COPPER
Communities in Pandemic Preparedness & Response

CONCEPTS IN COMMUNITY-LED MONITORING

OPPORTUNITIES FOR ADVANCING INTEGRATION IN CLM

ODELPA

CLAW
Community-Led Accountability Working Group

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ACRONYMNS

AGYW	Adolescent Girls and Young Women
C19RM	COVID-19 Response Mechanism
CLM	Community-led monitoring
COPPER	Communities in Pandemic Preparedness and Response
CRG	Community Rights & Gender
CSS	Community Systems Strengthening
DHIS2	District Health Information Systems 2
HIV	Human Immunodeficiency Virus
KVP	Key and Vulnerable Populations
MOH	Ministry of Health
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-child Transmission
POART	PEPFAR's Oversight Accountability Response Team
PPR	Pandemic Preparedness and Response
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
RSSH	Resilient and Sustainable Systems for Health
SR	Sub-Recipient
TB	Tuberculosis
US	United States
VMMC	Voluntary Medical Male Circumcision

01. INTRODUCTION

1.1 About the resource

Community-led monitoring (CLM) is an accountability mechanism designed to identify barriers to healthcare access, turn community data into advocacy 'asks', and engage with duty-bearers in government, donor organizations, and in the health system to rectify these barriers.

The CLM model was developed several decades ago and has been a core part of community advocacy throughout the response to HIV, tuberculosis (TB), and malaria. In its current form, the CLM model became a key donor priority in 2018, when PEPFAR, the United States government's bilateral HIV program, began funding and requiring all partner countries to implement a CLM program. This guidance led to a rapid proliferation of CLM programs worldwide and the implementation of the approach across several contexts. Shortly after PEPFAR's adoption of the model, the Global Fund began its own funding of CLM, and today has active programs in more than half of the countries it supports.

The CLM model involves a phase of data collection, a phase of reflection and analysis, the development of actionable and data-based recommendations, and targeted advocacy actions[1]. In all contexts, governments, program implementers, and donors are a core target of advocacy activities, with direct engagement typically taking place at the public facility level, at the district and/or provincial level, and at the national level. Where appropriate, CLM programs often additionally engage at the international level with bilateral and multilateral donors. As such, relationship building between the community advocates implementing CLM and government and donor stakeholders is crucial, and defining pathways and strategies for this engagement is a prerequisite for impactful CLM.

In 2025, the United States government took action to rapidly defund its bilateral HIV, TB, and malaria programs. To date, most PEPFAR contracts for CLM have been terminated, leaving these programs defunded or in financial limbo. In parallel, the Global Fund is responding to a challenging resource mobilization environment by pausing and reprioritizing grant activities. While Global Fund guidance explicitly recommends for countries to protect CLM budgets during reprioritization, its guidance emphasizes the need for multi-component programming with stronger integration.

In this context, there is an urgent need for a principled approach to funder engagement and integration pathways that ensure the sustainability and continuity of funding, while also protecting the core principles of the CLM model. With the model now well-defined and in operation across the majority of Global Fund-supported countries, an important opportunity has emerged to leverage the model as a response to the current polycrisis world, to develop sustainable and impactful practices for multi-stakeholder advocacy, and to leverage CLM programs as a strategy for building community power and ownership.

1.2 Target audience and proposed applications

This guide is intended to serve as a resource for implementers of existing and new CLM programs, and CLM partners and funders seeking to understand different types of integration and its applicability across different contexts and needs. Specifically, three types of integration will be discussed: integration of multiple CLM programs, integration of topics within existing CLM programs, and integration of CLM into existing national quality assurance/improvement systems.

[1] Rambau N, Policar S, Sharp AR, Lankiewicz E, Nsubuga A, et al. Power, data and social accountability: defining a community-led monitoring model for strengthened health service delivery. J Int AIDS Soc. 2024 Nov;27(11):e26374.

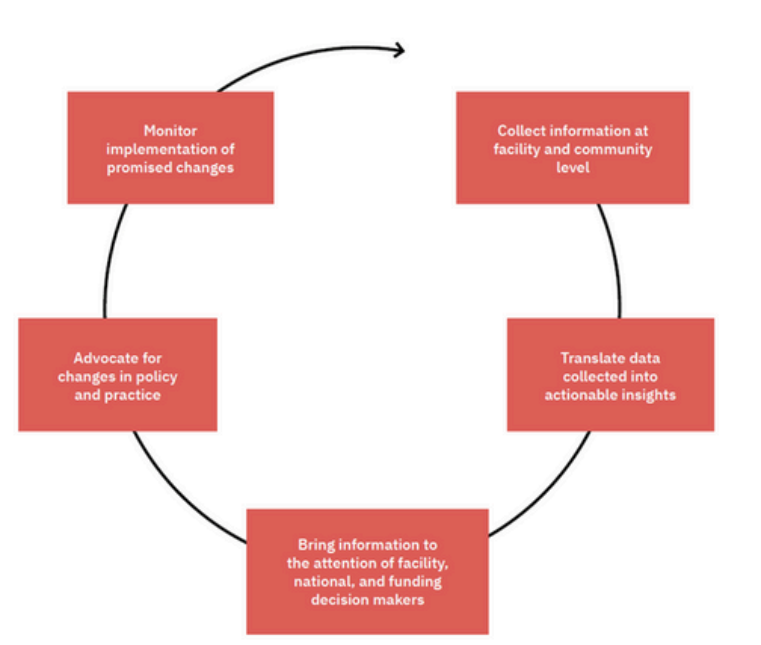
02. CORE DEFINITIONS

2.1 Core concepts in community-led monitoring

Community-led monitoring is a social accountability approach in which community-led organizations implement independent monitoring of and advocacy around the access and quality of services (Fig. 1). While the approach is adapted to each country's context, the CLM model follows a cyclical process of**:**

- Data collection on priority topics, usually healthcare service delivery
- Analysis of those data by communities
- Consensus building on priorities and proposed solutions
- Conducting advocacy with key stakeholders
- Monitoring to see if proposed changes are implemented and result in improvements

Figure 1. The CLM cycle[2]



2.2 Values, principles, and non-negotiable practices

CLM approaches are varied, because implementation and advocacy strategies are tailored by community and civil society to be most impactful in their different contexts. However, a number of core unifying principles differentiate the CLM approach from other monitoring and accountability strategies.[3][4] These principles find that CLM programs must:

- **Be led** by directly-impacted communities, including people living with HIV, TB and/or malaria and key populations;
- **Maintain** local leadership and independence, protecting against programmatic interference from other actors including donors, national governments, and other monitoring and evaluation systems;
- **Be owned** by communities in every stage, including identifying priority issues in the community, defining indicators, establishing preferred channels of communications with partners, and deciding how data are housed and used;
- **Include** advocacy activities aimed at generating political will and advancing equity, given CLM's fundamental function as a social accountability tool;
- **Adhere** to ethical data collection, consent, confidentiality, and data security. Data collection must be verifiable, reliable, conducted in a routine/continuous cycle and collected under the 'do not harm' principle;
- **Ensure** that data are owned by communities, with programs empowered to share CLM data publicly and at their discretion. CLM programs should not be made to re-gather, replace, or duplicate M&E data from existing systems;

[2] UNAIDS. Establishing community-led monitoring of HIV services: Principles and process. 2021. Available at: https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf.
[3] Community-Led Accountability Working Group (CLAW). Community-Led Monitoring: Best Practices for Strengthening the Model. December 2022.
[4] Rambau N, Policar S, Sharp AR, Lankiewicz E, Nsubuga A, et al. Power, data and social accountability: defining a community-led monitoring model for strengthened health service delivery. J Int AIDS Soc. 2024 Nov;27(11):e26374.

- **Ensure** community monitors are representatives of service users, and that they are trained, supported, and adequately paid for their labor, while maintaining the community independence from the donor;
- **Be coordinated** by a central, community owned structure capable of managing the programmatic, financial, and human resource components of the program.

