Community Systems Strengthening Questions and Answers

November 2013

Introduction:

This document provides an overview on community systems strengthening (CSS) in the context of changes taking place as the Global Fund rolls out its new funding model. The document summarizes how CSS interventions feature in the guidance provided to countries in developing concept notes, which are central to the new funding approaches being introduced by the Global Fund. This overview aims to help to civil society and key affected population groups gain insight on how to position their interests in CSS during the country dialogues and proposal development processes.

While the overview focuses primarily on CSS in the context of the Global Fund, it will introduce the steps being taking by Global Fund and other partners to deepen the understanding of CSS in other organizations and processes. However, the document will also touch on CSS in the context of UNAIDS-initiated investment frameworks, work done to link CSS and health systems strengthening and related plans for increased collaboration on CSS through an inter organizational task team (IOTT) on CSS.

1. What does the Global Fund mean by Community Systems Strengthening (CSS) and how did it come about?

The Global Fund recognizes that both strong health systems and strong community systems are essential for ensuring its investments have the biggest possible impact. However, it also recognizes that while health systems are a relatively well defined and understood concept at the country level, this is not always the case for community systems; and the contribution that strong community systems can make to effective responses to AIDS, tuberculosis and malaria is not always recognized and supported.

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 actors including community groups, community-based organizations and networks, enabling them to contribute as 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. From the point of view of the Global Fund, CSS leads to more effective prevention, treatment, care and support programs for people affected by AIDS, tuberculosis, malaria and other major health challenges.

The Global Fund has been at the forefront of the movement to provide more systematic support to communities in taking up their role in responding to AIDS, tuberculosis and malaria. Thanks to strong support from the NGO and Communities' delegations to the Global Fund Board, CSS as a concept was introduced in 2008. Beginning in Round 8, application forms for AIDS, TB and malaria programming included a new subsection on CSS where applicants were asked to describe what CSS activities were included. Specific guidance on activities and indicators were developed in 2009-10[i].

Community systems are structures and mechanisms through which community members, community-based organizations and other actors respond to the challenges and needs they face. Community organizations have a unique ability to identify, understand and respond quickly to the needs of those who are made vulnerable as a result of social and structural factors, and who are affected by inequitable access to health and other basic services. They often play a role in delivering services (particularly non facility-based health services, and other social services), and they are also essential to ensuring that formal health systems are responsive to needs, in particular the needs of marginalized groups. In some contexts, community actors have to operate outside of mainstream health systems in order to protect the health and human rights of people who are marginalized or criminalized – for example, undocumented migrants, sex workers, sexual minorities or people who use drugs.

Moreover, strong community systems play an important role in facilitating community participation in: design, implementation and evaluation of programs and services; advocacy; creation of demand for good-quality health services and equitable access; addressing broader determinants of health including gender inequalities and human rights; and promoting meaningful community engagement in health-related governance, oversight and accountability.

As such, community action on health is an important complement to clinical or facility based health services, as it helps to ensure the right people are reached for maximum impact, and that broader determinants of health are addressed. Support to community systems also builds ownership of health problems, and through this ownership communities articulate solutions and play an important role in implementing them.

2. How do we define 'community' in relation to CSS?

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; transgender individuals; injecting and other drug users; sex workers; people living in poverty; street children and out-of-school youth.

3. How do we define a community system?

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 components of 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.

4. Who else uses the concept of CSS and what is their understanding of the term?

As a concept, the need to support and strengthen community engagement to improve health or development outcomes has been around for a long time. Organizations working in the field of health, community development and environment promote the concept of community strengthening, engagement, empowerment or other variations on the wording.

The departure from previous thinking however has been the use of the word "system" and the desire to conceptualize a community system in the same way that a health system is framed in the World Health Organization (WHO) approach to health systems strengthening (HSS). The idea being that if you can map out and support a community system, this creates is a powerful vision. Thinking of systems allows us to approach the problem in a more systematic and strategic way than just focusing on the question "what about communities?".

Eventually with a systems view we will be able to create a stronger technical and empirical base upon which investments can be justified. It is not so much a question of "should we or should we not fund communities" – it is more about how we can best invest and support them. The systems analysis will help clarify and prioritize interventions.

