GOMBE STATE GOVERNMENT

A COMMUNITY SYSTEM STRENGTHENING FRAMEWORK FOR IMPROVED ACCOUNTABILITY AND OWNERSHIP OF INTEGRATED HEALTH SERVICES IN GOMBE STATE

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Contents

ACRONYMS

AIDS - Acquired Immune Deficiency Syndrome
ANC - Antenatal care
BCC - Behaviour Change Communication
CBO - Community-Based Organisation
CHW - Community Health Worker
CIYCF - Community-Based Infant and Young Child Feeding
CMAM - Community Management of Acute Malnutrition
CSO - Civil Society Organisation
DFID - UK Department for International Development
DRNCD - Diet Related Noncommunicable Diseases
EBF - Exclusive Breastfeeding
FAO - Food and Agriculture Organisation of the United Nations
FBO - Faith-Based Organization
FCT - Federal Capital Territory
FMOH - Federal Ministry of Health
GAIN - Global Alliance for Improved Nutrition
GDP - Gross Domestic Product
GSFNP – Gombe State Food and Nutrition Policy
GSPAN – Gombe State Plan of Action
HIV - Human Immunodeficiency Virus
HKI - Helen Keller International
HMIS - Health Management Information System
IFA - Iron and Folic Acid
IFAD - International Fund for Agricultural Development
IFPRI - International Food Policy Research Institute
IMCI - Integrated Management of Childhood Illnesses
IUGR - Intra-Uterine Growth Restriction
IYCF - Infant and Young Child Feeding
LBW - Low Birth weight
LGA - Local Government Authority
MDGs - Millennium Development Goals
M&E - Monitoring and Evaluation
MNCH - Maternal, Newborn, and Child Health
MNDC - Micronutrient Deficiency Control
MUAC - Mid-Upper Arm Circumference
NAFDAC - National Agency for Food and Drug Administration and Control
NCFN - National Committee on Food and Nutrition

NDHS - Nigeria Demographic and Health Survey
NFNP - National Food and Nutrition Policy
NGN - Nigerian Naira
NGO - Non-Governmental Organization
NHSPA - National Health Sector Strategic Plan of Action
NIPD - National Immunisation Plus Day
NPC - National Planning Commission
NPHCDA - National Primary Healthcare Development Agency
NSHDP - National Strategic Health Development Plan
NSS - Nutrition Surveillance System
PHC - Primary Healthcare Centres
PLWHA - People Living with HIV/ AIDS
PLW - Pregnant and Lactating Women
PMTCT - Prevention of Mother-to-Child Transmission of HIV
PPP - Public-Private Partnership
RUTF - Ready-To-Use Therapeutic Food
SAM - Severe Acute Malnutrition
SGA - Small-For-Gestational Age
SLEAC - Simplified LQAS Evaluation of Access and Coverage
SMART - Standardized Monitoring and Assessment of Relief and Transition
SMOH - State Ministries of Health
SOML - Saving One Million Lives Initiative
SON - Standards Organization of Nigeria
SQUEAC - Semi-Quantitative Evaluation of Access and Coverage
SUN - Scaling Up Nutrition
UN - United Nations
UNICEF - United Nations Children's Fund
VAD - Vitamin A Deficiency
WFP - World Food Program
WHO - World Health Organisation

FOREWORD

Community systems strengthening refers to interventions that promote the creation and maintenance of informed, capable, coordinated, and long-term structures, mechanisms, processes, and actors through which community members, organizations, and groups interact, coordinate, and deliver their responses to the challenges and needs that affect their communities.

