Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

# COMMUNITY SYSTEMS STRENGTHENING FRAMEWORK

**MAY 2010**

# ACRONYMS & ABBREVIATIONS

| | |
|---|---|
| ACSM | Advocacy, communication and social mobilisation |
| AIDS | Acquired immune deficiency syndrome |
| CBO | Community based organisation |
| CSO | Civil society organisation |
| CSS | Community systems strengthening |
| DOTS | Directly-observed treatment, short course |
| FBO | Faith-based organisation |
| GF *or* GFATM | Global Fund to fight AIDS, Tuberculosis and Malaria |
| GHI | Global health initiatives |
| HIV | Human immunodeficiency virus |
| HSS | Health systems strengthening |
| M&E | Monitoring and evaluation |
| MDGs | Millennium Development Goals |
| NGO | Non-governmental organisation |
| OGAC | Office of the Global AIDS Coordinator (US government) |
| PMTCT | Prevention of mother-to-child transmission (of HIV) |
| SDA | Service delivery area |
| TB | Tuberculosis |
| TWG | Technical Working Group |
| 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 |
| US | United States of America |
| USAID | United States Agency for International Development |
| WHO | World Health Organisation |

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# 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 re-launch 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 mobilise the many resources that community members can bring to the processes of policy 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 towards the goals of universal access to health care and realising 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 towards this.

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 (TWG) that included: UNAIDS, WHO, UNICEF, World Bank, MEASURE Evaluation, Coalition of the Asia Pacific Regional Networks on HIV/AIDS (7 Sisters), International HIV/AIDS Alliance, USAID Office of HIV/AIDS, and US Office of the Global AIDS Coordinator, UNDP Burkina Faso, Ministry of Health & Social Welfare Tanzania, Carolyne Greene as an independent consultant and Global Fund staff. Finalisation of the draft was supported by a Harmonisation workshop which brought together experts and consultants on monitoring and evaluation as well as 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, a broad health development approach has been taken and the

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

[2] *WHO – social determinants of health* http://www.who.int/hia/evidence/doh/en/index.html

[3] *The World Health Report 2008 - primary health care* http://www.who.int/whr/2008/en/index.html

[4] *Community involvement in tuberculosis care and prevention*; WHO 2008 http://www.stoptb.org/resource_center/assets/documents/Community%20involvement%20in%20TB%20care%20and%20prevention.pdf

[5] *Community involvement in rolling back malaria;* Roll Back Malaria / WHO 2002 http://www.rollbackmalaria.org/cmc_upload/0/000/016/247/community_involvement.pdf

[6] *Partnership work: the health-service community interface for the prevention, care and treatment of HIV/AIDS;* WHO 2002 http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf

[7] *Community Systems Strengthening – Civil Society Consultation;* International HIV/AIDS Alliance 2010/ICASO http://www.aidsalliance.org/Pagedetails.aspx?id=407

Framework will therefore also be useful for 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 organisations and networks, and public or private sector actors that work in partnership with civil society at community level, in the design, delivery, monitoring and evaluation of services and activities aimed at improving health outcomes. It 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 organisations 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 organisations and networks have 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 programmeming 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 have the aim of achieving improved outcomes for interventions to deal with major health challenges such as HIV, tuberculosis, malaria and many others. An improvement in health outcomes can be greatly enhanced through mobilization of key affected populations and community networks and an emphasis on strengthening community based and community led systems for: prevention, treatment, care and support; advocacy; and development of an enabling and responsive environment.

In order to have real impact on health outcomes, however, community organisations and actors must have effective and sustainable systems in place to support their activities and services. This includes a strong focus on capacity building, 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 prioritise adequate and sustainable funding for specific operational activities and services and, crucially, core funding to ensure organisational stability as a platform for operations and for networking, partnership and coordination with others.

## IMPLEMENTING COMMUNITY SYSYTEMS STRENGTHENING

In order to take a systematic approach to CSS, the Framework focuses on the *core components of community systems*, all of which are considered to be essential for creating functional, effective community systems and enabling community organisations and actors to fulfil their role of contributing to health outcomes:

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, maximising resources and impacts, and coordinated, collaborative working.
3. Resources and capacity building – including *human resources* with appropriate personal, technical & organisational capacities, *financing* (including operational and core funding) and *material resources* (infrastructure, information and essential medical & other commodities & 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. Organisational and leadership strengthening including management, accountability and leadership for organisations and community systems.
6. Monitoring & evaluation and planning including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

For each of the core components described in the Framework, potential CSS interventions and activities are grouped within specific *service delivery areas (SDAs)*, with a rationale and a non-exclusive list of activity examples for each of these SDAs.

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. It includes a number of recommended CSS indicators for each SDA with detailed definitions for each of them. These indicators have been developed in consultation with technical partners and civil society representatives. They are designed to enable measurement of progress in community systems strengthening over time.

In the context of the Global Fund, applicants are encouraged to consider CSS as an integral part of assessments of disease programmes and health systems, ensuring that they identify those areas where full involvement of the community is needed to improve the scope and quality of services delivery, particularly for those hardest to reach. A brief description is provided of how CSS can be included within Global Fund proposals; further guidance is to be found within the Global Fund Proposal Form and Guidelines relevant to each funding round, starting with Round 10.

This first edition of the CSS Framework is a major step in the direction of enhancing community engagement and effectiveness in improving health outcomes and increasing their collaboration with, and influence on, the public and private sectors in moving towards 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 wide 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 on 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 are the ones that 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 organisations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Many community systems are small-scale and/or informal. Others are more extensive – they may be networked between several organisations and involve various sub-systems. For example, a large care and support system may have distinct sub-systems for comprehensive home-based care, providing nutritional support, counselling, 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 organisations, 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 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 organisations 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, and 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.

*Key affected populations, people or communities* are those who are most vulnerable to and affected by conditions such as malaria, tuberculosis and HIV and are the most often marginalised and have the greatest difficulty in achieving their rights to health. This includes children, youth and adults affected by specific diseases such as HIV, tuberculosis or malaria; women and girls; men who have sex with men; injecting and other drug users; sex workers; people living in poverty; street children and out-of-school youth; prisoners; migrants and migrant labourers; people in conflict and post-conflict situations; refugees and displaced persons.[8]

*Community based organisations (CBOs)* are generally those organisations that have arisen within a community in response to particular needs or challenges and are locally organised by community members. *Non-governmental organisations (NGOs)* are generally legal entities, for example registered with local or national authorities; they may be operative only at community level or may also operate or be part of a larger NGO at national, regional and international levels. Some groups that start out as community based organisations register as non-governmental organisations when their programmes develop and they need to mobilise resources from partners that will only fund organisations that have legal status.

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[8] *Expanded from the UNAIDS definition:* http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/default.asp

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

*Civil society* includes not only community organisations and actors but also other non-governmental, non-commercial organisations, such as those working on public policies, processes and resource mobilisation at national, regional or global levels.

## 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 realised. 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 focus of the Framework is on strengthening community systems for scaled-up, quality, sustainable community based responses. This includes strengthening community groups, organisations 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. Further, this will further influence social change and healthy behaviours 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 wellbeing, 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." [9]

This fundamental principle was reinforced in the Millennium Development Goals (2000)[10]; the Abuja Declaration on Malaria (2000)[11]; the UNGASS Declaration of Commitment on HIV/AIDS (2001)[12]; and the Amsterdam Declaration to Stop TB (2000)[13]. The 2008 World Health Report advocated for renewal of the Alma

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

[10] *The Millennium Development Goals* http://www.undp.org/mdg/basics.shtml

[11] *The Abuja Declaration and Plan of Action* http://www.rollbackmalaria.org/docs/abuja_declaration_final.htm

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

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

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." [14]

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 organisations in: increasing access and adherence to treatment; development of health service performance assessment guidelines; and the need for joint development of partnership frameworks for between communities, health and other services.[15]

The CSS Framework is a flexible tool that can be adapted for use in different contexts and countries, and not solely those connected 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 and illustrative examples of potential activities, interventions and community-level monitoring & evaluation are provided.

The Framework also recognises that major funding gaps exist for key aspects of community action related to health outcomes. It highlights the need to support development and implementation of systems for policy and advocacy, resource mobilisation, and evidence-driven programme design and implementation. This will enable community action to achieve quality assured, equitable, appropriate delivery of interventions that contribute to improved health outcomes and an enabling socio-cultural, legal, economic and political environment.

The important roles that community actors can and should play in achieving better health outcomes are emphasised, highlighting the unique advantages of community organisations and networks in their ability to deliver of services within communities and with regard to their ability to affect the broader determinants of health that often outweigh any impacts intended through improving health service access and use.[16] [17] These determinants affect people's mental and physical health and wellbeing 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 behaviour and coping skills; 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 realise people's rights and enable them to reach important goals for their health and well-being.[18]

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[14] *The World Health Report* 2008: *Primary Health Care Now More Than Ever* http://www.who.int/whr/2008/en/index.html

[15] *Partnership work: the health-service community interface for the prevention, care and treatment of HIV/AIDS;* WHO 2002 http://www.who.int/hiv/pub/prev_care/en/37564_OMS_interieur.pdf

[16] *The Determinants of Health* http://www.who.int/hia/evidence/doh/en/index.html

[17] *Ottawa Charter for Health Promotion; First International Conference on Health Promotion* WHO 1986 http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

[18] *Increasing Civil Society Impact on the Global Fund to Fight AIDS, Tuberculosis and Malaria Strategic Options and Deliberations*; Brook K Baker, ICASO 2007 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 affecting the social determinants of health

2. **Community networks, linkages, partnerships and coordination** enabling effective activities, service delivery and advocacy, maximising resources and impacts, and coordinated, collaborative working;

3. **Resources and capacity building** – including *human resources* with appropriate personal, technical & organisational 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;

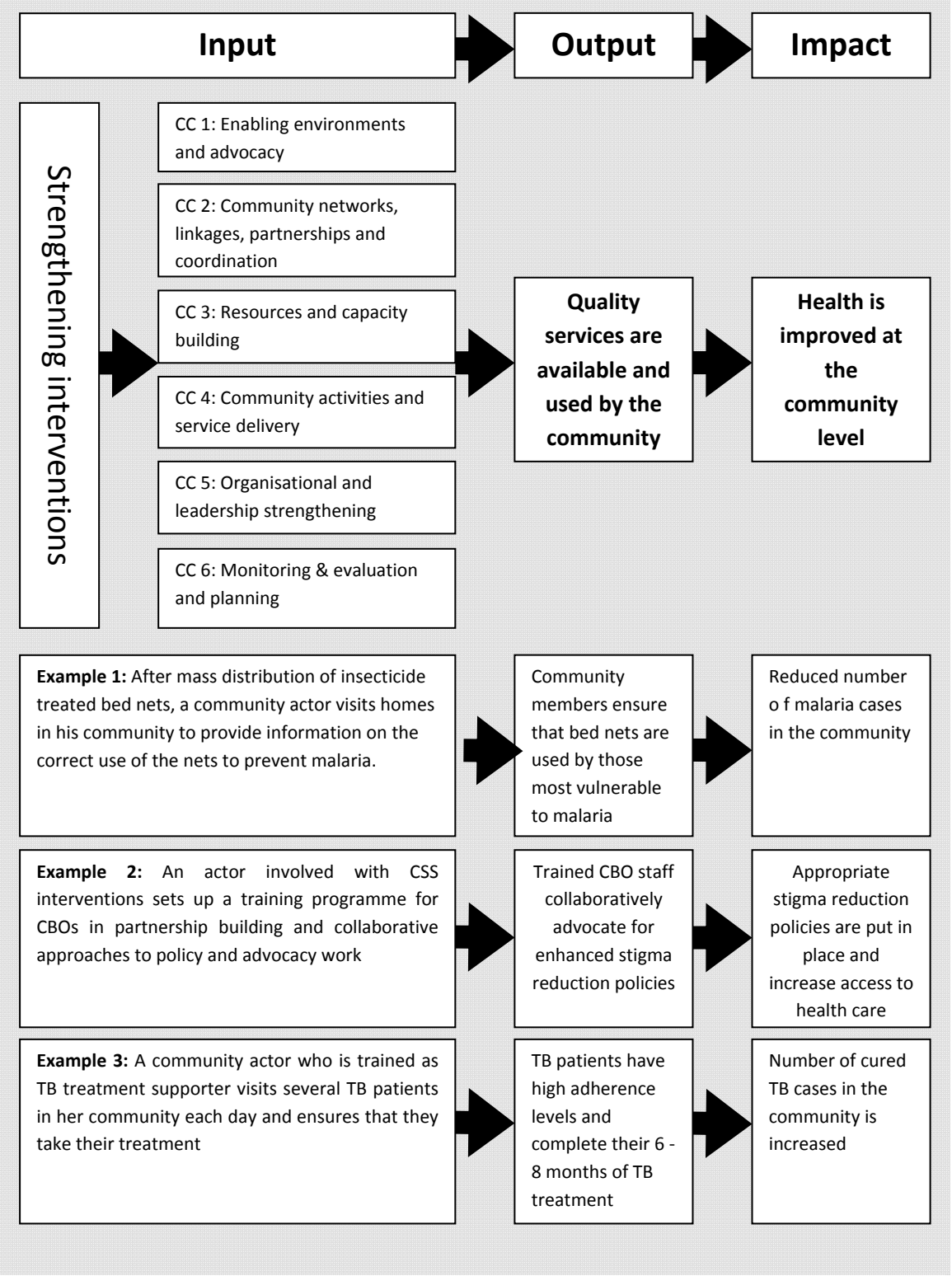
5. **Organisational and leadership strengthening** including management, accountability and leadership for organisations and community systems;

6. **Monitoring & 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 wellbeing,
- respect for people's health and other rights,
- social and financial risk protection, and
- 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 organisationss and key stakeholders. Effective and functional community systems are crucial for this, from both organisational and operational perspectives. Strengthening of community systems should be based on a capacity-building approach and backed up with adequate and appropriate financial and technical support.

Small community organisations and actors should find the Framework helpful for: planning their work; mobilising 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 organisations have faced particular difficulty in gaining funding for core organisational costs, advocacy and campaigns, addressing policy and legal barriers to evidence-informed programmeming and service delivery.

Larger community actors, such as networks of people affected by key diseases or NGOs, 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 organisations that need to adapt the Framework to local needs and mobilise funding and technical support. In the past, it has been difficult for community actors to explain clearly 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 non-health 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 meaningful inclusion of community actors at national level can contribute to a more balanced mix of interventions through health systems and community systems in order to maximise the use of resources, minimise duplication of effort and effectively improve health outcomes.

