



Community Systems and Responses (CS&R) in Global Fund GC7 Grants

Updates for the 2023-2025 Allocation Period (GC7)

20 February 2023

Community Systems & Responses

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- 1. Community Led and Based Responses within the Global Fund Strategy Framework 2023-2028**
 - 2. Key Performance Indicator (KPI) for CSS**
 - 3. Key resources, Community Systems Strengthening (CSS) technical brief and CSS decision-making guide**
 - 4. CSS in other technical guidance**
 - 5. Lessons learned from implementation**
 - 6. Innovations in CSS: Community-Led Monitoring (CLM)**
 - 7. Other CSS interventions in practice**
 - 8. CSS resources**
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CS&R

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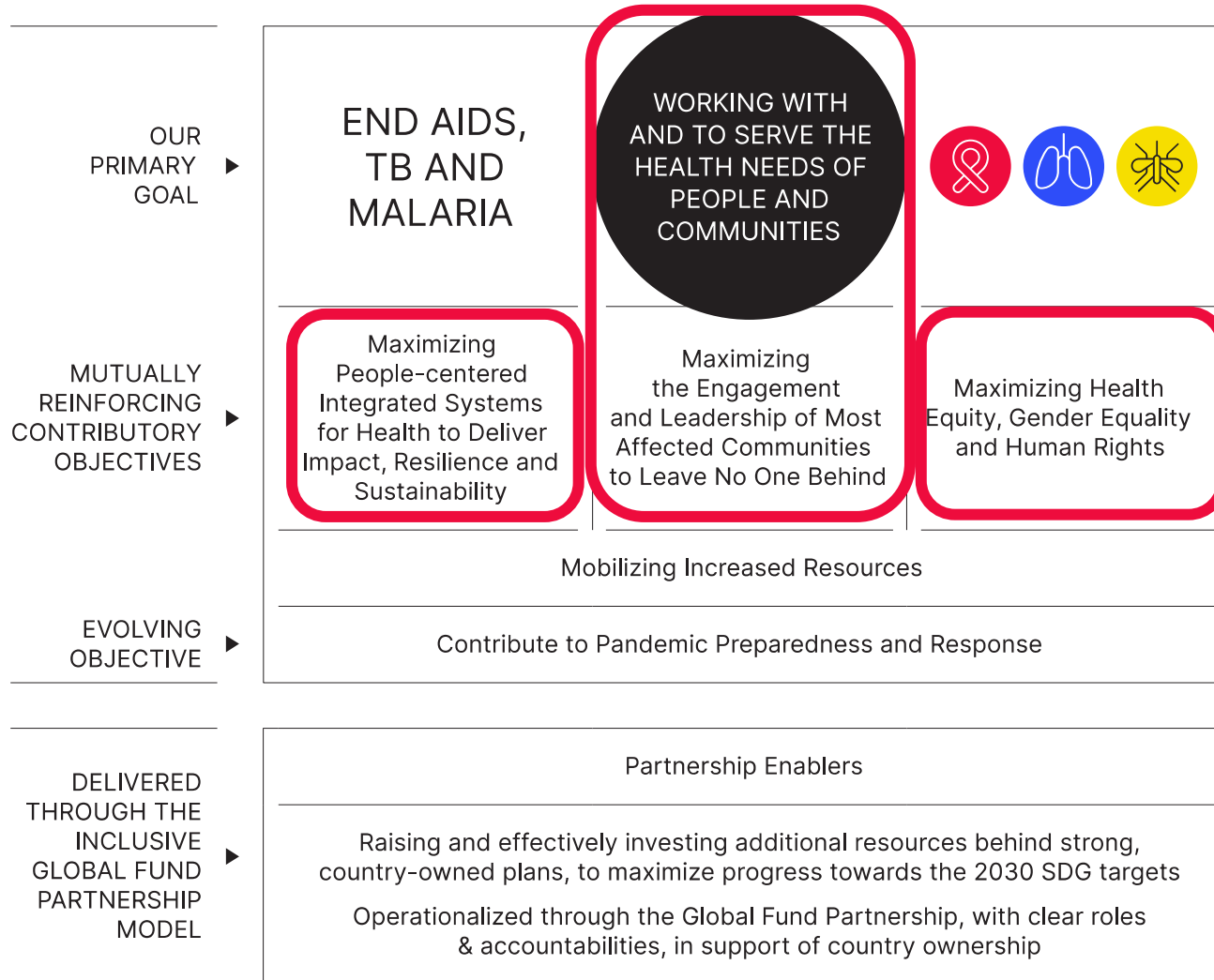
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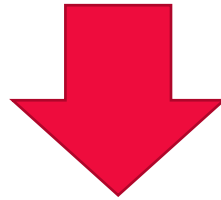
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Community health is core to global health and global goals, and the Global Fund Strategy recognizes this.



Community health is a must to end epidemics

- Communities can reach the most vulnerable and deliver services in some settings where formal health services are inaccessible.
- Community health workers can include public sector employed workers, or peers employed by Community-Led Organizations (CLOs) and Community-Based Organizations (CBOs). Complementarity between different cadres of community health workers is essential.
- A strong and accessible health system, including at community level, is critical for pandemic preparedness and response.



Community health is mission-critical
Communities are at the center of everything we do

CS&R

Definitions in the Global Fund context, drawn from partner guidance for improved grant and data management

Community-led organizations (CLO)

Self-determining and autonomous organizations whose governance, leadership, staff, spokespeople, membership, and volunteers represent the experiences, perspectives, and voices of their constituencies, who have transparent accountability mechanisms to their constituencies, and who are not influenced by government, commercial, or donor agendas.

Community-based organizations (CBO)

Organizations that have arisen within a community in response to needs or challenges and are locally organized by community members.

Key and vulnerable population-led organizations (TB)

Organizations where most of the governance, leadership, staff, spokespeople, membership, and volunteers, reflect the experiences, perspectives and voices of their constituencies and are led by people disproportionately - currently or previously living with - affected by TB.

Key and vulnerable population-led organizations (HIV)

Organization where most of the governance, leadership, staff, spokespeople, membership, and volunteers, reflect the experiences, perspectives and voices of their constituencies and are led by people living with HIV, female, male and transgender sex workers, gay men and other men who have sex with men, people who use drugs, and transgender people.

