



# SAT

**Southern African AIDS Trust**

*Supporting community responses to HIV and AIDS in Southern Africa*

## **Southern Africa Community Systems Strengthening (CSS) Framework**



**September 2011**

Produced by SAT (Southern African AIDS Trust) with the financial support under a Joint Financing Arrangement of the Canadian International Development Agency (CIDA), the Swedish International Development Agency (Sida), the Royal Netherlands Embassy (RNE), and the Swiss Agency for Development and Cooperation (SDC); and financial support for Civil Society Action Team (CSAT) from UNAIDS and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)), who do not necessarily share the views expressed here.

September, 2011

SAT Regional Office  
Suite 293, Dunkeld West Centre  
281 Jan Smuts Avenue, Dunkeld West  
Johannesburg, South Africa  
Tel: +27-11-341 0610  
Fax: +27-11-341 0661  
E-mail: [info@satregional.org](mailto:info@satregional.org)  
Website: [www.satregional.org](http://www.satregional.org)

## Foreword

Key to the success of community systems in the response to HIV, TB and Malaria, as well as any development challenge, is communities with the confidence, capacity and resolve to own and oversee processes that happen within their localities. Participation in development action involves communities directly informing the design and monitoring of services and actions appropriate to their contexts, needs and challenges. Participation also involves communities engaging with government and municipalities, health personnel and other key stakeholders, and having the confidence to hold government and non-governmental stakeholders accountable for resources and services.

In May 2010 the Global Fund (GF) finalized a Community Systems Strengthening (CSS) framework that provides a meaningful guide to CSS including definitions, principles, service delivery areas, activities and key indicators. The guide is useful to countries completing GF applications and for service providers engaged in CSS processes. However, the GF CSS framework falls short of regional contextualization and the elaboration of strategy to address the many competing interests and power imbalances at play in communities across the region. These factors often serve to neutralize or compromise its intent. The GF CSS framework also lacks emphasis on the need for communities to leverage their own resources in the face of dwindling funds, as well as substantive and practical guidance to the integration of the three epidemics. In addition, core challenges anchor around the often inappropriateness and inaccessibility of technical assistance relevant to community based organisations (CBOs) and non-government organisations (NGOs), as well as the lack of appreciation of the centrality of indigenous civil society organisations (CSOs) in the responses to HIV in the region.

This Southern African CSS Framework uses the GF CSS framework as its foundation but argues for an appreciation of the challenges, nuances and peculiarities of the Southern African region, the latter being the epicentre of the epidemics. Implicit within the regional CSS framework is four core elements: community systems; CSO capacity development and sustainability; integration agenda; philanthropy and social entrepreneurship.

Communities, through exposure to capacity development and support, must be allowed to build on their indigenous knowledge and skills as they apply these to health care, advocacy, health promotion and wider responses to the diseases. These capabilities and interventions must also be responsive to the contextual realities facing communities such as lack of shelter, education, food, income, social justice and equity. As a conceptual framework, this document encourages conversations among all key stakeholders as to its efficacy. Specifically this guide can assist to inform programming at country level with reference to any development challenge that prioritises local community participation and involvement. Also, it can help to inform the finalisation of GF country proposals. Organisations or country representatives are encouraged to extract what is appropriate and useful for their contexts and purposes. A few case studies have been included in this guide as a snapshot to the benefits of including CSS in development approaches.

This Framework is not intended to be prescriptive but rather a resource to be used to address the unique and individual needs of communities in the Southern African region. It is also not intended to be used alone but in conjunction with many of the resources developed by the Global Fund, WHO, UNAIDS and others at various levels.



Felicitas (Flanny) Chiganze  
Deputy Executive Director – Company Secretary (SAT)

## Acknowledgements

Southern African AIDS Trust (SAT) wishes to acknowledge individuals and organizations who contributed to this document through their vision, expertise, co-operation and hard work.

Special thanks goes to members of the Nucleus Group comprising of AIDS and Rights Alliance for Southern Africa (ARASA), Pan-African Treatment Action Movement (PATAM), Open Society Initiative-Southern Africa (OSISA), Hivos, World AIDS Campaign (WAC), SAT and UNAIDS RST ESA who provided technical support throughout the whole process to regionalise the framework.

SAT also wishes to thank civil society organisations who attended the Global Fund Regional Civil Society Workshop in October 2010 where it was recommended that there is a case to regionalising the CSS Framework and also those at the March 2010 regionalise meeting where the concept was further refined.

Special mention also goes to the National AIDS Council (NAC) heads or their representatives and the CCM Secretariats from the 10 Southern Africa countries who also gave their input at the regional consultation meeting in August 2011. The Global Fund- Civil Society and Private Sector Partnerships Unit has been supportive of the initiative to regionalise the CSS Framework and their support is acknowledged. All the other regional and local NGOs who participated in various consultation workshops are acknowledged.

Last but certainly not the least, SAT is particularly grateful for the technical expertise provided by Shaun Samuels who is the Consultant contracted to consult widely with stakeholders and draft the Framework.

## Table of Contents

	List of Acronyms	4
1.	Purpose of the framework	5
2.	Regional context	7
3.	Regional CSS framework – core CSS elements	8
3.1	<b>Community systems</b>	9
	SDA 1: Needs assessment and gaps analysis	10
	SDA 2: Community actors – skills building for service delivery	10
	SDA 3: Mapping of community assets and resources	11
	SDA 4: Integration of CSS with health systems	13
	SDA 5: Compendium of CSS interventions and best practices	13
	SDA 6: Community networks and partnerships	15
	SDA 7: Social mobilisation	15
	SDA 8: Mediating competing interests and conflict at community levels	15
3.2	<b>CSO capacity development and sustainability</b>	16
	SDA 9: Regional CSOs support national and local actors	17
	SDA 10: National NGO interventions	17
	SDA 11: International NGO interventions	18
	SDA 12: CBO interventions	18
	SDA 13: Advocacy	19
	SDA 14: Organisational strengthening and mentorship support	19
	SDA 15: Financial resources	19
	SDA 16: Monitoring and evaluation	20
3.3	<b>Integration agenda – of HIV, TB and Malaria with the national development framework</b>	21
	SDA 17: Communication and education for prevention, treatment and care	22
	SDA 18: Integration of the three epidemics	22
3.4	<b>Philanthropy and social entrepreneurship</b>	23
	SDA 19: Reinforcing philanthropy and social entrepreneurship at the community level	24
	List of figures:	
	1: Map of SADC countries	
	2: Core elements	
	3: Community action and results for health	
	4: Integration of HIV with development	
	List of Boxes:	
	1: Various dimensions of civil society	
	2: Challenges facing the African continent	
	Annexure:	
	1: Reference material	

## List of Acronyms

ART	Antiretroviral therapy
CBO	Community based organisation
CAA	Catholic AIDS Action
CSO	Civil society organisation
CSS	Community systems strengthening
DOTS	Directly Observed Therapy Short-course
DRC	Democratic Republic of the Congo
FBO	Faith based organisation
GBV	Gender-based violence
GF	Global Fund
HSS	Health systems strengthening
IDU	Injection drug users
INGO	International non-governmental organisation
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MDR	Multi-drug resistance
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non governmental organisation
OECD	Organisation for Economic Cooperation and Development
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child transmission
SADC	Southern Africa Development Community
SADCPF	Southern Africa Development Community Parliamentary Forum
SAT	Southern African AIDS Trust
SDA	Service delivery area
SRH	Sexual and reproductive health
TA	Technical assistance
TB	Tuberculosis
WHO	World Health Organisation
XDR – TB	Extensively drug resistant Tuberculosis

## 1. Purpose of the Framework

This framework focuses on community systems strengthening and is totally aligned to the CSS framework developed in May 2010 by the GF<sup>1</sup>. It fully embraces and is guided by the key imperatives as elucidated in the GF framework that says:

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

While aligning to the above, there is recognition of the fact that communities need to remain central to their own development. This regionalised framework is not simply about strengthening CBOs as the sole agents of change at the community and/or village levels. In reality, faith based organisations (FBOs) and a range of other local actors are all critical in helping to nurture and grow community systems. Another major departure is recognition of the fact that the Southern African region has its own nuances, history and contextual realities. This regional framework (as distinct from the global CSS framework) is a regionalised CSS framework that does not ignore the realities faced by civil society or the complexities in working at community level. One such reality is the nature of political regimes that continue to restrict the ability of organisations of civil society (and communities in general) to influence public affairs, regardless of the kinds of associations they belong to. The space for active citizenship gets marginalised and in some countries vulnerable groups such as men who have sex with men (MSM), sex workers and injection drug users (IDUs) are forced to go underground because of stigma and restrictive policies.