Partner organisations 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 organisations and why, and ensuring the full contribution of these organisations to national and global health priorities. The Framework will be of particular interest to organisations and stakeholders such as:

- networks and organisations of or for people with or affected by key diseases;
- international, regional and national civil society organisations and networks involved in advocacy and monitoring or “watchdog” activities;
- national funding mechanisms (such as GF Country Coordinating Mechanisms);
- bilateral and multilateral organisations and donors;
- technical partners including UNAIDS and co-sponsors, and private sector or non-governmental 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 organisations 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 systems strengthening (CSS) is therefore an *approach* that promotes the development of informed, capable and coordinated communities and community based organisations, 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 community level, including an enabling and responsive environment in which these contributions can be effective.

*Key underlying principles* of community systems strengthening include:

- ✓ Significant and equitable role in all aspects of programme planning, design, implementation and monitoring for community based organisations and key affected populations and communities, in collaboration with other actors;
- ✓ Programmeming based on human rights, including the right to health and non-discrimination;
- ✓ Programmeming informed by evidence and responsive to community experience and knowledge;
- ✓ Commitment to increasing accessibility, uptake and effective use of services to improve 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 which 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 organisations and networks, including organisationsal overheads and staff salaries and stipends, as well as targeted funding for implementation of programmes and interventions;
- Capacity building for staff of community based organisations 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 generation of research-based and experiential evidence for results-based programmeming.
- Sustainability of financial and other resources for community interventions implemented by community based organisations and networks.

## WHAT NEEDS STRENGTHENING?

The strategies outlined above indicate the priority areas for strengthening for the systems used by community based organisations and other community actors. Systems for organisation and delivery of activities and

services[19] are integral to any organised programme or service, whatever the size, structure or status of the group or organisation 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 counselling, 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.

The diagram below 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 and they are therefore crucial for contributing to meaningful effects on health and/or non-health factors. Health and non-health 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 which may enable or disable effective service delivery and functioning of systems.

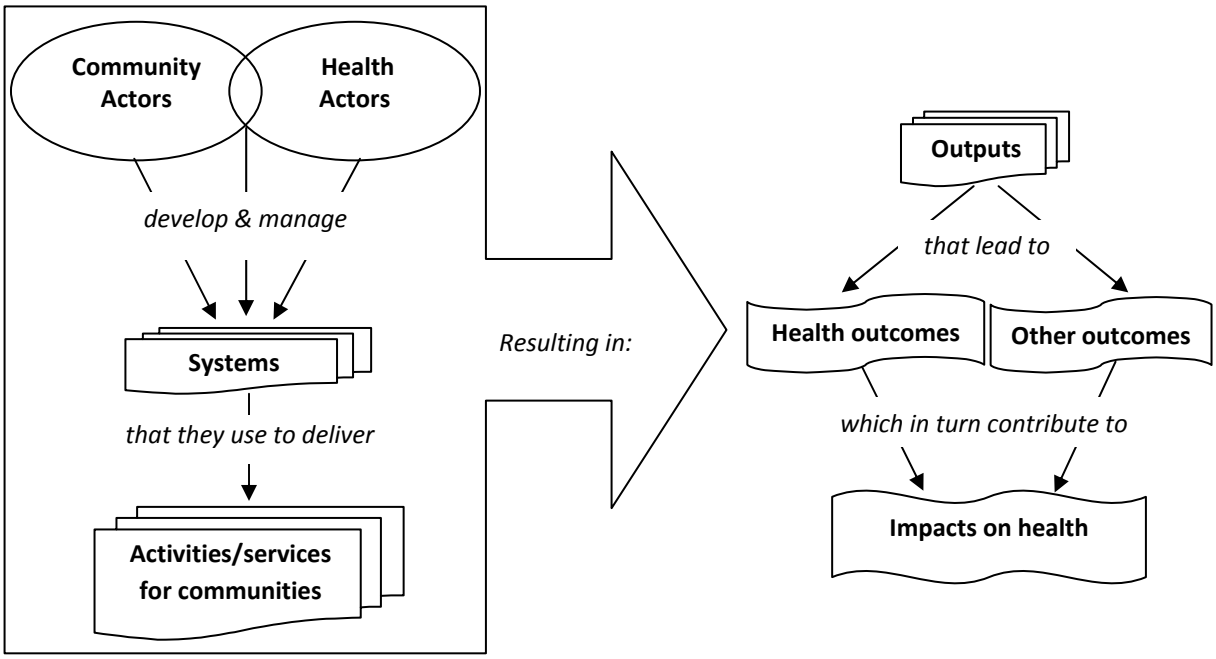



*Figure 2: Community action and results for health*

Community systems strengthening is not only 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 and also 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.

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

[19] Programmematic interventions by civil society actors are often called *activities;* in health systems, interventions are usually called *services*; the Global Fund and other agencies use the term *service delivery area* to cover the full range of programmematic activities and services – this is a key term used in this Framework.

and community organisations to be engaged and effective. The contexts of interventions to improve health are always multi-layered, and 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 organisations are rich in experience and close to communities but they are often the most poorly resourced in financial terms. CSS must therefore prioritise adequate and sustainable funding for community actors – not only project funds for specific operational activities and services but, crucially, core funding to ensure organisational stability as a platform 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 organisation to have the appropriate paid staff, supplies and infrastructure to build up their chosen programmes 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 an enabling socio-cultural environment. They muse emphasise 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 organisations, local and national governments, health, social and education systems and others – need to develop a greater understanding of the potential outcomes and impacts of community engagement, and of the ways in which interventions are best implemented by and with communities. It is also essential that civil society actors (such as faith-based and non-governmental organisations or organisations 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. This ensures that community actors play their role in reaching national health goals as well as concentrating on local needs and interventions.

By their very nature, communities are organic and diverse, and a great variety of groups and organisations – 'community actors' – arise in response to perceived community needs.[2021] At their simplest, they may lack formal structures or capacity for running administrative systems, managing funds or communicating effectively with officials and other organisations. Larger community organisations 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 marginalised or criminalised or 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 programmes.

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[20] *Exploring the concept of community: implications for NGO management;* Jo de Berry 2002, London School of Economics http://www.lse.ac.uk/collections/CCS/pdf/IWP/IWP8de-berry.PDF

[21] *Community Organizing and Community Building for Health*; Meredith Minkler (2004) Rutgers Univ. Press http://rutgerspress.rutgers.edu/acatalog/__Community_Organizing_and_Community_Building_for__664.html

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 between community organisations, and between them and government structures. Creating and maintaining good working relationships, and ensuring adequate, equitable and sustainable funding for community organisations and actors are therefore key priorities for strengthening and scaling up community systems.[22]

## WHAT HEALTH-RELATED ACTIVITIES & 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 recognise that community based and community led organisations 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 to achieve better health for all and universal access to essential care. The primary aim is to ensure the quality, reach and effectiveness of health programmes 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 behaviours and access to prevention commodities, and to accurate diagnosis and effective treatment. Where HIV is concerned, there are marked differences between generalised epidemics affecting many people within geographical areas, and focused epidemics affecting specific groups of people who are considered to be 'communities' due to their health or legal status and to 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 challenges to health. Communities of every kind need to be able to access services easily to address all their differing needs. Currently, there is increasing understanding of the need for integrated programmeming and delivery not just of health services but combinations of health, social, education, legal and economic support. Community based organisations 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 organisations, 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 non-government providers such as faith-based organisations (FBOs), 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 non-government health system input happens at 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 organisation or another community actor. Examples in the second category below are health-focused, but the best option for delivery

[22] *Strengthening Community Health Systems: Perceptions and responses to changing community needs*; CADRE 2007. http://www.cadre.org.za/node/197

at community level may be through functioning community systems rather than through the formal public health system.

Concentration on formal health systems and lack of clarity about the complementary and crucial role of community systems has led to conflicting opinions on where interventions in the other two categories should be placed in relation to funding and monitoring. This conflict remains to be resolved, but it is essential that such interventions should not be sidelined. Clear signals should be given to decision-makers at international and national levels that funding for CSS and community service delivery must include all categories of community-led and community based interventions. The support interventions listed in the second category are those where community actors provide added value to health system interventions – funding them under CSS may in many circumstances be a more helpful strategy in order to ensure that communities gain full benefit.

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[23],
   - Community delivered health interventions such as mobile HIV counselling & testing, treatment follow-up[24] or cross-cutting health interventions[25]
   - Disease prevention activities[26]
   - Community health services such as home-based care, TB-DOTS etc [27]
   - 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 community level:**
   - Community mobilisation 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;

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[23] *Civil Society Support and Treatment Access*; Fakoya A, Abdefadil L, Public Service Review: International Development #14, June 2009 http://www.publicservice.co.uk/article.asp?publication=International Development&id=391&content_name=Treatment access&article=12197

[24] *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*; Jaffar S, B Amuron et al (2009) Lancet http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61674-3/abstract

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

[26] *Advocacy, communication & social mobilisation (ACSM) for tuberculosis control – a handbook for country programmes*; Stop TB Partnership, 2007 http://whqlibdoc.who.int/publications/2007/9789241596183_eng.pdf

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

- Financial support for accessing services, such as cash transfers and assistance with out-of-pocket expenses for transport, food while away from home etc.

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

*Social determinants of health*

- Participation in local and national fora for policy change;
- Advocacy and campaigns;
- Community awareness on gender, sexual orientation, disability, drug dependency, child protection, harmful socio-cultural practices etc;
- Peer outreach and support;
- Services for: literacy and access to information; legal redress; individual & family social support (social transfers); welfare services; and rehabilitation;
- Educational services and support for children and youth
- Community mobilisation on stigma & discrimination, basic rights, poverty reduction, access to services, information, commodities (e.g. condoms, medicines etc);
- Oversight, monitoring and evaluation of implementation of programmes and services;

*Broader determinants of health*

- Participation in local and national fora for policy change;
- Nutrition, housing, water, sanitation and other material support to vulnerable children and adults;
- Livelihood support programmes such as microcredit or savings schemes, training schemes for unemployed adults and youth and for growing food to support 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 for access to and effective use of those services. In addition, community systems have unique advantages in advocacy, community mobilisation, 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, organised role in advocacy, policy and decision-making and in creating and maintaining and enabling environment that supports people's health and reduces the effects on vulnerable people of poverty, discrimination, marginalisation, criminalisation or exploitation and harmful socio-cultural 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 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 is that it is difficult to define 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. Another reason is that community and home-based care, mainly provided by women and girls, is often under-valued because of gendered assumptions about separation of public and private care and about the 'non-professional' status of voluntary care 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 socio-cultural 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 and inconsistent funding for community activities or services, and for organisational strengthening of community actors. There has been similar under-funding in the area of social protection and welfare services, especially regarding people living with or affected by HIV. For example resources are needed (but hard to mobilise) to support people with 'out of pocket' expenses incurred in accessing services, to accompany sick people to hospital, to provide family-centred 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 organisations 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 non-existent in the past and need to be prioritised now, especially since funders increasingly require that all programmes and interventions be measurable and evidence-based.

Health systems are not something separated 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 used as a stimulus for creative and innovative approaches to bring community, health and social systems into closer and more complementary partnerships.[28]

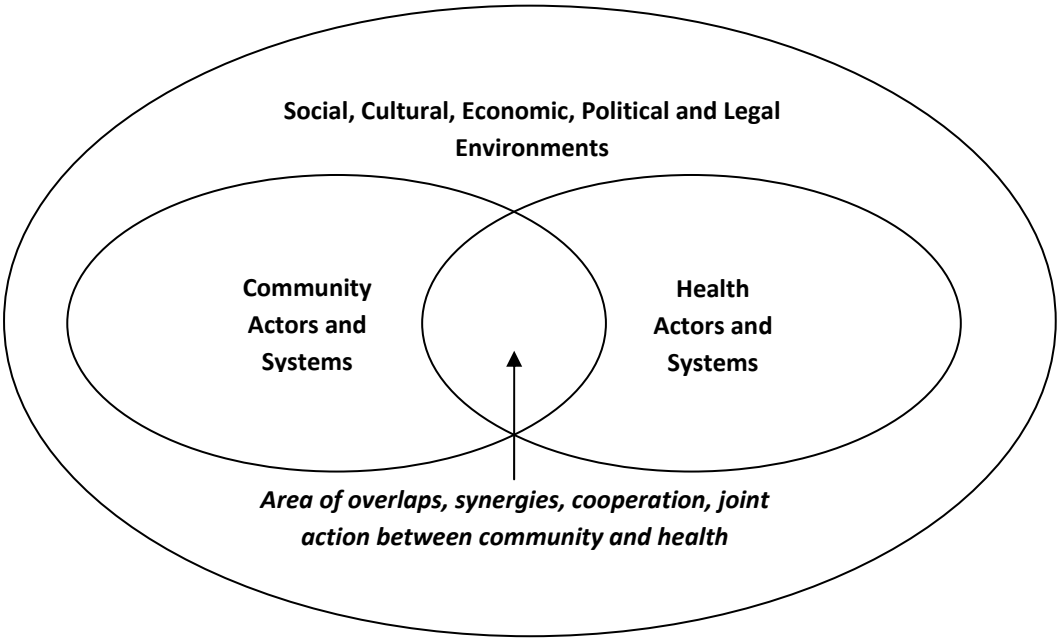


*Figure 3: Community and health actors & systems – complementary and connected*

[28] *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 Europe 2009
http://www.futuresgroup.com/wp-content/uploads/2009/11/FGE-Briefing-Paper-November-2009.pdf

# 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 in order for community systems to contribute fully and sustainably to health outcomes, both directly and indirectly.

Service delivery areas (SDAs) are suggested for each core component, with illustrative lists of activities. Chapter 4 of the Framework provides suggested indicators for each SDA suggested here. The SDAs and indicators are *not* mandatory – users of the Framework may wish to substitute other SDAs if they are more appropriate for the national or local context and plans. Detailed indicator descriptions are given in Annex 1.