Community Health Workers

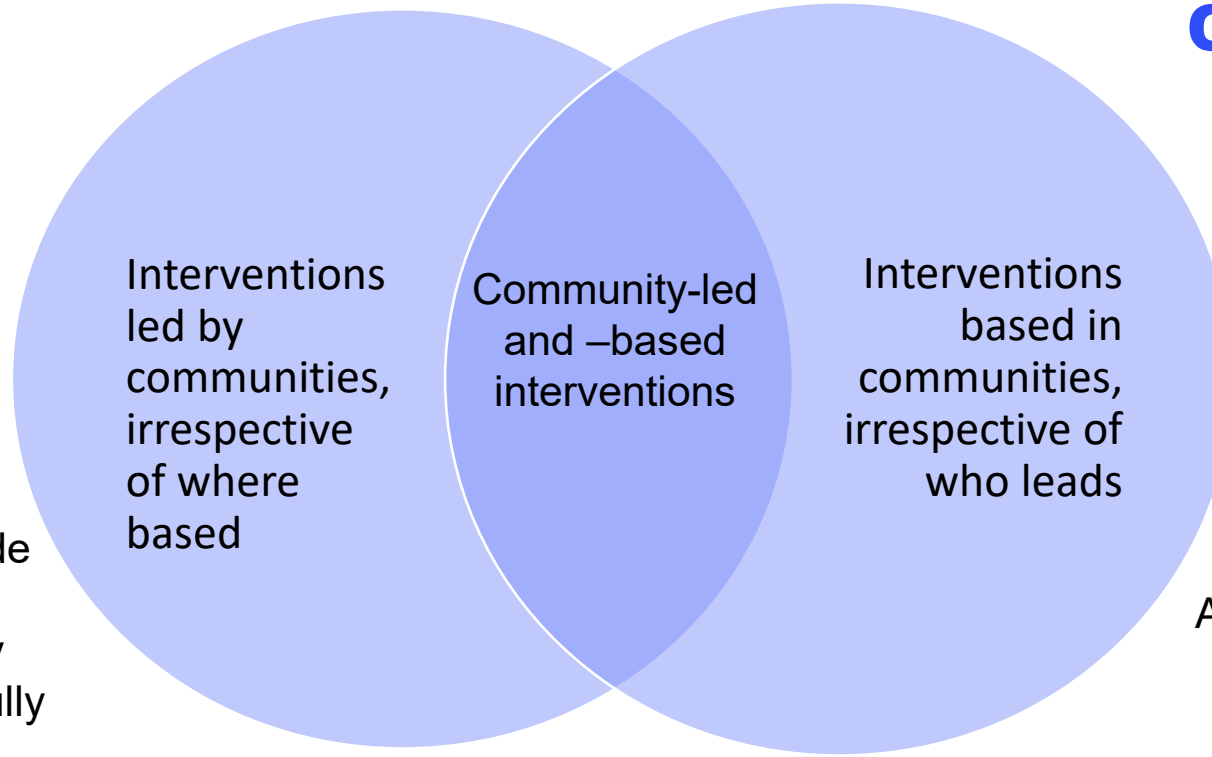
Community health workers (CHWs) are health and care workers who live in (and ideally are from) the community and population they serve. CHWs provide a broad range of services and typically have less formal training than professional nurses and doctors. The Global Fund recognizes CHWs of all types as workers, including peers and outreach workers.

Community-led and community-based responses are complementary

Community-led responses

Community responses independently managed by community organizations

As examples, these might include programs of community organizations that are funded by government contracts and yet fully directed and managed by community organizations, such as for engagement with marginalized populations, monitoring of programs and services, and related policy work and advocacy.



Community-based responses

Programs and services located in community settings and jointly directed by community organizations and government authorities

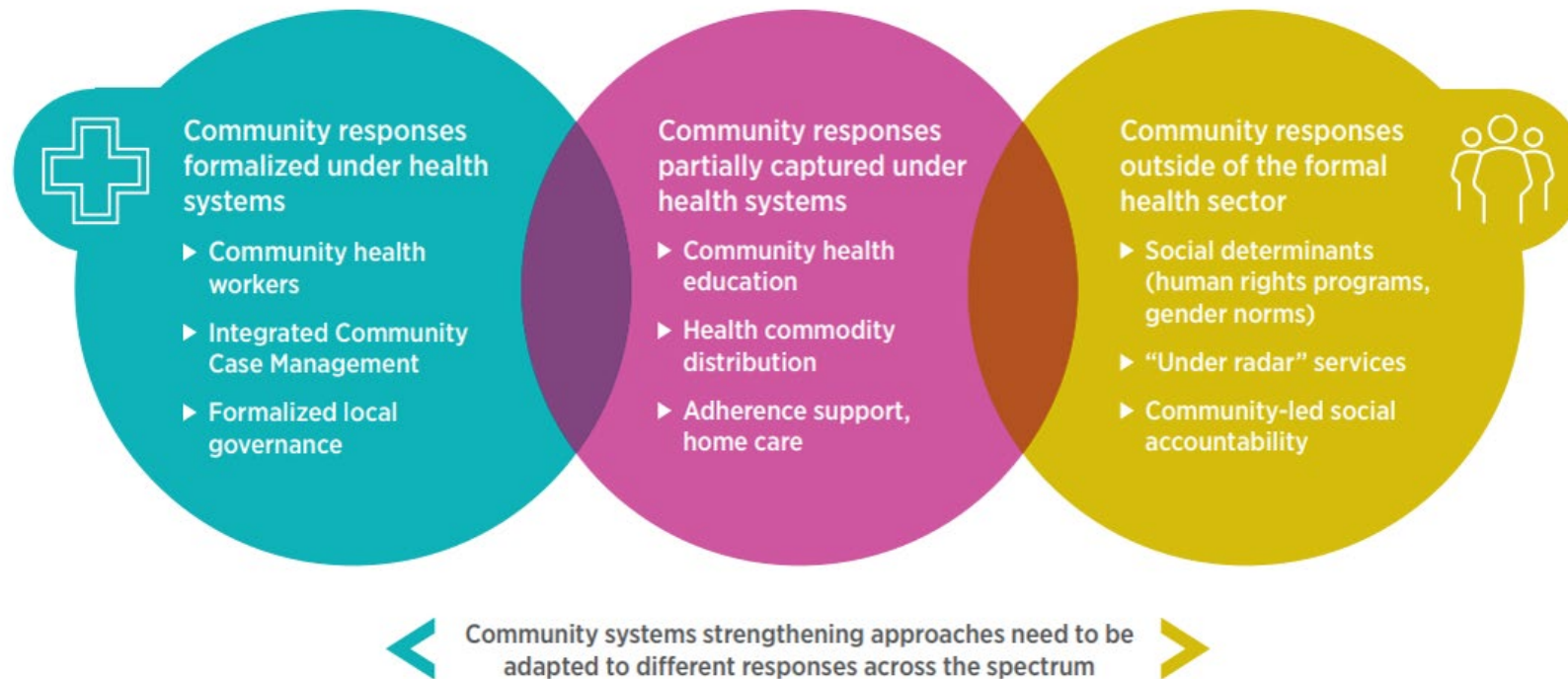
As examples, these might include health outreach and education, health services, and support services that are implemented by community-based or community-led organizations under contracts from, and with oversight and close collaboration with governmental agencies and providers.

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

CS&R consists of two parts:

(1) Community responses

delivered by community-led or community-based organizations within, partially or completely outside of the formal health system



Community responses are mainly supported through funding request modules other than RSSH

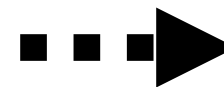
CS&R consists of two parts:

(2) Community Systems Strengthening

which is a set of four intervention areas to improve community responses and accelerate in-country results



Community systems strengthening approaches need to be adapted to different responses across the spectrum.



CSS is additive to direct interventions, and has specific indicators

Community systems strengthening reinforces, and is a distinct addition to the interventions delivered at community level, including:

- Disease-specific interventions focused on HIV, TB, TB/HIV, and malaria
- Human rights and gender equity interventions

Community systems strengthening also reinforces broader health systems by supporting capacity for:

- Domestic resource mobilization
- Country monitoring and evaluation (M&E) data quality

The Global Fund Modular Framework defines core indicators for countries and regions to track in relation to Community Systems Strengthening : *(these are new)*

RSSH/CSS –Coverage – CSS-2

Number of community organizations that received a pre-defined package of training.

RSSH/CSS –Coverage – CSS-3

Percentage of health service delivery sites with a community-led monitoring mechanism in place.

CS&R

Strategy Ambition

To realize the partnership's disease goals, the 2023 – 2028 Strategy commits to scaling up community-led and based responses and systems as a component of the Mutually Reinforcing Contributory Objective, **Maximizing People-centered Integrated Systems for Health to Deliver Impact, Resilience and Sustainability**. To operationalize this, a Secretariat-wide, tailored and differentiated approach is needed.

