

**Allocation Period 2023-2025**

# **Decision-making Guide for Community Systems Strengthening Interventions in Global Fund Grants**

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# 1. Decision-making on Community Systems Strengthening

This decision-making guide supports the conceptualization and design of effective community systems strengthening (CSS) interventions for HIV, TB and malaria to include in the Global Fund funding request. The guide is part of the **CSS Technical Brief**, which contains extensive information and definitions of priority interventions.

The intended audience of this guide are communities, Country Coordinating Mechanisms (CCMs), funding request writing committees and other stakeholders involved in the development of the Global Fund funding request.

The guide presents a set of critical questions to support the design of CSS interventions, relevant to country context and priorities. The critical questions are meant to guide and are not exhaustive.

The guide also highlights other areas (modules, annexes) in the funding request where the inputs of the community organizations are required.

## Community engagement in the design of CSS interventions

The process that enables meaningful participation of communities in grant design varies from country to country, based on the existing capacities, mechanisms and contexts. Meaningful engagement of the communities – including key and vulnerable populations – throughout the grant life cycle is an eligibility requirement by the Global Fund. It is particularly important to ensure that the communities' perspectives, experiences and needs guide program design and implementation and that budgeted, prioritized interventions are included in the final funding request and subsequent grant.

To ensure that the CSS interventions are considered in the funding request preparations it is important to:

- Identify the needs of community-led and community-based organizations, groups and networks, and enable their meaningful engagement and participation in developing the funding request, including priority CSS interventions.
- Through the **Community Engagement Strategic Initiative (CE-SI)**, access technical assistance to support engagement and contribution of community-led and community-based organizations, networks and groups. The support includes, but is not limited to, participation in all stages of the funding request development, including designing, prioritizing, reviewing and budgeting. Community-led and community-based organizations and networks are encouraged to explore the available technical assistance options and make use of the CE-SI.

### COMMUNITY-BASED ORGANIZATIONS

Community-based organizations are organizations that have arisen within a community in response to particular needs or challenges and are locally organized by community members.

### COMMUNITY-LED ORGANIZATIONS

Community-led organizations are organizations that are governed, led, and staffed by people who have experience and affiliations with the communities being served or intended to benefit from the organization's work. Community-led organizations are primarily accountable and responsive to the needs of their communities.

## 2. Four Steps of Developing CSS Interventions

These four steps support gathering strategic information to prioritize interventions for optimal outcomes.

**Step 1: Knowing the epidemic(s) in your context.**

**Step 2: Understanding your current community systems and responses.**

**Step 3: Consulting the evidence, such as results to date and lessons learned.**

**Step 4: Identifying how the community-led and community-based organizations, networks and groups can be strengthened to better engage and effectively contribute to national health response.**

It is important to keep track of any supporting and key reference documents and annex them to the funding request.

Information and responses to questions under steps 1-3 need to be documented and summarized so that writing teams and CCMs understand the evidence used to inform the CSS priorities for inclusion in the funding request.

Step four outlines critical questions, to further analyze the context, prioritize and align the community-led and community-based interventions in the next Global Fund HIV, TB and malaria grants, to achieve greater synergy between the community and the public health systems.

### Step 1: Knowing the epidemic(s) in your context

**Note:** Identify available strategic information, such as recent assessments, evaluations or program reviews, to determine what might be missing. This information should align with “Population, geographies and/or barriers addressed” across the modules of section 1.1. “Prioritized Request” point A of your funding request.

- Who are the key and most vulnerable populations? Which communities/people are disproportionately affected (what ages, genders, socio-economic status, which geographies)?
  - Who is being reached, where and through which interventions; are the interventions routine i.e., not one-off activities or events?
  - Who remains underserved or unreached and why?
- How do people prefer to access HIV, TB and malaria services? Where is this information documented?
- Where along the prevention, diagnostics, care and treatment cascade (for HIV, TB and malaria) are the major gaps?

(Cross-check with section 1.3 “Context” of the funding request: for funding requests with HIV modules – with the recent data on the 95-95-95 targets, and for funding requests with TB modules – with the cascade analyses).

- Which social and structural drivers fuel inequity and inequality in access, availability and affordability of HIV, TB, malaria services and, if disaggregated (sex, age, gender and other equity-related variables) information is available, which groups are most affected? What is done to address the inequity and inequality in relation to HIV, TB and/or malaria?
- Are there any issues with the quality of services or remaining gaps in service delivery packages or platforms identified by recent reviews and assessments?<sup>1</sup>

1. Various cross-cutting factors, such a lack of awareness activities for key and vulnerable populations, recruitment and remuneration to enable peer-to-peer support, availability of low threshold settings, etc. create or amplify barriers to services and impact service delivery throughout the whole cascade.

## Step 2: Understanding your current community systems and responses to the epidemics

**Note:** Document this information for inclusion in funding request section 2.2 under “How this request supports community systems strengthening”/Describe relevant community-led and community-based organizations.

- How are community-led and community-based organizations, networks and/or groups (these should include formal and informal structures) engaged in the HIV, TB and/or malaria response?
- Have community-led and community-based organizations been mapped and what are their roles in the health response? Is this documented in a national or community health strategy? If so, is the strategy implemented? What are the gaps?
- What are the current technical, organizational, leadership and financial capacities of the community-led and community-based structures? Where have these been documented and what are the major unaddressed capacity weaknesses or gaps?
- How are community-led and community-based organizations funded/supported?
- What mechanisms exist to manage, coordinate or link existing community groups, organizations and/or networks to each other?
- Are there links, referral mechanisms and pathways between the communities and the public and private health providers? Are there mechanisms for a broader dialogue between the communities and health authorities?
- How is the information generated by community structures used to inform program design and people-centered service delivery? Who has access to the data and how are they using the data?
- Are there existing regulatory frameworks for financing or contracting community-led and community-based organizations from domestic sources to deliver services? Are they translated into working implementation mechanisms which are amenable to the communities i.e., contracts or service level agreements?

