Community Systems Strengthening and Key Populations

A POLICY DISCUSSION PAPER

THE GLOBAL FORUM ON MSM & HIV (MSMGF)

Community Systems Strengthening and Key Populations

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Executive Summary

The Global Fund to Fight AIDS, Tuberculosis and Malaria is one of the most influential sources of international funding for its 3 target diseases. It has sought to prioritize programming with populations most affected by these diseases, and to ensure the involvement of these populations in program development, implementation, and monitoring - in particular by supporting community systems strengthening (CSS). Although CSS has helped improve the scale and quality of programs with men who have sex with men (MSM) and other key populations, there are technical weaknesses in the approach to CSS taken by the Global Fund and the broader global AIDS field, as well as political challenges to its uptake. These challenges include:

- **The ambiguities that exist in relation to CSS.** These ambiguities lead to different expectations from different actors of what can be achieved using CSS.
- **The limited range of tools and methods available to assess the role of community systems.** There is still no clear vision of how individual organizations operate collectively as community systems and how they relate to health systems, making it difficult for CSS advocates to make a clear case to governments and donors for the need for CSS.
- **Continued skepticism and in some cases hostility to programming with key populations.** Although CSS has significant potential to help resolve the particular challenges faced by key populations in the context of HIV and AIDS, there are many factors outside of the sphere of influence of CSS that also need to be addressed.

This paper proposes recommendations related to the future of CSS, outlining the roles of key population groups in taking these recommendations forward. Recommendations include:

- Provide input into the CSS modules in the Global Fund's New Funding Model frameworks.
- Conduct a detailed revision of the CSS monitoring and evaluation framework.
- Develop, test, and establish tools for assessing the role of community systems in a given country or context.
- Broaden CSS from its current position as a primarily Global Fund–focused initiative.

- Further clarify the meaning and role of community systems and, following that, of community systems *strengthening*.
- Develop a research agenda on CSS.
- Identify funding mechanisms that can support the neglected aspects of CSS.
- Ensure CSS is promoted at country level.

This paper also makes recommendations for key population advocacy on issues other than CSS:

- Continue to use all Global Fund policies and approaches aimed at improving programming for key populations, not just those explicitly related to CSS.
- Advocate for improved key population programming irrespective of the implementing sector.
- Prepare for and use the opportunities presented by the New Funding Model, and anticipate the challenges.
- Broaden and strengthen the movement for effective, evidence-based key population programming.

About This Paper

In 2009 the Global Fund to Fight AIDS, Tuberculosis and Malaria introduced the concept of community systems strengthening (CSS) to its funding model. While the participation of community groups and civil society organizations had always featured in the Global Fund's approach to governance, program design, and implementation, CSS took this a step further by encouraging applicant countries to budget and plan for interventions specifically aimed at building community mobilization, community-led service delivery, and strengthening accountability. The adoption of the CSS approach implied that community action should be strengthened in a systematic way in order to increase the scale and impact of responses to AIDS, tuberculosis, and malaria.

A CSS framework, first published in 2009, outlines the Global Fund's approach to CSS and the key related interventions, drawing inspiration from the building blocks of the Health Systems Strengthening (HSS) framework of the WHO. The framework was designed to indicate the types of CSS interventions that the Global Fund is prepared to invest in, and to enable community actors and civil society organizations to more clearly articulate and design their programs and funding requests. It made particular reference to the needs of key populations affected by HIV and AIDS, who remain largely underserved by HIV programs across the world. Civil society groups, particularly those emanating from or representing key populations, saw CSS as an opportunity to frame and strengthen their efforts in the response to AIDS, tuberculosis, and malaria and to redress the balance of programming toward the most neglected groups.

In 2013 the Global Fund rolled out a New Funding Model, with the aim of improving grant quality and management and increasing the overall impact of investments. CSS remains a feature of the model, based on the existing framework, although the changes in the application process mean there are likely to be some shifts in how CSS is approached.

As the Global Fund, and indeed the global response to AIDS, enters a new era, the Global Forum on MSM and HIV (MSMGF) offers this paper as a basis for further discussions on the relevance of CSS, and the opportunities CSS funding may offer for MSM, sex workers, transgender individuals, and people who use drugs under the Global Fund's New Funding Model. The paper also discusses the limits of CSS in relation to the challenges faced by these key populations in the context of the current global response to AIDS.

Background: Key Populations, HIV, and the Global Fund

Key Populations and HIV

Since AIDS was first identified, it has become widespread in the general population of many countries, making it a truly global pandemic. However, certain groups—gay men and other MSM, transgender people, sex workers, and people who use drugs—have been by far the most affected. This has long been acknowledged in countries with very low levels of HIV prevalence in the general population. More recently, epidemiological studies have shown that even in countries where HIV is generalized or hyperendemic, HIV prevalence is several times higher in these groups than it is in the general population.[1,2,3]

Irrespective of whether national AIDS strategies acknowledge these realities, the majority of national responses to AIDS have not worked effectively with key populations—and in large part this has contributed to the continued vulnerability of these key populations to the epidemic. The global response to HIV and AIDS, unprecedented in its scale and achievements, has failed key populations in a number of ways:

- **Effective programs have been too limited in scale**. There are many examples of good quality, effective programming with key populations but they tend to be isolated and rarely reach enough people to have an impact at the national level.
- **Programs have been limited in scope**. Despite evidence that programs must take a comprehensive, community-based approach to be effective, programs are too often focused on a limited number of interventions such as information, condom distribution, and HIV testing.
- **Programs have been harmful or ineffective**. In some countries harmful, prohibitionist, or coercive approaches have been adopted in the context of key populations—particularly when they are criminalized or persecuted.
- **Programs have been nonexistent**. Denial of the existence of key populations continues to be common in many countries. This denial is often compounded and justified by the lack of good quality epidemiological data about these populations.
- **Decision-makers claim that mainstream health services are accessible to key populations and that specific programs are not required**. Although improving access to mainstream services is an important objective, such services rarely cater to the special requirements of key populations. Marginalization, stigma, and discrimination mean that key populations are less likely to know about services and may not be willing to go to them.
- **Insufficient resources have been allocated to programs for key populations**. Recent studies indicate that there has been little improvement over time, whether or not national strategies call for a prioritization of key population programming.[4]

Punitive legal frameworks, as well as prejudiced political and social attitudes, are at the heart of the failure of the global AIDS response to work effectively with key populations. Even in contexts where national AIDS programs favor a progressive approach, they may not be able to influence national political frameworks. As a recent report by Human Rights Watch on HIV programs with

1 Baral S, et al. Elevated risk for HIV infection among men who have sex with men in low- and middle-income Countries 2000–2006: A systematic review. *PLoS Med.* 2007;4(12).

