on these issues alongside health, social welfare and other actors and systems. Together, they can achieve the scale, range and sustainability of interventions that will help to realize people's rights and enable them to reach important goals for their health and well-being.[17]

[15] WHO. The determinants of health [Internet]. Geneva: WHO; 2011. Available from: http://www.who.int/hia/evidence/doh/en/index.html

[16] WHO. Ottawa Charter for Health Promotion: first international conference on health promotion. Geneva: WHO; 1986. Available from: http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

[17] Baker BK. Increasing civil society impact on the global fund to fight aids, tuberculosis and malaria: strategic options and deliberations. Part 3: civil society options paper on community systems strengthening. ICASO; 2007. Available from: http://www.icaso.org/resources/CS_Report_Policy_Paper_Jan07.pdf

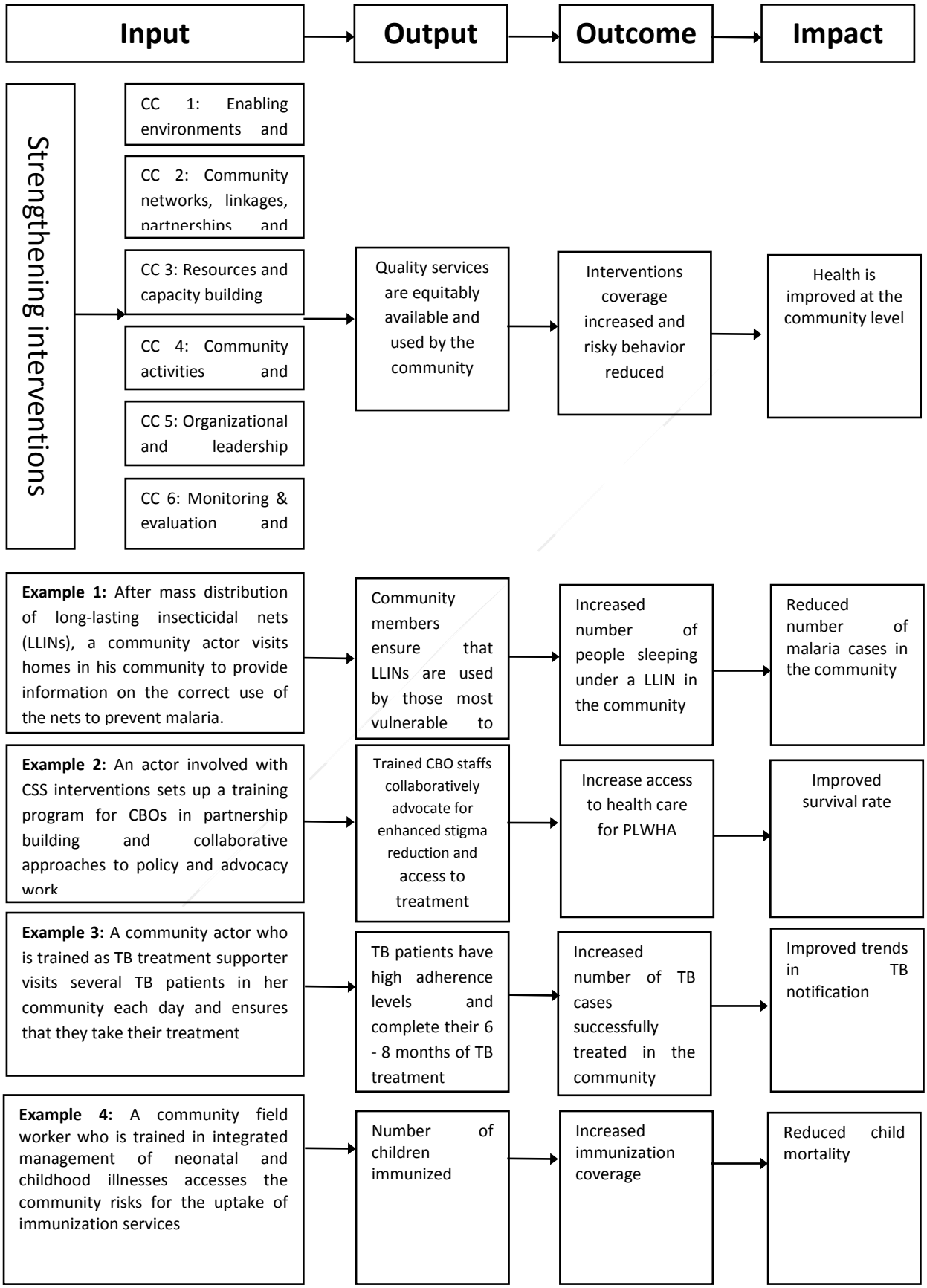
Table 1: The CSS Framework – Six Core Components of Community Systems

1. **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal, and governance environments, and for affecting the social determinants of health;
2. **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships;
3. **Resources and capacity building** – including *human resources* with appropriate personal, technical and organizational capacities, *financing* (including operational and core funding) and *material resources* (infrastructure, information and essential commodities, including medical and other products and technologies);
4. **Community activities and service delivery** – accessible to all who need them, evidence-informed and based on community assessments of resources and needs;
5. **Organizational and leadership strengthening** – including management, accountability and leadership for organizations and community systems;
6. **Monitoring and evaluation and planning** – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

When all of these are strengthened and functioning well, they will contribute to:

- improved outcomes for health and well-being;
- respect for people's health and other rights;
- social and financial risk protection;
- improved responsiveness and effectiveness of interventions by communities;
- improved responsiveness and effectiveness of interventions by health, social support, education and other services.

Figure 1: Overview of a Strengthened Community System, with Examples
(CC = core component)



Who Is This Framework for?

The CSS Framework is intended for use by all those who have a role in dealing with major health challenges and have a direct interest in community involvement and action to improve health outcomes, including community actors, governments, funders, partner organizationss and key stakeholders. Effective and functional community systems are crucial for this, from both organizational and operational perspectives. Strengthening community systems should be based on a capacity building approach and backed up with adequate and appropriate financial and technical support.

Small community organizations and actors should find the framework helpful for planning their work; mobilizing financial and other resources; collaborating with other community actors; and documentation and advocacy concerning barriers and challenges experienced at local, national, regional and global levels. These are high priorities for those within or working with key affected populations who frequently face difficulties in accessing support and funds for key activities. Many community organizations have faced particular difficulty in gaining funding for core organizational costs, advocacy and campaigns, addressing policy and legal barriers to evidence-informed programming and service delivery.

Larger community actors, such as NGOs or networks of people affected by key diseases, should also be able to use the framework as a tool for scaling up their health-related work. It will help them to focus their assistance to smaller organizations that need to adapt the framework to local needs and to mobilize funding and technical support. In the past, it has been difficult for community actors to clearly explain the connections between health outcomes and community activities that have potential impacts on health but are not directly related to health service delivery, for example advocacy, social protection and welfare services, home-based care or legal services. The framework provides a structure for addressing this and enabling inclusion of relevant nonhealth activities in funding mechanisms and allocations for health.

Government bodies and health planners and decision-makers should find the framework helpful for better understanding the varied and vital roles of community actors in health support and promotion. The framework shows how this role can be part of planning for health and highlights key interventions and systems that need resource allocation and support. It also highlights how the meaningful inclusion of community actors at the national level can contribute to a more balanced mix of interventions through health systems and community systems to maximize the use of resources, minimize duplication of effort and effectively improve health outcomes.

Partner organizations and stakeholders supporting community actors and receiving resources for CSS activities will find the framework helpful for understanding what funding and support are required for community-based and community-led organizations and why, and for ensuring the full contribution of these organizations to national and global health priorities. The framework will be of particular interest to organizations and stakeholders such as:

- networks and organizations of, or for people with or affected by, key diseases;
- international, regional and national civil society organizations and networks involved in advocacy and monitoring or “watchdog” activities;

- national funding mechanisms (such as Global Fund Country Coordinating Mechanisms);
- bilateral and multilateral organizations and donors;
- technical partners including UNAIDS and co-sponsors, and private-sector or nongovernmental technical support providers involved in capacity building, training and technical support for community actors

2. Strengthening Community Systems to Contribute to Health Outcomes

What Is Community Systems Strengthening?

The *goal* of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of community-based organizations in the design, delivery, monitoring and evaluation of services and activities related to the prevention of HIV, tuberculosis, malaria and other major health challenges and the treatment, care and support of people affected by these diseases.

Community systems strengthening (CSS) is therefore an *approach* that promotes the development of informed, capable and coordinated communities and community-based organizations, groups and structures. It involves a broad range of community actors and enables them to contribute to the long-term sustainability of health and other interventions at the community level, including an enabling and responsive environment in which these contributions can be effective.

Key underlying principles of community systems strengthening include:

- a significant and equitable role in all aspects of program planning, design, implementation and monitoring for community-based organizations and key affected populations and communities, in collaboration with other actors;
- programming based on human rights, including the right to health and to freedom from discrimination;
- programming informed by evidence and responsive to community experience and knowledge;
- commitment to increasing accessibility, uptake and effective use of services to improve the health and well-being of communities;
- accountability to communities – for example, accountability of networks to their members, governments to their citizens, and donors to the communities they aim to serve.

Strategies for CSS that are essential to the CSS approach and are reflected in the CSS Framework list of core components include:

- development of an enabling and responsive environment through community-led documentation, policy dialogue and advocacy;
- support both for core funding for community-based organizations and networks, including organizational overheads and staff salaries and stipends, as well as for targeted funding for implementing programs and interventions;
- capacity building for staff of community-based organizations and networks and for other community workers, such as community care workers and community leaders;
- networking, coordination and partnerships;

- strategic planning, monitoring and evaluation, including support for operational research and the generation of research-based and experiential evidence for results-based programming;
- sustainability of financial and other resources for community interventions implemented by community-based organizations and networks.

What Needs Strengthening?

The strategies outlined above indicate the priority areas for strengthening the systems used by community-based organizations and other community actors. Systems for the organization and delivery of activities and services[18] are integral to any organized program or service, whatever the size, structure or status of the group or organization that implements them. In practice, the systems of one actor are often linked to those of other actors to provide a functional overall system. For example, a well-developed community system for care and support might include specific systems for providing counseling; for policy advocacy; for legal support; for referral and access to services and follow-up; for home-based care; and for social protection and welfare of vulnerable children, youth and adults.