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. Achieving this goal is vital for making progress toward the goals of universal access to health care and realizing the rights of everyone to achieve the highest attainable standards of health, no matter who they are or where they live. The Community Systems Strengthening (CSS) Framework is a contribution toward this goal. It is in line with this and the commitment of my administration to better the lives of the people of Gombe state, that the state has developed its first ever community system strengthening framework for improved accountability and ownership of integrated health service. The framework was adapted from the The Global Fund to fight AIDS, Tuberculosis and Malaria framework developed the in collaboration with a range of stakeholders

For this reason, the State Ministry of Health with support from GTZ has planned to implement an integrated community health package over the next 2 years (2022-2023). The community strengthening framework will contribute to the SDG, MGD, HSSP-II and Gombe State sector strategic Plan (GSHSPP. The framework will support operationalization and gradual scale up of integrated community health delivery model in communities, especially underprivileged areas and for the key and vulnerable population.

It is expected that the full implementation of the framework backed with appropriate resources will lead to improved outcomes for health interventions dealing with major health challenges, including HIV, tuberculosis and malaria, among many others in line with the policy thrust of this administration, it is also envisaged that it will guide the, Civil Society Organizations (CSOs), Traditional Institutions, and Development Partners in aligning their support and activities with the identified strategies.

Dr Habu Dahiru
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ACKNOWLEDGEMENT

This community system strengthening framework for improved accountability and ownership of integrated health services in Gombe state is to reaffirm Gombe state's commitment towards improving the health outcomes of its people, with particular emphasis on key and vulnerable populations, women, and children. The Community Systems Strengthening Framework (CSS) will help strengthen community systems working to increase people's access to health, including prevention, care, and treatment.

The Gombe State Government through the Ministry of health wishes to express its gratitude to the numerous individuals and organizations that have contributed to the development of this document with aim of strengthening more effective community engagement and stronger partnerships between community, public and private actors in the state.

My special thanks go to all partners, the Civil Society Organizations (CSOs) and the Stop TB Partnership (STP) for their support and active participation in ensuring that a quality and user-friendly document is produced. I also appreciate the technical support from WHO and UNICEF, the staff the Ministry of Health, State Primary Health Care Development Agency, the State Agency for the Control of AIDS , the MNCH Coalition, the Media, traditional and religious leaders as well as the financial support from the GTZ. Finally, we thank Almighty God for the strength to complete this work successfully.

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EXECUTIVE SUMMARY

The right to health is a Universal Human Right, healthcare workers or human resources for health becomes critical to reaching communities with health interventions. Community getting to speak, act and guard health programme implementation.

Health programmes design for effective service delivery has direct relationship with the health needs of the community which depends largely on 'á two-way traffic' first on the designer of the program and secondly on the intended beneficiary. The programme designer, from the on-set, planned his interventions with the aim of responding to the need of the community based on identified evidence, however, inclusion of the intended beneficiaries in the planning, implementation and evaluation of such programmes guarantees ownership and sustainability of the programmes. If community inclusion is lacking, the expected deliverables of project development objectives suffer. Although meaningful community inclusion in these processes has to do with the level of knowledge about the role of communities in the context of social accountability which task them to note that services and services quality must be checked by them.

Community system strengthening provides the programmes designers and the intended beneficiaries the platform to appreciate and work together for the successes of the health programmes.

The Gombe State Community System Strengthening Framework is robust enough to provide short-, medium- and long-term plans for enhanced community participation in the design, implementation and evaluation of health and social programmes of the state.

This document development process involved critical community stakeholders who made their useful input in the development process.

INTRODUCTION

Community systems strengthening (CSS) is a strategy that promotes the growth of informed, capable, and coordinated communities as well as community-based organizations, groups, and structures. CSS engages a diverse range of community actors, allowing them to contribute as equal partners alongside other actors to the long term sustainability of health and other community interventions, including an enabling and responsive environment in which these contributions can be effective. CSS aims to improve health outcomes by strengthening the roles of key affected populations and communities, as well as community-based organizations, in the design, delivery, monitoring, and evaluation of services and activities related to HIV, tuberculosis, malaria, and other major health challenges.

The precise need and nature of community system strengthening varies depending on the social, political, and economic context of a country, as well as the strengths and weaknesses of the existing community and health systems of the country. The legal environment is particularly important because it determines whether communities have the rights and recognition to operate freely and effectively, or whether the legal and policy environment allows for contracting and public funding of civil society and community organizations to deliver services.

