



# **Technical Brief**

## **Community Systems Strengthening**

**Allocation Period 2023-2025**

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# Introduction

This technical brief provides guidance about community systems strengthening (CSS) interventions funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

**Community systems strengthening** supports the development of informed, strong, and coordinated communities, and the development of community-led and community-based organizations, groups and structures to advance health and equity in efforts against HIV, tuberculosis (TB) and malaria.

The Global Fund supports CSS as an essential part of Resilient and Sustainable Systems for Health (RSSH) and as a vital element of responses to HIV, TB and malaria.

In its [2023-2028 Strategy](#) and [2023-2025 allocation period](#), the Global Fund prioritizes funding for four CSS interventions:

- Community-led monitoring.
- Community-led research and advocacy.
- Capacity building and leadership development.
- Community engagement, linkages and coordination.<sup>1</sup>

This technical brief summarizes key concepts and investment opportunities for CSS, drawing from the [Global Fund Strategy](#), [Modular Framework](#), the [RSSH](#), [HIV](#) and [TB](#) Information Notes and technical partner guidance.

Members of Country Coordinating Mechanisms (CCMs) and Regional Coordinating Mechanisms (RCMs) are strongly encouraged to include comprehensively designed and adequately budgeted CSS interventions aligned to country and epidemiological contexts and community health strategies into funding requests to the Global Fund.

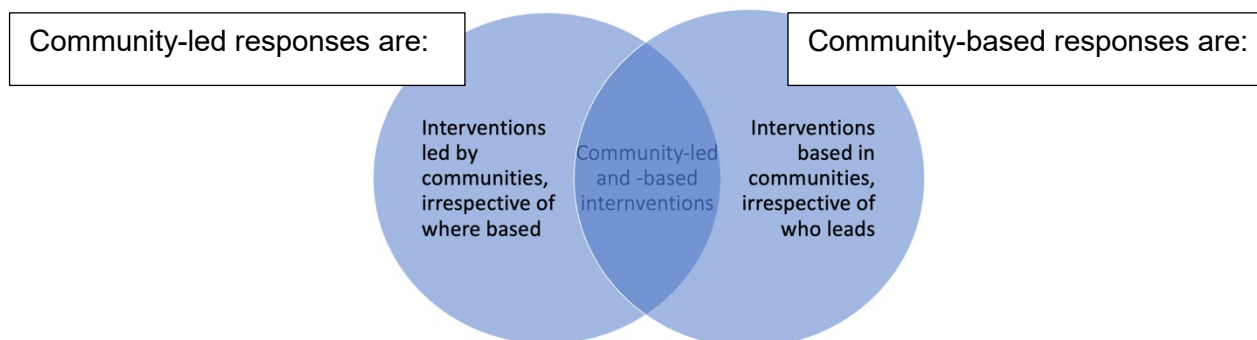
Country stakeholders seeking technical assistance for country dialogues related to this content are welcome to contact the Global Fund through its [Strengthening Community Engagement](#) page.

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<sup>1</sup> Note that the intervention category described in the Global Fund Modular Framework as “Community engagement, linkages and coordination” is also labelled “social mobilization, linkages and coordination” in the Global Fund RSSH Information Note.

CSS supports both **community-led** and **community-based** responses. Both are important to deliver programs to communities, and responses can be both community-led (if led by the community) and community-based (delivered in the community). Some community-based responses are delivered within government health programs and others by independent non-governmental organizations. All are complementary parts of a country's **community systems and responses (CS&R)**, and together these act as key components of a country's resilient and sustainable systems for health.

Community systems and responses may be community-led and/or community based.



These categories are complementary.

See Section 4 on page 15 for key terms and definitions, and Section 5 on page 16 for further references.

Examples of how CSS can strengthen HIV, TB and malaria programming at the country level include:

- [HIV](#): Support for people living with HIV, adolescent girls and young women (AGYW), and other key and vulnerable populations can improve the use of and access to condoms, PrEP, HIV testing, treatment, management of comorbidities and sexual health services, thereby reducing rates of HIV transmission, illness and AIDS-related mortality.
- [TB](#): Support for community-led organizations can improve outreach and TB screening programs among people at high risk, health literacy on TB and retention in outpatient TB treatment.
- [Malaria](#): Support for local community organizations to work with sub-district malaria clinics and health workers can improve rapid detection and diagnosis of malaria and encourage the use of rapid diagnostic tests (RDTs), intermittent preventive treatment (IPT) and insecticide-treated bed nets (ITNs and LLINs) at the community level.
- [Human rights and gender equity](#): CSS interventions can contribute to building capacity of communities to address stigma, discrimination and violence and provide legal services.
- CSS interventions may be of particular relevance in [challenging operating environments](#), where community-led and community-based organizations are vital partners to governments in the delivery of services, particularly in instances of natural disaster, armed conflict or civil unrest, weak governance, climate change-related crises and/or mass displacement.

# 1. Prioritized Interventions Funded by the Global Fund

The Global Fund invests in CSS to reinforce community systems and responses (CS&R) through disease-specific [modules](#) for HIV, TB, TB/HIV, and/or malaria, and through the module for Resilient and Sustainable Systems for Health (RSSH). The following are the four priority interventions to support CSS that are eligible for financial support from the Global Fund:

## 1.1 Community-led monitoring

These are independent accountability mechanisms that are designed, led and implemented by local community organizations working closely with recipients of care and key and vulnerable populations. Through community-led monitoring (CLM), recipients of care and other local community members use structured data collection and analysis to produce evidence-based recommendations for improved accessibility, acceptability, affordability and quality (AAAQ) and impact of health programs and services.