Evidence from CLM programs worldwide finds several practices are associated with more robust and impactful implementation[5]. These are described below:

What works well	What not to do
• Collecting data complementary to other sources • Collecting data that explains why a problem occurs in the system, rather than solely describing it	• Collecting the exact same data as donors or governments • Excluding priorities or communities because they are not the same as government or other stakeholder's priorities
• Capacity building to ensure all stakeholders have a shared understanding of CLM roles and aims • Advocacy and engagement with stakeholders, including government, until buy-in is reached on CLM effectiveness and principles	• Allowing non-community stakeholders to unilaterally define the role of CLM in the health system • Allowing non-community members to take on roles that belong to the community
• Engaging with other CLM programs to identify synergies in advocacy priorities and strategies	• Utilizing identical tools with other CLM projects, despite different priorities (for instance, using a survey instrument intended for PLHIV in a sex worker-specific CLM program)
• Aligning CLM indicators to policies where the challenge is ensuring policies are appropriately implemented	• Aligning CLM indicators to policies where the issue is a poor policy, not its implementation

2.3 Definitions

Community-led monitoring is a tool for convincing government, donor, and other duty bearers to act on community recommendations for improving the quality of healthcare services. Historically, the CLM model emerged from the HIV response, with examples of advocacy using community-gathered data dating back to the 1970s[6].

[5] AR Sharp, N Mpofu, E Lankiewicz, B Ajonye, NP Rambau, et al. Facilitators and barriers to community-led monitoring of health programs: Qualitative evidence from the global implementation landscape. PLOS Global Public Health 4 (6), e0003293

[6] Sharp AR, Mpofu N, Lankiewicz E, Ajonye B, Rambau NP, et al. Facilitators and barriers to community-led monitoring of health programs: Qualitative evidence from the global implementation landscape. PLOS Glob Public Health. 2024 Jun 20;4(6):e0003293.

Integration is a potential strategy for creating strong pathways for CLM programs to engage with other sectors and partners. Integration has the possibility to create impact, while also posing some risks that should be carefully considered. Where possible throughout this document, real-world examples of these strategies being deployed in practice are included. In general, integration refers to the harmonization, coordination, and embedding of certain processes into a unified whole. In the context of CLM, three types of integration are considered in this document:

Integration between multiple standalone CLM programs	This might mean combining the activities of multiple CLM programs into one unified effort, coordinating subnationally-focused CLM programs using national networks, or by creating greater harmonization between independent programs.
Integration of additional subject areas into a CLM program's activities.	This might involve adding monitoring of topic areas including HIV, TB, malaria, noncommunicable diseases, pandemic preparedness and response (PPR)[7], gender and human rights, social protections, mental health and climate change impact. CLM could also be used to monitor topics other than direct healthcare services, such as policy and budget monitoring related to health. Depending on the country context, this could involve integrating cross-cutting disease and population data collection, while maintaining standalone activities for specific populations, such as key populations, who need more nuanced data collection.
Integration of CLM activities into national quality assurance/improvement systems	While CLM data ownership must remain with the CLO implementers, and therefore cannot be integrated into government data systems such as DHIS2, there may be opportunities to facilitate stronger data sharing and triangulation with stakeholders. This might involve developing stronger ties between the CLM program and a government entity or donor systems, representing the closest form of alignment. This form of integration may offer a great opportunity for synergies, while exposing CLM programs to the greatest risks to their status as independent actors

2.4 Trade-offs, benefits, and additional considerations

Potential benefits of integration

Designing appropriate strategies for expanding the scope, partnerships, and integration of CLM programs can be highly beneficial for CLM programs, including by:

[7] World Health Organization. A framework for tracking global progress on preparedness for respiratory pandemics. 21 Feb 2025. Available from: https://www.who.int/publications/i/item/9789240094246.

Increasing the sustainability of the CLM program:	Fragmented CLM programs can achieve greater sustainability by integrating into a unified CLM framework or larger programs. This consolidation reduces the number of implementing partners and fosters collaboration among stakeholders, enabling them to co-create a cohesive data collection model.
Reducing duplication	An integrated CLM program can minimize the overlap of clients approached by multiple initiatives. By ensuring that data collection tools encompass questions relevant to all target communities, integrated programs can streamline engagement. Additionally, delineating data collection responsibilities among key implementers based on specific regions and populations can further reduce redundancy. This approach also allows for coordinated engagement with duty-bearers, ensuring that CLM implementers present recommendations simultaneously
Leveraging the CLM program to impact broader areas of health:	Integrated CLM programs can collect comprehensive data across intersecting health sectors. For instance, a CLM initiative focused on people who use drugs could incorporate questions related to sex work, criminalization, and the experiences of men who have sex with men and transgender individuals, highlighting the interconnectedness of these issues.
Empowering other sectors:	By broadening the scope of information gathered, integrated CLM programs can provide insights into experiences across various sectors. For example, a CLM initiative examining health service provision could assess the impact of climate change on healthcare access or analyze how budget allocations by Ministries of Finance influence health outcomes.
Enhancing advocacy impact:	By designing clear pathways, mechanisms, communication strategies, and information tools, community advocates can more effectively persuade duty-bearers to take action. Tailored advocacy efforts can significantly improve the likelihood of achieving desired outcomes.
Managing conflicts of interest in funding:	In Global Fund-supported CLM programs, funding typically flows through a Principal Recipient (PR) and may involve additional sub-recipients (SRs). As donor support for bilaterally-funded programs diminishes, governments or non-traditional funders may step in to finance CLM initiatives, often without prior experience with the CLM model. To navigate this landscape, CLM programs and their funders must establish protective measures that allow for donor oversight while safeguarding the program's autonomy over its activities and data.

Trade-offs of integration

While there may be important benefits of greater integration, there are also some significant risks to be considered. These include:

- **Reducing specialization:** One of the key strengths of CLM lies in the leadership of communities most affected by specific diseases or conditions. These communities develop technical expertise in crafting evidence-based advocacy messages and engaging with decision-makers. Expanding the CLM framework to encompass additional diseases or topics may dilute this specialized knowledge, forcing community experts to broaden their focus at the expense of depth. This shift could lead to a diminished sense of identity for the CLM program.

- **Decreasing flexibility:** Aligning CLM programs with the timelines and processes of other stakeholders may result in a loss of flexibility for implementers. This could hinder their ability to respond swiftly to emerging challenges or adapt data collection efforts to better reflect community needs and the local context.

- **Longer survey instruments**: Integrating additional diseases or topics necessitates the inclusion of new questions in data collection tools. This presents a dilemma for CLM programs: they can either expand the tools, increasing the burden on data collectors, patients, and clinicians, or deprioritize existing questions, which may compromise the robustness of the data collected.

- **Increasing bureaucracy:** Expanding the scope of data collection requires broader leadership that includes communities affected by the new topics. This inclusion can lead to larger governance teams, which may introduce additional bureaucracy, political complexities, and administrative challenges.

- **Creating security risks:** CLM programs, particularly those addressing HIV, often focus on key and vulnerable populations. In contexts where these communities face criminalization, stigma, and legal oppression, the safety of CLM implementers is paramount. Any engagement with external partners must be approached with caution, ensuring that the program's safety and independence are prioritized.

- **Eroding community leadership:** While collaboration with government stakeholders can enhance advocacy efforts, it may also undermine the independence of the CLM model. Involving government representatives in decision-making processes can expose the program to conflicts of interest (COI) and dilute community leadership, which is essential for maintaining the integrity of CLM initiatives.

Managing Conflicts of Interest (COI) in CLM Programs

***CLM programs** are vulnerable to several forms of actual, potential, and perceived conflicts of interest (COI)[8]. CLM is vulnerable to COI in funding streams, in which donor funding streams pass through a financial intermediary that is itself the subject of monitoring and advocacy activities. CLM is additionally vulnerable to COI arising from the selection of CLM implementers that are themselves implementers of programs that are being monitored.*
Finally, COI may arise when the CLM program's design fully integrates CLM activities into government structures and where the program is perceived as being a form of monitoring and evaluation (M&E).

One strategy for minimizing COI is by clearly defining the roles that all stakeholders can, may, and cannot play in the CLM cycle. In the case of government stakeholders, they cannot serve in a governance role for the CLM program or participate in data warehousing or ownership.

They should, however, lead in ensuring that the CLM program has access to public health facilities and by participating in feedback meetings. Understanding these 'dos and do nots' is essential for creating structures, roles, and norms that prevent the kinds of COI that undermine the impact and integrity of CLM.

[8] Community-Led Accountability Working Group (CLAW). Conflict of Interest in Community-led Monitoring programs. February 2022.