Strengthening community systems is critical to providing the safe, relevant, accessible, and high quality services and structures necessary to end HIV, tuberculosis, and malaria epidemics and develop resilient and sustainable health systems. It is also central to the integrated1, co-produced1, and people-centered1 packages that are critical to achieving Universal Health Coverage and making progress on all of the Sustainable Development Goals. International commitments and normative guidelines are increasingly recognizing the importance of strengthening community systems. However, in some countries, interventions to strengthen community systems are not adequately recognized, prioritized, or incorporated into national plans and budgets (for either specific diseases or health as a whole).

RATIONALE

Community organizations and networks have the distinct ability to interact with affected communities, respond quickly to community needs and issues, and engage with affected and vulnerable groups. They provide direct services to communities while also advocating for better programming and policy environments. This allows them to shape a community's contribution to health and to have a say in the development, reach, implementation, and oversight of public systems and policies.

The goal of community system strengthening initiatives is to achieve better outcomes for interventions addressing major health challenges such as HIV, tuberculosis, malaria, and many others. Health outcomes can be greatly improved by mobilizing key affected populations and community networks, as well as focusing on strengthening community-based and community-led systems for prevention, treatment, care, and support; advocacy; and the creation of an enabling and responsive environment.

On the other hand, community organizations and actors must have effective and sustainable systems in place to support their activities and services to have a real impact on health outcomes. This includes a strong emphasis on capacity building, as well as human and financial resources, to enable community actors to play a full and effective role. in addition to the health, social welfare, legal, and political systems CSS is a method of prioritizing adequate and sustainable funding for specific operational activities and services, as well as core funding to ensure organizational stability as a platform for operations, networking, partnership, and coordination with others.

DEVELOPMENT PROCESSES

The development of the Gombe State Community System Strengthening Framework was facilitated by a consulting firm engaged by the Ministry. Series of consultative meetings were held between the consultants and SMOH during which plans were finalized for the exercise.

The process adopted for the development of this framework involved desk reviews of available published documents and literature as well as consultative and participatory processes. Then a stakeholder workshop was convened involving technical officers from various sectors of the state to develop a roadmap to use the information to develop the framework. The process was consultative throughout. This was to ensure that the challenges related to community health intervention in the state would be successfully tackled in an integrated manner and the proposed interventions reflected all stakeholders' contributions. Following the stakeholders' workshop, a draft framework was developed and further review by the state stakeholders conducted to ensure accurate documentation of agreed intervention before finalization. The final draft of the CSS framework was presented by the consultant to the State Government for approval and implementation.

BACKGROUND

State Profile

Gombe State is in the North-eastern geo-political zone of Nigeria. Gombe state shares common borders with the states of Borno, Yobe, Taraba, Adamawa, and Bauchi states. Formed from Bauchi in 1996, Gombe state spans a total land mass of 20,265 Kilometers and is divided into 11 Local Government Areas (LGAs), and 114 political wards.

Gombe state population represents about 2.6% of Nigeria's population, estimated at 4 million people in 2021. The state experiences temporary rural-urban migration where most youth travel during the dry season and return to participate in farming practices during the rainy season. Hence more than 80 percent of the population resides in rural areas. The presence of some industries in the State including Coal mining activities in Maiganga, Ashaka Cement Factory, Gombe Oil Mill and Cotton Ginneries have also boosted economic activities in the State. It is estimated that 61% of the population live on less than a dollar a day and 69% live below the relative poverty line, which is set slightly higher at 1.25 dollars per day (66,802 NGN per year). Poverty is also higher in rural areas than in urban areas. The degree of inequity among the population, measured using the Gini coefficient, is also increasing.

The State has nine (9) tertiary institutions which are Federal University Kashere, Gombe State University, College of Nursing and Midwifery Gombe, College of Health Sciences and Technology Kaltungo, Federal College of Education Gombe, Gombe State College of Education Billiri, Gombe State Polytechnic Bajoga, Federal College of Horticulture DadinKowa, College of Legal and Islamic Studies Nafada.