## 1.2 Community-led research and advocacy

Activities to inform and support advocacy that are designed and led by community organizations, networks and civil society actors, especially advocacy led by marginalized, criminalized, under-served, key and vulnerable populations. Research and advocacy can relate to quality of health services and programs, financing of programs, legal and policy reform, and/or human rights barriers (such as age and gender inequities, stigma, discrimination, criminalization, violence and breaches of confidentiality).

## 1.3 Community capacity building and leadership development

Activities that support the establishment, strengthening and sustainability of community-led organizations to provide and improve health and other services to address HIV, TB and malaria. This includes developing capacity and leadership of key and vulnerable populations and supporting organizations that have trust engaging with these communities.<sup>2</sup>

## 1.4 Community engagement, linkages and coordination

Includes activities to create an interlinked and coordinated system of community-based and community-led programs and services that engage, inform and deliver services to people in key, vulnerable and other populations not benefitting from health programs. This includes social mobilization to inform and engage communities in decision-making about health services and policies<sup>3</sup>

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<sup>2</sup> For example, see Steen R. [Key Population Trusted Platforms](#). 2020.

<sup>3</sup> This is different from direct services for engaging people in health information, screening, prevention, treatment and support, which the Global Fund supports through disease modules).

CSS reinforces, and is a distinct addition to, the many interventions delivered at a community level, including:<sup>4</sup>

- Disease-specific interventions focused on HIV, TB, TB/HIV, collaborative activities and malaria.
- Interventions to address human rights- and gender-related barriers.
- Domestic resource mobilization.
- Country monitoring and evaluation (M&E), data quality.
- The hiring and retention of community health workers (CHWs) to provide HIV, TB and malaria services (RSSH/PP HRH indicators).<sup>5</sup>

The Global Fund uses the following CSS indicators to track performance and coverage of CSS activities; these can be included in the performance framework of each Global Fund grant:

Module	Type of indicator	Indicator code	Indicator description	Disaggregation categories
RSSH: CSS	Coverage	CSS-2	Number of community organizations that received a pre-defined package of training.	Type of organization (community-based, community-led). Type of community-led organization (KVP-led (TB), KP-led (HIV), women-led (all diseases)).
RSSH: CSS	Coverage	CSS-3	Percentage of health service delivery sites with a community-led monitoring mechanism in place.	Type of CLM mechanism (HIV, TB, malaria, TB/HIV, TB/HIV/malaria).

The Global Fund also has an indicator for social contracting of civil society organizations to deliver services and programs; this can be a complementary measure to CSS.

<sup>4</sup> More detail on these interventions can be found in the Global Fund [Modular Framework](#).

<sup>5</sup> Activities to bolster community systems strengthening, such as community-led monitoring, research and advocacy, coordination and capacity building, are strongly encouraged and should be included in the “Community Systems Strengthening” module. Community health workers (CHWs), including peers, should be included under the “Human Resources for Health (HRH) and Quality of Care” module.

Module	Type of indicator	Indicator code	Indicator description	Disaggregation categories
RSSH: HFS	Coverage	HFS-5	Percentage of civil society organizations contracted by public entities for provision of community-based services to key populations.	Source of financing (domestic, external). Disease (HIV, TB, malaria). Type of key populations.

## 2. Investment Approach

### 2.1 Understand: Compile community input about gaps and priorities

CSS interventions are designed to support country objectives and targets in the response to the three diseases of HIV, TB and malaria. CSS interventions should be informed by communities and focus on gaps in the existing community systems and community priorities. CSS interventions should also respond to epidemiological data and defined gaps in services and programs.

In advance of developing funding requests to the Global Fund, CCMs and RCMs will organize country consultations and dialogues to identify program gaps and funding priorities. CCMs and RCMs will also formally review national and regional strategic plans and program reviews and evaluations. Additional dialogues and reviews can also be organized about the design, implementation, evaluation and funding of community-based and community-led interventions.

In its 2023-2025 allocation period, the Global Fund requires all funding requests to report on these dialogues and reviews through formal annexes submitted as part of the application package, including a [“Country Dialogue Narrative,”](#) a [“RSSH Gaps and Priorities Annex,”](#) and a [“Funding Priorities of Civil Society and Communities Annex.”](#)

**THE GLOBAL FUND**

### RSSH Gaps and Priorities Annex – Template

Date Published: 31 July 2022

Instructions and illustrative examples to support applicants complete this template are available below.

**Section 1 – Analysis of RSSH priorities, including those related to community systems strengthening, based on programmatic gaps**  
Identify the top three priorities for RSSH (by module) for each disease program and briefly explain how investing in these areas will help to address specific programmatic gaps for HIV, TB and malaria, while contributing to RSSH and pandemic preparedness.