Priority considerations for communities

When considering integration of CLM in a country, communities should consider the following:

Protecting the independence of the CLM program

The core success of CLM programs is in the fact that they are structured as community led initiatives, with communities leading at every stage from data collection to advocacy. Communities should seriously consider whether integration will compromise the integrity of this structure and in the case where the answer is yes, they should opt not to proceed with integration.

Weighing 'value for money' with the quality of the CLM's implementation

During consideration of CLM integration, communities should ensure that in the cases where proposals on saving with integration are made, the value for money proposals are weighed alongside the ability to maintain quality CLM programs. Significant effort is invested by both the clients and the communities involved in implementing CLM, so it is essential to uphold the standards of CLM to ensure its continued value.

Country policies allowing integration

CLM integrated into government structures without clear actionable, agreed on goals, roles and principles will not be successful. Communities implementing CLM and governments need to ensure that policies are in place that define everyone's roles and that those roles are implementable especially in the case where the government will be paying for CLM.

Legal context

In the case of integration of CLM where laws that criminalise the CLM implementers still persist, other sources of funding should be considered to ensure that community data is safe and CLM can be carried out effectively and without fear. Integration must not come at the expense of visibility for key and marginalized populations. While aligning data collection frameworks can strengthen overall system efficiency, it is critical that governments include data from all communities at risk, including key populations, to ensure accurate, equitable planning and epidemic control. In many contexts, KVP data remains absent or deprioritized — particularly at sub-national levels where stigma is often greater and access is more easily blocked. Governments, especially at the national level, play a vital role in enabling safe, inclusive data collection by mandating cooperation across all levels of the system and committing to protect the independence and integrity of KVP-led data initiatives. Integration efforts must explicitly include marginalized communities, not erase or sideline them — because countries simply cannot reach epidemic control without data that fully reflects those most impacted.

Mapping community leadership

In the case of integration, who is best placed to implement CLM among community organisations? A review of the country context is key. In some countries, large networks have the capacity to cover larger geographies; however, these networks and organizations must be scrutinised to ensure that they are representative of community voices and have strong community support. Scale and geographic coverage, while important, should not be the only consideration. In some cases, nuanced data collection will require smaller, specialized teams (e.g. data collection focused on key populations).

Where immediate and full integration may not be an option at the time, CLM programs should consider the following as a pathway to integration

1- Improving coordination as a path to integration

In the context of CLM, **coordination** refers to tactics and strategies to better schedule and organize the program's activities to ensure they are aligned with the processes, schedules, and frameworks of other CLM programs, other partners, and duty bearers.

CLM coordination among different implementers can include organising to ensure agreements among the various stakeholders on geographic alignment, i.e. separation of data collection zones while integrating data collection among different diseases to eliminate duplication, review of data collection cycles to ensure agreement collection of data during similar cycles to ensure the targets are not overwhelmed and data for advocacy shows collective gaps and successes.

The government actors that CLM programs engage with typically operate as complex bureaucracies, under fixed calendars and annual plans, and with rigid protocols and legal guidelines. While CLM programs have no duty to adhere to government protocols in their own work, understanding and capitalizing on these structures can significantly improve the impact of advocacy activities. In general, integrating programs by improving coordination is achieved by emphasizing stronger communication, alignment, and engagement with government partners and other duty bearers.

2- Using harmonisation as a path to integration

Harmonization refers to the alignment of processes, policies, and goals across actors in a way that makes the outcomes of work complementary. For CLM implementers this could include integrating by agreeing on principles of data collection and reporting and collectively agreeing on CLM data collection frameworks that would guide CLM implementation in a country.

03. TYPES OF INTEGRATION

This section describes strategies and opportunities for integration of CLM programs at various stages in the program's lifecycle: while building, piloting and in the initial implementation; as part of data management and analysis; and during data use and advocacy activities. This list is not meant to be exhaustive, but rather highlights strategies for operationalizing integration approaches.

3.1 Integration between multiple standalone CLM programs

3.1.1 Combining multiple CLM programs into one

Integrating multiple CLM programs into a single cohesive initiative can enhance efficiency, streamline data collection, and amplify advocacy efforts. This approach allows for the consolidation of resources, expertise, and stakeholder engagement, ultimately potentially leading to a more impactful CLM framework.

If CLM programs decide to integrate into a single effort, it is essential to establish a clear governance structure that defines roles and responsibilities that ensures the leadership of communities. Careful consideration of existing data collection methodologies and indicators is also needed, both to harmonize indicators but also to respect the unique contexts and needs of different communities

3.1.2 Developing shared frameworks that integrate joint action plans, define roles and incorporate stakeholder feedback

Clarifying the roles of CLM stakeholders and developing joint action plans may be an effective strategy of integration. When communities and stakeholders understand their roles and responsibilities in CLM implementation, the programs can have stronger implementation, better impact, and reduce conflicts of interest[9]. For example, these frameworks should clearly define which community groups should take the lead in work planning, data collection, and formulating recommendations.

Meanwhile, government agencies can be assigned tasks such as participating in quarterly advocacy sessions, receiving regular CLM data for their quality assurance processes, and triangulating CLM data with their own monitoring and evaluation systems.

One such example is **the Philippines,** where the COVID-19 pandemic highlighted the critical need for robust and resilient health systems capable of maintaining essential services such as TB and HIV programs during emergencies. In response, the CLM program developed an integrated CLM framework, which included a pandemic preparedness and response (PPR) component, in order to strengthen health system accountability and resilience through community feedback mechanisms.

[9] Community-Led Accountability Working Group (CLAW). Conflict of Interest in Community-led Monitoring programs. February 2022

Case study: Philippines

About the CLM program

The CLM program in the Philippines is designed to transition from disease-specific monitoring to a unified national framework. This initiative is led by a consortium of four established organizations and aims to maintain a human rights-based, gender-transformative approach. The integration effort aligns with the Department of Health's (DOH) vision of unifying community and government systems, emphasizing the importance of organized community engagement for effective CLM.

Type of integration:

The integration of CLM in the Philippines occurs in four phases. Phase 1 focuses on laying the foundation for a unified TB and HIV CLM system, transforming previously siloed approaches into a cohesive model. This includes developing shared indicators guided by the AAAQ (Availability, Accessibility, Acceptability, and Quality) framework, and incorporating emergency preparedness components. Phase 2 involves pilot implementation across 10 regions to evaluate the feasibility and impact of the integrated system. Phase 3 emphasizes sustainability and scale-up, integrating data from OneImpact TB and expanding implementation to underserved regions. Finally, Phase 4 aims for institutionalization, embedding the CLM system into national and local health frameworks to ensure long-term recognition and sustainability.

Lessons learned:

Key lessons from the integration process include the importance of stakeholder engagement in developing common definitions and indicators, which ensures long-term sustainability and community ownership. Capacity-building efforts are crucial for effective data collection and implementation, particularly for new components like pandemic preparedness and response (PPR). Additionally, transitioning to a community host organization is vital for ensuring the CLM system remains responsive to community needs and can adapt to evolving health challenges. Institutionalizing CLM within government frameworks is expected to enhance accountability and resource mobilization, ultimately improving the quality and equity of TB and HIV services nationwide.

Similarly, in the **Democratic Republic of the Congo (DRC)**, the establishment of a CLM coordination framework ("*cadre de concertation*") provided a formal platform for multiple civil society organizations to align monitoring priorities, data collection tools, and advocacy messages. This framework enabled joint validation of CLM data, which bolstered the credibility of findings and helped secure government buy-in. The DRC case also illustrates that integration is not merely technical but requires significant relationship-building and negotiation among diverse stakeholders who may have overlapping but not identical agendas. Joint action plans not only mobilize support and foster partnerships around shared goals but also delineate activities that should not be led by government actors while including them in the larger CLM structure to ensure integration. This approach enhances transparency and trust while empowering community members to engage actively in decision-making processes, ultimately leading to more sustainable and impactful outcomes for the community.

Case study:Democratic Republic of the Congo

About the CLM program

In the DRC, CLM has emerged as a vital tool for strengthening the national response to HIV, TB, and malaria. Initially, the implementation landscape was fragmented, with multiple civil society organizations conducting independent monitoring activities using different indicators, data collection tools, and reporting formats. This fragmentation led to data duplication, inconsistencies, and inefficient resource use, ultimately limiting the strategic application of CLM evidence for advocacy and health system improvements.

