COMMUNITY SYSTEMS STRENGTHENING FRAMEWORK AUGUST 2011

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

ACRONYMS & ABBREVIATIONS

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

CONTENTS

FOREWORD

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

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

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

- the Joint United Nations Programme on HIV/AIDS (UNAIDS);
- the World Health Organization (WHO);
- the United Nations Children's Fund (UNICEF);
- the World Bank;
- MEASURE Evaluation;

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

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

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

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

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

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

- the Coalition of the Asia Pacific Regional Networks on HIV/AIDS (7 Sisters);
- the International HIV/AIDS Alliance;
- the United States Agency for International Development (USAID) Office of HIV/AIDS;
- the U.S. Office of the Global AIDS Coordinator (OGAC);
- United Nations Development Programme (UNDP) Burkina Faso;
- Ministry of Health and Social Welfare Tanzania;
- independent consultants and Global Fund staff.

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

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

EXECUTIVE SUMMARY

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

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

WHY IS COMMUNITY SYSTEMS STRENGTHENING IMPORTANT FOR HEALTH?

Community organizations and networks have a unique ability to interact with affected communities, react quickly to community needs and issues, and engage with affected and vulnerable groups. They provide direct services to communities and advocate for improved programming and policy environments. This enables them to build a

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

community's contribution to health, and to influence the development, reach, implementation and oversight of public systems and policies.

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

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

Implementing Community Systems Strengthening

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

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

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 nonexclusive list of activity examples for each 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 one. 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 programs and health systems, ensuring that they identify those areas where full involvement of the community is needed to improve the scope and quality of services delivery, particularly for areas hardest to reach. A brief description is provided for how CSS can be included within Global Fund proposals. Further guidance can be found within the Global Fund proposal form and guidelines relevant to each funding round, starting with Round 10.

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

1. COMMUNITY SYSTEMS STRENGTHENING – A FRAMEWORK

KEY TERMS USED IN THE FRAMEWORK

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

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

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

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

Key affected populations, people or communities are those who are most vulnerable to and affected by conditions such as malaria, tuberculosis and HIV. They are the most often marginalized and have the greatest difficulty achieving their rights to health. Key affected populations include 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 laborers; people in conflict and post-conflict situations; refugees and displaced persons.[8]

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

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

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

WHAT IS THE PURPOSE OF THE CSS FRAMEWORK?

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

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

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

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

The framework is strongly informed by a renewed sense that community engagement for health is essential for achieving the basic human right to health for all. The Alma Ata Declaration of 1978 was a key starting point, affirming that: "... *health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.*"[9]

More recently, this fundamental principle was reinforced in 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 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 organizations in: increasing access and adherence to treatment; development of health service performance assessment guidelines; and the need for joint development of partnership frameworks between communities and health and other services.[15]

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

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

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

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

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

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

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

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

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

The important roles that community actors can and should play in achieving better health outcomes are emphasized, highlighting the unique advantages of community organizations and networks in their ability to deliver services within communities and with regard to their ability to affect the broader determinants of health that often outweigh any intended impacts through improving health service access and use.[16,17] These determinants affect people's mental and physical health and well-being at many levels. They include, for example, income and social or cultural status; education; physical environment; employment and working conditions; social support networks and welfare services; genetics, personal behavior and coping skills; and gender. Community actors are in a unique position to work on these issues alongside health, social welfare and other actors and systems. Together, they can achieve the scale, range and sustainability of interventions that will help to realize people's rights and enable them to reach important goals for their health and well-being.[18]

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

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

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

Table 1: **The CSS Framework – Six core components of community systems**

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

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

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

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

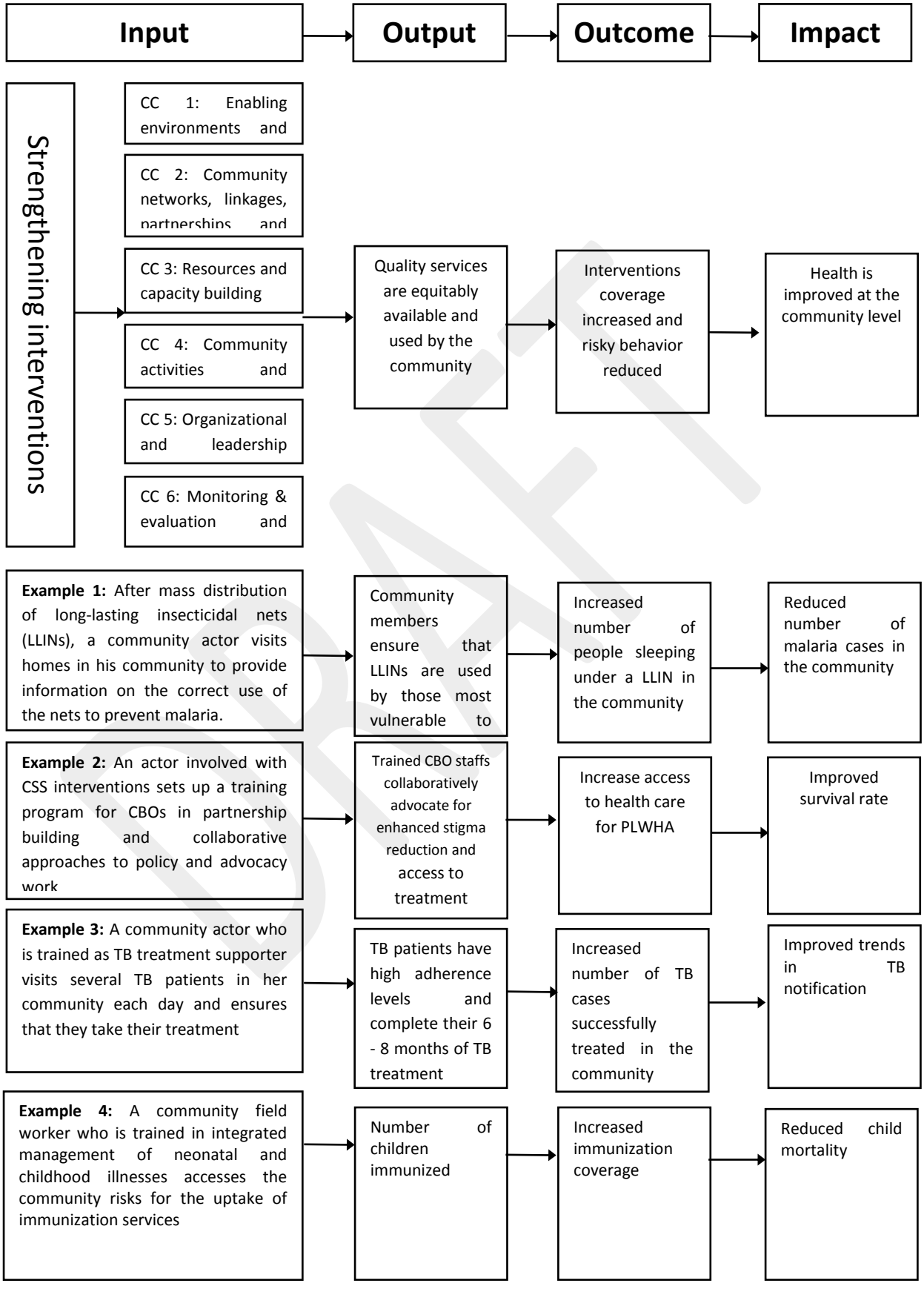
5. **Organizational and leadership strengthening** – including management, accountability and leadership for organizations and community systems;

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

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

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

Figure 1: Overview of a strengthened community system, with examples *(CC = core component)*



WHO IS THIS FRAMEWORK FOR?

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

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

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

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

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

- networks and organizations of, or for people with or affected by, key diseases;
- international, regional and national civil society organizations and networks involved in advocacy and monitoring or "watchdog" activities;
- national funding mechanisms (such as Global Fund Country Coordinating Mechanisms);
- bilateral and multilateral organizations and donors;
- technical partners including UNAIDS and co-sponsors, and private-sector or nongovernmental technical support providers involved in capacity building, training and technical support for community actors

2. STRENGTHENING COMMUNITY SYSTEMS TO CONTRIBUTE TO HEALTH OUTCOMES

WHAT IS COMMUNITY SYSTEMS STRENGTHENING?

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

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

Key underlying principles of community systems strengthening include:

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

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

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

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

WHAT NEEDS STRENGTHENING?

The strategies outlined above indicate the priority areas for strengthening the systems used by community-based organizations and other community actors. Systems for the organization and delivery of activities and services[19] are integral to any organized program or service, whatever the size, structure or status of the group or organization that implements them. In practice, the systems of one actor are often linked to those of other actors to provide a

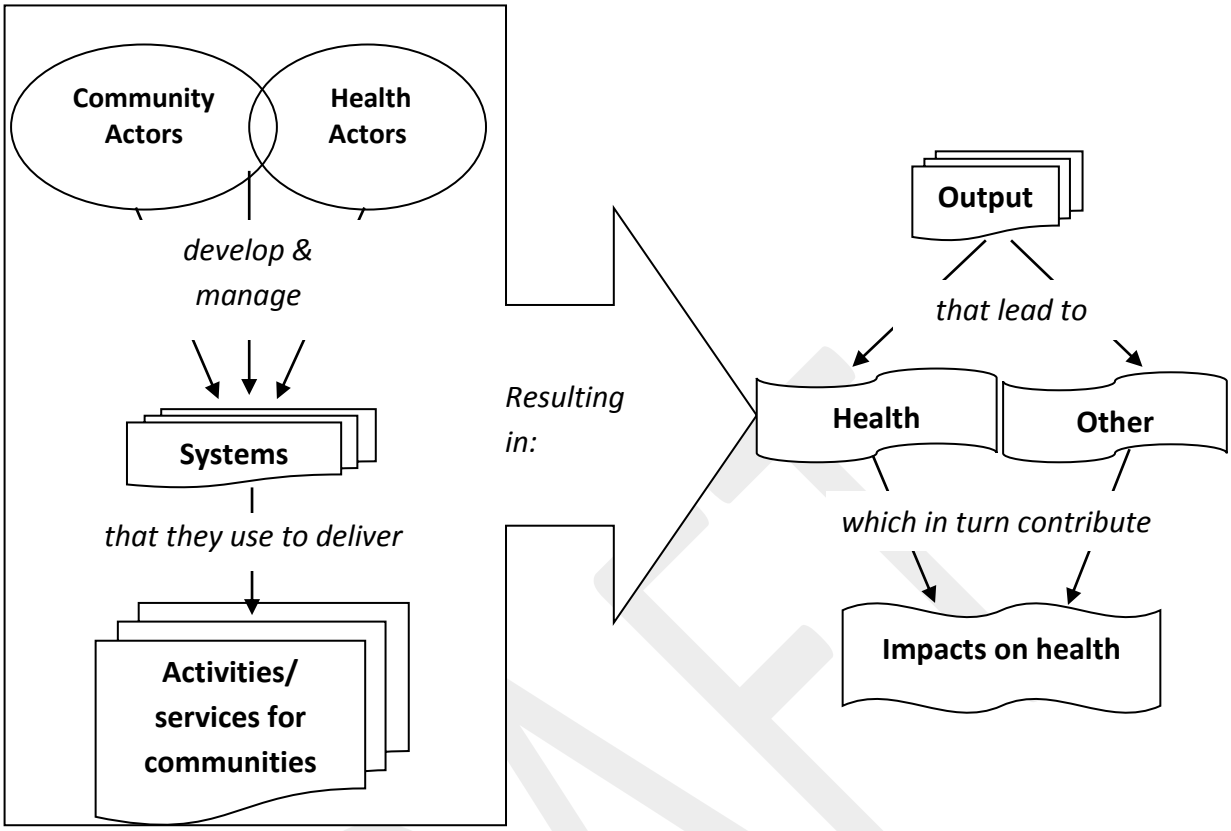
functional overall system. For example, a well-developed community system for care and support might include specific systems for providing counseling; for policy advocacy; for legal support; for referral and access to services and follow-up; for home-based care; and for social protection and welfare of vulnerable children, youth and adults.

Figure 2 shows how different actors, working together or separately, use systems to implement services and activities, providing results at the levels of outputs, outcomes and impacts. Effective and functional systems play an enabling role for actors to deliver activities. They are therefore crucial for contributing to meaningful effects on health and/or nonhealth factors. Health and nonhealth outcomes can both contribute to health impacts. However, the functioning of systems and their results also depends on the influence of factors in the surrounding environment that may enable or disable effective service delivery and the functioning of systems.

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

[19] Programmatic 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 programmatic activities and services. Service delivery area (SDA) is a key term used in this framework.

Figure 2: Community action and results for health



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

Community-based organizations are rich in experience and close to communities but they often have very limited financial resources. CSS must therefore proritize adequate and sustainable funding for community actors – not only funds for specific project activities and services, but crucial core funding to ensure organizational stability for operations and for networking, partnership and coordination with others. Unrestricted core funding, based on agreed structures and procedures, contributes to sustainability by ensuring continuity and

allowing an organization to have the appropriate paid staff, supplies and infrastructure to build up their chosen programs in response to the needs of the communities they serve.

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

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

By their very nature, communities are organic and diverse, and a great variety of groups and organizations – community actors – arise in response to perceived community needs.[20,21] At their simplest, they may lack formal structures or capacity for running administrative systems, managing funds or communicating effectively with officials and other organizations. Larger community organizations may have those skills and capacities but may be working in isolation from each other and from mainstream government systems.

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

In some settings there is excellent cooperation between different actors, but it is important not to overlook the inequalities, social hierarchies, discrimination and competitiveness that sometimes operate among community organizations, and between them and government structures. Creating and maintaining good working relationships, and ensuring adequate,

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

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

equitable and sustainable funding for community organizations and actors are therefore key priorities for strengthening and scaling up community systems.[22]

WHAT HEALTH-RELATED ACTIVITIES AND SERVICES DO COMMUNITY SYSTEMS DELIVER?

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

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

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

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

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

health systems are just one part of a wider set of social support systems that are relevant to people's health and well-being.

