

Malaria control, community systems strengthening and community-owned response

**Consensus on best practice for use in the development of
Global Fund Round 9 malaria proposals and
National Strategy Applications**



**Based on the
Malaria Control and Community Systems Strengthening Consultation
23-25 March 2009, Geneva**

**Co-hosted by:
World Vision International
The International Federation of Red Cross and Red Crescent Societies
The Roll Back Malaria Partnership Secretariat**

Acknowledgements

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Development and purpose of the document

Participants¹ at the Malaria Control (MC) and Community Systems Strengthening (CSS) Consultation held in Geneva, 23-25 March 2009, identified the need for additional guidance on CSS and malaria control best practice for all involved in the development, evaluation and eventual implementation of Round 9 malaria proposals and 'first learning wave' National Strategy Applications (NSA). In particular, participants felt the need for a greater focus on communities and people themselves as a key component of CSS and as the foundation for effective, sustainable malaria control.

The consensus on best practice that follows was developed during the MC/CSS consultation, with the purpose of complementing the current Global Fund To Fight AIDS, Tuberculosis and Malaria (GF) CSS fact sheet and the recently published UNAIDS guide² 'Supporting Community Based Responses to AIDS: A Guidance Tool for Including Community Systems Strengthening in Global Fund Proposals' which offers in-depth, practical guidance on developing and writing GF CSS proposals.

As the aim was to provide a tool for Round 9 proposal development, time was short, and the document is not exhaustive. The aim has been to define concepts, cover key proposal development issues, and provide links to further information sources.

Best practice

1. Community-owned response

1.1 A community-owned response is built on the principle of putting people first and on the belief that people have the capacity to respond, to take charge, to learn from each other, and to change. It aims to reveal, nurture and strengthen community capacity³ to identify, prioritize and address malaria control issues in the community. It enables communities to set, and advocate for, their own health agendas, and mobilize around shared goals.

1.2 In order to build on community capacities, the approach involves identifying, appreciating, working through and strengthening existing functional community relationships, processes, structures/groups, skills and resources. Where community members identify weaknesses in these community assets, it aims to support them, and those working with them, as they develop and implement solutions.

1.3 An authentic approach to promote community-owned response will involve:

- i. Understanding how a community is organized, and how relationships are formed
- ii. Understanding community interfaces with other communities and service providers
- iii. Identification of and respect for existing community capacities
- iv. Promoting equity and inclusiveness, especially of the most vulnerable members
- v. Considering gender dynamics and power relations
- vi. Being context specific and culturally sensitive
- vii. Valuing and enhancing existing community mobilization approaches
- viii. Enhancing transfer of knowledge and skills to communities
- ix. Enhancing transfer of experience within communities and community-to-community, and promoting learning from communities
- x. Strengthening self-generated action

¹ A full list of participants is attached as Annex 1.

² Located at: http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_en.pdf

³ Source: <http://www.aidscompetence.org>

- xi. Enhancing and building upon local resource mobilization
- xii. Strengthening the capacity of community members to advocate for change
- xiii. Ensuring that external facilitators interact with the community as 'equals, not as experts', and with the expectation that they will learn from the community.

1.4 The approach seeks to develop complementarities and synergies between community systems for health and social protection and national ones. It enables community members to become stronger, active partners in the fight against malaria.

1.5 In the community-owned response approach, CSS involves creating a space and structure for ongoing community dialogue that builds community capacity for action based on the recognition of community strengths and the transformation of community weaknesses.

2. Malaria control and community-owned response

2.1 Malaria can be controlled if those at risk have appropriate knowledge about malaria causation, prevention options and treatment, and access to long-lasting insecticidal nets (LLINs) and to diagnosis and treatment when needed. Although the supplies of LLINs, diagnostic tests, effective medicines, intermittent preventive treatment (IPT) and for indoor residual spraying (IRS) available to countries have increased significantly over recent years, there is still a major problem ensuring access to and correct use of these commodities. This is particularly true for the estimated 40% of communities outside the reach of existing health systems. Community-owned responses can potentially establish effective, sustainable links between available commodities, information about these commodities, and community members. Community-owned response can result in improved management of the local environment and efforts to promote appropriate health-seeking behavior, such as organizing transportation for complicated cases. Communities can also take a more active role in demand creation, influencing service provision (by monitoring local need), and regulating the activities of service providers, whether community-based volunteers, traditional healers, private sector vendors or health workers. Community-owned response approaches should, therefore, be used to complement conventional methods of communication and behavior change programming and service delivery.

