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Best Practices for Community-Led Monitoring

O'NEILL INSTITUTE FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

ACT THE ADVOCACY CORE TEAM

TAC TREATMENT ACTION CAMPAIGN

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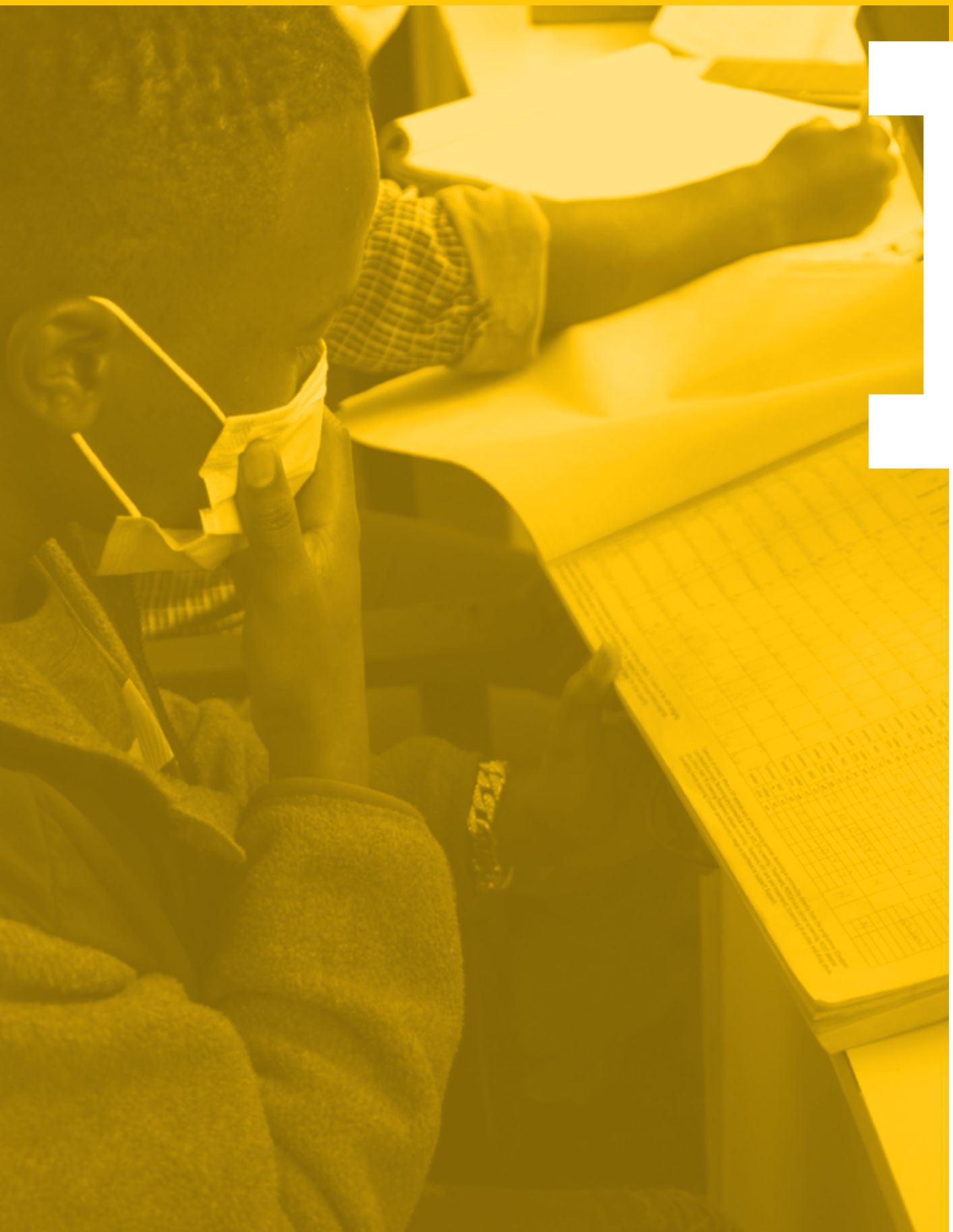
HEALTH GAP GLOBAL ACCESS PROJECT

BEST PRACTICES
FOR COMMUNITY-LED
MONITORING

Contents

Acronyms and Abbreviations

C19RM	COVID-19 Response Mechanism
CBO	Community-Based Organizations
CD4C	Community Data for Change Consortium
CHW	Community health worker
CLAW	Community-Led Accountability Working Group
CLM	Community-led monitoring
CRG	Community, Rights and Gender
CSO	Civil society organization
DHIS-2	District Health Information System 2
TA	Technical assistance



Introduction

This resource documents best practices for the implementation of community-led monitoring (CLM) based on surveys and interviews with CLM implementers around the world. The resource contributes to the growing evidence base for effective CLM implementation, drawing on targeted global engagement with CLM programs focused on HIV, tuberculosis, and malaria in the context of the COVID-19 pandemic. As CLM continues to grow and expands into new countries and new focus areas, this empirically-driven evidence base will support CLM implementers, funders, and global technical assistance (TA) providers to ensure CLM is implemented more effectively and achieves greater impact.

While community monitoring of health programs is not new,[1] more recently, CLM implementation has rapidly expanded. Donor interest in CLM has grown, with PEPFAR requiring CLM in all countries since COP20[2] and through Global Fund grants as well as technical assistance support as part of its Strategic Initiatives,[3] COVID-19 Response Mechanism (C19RM), Community, Rights and Gender (CRG) team and the UNAIDS technical support mechanisms.[4] The CLM approach has additionally been identified by the Global Fund as a key mechanism for identifying and mitigating the impact of COVID-19 disruptions on health service delivery.[5]

This analysis builds on an important body of work defining CLM and its core tenets, developed by CLM implementers, UNAIDS,[6] and global technical assistance consortia such as the Community-Led Accountability

1. Baptiste S, Manouan A, Garcia P, et al. Community-Led Monitoring: When Community Data Drives Implementation Strategies. Curr HIV/AIDS Rep. 2020 Oct;17(5):415-421.

2. PEPFAR. PEPFAR 2020 Country Operational Plan Guidance for all PEPFAR Countries. 2020.

3. The Global Fund. 2020-2022 Strategic Initiatives. July 2020.

4. UNAIDS. UNAIDS Technical Support Mechanism: Annual report 2020-2021.

5. The Global Fund. COVID-19 Response Mechanism Information Note. 25 June 2021.

6. UNAIDS. Establishing community-led monitoring of HIV services — Principles and process. 25 February 2021.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Working Group (CLAW),[7] Community Data for Change Consortium (CD4C),[8] and the EANNASO-APCASO-ATAC consortium.[9] However, as several CLM programs conclude their first years of implementation, this is a critical moment to evaluate country experiences, learn from key challenges and successes, and define effective approaches for CLM implementation.

These lessons presents empirically-derived guidance and best practices for CLM implementation from a global exploration of real-world implementation and suggestions from CLM implementers themselves. Best practices are implementation arrangements and approaches that help deliver CLM more effectively, and are aligned with the core values and principles of CLM.[10]

Throughout this report, the (narrative) findings and suggestions within the "challenges" and "best practices" sections were drawn from interviews with CLM implementers. The narrative also highlights "recommendations" from the programs. Given the nascent nature of many CLM programs, many recommendations emerged from existing challenges that are yet to be supported by evidence from implementation. Challenges were defined as practices or occurrences that challenged CLM programs' abilities to deliver on their strategic objectives. Best practices, by contrast, were practices described as having been helpful to overcome challenges/barriers. Recommendations were suggestions by CLM programs foreseen as a valuable practice. These findings represent the lived experiences and beliefs of CLM implementers, although future work is needed to continue identifying impactful and novel approaches for CLM.

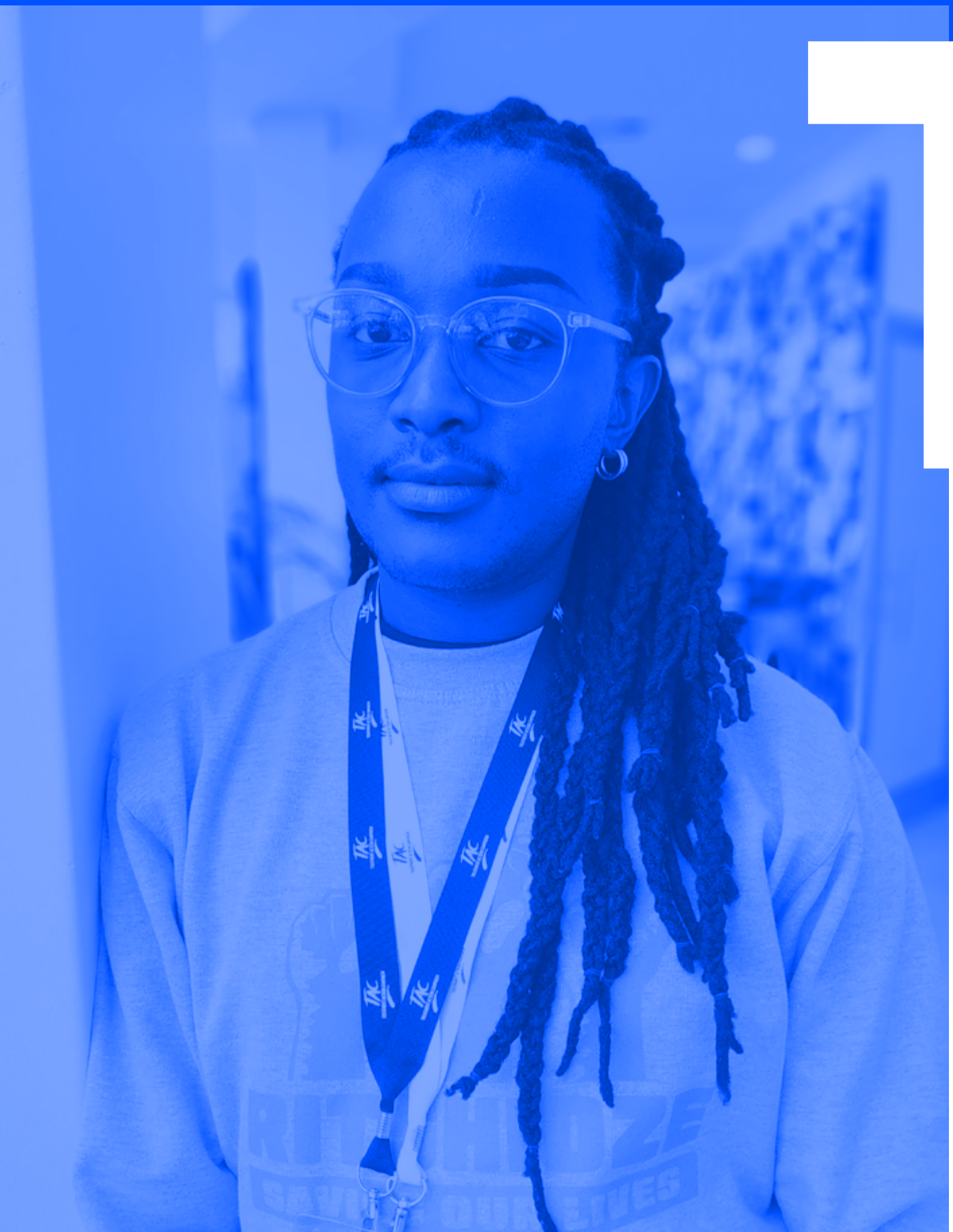
Other data presented in the form of statistics and figures are findings from a quantitative survey completed by the same CLM programs. As such, all data in this report are drawn from the information gathered through survey tools and during individual interviews conducted with CLM programs, except for what is included in the text boxes, *'Lessons from Technical Assistance Providers'*.

7. Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality. 2020.

8. Led by ITPC Global with MPact, African Men for Sexual and Rights (AMSHeR), Asia Pacific Coalition for Men's Sexual Health (APCOM), Caribbean Vulnerable Communities (CVC), Eurasian Coalition on Health, Rights, Gender and Sexual Diversity (ECOM), Global Coalition of TB Activists (GCTA), ITPC EECA and ITPC WCA.

9. Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO) with APCASO and Alliance Technical Assistance Centre (ATAC) in Ukraine.

10. Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality. 2020.



Target Audience

The findings and resources developed through this work will support learning, adaptation and adoption by communities implementing a range of CLM programs within and across regions. These resources will support key aims for four audiences, including:

1. **CLM implementers:** Developing evidence-supported lessons and experiences from implementing CLM, including what works, doesn't work, and what to keep in mind when starting or designing a CLM programs
2. **Donors:** Providing evidence-supported feedback on donor practices that are empowering and those that create challenges
3. **Global TA providers:** Reinforcing with evidence the core principles as outlined in the white paper,[11] adapt/expand on these principles as needed
4. **CLM stakeholders and duty bearers:** Informing key stakeholders, including Ministries of Health and public health bodies of good practices when collaborating with CLM programs to improve the quality of healthcare services.