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

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 for ensuring 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 counseling and testing, treatment follow-up[24] or crosscutting health interventions;[25]
   - disease prevention activities;[26]
   - community health services such as home-based care or TB-DOTS;[27]

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

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

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

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

[27] Fakoya A, Abdefadil L. Home is where the care is: the role of communities in delivering HIV treatment care and support [Internet]. Public Service Review: International Development: 15. 2009 Sept. 23. Available from:

- community health education and promotion;
- services to neglected and vulnerable populations;
- implementation and monitoring of policies that affect access to health and welfare services.

ii. Support activities for individuals accessing health-related services at the community level:

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

iii. Activities to create and improve the enabling environment:

Social determinants of health

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

Broader determinants of health

- participation in local and national forums for policy change;
- nutrition, housing, water, sanitation and other material support to vulnerable children and adults;

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http://www.publicservice.co.uk/pub_contents.asp?id=401&publication=International Development&content=3850&content_name=Health

- livelihood support programs such as microcredit or savings schemes, training schemes for unemployed adults and youth and support for growing food to feed families;
- support for civil rights and access to services, for example civil registration of births and deaths.

COMMUNITY SYSTEMS AND HEALTH SYSTEMS – COMPLEMENTARY AND CONNECTED

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

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

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

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

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

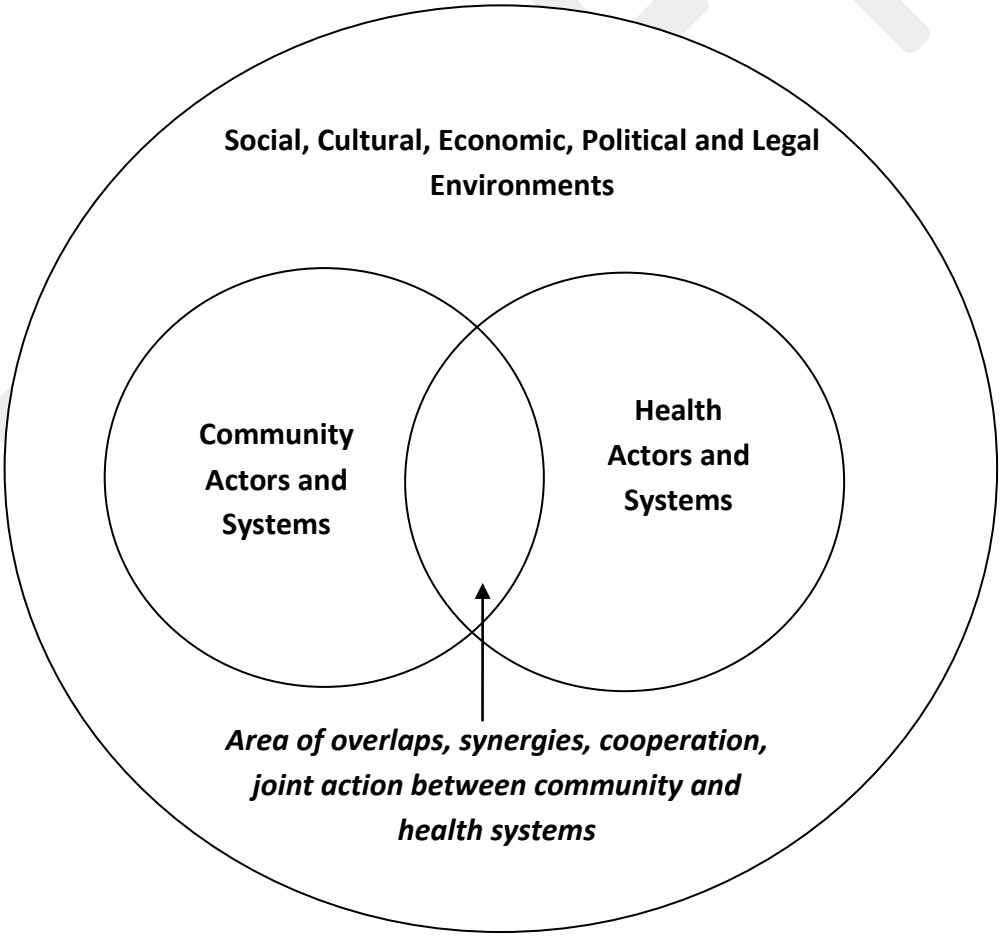

Figure 3: Community and health actors and systems – complementary and connected

evidence-based.

Health systems are not separate from communities. They are key community assets, part of the network of relationships and support that individuals, families and communities are entitled to rely on. Clearly, there are synergies as well as overlaps between health systems, community systems and social welfare systems, but these should be a stimulus for creative and innovative approaches to bring community, health and social systems into closer and more complementary partnerships.[28]

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

3. THE CORE COMPONENTS OF A FUNCTIONAL COMMUNITY SYSTEM

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

Service delivery areas (SDAs) are suggested for each core component, with illustrative lists of activities. Chapter 6 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 Section 6.3.

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

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

Table 2: Summary of CSS Core Components, and characteristics of strengthened service delivery areas (SDAs)

Core components *(not in order of priority; all 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 subgoals for CSS, indicating how a fully functional community system can be recognized when community systems strengthening has been successfully achieved)*
1. Enabling environment and advocacy	SDA 1: Monitoring and documentation of community and government interventions	Community-based organizations analyze and document relevant issues and plan and implement involvement in policy activities at appropriate levels.
	SDA 2: Advocacy, communication and social mobilization	Communities effectively advocate for implementation and improvement of national programs. Well-informed communities and affected populations engage in activities to improve their own environment.

2. Community networks, linkages, partnerships and coordination	SDA 3: Building community linkages, collaboration and coordination	Functional networks, linkages and partnerships between community actors and national programs are in place for effective coordination and decision-making.
3. Resources and capacity building	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 they 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: Service availability, use and quality	Effective, safe, high-quality services and interventions are equitably delivered to those in need.
5. Organizational 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 programs, systems and services.
6. Monitoring and evaluation and planning	SDA 9: Monitoring and evaluation, evidence-building	Relevant programmatic qualitative and quantitative data are 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 to ensure that their rights are respected and their needs are met. The environment should also be one in which community voices and experiences can be heard and community-based organizations can make effective contributions to policies and decision-making.

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

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

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

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

SDA 1: MONITORING AND DOCUMENTATION OF COMMUNITY AND GOVERNMENT INTERVENTIONS

Rationale: Community members and organizations 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 implemented at the community level. In order to fulfill this critical role, community-based organizations 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 data 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 organizations, 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 the planning and design of programs in which they are expected to play a role, for example programs for 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, policymaking and use of resources by public institutions;
- Participation of community actors in national consultative forums;
- Advocacy on legal and policy frameworks, e.g. decriminalization of behaviors or marginalized groups or development and enforcement of child protection policies;
- Contributing community experience and perspectives to the development of national strategies, including cross-sectoral and sector-wide approaches;
- Mapping communication needs and planning strategies for interventions with policymakers and decision-makers;
- Capacity building for communication through media – radio, television and print;
- Developing communication materials for specific audiences, e.g. children, women and sexual minorities;
- Developing relationships with key partners for resource mobilization.

SDA 2: ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION

Rationale: Community-based organizations 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. To play this role, community-based organizations 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 mobilization designed to engage communities at the 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 organizations and networks are also vital for bringing together the broader community and other stakeholders to collaborate in maintaining or improving the enabling environment.

To be successful, community-based organizations and networks need support and assistance to create and implement effective communication and advocacy plans and to set up and implement systems to work with community members, partners, media, government and broader constituencies. Depending on local and national conditions, work on advocacy, communication and social mobilization will depend on a range of different activities, such as direct dialogue with decision-makers and influencers, community consultations and dialogues, letterwriting and petitions, use of new and traditional media and public campaigns.

Examples of activities:

- Map challenges, barriers and rights violations experienced by key affected populations and developing policy analysis, recommendations and strategies to improve the environment;
- Map existing documentation on legal and other barriers or documenting new ones;

- Mobilize communities and key affected populations to engage actively with decision-makers, and represent community issues in major discussion forums relating to health and rights;
- Mobilize key affected populations and community networks to engage in campaigns and solidarity movements;
- Inform and empower community members to communicate and advocate for change and to improve enabling environments at the local level;
- Conduct policy dialogues and advocacy to ensure that issues of key affected populations are reflected in allocation of resources and in national proposals to the Global Fund and other donors, and in national strategic plans;
- Document key community-level challenges and barriers and develop advocacy messages and campaigns to communicate the concerns of affected populations;
- Promote and ensure community representation in policy, planning and other decision-making bodies;
- Actively engage in policy dialogue and advocacy with global, regional, subregional and national NGOs, major international partners such as the Global Fund, UNAIDS, Stop-TB, Roll Back Malaria and other forums such as high level meetings relating to the Millennium Development Goals and UNGASS.

CORE COMPONENT 2: COMMUNITY NETWORKS, LINKAGES, PARTNERSHIPS AND COORDINATION

Functioning community networks, linkages and partnerships are essential to enable effective delivery of activities and services. Strong informal and formal relationships between communities, community actors and other stakeholders enable them to work in complementary and mutually reinforcing ways, maximizing the use of resources and avoiding unnecessary duplication and competition.[29]

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

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

Strong national and regional networks of key affected populations and civil society groups can make important contributions to the accountability of governmental and nongovernmental bodies and organizations, and to the support of community-based activities and service delivery. Networks also have a vital role to play in technical assistance, due to

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

their ability to act as knowledge hubs, contribute to the development of communities of practice, and to distribute appropriate information through their networks, for example on technical tools, good practices and consultants. Strengthening networks for the role of advocates, watchdogs, and technical assistance providers is therefore likely to be an effective investment for effective implementation of services contributing to the broader environment for health.

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

SDA 3: BUILDING COMMUNITY LINKAGES, COLLABORATION AND COORDINATION

Rationale: Funding and support are 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 the consultation and accountability of government and nongovernment actors

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 knowledge and development of plans to involve community members and other stakeholders to play roles in design, implementation and oversight of programs or activities;
- Empower community actors, particularly CBOs and small organizations, to participate effectively in networking and partnerships for service delivery at local level;
- Develop community actor linkages to local, national regional and international coordination bodies;

- Provide operational support for implementing the coordination of activities, such as travel, per diem, communication and overhead costs;
- Develop 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 and district committees;
- Contribute to improved "knowledge management" by supporting sharing of information, tools, good practices or similar activities 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 organizational capacities;
- material resources, including adequate finance, infrastructure, information and essential commodities.

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

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

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

Development of human capacity is important for community leadership and progress toward community health goals. People are the central resource for community organizations and groups, including employees and volunteers and members of community groups and networks. In communities, there are also individuals who provide advice and guidance; act as influencers, enabling access to certain sectors of the community; and contribute to activities such as fundraising or supporting individuals and families. Recruitment, retention and management of human resources are key aspects of organizational strengthening and leadership for advocacy, but they are also essential to ensure that technical skills and experience are given high priority to assure program quality, achieve timely progress toward defined goals, and build the evidence base for

effective community contributions to health. The technical capacity of community actors is becoming increasingly important as combined strengthening of health and community systems and integrated service delivery is proritized in order to reach the Millennium Development Goals (MDGs), for example in TB/HIV integration, sexual and reproductive health and primary care in communities.

SDA 4: SKILLS BUILDING FOR SERVICE DELIVERY, ADVOCACY AND LEADERSHIP

Rationale: Skills-building for service delivery includes organizational 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, and adherence, among other activities. Technical capacity 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, working with multiple stakeholders and public speaking. Community actors also need to have an appropriate understanding of human rights, especially for key affected populations. Capacity building will be needed to ensure that community actors 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 behaviors and their access to and use of services.

Examples of activities:

- Technical capacity building for health support roles — including treatment adherence, peer counseling, HIV counseling and testing, DOTS, malaria prevention, newborn and child health, and nutrition;
- 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 criminalized or marginalized communities, providing integrated TB/HIV services, drug resistance, community audits such as "verbal autopsy" of reasons for deaths;
- Documentation and dissemination of good practice examples;
- Building new technical capacities to enhance the delivery of integrated services such as TB/HIV, sexual and reproductive health , comprehensive PMTCT, and 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 programs 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 counselors, 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 and follow-up;
- Training of trainers on challenging stigma, discrimination and harmful sociocultural practices;
- Advocacy on legal and policy frameworks, e.g. decriminalization of behaviors or marginalized groups and 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 the crucial core funding to ensure organizational stability as a platform for operations and for networking, partnership and coordination with others. It is essential that community actors have the appropriate financing and financial management skills.[30] Community organizations are often unsuccessful in mobilizing core funding that is "unrestricted" – that is, not tied to a specific project or intervention and aimed at support for an organization's basic running costs. However, when based on agreed contractual arrangements, such as a memorandum of understanding and financial reporting to funders, core funding contributes greatly to sustainability. It ensures continuity and allows organizations to have the appropriate paid staff, supplies and infrastructure to build up their programs in response to the needs of the communities they serve.

Organizations may need guidance and technical support to identify sources of funding, develop relationships with funders and successfully meet their criteria. They will need to develop their financial systems and manage them efficiently, transparently and sustainably. The same applies to organizations undergoing expansion due to scaling up of activities or services and increased funding. Different funders apply different rules and reporting requirements and support will be needed to enable organizations to deal with this without being distracted from programmatic work by increased administrative demands. Good management of finances is essential for organizational support and service delivery, and it is also essential for demonstrating good stewardship of funding from donors, governments and communities, which is important for sustainability and mobilizing further resources.[31]

SDA 5: FINANCIAL RESOURCES

Rationale: This SDA concerns support for better mobilization, management and effectiveness of financial resources. This support is required 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 to work successfully toward 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] Kelly K, Birdsall K. Funding for civil society responses to HIV/AIDS in Tanzania: status, problems, possibilities. Johannesburg: CADRE; 2008. Available from: http://www.cadre.org.za/node/192

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

- Hiring, training, supervising and mentoring resource mobilization staff;
- Planning for funding based on organizational development and programmatic needs identified by members and supporters;
- Proposal writing and accounting for and planning activities;
- Capacity building for financial management, bookkeeping, accounting, reporting, use of bank accounts, acquisition, use of accounting software and similar tasks;
- Capacity building on oversight of resources and budgets and the design and implementation of internal accountability systems;
- Hiring external auditors to support accountability to communities and funders;
- Capacity building on resource mobilization, 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;
- 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 organizations lack capacity for dealing with material resources infrastructure, information, and essential commodities (including medical and other products and technologies). They require funding and technical support to develop and operate reliable and sustainable systems for managing material resources, based on standards already developed and widely available.