2 Baral S, et al. Burden of HIV among female sex workers in low-income and middle-income countries: A systematic review and meta-analysis. *Lancet Infectious Diseases.* 2012;12(7).

3 Baral S, et al. Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. *Lancet Infectious Diseases.* 2013;13(3); Dutta, et al. The Global HIV Epidemics among People Who Inject Drugs, The World Bank, Washington DC. 2013.

4 Avdeeva O, et al. The Global Fund's resource allocation decisions for HIV programmes: Addressing those in need. *Journal of the International AIDS Society.* 2011;14(51); amFAR and Johns Hopkins Bloomberg School of Public Health. *Achieving an AIDS-free generation for gay men and other MSM in southern Africa.* 2013.

sexual minorities in Tanzania states, "While Tanzanian HIV policy calls for efforts to reduce stigma against at-risk groups, the daily violations and humiliation by state agents render that commitment ineffective. The government's HIV policy cannot succeed if government employees are further marginalizing the very targets of public health programs."[5]

These failures and challenges are of a technical as well as a political nature. Considerable effort is required to address these issues from both angles, and the continued inaction on the part of many decision makers means that aid donors such as the Global Fund have an important role to play.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Founded in 2002, the Global Fund was designed to scale up the global responses to its 3 target diseases. It has approved over $23 billion of funding to programs in 151 countries, with more than half being allocated to programs for HIV and AIDS. From its inception, the Global Fund has placed a strong emphasis on the role of affected communities. The Global Fund's Board is constituted of members representing donor countries, recipient country governments, private and nongovernmental organizations, and communities affected by the diseases. A similar principle is applied to grant giving, with a requirement that applicant countries constitute a country coordinating mechanism (CCM), with members democratically and transparently selected, and with clear conflict of interest policies.

The Global Fund has also been willing to adapt its policies and procedures in order to improve its performance. This includes introducing policies and mechanisms aimed at resolving the challenges associated with working through weak national health systems, the difficulties faced in scaling up programs with key populations, and the lack of attention to high-impact and cost-effective approaches. These include:

- Efforts to strengthen the criteria for **CCM membership** to ensure adequate representation of community organizations and key populations.
- Recommending that applicant countries use **dual-track financing** whereby grants are implemented by organizations from both government and non-governmental sectors.
- The introduction of **stricter criteria for funding** related to epidemic burden and country income status, with higher income and lower disease burden countries incentivized to work with neglected communities, including key populations.
- The introduction in funding Round 10 of a **MARPs channel** dedicated entirely to programs targeting most-at-risk populations (MARPs).
- Development of policies and guidance on comprehensive, evidence-based programming related to **gender**, **sexual orientation, and gender identity**; **harm reduction for people who use drugs;** and **human rights.**[6]

5 Human Rights Watch, "*Treat Us Like Human Beings". Discrimination against Sex Workers, Sexual and Gender Minorities, and People Who Use Drugs in Tanzania*. 2013.

6 Available at http://www.theglobalfund.org/en/accesstofunding/notes/ and http://www.theglobalfund.org/en/civilsociety/reports/

- The introduction of **community systems strengthening** and the creation of a CSS framework to "develop the roles of key affected populations and communities, community organizations and networks, and public- or private-sector actors that work in partnership with civil society at the community level, in the design, delivery, monitoring and evaluation of services and activities aimed at improving health."[7]
- Funding in certain circumstances of **non-CCM** or **regional grants**, including grants for programs targeting key populations that have been neglected in national grant applications.
- The development of a **New Funding Model** (NFM) in 2012, "designed to enable strategic investment for maximum impact."[8] The revision of the funding model was motivated by the increasingly constrained funding environment and by the recognition that applicants have not selected the highest impact and most cost-effective interventions.

  Implicit in the NFM's emphasis on "strategic investment" is the need to ensure that programs reach the populations most affected by AIDS, tuberculosis, and malaria. The NFM's adherence to the UNAIDS Strategic Investment Framework also implies a shift toward expanded programming with key populations in the context of HIV (1 of the 6 basic program activities of the Investment Framework) and a commitment to supporting community-based service delivery, community mobilization, and human rights, all of which are recognized as "critical enablers" of effective programs for HIV and AIDS.[9]

  A new pilot initiative that was recently launched provides additional funding to CCMs to increase the participation of people living with or affected by the three diseases and key populations, including MSM, in the country dialogue and concept note development process. The pilot initiative is being tested in 10 countries throughout 2013. Other important features of the NFM include the emphasis on basing funding on epidemiological and programmatic data and analysis, and the requirement that applications are based on a broad consultative process that is inclusive of key population groups.

CSS Framework "Building Blocks"

1. Enabling environments and advocacy
2. Community networks, linkages, partnerships, and coordination
3. Resources and capacity building
4. Community activities and service delivery
5. Organizational and leadership strengthening
6. Monitoring & evaluation and planning

In principle, the Global Fund has always been committed to ensuring that effective, comprehensive programs reach key populations, but performance in this area remains unsatisfactory. Although the NFM attempts to rectify this, key population organizations are concerned that these challenges will persist due to the poor quality of existing data on key populations and the history of national decision makers finding ways of excluding marginalized voices without losing their eligibility for funding.

7 Available at http://www.theglobalfund.org/documents/civil_society/CivilSociety_CommunitySystemsStrengthening_Framework_en/; see also http://www.theglobalfund.org/en/civilsociety/reports/ for further documentation.