Another appeal of the systems concept is that it helps to show how community action is an essential part of the bigger, complex system that influences peoples' health – this complex system includes health services, community action, laws and policies, and other social determinants.

A meta analysis by Tulane University (not yet published) *Selected Community System Strengthening-type interventions with health delivery services effects and health outcomes*, presented 36 evaluations and studies carried out since 1999 that try to measure the impact of community strengthening.

The work points to the common challenge among many governments and agencies in attributing results to CSS type activities. In June 2012, the Global Fund, ICASO, International HIV/AIDS Alliance and UNAIDS agreed to set up an Inter Organizational Task Team (IOTT) on CSS. The purpose of this multi stakeholder group is to try to build a common understanding of CSS among the many partners using this concept. Among other things, the IOTT will help

develop an evaluation framework and body of evidence to identify the most effective and efficient ways of investing in this area and to explain how CSS interventions link to better health outcomes. (See Annex 1 for the TORs for the IOTT on CSS)

5. Why is it important to have CSS 'components' in programming?

CSS is a way to prioritize adequate and sustainable funding for specific activities which will support community involvement in advocacy for access to services and ensuring accountability. This is achieved through things like core funding to ensure organizational stability as a platform for operations and for networking, partnership building and coordination with other agencies and stakeholders.

The importance of civil society engagement has been acknowledged and attempted in many programming areas. Establishing village health committees, patient advocates groups and hosting community dialogues in developing poverty reduction strategies are all attempts to engage communities. Often however these types of intervention are time bound and initiated, financed and facilitated by the government or funding agencies. While this kind of community engagement is essential, CSS is trying to focus on an approach that is driven by expressed needs at the community level rather than needs as perceived from the outside.

The CSS approach is based on the assumption that improving health outcomes requires interventions beyond and outside of the formal health sector. CSS will therefore be instrumental in supporting activities that may be outside the health sector but nevertheless have a dramatic impact on health. Advocacy for access to services for criminalized groups, stopping discriminatory practices, promoting legal reform are examples of community driven activities that are meant to be included in CSS programming. Examples of successful CSS programming can be found in documents produced by UNAIDS [ii], the HIV/AIDS Alliance[iii], and Roll Back Malaria.[iv]

6. What's the relation (or how can we relate) between CSS and the Investment Framework for HIV (UNAIDS) (i.e., critical enablers)?

UNAIDS was among the many organizations that helped to develop the concept of CSS and has promoted the inclusion and understanding of CSS through guidance material and training. In 2011, UNAIDS developed a Strategic Investment Framework (SIF) which presents a compelling argument for the need to support community-focused activities which are referred to as critical enablers. Both social enablers and programmatic enablers are defined as being essential to an effective response to HIV.

Social Enablers:

- political commitment and advocacy
- law, legal policies and practices
- community mobilization
- stigma reduction
- mass media
- local response to change risk environment

Program Enablers:

- community-centered design and delivery
- program communications
- management and incentives
- procurement and distribution
- research and innovation

The SIF also talks about development synergies. Development synergies are investments in other sectors that can have a positive effect on HIV outcomes. The Framework identifies a few key development sectors that present opportunities for synergies in multiple contexts: social protection, education, legal reform, gender equality, poverty reduction, gender-based violence, health systems (including treatment for sexually transmitted infections and blood safety), community systems and employment practices.

By comparison, the CSS framework identifies 6 core components which make up CSS programming. The Six Core Components of Community Systems are:

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

So far there has been no work to link critical enablers and development synergies to the CSS core components. Although the HIV/AIDS component of the New Funding Model is informed by the Strategic Investment Framework, the Global Fund has not adopted the SIF approach wholesale. The work underway to develop the disease specific modules as part of the New Funding Model may provide guidance on how CSS interfaces with critical enablers and development synergies, if at all. One way or another, the SIF clearly contains a lot of support for the CSS components. The SIF can therefore provide a basis for advocacy on the inclusion of CSS in the AIDS component of the New Funding Model.