### Box 1: Various dimensions of civil society

Civil society is characterised by the formal and non formal, traditional and modern, secular and religious, and not just NGOs; and because these diverse associations generate competing views about ends and means of the good society – it also means the public sphere, the places and the spaces both real and virtual in which different visions can be reconciled and societies can secure a political consensus about the best way forward.

Michael Edwards – “The challenges of civil society in Africa”, a lecture delivered in Dakar, Senegal, 12 February 2009  
([https://docs.google.com/viewer?url=http://www.trustafrica.org/documents/The\\_Challenges\\_of\\_Civil\\_Society\\_in\\_Africa.pdf](https://docs.google.com/viewer?url=http://www.trustafrica.org/documents/The_Challenges_of_Civil_Society_in_Africa.pdf))

Box 1 refers to the various dimensions of civil society in the region with the village at the very grassroots level being a microcosm of the countries they exist in.

What is pertinent for the Southern African region and for ensuring the centrality of communities to their own development is a focus on building the conditions within which communities shape themselves and their relationships with the state (health

<sup>1</sup>The Global Fund to fight AIDS, Tuberculosis and Malaria developed the Framework in collaboration with a range of stakeholders, supported by a Technical Working Group (TWG) that included: UNAIDS, WHO, UNICEF, World Bank, MEASURE Evaluation, Coalition of the Asia Pacific Regional Networks on HIV/AIDS (7 Sisters), International HIV/AIDS Alliance, USAID Office of HIV/AIDS, and US Office of the Global AIDS Coordinator, UNDP Burkina Faso, Ministry of Health & Social Welfare Tanzania, Carolyn Green as an independent consultant and Global Fund staff.



and other development systems). This means addressing all forms of inequality and discrimination as well as providing people with the means to be active citizens. Communities must also own the tools to fight to reform politics in an effort to encourage more space for participation, dealing with post-conflict realities and building a strong foundation for institutional partnerships, alliances and coalitions to flourish.

In bringing into the equation the integration agenda<sup>2</sup>, this regionalised framework firstly embraces the definitions provided in the GF CSS framework but seeks to situate CSS in the context of the above considerations. In this respect, the regional framework posits four key areas, some of which overlap with the GF CSS framework.

These are:-

- Community systems – building on traditions and local assets at community level to respond not only to HIV, TB and Malaria, but to other development challenges as well, in particular the Millennium Development Goals (MDG)
- CSO capacity development and sustainability – this area is well covered in the GF CSS framework but major questions relate to levels of CSOs and implementation
- Philanthropy and social entrepreneurship – encouraging local giving and finding more local means to sustain organisations with the emphasis on slowly reducing dependence on donor funding and drawing on in-country resources
- Integration agenda – assuming a more integrative perspective where HIV and AIDS is seen in the context of the national development framework, health, MDGs and others with implications for programming and delivery

The Framework is strongly informed by a renewed sense that community engagement for health is essential for achieving the basic human right to health for all. The Alma Ata Declaration of 1978 was a key starting point, affirming that: "...health is a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."<sup>3</sup>

**CASE STUDY 1:** The Catholic AIDS Action (CAA) in Namibia trains and supervises community volunteers to lead the local response to HIV. There are currently 2,241 volunteers providing care and support for almost 8,000 HIV positive adults and children and over 13,000 OVC. Volunteers, motivated by a strong faith and desire to care for the sick, provide initial screening and referrals for tuberculosis infection, and are often key supporters in ART treatment adherence. Volunteers receive monthly supervision meetings with professional staff members, a key feature of the programme's success. The integration of palliative care into its existing home-based care program resulted in a more effective mechanism for bi-direction referrals from the community to and from health facilities. The "men's only" home care groups where male volunteers are trained to care and support other men in their local area have been hugely successful. Volunteers are paid N\$50 per month (approximately US\$7.70) and are also provided with t-shirts and home care kits and supplies, in addition to a portion of any in-kind donations (shoes, clothing, umbrellas) the CAA receives. Orphans and vulnerable children supported through this initiative have a 96% school attendance rate

<sup>2</sup>Integrating SRH into HIV and AIDS, HIV in the broader health context, MDGs and in broader development frameworks

<sup>3</sup>Source: Community Systems Strengthening Framework, Global Fund, May 2010 that quotes from the "Declaration of Alma Ata – International conference on primary health care 1978



A critical consideration in the development of the framework is that CSS is relevant to any development intervention where communities need to be central to the interventions be it agriculture, local economic development, tourism, education, environment among others. While emphasis is placed on the GF as the biggest funder at present for the three diseases (HIV, TB and Malaria), the framework is not exclusive to the requirements of the GF. Also, the results to be achieved through CSS are about what communities will have in place and able to do and use for their own development benefit, as opposed to how CBOs are capacitated.

## 2. Regional Context

The African continent faces very daunting development challenges with the highest proportion of its people in extreme poverty.

Some of the key challenges facing the continent are captured in Box 2 where most, if not all countries in the region, are poised to fall short of meeting the Millennium Development Goals (MDGs) by 2015. The Southern African region is reflective of the continent and its challenges, in addition to the fact that it remains the epicentre of the HIV epidemic.

When it comes to HIV and AIDS, Southern Africa demonstrates mixed results regarding the various interventions and programmes targeting the epidemic<sup>4</sup>:

- ❖ New infections in most countries in Southern Africa have stabilized, albeit at a very high level. Eight of 13 countries with prevalence greater than 12% are all in Southern Africa.
- ❖ As of December 2009, 3.2 million people in Eastern and Southern Africa were receiving antiretroviral therapy (ART) based on WHO 2010 guidelines with an estimated 7.7 million needing ART. However, using the new World Health Organisation (WHO) criteria for starting treatment at CD-4 count 350, all countries fall short of their coverage targets
- ❖ Prevention of mother to child transmission (PMTCT) coverage rates for 2006 – 2009 have increased for virtually every country in the region but national targets have not been met by half of the countries.
- ❖ The data on women and men (aged 15 – 24) that correctly identify ways of preventing the sexual transmission of HIV reveals that the majority of countries reflect percentages of 50% and below and therefore clearly demonstrates that specific knowledge on transmission of HIV is not yet high enough among young adults
- ❖ Early sexual debut is especially high in Angola and Mozambique
- ❖ Reported sex with more than one partner appears to be decreasing
- ❖ With regard to financing and using PMTCT programmes in Africa as an example, bilateral donors account for 72% of funds whereas the public sector, only 11%. GF accounts for 7% and UN agencies 8%. Hence, there is still an over reliance on external donor funding for HIV and AIDS
- ❖ Health systems infrastructure compounded by a human resource crisis across most countries are weak and insufficient, relative to the

Fig1: Map of SADC countries



<sup>4</sup>Tabled by UNAIDS at the SADC meeting NAC Directors hel

- growing challenges that relate to HIV, TB and Malaria and other diseases
- ❖ A new threat is emerging in the form of extensively drug resistant tuberculosis (TB) or XDR-TB

The challenges and peculiarities of Africa and specifically Southern Africa are distinct and in many respects, unique. This calls for any intervention, plan or programme to take account of the realities of Africa especially given its history of colonisation, the many struggles for freedom, dictatorships and the failure of many nations to ensure that all people enjoy full democratic and citizenship rights (today 40 countries have had multi-party elections in contrast to 1973 when only three Heads of State were elected). Again, Southern Africa is a microcosm of the continent when reflecting on the aforesaid.