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

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

Essential commodities of good quality need to be available in the right quantities and at the right times to contribute to the continuity, credibility and effectiveness of activities and services. This includes office equipment and supplies; communication materials; utilities and

building maintenance; fuel for transport; medical products and technologies for prevention, treatment and care (e.g. condoms, insecticide-treated nets, medicines and lab equipment), safety equipment (universal precautions) for community health workers, home care workers and teachers.

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 organizational infrastructure items and supplies, and any items needed for operational activities and service delivery, including, for example, transport and office essentials. Essential commodities range from simple stationery items such as notepads and pencils through campaign and information materials to medicines, dressings, insecticide-treated 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 organization and programmatic context;
- Physical infrastructure development, including obtaining and retaining office space and equipment, improving communications technology, and 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 infrastructure materials and essential commodities, including supplier selection, storage and distribution, preventive maintenance of buildings, computers, office equipment and transport;
- Planning management systems for providing essential medical and other supplies for service delivery such as medicines, lab reagents, syringes, needles, condoms and other consumables, X-ray machines and microscopes;
- 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 centers and online information access systems;
- Packaging of information and lessons learned to disseminate 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/. See 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; and 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. They are therefore an essential and integral component of community systems strengthening. ”Learning by doing” is an important capacity building principle of, and is especially applicable to, systems for service delivery and support at the community level. Quality community programs, activities and services that are evidence-informed and cost efficient will build on existing systems and services and contribute to the creation of demand for services, social behavior change, increased health and reduced disease transmission in the community. Community-based organizations and members of key affected communities are in a unique position to assess and address the needs of their own people. This is especially true for marginalized people who are criminalized and/or stigmatized and who therefore often avoid state services. This direct involvement of organizations and other actors in their own community response brings greater credibility and relevance to community service delivery systems and adds strength to leadership and advocacy. It is essential to provide support to community actors for building and strengthening community systems to deliver services and to support communities to use those services.

A quality approach should underlie the design and implementation of community service delivery systems, from situation assessment and intervention design right through to delivery and assessment of outcomes and impacts. This depends on having a sound basis of informed management and technical skills and the ability to utilize evidence of what works. Systems for service delivery should also be implemented ethically and sustainably by people who are appropriately skilled and knowledgeable. Systems should be based on accepted national or other standards of practice where they exist and should be linked with national health, social care and M&E systems and standards. It may be necessary for community actors to advocate for and initiate development of new practice standards if none exist already. Adaptability of services is important for responding to changes in institutional capacity and resources, in patterns of disease or new knowledge on prevention, care and support, or to changing demographics and political or social environments.[33]

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

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

also focus on the added value that such services and activities can provide, ensuring better planning, implementation and quality improvement based on validated evidence.

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. Community-based services will also deliver interventions aimed at mitigating the effects of diseases on individuals and communities, including the 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 programming and harm reduction, are key concepts in the delivery of community-based services. National guidelines for key community activities and services must be developed 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 vital for delivery of these community-based interventions. Community actors will need appropriate support and technical assistance to identify what systems are in place or are needed to fill gaps, and to develop systems that maximize the 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. Community actors may need to adapt or develop new standards where new approaches and activities are being implemented. Systems for supportive mentoring and supervision will also be needed to ensure continuing quality in service delivery.

Examples of activities:

- Mapping community health and social support services and their accessibility to end users;
- Identifying, ensuring availability and implementing national or other relevant guidelines for delivering quality services;
- Identifying services and activities in which 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 available knowledge and analyzing information sources, flows of information and gaps that need to be addressed to improve decision-making and implementation at national, local and community levels;
- Developing and using knowledge management systems, including information centers, 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; counseling and psychological support systems, including peer-led counseling 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 centers providing a range of services such as information, testing and counseling, referrals, peer support, outreach to key affected people and communities and legal support;
- 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 programs to support key populations at risk, especially excluded and vulnerable populations.

CORE COMPONENT 5: ORGANIZATIONAL AND LEADERSHIP STRENGTHENING

Organizational strengthening is a key area that aims to build the capacity of community-actors to operate and manage the core processes that support their activities. Their activities include developing and managing programs, systems and services effectively; ensuring accountability to their communities, stakeholders and partners; and providing leadership for improving the enabling environment to achieve better health outcomes. Key knowledge and skills in this area would include, for example, leadership in representing the vision and goals of the organization externally and internally, development of systems of accountability and participation in decision-making, management of workers, and respect for employment rights and laws.

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

Accountability is an important aspect of strengthening organizations. It assures communities, stakeholders and partners that there is good stewardship of the organizations' resources. Mechanisms for independent oversight and guidance may be needed to demonstrate accountability. Such mechanisms could include meetings with stakeholders and community members; independent audits of finances and evaluations; open access to information; and

reports for stakeholders, community members and funders on a regular basis. Community organizations that hold themselves accountable to their communities will also build their capacity to engage in advocacy for greater transparency and accountability of public bodies and governments to communities.

SDA 8: MANAGEMENT, ACCOUNTABILITY AND LEADERSHIP

Rationale: Resources and technical support may be needed to build the capacity of organizations 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 organizational systems and of the capacity for strategic planning, monitoring and evaluation, and information management.

Examples of activities:

- Organizational capacity assessment;
- Organizational/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 and supply contracts;
- Developing capacity and plans for human resource recruitment, for example, of technical support systems and organizational needs;
- Development of plans for managing and building capacity of human resources, including job descriptions, career development plans and staff handbooks, to support and retain staff and volunteers;
- Development of key skills, for example writing official reports, letters and proposals;
- Development of systems for training, mentoring and experience-sharing for leadership, organizational development, management and accountability;
- Regularization of legal status (when appropriate) and authority to enter into agreements (for example, opening bank accounts, building leases or 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 program and information management;
- Developing capacity for project design and strategic planning and project cycle management;
- Support in making business plans to become self-sustainable (management training);
- Recruitment, management and remuneration of staff, community workers and volunteers;
- Newsletters for internal circulation to keep staff informed and to create a shared vision;
- Communication of a shared vision among the organizations and sustaining motivation;
- Strengthening community leadership, including shared leadership;
- Developing capacity building systems.

CORE COMPONENT 6: MONITORING AND EVALUATION AND PLANNING

Community-led M&E is essential for community systems. It will provide the strategic information needed to make good decisions for planning, managing and improving programs, and for formulating policy and advocacy messages. It also provides data to satisfy accountability requirements. Community-led M&E will make effective use of data provided by community members. These include data from qualitative and participatory methodologies, such as action research, operational research, focus groups and key informant interviews, as well as data from regular monitoring of operational inputs and outputs and internal or external evaluations. This means that both qualitative and quantitative indicators are needed, that community-level M&E methodologies are essential, and that feedback mechanisms must routinely be used to allow community organizations and community members to use M&E results for reflection and further planning and action.[34,35]

Data collection and analysis should also follow a gender and age-related approach in order to better understand the different vulnerabilities and needs of women and girls, men and boys, and transgender people. For example, gender norms affect women's and men's risks of exposure to mosquitoes and malaria, due to divisions of labor, leisure patterns and sleeping arrangements. This also affects treatment-seeking behaviors, 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. The steps are: definition of target groups and areas; stakeholder identification and consultation; assessment of needs and analysis of gaps and available resources. This will inform discussion about what can realistically be done to fill the gaps, who should be involved and how to make it happen, based on clear and achievable objectives. During implementation, regular review of implementation will help in analyzing progress and answering key questions such as:

- Are we doing the right things?
- Are we doing the right things well?
- Are we doing enough of the right things?
- Have our interventions made a difference?
- How do we know?[37]

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

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

[36] WHO, RBM. Gender, health and malaria. Geneva: WHO & RBM; June 2007. Available from: 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

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

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

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

SDA 9: MONITORING AND EVALUATION, EVIDENCE-BUILDING

Rationale: Community organizations 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, including a lack of computers or other equipment. Much work also needs to be done to improve supervision and planned training — to put effective systems in place 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 organizations 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 programs.

Larger organizations may already be familiar with M&E processes but lack sufficient capacity; smaller groups and organizations 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 that will add value and avoid unnecessary duplication of efforts and activities. This effort 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 on interventions is lacking, it will be important to include research within implementation plans, for example operations research, 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 within a broad group of stakeholders. It contributes to translating knowledge into policy and action, to sharing and applying knowledge based on experience at local level and with policy and program decision-makers at national, regional and international levels. Community organizations 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 the start of a program to ensure their buy-in and participation in situation analysis;
- Capacity building in the analysis of community situations, sources of vulnerability, resources, strategic partners, and gaps in and obstacles to accessing and using available services;
- Capacity building on rights, participation and protection for children and other vulnerable adults and youth, for example, in performing situation analysis, collecting qualitative data on outcomes and documentating experiences;
- 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 the development and use of simple-to-use standardized records and registers for essential data;
- Developing capacity for design and implementation of data collection, service-user interviews and desktop reviews;
- Developing capacity for analyzing data, and identifying and documenting key information and lessons learned;

[38] There are many guides to M&E and Project Management; a highly developed guide from the Global AIDS Monitoring and Evaluation Team (GAMET) 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

[39] See for example (especially chapters 4 and 6): WHO. Operations manual for delivery of HIV prevention, care and treatment at primary health centres in high-prevalence, resource-constrained settings [Internet]. Geneva: WHO; 2008 Dec 2. Available from: http://www.who.int/hiv/pub/imai/operations_manual/en/

- Training in the 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 and interviews;
- Exchange visits and peer-to-peer learning and support on community M&E.

SDA 10: STRATEGIC AND OPERATIONAL PLANNING

Rationale: Assessment of needs and analysis of gaps and available resources at the community level are essential first steps for community actors. Community needs and resources vary between communities and among key affected populations, such as drug users, sex workers and older people. Existing information sources need to be researched 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 the goals are, and what key activities and resources will be required to achieve the goals. An operational plan or workplan is important for community planning. It is based on a strategic plan and provides specific details, timelines and budgets for implementation of activities and programs. 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 interventions will happen, the resources available, and other factors. Effective planning should always be based on prior analysis and information gathering.

Small groups and organizations may use a simplified approach for strategic planning, but the steps required are very similar whatever the size of organization. First, it is important to decide how the process will work – who will be involved, how decisions will be made, and what timeline to follow to finalize the plan. There needs to be consensus on what is important to the organization and what it wants to achieve for the community. Are its values and community vision directed toward equality for women and girls, for example, or a community in which no one dies of malaria? This consensus will enable the group or organization to define its mission – the contribution it aims to make to the community – and specific goals and targets to achieve this. It will then be possible to start analyzing and costing resources and plan a timeline for implementation.

Evidence-based operational plans for implementation, based on the strategic plan, will include activities and budgets for defined periods, for example 6 or 12 months at a time. Other plans should also be developed from an early stage to support the organization and program implementation, for example plans for management and human resources, monitoring and evaluation, operations research and documentation of good practice, resource mobilization, 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 organizational and technical capacity building plans;
- Development of plans for regular reporting and communication to government, stakeholders, community and partners;
- Orientation for program staff on program vision, objectives, plans and policies at the start of a program 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 were revised in 2010 to reflect the increased importance of CSS within Global Fund proposals.

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

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

Applicants may include CSS-related interventions in their disease-specific proposal or under the HSS crosscutting 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 of interest, but should also include general community systems strengthening interventions.

It is important to focus on aspects related to strengthening community systems in the context of service delivery, advocacy and enabling environment for the three diseases. Because CSS particularly focuses on affected communities, CSS interventions should be harmonized across the three disease components whenever possible. Overlap should be carefully avoided. Thus, HIV, TB and malaria programs need to coordinate their efforts, avoid duplication and ensure that CSS interventions for the different diseases are complementary at

the community level. Since the Global Fund uses a performance-based funding system, it is important that a limited number of indicators are carefully chosen as a basis for regular reporting to inform disbursement decisions. Before and during the proposal development process the following steps should be undertaken:

- create an enabling environment for the participation of all stakeholders (representation of the different stakeholders involved in the national response, particularly the key populations);
- assess, in advance of a Global Fund call for proposals, the gaps and constraints to address in the funding request, the implementation model or strategy, the characteristics of potential beneficiaries, and the component (HIV/AIDS, TB, malaria or HSS);
- read the Global Fund proposal form and guidelines thoroughly and consider in every part of the proposal how communities can be strengthened;
- read all relevant Global Fund Information Notes, which can be found on the Global Fund website: 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 organized consultations).[40]

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

5. A SYSTEMATIC APPROACH FOR DEVELOPING CSS INTERVENTIONS INCLUDING MONITORING AND EVALUATION

The objective of this chapter is to provide guidance to CSS implementers on the different steps to be undertaken to build or strengthen a system for CSS interventions. CSS implementers will generally be larger organizations such as Principal Recipients, governmental departments or large NGOs that work with community organizations and actors. A functional system for CSS interventions addresses identified needs and demonstrates progress toward strengthening community systems. Table 3 provides a summary of the key steps to be undertaken by CSS implementers. These steps are explained in greater detail below.

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

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

The aim of CSS should not be to strengthen individual organizations but to strengthen the community system as a whole. For this reason when choosing to work on a specific geographic area CSS should focus on all organizations in this area that are involved

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.

Step 2: Conduct a needs assessment to determine the strengths and weaknesses of the community system in the targeted area(s).

Step 3: Based on expected results, define clear and achievable objectives.

Step 4: Determine the 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.

with service delivery for a particular disease. These organizations will together form the denominator for the CSS indicators. More information about how to define the denominator is included in Section 6.1 of the CSS Framework.

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

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

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 timeline).

To support this process an assessment tool could be used.[41] The Global Fund is currently developing such a tool in cooperation with partners.

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. 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).

Step 4: Building on the objectives and the outcome of the needs assessment, determine the

[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. Available from: http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_en.pdf (updated version in preparation)

list of SDAs for which system strengthening measures are required. It is important to understand that the six core components and the ten SDAs are equally essential for building strong community systems. The CSS implementing organization should focus on areas where strengthening is most needed. Core components and SDAs can be strengthened stepwise, for example in year one the focus can be on strengthening a particular set of SDAs, while in year two 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, resulting in improved health outcomes at the community level. Ensure that the selected interventions are based on evidence and match the needs identified by the community. A number of example activities are including for each of the SDAs in this document.