By the Strategy's mid-point (3 years), our ambition is to see progress in four areas:

- ① The advancement of approaches that strengthen the contribution of community health cadres, including key and vulnerable population peers, peer paralegals and treatment supporters, and community health workers employed by CLO/CBOs towards integrated systems for health.
- ② Strengthened platforms for service delivery through community-led and community-based organizations that allow flexible, people-centered service access options for clients.
- ③ Increased access to funding for community-led organizations, particularly those led by key and vulnerable populations across the three diseases.
- ④ The effective and routine use of community-led monitoring (CLM) data and feedback in program implementation oversight.

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KPI S4: Community systems for service delivery

Percentage of countries with systems in place for community health service delivery

Purpose

Measure the success of substantial Global Fund investments

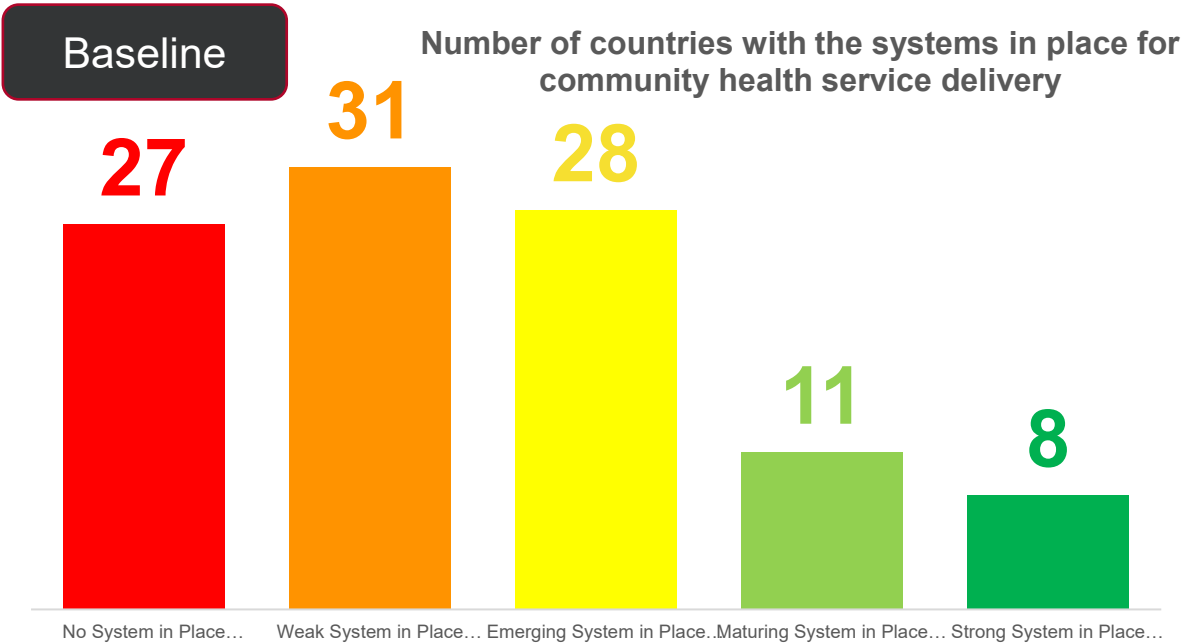
The Global Fund invested ~\$867 million in community systems and responses in NFM3 – a 66% increase from NFM2. Further increases are anticipated in Grant Cycle 7 with the new Strategy.

Provide a holistic view of the strength of community systems

The composite index advances a holistic view of CSS. The KPI reflects an ecosystem that contributes to HIV, TB and malaria impact, rather than discrete interventions without a clear link to disease modules.

Help the Global Fund make more prioritized and targeted investments

Systems weak points can be identified among the four criteria and across portfolios. This will enable the Global Fund to strategically direct investments to where they are needed the most.



Criteria & Thresholds

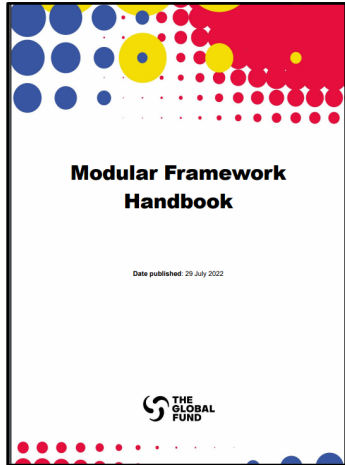
1. Country has no registration or regulatory restrictions on community service delivery.
2. Country submitted a National Community Health Strategy with last funding request.
3. Country where a Community Sector Principal Recipient has a PR rating of “adequate” as per GF assessment and/or if a capacity assessment of civil society SRs/implementers has been conducted and found to be adequate for at least one implementer.
4. Health facilities include data on referrals by community health workers / community volunteers.

Thresholds:
0/4 = No system in place
1/4 = Weak system in place
2/4 = Emerging system in place
3/4 = Maturing system in place
4/4 = Strong system in place

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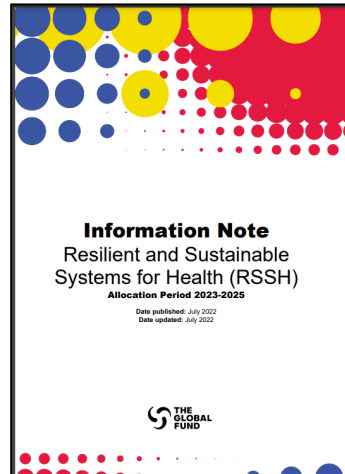
Key Resources for Funding Requests

CSS Updates for the 2023-2025 Allocation Period



Modular Framework

The Modular Framework is aligned with the revised Global Fund RSSH Information Note and Critical Approaches.



RSSH Information Note

Provides guidance to applicants preparing funding requests for RSSH. Information Notes for HIV, TB and malaria are available [here](#).

Additional Resources

1. Global Fund Strategy (2023-2028) ([link](#))

With an emphasis on priorities for integrated people centered care, community-led and –based responses.

2. CSS Technical Briefs, incl. CSS decision-making guide in annex ([link](#))

3. CLM Guide ([link](#))

3. Global Guidelines

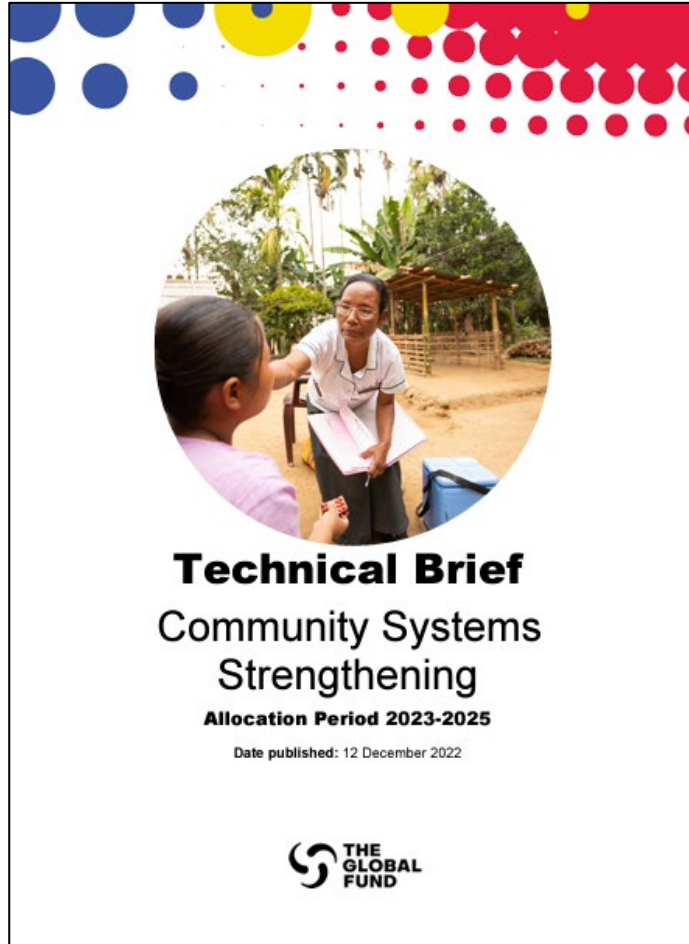
- Current international guidance/guidelines including WHO recommendations