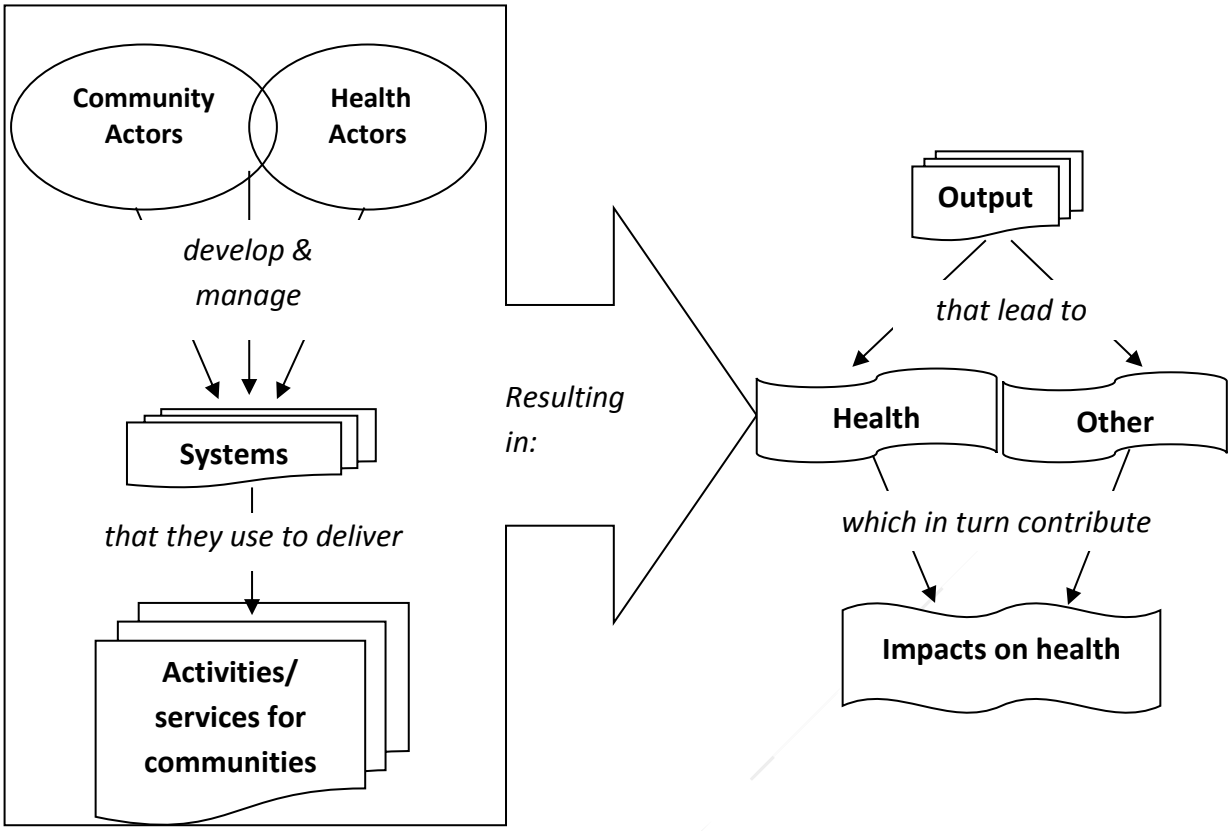
Figure 2 shows how different actors, working together or separately, use systems to implement services and activities, providing results at the levels of outputs, outcomes and impacts. Effective and functional systems play an enabling role for actors to deliver activities. They are therefore crucial for contributing to meaningful effects on health and/or nonhealth

factors. Health and nonhealth outcomes can both contribute to health impacts. However, the functioning of systems and their results also depends on the influence of factors in the surrounding environment that may enable or disable effective service delivery and the functioning of systems.

Community systems strengthening is more than a way to improve access to and utilization of formal health services. It is also, and crucially, aimed at increased community engagement – meaningful and effective involvement as actors as well as recipients – in health care, advocacy, health promotion and health literacy, health monitoring, home-based and community-based care and wider responses to disease burdens. It includes direct responses by community actors as well as their engagement in responses of other actors such as public health systems, local and national governments, private companies and health providers, and cross-sectoral actors such as education and social protection and welfare systems.

[18] Programmatic interventions by civil society actors are often called *activities*. In health systems, interventions are usually called *services*. In the past, the Global Fund used the term *service delivery area* to cover the full range of programmatic activities and services. Under the new funding model the terms “modules” and “interventions” are used – these are explained lower down.

Figure 2: Community action and results for health



The importance of creating enabling legal, social, political and economic environments should not be underestimated. An enabling environment is essential for people to achieve their rights and for communities and community organizations to be engaged and effective. The contexts of interventions to improve health are always multilayered. The effectiveness of interventions can be seriously impaired in environments that are hostile or unsupportive. As the Ottawa Charter points out, the *"... fundamental prerequisites for health are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites."* Ensuring that the basic conditions and resources for health are able to support all citizens is only possible through the combined efforts of communities, governments, civil society and the private sector. More effective community engagement and stronger partnerships between community, public and private actors are therefore essential in order to build enabling and supportive environments and to scale up effective responses by community, health and social welfare systems.

Community-based organizations are rich in experience and close to communities but they often have very limited financial resources. CSS must therefore proritize adequate and sustainable funding for community actors – not only funds for specific project activities and services, but crucial core funding to ensure organizational stability for operations and for networking, partnership and coordination with others. Unrestricted core funding, based on agreed structures and procedures, contributes to sustainability by ensuring continuity and allowing an organization to have the appropriate paid staff, supplies and infrastructure to build up their chosen programs in response to the needs of the communities they serve.

CSS must also have a strong focus on capacity building and human resources so that community actors can play a full and effective role alongside strengthened health and social welfare systems. Community, health and social welfare systems must increase their commitment to health equity and to an enabling sociocultural environment. They must emphasize the role of key affected populations as the drivers and contributors for improving health outcomes as well as ensuring equitable access to services and support for health rights.

All actors – community organizations; local and national governments; health, social and education systems; and other actors – need to develop a greater understanding of the potential outcomes and impacts of community engagement, and of the ways interventions can best be implemented by and with communities. It is also essential that civil society actors (such as faith-based and nongovernmental organizations or organizations for people affected by major diseases) should base their activities and services on national standards and guidelines and international best practice guidance wherever these exist. Adhering to accepted standards ensures that community actors play a role in reaching national health goals as well as concentrate on local needs and interventions.

By their very nature, communities are organic and diverse, and a great variety of groups and organizations – community actors – arise in response to perceived community needs.[19,20] At their simplest, they may lack formal structures or capacity for running administrative systems, managing funds or communicating effectively with officials and other organizations. Larger community organizations may have those skills and capacities but may be working in isolation from each other and from mainstream government systems.

In some contexts, community actors operate outside of mainstream systems in order to reach people who are marginalized or criminalized or who do not trust official systems – for example, undocumented migrants, sex workers, sexual minorities or drug users. Sometimes community actors are themselves isolated from the mainstream, due to barriers within the country or to donor processes that prevent them from acting as equal partners in planning, implementation, oversight and assessment of programs.

In some settings there is excellent cooperation between different actors, but it is important not to overlook the inequalities, social hierarchies, discrimination and competitiveness that sometimes operate among community organizations, and between them and government structures. Creating and maintaining good working relationships, and ensuring adequate, equitable and sustainable funding for community organizations and actors are therefore key priorities for strengthening and scaling up community systems.[21]

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[19] De Berry J. Exploring the concept of community: implications for NGO management. London: London School of Economics; 1999. Available from: http://eprints.lse.ac.uk/29100/

[20]Minkler M. Community organizing and community building for health. Piscataway, NJ: Rutgers Univ. Press; 2004. Available from: http://rutgerspress.rutgers.edu/acatalog/__Community_Organizing_and_Community_Building_for__664.html

[21] Makhubele MB, Parker W, Birdsall K. Strengthening community health systems: perceptions and responses to changing community needs. Johannesburg: Centre for AIDS Development, Research and Evaluation (CADRE); 2007. Available from: http://www.cadre.org.za/node/197

What Health-related Activities and Services Do Community Systems Deliver?

Through community systems, community actors currently provide several categories of activities or services that directly or indirectly affect health outcomes. These categories are not mutually exclusive and there are many synergies and overlaps within and between community systems and health systems, especially within integrated packages of care, support and protection.

It is also important to recognize that community-based and community-led organizations have different roles depending on which health challenges they are working on. For tuberculosis, for example, the emphasis is on the partnership of people with TB and their communities with political and health institutions. This partnership promotes better health for all and universal access to essential care. The primary aim is to ensure the quality, reach and effectiveness of health programs for prevention and treatment. For malaria, there is a similar emphasis on partnerships and on the community's role in malaria control, primarily through improved community knowledge, prevention behaviors and access to prevention commodities, and to accurate diagnosis and effective treatment. Where HIV is concerned, there are marked differences between generalized epidemics affecting many people within a geographical area, and focused epidemics affecting specific groups of people who are considered "communities" because of their health or legal status and their specific vulnerabilities to HIV and to stigma and discrimination.

In many parts of the world, of course, communities are affected by all three diseases and by many other health challenges. Communities of every kind need easy access to services that address all their differing needs. There is increasing understanding of the need for integrated programming and delivery — not just of health services but also social, education, legal services and economic support. Community-based organizations and networks have a vital role to play in the development of such integrated and community-driven approaches.

The WHO definition of a health system comprises *"... all organizations, institutions and resources devoted to producing actions whose primary intent is to improve health."* In practice, government health systems have limited resources and are often supplemented by nongovernment providers such as faith-based organizations, CBOs or NGOs working in collaboration with government systems or in parallel systems that may or may not be linked with national health systems. Much nongovernment health system input happens at the community level. Community systems thus have a role in taking health systems to people in communities and in providing community inputs into health systems. At the same time, health systems are just one part of a wider set of social support systems that are relevant to people's health and well-being.