8 Information available at http://www.theglobalfund.org/en/activities/fundingmodel/

9 Available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60702-2/abstract

Community Systems Strengthening and the Global Fund

The Origins of Community Systems Strengthening

As the previous section explains, communities and civil society played a central role in the creation of the Global Fund. Although the founding documents and procedures of the Global Fund prioritized community involvement in governance and implementation of grants, the concept of Community Systems Strengthening (CSS) was only introduced in 2007. At that stage the Global Fund issued information notes advising applicants how to include CSS in their proposals.

In 2009 the Global Fund published a CSS framework, developed in close collaboration with civil society organizations. The framework provided a clearer structure for applicants seeking CSS funding, providing 6 building blocks (see box on page 6), each composed of a number of service delivery areas (SDAs) and interventions and complemented by a set of indicators designed to ensure adequate monitoring and evaluation of CSS investments. The framework was updated from its original version in 2011.[10]

As the CSS framework was introduced, partners such as UNAIDS and Roll Back Malaria published guidance on how to use the framework in funding applications.[11] However, there is no global reference organization or "technical partner" leading CSS at a global level. As a result much of the technical leadership on the development of CSS has come from the Global Fund itself. This stands in contrast with the Global Fund's work on HSS, for which the Global Fund has been able to rely on UNAIDS, Stop-TB, Roll Back Malaria, the WHO, and other technical partners for technical and political leadership on AIDS, tuberculosis, malaria.

The emergence of CSS was to some extent a response to the Global Fund's increasing recognition of the need to combine funding for disease-specific interventions with a more generalized approach to HSS. While this orientation was valuable, it was recognized that HSS efforts typically tend to focus on health care infrastructures, personnel, and facilities; rarely do they address contributions outside of those confines or the myriad entities that influence the social and economic determinants of health. CSS recognizes these broader factors, and it emphasizes efforts to mobilize communities; to increase accountability of governments, donors, and health programs; and to strengthen community advocacy, particularly for marginalized populations. Like dual-track financing, CSS is encouraging for the community sector in general - and key population groups in particular - because it raises the possibility of channeling funds directly to the community sector to support its infrastructure, staff, and agencies that governmental organizations are not always willing to endorse.

The introduction of CSS represented a major conceptual shift. Although the importance of strengthening community engagement and action has long been recognized, this was possibly the first time community action was described as a "system" that could be defined and strengthened in much the same way as health systems can. However, despite the appeal of supporting community action in a systematic way, the breadth and diversity of the community and civil society sector proved challenging. Unlike the health sector, community groups do not constitute a clearly defined or hierarchical system, and indeed different entities within the community and civil society sector often have different and sometimes opposed priorities.

10 PDF available at http://www.theglobalfund.org/documents/civil_society/CivilSociety_CommunitySystemsStrengthening_Framework_en/

11 PDF available at http://www.unaids.org/en/media/unaids/contentassets/documents/programmes/programmeeffectivenessandcountrysupportdepartment/gfresourcekit/20110920_JC2170_community_systems_strengthening_en.pdf and http://www.rollbackmalaria.org/toolbox/tool_CommunitySystemsStrengthening.html

There is a dearth of research focused on community systems and their relevance to health, and the topic is largely neglected within formal health systems research. Health systems analysis tools such as Service Provision Assessments and Joint Assessment of National Strategies (JANS) focus primarily on assessing the capacities of health-sector facilities, policies, systems, and resources.[12] This lack of research has implications for the planning and implementation of CSS efforts at the country level, as most countries have little understanding of the scope and scale of existing community systems and the level and types of resources needed to maximize their potential.

Unlike HSS, applicants have never been able to request funding for a stand-alone CSS proposal, and unlike the MARPs channel (mentioned above), CSS has never been a funding stream with specific funding levels attached to it. Rather, CSS funding has been considered to be a sub-component of disease-specific or HSS proposals—albeit a sub-component that should be considered critical to the success of these proposals.

CSS funding requests have also been subject to the usual eligibility procedures, notably that they should be prepared and endorsed by a national or regional CCM, except in certain rare circumstances such as non-CCM proposals. The NFM will continue to apply these principles with respect to CSS funding. At the Global Fund's June 2013 Board Meeting, the Executive Director Mark Dybul outlined his strong commitment to supporting an expanded concept of health systems that goes beyond health facilities and encompasses strong community action (see box).

Mark Dybul, Executive Director of the Global Fund

"Clearly, government-based planning, health information systems and public health clinics are critical components for delivering health services to people. But the health system does not stop there. The health system extends deep into communities… Because vulnerable populations are often the hardest to reach we need to leverage and strengthen the systems that are best positioned to effectively deliver services to them. In many cases that means partnering closely with and strengthening civil society…"

Report of the Executive Director, 29th Board Meeting, 18-19 June 2013

What CSS Has Achieved

Since the introduction of CSS, the Global Fund has monitored how applicants have included CSS interventions in new funding proposals. The analysis has focused on identifying the proportion of countries that include CSS in proposals; the comparative extent to which CSS has appeared in AIDS, tuberculosis, malaria, and HSS proposals; comparisons of CSS uptake by region; proportions of overall requested funding allocated to CSS; distribution of funding requests across the different CSS SDAs; and distribution of CSS funding between governmental and non-governmental organizations.[13]

These analyses provide some revealing insights into how CSS has been used:

- **Just under half of proposals received in Round 10 included at least 1 activity from the CSS framework**. However, it is likely that many proposals included activities that can be considered to be CSS without classifying them as CSS or using the CSS framework.
- **The proportion of CSS funding approved by the Global Fund is lower than the proportion requested**. For instance, in Round 10 around 30% of the value of all funding requests submitted by Latin America and the Caribbean (LAC) was for CSS activities. In approved proposals this proportion dropped to less than 20%. Other regions saw similar drops between the requested amount and the approved amount of funding for CSS.

12 For more information about Service Provision Assessments see http://www.measuredhs.com/What-We-Do/Survey-Types/SPA.cfm; for JANS see http://www.internationalhealthpartnership.net/en/key-issues/national-health-planning-jans/.