Step 6: When a decision has been made regarding the types of interventions, it is necessary to work on the indicators to measure progress in CSS over time. Section 6.2 provides an overview of the recommended CSS indicators and section 6.3 contains detailed definitions for each indicator. It is important to understand that not all indicators listed in this document are relevant for each CSS program.

A great variety of organizations are active at the community level, as well as many regional and national variations. A tailored package of appropriate indicators should be selected for each country and organizational context. For this reason many indicators have been defined broadly to allow for flexibility.

For example, some of the indicators make reference to “minimum acceptable capacity” to deliver services (indicator 7.1). For this indicator, specific standards for minimum capacity will have to be defined that are appropriate for the country context. Also the reporting frequency should be adjusted for each indicator to match existing reporting cycles. In addition, the indicator definitions should be adjusted when 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.

The Global Fund recommends selecting a limited number of indicators for CSS interventions. A CSS program could contain 10 to 15 indicators or, if included in a disease component, 4 to 6 indicators. It is important to note that CSS indicators cannot be completely separated from HSS indicators. Some indicators will cover both CSS and HSS, as does indicator 6.4. “Community-based organizations/facilities that maintain acceptable storage conditions and handling procedures.” The indicators can be used for Global Fund-supported programs and for other programs.

In consultation with the identified stakeholders, applicants should agree on a limited number of simple-to-use, clearly defined and harmonized CSS indicators. Also, M&E efforts need to ensure consistency between the gap analysis of the community systems and the selected SDAs and indicators. Make sure that collected data are useful for program 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 and retraining 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: Develop the budget and workplan to define baselines and set targets. The needs assessment conducted in Step 3 should inform setting baselines for each of the selected indicators. Define the scale on which the CSS interventions should be implemented to reach the set objectives. Take into account limitations such as availability of human and material resources, environmental obstacles such as geography and terrain as well as political and physical infrastructure. Determine the resources currently available for CSS interventions and identify what and how many additional resources will be required. Building on this analysis, set ambitious yet realistic targets for all selected CSS indicators.[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 workplan and budget for the CSS interventions. Remember that the budget should provide detailed assumptions of estimated costs for all planned activities. The workplan should identify a clear timeline and responsible actors for implementing each planned activities.

Step 8: Information related to CSS such as leadership, advocacy, governance and accountability is often not captured by health information management systems. Other issues such as resource mobilization, partnership and staff performance at the community level are not completely captured but require further integration. Strong leadership and joint planning with community stakeholders are key to creating a conducive environment for the integration of M&E for CSS into the national reporting system. When setting up the M&E system for CSS interventions, it is important to ensure that the reporting flow follows existing reporting lines and established structures. Also ensure that there is no parallel system for reporting on CSS within or between disease components through close coordination between community-based organizations, other community actors and local government authorities.

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

Step 10: Develop appropriate reporting forms and data collection tools in consultation with the community-based organizations and actors. Tools and forms should be easy to use and should only capture information that is useful for program management and informed

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

decision-making. It is imporant that the same tools and forms are used by all stakeholders involved in the CSS program to facilitate integration of data into the national reporting system. Not all information collected at the community level needs to be reported to the national level. Community stakeholders and CSS implementers should discuss and agree what needs to be reported.

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

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

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

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

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

6. MONITORING AND EVALUATING COMMUNITY SYSTEMS STRENGTHENING

6.1 CSS INDICATORS

This section contains 29 process and output indicators for CSS that have been developed through a series of consultations with a large number of stakeholders representing key affected populations, community-based organizations and implementers, governments, and various international bilateral and multilateral organizations. Please refer to Table 5 for more details on the development process.

Table 5: CSS indicator development process

August 2008: The Global Fund commissioned a review exercise in Pretoria, South Africa, 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 multipartner technical working group on CSS commissioned nine case studies in different countries on community systems strengthening and community level monitoring and 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. A new list was developed that 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 two day civil society consultation meeting in Brighton, United Kingdom.

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

April-August 2011: A multipartner technical working group reviewed the 27 CSS indicators in consultation with implementing partners to derive the 29 indicators currently in the CSS framework.

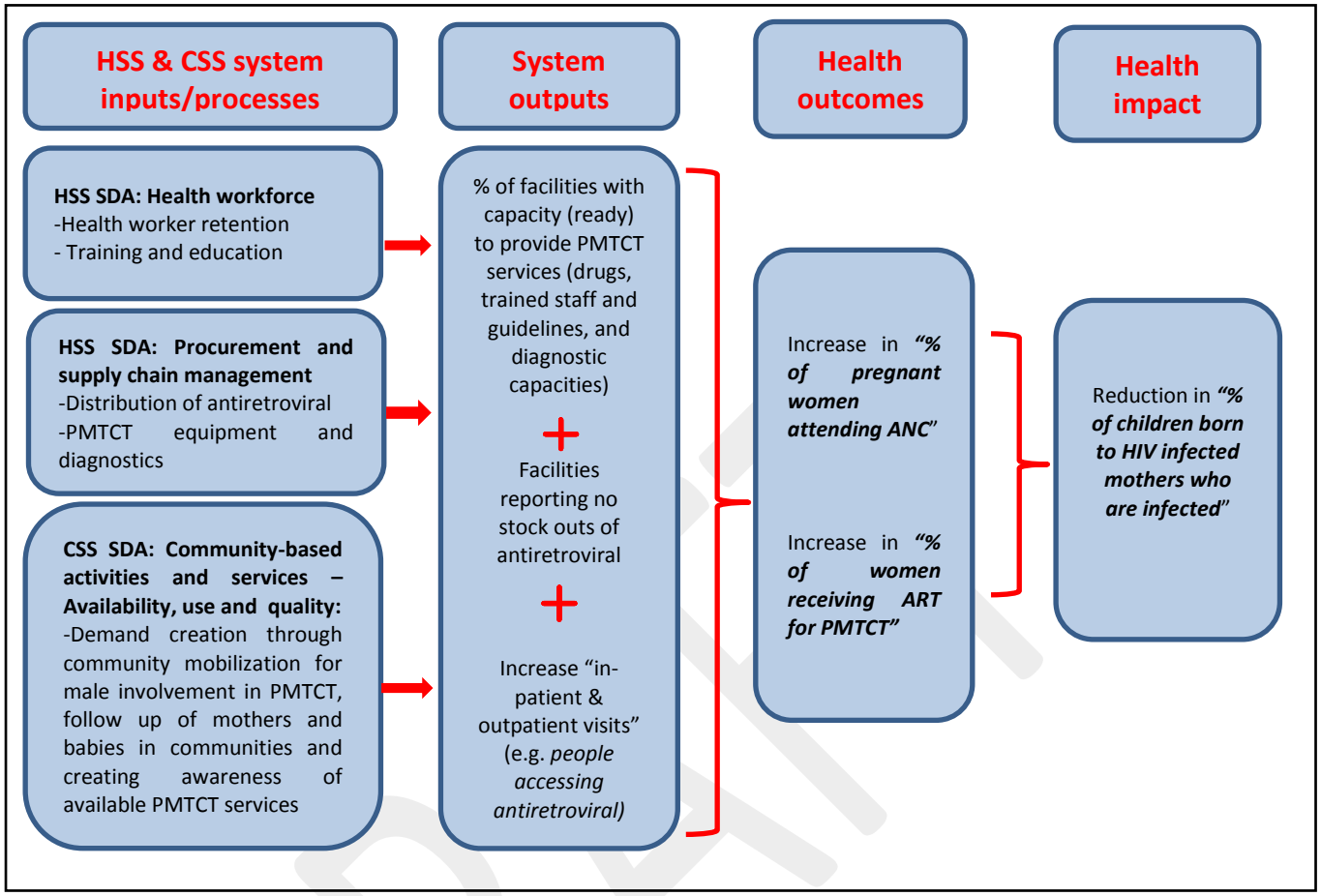
SELECTION OF CSS INDICATORS

The selection of indicators for use at the country level to track progress in community systems strengthening interventions should be guided by the understanding that CSS and all related actions are geared toward improving service delivery, increasing coverage and ensuring equitable distribution of these services for improved health outcomes. In addition, the implementation of community-based services should be conducted as part of the overall

health system, in collaboration with the facility-based health sector. It is therefore important to view CSS actions and community-based service provision as part of the continuum of health care. The disease outcome and impact indicators in Table 6 reflect that CSS efforts have to be implemented collaboratively with relevant disease program interventions and with HSS efforts to result in improved health outcomes. Accordingly, the choice of CSS indicators should complement "people-reached with services indicators" under HIV, TB and/or malaria, as applicable which will eventually link to health outcomes and impact. Table 7 explains the difference between these two types of indicators. For a comprehensive M&E framework for the community response, a selection of relevant outcome and impact indicators for inclusion in CSS programs as appropriate is also required. Tables 10 and 11 below present the recommended outcome and impact indicators.

The disease-specific people-reached with services indicators by community-based organizations remain within the respective disease components of the partner M&E toolkit and can be assessed at http://www.theglobalfund.org/en/me/documents/toolkit/. Figure 4 below illustrates the complementarity between community systems strengthening and health systems strengthening efforts to improve health outcomes. Three illustrative SDAs are presented. The first SDA focuses on health workforce development in the context of delivering PMTCT services. The second SDA focuses on procurement and supply chain management, for the procurement and distribution of condoms, medicines, commodities, equipment and diagnostics for PMTCT. The third is a CSS SDA: community-based activities and services. It involves the availability, use and quality with which women groups in the respective communities follow up mothers/pregnant women to advocate for male involvement; promote increased adherence to and completion of PMTCT prophylaxis; encourage pregnant women to deliver at health facilities; and to follow up with babies at six weeks of age. These combined actions should create increased demand for PMTCT services at health facilities. Please refer to the annex for HSS/CSS complementarity illustrations for TB and malaria programs. For more details about HSS interventions and indicators, refer to the M&E Toolkit section on HSS/CSS.

Figure 4: Complementarity between HSS and CSS efforts to improve health outcomes



USER CAVEAT

The list of indicators contained in this document is work in progress. Many of the indicators are newly developed and have not been field-tested. Only 5 out of the 29 indicators are known to be in use in certain regions. The immediate next step is to launch a comprehensive field-testing exercise of the whole indicator set in representative settings globally.

Table 6: Proposed indicators for monitoring and evaluating community systemS strengthening

Community System Inputs & Processes	→	Community System Outputs	→	Health Outcomes	→	Health Impact
Enabling Environment and Advocacy • CBOs/networks meaningfully participating in joint national program reviews • Community led advocacy campaigns that saw a targeted policy change • CBOs/networks that have documented and publicized barriers to equitable access to health services **Community networks, linkages, partnerships and coordination** • Percentage of CBOs that are represented through membership in national or provincial level technical or policy bodies • Percentage of CBOs that implemented at least one documented feedback mechanism with the community they serve in the last six months **Resources and capacity building** • Percentage of volunteers that are provided with incentives • Percentage of CBOs that keep accurate data for inventory management • Percentage of CBOs that maintain adequate storage conditions and handling procedures for essential commodities **Community activities and service delivery** • Percentage of CBOs that implemented activities contributing to the national disease strategic plan **Leadership and organizational strengthening** • Percentage of staff of CBOs with written terms of reference and defined job duties **Monitoring & Evaluation and planning** • Percentage of CBOs with at least one staff member in charge of M&E • Percentage of CBOs using standard data collection tools and reporting • Percentage of CBOs conducting documented reviews of their own program performance according to their strategic plan • Percentage of CBOs with a developed strategic plan covering 2 to 5 years • Percentage of CBOs that are implementing a budgeted annual workplan		• HIV, TB, malaria and immunization service organizations with referral protocols in place • Percentage of staff members that have worked for the organization for more than 1 year • Percentage of CBOs that received supportive supervision in accordance with national guidelines • Percentage of CBOs that have a complete and sound financial management system • Percentage of CBOs that have secured core funding • Percentage of CBOs submitting timely, complete and accurate financial and programmatic reports to the national level • Percentage of CBOs that deliver HIV, TB, malaria and immunization services • Percentage of CBOs reporting no stock-out of HIV, TB, malarial or immunization essential commodities • Percentage of people with access to community-based HIV, TB, malaria or immunization services in a defined area • Percentage of % community health workers who received training or retraining in HIV, TB, malaria or immunization service delivery • Percentage of CBOs with staff responsible for stock management • Percentage of CBOs with staff in managerial positions trained or retrained in management, leadership or accountability • Percentage of CBOs with received technical support for institutional strengthening • Percentage of CBOs with at least one staff member in charge of M&E trained or retrained in M&E		• Suspected malaria cases that have laboratory diagnosis • Uncomplicated malaria cases receiving appropriate treatment • Women who received two or more doses of IPT during their last pregnancy • Case notification rate • Treatment success rate • Percentage of of adults/children with advanced HIV infection receiving ART • Percentage of of HIV-positive pregnant women who receive ART for PMTCT • Percentage of of women attending antenatal care • Percentage of of births attended by professional health provider		• Child mortality (neonatal, infant, perinatal) • Mortality due to major cause of death • ART 12 months retention rate • PMTCT transmission rate • Confirmed malaria cases • Inpatient confirmed malaria cases • Maternal mortality ratio • The ratio of household out-of-pocket payments for health to total expenditure on health

CORE INDICTORS AND ADDITIONAL INDICATORS CLASSIFICATION

The set of process and output CSS indicators have been classified either as CORE or additional. The core indicators are the most important for monitoring progress under CSS. It is *strongly* recommended that countries incorporate these into their CSS programs as appropriate to facilitate a basic understanding of the progress under CSS. Ten core indicators have been drawn from each service delivery area across the six CSS components. Please refer to Table 8 below for an overview of the recommended core CSS indicators. More detailed definitions for each indicator can be found after Table 11 of impact indicators.

The 19 additional indicators will facilitate programs to collect a broader range of information to track progress of CSS interventions. Countries are encouraged to incorporate these into their programs as necessary and as M&E systems and resources may permit. Please refer to Table 9 below for an overview of the additional CSS indicators. More detailed definitions for each indicator can be found after Table 11 of impact indicators.

DEFINITION OF THE DENOMINATOR

COMMUNITY-BASED ORGANIZATIONS: Many of the indicators focus on community-based organizations. While acknowledging the important role of community-based organizations in delivering services to the community, it is also important to acknowledge that other actors contribute to this process. Examples of other organizations involved in service delivery to the community include private-sector organizations, nongovernmental organizations or local government authorities. CSS interventions could focus on community-based organizations or on these other types of organizations. When working with other types of organizations, it is important to adjust the indicators to correspond to these targeted organizations as well as to reflect the link between these organizations and the community.