Type of integration:

The integration and harmonization of CLM in the DRC were driven by the need to address critical gaps, such as the lack of standardized indicators and fragmented reporting that hindered the systematic use of CLM data by the Ministry of Health. Stakeholders initiated a mutualisation process to develop a single national CLM coordination mechanism, agree on priority indicators, and create shared digital tools for real-time data management. A national roadmap was adopted to guide this transition, emphasizing coordination between civil society and government actors.

Lessons learned:

Key lessons from the DRC's CLM integration experience highlight that the process is gradual and requires sustained engagement, relationship-building, and transparent communication between civil society and government. Establishing a unified national indicator framework is essential for systematic data aggregation and effective advocacy. While digital solutions can enhance efficiency, they necessitate investments in infrastructure and capacity-building. Additionally, embedding joint validation processes strengthens the reliability of CLM data, and integrating a human rights perspective enhances the relevance of findings. The DRC case illustrates that despite the complexities of integration, it is a critical strategy for ensuring that CLM data drives meaningful change in health policies and service delivery, serving as a model for community-led data systems within national health monitoring frameworks.

Case study:Burkina Faso

About the CLM program

The Observatoire Citoyen sur l'Accès aux Services de Santé (OCASS) was established in Burkina Faso by the Réseau Accès aux Médicaments Essentiels (RAME) and community partners in 2011. Over the years, OCASS evolved into a nationwide monitoring mechanism that encompasses all 70 health districts and major public and private health facilities. The initiative aimed to coordinate fragmented community monitoring efforts, creating a unified advocacy voice while ensuring alignment with national health priorities, including HIV, TB, malaria, maternal and child health, and human rights.

[1] Community-Led Accountability Working Group (CLAW). Conflict of Interest in Community-led Monitoring programs. February 2022

Type of integration:

The integration approach taken by OCASS involved developing standardized tools, establishing structured communication channels, and implementing joint validation processes. Standardized documents and data collection tools were created to ensure consistency across various actors and regions. A robust communication system facilitated regular meetings, data-sharing protocols, and public dissemination of findings. Additionally, the data validation process included harmonized meetings where different networks collaborated to review findings and agree on key messages, ensuring a cohesive advocacy strategy at both district and national levels.

Lessons learned:

The OCASS initiative demonstrated that collaborative frameworks are pivotal for successful integration, as multi-actor partnerships foster shared ownership and enhance credibility. While significant progress was made, challenges such as data system fragmentation and hesitance from district-level officials highlighted the need for ongoing training and capacity building. Integration is an ongoing process that requires time, trust-building, and clear agreements on roles. Consistent communication channels are essential for stakeholder engagement, and integrating CLM findings into national health discussions significantly enhances the relevance of community voices. Ultimately, embedding a human rights perspective into monitoring priorities strengthens advocacy efforts and ensures the sustainability of CLM initiatives.

3.1.4. Harmonization of data tools, analysis, and use

While **integration** does not imply that all programs must adopt identical indicators—given that, for example, PEPFAR-supported CLM initiatives may focus less on malaria services than those funded by the Global Fund—it does facilitate comprehensive data collection and analysis. When monitoring priorities align and similar indicators are used, data can be triangulated or aggregated to create a more holistic understanding of service quality and access. This is particularly valuable for advocacy efforts directed at government stakeholders, who need a **consolidated national perspective** to inform policy and resource allocation.

In **Burkina Faso,** for example, efforts were made to develop a unified national indicator framework under the leadership of OCASS and its partners, enabling consistent data collection across different implementing organizations. Despite the fact that individual programs—like those focusing on HIV, TB, or gender-based violence—each had unique operational contexts, the establishment of a shared indicator set facilitated data aggregation at national level. This integrated approach strengthened advocacy by allowing stakeholders to speak with a single voice when engaging national authorities. However, Burkina Faso's experience also highlighted challenges, such as the need for sustained training for data collectors to manage new digital tools and to ensure quality and consistency across diverse regions.

Additionally, experiences in the **DRC** and other settings show that aligning timelines and advocacy strategies across CLM programs can significantly improve effectiveness. In contexts where government officials are already managing high workloads and complex priorities, repeated engagement by different CLM programs—each with separate requests or messages—can lead to

frustration or resistance. By collaborating to present unified analyses and recommendations, CLM implementers increase their chances of influencing policy. For instance, in the DRC, partners involved in the CLM mutualization process coordinated advocacy calendars to avoid overwhelming duty bearers and to ensure that advocacy was strategically timed around national planning cycles.

Similarly, in **Thailand**, several key population networks worked alongside government agencies to develop a national online dashboard, consolidating CLM data across HIV, harm reduction, and human rights issues, enabling joint planning and accountability (UNAIDS Asia-Pacific Report, 2021).

Achieving this level of integration requires not only technical alignment of indicators and tools but also intentional coordination of advocacy plans and timelines. Programs must map government decision-making processes and budget cycles to ensure that data collection and reporting align with key moments for policy dialogue and resource allocation.

While integration is complex and context-specific, case studies from Burkina Faso, the DRC, and other regions show that it can yield significant benefits—enabling collective advocacy, more robust data systems, and a stronger impact on national health policies. The lessons learned underscore that integration is as much about building relationships and shared understanding as it is about technical standardization.

3.2 Integration of additional subject areas into a CLM program's monitoring and advocacy activities

Traditionally, the earliest CLM programs for health were focused on HIV. These programs were led by HIV activists seeking to gather real-world evidence of barriers to HIV prevention and treatment, including stock-outs and shortages, costs of care, stigmatizing staff treatment, and more. Integrating the monitoring of additional diseases, health services, or relevant topics into existing CLM programs can significantly enhance their responsiveness to community priorities.

This approach allows for a holistic understanding of health challenges and facilitates the identification of intersecting issues that affect health outcomes. For instance, monitoring diseases such as TB or malaria, alongside HIV, can strengthen the response to conditions that impact similar populations. Integrating broader topics, such as access to clean water or mental health services, can provide a more comprehensive picture of wellbeing and social determinants of health. This expanded focus empowers communities to advocate for systemic changes that address underlying issues, leading to improved health outcomes.

3.2.1. Monitoring other illnesses and conditions that impact people living with HIV (PLHIV)

When integrating additional conditions into a CLM program's monitoring, HIV-focused CLM programs may consider adding monitoring on opportunistic infections and other conditions that people living with HIV (PLHIV) are at elevated risk of acquiring or experiencing poor health outcomes. These include:

- **TB.** TB is a major cause of death among PLHIV, since people who are immunocompromised are more likely to have active TB disease. Access to TB testing and treatment are key areas for CLM programs to monitor.

- **Other opportunistic infections:** In addition to TB, common opportunistic infections include candidiasis, pneumocystis pneumonia, and certain types of herpes.

- **STI Testing and Treatment**: Addressing sexually transmitted infections (STIs) is crucial for the overall health of PLHIV, who may be more vulnerable to these infections and who may experience increased severity or complications. Community monitors can track access to timely and confidential testing and treatment for STIs, including syphilis, gonorrhea, and chlamydia. Monitoring also includes evaluating the availability of test kits, medication stock levels, client privacy, and provider competency in delivering nonjudgmental care.

- **HPV Prevention**: Monitoring and promoting human papillomavirus (HPV) vaccination and screening can help reduce the risk of cervical cancer among women living with HIV, who are at a higher risk of HPV acquisition and of progression into cervical cancer. CLM can assess the community's access to HPV-related services such as vaccination, cervical cancer screening and treatment of precancerous lesions. It also gathers feedback on service delivery barriers, public awareness, and outreach efforts to ensure equity in prevention and care

3.2.2. Monitoring access to wraparound healthcare

Regardless of the disease focus of the CLM program, ensuring access to general health care services is an important consideration, since people living with and impacted by HIV, TB, and malaria also need accessible, affordable, and quality services to address other healthcare needs. These may include:

- **Primary health care:** This could include gathering CLM data on access to holistic care that addresses all aspects of their health, including routine medical check-ups and care for chronic and non-infectious illnesses.

- **Sexual and reproductive health (SRH):** Ensuring that PLHIV have access to comprehensive sexual and reproductive health services, including contraceptives, family planning, perinatal services, and safe abortion, is vital for their overall well-being.