## Step 3: Consulting the evidence, results to date and lessons learned

**Note:** Document for inclusion in funding request section 1.4 “Lessons Learned” to describe the main lessons learned from current programs, including community-led and community-based service delivery. Distinguish what has already been operationalized into programs, what is planned for operationalization and which lessons learned are not operationalized, and why.

- Were there any studies, assessments or evaluations conducted that measure contributions or impact of the community-led and community-based interventions on the national targets/objectives?
- Have good CSS practice interventions been described and evidence of their effectiveness documented?
- Have community-led and community-based interventions been costed?
- Have existing CSS interventions been assessed to understand what has worked, what holds the greatest potential for impact, and what gaps remain?
- Have linkages or synergies between actors in community systems and more formal community-based service delivery been assessed? What barriers remain?
- What could improve the scale and reach of the existing CSS interventions?

## Step 4: Identifying how the community-led and community-based organizations, networks and groups can be strengthened to better engage and effectively contribute to national health response

**Note:** Document for inclusion in funding request section 1.1.A “Prioritized request.”

Based on the information gathered in steps 1-3, this is the final step to develop a package of CSS interventions that will support community-led and community-based organizations (particularly key and vulnerable populations) to respond to the country’s health objectives, contribute to country targets, and deliver integrated and people-centered services. CSS interventions can include activities identified as missing while answering questions in Steps 1-3. For instance, a mapping of community-led and community-based organizations engaged in the response, or a review of regulatory frameworks related to contracting and financing community-led and community-based organizations.

## 3. Applying Critical Questions to Define CSS Interventions and Activities

The four intervention areas listed below, and corresponding critical questions, are interconnected. It is encouraged to combine interventions across one or more areas, in line with the prioritization decisions. The critical questions, while not exhaustive, provide guidance on how to shape the CSS module in the funding request to context and needs while ensuring you provide the necessary evidence and rationale.

1. Community-led monitoring (CLM).
2. Community-led research and advocacy.
3. Community engagement, linkages and coordination.
4. Capacity building and leadership development.

If undecided whether the response to a “critical question” should be a “yes” or a “no,” craft your own suitable combination of interventions.

### Priority Area 1: Community-led Monitoring

#### Issue:

Service providers/decision-makers do not routinely include perspectives and experiences of clients to improve accessibility, acceptability, affordability and quality (AAAQ) of services.

#### Objectives:

Supporting community-led and community-based organizations and networks to set up, harmonize and effectively implement CLM platforms that routinely, systematically and independently collect and analyze data to improve AAAQ, promote accountability and advocate for service improvements that result in better health outcomes.

### Critical questions and recommended CSS requests:

#### Question 1.1.

**Is there an understanding of and capacity to undertake CLM in the country, including capacity to design, manage, implement and coordinate CLM?**

**If the answer is “yes,” then skip to next question.**

#### **If the answer is “no,” then:**

- Engaging all stakeholders, including communities, relevant government representatives and service providers, training (where applicable) and jointly developing strategies and tools will be needed to enable buy-in, cooperation and capacities in implementing CLM.
- Training for CLM implementers on data management and security, data collection processes, data analysis, sharing, use, and CLM-based advocacy can be included in the funding request.
- CLM pilots can be supported as part of CSS, along with strategies for CLM-based learning and decision-making, continuous improvement and CLM scale up, once pilot phases have been completed.



**Question 1.2.****Is CLM being implemented in your country?****If the answer is “yes,” then:**

- A mapping or review to understand if all key and vulnerable populations are included and what results CLM implementation have led to can be included in the funding request. If there are multiple CLM instruments or approaches – review alignment/harmonization, including the current levels/sources of funding, to assess whether the existing CLM can be expanded, adapted or scaled up and what support and investment are required.
- Assess whether the CLM cycle<sup>2</sup> leads to improvements in services – CSS requests can include an assessment of all steps in the CLM cycle to identify gaps or system weaknesses.

**If the answer is “no,” then:**

- An independent (readiness) assessment would be useful to determine if CLM is understood, and what groundwork might be needed to get started with planning or piloting a CLM model that is suitable for the country, community and disease contexts.
- CSS funding can be requested to develop a national CLM framework and strategy to guide future implementation and scale up of CLM – one that involves all relevant disease programs, key stakeholders and that garners broad support.
- Community-led and community-based organizations can be supported to start a pilot CLM mechanism if none exists in their relevant disease context.

**Question 1.3.****Are there well-aligned, capacitated community-led and community-based organizations or groups that are well positioned and can be easily engaged to undertake CLM?****If the answer is “yes,” then:**

- Consider including the establishment of a joint platform or a similar mechanism to share CLM data for advocacy in the CSS module of the funding request, to bring together community-led and community-based organizations with common concerns and ensure sustained and cost-effective peer learning and engagement.

**If the answer is “no,” then:**

- A mapping of community-led and community-based organizations and capacity assessments to determine their challenges and needs can be supported. Such mapping should help gain an understanding of the existing efforts to collect information from service users on AAAQ of health services as well as information about the structural and social barriers, like those related to human rights and gender.