**Translations are in process
for all Global Fund materials.**

Technical Brief

Community Systems Strengthening



Contents

The CSS technical brief is available [here](#), including CSS Decision Making Guide (in annex)

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CSS Technical Brief

Four priority interventions

- 1. Community-led monitoring:** Accountability mechanisms designed, led, and implemented by local community organizations. CLM uses structured data collection and analysis to produce evidence-based recommendations for improvements in availability, accessibility, acceptability, affordability, quality (AAAAQ) and impact of health programs and services.
- 2. Community-led research and advocacy:** Activities to inform and support advocacy led by community organizations, networks, and civil society actors, particularly those representing marginalized, under-served and 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, violence, and breaches of confidentiality.
- 3. Community capacity building and leadership development:** Activities that support the establishment, strengthening, and sustainability of civil society organizations to provide and improve health services and other programming to address HIV, TB and malaria. This includes developing capacity and leadership within communities of key and vulnerable populations and within organizations that have trust and engagement with those populations.
- 4. Community engagement, linkages and coordination:** Activities to contact, inform and organize people in key and vulnerable populations and others not benefitting from health programs. This includes social mobilization to empower and inform people about health and engage in decision making about health services and policies.

Understand: Compile community input on gaps & priorities

Intervention	Examples of gaps	Potential priorities
Community-led monitoring	Country programs for HIV, TB and malaria are challenged by issues of service quality, supply of commodities, and human rights.	- Development of CLM strategies. - Refinement of CLM indicators, tools, data collection processes. - Community capacity to share CLM data and recommendations for action.
Community-led research and advocacy	Community organizations, networks, and leaders lack capacity and funding for high quality research and evidence-informed advocacy.	- Community-led research such as analyses of services, programs, and policies. - Capacities for communication and community organizing. - Effective community contacts with policy makers and program managers for improved collaboration.
Community capacity and leadership development	Organizations need to gain basic legal status, improve functional governance, strategic planning, capacity for financial and human resource management, secure sufficient funding and infrastructure.	Differentiated (need-based) trainings, mentorship, and small grants to build relevant staffing, skills, plans, structures, systems, tools, and experience.
Community engagement, linkages and coordination	Community organizations and networks need improved coordination and linkages across community programs and formal health sector programs to better engage and benefit people in key and vulnerable populations.	Coordination 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.

Design: Describe CSS activities

Intervention	Examples of activities
Community-led monitoring	• Development of CLM frameworks and strategies. • Technical support and training for CLM indicator selection, data collection, data management and security, data analysis, and use of CLM data to improve programs. • Piloting and implementation of CLM to identify and address barriers and gaps in services and programs.
Community-led research and advocacy	• Community-led research of needs, barriers, and opportunities for improvements in services and programs. • Related production, publication and dissemination of reports and other communications and campaigns. • Engagement by communities with policy makers and program managers to communicate recommendations and co-create shared solutions for improved health services and/or enabling environments.
Community capacity and leadership development	• Development of strategy, governance and policy documents for community-led and community-based organizations, such as human resource policies, resource mobilization and social dialogue strategies for either individual organizations and/or networks to improve their capacity to participate in the disease response. • Making differentiated capacity development plans, and funding for their implementation to ensure small and nascent community-led and community-based organizations, which represent under-served populations, are able to take up a stronger role in the national response.
Community engagement, linkages and coordination	• Assessment of existing barriers for linkages and coordination at different levels: from the national to the level of the service points. • Setting-up or improving the existing referral mechanisms between formal and community-led services, such as establishing joint planning and collaboration mechanisms. • Conducting consultations between the community-led and community-based organisations and the government (and private) health facilities to ensure better integration.

Design: Describe CSS costs

Intervention	Potential investments specific to CSS interventions	Cross-cutting investments in community systems
Community-led monitoring	- Community researchers, data collectors, technical program staff, data management specialists, data analysts. - Tools for data collection and management and results dissemination. - Travel and meeting costs for data collection and results dissemination.	- Personnel for financial, human resources, administrative, and program management at community organizations. - Personnel to coordinate trainings, communications, and community engagement. - Travel and meeting costs for trainings and peer learning networks, and for staff supervision and support. - Communications costs (phones, websites, airtime, etc.). - Organization indirect and overhead costs (up to 10 percent of overall budgets to cover general shared costs that may be impractical to itemize, such as office supplies, insurance, equipment maintenance, and utilities).
Community-led research and advocacy	- Policy and program analysts and other researchers. - Specialists in advocacy communications. - Advocates with connections and influence with policy makers and program managers. - Travel and meeting costs to engage constituents and decision-makers.	
Community capacity and leadership development	- Technical support for strategic planning, organizational development, financial management, and human resource development to deliver HIV, TB and malaria services. - Small grants to community-led organizations.	
Community engagement, linkages and coordination	- Outreach workers, educators, organizers. - Specialists in communications with KVP. - Specialists in service linkages and referrals. - Travel costs and other incentives to help people engage in services and overcome social and structural barriers to health.	

Design: Describe CSS value for money

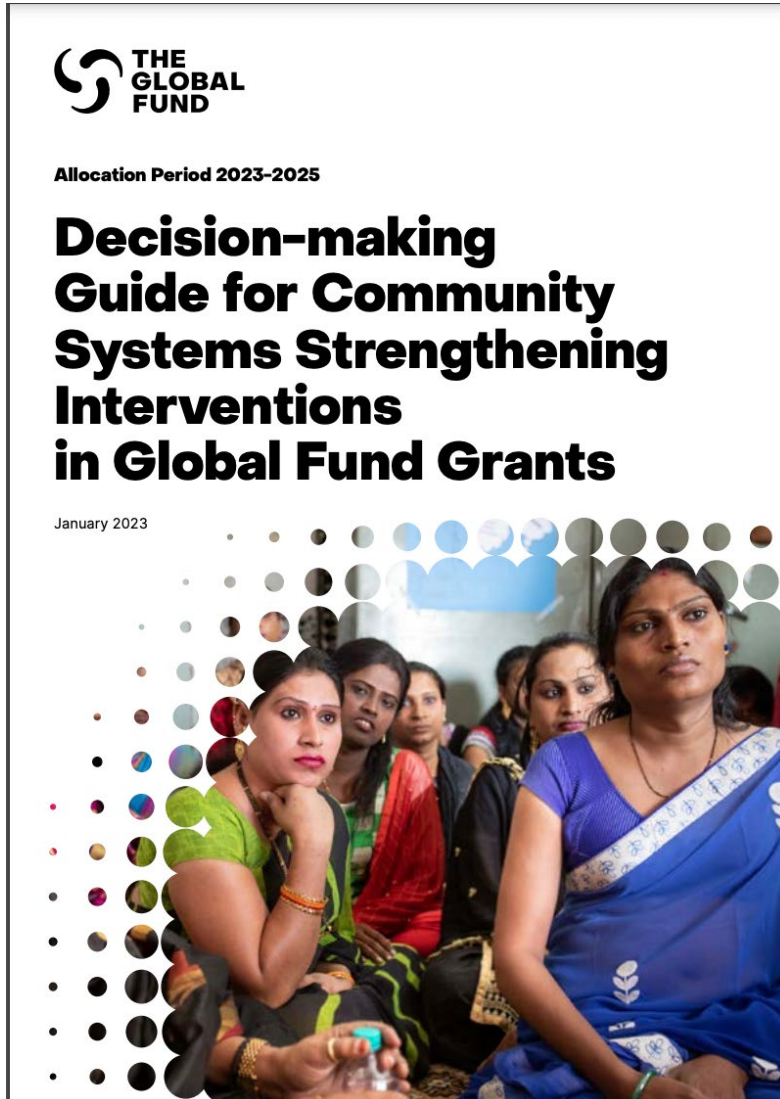
Intervention	Rationale and value of investments in CSS
Community-led monitoring	• CLM generates data - regular localized, actionable evidence – that can help managers and providers improve services and programs. • CLM also empowers key and vulnerable populations in dialogue about intended health outcomes and rights- and gender-related barriers.
Community-led research and advocacy	• 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 priority. • Advocacy can promote change but is more effective when it is reinforced with evidence, clear communication, powerful constituencies, and sustained relationships with decision-makers.
Community capacity and leadership development	• Investments in organizational development through assessment-based training and mentorships, practical tools, and small grants strengthens the capacity of community organizations to deliver HTM services and programs.
Community engagement, linkages and coordination	• Coordination meetings, mapping, trainings, tools and funding to improve the coordination and linkages among services and programs, including 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 to achieve their goals and targets.

