An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming

Meeting Report

October 18-20, 2023
Manila, Philippines

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Acronyms

AAAQ	*Availability, Accessibility, Acceptability, Quality*
ARV	*Antiretroviral*
C19RM	*COVID-19 Response Mechanism*
CBM	*Community-based monitoring*
CBO	*Community-based organizations*
CCC	*CLM Coordinating Committee*
CCM	*Country Coordinating Mechanism*
CLM	*Community-led monitoring*
CLO	*Community-led organizations*
CRG	*Community, rights, and gender*
CSO	*Civil society organizations*
CSS	*Community Systems Strengthening*
DOTS	*Directly observed treatment, short-course*
DSTB	*Drug-sensitive TB*
DRTB	*Drug-resistant TB*
GC7	*Grant Cycle 7*
GF	*Global Fund*
HIV	*Human Immunodeficiency Virus*
IDP	*Internally displaced persons*
KAP	*Key affected populations*
KP	*Key populations*
KVP	*Key and vulnerable populations*
M&E	*Monitoring and evaluation*
MDR	*Multidrug-resistant*
MOH	*Ministry of Health*
MSM	*Men who have sex with men*
NTP	*National Tuberculosis (Control) Programme*
PLHIV	*People living with HIV*
PPR	*Pandemic Preparedness and Response*
PR	*Principal Recipient*
SR	*Sub-recipient*
TA	*Technical assistance*
TAF	*Technical Assistance Fund*
TB	*Tuberculosis*
TG	*Transgender*
TPT	*TB Preventive Therapy*

Organizations

ACHIEVE (PH)	*Action for Health Initiatives*

APCASO	*APCASO Foundation*
ASD (PK)	*Association for Social Development*
CDC	*Centers for Disease Control and Prevention*
CENAT (KH)	*National Center for Tuberculosis and Leprosy Control*
CFCS (STP)	*Challenge Facility for Civil Society*
CLAW	*Community-led Accountability Working Group*
CPAG (PH)	*Cavite Positive Action Group*
IAC (ID)	*Indonesia AIDS Coalition*
ITPC	*International Treatment Preparedness Coalition*
KPAC (PNG)	*Key Population Advocacy Consortium*
MTC (MN)	*Mongolia Anti-TB Coalition*
PASTB (PH)	*Philippine Alliance to Stop TB*
PBSP (PH)	*Philippine Business for Social Progress*
PEPFAR	*U.S. President's Emergency Plan for AIDS Relief*
POPTB (ID)	*Perhimpunan Organisasi Pasien TB*
SKPA	*Sustainability of HIV Services for Key Populations in Asia*
STP	*Stop TB Partnership*
TBHEALS (PH)	*TB Health Education And Livelihood Support*
TB LON	*TB Local Organization Network*
UN	*United Nations*
UNAIDS	*Joint United Nations Programme on HIV/AIDS*
USAID	*United States Agency for International Development*
WHO	*World Health Organization*

1. Background

1.1. Context

Every year an estimated 10 million people develop TB globally. Among them, 3-4 million people with TB are missed by health systems – they are not diagnosed, treated or reported because of various access barriers, including stigma, discrimination, and other equity, human rights, gender-related barriers.

Over 80% of the TB infection and TB-related death happens in low- and middle-income countries. In particular, the Southeast Asia region carries the highest TB burden among all regions with 46% of all new TB infections. More importantly, six countries in the region are among 13 countries where 75% of the missing people with TB reside.

The Global Fund is a major international donor to TB, providing 76% of all international donor financing. Due to the high TB burden, the Global Fund investment in TB is largely concentrated in the High Impact and Southeast Asia region.

The new Global Fund Strategy recognizes that Community, Rights and Gender related barriers further undermine an effective response to TB and has acknowledged the importance of addressing the needs of high risk and underserved populations to reach the missing millions in the TB response. It further emphasizes the critical role of communities and civil society, who are often best positioned to identify barriers to their health outcomes, and guide and implement health programs to effectively respond to their diverse needs. The Human Rights and TB and Community System Strengthening technical briefs provide detailed programmatic guidance on strengthening CRG-response, including community-led monitoring.