13 Available at http://www.theglobalfund.org/en/civilsociety/reports/

- **Wide regional disparity in CSS uptake**. As noted above, 30% of the funding requested in Round 10 by countries in the LAC region was for CSS. In Southwest Asia the proportion was 5.5%—the lowest proportion by region.
- **The SDA for which most support was requested was community-based service delivery**. This is significant because service delivery does not reflect the more traditional notions of community systems strengthening like advocacy, capacity building, and leadership development.
- **The SDA for which least support was requested was strategic planning**. This implies that there are likely to be weaknesses in the strategic approach to CSS.
- **The proposals with the highest proportion of CSS included were those submitted through the MARPs channel**. The MARPs channel was introduced in 2010. It is likely that there is a close link between the higher proportion of CSS in MARPs channel proposals and the higher proportion of CSS in proposals from the LAC region, since many LAC proposals were submitted through the MARPs channel.
- **HIV proposals were the most likely to include CSS activities**. In Round 10, 37% of HIV proposals included CSS, compared to 23% of MARPS channel proposals, 17% of tuberculosis proposals, 13% of malaria proposals, and 11% of HSS proposals.
- **In Round 10, over half of all CSS funding was requested for activities aimed at strengthening the government sector. CSS is not exclusively used for key populations programs, and a relatively small proportion of CSS applications are oriented toward human rights or enabling environment activities.** Community systems can be part of the government sector—for instance, in many countries, effective community health volunteer programs are established by local health sector officials. However, this finding underlines that CSS is not necessarily synonymous either with civil society programming or with key population programming. The fact that such a high proportion of CSS funding is used by the governmental sector indicates that a smaller proportion of CSS funding is being used for activities that the government neglects or that are most effectively carried out by civil society organizations. This is particularly true for interventions targeting key populations.

The analysis suggests that it is relatively common for some CSS activities to appear in funding requests, but that the proportion of funding allocated to CSS within these requests is low. The fact that the proportion of funding eventually approved for CSS is significantly lower than the amount requested could be due to a number of factors, including poor quality or lack of relevance of CSS proposals; readiness of CCMs and the Global Fund Secretariat to de-prioritize CSS when budget reductions are negotiated; and lack of commitment from the Global Fund to accept CSS requests.

The regional disparities in CSS uptake are harder to explain, but it is possible that they are related to varied capacity and recognition of civil society action in different regions. As noted above, the higher CSS uptake in the LAC region may in part be due to the greater level of recognition of MARPs in the region. The fact that a high proportion of requested CSS funding was for community-based service delivery may in part be related to the higher cost of this intervention—particularly when it is implemented at scale. However, it may also reflect that CCMs and governments consider community service delivery to be relatively uncontroversial, unlike efforts to enhance accountability, create enabling environments, and promote human rights – which are central to the CSS framework. Strategic planning for community systems has also received limited support.

This is significant for some of the reasons highlighted above, namely that the community sector in most countries fails to reach its potential because it is relatively unplanned and unevenly distributed.

Perhaps the most striking finding from the Global Fund's analysis is that well over half of requested and approved CSS funding is used to support governmental organizations. This partially reflects the fact that some government services also work at community level, and in some country contexts, community-based organizations are part of the state. Moreover, there is nothing in the CSS framework to say that CSS interventions should exclusively be implemented by civil society or independent community-led organizations, or that it should only be used in the context of key population programming. However, in many cases, some activities that have been funded as government-led CSS much more closely resemble HSS. For instance, the Global Fund's Round 9 CSS analysis states that the funded CSS activities included microscopes and training for microscope operators in community health centers; renovation of local, regional, and national health facilities; capacity building for local government units in HIV planning; and training of health care professionals.

The Global Fund's analysis sheds some light on the feelings of some civil society organizations, and key populations groups in particular, that in many countries CSS has not lived up to its promise. To some extent, CSS seems to have constituted a re-branding of activities that were already eligible for funding and included in grants under previous rounds as either HSS or disease-specific activities. Community-based service delivery through governmental and non-governmental organizations is a case in point. Moreover, it appears that activities targeting key populations, which were always eligible (and indeed encouraged) under disease programs, may have been shifted toward CSS by many CCMs, as the results from the LAC region suggest.

The ways in which interventions are labeled or justified is, of course, less important than whether they are included at all or not. Although there is no clear evidence that CSS has led to a stronger, more systematic approach to community programming or to civil society–led programming, there are indications that national funding applications in general are increasingly inclusive of community programming in one form or another—whether labeled as CSS or not, or whether implemented by the government or not. The clearest example of this is the increasing use of community health volunteers and peer educators to conduct health promotion and to deliver services at the community level for all 3 diseases, and for broader health issues such as reproductive, maternal, child, and newborn health.

The analysis also points to an anomaly within the CSS framework: while in principle CSS is about strengthening systems (as is the case for HSS), the framework can easily be interpreted as including direct, disease-related service delivery (which is not the case for HSS). For instance, one of the SDAs in the CSS framework is "community activities and service delivery." There are risks in this approach since it implicitly fragments different program components that should be designed in an integrated way. Indeed there is some evidence that as a result, community service delivery activities—both government and non-government led—which in previous funding rounds had been included in mainstream disease proposals, have been shifted toward the CSS sub-component. This may also have had the effect of reducing the emphasis on the *systems strengthening* aspect of CSS, even though this was the initial purpose of CSS.

By the same token, many funding requests to the Global Fund have included other activities related to CSS under disease-specific or HSS components, without necessarily labeling them as CSS. This shows that, while on the one hand a significant amount of CSS activity may be misclassified and not labeled as CSS, on the other hand a significant proportion of activities that are funded as CSS may also have been misclassified. This level of misclassification in both directions also suggests that the CSS framework has, to date, not been an effective tool for tracking CSS activity. It is very difficult to assess whether CSS strategies and funding levels are adequate to meet existing needs, particularly when these activities are civil society led (as opposed to government led).

Despite these challenges, a number of regional funding applications developed by civil society networks have effectively used the CSS framework to more clearly define their programs. The framework provides a clearer description of the types of activities conducted by the community sector and how they link together. In some countries the introduction of the CSS framework has also helped facilitate networking and collective planning by community sector organizations. However, at the national level, planning of comprehensive community systems responses still seems to be limited, particularly with respect to civil society and community-based organizations. To the extent that CSS has featured in national grant applications, it has largely been based on a combination of separate requests from different civil society organizations and government agencies rather than on a comprehensive analysis of needs and a strategy that defines the role of the community sector in the national response.