2.2 Community-owned response⁴ motivates behavior change by stimulating community dialogue about malaria during which communities can assess their own malaria situation and come up with relevant solutions. It is important not to think in terms of behaviour change alone, but of social change. Behaviour change, while important, assumes *individual* behaviour change and therefore *individual* responsibility. Many changes needed for better health outcomes depend on changes at a fundamental level, requiring wider, social, cultural changes in norms, practices and attitudes, or even changes in the policies that set the environment within which people live e.g. on sanitation, housing, roads. It is important not to inadvertently locate the responsibility for action on the individual alone. Communication for broader social change will result in behaviour change, and will be more sustainable.

2.3 Community members need to understand the malaria control targets set out in the Global Malaria Action Plan⁵ (GMAP) to ensure universal access of people at risk to prevention and treatments.

2.4 Table 1 lists the range of malaria control interventions that are potentially relevant in a community-owned response. Annex 2 provides a summary of current thinking and practice regarding community-based management of malaria (CBMM). Annex 3 considers

⁴ Source: *The Role of Communication in Malaria Control in Africa: A Concept Paper for the First RBM Communication Working Group Meeting* September 2003. <http://www.rollbackmalaria.org/cwg.html>.

⁵ The Global Malaria Action Plan can be located at: <http://www.rollbackmalaria.org/gmap/index.html>.

programmatic issues at the community level related to the ‘scale up’ and ‘sustained control’ phases of malaria control. The GMAP provides further background on all the above.

2.5 It is vital to ensure that communities are able to choose the most appropriate and efficient malaria control intervention(s) according to their local context; as the PAHO Central America experience illustrates, for example, malaria control need not be about ‘commodities’ alone. The environmental route to malaria reduction, engaging participation and ownership of people can be an effective way (Annex 4).

3. The role of civil society organizations (CSO)

3.1 An ‘external’ CSO will often play a role in catalyzing, facilitating, and building the capacity of community members to achieve a community-owned response to malaria. Figure 1 provides one view of the interaction between communities, health service providers and ‘external’ civil society or private sector organizations. The diagram aims to help visualize how a program of activities for CSS may be structured with regard to the Global Fund architecture, including oversight by the Country Coordinating Mechanism (CCM). The diagram shows a separation between service provision on the left and community-owned response programs on the right. Of course, in reality, there is often overlap.

We see on the right-hand side how a strong CSO (e.g. a NGO, FBO or network) or private sector organization may take a lead as a potential principal recipient (PR) or lead sub-recipient (lead-SR) in developing a large CSS program for inclusion in the Global Fund proposal. The potential PR or lead-SR would do this in consultation with a range of CSOs, including community-based organizations (CBO) that already have good links with affected or target communities and marginalized groups – these organizations would be the potential implementers of the community-owned response approach as Global Fund sub- (SR) or sub-sub-recipients (SSR). In developing the CSS program, the potential PR or lead-SR identifies and costs the capacity building requirements of the potential implementers required to start/strengthen, implement, learn from and report on CSS activities. The relevant infrastructure, organizational and institutional costs of the potential implementers would be

Table 1 Malaria control interventions potentially as part of a community-owned response

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| <ul style="list-style-type: none"> i. <i>Behavior change induced through social change communication</i> ii. <i>Management of stagnant water in the community</i> iii. <i>Ensuring community-wide LLIN distribution, particularly for ‘hard to reach’ families</i> iv. <i>Ensuring nets are hung and used correctly and periodic net re-treatment is organized</i> v. <i>Mobilization of community for IRS</i> vi. <i>Sensitization of communities on appropriate health-seeking behavior for malaria, including knowledge about effective treatment</i> vii. <i>Community-based management of simple malaria (according to country policy)</i> viii. <i>Ensuring timely referral of severe malaria cases</i> ix. <i>Ensuring pregnant women attend antenatal care and receive at least two doses of IPT</i> x. <i>Data collection to inform procurement and service delivery e.g. mapping LLIN needs, IRS coverage, malaria morbidity and mortality</i> xi. <i>Identification of candidates for Community-based Integrated Management of Childhood Illness (C-IMCI) and/or training for community-based management of malaria</i> xii. <i>Identification of malaria as a priority for local action and development of a local malaria action plan</i> xiii. <i>Monitoring and evaluation of the community-owned response</i> |
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included in the proposal. The potential PR or lead-SR could package the information from individual implementers and present it to the CCM as a ‘CSO support program of strengthening community systems’. The potential PR or lead-SR would also include its own capacity building, infrastructure, organizational and institutional costs. The programme may also include policy and advocacy activities – this is represented in the diagram by the consultation and feedback loop from the community to the CCM. Making this loop work is the responsibility primarily of the civil society representatives who will have been elected by their constituencies to serve on the CCM.