The core components described below are <u>all</u> 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 development of strong links and coordination between different systems and actors working towards 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, and characteristics of strengthened Service Delivery Areas (SDAs):*

| **Core components** *(not in order of priority; <u>all</u> are essential)* | ***Service Delivery Areas*** *(not in order of priority; may be replaced with other SDAs if more appropriate to national situations)* | ***Characteristics of strengthened SDAs*** *(a set of sub-goals for CSS, indicating how a fully functional community system can be recognised when community system strengthening has been successfully achieved)* |
|---|---|---|
| 1. Enabling environment and advocacy | SDA 1: Monitoring and documentation of community and government interventions | Community based organisations analyze and document relevant issues and plan and implement involvement in policy activities at appropriate levels. |
| | SDA 2: Advocacy, communication and social mobilisation | Communities effectively advocate for implementation and improvement of national programmes. Well informed communities and affected populations engage in activities to improve their own environment. |
| 2. Community networks, linkages, partnerships and coordination | SDA 3: Building community linkages, collaboration and coordination | Functional networks, linkages and partnerships between community actors and national programmes are in place for effective coordination and decision making. |
| 3. Resources and capacity building | SDA 4: Human resources: skills building for service delivery, advocacy and leadership | Community actors have good knowledge of rights, community health, social environments and barriers to access and develop and deliver effective community based services. |

| | | |
|---|---|---|
| | SDA 5: Financial resources | Community actors have core funding secured and mobilize and manage financial resources sustainably. Financial reporting is transparent, timely and correct. |
| | SDA 6: Material resources – infrastructure, information and essential commodities (including medical and other products and technologies) | 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 | SDA 7: Community based activities and services – delivery, use, quality | Effective, safe, high quality services and interventions are equitably delivered to those in need. |
| 5. Organisational and leadership strengthening | SDA 8: Management, accountability and leadership | While ensuring accountability to all stakeholders community actors provide leadership in the development, operation and management of programmes, systems and services. |
| 6. Monitoring & evaluation and planning | SDA 9: Monitoring & evaluation, evidence-building | Relevant programmematic qualitative and quantitative data is collected, analyzed, used and shared. Appropriate mechanisms for data quality, feedback and supervision are in place. |
| | SDA 10: Strategic and operational planning | 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 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 in which community based organisations 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. For example, access to health services, education, adequate food, water and shelter, sexuality and family life, security. At the same time, people also need freedom from such things as: harassment, discrimination, violence and harmful socio-cultural practices. All of these factors can either support or hinder such things as access to services, access to funding and the ability of community organisations to function effectively. Failure to address them 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 organisations and systems. The contexts of major diseases such as HIV, tuberculosis and malaria (and many others) are always multi-factored, 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; 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 criminalised and/or marginalised.

Community monitoring and documentation are powerful tools for advocacy and policy dialogue, for example when there are rights violations or access to services is restricted. Communities and community networks have a watchdog role and are able to mobilise communities towards creating more favourable environments. They are able to work with policy-makers 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 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 community level and through coalitions, networks and civil society advocacy groups that operate in national, regional, and international fora.

**SDA 1:** MONITORING AND DOCUMENTATION OF COMMUNITY AND GOVERNMENT INTERVENTIONS

**Rationale**: Community members and organisations are uniquely positioned to effectively monitor and document the experiences of key affected people and communities, the quality and reach of services and the policies that are being implemented at community level. In order to fulfil this critical role, community based organisations and networks need to improve their capacity to collect and analyze data, including strategic choices about what data to collect, and how to target and use it effectively. Strong community-led documentation and monitoring will contribute to more efficient, responsive, and accountable structures at community and higher levels, providing feedback to government and civil society organisations and supporting greater cooperation and accountability. Monitoring and documentation will also contribute to engaging and empowering community members, who often feel they have little or no role in planning and design of programmes in which they are expected to play a role, for example in disease prevention or community health care.

**Examples of activities:**

- Developing and implementing, in collaboration with other actors, plans to increase government buy-in for dealing with public health challenges;
- Developing and implementing, in collaboration with other actors, plans to monitor implementation of public policies and services related to health and social support;
- Lobbying for better governance on decision-making, policy-making and use of resources by public institutions;
- Participation of community actors in national consultative forums;
- Advocacy on legal and policy frameworks e.g. decriminalisation of behaviours or marginalised groups; development and enforcement of child protection policies;
- Contributing community experience and perspectives to development of national strategies, including cross-sectoral and sector-wide approaches;
- Mapping communication needs and planning strategies for interventions with policy and decision makers;
- Capacity building for communication through media – radio, television, print;
- Developing communication materials for specific audiences e.g. children, women, sexual minorities etc;
- Developing relationships with key partners for resource mobilisation.

**SDA 2**: ADVOCACY, COMMUNICATION AND SOCIAL MOBILISATION

**Rationale:**

Community based organisations and networks have an important role to play in engaging with governments and other institutions at all levels (local, national, regional and global) to use well-informed dialogue and discussion to advocate for improved policies and policy implementation. In order to play this role, community based organisations and networks need support and assistance to create and implement effective communication and advocacy plans, and to develop systems for working with partners, government agencies, media, and broader constituencies. They also have a key role in communication and social mobilisation to engage communities at local level. For example, they may advocate to change discriminatory practices, policies and laws, work for social changes that support better prevention and care-seeking, and participate in public campaigns for improved quality and reach of services. Community organisations and networks are also vital for bringing together the broader community and other stakeholders to collaborate in maintaining or improving the enabling environment.

In order to play these roles, community based organisations and networks need support and assistance to create and implement effective communication and advocacy plans and to set up and implement systems to enable them to work with community members, partners, media, government and broader constituencies. Depending on local and national conditions, work on advocacy, communication and social mobilisation will depend on a range of different activities, such as direct dialogue with decision makers and influencers, community consultations and dialogues, letter-writing and petitions, use of new and traditional media and public campaigns.

**Examples of activities:**

- Mapping of challenges, barriers and rights violations experienced by key affected populations and developing policy analysis, recommendations and strategies to improve the environment;
- Mapping of existing documentation on legal and other barriers or document new ones;
- Mobilization of communities and key affected populations to engage actively with decision makers, and represent community issues in major discussion forums relating to health and rights;
- Mobilization of key affected populations and community networks to engage in campaigns and solidarity movements;
- Informing and empowering community members to communicate and advocate for change and improving enabling environments at local level;
- Policy dialogues and advocacy to ensure that issues of key affected populations are reflected in allocation of resources and in national proposals to TGF and other donors, and National Strategic Plans;
- Documentation of key community level challenges and barriers and development of advocacy messages and campaigns to communicate concerns of affected populations;
- Promote and ensure community representation in policy, planning and other decision making bodies;
- Actively engaging in policy dialogue and advocacy with global, regional, sub-regional and national NGOs, major international partners such as TGF, UNAIDS, Stop-TB, Roll Back Malaria and other forums such as high level meetings (HLM) relating to MDGs and UNGASS.

## CORE COMPONENT 2: COMMUNITY NETWORKS, LINKAGES, PARTNERSHIPS & 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, maximising the use of resources and avoiding unnecessary duplication and competition.[29]

A *network* is a system for connecting people with common interests. A *linkage* is a connection that helps to connect a person or organisation to others. A *partnership* is a more formal agreed relationship between people or organisations 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 mobilisation. Some community based networks are formally organised, for example networks of people living with HIV advocating for better access to legal support, or village health committees mobilising support for better malaria diagnostic equipment at local level. However, informal networks also have important roles at 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 behaviours.

Strong national and regional networks of key affected populations and civil society groups can make important contributions to the accountability of government and non-government bodies and organisations and to supporting 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 development of communities of practice, and 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 towards effective implementation of service delivery and contributing towards 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 between countries with similar cultural backgrounds and needs. This leads to significant added value as experience is shared more broadly and duplication of effort is prevented. Partnerships between organisations with shared objectives can develop joint approaches to community-led service delivery and provide each other with operational support. For example they may work together on financial and other resource mobilisation, shared planning and delivery of activities and services, shared use of community based facilities or shared procurement of health and other commodities.

**SDA3:** BUILDING COMMUNITY LINKAGES, COLLABORATION AND COORDINATION

**Rationale**: Funding and support is required to build and sustain functioning networks, linkages and partnerships, improve coordination and decision-making, enhance impacts and avoid duplication of activities and services. Where local or national community and key affected population networks are weak or lack key capacities, regional networks can play a significant role in assisting with consultation and accountability of government and non-government actors

[29] *National Partnership Platforms on HIV and TB: A toolkit to strengthen civil society information, dialogue and advocacy*; HDN/IHAA/SAfAIDS/AIDS Portal, December 2009
http://aidsalliance.photolinknewmedia.com/Publicationsdetails.aspx?Id=430

**Examples of activities:**

- Develop and maintain coordination mechanisms and agreements or contractual arrangements to enable community actors, CBOs and NGOs to collaborate and work together;
- Develop and maintain coordination mechanisms agreements or contractual arrangements with partners and stakeholders at local, national, regional and international levels;
- Develop communication platforms to share community knowledge and experiences and support networks;
- Develop national partnership platforms and national level advocacy coordination mechanisms;
- Networking and partnership development between community and other actors, for access to services, particularly for the most affected population groups;
- Sharing of knowledge and development of plans to involve community members and other stakeholders to play roles in design, implementation and oversight of programmes or activities;
- Empowerment of community actors, particularly CBOS and small organisations, to participate effectively in networking and partnerships for service delivery at local level;
- Development of community actor linkages to local, national regional and international coordination bodies;
- Operational support for implementation of coordination activities, such as travel, per diem, communication and overhead costs;
- Development of community actor linkages and collaboration in local and national coordination bodies;
- Create community based networks for malaria, TB or other disease initiatives;
- Create networking structures with local authorities such as councils, district committees etc;
- Contribute to improved "knowledge management" by supporting sharing of information, tools, good practices etc within communities.

## 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 organisational capacities; and
- material resources, including adequate finance, infrastructure, information and essential commodities.

These resources are essential for running systems and organisations, and for delivering activities and services. Human resources are of course the key to any intervention at community level or by community based organisations 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 programmes and interventions. For example: community knowledge and experience contributions 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 organisational costs and for capacity building are also vital for community actors in order to enable them to provide sustainable and effective responses, as well as funding for implementation of programmes and interventions. It is essential also to include funding for infrastructure items and services, information systems, and systems for sourcing and managing essential.

### 3.1 HUMAN RESOURCES: SKILLS BUILDING FOR SERVICE DELIVERY, ADVOCACY AND LEADERSHIP

Development of human capacity is important for community leadership and progress towards community health goals. People are the central resource for community organisations 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, enable

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 organisational strengthening and leadership for advocacy, but it is also essential to ensure that technical skills and experience are given high priority in order to assure programme quality, achieve timely progress towards 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 prioritised in order to reach the Millennium Development Goals (MDGs), for example in TB/HIV integration, sexual & reproductive health and primary care in communities.

**SDA 4**: SKILLS BUILDING FOR SERVICE DELIVERY, ADVOCACY & LEADERSHIP

**Rationale:** Skills-building for service delivery includes organisational skills and management to ensure timely and efficient operational support for services. Technical capacity of community actors needs to be built so that they can develop and deliver effective community based services and can ensure that communities are well-informed and supported for access to services, referrals, follow-up, adherence etc. This also needs to be backed up with technical skills for documenting experiences and engaging in community research methodologies to determine what works best for communities. Individuals with capacity for leadership will also need to gain skills such as negotiation, multi-stakeholder working and public speaking. Community actors also need to have appropriate understanding of human rights, especially for key affected populations. Capacity building will be needed to ensure that they understand community health, social and other challenges and that they are able to understand and make effective use of interventions designed to improve people's health knowledge and behaviours and their access to and use of services.

**Examples of activities:**

- Technical capacity building for health support roles - treatment adherence, peer counselling, HIV counselling and testing, DOTS, malaria prevention, newborn & child health, nutrition etc;
- Development and implementation of referral and support networks and systems;
- Planning for continuous improvement of quality services through mentoring, updating of skills and information and regular reviews of service availability, use and quality;
- Training in special technical areas such as child protection, social protection, working with criminalised or marginalised communities, providing integrated TB/HIV services, drug resistance, community audits such as 'verbal autopsy' of reasons for deaths etc;
- Documentation and dissemination of good practice examples;
- Building new technical capacities to enhance the delivery of integrated services such as TB/HIV, SRH, comprehensive PMTCT, maternal and child health and protection;
- Capacity building on appropriate research methods e.g. operational research methodologies;
- Capacity and skills building to enable personnel to work effectively, safely and ethically;
- Mentorship for providing quality technical support;
- Development of linkages and programmes for training and supervisory support by regional networks or national bodies;
- Planning for continuing skills development and review, for example: seminars and meetings; access to up-to-date information; professional and mentoring support; strengthening professional networks e.g. for counsellors, TB outreach workers, malaria prevention educators;
- Development of communication, participation and leadership skills for working with communities and individuals and implementing local advocacy initiatives;
- Capacity building on use of new and traditional communication technologies for advocacy and service delivery (e.g. adherence support, follow-up);
- Training of trainers on challenging stigma, discrimination and harmful socio-cultural practices;
- Advocacy on legal and policy frameworks e.g. decriminalisation of behaviours or marginalised groups; development and enforcement of child protection policies;

- Training for community actors and stakeholders in partnership building and collaborative approaches to policy and advocacy work;
- Leadership training for policy and advocacy roles and community representation at national levels;
- Increasing community actor knowledge of policy issues and broader social, cultural, political and economic determinants of health;
- Developing documentation, reporting and dissemination skills.

## 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, crucially, core funding to ensure organisational 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 the financial management skills.[30] Community organisations are most often unsuccessful in mobilising core funding that is 'unrestricted' – that is, not tied to a specific project or intervention and aimed at support for an organisation'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 organisations to have the appropriate paid staff, supplies and infrastructure to build up their programmes in response to the needs of the communities they serve.

Organisations 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 organisations 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 organisations to deal with this without being distracted from programmematic work by increased administrative demands. Good management of finances is essential for organisational support and service delivery, and it is also an essential for demonstrating good stewardship of funding from donors, governments and communities, which is important for sustainability and mobilising further resources.[31]

**SDA 5**: FINANCIAL RESOURCES

**Rationale**: This SDA concerns support for better mobilisation, management and effectiveness of financial resources. This support is required in order to enable actors to plan for and achieve predictability of financial resources for start-up, implementation, scale-up and longer-term sustainability of community interventions, and work successfully towards improved outcomes and impacts. It includes identifying and leveraging existing sources of finance (and staffing) but without engaging in undue competition with other actors.

**Examples of activities:**

- Assessing the level of funding required for CSS and service delivery;
- Advocacy for CSS funding from governments and donors;

[30] *Funding for civil society responses to HIV/AIDS in Tanzania: Status, problems, possibilities*; CADRE May 2008 http://www.cadre.org.za/node/192

[31] *Models for Funding and Coordinating Community-Level Responses to HIV/AIDS*; CADRE 2007 http://www.cadre.org.za/node/198

- Hiring, training, supervision and mentoring of resource mobilisation staff;
- Planning for funding based on organisationsal development and programmematic needs identified by members and supporters;
- Proposal writing, accounting for and planning activities;
- Capacity building for financial management, book-keeping, accounting, reporting, use of bank accounts, acquisition and use of accounting software etc;
- Capacity building on oversight of resources and budgets, design and implementation of internal accountability systems;
- Hiring external auditors to support accountability to communities and funders;
- Capacity building on resource mobilisation, including leveraging existing resources without creating competition across various projects or geographical areas and the role of policies and processes relating to global health initiatives (GHIs);
- Development and management of small grant schemes for communities, including core support such as social transfers for vulnerable people, social welfare services, child protection and health-related income generating activities;
- Development and management of schemes for remunerating community outreach workers and volunteers or providing other incentives and income-generation support.