11. Community-Led Monitoring of Health Services: Building Accountability for HIV Service quality. December 2019. O'Neill; TAC; Health GAP; ITPC; ICWEA; SMUG ;HEPS

Community-Led Monitoring

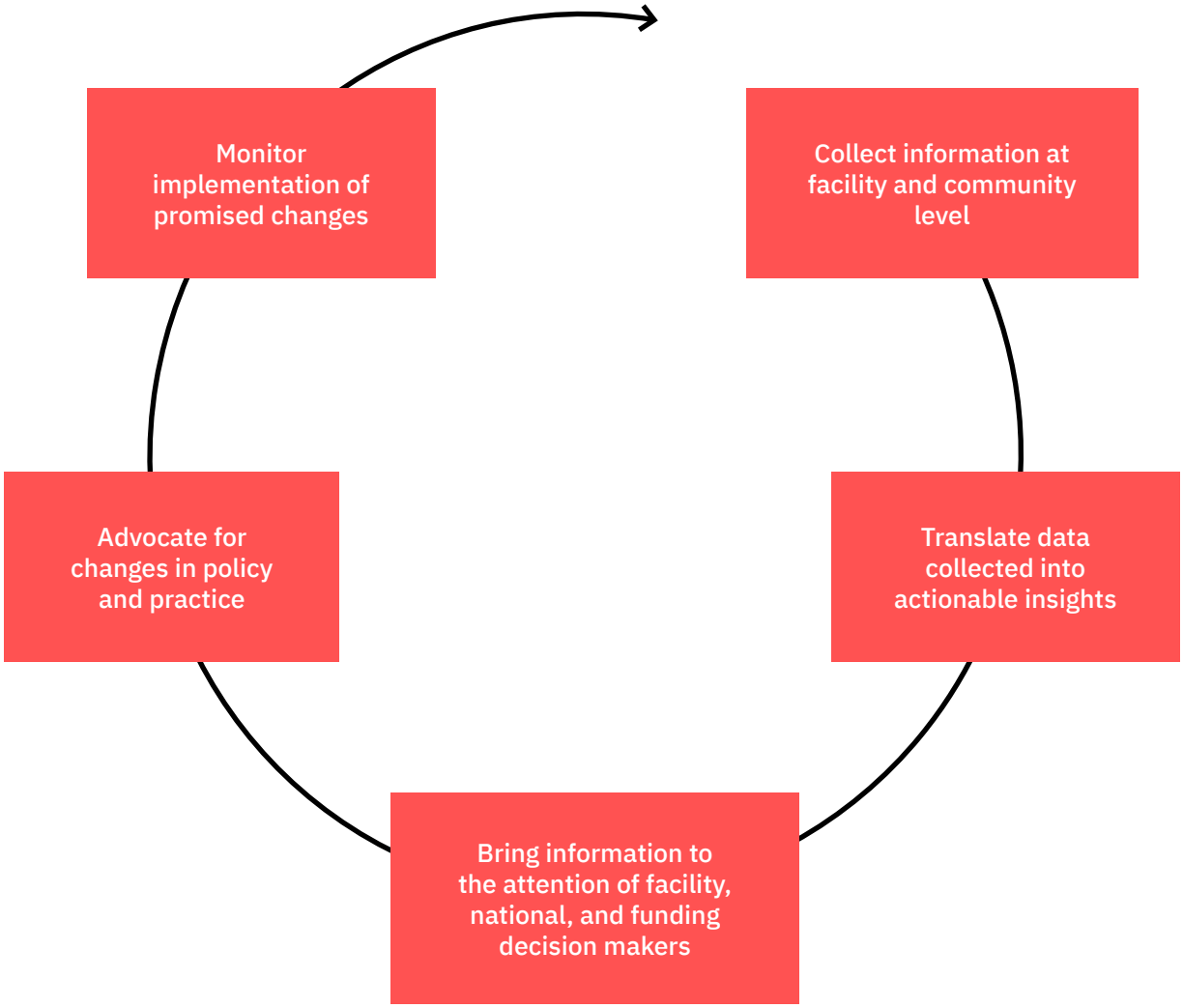
The joint efforts of civil society, governments, and donors have achieved tremendous progress in the fight against HIV, tuberculosis, and malaria as public health threats. Despite progress in many countries toward elimination and control targets, many countries continue to be left behind. The COVID-19 pandemic has widened gaps and challenges in access to and quality of services, overwhelmed healthcare systems, exacerbated financial pressure on domestic financing of healthcare, increased incidence of intimate partner and gender-based violence, and increased experiences of stigma and discrimination in health care settings and other human rights and gender-related violations among key and vulnerable populations. Early evidence from the Global Fund suggests that the added pressure of COVID-19 has reduced access to HIV prevention and testing services, TB treatment, and testing for malaria.[12]

Identifying ways of improving healthcare quality and access, while mitigating the impact of COVID-19 on HIV, TB, and malaria services, is an urgent priority. Community-led monitoring of healthcare services has emerged as an important tool for improving the quality and accessibility of healthcare services while building political accountability of healthcare providers, governments, and donors too, and by the people and communities they serve.

In general, CLM is implemented through routine information gathering (at the community or facility level), analysis of data to identify gaps and barriers, co-creating solutions to issues identified in the data, feedback of findings and solutions to decision makers and duty-bearers, and advocacy for changes to policy and practice. In contrast to traditional monitoring and evaluation methods, community-led monitoring is

12. The Global Fund to Fight AIDS, Tuberculosis and Malaria. Results Report 2021.

Figure 1: The cycle of activities in the CLM model



differentiated by a service user- and community-driven approach that not only identifies gaps but uses routine data collection to advocate to duty bearers to improve service delivery, generate political will, and improve accountability.[13] Importantly, CLM must be led and owned by organized communities and users of healthcare services.

13. Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality. 2020.

Foundations of community-led monitoring

CLM is based on three key principles[14] which are consistently present across CLM definitions by the Global Fund,[15] PEPFAR,[16] and UNAIDS:[17]

1. Community-led monitoring requires leading and ownership by independent communities/civil society.

2. Community-led monitoring requires organized communities for effective monitoring.

3. Community-led monitoring focuses on generating political will to enact change and ensure accountability of decision-makers and other duty bearers.

14. Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality [white paper]. February 2020

15. The Global Fund. Technical Brief: Community systems strengthening. October 2019.

16. PEPFAR. Community-led Monitoring. 2020.

17. UNAIDS. Establishing community-led monitoring of HIV services. 2021.

Methodology and Study Participation

Sources of data

Participants were recruited electronically using a brief screening questionnaire, which gathered informed consent and data on key parameters of the participants' CLM program. A brief study description and link to the screening questionnaire was distributed widely through the following channels: a) directly to CLM programs identified by the CLAW consortium; b) via CLAW consortium members to networks more broadly, including through the CD4C and EANNASO-APCASO-ATAC consortia, the Global Fund, and UNAIDS; c) via social media; and d) on electronic notice boards on global public health institutions and universities. The screening questionnaire was available in English, French, Portuguese, Spanish, and Russian. After completing the brief screening questionnaire, CLM programs that met two of the three following inclusion criteria were invited to participate in the second phase of data collection:

1. Program implementation is led by a local civil society organization; key, vulnerable, or priority populations; and/or people living with or impacted by HIV, tuberculosis, or malaria;

2. Program activities include collecting data on healthcare quality and access; and

3. Program activities include advocating for solutions and working with decision-makers for change.

Programs operated by international research bodies operating across multiple countries were excluded. CLM programs that met this inclusion

criteria were sent an invitation with a link to the longer, quantitative survey.

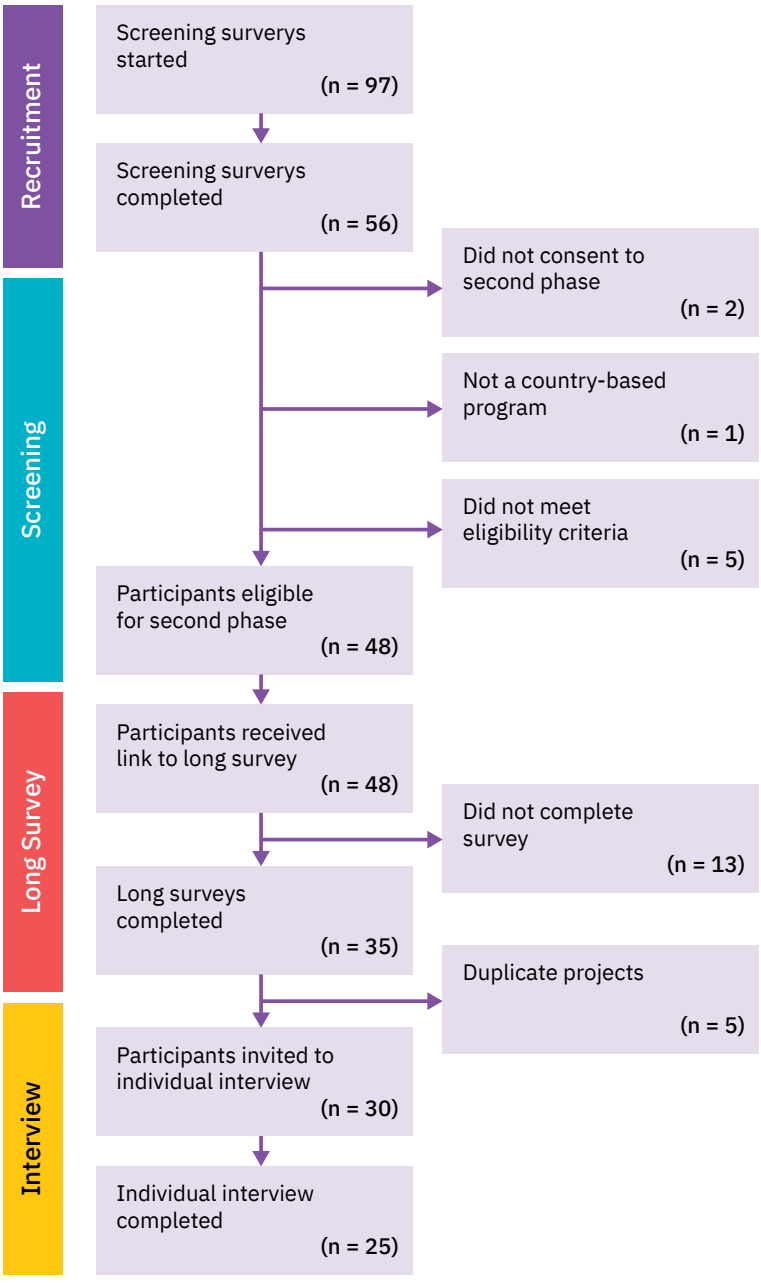
The second phase of data collection consisted of a longer, more in-depth quantitative questionnaire, followed by a tailored, semi-structured interview, exploring the implementation of CLM programs in greater detail. Once a CLM program had completed the quantitative questionnaire, they were invited to a qualitative interview to discuss in-depth, key aspects of their program, with a particular focus on challenges, successes, key learnings, and recommendations for best practices. Interviews were conducted on recorded Zoom or phone calls in the respondent's preferred language.

In keeping with the principles of community-based participatory research, all tools and resources were designed with and for the benefit of CLM programs and the communities they represent and serve. As such, the data collection tools were developed using a consultative process to ensure that survey instruments were not only technically sound, but also prioritized collecting information on key issues and themes that would be valuable to CLM implementers and their allies. Input on tool design was gathered through key informant interviews with four current implementers of CLM programs, as well as from the CLAW, CD4C, and EANNASO-APCASO-ATAC consortia. Tools were designed to prioritize collecting data on the key areas of the CLM cycle, with a focus on exploring existing challenges and proven and suggested best practices from the perspectives and experiences of CLM implementers.

Initial findings were shared with CLM implementers for review and to provide additional feedback. In this consultation, hosted as part of the UNAIDS Communities of Practice, the original respondents were invited to attend, as well as other CLM implementers identified through the screening tool and through CLAW and UNAIDS networks.

Program participants

Between 13 January and 8 February, 2022, 97 participants consented to participate in the project, of whom 60 respondents from 29 countries completed the initial

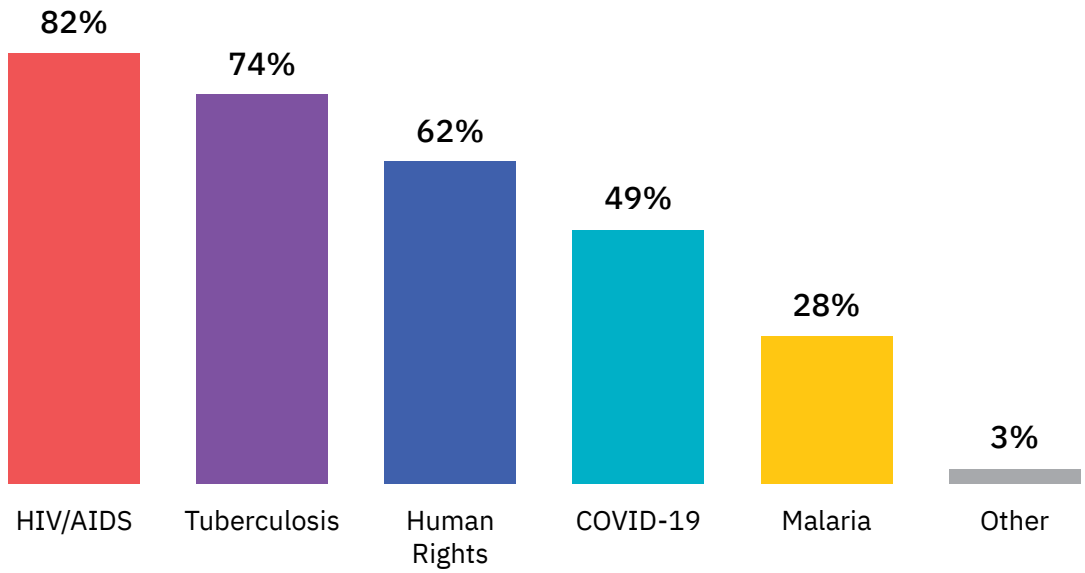


screening survey. Thirty-five eligible respondents, representing 23 countries, completed the long-form survey. The majority of countries represented were in Sub-Saharan Africa (77%), with additional representation from Asia (17%), Europe (3%), and Latin America and the Caribbean (3%). In 9 of the 23 countries represented, multiple respondents per country completed the initial survey; in some countries these respondents were from the same CLM initiative, in other countries these respondents were from differing CLM initiatives due to the open distribution approach of the screening questionnaire.