Liberation struggles from colonisation were interwoven among many countries within the Southern African Develop Community (SADC) (Figure 1). To this day, conflicts persist in the Democratic Republic of Congo (DRC) and Zimbabwe. Countries such as Angola and Mozambique have emerged from longstanding wars and South Africa is only in its 17<sup>th</sup> year of democracy. This region is the epicentre of the HIV, TB and Malaria epidemics (not to mention other critical development challenges) and much greater efforts are needed to halt and reverse the impacts of the three diseases and to meet the MDG targets. There is significant inter-country movement of people for economic and other reasons as has been the case for decades. This reality sits alongside the realisation that the epidemics cannot simply be dealt with at country level alone. Most SADC countries are heavily reliant on foreign donor funding with the exception of South Africa and Botswana that make substantial contributions from the national fiscus and private sectors. Civil society across the region experiences different and varying constraints and challenges.

These regional particularities are some of the key omissions of the CSS framework developed by the GF and partner organisations. However, advocacy for greater collaboration between civil society and the state and greater ownership and involvement of CSOs in policy, programming and resource allocation decisions remain a common imperative. The global framework is generic and essentially not problematic but interventions where civil society is concerned have to take cognizance of the socio-economic and other contextual realities that are specific to countries in this region. For this reason the CSS framework has to be contextualised.

### 3. Regional CSS Framework – Core CSS Elements

Given the focus on the contextual specificities of Southern Africa and the need for a regional CSS framework that is responsive, four core elements constitute the regional CSS framework. These are graphically illustrated in figure 2 below and discussed in more detail.

Fig 2: core elements



Each of the core elements will be discussed in turn, supported by suggested Service Delivery Areas (SDAs)<sup>5</sup>, examples of activities and sample indicators. This guide was designed primarily to inform programming at country level and/or finalisation of GF country proposals. Organisations or country representatives are encouraged to extract what is appropriate and useful for their contexts and purposes. It is the hope that the SDAs, activities and indicators will grow as a dynamic resource for all as lessons learned and good practices are drawn out from CSS experiences. The SDAs below are numbered for ease of reference and should not be read in any particular order.

**CASE STUDY 2:** The World AIDS Campaign (WAC) collaborates with a diverse range of communities to ensure commitments to HIV and AIDS are realised. The organisation has been working with the community of KwaCele in Lusikisiki in the Eastern Cape to reduce gender-based violence (GBV) with particular focus on the practice of “ukuthwala” or “bride abduction. Young girls are now being forced to marry older men unknown to them, often with the consent of the parents or guardians and therefore at risk of unwanted pregnancies, HIV and other STIs as well as both physical and emotional abuse. The World AIDS Campaign in partnership with CSOs launched a targeted campaign to train nurses, the police, educators and traditional leaders on GBV and related legislation. As a result a community partnership forum, The Eastern Cape UbumthuBethu Campaign (ECUB) emerged which has strengthened the relationship between the government and CSOs on the issue and provided a space for the community to articulate their views and share knowledge. The community has now taken ownership of the campaign with traditional leaders taking a leading role in denouncing “ukhuthwala”, a significant step given that they are the custodians of culture in the community. Success of the campaign can be seen in an increase in arrests of perpetrators including parents of the girls and husbands, and removal of the survivors to places of safety.

<sup>5</sup> Please note that the SDAs provided in this Framework are additional and should not be confused with those provided in the Global Fund (May 2010) and related documents.

### 3.1 Community Systems

Communities represent people that live or co-exist in close proximity within a defined geographic location and who are connected to each other by shared experiences and history. Implicit within communities are various groupings with their own interests, religious and cultural beliefs and the like. In the context specific to the three epidemics, reference is made to affected populations such as children, youth and adults infected or affected by the epidemics, women and girls, men who have sex with men, injecting drug users, sex workers, migrants, refugees and other groups including those with physical challenges. The principle is that these affected populations have the right and should be afforded opportunities to influence and participate in programme interventions that directly impact on them.

The community systems approach is one that accentuates the need for and rights of communities to be central to their own development. This includes communities prioritizing what needs to be addressed, deciding who needs to be targeted at village level and how interventions unfold in tandem with local traditions and existing coping mechanisms. Communities have, over time, developed their own survival strategies in dealing with poverty, environmental disasters, health challenges and other social ills. These local systems of dealing with conflict, stress and under-development need to be nurtured and allowed space to grow and mature as part of a sustained response to HIV and other critical development challenges. In addition to the effects of human and income poverty, HIV, TB and Malaria represent the epidemics that are today ravaging communities. It is evident the cooperation of a broad range of local community actors with capabilities and resources to contribute to sustained health and other interventions in the context of an enabling and responsive environment is urgently required.

#### Local Community Actors

The term “local community actors” covers a range of groups which can be formal and informal, rural and urban. Some of these groups include communities, indigenous people, village associations, local NGOs and CBOs, micro-enterprises, youth and women’s groups, cooperatives, self-help groups, savings groups, local and traditional authorities, municipalities, churches and FBOs. Other groupings include affected populations that are at risk such as people living with HIV, women and girls, sex workers, women and men with physical challenges, men who have sex with men (MSM) among others. These groups make up the character of communities and therefore must benefit from and drive CSS processes and activities including training, access to resources, advocacy, monitoring and reporting, service delivery among others). In short, all community actors need to fully participate in the design and monitoring of the interventions that impact them.

Some relevant SDAs refer to the following:

- ✓ SDA 1: Needs assessment and gaps analysis
- ✓ SDA 2: Community actors – skills building for service delivery

#### **Service Delivery Area 1: Needs assessment and gaps analysis**

**Description:** Each community or village should not only have a clear sense of their needs but also the assets and resources that they have at their disposal. When these are mapped and identified programmes and strategies can be designed and implemented that would address both the gaps and assets present in the community. Identified needs and challenges should pertain to the three epidemics, the key goal areas of the MDGs and other local development challenges.

**Examples of activities:**

- Compile and develop needs assessment instruments
- Train community actors in needs assessment and resource mapping processes
- Plan and manage the rollout of community needs assessment, analysis and identification of gaps
- Identify specific capacity building needs at community level
- Assess what personnel is needed and the capacities and levels of skills required
- Determine the resources required to support existing community systems and approaches
- Organise community meetings to share and discuss the results of the analysis in order to allow community to prioritise agreed-upon actions and interventions
- Conduct a baseline survey

**Sample indicators:**

- Number of communities where needs assessments done and where findings have been reported to the participating communities
- Number of community actors trained to do needs assessments
- Strategies to address needs in place and endorsed by communities
- Completed baseline data that informs programming

**Service Delivery Area 2: Community actors: skills building for service delivery**

**Description:** The technical capacity of community actors must be built in order for them to develop and deliver effective community-based services where relevant. Trained community resource persons such as home based carers, religious leaders, traditional leaders, CBO workers, skilled and retired individuals, among others can help to ensure that communities are well-informed and supported in regard to access to services, referrals, follow-up, adherence to treatment regimes, food security, behaviour change, dealing with stigma, addressing violence against women, etc. This helps to increase uptake of services, enables better implementation and use of interventions for prevention and care, and can reduce problems caused by lack of follow up and negative social pressures. In essence, training community actors will assist in establishing and maintaining a clear interface between communities and the more formal health systems. A key component of this strategy is encouraging health systems personnel to participate in the training and “building on indigenous knowledge” sessions.

**Examples of activities:**

- Develop a plan for managing and building capacity of local human resources. This includes exploring incentives for locally trained personnel to remain in their communities
- Technical capacity building for health support roles such as treatment adherence, peer counselling, HIV counselling and testing, DOTS, malaria prevention, development of integrated programmes, monitoring and evaluation (M&E) etc.
- Development and implementation of referral and support networks and syst which uses local communities mechanisms to reinforce mutual support
- Peer education and community outreach programmes to support key populations at risk
- Advocacy and sensitisation programmes to counter stigma and negative cultural practices
- Training of local resource persons to deal with the psychosocial effects of the epidemics and poverty
- Capacity and skills building to enable personnel to work effectively, safely and ethically

**Sample indicators:**

- Referral and support networks in place and fully functional
- Number of community resource persons trained
- Number of sensitisation programmes run that deals with stigma and negative cultural practices
- Number of community persons involved in sensitisation and advocacy processes
- Number of key at-risk populations that have been reached through sensitisation and training programmes
- Number of trained psychosocial support resource persons that are offering this level of support to communities
- Number of home-based care programmes in the community or village that are active and functional

### Local community assets

An important emphasis is allowing communities to acknowledge and recognise that even though they are resource-poor, they have assets that can be used and mobilised in the response to the epidemics and other development challenges. Time and energy are assets, as are traditions and cultural practices, local leadership, religious practices and values, physical infrastructure, agricultural produce among others. All these can be harnessed alongside the more technical capacities such as home based care, prevention activities or engaging health actors. These local assets must be reinforced or leveraged by

*It is not sufficient to simply focus on how CSOs/FBOs sustain themselves and their interventions. It is necessary to agree and help ensure that communities have the capabilities, demand culture, partnerships, local leadership structures and leveraged assets to sustain their responses to the epidemics and other development challenges*

communities in the fight against the epidemics and furthermore, must become the basis for any capacity development interventions by the various organisations of civil society and FBOs. Communities through exposure to capacity development and support must be allowed to build on their indigenous knowledge and skills as they apply these to health care, advocacy, health promotion and literacy, health monitoring, home based and community based care, as well as the wider responses to the diseases and other priority development issues. These capabilities and interventions must also be responsive to the contextual realities facing communities such as shelter, education, food, income, social justice and equity challenges.