### 3.3 Material resources – infrastructure, information and essential commodities

Many organisations lack capacity in dealing with material resources infrastructure, information, and essential commodities (including medical and other products and technologies). They require funding and technical support in order to develop and operate reliable and sustainable systems for these, 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 & 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 organisational information systems – accounting, management etc, 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 & supplies; communication materials; utilities & building maintenance; fuel for transport; medical products and technologies for prevention, treatment and care (condoms, bed nets, medicines, lab equipment etc.), safety equipment (universal precautions) for community health workers, home care workers, teachers etc.

**SDA 6**: MATERIAL RESOURCES – INFRASTRUCTURE, INFORMATION AND ESSENTIAL COMMODITIES (INCLUDING MEDICAL AND OTHER PRODUCTS AND TECHNOLOGIES).

**Rationale:** This SDA focuses on capacities by all actors for: forecasting, quantification, sourcing, management and appropriate use of materials. Materials include all necessary organisational infrastructure items and supplies, and any items needed for operational activities and service delivery, including transport and office essentials, for example. Essential commodities range from simple stationery items such as notepads and pencils through campaign and information materials to medicines, dressings, bed nets and condoms. Some actors and interventions may have limited needs for material resources and will only need very simple systems for dealing with them. More developed systems will be needed if large quantities and expenditures are involved and there will need to be greater attention to management, maintenance and security of such supplies. However, the basic principles of managing material resources are the same, whatever the size of the system.[32]

**Examples of activities:**

- Development and management of systems for calculating needs and monitoring usage of material resources;
- Selection of appropriate methodologies for replenishing supplies according to size of organisation and programmematic context;
- Physical infrastructure development, including obtaining and retaining office space and equipment, improving communications technology, provision and maintenance of transport;
- Training in skills, good practice and quality standards for sourcing, procurement and supply of consumables (especially medicines and health goods);
- Training in skills, good practice and standards for ensuring good quality of infrastructure materials and essential commodities, including supplier selection, storage & distribution, preventive maintenance of buildings, computers, office equipment and transport;
- Planning, management systems and provision of essential medical and other supplies for service delivery such as medicines, lab reagents, syringes, needles, condoms and other consumables, X-ray machines, microscopes etc;
- Developing and implementing systems to routinely record community experiences and disseminate good practices and lessons learned;
- Developing appropriate community-level information and knowledge management systems;
- Establishing information centres and online information access systems;
- Packaging of information and lessons learned to disseminate as evidence of good practices;
- Training and mentoring in information management (paper-based or computer-based);
- Training and mentoring in use of information and communication technologies.

[32] PSM (procurement & supply management) resources are accessible at: http://www.psmtoolbox.org/en/

*Handbook of supply management at first level health care facilities* http://www.who.int/hiv/amds/HandbookFeb2007.pdf

*Managing TB medicines at the primary level* http://erc.msh.org/toolkit/toolkitfiles/file/TB-Primary-Level-Guide-April-2008_final-English.pdf

*Guidelines for the storage of essential medicines and other health commodities* http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/GuidStorEsse_Pock.pdf

## CORE COMPONENT 4: COMMUNITY ACTIVITIES AND SERVICES

Community activities and services are essential for achieving improved health outcomes and 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 community level. Quality community programmes, activities and services that are evidence-informed and cost efficient will build on existing systems and services and contribute to creation of demand for services, social behaviour change, increased health and reduced disease transmission in the community. Community based organisations 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 marginalised people who are criminalized and/or stigmatized and who therefore often avoid state services. This brings greater credibility and relevance to community service delivery systems and adds strength to leadership and advocacy. It is therefore 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 ability to utilise 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.[33]

There are many interventions, particularly support activities for community members accessing health-related services at 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 programmes are moving towards integrated delivery of services - the same person on the same day may deliver both health and non-health 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.

[33] *Strengthening Community Health Systems: Perceptions and responses to changing community needs*; CADRE 2007. http://www.cadre.org.za/node/197

**SDA 7**: SERVICE AVAILABILITY, USE AND QUALITY

**Rationale:** Well planned and implemented community based services can deliver effective, safe, high quality and accessible interventions on an equitable basis to those who need them, for example prevention, care and treatment of HIV, TB and malaria. They will also deliver interventions aimed at mitigating the effects of diseases on individuals and communities, including care and support of children and other vulnerable people, such as people who use drugs, pregnant women and prisoners. Access, equity and quality, along with rights-based programmeming and harm reduction, are key concepts in the delivery of community based services. It must be ensured that national guidelines for key community activities and services are developed in order to ensure that minimum standards for quality are met, while also recognizing that not all community activities will be included in a set of national standards. Community systems therefore need to be strengthened not only to plan and provide services but also to implement and develop standards and protocols, provide supportive supervision, and ensure continuous quality improvement. Functional and efficient systems are therefore vital for delivery of these community based interventions including and community actors will need appropriate support and technical assistance to identify what systems are in place or needed in order to fill gaps, and to develop systems that maximise use of resources and deliver quality services to target populations. They will also need to develop the technical capacity to implement existing national or other standards and to adapt them or develop new standards where new approaches and activities are being implemented. Systems for supportive mentoring and supervision will also be needed in order to ensure continuing quality in service delivery.

**Examples of activities:**

- Mapping of community health and social support services and their accessibility to end users;
- Identification, ensuring availability and implementation of national or other relevant guidelines for delivering quality services;
- Identification of services and activities where good practice standards are not available or need to be adapted, and developing strategies to address such gaps in ways appropriate to community service delivery and systems;
- Mapping of available knowledge and analysing information sources, flows of information and gaps that need to be addressed to improve decision-making and implementations at national, local and community levels;
- Developing and using knowledge management systems, including information centres, in order to share experience and good practice and inform planning and implementation of quality service delivery;
- Identification of populations most at risk and most in need of services;
- Identification of obstacles to accessing and using available services;
- Participatory development and implementation of referral systems to ensure access to and use of services, and re-referral to community systems for ongoing support;
- Planning for community based service delivery based on mapping and analysis of needs and gaps;
- Planning for continuous improvement of quality services through mentoring, updating of skills and information and regular reviews of service availability, use and quality;
- Development of integrated service delivery systems to address the range of health, social and related needs in communities, for example: comprehensive home-based care systems, counselling and psychological support systems, including peer-led counselling and self support groups; social, family and economic support systems; systems to provide support to individuals for service use and follow-up, including accompaniment, translation, locating and accessing further services;
- Development of community support centres providing a range of services such as information, testing & counselling, referrals, peer support, outreach to key affected people and communities, legal support etc;
- Development of systems to create demand for improved access to and use of health, social welfare, legal and other services and advancing the health and other rights of key affected populations, including community treatment and health literacy campaigns and community education to prevent stigma and discrimination;
- Development of peer education and community outreach programmes to support key populations at risk, especially excluded and vulnerable populations.

## CORE COMPONENT 5: ORGANISATIONAL AND LEADERSHIP STRENGTHENING

Organisational strengthening is a key area, aiming to build the capacity of community-actors to operate and manage the core processes that support their activities - developing and managing programmes, systems and services effectively; ensuring accountability to their communities, stakeholders and partners; and providing leadership for improving the enabling environment in order to achieve better health outcomes. Key knowledge and skills in this area would include, for example, leadership in representing the vision and goals of the organisation 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 organisations at community level, such as those of 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 organisational 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 in existence, or there may be several strong networks, CBOs or NGOs working in the same field, and they may need support to work together to avoid duplication of activities and promote joint planning and decision making.

Accountability is an important aspect of strengthening organisations, assuring communities, stakeholders and partners that there is good stewardship of the organisations's resources. Mechanisms for independent oversight and guidance may be needed to demonstrate this, for example: 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 organisations 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.

**SDA 8**: MANAGEMENT, ACCOUNTABILITY AND LEADERSHIP

**Rationale**: Resources and technical support may be needed to build the capacity of organisations to support delivery of the proposed range and quality of activities and services. This includes capacity for long term strategic planning, management, sustainability, scaling-up and responding to change through development of organisationsal systems and the capacity for strategic planning, monitoring and evaluation, and information management.

**Examples of activities:**

- Organisational capacity assessment;
- Organisationsal/management support and training for small and new NGOs/CBOs;
- Developing capacity for negotiating and entering into agreements and contractual arrangements such as memoranda of understanding, terms of reference, supply contracts etc;
- Developing capacity and plans for human resource recruitment including for technical support systems and organisational needs;
- Development of plans for managing and building capacity of human resources, including job descriptions, career development plans, staff handbooks etc. in order to support and retain staff and volunteers;
- Development of key skills, for example: writing official reports, letters, proposals etc;
- Systems for training, mentoring and experience sharing for leadership, organisationsal development, management and accountability;
- Regularisation of legal status (when appropriate) and authority to enter into agreements (for example, opening bank accounts, building leases, purchasing property);

- Increasing transparency and accountability through 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;
- Training and ongoing mentoring and supervision for programme and information management;
- Developing capacity for project design and strategic planning, project cycle management;
- Support in making business plans to become self-sustainable (management training);
- Recruitment, management & remuneration of staff, community workers and volunteers;
- Newsletters for internal circulation to keep staff informed; creating shared vision;
- Communication of shared vision among the organisations and sustaining motivation;
- Strengthening community leadership, including shared leadership;
- Capacity building systems.

## CORE COMPONENT 6: MONITORING & 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 programmes, 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 organisations and community members to use M&E results for reflection and further planning and action.[3435]

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 labour, leisure patterns and sleeping arrangements. This also affects treatment-seeking behaviours and household decision-making, resource allocation and financial authority.[36]

The first steps for building or strengthening community systems are also essential for building a meaningful M&E system: 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 analysing 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?" and "how do we know?"[37]

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[34] *The 'Most Significant Change' (MSC) Technique – a guide to its use*; R Davies & J Dart 2005 http://www.mande.co.uk/docs/MSCGuide.pdf

[35] *Self-Assessment tools on HIV, malaria and other community issues*; The Constellation 2008 http://www.communitylifecompetence.org/en/94-resources

[36] *Gender, Health and Malaria;* WHO & RBM June 2007; http://www.rollbackmalaria.org/globaladvocacy/docs/WHOinfosheet.pdf

[37] *"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

For example, a focus group discussion among injecting drug users might reveal that a needle exchange service would have more impact by distributing syringes of a 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, analysing, understanding and communicating key information throughout the life of an intervention or programme. The plan should cover the wide range 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 should 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 national level contributes to national data and is also incorporated into the local system without creating extra burdens 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 community level so that they can respond effectively to political, social and economic challenges and address behaviours, rights violations and other factors that drive the need for improvements in health and social care and the surrounding environments. It will also provide community members with access to news, information on good practices, information on available tools and technical assistance opportunities, information about policy and opportunities to engage in policy dialogue and network with each other. It

**SDA 9**: MONITORING & EVALUATION, EVIDENCE-BUILDING

**Rationale:** Community organisations often have limited human and material resources for building and operating M&E systems. They lack training in M&E, and can be seriously overburdened because of multiple reporting requirements, high staff turnover, unreliable electricity and limited infrastructure such as computers or other equipment. Much work also needs to be done, in terms of supervision and planned training, to put in place effective systems to strengthen M&E capacity at the community level. For example, an important step would be to increase support from the national level for systematic involvement of CSOs in national strategies. Currently many community organisations are registered with departments other than health, which makes integration into health M&E difficult. Much work remains to be done to ensure that all actors work together in integrated national disease programmes.

Larger organisations may already be familiar with M&E processes but lack sufficient capacity; smaller groups and organisations may be unfamiliar with them and will need ongoing support to develop and implement M&E successfully.[38] Existing actors, systems and resources need to be clearly identified in order to correctly plan and target interventions, aiming at 'added value' and avoiding unnecessary duplication of efforts and activities.

[38] There are many guides to M&E and Project Management; a highly developed guide can be found at http://gametlibrary.worldbank.org/pages/25_Introduction_Background_English.asp ;
- a simple guide aimed at smaller community actors and CSOs can be found at http://www.coreinitiative.org/Resources/Publications/ProjectCycleManagementToolkit.pdf

This will include having up to date information on what works for specific populations and communities in order to make new interventions as evidence-informed as possible.

Where formal evidence for interventions is lacking, it will be important to include research within implementation plans, for example operations research, in order to strengthen the evidence base. Community knowledge management contributes to evidence building and access to key information. It enables the sharing of community knowledge both within communities and with a wider range of stakeholders. It contributes to translating knowledge into policy and action, to sharing and applying knowledge based on experience both at local level and with policy and programme decision makers at national, regional and international levels. Community organisations will need funding for knowledge management activities such as the development of communication platforms; gathering, collating and disseminating good practices and useful tools; making use of opportunities to promote networking and the development of "communities of good practice."

**Examples of activities:**

- Recruitment of M&E staff / ensuring staff capacity to implement M&E activities;
- Orientation of community groups, stakeholders and staff at start of programme to ensure their buy-in and participation in situation analysis;
- Capacity building in analysis of community situations, sources of vulnerability, resources, strategic partners, gaps and obstacles to accessing and using available services;
- Capacity building on rights, participation and protection for working with children and other vulnerable adults and youth, for example in performing situation analysis, collecting qualitative data on outcomes, documentating experiences etc;
- Community monitoring and evaluation of service quality, including linkage and referral systems, and clinical services;[39]
- Training, mentoring and supervision for monitoring and evaluation, including development and use of simple to use standardized records & registers for essential data;
- Developing capacity for design and implementation of data collection, service user interviews, desktop reviews;
- Developing capacity for analysing data, and identifying and documenting key information and lessons learned;
- Training in analysis and use of available data such as surveys of key affected populations;
- Use of participatory research methodologies such as action research, operational research, use of focus groups, interviews etc;
- Exchange visits and peer-to-peer learning and support on community M&E.

[39] See for example: *Operations Manual for Delivery of HIV Prevention, Care and Treatment at Primary Health Centres in High-Prevalence, Resource-Constrained Settings* – especially Chapters 4 & 6; WHO IMAI Team Dec 2008; http://www.who.int/hiv/pub/imai/operations_manual/en/

**SDA 10**: STRATEGIC AND OPERATIONAL PLANNING

**Rationale:** Assessment of needs and analysis of gaps and available resources at community-level are essential first steps for community actors. Community needs and resources vary between communities and among key affected populations, for example drug users, sex workers, older people. Existing information sources need to be researched in order to link community assessment findings with national plans and strategies, with available guidance for interventions and with research that provides supporting evidence for addressing the needs and gaps that are found to exist.