Disease component (based on allocation letter)	Top three RSSH priorities (by module), including those related to community systems	Link with specific programmatic challenges and/or priorities to ensure quality
HIV		
TB		
Malaria		

**Section 2 – Prioritization process**  
Based on the analysis above: (1) Explain the approach used by the disease programs to collaboratively discuss and prioritize their health and community system bottlenecks; (2) Summarize why these RSSH areas have been prioritized between the three diseases for inclusion in the funding request; and (3) Explain how these priorities are aligned with those articulated in the national health sector plan and other key national policies and strategies.

**Section 3 – Funding gap analysis**  
Fill in the funding landscape table below for the relevant RSSH modules that are the main cost drivers in the funding request. Alternatively, applicants can include a funding gap analysis table using their own format.

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### Funding Priorities of Civil Society and Communities Most Affected by HIV, Tuberculosis and Malaria

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This mandatory funding request annex aims to capture a list of highest priority recommended interventions from the perspective of civil society and communities most affected by the three diseases, even if these are not prioritized in the final funding request submitted to the Global Fund.<sup>1</sup> This information will be used by the Global Fund to assess the effectiveness of country dialogue and to give a fuller picture of community needs.

Civil society representatives on the Country Coordinating Mechanism (CCM) should coordinate the completion of this form with the support of the CCM Secretariat and submit it through the CCM as part of the formal funding request submission. Only one consolidated list with **maximum 20 items** may be submitted.

Country Component(s) <sup>2</sup>			
Civil Society Representative(s)			
Description of recommended intervention and expected impact or outcome <sup>3</sup>	Activity included in the final funding request submitted to the Global Fund	Activity included in the final PAAR submitted to the Global Fund	Additional comments
	<input type="checkbox"/> Yes <input type="checkbox"/> Partially <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Partially <input type="checkbox"/> No	
<i>(Add rows as needed)</i>			

List of civil society organizations and constituencies consulted and represented in the development of this list.

Organization, Constituency and Email

An **RSSH Gaps and Priorities Annex** needs to list the top three priorities for RSSH by Global Fund module for each disease program and describe how investing in these priorities will address specific programmatic gaps and priorities.

The **Funding Priorities of Civil Society and Communities Annex** needs to describe as many as 20 of the highest-priority interventions identified by civil society and communities during the country dialogue process.



The following table provides examples of how CSS gaps and priorities could be described:

<b>Intervention</b>	<b>Examples of gaps</b>	<b>Potential priorities</b>
Community-led monitoring	Country programs for HIV, TB and malaria are challenged by issues of service quality, supply of commodities and human rights. Community-led organizations and recipients of care can contribute evidence and perspectives to overcome these challenges but need support to do so.	<ul style="list-style-type: none"> <li>• Development of CLM strategies.</li> <li>• Refinement of CLM indicators and tools.</li> <li>• Community capacity to share CLM data, develop and present recommendations for action and engage in the response.</li> </ul>
Community-led research and advocacy	Community-led organizations, networks and leaders lack capacity and funding for high-quality research and evidence-informed advocacy. Prevailing economic, social, legal and policy environments constrain abilities of community leaders to assess gaps in HIV, TB and malaria responses, formulate evidence-based recommendations and communicate with policymakers and program managers.	<ul style="list-style-type: none"> <li>• Community-led research such as analyses of services, programs, policies, budgets, and expenditures.</li> <li>• Capacities for communications and community organizing and effective community engagement with policymakers and program managers for improved communication and participation in decision-making.</li> </ul>
Capacity and leadership development	Community-led organizations need to gain basic legal status, functional governance, strategic plans, capacity for financial and human resource management and sufficient funding and infrastructure.	<ul style="list-style-type: none"> <li>• Trainings, mentorship, small grants and sustained support to build relevant competencies: staffing, skills, plans, structures, systems, tools and experience.</li> </ul>
Community engagement, linkages and coordination	Key and vulnerable populations are inadequately engaged in and benefitting from HIV, TB and malaria efforts. Improved coordination and linkages are needed among community-based, community-led and formal health sector programs, along with social mobilization efforts.	<ul style="list-style-type: none"> <li>• Meetings, mapping, trainings, tools and funding to improve the coordination and linkages among services and programs, provide incentives, eliminate barriers, inform and mobilize key and vulnerable populations.</li> </ul>

See Annex 2 for practical questions to help stakeholders define CSS needs.

## 2.2 Design: Describe CSS activities, costs and value for money

CSS interventions should define specific, measurable activities to be funded and implemented. Representatives of communities intended to benefit from the CSS interventions should be involved in the design process to reflect their needs and priorities. The following are examples of possible CSS activities:

Intervention	Examples of activities <i>(Illustrative examples drawn from the Global Fund <a href="#">Modular Framework</a>.)</i>
Community-led monitoring	<ul style="list-style-type: none"> <li>• Development of CLM frameworks and strategies to coordinate CLM efforts.</li> <li>• Technical support and training for CLM indicator selection, data collection, data management and security, data analysis, or use of CLM data to improve programs.</li> <li>• Piloting and implementation of CLM to identify and address barriers and gaps in services and programs.</li> </ul>
Community-led research and advocacy	<ul style="list-style-type: none"> <li>• Community-led research of needs, barriers and opportunities for improvement in service delivery including research on stigma, discrimination and legal and gender-related issues, and research about funding allocations and expenditures in efforts against HIV, TB and malaria.</li> <li>• Production, publication and dissemination of reports and other communication and campaigns.</li> <li>• Communities engaged with policymakers and program managers to communicate recommendations and co-create shared solutions for improved health services and/or enabling environments.</li> </ul>
Capacity building and leadership development	<ul style="list-style-type: none"> <li>• Trainings, mentorship, small grants, and sustained support to help community-led and -based organizations gain legal status, create functional governance, develop strategic plans, increase capacity for financial and human resource management and equip with sufficient funding and infrastructure.</li> </ul>
Community engagement, linkages and coordination	<ul style="list-style-type: none"> <li>• Meetings, mapping, trainings tools and funding to improve the coordination and linkages among services and programs and provide incentives and eliminate barriers for key and vulnerable populations.</li> </ul>

See Annex 1 for practical questions to support stakeholders prioritize CSS activities.