Three main categories of community-level activities and services that support health in different ways can be described, as shown below. However, the interface between government and community health-related services depends on the local context. For purposes of definition, it is probably best to distinguish health system interventions from others based on *what* the intervention is rather than *who* is providing it. To take an obvious example from the first category below, provision of TB medication is clearly a health system intervention, which may be provided by the national health system, by a faith-based organization or another community actor. Examples in the second category below are health-

focused, but the best option for delivery at the community level may be through functioning community systems rather than through the formal public health system.

i. **Direct provision of health services in cooperation with or separately from public health services**:
   - diagnosis, treatment and care through community-level facilities such as clinics, hospitals, laboratory services;[22]
   - community-delivered health interventions, such as mobile HIV counseling and testing, treatment follow-up[23] or crosscutting health interventions;[24]
   - disease prevention activities;[25]
   - community health services such as home-based care or TB-DOTS;[26]
   - community health education and promotion;
   - services to neglected and vulnerable populations;
   - implementation and monitoring of policies that affect access to health and welfare services.

ii. **Support activities for individuals accessing health-related services at the community level:**
   - community mobilization for access to and use of health services in a "health friendly" local environment;
   - comprehensive home-based care;
   - referrals and support for access to health and other services;
   - support to individuals for service use and follow-up;
   - disease prevention, harm reduction and behaviour change interventions;
   - increasing community literacy on testing and diagnosis;
   - treatment literacy and adherence support;
   - reducing stigma and discrimination;
   - advocacy and access to legal services;
   - psychological, social and economic support;
   - community-based health insurance schemes;
   - financial support for accessing services, such as cash transfers and assistance with out-of-pocket expenses for transport or food while away from home.

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[22] Fakoya A, Abdefadil L. Civil society support and treatment access. Public Service Review: International Development: 14 [Internet]. 2009 June. Available from: http://www.publicservice.co.uk/article.asp?publication=International Development&id=391&content_name=Treatment access&article=12197

[23] Jaffar S, Amuron B et al. Rates of virological failure in patients treated in a home-based versus a facility-based HIV-care model in Jinja, southeast Uganda: a cluster-randomised equivalence trial [Internet]. Lancet 374(9707):2080-2089. 2009 Dec 19. Available from: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61674-3/abstract

[24] WHO. Community directed interventions for major health problems in Africa: a multicountry study. Geneva: WHO; 2008. http://apps.who.int/tdr/svc/publications/tdr-research-publications/community-directed-interventions-health-problems

[25] WHO/Stop TB Partnership. Advocacy, communication & social mobilization (ACSM) for tuberculosis control – a handbook for country programmes. Geneva: WHO/Stop TB Partnership; 2007. Available from: http://whqlibdoc.who.int/publications/2007/9789241596183_eng.pdf

[26] Fakoya A, Abdefadil L. Home is where the care is: the role of communities in delivering HIV treatment care and support [Internet]. Public Service Review: International Development: 15. 2009 Sept. 23. Available from: http://www.publicservice.co.uk/pub_contents.asp?id=401&publication=International Development&content=3850&content_name=Health

iii. **Activities to create and improve the enabling environment**:

Social determinants of health

- participation in local and national forums for policy change;
- advocacy and campaigns;
- community awareness on gender, sexual orientation, disability, drug dependency, child protection, harmful sociocultural practices, and similar issues;
- peer outreach and support;
- services for literacy and access to information, legal redress, individual and family social support (social transfers), welfare services, and rehabilitation;
- educational services and support for children and youth;
- community mobilization on stigma and discrimination, basic rights, poverty reduction, access to services, information and commodities (e.g. condoms and medicines);
- oversight, monitoring and evaluation of implementation of programs and services.

Broader determinants of health

- participation in local and national forums for policy change;
- nutrition, housing, water, sanitation and other material support to vulnerable children and adults;
- livelihood support programs such as microcredit or savings schemes, training schemes for unemployed adults and youth and support for growing food to feed families;
- support for civil rights and access to services, for example civil registration of births and deaths.

Community Systems and Health Systems – Complementary and Connected

Community systems are complementary to and closely connected with health systems and services. As outlined above, both types of systems engage in delivery of health services and, to a greater or lesser degree, in supporting communities' access to and effective use of those services. In addition, community systems have unique advantages in advocacy, community mobilization, demand creation and linkage of communities to services. They also have key roles in health promotion and delivery of community health services, and in monitoring health systems for equity and quality of services. Community actors are also able to play a systematic, organized role in advocacy, policy and decision-making, and in creating and maintaining an enabling environment that supports people's health and reduces the effects on vulnerable people of poverty, discrimination, marginalization, criminalization or exploitation and harmful sociocultural practices.

Lack of clarity in the past has made it difficult to discuss how community systems relate to health outcomes and how they link with health systems. One reason this is difficult may be that community systems are often more fluid and harder to define than the structured systems of a health or social support service. Another reason may be the difficulty in defining exactly what the boundaries between health and community systems are, and to identify the links between them. This is especially the case when community actors are direct health care providers and major contributors to health through home-based and facility-based services. In addition, community and home-based care, mainly provided by women and girls, is often undervalued because of assumptions about gender roles and the separation of public and private care and about the nonprofessional status of voluntary caregiving work provided by women and children.

In addition to gaining clarity about the relationship between health systems and community systems, it is also important to be clear about how community systems may have

comparative advantage with respect to certain health-related activities. These are specific to local contexts, but may include ensuring that services and support are available close to people's homes, using the language skills of trusted, culturally competent community members, ensuring continuity of follow-up for people with chronic diseases, community-level promotion of health literacy, social and psychological support, changing harmful sociocultural practices, outreach to key affected communities and individuals, and providing respite for home-based carers.

The lack of clarity about community systems and their comparative advantages has also resulted in limited or inconsistent funding for community activities, services, or organizational strengthening. There has been similar underfunding of social protection and welfare services, especially regarding people living with or affected by HIV. For example, resources are needed (but hard to mobilize) to support people with out-of-pocket expenses incurred to access services, accompany sick people to hospital, provide family-centered nutritional support for people taking antiretroviral or other medication, and to implement community-based child protection.

Much more evidence-building and research is needed on community systems and the role of community organizations and actors in health support for vulnerable communities. This applies especially to interventions indirectly related to health (such as those focused on poverty or other health determinants) and for health-related support interventions focused on prevention, access, care and advocacy rather than direct delivery of medical services. Support and resources for research on the health consequences of community-led interventions have been very limited or even nonexistent in the past, and need to be proritized now, especially since funders increasingly require that all programs and interventions be measurable and evidence-based.

Health systems are not separate from communities. They are key community assets, part of the network of relationships and support that individuals, families and communities are entitled to rely on. Clearly, there are synergies as well as overlaps between health systems, community systems and social welfare systems, but these should be a stimulus for creative and innovative approaches to bring community, health and social systems into closer and more complementary partnerships.[27]

[27] Futures Group Europe. Support for collaboration between government and civil society: the twin track approach to strengthening the national response to HIV and AIDS in Kenya. Futures Group Briefing Paper. Bath, UK: Futures Group Europe; 2009. Available from: http://www.futuresgroup.com/wp-content/uploads/2009/11/FGE-Briefing-Paper-November-2009.pdf

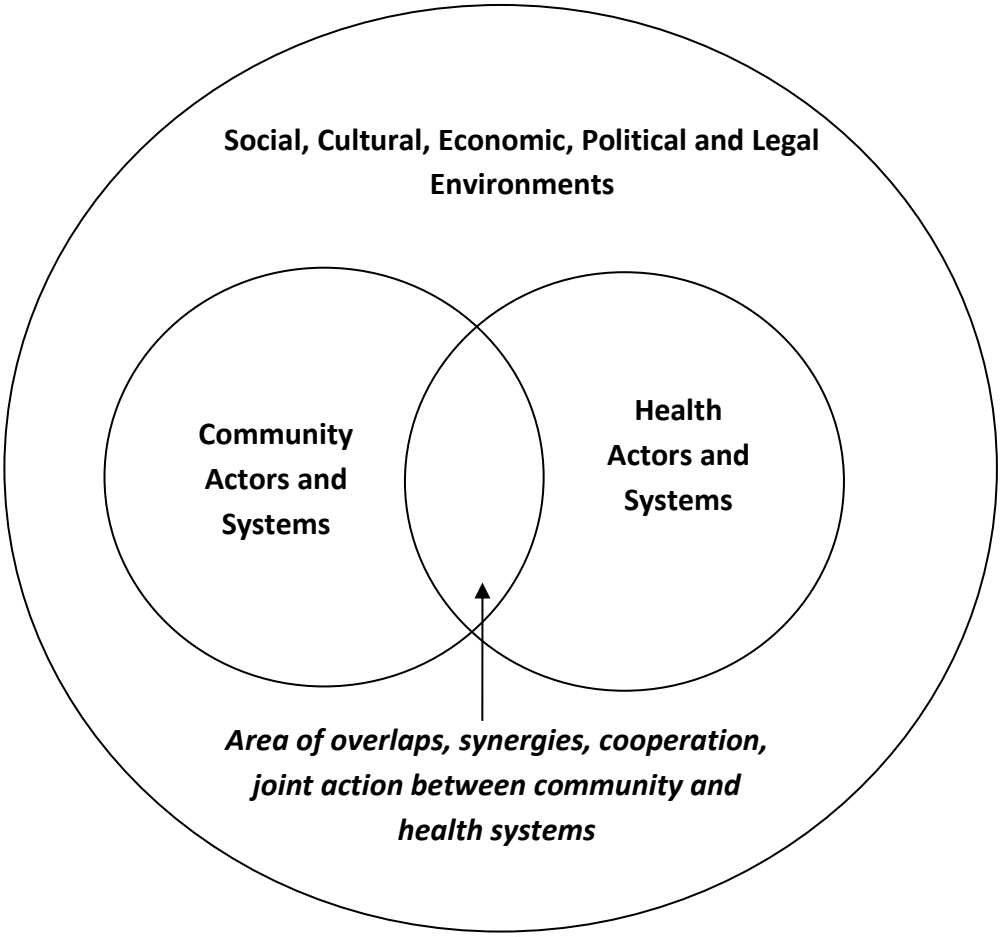

Figure 3: Community and health actors and systems – complementary and connected

3. The Core Components of a Functional Community System

This section defines six core components for CSS. These must all be in place and functioning effectively for community systems to contribute fully and sustainably to health outcomes, both directly and indirectly.