A final point to note is the fact that CSS features more often in HIV than in tuberculosis, malaria, or HSS funding requests—most likely due to the stronger tradition of community-based action in response to HIV and AIDS, and the particular forms of marginalization and stigma faced by people affected by HIV.

CSS and Key Populations

Many key population and civil society groups hoped that the introduction of the CSS framework, and its emphasis on organizational strengthening, mobilization of key population networks, and support for advocacy and human rights work, would contribute to an improvement in the stubborn failure of national AIDS responses to work effectively with key populations.

The Global Fund's analyses of CSS uptake do not indicate whether the introduction of CSS has helped increase the scale and improve the quality of programming for key populations in the context of HIV and AIDS. However, some of the findings suggest that CSS funding requests have indeed been closely associated with key population programming—for instance, the higher uptake of CSS in the LAC region (where key population programming is a major focus), in MARPs channel applications during funding Round 10, and particularly in some regional funding applications. Many key population programs have found CSS a useful approach for framing and defining their strategies.

The introduction of the CSS framework has also helped to open up another channel for discussing the need to include key population programming, as CCMs are required in principle to consider and include CSS activities. At the same time, reports from key population networks around the world suggest that they continue to face challenges when attempting to establish the rationale for

and the content of key population programming in Global Fund proposals. The same challenges that key population groups have always faced when negotiating with CCMs—which include representatives of national authorities and a wide range of competing interests—are still present in discussions regarding CSS because CSS and key population programming must still go through the CCM process in the vast majority of cases.

In summary, CSS appears to have had the most positive impact for key populations in contexts where CCM members in general, and national decision makers in particular, are already sympathetic to the need to ensure that programs reach key populations and where there is sound epidemiological evidence of the need to prioritize key populations. In other contexts, the CSS framework has helped improve the way in which key population programming has been articulated in funding requests, but in and of itself the framework is unlikely to have had a positive impact on strong political opposition to key populations—particularly, in contexts of high stigmatization or criminalization. The high uptake of CSS in regional funding applications submitted by key population networks suggests that there is a greater potential for CSS focused on key populations when proposals are developed with a degree of independence from national CCMs. Regional key population proposals have also focused less on civil society or community-led service delivery, and focused more on capacity building, systems strengthening, and advocacy.

Examples of Successful Use of CSS

The Global Fund's own analyses are the only systematic assessment of CSS uptake. However, they focus on requests and approved funding for CSS. A more in-depth look at individual grants helps provide a clearer view of how CSS has been successfully used.

Latin America and the Caribbean, Round 10. During Round 10, 3 multi-country proposals, which were directed each toward MARPs, made considerable use of the CSS framework. In Latin America and the Caribbean, the regional network of female sex workers was funded for a proposal based primarily on CSS interventions designed to strengthen sex worker organizing and participation in national responses to HIV in participating countries. Although additional activities were aimed at reducing stigma toward sex workers in health care settings, the proposal did not include any direct service delivery, as the Global Fund encourages activities in multi-country proposals to complement existing national efforts. A major challenge in negotiating the final grant agreement was the insistence of the Global Fund that the performance framework include high-level impact indicators related to service delivery, even though service delivery was not a component of the project and the factors influencing these indicators were out of the control of the project.

The Asia-Pacific Network of People Living with HIV (APN+), Round 10. APN+ received multi-country funding for a project that was squarely based on the CSS framework. CSS elements of the proposal included activities to strengthen organizations of people living with HIV and to strengthen capacity for community-level service provision. Funding for actual service provision (i.e., non-CSS funding) was also included in this grant. The grant is therefore an example of how CSS activities can be used to build and strengthen systems for community-level service delivery.

Southeast Asia, Round 10. This proposal was designed to focus on MSM and transgender individuals, strengthening community systems by building the capacity of MSM and transgender organizations to work on service provision, policy, and advocacy, and in so doing using most of the SDAs of the CSS framework.

In 2009 the Global Fund and the International HIV/AIDS Alliance published a report titled **Civil society success on the ground. Community systems strengthening and dual-track financing: Nine illustrative case studies**. This report also details a number of examples of CSS implementation. Many of these case studies describe how civil society organizations have used the CSS framework at the country level to develop a systematic approach to large-scale mobilization and capacity building for service provision by community-based organizations.

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Many of the analyses conducted to date (including those described above) are based on requests for funding, and they therefore reflect how CSS has been used in developing and designing programs. Now that the CSS framework has been in use for a number of years it would also be useful to evaluate how CSS-focused grants have performed—in other words, what the impact of the CSS framework has been at the level of implementation. It is likely that CCM members, CSS advocates at the country level, and those involved in writing proposals (including consultants) can provide additional insights into how CSS has been integrated into funding requests, how CSS activities have been implemented, and what the impact of these activities has been.

Conclusions–Ensuring Key Populations Are Effectively Served by CSS and the Global Fund

As evidence suggests, CSS is being interpreted in a number of ways in funding requests submitted to the Global Fund. Many of these interpretations are reasonable, as for the most part they involve efforts to strengthen community-based action–albeit more often on HIV and AIDS than on tuberculosis, malaria, or health systems strengthening. There are also some cases where activities have been included under CSS that are not clearly in the spirit of the gaps that CSS was intended to fill–for example, investments in renovating health facilities. These may well be reasonable investments, but they are a more obvious fit under HSS or disease-specific programming. Comparatively less attention has been paid, in CSS funding requests, to activities such as advocacy, accountability, and improving the environment for key population programming.

The high variation in ways that CSS has been approached suggests that there is some ambiguity about the precise purpose of CSS, as well as a degree of overlap between CSS, disease interventions, and HSS. Many interventions that could be considered to be CSS have been funded under HSS or disease-specific labels–as was the case, to some extent, before CSS was introduced.