**Question 1.4.****Do community-led and community-based organizations or groups have functional relationships with and access to health facilities / other service providers, and their service users, to undertake CLM?****If the answer is “yes,” then:**

- Ensure that the outcomes and impact of these relationships are documented and formalized in policy and processes so that they are sustained even if there are changes in health administration, civil society and community leadership. Consider regular meetings, consultative fora or development of memoranda of understanding, at the local/facility but also at regional and national levels where the CLM data is used to inform action.
- The funding request can include interventions to reach additional formal agreements on data access, data use and data systems for CLM.

2. The CLM cycle includes communities: 1) identifying issues to monitor based on experiences using health and other services; 2) collecting information from service delivery sites; 3) analysing the information; 4) sharing information with service providers and decision-makers; 5) advocating for service improvements; 6) monitoring that changes have been implemented. Along each of the steps in the cycle, community-led organizations implementing CLM require resources, skills and capacity.

**If the answer is “no,” then:**

- An assessment of the current relationships and agreements between community-led and community-based organizations, health facilities and health management structures in the context of CLM can be supported to better understand the situation, gaps and potential solutions.
- Interventions to catalogue or establish and strengthen joint structures, involving community-led and community-based organizations, groups and networks representing key and vulnerable populations, in health facilities and other service delivery platforms can be supported through CSS funding. For instance, through establishing, expanding, or capacitating clinic health committees, district community health advisory groups, planning and budgeting assemblies, or provincial multisectoral structures as potential enablers of CLM and responders to issues identified through CLM.

**Question 1.5.**

**Are there existing mechanisms with the necessary authority and influence to use CLM feedback to effect the needed changes or program shifts?**

**If the answer is “yes,” then:**

- A strategy to ensure complementarity of CLM and national Monitoring & Evaluation (M&E)/data systems (e.g., how to use CLM feedback in combination with Health Management Information System/ District Health Information System data) and inter-operability of CLM platforms and tools would be useful for sustained use of CLM and any potential expansion and can be a part of the CSS funding request.
- Consider supporting an effective mechanism or a platform where the CLM data is discussed to inform the HIV, TB and/or malaria programming, initiating and strengthening broader interventions to foster supportive legal environments, and adherence to human rights at large.

**If the answer is “no,” then:**

- Identify and formalize information flows and accountabilities for responses to CLM data and for using CLM data to inform people-centered service delivery. This can be through the development of national strategies, plans and approaches and through setting up and sustaining joint structures at community, district and national levels that are accountable for responding to CLM findings.
- Consider developing and funding advocacy plans and strategies and building the capacity among communities and the networks and organizations that represent them, and ensure that there are the shared referral pathways or linkages to services, needed to act upon CLM results.



## Examples of CLM

- In 2021, **Nigeria** developed and adopted a national strategic framework for CLM of HIV services. The goal was to use a data-driven approach to improve service delivery and client outcomes at the facility and community levels. The implementation of the CLM was supported jointly by the Global Fund and PEPFAR investments.
- CLM in **Cambodia** identified that challenges, which were reported by people with TB, were primarily in the areas of service quality and acceptability. Community health workers were the first responders to the CLM-reported challenges. Thanks to CLM now they can better understand, monitor and respond to issues faced by people with TB.<sup>3</sup>
- In **Malawi**, the use of a CLM tool, known as community scorecard, significantly improved relationships between health providers and the community members accessing health facilities. The use of the community scorecards also brought about such changes as better access to information, increased male involvement in maternal and newborn health and family planning, and increased young people's involvement in reproductive health services.<sup>4</sup>
- Through a regional grant to the Center for Health Policies and Studies (PAS), the community-led and community-based organizations from **Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan and Ukraine** organized regular exchanges to share their CLM experiences, problems, solutions and results achieved through CLM, using **OnelImpact** mobile application for TB services.<sup>5</sup>
- Frequency of TB drug stock outs reduced from 95% to 5% after one year of implementation of the TB/HIV community treatment observatory model in the **Democratic Republic of the Congo**. Similar CLM instrument in Cote d'Ivoire noted and addressed the issue of user fees as a barrier to services.<sup>6</sup>
- In **Ghana**, systematic use of a community scorecard to enhance accountability for malaria resulted in successful advocacy for the construction and renovation of health facilities, procurement of medical equipment and medicines, electrical generators, water tanks, emergency transport vehicles, and more. The country trained Members of the Parliamentary Committee on Health on how to access quarterly CLM data and piloted the use of CLM to inform the planning and budgeting processes.

## Resources and tools to guide CLM conceptualization and planning

- IAS, **Community-led monitoring of programs and policies related to HIV, tuberculosis, and malaria. A guide to support inclusion of CLM in funding requests to The Global Fund**; 2022.
- CLAW Consortium, **Best Practices for Community-led Monitoring**; 2022.
- Coalition of Women Living with HIV and AIDS (COWLHA) and Treatment Action Group (TAG), **Community-Led Monitoring for Access to Tuberculosis Screening and Diagnostic Testing**; 2022.
- International Treatment Preparedness Coalition (ITPC), **How to Implement Community-Led Monitoring A Community Toolkit**; 2021.
- UNAIDS, **Establishing Community-led Monitoring of HIV Services**; 2021.
- The Global Fund, **Towards a Common Understanding of Community-Based Monitoring and Advocacy**; 2020.
- The Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO), Frontline AIDS, Stop TB partnership and GIZ, **Community-led Monitoring: A Technical Guide for HIV, Tuberculosis and Malaria**; 2020.
- African Leaders Malaria Alliance (ALMA), **How to implement a Community Scorecard**.