The core components described below are *all* regarded as essential for building strong community systems. Together, they will enable CBOs and other community actors to deliver activities and services effectively and sustainably. They also support the development of strong links and coordination between different systems and actors working toward the shared goal of improving health.

CSS should always start with an analysis of how systems are already functioning, how they need to be strengthened and how they can be built into a functional and coherent whole. CSS is a gradual process and interventions should focus on addressing all the individual components and their combined functioning in order to assure delivery of quality, equitable, appropriate and sustainable interventions and outcomes within empowered communities.

Table 2: Summary of CSS Core Components

Core components *(not in order of priority; all are essential)*	***Characteristics when strengthened*** *(a set of subgoals for CSS, indicating how a fully functional community system can be recognized when community systems strengthening has been successfully achieved)*
1. Enabling environment and advocacy	Community-based organizations analyze and document relevant issues and plan and implement involvement in policy activities at appropriate levels. Communities effectively advocate for implementation and improvement of national programs. Well-informed communities and affected populations engage in activities to improve their own environment.
2. Community networks, linkages, partnerships and coordination	Functional networks, linkages and partnerships between community actors and national programs are in place for effective coordination and decision-making.
3. Resources and capacity building	Community actors have good knowledge of rights, community health, social environments and barriers to access and develop and deliver effective community-based services. Community actors have core funding secured and they mobilize and manage financial resources sustainably. Financial reporting is transparent, timely and correct. Functional systems are in place to forecast, quantify, source, manage and use infrastructure and essential commodities in appropriate and efficient ways.
4. Community activities and service delivery	Effective, safe, high-quality services and interventions are equitably delivered to those in need.

5. Organizational and leadership strengthening	While ensuring accountability to all stakeholders, community actors provide leadership in the development, operation and management of programs, systems and services.
6. Monitoring and evaluation and planning	Relevant programmatic qualitative and quantitative data are collected, analyzed, used and shared. Appropriate mechanisms for data quality, feedback and supervision are in place. Strategic information generated by the M&E system is used for evidence-based planning, management, advocacy and policy formulation.

Core Component 1: Enabling Environments and Advocacy

Communities need an enabling environment to function effectively and to ensure that their rights are respected and their needs are met. The environment should also be one in which community voices and experiences can be heard and community-based organizations can make effective contributions to policies and decision-making.

This enabling environment includes the social, cultural, legal, financial and political environments as well as the day-to-day factors that enable or hinder people's search for better health. People may seek, for example, better access to health services, education, adequate food, water and shelter, sexuality and family life, and security. At the same time, people also need freedom from harassment, discrimination, violence, harmful sociocultural practices and other barriers to health. All of these factors can either support or hinder people's health by affecting, for example, access to services, access to funding and the ability of community organizations to function effectively. Failure to address these factors will increase the risk that interventions for health may fail or be unsustainable.

Establishing and sustaining the enabling environment is a priority that should not be neglected. These processses should receive adequate funding as an investment for health and to support the establishment, working and strengthening of community-based organizations and systems. The contexts of major diseases such as HIV, tuberculosis and malaria (and many others) are always multifaceted, and effectiveness of interventions can be seriously impaired in environments that are unsupportive or hostile. For example, adherence to treatment regimens is always at risk in environments with high levels of stigma and discrimination. Likewise, prevention and harm reduction interventions may be extremely difficult or impossible to deliver when certain groups of people, such as drug users or sex workers, are criminalized or marginalized.

Community monitoring and documentation are powerful tools for advocacy and policy dialogue, for example when rights are violated or access to services is restricted. Communities and community networks have a watchdog role and are able to mobilize communities to create more favorable environments. They are able to work with policymakers and implementers to redress specific problems experienced by communities and scale up the responses for all sectors of the population.

Support will be needed to develop effective community action for the enabling environment at the community level. This will empower communities and key affected populations to communicate their experiences and needs to decision-makers at all levels, through linkages at the community level and through coalitions, networks and civil society advocacy groups that operate in national, regional, and international forums.

Core Component 2: Community Networks, Linkages, Partnerships and Coordination

Functioning community networks, linkages and partnerships are essential to enable effective delivery of activities and services. Strong informal and formal relationships between communities, community actors and other stakeholders enable them to work in complementary and mutually reinforcing ways, maximizing the use of resources and avoiding unnecessary duplication and competition.[28]

A *network* is a system for connecting people with common interests. A *linkage* is a connection that helps to connect a person or organization to others. A *partnership* is a more formal agreed relationship between people or organizations in which they share resources and responsibilities in order to achieve common goals.

Networks often have multiple functions, for example networks of people living with HIV and AIDS or other health challenges. Many networks concentrate on exchanging information, experiences and learning, and on mutual support for advocacy, strategy development, capacity building and resource mobilization. Some community-based networks are formally organized, for example networks of people living with HIV advocating for better access to legal support, or village health committees mobilizing support for better malaria diagnostic equipment. However, informal networks also have important roles at the community level, sharing information, providing support to individuals and bringing about change in the community, such as working to remove stigma and discrimination against people with TB and/or HIV or educating peers on disease prevention and changing health-related behaviors.

Strong national and regional networks of key affected populations and civil society groups can make important contributions to the accountability of governmental and nongovernmental bodies and organizations, and to the support of community-based activities and service delivery. Networks also have a vital role to play in technical assistance, due to their ability to act as knowledge hubs, contribute to the development of communities of practice, and to distribute appropriate information through their networks, for example on technical tools, good practices and consultants. Strengthening networks for the role of advocates, watchdogs, and technical assistance providers is therefore likely to be an effective investment for effective implementation of services contributing to the broader environment for health.

Where advocacy by national networks is challenged, for example by stigma or discriminatory laws, regional networks can represent the needs of key affected people and communities and act as watchdogs. They are also vital for knowledge management and sharing of good practices, tools and information among countries with similar cultural backgrounds and needs. The involvement of these networks leads to significant added value as experience is shared more broadly and duplication of effort is prevented. Partnerships between organizations with shared objectives can lead to combined approaches to community-led service delivery and joint operational support. For example organizations may work together on financial and other resource mobilization, shared planning and delivery of activities and services, shared use of community-based facilities or shared procurement of health and other commodities.

[28] Health & Development Networks (HDN), International HIV/AIDS Alliance (the Alliance), AIDSPortal, Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS). National Partnership Platforms on HIV and TB: a toolkit to strengthen civil society information, dialogue and advocacy. HDN/the Alliance; 2009. Available from: http://www.aidsalliance.org/publicationsdetails.aspx?id=430

Core Component 3: Resources and Capacity Building

Resources for community systems include:

- human resources – people with relevant personal capacities, knowledge and skills;
- appropriate technical and organizational capacities; and
- material resources, including adequate finance, infrastructure, information and essential commodities.

These resources are essential for running systems and organizations, and for delivering activities and services. Human resources are of course the key to any intervention at the community level or by community-based organizations and networks. It is important to note that communities themselves provide human resources, skills and knowledge, and often contribute funds, effort and materials to community programs and interventions. For example, community knowledge and experience contribute to planning and implementation processes, providing places to meet, food, income-generating activities, or assisting community members in gaining access to services.

Funding for core organizational costs and for capacity building are also vital to enable community actors to provide sustainable and effective responses, as is funding to implement programs and interventions. It is essential also to include funding for infrastructure items and services, information systems, and systems for sourcing and managing essential commodities.

3.1 Human Resources: Skills Building for Service Delivery, Advocacy and Leadership

Development of human capacity is important for community leadership and progress toward community health goals. People are the central resource for community organizations and groups, including employees and volunteers and members of community groups and networks. In communities, there are also individuals who provide advice and guidance; act as influencers, enabling access to certain sectors of the community; and contribute to activities such as fundraising or supporting individuals and families. Recruitment, retention and management of human resources are key aspects of organizational strengthening and leadership for advocacy, but they are also essential to ensure that technical skills and experience are given high priority to assure program quality, achieve timely progress toward defined goals, and build the evidence base for effective community contributions to health. The technical capacity of community actors is becoming increasingly important as combined strengthening of health and community systems and integrated service delivery is proritized in order to reach the Millennium Development Goals (MDGs), for example in TB/HIV integration, sexual and reproductive health and primary care in communities.

3.2 Financial Resources

CSS must include adequate and sustainable funding for community actors, especially CBOs. This includes both project funds for specific operational activities and services and the crucial core funding to ensure organizational stability as a platform for operations and for networking, partnership and coordination with others. It is essential that community actors have the appropriate financing and financial management skills.[29] Community organizations are often unsuccessful in mobilizing core funding that is ”unrestricted” – that is, not tied to a

[29] Kelly K, Birdsall K. Funding for civil society responses to HIV/AIDS in Tanzania: status, problems, possibilities. Johannesburg: CADRE; 2008. Available from: http://www.cadre.org.za/node/192

specific project or intervention and aimed at support for an organization's basic running costs. However, when based on agreed contractual arrangements, such as a memorandum of understanding and financial reporting to funders, core funding contributes greatly to sustainability. It ensures continuity and allows organizations to have the appropriate paid staff, supplies and infrastructure to build up their programs in response to the needs of the communities they serve.

Organizations may need guidance and technical support to identify sources of funding, develop relationships with funders and successfully meet their criteria. They will need to develop their financial systems and manage them efficiently, transparently and sustainably. The same applies to organizations undergoing expansion due to scaling up of activities or services and increased funding. Different funders apply different rules and reporting requirements and support will be needed to enable organizations to deal with this without being distracted from programmatic work by increased administrative demands. Good management of finances is essential for organizational support and service delivery, and it is also essential for demonstrating good stewardship of funding from donors, governments and communities, which is important for sustainability and mobilizing further resources.[30]

3.3 Material Resources – Infrastructure, Information and Essential Commodities

Many organizations lack capacity for dealing with material resources infrastructure, information, and essential commodities (including medical and other products and technologies). They require funding and technical support to develop and operate reliable and sustainable systems for managing material resources, based on standards already developed and widely available.