Different actors and sectors have interpreted and used CSS in ways that most closely align with their own priorities. Hence, some government agencies have used the CSS framework to support community-based public sector programs. In many cases this should be seen as a positive development, as it suggests that CSS as a concept has helped to shift the health sector toward a better understanding of the role of communities. In contrast, NGOs and other civil society organizations have found the CSS framework to be a helpful basis for designing and framing their community service delivery work.

Some key population organizations have used the framework to focus on strengthening organizing among marginalized communities, creating an enabling environment, and supporting human rights work. However, their efforts have often been constrained by a lack of capacity and strong, credible data to make their case clearly at the level of CCMs, as well as by opposition from CCM members or other decision makers who are antagonistic to key population programming. In this latter respect, efforts to use CSS for key populations have faced the same challenges that key population programming has faced since the creation of the Global Fund.

CSS has also introduced the notion of community actors and actions working together as an integrated system. Community systems are uniquely valuable in part because of their bottom-up orientation, close ties to constituent needs, and lack of bureaucracy. Despite their differences with more hierarchical systems, it is nonetheless important that communities receive the support they require to be effective. The notion of “community systems” has helped generate conversations about how to ensure that community action receives systematic support, how to ensure community is well integrated with more formal health systems, and how community can act to make these systems more accessible and more effective (for example, by improving the social and legal environment), particularly for marginalized or key populations.

At the same time it is also clear that at present the tools for assessing community actors and actions as a system are limited, that the CSS framework has served primarily as a menu of activities eligible for funding rather than as a basis for developing community systems strategies, and that community action is largely neglected in the standard health systems research and measurement tools. The recent establishment of an inter-organization task team (IOTT) on CSS is one illustration of how civil society and international organizations are attempting to take this systems approach forward.

The Global Fund's promotion of CSS seems to have had some impact from a technical point of view, by encouraging a more expansive view of the range of inventions and actors that are required to respond to AIDS, tuberculosis, and malaria. However, there is little indication that CSS has so far had a major impact on the political and social factors that continue to marginalize key populations.

As has been described, a number of challenges have limited the potential role that CSS can play in improving responses to AIDS, tuberculosis, and malaria; in strengthening health systems; and in ensuring that the most marginalized and affected communities are able to participate and benefit fully from efforts to improve health. Some of the main challenges can be summarized as follows:

- **The continued ambiguities that exist in relation to CSS**. Varied interpretations see CSS as being about non-governmental responses; local or community-level programming (governmental and/or non-governmental); marginalized or key populations; or activities outside of the formal health sector but that are crucial to improving health. These are not necessarily contradictory but the assumptions and aims of each interpretation are somewhat different.
- **The limited range of tools and methods available to assess the role of community systems (and by extension, community systems strengthening) in a given disease program or health system, and the gaps that need to be addressed.** Tools exist for assessing and strengthening individual community sector organizations, but there is a little clear vision of how individual organizations operate as community systems and how they relate to health systems. This makes it difficult for CSS advocates to make a clear case for CSS to governments or donors and to assess the scale of resources needed to implement CSS effectively.
- **Continued skepticism and in some cases hostility from governments and health sector leaders.** Many government and health sector leaders remain skeptical and hostile regarding the role of communities in both service provision activities and community mobilization, accountability, and human rights activities. A great deal of expectation has been placed on CSS as a strategy for resolving the particular challenges faced by key populations in the context of HIV and AIDS. Although CSS does have potential to help achieve this, there are many factors outside of the sphere of influence of CSS that must also be addressed. Similarly, there are many examples of ethical and effective programming for key populations that have been developed without necessarily referring to the CSS framework.

In addition, the experience to date with CSS suggests that its relevance and focus is closely related to country context—to the performance of formal health systems and to government attitudes toward community action and key populations in particular. This makes it very difficult

to establish global norms about what an optimal CSS approach should look like at country level, or what proportion of funding the Global Fund, national governments, and other donors should allocate to it.

Recommendations: The Evolution of CSS

A number of possible actions may help to build on the momentum created by the introduction of CSS. Although each of these recommendations are relevant to key population programming, they are not all specifically aimed at key population organizations. However, some potential options for increasing involvement of key population organizations are proposed.

1. **Provide input on the integration of CSS into the Global Fund's New Funding Model Frameworks**. The Global Fund is currently producing the modules that will form the basis of future funding requests. A set of modules will be produced for each disease and for HSS. The Global Fund is in the process of integrating CSS into each of these, as CSS is not a standalone funding stream. This therefore constitutes an important opportunity to provide input on how CSS will appear in the New Funding Model.

    - Mechanism: This CSS integration process is being led by the Global Fund secretariat. The IOTT on CSS is assisting the secretariat in obtaining input from CSS advocates. The IOTT will circulate drafts of the frameworks for each disease and for HSS for comment and input from community sector constituents.
    - Potential Key Population Involvement: Key population organizations should participate in this review through the IOTT. Key population organizations are likely to focus on the HIV framework but should also aim to comment on the cross-cutting HSS framework, which also has relevance to key populations. Input should not be limited only to the CSS aspects of the HIV framework; key population organizations should also provide input regarding the complete framework because there are many non-CSS modules that are focused on key populations as well. The key populations task force being established by the Global Fund is a further opportunity for key populations to input to the New Funding Model.

2. **Conduct a detailed revision of the CSS monitoring and evaluation framework**. This revision is already on the Global Fund's agenda. However, it is important that the revision takes certain points into account. Firstly, producing an effective CSS monitoring and evaluation (M&E) framework will be largely dependent on the development of community systems assessment tools. Compared to community systems, health systems analysis is fairly straightforward because health facilities of a given level in a given country look more or less the same and have established quality standards. Community sector organizations cannot be normalized in the same way. More progress needs to be made in terms of understanding what the community system is and what is expected of it in a given country before adequate measures of CSS can be developed.

    Secondly, CSS advocates should not commit to an M&E framework that aims to track the effects of CSS only at the high level of impact on disease incidence and mortality (indeed, the same principle applies to investments in HSS). Community systems are complementary

to established health systems, and they make them more effective. Therefore the work and impact of a community-based service organization or a community organization focused on advocacy and accountability should not be measured by an indicator solely focused on disease incidence and mortality; rather, high-level impact should be attributed to the combined performance of community and health systems and other sectoral programs.