## Budgeting for CSS activities

The following is guidance for budgeting CSS costs in Global Fund funding request:

Intervention	Costs specific to CSS focus area (examples)	Cross-cutting costs (examples)
Community-led monitoring	<ul style="list-style-type: none"> <li>Salaries and stipends for community researchers, data collectors, technical program staff, data management specialists and analysts.</li> <li>Tools, software and communications costs (such as airtime) for data collection, data management and results dissemination.</li> <li>Travel and meeting costs for data collection and results dissemination.</li> </ul>	<ul style="list-style-type: none"> <li>Personnel for financial, administrative and program management at community organizations.</li> <li>Personnel to coordinate trainings, communications and community engagement.</li> </ul>
Community-led research and advocacy	<ul style="list-style-type: none"> <li>Policy and program analysts and other researchers.</li> <li>Specialists in advocacy communications.</li> <li>Advocates with connections and influence with policy-makers and program managers.</li> <li>Travel and meeting costs to engage constituents and decision-makers.</li> </ul>	<ul style="list-style-type: none"> <li>Travel and meeting costs for trainings and peer learning networks, and for staff supervision and support.</li> <li>Communications costs (phones, website, airtime, etc.)</li> </ul>
Capacity building and leadership development	<ul style="list-style-type: none"> <li>Technical support for strategic planning, organizational development, financial management and human resource development to deliver HIV, TB and malaria services.</li> <li>Small grants to community-led organizations.</li> </ul>	<ul style="list-style-type: none"> <li>Organization's indirect and overhead costs (up to 10 percent of overall budgets to cover general shared costs that may be impractical to itemize, such as space rental, security, phone and data airtime subscriptions, website maintenance, and utilities).</li> </ul>
Community engagement, linkages and coordination	<ul style="list-style-type: none"> <li>Specialists in service linkages and referrals.</li> <li>Outreach workers, educators, organizers.</li> <li>Specialists in communications with KVP.</li> <li>Travel costs and other incentives to help people engage in services and overcome social and structural barriers to health.</li> </ul>	

### Notes:

- CHWs employed by formal health systems should be budgeted under the RSSH Human Resources for Health (HRH) module.
- Social contracting and costs for community advocacy for domestic resource mobilization should be budgeted under RSSH Health Financing Systems (HFS).
- Costs of M&E systems to improve the use of data from community-led monitoring may be funded as a part of country M&E data quality efforts.

Budgets for the multi-year period of 2023-2025 should consider gradual increases in spending to account for inflation. Multi-year budgets should also consider gradual increases in spending on CSS activities as new CSS activities are piloted, assessed and then scaled up.

Budgets should be accompanied by narratives to justify costs and demonstrate expected [value for money](#).

- Justifications should describe appropriateness of costs in relation to local prevailing rates and sufficient explanations of key costs (such as for equipment, per diems, incentive payments, organizational grants and organizational overheads).
- Budgets for interventions in community settings should consider the added costs of activities conducted in rural and dispersed settings, in settings with limited infrastructure, and those implemented during evening hours. These costs might, for example, include supplemental security, supervision, support and overtime costs for employees.
- Remuneration rates for individuals working at community-based and community-led organizations should align with local prevailing rates but also should be sufficient to attract and retain people with the necessary experience and skills.
- Remuneration of individuals experienced in working with key and vulnerable populations should include costs of accommodating specific health, social service and transport needs.
- Budgeted grants for small community organizations should describe capacity considerations such as the size of grants in relation to total recent organization budgets.

More guidance and a useful costing and budgeting tool can be found in the Global Fund Costing Guide for Civil Society and Community Priorities [[link forthcoming](#)]. Country stakeholders seeking technical assistance for costing and budgeting are also welcome to contact the Global Fund through its [Strengthening Community Engagement](#) page.