The denominator for many of the indicators is the "total number of targeted community-based organizations or all community-based organizations in a targeted area." It is essential to adjust this denominator to the specific CSS program. The denominator should be determined in Step 1 of the development of a system for CSS. It is also important to strengthen community systems as a whole and not focus only on a limited number of community actors or organizations. Examples of adjusted denominators could be:

- all community-based organizations with less than 100 staff members or volunteers in district *x* that are involved with prevention, care or treatment services for HIV/AIDS;
- all organizations in province *x* supporting TB patients' adherence to treatment, including CBOs, NGOs, FBOs and private-sector organizations;
- all community-based organizations 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. However, for formulating indicators, volunteers have been removed. It is recommended that data be collected and aggregated by staff or volunteer for all indicators focusing on organizational staff. The one exception is staff responsible for monitoring and evaluation — to ensure that this key organizational function is strengthened. Community volunteers may include nonhealth workers, including office workers, drivers and activity organizers. 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, according to the individual country's definition.

USING TRAINING INDICATORS: Four out of the 19 additional 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 multiple days. Participating in a one-day workshop, for example, is not considered receiving training. When training indicators are used,e ensure that specific training modalities are defined beforehand.

DEFINITON OF DATA SOURCES

ADMINISTRATIVE RECORDS: Twenty-five of the 29 indicators have administrative records as the recommended data source. These are the source documents used for routine running of the organization in the course of program implementation and service delivery. The records will differ by indicator and organization and therefore need to be defined at the planning stage when the indicator is being incorporated into the program. Measuring an indicator may actually require information from multiple administrative records. Examples of these include activity reports, policy documents, monitoring reports and checklists, client registers and training records. Indicator-specific guidance has been included in the indicator definition.

INSTITUTIONAL SURVEYS AND ASSESSMENT: These are periodic data collection exercises from community-based organizations to gather information on defined aspects of the organization, usually related to performance and or quality standards. These surveys and assessments are the recommended data sources for six indicators. CSS implementers are encouraged to consider setting up an evaluation system that can be implemented as part of the monitoring system. These are commonly implemented by the national-level designated entity with oversight responsibility for community-based activities and services. These can either be conducted as part of routine supervision or as an exclusive exercise. Predefined standards checklist and interview questionnaires will be required to conduct these.

POPULATION-BASED SURVEYS: Surveys are based on sampling the target or general population, generally aiming to represent the characteristics, behavior and practices of that population. They require sufficient sample size to represent the larger population and to be

analyzed by age, sex, region and target population group. They are usually implemented by a designated national level program authority with the involvement of all partners. CSS implementers are encouraged to participate as much as possible in the planning and execution of the surveys. Survey questionnaires are required to use close-ended questions. Examples of population-based surveys include Multiple Cluster Surveys (MICS), Demographic and Health Surveys (DHS and DHS+) and AIDS Indicator Surveys (AIS).

PROGRAM REVIEW/EVALUATION OF CSS EFFORTS

The CSS Technical Working Group meeting for the review of the CSS indicators, hosted by the Global Fund in June 2011, determined that there are major differences in the approaches used to evaluate CSS interventions. Comprehensive guidance for countries is being developed through 2012. Ongoing efforts to learn from evaluation exercises in select countries are in place.

Countries with CSS programs are encouraged to include the recommended outcome and impact indicators in their M&E plans as the initial step to assessing and evaluating the contribution of CSS interventions to health results. In addition, CSS programs need to plan for program evaluations at appropriate intervals throughout the lifetime of the program. The evaluations should occur in the formative stage, at midterm (through program implementation), and at the end of the program. These reviews and evaluations are embedded in the systematic approach for developing CSS interventions that is outlined in the CSS framework (see Chapter 5).

To prepare for the periodic program reviews, appropriate review questions need to be identified at the CSS program development stage. The responses to these questions will be assessed and analyzed to inform reprogramming and resource allocation. Progress against the relevant Core indicators also needs to be analyzed to inform the program review.

DEFINITION OF THE DENOMINATOR: Many of the indicators have "total number of targeted community-based organizations or all community-based organizations in a targeted area" as their denominator. It is *essential* to adjust this denominator to the specific CSS program. The denominator should be determined in Step 1 of the development of a system for CSS. It is important to strengthen community systems as a whole and not to focus only on a limited number of community actors or organizations. Examples of adjusted denominators could be:

Table 7: Community systems strengthening indicators and community level service delivery indicators

An effective disease-specific program collects both CSS indicators and community level service delivery indicators. CSS indicators measure the progress of CSS interventions toward program goals and objectives against set targets. Community level service delivery indicators measure the programmatic progress in the actual delivery of services at the community level toward goals and objectives against set targets.

An example of a CSS indicator is: "Number and percentage of community-based organizations that have core funding secured for at least two 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."

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

6.2 Overview of recommended CSS indicators

Table 8. Recommended CORE process and output indicators for monitoring and evaluating community systems strengthening efforts

Core Component	Service delivery area	Indicators	Data source	Frequency
Core component 1: Enabling environments and advocacy	SDA 1: Monitoring and documentation of community and government interventions	Number of community-based organizations and/or networks that have meaningfully participated in joint national program reviews or evaluations in the last 12 months (1.1)	Administrative records and evaluation reports	Annually
	SDA 2: Advocacy, communication and social mobilization	Number of community-led advocacy campaigns that saw a targeted policy change or can clearly document improved implementation of an existing (targeted) policy within 2 years of the start of the advocacy campaign (2.1)	Administrative records and special survey	2 years
Core component 2: Community networks, linkages, partnerships and coordination	SDA 3: Building community linkages, collaboration and coordination	Number and percent of community-based HIV, TB, malaria and immunization service organizations with referral protocols in place that monitor completed referrals according to national guidelines (3.1)	Administrative records	Quarterly/semiannually
Core component 3: Resources and capacity building	SDA 4: Human resources: skills building for service delivery, advocacy and leadership	Number and percentage of staff members and volunteers currently working for community-based organizations that have worked for the organization for more than 1 year (4.1)	Administrative records	Annually
	SDA 5: Financial resources	Number and percentage of community-based organizations that have a complete and sound financial management system, which is known and understood by staff and consistently adhered to (5.1)	Institutional assessment and administrative records	Annually
	SDA 6: Material resources – infrastructure and (including medical and other products & technologies)	Number and percentage of community-based organizations reporting no stock-outs of HIV, TB, malaria or immunization essential commodities according to program implementation focus during the reporting period (6.1)	Administrative records	Quarterly/semiannually
Core component 4: Community activities and service	SDA 7: Community-based activities and services – delivery, use and	Number and percentage of community-based organizations that deliver services for HIV, TB, malaria and immunization according to national or international accepted	Institutional assessment	Annually

delivery	quality	service delivery standards (7.1)		
Core component 5: leadership and organizational strengthening	SDA 8: Management, accountability and leadership	Number and percentage of staff members of community-based organizations with written terms of reference and defined job duties (8.1)	Administrative records	Annually
Core component 6: monitoring & evaluation and planning	SDA 9: Monitoring and evaluation, evidence-building	Number and percentage of community-based organizations that submit timely, complete and accurate financial and programmatic reports to the national level according to nationally or internationally recommended standards and guidelines (where such guidelines exist) (9.1)	Administrative records	Quarterly/semiannually
	SDA 10: Strategic planning	Number and percentage of community-based organizations with a developed strategic plan covering 2 to 5 years (10.1)	Administrative records	Annually

Table 9: Additional process and output indicators for monitor and evaluating community system strengthening efforts

	Service delivery area	Indicators	Data source	Frequency
Core component 1: Enabling environments and advocacy	SDA 1: Monitoring and documentation of community and government interventions	Number of community-based organizations and/or networks that have documented and publicized barriers to equitable access to health services and/or implementation of national HIV, TB, malaria and immunization programs during the last 12 months (1.2)	Administrative records	Annually
Core component 2: Community networks, linkages, partnerships and coordination	SDA 3: Building community linkages, collaboration and coordination	Number and percentage of community-based organizations that are represented through membership in national or provincial level technical or coordination policy bodies of disease programs and that are providing feedback to communities (3.2)	Administrative records	Annually
		Number and percentage of community-based organizations that implemented at least one documented feedback mechanism with the community they serve in the last 6 months (3.3)	Administrative records	Semiannually
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 currently working with community-based organizations who received training or retraining in HIV, TB, malaria or immunization service delivery according to national guidelines (where such guidelines exist) during the last national reporting period (4.2)	Administrative records	Quarterly
		Number and percentage of community-based organizations that received supportive supervision in accordance with national guidelines (where such guidelines exist) in the last 3 to 6 months (4.3)	Administrative records	Quarterly/semiannually
		Number and percentage of volunteers	Administrative	Quarterly

	Service delivery area	Indicators	Data source	Frequency
		working with community-based organizations who are provided with incentives (4.4)	records	
	SDA 5: Financial resources	Number and percentage of community-based organizations that have core funding secured for at least 2 years (5.2)	Administrative records	Annually
	SDA 6: Material resources – infrastructure information and essential commodities (including medical and other products and technologies)	Number and percentage of community-based organizations that keep accurate data for inventory management according to national or international policy (6.2)	Institutional survey	Annually
		and percentage Number of community-based organizations with staff or volunteers that are responsible for stock management trained or retrained in stock (inventory) management in the past 12 months (6.3)	Administrative records	Quarterly
		Number and percentage of community-based organizations that maintain adequate storage conditions and handling procedures for essential commodities (6.4)	Institutional survey	Annually
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 organizations that implemented activities contributing to the national disease strategic plan as documented by their plans and reports to the national designated entity (7.2)	Administrative records	Annually
		Number and percentage of people that have access to community-based HIV, TB, malaria or immunization services in a defined area (7.3)	Population based-survey	2-3 years
Core component 5: leadership and organizational strengthening	SDA 8: Management, accountability and leadership	Number and percentage of community-based organizations with staff in managerial positions who received training or retraining in management, leadership or accountability during the last reporting period (8.2)	Administrative records	Quarterly/semiannually
		Number and percentage of community-based organizations that received technical support for institutional strengthening in accordance with their requests the last 12 months (8.3)	Administrative records	Annually
Core component 6: monitoring & evaluation and planning	SDA 9: Monitoring and evaluation, evidence-building	Number and percentage of community-based organizations with at least one staff member in charge of M&E (9.2)	Administrative records	Annually
		Number and percentage of community-based organizations with at least one staff member in charge of M&E who received training or retraining in M&E according to nationally recommended guidelines (where such guidelines exist) during the last national reporting period (9.3)	Administrative records	Quarterly/semiannually
		Number and percentage of community-based organizations using standard data collection tools and reporting formats to report to the national reporting system (9.4)	Administrative records	Annually
		Number and percentage of community-based organizations conducting documented reviews of their own program performance according to their	Administrative records	Quarterly

	Service delivery area	Indicators	Data source	Frequency
		strategic plan in accordance with the national reporting cycle (9.5)		
	SDA 10: Strategic planning	Number and percentage of community-based organizations that are implementing a budgeted annual workplan (10.2)	Administrative records	Annually

Table 10: Health outcome indicators for monitoring and evaluating health and community systems strengthening

Indicator	Topic	Frequency of Reporting	Preferred Data Source
Outcomes: Malaria, tuberculosis, HIV/AIDS, and maternal, newborn and child health			
Percentage unsuspected malaria cases that have laboratory diagnosis	Malaria	Quarterly	Routine facility reporting system
Percentage of uncomplicated malaria cases receiving appropriate treatment	Malaria	Quarterly	Routine facility reporting system
Percentage of women who received two or more doses of IPT during their last pregnancy	Malaria, MNCH	3-5 years	Population-based survey
Case notification rate	TB	Annually	Routine facility reporting system
Treatment success rate	TB	Annually	Routine facility reporting system
Percentage of adults/children with advanced HIV infection receiving ART	HIV, MNCH	Quarterly	Routine facility reporting system
Percentage of HIV-positive pregnant women who receive ART for prevention of mother-to-child transmission of HIV	HIV, MNCH	Quarterly	Routine facility reporting system
Percentage of women attending antenatal care	MNCH	3-5 years	Population-based survey
Percentage of births attended by a skilled health professional	MNCH	3-5 years	Population-based survey

Table 11: Health impact indicators for monitoring and evaluating health and community systems strengthening

Indicator	Topic	Frequency of reporting	Preferred data source
Impacts: health status			
Mortality due to major cause of death by sex and age (Top 20 major causes of death, ICD-based) [10,16]	HIV, TB, Malaria, MNCH	3-5 years	Death registration, survey, census, facility reports
Percentage of adults and children known to be on treatment 12 months after initiation of antiretroviral therapy	HIV	Annually	Facility records
Percentage of infants born to HIV-infected mothers who are infected	HIV	Annually	Modeling
Confirmed malaria cases (rapid diagnostic tests/microscopy)	Malaria	Quarterly	Routine facility reporting system
Inpatient confirmed malaria cases	Malaria	Quarterly	Routine facility reporting system
Maternal mortality ratio	MNCH	3-5 years	Death registration, survey, census, facility reports

Indicator	Topic	Frequency of reporting	Preferred data source
Child mortality (neonatal, infant, perinatal)[15,17]	MNCH	3-5 years	Death registration, survey, census
The ratio of household out-of-pocket payments for health to total expenditure on health[9]	HSS health financing	3-5 years	Population-based surveys

6.3 DETAILED CSS INDICATOR DEFINITIONS

Before using the CSS indicators, please read the following:

Note that most of the indicators refer to community-based organizations. However it is important to understand that other organizations such as private-sector organizations, 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, make sure that the definitions are adjusted to include all types of organizations that are included in a specific CSS program.