Infrastructure includes such things as office space; utilities (water, power, waste); transport; communications and information management systems; maintenance and repair of building and equipment. Ensuring the viability and adequacy of infrastructure is essential. Failure to achieve this can have catastrophic effects on activities and services.

Information includes access to information materials in appropriate formats and languages, systems for storing and retrieving as part of an overall knowledge management system. Community actors need funding for organizational information systems – e.g. accounting and management – M&E information, and technical information for design, management and delivery of activities and services. This latter area is often neglected, causing implementers to work with outdated information, risking weaknesses and inappropriate activities in their interventions. Support will be required to ensure that information is properly recorded, stored, updated and communicated so that implementers, the community, stakeholders and partners can share knowledge for future planning and decision-making and for policy dialogue and advocacy.

Essential commodities of good quality need to be available in the right quantities and at the right times to contribute to the continuity, credibility and effectiveness of activities and services. This includes office equipment and supplies; communication materials; utilities and building maintenance; fuel for transport; medical products and technologies for prevention, treatment and care (e.g. condoms, insecticide-treated nets, medicines and lab equipment), safety equipment (universal precautions) for community health workers, home care workers and teachers.

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[30] Birdsall K, Ntlabati P, Kelly K, Banati P. Models for funding and coordinating community-level responses to HIV/AIDS. Johannesburg: CADRE; 2007. Available from: http://www.cadre.org.za/node/198

Core Component 4: Community Activities and Services

Community activities and services are essential for achieving improved health outcomes. They are therefore an essential and integral component of community systems strengthening. ”Learning by doing” is an important capacity building principle of, and is especially applicable to, systems for service delivery and support at the community level. Quality community programs, activities and services that are evidence-informed and cost efficient will build on existing systems and services and contribute to the creation of demand for services, social behavior change, increased health and reduced disease transmission in the community. Community-based organizations and members of key affected communities are in a unique position to assess and address the needs of their own people. This is especially true for marginalized people who are criminalized and/or stigmatized and who therefore often avoid state services. This direct involvement of organizations and other actors in their own community response brings greater credibility and relevance to community service delivery systems and adds strength to leadership and advocacy. It is essential to provide support to community actors for building and strengthening community systems to deliver services and to support communities to use those services.

A quality approach should underlie the design and implementation of community service delivery systems, from situation assessment and intervention design right through to delivery and assessment of outcomes and impacts. This depends on having a sound basis of informed management and technical skills and the ability to utilize evidence of what works. Systems for service delivery should also be implemented ethically and sustainably by people who are appropriately skilled and knowledgeable. Systems should be based on accepted national or other standards of practice where they exist and should be linked with national health, social care and M&E systems and standards. It may be necessary for community actors to advocate for and initiate development of new practice standards if none exist already. Adaptability of services is important for responding to changes in institutional capacity and resources, in patterns of disease or new knowledge on prevention, care and support, or to changing demographics and political or social environments.[31]

There are many interventions, particularly support activities for community members accessing health-related services at the community level, that may fail to acquire funding because of differing views on whether they fit within community systems or health systems. It is important not to lose sight of the fact that, wherever they fit, they are essential services for people in need. Delivery through community systems may be the most effective and acceptable to a community, even for interventions clearly related to health. Many community-based programs are moving toward the integrated delivery of services. The same person on the same day may deliver both health and nonhealth interventions for a range of health and other challenges. It is therefore logical that funding and monitoring should also be integrated for the community actors responsible for delivery. Funding for research should also focus on the added value that such services and activities can provide, ensuring better planning, implementation and quality improvement based on validated evidence.

Core Component 5: Organizational and Leadership Strengthening

Organizational strengthening is a key area that aims to build the capacity of community-actors to operate and manage the core processes that support their activities. Their activities include developing and managing programs, systems and services effectively; ensuring accountability to their communities, stakeholders and partners; and providing leadership for improving the enabling environment to achieve better health outcomes. Key knowledge and

[31] Makhubele MB, Parker W, Birdsall K. Strengthening community health systems: perceptions and responses to changing community needs. Johannesburg: CADRE; 2007. Available from: http://www.cadre.org.za/node/197

skills in this area would include, for example, leadership in representing the vision and goals of the organization externally and internally, development of systems of accountability and participation in decision-making, management of workers, and respect for employment rights and laws.

There is particular need to strengthen support and funding for networks and small organizations at the community level, such as those that serve people living with and affected by HIV or other key health problems. Funding has in the past been limited mainly to specific projects, advocacy and profile-raising opportunities, and there has been little support for developing organizational capacity or increasing knowledge and skills for a wider health support role. This pattern needs to change in order to strengthen the effectiveness of community systems. In some countries there may be more than one network, or there may be several strong networks, CBOs or NGOs working in the same field. These networks and organizations may need support to work together to avoid duplication of activities and to promote joint planning and decision-making.

Accountability is an important aspect of strengthening organizations. It assures communities, stakeholders and partners that there is good stewardship of the organizations' resources. Mechanisms for independent oversight and guidance may be needed to demonstrate accountability. Such mechanisms could include meetings with stakeholders and community members; independent audits of finances and evaluations; open access to information; and reports for stakeholders, community members and funders on a regular basis. Community organizations that hold themselves accountable to their communities will also build their capacity to engage in advocacy for greater transparency and accountability of public bodies and governments to communities.

Core Component 6: Monitoring and Evaluation and Planning

Community-led M&E is essential for community systems. It will provide the strategic information needed to make good decisions for planning, managing and improving programs, and for formulating policy and advocacy messages. It also provides data to satisfy accountability requirements. Community-led M&E will make effective use of data provided by community members. These include data from qualitative and participatory methodologies, such as action research, operational research, focus groups and key informant interviews, as well as data from regular monitoring of operational inputs and outputs and internal or external evaluations. This means that both qualitative and quantitative indicators are needed, that community-level M&E methodologies are essential, and that feedback mechanisms must routinely be used to allow community organizations and community members to use M&E results for reflection and further planning and action.[32,33]

Data collection and analysis should also follow a gender and age-related approach in order to better understand the different vulnerabilities and needs of women and girls, men and boys, and transgender people. For example, gender norms affect women's and men's risks of exposure to mosquitoes and malaria, due to divisions of labor, leisure patterns and sleeping

[32] Davies R, Dart J. The 'Most Significant Change' (MSC) Technique – a guide to its use [Internet]. Care International U.K. et al.; 2005. Available from: http://www.mande.co.uk/docs/MSCGuide.pdf

[33] The Constellation. Reources and tools: Blended learning online course [Internet]. Grez-Doiceau, Belguim: The Constellation; 2008. Available from: http://www.communitylifecompetence.org/en/94-resources

arrangements. This also affects treatment-seeking behaviors, household decision-making, resource allocation and financial authority.[34]

The first steps for building or strengthening community systems are also essential for building a meaningful M&E system. The steps are: definition of target groups and areas; stakeholder identification and consultation; assessment of needs and analysis of gaps and available resources. This will inform discussion about what can realistically be done to fill the gaps, who should be involved and how to make it happen, based on clear and achievable objectives. During implementation, regular review of implementation will help in analyzing progress and answering key questions such as:

- Are we doing the right things?
- Are we doing the right things well?
- Are we doing enough of the right things?
- Have our interventions made a difference?
- How do we know?[35]

A focus group discussion among injecting drug users, for example, might reveal that a needle exchange service would have more impact by distributing syringes the size preferred by drug users, a fact that would not be detected in quantitative data on the number of syringes distributed. Evidence of the effectiveness of a changed approach could be validated through the design and implementation of an operational research project, thus adding significant new data to the existing evidence base.

An effective community-level M&E plan provides a structure for collecting, analyzing, understanding and communicating key information throughout the life of an intervention or program. The plan should cover the wide array of actions and processes, from gathering information for planning activities and interventions, through designing and implementing workplans, reviewing progress and evaluating what has been done and communicating results to implementers, communities, stakeholders and funding partners. It is highly recommended that community M&E systems be aligned with the national health and social welfare M&E systems and with the legal and policy environment. This will ensure that reporting to the national level contributes to national data and is incorporated into the local system, without creating the extra burden of data collection and analysis.

It is also essential to build up systems for community-level knowledge management. This includes data from the M&E system and from formal and experiential research, based on the experiences of communities and key affected populations. A good knowledge management system will enable community actors and key affected populations to establish evidence of what works and does not work at the community level so they can respond effectively to political, social and economic challenges, and address behaviors, rights violations and other factors that drive the need for improvements in health and social care and surrounding environments. It will also provide access to news, information on good practices, information on available tools and technical assistance opportunities, and information about policy and opportunities to engage in policy dialogue and network with each other.

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[34] WHO, RBM. Gender, health and malaria. Geneva: WHO & RBM; June 2007. Available from: http://www.rollbackmalaria.org/globaladvocacy/docs/WHOinfosheet.pdf

[35] "*If you do not measure results, you cannot tell success from failure; if you cannot see success, you cannot reward it; if you cannot reward success, you are probably rewarding failure; if you cannot see success, you cannot learn from it; if you cannot recognize failure, you cannot correct it; if you can demonstrate results, you can win public support.*" Cited on the World Bank GAMET site at http://gametlibrary.worldbank.org/pages/12_1)HIVM_ESystems-12components_English.asp

4. CSS in the Context of the Global Fund's New Funding Model

4.1 How community systems and community systems strengthening appear in the new funding modelmodel

Modular approach

Among the resources being introduced by the Global Fund to facilitate the development of funding requests are a set of four **measurement frameworks**, one for each of the four components for which funding can be requested (HIV/AIDS, tuberculosis, malaria and health systems strengthening, or HSS). One of the main principles applied in the design of these measurement frameworks is to enable clear differentiations between different types of programs and interventions, and to reduce overlaps in order to improve the ability of the Global Fund and its grantees to track investments and measure impact. They are made up of a series of modules including "core program" modules (relating to various types of service delivery) and "essential supportive" modules. Each of the Measurement Frameworks for AIDS, tuberculosis and malaria include a CSS module, which is one of the "essential supportive" modules.