3. OnelImpact K+ Cambodia Country Case Study, KHANA,

<https://stoptbpartnershiponeimpact.org/resources/Case%20Studies/Case%20Studies/OnelImpact%20K+%20Case%20Study%20-%20Cambodia.pdf>

4. Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: a cluster randomized controlled evaluation. Sara Gullo, Christine Galavotti, Anne Sebert Kuhlmann, Thumbiko Msiska, Phil Hastings, C. Nathan Marti, 2017 <https://doi.org/10.1371/journal.pone.0171316>

5. Center for Health Policies and Studies (PAS), Republic of Moldova.

6. Community-Led Monitoring: When Community Data Drives Implementation Strategies, Baptiste, Solange & Manouan, Alain & Garcia, Pedro & Etya'ale, Helen & Swan, Tracy & Jallow, Wame. 2020. Current HIV/AIDS Reports. 17. 1-7. 10.1007/s11904-020-00521-2.

## Priority Area 2: Community-led Research and Advocacy

### Issue:

Programming for key, and vulnerable populations is not reaching specific groups, or is under-performing because of a lack of funding and persistent structural barriers that undermine their reach and impact.

### Objectives:

Communities' advocacy is evidence-based and effective, and communities define their own research agendas and priorities, and have the capacity and means to carry out operational research, particularly addressing the needs of key and vulnerable populations.

### Critical questions and recommended CSS requests:

#### Question 2.1.

**Do communities have a framework, knowledge, skills and resources to plan, design and carry out community-led research to address local or national health issues, inform decision-making, build evidence for community advocacy and document impact of community-led interventions?**

#### If the answer is "yes," then:

- Publishing, communication and dissemination of the community-led research results, documenting the experiences and lessons learned, as well as supporting continuous development of the community-led research capacity can be included in the funding request.

#### If the answer is "no," then:

- Assess if there are barriers to community-led research and advocacy, such as the regulatory framework, a lack of capacity to plan, design and carry out community-led research, and interventions to overcome the barriers, which could be part of CSS requests.
- Consider including qualitative, quantitative and operational community-led research and the production, publication and dissemination of reports and communication materials.
- Consider including community-led situational analyses of local and national health issues, participatory needs assessments and community-led assessments of program implementation (e.g., shadow or alternative reports<sup>7</sup>).
- Technical assistance and training can be requested under CSS to strengthen the capacity of the communities to plan, design and carry out community-led research on the three diseases, barriers to accessing health and other social services, social determinants of health and progress towards Universal Health Coverage and the realization of the Sustainable Development Goals.

7. Shadow reporting and alternative reporting are tools used by civil society to highlight issues that are misrepresented, neglected or otherwise not reported by the government or responsible governing bodies.

**Question 2.2.**

**Do your country's disease response efforts continue to face persistent human rights or gender disparities or other inequalities that are broader than what health interventions alone can address?**

**If the answer is "yes," then:**

- Support community-led research to assess barriers to and acceptability of services, and help prioritize areas that have the greatest impact to remove barriers to health. The research should be cognizant of human rights, gender, age and other considerations. Funding for community-led research, including assessments of program implementation and shadow reporting can be included.
- Consider including technical support for training to develop, plan, undertake and assess the results of advocacy; campaigns and lobbying to address barriers at community and national level and create enabling environment for improved health services and outcomes.
- Community-led research and advocacy efforts can support evidence-based decision-making on laws or policies that continue to inhibit access to services. Consider including support for community-led and community-based organizations to conduct research (including community consultations), document impact, and build advocacy for the changes in laws and policies that negatively impact on reaching country targets, especially relating to key and vulnerable populations.
- Efforts which require advocacy and mobilization of communities at large (i.e., across more than one disease) to drive integration of gender and human rights into the formal health response strategies and plans can be supported as part of CSS.

**If the answer is "no," then:**

- Documenting and sharing the impact of the country disease response, using multi-sectoral approaches. This will help address intersectional disparities related to human rights, gender or other inequalities impacting health and benefit other communities and countries.

**Question 2.3.**

**Does the country plan to expand health programming to new geographical areas, reach other key or vulnerable populations or increase investment in programs to remove human rights and gender-related barriers?**

**If the answer is "yes," then:**

- Consider including community-led needs assessments to ensure that new/expanded programs meet the needs of the populations you aim to reach, are evidence-based, accessible and acceptable. Community-led needs assessments drive new programs to make the best use of existing community-led and community-based services, scale them up where required, and integrate them in the service delivery ecosystem.
- The funding request can include targeted interventions to address barriers faced by community-led and community-based organizations to actively engage in existing new or expanded programs. These interventions may include advocacy to repeal laws that restrict the registration and official recognition of community-led and community-based organizations representing key and vulnerable populations.
- Interventions to enable active and meaningful participation of the communities in defining health strategies and (co-)implementing them can be funded through the CSS module.

**If the answer is "no," then:**

- Consider including community-led research to inform programming and advocacy efforts. Identify any gaps, such as insufficient programming in all critical geographical areas, or failure to reach key populations, and address human rights and gender-related barriers. Such research and the ensuing advocacy activities and/or programming can also be included in the funding request.

**Question 2.4.**

**Does the participation and engagement of community-led and community-based organizations in your programming largely or exclusively depend on donor funding?**

**If the answer is “yes,” then:**

- Consider investments in research on the contribution of community-led and community-based organizations to health objectives and outcomes, particularly among populations that are under-served in the national response. This research can include value-for-money and costing dimensions, to provide the basis and evidence for domestic resource allocations in national budgets.
- Consider including support to community-led and community-based organizations in their efforts to diversify funding sources and evaluate issues around sustainability.