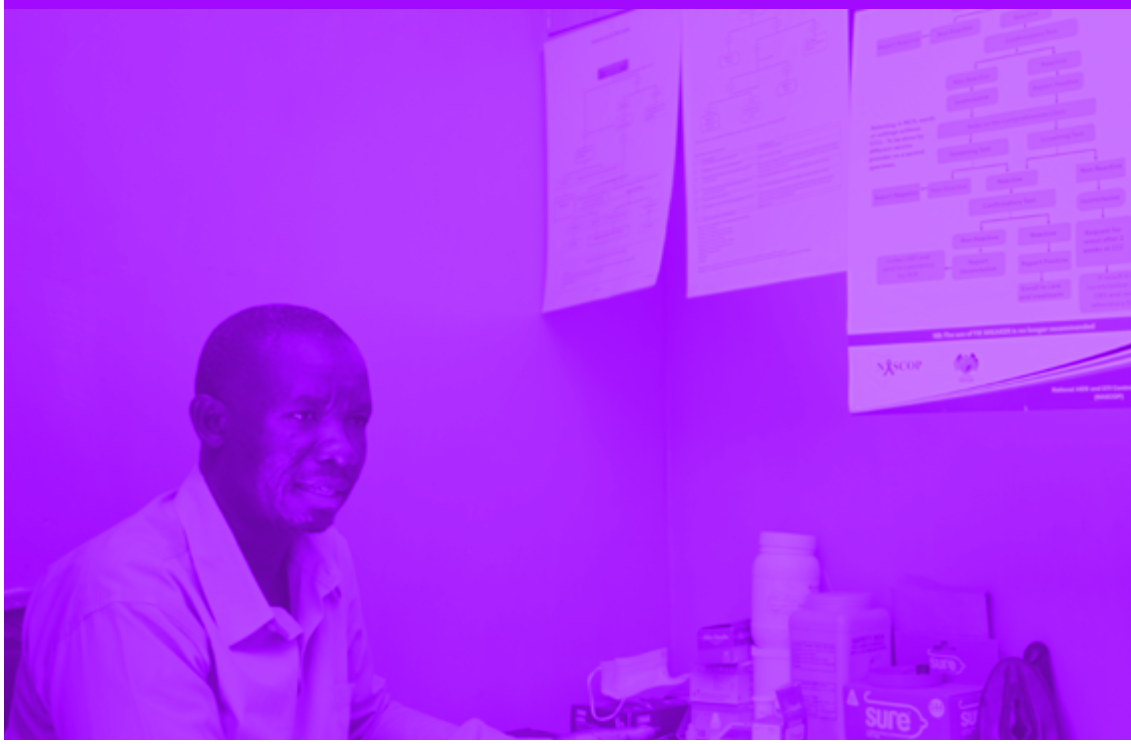
Figure 2: Regions of countries that completed the long-form survey

The majority of respondents that participated in the long survey were either staff at an organization leading the CLM program (72%) and/or community members involved in the program (26%). Most programs (82%) monitor indicators related to HIV, and 74% include TB indicators. Less commonly, 62% monitor indicators related to human rights and 49% monitor COVID-19 indicators. Only 28% of programs include monitoring on malaria indicators.

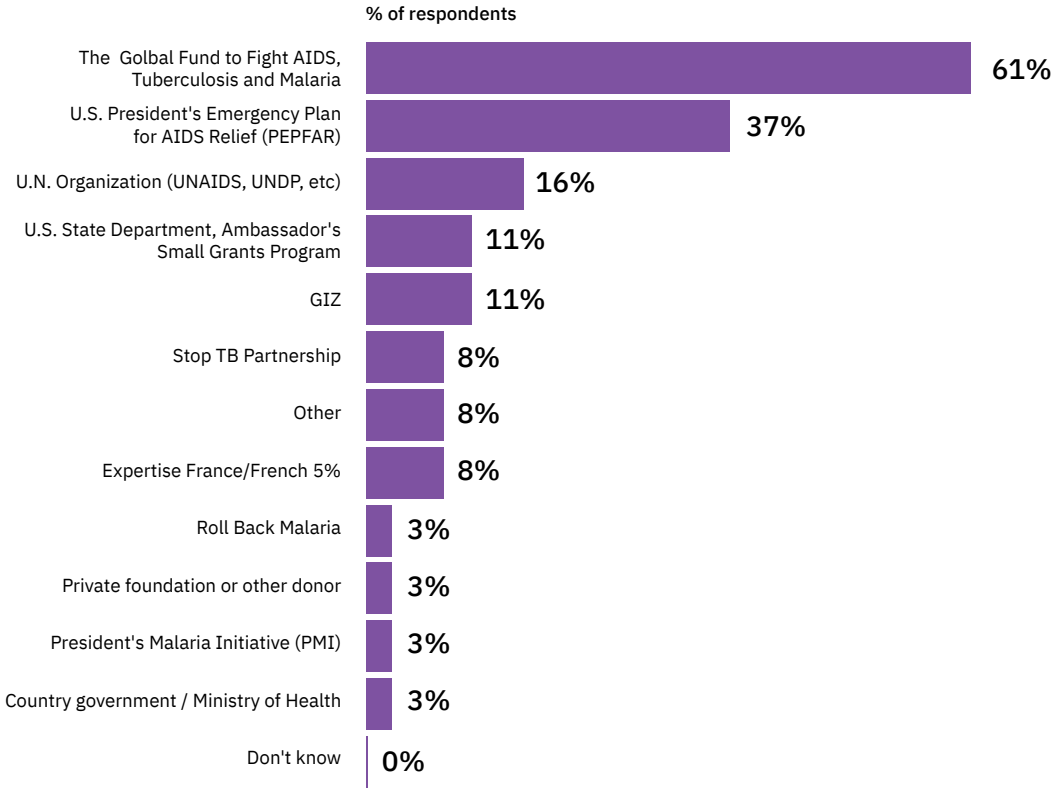
Survey question: “What is the focus of this project?”



Most (61%) participants in the long survey identified the Global Fund to Fight AIDS, Tuberculosis and Malaria as a current or former source of funding for CLM programs. Other commonly-identified donors included PEPFAR (identified by 37% of participants), a United Nations agency (16%), the U.S. State Department Ambassador’s Small Grants Program (11%), and GIZ (11%). Less commonly-identified donors included the Stop TB Partnership (8%) and Expertise France/French 5% (8%).



Survey question: “Which of the following have ever funded your CLM program?”



Project Set-up and Governance

The first phase of setting up a CLM program is creating an independent structure for project implementation and governance led by local, community-led and community-based organizations (CBOs), people living with and impacted by the three diseases, key populations, and other service users. According to the programs surveyed, these governance structures are often highly collaborative, with 92% of programs reporting more than one organization involved in program implementation.

A strong governance structure is key for enabling CLM programs to solicit funding, manage staffing and other start-up steps, and ensure the successful implementation of the project. Coordinated, community-led governance structures are not only key for successful monitoring and advocacy, but are also identified as an outcome of themselves: 63% of programs report increased capacity for local organizations to conduct advocacy as a key program outcome, and 60% identify strengthening local capacity to collect and analyze data as another.

89%

of respondents' programs are implemented by at least one organization led by key, priority, vulnerable, or affected population groups

64%

of respondents report at least six organizations involved in project implementation

63%

of respondents report increased capacity for local organizations to conduct advocacy as a key program outcome

According to survey data, most programs found the engagement of donors and governments to be productive, and many wished for stronger partnership in key areas, particularly around using CLM data to improve partner performance. Nonetheless, 29% of respondents indicated that donors have attempted to challenge their program's independence, and 22% said the same of local and national governments.

Common challenges in project set-up and governance

Hiring and retaining project staff.

Among CLM programs surveyed, 46% reported managing human resources (such as hiring, retaining, and training project staff) as an important challenge. While CBOs play a critical role in project set-up and governance, some programs additionally described during interviews substantial turnover and attrition in project staff and community volunteers as an ongoing challenge in implementation. Reasons offered for high turn-over included lack of adequate or sustainable payment available for project staff, and younger groups of community cadres who move on to other opportunities.

Coordinating community-based organizations.

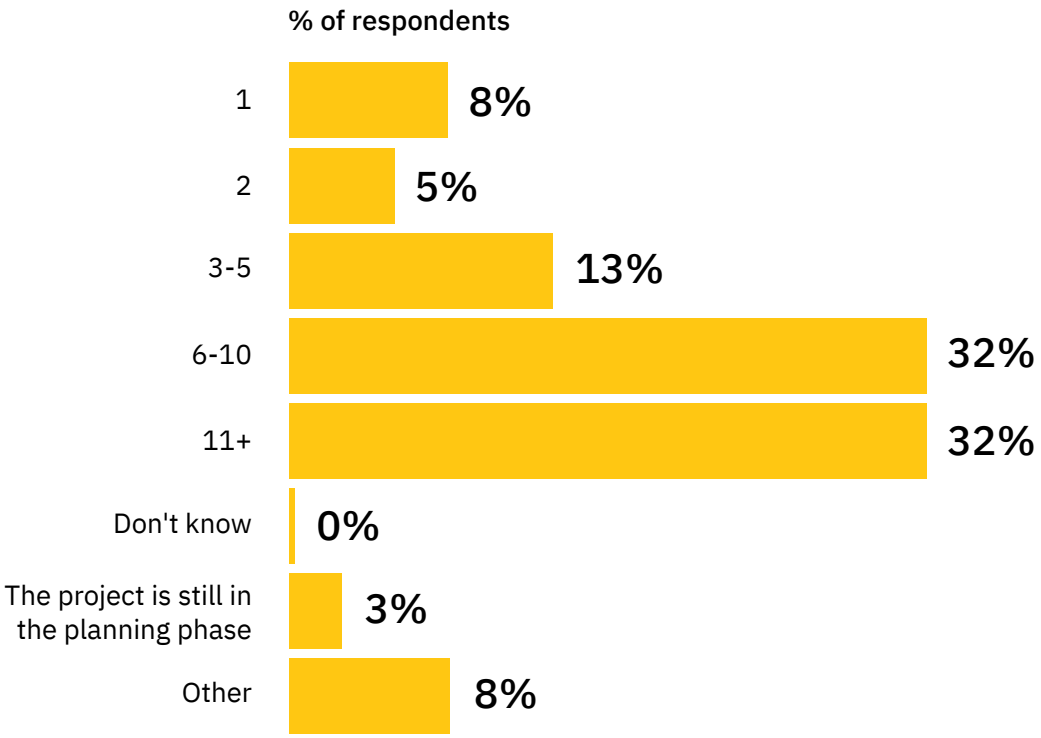
During interviews it was shared that although the participation of civil society and community-based organizations is a key strength of community-led monitoring, coordinating multiple organizations within the program can present challenges. Respondents described the need to manage the differing interests, priorities, and agendas during set-up and throughout implementation.

"When you engage the CBOs in the monitoring process, it tends to be a little bit more challenging than when you engage the normal citizens, because the CBOs – although they are in the localities where you want to do the monitoring – they have their own interests, agenda [...] So, what we did [was] we came to an agreement that we will use individuals instead of the organisations, [...] we will engage the organisation but the modality of using the organisation will be through the individuals. [If] the nature of funding allows you to to sub-grantee those CBOs, then it's better if you design a small project, you subcontract them to do that kind of monitoring for a given period of time, so that after you leave, they could have gained that skills, they could have gained the knowledge and then they could sustainably conduct it without depending on you."

— Respondent from Eastern Africa

Survey question: "How many organisations are involved in the implementation of this project?"