The flow of services for health to communities from government and non-governmental sectors is shown on the left-hand side of the diagram. These services are funded by the Global Fund via the same or a separate PR. A consultation and feedback loop between the community and the providers shows how communities and providers can work together on demand, design and delivery. Oversight is again given by the CCM where, as on the right-hand side, non-governmental representatives are responsible for ensuring consultation and feedback to their constituencies. Clearly commitment and resources are required for this to really happen, though this critical aspect is not covered in any great detail in this document.

3.2 The community-owned response approach generally involves community members in a learning and action cycle that includes the following key stages:

- Introductions (of the CSO to the community and the community to the CSO and way of working)
- Identification of groups in the community who will ‘carry’ the process (or initiation of a group in exceptional circumstances)
- Assessment of community assets and strengths
- Identification of issues of concern to the community
- A deliberation phase when community members consider options for addressing these problems and set priorities for action
- Internal and, where necessary, external resource mobilization
- Action, and
- Evaluation.

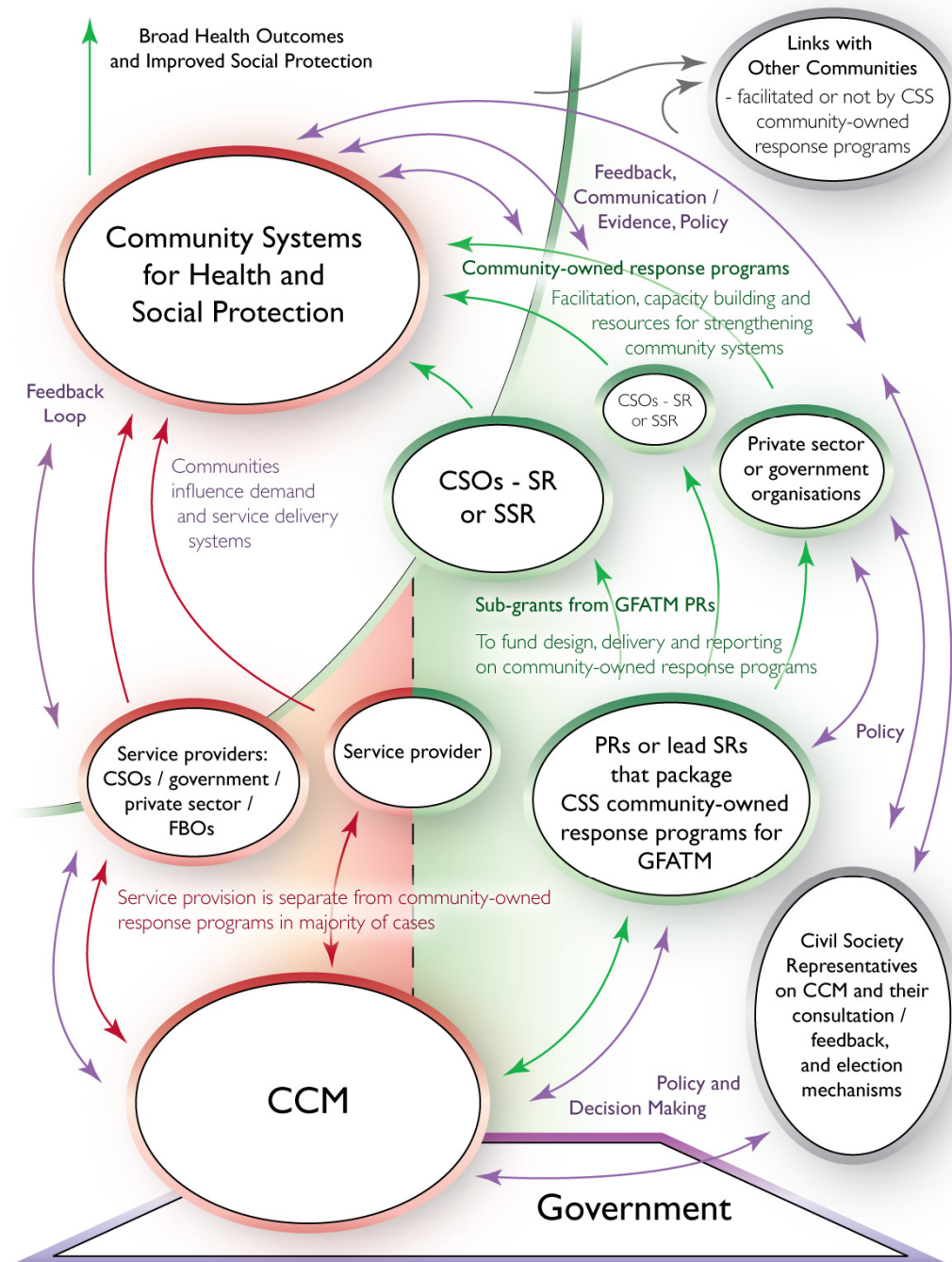
The amount of structure in the process and the tools used will vary according to community preferences and the methodology followed.

