INTRODUCTION

Achieving the global 2020-2030 targets is critically dependent on finding the missing positives, addressing unacceptable high rates of new infections and deaths due to HIV through treatment and care. Community-led Monitoring (CLM) is an important approach for improving the quality of healthcare services through social accountability and political accountability.

CLM is based on three key principles that are consistently present across all CLM definitions by the Global Fund, PEPFAR, and UNAIDS:
1. Community-led monitoring requires leadership and ownership by independent communities/society.
2. Community-led monitoring requires organized communities for effective monitoring.
3. Community-led monitoring focuses on generating political will to ensure change and ensure accountability of decision-makers and other duty bearers.

COMMUNITY-LED MONITORING CYCLE

Driven by increasing support from donor, a growing number of countries are implementing CLM, creating an opportunity to identify best practices in CLM implementation.

This analysis builds on an important body of work defining CLM and its core tenets, developed by CLM projects like UNAIDS' Global technical assistance consortium such as the Community-Led Accountability Working Group (CLMWG), Community Data for Change- Consortium (CDCC), and the ENN-APCASO-ATAC consortium. However, as several CLM projects conclude their first few years of implementation, this is a critical moment to evaluate community experiences, learn from key challenges and successes, and define effective approaches for CLM implementation.

STUDY OBJECTIVE

This analysis presents empirically derived guidance and best practices for CLM implementation, from a global exploration of real-world implementation and suggestions from CLM implementation teams. Best practices are elements and considerations that help deliver CLM more effectively, and are aligned with core values and principles of the approach.

In keeping with the principles of community-based participatory research, all tools and resources were designed with and for the benefit of CLM projects and the communities they represent and serve. As such, the data collection tools were developed using a consultative process to ensure the survey instruments were not technically sound but also prioritized collecting information on key issues and themes that would be valuable to CLM implementers and their allies.

PARTICIPANT RECRUITMENT

“Challenges” and “best practices” in CLM implementation were drawn from data collected from two rounds of CLM implementation. Participants were recruited electronically using a brief screening questionnaire that gathered informed consent and data on key parameters of CLM participated CLM projects. The screening questionnaire was available in English, French, Spanish, and Russian.

After completing the brief screening questionnaire, CLM projects that met two of the three following inclusion criteria were invited to participate in the second phase of data collection:
1. Project 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. Projects actively include collecting data on healthcare quality and access; and
3. Projects actively include advocating for solutions and working with decision-makers for change.

The majority of respondents that participated in the long survey were either staff or an organization leading the CLM project (72%) and/or community members involved in the project (28%). Most projects (82%) monitor indicators related to HIV and TB (71%), and the remaining indicators included in the Assessment Tool for the Longitudinal Monitoring of CLM projects (ATAC) (Fig. 3).

RESULTS

The most common success achieved by CLM projects was increasing the capacity of local organizations, including to conduct advocacy (reported by 65% of respondents), gather data and analyze data (71%), and receive and manage grants (43%) (Fig. 4). To develop organizational capacity, respondents described trends towards building dedicated, specialized teams; investing in ongoing training for CLM teams and build capacity for organizations to access and receive funds.

In addition to building local community CLM projects, were also described as creating more frequent and more productive engagements between civil society and governments (60%) and donors (54%). Interviewed participants described the importance of early stakeholder engagement with governments and civil society networks to build buy-in and support for CLM.

According to participants in the long-form survey, the most common challenge faced by CLM implementing projects was COVID-19 (reported by 57% of participants), mostly due to travel restrictions, uncertainty, and sackings being focused on COVID, and the need to adapt monitoring frameworks (Fig. 6). During project set-up, respondents described challenges in hiring and retaining project staff, coordinating multiple development or monitoring workplans, and a lack of alignment between the political situation in the country (34%), engagement with government (28%), and challenges to the independence of the project (19%) and government (22%).

CONCLUSIONS

The findings from this analysis present important and actionable insights into the challenges and successes faced by CLM implementing organizations. The consideration and option of these recommendations by CLM implementers, technical assistance providers, donors, governments, and allied institutions will be critical to ensuring the ability of CLM to improve healthcare quality. While these findings represent the lived experiences and beliefs of CLM implementers, future work is needed to continue identifying impactful and novel approaches for CLM implementation.

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7. Eastern Africa National Network of AIDS and sexual and reproductive health services organizations (EANANAS) with APFASO and Alliance Technical Assistance Centre (ATAC) in Ukraine.