The specific SDA:

- ✓ SDA 3: Mapping of community assets and resources

#### **Service Delivery Area 3: Mapping of community assets and resources**

**Description:** Communities are often not aware of the assets they have at their disposal that can and should be used for their own development. These assets such as time, energy, local produce, local infrastructure, community norms and practices, etc must be leveraged so that communities take direct ownership of their own development. Using assets do not suggest that these communities not hold government accountable for what the latter is constitutionally obligated to do. On the contrary, meeting government and other funding sources halfway is important in that it secures both ownership and sustainability, and will serve to neutralise the sense of waiting or entitlement on the part of communities.

#### **Example of activities:**

- Conduct asset-based workshops that sensitises the community to their assets and how these assets can be leveraged
- Build capacity of local actors to conduct asset mapping and reporting
- Map the resources and assets of communities as the basis for leveraging support and development interventions
- Assist communities to develop strategies and programmes on leveraging their assets for their own development through training and awareness raising workshops

#### **Sample indicators:**

- Number of communities where assets have been mapped and where communities understand the leveraging power of their assets
- Number of communities that are effectively using their local assets for their own development
- Amount of funds leveraged by communities through the use of their own assets
- Evidence (stories) of how leveraging community assets have effected change at community

- |  |
|--|
| level <ul style="list-style-type: none"> <li>• Evidence that community resources other than money have been leveraged</li> </ul> |
|--|

### CSS and Health Systems Strengthening (HSS)

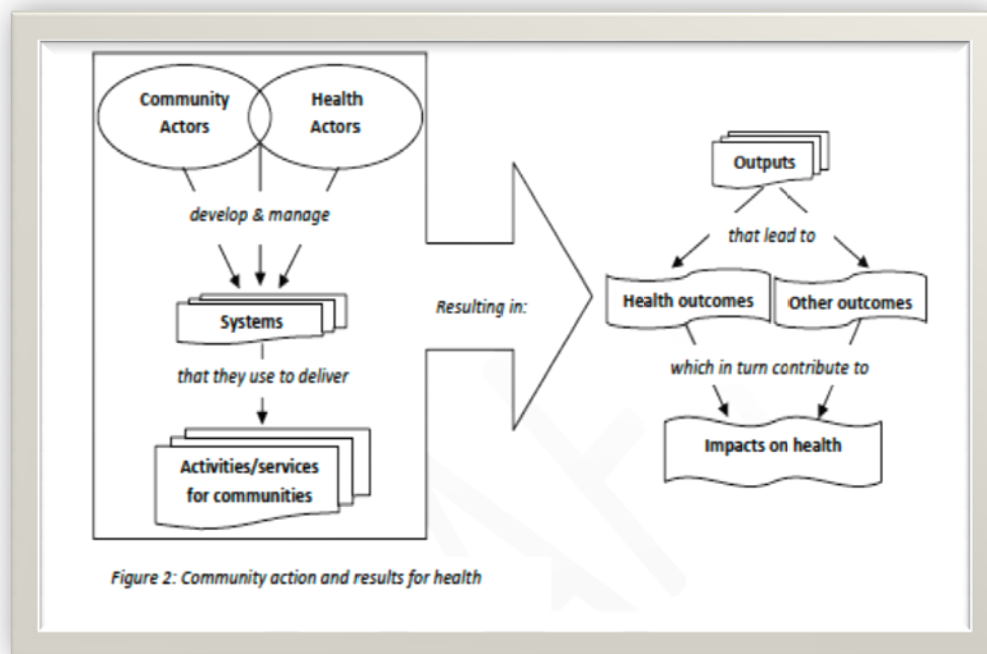
Community systems strengthening and HSS are indelibly linked with one unable to be effective without the other. The current challenge lies in the integration of the two systems. The intent of CSS is to achieve improved community capabilities and participation in the design, delivery and M&E of services and activities related to the prevention, treatment, care and support of people affected and infected by HIV, TB and Malaria. This can only be effective in the presence of operational and effective health systems. Such health systems include effective clinical services; an adequate and professional health work-force; access to essential pharmaceutical and health products as well as technologies; and efficient health information systems.

*Consistent advocacy and educational efforts are needed to ensure that communities and health systems personnel appreciate the fact that CSS and HSS are implicit within each other; and that one without the other generally amounts to an incomplete intervention*

The successful treatment and care of persons can be rendered more effective and sustained when communities act as enablers and are able to support households and groups in this respect. However, the more important challenge lies in the attitudes and work modalities in the formal health systems. It is possible in many instances health personnel may not see the value of community participation or communities being afforded the space to influence health services. Hence, the sensitisation of health personnel and the demonstration of the value of community partnerships is an important area of intervention.

The synergies required of CSS and HSS are best illustrated in the graphic below – figure 3<sup>6</sup>

Figure 3: Community Action and Results for Health



<sup>6</sup>Source: Draft Community Systems Strengthening Framework, January 2010



Relevant SDAs are the following:

- ✓ SDA 4: Integration of CSS with health systems
- ✓ SDA 5: Compendium of CSS interventions and best practices with reference to enabling health systems

#### **Service Delivery Area 4: Integration of CSS with health systems**

**Description:** Communities need to understand the relationship between health systems and community systems. These two systems are often described differently for ease of reference but in reality are inter-dependent. Thus, a purely clinical response to HIV and AIDS outside of community ownership and the recognition of communities' customs and organic processes is in fact incomplete, unsustainable arguably inappropriate. Communities must be able to influence the kinds of health services they most need, particularly in accessible locations. Such services should draw on local knowledge and local partnerships for better referrals and follow-ups.

#### **Example of activities:**

- Mapping of formal community health and social support services and their accessibility to community members
- Identification of populations most at risk and most in need of services that are accessing or not accessing services
- Identification of obstacles to accessing and using available health and other development services
- Development of integrated service delivery systems to address the range of health, social and related needs in communities
- Linking of community supported referral systems to the more formal service referral systems
- Identification, availability and ongoing use of national or other relevant guidelines for delivering quality services
- Planning for continuous improvement of quality services through mentoring, updating of skills and information and regular reviews of service availability, use and quality
- Developing a local monitoring and reporting system that tracks the responsiveness of health systems to community systems, accessibility and quality

#### **Sample indicators:**

- Number of communities that are meaningfully involved in planning and programming related to health systems in their localities
- Confirmed data available on vulnerable groups and the multi-sectoral services they need
- Evidence of an integrated service delivery system at community/villages levels
- Monitoring system of service quality, provision and consistency in place at the local levels
- Evidence of interconnections between the community and more formal systems of referral and follow up
- Improved access of people including vulnerable groups to health facilities and to medication

#### **Service Delivery Area 5: Compendium of CSS interventions and good practices with reference to enabling health systems**

**Description:** This SDA is more relevant to a national or regional organisation that is well placed to monitor, report and collate good practices and lessons learned of CSS interventions, approaches and programmes. Should a compilation is designed to bear witness to the criticality of meaningful community participation, involvement and self-determination in their own development challenges. It is important that communities or countries become inspired by the good practices demonstrated by others which highlight, qualitatively, the manner in which community driven and owned interventions are different to those that are imposed.