The construction of CSS has been dominated by thinking from the global AIDS response– hence the strong support for CSS-related interventions in the SIF. Community action in the responses to TB and malaria has evolved differently. Although community-based service provision, either via civil society or community-based or via state-supported community health workers, is common in both TB and malaria programs, it is less common for advocacy, monitoring, and social mobilization work to appear – particularly in the case of malaria. Although this can be partly explained by the different social characteristics of the diseases, it is also to an extent explained by the greater degree of integration of communities within TB and malaria programs. Any future work on CSS development should pay close attention to the ways community action does and does not form a part of responses to each disease so as to ensure that disease specificities are taken into account and lessons are shared across

the different responses. A greater emphasis on CSS could also help improve the scope of cross-cutting Health Systems Strengthening funding.

7. Why is CSS important? And why is it not a stand-alone programming area like HSS?

As mentioned earlier, both CSS and HSS are essential to effective disease programs. There have been efforts to link CSS and HSS more closely and to be clearer about how CSS activities link with HSS activities. In an effort to further build links between health and community systems strengthening the Global Fund hosted discussions in late 2012 to assess how CSS and HSS could be used to complement each other in building a strong and sustainable response. In the end, the decision was taken to keep CSS and HSS separate. HSS is a separate funding component in the NFM (alongside AIDS, TB and malaria) while CSS activities are specified in each of the disease components as well as in HSS. The four components are made up of modules. Each module is made up of interventions. CSS will appear in each component at the module and/or intervention level (see Annex 2).

The question is often asked: "why is CSS not a stand-alone programming area like HSS?" The consensus at the moment is that CSS is too integral to successful and sustainable programming in each disease area to be given a stand-alone status. Keeping CSS as a module and/or intervention to delivering sustainable programming is one way to ensure that CSS is not overlooked in the planning and implementation of programs.

Another important distinction is that HSS investments are promoted to avoid duplications when more than one disease gets funding. CSS is much more disease specific and therefore should feature clearly in the disease components as an interventions focused on strengthening the community system.

HSS is a well understood and designed concept and has been for years. We know what a functional health system looks like and therefore we know how to strengthen and invest in it. We do not have the same consensus concerning what a functional community system looks like yet. This concept takes a long time to articulate and gain acceptance which points to the need for ongoing dialogue and research in this area.

8. What was meant by CSS when it was first introduced by the Global Fund? What's meant now?

Since CSS was first introduced by the Global Fund there has been an effort to refine and clarify the scope and intention. Given that CSS was developed in a collaborative way with the Global Fund being only one of the authors of the CSS framework, it sometimes appears that there are differing definitions and understandings of the concept of CSS. In the Global Fund's new funding model, the plan is that any direct service provision is to be included as part of the comprehensive package of services for program delivery regardless of whether the work is carried out by an NGO or a state institution. CSS activities need to focus specifically on the subset of interventions that build a communities' capacity to do things like negotiate, participate, advocate, monitor or network concerning their needs. It also includes building the skills to deliver services and to evaluate the effectiveness of these interventions

It is important to note that there are reasons to expect that state institutions will receive funding for CSS activities. For example, building the capacity of a district health authority to engage community health workers or grandmothers working with orphan children is a legitimate system strengthening activity and therefore an important CSS activity.

9. What's not meant to be CSS?

Some advocates have assumed that CSS refers to the NGO or civil society implemented parts of Global Fund projects. Looking at CSS as a catchall for NGO or civil society programming is missing the point. CSS is not meant to be a catchall for programming run by NGOs or for all programming related to key populations. CSS is about strengthening the capacity of communities to be involved in responding to their health and development needs. Building the capacity of a community or community organization to advocate or delivery services would be a CSS activity but the actual delivery of that service is counted by the Global Fund as a part of the comprehensive package of services for a health intervention regardless of who delivers it—NGO or government clinic. CSS is not just about key populations or HIV programming interventions. Malaria and TB programming have specific community strengthening activities that are central to the success of these disease interventions. Community action can be directed towards other health issues and towards the improvement of the overall health system, and CSS can therefore apply outside of the three diseases, to broader HSS efforts.

10. What is needed for CSS to be successful?

The success of CSS depends on a strong coordinated effort to explain the concept and address misunderstandings. Efforts to refine the CSS framework to be specific to regions and disease interventions would help clarify exactly what sorts of interventions are needed and in which settings. CSS guidance has been "translated" for use in Southern Africa by Southern Africa AIDS Trust (SAT) and there was some work done to spell out the TB specific CSS interventions.