3.3 The Malaria Community Competence methodology⁶ is based on the concept of ‘accompaniment’ (see Annex 5 for further details). Accompaniment illustrates the importance of a particular set of attitudes and practices that are the foundation of a community-owned response approach.

External ‘visitors’ to the community interact as equals, not as experts. To stimulate local action in response to malaria, they ask appreciative questions, and refrain from teaching and preaching. Through these questions, visitors and the community explore their own strengths. Several methods exist to guide the dialogue. One of these is the self-assessment framework (Annex 6). As they work on the self-assessment process, communities come to recognize their own strengths and build on these strengths to plan further progress. The key to accompaniment is to ‘walk alongside’ the community during its learning cycle on dealing with malaria. In this cycle, the community makes assessments, acts, measures progress and

⁶ Source: www.malariacompetence.org.

Figure 1: A view of how a program of activities for community systems strengthening could be structured with regard to the Global Fund architecture



adapts its actions. As the plans and related actions are coming from within, chances for sustained success increase.

While the visitors do not provide technical answers or resources by themselves, they do offer to link the community with the resources existing in its environment. In this way, community members learn to appreciate the services made available to them, and are much more likely to make use of them.

To carry out such accompaniment, the 'expert mode' of interaction with communities must be unlearned. This deconstruction of the usual 'way of doing business' is not easy. Faced with a challenge from the community, visitors can easily revert to the expert/donor mode. Hence, accompaniment is a team activity, as team members help each other in maintaining the ethos of accompaniment.

3.4 The values of trust, dialogue, 'process' and the 'facilitator' role are all well developed in communication for social change approaches⁷.

3.5 The community accompaniment process and other community facilitation and capacity building processes are highly dependent on the availability of skilled facilitators or 'visitors' who come to the process with the right mindset. Therefore, adequate funds must be included in the proposal for facilitator selection, training, coaching and support supervision. The community accompaniment process takes time. Therefore, it is important to be explicit about the community dialogue process in the proposal and budget adequate time and money for it.

4. Linking community-owned response with national policies and strategies

4.1 In line with Global Fund principles, it is vital to ensure that arguments for community-owned response programming and associated CSS are grounded in existing country policies, strategies and plans. In general, the greater the political commitments to the approach at the outset the better for program implementation and resourcing. Check existing national policies and strategies for references to primary health care (PHC) based on Alma-Ata principles, to the WHO-led PHC revitalization strategy, the recommendations of the WHO Commission on Social Determinants of Health⁸, and/or the Ottawa and Bangkok Charters⁹ for Health Promotion, which can be used to establish that country policy and strategy includes a commitment to community involvement.

4.2 The 2008 World Malaria Report¹⁰ is a recent and powerful document in which WHO calls for universal access to health care.