#### **Example of activities:**

- Compile best practice CSS case studies nationally or across the region where there are clear linkages with HSS
- Develop a compendium of the case studies and disseminate to all countries in the region

- Extract key lessons in CSS applications that will inform future program designs
- Compile key indicators used by countries that speak to the integration between CSS and HSS

**Sample indicators:**

- Regional CSS best practices compendium developed and disseminated to all countries in the region
- National and regional reports that take cognizance of the lessons learned in CSS and that are easily accessible
- Compendium of CSS indicators used in the region

**CASE STUDY 3:** The Namibia-based Positive Vibes works largely with self-help groups of PLHIV, their children, and other community-based HIV initiatives through networking, training, grants, mentoring and outreach. The organisation supports its partners within the sphere of Positive Health, Dignity and Prevention, an area where community members are making an indelible mark. In addition, Positive Vibes works with traditional and local leaders towards building an environment in which self-help groups can flourish. There is evidence that the organisation's approach has formed a "chain of action" that empowers socially active individuals and groups of PLHIV to "push back" stigma and discrimination in their own and neighbouring communities. In this way, a grassroots social movement involving PLHIV has emerged. In addition, new forms of communication have emerged between community-based self-help groups and government structures, particularly in the area of service delivery. Other notable successes are an increase in disclosure of status to sexual partners, an increase in safe sex practices and greater adherence to treatment. There has also been a great awareness of the dangers of multiple and concurrent partnerships. The 33 "Community Action Groups" established by the children meet regularly with the support and guidance of the trained community-based facilitators.

### Civil Society Ownership and Participation

Key to the success of community systems is communities with the confidence and resolve to more fully own processes that happen within their localities. Ownership and participation are key to community driven development facilitation. Participation involves communities informing prioritization, programming, monitoring and reporting as well as service provision. Participation also involves communities engaging with government and municipalities, health personnel and other key stakeholders, and having the confidence to hold government as well as CBOs/NGOs accountable for resources and services. However, communities are not homogenous and there are normally competing interests, tensions and conflicts that need to be mediated. There are also traditions and cultural practices that may hinder necessary interventions in the three epidemics and these must be addressed. Different affected populations may have different needs and considerations and while ownership and participation are the intent of CSS, this is not easily realized when considering the aforementioned. In addition to the required technical and organizational capacities Community-based organisations/FBOs and NGOs working at this level need to have conflict management and change management capacities.. In this way they are able to assist communities to address and resolve competing interests or interests driven by power blocs. These organisations also need to have the necessary profile and respect of communities to play such roles and themselves need to be accountable for any resources raised in the name of the community. Critical to all of the above is accountability; accountability of leadership structures within communities; accountability of the CBOs/FBOs and other service providers; and social accountability in the context of democratic governance.

According to the report 'UNDP Engagement with Civil Society'<sup>7</sup> "the concept of accountability is at the heart of democratic governance. It is also central to all

<sup>7</sup>Source: [http://www.undp.org/partners/civil\\_society/promoting\\_participatory\\_citizen\\_action.shtml](http://www.undp.org/partners/civil_society/promoting_participatory_citizen_action.shtml)

aspects of human development since it contributes to ensuring that the interests of the poorest, most marginalized, and hard to reach groups in society are taken into account. Social accountability emerges through actions by citizens and CSO aimed at holding the state to account, as well as efforts by government and other actors such as media, private sector and donors to support these actions. Social accountability provides extra sets of checks and balances on the state in the interests of the public and thus is a central tenet of the regional CSS framework.

Relevant SDAs are:

- ✓ SDA 6: Community networks and partnerships
- ✓ SDA 7: Social mobilisation
- ✓ SDA 8: Mediating competing interests and conflict at community levels

#### **Key Delivery Area 6: Community networks and partnerships**

**Description:** One of the key assets that communities possess is “social capital”, networks and partnerships that are internal as well as external to the community. Social capital within a community is fundamental to the success of development facilitation and health interventions and must therefore be well understood and appreciated by communities and by those who intervene from the outside.

#### **Example of activities:**

- Map the partnerships and networks the community has access to with an understanding of the added value and roles of each
- Formalise partnerships with key resources at district, regional and national levels based on their value offerings and comparative advantages
- Formalise partnerships within communities that bring together traditional and religious leadership, NGOs and CBOs, local municipality representation and organised social interest groups among others

#### **Sample indicators:**

- Communities where partnerships and networks are clearly mapped and understood
- Evidence of the value of partnerships and networks in helping to realise priority development interventions

#### **Key Delivery Area 7: Social mobilisation**

**Description:** In order to have a functioning community system, a range of people, groups and organisations need to be mobilised. The nature of such mobilisation will depend on the programme objectives and on thorough analysis of the local situation, including identifying and recruiting mobilisers, raising community awareness and engagement with the programme, and enlisting the support of key stakeholders.

#### **Example of activities:**

- Development and implementation of plans for community mobilisation that centre on key issues affecting community health and wellbeing
- Recruitment of mobilisers to work with communities
- Development of communication, participation and leadership skills for working with communities and individuals and representing their needs to other actors and services
- Developing plans to involve stakeholders to play roles in design, delivery and oversight of programmes or activities
- Community mobilization events to raise awareness and create an enabling environment for activities aimed at vulnerable populations
- Developing innovative approaches to communication such as cell phones, social networking etc
- Community mobilization on stigma & discrimination, basic rights, poverty reduction, access to services, information, commodities (e.g. condoms, medicines etc)

**Sample indicators:**

- Evidence of community mobilisation strategies and plans in place
- Number of community mobilisers trained and active in their communities
- Evidence of the creative use innovative approaches to communications at community levels

**Key Delivery Area 8: Mediating competing interests and conflict at community levels**

**Description:** As already noted in this guide, communities are not homogenous and reflect class, cultural, religious beliefs and practices, and other divisions with their own worldview, interests and needs. Yet these different groupings live in the same locality and are considered part of the community by standard definitions. Regarding allocation and distribution of resources and prioritisation of needs and interests within these groups, the clash between modernity and tradition, as epitomised within the generation gap, can result in tensions and conflict that threatens to compromise any development intervention and has in the past, proven to do so. To address the all-encompassing needs of a community may require mediation and conflict resolution interventions that must target win-win outcomes for communities. In the absence of this only certain groupings in the community may get resources or support at the expense of others. In addition, growing tensions will delay the much needed services that communities need and community leaders may act against each other.

**Example of activities:**

- Training of trainers workshops for community resource persons in mediation and conflict management skills
- Reduction in debilitating conflicts at community levels when it comes to development interventions and resources
- Availability of local materials in local languages that offer guidelines in mediation and resolution processes

**Sample indicators:**

- Number of training of trainer workshops
- Number of community resource persons trained and active in their communities
- Number of communities that demonstrate reduced conflicts
- Number of local materials available

### 3.2 CSO Capacity Development and Sustainability

Civil society organisations are considered the primary instruments through which the capacity of communities at the local village level is built with CBOs as the main conduits. Implicit within the current GF CSS framework is an emphasis on building the capabilities of CBOs, to secure core funding for their operations and project based funding for their programmes aimed at strengthening community systems. A strong emphasis is placed on the sustainability of these organisations. This regional framework advocates the strengthening of CBOs that function at the interface with communities that can be understood as the de facto resources sufficiently accessible to help build community systems. It must be stated that CBOs are not the only agents of change at the local level as other forms of organisation also exist. There is also a layer of organisations from grassroots to regional level and there are experiences that speak to the difficulties and frustrations related to technical assistance and organisational development. Reference is made to fragmentation of civil society and in particular, how organisations may undermine each other for the sake of self-sustenance.

#### Layers of CSOs

The CSO world is complex, with organisations competing for the same limited resources and operating within defined niche areas and constituencies. However,

anecdotal evidence suggests that the general quality and consistency of interventions by CSOs/FBOs relating to HIV, TB and Malaria at various levels remain questionable. Most CBOs/FBOs lack access to technical assistance and find it difficult to participate in capacity development processes that seem to be focused more in urban environments or at national levels.