Strategic planning helps to clarify what is to be done, why it is being done, what are the goals and what key activities and resources will be required to achieve the goals. An operational plan or work-plan is important for community planning, is based on a strategic plan and provides specific details, timelines and budgets for implementation of activities and programmes. Clearly, these planning processes depend on having available sufficient and accurate information about the community to be served, the national and local contexts in which will interventions will happen, the resources available and so on. Effective planning should always be based on prior analysis and information gathering.

Small groups and organisations may use a simplified approach for strategic planning, but the steps required are very similar whatever the size of organisation. Firstly, it is important to decide how the process will work – who will be involved, how decisions will be made, and what timescale to follow in order to finalise the plan. Then there needs to be consensus on what is important to the organisation and what it wants to achieve for the community - its values and community vision – for example, 'equality for women and girls' or 'a community in which no-one dies of malaria'. This consensus will enable the group or organisation to define its mission – the contribution it aims to make to the community – and specific goals and targets to achieve this. It will then possible to start analysing and costing resources and plan a timescale for implementation.

Evidence-based operational plans for implementation, based on the strategic plan, will include activities and budgets for defined periods, for example twelve or six months at a time. Other plans should also be developed from an early stage to support the organisation and programme implementation, for example plans for management and human resources, monitoring & evaluation, operations research and documentation of good practice, resource mobilisation, procurement and supply management, strategic communications, technical assistance and capacity building.

**Examples of activities:**

- Assessment of service gaps;
- Assessment of what personnel will be needed for interventions, what attributes, capacities and skills they need to have, and what resources will be needed to support them;
- Mapping of health and social support actors and services, service providers and networks and understanding their roles in the target community;
- Review and sharing of national plans, strategies and policies relevant to proposed activities and communities;
- Developing community-level M&E and operational plans, including reporting systems, regular supervision, mentoring and feedback to community actors and stakeholders;
- Capacity building on participating in and understanding research affecting communities, and putting relevant research findings into practice;
- Identification and development of plans for capacity building and technical assistance;
- Development of organisational and technical capacity building plans;
- Development of plans for regular reporting and communication to government, stakeholders, community and partners;
- Orientation for programme staff on programme vision, objectives, plans and policies at start of programme and when new staff/volunteers commence work;

- Training and support for development of community actors' strategic and operational plans, linked to national strategies and plans.

# 4. CSS IN THE CONTEXT OF THE GLOBAL FUND

The Global Fund encourages applicants to include CSS interventions routinely in proposals wherever relevant for improving health outcomes. The proposal form and guidelines have been revised in 2010 to reflect the increased importance of CSS within proposals to the Global Fund.

In preparation for completing the proposal form, applicants will need to work closely with community organisations and actors to identify which community system 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 and thus ensure that CSS funding will be appropriately targeted.

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

Applicants may include CSS-related interventions in their disease-specific proposal or under the HSS cross-cutting section of the proposal form. The set of CSS interventions that are included in an HIV, TB or Malaria proposal should focus both on the specific disease being applied for, but should also include general community systems strengthening interventions as far as possible.

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 and overlap should be carefully avoided. This means that HIV, TB and malaria programmes need to coordinate their efforts, avoid duplication and ensure that CSS interventions for the different diseases are complementary to each other at community level. Secondly, 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 most at-risk populations);
- Reflect critically in advance of the announcement of a Global Fund Round on which of the identified gaps and constraints a proposal for funding should be developed for, 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 website of the Global Fund: www.theglobalfund.org
- 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 through organized consultations).[40]

[40] *Supporting community based responses to AIDS: A guidance tool for including Community Systems Strengthening in Global Fund proposals*; UNAIDS 2009 (new edition in preparation 2010)
http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_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 organisations such as Principal Recipients, Governmental departments or large NGOs that work with community organisations and actors. A functional system for CSS interventions addresses identified needs and demonstrates progress towards strengthening community systems. *Table 3* provides a summary of the key steps to be undertaken by CSS implementers. These steps are explained in greater detail below.

*Table 3: 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.

**Step2**: 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 SDAs where strengthening interventions are required.

**Step 5:** For each of the selected SDAs agree on the most appropriate CSS interventions.

**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 system 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 organisations for the delivery of services in a specific geographic area such as a district or a province;
- All community based organisations working with a specific population sub-group 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 organisations but to strengthen the community system as a whole. For this reason when choosing to work on a specific geographic area it is recommended to focus on all organisations in this area that are involved with service delivery for a particular disease. These organisations will together form the denominator for the CSS indicators. More information about how to define the denominator is included in chapter 6.1 of the CSS Framework.

**Step 2:** The CSS implementing organisation 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 organisations, representatives of key affected populations, national or provincial level programme managers, local government officials, M&E experts, representatives of the CCM, 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 6 core components. The outcome of the assessment should clarify the current status of community systems and would clarify what needs to be strengthened. A needs assessment could involve the dissemination and analysis of printed or electronically administered questionnaires, community consultations and in-depth mapping of partnerships and interventions. During the planning phase please keep in mind that the needs assessment should:

1. be feasible to implement
2. identify the current status of community systems (the baselines)
3. identify the key players involved in the CSS interventions (the stakeholders)
4. inform what should be achieved

To support this process an assessment tool could be used.[41] The Global Fund is currently developing such a tool in cooperation with partners; this should be available in the second half of 2010.

**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 look like. 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. Good objectives are defined in a SMART way, see *table 4*.

*Table 4: SMART objectives*

SMART objectives are:

- **S**pecific (concrete, detailed, well defined);
- **M**easureable (in terms of numbers, quantity, comparison);
- **A**chievable (feasible, actionable);
- **R**ealistic (considering resources);
- **T**ime-Bound (defined time line).

**Step 4:** Building on the objectives and the outcome of the needs assessment, determine the list of SDAs for which system strengthening measures are required. It is important to understand that the 6 core components and the 10 SDAs are all equally essential for building strong community systems. In countries were one or more of the core components or SDAs are already well functioning, the CSS implementing organisation should focus on those areas where strengthening is most required. Core components and SDAs can be strengthened step wise, e.g. in year 1 the focus can be on strengthening a particular set of SDAs while in year 2 the focus will be on a different set of SDAs.

**Step 5:** In consultation with community stakeholders and technical partners discuss the most appropriate and effective interventions for each of the selected SDAs. CSS interventions should aim at ensuring that quality services are available and used by the community, which results in improved health outcomes at the community level. Ensure that the selected interventions are based on evidence and match with the needs identified by the community. A number of example activities are including for each of the SDAs in chapter 3 of this document.

**Step 6:** When a decision has been made regarding the types of interventions, then it is necessary to work on the indicators to measure progress in CSS over time. Chapter 6.2 provides an overview of the recommended

[41] 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*; http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_en.pdf (updated version in preparation 2010)

CSS indicators for use. Chapter 6.3 contains detailed definitions for each of the indicators. It is important to understand that not all indicators listed in this document are relevant for each CSS programme.

A great variety of organisations are active at community level and there are also regional and national variations to take into account. A tailored package of well selected indicators should therfore be selected to fit with the specific country and organisational context. For this reason many of the indicators have been defined rather broadly to allow for flexibility.

For example, some of the indicators make reference to "minimum capacity to deliver services" (indicator 7.1). For this indicator, specific standards for minimum capacity will have to be defined that fit with the country context. Also the reporting frequency should be adjusted for each of the indicators to match with existing reporting cycles. In addition, the indicator definitions should be adjusted if key affected populations are targeted in concentrated epidemics. Some indicators might be more relevant for measuring CSS for larger more advanced CBOs while others are more relevant for smaller CBOs.

It is recommended to select a limited number of indicators for the CSS interventions. A CSS programme could contain around 10 to 15 indicators or if included in a disease component around 4 to 6 indicators. Furthermore, it is important to note that CSS indicators cannot be completely separated from HSS indicators. Some indicators will cover both CSS and HSS, such as indicator 6.4 "Community based organisations/facilities that maintain acceptable storage conditions and handling procedures". The indicators could be used for Global Fund supported programmes but also for other programmes.

In consultation with the identified stakeholders, reach agreement on the use of a limited number of simple to use, clearly defined and harmonized CSS indicators. Ensure consistency between the gap analysis of the community systems and the selected SDAs and indicators. Make sure that collected data is useful for programme management at the national level and ensure that quality data can be produced for each of the selected CSS indicators. Data quality needs to be embedded in all parts of the data management system and should be strengthened through:

- Publication of and adherence to M&E guidelines;
- Training & re-training of staff in M&E;
- Provision of frequent written feedback and supervision;
- Standardization of data bases;
- Use of existing data quality assurance tools and adherence to data quality assurance protocols.

**Step 7:** The next step will be to develop the budget and work plan, to define baselines and to set targets. The needs assessment conducted in step 3 should give an idea with regards to the baselines for each of the selected indicators. Now define the scale in 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. [42] Ensure that targets are achievable and that all stakeholders involved have a clear understanding of their respective roles, responsibilities and contributions. Now finalize the work plan and budget for the CSS interventions. Remember that the budget should provide detailed assumptions of estimated costs for all planned activities. The work plan should identify a clear timeline and responsible actors for the implementation of each of the planned activities.

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

**Step 8:** Information related to CSS such as leadership, advocacy, governance and accountability is often not captured by health information management systems. Other issues such as resource mobilization, partnership and staff performance at the community level are only captured to a certain extent 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 organisations, other community actors and local government authorities.

**Step 9:** It is very important that all stakeholders involved in the CSS programme have a clear idea regarding their roles and responsibilities. A good way of ensuring that everybody shares a common understanding is by developing memoranda of understanding between community based organisations involved and the CSS implementer.

**Step 10:** Appropriate reporting forms and data collection tools will need to be developed in consultation with the community based organisations and actors. Tools and forms should be easy to use and should only capture information that is useful for programme management and informed decision making. It is of key importance that the same tools and forms are used by all stakeholders involved in the CSS programme 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 on.

**Step 11:** Reach agreement on arrangements for regular supervision and feedback. The purpose of supervision and feedback is to improve the quality of programmes and to create an environment to enable staff to perform to their maximum potential. Supervision should be supportive and is not a means for 'controlling' the performance of an individual or an organisation. 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 trainings. 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**: The final step will be to set an agenda for joint programme review and evaluation. Joint programme reviews and evaluations shed light on the outcome and impact of programmes 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 at a large enough scale?

It is important that community system strengthening is integrated in the annual disease/health sector review to strengthen the link between the community and the national programme. Community based organisations and actors should be systematically involved in joint evaluations, operational research and reviews.[43]

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

# 6. INDICATORS FOR CSS

## 6.1 DEVELOPMENT OF CSS INDICATORS

This chapter contains 27 recommended indicators for CSS. These indicators have been developed in consultation with a large number of stakeholders representing key affected populations, community based organisations, governments and various bilateral and multilateral organisations. *Table 5* provides an overview of the key milestones in the CSS indicator development process.

*Table 5: CSS indicator development process:*

**August 2008:** The Global Fund commissioned a review exercise in Pretoria where a list of 13 CSS indicators was developed;

**January 2009:** UNAIDS developed a guidance tool for including Community Systems Strengthening in Global Fund proposals and included a number of recommended indicators for CSS;

**November-December 2009:** A multi-partner technical working group on CSS commissioned 9 case studies in different countries on community systems strengthening and community level monitoring & evaluation. During the field exercises a large number of CSS indicators were collected;

**February 2010:** During a harmonization workshop in Geneva, existing CSS indicators were reviewed by M&E experts representing UNAIDS, WHO, USAID, OGAC, Measure Evaluation, the International HIV/AIDS Alliance, 7 Sisters and The Global Fund and a new list was developed aligned with the core components and SDAs of the CSS Framework;

**March 2010:** An internal review and further definition of the CSS indicators was conducted by the Global Fund. Comments from the technical working group on CSS and others were integrated into this process; CSS indicators were reviewed and updated during a 2 day civil society consultation meeting in Brighton;

**April 2010:** Several rounds of e-based reviews were conducted with various stakeholders including representatives of key affected populations and community actors and organisations.

A number of selection criteria including the UNAIDS MERG indicator standards[44] have guided the CSS indicator development process. *Table 6* provides an overview of these criteria.

The list of indicators contained in this document is work in progress. CSS implementers are encouraged to make use of them but it is essential to understand that there are a number of limitations to take into consideration:

Firstly, it is important to understand that the main objective of CSS interventions is to contribute to better service delivery, resulting in improved health outcomes at the community level. For this reason it is important that both CSS indicators and community level service delivery indicators are used simultaneously. *Table 7* explains the difference between these two types of indicators. This document only contains recommended CSS

[44] UNAIDS MERG Indicator Standards: Operational Guidelines for Selecting Indicators for the HIV Response indicator, available at: http://www.globalhivmeinfo.org/AgencySites/MERG%20Resources/MERG%20Indicator%20Standards_Operational%20Guidelines.pdf

indicators but does not provide indicators to monitor service delivery at the community level. For community-level service delivery indicators, other resources should be referred to such as The Global Fund Monitoring and Evaluation Toolkit.[45]

*Table 6: Criteria for the development of CSS indicators*

**UNAIDS MERG indicator standards:**

- The indicator is **needed and useful**
- The indicator **has technical merit**
- The indicator **is fully-defined**
- It is **feasible to collect and analyze data** for this indicator
- The indicator has been **field-tested or used in practice**

**Additional criteria applied for the selection of CSS indicators:**

- The indicator allows to measure quantitative improvements over time, e.g. indicators that can only be answered with yes or no were not considered;
- The indicator is simple and easy to use by all actors of the reporting system**.**

Secondly, many of the indicators are newly developed and not all have been field tested or used in practice. For this reason the CSS indicators will be pilot tested in 2010 and further fine-tuned where necessary.

Thirdly, the indicators focus mainly on CSS inputs, processes and outputs. The outcomes and impacts of CSS interventions should be measured by disease specific indicators focusing for example on prevalence or mortality rate. This also means that the list of CSS indicators focuses more on monitoring than on evaluation. However, evaluation is an important component of M&E and actors involved with CSS are encouraged to also think about setting up an evaluation system that can be implemented when the monitoring system is in place and functioning well.

*Table 7: Community system strengthening indicators and community level service delivery indicators*

**An effective disease-specific programme collects both CSS indicators and community level service delivery indicators.** CSS indicators measure the strengths and weaknesses of community systems. Community level service delivery indicators measure the actual services delivered at the community level.

**An example of a CSS indicator is:** "Number and percentage of community based organisations that have core funding secured for at least 2 years."

**An example of a community level service delivery indicator is:** "Number of adults and children living with HIV who received care and support services outside facilities during the reporting period."