Community-Led Monitoring (CLM) for TB

Community-led monitoring is a powerful model for sustainably improving access to and quality of healthcare services. Through CLM, healthcare service users/affected communities design and carry out routine data collection and analysis leading to data-informed advocacy on barriers to healthcare that they have defined as priorities. Information generated by CLM is a critical complement to other monitoring and evaluation efforts conducted by governments and donors. The CLM model builds on decades of global community and civil society advocacy efforts to improve the right to health. CLM is rooted in core principles of community ownership and independence in monitoring and advocating for people-centered solutions for equitable access to quality healthcare services while promoting accountability and stronger system for health and government and community levels. CLM promotes an integral feature of the right to health: the active and informed participation of individuals and communities in health decision-making that affects them. CLM has already proven to be effective in catalyzing progress to improve programs and service delivery through strengthening the capacity of civil society to regularly engage with and advocate to service providers on (a) what is deficient and (b) what is working well and should be scaled up.

Community-led monitoring in TB is not new. In 2018, the Stop TB Partnership launched OneImpact; a CLM approach for TB. OneImpact is a community engagement approach and a process through which people affected by TB are empowered to meaningfully engage and

be part of the TB response to ensure that quality TB care and services are available, accessible, acceptable to all, and free from stigma and discrimination. People, processes, technology, and information for action are the four building blocks of the OneImpact approach. The OneImpact approach is now being implemented in 26 countries, including Bangladesh, Cambodia, Pakistan, and Philippines. Overall for TB, the uptake, scale up and institutionalization of CLM has been challenging.

There are many reasons for the challenge, including the differences across the region in understanding the concept of community-led and community-based; understanding the concept of 'monitoring'; the role of communities in each of the stage of the CLM cycle; TB affected community organising and lack of TB-led organisations in many contexts; and how to integrate human rights indicators (i.e. stigma, discrimination and other violations happening beyond the facilities) in the overall CLM TB approach and framework. The lack of commitment to community engagement and misunderstanding of CLM often leads to limited resources in CLM.

The Global Fund's CLM Strategic Initiative (CLM SI) included specific focus on TB in Bangladesh, the Philippines, and Mongolia with varied success. In Bangladesh, the uptake of CLM has been slow due to challenges to identify appropriate community-led organizations to lead the work and limited understanding from country partners. In the Philippines, the Global Fund-supported CLM program was slow to start but has been more rapidly progressing through the launch of a TB hotline linked to a redress mechanism. In Mongolia, country partners have expressed enthusiasm for its first ever CLM program which has led to completion of a CLM strategy and workplan to design and launch a CLM program in GC7. Cambodia, Pakistan have also implemented OneImpact with various successes.

In GC7, the Global Fund's Breaking Down Barriers (BDB) Initiative will be expanded to Bangladesh and Thailand in the Asia-Pacific region. While the community-led and based monitoring of human rights violations in HIV and TB has scaled up as part of the core Human Rights programming, there are differences in maturity and progress among the priority countries in the region.

Given the launch of the new Global Fund Strategy and the ongoing GC7 processes, as well as expansion of the BDB initiatives in the region, it is an opportune time to reflect on how TB CLM can be implemented in a way that strives towards globally adopted CLM principles.

On October 18-20, 2023, the Global Fund and Stop TB Partnership with host, APCASO, co-organized an Asia-Pacific Community-led Monitoring (CLM) TB meeting to take stock of lessons from experiences of TB CLM and CLM-like implementation in the Asia-Pacific region to support country-owned TB CLM agendas and work plans.

The meeting had a total of 45 attendees: CLM implementers, regional TA providers, national TB program representatives in nine countries–Bangladesh, Cambodia, Indonesia, Mongolia, Nepal, Papua New Guinea, Pakistan, Philippines, and Thailand–as well as donors and technical partners.

As a supplement, a Google folder has been created which includes the presentations and resources from the meeting. The folder can be accessed here. (https://drive.google.com/drive/folders/1Yx_8F0w7WHk6vYlCrELKHNELELuK5fyR)

1.2. Meeting objectives and expected outcomes

The meeting focused on the following objectives:

1. To share and learn about CBM/CLM TB interventions in the region
2. To build an understanding of CLM principles, building blocks, and approaches, and how to apply CLM principles to the TB context
3. To explore opportunities of integration with CLM approaches in HIV or as part of UHC
4. To identify gaps or needs on CLM in TB in the region, specifically related to:
    - Effective implementation of existing CLM TB activities
    - Expanding the breadth and depth of CLM TB (i.e. scale up)
    - Community capacity to successfully carry out all phases of the CLM cycle
    - Documenting case studies and summaries on CLM experiences and lessons for sharing across Asia-Pacific countries and other regions (i.e. regional collaboration)
    - Technical assistance (TA)
    - Guiding resources and tools