3.2.3. Responding to new and emerging topics.

One of the strengths of the CLM model is its ability to evolve and incorporate emerging topics, since the data collection is conducted cyclically with periodic revision to the data collection tools. These emerging topics could include:

- **Pandemic preparedness and response:** In anticipation of new epidemics or pandemics, CLM programs may gather data on and advocate for health system resilience, community preparedness, and readiness to respond to pandemics.

- **Emerging diseases or infections**: CLM programs can serve as a form of sentinel surveillance of the healthcare system's response to emerging threats. Historically, this has included COVID-19 and Mpox.

3.2.4. Monitoring human rights

Monitoring human rights is essential for promoting health equity and ensuring that all individuals have access to the care and support they need. Human rights violations can significantly impact health outcomes, particularly for marginalized and criminalized groups who often face systemic discrimination and barriers to healthcare. By actively monitoring these violations, health programs can advocate for policy changes, raise awareness, and foster an environment that respects and protects the rights of all individuals.

- **Gender and Equity:** Addressing gender disparities is crucial in the context of human rights monitoring. Women, girls, and gender minorities often experience unique challenges that affect their access to healthcare, including gender-based violence, discrimination, and socio-economic inequalities. Monitoring these issues helps to identify gaps in services and inform targeted interventions that promote gender equity and empower marginalized populations.

- **Human rights violations for criminalized and marginalized groups**: Criminalized and marginalized groups, such as sex workers, people who use drugs, and LGBTQ+ individuals, frequently face human rights abuses that hinder their access to healthcare. Monitoring these violations is vital for documenting instances of discrimination, violence, and stigma. By responding to these issues through advocacy, legal support, and community engagement, health programs can help protect the rights of these vulnerable populations and ensure they receive the care they need without fear of retribution or discrimination

3.2.5. Monitoring climate change

The addition of climate change monitoring to CLM can be an inclusive, bottom-up approach to empowering communities to monitor the local impacts of climate change on health systems and vulnerable populations. This form of integration recognizes that environmental changes—such as extreme weather, rising temperatures, and natural disasters—can worsen health outcomes, disrupt services, and increase the vulnerability of at-risk groups, particularly in low-resource settings.

By embedding climate change indicators into existing CLM frameworks, communities can collect and report data on climate-related health risks (e.g., resilience of infrastructure, heat-related illnesses, vector-borne disease patterns, disaster-related service disruptions) alongside traditional service delivery metrics. This enables communities to provide timely, localized data to advocate for governments, health systems, and partners to adapt policies and interventions to be more climate-resilient. The integrated CLM also supports early warning systems, strengthens emergency preparedness and response, and ensures that health planning includes the voices of those most affected by both health and environmental challenges.

Ultimately, this approach not only enhances accountability and service improvement but also positions communities as active partners in building climate-resilient, equitable health systems that can withstand and adapt to environmental shocks.

3.2.6. Monitoring budget allocation and domestic financing

Incorporating monitoring of government spending into a CLM program's monitoring activities can be a strong strategy for ensuring that resources are effectively utilized to meet community health needs. This could involve tracking how financial resources are allocated, spent, and managed within health systems, particularly in relation to programs addressing HIV, TB, malaria, and other health priorities.

By monitoring budget allocation, communities can advocate for equitable distribution of resources and ensure that funding aligns with the most pressing health challenges. Additionally, this type of monitoring can not only enhance accountability and foster trust between communities and health authorities, but can be an important technique for building sustainable accountability pathways.

3.3 Integration of CLM activities into national quality assurance/improvement systems.

3.3.1. Formalizing the role of CLM within the health system

Formalizing the role of CLM within health systems and other cross-cutting sectors is critical for transforming community-generated data into actionable policy and program improvements. Beyond being external watchdogs, CLM programs can serve as recognized contributors within national health governance structures. For instance, during routine data review meetings—such as quarterly or annual performance reviews—CLM programs can be allocated specific time slots to present their findings, trends, and recommendations alongside government routine health information system data and data from implementing partners. A notable example was the PEPFAR's operational model, which mandated the inclusion of CLM data in Country Operational Planning (COP) processes. Here, CLM data was not merely supplemental—it was discussed alongside government and PEPFAR-generated monitoring data, ensuring community voices informed decisions about budget allocations and programmatic priorities.

Additionally, formalizing CLM engagement can take the shape of direct representation on government technical working groups, inter-agency coordinating committees (TWGs), or expert advisory panels related to areas like HIV, TB, maternal health, or broader health systems strengthening. This inclusion helps ensure that issues surfaced by community monitors are incorporated into national policy debates, guideline revisions, and resource prioritization. For example, in **South Africa**, CLM representatives participate in ART adherence TWGs, ensuring community perspectives influence national strategies for improving retention in care.

Governments can also institutionalize CLM data by requiring its integration into official reports such as annual health sector reviews, Global Fund performance frameworks, national strategic plans, or universal health coverage progress reports. In **Kenya**, the Ministry of Health has begun including summary sections on community-led monitoring findings in annual HIV program reviews, strengthening accountability and highlighting community-identified gaps that require programmatic attention.

Case study:Democratic Kenya

About the CLM program

Kenya's Community-Led Monitoring (CLM) systems are designed to be sustainable tools embedded within community and national frameworks for enhancing accountability in health service delivery. Grounded in three core principles—community ownership, accountability, and a results-driven approach—CLM is led by communities, including networks of people living with HIV (PLHIV), key and vulnerable populations (KVPs), and civil society organizations (CSOs). These communities take charge of data collection, advocacy, and oversight to ensure that health interventions are relevant and responsive to local needs.

Type of integration:

To build a coordinated and effective CLM system, Kenya emphasizes integration and harmonization across governance, service delivery, advocacy, and capacity-building efforts. CLM partners engage with existing national and county platforms, such as health sector technical working groups, to incorporate CLM data and community priorities into routine

routine health planning and budgeting processes. This approach ensures that CLM is integrated into the broader health system rather than operating in isolation. Additionally, a national CLM oversight working group, led by community representatives and diverse stakeholders, provides strategic direction and coordination, supporting evidence-based advocacy and resource mobilization.

Lessons learned:

Key lessons from Kenya's CLM experience highlight the importance of community ownership and leadership in ensuring the relevance and sustainability of health interventions. Financing for CLM sustainability is addressed early through cost projections and diversified resource mobilization strategies, including securing support from established funders and exploring innovative funding mechanisms. Comprehensive capacity-building modules empower communities by equipping them with skills in human rights, health governance, and advocacy. Regular impact assessments are integrated into CLM plans to measure effectiveness and inform continuous improvement. Overall, the principles of inclusivity, shared responsibility, transparency, and good governance are essential for the long-term adaptability and success of CLM systems in Kenya

However, practical barriers often remain. One key challenge is access to patients and facilities, particularly for data collection activities. Unlike community-based data collection, facility-based CLM requires permissions from the Ministry of Health and sometimes regional or district health authorities. In several countries, facility managers have blocked CLM access, either due to misunderstandings of the program's purpose, fear of criticism, or concerns over confidentiality. Such bureaucratic hurdles can stall CLM implementation and delay critical data collection efforts.

Therefore, it's essential for CLM implementers to proactively establish formal relationships and agreements with Ministries of Health and subnational health authorities. Introductory meetings and orientation sessions at national, regional, and district levels help sensitize government officials about the purpose, methodology, and value of CLM. Governments, in turn, should create clear policies and standing directives that facilitate CLM teams' access to health facilities, ensuring cooperation from facility managers and staff.

Moreover, governments and donors can support these efforts by formalizing CLM partnerships through Memoranda of Understanding (MOUs) or integrating CLM into grant agreements. Such agreements can define expectations for data sharing, outline protocols for facility access, and affirm the rights of CLM teams to engage in monitoring activities without retaliation or obstruction.

The formal inclusion of CLM in health governance structures elevates its credibility, fosters trust, and ensures community evidence is systematically incorporated into national health priorities and decision-making processes. However, this requires intentional advocacy, policy development, and continuous dialogue to overcome structural and bureaucratic barriers and ensure CLM fulfills its transformative potential.

3.3.2. Integration by establishing a regular meeting schedule and maintaining open, consistent communication channels

The CLM model is implemented as a regular cycle of activities: data are collected in facilities and communities, these data are analyzed and recommendations are created to address barriers to care, these recommendations are delivered to the local, regional, national, and global duty bearers empowered to resolve the issues, and the cycle begins anew. However, these cycles might not be at the same time for all CLM implementers. Integrating feedback sessions by coordinating feedback can prove critical for both stakeholders and duty bearers.