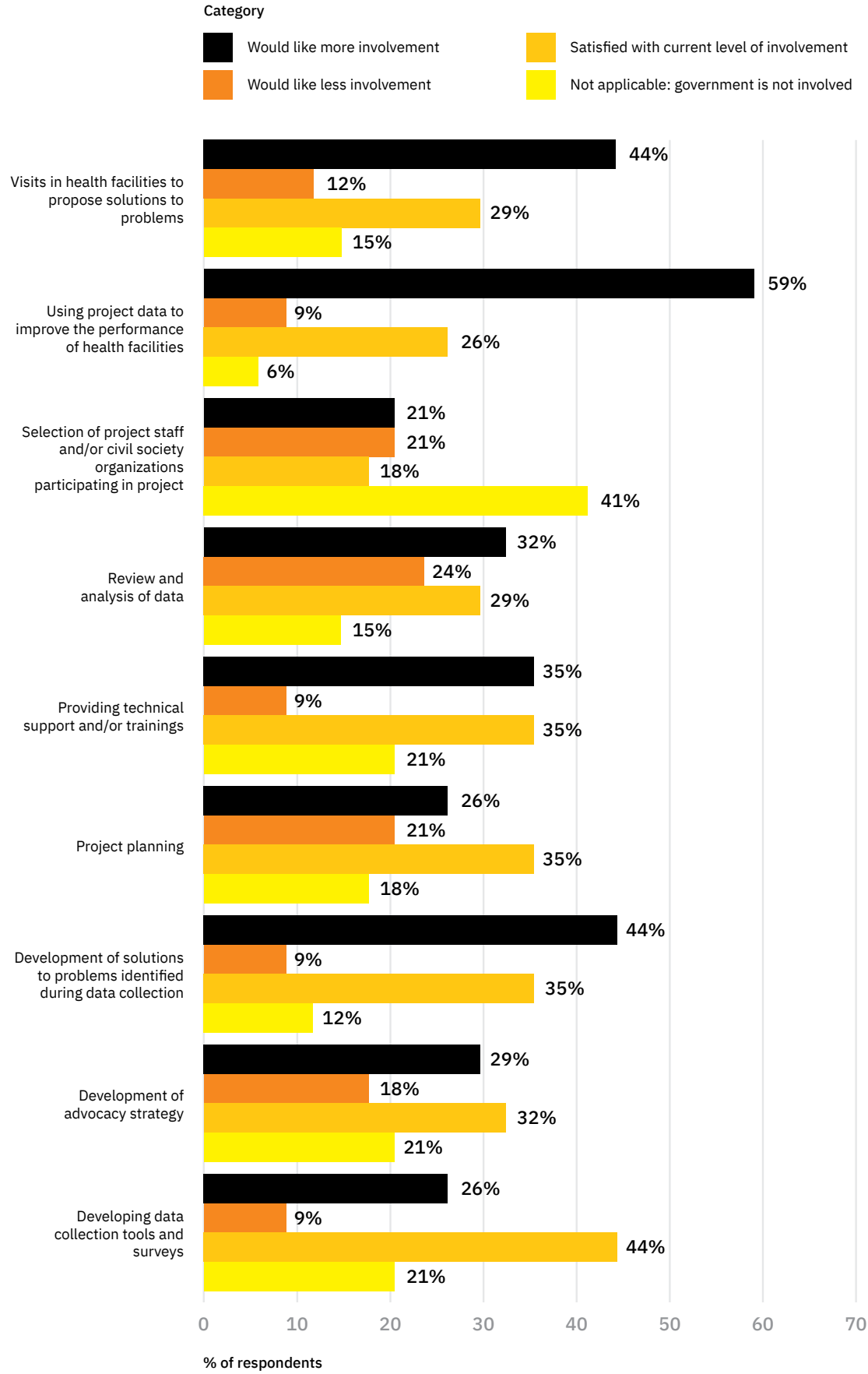
(Not including government, donors, or technical assistance providers)



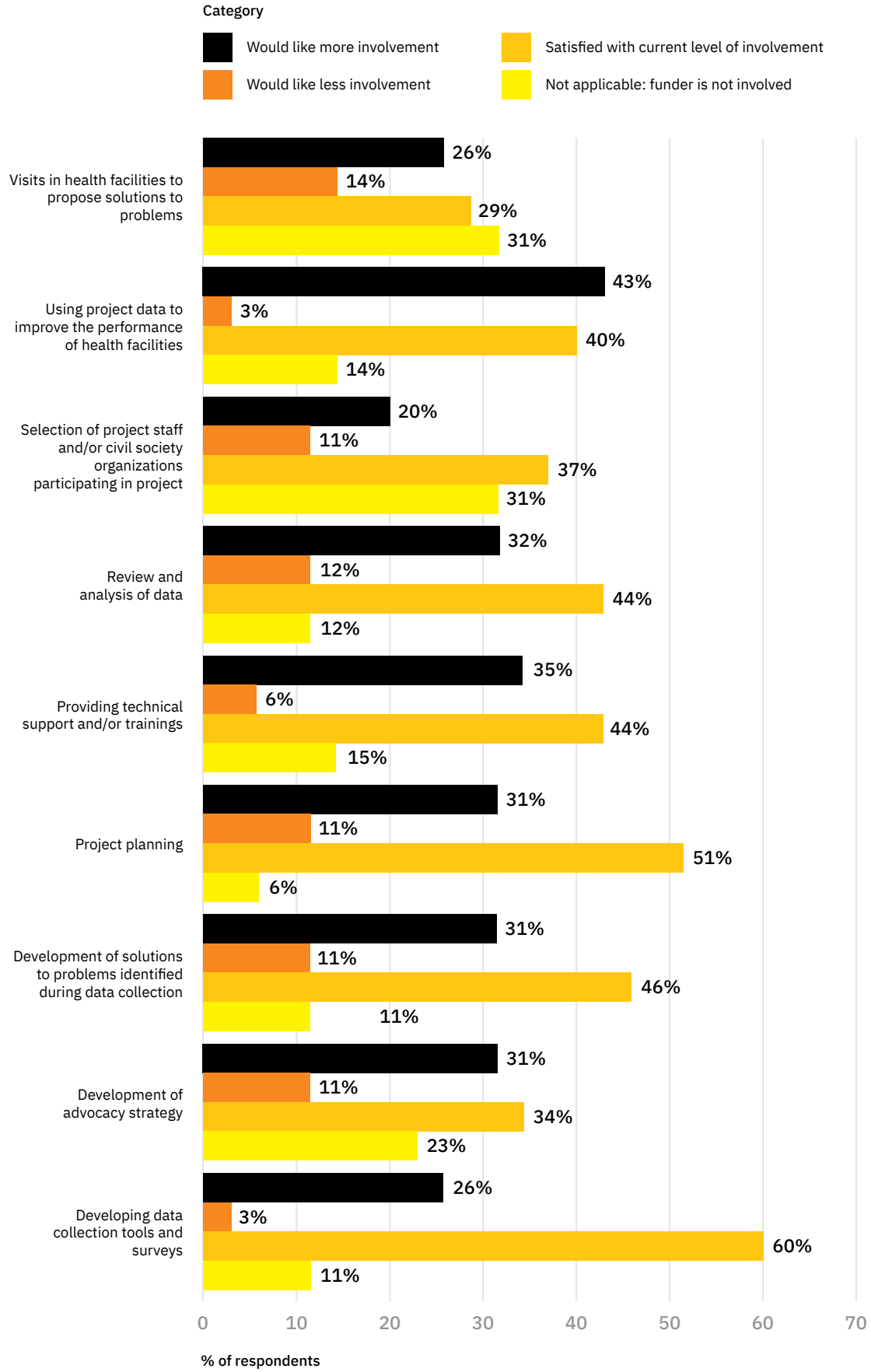
Engagement with government.

When starting a new CLM program, a key start-up challenge reported is securing the buy-in of government, which typically requires a phase of sensitization of national and local government actors and key stakeholders, e.g. Ministry of Health. Among survey respondents, 34% identified the political situation in the country as a challenge to conducting CLM. Some respondents described difficult relationships between government and the non-governmental sector in their countries, which can make CLM work dangerous due to sanctions, discrimination, or other barriers. In some cases, governments were reportedly actively hostile to CLM, while in others CLM teams faced challenges in securing meetings and drawing attention to the program, particularly when governments are prioritizing addressing COVID-19 and other competing health challenges.

How satisfied are you with the government's level of involvement in the project?



How satisfied are you with the program funders level of involvement in the project?



Delays in receiving funding.

Programs that experienced delays in receiving initial funding, either as a result of protracted contract negotiations, or late disbursements from donors or lead organizations, reported facing challenges around loss of support from governments and other stakeholders. Interviewed programs described developing a governance structure and successfully soliciting buy-in from government while waiting for secured funding to arrive, yet losing momentum when implementation was blocked by unanticipated and prolonged delays in financing. Other ongoing programs, which shared experiencing delays in receiving funding from donors, described ways in which other organizations had stepped in to cover expenses during these funding delays, but voiced concerns regarding the sustainability of CLM programs that relied on this approach.

Selection of health facilities/ communities.

Respondents described two main challenges related to the selection of health facilities and communities in which CLM is implemented. Firstly, some CLM budgets were said to be inadequate to allow CLM to be conducted in a sufficient number of health facilities or communities to achieve adequate national coverage, thus challenging the program's ability to produce useful results for advocacy. Secondly, some programs described situations in which they have not been able to choose which facilities are selected, as these are often predetermined by donors and/ or the government.

> "We only needed to [monitor] 14 facilities out of over a hundred. [...] We then had a discussion also with DoH, and they say they would want to recommend those facilities themselves as Department of Health, and when they selected the facilities themselves, we had no influence, in terms of 'we want that one, or we want that one.'"
>
> — Respondent from Southern Africa

Difficulty receiving permission to visit facilities.

For most CLM programs, some form of permission from the government is required before data collection can begin. Among 37% of respondents, accessing clinics and receiving permission to monitor was identified as a program challenge. Due to COVID, some of the health facilities were intermittently closed, which impeded access to CLM programs.

46%

of respondents reported that hiring, training, and retaining project staff was a challenge

59%

of respondents would like more engagement from governments in using CLM data to improve health facility quality

29%

of respondents say donors have sought to influence or challenge the independence of the program

Recommendations and best practices for project set-up and governance

Sensitize the project team to CLM principles.

When starting a new CLM program, implementers should prioritize, via an internal process, ensuring that the entire governance team understands the purpose, mission, and methodology of CLM. This step builds the capacity for all involved parties to support project planning and implementation. Further, during interviews, several projects suggested building a fora for collaboration between CLM programs; they described that this could help promote opportunities for learning and information sharing among implementers of CLM, such as through regional or topic-specific webinars and learnings. An additional suggestion was the opportunity for site visits to other projects in the region, which has successfully been done previously.

Lessons from technical assistance providers

Site visits by implementation teams to visit more mature CLM programs can be a valuable tool. These visits can be an opportunity for project leads from one program or country to shadow community monitors and advocates in a second country or program as they conduct data collection, feedback meetings, and accountability efforts. Teams can also benefit from observing and discussing strategies for reducing conflicts within implementation teams, as well as discuss best practices for securing financing, creating governance structures, and engaging with donors. Since the greatest impact is achieved through face-to-face learning, programs should consider travel for this in their budgets, although virtual engagement and relationship building between countries is also beneficial when costs are prohibitive.

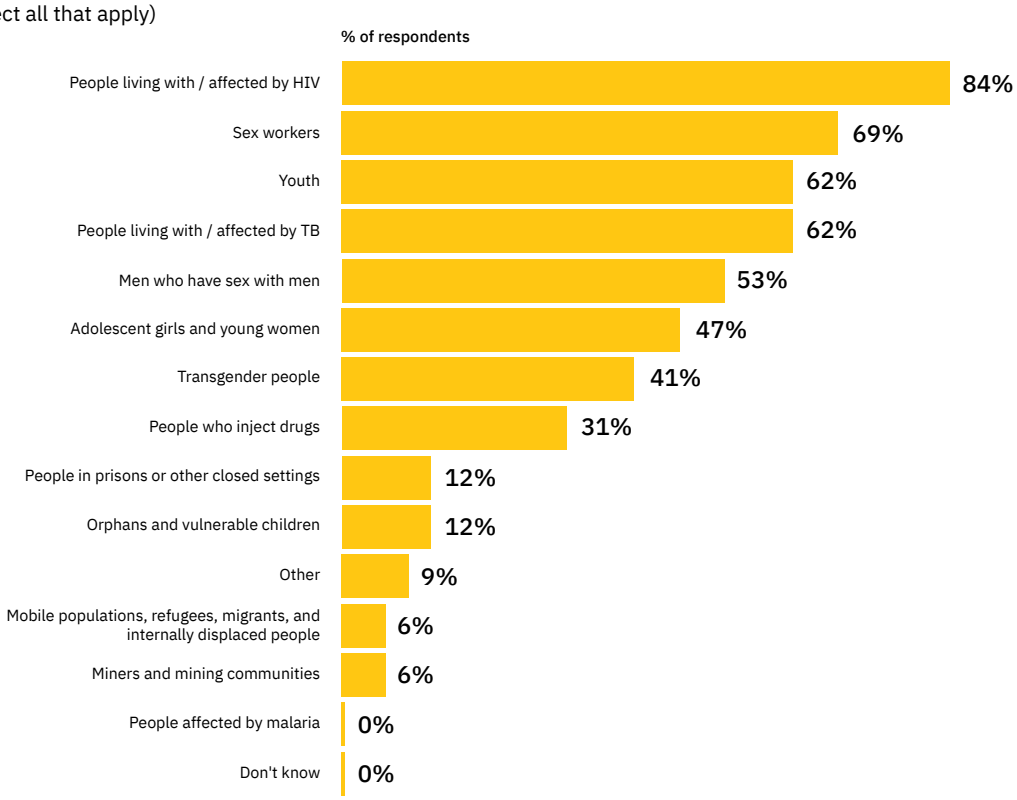
Promote early stakeholder engagement.

Given the need for buy-in and support from government, donors, and other duty-bearers, CLM programs should engage with key stakeholders early in the project set-up and throughout implementation. This must include a phase of sensitization, where the governance team should explain the value of CLM, including clearly defining it as being independent from government projects and functions.

Invest time for the project team to build awareness of the local, (provincial) and national political environment. While developing the approach to the CLM program, this will allow for more informed decisions related to all stages.

Please specify which key, priority, vulnerable, or affected population group(s) are part of leading implementation?

(Select all that apply)



Ensure representation from key populations.