Finally, for some of the SDAs only a limited number of indicators are proposed. (e.g. SDA 1 currently only contains 1 indicator). The reason for this small number of indicators is that issues such as advocacy or enabling environments are difficult to meaningfully capture in quantitative values. For this reason the Global Fund and partners are planning to develop an index for CSS similar to the UNGASS National Composite Policy Index

[45] *Monitoring and Evaluation Toolkit HIV, Tuberculosis and Malaria and Health Systems Strengthening, 3rd edition*; The Global Fund 2009; http://www.theglobalfund.org/documents/me/M_E_Toolkit.pdf

(NCPI)[46]. This index will include a number of yes/no questions covering areas where no good indicators could be formulated.

Examples of these types of questions could be:

- Have barriers to equitable access to health services been identified?
- Are legal arrangements such as anti-discrimination laws in place for the development of an enabling environment?
- Are public campaigns organized by the community resulting in policy change?

The index will produce a score reflecting the current situation of targeted community systems. CSS implementing organisations will be encouraged to use this tool to assess the status of their community systems once every two or three years. The results of these assessments will provide a measure of CSS improvement over time.

**Before developing or using the CSS indicators please make sure that you have read the following:**

**Community based organisations:** Many of the indicators focus on community based organisations. While acknowledging the important role of community based organisations in delivering services to the community, it is also important to acknowledge that other actors contribute to this process. Examples of other organisations involved in service delivery to the community are: private sector organisations, non-governmental organisations or local government authorities. CSS interventions could focus on community based organisations but also on these other types of organisations. When working with other types of organisations, it is important to adjust the indicators to fit with these targeted organisations as well as reflect the link between these organisations and the community.

**Definition of the denominator:** Many of the indicators have "total number of targeted community based organisations or all community based organisations in a targeted area" as their denominator. It is essential to adjust this denominator to the specific CSS programme. The denominator should be determined in step 1 of the development of a system for CSS. Furthermore, it is important to strengthen community systems as a whole and not to focus only on a limited number of community actors or organisations. Examples of adjusted denominators could be:

- All community based organisations with less than 100 staff members or volunteers in district x that are involved with prevention, care or treatment services for HIV/AIDS.
- All organisations in province x supporting TB patients' adherence to treatment including CBOs, NGOs, FBOs and private sector organisations.
- All community based organisations in country x that work with orphans and vulnerable children.

**Staff/volunteers:** A large proportion of community services are delivered by volunteers. Volunteers contribute considerable added value to improving health outcomes at the community level and are for that reason systematically incorporated in all indicators focusing on staff. Community volunteers may include a range of include a range of non-health workers, including office workers, drivers, activity organisers etc. They may also include a variety of health workers such as peer educators, community health outreach workers, DOTS coordinators, village health workers, malaria village workers, home-based care providers, outreach workers, health educators, health promoters and other volunteers in accordance with the individual country's definition.

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[46] More information on the UNGASS National Composite Policy Index is in the *UNGASS Guidelines for 2010 reporting*: http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090331_UNGASS2010.asp

**Training**: Many of the indicators focus on training. Training offered to a staff member or volunteer aims at updating or adding new knowledge and skills. Training normally refers to an interactive process which lasts for multiple days. E.g. participating in a one day workshop is not considered as receiving training. When training indicators are used please ensure that specific training modalities are defined beforehand.

## 6.2 Overview of recommended CSS indicators

**Core component 1: Enabling environments and advocacy**

| SDAs | Indicators | Source |
|---|---|---|
| SDA 1: Monitoring and documentation of community and government interventions | Number and percentage of community based organisations that have been involved in joint national programme reviews or evaluations in the last 12 months (1.1) | Consultative CSS indicator development process (February-April 2010) |
| SDA 2: Advocacy, Communication and Social mobilisation | Number and percentage of community based organisations that implemented a costed communication and advocacy plan in the last 12 months (2.1) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations with a staff member or volunteer responsible for advocacy (2.2) | Consultative CSS indicator development process (February-April 2010) |

**Core component 2: Community networks, linkages, partnerships and coordination**

| | | |
|---|---|---|
| SDA 3**:** Building community linkages, collaboration and coordination | Number and percentage of community based organisations that are represented in national or provincial level technical and policy bodies of disease programmes (3.1) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations that deliver services for prevention, care or treatment and that have a functional referral and feedback system in place (3.2) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations that held at least one documented feedback meeting with the community they serve in the last 6 months (3.3) | Consultative CSS indicator development process (February-April 2010) |

**Core component 3: Resources and capacity building**

| | | |
|---|---|---|
| SDA 4: Human resources: skills building for service delivery, advocacy and leadership | Number and percentage of community health workers and volunteers currently working with community based organisations who received training or re-training in HIV, TB or malaria service delivery according to national guidelines (where such guidelines exist) in the last 12 months(4.1) | Adapted M&E Toolkit HSS-HR2 |
| | Number and percentage of staff members and volunteers currently working for community based organisations that have worked for the organisation for more than 1 year (4.2) | Adapted M&E Toolkit HSS-HR3 |
| | Number and percentage of community based organisations that received supervision and constructive feedback in accordance with national guidelines (where such guidelines exist) in the last 3/6 months (4.3) | Adapted M&E Toolkit HSS-HR7 |
| | Number and percentage of volunteers working for community based organisations that are provided with a stipend/allowance (4.4) | Adapted M&E Toolkit HSS-HR9 |
| SDA 5: Financial resources | Number and percentage of community based organisations that submit timely, complete and accurate financial reports to the nationally designated entity according to nationally recommended standards and guidelines (where such guidelines exist) (5.1) | Adapted M&E Toolkit HSS-HI7 |
| | Number and percentage of community based organisations that have core funding secured for at least 2 years (5.2) | Consultative CSS indicator development process (February-April 2010) |
| SDA 6: Material resources – infrastructure and essential commodities (including medical and other products & technologies) | Number and percentage of community based organisations reporting no stock-out of essential commodities during the reporting period (6.1) | Adapted M&E Toolkit TB1.3.1 |
| | Number and percentage of community based organisations that keep accurate data for inventory management (6.2) | Adapted M&E Toolkit HSS-HP2 |

| | | |
|---|---|---|
| | Number and percentage of community based organisations with staff or volunteers trained or re-trained in stock management in the last 12 months (6.3) | Adapted M&E Toolkit HSS-HP3 |
| | Number and percentage of community based organisations that maintain adequate storage conditions and handling procedures for essential commodities (6.4) | Adapted M&E Toolkit HSS-HP4 |

**Core component 4: Community activities and service delivery**

| | | |
|---|---|---|
| SDA 7: Community based activities and services – delivery, use and quality | Number and percentage of community based organisations with the minimum capacity to deliver services according to national guidelines (where such guidelines exist) (7.1) | Adapted M&E Toolkit HSS-SD4 |
| | Number and percentage of people that have access to community based HIV, TB or malaria services in a defined area (7.2) | Consultative CSS indicator development process (February-April 2010) |

**Core component 5: leadership and organisational strengthening**

| | | |
|---|---|---|
| SDA 8: Management, accountability and leadership | Number and percentage of community based organisations with staff or volunteers who received training or re-training in management, leadership or accountability in the last 12 months (8.1) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of staff members and volunteers of community based organisations with written terms of reference and defined job duties (8.2) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations that received technical support for institutional strengthening in the last 12 months (8.3) | Consultative CSS indicator development process (February-April 2010) |

**Core component 6: Monitoring & Evaluation and Planning**

| | | |
|---|---|---|
| SDA 9: Monitoring & evaluation, evidence-building | Number and percentage of community based organisations with a staff member or volunteer responsible for monitoring and evaluation (9.1) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations that are implementing a costed annual work plan which includes monitoring and evaluation activities (9.2) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations with at least one staff member or volunteer who received training or re-training in planning or M&E according to nationally recommended guidelines (where such guidelines exist) in the last 12 months (9.3) | Consultative CSS indicator development process (February-April 2010) |
| | Number and percentage of community based organisations using standard data collection tools and reporting formats which enable to report to the national reporting system (9.4) | Adapted M&E Toolkit HSS-HI5 |
| | Number and percentage of community based organisations conducting reviews of their own programme performance in the last 3/6 months (9.5) | Consultative CSS indicator development process (February-April 2010) |
| SDA 10: Strategic planning | Number and percentage of community based organisations with a developed strategic plan covering 3 to 5 years (10.1) | Consultative CSS indicator development process (February-April 2010) |

## 6.3 DETAILED CSS INDICATOR DEFINITIONS

**Before using the CSS indicators please make sure that you have read the following:**

Please note that most of the indicators refer to community based organisations. However it is important to understand that other organisations such as private sector organisations, NGOs, FBOs, networks of people living with HIV, pharmacies or local governments are also involved in service delivery to the community. Before using the CSS indicators please make sure that the definitions are adjusted to include all types of organisations that are included in a specific CSS programme.

Regarding the definition of the denominator, many of the indicators have "total number of targeted community based organisations or all community based organisations in a targeted area" as their denominator. It is essential to adjust this denominator so that it is aligned with the specific CSS programme for which it will be used. Section 6.1 of this chapter (above) provides more details on how to define the denominator.

**(1.1)**

Number and percentage of community based organisations that have been involved in joint national programme reviews or evaluations in the last 12 months

**Rationale**

National disease programmes undertake programme reviews and evaluations for a comprehensive appraisal of the programme. This enables them to formulate conclusions and recommendations for improving the programme implementation. There are multiple objectives, including review of the structure, policies and procedures of the national programme, delivery of services, client satisfaction, various resources, partnerships, monitoring and evaluation procedures, social mobilization, etc. Usually, appropriate national and international technical partners and stakeholders are involved in programme reviews and evaluations, which include a review of documents, field visits, interviews with staff and clients, review of facilities, etc. Joint national programme reviews and evaluations are usually performed according to an agreed protocol.

Joint national programme reviews and evaluations help to identify gaps, create opportunities for finding synergies between community and health system responses to HIV, TB and malaria and are a platform for sharing and documentation of information and experiences. Joint national programme reviews and evaluations contribute to building mutual understanding of long-term strategies, goals and objectives to effectively stop and reverse epidemic diseases.

**Definition of the indicator**

This indicator measures the participation of community based organisations in joint national programme reviews and evaluations. All organisations that contribute to reaching the objectives of the national programme should normally be involved in joint national programme reviews or evaluations. Joint national programme reviews and evaluations can be conducted nation wide but also in a specific district or province.

***Numerator:*** Total number of community based organisations targeted for CSS that report that they have been involved in at least one joint programme review or evaluation at the national or provincial level during the last 12 months.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Community based organisations are requested to report whether or not they have been involved in a joint programme review or evaluation during the last 12 months.

**Data sources:** Administrative records; evaluation reports

**Frequency:** Annually

**(2.1)**

Number and percentage of community based organisations that implemented a costed communication and advocacy plan in the last 12 months

**Rationale**

Communication and advocacy are integral parts of the work of community based organisations. A communication and advocacy plan should be developed and implemented to fight against stigma and discrimination, improve access to quality health services and effectively mobilize community responses to HIV, TB and malaria.

**Definition of the indicator**

This indicator measures in the first place the existence of a costed plan that includes communication and advocacy activities. These activities could be integrated in the general work plan, could be part of a separate communication and advocacy plan or could be integrated into another type of costed plan. Secondly, this indicator measures whether communication and advocacy activities included in the costed plan are actually being implemented.

A "costed" plan provides estimated costs for all activities included in the plan.

***Numerator:*** Total number of community based organisations targeted for CSS which demonstrate that they have implemented communication and advocacy activities included in a costed plan during the last 12 months.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Organisations targeted for CSS are requested to submit a costed plan which includes communication and advocacy activities along with records of the implementation of these activities according to the plan in the last 12 months at the time of reporting. For the calculation of the numerator, community based organisations that implemented at least one communication and advocacy activity included in their costed plan should be counted.

**Data sources:** Costed plans containing communication and advocacy activities, regular programme reporting

**Frequency:** Annually

**(2.2)**

Number and percentage of community based organisations with a staff member or volunteer responsible for advocacy

**Rationale**

Conducting successful advocacy activities requires strong evidence and documentation, but also highly skilled staff with the ability to identify effective strategies. Advocacy requires a degree of dedication and staff time allocation and should not be added to the existing workload of programme staff or volunteers.

**Definition of the indicator**

This indicator measures the number and percentage of community based organisations with a staff member or volunteer responsible for planning and implementation of advocacy activities. This staff member or volunteer can also be involved with other activities of the organisations but is responsible for all advocacy activities. Advocacy activities may include public campaigns through advertisements, public events, internet, or other forms of media. It can also include policy dialogue with government officials at various levels, community mobilization to address specific issues or concerns and other activities aimed at improving policies or social and political environments for the improvement of quality and access to HIV, TB and malaria-related health services.

***Numerator:*** Total number of community based organisations targeted for CSS that are conducting advocacy activities, with a staff member or volunteer responsible for planning and implementation of advocacy activities.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Organisations targeted for CSS are requested to submit the name of the staff member or volunteer responsible for the advocacy activities within the organisation. Written terms of reference defining the job duties of staff members or volunteers should also be provided.

**Data sources:** Administrative records, terms of reference

**Frequency:** Annually

**(3.1)**

Number and percentage of community based organisations that are represented in national or provincial level technical and policy bodies of disease programmes

**Rationale**

This indicator intends to measure participation by community based organisations in national or provincial level decision-making on technical and policy issues.

**Definition of the indicator**

This indicator includes representation in national or provincial level technical and policy bodies either by a representative of the community based organisation or by a representative of a network/association of which the community based organisation is a member. "Community representation" therefore means that at least one staff member or volunteer of the targeted organisation or one staff member or volunteer of a network/association representing the targeted organisation, is a member of a technical or policy body and participated in at least one meeting during the last 12 months as demonstrated by a copy of the attendance list of the meeting at the time of reporting.

National level technical and policy bodies may include those related to strategic planning, policy and guideline development, oversight, operational research, involvement of the private sector and others. These bodies can be directly related to HIV, TB or malaria but also to broader health issues.

***Numerator:*** Total number of community based organisations which report that they were represented in at least one meeting of a national or provincial level technical or policy body of the national disease programmes during the last 12 months at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Limitation**

This indicator measures the representation of community based organisations but will not necessarily measure the impact of their participation.

**Measurement**

Targeted community based organisations are requested to report whether or not they were directly or indirectly represented in at least one meeting of a national or provincial level technical or policy body of the national disease programmes during the last 12 months at the time of reporting. Attendance should be demonstrated by submitting the list of participant of the meeting. Community based organisations that have a representative in a technical or policy body but who did not attend any meeting in the last reporting period should not be taken into consideration for the calculation of the numerator.

**Data sources:** Administrative records, participants lists

**Frequency:** Annually

**(3.2)**

Number and percentage of community based organisations that deliver services for prevention, care or treatment and that have a functional referral and feedback system in place

**Rationale**

This indicator will measure whether community based organisations that deliver services for prevention, care or treatment do so in collaboration with other community based organisations and/or with public health care institutions through implementation of a functional referral and feedback system.