Health system administration and governance in the state is decentralized in line with the provisions of the National Health Policy (FMOH 2006); consequently, the State Primary Health Care Development Agency (SPHCDA) take administrative responsibility for primary health care facilities, while the State Ministry of Health is responsible for secondary health facilities. The Federal government owns and is responsible for the Federal Teaching Hospital Gombe. The State Ministry of Health occupies the central position in this structural and functional arrangement and sets and adapts policy, provides strategic leadership and stewardship for the entire health system. Health governance permeates down to the community level through Ward Development Committees (WDC) and Health Facility Management Committees.

Gombe state has about 627 health facilities, and The State has 627 public and private health facilities. 413 of these figures are public Primary Health Care (PHC) with 7,393 Health Workers and 1,279 Nurses and Midwives. Health Workers Density is 20 persons: 10,000pop. Health

Facility Density is 1.7person 10, 000 pop (2021 PHC diagnostics). Currently, more the 50% of the State's PHCs are implementing minimum service package (MSP).

2.3 Situation of Community Participation and Ownership in Gombe State

Community participation involves the participation of communities in the planning, implementation, monitoring, and evaluation of various health interventions to promote ownership and survival, thus empowering them to manage their health challenges. This approach also ensures that the services are provided to the underserved populations. The state has 114 Ward Development Committees (WDCs) that function in all 114 Wards. The WDCs are linked to the PHCs in their wards. The WDCs oversee the affairs of PHCs in their wards and meet regularly at ward level to address challenges affecting their communities. However, State Primary Health Care Agency (SPHCDA) and Local Government Area Primary Health Care Development Committees (LGAPHCDC) were not established

2.4 Scope of Gombe State community system framework

The Community Systems Strengthening (CSS) framework is one step toward achieving this goal. The State adapted the Global Fund Community System Strengthening Framework. It is a 5-year framework that will guide the State Ministry and stakeholders in the implementation of interventions that will address community system challenges while taking into account key and vulnerable populations. It will provide strategies and facilitate the implementation of key activities that will help to achieve the overall goal of ensuring access to care for all. The CSS framework interventions are cross-cutting and are expected to address barriers to accessing health services toward achieving universal health coverage in the State. Several innovations arising from reviews and operational research may occur, the intervention in the Framework will be flexible to accommodate new approaches to ensure the expected goals are achieved. The ministry will review the implementation this framework and use the lessons learnt from the interventions to adjust it. The scope includes the following:

- **a)** There will be community engagement and advocacy to improve the policy, legal, and governance environments and to affect social determinants of health.
- **b)** The framework will ensure community networks, linkages, partnerships, and coordination – enabling effective activities, service delivery and advocacy, maximizing resources and impacts, and coordinated, collaborative working relationships.
- **c)** Promoting community resources mobilisation and capacity building – including human resources with appropriate personal, technical and organizational capacities, financing (including operational and core funding) and material resources (infrastructure, information and essential medical and other commodities and technologies).
- **d)** Community activities and service delivery – accessible to all who need them, evidence-informed and based on community assessment of resources and needs.
- **e)** Organizational and leadership strengthening – including management, accountability and leadership for organizations and community systems.
- **f)** Monitoring and evaluation and planning – including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management.

OVERALL GOAL OF THE CSS FRAMEWORK

Strengthen community accountability and ownership of HIV, TB, Malaria, Immunisation, and RMNCAH + N interventions in the state.

OBJECTIVES

1. To clearly outline the roles and responsibilities of different stakeholders on community accountability and ownership of integrated health services
2. To set out accountability mechanisms that will ensure improved ownership of health interventions at the community level
3. To develop a Framework for strengthening of Community Accountability and Ownership of HIV, TB, Malaria, Immunisation and RMNCAH+N Interventions, including Community MPDSR
4. Produce/Review the accountability framework documents
5. To organise and facilitate a capacity building workshop for policy implementers (program officers, primary healthcare (PHC) Coordinators, ward development committees (WDCs), Civil Society Organisation (CSOs), etc.)