The following key points can help in describing the rationale and value of investments in CSS activities:

<b>Intervention</b>	<b>Examples of rationale and value of investments in CSS</b>
Community-led monitoring	<ul style="list-style-type: none"> <li>• CLM generates quantitative and qualitative data – regularly localized, actionable evidence – that can support managers and providers in improving services and programs.</li> <li>• CLM also directly engages and empowers key and vulnerable populations to be in dialogue with providers about intended health outcomes and rights- and gender-related barriers, thereby reinforcing accountability and people-centered approaches to health.</li> </ul>
Community-led research and advocacy	<ul style="list-style-type: none"> <li>• Improvements to the quality and effectiveness of services, programs and policies can be blocked by subjective factors such as bureaucratic complexity and inertia or decision-maker perceptions about what is possible and what is a priority.</li> <li>• Advocacy can promote change but is more effective when it is reinforced with evidence, clear communication, powerful constituencies and sustained relationships with decision-makers.</li> </ul>
Community capacity building and leadership development	<ul style="list-style-type: none"> <li>• Investments in organizational development (through training and mentorships, practical tools and small grants) strengthen the capacity of community-led organizations to deliver HIV, TB and/or malaria services and programs.</li> </ul>
Community engagement, linkages and coordination	<ul style="list-style-type: none"> <li>• Coordination meetings, mapping, trainings, tools and funding for community-led organizations can improve the coordination and linkages among services and programs. This, along with social mobilization and coordinated provision of incentives and elimination of barriers for key and vulnerable populations, helps people to overcome limited information, social barriers, and structural barriers to health, which in turn helps country programs achieve their goals and targets.</li> </ul>

### **2.3 Deliver: Strengthen community systems for outcomes and impact**

CSS interventions can be shown to reinforce the effectiveness of country health systems in their responses to the three diseases of HIV, TB, and malaria. CSS activities also directly contribute to the Global Fund objectives of:

- People-centered integrated systems for health
- Engagement and leadership of the most-affected communities
- Health equity, gender equality, and human rights

The following are additional examples of how to link CSS implementation with outcomes.

<b>Intervention</b>	<b>Examples of possible expected outcomes and impacts</b>
Community-led monitoring	<ul style="list-style-type: none"> <li>• Evidence from CLM will be used by service providers and program managers to improve service quality, commodity supplies, human rights and gender-related barriers, and engagement of recipients in services.</li> <li>• Through CLM, recipients of care and others in key and vulnerable populations will engage in dialogue with service providers and program managers about how to overcome barriers and deliver HIV, TB and malaria outcomes. This reinforces accountability and a people-centered approach to health.</li> </ul>
Community-led research and advocacy	<ul style="list-style-type: none"> <li>• Community-led research and advocacy will identify priorities for improvements in services and programs.</li> <li>• Community researchers and advocates will communicate these priorities and recommendations through presentations, reports, digital media and other channels.</li> <li>• Communities will engage with policymakers and program managers to improve services and programs.</li> </ul>
Community capacity building and leadership development	<ul style="list-style-type: none"> <li>• Community-based and community-led organizations will gain increased capacity to support improved scale, quality, and sustainability of community interventions for HIV, TB, malaria and human rights.</li> </ul>
Community engagement, linkages and coordination	<ul style="list-style-type: none"> <li>• Through coordinated and interlinked programs and services and social mobilization, more communities, especially among key and vulnerable populations, will benefit from health information and education campaigns, health screening, prevention and treatment programs and related support services.</li> </ul>

### 3. List of Abbreviations

<b>AAAQ</b>	Availability, Accessibility, Acceptability, and Quality
<b>AGYW</b>	Adolescent Girls and Young Women
<b>ANC</b>	Antenatal Care
<b>ART</b>	Antiretroviral therapy
<b>CCM</b>	Country Coordinating Mechanism
<b>CHW</b>	Community Health Worker
<b>cIPTp</b>	Community-level Intermittent Preventive Treatment of Malaria in Pregnancy
<b>CLM</b>	Community-Led Monitoring
<b>COE</b>	Challenging Operating Environment
<b>CS&amp;R</b>	Community Systems and Responses
<b>CSS</b>	Community Systems Strengthening
<b>DSD</b>	Differentiated Service Delivery
<b>GBV</b>	Gender Based Violence
<b>HRH</b>	Human Resources for Health
<b>HSS</b>	Health Systems Strengthening
<b>iCCM</b>	Integrated Community Case Management
<b>IPCQS</b>	Integrated People-Centred Quality Health Services
<b>KVP</b>	Key and Vulnerable Populations
<b>MEWS</b>	Malaria Early Warning System
<b>MMD</b>	Multi-Month Dispensing
<b>NSP</b>	National Strategic Plan
<b>PSEAH</b>	Protection from Sexual Exploitation, Abuse, and Harassment
<b>RSSH</b>	Resilient and Sustainable Systems for Health
<b>SDGs</b>	Sustainable Development Goals
<b>SMC</b>	Seasonal Malaria Chemoprevention
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>TB</b>	Tuberculosis
<b>TPT</b>	Tuberculosis Preventive Treatment
<b>UHC</b>	Universal Health Coverage

## 4. Key Terms and Definitions

Communities	Communities are groups of people with similar characteristics or interests. People often self-identify as part of several communities that are defined in various ways, such as shared geographic location, gender, age, or cultural or social identities. Communities might also form around shared economic, political, or human rights issues.
Key and vulnerable populations	In the context of HIV, TB and malaria, key and vulnerable populations are people who experience <i>increased</i> vulnerability to and impact from one of the diseases, combined with <i>decreased</i> access to services. Key populations may also experience human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization.
Community-based organizations	Community-based organizations operate in community settings or locations. Often they are organizations that have arisen from a community in response to particular needs or challenges.
Community-led organizations	Community-led organizations are organizations that are governed, led and staffed by people who are experienced and affiliated with the communities being served or intended to benefit from the organization's work.
Community-led responses	Community-led responses are specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.
Community systems	Community systems are the structures, mechanisms, processes, and actors that engage and deliver interventions to communities. They may be community-focused, community-based, or community-led.
Community systems strengthening	Community systems strengthening (CSS) is a set of interventions intended to support development of informed, capable and coordinated communities, and community-based and community-led organizations, groups and structures.