Deliver: Strengthen community systems for outcomes and impact

Intervention	Examples of possible outcomes and impacts
Community-led monitoring	• 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 of services. • 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 HTM outcomes.
Community-led research and advocacy	• Community-led research and advocacy will identify priorities for improvements in services and programs. • Community researchers and advocates will communicate these priorities and recommendations through presentations, reports, digital media, and other channels. • Communities will engage with policy makers and program managers to improve services and programs.
Community capacity and leadership development	• 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.
Community engagement, linkages and coordination	• Through coordinated and interlinked programs and services, more people, especially in key and vulnerable populations, will benefit from health information and education campaigns, health screening, prevention and treatment programs, and related support services.

Decision-making Guide for CSS

CSS decision making guide is available ([link](#))



Goal:

To support the conceptualization and design of effective CSS interventions for HIV, TB and malaria to include in the Global Fund funding request.

Audience:

Communities, Country Coordinating Mechanisms, funding request writing committees and other stakeholders involved in the development of the Global Fund funding request.

Structure:

Four Steps:

1. Knowing the epidemic(s) in the country context.
2. Understanding the current community systems and responses.
3. Consulting the evidence, such as results to date and lessons learned.
4. Defining CSS activities

Questions to help define CSS activities (yes/no questions and decision-making guide)

Community-led monitoring	▪ Is there understanding of and capacity to undertake CLM in the country? ▪ Is CLM being implemented in your country? ▪ Are CLOs and CBOs well positioned to undertake CLM? ▪ Do community organizations have sufficient functional relationships and access to undertake CLM? ▪ Are there existing mechanisms with the necessary authority and influence to use CLM findings?
Community-led research and advocacy	▪ Do communities have capacity to plan, design, and carry out community-led research? ▪ Do country disease responses face persistent challenges that health interventions cannot address? ▪ Does the country plan to expand health programming or rights- and gender-related programming? ▪ Do CLOs and CBOs largely or exclusively depend on donor funding?
Community capacity and leadership development	▪ Are community-led services linked with and jointly planning with public and private health facilities? ▪ Are communities represented and participating in formal national and subnational level structures and mechanisms for periodic strategic planning, oversight and evaluation in health? ▪ Does the country routinely collect information about the quality of community-led and -based services? ▪ Do community platforms (e.g., coalitions, consortia, joint committees) facilitate planning and links across communities, and between the communities and broader public movements?
Community engagement, linkages and coordination	▪ Have there been recent capacity assessments of CLOs and CBOs? ▪ Are there standards or guidelines for the delivery of community-led and community-based services? ▪ Does the country have accessible mechanisms for registering community organizations? ▪ Do CLOs, CBOs and networks have suitable infrastructure and core funding for HIV, TB and malaria responses?

Example of using the decision-making guide

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

If the answer is “yes,” then:

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

If the answer is “no,” then:

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

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CS&R in other technical guidance

HIV information note



Prevention

The guidance recommends **expanded platforms for community-based and peer outreach-based HIV prevention programs and services** as to reduce HIV incidence and close coverage gaps in HIV prevention, and provide people who are most at risk of HIV infection with increased access to HIV prevention options. Strengthening HIV prevention systems and program stewardship includes capacity development, including human resources to support prevention program management and delivery (**including in community-based and community-led service delivery**).

Testing

A strategic mix of differentiated HIV testing services and routine viral load testing includes **community-based testing**. **Community and peer engagement** can promote demand for services, **provide treatment literacy and patients' rights education**, and mitigate the impact of stigma (including self-stigma). Involvement of peers, and engagement of peer navigators is recommended to link those who test HIV positive to treatment.

CS&R in other technical guidance

HIV information note



Treatment

Treatment offered as close to point of HIV testing as possible, both in facilities and communities, enables linkage to rapid ART initiation. **Community ART initiation and task-shifting** per WHO guidance is encouraged, in particular for adolescents and key populations.

Community-led models include community ART distribution points, decentralized drug distribution, drop-in-centers, out-of-facility pick-up points and community and peer-led ART groups. Communities and peers can help address human rights- and gender-related barriers to ART and other care critical for health and well-being of all people living with HIV.

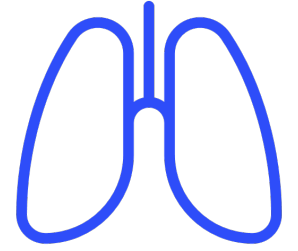
Treatment continuity and retention, for instance of the mother-infant pair throughout the breastfeeding period should **include community-led support services**, such as peer-to-peer support and treatment literacy efforts.

CLM

The importance of community-led monitoring is underlined in interventions to ensure people-centered and rights-based HIV services at health facilities, where CLM is used to monitor the provision of treatment and drug supply chains. Besides, **community-led monitoring provides valuable data on the quality, accessibility, acceptability and affordability of HIV prevention/sexual health commodities, services, and programs.**

CS&R in other technical guidance

TB information note



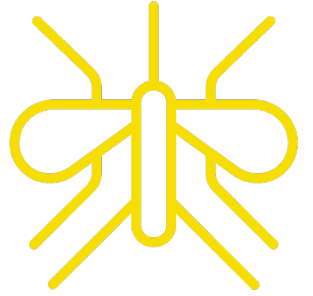
Priority interventions related to community systems and responses include **strengthening the institutional capacity and leadership of TB community-based and community-led organizations**, increasing community-based services across the TB care cascade, and **forming national TB survivor networks**. **Facilitating links with the formal health system** and scaling-up **community-led monitoring to gather information** from service user experiences, including human rights violations, stigma, and gender related barriers are other priorities.

Examples of the recommended priority intervention:

- Strengthen the institutional capacity and leadership of TB CBOs and CLOs and networks of TB survivors to facilitate their participation in national TB governance and decision-making processes.
- Support social mobilization, i.e., enable CBOs and CLOs to effectively collaborate among themselves and with the formal health system.
- Support community-led research to provide a better understanding of the barriers and gaps that inhibit effective, people-centered TB services from the perspective of communities themselves to inform advocacy for change and improvements.