EXPECTED OUTCOMES

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

- improved outcomes for health and well-being.
- Improved community participation and ownership of health intervention
- social and financial risk protection.
- improved responsiveness and effectiveness of interventions by communities.
- improved responsiveness and effectiveness of interventions by health, social support, education, and other services.

KEY TERMS ADAPTED IN THE DEVELOPMENT AND IMPLEMENTATION OF THE FRAMEWORK

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

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

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

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

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

Community organizations and their members are all those who act at the community level to deliver community-based services and activities, and to promote improved practice and policies. This includes many communities led associations, civil society organizations, groups and individuals that work with communities, particularly community-based organizations, non-governmental organizations and faith-based organizations (FBOs), and networks or

associations of people affected by particular challenges such as HIV, tuberculosis and malaria or association of groups with similar or same interest. Community organizations also include those public- or private-sector actors who work in partnership with civil society to support community-based service delivery, for example local government authorities, community entrepreneurs, Community development associations and cooperatives.

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

PROCESS/METHODOLOGY/APPROACH

Step 1: identify where community systems strengthening interventions are required. This decision will be based on the priorities identified in respective State Ministry of Health/ SPHCDA strategic plans. The aim of CSS is not to strengthen individual organizations but to strengthen the community system. For this reason, when choosing to work on a specific geographic area CSS will focus on all organizations in this area that are involved with service

delivery for a particular disease/ issue. These organizations will together form the denominator for the CSS indicators.

Step 2: Conduct a needs assessment to determine the strengths and weaknesses of the targeted community systems. It is of key importance that all relevant stakeholders are consulted during the needs assessment and that the assessment is conducted fully participatory. Relevant stakeholders may include representatives of community-based organizations, representatives of key affected populations, local government officials, M&E experts, and others. This is based on service delivery mapping per organizations in the State (key stakeholders and partners must understand the service delivery environment by mapping who is providing which services, to whom and where, and who is not being reached). The needs assessment must systematically analyze the status of community systems for all six core components. The outcome of the assessment will clarify the status of community systems and what needs to be strengthened. The assessment will take into consideration the following element when planning is feasible to implement; identify the current state of community systems (the baselines); identify the key players involved in CSS interventions (the stakeholders); identify what should be achieved. To support this process an assessment tool will be used.

Step 3: Building on the needs assessment, clear and achievable objectives will be identified. which will be aligned with the state Ministry of Health and the SPHCDA strategic plan.

Step 4: Based on the objectives and the outcome of the needs assessment, determine the list of interventions from the CSS module for which system strengthening measures are required. These decisions will depend to a great extent on the role that civil society and community organizations are going to play as implementers of core programs. Areas where strengthening is most needed will be our major focus.

Step 5: In consultation with community stakeholders and technical partners, discuss the most appropriate and effective activities for each intervention. CSS interventions aim at ensuring that quality services are available and used by the community, resulting in improved health outcomes at the community level. The emphasis will be to ensure that the selected interventions and activities are based on evidence and correspond to the needs identified by the community.

Step 6: Interventions are made, while indicators will be developed to measure progress in CSS over time. A great variety of organizations are active at the community level, as well as many state variations. A tailored package of appropriate indicators will be selected for organizational context.

Step 7: Develop the budget and workplan to define baselines and set targets. The needs assessment conducted in Step 3 will inform setting baselines for each of the selected

indicators. Define the scale at which CSS interventions should be implemented to achieve the set objectives.