**If the answer is “no,” then:**

- Documenting and sharing examples of enabling domestic funding for community-led and community-based organizations, particularly interventions focusing on under-served populations, will benefit other communities and countries.

## Examples of community-led research and advocacy

- After the launch of the Global Prevention Coalition in October 2017, Frontline AIDS supported activists from 22 countries to participate in workshops to learn, share and agree on the HIV prevention advocacy priorities. As part of this process, activists from community-led and community-based organizations decided to work together to analyze respective progress on HIV prevention, using a data collection tool developed by Frontline AIDS. In 2020, activists from seven countries updated their shadow reports, which offered an alternative to the official assessments put forward by governments.
- The Zimbabwe Civil Liberties and Drug Network (ZCLDN) partnered the Mental Health Services Department in the Ministry of Health and Child Care and other organizations to finalize the Zimbabwe National Drug Master Plan (ZNDMP 2020–2025). The ZCLDN advocated for human rights informed approaches and harm reduction services as part of the long-awaited Master Plan. The plan offers both an integrated and comprehensive approach that addresses a range of drug related issues in **Zimbabwe**.<sup>8</sup>
- In response to a lack of a national strategy to counteract gender-based violence in South Africa, a National Strategic Plan on Gender-based Violence Shadow Framework was developed in 2017 under the leadership of Networking HIV and AIDS Community of Southern Africa (NACOSA). The shadow strategy eventually caught the attention of all national stakeholders and prompted the development and implementation of a national strategic plan on gender-based violence and femicide in 2020.
- In 2021, Facilitators of Community Transformation (FACT) and COWLHA conducted a budget assessment to determine whether the funding for TB preventive therapy (TPT) was sufficient compared to the targets and roll-out plans in **Malawi**. Findings revealed a funding gap and a lack of the necessary disaggregated financial information. Civil society advocated for changes in financial planning with different stakeholders, including the parliamentary TB caucus and undertook activities to generate demand for TPT among the communities.<sup>9</sup>

## Resources and tools for community-led research and advocacy

- CLAW Consortium, **Community Evidence to Create Change**; 2022.
- International Drug Policy Consortium (IDPC), **Decriminalisation of people who use drugs: a guide for advocacy**; 2022.
- PITCH, Aidsfonds, Frontline AIDS and Dutch Ministry of Foreign Affairs, **Accelerating Community-led HIV Responses: Adapting Positive Practice Beyond the COVID-19 Crisis**; 2021.
- PITCH, Aidsfonds, Frontline AIDS and Dutch Ministry of Foreign Affairs, **Measuring Up, Learning from Practice: Planning Monitoring and Evaluating HIV-Related Advocacy**; 2021.
- INPUD, **Surviving and Thriving Lessons in Successful Advocacy from Drug-User Led Networks**; 2022.
- UNAIDS and Stop AIDS Alliance, **Communities Deliver: The Critical Role of Communities in Reaching Global Targets to end the AIDS Epidemic**; 2015.

8. Zimbabwe national drug master plan: a game changer to Zimbabwe drug scourge, The Zimbabwe Drug Reporter, ZCLDN, 2022, <https://zcldnzim.net/2022/04/20/zcldn-newsletter-april-2022/>

9. IMPAACT4TB, 2021, <https://www.impaact4tb.org/levering-budget-advocacy-for-tpt-scale-up-in-malawi/>

## Priority Area 3: Community Engagement, Linkages and Coordination

### Issue:

Community-led and community-based service delivery efforts are not, or only partially, integrated into the health system response. They may not be reflected in the national health planning and links to the formal health system remain weak or uneven, resulting in service users, especially key and vulnerable populations, being underserved or lost to follow up and community-led services operating in parallel rather than synergistically with formal health services.

### Objectives:

Community-led and community-based services are known and recognized; organizations providing these services are engaged in joint planning and implementation, and their role and impact reflected in national planning and resource mobilization.

### Critical questions and recommended CSS requests:

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#### Question 3.1.

**Are community-led service delivery points linked to and engaged in joint planning and implementation efforts with public and private health facilities?**

#### If the answer is "yes," then:

- Strengthen the capacity of the community-led and community-based organizations in using appropriate new information, communication and coordination tools and technologies, including digital tools. This may expedite the adoption of innovations by other local and/or national health providers.
- Successful coordination and joint implementation at service delivery points may be a good opportunity for developing and formalizing national multisectoral health responses, based on equity and inclusion of communities. Funding and assistance could be requested to improve coordination, conduct joint planning, and foster effective linkages between the communities, community-led and community-based organizations and formal health systems.

#### If the answer is "no," then:

- Engage with community representatives to assess existing barriers for linkages and coordination at the level of the service points. Indicative budget to address the identified CSS-related barriers can be included.
- Set-up/improve the referral mechanisms between formal and community-led services, such as establishing joint planning and collaboration mechanisms, e.g., facility health committees, community advisory boards or other suitable local solutions to ensure better and more inclusive decision-making, implementation and evaluation.
- Conduct consultations between the community-led and community-based organisations and the government (and private) health facilities to ensure better integration. Based on the identified needs, budget for the development, piloting and scaling up of the consistent and formalized partnership pathways.