CS&R in other technical guidance

Malaria information note

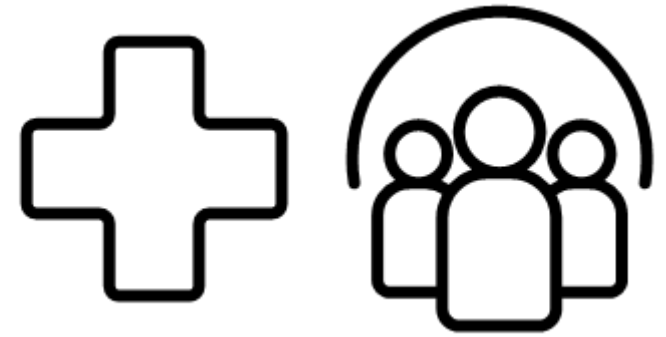


CSS to improve and monitor access to malaria services for most affected, marginalized, and underserved populations in endemic areas includes **empowering and supporting communities**, especially the most vulnerable, to **participate in national and local structures**, platforms, and processes, including in country coordination mechanisms (CCMs). It also includes ensuring that communities and civil society are key partners and play a meaningful role in the Global Fund grant application, decision-making and implementation. **Community leadership and engagement** have been and continue to be key to supporting strong responses to malaria: they should be at the heart of future efforts to address novel health threats.

- Strengthening community participation may be especially important in elimination settings. Elimination strategies represent an opportunity for rights-based action to reach traditionally excluded and geographically marginalized populations with malaria services.
- Applicants are encouraged to explore the potential of CLM as part of efforts to improve availability, accessibility, responsiveness, and quality of services. CLM can focus on general health, disease-specific or intervention-specific services (e.g., monitoring of correct usage of Insecticide-Treated Nets, stock/workforce availability at health facilities or geographic and other structural, and human rights and gender-related barriers).

CS&R in other technical guidance

RSSH



Applicants should adequately **connect community and public infrastructure** through a systems approach to avoid fragmentation and strengthen coordination and sustainability.

Community health systems should be recognized by governments with roles and responsibilities articulated, financing pathways and targets defined and agreements for public-community referrals in place. This may include **reinforcing community cadres of all types, harmonizing retention/renumeration and ensuring community data is captured in health information systems**, for example.

Applicants should **assess barriers, needs, capacities and opportunities** (including identifying champions or allies) **of community systems and responses** among partners, as a basis for designing capacity development and institutional strengthening interventions. They should also prioritize interventions that contribute towards holding health systems accountable.

Applicants should strongly consider what **health system requirements are needed to deliver effective community health services**.

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TRP observations

2020 - 2022 allocation period (GC6)

Maximizing people-centered, integrated systems for health to deliver impact, resilience and sustainability – take home messages:

Place greater emphasis on CML

- Invest in community-led monitoring as an important part of a quality assessment approach.

Revisit investments in community systems

- Pay more attention to the broad spectrum of community system infrastructure.
- Develop longer term plans and execute viable sustainable financing pathways.

Invest more national and other resources in communities

- Increase financing, from domestic sources as well as Global Fund investments, for comprehensive community systems, including for CBOs and service delivery led by key and vulnerable populations and most affected communities, as well as for health care workers of all types.
- Increase domestic health financing and strengthen public financial management systems.
- Strengthen government leadership, working in partnership with relevant stakeholders, to design and operationalize policies and practices that will place people at the center of quality services.

Lessons Learned from CS&R implementation

Strategy Delivery Challenges & Lessons

Successfully operationalizing the Strategy's vision for strengthening community systems and responses requires taking stock of lessons learned and challenges faced to date, including:

Long-term capacity building

Community-led response implementation and results are variable across contexts and highly dependent on the **enabling environment and specific support** and involvement by the country teams and partners, including long-term investments in capacity strengthening (TERG, 2022).

Measurement limitations

Current indicators and measurement approaches do **not adequately capture aspects of community systems strengthening or qualitative impacts of RSSH investments**, including long-term effectiveness, sustainability, and resilience of systems (TERG, 2022 & GF PCE, 2019).

Inadequate TA and capacity building

Technical **support and assistance has not prioritized community organizations** with differentiated options to improve programmatic, technical, and institutional capacity and leadership development (TERG, 2022).

Capacity and turnover in community organizations are key challenges requiring understanding and support, and efforts to strengthen capacity over the long-term are delivering positive and replicable results (TERG, 2022).

Lessons learned from CS&R implementation

Strategy Delivery Challenges & Lessons (continued)

Barriers to financing

Aspects of the GF business model (e.g., grant implementation arrangements and the absence of flexible contracting modalities) **hinder ability to fund CBOs/CLOs** because they do not accommodate the complexity and diversity of community structures and the contexts in which they operate (TRP, 2021, TERG, 2022).

Positive and replicable examples of institutional and financial sustainability exist for community-led response in service delivery, however not in monitoring or **advocacy – with the latter unlikely to secure long-term domestic financing** (TERG, 2022).

Linkages and collaboration

Community-led responses tend to be more effective when their contribution is understood and valued by the government, particularly when **community services and government services are linked** (for example from a community referral service to a government treatment center), which also appears to be a key aspect of sustainability (TERG, 2022).

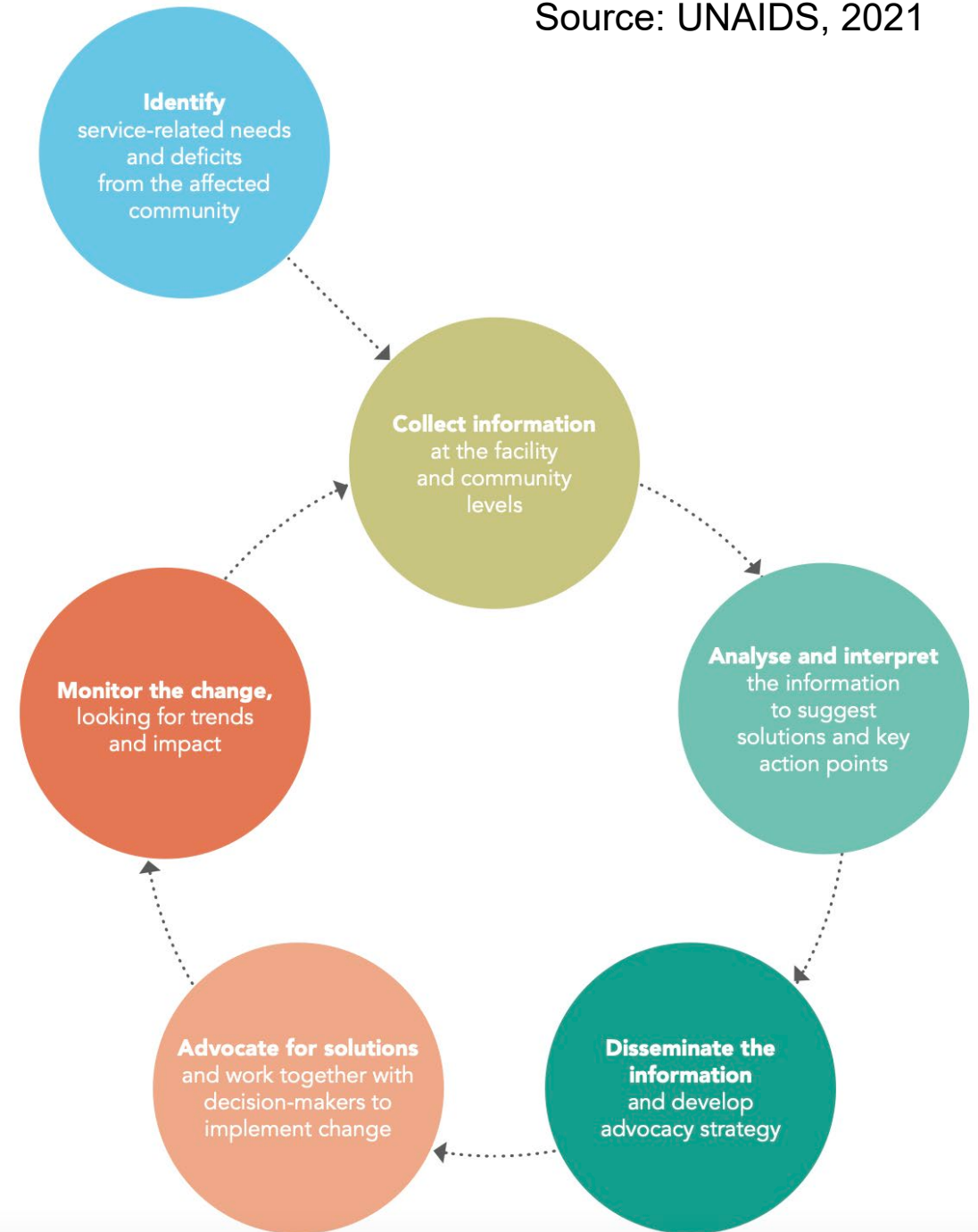
Cross-Secretariat engagement

Achieving our ambition will require **joint accountability across the secretariat** through collaboration and knowledgeable technical and grant management teams (TERG, 2022).