Key partnerships are needed between CSOs/FBOs, donor agencies, the UN family among others. Such partnerships can assist in developing strategies aimed at improving technical assistance to CSOs/FBOs and that speak to the above findings. The challenges are compounded when considering the remote environments where many CBOs/FBOs operate and their under-developed organisational capabilities such as governance, management, financial systems, programming, M&E and reporting, among others. In addition there is also the challenge of sustaining the capabilities and the value offerings of the CBOs/FBOs and the extent to which they are able to build upon the strengths and local resources within the community in order to sustain their interventions.

The layers of CSOs include the CBO/FBO, the local, provincial level or national NGO, the international NGO (INGO) and the regional NGOs. All of these layers of organisations have their role and place and advocacy processes are needed to help ensure they work in tandem with each other.

Relevant SDAs:

- ✓ SDA 9: Regional CSOs supporting national and local actors in CSS interventions
- ✓ SDA 10: National NGO interventions
- ✓ SDA 11: International NGO interventions
- ✓ SDA 12: CBOs/FBOs interventions
- ✓ SDA 13: Advocacy
- ✓ SDA 14: Organisational strengthening and mentorship support
- ✓ SDA 15: Financial resources
- ✓ SDA 16: Monitoring and evaluation

**Service Delivery Area 9: Regional CSOs supporting national and local actors in CSS interventions**

**Description:** There is significant value to having regional organisations support country level interventions. Regional organisations have a bird's eye view of developments, good practices, lessons learned, technical assistance(TA)and resources across countries in the region and have the advantage of access to SADC, SADC Parliamentary Forum (PF) and other regional stakeholders. Regional organisations can combine their knowledge capital to offer higher quality resource materials, training and in-country support.

**Example of activities:**

- Compile, process and publish good practices and guides to assist national NGOs and CBOs/FBOs
- Manage a regional monitoring reporting tool on CSS in the region and through peer pressure and advocacy efforts, assist those countries struggling to achieve results
- Develop a series of guides on CSS (SDAs, indicators, activities, methodologies); on the integration of the three epidemics, on CSS relevant to the specific epidemics, and on integration with health systems
- Monitor the quality of TA offered at country level, highlight challenges that relate to accessibility to TA, advocate funding partners to consider funding innovative TA processes and form partnerships with the Technical Support Facility and other similar services
- Engage SADC and SADCPF in pressuring Member States (also National AIDS Council (NAC) Directors, Ministers of Health, etc) to create spaces for effective community participation in health and other development challenges

- Help to source and inform TA that is offered in helping countries complete GF proposals and proposals for bilateral funding partners
- Through the establishment of a formal multi-epidemics regional reference group, assist, in the capacity of a regional advisor countries with programming and integration for each of the epidemics
- Develop a learning system that can be applied at country and local levels to facilitate the sustainability and replicability of local action
- Research and help countries identify and use local philanthropy sources that can be leveraged for funds and help encourage social entrepreneurship ideas

**Sample indicators:**

- Regional guides in relevant languages distributed to and used by country stakeholders
- Number of monitoring reports of technical assistance in the region
- Functional and value adding multi-epidemics regional reference group
- Number of training processes in the region
- Number of country resource persons trained and supported
- Number of TA interventions at country
- Availability of research findings on philanthropy as a means of sustainability

**Service Delivery Area 10: National NGO interventions**

**Description:** In each country there is a proliferation of NGOs that offer direct services to target markets and/or organisational development and training to organisations and CBOs. Some of these national NGOs also act as intermediaries for donor funds aimed to assist in building smaller organisations (including CBOs) that are large in number or harder to reach. Many of these NGOs that function at the provincial and district levels are themselves in need of capacity development.

**Example of activities:**

- Champion for direct service delivery in strengthening community systems (prevention, managing home based care services, managing their own health facilities, monitoring services and other)
- Training, mentorship and support of CBOs/FBOs involved in CSS activities
- Monitoring, evaluation and reporting of results, challenges and opportunities related to CSS
- Situating national NGOs as a conduit of funding for CBOs/FBOs
- Involve social marketing, advocacy and lobby groups that take up community issues
- Involve national networks of organisations and support their members such PLHIV, AIDS service organisations, faith based networks and other
- Help to drive local philanthropic initiatives that provide alternative sources of funding for sustainability

**Sample indicators:**

- Number of training processes involving CBOs and NGO resource persons in CSS
- Amount of funds in USD raised and disbursed
- Number and type of philanthropic initiatives as sources of funding
- Number of CBOs/FBOs and other organisations successfully mentored and supported

**Service Delivery Area 11: International NGOs (INGOs) interventions**

**Description:** In each country there are international NGOs (INGOs) that are often seen as undermining local, indigenous organisations. In other cases they are criticised for being the trusted or preferred funding intermediaries for some donors over that of local NGOs. However, many of these INGOs offer good programming, interventions and services. Still, it is important to ensure they are constructive and empowering at the national and local levels in the context of what CSS tries to achieve.

**Example of activities:**

- Collaborate with INGOs working in the country to consolidate capacity development processes, resource materials and other
- Partner with local NGOs to build capacity and offer mentorship support that helps to sustain capabilities and service offerings

- Actively support local campaigns that fight for greater civil society participation in health systems and processes
- Make use of international linkages to bring good practices to the country but also to publish local good practices for global consumption

**Sample indicators:**

- Number of INGOs that successfully collaborate with each other and with local organisations
- Number of capacity development programmes managed by INGOs and targeting local organisations
- The number of local campaigns that successfully allow increased participation by civil society
- Number of functional and meaningful partnerships between INGOs and local organisations

**Service Delivery Area 12: Community Based Organisations (CBOs) interventions**

**Description:** In most countries there are thousands of CBOs/FBOs vying for resources and capacity development support. Community-based organisations/FBOs are important organisational forms that work at the interface with communities. They are accessible and represent the frontline service delivery hope of communities that are marginalised from resources and support. Often CBOs/FBOs are the most trusted and consistent agents of change for communities although they are not the sole agents of change. In light of their key roles, CBOs/FBOs must have the capacity and resources to maintain their frontline service delivery to communities, assist communities leverage their assets and partnerships, and engage outside resource agents.

**Example of activities:**

- Argue for effective service delivery at the village level
- Training and capacity building of community groupings, local leadership and service providers. This includes building on local traditional systems and indigenous knowledge, encouraging a demand culture and confidence to engage government, advocacy strategies, service delivery programming and monitoring and other)
- Local monitoring and reporting
- Facilitation of partnerships and alliances between communities and services
- Advocacy support to communities wanting to claim spaces for their own participation and influence, that essentially results in them fighting for an enabling environment
- Support in the design and management of integrated programmes at grassroots levels that involve not only the three epidemics but also other development challenges
- Helping to manage the interface with government and health personnel
- Community mobilization on stigma & discrimination, basic rights, poverty reduction, access to services, information, commodities (e.g. condoms, medicines etc)among others
- Facilitate learning to make local action more effective, sustainable and replicable
- Actively advocate asset-based community development approaches and encourage local giving

**Sample indicators:**

- Number and quality of services delivered at the local levels
- Number of community resource persons trained and supported
- Evidence of community participation in and influence of health systems programmes and processes
- Evidence of increased access to services by community
- Increased number of services offered at community level
- Community understanding of the integration between HIV and other development issues

**Service Delivery Area 13: Advocacy**

**Description:** This SDA focuses on the capacity and skills needed for community actors to engage a range of stakeholders including target groups, local government decision makers, and the community in general where appropriate. Community actors need skills for effective communication and advocacy in order to achieve this, ensuring that programmes benefit from community inputs and communities are able to gain the maximum benefit from services and activities.



**Example of activities:**

- Mapping communication needs and planning strategies for interventions with policy and decision makers
- Developing relationships with key partners for resource mobilisation
- Mobilisation of funding
- Training of community actors and stakeholders in policy and advocacy work
- Training in implementation of local advocacy initiatives
- Stakeholder workshops for training in policy development
- Capacity building for communication through various media such as radio, television and print

**Sample indicators:**

- Number of community resource persons trained in advocacy and policy work
- Number of local advocacy initiatives at local levels
- Evidence of media such as radio, TV and print airing community advocacy issues

**Service Delivery Area 14: Organisational strengthening and mentorship support**

**Description:** Resources and technical support may be needed to build the capacity of organizations to support delivery of the proposed range and quality of activities and services. This includes capacity for long term strategic planning, management, sustainability, scaling-up and responding to change through development of organizational systems and the capacity for strategic planning, M&E, and information management.