**Question 3.2.**

**Is there adequate support to ensure consistent representative participation of the communities in formalized national and subnational level structures and mechanisms for periodic strategic planning, oversight and evaluation in health?**

**If the answer is “yes,” then:**

- Consider including funding for documenting this engagement and any lessons that can be replicated to further strengthen participation of civil society and the communities in national and sub-national processes and discussions.
- Consider including funding to strengthen the feedback loops between community representatives and their constituencies.

**If the answer is “no,” then:**

- Engage with community representatives to assess existing barriers for linkages and coordination at (sub)national level, including but not limited to identifying and addressing gaps in support, funding and/or capacity. Include indicative budget for interventions to remove barriers/address these gaps.
- Assess the existing national health accountability and governance mechanisms. Include indicative funding to address any weaknesses or gaps in regular and participatory (inclusive of communities) strategic planning, oversight and evaluation in health programs.
- Include feasibility studies or other activities aimed to establish and formalize multisectoral accountability and governance mechanisms to foster representation, equity and inclusion of communities, especially key and vulnerable groups. Consensus building exercises could be part of the approach.

**Question 3.3.**

**Does the country have an overview of community-led and community-based services and routinely collects information about the quality of these services?**

**If the answer is “yes,” then:**

- Include interventions to feed the information on community-led and community-based services, including efforts to address human rights, stigma and gender-related issues into developing or updating national community-led and community-based strategies as integral to country strategies and plans to fight HIV, TB and malaria.
- To enable broad and effective community engagement in the above strategy development or revision, consider community capacity building on strategic planning, including (formative) assessment methods, gap analysis, monitoring and evaluation and budgeting.

**If the answer is “no,” then:**

- To understand the current landscape of community-led and community-based services, including efforts to address human rights, stigma and gender-related issues, a mapping could be conducted to establish what service packages are offered, by whom, to what populations, where and with what results/impact.



**Question 3.4.**

**Are there platforms (e.g., coalitions, consortia, joint committees) that coordinate community-led and community-based responses in health responses, facilitate linkages within and between the HIV, TB and malaria and broader public movements and communities?**

**If the answer is “yes,” then:**

- Document experiences and lessons learned, assess development and capacity building needs of these platforms.
- Facilitate learning, such as through (virtual) exchange visits with similar structures to promote the evolution of the platforms that help inter- and intra-community health response coordination and linkages.

**If the answer is “no,” then:**

- Existing community-led and community-based organizations could start a discussion on ways to strengthen engagement and coordination within and between the communities, given the country context and sustainability considerations. Coordinating platforms can cover one or more disease areas and more than one country.
- Funding and assistance could be requested for creating a platform to improve coordination, joint planning and effective linkages between communities and other health actors and broader movements such as human rights and women’s movements.

## Examples of community engagement, linkages and coordination

- In **South Africa**, the first National Sex Worker HIV, TB and STI Plan was developed through active engagement of sex workers. Such engagement was facilitated by the national sex worker network, and the South African National Aids Council. The Plan was first launched in 2016, updated in 2021, and includes shared accountability for sustaining national responses to HIV, TB and STI's.<sup>10</sup>
- In **Burundi**, the Burundi Association of People who Use Drugs (BAPUD) were one of the few drugs user-led networks in Western Africa that received core support from Global Fund grants. With these funds, BAPUD was able to develop leadership capacity and strengthen their network. In 2022 for the first time the association was planning to engage in the Universal Periodic Review – a process of the Human Rights Council to monitor, analyze, and draw attention to human rights violations.
- In **Uganda and Mozambique**, LGBT-led organizations in collaboration with national health authorities have successfully established Trusted Access Platforms to increase access to HIV and health services for local LGBT communities. Key populations Trusted Access Platforms offer services in a variety of community settings, with convenient operational hours and using different providers to meet people's different needs and preferences.<sup>11</sup>
- In **Bangladesh**, a Global Fund sub-recipient – the Network of People who Use Drugs (NPUD) was advised by the International Network of People who Use Drugs (INPUD) on organizational development. It was then supported by the principal recipient "Save the Children" to make an organizational development plan and obtain financial support to carry it out. In 2014 in the **Republic of Moldova**, the Key Affected Populations (KAP) Committee was created to ensure the participation of the communities affected by HIV and TB in the national and local disease responses. KAP Committee coordinates the implementation efforts and decision-making of its members; it also contributes to members' social mobilization and maintains a capacity building plan.<sup>12</sup>

## Resources and tools for community engagement, linkages and coordination

- Advancing Partners and Communities, USAID, **Community Health Systems Catalog Survey Tool and Community Health Systems Framework for Advance Family Planning**; 2019.
- Kristen Devlin, Tanvi Pandit-Rajani, and Kimberly Farnham Egan. **Senegal's Community-based Health System Model: Structures, Strategies, and Learning**. Arlington, VA: Advancing Partners & Communities; 2019.
- Kristen Devlin, Tanvi Pandit-Rajani, and Kimberly Farnham Egan. **Malawi's Community-based Health System Model: Structure, Strategies, and Learning**. Arlington, VA: Advancing Partners & Communities; 2017.
- Stop TB Partnership, **Community System Strengthening and TB**; 2014.