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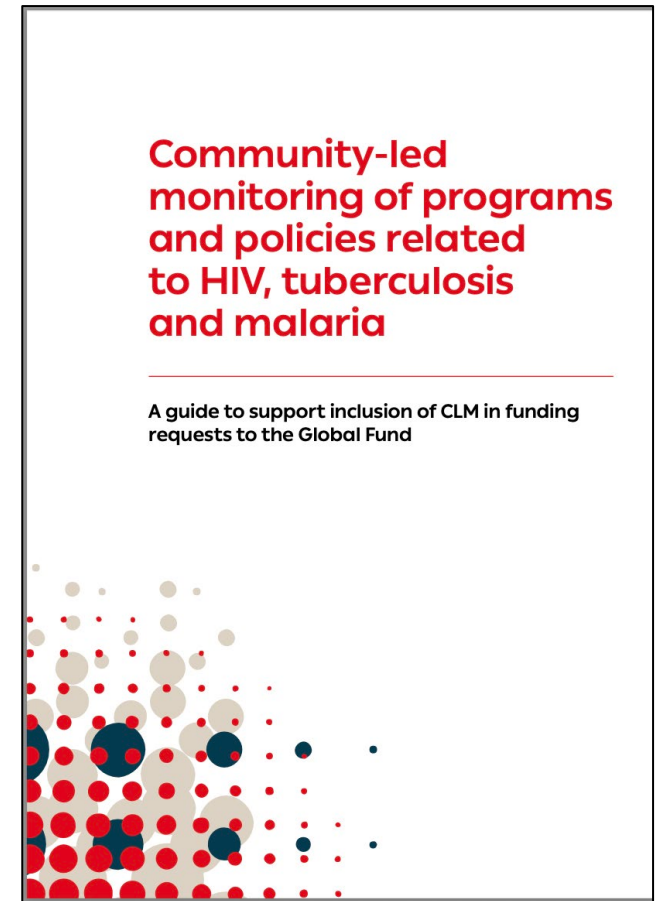
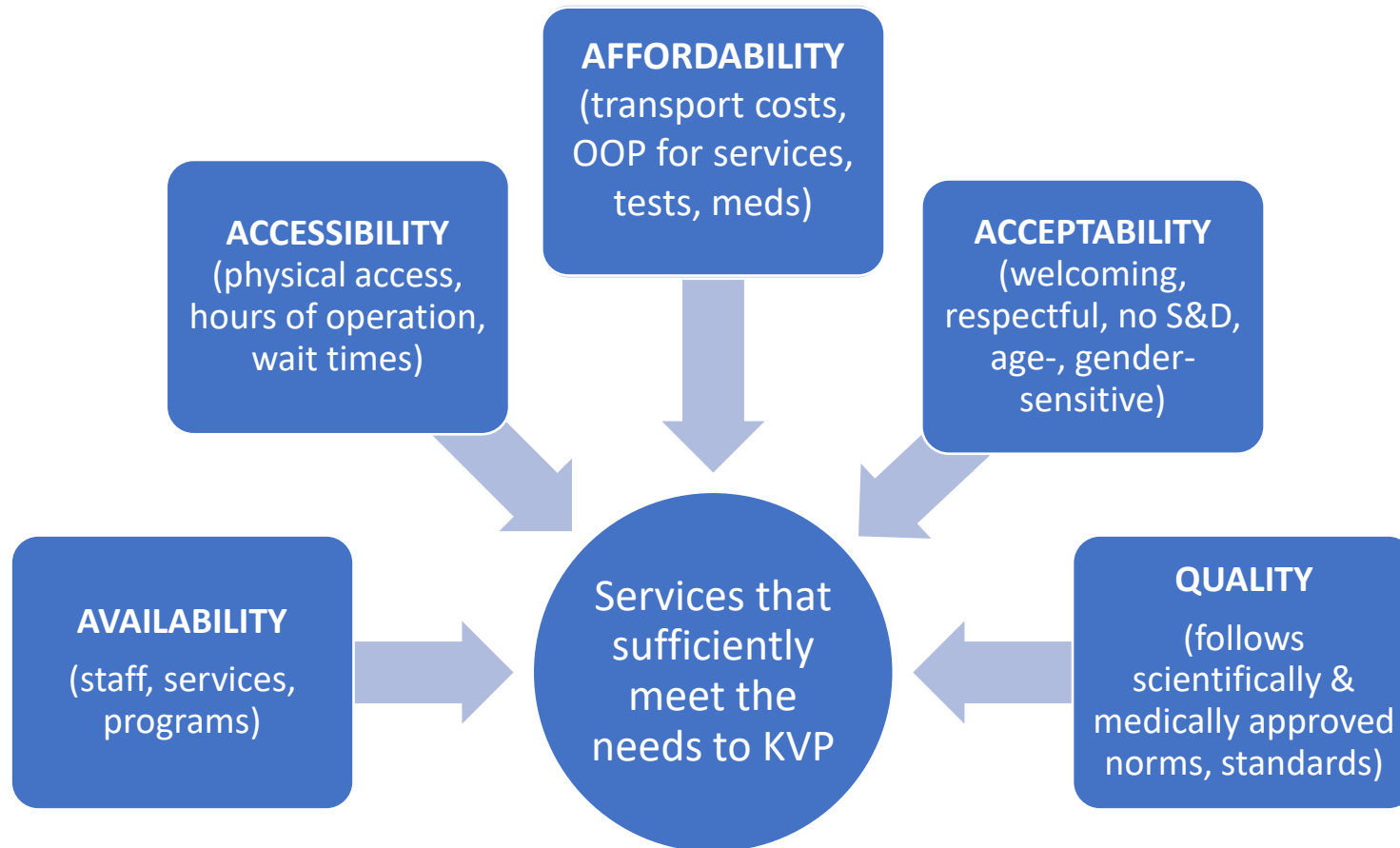
Integration of CLM into service review and improvement processes

The Global Fund defines CLM as an accountability mechanism that uses an independently structured and planned process designed and led by equipped, trained and paid members of community-led organizations of affected communities, to systematically and routinely collect and analyze quantitative and qualitative data from health service delivery sites (i.e., facility-based and beyond) and affected communities either for a specific disease component (i.e., HIV, HIV/TB, TB, malaria) or broader primary health care.



Innovations in CSS: Community-Led Monitoring

What are we monitoring in CLM?



Key Aspects of CLM

CLM is community-centered

The community chooses their own indicators of what to monitor and where to work, prioritizing those things that matter most to them, centered around the Availability, Accessibility, Affordability, Acceptability & Quality (AAAAQ).

CLM is independent from national M&E

CLM data is complementary to national M&E of disease programs and is owned by the communities.

CLM is implemented by affected community

CLM should *ideally* be implemented by affected community organizations as they know their communities and issues the best.

CLM needs to be routine

CLM is not a “one hit wonder” as monitoring is an on-going, routine, systematic activity. Data is collected monthly or quarterly and analyzed for trends.