4.2 Where CSS and community-led program implementation and service delivery appear in the new funding model

The CSS module contains four interventions and illustrative activities aimed at the strengthening of community systems. The module was developed on the basis of the CSS service delivery areas included in the CSS Framework supported by the Global Fund in the past. However they have been streamlined to reduce overlaps and to ensure they are focused on *strengthening* community systems to fulfill the wide range of roles described above.

The biggest difference between the SDAs used previously and the CSS module under the new funding model, is that it does not itself include direct community-led program implementation or service delivery. This is because program implementation and service delivery are part of core programming and are already included in other modules and interventions within each component. For instance, specific services, such as HIV counseling and testing, mosquito net distribution, or treatment adherence support, are all included as core programming elements for HIV, malaria and tuberculosis respectively, and they can be provided or delivered by any sector, including by community sector organizations. Applicants should decide on the role that communities and community organizations will play in implementing these services, based on their own context, and should include the necessary strengthening interventions from the CSS framework to ensure these organizations can fulfill their roles effectively.

Because many applicants under the new funding model will be familiar with the SDAs used in the past, the **table below shows how the old SDAs map onto the new modular approach**.

Table 3: Links Between the Old SDAs and the New Modular Approach

CSS Framework Core Components	Current SDAs	Changes to the SDA	New CSS Module Interventions
1. Enabling environment and advocacy	SDA 1: Monitoring and documentation of community and government interventions	Reworded; entire content moves to Intervention 1	Intervention 1: Community-level monitoring for accountability of all services, activities and other interventions related to the disease as well as respect for human rights
	SDA 2: Advocacy, communication and social mobilization	Advocacy moves to Intervention 2. Communication covered throughout all interventions. Social mobilization moves to Intervention 3.	
2. Community networks, linkages, partnerships and coordination	SDA 3: Building community linkages, collaboration and coordination	Moves to Intervention 3 with the addition of Social Mobilization	Intervention 2: Advocacy to ensure accountability and continuous improvement of responses to the disease
3. Resources and capacity building	SDA 4: Skills building for service delivery, advocacy and leadership	Some aspects (service delivery) covered in core program modules. Other aspects (advocacy and leadership) move to Intervention 4.	
	SDA 5: Financial resources	Resources for service delivery covered in core program modules. Financial systems for CS move to Intervention 4.	Intervention 3: Social mobilization, building community linkages,

	SDA 6: Material resources – infrastructure, information, essential commodities (including medical products and technologies)	Resources for service delivery covered in core program modules. Core organizational equipment and management systems for CS move to Intervention 4.	collaboration and coordination
4. Community activities and service delivery	SDA 7: Service availability, use and quality	Primarily covered in core program modules. All community sector or community led service delivery should be planned and programmed in the relevant core program modules, not under CSS.	Intervention 4: Institutional capacity building, planning and leadership development in the community sector
5. Organizational and leadership strengthening	SDA 8: Management, accountability and leadership	Moves to Intervention 4.	
6. Monitoring and evaluation and planning	SDA 9: Monitoring & evaluation, evidence-building	Covered in overall M&E module for each disease rather than being included as an intervention for each module (avoids repetition).	
	SDA10: Strategic and operational planning	Moves to Intervention 4.	

4.3 Detailed Description of the CSS Module in the New Funding Model

Intervention 1: Community- based monitoring for accountability

Scope and description of package: Community-based organizations and other community groups are strengthened to monitor, document and analyze the performance of health services as a basis for accountability, advocacy and policy activities. Community-based organizations establish and implement mechanisms for ongoing monitoring of health policies and performance and quality of all services, activities, interventions and other factors that are relevant to the disease, including prevention, care and support services, financing of programs, and of issues and challenges in the environment, (such as discrimination and gender-based inequalities), that constitute barriers to an effective response to the disease and to an enabling environment.

There are different ways of conducting effective community monitoring: recently, a lot of emphasis has been placed on using information technology to collate and transfer data so that it can be used for dialogue and advocacy not only at local level but also at national level. Effective community monitoring initiatives are often based on existing community accountability mechanisms, or local decision-making structures. However it is important to keep in mind that existing structures may reinforce the exclusion of already excluded or marginalized groups. Programs aiming to support excluded or marginalized populations, including "key populations" in the context of HIV and AIDS, should consider this reality when deciding which type of monitoring mechanism to develop.

While this intervention focuses on broad monitoring of availability, accessibility and quality of services, monitoring that is specifically focused on criminalization and human rights-related barriers should be planned under the "Removing legal barriers to services" module as it is a critical part of the package of services needed to address human rights.

Applications for this intervention, as is the case for all of the other CSS interventions, should include the costs of recruiting and strengthening the human resources required to conduct them.

Intervention 2: Advocacy for social accountability

Scope and description of package (includes human resources required): Service providers, national programs, policy makers, and local and national leaders are held accountable by community sector organizations for the effective delivery of services, activities and other interventions, as well as for the protection and promotion of human rights and gender equality. Communities and affected populations conduct consensus, dialogue and advocacy at local and national levels aimed at holding to account responses to the disease, including health services, disease specific programs as well as broader issues such as discrimination, gender inequality and sustainable financing, and aimed at social transformation.

Strong feedback loops and advocacy from the community level are a vital way of encouraging service providers, authorities and decision makers to identify and address problems. Community sector organizations use a range of tactics to channel feedback and to demand accountability from those in a position of influence. In many cases providers and authorities welcome receiving feedback and advice from communities and work closely with them; however it is also common for community experiences to be sidelined or ignored, and for community organizations to have to more proactively and visibly advocate in order to have impact. A range of methods can be considered: new technologies for knowledge-sharing and advocacy (e.g., social network tools, online alerts); as well as dialogue at the community level between affected communities, local authorities and service providers. An important backdrop to effective advocacy is to ensure that community members are informed and empowered to communicate and advocate for change and to improve environments at local

level; and where necessary to support efforts to bring this advocacy to national and even regional levels.

While this intervention focuses on broad advocacy related to improving the availability, accessibility and quality of services, advocacy that is specifically focused on criminalization and human rights-related barriers should be planned under the "Removing legal barriers to services" module as it is a critical part of the package of services needed to address human rights.

Intervention 3: Social mobilization, building community linkages, collaboration and coordination

Scope and description of package (includes human resources required): Communities and affected populations engage in activities to improve their health and their own environment. Community action, establishment of community organizations and creation of networking and effective linkages with other actors and broader movements such as human rights and women's movements. Strong informal and formal relationships between communities, community actors and other stakeholders enable them to work in complementary and mutually reinforcing ways, maximizing the use of resources and avoiding unnecessary duplication and competition.

Mobilized, cohesive communities play a vital role in challenging negative norms – including those that influence peoples' vulnerability to AIDS, tuberculosis and malaria – and in promoting and defending the right to health. Communities often come together to address health and social problems, but they seldom receive the support to organize and plan so they can be effective. This is particularly true for key affected populations, whose exclusion is already one of the main factors of their vulnerability. CSS support is therefore crucial to encouraging social mobilization. Under this intervention, applicants can also request support to ensure that there are strong links between different types of service and support – such as between community-based social services, and clinical services, as well as services linked to human rights and livelihoods. Community sector organizations can help clinical services become more amenable and acceptable to excluded groups, by partnering with them to improve "key population friendly" services.

Finally, collaboration and coordination activities supported under this intervention are an important means of ensuring that all those who need have access to services, and that overlaps, duplications and even contradictions between services are minimized.

Intervention 4: Institutional capacity building, planning and leadership development in the community sector

Scope and description of package (includes human resources required): capacity building of community sector groups, organizations and networks in a range of areas necessary for them to fulfil their roles in service provision, social mobilization, monitoring and advocacy. Includes support in planning, institutional and organizational development, systems development, human resources, leadership, and community sector organizing. Provision of stable, predictable financial resources for communities and appropriate management of financial resources by community groups, organizations and networks. Provision of technical, material and financial support to the community sector as required to enable them to fulfil roles in service provision, social mobilization, monitoring and advocacy.

Most of the formal structures involved in health care provision – clinics, hospitals, social services, and ministries of health – are long-established and have core infrastructure, systems equipment, and human resources. Where there are weaknesses, most countries have a roadmap for addressing these and investing in the health system. This is rarely the case for community systems, which are made up of many small, autonomous organizations with very varied capacities, roles and priorities.

Core support to improve the capacity of these organizations, so that they can effectively play important roles in mobilizing communities, promoting accountability, advocating for change, and indeed in delivering many types of health and social services at community level, is therefore an essential CSS intervention. This includes support for individual organizations in: organizational strengthening, management and leadership, financial management, human resources, technical skills, as well as support for developing mentoring systems. Capacity building systems for community sector organizations can use a mix of short-term and longer-term interventions adapted to the needs of each organization. The intervention can also include professional development for community workers/volunteers not covered elsewhere, e.g. for professional ethics, human rights, gender sensitivity and equality, and stigma reduction.

As well as including support for capacity building of individual organizations, this intervention can also be used to provide support at the "systems" level. This can include support for organizing the community sector as a whole, needs assessments for the sector, and strategic planning for community systems.

4.4 CSS In The Health Systems Strengthening (HSS) Measurement Framework

Funding for CSS is also available under the cross-cutting health systems strengthening measurement framework. However, unlike under the disease measurement frameworks, CSS is not included as a standalone module under HSS. Rather, reflecting that community systems and health systems are closely linked, applicants who wish to support CSS in a cross-cutting (not disease specific) way are encouraged to apply the HSS interventions to community systems strengthening. In order to facilitate this, there are a number of specific references to community sector programming in the HSS framework. Many of the modules and interventions under HSS can therefore be used to support strengthening of community systems.

The most important consideration to take into account in relation to HSS is that it is concerned with cross-cutting programs: programs that are relevant to more than one of the three diseases, and indeed that are relevant to health more generally. The main difference between applying for CSS under a disease-specific grant or under cross-cutting HSS is therefore whether the CSS interventions for which funding is sought are disease-specific or are cross-cutting.

Applicants interested in receiving funding for CSS under a cross-cutting HSS grant should consult the Global Fund Eligibility List to see whether they are eligible to submit a stand-alone cross-cutting HSS funding request[36], and the HSS information note for more information[37].

A summary of the scope of these CSS interventions and a list of illustrative activities for each is included in the Annex.