10. 2nd National Sex Worker Plan Launched, NACOSA, 2021 <https://www.nacosa.org.za/2021/11/08/2nd-national-sex-worker-plan-launched/>

11. Frontline AIDS, 2021, <https://frontlineaids.org/resources/trust-and-choice/>

12. TB Europe Coalition, analytical report, 2020 [https://www.tbcoalition.eu/wp-content/uploads/2020/12/AnalitichZap\\_Moldova\\_Engl.pdf](https://www.tbcoalition.eu/wp-content/uploads/2020/12/AnalitichZap_Moldova_Engl.pdf)

## Priority Area 4: Capacity Building and Leadership Development

### Issue:

Community-led and community-based organizations and networks require core funding and differentiated capacity building to participate in the health and social services responses, innovate and address changes and shifts in HIV, TB and malaria. Organizational leadership requires capacity to hold decision makers accountable, engage duty bearers and lead active and well-functioning civil society. However, organizational capacity and leadership development activities are often ad hoc, sporadic and not tailored to the countries' and communities' contexts.

### Objectives:

Capacity building<sup>13</sup> and leadership development of community-led and community-based organizations is tailored to community needs and contexts in which they operate (including communities' safety and security), is linked to health objectives, and entrenches meaningful participation and engagement of the communities in the health and social response.

### Critical questions and recommended CSS requests:

#### Question 4.1.

**Are there capacity gaps at community-led and community-based organizations, especially community-led organizations representing key and vulnerable populations, identified through recent (capacity) assessments?**

#### If the answer is "yes," then:

- Capacity development through cross-learning and mentorship programs or platforms that strengthen the capacities of community-led and community-based organizations (in governance, financial management, strategic and sustainability planning, leadership development, program management, monitoring and reporting) necessary for meaningful participation in the national response can be included.
- Development of strategy, governance and policy documents for community-led and community-based organizations, such as human resource policies, resource mobilization and social dialogue strategies for either individual organizations and/or networks of organizations will contribute positively to their capacity to participate in the disease response.
- Funding requests can include activities to create differentiated capacity development plans, and funding for their implementation to ensure small and nascent community-led and community-based organizations, which represent under-served populations (and/or in priority geographical areas, or specific operational contexts), are able to take up a stronger role in the national response.
- Small grants to community-led and community-based organizations and networks can be used to strengthen their capacities, especially for community service provision, social mobilization, CLM, research and advocacy, and through enhancing South-South collaboration among community organizations, peer-to-peer technical support and mentorship.

13. Such as institutional strengthening, including financing management, community mobilization, program design, management, monitoring and evaluation.

**Question 4.2.**

**Are there standards or guidelines for recommended capacities and competencies for community-led and community-based services, based on defined roles and service packages? Are these accessible for community-led and community-based organizations?**

**If the answer is “no,” then:**

- CSS modules can include participatory development of capacity assessment tools, their piloting and implementation. Funding to formulate capacity development plans and support their execution can be requested.

**If the answer is “yes,” then:**

- As part of CSS activities, develop and carry out the (technical and programmatic) capacities and competencies development plans for community-led and community-based organizations. The plans should be needs-based and can cover leadership development and strengthening of the institutional and organizational governance, financial management, sustainability planning, internal policies, program management, M&E, learning and reporting.

**If the answer is “no,” then:**

- Consider developing standards for the required competencies for the delivery of community-led and community-based services. The standards and competencies must be developed with the participation of community-led and community-based groups, organizations and networks, as well as other stakeholders, and linked to costing community-led and community-based interventions.
- Funding requests can include budgets to build the capacity of community-led and community-based organizations in delivering quality HIV, TB and malaria services, aligned to national/community health strategies and operational plans.

**Question 4.3.**

**Does the country have mechanisms for registering community organizations and are these mechanisms accessible to community-led and community-based groups, networks, or organizations?**

**If the answer is “yes,” then:**

- Funding can be requested to disseminate information and assist community-led and community-based groups in understanding, accessing and complying with the registration mechanisms, processes and policies.
- Legal registration of community organizations, especially those led by and/or working with marginalized populations, including preparation of necessary documents can be included in the CSS module.

**If the answer is “no,” then:**

- Funding requests can include advocacy and other activities to reform policies to remove barriers in registration mechanisms for community-led and community-based organizations.
- A lack of enabling legal and regulatory environment may hinder community-led and community-based health responses, especially for key and vulnerable populations. It may also restrict the engagement of non-registered, small and nascent community groups, as part of CSS, to produce investment cases, inform advocacy and organize consensus building around change interventions.
- CSS interventions can include the development of templates and tools that can be adapted and used by community-led and community-based organizations to ensure that they have the necessary documents, policies and governance structures in place for legal registration and operations.

- Funding can also be requested to make sure community-led and community-based organizations understand and adhere to the financial and reporting standards and requirements.

**Question 4.4.**

**Do community-led and community-based organizations and networks have the suitable infrastructure and core costs funding to strengthen their response to HIV, TB and malaria?**

**If the answer is “yes,” skip question.**

**if the answer is “no,” then:**

- Infrastructure (furniture, equipment and software) and core costs of community organizations and networks to support/strengthen service provision, social mobilization, community monitoring, advocacy, and social dialogues can be included. Core costs do not directly produce the above outputs, but are necessary to deliver them and include, e.g., (a percentage of) general management salaries, governance costs, telecommunications, rent, networking, monitoring and evaluation.