Further definitions and discussion of communities, community organizations, and community systems in efforts against HIV, TB and malaria can be found in the [RSSH Information Note](#), the [HIV](#), [TB](#) and [Malaria](#) information notes, in the References section, and at the following Global Fund webpages:

- Women and Girls <https://www.theglobalfund.org/en/women-girls/>
- Key Populations <https://www.theglobalfund.org/en/key-populations/>
- Human Rights <https://www.theglobalfund.org/en/human-rights/>



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# Annex 1: Questions to Help Define CSS Gaps and Priorities

The following is a set of questions to help communities, CCM and RCM members, funding request writing committees and other stakeholders to define CSS gaps and priorities that are relevant to country contexts, strategies and operational frameworks.

Stakeholders can use these questions to guide community dialogue and research. Stakeholders should collect and document this process so that they can support Global Fund funding requests. This information will support writing teams and CCMs to understand the evidence used to inform CSS priorities.

## Community participation is essential.<sup>6</sup>

The Global Fund requires that communities, including key and vulnerable populations, be meaningfully engaged throughout the grant life cycle and that community perspectives, experiences and needs be included in the final funding request, program design and program implementation.

- ***Who are the community-led and based organizations, groups and networks that might provide important perspectives about community systems gaps and priorities?***
- ***What support might they need to enable their meaningful engagement and participation in program planning and in processes to inform the development of a Global Fund funding request?***

## Three questions to help define CSS gaps and priorities

### Question 1: What do you already know about epidemics in your context?<sup>7</sup>

(Note:

- Who are the key and most vulnerable populations? Which communities or populations are disproportionately affected by epidemics (what ages, genders, socio-economic status, geographies)?

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<sup>6</sup> The Global Fund can link country stakeholders to technical assistance supporting community participation in all stages of developing a funding request. Community-led and community-based organizations and networks are encouraged to contact the Global Fund to make use of this support. <https://www.theglobalfund.org/en/funding-model/throughout-the-cycle/community-engagement/>

<sup>7</sup> For the Global Fund funding request, document what is already known and not known from recent assessments, evaluations, program reviews and other strategic documents. That information, along with findings from consultations and dialogues, will fit within the "Population, geographies and/or barriers addressed" fields across the modules of section 1.1. "Prioritized Request" point A of the funding request.)

- Who is being reached and where? And with which interventions? Are the interventions routine and not one-off activities or events?
- Who remains underserved or unreached and why?
- How do people prefer to access essential HIV, TB and malaria services? Where is this information documented?
- Where along the prevention, diagnostics, care and treatment cascade (for HIV, TB and malaria) are the major gaps?<sup>8</sup>
- Which social and structural drivers fuel inequity and inequality in access, availability and affordability of HIV, TB, malaria services and, if disaggregated (sex, age, gender, etc.) information is available, which groups are most affected? What, if any interventions are being implemented to address the inequity in access to services?
- Are there any issues with the quality of services (i.e., comprehensiveness) or remaining gaps in service delivery packages or platforms?<sup>9</sup>

## **Question 2: How are communities engaged in the response to the epidemics?**

*(This information should be added in funding request section 2.2 under “How this request supports community systems strengthening / Describe relevant community-based and -led organizations”).*

- To what extent and how are community-based and community-led organizations, networks and/or groups (including both formal and informal structures) engaged in the HIV, TB and/or malaria response?
- Have community-led and community-based organizations been mapped in the country/district and what are their roles in the health response? Is this documented in a national or community health strategy? If so, is this implemented according to the strategy? What are the gaps?
- What are the current technical, organizational, leadership and financial capacities of the community-based and led structures? Where have these been documented and what are the major capacity weaknesses?
- How are community-led and community-based organizations funded/supported?
- What mechanisms exist to manage, coordinate or link existing community groups, organizations and/or networks to each other?
- Are there links and a clear referral mechanism and pathway between the communities and the public and private health providers?

<sup>8</sup> This content will align with section 1.3 “Context” of the funding request, particularly – for funding requests with HIV modules – with the recent data on the 95-95-95 targets, and for funding requests with TB modules – with the cascade analyses.

<sup>9</sup> Various cross-cutting factors, such a lack of awareness activities for key and vulnerable populations, recruitment and remuneration to enable peer-to-peer support, availability of low threshold settings, etc. create or amplify barriers to services and impact service delivery throughout the whole cascade.

- How is the information generated by community structures used to inform program design and people-centered service delivery? Who has access to the data and how are they using it?
- Are there existing regulatory frameworks for financing or contracting community-led and community-based organizations from domestic sources to deliver services? Are they translated into working implementation mechanisms which are amenable to the communities?

**Question 3: What do you know about existing community engagement and to what extent have results and lessons learned, including for community-based and community-led service delivery, been documented?<sup>10</sup>**

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

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<sup>10</sup> This information should be documented for inclusion in funding request section 1.4 “Lessons Learned” where are described the main lessons learned from current programs, distinguishing those which have already been operationalized into programs, which are planned for operationalization and which are not addressed or no longer included, and why.