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

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

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

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

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

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

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

MAPPING OF COMMUNITY SYSTEM STRUCTURES

Community mapping is an important step in starting the engagement process with people of concern. It provides the foundation for developing a communication plan for information provision and feedback. The process aims to better understand the trusted structures that exist in the community and their levels of influence. Identifying key influencers in a community is important to determine how to engage with the community when providing information and collecting feedback. This understanding also forms the basis of engagement plans for different groups in the community. The following stakeholders were identified from the community for engagement

a) Key populations and
b) adolescent and young people
c) WDCs
d) NURTW
e) Religious Leaders
f) Traditional leaders
g) CSOs/CBOs
h) Affected communities PLHIV

KEY POPULATIONS AND ADOLESCENT AND YOUNG PEOPLE IN THE HIV RESPONSE

people who inject drugs, Men who have sex with men and sex workers are socially marginalized, often criminalized and face a range of human rights abuses that increase their risk of HIV infection. In every country where surveillance data are reliably collected and reported, these populations have higher HIV mortality and/or morbidity compared to the general adult population in the past; however, the recent IBBSS 2021 is also largely pointing to the AYP which might be as a result of an absolute lack of extensive interventions targeted at them. Access to, or uptake of, relevant services is significantly lower for these populations than for other groups.

i. **<u>Key populations and Pediatric in the TB response</u>**

Prisoners and incarcerated populations; people living with HIV; migrants and displaced populations, children living with HIV are all groups at increased risk for TB infection. These groups experience significant marginalization, human rights abuses, and decreased access to quality services.

ii. Key populations in the malaria response

Knowledge of key populations in the response to malaria is relatively new, compared to the HIV and TB epidemics. Displaced populations and indigenous people in malaria endemic areas are often at greater risk of transmission, may have decreased access to care and services, and are also often marginalized.

iii. Additional factors

The stigma associated with HIV and TB infection in many settings means that often those who have been diagnosed with one of these illnesses experience additional risks for co-infection, marginalization, or human rights abuses. For this reason, these populations qualify as key populations under this action plan and should be given unique consideration even when they fall within other key populations. Similarly, women and girls, including transgender women, experience an increased biological vulnerability to HIV and are disproportionately exposed to violence and other forms of gender oppression that increase HIV risk. This is compounded for women and girls who work as sex workers and/or inject drugs and who can be described as 'key affected women'. Young people from key populations face increased marginalization as age-related laws and policies can hinder their ability to access HIV-related and other health services.

iv. Other vulnerable populations

In every context, there are communities and groups that fall outside of the above definition of 'key populations', but experience a greater vulnerability and impact of HIV, tuberculosis, and malaria. These may include people whose situations or contexts make them especially vulnerable, or who experience inequality, prejudice, marginalization, and limits on their social, economic, cultural and other rights. Depending on the context this might include groups such as orphans, street children, people with disabilities, mobile workers, and other migrants. Some occupations – mining – and contexts may enhance the risk of TB even more by limiting access to healthy environments. Children and pregnant women – women with HIV - are particularly vulnerable to malaria as their immunity is reduced. In many African countries women and girls who are not marginalized – and so would not be defined as “key affected women” – are highly affected by HIV and must be considered as a vulnerable population.

Depending on the local context, vulnerable populations require focused efforts and resources that address their enhanced needs, although they do not fall under the

general definition of ‘key populations’ and therefore are not specifically covered by this action plan. Regardless of categorization, the Global Fund’s financing model directs resources to priority services where needs are greatest in order to achieve impact.

PROPOSED CSS FRAMEWORK/ INTERVENTION

Interventions	**Scope and description of intervention package** (Includes human resources required under each intervention)	**activities**
Strengthening of Community Structures	Identification of existing community structures, reorganization and orientation of such structures on basic mandate and relationship to **health**	Mapping and profiling of relevant community structures in the state
		Advocacy visits/review meetings with the leadership of the groups
		Orientation meeting with the identified groups on their basic mandate
		Coordination Work plan for all groups as instrument for measurement
Capacity Building	Capacity building of the different groups on advocacy, community mobilization, networking, reporting and general result-based coordination	Community advocacy tool kits development meetings
		Training Meetings on different result-based community mobilization strategies
		Consensus meetings on joint reviews. Monitoring & evaluation and reporting
		Leadership training and effective coordination
		Training on community level monitoring and evaluation
		Development and planning of community-based monitoring and documentation Mechanisms for the groups,
		Design, establishment, and maintenance of research plans, community-based