4.3 Identify implementation gaps due to lack of coverage of primary health care services where a community-owned response would improve access. Discuss the potential of community-owned response to affect the health-seeking or care-providing behaviors of individuals and communities, creating demand and sustaining use of malaria services and products. In addition to demand creation, also focus on increasing appropriate utilization of services and products, such as ensuring a household dynamic where pregnant women and children sleep under mosquito nets. The resulting field effectiveness due to appropriate utilization of preventive interventions is a key driver of treatment costs¹¹.

⁷ Located at: <http://www.communicationforsocialchange.org/>;

http://www.who.int/hiv/pub/toolkits/2-3a_SocialChangeCommunication_09EN.pdf

⁸ Located at: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

⁹ Located at: <http://www.who.int/healthpromotion/conferences/en/>

¹⁰ Located at: <http://www.who.int/malaria/wmr2008/>

¹¹ Source: Global Advocacy Framework. Roll Back Malaria 2006 - 2016. Located at: <http://www.rollbackmalaria.org/globaladvocacy/docs/GlobalAdvocacyStrategy.pdf>

Highlight the key reason for implementing CBMM. Malaria is an acute and rapidly-progressing disease and a 24-hour delay, especially in children under five, in accessing effective treatment can mean the difference between life and death.

4.4 To strengthen the malaria CSS proposal, organize a joint (government and non-government stakeholders) CSS assessment and planning exercise. Develop a context-specific assessment process or use one developed for this purpose e.g. the UNAIDS framework¹² or that developed by the International HIV/AIDS Alliance¹³. Both assessment tools can be used for planning CSS as part of a malaria proposal.

4.5 Only 18% of approved Round 8 CSS funding was earmarked for CSOs alone, notably as a result of health system initiatives being included under CSS in many proposals¹⁴. CCMs are requested to include the training and support of community health workers, and other measures to strengthen primary/district level health services, under health system strengthening (HSS) going forward. CSS proposals should include only activities related to strengthening CSOs and communities in order better to isolate and understand the impact of CSS funding as well as ensure adequate funding for the non-governmental sector.

5. Disease-specific or cross-cutting CSS applications?

5.1 CSS should result in cross-cutting skills, tools and structures in communities and CSOs. However, disease-specific applications may offer the best chance to ring-fence CSS funds, unless there is high-level, in-country commitment to a cross-cutting CSS application. If a disease-specific CSS application for Round 9 is chosen, clearly state that the disease-specific application is considered a point of entry, that the intention is to build a platform for integration across HIV/AIDS, TB and other diseases, and that efforts will be made to ensure the transferability of learning and tools.

6. The evidence base for community-owned response

6.1 A comprehensive, conventional body of research showing the effectiveness of community-owned response approaches is currently lacking. This lack of ‘hard’ evidence largely reflects the difficulty of measuring community-owned response. However, Annex 7 contains a number of recent papers and reviews that can be used to underpin a proposal.

6.2 Further strengthening of the evidence base for community-owned response is vital, and efforts to carry out appropriate and rigorous operations research and evaluation should be supported as a key component of CSS. Proposals should include an operations research component.

7. CSS indicators

7.1 The Global Fund monitoring and evaluation toolkit¹⁵ includes a number of recommended CSS indicators among the HSS indicators. The UNAIDS publication mentioned earlier includes a wider range of CSS indicators that can be used equally well in a malaria proposal. The available indicators are geared more towards measuring the coverage and capacities of CSOs that implement the community-owned response approach than measuring change at the community level. Proposal writers can use a combination of available CSO-related indicators (to capture the increased availability of capacity to implement and scale up the response) and malaria specific indicators (to capture the end result of the community-owned response approach) in a proposal. Available indicators can also be adapted to capture changes at

¹² Located at : http://data.unaids.org/pub/Manual/2009/20090218_jc1667_css_guidance_tool_en.pdf

¹³ Located at : <http://physiciansforhumanrights.org/library/documents/reports/css-analysis-framework.pdf>

¹⁴ Source: Mick Matthews at the consultation citing the Global Fund Round 8 CSS funding analysis.