## Annex 2: Questions to Help Prioritize CSS Activities

The following is a set of questions, organized by each of the four aspects of CSS, to help stakeholders prioritize activities most relevant to country contexts, strategies and operational frameworks.

Stakeholders can use these questions to guide community dialogues and focused research. Stakeholders should collect and keep track of any supporting or key reference documents through this process so that they can be attached to any future funding request. The compilation of this information will support writing teams and CCMs to understand the evidence used to inform the CSS priorities for inclusion in the funding request.

### Priority Area: Community-led Monitoring

#### **Question 1: Is there an understanding of and capacity to undertake CLM in the country, including capacity to manage, implement and coordinate CLM?**

*If the answer is “yes,” i.e., there is capacity to manage, implement and coordinate CLM, then skip to next.*

*If the answer is “no,” then (include in your funding request):*

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

#### **Question 2: Is CLM being implemented in your country?**

*If the answer is “yes,” then:*

- A mapping and review to understand if all key and vulnerable populations are included and what results CLM implementation have led to can be part of the funding request. In case there are multiple CLM instruments or approaches, reviewing their alignment/harmonization will be useful in assessing whether they can be expanded, adapted or scaled up and what support might be needed, including the current levels/sources of funding and the required investment.
- Assessing whether the entire CLM cycle<sup>11</sup> has been covered will be useful to address any blockages or barriers to ensuring that CLM implementation results in

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<sup>11</sup> The CLM cycle includes communities: 1) identifying issues to monitor based on experiences using health and other services; 2) collecting information from service delivery sites; 3) analyzing the information; 4) sharing information with service providers and decision-makers; 5) advocating for service improvements; 6) monitoring that changes have been implemented. Community-led organizations implementing CLM require resources, skills and capacity at each step in the cycle

improvements in services – CSS requests can include an assessment of all steps in the CLM cycle to identify gaps or system weaknesses.

*If the answer is “no,” then:*

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

***Question 3: Are there well-aligned, capacitated community-led and community-based organizations that are well-positioned and can be easily engaged to undertake CLM?***

*If the answer is “yes,” then:*

- Consider including the establishment of a joint platform to share CLM data for advocacy in your CSS request, one that brings together community-led and community-based organizations with common concerns and which could ensure sustained and cost-effective peer learning opportunities and engagement, and continued involvement in CLM outcomes.

*If the answer is “no,” then:*

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

***Question 4: Do community-based and community-led organizations have functional relationships with, and access to, health facilities or other service providers and their service users to undertake CLM?***

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*



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

**Question 5: Are there existing mechanisms with the necessary authority and influence to use CLM feedback to effect needed changes or program shifts?**

*If the answer is “yes,” then:*

- A strategy to ensure complementarity of M&E and data systems (e.g., how to use CLM feedback in combination with HMIS/DHIS data) and inter-operability of CLM platforms and tools would be useful for sustained use of CLM and any potential expansion.
- Consider if support is needed to ensure effective functioning of the mechanism or a platform where the CLM data is discussed to inform the HIV, TB and malaria programming and initiate and strengthen broader interventions to foster supportive legal environments, and adherence to human rights in the community at large.

*If the answer is “no,” then:*

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

**Priority Area: Community-Led Research and Advocacy**

**Question 1: Do communities have a framework, knowledge, skills and resources to plan, design and carry out community-led research to address local or national health issues, inform decision-making, build evidence for community advocacy and document impact of community-led interventions?**

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*

- Assessing whether there are any barriers to community-led research and advocacy, such as the existing regulatory framework, or a lack of capacity to plan, design and carry out community-led research and interventions to overcome the barriers, could be part of CSS requests.
- Qualitative, quantitative and operational community-led research and the production, publication and dissemination of reports and communication materials can be included in the funding request.
- Community-led situational analyses, participatory needs assessments, and assessments of program implementation (e.g., shadow or alternative reports)<sup>12</sup> can be part of the funding request.
- Technical assistance and training can be requested under CSS to strengthen the capacity of the communities to plan, design and carry out community-led research on the three diseases, barriers to accessing health and other social services, social determinants of health and progress towards Universal Health Coverage (UHC) and the realization of the Sustainable Development Goals (SDGs).

**Question 2: Do the country’s disease response efforts continue to face persistent human rights or gender disparities or other inequalities that health interventions alone cannot address?**

*If the answer is “yes,” then:*

- Support for community-led research (cognizant of gender, age, human rights and other considerations) to assess barriers to and acceptability of services will help to focus attention in the areas that have the greatest impact on barriers to health. The CSS request can include funding for community-led assessments of program implementation and shadow reporting.
- The CSS request can include technical support and training to develop, plan, undertake and assess the results of advocacy, campaigns and lobbying to address specific barriers at the community and national levels with the objective of improving health services as well as the context in which they operate.
- Community-led research and advocacy efforts can support evidence-based decision-making on laws or policies inhibiting access to services. The CSS request can include support for community-led and community-based organizations to conduct research (including community consultations), document impact, and build advocacy on evidence for the changes in laws and policies that negatively impact achievement of country target, especially those relating to key and vulnerable populations.
- Efforts which require advocacy and mobilization of communities at large (i.e., across more than one disease) to drive integration of gender and human rights into the formal health response strategies and plans can be supported as part of CSS.