A key principle of CLM is that populations impacted by *the three diseases* must lead the programs governance and implementation. Programs should ensure representation from relevant key and vulnerable populations in governance structures, key staff positions, and among community monitor.

Engage with civil society networks.

In many countries, existing community networks have a well-established presence in communities and with local and national government. Coordinating and cooperating with these networks can build the CLM program's visibility and capacity to conduct advocacy with government, such as through coordinating bodies like National AIDS Councils.

"One of the best practices is the patient-centered approach. Use the affected population. That's one of the best practices I can tell any country that wants to start [CLM]. Make sure you map those affected populations and involve them to take leading roles in the fight against the disease. This is one of the best practices and we have applied here and that's working. Because he who feels it, knows it. He can explain it better."

— Respondent from Western Africa

Solicit letters of approval from government.

Approval letters or Memoranda of Understanding (MOU) from Ministries of Health or other government bodies help facilitate positive engagements with government authorities and other stakeholders during project set-up and early implementation and can be a prerequisite to entering health facilities. For instance, CLM programs described having more productive engagements with health facilities and hesitant communities when accompanied by a formal letter of support.

"And every time we would bring up our ideas, the government would say, "OK, this is great, but again, this isn't what we hired you for, this isn't what we're paying for. Maybe some other time you will be able to use that." They basically just wanted to use us as a data collection tool, and just to do whatever they want with this data; they wanted to implement everything and regulate everything and manage everything themselves. So regardless of the ideas that we might have had, that didn't go anywhere."

— Respondent from Central Asia

Lessons from technical assistance providers

Documenting and formalizing how civil society and community organizations can participate in CLM governance is a critical step in building strong governance structures and supporting collaboration among the CSO partners. CLM programs should develop memoranda of understanding (MOU) that clearly define organizational responsibilities and expectations, define project decision-making procedures, delegation of powers on day-to-day implementation, frequency of meetings, and remuneration (if applicable). These MOU can ensure representation from all civil society networks and organizations involved, enable community members to participate in the project, and support cohesive implementation across the program.

Build a dedicated, specialized team and invest in ongoing training for CLM teams.

When planning staffing arrangements, some CLM programs described increased success when led by full-time staff members as opposed to part-time staff or volunteers. Team structures should include dedicated positions for specific tasks, such as team leads on advocacy, grant management and finance, data and analysis, and project management.

Prepare for high attrition.

Particularly for cadres of community team members and volunteers, programs should develop plans for how to mitigate high rates of turnover in order to minimize disruption. Suggestions for reducing turnover included building flexibility into their budget for recruiting and re-training team members, offering stipends and incentives to the project team, providing ongoing mentorship, and employing individuals already established in the community with a track record of engagement with similar projects.

Selection of health facilities / communities.

Financing should be adequate enough to allow for enough health facilities and communities to be included in the CLM program to properly identify and measure challenges faced by health service users. CLM programs should have ownership over, or be able to contribute to the decision of which facilities and communities are included in the program. Facilities and communities should be chosen with input from a number of stakeholders and feedback from key populations, following a pre-determined selection criteria.

"We had to pick a different approach that will actually give a complete picture of a community system itself. So, with the facilities, first of all, because we are working on HIV/TB, we gave a priority to the facilities with CTC ('Care and Treatment'). That was the first criteria, and then the other [was ensuring a] mix of facilities' level of service provision, like health centres and dispensaries, [...and] to have a mix of rural, urban or semi-urban facilities [...] That is how we determined the facilities. [...In addition to] the individuals that we were working [with], we also worked with the community systems, like the health facility governing committees, we also worked with the community health workers, we also worked with the particular individuals, like clients, like ex-TB patients, as well as PLHIV, as well as local leaders like village leaders or one of the executive officers, as well as we also engaged with these CBOs in particular area."

— Respondent from Eastern Africa


LOVELY LEOPARD

Financing

Community-led monitoring costs money: implementing organizations have to hire core staff, pay for office space and equipment, buy data collection tools like tablets and server hosting services, pay for travel expenses and salaries for data collectors and advocates, and publish reports and media products. The most commonly reported donors were the Global Fund and/or PEPFAR, with 97% of respondents reporting receiving funding from at least one donor, and 40% receiving funding from more than one donor

Funding levels for CLM programs ranged widely, from those with budgets less than $10,000 per year (40% of which are HIV projects) to programs spending more than $1 million per year (primarily large TB monitoring projects). In general, programs averaged between $8,000 and $9,000 per site monitored. Nonetheless, nearly all programs reported not having enough funding to pay for all their planned activities, and 67% reported that funding is sometimes, often, or always delayed.

61%
of programs received funding from the Global Fund

88%
of programs report not having enough funding to reach their objectives

67%
of programs report that funding is sometimes, often, or always delayed

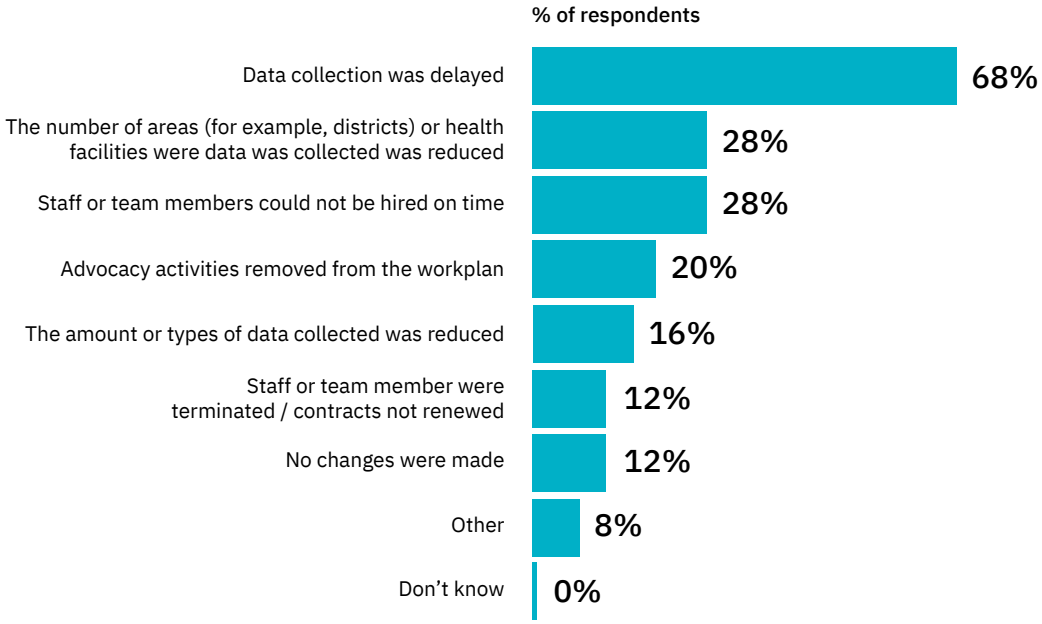
Common challenges in financing

Insufficient funding and inadequate budgeting.

Insufficient funding was a common challenge, reported by 88% of programs. Facing budget shortfalls, projects often cut back on key CLM activities, such as by limiting the geographic scope of monitoring, not being able to afford all the project's supplies, not hiring all the staff they needed, or cutting back on types of data collected and/or advocacy activities planned. Budget issues often impacted advocacy efforts, such as by prioritizing data collection over advocacy, or cuts to data collection impacted the representativeness or legitimacy of monitoring data. In other cases, insufficient funding meant projects did not have the budget to remediate urgent issues identified during data collection. Programs described instances in which disbursed funding was less than that which had been discussed and agreed during consultation periods, or instances in which funding only covered CLM activities and not other core costs, leaving a gap in budgets. Further, during interviews, some projects also shared facing challenges in knowing how to adequately cost the full range of CLM activities.

What changes did your CLM program make because of delays in receiving funding?

(Select all that apply)



"The biggest challenge for success: the financial constraints. The main problem of CLM is financial constraint."

— Respondent in Central Africa

Challenging funding models.

Despite the need for independence and community leadership in CLM programs, many respondents described challenges as a result of receiving funding directly from donors. For some donors, small community-based and -led organizations are described as being either ineligible to receive funds or only being eligible as sub-grantees or sub-recipients to larger implementing organizations. Granting mechanisms with layers of intermediary recipients limited the ability of implementing organizations to reimburse indirect costs, thus challenging the financial sustainability of the program. Survey respondents reported that unsustainable funding streams (54%) and coordinating between multiple donors during funding applications (26%) are key challenges.

"When you are a sub-grantee with these Global Fund funds you are kindly forced to be given funds for just the activity implementation, instead of a project. So, when you are given CLM as an activity, then you will see much of funding goes to activities instead of covering the indirect costs as well. So, that affects the organization because there are people who will not travel, there are people who will be in the office, there will be utilities..."

— Respondent in Eastern Africa

Budget restrictions.

Programs identified donor resistance to funding specific types of activities, most commonly purchasing tablets and other digital tools to collect data, providing adequate incentives and stipends to data collectors, and fully reimbursing travel costs to remote communities and health facilities. In some cases, programs asked data collectors to gather data with personal telephones or asked data collectors to reimburse their travel expenses out of pocket. Other programs reported lack of flexibility in budgeted activities as a challenge, which prevented programs from adapting activities to projects' needs.

"The funding model is not working, it is too layered. Funding monitoring via Ambassador's Small Grants [...] is viewed as being politically aligned since the Embassy comments on political discourse"

— Respondent from Eastern Africa

Delays in receiving funding.

Delays in receiving funding from a donor or intermediary organization were reported by 66% of programs, with funding "often" delayed or "always" delayed among 16% of respondents. Delays were typically 1-3 months, although 8% of respondents reported delays longer than six months. In some cases, delays were mitigated by an allied organization fronting the project costs, although 68% of programs that experienced delays experienced delays in data collection, 28% could not hire staff on time, 20% removed advocacy activities from workplans, and 12% terminated or did not renew staff.

> "We really don't know if we'll get this funding, because it has been promised that it comes, then it's not coming. So we are just in a dilemma [...] We are not given even the reasons why the funding is delayed or what. So, we are just waiting, but we're really disappointed and we're not sure."
>
> — Respondent from Eastern Africa

Complicated funding applications.

To finance CLM programs, several projects reported engaging in lengthy consultations during national funding applications, only to find that the eventually allocated CLM budget was significantly reduced in the final approved budget. Other programs, particularly smaller or newer programs described that knowing where to apply for funding or how to navigate and engage with the funding process was not always straightforward.

> "While we are writing [the Global Fund funding request], we had a community consultation. All the constituencies [...] joined together, we prioritized our program under the fast-track contract, and allocation grant that we submitted to the Global Fund. According to Global Fund guidelines, there was a clear guideline: the community investment should be optimum 25%. When we received the final grant signed from the Global Fund, when they approved, we can see that only 4% [was allocated for communities]. That's ridiculous [...] it is peanuts."
>
> — Respondent from Southern Asia

Lessons from technical assistance providers

PEPFAR promotes the U.S. State Department Ambassador's Small Grants Program as a funding mechanism for CLM in its COP guidance. Yet in practice, the siloed dispersal of small funding packages has created challenges in coordination across implementers, delayed project implementation, fragmented civil society, and put substantial reporting burdens on organizations already struggling with capacity to meet CLM implementation requirements. Underfunded individual implementers have struggled to overcome the coordination burden inherent to this funding structure. PEPFAR should customize CLM funding structures to countries' context and community feedback, with a focus on streamlining funding flows, reducing intermediary funding recipients, and allocating regular funding levels through core funding streams.

CLM programs utilizing single "pass-through" entities such as UNAIDS have had good success with this model — especially when the expectations of the pass-through entity's involvement in the project is made clear and limited at the beginning. In these circumstances, the pass-through organization is responsible for official tracking and managing all finances for the CLM program as well as reporting to the donor, allowing CSOs to focus on CLM implementation. It's important that the pass-through entity is seen as neutral by all parties (like UNAIDS) as opposed to being a service delivery or implementing partner where conflict of interest (COI) could develop. Additionally, for this model, ideally CSO implementing organizations should already have a clearly defined MOU and coalition in place, rather than the pass-through entity being responsible for choosing CSOs to implement CLM after funding has been released to it.

Conflict of interest in funding arrangements.

Surveyed projects reported challenges in funding arrangements that risked creating conflicts of interest. In scenarios where the CLM program is tasked with monitoring an intermediary organization, some respondents expressed concerns around maintaining independence in the project implementation. Others expressed a perception that by funding CLM programs, donors were retaining control over the project and its data.

> "[Funding] was supposed to come since last year. We're expecting to start the CLM by — it was just immediately after the training and other arrangements, I think by July, they're supposed to start by July, so we've been waiting for funds, no funds."
>
> — Respondent from Eastern Africa

Lack of compensation for data collectors.