Key Aspects of CLM

CLM uses quantitative and qualitative indicators

CLM uses quantitative and qualitative indicators to provide a full picture of the issues to inform advocacy and monitor progress.

Quantitative data e.g., # of PLHIV that got a viral load test.

Qualitative data to document a person's lived experience e.g., "Ever since the drop-in center closed, I have felt isolated"; "COVID-19 lockdown measures have made it difficult to avoid my aggressor"; "I didn't go for a VLT because ever since COVID-19, the clinic doesn't offer it".

CLM data is shared with decision-makers

CLM data is only useful if it is shared with decision-makers. Some information will require an immediate response, while others a medium- or long-term action.

Results of CLM on HTM and COVID-19 Programs

**VL suppression
increased from 48%
to 77%**

Across 11 countries in West Africa, viral load suppression improved from 48% to 77% in less than two years of CLM implementation¹

**757 cases referred for
legal support**

In Kenya, advocates used CLM to collect evidence on barriers to accessing health services, and successfully referred 757 cases for legal support to a network of pro bono lawyers or to the HIV Tribunal²

**TB medicine
stockouts reduced
from 95% to 5%**

In the Democratic Republic of the Congo, TB medication stock-outs were drastically reduced from 95% at the beginning of 2019 to 5% in December 2019, thanks to a CLM Observatory on the Quality of Care for HIV/TB³

1. Regional Community Treatment Observatory in West Africa (RCTO-WA), implemented by ITPC and 11 civil society partners, found that the rate of viral load suppression improved, rose from 48.4% in January-June 2018 to 77.4% during period three the following year. Source: *Towards a Common Understanding of Community Based Monitoring and Advocacy. The Global Fund. February 2020.* https://www.theglobalfund.org/media/9632/crs_2020-02cbmmeeting_report_en.pdf?u=637319005551530000

2. The Kenya National HIV, TB and Human Rights Training and Advocacy Country Programme, implemented over a two-year period by Kenya Legal & Ethical Issues Network on HIV and AIDS (KELIN) in collaboration with local partners, across five counties in Kenya. Source: *Towards a Common Understanding of Community Based Monitoring and Advocacy. The Global Fund. February 2020.* https://www.theglobalfund.org/media/9632/crs_2020-02cbmmeeting_report_en.pdf?u=637319005551530000

3. Implemented by Congolese Union of People Living with HIV Organizations (UCOP+) across 3 provinces in DRC. Source: *Towards a Common Understanding of Community Based Monitoring and Advocacy. The Global Fund. February 2020.* https://www.theglobalfund.org/media/9632/crs_2020-02cbmmeeting_report_en.pdf?u=637319005551530000

Impact of CLM on TB, HIV and COVID-19 Programs

Network of HIV Positives in Sierra Leone (NETHIPS)

- CLM data from September to November 2020 showed a declining trend in GeneXpert TB testing in Sierra Leone due to GeneXpert machines were being overwhelmed and monopolized by COVID-19 testing; as a result, TB had been deprioritized by healthcare workers and laboratories.
 - **CLM RESULT: Data used to reinforce advocacy messages in partnership with Stop TB call on government to leverage testing platforms for both C19 and TB.**
- Age-disaggregated data from CLM revealed that one third of people on ART who were Lost-To-Follow-Up (LTFU) were young people.
 - **CLM RESULT: Adolescents LTFU strategy created to retain them using text messaging and other social media platforms to track and trace LTFU and bring them back into care.**

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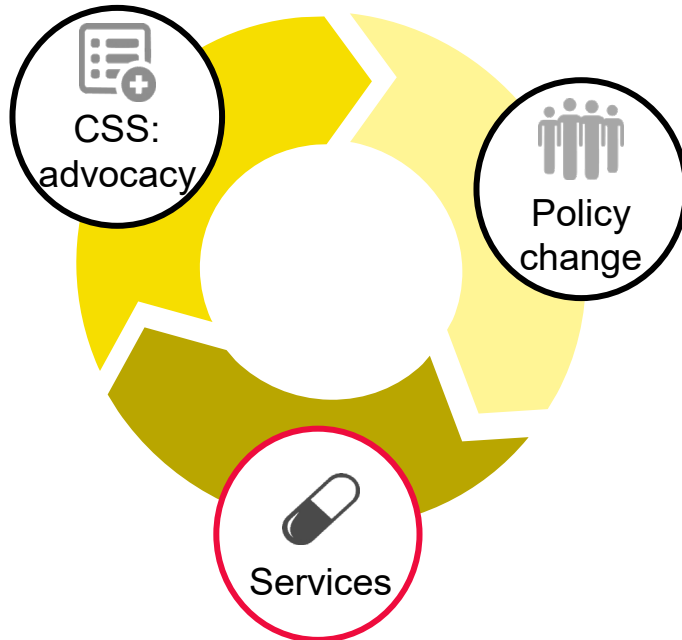
CS&R in Practice

Community-led advocacy to fight HIV in Mali.



The issue:

- Antiretrovirals (ARVs) were not accessible in Mali.
- ARCAD-SIDA Mali, Principal Recipient in the country, supported **social mobilization** via the creation of people living with HIV networks.
- In 2001, the 'Mali ARVs Access Initiative' was formed.



Community System Strengthening:

Between 2001 and 2004, the 'Mali ARVs Access Initiative' engaged in **community-led advocacy** work.



Impact:

In 2004, the authorities in Mali declare **ARVs are free for all**.

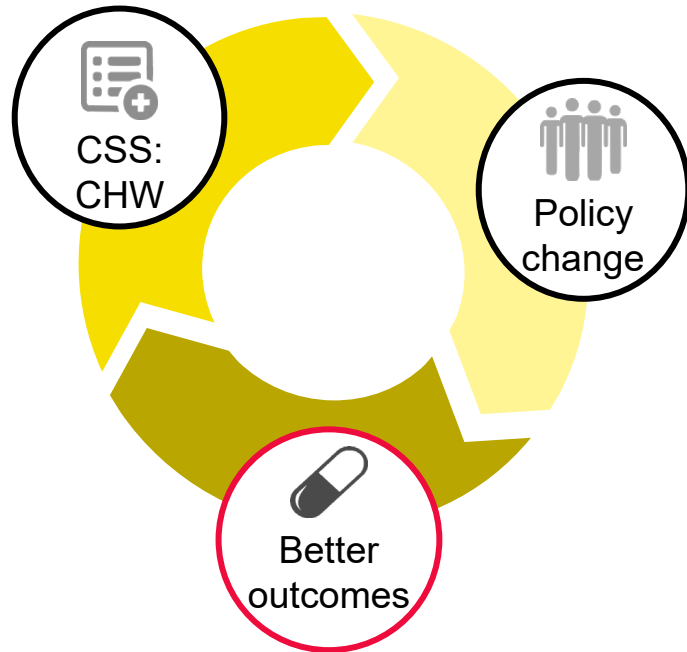
CS&R in Practice

Community Health Workers to improve tuberculosis service coverage in Pakistan.



The issue:

Pakistan is one of the eight countries that account for two-thirds of the global TB burden. Over one third of TB patients (36%) are unreachable by current services and systems.



Community System Strengthening:

Community-based screening by **the government's lady health workers (LHWs)** to find missing TB cases in three rural districts of Sindh province between 2017-2018, with support from TB Reach and the Global Fund.

Result:



- A 17% **increase in TB cases reported** in just less than a year.
- People with presumptive TB were **diagnosed 47 days earlier** by LHWs.
- Chest camps organized in LHWs' catchment populations **helped the Government surpass its targets** for coverage of people who were unable to reach services.
- The significant contribution of LHWs in TB service coverage resulted in the **institutionalization of learnings from the LHW program** throughout Pakistan and elsewhere.

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