It is commonly assumed that governments are somewhat unfriendly or in some cases antagonistic to CSS but another way to look at this problem is that we have not done a good job of explaining the importance of CSS. One way of making CSS more successful will be to explain to national authorities the agenda and vision of CSS and clarify how it strategically links to the rest of the disease response. As mentioned earlier, a better evidence base on the links between CSS interventions and health outcomes will facilitate buy-in and better decision-making. A communication and advocacy strategy would be very helpful in increasing political sustainability for CSS as an essential programming area.

11. In measuring CSS, what are the key considerations? (indicator-based)

Right now the Global Fund can report how much money is directed to CSS specific activities but this info is of limited value. Many CSS type activities are not counted because they have been included in other terms such as Advocacy Communications and Social Mobilization (ACSM) in TB programming. The evaluation framework currently in place by the Global Fund attempts to use proxy measures to determine whether the community has been strengthened. There is no guarantee that health outcomes will improve just because CSS activities have supported the development of strategic plans and governance structures in civil society organizations. Attribution is particularly hard in the area of advocacy but not

impossible. One of the challenges going forward will be the development of a CSS evaluation framework.

12. Who are the recipients of CSS-based activities?

Improved health outcomes result from a range of policies, services, and other activities, which are developed and implemented by a wide range of actors. Together, they form a complex system, which includes not only government or public health systems (made up of public health facilities, regulatory and governance bodies, and state-employed health care professionals), but also other sectors and actors within communities and the private sector, all of which are vital for improving health outcomes.

Anyone who has a role to play in improving and strengthening the advocacy, sustainability, effectiveness, measurability of the community's role in improving health or development outcomes should be considered an eligible recipient of CSS funding.

In other words, any number of actors can be the recipients and implementers of CSS activities but in all cases the goal of this support will be to strengthen community systems.

13. How can we make CSS into an outcome-based model for community investment?

The next step for CSS is the development of an evaluation methodology that goes beyond the proxy indicators in the current Global Fund guidance and incorporates an outcomes based analysis.

Annex 1

Terms of Reference

The Inter Organizational Task Team on Community Systems Strengthening

The aim of the Inter-Organizational Task Team (IOTT) on CSS is to increase the awareness, overall understanding, and profile of Community Systems as a critical component of any effective response to HIV, TB and malaria, by creating more inclusive, equitable, and effective systems leading to improved health outcomes in relation to the three diseases as well as by incorporating interventions that promote human rights; to deepen the understanding and expand the use of Community System Strengthening by key donors, UN agencies, bilateral organizations, national and ministries of health and other relevant government bodies, and other key stakeholders by:

- Supporting information sharing between partners engaged in design, and development of CSS concepts, tools, training and research
- Supporting the alignment of the Community Systems Strengthening framework with guidance from technical agencies and donors
- Developing tools and indicators that enable an analysis of the role of Community Systems in improving health at country level and gather evidence that provides the basis for planning appropriate support to these systems.
- Promote the inclusion of interventions that promote human rights, sexual orientation and gender equality, Maternal, Newborn and Child health, Family Planning, Sexual and reproductive health rights, and broader health of communities
- Gathering evidence on the most effective ways of developing, supporting and strengthening Community Systems
- Developing and sharing tools to carry out a gap analysis on CSS
- Mapping the availability of capacity building and training on CSS, particularly for CCMs, and assess gaps related to needs.

Annex 2

Interventions included in the CSS Module in the New Funding Model[v]

(NB: in the Modular Framework tool, applicants will be able to select Modules and Interventions, and will be able to choose from indicative activities or add new activities).