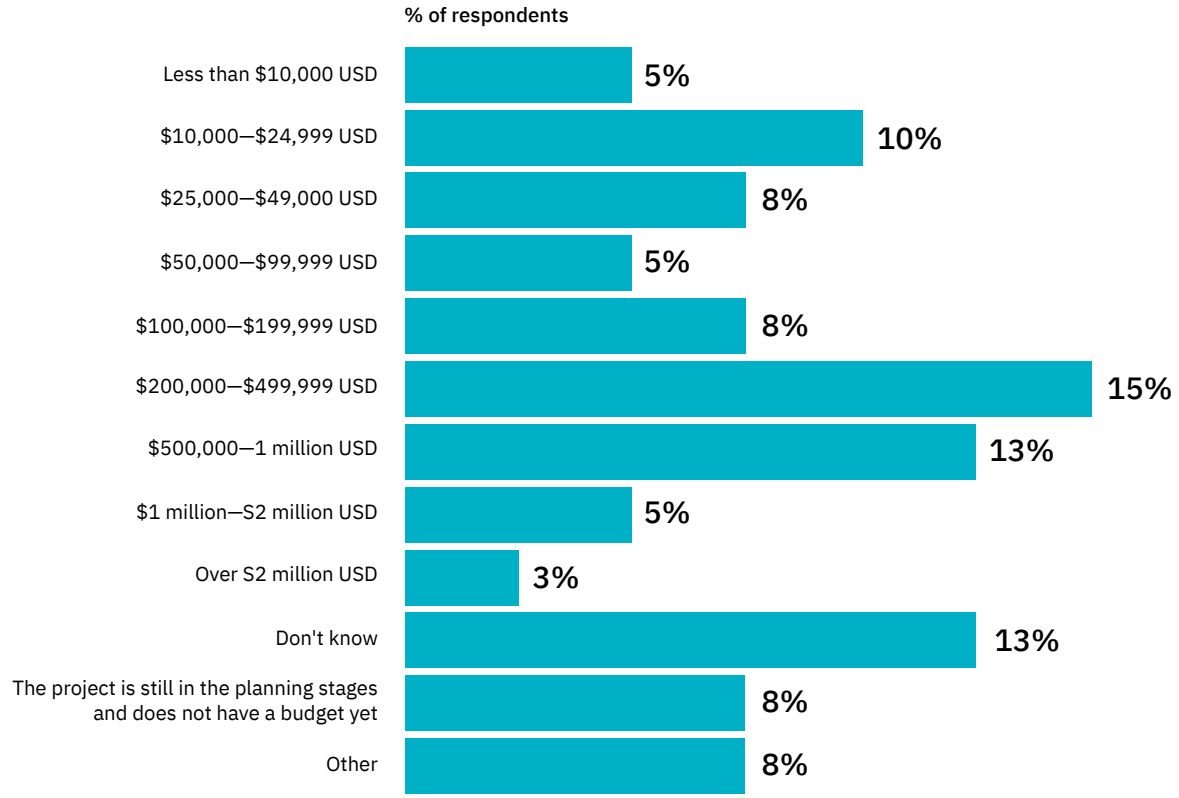
In cases where budgets were too small, or where donors did not reimburse incentives for data collectors, the monitoring team were either asked to work uncompensated or to pay out-of-pocket for some expenses. Some respondents described requirements by donors to align the pay of CLM monitors with that of government-funded community health workers (CHW), which created challenges when CHW salaries were considered to be very low.

> "The problem we have is they have community health workers [...] that are directly working for governments and what they are giving them is very small. So the Global Fund will always say we are giving this [amount of payment] to these people so we want to give you the same. And that is a different thing because we're CSO, we use a CSO approach, and we have CSO monitors, they are not government. Global Fund will always say we will not give this one this, or that, they will compare."
>
> — Respondent from Western Asia

> "It's difficult because the funder is saying, "That's the [funding] ceiling, we can't go beyond." And when you look at the expectation in terms of the outcome, the expectation is so huge. But [...] the funders will always talk about this concept of 'low cost and high impact.' You go for some review meetings and people ask me a whole lot of interesting questions, like "If you could speak to that [issue], if you could speak to these things too, but you didn't look at them?" The investment that we received did not allow us and can't allow us to be able to speak convincingly or look critically at some of these things. So, the issue of investment or funding is very critical."
>
> — Respondent from Southern Africa

What is the approximate annual budget for your monitoring project in the most recent fiscal year?

(Select all that apply)



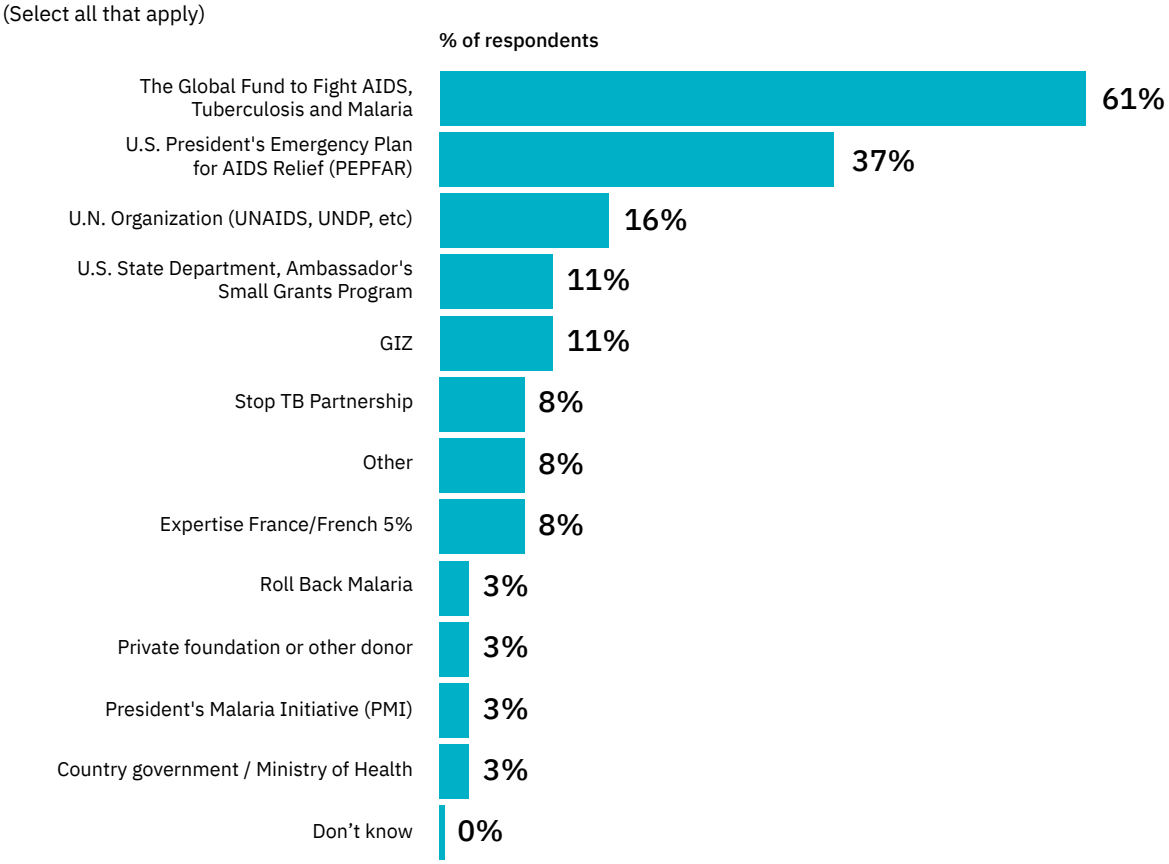
Recommendations and best practices for financing

Fully fund CLM budgets.

Increasing funding was described by 89% of programs as needed for CLM to be more effective in the future. Program implementers and donors must ensure that the full cycle of CLM activities are fully funded. Approved budgets must be sufficient to reach an adequate geographic and population coverage, collect data on the areas prioritized by communities and service users, and conduct advocacy using these data. In early phases of CLM implementation, budgets must also fully fund start-up costs such as purchasing tablets for electronic data collection. Budgets also need to be adequate and sufficiently flexible to respond to fluid, context specific circumstances such as inflation-adjusted fuel costs. Project implementers and donors must also ensure that the scope and scale of the CLM program is not overly ambitious given the funding levels and that essential elements, like advocacy and indirect costs, are covered from project funds.

What is the approximate annual budget for your monitoring project in the most recent fiscal year?

(Select all that apply)



Donors and intermediary recipients commit to on-time disbursement of funds.

Noting the often limited capacity for community-based organizations to fill funding gaps, donors should ensure on-time release of funds and commit to monitoring the passage of funds through intermediary implementing organizations. Ensuring stronger guarantees of funding arriving on time was recommended by 66% of respondents as an enabler of program success. Donors should additionally improve transparency around funding arrangements and flows, particularly in cases where CLM implementing organizations have poor visibility on the status of funding.

Approve funding to evolve approaches and course-correct.

Given the inherently iterative approach of CLM, donors and intermediary funding recipients should build flexibility into grant budgets. This should involve leaving a portion of the grant not associated with specific activities, or, given as core funding or indirect costs in order to allow for mid-cycle course corrections, adjustment of the data collection methodology, and improvements to the advocacy strategy. In addition, donors should approve budget lines for standard CLM technologies, including tablets for data collection.

Build capacity and eligibility for CBOs to receive funds.

Donors should improve the ability for community-based organizations to successfully solicit funding by delivering outreach and educational activities and support capacity

building (via technical assistance) for CLM programs to more effectively develop and manage budgets. These could include webinars to guide applicants through the application process or technical assistance with developing workplans and budgets.

Where possible, creating or modifying eligibility for funding streams creates greater opportunities for local, community-based organizations to act as direct recipient of funds. Without compromising CLM independence, donors should invest in neutral capacity-building activities for community organizations, to strengthen their ability to receive and manage funds, such as through strengthening financial systems, support with resource mobilization, and building programmatic capacity.

> "If there could be a mechanism that could channel resources direct to the consortium itself, or if possible, they assess the capacity of organizations and see if these organizations can access monies [directly]. The question that we have been always raising has been that since the National AIDS Council is the coordinating board, if it is seen to be implementing programs, then that creates some kind of conflict of interest. [...] But if the flow is direct [...] they just put some good monitoring mechanisms that will help those that are implementing not to go astray in budgetary allocations, so that they [...] have the controls to make sure that things are followed as they are supposed to be."
>
> — Respondent from Eastern Africa

> "It's really important for donors to not underestimate communities as professionals, because they know what they're doing, and [...] they definitely need to have more trust in them because they don't and it's a little frustrating."
>
> — Respondent from Central Asia

Lessons from technical assistance providers

To build the financial capacity of recipient organizations and to enable local community organizations to implement CLM, donors should develop guidelines for intermediary organizations on expectations and policies to follow specifically when subcontracting for CLM programs. Such guidance should complement or build on existing guidance, but should additionally clarify expectations that sub-agreements are eligible for indirect cost recovery in most cases and limitations on the intermediary's role in project implementation.

Data Collection and Use

Data collection, primarily in health facilities and surrounding communities, is the first phase of the CLM cycle after project set-up. The focus of the monitoring is usually determined by the organization(s) implementing the project (in 69% of programs) and community members (62%), although a minority of respondents described donor and government leadership in designing data collection tools (26% and 23%, respectively). The most common topics monitored include accessibility and quality of services for key and vulnerable populations (90% of programs); stigma, discrimination, and staff attitudes (82%); availability of services in the community (79%); and availability of medicines and stock-outs/shortages (79%).

In 55% of programs surveyed, data are collected by members of communities impacted by the three diseases using electronic tools such as District Health Information Software 2 (DHIS-2), CommCare, and OneImpact. While many programs report a small scope, with 26% monitoring in 25 or fewer facilities, a small minority of programs report monitoring in more than 400 facilities. Data collection

90%

of programs monitor accessibility and quality of services for key and vulnerable populations

40%

of programs report data collection and management as a key challenge

55%

of programs use electronic tools to gather data, like CommCare or DHIS2

and management, including IT and technology, was listed as a challenge by 40% of survey respondents.

Common challenges in the collection and use of data

Monitoring using indicators inappropriate for the context.

In some cases, projects developed survey tools using standard indicators taken from other regions or countries that proved inappropriate for the program's context. In some cases, this was driven by a "top-down" implementation approach, where local input was not incorporated into tool design; other drivers included pressure to align CLM indicators with PEPFAR or national government monitoring and evaluation systems. The purpose of CLM is not to generate a new data stream on behalf of and for use by PEPFAR, the Global Fund or national governments, but to build evidence that is relevant to communities working to improve the quality and accessibility of health services. Moreover, while adaptation of indicators to understand the changing landscape due to COVID was not overtly presented as a challenge, there were cases where projects needed external technical assistance and guidance to develop a set of COVID relevant indicators.