¹⁵ Located at: http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HSS_en.pdf

community level (e.g. the number and distribution of CBOs that have developed a malaria action plan and/or are represented at regular, formal, health-system planning meetings). Use existing best practices from within international NGOs.

7.2 CSS funding could be used to develop and validate specific community-owned response indicators for inclusion in the Global Fund list of recommended HSS/CSS indicators.

7.3 Note that, on implementation, it is essential that each community has the opportunity to define what it wants to achieve and how to measure changes taking place. The 'most significant change' technique offers a relevant tool for monitoring and evaluation¹⁶.

8. Time frame

8.1 Donor funding time frames may not align with the pace of community-owned response. In the case of the Global Fund, the overall five-year funding cycle works for community-owned response programming, but the Phase 1 evaluation after only 18 months may pose a problem. It will be important to develop a realistic and detailed work plan for the CSS proposal, and provide strong reasons to support it. Be realistic when choosing Phase 1 indicators; keep them few, measurable and achievable.

9. Sustaining community involvement

9.1 Volunteers are motivated by a sense of achievement (i.e. seeing the results of behavior change and increased service provision in terms of decreased morbidity and mortality), but also by their experience of the volunteering process. Volunteer programs that are 'sold' as no-cost or extremely low-cost options often end up with inadequate funding to ensure that volunteers have a positive experience. Volunteer programs potentially offer huge opportunity costs (due to the unpaid contribution of volunteers as opposed to the paid costs of health workers carrying out the same tasks), but need to be funded to sustain volunteer action in order to realize these benefits.

9.2 Therefore, ensure that proposals include provision to address, manage and track a range of factors that act together to encourage and sustain voluntarism:

- i. Quick wins/visible results
- ii. Ensuring volunteers have well-defined, achievable roles
- iii. Providing them with necessary training and tools to enable them to carry out their role with confidence (and feel they have gained additional life skills or skills for work)
- iv. Ensuring recognition of volunteers' contributions
- v. Ensuring that volunteers know where they can find support when the going gets tough (from other volunteers and/or external sources)
- vi. Involving volunteers in all aspects of program design and evaluation from the outset and trusting volunteers to make good decisions
- vii. Using transparent processes and straightforward language to build general trust in the program
- viii. Celebrating successes and learning constructively from mistakes
- ix. Including opportunities for communities to champion their own work and enjoy external recognition for their achievements and expertise, and
- x. Providing ongoing accompaniment and feedback.

9.3 Program planners are urged to consider contextual norms carefully before offering incentives (particularly cash) to volunteers for their day-to-day contributions. Do, however, aim to compensate volunteers for direct expenses incurred when attending trainings, planning

¹⁶ Located at: http://www.communicationforsocialchange.org/pdf/measuring_change.pdf

meetings, participating in community exchanges. Any 'reward' system should be carefully planned and agreed with the volunteers involved.

9.4 Communities themselves may need to find ways to support a community member tasked with CBMM, so that they do not become overburdened or risk loss of income as demand increases.

9.5 Volunteers need to include both males and females, to avoid women in the community being overburdened as community action is identified, planned and implemented.

10. A gender-sensitive approach

10.1 A gender-sensitive approach in malaria programming recognizes both gender and sex differences and strives to achieve equity in access to malaria prevention and treatment options. Social and biological differences determine different health risks, patterns of exposure, health seeking behavior, responses from health systems and also outcomes for both men and women, and all these differences have to be considered when programming for malaria.

10.2 Use the WHO 'Gender, Health and Malaria'¹⁷, and 'Mainstreaming Gender into Malaria and CSS Programming' fact sheets (Annex 8), and the Global Fund gender fact sheet¹⁸ and technical guidance to inform proposal development.

10.3 Gender has to be considered within these guidelines not as a separate approach to be taken in a specific phase of the programme design, but as a cross-cutting issue to be mainstreamed in all the programme cycle. To do so, it is important to consider the different impacts that a programme may have on women and men as part of the community. For examples on different approaches to integrating gender into malaria policies and programmes, see Part II of the Toolkit 'Mainstreaming Gender into Malaria Programming'. Please note that gender-unequal and gender-blind approaches should be avoided.

10.4 In order to understand how a community is organized and what the gender dynamics and power relations are among women and men in that community, create and promote spaces only for women, only for men, and mixed ones, e.g. focal groups organized to analyse different needs or resources, access and control profiles.