4.5 Integrating CSS into Requests For Funding Under the New Funding Model

The Global Fund encourages applicants to include CSS interventions routinely in proposals wherever relevant for improving health outcomes. The proposal form and guidelinesreflect the increased importance of CSS within Global Fund proposals, in particular through the inclusion of CSS as a separate module under the measurement framework for each disease.

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[36] http://www.theglobalfund.org/en/fundingmodel/single/

[37] http://www.theglobalfund.org/en/fundingmodel/support/infonotes/

Before completing the proposal form, applicants will need to work closely with community organizations and actors to identify which community systems strengthening interventions need to be funded, based on analysis of existing resources and the gaps and weaknesses that need to be addressed. It is also important to show clearly how systems will be strengthened by interventions, thus ensuring that CSS funding will be appropriately targeted.

Applicants are encouraged to consider CSS as an integral part of the assessments of disease programs and health systems, ensuring that they identify those areas where full involvement of the community is needed to improve (1) the scope and quality of service delivery, particularly for those hardest to reach, (2) the scope and quality of interventions to create and sustain an enabling environment, and (3) evidence-based policies, planning and implementation.

Applicants may include CSS-related interventions in their disease-specific proposal or as part of a cross cutting HSS applicationapplication, if the CSS interventions are relevant to more than one of the diseases.

It is important to focus on aspects related to strengthening community systems in the context of service delivery, advocacy and enabling environment for the three diseases. Because CSS particularly focuses on affected communities, CSS interventions should be harmonized across the three disease components whenever possible. Overlap should be carefully avoided. Thus, HIV, TB and malaria programs need to coordinate their efforts, avoid duplication and ensure that CSS interventions for the different diseases are complementary at the community level. Since the Global Fund uses a performance-based funding system, it is important that a limited number of indicators are carefully chosen as a basis for regular reporting to inform disbursement decisions. Before and during the proposal development process the following steps should be undertaken:

- create an enabling environment for the participation of all stakeholders (representation of the different stakeholders involved in the national response, particularly the key populations);
- assess, in advance of a Global Fund call for proposals, the gaps and constraints to address in the funding request, the implementation model or strategy, the characteristics of potential beneficiaries, and the component (HIV/AIDS, TB, malaria or HSS);
- read the Global Fund proposal form and guidelines thoroughly and consider in every part of the proposal how communities can be strengthened;
- read all relevant Global Fund Information Notes, which can be found on the Global Fund website: http://www.theglobalfund.org/en/fundingmodel/support/infonotes/ ;
- gather together all relevant experts, stakeholders and sectors and determine a system by which each can engage in proposal development (either through a proposal development committee, technical working groups or organized consultations).[38]

More guidance on the proposal development process can be found on the relevant pags of the Global Fund website:

http://www.theglobalfund.org/en/about/grantmanagement/fundingmodel/

[38] Supporting community-based responses to AIDS, tuberculosis and malaria A guidance tool for including community systems strengthening in proposals for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Geneva: UNAIDS; 2011. Available from: http://www.unaids.org/en/media/unaids/contentassets/documents/programmes/programmeeffectivenessandcountrysupportdepartment/gfresourcekit/20110920_JC2170_community_systems_strengthening_en.pdf

5. A Systematic Approach for Developing CSS Interventions Including Monitoring and Evaluation

The objective of this chapter is to provide guidance to CSS implementers on the different steps to be undertaken to build or strengthen a system for CSS interventions. CSS implementers will generally be larger organizations such as Principal Recipients, governmental departments or large NGOs that work with community organizations and actors. A functional system for CSS interventions addresses identified needs and demonstrates progress toward strengthening community systems. Table 4 provides a summary of the key steps to be undertaken by CSS implementers. These steps are explained in greater detail below.

Table 4: Summary of the steps to be undertaken by CSS implementers for the development of a system for CSS interventions

Step 1:	Define where community systems strengthening interventions at are required in order to successfully implement the health sector plans / specific disease programs.
Step 2:	Conduct a needs assessment to determine the strengths and weaknesses of the community system in the targeted area(s).
Step 3:	Based on expected results, define clear and achievable objectives.
Step 4:	Determine the Interventions where strengthening interventions are required.
Step 5:	For each of the selected Interventions agree on the most appropriate activities.
Step 6:	Select a number of CSS indicators and modify as needed to fit with the specific country context.
Step 7:	Determine baselines for each of the selected indicators, set ambitious yet realistic targets and finalize the budget and work plan for the CSS interventions.
Step 8:	Ensure that M&E for CSS is integrated into the national reporting system.
Step 9:	Reach an agreement on roles and responsibilities of the various stakeholders involved.
Step 10:	Develop harmonized data collection methods and formats.
Step 11:	Reach agreement on arrangements for regular supervision and feedback.
Step 12:	Set an agenda for joint program review and evaluation.

Step 1: The first step is to identify where community systems strengthening interventions are required. This decision should be based on the priorities identified in respective national disease strategic plans and/or in the health sector. Depending on the country context, the focus of CSS interventions could be for example to strengthen:

- all community-based organizations for the delivery of services in a specific geographic area, such as a district or a province;
- all community-based organizations working with a specific population subgroup, such as vulnerable populations, orphans and vulnerable children, or people living with a specific disease in a country.

The aim of CSS should not be to strengthen individual organizations but to strengthen the community system as a whole. For this reason when choosing to work on a specific geographic area CSS should focus on all organizations in this area that are involved with service delivery for a particular disease. These organizations will together form the denominator for the CSS indicators. **Step 2:**CSS implementing organizations should conduct a needs assessment to determine the strengths and weaknesses of targeted community systems. It is of key importance that all relevant stakeholders are consulted during the needs assessment and that the assessment is conducted in a fully participatory manner. Relevant stakeholders may include representatives of community-based organizations, representatives of key affected populations, national or provincial program managers, local government officials, M&E experts, representatives of the Country Coordinating Mechanism, technical partners, disease experts, and others. Before a proposal can be developed, key stakeholders and partners must fully understand the service delivery environment by mapping who is providing which services, to whom and where, and who is not being reached. A good needs assessment would systematically analyze the status of community systems for all six core components. The outcome of the assessment should clarify the current status of community systems and what needs to be strengthened. A needs assessment could involve the dissemination and analysis of printed or electronically administered questionnaires, community consultations and indepth mapping of partnerships and interventions. During the planning phase, please keep in mind that the needs assessment should:

- be feasible to implement;
- identify the current status of community systems (the baselines);
- identify the key players involved in the CSS interventions (the stakeholders);
- identify what should be achieved.

To support this process an assessment tool could be used.[39]

Step 3: Building on the needs assessment, clear and achievable objectives should be identified. Table 2 provides an overview of how a strengthened community system could

[39] More information on how to conduct a CSS needs assessment can be found in: Supporting community based responses to AIDS: a guidance tool for including community systems strengthening in Global Fund proposals. UNAIDS, January 2009. Available from: http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_en.pdf (updated version in preparation)

look. This table could be used for the development of the objectives. Please keep in mind that CSS objectives should be consistent with the objectives of the national disease control or health sector strategic plan.

Step 4: Building on the objectives and the outcome of the needs assessment, determine the list of interventions from the CSS module for which system strengthening measures are required.These decisions will depend to a great extent on the role that civil society and community organizations are going to play as implementers of core programs. The CSS implementing organization should focus on areas where strengthening is most needed.

Step 5: In consultation with community stakeholders and technical partners, discuss the most appropriate and effective activities for each interventionintervention. CSS interventions should aim at ensuring that quality services are available and used by the community, resulting in improved health outcomes at the community level. Ensure that the selected interventions and activities are based on evidence and match the needs identified by the community. A number of example activities are including for each of the interventions is included in the annexeannexe.

Step 6: When a decision has been made regarding the types of interventions, it is necessary to work on the indicators to measure progress in CSS over time. A great variety of organizations are active at the community level, as well as many regional and national variations. A tailored package of appropriate indicators should be selected for each country and organizational context. For this reason many indicators have been defined broadly to allow for flexibility.

Further guidance on indicators and monitoring and evaluation of CSS under the new funding model is under development and will be disseminated and annexed to this framework once it is available.

Step 7: Develop the budget and workplan to define baselines and set targets. The needs assessment conducted in Step 3 should inform setting baselines for each of the selected indicators. Define the scale on which the CSS interventions should be implemented to reach the set objectives. Take into account limitations such as availability of human and material resources, environmental obstacles such as geography and terrain as well as political and physical infrastructure. Determine the resources currently available for CSS interventions and identify what and how many additional resources will be required. Building on this analysis, set ambitious yet realistic targets for all selected CSS indicators.[40] Ensure that targets are achievable and that all stakeholders involved have a clear understanding of their respective roles, responsibilities and contributions. Now finalize the workplan and budget for the CSS interventions. Remember that the budget should provide detailed assumptions of estimated costs for all planned activities. The workplan should identify a clear timeline and responsible actors for implementing each planned activities.

Step 8: Information related to CSS such as leadership, advocacy, governance and accountability is often not captured by health information management systems. Other

[40] For target setting refer for example to: WHO, UNODC, UNAIDS. Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: WHO, UNODC, UNAIDS; 2009. Available from: http://www.who.int/hiv/pub/idu/targetsetting/en/

issues such as resource mobilization, partnership and staff performance at the community level are not completely captured but require further integration. Strong leadership and joint planning with community stakeholders are key to creating a conducive environment for the integration of M&E for CSS into the national reporting system. When setting up the M&E system for CSS interventions, it is important to ensure that the reporting flow follows existing reporting lines and established structures. Also ensure that there is no parallel system for reporting on CSS within or between disease components through close coordination between community-based organizations, other community actors and local government authorities.

Step 9: Develop memoranda of understanding between community-based organizations involved and the CSS implementer. This will ensure that all stakeholders involved in the CSS program have clear roles and responsibilities.

Step 10: Develop appropriate reporting forms and data collection tools in consultation with the community-based organizations and actors. Tools and forms should be easy to use and should only capture information that is useful for program management and informed decision-making. It is imporant that the same tools and forms are used by all stakeholders involved in the CSS program to facilitate integration of data into the national reporting system. Not all information collected at the community level needs to be reported to the national level. Community stakeholders and CSS implementers should discuss and agree what needs to be reported.