> "There are national level interventions that are going on, with indicators that are tracking those interventions, and there is PEPFAR as a partner, they also have their indicators that they report on [...] Last time this was also the discussion whereby we were saying: "PEPFAR are requiring that we track their indicators". 'No, this is a community thing: we have to do it the community way.'"
>
> — Respondent from Eastern Africa

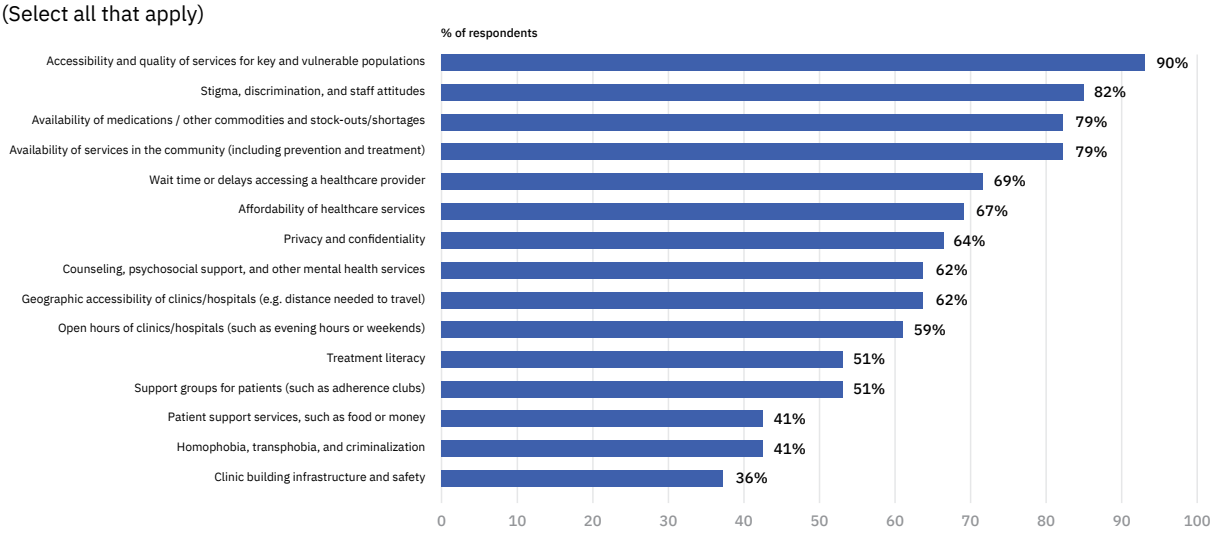
> "The type of tools are very global in nature, and when you get to district level, probably things will be slightly different. And I do appreciate why they've been made global in nature: global because we want them to be part and parcel, to fit into, or to feed into the DHIS2. So whatever we are developing, we want them to feed into the DHIS2. So, [its] very good, I think, probably the tools might be very good for national level advocacy, right? But for the local level advocacy, they might be missed out in the process."
>
> — Respondent from Eastern Africa

Survey design not adapted to respondents.

Respondents described that data collection tools were not always properly tested or adapted for the target population, creating challenges for respondents speaking different languages or with different levels of education. Insufficient financing and inadequate budgeting were described as an important barrier to translating tools into regional and local languages or dialects.

What are the major topic areas that are being monitored in this CLM program?

(Select all that apply)



Lack of data collection equipment.

Despite the majority of respondents gathering data electronically, several respondents described challenges convincing donors to pay for data collection tablets and the initial investment required to set-up electronic data collection systems. Others noted challenges around long procurement [processes?], with delays of more than six months reported when ordering electronic equipment like computers.

> "The procurement of [tablets], even up to now, they are still raising up the issue of the number of [tablets]. So, those are issues that we need to clarify with the LFAs, so that they can understand. Because if somebody is going to collect data in the field, on a real-time basis, they need to have a [tablet] to actually record, to make sure that the person is collecting that data at a health facility, or is collecting it within the communities.
>
> — Respondent from Western Africa

Insufficient budget for travel expenses.

Particularly when data collection takes place in remote areas outside of urban hubs, travel expenses are described as being an important challenge. Some countries described inflation as a driver for high gasoline prices, which have made transportation expenses higher than expected. Projects faced with budget shortfalls for data collection frequently reduced the geographic scope of monitoring and reduced the types of data collected, raising potential challenges for advocacy efforts. COVID's impact on the economy also directly impacted the possibility of traveling for the CLM program. Overall, programs consistently reported the lack of possibility of traveling during COVID due to lockdowns.

"For them to collect the data, they have to pay out of their pocket, which is not actually nice for them to be paying out of their pocket to collect data."

— Respondent from Western Africa

Challenges around timely data analysis and reporting.

Programs noted that the time required to analyze CLM data created a lag in the dissemination of findings, such that potentially outdated findings were being shared. Older data threatened the relevance of results and the usefulness of data for decision-making. Other respondents noted that the majority of the project's capacity was focused on data collection and data analysis, at the expense of feedback meetings with duty-bearers and advocacy activities. Due to COVID, some programs reported a complete stop of data collection for a specific amount of time until they were able to either adapt to digitalized remote data collection or were able to return to in-person data collection.

And almost every time that the donors are involved, they almost hire [the CLM team] and the organization only to collect data, and that's it. And then after they collect the data, the donors just take the data off their hands and do whatever they want with it. So, [the respondents] feel like they have no control over it, and that's a serious problem"

— Respondent from Central Asia

> "The other fear is related to community representatives' attrition. Our CLM relies and is layered on community cadres presence and participation. Their movement affects roll-out and continuity."
>
> — Respondent from Eastern Africa

Conflicts around data ownership.

Despite the CLM principle of community ownership, respondents described facing challenges when trying to use data or in releasing it to public audiences, with just 14% of survey respondents reporting that data are available to the public. In some cases, respondents described donors blocking the release of CLM data in an effort to block the release of facility-level data. Other respondents suggested that they were effectively "hired" by donors or governments to conduct data collection, with the data being taken and used without community participation.

COVID impact on data collection and analysis.

The lack of possibility to travel and the health facilities closures due to COVID were the main barriers faced by CLM programs. Moreover there was an instance that COVID's economic impact also posed an overall barrier for the program, resulting in per diem or travel reimbursement being unavailable or additional costs for internet as a result of meetings moving online, and one respondent described specific challenges in gathering COVID related information due to stigmatization and discrimination against those who may be infected.

Who is currently able to see, use, and analyze the CLM data?

(Select all that apply)

Recommendations and best practices in the collection and use of data

Collaborative data tool design and data collection.

Respondents highlighted the importance of involving a wide variety of community stakeholders in every stage of developing survey tools, data collection, and data analysis and interpretation. Programs noted the value of leadership and engagement of local community members, service users, people impacted by the diseases, and key populations both as data collectors, but also as participants in the data interpretation and advocacy phases.

> "What we found out, when we have people from the key populations and the person living with HIV go to the site, and then to talk with those person for the survey, the patient — the client — are more open to talk with them because they make confidence, they are very confident to speak with them."
>
> — Respondent from the Caribbean

Field test survey tools.

A key recommendation was to build in time and resources to fully pilot the data collection tools, and incorporate early modifications as needed. During the testing phase, members of the target populations should assess the clarity and appropriateness of each question as well as the time requirements for participants to complete the survey. All data collection tools should be translated into each of the languages and/or dialects spoken in the regions to be surveyed, and tailored to local literacy levels in order to improve inclusivity and data quality while reducing the time needed to collect data.

Lessons from technical assistance providers

Automation of standard data processes is essential for CLM programs. As noted, many CLM programs face challenges in analyzing data and utilizing it quickly for feedback to facilities and advocacy with decision makers and duty bearers. Building tools for automating many of the routine data extraction, cleaning, visualization, and reporting requirements for CLM programs is critical to relieve the burden on CLM programs of time-consuming manual processes. Additionally, as CLM programs scale, tools that support elements of project management and oversight are necessary to ensure completion of data collection and highlighting of issues that require rapid remediation.

These tools need to be sufficiently flexible, scalable, and intuitive to support different CLM programs individual needs rather than one-size-fits-all models. Data dashboards have been developed for programs in Haiti, Malawi, South Africa, Uganda, and Zimbabwe that automate all these processes. Additionally, these dashboards can support data transparency to other stakeholders and the public by making the dashboards publicly accessible.

Tailor indicators to context and advocacy needs.

In the CLM model, data collected during the first phase of the cycle are analyzed and used in decision maker and duty-bearer engagement and advocacy. As such, the design of survey tools should be explicitly designed to provide useful data in identifying gaps and developing solutions. Respondents recommended developing indicators that are drawn from standardized indicators but adapted to local needs, and developed in coordination with the advocacy team and data users. They suggested that having access to a repository of a variety of tools in use by CLM programs could help guide and support this process while still allowing CLM to remain community driven and context specific, collecting data on the community's priorities and at a level granular enough to help inform possible solutions. Quick adaptation of tools to capture COVID's impact on service delivery allowed programs to tailor their advocacy for the most urgent needs.

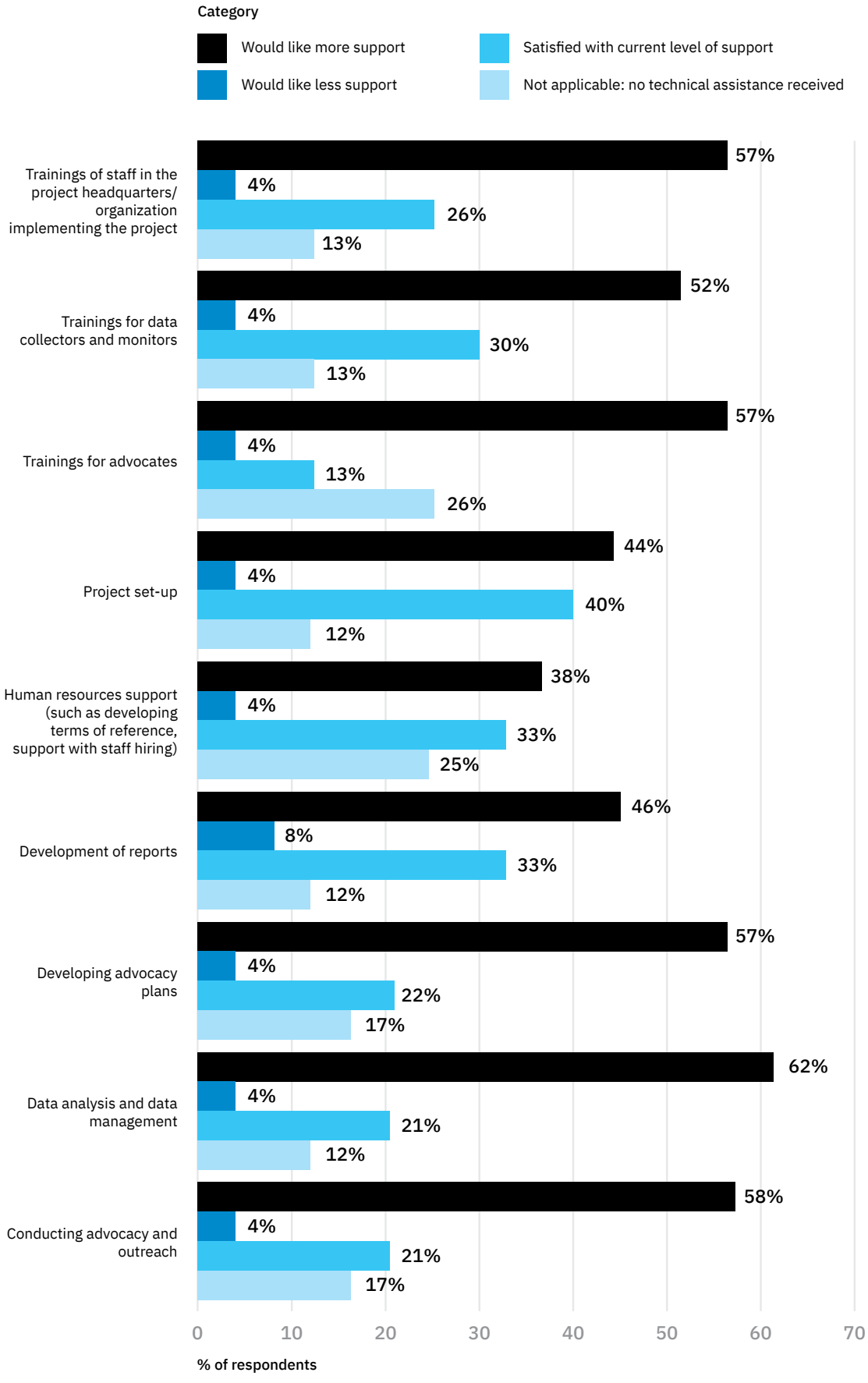
Retain flexibility to adapt tools during project implementation.

Programs should build in time and budget to revisit data collection tools each cycle or quarter as appropriate, and donors support flexibility related to tool refinement. While revisiting tools, the number of indicators should be held steady so avoid burdening participants and data collectors.

Adhere to principles of ethical data collection.

Data collection should adhere to best

How satisfied are you with the types of support your project has received from a technical assistance provider?



practices for ethical data collection, including ensuring the privacy of respondents, treating respondents with respect and dignity, and being transparent about the purpose and use of the data being collected. In general, CLM programs should avoid collecting personally identifying information about respondents as part of routine data collection.

Modernize data collection and analysis methods.

Respondents identified the use of digital tools as key for improving the ease of gathering data, the quality of data collected, the capacity to analyze data, and the ability for projects to strategically pivot in response to findings. Particularly for data collection in rural areas, data collection technology must operate on batteries and off-line; respondents suggested coordinating hot spots where data collectors can access an internet connection to upload data. COVID had an unexpected positive impact as a driver for digital solutions for data collection. Some programs were able to shift to online data collection, while other programs were able to purchase necessary equipment for digital data collection.

Strengthen technical assistance.

Real-time data collection was identified as a key need, particularly in the rapidly-evolving context of COVID-19, yet trainings on data systems and analysis are often inadequate. Routine training, mentorship, and technical assistance on data analysis are important for increasing local ownership and project sustainability.

Increase data transparency.

Programs described a need to increase transparency and access to data, such that all stakeholders are able to view, analyze, and understand the findings. This access should be complemented by tools and capacity building to facilitate data use by community members and data collectors. Additionally, to support learning and knowledge exchange between programs, knowledge-sharing platforms, webinars, and inter-program learning opportunities should be built and supported to allow CLM programs to share data collection tools, systems, and best practices.

Develop rigorous data collection frameworks.