10.5 If health equity is to be promoted, programmes should not only satisfy women's practical needs, e.g. in a community where males are privileged to sleep under the net, it is not enough to provide a net for women, it is also important to include activities that address the strategic needs of women, such as awareness-raising activities on gender equality.

10.6 Applying a gender-sensitive approach to malaria programming does not mean considering issues relating to women alone or developing projects just for women, as gender relates to both women and men as well as to the power relations between them. Key to CSS is the involvement of the community in all steps of the programme. However, it has to be considered at what levels, and for what, women and men participate. Inequality is created or perpetuated when women's input relates to work as volunteers and men are paid for their work contribution in one form or the other. This further perpetuates gender stereotypes which affirm that women only are responsible for caring roles and volunteer activities. In order to change gender stereotypes and to promote health equity and gender equality, involve both men and women in volunteer activities and also in remunerated activities.

11. Enhance learning exchange and communities of practice

¹⁷ Located at: http://www.who.int/gender/documents/gender_health_malaria.pdf.

¹⁸ Located at: http://www.theglobalfund.org/documents/rounds/9/CP_Pol_R9_FactSheet_1_Gender_en.pdf.

11.1 This concept is important for three main reasons. First, community-to-community transfer of concepts, skills and problem-solving processes and tools can be a very powerful mechanism for ‘horizontal’ scale-up. Second, communities can be considered the ‘universities’ of learning in this process, and, if program managers, policy makers, academics and donors want to learn more about community-owned response, they need to be present in communities and learn directly from the people involved in the process. Third, being part of a ‘learning’ community may be satisfying for many volunteers.

11.2 Use CSS funding to provide opportunities for community members to get together to share or transfer experience, to carry out peer reviews of initiatives, and so on. Include opportunities for communities to host learning visits from policy makers, program managers and donors.

12. New technologies

12.1 New technologies such as community-managed community radio, mobile telephony-based initiatives, community-oriented use of digital still and video cameras, 2.0 web-based collaborative tools such as social networking sites, and solar powered technology, have rapidly become more accessible and present new opportunities for communication, gathering information, sharing experience, and organizing, coordinating and increasing participation. Grameen Solutions, part of the Grameen Bank in Bangladesh, are recognized for their advances in using mobile telephony for health. Web4dev.org is a regular conference held by the United Nations where innovations in web technology for development are discussed at length. Presentations are available on YouTube.

13. Linking the community system with the local health system

13.1 Community system linkages with the local health care system should work in both directions. Communities are typically called upon only when the local health care system needs information and in-kind or financial resources. Community systems should also link with health care systems in order to mobilize technical resources for prevention and care or when they identify needs in communities that are not addressed effectively, either for managerial or structural reasons.

13.2 Where community understanding of malaria and demand for effective responses is increased but service provision lags behind, community members can become de-motivated. Proposals for community-owned response programs should describe available provision for joint planning and for transparent reporting on planning processes. The proposal should also refer to the supply chain and logistical arrangements that will ensure reliable community access to malaria-control commodities. Where joint planning processes and/or supply-chain management need to be strengthened, these issues should be addressed in the proposal, ideally as a complementary HSS strategy.

13.3 The interconnections between CSS and HSS (at the local, sub national and national levels) are critical and should be integral to proposal development. Work to connect the two will help build bridges and mutual sensitization of each others' issues, and could lead to joint identification of sustainable solutions and greater ownership.

13.4 In addition, in order to address the root cause(s) of an issue i.e. the social, political, and environmental determinants of any health issue, action outside the health sector is often necessary. Working intersectorally is therefore a key to ensuring the success of a community-owned response. In maternal health, for example, involving the transport sector has proved vital in ensuring safe deliveries for women in remote rural areas¹⁹, and could make a

¹⁹ Source: www.who.int/making_pregnancy_safer/health_systems/involving_communities/en/index.html

difference in terms of arrangements for transporting a child sick with malaria fever. Working with municipalities potentially creates links between all sectors at the district level. It can make for an excellent, coordinated response, addresses determinants, and is good for local advocacy.