In practice, the calendar of activities for CLM programs is often guided by factors outside of the program's control, including availability of funds, donor funding cycles, and local factors. However, in contexts where multiple CLM programs are operating, integrating CLM by coordinating CLM programs feedback meetings across partners to engage duty bearers at local and regional levels more efficiently is an effective option. This can both improve synergies between the programs, thus improving the impact of advocacy activities, reducing duty-bearer fatigue due to repeatedly being the target of advocacy activities on similar issues, lower the overall cost of accountability processes, and foster stronger mutual support for shared recommendations.

Non-integrated format	Integrated format
Multiple CLM programs have multiple calendars for engaging duty bearers	Creating a shared calendar of meetings with key stakeholders. This may include meeting with other CLM programs to discuss the findings from data collection efforts, align on advocacy messages and recommendations, and strategize to minimize overlap during advocacy activities.
CLM programs have haphazard reporting systems that are not aligned with national reporting systems	CLM programs may benefit from understanding the timing of government budget cycles; existing consultations, stakeholder meetings, and planning meetings with opportunities for external civil society input; key legislative timelines that may impact health policies; and the Ministry of Health's overall workplan and calendar and working with government to be embedded in those schedules.
CLM advocacy phases are not aligned with national meeting schedules	To maximize synergies, these meetings should align with the advocacy phase of the CLM cycle, although the cycle may not always follow a predictable schedule. These meetings do not have to be initiated solely by the CLM program. For example, participating in the Country Coordinating Mechanism's (CCM) regular activities can provide valuable engagement opportunities. Historically, involvement in PEPFAR's Oversight Accountability Response Team (POART) meetings has also facilitated consistent interaction for CLM programs. Regardless of ownership, establishing regular meeting opportunities is crucial. Additionally, being aware of national and local health observances or awareness campaigns can help CLM programs strategically time their activities to maximize visibility and impact.

Quick tip:

Integrating CLM can also include coordinating advocacy activities with duty-bearers, including facility managers and regional and national government partners. In addition to meetings, creating user-friendly communication channels is vital for effective CLM implementation and integration. Mozambique's CLM programs have established WhatsApp groups linking community monitors directly with district health management teams, allowing rapid escalation of issues like stockouts.[10] In Kenya, NEPHAK uses a digital platform coupled with SMS alerts to connect community monitors to county health officials for swift action.[11] Lesotho conducts monthly community dialogues to jointly review CLM findings and co-create solutions. Thailand's integrated web dashboards give both civil society and health authorities real-time visibility into service quality gaps, fostering joint problem-solving.[12] Meanwhile, Uganda's UNYPA leverages social media to rapidly communicate monitoring results and mobilize advocacy efforts.[13] Such diverse tools illustrate how adaptable, multi-channel communication is central to successful CLM operations.

3.3.3. Creating data sharing agreements

Facilitating the ability of duty bearers to access and use CLM data is an important strategy, which can build buy-in, develop allies and partners, and increase trust around community data. While governments cannot own CLM data, creating easy pathways for the regular, systematic use of real-time CLM data is important. This can include developing formal agreements for how and when CLM programs will share data with governments.

Importantly, data sharing is not only relevant in government relationships—it can also strengthen collaboration between different CLM programs operating within the same country or region. When multiple CLM implementers collect data on similar issues, sharing selected, aggregated data among programs can enable triangulation of findings, present a unified advocacy voice, and reduce duplication of effort. However, this also requires clear agreements and shared data governance rules to protect confidentiality and avoid unintended consequences.

When developing data sharing agreements—whether with governments or between CLM programs—several considerations are key. In general, and particularly in contexts that are hostile to key and vulnerable populations (KVP), raw data should never be released if it includes any identifiable information or any pathway by which one could retaliate against or target a respondent. This could include identifiers that could be merged into other systems, individual characteristics that might be recognizable, or in some cases, data about when and where KVP access services. If there is any risk that CLM indicators could place individuals at risk—including respondents, CLM implementers, or healthcare workers—these data should not be shared. Instead, the CLM program should confer and agree on what level of data and which indicators are safe and appropriate to share. Once these rules and roles around data access are agreed upon, agreements outlining them can be formalized through processes like memoranda of understanding (MOUs), ensuring clarity, security, and mutual trust.

[10] Global Fund CLM SI. (2023). Midterm Implementation Update – Mozambique CLM. Internal Report.
[11] PEPFAR/USAID. (2022). Community-Led Monitoring: Lessons Learned from Early Implementations.
[12] UNAIDS Asia-Pacific. (2021). Regional Workshop on Community-Led Monitoring. Bangkok: UNAIDS.
[13] UNYPA. (2022). Annual Report. Uganda Network of Young People Living with HIV.

Case study: Nigeria

About the CLM program

In Nigeria, the Community-Led Monitoring (CLM) program is designed to enhance service delivery in areas such as HIV/AIDS, TB, malaria, and other significant public health concerns. The program empowers communities to actively participate in the monitoring and evaluation of health services, prioritizing the voices of service users, especially those from marginalized or hard-to-reach populations. By generating data that reflects the lived experiences of these communities, Nigeria's CLM aims to place them at the heart of the health service process.

Type of integration:

The CLM program in Nigeria is operationalized by multiple organizations working collaboratively to implement a bottom-up approach. Data collected at the community level is reviewed by stakeholders at various levels, including Local Government Areas (LGAs), State Ministries of Health, and the Federal Government. This collaborative review process leads to evidence-based advocacy for targeted improvements in health services and systemic changes. Nigeria seeks to embed CLM within the Community Systems Strengthening (CSS) framework, ensuring that it is a core component of the broader health and development agenda. The proposed integration combines quantitative and qualitative indicators across six key areas, supported by a harmonized reporting platform for streamlined data collection and analysis.

Lessons learned:

Key lessons from Nigeria's CLM sustainability planning emphasize the importance of institutionalization for longevity. Embedding CLM components into national, state, and local health policies strengthens accountability and secures its role within the health system. Policy integration with national strategies ensures that community monitoring is recognized in planning and budgeting processes, making it part of mainstream health governance. Capacity building through partnerships with community-based organizations enhances local ownership and institutional memory. Multi-stakeholder collaboration is crucial for coordination and sustainability, while dedicated domestic funding, such as creating a specific budget line for CLM, ensures financial sustainability. Finally, effectively utilizing community-generated data in decision-making processes is essential for driving policy reforms and improving service delivery, justifying sustained investment in CLM initiatives.

3.3.4. Using complementary data to integrate CLM feedback to national and donor processes

Developing shared monitoring frameworks that align community-led indicators with the data collection tools and advocacy approaches used by other CLM programs, or with government priorities. Integrating by harmonizing frameworks creates a common language for data, enables joint validation processes, and ensures that community evidence directly feeds into national health planning, budget allocation decisions, and donor dialogues, thereby amplifying the credibility and impact of CLM advocacy efforts.

TThis can also involve co-creating a set of metrics that reflect both community needs and governmental objectives. Critically, this does not mean that government and CLM should be collecting the same data, but rather that where priorities align, government and CLM can collect data that speaks to the same priorities in a complementary way. While governments cannot themselves develop CLM tools, they may be invited to share ideas that communities could consider while creating data collection indicators.

Table 1 displays an example of what this can look like in practice. In this example, government data is able to describe trends in overall PrEP services being available and taken up, while CLM indicators will answer why or why not and how these services could be improved. Collectively, these data offer a more comprehensive picture of what must be done to achieve a key priority for both groups, improved prevention for young women.

Table 1. Integration in practice: Prevention for adolescent girls and young women.