Expected outcomes included:

- Gain common understanding of the relevance of CLM in TB and the application of CLM principles into practice in the context of TB in Asia-Pacific
- Increase knowledge of successes and challenges to CLM for TB implementation in the Asia-Pacific region
- Explore opportunities and strategies to align and integrate CLM TB with HIV, where appropriate
- Development of country-specific CLM plans (including for TA) for start-up, improvement and/or scale up
- Identify platforms for continuous individual country and regional sharing and learning

2. Setting the CLM scene

2.1 CLM Strategic Initiative, Global Fund

The Global Fund team kicked off the meeting with a presentation on the technicalities of CLM principles and cycle of key activities in the design and implementation of CLM programs funded through HIV/TB and TB grants.

CLM means collecting data and experiences from TB-affected people and communities to be used for advocacy with the overall goal of improving health service provision. It uses qualitative and quantitative indicators and is based on the Availability, Accessibility, Acceptability, Quality (AAAQ) framework for assessing the fulfilment of people's right to health. CLM is not meant to be the main monitoring mechanism for TB programs but a complementary and critical source of information, and an accountability mechanism. Further, CLM is not just an assessment or evaluation but constant monitoring, feeding back information to communities, and sharing them with service providers and health decision makers.

The discussion also delved into distinguishing community-based monitoring (CBM) and CLM, emphasizing that CBM may involve collaborative design by communities, government, and donors, while CLM is intended to be designed **and led** by CLOs/CBOs/CSOs and particularly

TB affected communities. It was also highlighted that in countries where CLOs and community-led approaches are still in early stages of development, a CBM approach may be more appropriate and can be used as a foundation for eventual transition to CLM.

This perspective on CLM follows the UNAIDS framework for CLM design and implementation activities. These definitions, principles, and activities eligible for funding support can be accessed in Global Fund's HIV, TB, Malaria and Resilient and Sustainable Systems for Health information notes, the Community Systems Strengthening Technical Brief, and their revised Modular Framework Handbook.

The Global Fund team shared highlights from the CLM Strategic Initiative (CLM SI) and the CLM C19RM Centrally Managed Limited Investment (CMLI) and important learnings form CLM implementation in the Global Fund's Grant Cycle 6 (GC6). These were relayed in the form of challenges namely: varying budgets for CLM initiatives, with most of them being limited and insufficient; a lack of overall understanding of CLM as accountability mechanism and tool for strengthening community engagement and leadership; diverse CLM approaches and models leading to challenges in coordination and data sharing; feedback loops not immediately resulting in systemic improvements; concerns in coordination among donors and technical agencies supporting CLM implementation and technical assistance; and the observation that CLM setup requires a significant amount of time.

Despite these noted challenges, the Global Fund emphasized that the future of CLM is hopeful. CLM investment values, based on GC6 approved grants, amount to USD26M total across 34 countries. In October 2023, Windows 1 and 2 funding requests were estimated at USD59M for CLM across 44 countries.[1] New and scaled-up CLM initiatives are encouraged to be conducted with a phased approach, taking into consideration the time it takes to set up and implement CLM with fidelity. Engagement and buy-in from national TB programs on the valuable contribution of CLM data is encouraged and needed for the success of CLM activities and programs.

2.2 OneImpact CLM, Stop TB Partnership

The Stop TB Partnership (STP) team discussed OneImpact CLM–a community engagement approach and a process through which people affected by TB are empowered to meaningfully engage and be part of the TB response to ensure that quality TB care and services are available, accessible, acceptable to all, and free from stigma and discrimination.

It was emphasized that OneImpact is not just a mobile application but a community-led process facilitated by technology. Neither is it just a tool for monitoring and evaluating the contributions of community health workers and civil society to the TB response. It is not just a monitoring and evaluation mechanism that includes community-centered TB indicators, but a conceptual and implementation framework for CLM in TB.