13.3 CSS funds can be used to prepare community representatives to engage effectively in joint planning sessions and to facilitate their attendance (cover transport costs, offer a per diem for time spent on meeting preparation, participation and follow up). CSS can be used to ensure that community members have lobbying skills, data collection skills and tools, and are able to carry out community assessments and consultations. The preparation for effective participation is an important aspect of capacity building and minimises tokenism. This is especially true for the participation of women and youth, who may not be familiar with participating in formal fora and may require new knowledge and skills in order to be effective participants.

14. Transparency and accountability

14.1 Transparency and accountability are key concepts that foster trust in the community-owned response approach at community, implementer, policy and donor levels, and enhance the implementation process. They can be promoted by:

- i. Ensuring community involvement in proposal development (i.e. ensuring accountability to the program constituency from the outset)
- ii. Working closely with CCM civil society representatives to ensure that timely and accurate information regarding the Global Fund proposal development process is available to their constituency in line with recommendations on partnership and implementation made by participants at the 2008 Global Fund Partnership Forum²⁰
- iii. Ensuring community-owned response programs are based on a sound conceptual framework and documented process. Organizations may have their own implementation model or may adopt an approach such as the malaria community competency model.
- iv. Being specific when defining CSS activities and associated budgets within the proposal to ensure that funds are effectively ring-fenced and can be tracked
- v. Working with community members to build appropriate and acceptable checks and balances into programs to protect community members and program managers from any attempt to misuse program resources
- vi. Including opportunities (e.g. stakeholder meetings) for communities to hold service providers, decision makers and program managers accountable, and building associated community capacities
- vii. Building complaints and redress mechanisms into the program and ensuring that all stakeholders know when and how to access them
- viii. Use simple language throughout, and pay close attention to translation of concepts and definitions into local languages.

15. Going to scale through community-owned response programming

15.1 Proposals should include an intentional plan for going to scale. From the outset, program design should balance the need for an authentic response with the need for community processes that are feasible and affordable at large scale. However, programs must be flexible enough to respond to variations between and within communities and must allow adequate

²⁰ Located at: http://www.theglobalfund.org/documents/partnershipforum/2008/PF2008_Recommendations.pdf

time for the process of capacity building. Programs should not cut out or limit essential steps such as problem identification, prioritization and strategy formulation by communities²¹.

15.2 Going to scale through community-owned response depends on two, concomitant and complementary processes: scaling *up* accompaniment and scaling *out* through community-to-community transfer. Scaling up accompaniment requires investment in ongoing training, coaching and organizational development and the use of cost-effective methods such as cascade training structures. Methods can be disseminated through manuals, training packages and internet sites and the approach can be promoted through available mass media channels.

15.3 Communities taking charge of the issue of malaria are highly motivated to share their experience with other communities. Therefore, scaling out will take place on an opportunistic basis, but proposals should also include strategies to enable community members to network. Community members can be physically brought together at meetings and events or, increasingly, linked via electronic means. Electronic means of communication could also be used to document community experiences. They could be used to 'communicate' the experience by capturing the voices of community members closely involved with success in one community for sharing with other communities. This could supplement the actual movement of people, and help document the experience for other audiences, serving a crucial advocacy purpose.

15.4 Both strategies of scaling up and scaling out require trust in the capacity of community members to identify threats, act on them, measure change, learn and adapt. Communities use their own strengths to act, and inspire others into action. Hence CSOs need to look at communities as a source of partnership and inspiration. Nurturing this world view among CSO workers, program managers and local authority representatives is a key ingredient in any large-scale community-owned response.

Next steps

At present, organizations using approaches that prioritize community ownership need to work creatively to fit their programs within the Global Fund performance-based framework. In recognition of the vital role of community-owned responses in malaria control, an expansion of the Global Fund CSS framework is recommended. It is recommended that a Roll Back Malaria Partnership Communication and Behaviour Change Methodologies (including CSS) working group be set up to take this forward and work to ensure that community-owned response strategies are strongly represented in National Strategies. All involved in community-owned response programming should build on their efforts to document their work, share experiences, and build networks among successful community initiatives. This will involve establishing better links with colleagues advocating for this approach in the fields of HIV/AIDS and TB.

²¹ Source: Costello A *et al.* 2008 Alma-Ata: Rebirth and Revision 5. Community participation: lessons for maternal, newborn and child health. *Lancet* **372** 962-71.