Priority from a National Strategic Plan	Indicators available from government data systems	Possible complimentary CLM indicators	How does this harmonisation lead to integration?
By 2030, 90% of adolescent girls and young women (AGYWs) have access to combination prevention services.	Number of AGYWs newly initiated on PrEP Percent of AGYWs retained on PrEP after 12 months Number of facilities offering all components of comprehensive prevention services inclusive of PEP, PrEP, VMMC, PMTCT, and harm reduction services.	Were you offered information about PrEP services at your last HIV test? How satisfied were you with the PrEP services offered? Why were you unsatisfied with these services? Do you think staff at this facility are friendly to AGYWs?	The data that is collected is complementary as the information collected by the CLM program enriches the government data. Integration takes place when the two programs (Government and CLM) align findings to ensure better outcomes

3.3.5. Ensuring data access while preserving community ownership

Many governments use national-level data systems to track routine health data, such as the DHIS2 system. In some contexts, governments have proposed entering CLM data into a national system like DHIS2. This presents a number of issues. First, ultimately, the government would be responsible for allowing access to data once submitted, which conflicts with core principles of CLM, given that CLM teams would be reliant on the government to access data. To update or change indicators, CLM programs may also become reliant on responses from the government when using the DHIS2 system. Second, while DHIS2 is tailored slightly differently in different contexts, it ultimately has less flexibility around how data and indicators can be formatted than what is used by many CLM processes. Finally, the DHIS2 may not be a safe space for data related to key or criminalized populations. Policy and laws can change at any time—even data that seems safe for the government to house may not always remain so. As such, CLM data can never be integrated into government data systems.

However, there are substantive benefits to ensuring that the government can access data when they need to and ensuring CLM indicators speak to other government data systems. One practical approach to data sharing is the creation of a data dashboard. CLM teams can decide which data are publicly available and allow other stakeholders to review data at any time. Critically, this process will require substantive capacity building to ensure that external stakeholders know not just how to access the data, but also how to interpret it appropriately and understand its limitations.

In addition to data sharing with governments, data access agreements between different CLM programs themselves can be highly beneficial. When multiple CLM programs operate in a country —sometimes funded by different donors or working in different regions—sharing selected, aggregated data can improve triangulation, avoid duplicative data collection, and support a unified advocacy voice. Establishing data access agreements between CLM programs helps define what data can be shared, under what conditions, and how data security and confidentiality will be maintained. These agreements should explicitly address sensitive indicators, especially when dealing with key populations or criminalized communities, to ensure that shared data cannot be used for surveillance, persecution, or unintended harm.

Such agreements, whether between CLM programs or between CLM programs and governments, are best formalized through Memoranda of Understanding (MOUs) or similar legal instruments. These documents should detail data ownership, permissible uses, processes for updating or correcting data, and protocols for responding to potential data security breaches. This structured approach ensures clarity, mutual trust, and continued protection of community-led monitoring's core principles of independence, community ownership, and rights-based advocacy..

3.3.6. Alignment of CLM monitoring with government policies on healthcare provision

Integration can also occur between CLM indicators and national-level policy. While CLM advocacy may try to change policies, it can also be directed at ensuring services are implemented in alignment with national policy. As a result, integrating CLM findings into government decision making can be important to ensure that indicators inform policy questions. In the example in Table 2, by aligning the response options with the national policy, CLM advocates can be able to report to the government what percentage of respondents reported viral load experiences aligning with government policy, potentially setting them up to have a stronger advocacy case. Data on compliance - or non-compliance - of clinics with national policies can be very powerful.

Table 2. Integration in practice: examples of integrating data collection indicators.

Example of policy	Example of an unharmonized CLM indicator	Example of a harmonized CLM indicator
The Ministry of Health sets a national target that viral-load (VL) results move from sample collection to being printed at the facility and disclosed to the client within 14 days.	After your last viral test, how long did it take you to receive the results? • Same day • 1 week • 1 month • Never	After your last viral test, how long did it take you to receive the results? • Same day • Less than 1 week • Less than 2 weeks • 2 weeks to one month • More than a month • Never

Quick tip:

Integrating CLM by harmonising the shared understanding of CLM and its value

Establishing a shared understanding of what CLM is, how it is implemented, and its role within the health system and other cross-cutting sectors by fostering consensus on the value and purpose of CLM among all stakeholders, duty bearers ensures that they are more likely to act on CLM data and advocacy efforts.

A key strategy to mitigate the risk of differing interpretations of CLM is to engage a diverse range of duty bearers throughout the CLM cycle, particularly during the preparation and planning phases. Providing training to government officials on data collection methodologies and incorporating their feedback into data collection tools can enhance their investment in the CLM process. This engagement fosters trust in the data and clarifies each actor's role, highlighting how their contributions are complementary rather than duplicative.

Additionally, these roles can be formalized through memorandums of understanding or other agreements among key CLM stakeholders, further solidifying collaboration and understanding.

04. EXPLORING GUIDING THEMES AND QUESTIONS

Integration should be pursued as a deliberate, principled approach to enhance the effectiveness and sustainability of CLM without compromising its independence. To operationalize integration approaches, the below strategies are designed to guide CLM implementers and funders.

For CLM implementers and for donors, the following framework should be used to determine if an integration activity is appropriate for the CLM model (Table 3).

Table 3. Framework for evaluating integration activities.

Proposed integration activity:	Acceptable activities	Inappropriate activities
Give the government decision-making authority over the activities that the CLM program will perform?	In the case of a government that funds or acts as a financial conduit for donor funding, governments must exercise a minimum level of oversight that is required of all grantees	Integrating government authorities into workplanning activities, in a decision-making capacity
Grant the government the ownership of raw data collected by the CLM program?	Data sharing agreements that would permit governments to access CLM data in a "read only" way, such as through reports, data sharing, or dashboards	Any level of access that would allow the government to edit data, change access rights, dictate the format of data to be collected, or be considered the owner of the data
Grant the government the power to create the CLM indicators?	Government can share ideas of indicators they would like to see in CLM data collection but the final indicators need to come from the communities	Governments taking over the indicator creation process and creating the tools on behalf of communities
Require the removal of data from marginalised communities	Governments need to allow data collection for all communities and support the implementation of CLM by supporting introductory meetings and providing support where access is denied	Removing data for marginalised communities to avoid reporting about them

4.1 Strategies and principles for CLM implementers

From the perspective of CLM implementers, greater alignment between CLM programs and governments should always be oriented around increasing the impact of advocacy. From this perspective, integration should be designed to remove barriers to governments seeing community data, receiving advocacy messages, and acting on those requests.

Understanding whether greater integration may benefit the CLM program, the community implementers should map out the existing barriers to strong engagement. Are donors aware of the CLM program? Do they understand what its goals are? Do they understand the data that the CLM program has collected? Are they receiving recommendations in a format or by a pathway they can easily act on?

Decisions about how to more closely align the CLM program with duty bearers should not be taken lightly and should always be proposed and agreed upon collectively by the CLM program and community, without the engagement of duty bearers. These consultations should consider the potential risks and benefits, and should prioritize above all else protecting the independence and community ownership of the CLM program, and the safety and wellbeing of the people it serves.