Programs should invest time in clearly defining key indicators, to avoid misinterpretation and data quality issues that arise when data monitors or survey participants have differing understanding of indicators. Additionally, programs should develop clear frameworks and rigorous data collection protocols, and training to guide data collection, to ensure that teams understand which data to collect, when and how to collect it, and to track progress towards data collection targets.


Go light

Conducting Advocacy

Data collection is only one of the phases of CLM; in next stage, CLM programs gather the gaps identified during data collection, develop actionable recommendations, and advocate to duty-bearers and decision makers at health facilities, local and national government, and international funders.

According to survey data, the development of solutions and advocacy messages is a collaborative process, with the project staff, data collectors, civil society members, health facilities, community-based service providers, governments, and donors all frequently engaged. These recommendations are disseminated through meetings with government, visits in health facilities, meeting with communities, and developing reports and documents for advocacy.

82%
of programs hold meetings with government decision makers and duty-bearers to share CLM findings

65%
of programs describe insufficient funding as a challenge in conducting advocacy

17%
of programs pay their entire advocacy team

Common challenges in conducting advocacy

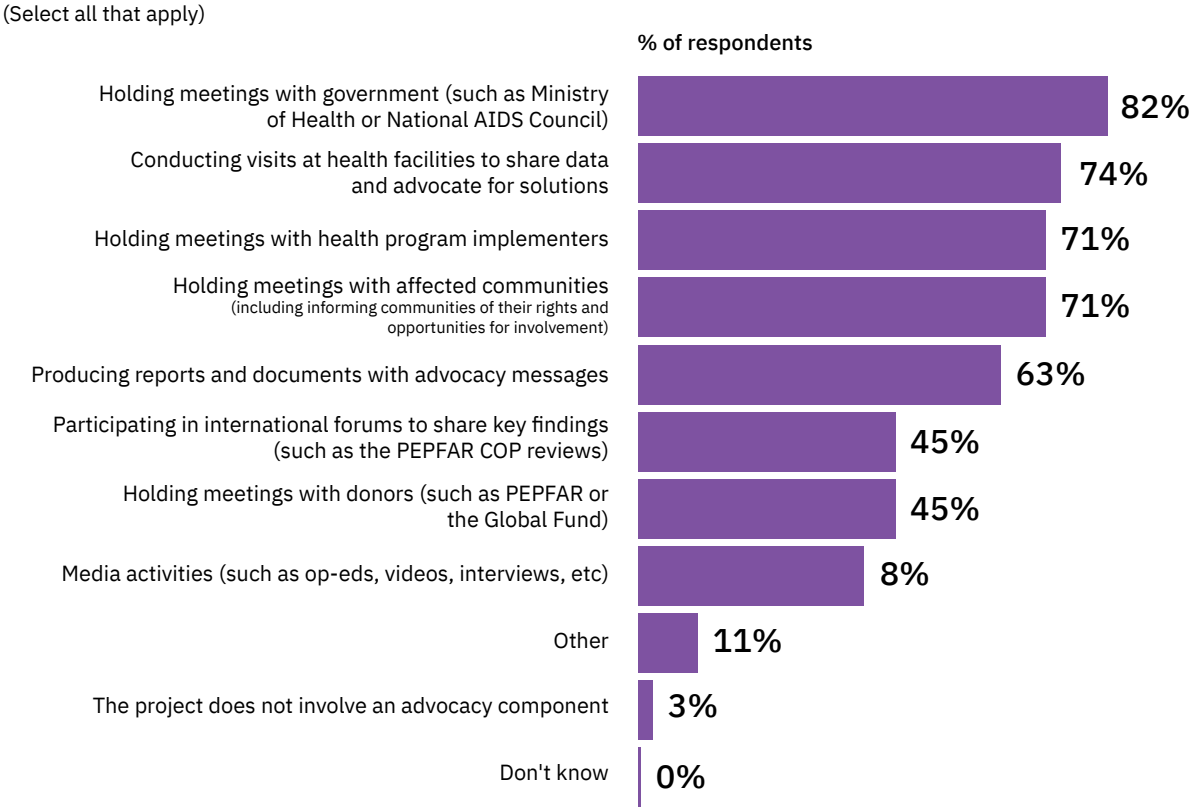
Meetings with the non-relevant stakeholders.

Programs reported that despite successfully securing meetings with local and national government stakeholders, in some cases the appropriate decision-maker delegated a more junior or alternate team member to participate in discussions. As a result, if the proposed solutions require a higher level of authority or engagement, the advocacy messages could not be implemented.

> "Usually, we try to set meetings with key decision-makers at the local and national level, and usually they are just not available to meet with us. So, I think that's a crucial problem. So, the work-around we had was the one I mentioned earlier, that we just send them some brief or information that we gathered from our project and send them also the recommendations, hoping that they will read those messages that we sent them. Our plan actually was to hold additional meetings with only the decision makers, however, it was not feasible at that time."
>
> — Respondent from Southeast Asia

Which advocacy activities does the project fund?

(Select all that apply)



"The people that normally they send to represent them in these meetings don't have much decisions to take over these issues. So, that's a challenge for us because if the head of the institution is on a roundtable and discussing some of these issues, then we can know how. But normally we discuss some of these issues, the action points we take are very difficult for it to be implemented because the head of the institution, who actually takes the decision, did not attend the meeting."

— Respondent from Western Africa

Challenges developing an advocacy strategy.

According to survey respondents, 34% identified developing a plan for advocacy as a major challenge. Some described challenges around applying advocacy methodologies derived from other contexts, without properly adapting them to the local environment, while it was suggested that technical assistance related to advocacy could be strengthened by helping support projects in developing actionable advocacy plans, as opposed to providing guidance which was sometimes seen to be vague in nature.

Insufficient funding and prioritization for advocacy.

According to surveyed participants, 65% of programs highlighted insufficient advocacy budgets as a key challenge. Programs highlighted challenges around budgets not including enough resources to conduct the advocacy activities they wanted to do, insufficient budgets overall, other aspects of CLM (such as data collection) being prioritized, or intermittent and delayed funding from donors. Programs that faced delays in receiving funding noted that advocacy activities were often delayed or had to be removed from the workplan. Due to the significant effort dedicated to gathering and analyzing data, some programs noted the lack of capacity, time, and resources left for advocacy.

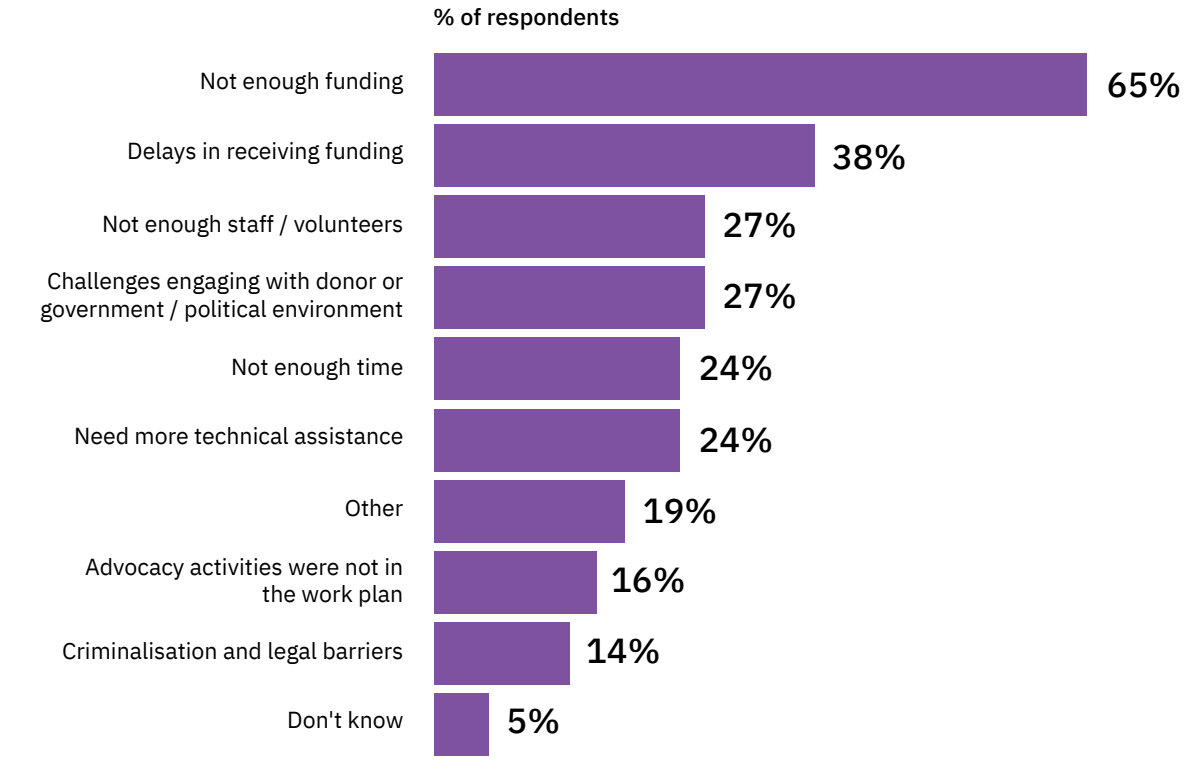
"The enhanced quality of services and advocacy to the donors, advocacy to the government and advocacy for the standard of service packages for our community, these kinds of interventions we came up and we finalized our advocacy action plan. But after that, you know, who will fund?"

— Respondent from Southern Asia

> “We are continuously overworked on data, continuously, and I think we are not doing, we don’t have sufficient time for the advocacy, we are doing a lot of advocacy [...] but we don’t have sufficient time to hammer on those health facilities that are not implementing the policy there. It needs also sufficient time to be able to really touch the people responsible.”
>
> — Respondent from Central Africa

Which advocacy activities does the project fund?

(Select all that apply)



Recommendations and best practices in conducting advocacy

Engage duty-bearers and decision makers throughout the project.

Interview respondents spoke about how this increased engagement facilitates building mutual ownership and trust, and ultimately results in duty-bearers and decision makers being more receptive to suggestions and co-creating solutions.

> "First of all, the engagement of the beneficiary in the process actually simplifies your advocacy. During advocacy, you have less to speak than them. So, it is easier for [healthcare service users] to grasp what the message you want to portray, to convey, to [stakeholders]. That has been a best practice we have seen, that if the beneficiary is involved in the process, then during advocacy — they convey the message, they provide what we call 'homegrown solutions' during those advocacy meetings. So, those are the things we have seen during advocacy; they are more effective when you involve the beneficiary throughout the process.
>
> — Respondent from Eastern Africa

Ensure that data are relevant and community-owned.

Advocacy messages should be based on data that monitor the community's priorities and should be developed in partnership with clients of the healthcare system. When messages are clearly derived from local communities, advocates are better able to build trust and justify to duty-bearers and decision makers why issues should be addressed.

Fully fund advocacy activities.

Programs and donors must ensure that advocacy activities are adequately resourced, including by budgeting to pay for advocates and technical assistance. Programs should be offered guidance and supported in developing realistic and costed advocacy budgets to ensure that advocacy plans are adequately resourced.

Increased technical assistance for advocacy.

According to surveyed participants, 54% of programs identified technical assistance for advocacy as a key need for making projects more impactful. Programs suggested capacity building and mentorship around designing advocacy action plans, in addition to delivering trainings. Particularly as advocacy activities shift from the local level to national level, projects report the need to build the technical capacity of advocacy staff to develop high-quality materials and policy briefs.

Solution-driven, evidence-based advocacy.

The strongest advocacy messages, and those most likely to be adopted and implemented, were those that are solution-driven and which propose concrete actions to address

gaps and challenges. Programs noted the importance of highlighting CLM data during advocacy, to clearly present recommendations and findings that are rooted in and supported by data. Other strategies include developing messages that dovetail with government priorities, such as by providing innovative ideas to address persistent gaps and strengthen national efforts.

Develop workplans for advocacy.

Clearly defining the plan for advocacy helps the program to set objectives, organize the CLM staff and advocate, and map timelines. Workplans should be developed in consultation with key stakeholders, community members, and members of key and affected populations. Sufficient leeway should be granted in work planning to allow for the incorporation of innovative ideas or course corrections.

Disseminate advocacy messages broadly.

A variety of dissemination strategies can be impactful, ranging from participating in less formalized advocacy activities (such as engaging in ongoing conversations with stakeholders) to more formal activities (like public report launches or feedback meetings with governments and donors. Advocacy activities should include engaging a variety of media outlets, as a mechanism for reaching a wider audience and promoting community-led, grassroots advocacy.

Strengthen community partnerships.

Advocacy messages and activities should build on collaborations with other community-based organizations, civil society organizations, and non-governmental organizations. By building partnerships with other accountability groups and engaging in existing community dialogues, CLM data and messages can be amplified by presenting a unified voice.

> "There is advocacy where you make a lot of noise, making a lot of noise and there is a resistance. But sometimes there is that kind of advocacy where you are saying, 'Hey, guys, this is what is the situation here, we definitely need to work around this'."
>
> — Respondent from Southern Africa

Hire dedicated staff for advocacy.

Programs described the importance of hiring team members to lead specifically on advocacy efforts, rather than hiring general staff to conduct advocacy and other activities. Advocacy team members should be hired for their previous experience and engagement in advocacy work.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BEST PRACTICES FOR COMMUNITY-LED MONITORING

Led by the Community-Led Accountability Working Group (CLAW)

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