- Mechanism: The IOTT on CSS has established a Working Group focused on the revision of the Indicator Framework for CSS, and is working in partnership with the Global Fund Secretariat to conduct this review.
- Potential Key Population Involvement: Key population organizations should participate in this process through the IOTT. They should focus particularly on the development of indicators aimed at assessing the effectiveness of efforts to strengthen community-based organizations that focus on key populations, and at ensuring that indicators are a reasonable measure of CSS efforts.

3. **Develop, test, and establish tools for assessing the role of community systems in a given country or program context**. These efforts should include a focus on how community systems relate to health systems, whether by providing complementary services or by focusing on monitoring and accountability of health systems. Adaptation of existing health systems tools and instruments will be a useful starting point, and should aim at ensuring that health systems analysis encompasses the broad range of factors and sectors that improve health rather than focusing on health sector and clinical service provision. Better assessments of community systems will also enable CSS advocates to make a stronger case for planning systems strengthening activities, as well as helping to develop clearer quality standards for certain activities, such as community-based service delivery and more efficient allocation of resources to community systems.

    - Mechanism: This activity should be a priority for the Global Fund; however there does not appear to be a mechanism currently in place to develop these tools. As a result it is likely that the systems and response analyses that countries use to develop their funding requests under the NFM will be deficient in their analysis of CSS. It is recommended that the IOTT advocate for the development of these tools as a matter of priority.
    - Potential Key Population Involvement: Involvement is recommended through the IOTT; the input of key population organizations will help ensure that these tools pay sufficient attention to the needs of key populations.

4. **Broaden the CSS movement from its current position as a primarily Global Fund-focused initiative**. CSS has been championed by the Global Fund and its partners in civil society, and it has become most developed in the context of HIV and AIDS. However, as many countries become less reliant on donor funding—including Global Fund funding—and as the global health movement begins to focus on different disease priorities and concepts such as universal health care, it is timely that CSS should become more than a Global Fund– or HIV/AIDS–focused initiative. The CSS movement that has emerged in the context of the Global Fund should seek to ally with other health and health systems advocates in order to share learning and advocate further.

- Mechanism: The IOTT on CSS established in 2012 should constitute a platform for ensuring that existing momentum takes CSS outside of the realm of the Global Fund. It will also help to establish the global technical leadership that CSS currently lacks.
- Potential Key Population Involvement: Key population organizations have a particular interest in supporting the development of the CSS concept outside of the Global Fund. As countries become less dependent on Global Fund and other donor funding to support their responses to HIV and AIDS, it is important that concepts such as CSS be adopted by a broader set of actors, not least of which are national civil society organizations and governments. Taking CSS beyond the Global Fund is a strategy to ensure that CSS and the underlying principles are seen as central to health programming rather than a requirement of a particular donor.

5. **Further clarify the meaning and role of community systems and, by extension, community systems *strengthening***. Given the ambiguities and different understandings of CSS, it is important for actors to recognize the diversity of interpretations and roles under the broad heading of community systems. A community system should be understood as a set of interdependent actors and actions with a set of identifiable and interrelated characteristics that form an integrated whole, needed to guarantee the right to health.

   Community systems are a component of and a complement to health systems. Efforts to clarify the role of community systems and CSS should also aim to identify what a community systems approach can realistically achieve in these different areas—such as improving service delivery on the one hand, and achieving social and political change on the other. Finally, efforts should clarify how community systems and health systems are articulated. A clearer understanding of and consensus about *community systems* will help strengthen the basis for community systems *strengthening*.

   - Mechanism: This process should be led by the IOTT, potentially in collaboration with other health systems/community systems initiatives such as those being established by WHO and the World Bank.
   - Potential Key Population Involvement: Key population organizations should aim to participate in this process through the IOTT. Because this process involves taking the conversation on community systems and CSS beyond AIDS toward a broader approach to health, the input of key population organizations will be important to help ensure that community systems continue to capture the importance of addressing the needs of marginalized and stigmatized populations.

6. **Develop a research agenda on CSS**. As this paper explains, CSS is a relatively new concept, and although there is a great deal of evidence of the roles that community organizations and responses can play in improving health, there is comparatively little research on how to develop and optimize these roles in a systematic way. The Global Fund's internal analysis also shows that at present the CSS framework provides an unreliable means of tracking CSS spending. Finally, most of the existing research on CSS focuses on how CSS has influenced the development of funding requests, but there is little if any research into the impact of CSS at the level of grant implementation, or on whether the introduction of the framework has helped increase the performance of programs.

- Mechanism: The IOTT has established a working group on CSS research.
- Potential Key Population Involvement: Key population organizations should work through the IOTT to develop this research agenda. Further down the line, they should aim to participate in conducting research, particularly in relation to how CSS has impacted key population programming.

7. **Identify funding mechanisms that can support the neglected aspects of CSS**. The Global Fund's approach to supporting national programs through CCMs has provided opportunities, albeit limited, for engagement of marginalized groups and key populations in national planning and decision making. However, in many countries experience shows that national decision makers – and sometimes technical partners – continue to override, overlook, and/or neglect key population concerns, particularly when they are related to human rights.

   Regional funding proposals to the Global Fund have been one way of ensuring that more meaningful CSS activities for key populations are funded. However, regional or multi-country proposals generally still require approval from each national CCM in the countries that they include. Furthermore, managing a regional project is burdensome and presents particular challenges for principal recipients. It is especially challenging for regional projects to deliver scaled-up services to key populations in multiple countries. National and local key population organizations would benefit greatly from having additional opportunities to obtain CSS- or key population–focused funding directly.

   - Mechanism: Direct advocacy with the Global Fund, potentially using the Key Affected Populations task force mechanism.
   - Potential Key Population Involvement: This recommendation is a high priority for key population organizations as it primarily concerns key population programming. Key population organizations should lead advocacy efforts in this area.