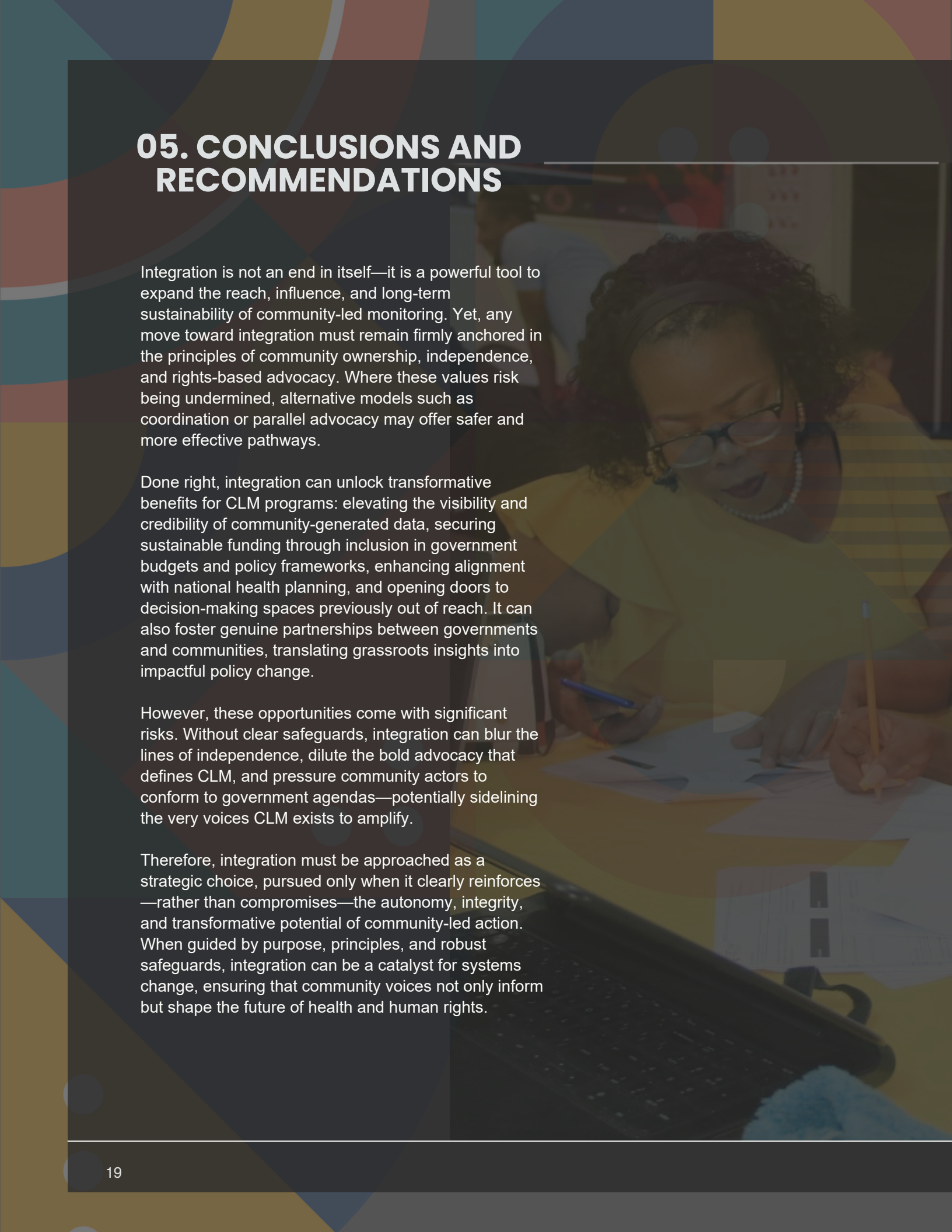
4.2 Strategies for donors

Donors play a pivotal role in enabling the successful operationalization of integration among CLM programs and government entities. As a first principle, donors must recognize the primacy of community leadership in CLM program operation. As such, donors should not mandate CLM programs to integrate their operations with governments, donors, or other non-community stakeholders.

However, donors may provide supportive incentives, such as by providing funding for collaboration between CLM programs and government agencies, such as joint training sessions and capacity-building workshops. Where desired by the CLM program, donors may deliver technical assistance with mapping of CLM activities, creating joint action plans, and capacity building about government planning and policies. Where donor budgets are oriented toward integration activities, this should not detract from core funding for the CLM cycle, and should always be oriented toward more impactful advocacy, rather than integration as an end unto itself.

In scenarios where donor funding passes through government entities, such as Ministries of Health, donors have an important role in ensuring that these financial conduits understand the CLM model and are not empowered to take an ownership role in CLM decision-making. Similarly, in any case where a donor-supported CLM program is transitioned to being funded by governments, donors have an essential role in making sure that governments have social contracting mechanisms to allow community-led organizations to be directly funded to implement CLM and that safeguards are in place to preserve CLM independence.

05. CONCLUSIONS AND RECOMMENDATIONS



Integration is not an end in itself—it is a powerful tool to expand the reach, influence, and long-term sustainability of community-led monitoring. Yet, any move toward integration must remain firmly anchored in the principles of community ownership, independence, and rights-based advocacy. Where these values risk being undermined, alternative models such as coordination or parallel advocacy may offer safer and more effective pathways.

Done right, integration can unlock transformative benefits for CLM programs: elevating the visibility and credibility of community-generated data, securing sustainable funding through inclusion in government budgets and policy frameworks, enhancing alignment with national health planning, and opening doors to decision-making spaces previously out of reach. It can also foster genuine partnerships between governments and communities, translating grassroots insights into impactful policy change.

However, these opportunities come with significant risks. Without clear safeguards, integration can blur the lines of independence, dilute the bold advocacy that defines CLM, and pressure community actors to conform to government agendas—potentially sidelining the very voices CLM exists to amplify.

Therefore, integration must be approached as a strategic choice, pursued only when it clearly reinforces —rather than compromises—the autonomy, integrity, and transformative potential of community-led action. When guided by purpose, principles, and robust safeguards, integration can be a catalyst for systems change, ensuring that community voices not only inform but shape the future of health and human rights.

06. FURTHER READING AND ADDITIONAL RESOURCES

About the CLAW, Coalition Plus, and WACI Health coalition

CLAW

Community-Led Accountability Working group (CLAW) established in 2020, is a partnership of diverse groups of community-led organizations working in longstanding collaborating with international advocacy and academic partners. Members include:

ODELPA l'Organisation de Développement et de Lutte contre la Pauvreté, which leads Haiti's CLM program	**OCSEVIH** Observatoire Communautaire sur de Services VIH	**ICWEA** International Community of Women Living with HIV Eastern Africa
SMUG Sexual Minorities Uganda	**ACT** Advocacy Core Team of Zimbabwe	**TAC** Treatment Action Campaign
HEPS-Uganda Coalition for Health Promotion and Social Development	**UKPC** Uganda Key Populations Consortium	**amfAR's Public Policy Office**
Housing Works Haiti	**O'Neill Institute for National and Global Health Law**	**Health GAP**

CLAW members have extensive expertise providing peer-led technical assistance (TA) and capacity building in establishing and strengthening Community-Led Monitoring (CLM) programs to improve the quality and accessibility of health services, and to overcome human rights barriers that obstruct access.

Coalition PLUS

Established in 2008, **Coalition PLUS** is an international advocacy network working across over 50 countries with more than 110 community member organizations, fighting against HIV and hepatitis and committed to achieving the global goals of defeating HIV as a public health threat by 2030 through expanding leadership of directly impacted communities. Coalition PLUS works with its member organizations across West and Central Africa, Middle East and North Africa, Asia, and Latin America and the Caribbean. Coalition PLUS' strategic approach leverages advocacy, community-based research, knowledge management and South-to-South cooperation especially in French-speaking Africa, driven by the values of respect for diversity, solidarity, and innovation. The presence and reach of Coalition PLUS network members, particularly in West and Central Africa, brings extensive community capacity and expertise to the Coalition in a region with persistent and grave health inequities that require greater community-led advocacy.

WACI Health

WACI Health, registered in South Africa in 2008, is a regional African advocacy organization that influences political priorities through effective, evidence-based Pan-African Civil Society voice and action, championing the end of life-threatening epidemics and improved health outcomes for all in Africa. At the onset of COVID-19, WACI Health established itself at the forefront of PPR advocacy at the national, regional and global levels. WACI Health has mobilized and convened communities and civil society to ensure inclusion, equity, and human rights principles and approaches are adhered to in all aspects national, regional and global PPR processes, policies, and systems. WACI Health is also a co-founder of the Coalition of Advocates for Global Health and Pandemic Preparedness and is a member of the Pandemic Action Network (PAN) African Working Group on Pandemic Preparedness.

In 2024, **CLAW** entered into a partnership with WACI Health and Coalition Plus to collaborate in the provision of technical assistance through the communities in pandemic preparedness and response (COPPER) through Community-led Monitoring (CLM) in the implementation period from April 2024 to December 2025. This is funded through the COVID-19 Response Mechanism (C19RM), Centrally Managed Limited Investment (CMLI). This initiative is grounded on the significant progress made and lessons gained by the CRG-led C19RM over the implementation period 2021-2023.

With the Global Fund Board approval of an additional US $2 million for COPPER CLM, the C19RM implementation is extended to December 2025 to strengthen capacity and literacy of community-led and civil society partners and adapt/or expand existing CLM mechanisms to include PPR priorities; support advocacy efforts for the meaningful participation of communities, CLM implementers and civil society partners in relevant PPR engagements and conversations at the national and local levels; increased utilization of evidence generated by CLM to advocate for stronger CSS and RSSH support and community-led responses, and build pandemic preparedness; and generate evidence and learning on CLM-PPR, publishing of peer-reviewed academic articles, documentation of case studies and success stories, development of CLM-PPR resources and tools, and supporting global and regional learning events.

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CLAW Community-Led Accountability Working Group
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