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

Detailed description of recommended CORE process and output indicators for monitoring and evaluating community systems strengthening

Enabling environments and advocacy (Core Indicator 1.1)

Number of community-based organizations and/or networks that have meaningfully participated in joint national program reviews or evaluations in the last 12 months

Rationale

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

Joint national program reviews and evaluations help identify gaps and develop strategies to fill those gaps, and to create opportunities for finding synergies between community and health system responses to HIV, TB and malaria. The review process can also provide a platform for mapping existing efforts and avoiding duplication among several implementing partners and the sharing and documentation of information and experiences. Joint national program reviews and evaluations are an opportunity for critical dialogue between diverse implementing agents (such as government and grassroots CBOs) and contribute to building mutual understanding of common objectives and long-term strategies to effectively stop and reverse epidemic diseases. Finally, the participation of CBOs and community representatives on such reviews is important, as they have intimate knowledge of the key populations and their needs.

Definition of the indicator

This indicator measures the total number of CBOs and community networks participating in joint national program reviews and evaluations. All organizations that contribute to reaching the objectives of the national program should normally be involved in joint national program reviews or evaluations, though many will be involved via proxy, submitting their input and feedback for inclusion in the review process. Joint national program reviews and evaluations can be conducted at the national level, but similar processes can also take place at district or provincial levels, with results from the lower-level review included in the national review and evaluation.

“Meaningful” participation is more than mere presence in a meeting or discussion. While it is impossible to measure absolutely, the following criteria can be used to assess how meaningful such participation was.

At least five of the following seven criteria should be in place to allow participation to be **considered "meaningful** *(criteria number 2 is considered key and very crucial and should be one of the minimum five for this indicator to be counted)*

1. Have community members been involved in defining the scope of work for the review and in selecting the review team?
2. Do community members enjoy equal status and rights within the review process? (e.g. Are they allowed to speak and contribute freely? Is it possible for a community group or network to chair the review, or lead working groups within the review process? Are they allowed to prepare a position paper, and does the agenda provide an opportunity for them to present their statement?)
3. Do community members have to validate the report before it is disseminated?
4. Do community representatives monitor the implementation of the recommendations made by the review?
5. Do CBO and community network members provide a report and feedback to their constituencies during and after the review process?
6. Are community groups or networks provided assistance and/or funding to solicit feedback and input from their constituencies, and allocated time to present this feedback during the review process?
7. Do national review guidelines specify the nature of the representatives of CSO or CBO participation (including networks representing key populations and their representatives) who are included in the review process? Are these representatives designated or chosen by their constituencies to represent CBOs?

Numerator: Total number of targeted community-based organizations that report that they have been meaningfully involved in at least one joint program review or evaluation at the national or provincial level during the last 12 months.

Denominator: Total number of community-based organizations in a targeted area.

Limitations

This indicator does not measure change in the capacity of community-based organizations or the community system. The indicator has not been field tested, but many countries incorporate CBO and community representation into national reviews and assessments. For instance in Uganda, civil society organizations (CSOs) have a slot at the annual health joint assembly, where they present their statement regarding the status of health in the country. They usually conduct consultations including fieldwork as they prepare their statement. A CSO representative on a health advisory committee or their selected representatives chair some of the sessions or Technical Working Groups in preparation for the health assembly.

Measurement

Community-based organizations and/or networks are requested to report whether or not they have been involved in a joint program review or evaluation during the last 12 months.

Records of the review process should be reviewed by the external assessment team, including participation, submissions, community-level participation or feedback processes, and inclusion of different recommendations or submissions in the final report/evaluation.

Data sources: Administrative records, evaluation reports, NGO's activity reports

Frequency: Annually

Enabling environments and advocacy (Core Indicator 2.1)

Number of community-led advocacy campaigns that saw a targeted policy change or can clearly document improved implementation of an existing (targeted) policy within two years of the start of the advocacy campaign

Rationale

Public campaigning is one of the key ways communities can organize their voices and bring attention to issues that concern them or affect their health and well-being. However, without a catalyzing force such as an advocacy campaign begun by a local organization, few communities are able to make their collective voices heard by policymakers to effect policy change or improve policy implementation. Organizing and carrying out public campaigns for improved quality of or access to health services is an important means to build the capacity of CBOs in areas such as data collection and analysis, documentation, strategic planning, and communication with community partners. These activities all contribute toward a stronger and more effective community system.

Definition of indicator

This indicator measures the number of targeted advocacy campaigns organized and conducted by CBOs or community networks aimed at changing, eliminating, or introducing specific policies (or implementing existing policies or regulations) related to quality or access to health services, and that can show a clear correlation with a policy or policy implementation change.

Limitations

There is an inherent difficulty attributing policy or implementation change to a specific advocacy campaign or activity, but it is assumed that some proportion of the effort that resulted in policy change is attributable to advocacy campaigns and activities if there are well-documented advocacy reports, including background analysis, strategy, activities, and evidence of policy or implementation change during the advocacy campaign period.

Measurement

Civil society organizations will be asked to provide information about advocacy campaigns including advocacy campaign action plans, responses from relevant government agencies, and an analysis of their impact on policy change or implementation. All such records and data should be submitted to the principal implementing agent who is conducting program M&E.

Data sources:

A special survey is required to review administrative records; CBO records and reporting on advocacy campaign action plans; policy documents or implementation guidelines or toolkits related to advocacy campaigns, public and media records.

Frequency: Every two years or according to national reporting cycle

Community networks, linkages, partnerships and coordination (Core Indicator 3.1)

Number and percentage of community-based HIV, TB, malaria and immunization service organizations with referral protocols in place that monitor completed referrals according to national guidelines

Rationale

This indicator provides information on the referral infrastructure supported by community-based organizations offering HIV, TB, malaria and immunization services designed to improve health outcomes. Good coverage of essential health and/or support services may not necessarily be achieved through a single organization/institution. Therefore, a referral network should be in place that includes public institutions and community-based organizations as well as community-based organizations. Each organization or institution should have referral protocols for clients and patients. If they exist, community-based organizations should adhere to national guidelines on providing appropriate referrals. If national guidelines do not exist, CBOs should establish referral procedures considering best practices and local needs. Providing initial referrals is important, however, referral protocols should also include a mechanism to confirm that the referral is completed. Each organization should track the percent of initial referrals that are completed within the reporting period.

Definition of the indicator

This indicator measures the number of CBOs with referral protocols and referral tracking systems that include monitoring completed referrals. Referral infrastructures will vary. Some countries or communities may have official referral systems that include formal agreements between organizations/institutions and/or standardized tracking systems. Others may be organized via informal agreements. Each CBO should implement referral protocols that are appropriate to the context within which they work and use national guidelines where they exist. Examples of referral tracking systems include referral slips that are carried from one provider to another, the use of unique identifiers that can be tracked within one database or across several databases and a log or register that tracks visits from a health care worker to ensure the referral is complete.

Numerator: Total number of targeted community-based organizations with referral protocols, referral tracking systems, and that report at least one completed referral during the reporting period

Denominator: Total number of community-based organizations in targeted area providing health or support services to individual clients

Limitations

This indicator does not measure the appropriateness of individual referrals made by the organization or the quality of services received by the individual. This indicator does not measure whether or not the referral protocols are implemented as intended, or if the referral data are reliable.

Measurement

This indicator can either be self reported or reported by an external organization providing supervision/oversight to the organization. The organization should be able to provide written protocols for appropriate referrals, tracking systems for individual clients/patients (databases, paper logs, paper registers) and be able to report that at least one completed referral was made during the reporting period.

Data sources: Administrative records

Frequency: Every three to six months

Resources and capacity building (Core Indicator 4.1)

Number and percentage of staff members and volunteers currently working for community-based organizations that have worked for the organization for more than one year

Rationale

The community health sector experiences many challenges in retaining health professionals. This indicator intends to measure to what extent community-based organizations 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 organizations: 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 organizations that have finished more than 12 months of service for the organization.

Denominator: Total number of staff and volunteers who are currently working for an organization in the targeted area.

Disaggregation: Different professional categories such as community health workers, outreach workers or counselors by paid staff and volunteers and according to profession.

Limitation

Staff retention does not reflect the capability of staff to carry out implementation, which is influenced by many other factors. In certain regions such as East Asia, most organizations work on a year-to-year basis so staff turnover may appear to be high. In some cases high staff turnover may not indicate poor performance, it is also a way of transfering knowledge and skills from one organization and community to another.

Measurement

Targeted community-based organizations are requested to submit a copy of appropriate administrative records that should contain information on 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 organization.

Data sources: Administrative records

Frequency: Annually

Resources and capacity building (Core Indicator 5.1)

Number and percentage of community-based organizations that have a complete and sound financial management system that is known and understood by staff and consistently adhered to.

Rationale

Good financial management practices are a critical part of strong organizational management. It is important for an organization to have an accurate record of its finances, both for internal planning purposes and to show donors that it can appropriately manage funds.

Definition of the indicator

A complete and sound financial management systems for this indicator is defined as the following:

- Written financial policies and procedures that include:
  - financial controls (separation of duties, description of who has signatory authority, review procedures, bank reconciliations);
  - instructions for managing financial documents (recording of financial transactions, supporting documents, record retention);
  - definitions for allowable/unallowable expenses;
  - detailed cash management procedures (i.e. check and/or petty cash procedures, if needed) and income/receipt procedures;
  - billing procedures/financial reporting;
  - audit procedures
- Financial documents kept in a secure location with limited access (can be locked and accessed only by those identified as needing access).
- Finance staff that are appropriately trained and periodically retrained in financial management.

If the organization is required by law or donors to submit annual audits, it should have audit procedures.

Numerator: Number of community-based organizations in the target area that meet the definition of a complete and sound financial management system

listed above.

Denominator: Total number of community-based organizations in the target area.

Limitations

If reviews are done in-country, community-based organizations that represent subpopulations that engage in illegal activities in-country (e.g. injecting drug users or sex workers) may not be recognized and therefore will not be captured by this indicator.

Measurement

The indicator is measured through a review by the organization in a facilitated assessment process. The process involves examining documentation of organizational financial management policies and procedures and sample transactions and reports to ensure policies and procedures are being adequately implemented.

This is information that is routinely gathered through institutional assessments completed by community-based organizations or technical assistance providers.

Data sources: Institutional assessment, administrative records

Frequency: Annually

Resources and capacity building (Core Indicator 6.1)

Number and percentage of community-based organizations reporting no stock-outs of HIV, TB, or malaria essential commodities according to program implementation focus 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 measure whether organizations working at the community level have an effective supply management system in place. Efficient supply management is needed to ensure that organizations do not run out of stocks of required commodities. This is important for, for example, mass LLIN distribution, harm reduction and syringe programs and vaccines.

Definition of the indicator

Given the variety of country contexts, organizations and programs, it is necessary to define in advance essential commodities on a case-by-case basis in the context of the country. At the programs outset, each organiziation should have a predefined list of supplies they will be monitoring. Depending on the specific context, essential commodities may include but are not limited to the following:

- medicines such as ARVs, ACTs anti TB drugssupplies such as syringes and condoms
- insecticide-treated nets
- laboratory reagents

Numerator: Number of community-based organizations in the targeted area that report no stock-out of essential commodities on the last day of the reporting period.

Denominator: Total number of community-based organizations in a targeted area that require a predefined set of essential commodities in order to deliver services.

Disaggregation: By stock-out [commodity] and by disease

Measurement

Targeted organizations 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

Community activities and service delivery (Core Indicator 7.1)

Number and percentage of community-based organizations that deliver services for HIV, TB, or malaria according to nationally or internationally accepted service delivery standards

Rationale

This indicator measures the capacity of community-based organizations to provide good-quality HIV, TB, and malaria services that meet national or international guidelines where such guidelines exist.

Definition of the indicator

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

Numerator: Total number of community-based organizations in the targeted area that have the minimum acceptable capacity to deliver HIV, TB, malaria or immunization services.

Denominator: Total number of community-based organizations in a targeted area, that deliver services for HIV, TB, malaria or immunization.

Disaggregation: This indicator should be calculated separately for HIV, TB, malaria or immunization.

Limitations

This indicator does not take into account legal/cultural barriers; neither does it indicate the quality of services delivered.

Measurement

Data for this indicator are collected through a capacity assessment using a standardized checklist. Community-based organizations are assessed by whether they meet the minimum acceptable standards to deliver HIV, TB, malaria or immunization services in compliance

with the defined standards. This assessment can be conducted as part of routine support supervision or as an independent external exercise.

Data sources: Institutional assessment

Frequency: Annually

This indicator is already in use in the Southern Africa region and in West and Central Africa where it is being collected through CBO capacities analysis.

Resources

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

For malaria: http://www.who.int/topics/malaria/en/

Leadership and organizational strengthening (Core Indicator 8.1)

Number and percentage of staff members of community-based organizations with written terms of reference and defined job duties

Rationale

It is important that all staff members and volunteers of community-based organizations have written terms of references with defined job duties. 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 within the organization;
- the responsibilities of the staff member/volunteer;
- key results expected;
- the conditions of the contract including working hours and compensation.

Numerator: Total number of staff members that have written terms of reference with job duties defined and that work for targeted community-based organizations in the targeted area at the time of reporting.

Denominator: Total number of staff members working for community-based organizations in the targeted area at the time of reporting.

Disaggregation: By salaried staff or volunteer

Limitaton

This indicator does not provide a measurement of change in staff capabilities and performance. In addtion, it does not assess the human resource gap in relation to the needs of the organization.

Measurement

Targeted community-based organizations are asked to report on the total number of staff members and volunteers working for the organization 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

Monitoring and Evaluation and Planning (Core Indicator 9.1)

Number and percentage of community-based organizations that submit timely, complete and accurate financial and programmatic reports to the national level according to nationally or internationally recommended standards and guidelines (where such guidelines exist)

Rationale

National or otherwise recognized entities that oversee the implementation of the community response need accurate program information on a routine basis from all implementing organizations. Tracking this indicator will facilitate the identification of organizations that may need support to report accurately and on time. Good financial and programmaitic reporting practices contribute to the efficient use of available funds and effective allocation of resources. National level organizations that may be designated to collect reports may include strong domestic NGOs, international NGOs, national agencies or ministries as well as umbrella organizations, depending on the country context.

Definition of the indicator

For financial reporting at least the following documents should be submitted according to the national system:

- financial statements as described in the national guidelines (where such guidelines exist)
- audit reports
- analyses of budgets and expenditures

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

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

Denominator: Total number of community-based organizations in the targeted area

Limitations

Although the rate and quality of the reports will provide an indication of the quality of the finanacial or programmatic reporting sysems, they will not specifically diagnose system gaps. Follow-up assessments will be required to identify specific system gaps for targeted capacity building.