Intervention 1: Community-level monitoring and documentation of all services, activities and other interventions related to the disease as well as respect for human rights	
Outcome: Community-based organizations and other community groups monitor, document and analyze relevant issues as a basis for accountability, advocacy and policy activities.	
Scope and description of package (includes human resources required):	Community-based organizations establish and implement mechanisms for ongoing monitoring of laws and health policies and performance and quality of all services, activities, interventions and other factors that are relevant to the disease, including prevention, care and support services, financing of programs, and of issues and challenges in the environment, (such as human rights abuses, criminalization, and gender-based inequalities), that constitute barriers to an effective response to the disease and to an enabling environment.
Illustrative activities:	Development and planning of community based monitoring and documentation mechanisms
	Design and establishment of community-based monitoring and documentation tools and systems
	Equipment for monitoring (e.g. relevant information technology)
	Conduct of monitoring for accountability activities (including baseline monitoring, data collection by communities, and use of official/government data)
	Collation, centralization and analysis of monitoring data and development of recommendations and demands for improvement
	Dissemination of community monitoring data and recommendations
	Technical support and training
	Other
Possible areas for output indicator development (*NB these are tentative and are intended to be used as a starting point for further discussions on indicators)*	- Community based monitoring tools developed/adapted. - Number of active community based monitoring points/systems. Or numbers/proportions of service delivery points being monitored continuously by community organizations. - Results/trends in key issues monitored at community level. - Evidence of utilization of community based monitoring data in programming. - Community/health service joint monitoring agreements.

Intervention 2: Advocacy to ensure accountability and continuous improvement of responses to the disease

Outcome: Service providers, national programs, policy makers, and local and national leaders are held accountable by community sector organizations for the effective delivery of services, activities and other interventions, as well as for the protection and promotion of human rights and gender equality.	
Scope and description of package (includes human resources required):	Communities and affected populations conduct consensus, dialogue and advocacy at local and national levels aimed at holding to account responses to the disease, including health services, disease specific programs as well as broader issues such as justice, human rights and sustainable financing, and aimed at social transformation.
Illustrative activities:	Planning of consensus, dialogue and advocacy work with decision makers and service providers at local and national level
	Development and dissemination of advocacy products/materials
	Conduct of advocacy activities (e.g. meetings, campaigns, public advocacy events)
	Support to participation of community actors (including key populations) in local and national decision making/consultative bodies
	Technical support and training
	Other
Possible areas for output indicator development: (*NB these are tentative and are intended to be used as a starting point for further discussions on indicators)*	- Documented/verified changes in areas addressed through consensus, dialogue, advocacy activities (eg. Influence on policy documents or on program delivery) - Representation of community actors (including key populations) in relevant decision making/consultative bodies - Degree of satisfactory investigation/resolution of complaints (e.g. human rights-related). - Record of relevant policies developed in coordination/collaboration with community sector.

Intervention 3: Social mobilization, building community linkages, collaboration and coordination	
Outcome: Communities and affected populations engage in activities to improve their health and their own environment	
Scope and description of package (includes human resources required):	Community action, establishment of community organizations and creation of networking and effective linkages with other actors and broader movements such as human rights and women's movements. Strong informal and formal relationships between communities, community actors and other stakeholders enable them to work in complementary and mutually reinforcing ways, maximizing the use of resources and avoiding unnecessary duplication and competition.
Illustrative activities:	Community/social mobilization activities (including participatory assessments, community meetings and identification of issues, mapping of community efforts, planning)
	Support to establishment of community organizations

	Develop and maintain coordination and joint planning mechanisms to link community actors with each other, and with other relevant actors, at local, national, regional and international levels
	Develop and maintain referral mechanisms between different service providers, in particular between community and other sector providers, and across borders where relevant
	Develop and support networking of community groups [on HIV, TB, malaria, health and women's], particularly of key populations, to ensure representation and advocacy at national level is effective, and for experience sharing, mentoring etc.
	Core support for participation in coordination mechanisms by community representatives (including transport/travel costs)
	Technical support and training
	Other
Possible areas for output indicator development: (*NB these are tentative and are intended to be used as a starting point for further discussions on indicators)*	- Coverage of community / social mobilization - Records on effectiveness of referrals between different service providers (e.g. between community and formal health sector providers) - Levels of representation & meaningful engagement of communities in decision making bodies or proportions of relevant coordination mechanisms with adequate representation of people affected by diseases - Proportion of CBOs/community groups affiliated to one or more networks (definition of "affiliated" needs to be considered – meaningful affiliation is important) - Monitoring of interaction of disease focused and broader movements (human rights, women's etc); indicators of support to HIV/TB/malaria work and m from these other movements