*If the answer is “no,” then:*

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<sup>12</sup> Shadow reporting and alternative reporting are tools used by civil society to highlight issues that are misrepresented, neglected or otherwise not reported by the government or responsible governing bodies.

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

**Question 3: Does the country plan to expand health programming to new geographical areas or to reach other key or vulnerable populations, or increase investment in programs to remove human rights and gender-related barriers?**

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*

- Consider if there is adequate programming being implemented in all relevant geographical areas and key populations, and if sufficient investment in human rights are made; relevant community-led research to provide evidence to inform advocacy efforts and/or programming can be part of CSS. Funding to subsequently carry out advocacy activities and/or programming can be included in the funding request.

**Question 4: Does the participation and engagement of community-led and community-based organizations in your programming largely or exclusively depend on donor funding?**

*If the answer is “yes,” then:*

- CSS requests can include support for research on the contribution of community-led and community-based organizations to health outcomes, particularly among populations that are under-served in the national response. This research can include value for money and costing dimensions, to provide the basis and evidence for domestic resource allocations in national budgets.
- Support to strengthen community-led and community-based organizations to enable them to diversify funding sources and evaluate issues around sustainability can be included in the funding request.

*If the answer is “no,” then:*

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

## Priority Area: Community Engagement, Linkages and Coordination

### ***Question 1: Are community led service delivery points linked to and engaged in joint planning and implementation efforts with public and private health facilities?***

*If the answer is “yes,” then:*

- Consider including in the CSS request activities for strengthening the capacity of the community-led and community-based organizations to use appropriate new information communication and coordination tools and technologies, including digital tools. Besides strengthening the community responses, strengthening the community’s capacity may expedite the adoption of innovations by other local and/or national health providers.

*If the answer is “no,” then:*

- Engage with community representatives to assess what barriers exist for linkages and coordination at the level of the service points, identifying capacity gaps and other barriers that could be addressed in CSS requests.
- Setting up or assessing the existing referral mechanisms between formal and community-led services can be included in CSS requests, such as the establishment of joint planning and collaboration mechanisms at different levels, including clinic health facilities, community advisory boards, or other context-suitable mechanisms to ensure better and more inclusive decision-making.
- Conducting consultations for and the development of consistent and accepted pathways for formalized relationships between community-led services and government (and private) health facilities will be helpful for better integration.

### ***Question 2: Is there adequate support to ensure consistent representative participation of the communities in formalized national and subnational level structures and mechanisms for periodic strategic planning, oversight and evaluation in health?***

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*

- Engaging with community representatives to assess what barriers exist for linkages and coordination at (sub)national level, including but not limited to identifying and addressing gaps in support, funding and/or capacity gaps, could be included in CSS requests.
- Assessing the existing national health accountability and governance mechanisms can be included in CSS requests, as well and funding for addressing any weaknesses

or gaps in regular and participatory (inclusive of communities) strategic planning, oversight and evaluation in health.

- Feasibility studies and other activities aiming to establish and formalize multisectoral accountability and governance mechanisms to work based on representation, equity and inclusion of communities, especially key and vulnerable groups, could be undertaken. Consensus-building exercises could be part of the approach and funded under CSS.

**Question 3: Does the country have an overview of community-led and community-based services and routinely collects information about the quality of these services?**

*If the answer is “yes,” then:*

- Collecting information on community-led services, including efforts to address human rights, gender inequality and stigma, is fed into developing or updating community-led and community-based strategies and plans to fight HIV, TB and malaria, as part of national strategies, will result in streamlined response. Technical assistance can be requested where required.
- To enable broad and effective community engagement in the above strategy development or revision, consider community capacity building on strategic planning, including (formative) assessment methods, gap analysis, monitoring and evaluation and budgeting.

*If the answer is “no,” then:*

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

**Question 4: Are there platforms (e.g., coalitions, consortia, joint committees) that help coordinate community-led and community-based responses in health responses, facilitate intra and inter-communities planning and other linkages between communities and broader movements?**

*If the answer is “yes,” then:*

- Documenting the experiences and lessons learned, taking stock of the development and capacity building needs of these platforms and providing the necessary inputs, facilitating learning such as through (virtual) exchange visits with similar structures will promote the evolution of the platforms and can be included in the funding request.

*If the answer is “no,” then:*

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

## Priority Area: Capacity Building and Leadership Development

### **Question 1: Have there been recent capacity assessments that flag capacity gaps for community-led and -based organizations?**

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*

- The participatory development of tools for a capacity development needs assessment can be supported in CSS requests, as well as funding to carry out the assessment, formulate capacity development plans and support their execution.

### **Question 2: Are there standards or guidelines for the delivery of community-led and community-based services?**

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*

- CSS requests could include the development of standards for delivery of community-led and community-based services.
- Funding requests can include budgets to build the capacity of community-led and community-based organizations to deliver HIV, TB and malaria services.

**Question 3: Does the country have mechanisms for registering community organizations and are these mechanisms accessible to community-led and community-based groups, networks or organizations?**

*If the answer is “yes,” then:*

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

*If the answer is “no,” then:*

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

**Question 4: Do community-led and community-based organizations and networks have the suitable infrastructure and core costs funding to strengthen their response to HIV, TB and malaria?**

*If the answer is “yes,” skip, if the answer is “no,” then:*

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