Step 11: Reach agreement on arrangements for regular supervision and feedback. The purpose of supervision and feedback is to improve the quality of programs and to create an environment to enable staff to perform to their maximum potential. Supervision should be supportive and is not a means of controlling the performance of an individual or an organization. Supervision normally includes skills development, review of records and reports, field visits, quality assurance and personal as well as professional development through on the job training. It can involve individual sessions or group sessions. Supervision is an opportunity for two-way feedback and ensuring improved understanding of the tasks and issues involved in delivering high-quality services.

Step 12: Set an agenda for joint program review and evaluation. Joint program reviews and evaluations shed light on the outcome and impact of programs and contribute to building mutual understanding of long-term strategies, goals and objectives. They aim to answer the following questions:

- What results have we achieved against the predefined time-bound targets?
- Are we doing the right things?
- Are we doing them in the right way?
- Are we doing them on a large enough scale?

It is important that community systems strengthening is integrated in the annual disease/health sector review to strengthen the link between the community and the national Program. Community-based organizations and actors should be systematically involved in joint evaluations, operational research and reviews.[41]

6. Useful Resources

a. *Sources Of Support and Technical Assistance*

- *African Council of AIDS Service Organisations (AfriCASO).* http://www.africaso.net/
- *AIDS & Rights Alliance for Southern Africa – capacity building.* http://www.arasa.info/capacitybuilding
- *Asia Pacific Council of AIDS Service Organisations (APCASO).* http://www.apcaso.org/
- *Asian Harm Reduction Network - Technical Assistance and Capacity Building Unit.* http://www.ahrn.net/index.php?option=content&task=view&id=2117&Itemid=2
- *Aidspan guides to the Global Fund.* http://www.aidspan.org/index.php?page=guides
- *Caribbean HIV/AIDS Regional Training Network (CHART).* http://www.chartcaribbean.org/
- *Civil Society Action Team (CSAT).* http://www.icaso.org/csat.html
- *Eurasian Harm Reduction Network (EHRN) – trainings and technical assistance* http://www.harm-reduction.org/hub.html
- *Funding for civil society responses to HIV/AIDS in Tanzania: Status, problems, possibilities.* CADRE; May 2008. http://www.cadre.org.za/node/192
- *Global Network of People Living with HIV (GNP+).* http://www.gnpplus.net/content/view/14/86/
- *Latin American and Caribbean Council of AIDS Service Organizations (LACCASO)* http://www.laccaso.net/
- *MEASURE Evaluation Capacity Building Guides.* http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/capacity-building-guides/capacity-building-guides-index.html
- *Roll Back Malaria Toolbox.* http://www.rollbackmalaria.org/toolbox/index.html
- *Stop-TB - TB Technical Assistance Mechanism (TEAM).* http://www.stoptb.org/countries/tbteam/default.asp
- *UNAIDS Technical Support Facilities.* http://www.unaids.org/en/CountryResponses/TechnicalSupport/TSF/

b. *Other Information Sources, Including Those Referenced in the CSS Framework*

- *A model quality assurance system for procurement agencies. Module IV. Receipt and storage of purchased products: WHO Expert Committee on Specifications for Pharmaceutical Preparations: 40th report.* Geneva: WHO; 2006. http://whqlibdoc.who.int/trs/WHO_TRS_937_eng.pdf

[41] Useful resources on review and evaluation can be found at: Global HIV M&E information [Internet]. Available from: http://www.globalhivmeinfo.org/DigitalLibrary/Pages/12%20Components%20HIV%20Evaluation%20Research%20and%20Learning%20Resources.aspx

- *A model quality assurance system for procurement agencies: recommendations for quality assurance systems focusing on prequalification of products and manufacturers, purchasing, storage and distribution of pharmaceutical products.* WHO/UNICEF/UNDP/UNFPA/World Bank; 2007. http://www.who.int/medicines/publications/ModelQualityAssurance.pdf
- *Abuja Declaration and Plan of Action.* http://www.rollbackmalaria.org/docs/abuja_declaration_final.htm
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- *Amsterdam Declaration to Stop TB.* http://www.stoptb.org/assets/documents/events/meetings/amsterdam_conference/decla.pdfAnalysis of CSS applications in Round 10 / Global Fund www.theglobalfund.org/documents/civil_society/CivilSociety_Round10CommunitySystemsStrengthening_Analysis_enAnalysis of CSS applications in Round 10 / Global Fund www.theglobalfund.org/documents/civil_society/CivilSociety_Round10CommunitySystemsStrengthening_Analysis_en
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ANNEX: Illustrative Activities for CSS Interventions

N.B. as these activities are illustrative, applicants may also define additional activities if they fit within the scope of each intervention.

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
Community-based monitoring for accountability	Community-based organizations establish and implement mechanisms for ongoing monitoring of health policies and performance and quality of all services, activities, interventions and other factors that are relevant to the disease, including prevention, care and support services, financing of programs, and of issues and challenges in the environment, (such as discrimination and gender-based inequalities), that constitute barriers to an effective response to the disease and to an enabling environment.	Development and planning of community based monitoring and documentation mechanisms
		Design, establishment and maintenance of research plans, community-based monitoring and documentation tools and systems
		Monitor or develop indicators to measure legal rights
		Equipment for monitoring (e.g. relevant information technology)
		Implementation of monitoring for accountability activities (including baseline monitoring, data collection by communities, discussions with service providers, and use and appraisal of official/government data)
		Collation, centralization and analysis of monitoring data and development of recommendations and demands for improvement
		Publication and dissemination of community monitoring data and recommendations
		Technical support and training
		Training for community researchers/monitors
		Other

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
Advocacy for social accountability	Communities and affected populations conduct consensus, dialogue and advocacy at local and national levels aimed at holding to account responses to the disease, including health services, disease specific programs as well as broader issues such as discrimination, gender inequality and sustainable financing, and aimed at social transformation.	Planning of consensus, dialogue and advocacy work with decision makers and service providers at local and national level
		Consultations with community members
		Consultations with relevant government representatives
		Development and dissemination of advocacy products/materials
		Conduct of advocacy activities (e.g. meetings, campaigns, public advocacy events)
		Support to participation of community actors (including key populations) in local and national decision making/consultative bodies
		Technical support and training
		Other
Social mobilization, building community linkages, collaboration and coordination	Community action, establishment of community organizations and creation of networking and effective linkages with other actors and broader movements such as human rights and women's movements. Strong informal and formal relationships between communities, community actors and other stakeholders enable them to work in complementary and mutually reinforcing ways, maximizing the use of resources and avoiding unnecessary	Community/social mobilization activities (including participatory assessments, community meetings and identification of issues, mapping of community efforts, planning)
		Support to establishment of community organizations
		Develop and maintain coordination and joint planning mechanisms to link community actors with each other, and with other relevant actors, at local, national, regional and international levels
		Develop and maintain referral mechanisms between different service providers, in particular between community and other sector providers, and across borders where

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
	duplication and competition.	relevant
		Develop and support networking of community groups [on HIV, TB, malaria, health and women's], particularly of key populations, to ensure representation and advocacy at national level is effective, and for experience sharing, mentoring etc.
		Core support for participation in coordination mechanisms by community representatives (including transport/travel costs)
		Establishment of community health worker programming, strengthening, integration within the health systems and linkages with the community systems.
		Community level groups (e.g. health committees) whose mandate includes coordination and networking, identifying and responding to issues and barriers and mobilizing actions, support, linking with the health system, etc.
		Awareness-raising amongst community members about their entitlements, as specified in service-provider commitments
		Technical support and training
		Other
Institutional capacity building, planning and leadership development in the	Capacity building of community sector groups, organizations and networks in a range of areas necessary for them to fulfil their roles in service provision, social mobilization, monitoring and advocacy. Includes support in planning, institutional and organizational development, systems	Assessment of needs in human resources, systems, equipment, organizational and institutional development, leadership, etc.
		Provision of resources for institutional support including legal support, support for registration etc.
		Evidence informed planning, management, and policy formulation for community

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
community sector	development, human resources, leadership, and community sector organizing. Provision of stable, predictable financial resources for communities and appropriate management of financial resources by community groups, organizations and networks. Provision of technical, material and financial support to the community sector as required to enable them to fulfil roles in service provision, social mobilization, monitoring and advocacy.	systems. Development of systems for planning community action.
		Development and implementation of systems and policies for recruitment, supervision, motivation and support of community level workers and volunteers
		Capacity building in leadership, project management, volunteer management and supervision, motivation
		Professional development for community workers/volunteers not covered elsewhere, e.g. for professional ethics, human rights, stigma reduction.
		Training in special technical areas such as child protection, social protection, gender mainstreaming, working with criminalized or marginalized communities, providing integrated TB/HIV services, drug resistance, community audits such as verbal autopsy of reasons for deaths
		Strengthening communications skills and infrastructure
		Mentoring programs for community sector actors (including leaders and volunteers)
		Development of systems for rational, transparent and effective distribution of funds to community sector organizations within the framework of the national response and, if necessary for neglected themes, outside of this framework
		Capacity building for community groups, organizations, networks in strategic investment of resources, financial planning, financial management and resource mobilization, planning for sustainability

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
		Development and management, and where possible standardization of schemes for remunerating community outreach workers and volunteers or providing other incentives and income-generation support
		Procurement of infrastructure and equipment as well as other materials and resources required by community groups, organizations and networks and appropriate to their needs and roles within the response
		Support to ongoing organizational running costs in line with roles in the national response
		Development and dissemination of good practice standards for community sector service delivery and implementation including protocols, supervision and management.
		Development of accountability and governance plans for leaders of groups, organizations and networks
		Development of systems for M&E and other data collection of community led action, sharing of information, and integrating this information with national monitoring systems
		Adaptation of health sector assessment tools to ensure they capture community systems and CSS
		Establishment of / support to community support centers providing a range of services such as information, testing and counselling, referrals, peer support, outreach to key affected people and communities and legal support.

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
		Identification and support to development of community sector services that are critical and yet under-supported, such as human rights and legal services, and linkages with services related to gender and social welfare
		Planning for community sector led service delivery including monitoring, supervision, quality assurance, and linkages and referrals with other services
		Staff/volunteer retreats
		Technical support
		Other