## Examples of capacity building and leadership development

- In **South Africa**, community-led and community-based organizations were invited to apply for capacity building support. This support included capacity assessments, capacity development and access to training and mentorship. As part of this effort, the national sex worker movement, Sisonke, was supported by a Global Fund principal recipient (NACOSA) to strengthen their institutional capacity. As a result, Sisonke accessed further financial support for their work.
- Mentors from TB Europe Coalition, active in Eastern Europe and Central Asia region, piloted a program “3C to End TB: Competence, Confidence, Change,” providing series of supporting sessions to the leaders of community organizations from **Azerbaijan, Belarus and Uzbekistan**. The aim was to enhance organizational and interpersonal skills of the participating leaders to to strengthen external partnerships and improve internal management practices.<sup>14</sup>
- In **Nepal**, through technical assistance from the Community Engagement Special Initiative, the principal recipient Save the Children supported women-led and youth-led organizations to ensure that the harm reduction programs in the context of HIV were gender-responsive, and these organizations are engaged in the program delivery.
- In **Papua New Guinea**, the Network of Sex Work Projects has been supporting Friends Frangipani, a sex workers-led organization, to strengthen their organizational structure and governance to access Global Fund funding to implement HIV programs for sex workers.

## Resources and tools for capacity building and leadership development

- AIDS Rights Alliance of Southern Africa (ARASA), **Training and Leadership Programme (TaLP) trainer manuals and resources**; 2021.
- PITCH, **Does capacity Development increase the demand for health services and rights for key populations? Lessons from a systematic literature review**; 2020.
- Global Network of People Living with HIV (GNP+), **Young Wild and Free: Implementation Guide**; 2020.
- United Nations Office on Drugs and Crime, INPUD, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organization, United States Agency for International Development. **Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions**. Vienna: United Nations Office on Drugs and Crime; 2017.
- UNDP, IRGT: A Global Network of Trans Women and HIV, UNFPA, UCSF Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health, WHO, Joint United Nations Programme on HIV/AIDS, USAID, **Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions** (the ‘TRANSIT’); 2016.
- World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, The World Bank. **Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions**. Geneva, World Health Organization, 2013.

14. TB Europe Coalition, pilot mentoring program reports available <https://www.tbcoalition.eu/>

# Prioritization Approach

Include a brief description under section 1.2. "Rationale," points A and B of the funding request. Reference any documentation (such as analyses, prioritization exercises, etc.) which informed your responses, include this documentation in the List of Annexes and Abbreviations, and submit in the application package.

To prioritize:

- Based on the above critical questions, articulate the full CSS needs to include in the funding request.
- Develop an approach to agree which costed CSS interventions should be in the allocation funding and which in the Prioritized Above Allocation Request. Consider costing, potential contribution – even indirect – of the interventions to the national strategies and plans, and the availability and capacity of the community organizations to implement the activities.
- Conduct prioritization discussions with key stakeholders.
- Document the decision-making process and rationale followed to make this prioritization.

## Resources and tools

**"Civil Society and Community Priorities Costing Guide for the 2023-2025 Allocation Period."**

# Additional Information for the Funding Request

Note that the funding request format will also require the following information:

- Section 2.3. "Engagement and Leadership of Most Affected Communities" requires a description of how the design for the Global Fund-supported program(s) will maximize the engagement and leadership of most affected communities, namely:
  - How program priorities and design were informed by input from communities engaged in the design of these services or in the development of this funding request: what processes, mechanisms and methodology were used.
  - How ongoing feedback and input from communities will be used to continuously improve the accessibility, availability and quality of services during grant implementation.
- Section 3. Implementation Arrangements:
  - Question 3.1.A requires a description of the changes to implementation arrangements which will maximize implementation effectiveness. Namely, how connections between public, community, private for-profit, and private non-profit sectors will be strengthened. This is an opportunity to include the prospective roles that community-led and community-based organizations will play in the health response.
  - Question 3.1.B requires a description of the role that community-led and community-based organizations will have in implementing and monitoring programs supported by the Global Fund. Namely:
    - The role that community-led and community-based organizations will play in the implementation arrangement(s), including the value/opportunity cost of such approaches.
    - Actions taken to address barriers that prevent community-led and community-based organizations from inclusion in implementation.
- Finally, there is a mandatory annex "Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria." Civil society representatives in the CCM should coordinate the completion of this annex with the support of the CCM Secretariat using the evidence generated through the responses above as justification/rationale. Maximum of 20 priorities should be included.



# Abbreviations and Acronyms

<b>AAAQ</b>	Accessibility, Acceptability, Affordability and Quality
<b>ALMA</b>	African Leaders Malaria Alliance
<b>ARASA</b>	AIDS Rights Alliance of Southern Africa
<b>CCM</b>	Country Coordinating Mechanism
<b>CE-SI</b>	Community Engagement Strategic Initiative
<b>CLM</b>	Community-Led Monitoring
<b>COWLHA</b>	Coalition of Women Living with HIV and AIDS
<b>CSS</b>	Community Systems Strengthening
<b>EANNASO</b>	Eastern Africa National Networks of AIDS and Health Service Organizations
<b>FACT</b>	Facilitators of Community Transformation
<b>GNP+</b>	Global Network of People Living with HIV
<b>IDPC</b>	International Drug Policy Consortium
<b>INPUD</b>	International Network of People who Use Drugs
<b>ITPC</b>	International Treatment Preparedness Coalition
<b>KAP</b>	Key Affected Populations
<b>M&amp;E</b>	Monitoring & Evaluation
<b>NACOSA</b>	Networking HIV and AIDS Community of Southern Africa
<b>NPUD</b>	Network of People who Use Drugs
<b>NSP</b>	National Strategic Plan
<b>PAAR</b>	Prioritized Above Allocation Request
<b>PLHIV</b>	People Living with HIV
<b>TAG</b>	Treatment Action Group
<b>TPT</b>	Tuberculosis Preventive Therapy
<b>ZCLDN</b>	Zimbabwe Civil Liberties and Drug Network