**Definition of the indicator**

Delivering services in collaboration with other community organisations and public institutions refers to services provided jointly by community based organisations and the public health care system. For example, outreach voluntary testing and counseling service could be delivered jointly, where laboratory staff from the public health institution perform rapid HIV tests and the community workers provide pre- and post test counseling. In a functional referral and feedback system, community based organisations refer clients for services to other community organisations or to public institutions and receive feedback on services provided to the clients referred by them and vice versa.

***Numerator:*** Community based organisations that deliver services for prevention care or treatment and that have a functional referral and feedback system in place.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Limitation**

This indicator does not measure the extent to which the services are provided by community based organisations and the public institutions. In some cases community based organisations will only be responsible for referring clients to another community based organisation or a public institution; in other cases they will also be involved in delivering the actual services such as counseling.

**Measurement**

Community based organisations are requested to submit evidence of the services they deliver in collaboration with other community organisations or public institutions. They should also provide evidence on the functionality of their referral and feedback system. Evidence can be provided in the form of a report and/or other supporting documentation. The data received should be cross-checked with the records from other community organisations or public institutions.

**Data sources:** Annual reports and supporting documentation from community based organisations; referral slips; patient records.

**Frequency:** Annually

**(3.3)**

Number and percentage of community based organisations that held at least one documented feedback meeting with the community they serve in the last 6 months

**Rationale**

This indicator intends to measure community linkages. Meetings are a good method of 2-way communication between community based organisations and the community itself and provide the community with an opportunity to participate and establish strong linkages.

**Definition of the indicator**

"The community" refers to all individuals that community actors and organisations aim to serve/support. This could be specific groups such as people living with HIV, TB patients, mothers with children under 5 years of age or a specific population sub-group in a defined geographic or administrative area.

***Numerator:*** Total number of community based organisations that held at least one documented feedback meeting with the community they serve in the last 6 months.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Limitation**

If participants are not selected with care, appropriate community linkages would not be established despite holding documented feedback meetings.

**Measurement**

Targeted organisations are requested to report on the total number of feedback meetings held with the community they serve in the last 6 months at the time of reporting. They should also submit written minutes of meetings. These documents should be brief and should contain a participants list, the main issues of discussion and follow-up actions.

**Data sources:** Meeting minutes

**Frequency:** Every 6 months

**(4.1)**

Number and percentage of community health workers and volunteers currently working with community based organisations who received training or re-training in HIV, TB or malaria service delivery according to national guidelines (where such guidelines exist) in the last 12 months

**Rationale**

Available data suggest a shortage of community health workers that are delivering services for HIV, TB and malaria at the community level. This shortage jeopardizes the achievement of the Millennium Development Goals related to health. Action is needed to increase the numbers of people trained, recruited and retained as community health workers.

**Definition of the indicator**

Community health workers and volunteers refer to all people who are involved in the delivery of health services to the community. This includes peer educators, community health outreach workers, DOTS coordinators, village health workers, malaria village workers, home-based care providers, outreach workers, health educators, health promoters and other volunteers in accordance with an individual country's definition.

***Numerator:*** Total number of community health workers and volunteers that have received training or re-training in HIV, TB or malaria service delivery according to national guidelines (where such guidelines exist) in the last 12 months and that are working for an organisation targeted for CSS at the time of reporting.

***Denominator:*** Total number of community health workers and volunteers working for an organisation targeted for CSS.

**Limitation:**

This indicator does not measure the quality of the training, neither the outcome of the training in terms of the competencies of individuals trained or their job performance, nor the placement or retention of the health workforce of trained individuals.

**Measurement**

Targeted organisations are requested to submit appropriate administrative records to demonstrate the names of staff members and volunteers that received training or re-training in HIV, TB or malaria service delivery. The organisations should also report whether or not the trained or re-trained staff and volunteers are still working for the organisation at the time of reporting. Only staff members and volunteers that received training or re-training in the last 12 months and that are still working for the community based organisation at the time of reporting should be taken into consideration for the calculation of the numerator.

**Data sources:** Appropriate administrative records

**Frequency:** Every 3/6 months

**(4.2)**

Number and percentage of staff members and volunteers currently working for community based organisations that have worked for the organisation for more than 1 year

**Rationale**

The community health sector experiences many challenges in retaining health professionals. This indicator intends to measure to what extent community based organisations retain their staff members and volunteers.

**Definition of the indicator**

This indicator takes into consideration all categories of staff and volunteers who are currently working for community based organisations. This includes health professionals as well as other types of staff and volunteers.

***Numerator:*** Total number of staff and volunteers who are currently working for community based organisations that have finished more than 12 months of service for the organisation.

***Denominator:*** Total number of staff and volunteers who are currently working for an organisation targeted for CSS.

**Disaggregation:** Different professional categories such as community health workers, outreach workers, counselors etc.

**Measurement**

Targeted community based organisations are requested to submit a copy of appropriate administrative records that should contain the information of the total number of staff and volunteers working for them as well as the number of months of service the staff and volunteers completed for the organisation.

**Data sources:** Administrative records

**Frequency:** Annually

**(4.3)**

Number and percentage of community based organisations that received supervision and constructive feedback in accordance with national guidelines (where such guidelines exist) in the last 3/6 months

**Rationale**

Constructive supervision is key to improving programme performance. This indicator measures whether providers of HIV, TB and malaria services at the community level receive constructive feedback on their performance and capacity building to improve the quality of services delivered.

**Definition of the indicator**

The purpose of supervision is to improve the quality of programmes and to create an environment to enable staff and volunteers to perform to their maximum potential. Supervision should be supportive and is not a means for 'controlling' the performance of an individual or an organisation. Supervision normally includes skills development, review of records and reports, field visits, quality assurance and personal as well as professional development, on-the-job training and mentorship. It can involve individual sessions or group sessions, review of inventory, laboratories and storage facilities etc. Supervision is also an opportunity for two-way feedback and ensuring improved understanding of the tasks and issues involved in delivering high-quality services.

This indicator does not only focus on supervision of service delivery but also on supervision of overall programme implementation which includes supervision in areas such as finance, logistics and human resources etc.

For the calculation of the numerator only external supervision (provided by someone from outside the organisation) is counted. Internal supervision (for example provided by the head of a community based organisation to community health workers within the organisation) is not taken into consideration.

***Numerator:*** Total number of community based organisations targeted for CSS which report that they have received supervision in the last 3/6 months.

***Denominator:*** Total number of targeted community based organisations or all community-based organisations in a targeted area.

**Measurement**

Targeted community based organisations are requested to report whether they received supervision from an external organisation during the last 3/6 months.

**Data sources:** Administrative records, supervision reports

**Frequency:** Every 3/6 months

**(4.4)**

Number and percentage of volunteers working for community based organisations that are provided with a stipend/allowance

**Rationale**

This indicator intends to measure the efforts undertaken by community based organisations to increase the retention of volunteers.

**Definition of the indicator**

A stipend or allowance is a type of remuneration that is mainly meant to cover the costs incurred while providing services and is not equivalent to a salary.

Volunteers may include a range of non-health workers, including office workers, drivers, activity organisers etc. They may also include a variety of health workers such as peer educators, community health outreach workers, DOTS coordinators, village health workers, malaria village workers, home-based care providers, outreach workers, health educators, health promoters and other volunteers in accordance with the individual country's definition.

Some community based organisations may attract skilled volunteers from national and international organisations or affiliates that pay them directly (and not through the host community based organisation). This category of staff should, therefore, be considered "paid" volunteers and should not be counted. The volunteers working directly and/or collaborating with the local government authorities or any other recognized entity should be counted.

***Numerator:*** Total number of volunteers working for targeted community based organisations that received a stipend/allowance for providing services during the last 3/6 months.

***Denominator:*** Total number of volunteers working for community based organisations targeted for CSS.

**Measurement**

Organisations targeted for CSS are requested to report on the total number of volunteers who provided services for the organisation and should identify how many volunteers were provided with a stipend/allowance in the last 3/6 months at the time of reporting. The organisations should report on the type of stipend/allowance provided.

**Data sources:** Administrative records

**Frequency:** Every 3/6 months

**(5.1)**

Number and percentage of community based organisations that submit timely, complete and accurate financial reports to the nationally designated entity according to nationally recommended standards and guidelines (where such guidelines exist)

**Rationale**

Good financial reporting practices contribute to the efficient use of available funds and effective allocation of resources.

**Definition of the indicator**

For financial reporting at least the following documents should be submitted:

- Financial statements as described in the national guidelines (where such guidelines exist)
- Audit reports
- Analyses of budgets versus expenditure

*Timely* means that reports have been received before or on the day of the reporting deadline.
*Complete* means that all relevant data has been provided.
*Accurate* means that the figures reflect the actual financial status of the organisation.

***Numerator:*** Total number of community based organisations targeted for CSS submitting timely, complete and accurate financial reports according to nationally recommended guidelines (where such guidelines exist).

***Denominator:*** Total number of targeted community based organisations or all community-based organisations in a targeted area.

**Measurement**

This indicator is measured through a review of the financial reports that were received during the last reporting period for timeliness, completeness and accuracy.

**Data sources:** Financial reports

**Frequency:** Every 3/6 months

**(5.2)**

Number and percentage of community based organisations that have core funding secured for at least 2 years

**Rationale**

Core funding is provided to organisations to enable them to deliver on strategic objectives and to achieve set goals. This type of funding allows organisations to have the appropriate support and paid staff according to an organogram structured around the different streams of work, as well as having adequate office supplies, systems and hardware in place. Core funding enables organisations to grow and develop and to be responsive to change.

**Definition of the indicator**

Core funding refers to financial support that covers basic "core" organisational and administrative costs in addition to programme-specific requirements. Core funding provides stability, allowing organisations to operate their own chosen programmes. Community based organisations receiving core funding retain a significant degree of independence in selecting and implementing programme and organisational objectives. Core funding is normally of longer duration than project funding and is considered a more predictable form of funding.

Core funding is different from project funding which often focuses exclusively on project costs. Project funding typically allows organisations to include a portion of administrative costs such as phone or rent in a project budget, but there are strict terms and conditions detailing what is an acceptable expenditure and what is not. Project funding generally results in the funder retaining control of the content of services delivered by community based organisations. Project funding is typically short-term and limits the ability of community based organisations to plan for the long-term.

Provision of core funding is normally defined in an institutional document that is developed in accordance with the organisations' needs and which is approved by a relevant organisational body such as the board or general assembly.

***Numerator:*** Total number of community based organisations targeted for CSS with confirmed core funding for at least 2 years starting at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community-based organisations in a targeted area.

**Measurement:**

Targeted community based organisations are requested to provide the institutional document describing the agreement on the provision of core-funding. For the calculation of the numerator, only those community based organisations that have reached an agreement to receive core-funding for at least 2 years or more from the time of reporting onwards should be taken into consideration for the calculation of the numerator.

**Data sources:** Institutional documentation, administrative records

**Frequency:** Annually

**(6.1)**

Number and percentage of community based organisations reporting no stock-out of essential commodities during the reporting period

**Rationale**

Continuous availability of essential commodities is a basic requirement for service delivery at the community level. This indicator intends to measures whether organisations working at the community level have a supply management system in place that ensures this. Efficient supply management is needed to ensure that organisations do not run out of stocks of required commodities.

**Definition of the indicator**

Given the variety of country contexts, organisations and programmes, it is suggested to define essential commodities on a case by case basis in advance. Depending on the specific context, essential commodities may include but are not limited to the following:

1. Medicines such as ARVs, ACTs
2. Supplies such as syringes, condoms etc.
3. Bed-nets
4. Laboratory reagents

***Numerator:*** Number of community based organisations targeted for CSS that report no stock-out of essential commodities on the last day of the reporting period

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area that require a predefined set of essential commodities in order to deliver services.

**Measurement:**

Targeted organisations are requested to report whether they experienced a stock out of one or more essential commodity on the last day of the reporting period.

**Data sources:** Administrative records

**Frequency:** Every 3/6 months

**(6.2)**

Number and percentage of community based organisations that keep accurate data for inventory management

**Rationale**

This indicator determines the extent to which stock records are maintained. The presence of adequately maintained and accurate stock records contributes to proper management of essential commodities and estimation of need and facilitates the reordering of the essential commodities.

**Definition of the indicator**

***Numerator:*** Number of community based organisations targeted for CSS that keep accurate logistics data for inventory management.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area that require a predefined set of essential commodities in order to deliver services.

**Measurement**

A list of essential commodities is a prerequisite. The information is collected through a representative sampled survey. For each of the essential commodities, examine the data on the stock card and count the physical stock and then compare physical and recorded stock. The error rate can then be identified. The user of this indicator should determine in advance what an acceptable error rate is for the logistics data to be considered "accurate".

**Data sources:** Survey/supervision or evaluation visits

**Frequency:** Annually

**(6.3)**

Number and percentage of community based organisations with staff or volunteers trained or re-trained in stock (inventory) management in the past 12 months

**Rationale**

Capacity-building through training in stock (inventory) management enables community based organisations to manage stocks efficiently and to ensure the availability of quality medicines and other essential commodities.

**Definition of the indicator**

The training or re-training should be conducted in accordance with national recommended guidelines (where such guidelines exist).

***Numerator:*** Total number of community based organisations targeted for CSS that have at least one staff member who received training or re-training in stock management according to national recommended guidelines (where such guidelines exist) during the last 12 months at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area that require a predefined set of essential commodities in order to deliver services.

**Limitation**

This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained or their job performance.

**Measurement**

Targeted organisations are requested to submit appropriate administrative records to demonstrate the name(s) of staff and volunteers who received training or re-training in inventory management. For the calculation of the numerator, organisations will only be counted if at least one staff member or volunteer received training or re-training in inventory management in the last 12 months. Only staff members and volunteers that received training or re-training in the last 12 months and that are still working for the community based organisation at the time of reporting should be taken into consideration for the calculation of the numerator.

**Data sources:** Appropriate administrative records

**Frequency:** Every 3/6 months

**(6.4)**

Number and percentage of community based organisations that maintain adequate storage conditions and handling procedures for essential commodities

**Rationale**

The quality of essential commodities is highly dependent on storage and handling capability. Tracking the standards and procedures for storage and handling is therefore critical in ensuring the existence of adequate standards to assure safe storage and handling of essential commodities.

**Definition of the indicator**

***Numerator:*** Total number of community based organisations targeted for CSS that maintain acceptable storage conditions and handling procedures.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area that require a predefined set of essential commodities in order to deliver services.