Intervention 4: Institutional capacity building, planning and leadership development in the community sector	
Outcome: Community groups, organizations and networks have appropriate capacity to perform roles in service delivery, advocacy, leadership and community sector organizing	
Scope and description of package (includes human resources required):	Capacity building of community sector groups, organizations and networks in a range of areas: planning, institutional and organizational development, systems development, human resources, leadership, and community sector organizing. Development of systems to ensure stable, predictable financial resources for communities and appropriate management of financial resources by community groups, organizations and networks. Development of systems to ensure community sector access to technical, material and financial support.
Illustrative activities:	Assessment of needs in human resources, systems, equipment, organizational and institutional development, leadership, etc.
	Provision of resources for institutional support including legal support, support for registration etc.
	Evidence informed planning, management, and policy formulation for community systems. Development of systems for planning community action.

	Development and implementation of systems and policies for recruitment, supervision, motivation and support of community level workers and volunteers
	Capacity building in leadership, project management, volunteer management and supervision, motivation
	Professional development for community workers/volunteers not covered elsewhere, e.g. for professional ethics, human rights, stigma reduction.
	Training in special technical areas such as child protection, social protection, gender mainstreaming, working with criminalized or marginalized communities, providing integrated TB/HIV services, drug resistance, community audits such as verbal autopsy of reasons for deaths
	Mentoring programs for community sector actors (including leaders and volunteers)
	Development of systems for rational, transparent and effective distribution of funds to community sector organizations within the framework of the national response and, if necessary for neglected themes, outside of this framework
	Capacity building for community groups, organizations, networks in strategic investment of resources, financial planning, financial management and resource mobilization, planning for sustainability
	Development and management, and where possible standardization of schemes for remunerating community outreach workers and volunteers or providing other incentives and income-generation support
	Procurement of infrastructure and equipment as well as other materials and resources required by community groups, organizations and networks and appropriate to their needs and roles within the response
	Support to ongoing organizational running costs in line with roles in the national response
	Development and dissemination of good practice standards for community sector service delivery and implementation including protocols, supervision and management.
	Development of accountability and governance plans for leaders of groups, organizations and networks
	Development of systems for M&E and other data collection of community led action, sharing of information, and integrating this information with national monitoring systems
	Adaptation of health sector assessment tools to ensure they capture community systems and CSS
	Establishment of / support to community support centers providing a range of services such as information, testing and counseling, referrals, peer support, outreach to key affected people and communities and legal support.
	Identification and support to development of community sector services that are critical and yet under-supported, such as human rights and legal services, and linkages with services related to gender and social welfare
	Planning for community sector led service delivery including monitoring, supervision, quality assurance, and linkages and referrals with other

	services
	Staff/volunteer retreats
	Technical support
	Other
Possible areas for output indicator development: (*NB these are tentative and are intended to be used as a starting point for further discussions on indicators)*	- Proportion of community actors/institutions achieving set standards/accreditation in different areas of technical and financial management capacity and governance - Community actors meeting quality standards in advocacy, communication and service delivery work (and improvements in capacity at organizational level, e.g. % organizations showing improvements) - Community organizations effectively managing funding - Staff / volunteer retention and training metrics - Proportion of community staff/volunteers that indicate to have adequate skills to carry out their activities - Proportion of national response budget implemented through community sector - Proportion of funding for community responses coming from domestic sources (including government) - Measures of adherence to quality standards and of user satisfaction with community sector service delivery - Measures of user satisfaction - Degree of recognition of CBOs by community members - Existence of robust and up to date information on current gaps in community sector response

[i] The current version of the CSS Framework, last updated in 2011, can be found at: http://www.theglobalfund.org/documents/civil_society/CivilSociety_CommunitySystemsStrengthening_Framework_en/.

[ii] Supporting Community Based Responses to AIDS: A guidance tool for Including Community Systems Strengthening in Global Fund Proposals
http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_en.pdf

[iii] Civil Society Success on the Ground CSS and DTF: Nine Illustrative Case Studies
http://www.aidsalliance.org/includes/Publication/Civil_society_success_eng.pdf

[iv] Malaria Control, Community Systems Strengthening And Community-Owned Response
http://www.rollbackmalaria.org/toolbox/tool_CommunitySystemsStrengthening.html

[v] Taken from the Global Fund document: "Community Systems Strengthening in the New Funding Model – rationale and decisions 5 Oct".