**Example of activities:**

- Training & mentoring in leadership, organizational development & management, and accountability
- Regularisation of legal status and authority to enter into agreements such as opening bank accounts, building leases and purchasing property among others
- Training in programme management and information management.
- Developing capacity for project design and strategic planning, project cycle management
- Developing capacity and plans for human resource recruitment and management including technical support systems and organisational needs

**Sample indicators:**

- Number and quality of organisational development processes aimed at local organisations
- Number of organisational representatives trained in programme management and information management
- Number of local organisations with legal persona
- Number of local leaders mentored and supported

**Service Delivery Area 15: Financial resources**

**Description:** Support will be provided for better allocation and management of financial resources. This support is required to enable actors to plan for and achieve predictability of financial resources for start-up, implementation, scale-up and longer-term sustainability of community interventions. In short community actors will be assisted to work successfully towards improved outcomes and impacts.

**Example of activities:**

- Planning of funding needs based on organizational development and informed by needs identified by members and supporters
- Physical infrastructure development, including obtaining and retaining office space, holding bank accounts, and improving communications technology
- Capacity strengthening for resource mobilization
- Capacity building on oversight of resources and budgets

- Capacity building for financial management and book - keeping and reporting
- Design and implementation of internal accountability systems
- Proposal writing, accounting for and planning activities
- Development and management of small grant schemes for community actors, including core support such as cash transfers for vulnerable people
- Development and management of schemes for remunerating community outreach workers and volunteers

**Sample indicators:**

- Number of local organisations with proper financial systems and infrastructure
- Number of local organisations trained and supported regarding resource mobilisation
- Amount of funds in USD raised as a result of support received
- Number of functional and active small grants schemes
- Number of outreach workers and volunteers that get paid

**Key Delivery Area 16: Monitoring and evaluation**

**Description:** Monitoring and evaluation is an important part of this process, and should be integrated from the beginning in the development of a project or programme, based on the objectives and intended outcomes. Community actors often face challenges in dealing with the varied M&E requirements of funders and national bodies, and in reconciling them with the information most needed at local level. Community actors may therefore need capacity building and support to develop workable M&E plans suitable for their context and funding environments. Capacity for evidence building and research are needed by community actors in order for them to understand how research can be conducted at community level and how its results can be interpreted. In addition, they need to be capacitated to use existing evidence, help gather new evidence and engage with findings relevant to the community. Direct participation of community actors in developing and implementing research projects will help to ensure relevance, build community skills and ensure community ownership of the results.

**Example of activities:**

- Training in M&E, and information management
- Developing and implementing information and knowledge management systems
- Developing capacity in design and implementation of data collection activities.
- Developing and implementing M&E plans
- Developing documentation, reporting and dissemination skills
- Developing analytical skills for extracting key information and lessons learned from data
- Capacity building on evidence - based programming,
- Capacity building on participating in and understanding research affecting communities, and putting relevant research findings into practice
- Implementation and monitoring of policies that affect access to health and welfare services

**Sample indicators:**

- Number of resource persons trained and mentored in M&E
- Number of functional M&E plans in place
- Improvement in monitoring the consistency and quality of reports and data analysis
- Number of research processes undertaken where findings are reported back to communities
- Number of programmes directly informed by evidence

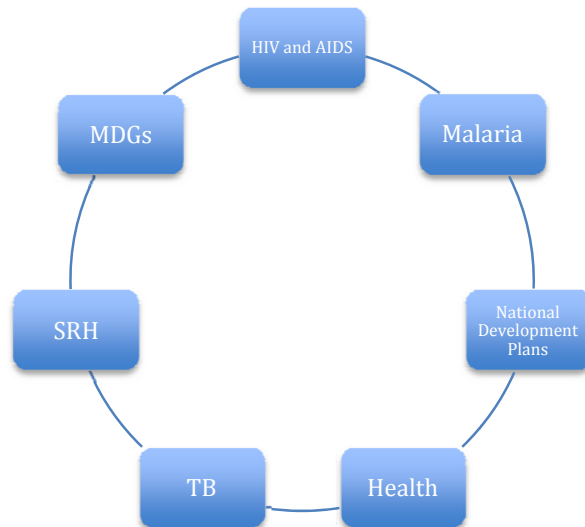
### 3.3 Integration Agenda - of HIV, TB and Malaria with the National Development Frameworks

The three epidemics are equally devastating and there is sufficient evidence to suggest they are inter-related. However, the integration agenda is complex and includes the integration of the following:

- ✓ TB and Malaria with HIV and AIDS
- ✓ Sexual and Reproductive Health (SRH) and HIV
- ✓ HIV and AIDS in the broader health context
- ✓ HIV and AIDS in the context of the MDGs
- ✓ HIV, TB and Malaria in national development plans
- ✓ Country level development plans in the context of regional development frameworks

Tuberculosis is the leading cause of death among individuals with AIDS in Africa and in the region. The prevalence of HIV infection among patients in TB clinical settings is extremely high. In addition, the emergence of multi-drug-resistant (MDR) and extensively drug-resistant (XDR) TB creates additional challenges in expanding HIV care and treatment. Given the overlap in patient populations and the susceptibility of people living with HIV (PLHIV) to TB infection, there is clear need to reduce the burden through provision of routine screening, diagnosis, treatment and prevention of TB among PLHIV. In a similar vein, there is need to ensure that families impacted by HIV are able to access Malaria prevention and treatment. The prevention of Malaria is achieved through providing long lasting insecticide nets and treatment that is highly effective at a limited cost. However, progress is still lacking in many countries in the region in this regard. There are key health system challenges and it is clear the role of communities is critical when dealing with the integration between the three epidemics and other development domains as depicted in figure 4.

Figure 4: Integration of three epidemics and other development domains



However, the integration agenda extends beyond HIV, Malaria and TB as each country has its own national development plan. Also, the successful meeting of the MDG goals is based on the effective and meaningful integration of the eight goal areas.

Much work is needed for CSOs to develop interventions and indicators that speak to the integration agenda at community level. This is based on the imperative that communities need to understand integration as part of a coherent response rather than viewing the epidemics in isolation of each other.

Relevant SDA:

- ✓ SDA 17: Communication and education for prevention, treatment and care
- ✓ SDA 18: Integration of the three epidemics with the national development framework

#### **Service Delivery Area 17: Communication and education for prevention, treatment and care**

**Description:** The role of community actors in this area is important for extending the reach, credibility and effectiveness of health promotion and disease prevention initiatives such as behaviour change communication. It is also important for educating communities and removing myths and misinformation concerning causes of disease, and treatment and care. Funding and technical skills building are needed to make better use of this resource for health. Community actors are uniquely equipped to relate to community members and communicate in terms that are readily understood.

#### **Example of activities:**

- Developing and implementing plans for improved community education and responsiveness to health - related issues such as treatment literacy, SRH rights, use of preventive materials etc.
- Developing communication materials for specific audiences e.g. children, women, sexual minorities etc.
- Recruiting and training community support workers to provide grass - roots education, prevention ,treatment and care; and factors affecting health such as nutrition, social issues, stigma etc;
- Providing education to individuals and community groups on prevention, treatment and care, and on associated factors such as nutrition, poverty alleviation, stigma etc

#### **Sample indicators:**

- Number of local communities exposed to health, development and rights education
- Number of materials developed and distributed at local community levels

#### **Service Delivery Area 18: Integration of the three epidemics with the national development framework**

**Description:** Specific education and awareness raising processes are needed for communities to understand and appreciate the interconnection between development themes and processes. This includes understanding HIV and AIDS in the context of the broader integration agenda where the three epidemics for example, are linked and where there are clear linkages between poverty, health education and all the other development challenges.