**Measurement**

It is essential to have available a checklist of minimum criteria for adequate storage conditions and handling of essential commodities available at the organisation. Such a checklist should be developed in order to use this indicator and should be based on WHO good storage practices (see resources below) and national guidelines (where such guidelines exist). During a survey, supervision or evaluation visit, the items of the checklist for storage conditions and handling of essential commodities are rated "true" or "false". For the calculation of the numerator only those organisations should be counted that respond "true" to all the items of the checklist.

**Data sources:** Survey, supervision or evaluation visits

**Frequency:** Annually

**Resources:** *WHO operational package for assessing, monitoring and evaluating country pharmaceutical situations. Guide for coordinators and data collectors*. Geneva, World Health Organisation, 2007
http://www.who.int/medicinedocs/index/assoc/s14877e/s14877e.pdf

*A model quality assurance system for procurement agencies. Module IV. Receipt and storage of purchased products and appendix 14. In: WHO Expert Committee on Specifications for Pharmaceutical Preparations: fortieth report*. Geneva, World Health Organisation, 2006 (WHO Technical Report Series, No. 937);
http://whqlibdoc.who.int/trs/WHO_TRS_937_eng.pdf

WHO, UNICEF, UNDP, UNFPA and World Bank. *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*. Geneva, World Health Organisation, 2007
http://www.who.int/medicines/publications/ModelQualityAssurance.pdf

**(7.1)**

Number and percentage of community based organisations with the minimum capacity to deliver services according to national guidelines (where such guidelines exist)

**Rationale**

This indicator measures the capacity of community based organisations to provide quality HIV, TB and malaria services that meet national guidelines (where such guidelines exist).

**Definition of the indicator**

The organisational capacity required to deliver quality services includes technical and human resources as well as financial, M&E and stock management. Given the variety of programmes, organisations and country contexts, there is a huge difference in capacity needs between actors. It is, therefore, recommended that countries define the minimum capacity requirements depending on their specific context. Please refer to national guidelines where these exist or to any other type of guideline. Implementers of CSS interventions should agree on the minimum capacity requirements in consultation with the targeted community based organisations. It is important to understand that the minimum capacity might vary across different types of organisations. If working with different types of organisations please ensure that minimum capacity requirements are defined for all these types of organisations.

***Numerator:*** Total number of community based organisations targeted for CSS that have the minimum capacity to deliver HIV, TB or malaria services.

***Denominator:*** Total number of targeted community based organisations, or all community based organisations in a targeted area, that deliver services for HIV, TB or malaria.

**Disaggregation:** This indicator should be calculated separately for HIV, TB and malaria.

**Measurement**

Community based organisations are requested to report whether they have the minimum capacity to deliver HIV, TB or malaria services in compliance with the defined standards for minimum capacity agreed between the CSS implementer and the targeted organisations.

**Data sources**: Administrative records

**Frequency**: Annually

**Resources**

More information regarding capacity for service delivery can be found at the following sites:
For HIV: http://www.who.int/hiv/topics/en/index.html
For malaria: http://www.who.int/topics/malaria/en/
For TB: http://www.who.int/tb/topics/en/

**(7.2)**

Number and percentage of people that have access to community based HIV, TB or malaria services in a defined area

**Rationale**

This indicator intends to measure access to services provided by community based organisations for HIV, TB and malaria.

**Definition of the indicator**

This indicator should focus on all people or a specific population sub-group in a defined area such as a district, a province or a country.

***Numerator:*** Total number of individuals that have access to community based HIV, TB or malaria services.

***Denominator:*** All people, or those belonging to a specific population sub-group, in the defined area.

**Disaggregation:** By disease, type of service and living environment (rural or urban).

**Limitation**

This indicator does not measure the quality of services provided neither equity in service delivery.

**Measurement**

This indicator should be calculated separately for each type of HIV, TB and malaria service. Data on the total number of organisations that offer specific services and the populations they serve can be obtained through in-country mapping exercises. The relevant bodies that oversee the work done by community based organisations need to plan and execute these exercises regularly to facilitate the assessment process.

**Data sources**: Population-based survey

**Frequency**: 2–3 years

**(8.1)**

Number and percentage of community based organisations with staff or volunteers who received training or re-training in management, leadership or accountability in the last 12 months

**Rationale**

Skills in management, leadership and accountability are important drivers for effective governance of community based organisations. This indicator provides valuable information on the increase in organisational capacity.

**Definition of the indicator**

The training or re-training in management, leadership and/or accountability should be conducted in accordance to nationally recommended guidelines (where such guidelines exist).

***Numerator:*** Total number of community based organisations targeted for CSS that have at least one staff member or volunteer who received training or re-training according to nationally recommended guidelines (where such guidelines exist) in management, leadership or accountability during the last 12 months and who is still working for the community based organisation at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community-based organisations in a targeted area.

**Limitation**

This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained or their job performance.

**Measurement**

Targeted organisations are requested to submit training records which include the dates and names of the staff members and volunteers that received the training or re-training. Community based organisations will only be counted if at least one staff member or volunteer received training in management, leadership or accountability in the last 12 months. Only staff members and volunteers that received training or re-training in the last 12 months and that are still working for the community based organisation at the time of reporting should be taken into consideration for the calculation of the numerator.

**Data sources:** Training records

**Frequency:** Every 3/6 months

**(8.2)**

Number and percentage of staff members and volunteers of community based organisations with written terms of reference and defined job duties

**Rationale**

It is important that all staff members and volunteers of community based organisations have written terms of references with job duties defined. Such documents describe the specific roles and responsibilities of each staff member and volunteer and clarify reporting lines.

**Definition of the indicator**

Terms of reference normally contain:

- The role of the staff member/volunteer
- The responsibilities of the staff member/volunteer
- Key results expected
- The conditions of the contract including working hours, compensation, etc.

***Numerator:*** Total number of staff members and volunteers that have written terms of reference with job duties defined and that work for targeted community based organisations at the time of reporting.

***Denominator:*** Total number of staff members and volunteers working for targeted community based organisations at the time of reporting.

**Measurement**

Targeted community based organisations are requested to report on the total number of staff members and volunteers working for the organisation and should report if and how many of them have written terms of reference with defined job duties at the time of reporting.

**Data sources:** Administrative records, terms of reference

**Frequency:** Annually

**(8.3)**

Number and percentage of community based organisations that received technical support for institutional strengthening in the last 12 months

**Rationale**

Many community based organisations have weak institutions and would benefit from technical support for institutional strengthening. Institutional strengthening supports community based organisations in strategic planning, decision making and services delivery.

**Definition of the indicator**

Technical support in the context of this indicator refers to cooperation between external experts and the organisation's staff and volunteers for the assessment of existing institutions, development of a plan for institutional strengthening and implementation of the plan.

Technical support for institutional strengthening may include but is not limited to: administrative and managerial development, strategic planning, governance and leadership, programme and financial management, procurement and supply management, monitoring and evaluation of performance and development of a computerized information system.

***Numerator*:** Total number of community based organisations who report to have received technical support for institutional strengthening in the last 12 months.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Targeted organisations should be requested to report whether or not they received technical support for institutional strengthening in the last 12 months.

**Data sources:** Administrative records

**Frequency:** Annually

**(9.1)**

Number and percentage of community based organisations with at least one staff member or volunteer responsible for monitoring and evaluation

**Rationale**

This indicator measures whether organisations that are working at the community level have a designated staff member or volunteer who is responsible for monitoring and evaluation. Monitoring and evaluation includes activities such as data collection, analysis and use to improve programme planning and decision-making.

**Definition of the indicator**

This indicator measures whether community based organisations have one staff member or volunteer who is responsible for all activities related to monitoring and evaluation.

***Numerator:*** Total number of community based organisations targeted for CSS that have one staff member or volunteer responsible for monitoring and evaluation of the organisation at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement:**

Targeted organisations are requested to provide the name of the staff member or volunteer responsible for all monitoring and evaluation activities of the organisation as well as his or her terms of reference which describes the monitoring and evaluation responsibilities.

**Data sources:** Annual organisational reports; terms of reference

**Frequency:** Annually

**(9.2)**

Number and percentage of community based organisations that are implementing a costed annual work plan which includes monitoring and evaluation activities

**Rationale**

Having a functional costed work plan in place which includes monitoring and evaluation activities is important for contributing to effective service delivery for HIV, TB and malaria. A good work plan provides structure and helps in planning and implementation of operations.

**Definition of the indicator**

Firstly, this indicator measures in the first place the existence of a costed annual work plan that includes all activities conducted by the organisation including those related to monitoring and evaluation. Secondly, this indicator measures whether the costed annual work plan is actually being implemented. A work plan is an operational plan which contains all operational activities of the organisation such as programmematic activities, monitoring and evaluation activities, communication, advocacy, resource mobilization, procurement and human resources. A functional work plan includes:

- A list of goals and objectives (preferably harmonized with the national strategy);
- A list of all activities that will be undertaken by the organisation. All activities should be linked to the identified objectives;
- A clear timeframe showing which activities will be implemented when;
- A responsible actor for each of the identified activities;
- Estimated costs of all activities;
- Funding sources for all of the activities.

Costed annual work plans of community based organisations should be developed in consultation with all relevant community stakeholders.

***Numerator:*** Total number of community based organisations targeted for CSS that have a costed annual work plan in place which includes monitoring and evaluation activities and that provide evidence to demonstrate the implementation of the plan.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Community based organisations are requested to submit their current costed annual work plan at the time of reporting. Targeted community based organisations are requested to provide some form of evidence demonstrating the implementation of monitoring and evaluation related activities according to the annual work plan. This evidence could be provided in the form of a report or other written documentation.

**Data sources:** Annual work plan, implementation reports, other documentation

**Frequency:** Annually

**(9.3)**

Number and percentage of community based organisations with at least one staff member or volunteer who received training or re-training in planning or M&E according to nationally recommended guidelines (where such guidelines exist) in the last 12 months

**Rationale**

Capacity-building through training in planning and M&E enables trained individuals to generate relevant high-quality data, analyze them and then to use these data to improve programme planning and decision-making. This indicator provides valuable information on the increase in organisational capacity in planning and M&E of HIV, TB and malaria programmes at the community level.

**Definition of the indicator**

The training or re-training should be conducted in accordance with nationally recommended guidelines (where such guidelines exist).

Organisations will only be counted if at least one staff member or volunteer received training in planning or M&E in the last 12 months.

***Numerator:*** Total number of community based organisations targeted for CSS that have at least one staff member or volunteer who received training according to nationally recommended guidelines (where such guidelines exist) in planning or monitoring & evaluation during the last 12 months at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Disaggregation:** By training in M&E or planning

**Limitation**

This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained or their job performance.

**Measurement**

Targeted organisations are requested to submit training records which include the names and dates of the staff members and volunteers that received training or re-training in M&E or planning. For the calculation of the numerator, organisations will only be counted if at least one staff member or volunteer received training or re-training in planning or M&E in the last 12 months. Only community based organisations with a staff member or volunteer that received training or re-training in the last 12 months and that is still working for the community based organisation at the time of reporting should be taken into consideration for the calculation of the numerator.

**Data sources:** Training records

**Frequency:** Every 3/6 months

**(9.4)**

Number and percentage of community based organisations using standard data collection tools and reporting formats that enable reporting to the national reporting system

**Rationale**

Data collected at the community level is often not integrated in the national reporting system. Integrating community level data into the national reporting system is important for programme planning and informed decision making. This indicator intends to measure to what extent community based organisations make use of standard data collection tools and reporting formats that facilitate the integration of community level data into the national reporting system.

**Definition of the indicator**

Data collection tools can include manual primary source documents, registers and both manual and electronic databases for data collection. Standard reporting formats refer to those recommended by national guidelines (where such guidelines exist).

To enable the integration of community level data into the national reporting system, it is important that data collection tools capture all relevant information that is required by the national reporting system. A description of what information should be captured is normally included in the national monitoring and evaluation plan.

***Numerator:*** Total number of community based organisations targeted for CSS that are using standard data collection tools and reporting formats that enable reporting to the designated entity of the national reporting system.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Targeted organisations are requested to submit copies of their data collection tools. A desk review should be conducted to evaluate whether the data collection tools used by the targeted organisations enable them to report to the national reporting system. Constructive feedback should be provided. The use of standard reporting formats can be verified by the designated entity of the national reporting system, by counting the number of reports received in the standard reporting format out of the total number of reports received.

**Data sources:** Data collection tools and reporting formats

**Frequency:** Annually

**(9.5)**

Number and percentage of community based organisations conducting reviews of their own programme performance in the last 3/6 months

**Rationale**

Regular review of programme performance is important for organisations to identify gaps and to increase the efficiency and quality of services delivered.

**Definition of the indicator**

This indicator measures whether community based organisations conduct regular reviews of their own programme performance. A good review of programme performance should take the following steps into consideration:

- Definition of the review process;
- Discussion of each of the activity areas regarding past performance, best practices, challenges and risks.
- Preparation of an action plan which identifies the next steps to address the issues raised during the review.

Performance reviews should be conducted every 3 or 6 months depending on the country context and reporting cycles. This indicator focuses on reviews conducted by the targeted organisations themselves on their own programme performance and does not refer to participation in larger review processes such as a joint national programme review.

***Numerator:*** Total number of community based organisations targeted for CSS that have conducted a review of their programme performance in the last 3/6 months at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Community based organisations are requested to report whether they have conducted a review of their own programme performance in the last 3/6 months. They should be requested to submit a simple documented description of the review process which includes:

- The names of the participants;
- A summary of the issues raised during the review;
- Action points addressing the issues raised during the review.

**Data sources:** Documented description of the review process

**Frequency:** Every 3/6 months

**(10.1)**

Number and percentage of community based organisations with a developed strategic plan covering 3 to 5 years

**Rationale**

A strategic plan helps to ensure that delivered services contribute to long-term goals and objectives. A good strategic plan provides a vision and structure and supports the planning and implementation of operations.

**Definition of the indicator**

This indicator is intended to measure whether community based organisations have a strategic plan in place, covering 3 to 5 years, which is valid at the time of reporting. For example an organisation that has a 5 year strategic plan in place covering 2006-2011 would still be counted in the numerator in 2010.

A good strategic plan contains the following elements:

- A vision
- A mission statement
- Critical success factors
- Strategies and actions to achieve defined objectives
- A prioritized implementation schedule

***Numerator:*** Total number of community based organisations targeted for CSS that have a strategic plan in place, covering a total period of 3 to 5 years, which is still valid at the time of reporting.

***Denominator:*** Total number of targeted community based organisations or all community based organisations in a targeted area.

**Measurement**

Community based organisations are requested to submit a copy of their strategic plan**.**

**Data sources:** Strategic plans

**Frequency:** Annually

# 7. 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

*Eurasion 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 the Caribbean Council of AIDS Service Organisation (LACCASO)* http://www.laccaso.org/

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