Measurement

The numerator is calculated from a count of financial and prorgrammatic reports received before or on the day they were due and are checked for errors and are found to be accurate in accordance with defined criteria. The denominator can be determined from administrative system records such as service providers mapping reports.

National programs and implementing partners and stakeholders at all levels need to develop and implement data dissemination and feedback mechanisms to further enhance information use for evidence-based decisions as well as data quality assurance procedures.

Data sources: Administrative records, financial reports and programmatic reports

Frequency: Every three to six months

Indicator is currently in use in APN+ regional AIDS program in East Asia region, in the Southern Africa region and West and Central Africa region.

Monitoring and evaluation and planning (Core Indicator 10.1)

Number and percentage of community-based organizations with a developed strategic plan covering two to five years

Rationale

A strategic plan helps ensure that delivered services contribute to long-term goals and objectives. A good strategic plan is developed in consultation with stakeholders. It 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 organizations have a strategic plan in place, covering two to five years, which is valid at the time of reporting. For example an organization that has a five-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
- the measurement of progress

Numerator: Total number of community-based organizations in the targeted area that have a strategic plan in place, covering a total period of two to five years, which is still valid at the time of reporting.

Denominator: Total number of community-based organizations in a targeted area.

Limitations

This indicator does not measure the implementation of the strategic plan. Please refer to indicator 7.1 for a measure of implementation.

Measurement

Community-based organizations are requested to submit a copy of their strategic plan. Verification of the process of development of the plan for stakeholder consulation and participation should be done. This can be done through the contents of the plan itself that usually indicate the list of stakeholders and partners that were engaged in the process. This indicator is currently being used in West and Central Africa

Data sources:	Administrative records, organizational strategic plans
Frequency:	Annually

Detailed description of additional process and output indicators that national programs may use to monitor and evaluate community systems strengthening

Enabling environments and advocacy (Additional Indicator 1.2)

Number of community-based organizations and/or community networks that have documented and publicized barriers to equitable access to health services and/or implementation of national HIV, TB, malaria and immunization programs during the last 12 months

Rationale

Removing barriers to equitable access to health services is an important role for communities. Strong documentation and monitoring capacity will lead to more efficient, responsive, and accountable structures at both community and higher levels (e.g. both NGOs and governments should be held accountable). These activities will also be important for creating a more enabling environment, and allowing for more effective policy dialogue and advocacy work by civil society. At the community level, CBOs have the potential to be the "eyes and ears" of development efforts, providing a more accurate and complete picture of the impact that interventions are having on the ground and benefiting both government and international efforts.

Definition of indicator

This indicator will measure the total number of civil society organizations documenting services related to HIV, TB, malaria and immunization provided within the communities where they work, and any barriers community members face in accessing those services (including barriers created by government policy, non-implementation of existing regulations or policies, or other factors). Documentation can take many forms, including printed or online reports, websites, or even highly targeted advocacy (such as petitions or letters to the president, parliament members, health minister, or district local assembly) that clearly documents barriers to equitable access to services and/or to implementation of national HIV, TB, malaria or and immunization programming along with demands that such barriers be removed or remedied.

Barriers to access include factors such as existing law or policy, cost, location and opening hours of service providers, stigmatizing or discriminatory attitude of service providers, and any restrictions (entry requirements or required tests of criteria) or quotas placed on service provision. For the purposes of this indicator, the definition of equitable is to be determined by the community group or networks themselves, as end-users of such services.

Limitations

There will inevitably be different types of documentation and publicity, and a quantitative measure such as this one will miss some of the documentation. It also does not attempt to measure the quality of such documentation, as any attempt to systematically analyze and document access and access barriers will both build community capacity and help focus attention on needed policy or implementation changes.

Measurement

Groups or networks conducting documentation and monitoring will be required to submit records of documentation activities and any publications or dissemination of the information documented that have been implemented according to the plan in the last 12 months at the time of reporting.

Data sources: Administrative records, regular program reporting, websites, publications, open letters, campaign publications, review/operational research with the beneficiaries of the services, among other sources.

Frequency: Annually

Community networks, linkages, partnerships and coordination (Additional Indicator 3.2)

Number and percentage of community-based organizations that are represented through membership in national or provincial level technical or coordination policy bodies of disease programs and that provide feedback to communities

Rationale

This indicator intends to measure the inclusion of and participation by community-based organizations in national or provincial level decision-making on technical or 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 organization or by a representative of a network/association of which the community-based organization is a member. "Community representation" therefore means that at least one staff member or volunteer of the targeted organization or one staff member or volunteer of a network/association representing the targeted organization, 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 or provincial 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 organizations in the targeted area that report they were represented in at least one meeting of a national or provincial level technical or policy body of the national disease programs during the last 12 months at the time of reporting and have provided feedback to their constituency.

Denominator: Total number of community-based organizations in a targeted area.

Limitation

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

Measurement

Targeted community-based organizations 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 programs during the last 12 months at the time of reporting. Attendance should be demonstrated by submitting the list of meeting

participants. Community-based organizations 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. Those participating in the review process should submit evidence of feedback to their constituencies, and/or solicitation of input from their constituencies.

Data sources: Administrative records, participants lists, communication records with constituencies.

Frequency: Annually

This indicator is already in use in West and Central Africa.

Community networks, linkages, partnerships and coordination (Additional Indicator 3.3)

Number and percentage of community-based organizations that implemented at least one documented feedback mechanism with the community they serve in the last six months

Rationale

This indicator intends to measure community linkages. Meetings, biannual newsletters, bulletins, or pamphlets, and posts on webpages are good methods of communication between community-based organizations and the community itself. They provide the community with an opportunity to participate in the community-based interventions and help establish strong linkages and ownership in common goals and activities.

Definition of the indicator

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

Numerator: Total number of community-based organizations in the targeted area that implemented at least one documented feedback mechanism with the community they serve in the last six months.

Denominator: Total number of community-based organizations in a targeted area.

Limitation

If participants are not selected with care, appropriate community linkages would not be established despite implementing documented feedback meetings. Community feedback mechanisms, although important, do not show community ownership of the problem. Community ownership is key to lasting change.

Measurement

Targeted organizations are requested to report on the total number of feedback mechanisms implemented with the community they serve in the last six months at the time of reporting. Feedback mechanisms should be representative of *all* the communities the organizations serve (if they serve more than one). Mechanisms do not encapsulate the diverse group some of these constituencies can cover, hence the number of people they met, who they represent, and outcomes should be documented in detail. Also, meetings with key affected populations should be accorded higher scoring than meetings with organizations that represent, but do not include, the population in question. They should also submit written minutes of meetings. These documents should be brief and should contain a participant list, the main issues of discussion and follow-up actions.

Data sources:	Administrative records, meeting minutes
Frequency:	Every six months

Resources and capacity building (Additional Indicator 4.2)

Number and percentage of community health workers currently working with community-based organizations who received training or retraining in HIV, TB, malaria or immunization service delivery according to national guidelines (where such guidelines exist) during the last national reporting period

Rationale

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

Definition of the indicator

Community health workers 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. The program should adapt to their local setting for purposes of tracking this indicator. 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. Participating in a one-day workshop is not considered receiving training. When training indicators are used, ensure that specific training modalities are defined in advance.

Numerator: Total number of community health workers in the targeted area that have received training or retraining in HIV, TB, malaria or immunization service delivery according to national guidelines (where such guidelines exist) during the last national reporting period.

Denominator: Total number of community health workers working for community-based HIV, TB, malaria or immunization service organizations in the targeted area.

Disaggregation: Data should be analyzed separately for salaried staff and volunteers and by disease.

Limitations

This indicator does not measure the quality of the training, the outcome of the training in terms of the competencies or job performance of individuals trained, nor the placement or retention of the health workforce of trained individuals.

Measurement

Targeted organizations are requested to submit appropriate administrative records to document the names of staff members that received training or retraining in HIV, TB, malaria or immunization service delivery. The organizations should also report whether or not the trained or retrained staff and volunteers are still working for the organization at the time of reporting. Only staff members and volunteers that received training or retraining in the last 12 months and that are still working for the community-based organization at the time of reporting should be considered in the calculation of the numerator.

Data sources: Appropriate administrative records

Frequency: Quarterly or according to national reporting cycle

This indicator is already in use in West and Central Africa. Usage information shows that it is easier to track absolute numbers rather than percentages. Programs need to develop comprehensive capacity building plans to track progress against an absolute training need.

Resources and capacity building (Additional Indicator 4.3)

Number and percentage of community-based organizations that received supportive supervision in accordance with national guidelines (where such guidelines exist) in the last three to six months

Rationale

Supportive supervision is key to improving program 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. The purpose of supervision is to improve the quality of programs and to create an environment to enable staff and volunteers to perform to their maximum potential.

Definition of the indicator

Supervision should be supportive and is not a means for controling the performance of an individual or an organization. Supervision normally includes skills development, review of records and reports, field visits, quality assurance, personal as well as professional development, on-the-job training and mentorship. It can involve individual sessions or group sessions and review of inventory, laboratories and storage facilities. Supportive supervision is also an opportunity for *two-way feedback* and for ensuring improved understanding of the tasks and issues involved in delivering high-quality services.

Supportive supervision is a process that promotes sustainable and efficient program management by encouraging effective two-way communication, as well as performance planning and monitoring. Supportive supervision is usually provided by a designated national entity which could be the government through the relevant national and or subnational offices, or a nationally or subnationally designated CBO.

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

Numerator: Total number of community-based organizations in the targeted area that report they have received supportive supervision in the last three to six months.

Denominator: Total number of community-based organizations in a targeted area.

Limitations

This indicator does not measure the quality of the supervision or the community-based organization's performance.

Measurement

Targeted community-based organizations are requested to report whether they received effective and supportive supervision from an external organization during the last three to six months.

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

The quality of the supportive supervision is essential – it is too easy for this to become top-down, one-way supervision by national entities, such as governement or big community-based organizations. The organizations receiving supervision should use two-way dialogue as much as possible to provide feedback on the quality of the support they receive. Periodic evaluations may also be used to measure the quality of the supervision.

Data sources: Administrative records, supervision reports

Frequency: Every three to six months

This indicator is already in use in West and Central Africa at national level.

Resources and capacity building (Additional Indicator 4.4)

Number and percentage of volunteers working with community-based organizations who are provided with incentives

Rationale

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

Definition of the indicator

An incentive can be a financial or in-kind allocation mainly meant to acknowledge the efforts of the volunteer and not to be remunerative. This may or may not be in addition to remuneration of costs incurred.

Volunteers may include a range of nonhealth workers, including office workers, drivers and activity organizers. 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, peer outreach workers, health educators, health promoters and other volunteers in accordance with the individual organization or country's definition.

Numerator: Total number of volunteers working for targeted community-based organizations in the area that have received an incentive for providing services during the last three months.

Denominator: Total number of volunteers working for community-based organizations in the targeted area.

Disaggregation: By incentive: monetary, in-kind
By length of service as a volunteer in the organization: ≤1 year, >1 year

Limitations

This indicator does not capture the amount or size of the incentive or the type of incentive given to the volunteer, nor the type of volunteer who received the incentive.

Measurement

Organizations within the community system are requested to report on the total number of volunteers who provided services for the organization and should identify how many volunteers were provided with incentives in the last three months at the time of reporting. The organizations should report on the type of stipend/allowance provided and the length of time the volunteer has provided services for the organization by the disaggregation listed above.

Data sources:	Administrative records
Frequency:	Every three months

Resources and capacity building (Additional Indicator 5.2)

Number and percentage of community-based organizations that have core funding secured for at least two years

Rationale

Core funding is provided to organizations to enable them to deliver on strategic objectives and to achieve defined goals. This type of funding includes basic "core" organizational and adminstrative costs and allows organizations to have the appropriate support and paid staff according to an organogram structured around the different streams of work to meet organisational objectives, as well as having adequate office supplies, systems and hardware in place. Core funding enables organizations to grow and develop and to be responsive to change.

Definition of the indicator

Core funding refers to financial support that covers basic core organizational and administrative costs in addition to program or project-specific budget requirements. Core funding provides stability, allowing organizations to operate their own chosen programs. Community-based organizations with secured core funding retain a significant degree of independence in selecting and implementing program and organizational 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 organizations 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 organizations. Project funding is typically short-term and limits the ability of community-based organizations to plan for the long-term. However, project funding in some cases may be the source of securing the core funding.

Provision of core funding is normally defined in an institutional document that is developed in accordance with the organizations' needs and in some cases may be approved by a relevant organizational body such as the board or general assembly.

Numerator: Total number of community-based organizations in the targeted area with confirmed core funding for at least two years starting at the time of reporting.

Denominator: Total number of community-based organizations in a targeted area.

Limitations

The indicator will not verify the actual use of core funds.

Measurement

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

The indicator will only measure progress if information on the baseline is available and it can show an increase in sustained financial support over time.

Data sources: Institutional documentation, administrative records

Frequency: Annually

Indicator currently in use in APN+ regional AIDS program in the East Asia region.

Resources and capacity building (Additional Indicator 6.2)

Number and percentage of community-based organizations that keep accurate data for inventory management according to national or international policy

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 essential commodities.

Definition of the indicator

Numerator: Number of community-based organizations in the targeted area that require a predefined set of essential commodities in order to deliver services that keep accurate logistics data for inventory management

Denominator: Total number of community-based organizations in a targeted area that require a predefined set of essential commodities in order to deliver services

Limitations:

The indicator will not measure the quality of inventory management,

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. Acurracy is also known as validity. Accurate data measure what they are intended to measure. Accurate data minimize error (e.g. recording or interviewer bias, transcription error or sampling error) to a negligible level.

Data sources: Survey/supervision or evaluation visits

Frequency: Annually

Resource: WHO operational package for assessing, monitoring and evaluating country pharmaceutical situations. Guide for coordinators and data collectors. Geneva: WHO; 2007. Available from: http://www.who.int/medicinedocs/index/assoc/s14877e/s14877e.pdf

Resources and capacity building (Additional Indicator 6.3)

Number and percentage of community-based organizations with staff who are responsible for stock management trained or retrained in stock (inventory) management in the past 12 months

Rationale

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

Definition of the indicator

The training or retraining should be conducted in accordance with national recommended guidelines (where such guidelines exist). 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. Participating in a one-day workshop, for example, does not count as receiving training. When training indicators are used, ensure that specific training modalities are defined in advance.