#### **Example of activities:**

- Educate and provide information aimed at local communities about the three epidemics and how they impact on each other
- Reinforce community participation in helping to develop practical models of involvement in TB care and prevention that should include, for example encouraging self referral of people with symptoms, ensuring proper care and encouraging adherence to treatment among others
- Build community capacity to mobilize people with Malaria symptoms to access health services, provide care that complements government services, and in particular, help to reach marginalized or hard-to-reach communities
- Support partnership building of key resource actors in the three epidemics and the consolidation of community level actions that address the integration of the three epidemics
- Participate in monitoring processes of all three epidemics and advocate for one monitoring and reporting system

- Target locally appropriate behavior change communications aimed at all three epidemics
- Advocate health systems to offer a coherent clinical response to all three epidemics at the same service points
- Support the development and growth of community health services such as home-based care, TB-DOTS etc
- Distribute nutrition, housing, water, sanitation and other material support to vulnerable children and adults
- Design livelihood support programmes such as microcredit or savings schemes, training schemes for unemployed adults and youth and for growing food to support families
- Support for civil rights and access to services such as civil registration of births and deaths
- Encouraging community awareness on gender, sexual orientation, disability, drug dependency, child protection, harmful socio-cultural practices etc;

**Sample indicators:**

- Number of communities that show a clear understanding of the integration of HIV and AIDS with other development frameworks and challenges
- Monitoring mechanisms in place for communities that consolidate data reporting of the three epidemics
- Extent of community involvement and participation in prevention and care processes
- Number of people with malaria and TB symptoms that access available services
- Evidence of increased community awareness regarding gender and HIV

### 3.4 Philanthropy and Social Entrepreneurship

Philanthropy is the act of giving; this could be in the form of money, property, services, and time among others. Social entrepreneurs are individuals with innovative solutions to society's most pressing social problems. By nature social entrepreneurs are ambitious and persistent, tackling major social issues and offering new ideas for wide-scale change. Rather than leaving societal needs to the government or business sectors, social entrepreneurs highlight what is not working and attempt to solve the problem by changing the system, spreading the solution, and persuading entire communities to embrace this solution.

The focus specific to philanthropy and social entrepreneurship in this framework is about local giving and local creativity to help communities address and sustain their responses to the epidemics and general development challenges. In Southern Africa, there is significant dependence on foreign donor aid; yet communities have assets that can be leveraged. The corporate sector needs to be encouraged to invest through their corporate social investment programmes, workplace programmes and others. Similarly governments need to be lobbied to increase allocations from the national fiscus for community processes aimed at responding to the epidemics. In most countries there are private foundations, estates of deceased persons and community foundations that can be canvassed to help with sustained funding. The emphasis on sustainability through GF funding is dangerous as the GF cannot guarantee predictable funding and development partners in general, are reducing their funding allocations to Africa. The GF itself has reported deficits in its funding and Southern Africa as region, more now than ever, needs to look within for resources to address its development challenges.

*An excellent example of local giving is when a mother in a rural village takes over the running of five households as part of her home based care offering - of her own accord and with no outside help. She has leveraged her own local assets and developed a solution in how best to run six households (including her own). There are many examples of these remarkable women in the region.*

In the context of the CSS, it is incumbent on all actors to explore more local means of accessing funding and to encourage asset-based community development that helps to reduce community dependence on government and donors. However, this reduced dependence must not negate the process of communities holding government accountable for what needs to be delivered through their public sector systems. Communities need guidance and capacity to make maximum use of their local assets in their response to the epidemics and other development challenges. They also need to leverage financial support from the various sources mentioned based on their resolve to share the cost burden.

Relevant SDA:

- ✓ SDA 19: Reinforcing philanthropy and social entrepreneurship at the community level

**Service Delivery Area 19: Reinforcing philanthropy and social entrepreneurship at the community level**

**Description:** There is a range of funding and non-financial resources that can be accessed in-country and at the local levels. The reality is that funds are in decline and the years of dependence on donors in the region has seriously limited the ability and resolve of local organizations to seek alternative and in-country funding sources for their programmes. The non-financial resources refer to time of people (working as volunteers), of retired skilled resources and other that need to be more strategically used. Local giving by communities and by national resources must be encouraged and government (national and local levels) must be consistently advocated to increase financial allocations to community level development.

**Example of activities:**

- Find partnerships and alliances (starting at the regional level) with resources that are engaged in asset-based community development and philanthropy in Africa (example: Global Fund for Community Foundations)
- Build capacity in these areas from regional levels down to the local levels of key actors that can capacitate and support communities to unlock local philanthropic initiatives
- Build a regional and national advocacy campaign for donors to invest in the development of philanthropy at country level including the means to research the scale and scope of giving in each country and possibilities for local giving
- Publish good practices of communities where they have used their own assets and resources in the response to the three epidemics
- Develop a regional resource repository on philanthropy in and for Africa as well as for social entrepreneurship

**Sample indicators:**

- Amount of resources in USD raised and sourced from local levels
- Number of communities exposed to workshops reinforcing and examples of local giving
- Regional and national advocacy campaign in place
- Number of donors that invest in unlocking local philanthropy as a means to help ensure sustainability
- Good practices documentation that is available and used
- Regional philanthropy repository in place and utilised by country stakeholders

## Annexure 1: Reference Material

Abdefadil L, Fakoya A, Public Service Review: International Development #15, September 2009	Home is where the care is. The role of communities in delivering HIV treatment care and support; <a href="http://www.publicservice.co.uk/pub_contents.asp?id=401&amp;publication=InternationalDevelopment&amp;content=3850&amp;content_name=Health">http://www.publicservice.co.uk/pub_contents.asp?id=401&amp;publication=InternationalDevelopment&amp;content=3850&amp;content_name=Health</a>
Abuja Declaration and Plan of Action	<a href="http://www.rollbackmalaria.org/docs/abuja_declaration_final.htm">http://www.rollbackmalaria.org/docs/abuja_declaration_final.htm</a>
Brook K Baker, ICASO 2007	Increasing Civil Society Impact on the Global Fund to Fight AIDS, Tuberculosis and Malaria: Strategic Options and Deliberations; <a href="http://www.icaso.org/resources/CS_Report_Policy_Paper_Jan_07.pdf">http://www.icaso.org/resources/CS_Report_Policy_Paper_Jan_07.pdf</a>
CADRE 2007	Models for Funding and Coordinating Community Level Responses to HIV/AIDS; <a href="http://www.cadre.org.za/node/198">http://www.cadre.org.za/node/198</a>
Civil Society Action Team (CSAT)	<a href="http://www.icaso.org/csats.html">http://www.icaso.org/csats.html</a>
Civil Society Support and Treatment Access; Fakoya A, Abdefadil L, Public Service Review: International Development #14, June 2009	<a href="http://www.publicservice.co.uk/article.asp?publication=InternationalDevelopment&amp;id=391&amp;content_name=Treatmentaccess&amp;article=12197">http://www.publicservice.co.uk/article.asp?publication=InternationalDevelopment&amp;id=391&amp;content_name=Treatmentaccess&amp;article=12197</a>
Global Fund, May 2010	Draft Community Systems Strengthening Framework
International Treatment Preparedness Coalition, October 2008	CCM Advocacy report: Making Global Fund Country Coordinating Mechanisms work through full engagement of civil society
Michael Edwards, February 2009	The challenges of civil society in Africa", a lecture delivered in Dakar, Senegal <a href="https://docs.google.com/viewer?url=http://www.trustafrica.org/documents/The_Challenges_of_Civil_Society_in_Africa.pdf">https://docs.google.com/viewer?url=http://www.trustafrica.org/documents/The_Challenges_of_Civil_Society_in_Africa.pdf</a>
The Global Fund Information Notes Fact Sheets:	Community Systems Strengthening Information Note: <a href="http://www.theglobalfund.org/documents/rounds/10/R10_Infonote_CSS_en.pdf">http://www.theglobalfund.org/documents/rounds/10/R10_Infonote_CSS_en.pdf</a>
The International HIV and AIDS Alliance	Civil Society Success of the Ground – Community Systems Strengthening and Dual track financing: Nine Illustrative case studies
UNAIDS, 2009	Supporting Community based responses to AIDS: A guidance tool for including community systems strengthening in Global Fund Proposals, Geneva, Switzerland
UNDP, 2005	Community Capacity enhancement handbook
WHO Malaria website	<a href="http://www.who.int/topics/malaria/en/">http://www.who.int/topics/malaria/en/</a>
WHO TB website	<a href="http://www.who.int/tb/topics/en/">http://www.who.int/tb/topics/en/</a>
Yelula /U-Khâi, 2007 - 2010	Helping Communities help themselves – an alliance in support of organic responses to HIV and AIDS