8. **Ensure CSS is promoted at the country level**. The introduction of concepts such as CSS has helped to indicate to countries, and governments in particular, the priorities of the Global Fund. However, experience shows that even though the Global Fund has since its inception clearly communicated priorities such as the need for impact and the importance of engagement of key populations, many countries are still not performing strongly in these areas–almost certainly due to a lack of capacity and political will at country level. If CSS is merely seen as a Global Fund recommendation or imposition, it is unlikely to gain traction at country level. The bigger objective for CSS should therefore be to increase country-level ownership and acceptance of the importance of CSS, so that it receives the political support–and eventually the domestic financial support–that is required to ensure it is adopted in a sustainable way. To achieve this, considerable efforts need to take place at the country level to increase learning and understanding of the role of CSS. The efforts outlined in recommendations 3, 4, 5, and 6 will contribute to this effort.

   - Mechanism: None yet established. IOTT should consider developing a strategy to achieve this. International organizations and NGOs that are active in research, advocacy, and technical support at the country level should prioritize this activity.

- Potential Key Population Involvement: Involvement is recommended in strategy development through the IOTT, and at the country level through key population organizations.

Beyond CSS: Additional Recommendations for Key Population Advocacy at the Global Fund

As this report has outlined, CSS is not the main or only mechanism for improving the Global Fund's performance on concerns related to key populations. The recommendations below point to additional ways in which key population organizations should advocate with the Global Fund. The establishment of a task force on key affected populations is the ideal channel to conduct this advocacy.

9. **Continue to use other Global Fund policies and approaches aimed at improving programming for key populations**. The Global Fund's strategic plan clearly states the organization's commitment to protecting and promoting human rights, particularly in relation to key populations. Guidance on human rights, gender, sexual orientation, gender identity, and representation of key populations in the development of funding requests and of program implementation are all levers that key population advocates can use at the national level whether within the context of CSS applications or not. The AIDS, tuberculosis, malaria, and HSS funding modules developed under the New Funding Model all provide considerable scope for key population programming and for community-based service delivery, mobilization, accountability, and human rights protection.

10. **Focus on improving programming for key populations irrespective of the implementing sector**. There is a potential risk that using CSS as a mechanism for service delivery to key populations will, in the longer term, be unsustainable and will further distance key populations from standard health facilities. It is important therefore that this approach be combined with efforts to improve the accessibility and quality of provision for key populations within the mainstream health sector.

11. **Prepare for opportunities and challenges that are presented by the New Funding Model**. The changes in the funding mechanism will cause disruption and will require country actors to learn and adapt to the new approaches. The NFM is designed to be data-driven and to improve the accessibility and quality of services for key populations. This presents both opportunities and challenges to key populations. The opportunities are that key population–focused interventions have, time and again, been shown to be a highly cost-effective investment, particularly in the response to HIV and AIDS. Because countries are increasingly expected to achieve more results with less funding, the case for investing in key population programming is sound. However, the challenge is that many countries lack the basic data—information on sizes of key populations and epidemiological risk—that are needed to prove the necessity of key population investments. This lack of data is of course aggravated by the unwillingness of many governments to invest in collecting better data.

    Moreover, for key population interventions to be effective it is not sufficient to simply provide the behavioral and clinical interventions for which there is a good evidence base and which are easily quantifiable. Key population organizations have to be engaged and strengthened,

and they require support to monitor services and to advocate for human rights. These interventions are less easy to quantify and can often take a long time to achieve results, particularly in environments that are hostile to key populations. However, although they do not lend themselves to cost-effectiveness analysis in the way that clinical interventions do, they are no less important.[14] Key population networks must therefore continue to advocate with Global Fund decision makers, and other partners, for support to be provided to enable the collection of better data on key populations and to ensure that key population organization strengthening, accountability, and human rights interventions are fully supported. It may be that the most effective way of ensuring that this support is provided will be if the Global Fund and other donors establish dedicated funding channels that do not require the approval of CCMs (and, by implication, national authorities).

12. **Broaden and strengthen the movement for effective, evidence-based key population programming.** As this paper has argued, CSS has not exclusively been used to support key populations, and good key population programming has been supported by the Global Fund outside of a CSS framework. However, there are still many barriers to effective key population programming whether it occurs under a CSS framework or not. One of the reasons for this is that most Global Fund investment requires approval from a wide range of actors at country level, each of which has a different level of commitment to work for key populations and CSS. CCMs tend to be seen as a forum for advocacy, and indeed they have created a space for raising controversial issues. However, a CCM is not a homogenous entity–it is made up of many different actors. Rather than targeting CCMs as a single unit, key population advocates should seek to identify individual allies within and outside of CCMs to support their efforts to promote CSS and key population programming, whether this is in relation to Global Fund applications or other potential funding sources.

Key mechanisms for key population organizations to implement all of these recommendations include:

- Advocacy with the Global Fund using the Task Force on Key Populations.
- Advocacy with technical partners, in particular UNAIDS, to ensure that support is provided to key populations at the country level.
- Capacity building and communication with key population organizations at the country and regional level to ensure awareness of the range of policies and mechanisms aimed at supporting key populations. Global key population organizations should consider developing guidelines, tool, and trainings to country and regional key population organizations.
- Capacity building of country- and regional-level key population organizations in advocacy; development of advocacy strategies for effectively influencing CCMs.

14 See recent report by the Center for Global Development on value for money and the Global Fund, acknowledging that cost effectiveness criteria can only be applied to a limited range of interventions. Glassman, A; Over, M; Fan, V; and the Center for Global Development Working Group on Value for Money in Global Health. (2013) "More Health for the Money" Washington, DC: Center for Global Development. http://www.cgdev.org/event/more-health-money-progress-and-potential-global-fund

The Global Forum on MSM & HIV (MSMGF) is a coalition of advocates working to ensure an effective response to HIV among MSM. Our coalition includes a wide range of people, including HIV-positive and HIV-negative gay men directly affected by the HIV epidemic, and other experts in health, human rights, research, and policy work. What we share is our willingness to step forward and act to address the lack of HIV responses targeted to MSM, end AIDS, and promote health and rights for all. We also share a particular concern for the health and rights of gay men/MSM who: are living with HIV; are young; are from low and middle income countries; are poor; are migrant; belong to racial/ethnic minority or indigenous communities; engage in sex work; use drugs; and/or identify as transgender.

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