Numerator: Total number of community-based organizations in the targeted area that have at least one staff member who received training or retraining 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 community-based organizations 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 or job performance of individuals trained. This indicator makes the assumption that there is a viable system of orders and deliveries *already* in place.

Measurement

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

Data sources:	Appropriate administrative records
Frequency:	Every three to six months

Resources and capacity building (Additional Indicator 6.4)

Number and percentage of community-based organizations 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 organizations in the targeted area that require a predefined set of essential commodities in order to deliver services that maintain acceptable storage conditions and handling procedures.

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

Limitations

The indicator will not measure the availabilty of the essential commodities. These data will be collected through indicator 6.1

Measurement

It is essential to have available a checklist of minimum criteria for adequate storage conditions and handling of essential commodities available at the organization, for example, warehouse temperature and cool storage for diagnostics and some medicines. Such a checklist should be developed in advance 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 checklist items for storage conditions and handling of essential commodities are rated “true” or “false.” For the calculation of the numerator only those organizations should be counted that respond “true” to all the items of the checklist.

Data sources: Survey, supervision or evaluation visits

Frequency: Annually

This indicator is reported as difficult to collect in West and Central Africa and is inadequately used in the Southern Africa region.

Resources: *WHO operational package for assessing, monitoring and evaluating country pharmaceutical situations. Guide for coordinators and data collectors*. Geneva: WHO; 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: WHO; 2006 (WHO Technical Report Series, No. 937). http://whqlibdoc.who.int/trs/WHO_TRS_937_eng.pdf

A model quality assurance system for procurement agencies: recommendations for quality assurance systems focusing on prequalification of products and manufacturers, purchasing, storage and distribution of pharmaceutical products. WHO, UNICEF, UNDP, UNFPA and World Bank. Geneva: WHO; 2007.
http://www.who.int/medicines/publications/ModelQualityAssurance.pdf

Community activities and service delivery (Additional Indicator 7.2)

Number and percentage of community-based organizations that implemented activities contributing to the national disease strategic plan as documented by their plans and reports to the national designated entity

Rationale

Numerous community-based organizations (CBOs) are involved in implementing interventions by contributing to the national disease strategic plan. These contributions, however, often are not fully documented. It is important therefore to document the involvement of CBOs in the implementation of interventions by looking at their own plans (e.g. annual operational plans) or, even better, what they have accomplished through their own quarterly, semester, or annual reports and reports to designated national entities.

Definition of the indicator

This indicator measures the contribution of community-based organizations to implementing one or more program activities (e.g. PMTCT, condom promotion and distribution, key populations, treatment, care and support, male circumcision or behavior change communication) planned by the CBOs contributing to the national strategic plan (see indicator 9.5). While CBO workplans should be reviewed as documentation of planned activities, the focus of this indicator is on evidence of actual implementation of relevant activities that support the national strategic plan.

Numerator: Number of community-based organizations in the targeted area that implemented the planned interventions according to their own plan.

Denominator: Total number of community-based organizations in the targeted area that planned interventions contributing to the relevant national disease strategic plan.

Limitations

This indicator does not measure change in capacity of community-based organizations or the community system. It has not been field tested and there is no information to verify whether it is in use anywhere.

Measurement

CBOs use the data sources detailed below to review carefully their achievements and gaps in relation to effective interventions they have planned.

Data sources: Administrative records; progress reports (quarterly, semester, annual); evaluation reports; special studies and reports to national designated entitities

Frequency:	Annually

Community activities and service delivery (Additional Indicator 7.3)

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

Rationale

This indicator seeks to measure the physical access or reachability of HIV, TB, or malaria services provided by community-based organizations in settings outside the health facility that meet a minimum standard. This is only one dimension of measuring access to services that looks at service availability. These services and the service providers will vary from setting to setting and according to the disease epidemiological phase. In TB response for instance, a service provider can be a family member or friend and not necessarily a CBO. The definition of what is to be counted for this indicator needs to be clearly determined at the baseline or at the very beginning of the program.

Definition of the indicator

This indicator should focus on all people or a specific population subgroup 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, malaria or immunization services in the defined area.

Denominator: All people, or those belonging to a specific population subgroup, in the defined area.

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

Limitation

This indicator does not measure the other dimensions of access — financial and socio-psychological dimensions — nor does it monitor the quality and equity of service delivery. In addtion, it provides no information about the number of people who are informed about the availability of these services or the level of service utilization.

Measurement

Data for this indicator can only be obtained through on-site visits, using standardized data collection instruments. Data on the population distribution are required to estimate physical access. In addition, information on the total number of organizations that offer specific services and the populations they serve is required for the measurement. These data can be obtained through in-country mapping exercises and the national statistical bureaus or their equivalent, particularly for the populaton estimates. The relevant bodies that oversee the work

done by community-based organizations need to collaboratively plan with stakeholders and execute these exercises regularly to facilitate national programming and disease reponses.

Comprehensive measurement of access requires a systematic assessment of the physical, financial and sociopsychological dimensions of access to services. It is therefore important for countries to complement these assessments with relevant data from service affordability and acceptability assessments.

Data sources: Population-based survey

Frequency: Two to three years

This indicator is already in use in West and Central Africa.

Leadership and organizational strengthening (Additional Indicator 8.2)

Number and percentage of community-based organizations with staff in managerial positions who received training or retraining in management, leadership or accountability during the last reporting period

Rationale

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

Definition of the indicator

The training or retraining in management, leadership and/or accountability should be conducted according to nationally recommended guidelines (where such guidelines exist). Training offered to a staff member or volunteer should update or add new knowledge and skills. Training normally refers to an interactive process that lasts for multiple days. Participating in a one-day workshop, for example, is not counted as receiving training. When training indicators are used please ensure that specific training modalities are defined in advance.

Numerator: Total number of targeted community-based organizations that have at least one staff member or volunteer who received training or retraining 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 organization at the time of reporting.

Denominator: Total number of community-based organizations in a targeted area.

Disaggregation: By salaried staff or volunteer, type of training, sex

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 or job performance of individuals trained.

Measurement

Targeted organizations are requested to submit training records that include the dates and names of the staff members and volunteers who received the training or retraining. Community-based organizations 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 who received training or retraining in the last 12 months

and that are still working for the community-based organization at the time of reporting should be taken into consideration for the calculation of the numerator.

Data sources: Administrative records, training records

Frequency: Quarterly or according to national reporting cycle

Leadership and organizational strengthening (Additional Indicator 8.3)

Number and percentage of community-based organizations that received technical support for institutional strengthening in accordance with their requests the last 12 months

Rationale

Many community-based organizations have weak institutions and would benefit from technical support for institutional strengthening. Institutional strengthening supports community-based organizations 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 organization'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, program 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 organizations in the targeted area that report having received technical support for institutional strengthening in the last 12 months.

Denominator: Total number of community-based organizations in a targeted area.

Limitations

This indicator will provide information about the proportion of CBOs receiving technical support, but not whether the technical support had any effect or whether institutional capacity was indeed strengthened.

Measurement

Targeted organizations 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

Monitoring and evaluation and planning (Additional Indicator 9.2)

Number and percentage of community-based organizations with at least one staff member in charge of M&E

Rationale

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

Definition of the indicator

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

Numerator: Total number of community-based organizations in a targeted area that have at least one staff member responsible for monitoring and evaluating the organization at the time of reporting.

Denominator: Total number of community-based organizations in a targeted area.

Limitations

The indicator will not provide information on the performance of the M&E system of the program.

Measurement

Targeted organizations are requested to provide the name(s) of the staff member(s) responsible for all monitoring and evaluation activities of the organization as well as their terms of reference describing the monitoring and evaluation responsibilities, together with proof of qualification.

Data sources: Administrative records, annual organizational reports, terms of reference

Frequency: Annually

Monitoring and evaluation and planning (Additional Indicator 9.3)

Number and percentage of community-based organizations with at least one staff member in charge of M&E who received training or retraining in M&E according to nationally recommended guidelines (where such guidelines exist) during the last national reporting period

Rationale

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

Definition of the indicator

Organizations will only be counted if at least one staff member received training in M&E in the last reporting period. Training offered to a staff member should update or add new knowledge and skills. Training normally refers to an interactive process which lasts for multiple days. Participating in a one-day workshop, for example, is not counted as receiving training. When training indicators are used please ensure that specific training modalities are defined in advance.

Numerator: Total number of community-based organizations in a targeted area that have at least one staff member who received training according to nationally recommended guidelines (where such guidelines exist) in monitoring and evaluation during the last 12 months at the time of reporting.

Denominator: Total number of community-based organizations within 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 or job performance of individuals trained.

Measurement

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

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

Data sources:	Administrative records, training records
Frequency:	Quarterly or according to national reporting cycle

Monitoring and evaluation and planning (Additional Indicator 9.4)

Number and percentage of community-based organizations using standard data collection tools and reporting formats to report 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 linking this with information from the public health sector is important for program planning and informed decision-making. This indicator intends to measure the extent to which community-based organizations make use of standard data collection tools and reporting formats to integrate 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 report forms recommended by national guidelines (where such guidelines exist) for submitting reports to the national reporting system.

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 should ideally be included in the national monitoring and evaluation plan.

Numerator: Total number of community-based organizations in the targeted area 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 community-based organizations in a targeted area.

Limitatons

This indicator assumes that the national M&E system is fully defined and well disseminated. This is not correct in all countries. Also, while the information needs should be captured in the M&E plan, in some cases they are not. The indicator will not provide information about the use of reports and program information.

Measurement

Targeted organizations 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 organizations 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:	Administrative records, data collection tools and reporting formats
Frequency:	Annually

Monitoring and evaluation and planning (Additional Indicator 9.5)

Number and percentage of community-based organizations conducting documented reviews of their own program performance according to their strategic plan in accordance with the national reporting cycle.

Rationale

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

Definition of the indicator

This indicator measures whether community-based organizations conduct regular reviews of their own program performance against set targets. A good review of program performance should take the following steps into consideration:

- definition of the review process;
- discussion of each activity area with regard to past performance, best practices, challenges and risks;
- preparation of an action plan that identifies the next steps to address the issues raised during the review.

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

Numerator: Total number of community-based organizations in a targeted area that have conducted a review of their program performance in the last three to six months at the time of reporting.

Denominator: Total number of community-based organizations in a targeted area.

Limitation

This does not measure the quality of services unless the organization integrated some quality indicators in its review and action plan.

Measurement

Community-based organizations are requested to report whether they have conducted a review of their own program performance in the last reporting period. Verification can be conducted by reviewing a simple documented description of the review process that includes:

- the names of the participants

- a summary of the issues raised during the review
- action points addressing the issues raised during the review

This information can be complemented with results from external periodic perfomance reviews (e.g. quarterly, annual and midterm evaluations).

Data sources: Administrative records, documented description of the review process

Frequency: Quarterly or according to national reporting cycle

Monitoring and evaluation and planning (Additional Indicator 10.2)

Number and percentage of community-based organizations that are implementing a budgeted annual workplan

Rationale

Having a functional budgeted workplan in place is important for setting priorities for the implementation of crosscutting organizational activities as well as those that contribute to the effective service delivery for HIV, TB and/or malaria. A good workplan provides structure and helps in the planning and implementation of operations.

Definition of the indicator

This indicator measures two aspects of an organization's program. First is the existence of a costed annual workplan that includes all activities conducted by the organization. Second, it measures whether the costed annual workplan is actually being implemented. A workplan is an operational plan that contains all operational activities of the organization such as programmatic 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 linked or harmonized with the national strategy);
- a list of all activities that will be undertaken by the organization. All activities should be linked to the identified objectives;
- a clear timeline 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.

Budgeted annual workplans of community-based organizations should be developed in consultation with all relevant community stakeholders.

Numerator:	Total number of community-based organizations in targeted area that have a budgeted annual workplan in place that includes monitoring and evaluation activities and that provides evidence of the implementation of the plan.
Denominator:	Total number of community-based organizations in a targeted area.
Disaggregation:	This indicator can be tracked separately for the different functional components of an organization where planning and costing is required. This should be adapted according to organizational needs and planning processes. The different plans that should be tracked include monitoring and evaluation, communication, and advocacy.

Limitation

This indicator does not give information about the effectiveness or the quality of implementation of the workplan or improvement in health outcomes.

Measurement

Community-based organizations are requested to submit their current budgeted annual workplan at the time of reporting. Demonstration of implementation can be provided through service delivery registers, client records, M&E reports and news bulletins as applicable.

Data sources: Administrative records, annual workplan, implementation reports, and other documentation

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

Eurasian Harm Reduction Network (EHRN) – trainings and technical assistance http://www.harm-reduction.org/hub.html

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

Global Network of People Living with HIV (GNP+). http://www.gnpplus.net/content/view/14/86/

Latin American and Caribbean Council of AIDS Service Organizations (LACCASO) http://www.laccaso.net/

MEASURE Evaluation Capacity Building Guides. http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/capacity-building-guides/capacity-building-guides-index.html

Roll Back Malaria Toolbox. http://www.rollbackmalaria.org/toolbox/index.html

Stop-TB - TB Technical Assistance Mechanism (TEAM). http://www.stoptb.org/countries/tbteam/default.asp

UNAIDS Technical Support Facilities. http://www.unaids.org/en/CountryResponses/TechnicalSupport/TSF/

b. *Other information sources, including those referenced in the CSS Framework*

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

A model quality assurance system for procurement agencies: recommendations for quality assurance systems focusing on prequalification of products and manufacturers, purchasing, storage and distribution of pharmaceutical products. WHO/UNICEF/UNDP/UNFPA/World

Bank; 2007. http://www.who.int/medicines/publications/ModelQualityAssurance.pdf

Abuja Declaration and Plan of Action.
http://www.rollbackmalaria.org/docs/abuja_declaration_final.htm

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

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

C*ommunity 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

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

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

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

Community involvement in tuberculosis care and prevention: Guiding principles and recommendations based on a WHO review. WHO; 2008.
http://www.stoptb.org/resource_center/assets/documents/Community%20involvement%20in%20TB%20care%20and%20prevention.pdf

Community Organizing and Community Building for Health. Meredith Minkler. Rutgers University Press; 2004.
http://rutgerspress.rutgers.edu/acatalog/__Community_Organizing_and_Community_Building_for__664.html

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

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

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

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

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

Global HIV M&E [information website].
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