Community-based monitoring for accountability	Community-based organizations establish and implement mechanisms for ongoing monitoring of 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 rights and discrimination and gender-effective response to the disease and to an enabling environment.	monitoring and documentation tools and systems
		Monitor or develop indicators to measure legal rights
		Equipment for monitoring (e.g., relevant information technology)
		Implementation of monitoring for accountability activities (including baseline monitoring, data collection by communities, discussions with service providers, and use and appraisal of official/government data)
		Collation, centralization and analysis of monitoring data and development of recommendations and demands for improvement
		Publication and dissemination of community monitoring data and recommendations
		Technical support and training
		Training for community researchers/monitors
		Other

Interventions	**Scope and description of intervention package** (Includes human resources required under each intervention)	**Illustrative activities**

Advocacy for social accountability	Communities and affected populations conduct consensus, dialogue and advocacy at state and local levels aimed at holding to account responses to the disease, including health services, disease specific programs as well as broader issues such as discrimination, gender inequality and sustainable financing, and aimed at social transformation.	Planning of consensus, dialogue and advocacy work with decision makers and service providers at local and national level
		6 days Consultations with community members
		Consultations with relevant government representatives
		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
Social mobilization, building community linkages, collaboration and coordination	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	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

Interventions	Scope and description of intervention package (Includes human resources required under each intervention)	Illustrative activities
	duplication and competition.	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)
		Establishment of community health worker programming, strengthening, integration within the health systems and linkages with the community systems.
		Community level groups (e.g. health committees) whose mandate includes coordination and networking, identifying and responding to issues and barriers and mobilizing actions, support, linking with the health system, etc.
		Awareness-raising amongst community members about their entitlements, as specified in service-provider commitments
		Technical support and training
		Other
Refreshers	Capacity building of community sector	Assessment of needs in human resources, systems, equipment, organizational and institutional development, leadership, etc.

on Institutional capacity building, planning and leadership development in the	groups, organizations and networks in a range of areas necessary for them to fulfil their roles in service provision, social mobilization, monitoring and advocacy. Includes support in planning, institutional and organizational development, systems	Provision of resources for institutional support including legal support, support for registration etc.
		Evidence informed planning, management, and policy formulation for community

Interventions	**Scope and description of intervention package** (Includes human resources required under each intervention)	**Illustrative activities**
community sector	development, human resources, leadership, and community sector organizing. Provision of stable, predictable financial resources for communities and appropriate management of financial resources by community groups, organizations, and networks. Provision of technical, material, and financial support to the 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.

	sector as required to enable them to fulfil roles in service provision, social mobilization, monitoring, and advocacy.	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
		Strengthening communications skills and infrastructure
		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

Interventions	**Scope and description of intervention package** (Includes human resources required under each intervention)	**Illustrative activities**
		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 counselling, referrals, peer support, outreach to key affected people and communities and legal support.

Interventions	**Scope and description of intervention package** (Includes human resources required under each intervention)	**Illustrative activities**
		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

REFERENCES

- MEASURE Evaluation Capacity Building Guides. http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/capacity-building-guides/capacity-building-guides-index.html
- Roll Back Malaria Toolbox. http://www.rollbackmalaria.org/toolbox/index.html
- Stop-TB - TB Technical Assistance Mechanism (TEAM). http://www.stoptb.org/countries/tbteam/default.asp
- UNAIDS Technical Support Facilities. http://www.unaids.org/en/CountryResponses/TechnicalSupport/TSF/

a. Other Information Sources, Including Those Referenced in the CSS Framework

- A storage of purchased products: WHO Expert Committee on Specifications for Pharmaceutical Preparations: 40th report. Geneva: WHO; 2006. http://whqlibdoc.who.int/trs/WHO_TRS_937_eng.pdf