STP's perspective on CLM originated as a strategic response to the Community, Rights, and Gender (CRG) assessment findings[2] that: people affected by TB do not systematically engage and inform the TB response; people affected by TB, in particular key vulnerable

[1] This is an estimate only. The total amount of funding for CLM interventions from Windows 1 and 2 will be confirmed once grants are signed.
[2] Citro, B., Soltan, V., Malar, J., Katlholo, T., Smyth, C., Sari, A. H., Klymenko, O., & Lunga, M. (2021). Building the Evidence for a Rights-Based, People-Centered, Gender-Transformative Tuberculosis Response: An Analysis of the Stop TB Partnership Community, Rights, and Gender Tuberculosis Assessment. Health and human rights, 23(2), 253–267.

populations (KVP)s face multiple barriers to access (stigma, heavy administrative workload, absence of counseling and social protection, etc.); data on TB challenges/barriers to access is not systematically collected nor responded to; and there is an absence of social accountability mechanisms. Conceptualizing CLM for TB is predicated on supporting gaps and community priorities in the TB response.

Through the Stop TB Partnership Challenge Facility for Civil Society (CFCS) and the demand generated to support the implementation of the OneImpact CLM approach, the latest round of CFCS (Round 12) will support CLM in TB through grants in 36 countries. Supported by USAID, the Global Fund TB Strategic Initiative and L'Initiative (operated by Expertise France), the CFCS is the Stop TB Partnership support mechanism for Community, Rights and Gender in TB.

Leveraging the Right to Health framework, the OneImpact CLM conceptual framework is guided by the AAAQ framework, including support services, as well as stigma and protection and promotion of the rights of people affected by TB.

Key elements of the OneImpact CLM implementation framework includes: creating a common understanding of CLM at a national level, National Tuberculosis Programme (NTP) buy-in and support, leveraging existing community systems, phased implementation towards scale up, the generation of actionable disaggregated (KVP, age and gender) data for targeted responses, which focus on TB screening, testing and treatment, ongoing documentation and learning. Although technology use is not prescribed, the approach encourages the use of OneImpact technology, which enhances accountable responses and the generation of actionable data for advocacy and programmatic decision-making.

The team also shared lessons learned from CLM implementation in different countries in Asia Pacific. Pakistan demonstrated that with political leadership and support, CLM can be institutionalized; that where commitment to and investments in community mobilization are strong, communities can lead and coordinate responses effectively. Ukraine demonstrated how strong community structures can ensure action and timely responses to people in very vulnerable situations due to war. Mozambique demonstrated that effective use of technology and data analytical tools can be an effective alert system to improve service delivery and programmatic outcomes. Cambodia demonstrated that CLM is key to operationalizing the principle of meaningful community engagement in TB.

2.3 Participants' reflections

2.3.1. Stages of the CLM cycle

Participant reactions to the introductory CLM presentations began with a note to reflect country experiences in implementation of activities across the CLM cycle. In some countries, CLM has incorporated a prevention and treatment education component – information is delivered by CLM data collectors when engaging with TB KAP and KVP clients. While CLM data is intended for use in advocacy and health decision-making, CLM activities also have the potential to contribute to relatively shorter-term gains such as improved health and legal literacy and empowerment, leading to improvement of health-seeking behavior and eventually, improved health outcomes.

2.3.2. CLM indicators

A critical need identified during discussions is for communities to autonomously craft their own CLM indicators that are complementary to a selected set of indicators in the national M&E framework for the disease program, thus showing the contribution of CLM data to the NSP. These indicators, while not the same national disease M&E indicators, serve as complementary data points capturing the community's nuanced experiences related to service quality and accessibility. Emphasizing flexibility, these indicators are anticipated to evolve, possibly expanding to encompass broader health and social dimensions. Ultimately, community-crafted indicators are seen as dynamic tools empowering communities to report key concerns, significantly enhancing the effectiveness and responsiveness of TB programs.

2.3.3. Funding and sustainability

Questions regarding funding and support sources, its arrangements, and sustainability were also raised. There was expressed interest from country representatives to find out whether "*community-led*" translates to CSOs and community groups being the intentional recipients of funds to implement CLM. Investment in communities more broadly was raised, not just for skills and knowledge as it relates to disease programming or human rights, but for them to be supported to take lead in the CLM process and engagement with decision makers.

Participants were reminded that when communities design CLM mechanisms, funding flows, triggers and requirements for payment should be clearly outlined. Communities were also advised to make costs explicit in budgets and negotiations during Global Fund processes such as grant making.

Sustainability of CLM activities was also raised, specifically, in the context of being required to pay the community members for the systematic, cognitive and physical, time-consuming monitoring work they do. This can be tackled, at least in part, through continued conversation with governments, ensuring the inclusion of CLM as a social accountability tool in national and community health responses and strategic frameworks. CLM is community-led but requires receptive decision makers and responsive health systems to be successful. As communities decide what they want to monitor, part of this process can include national level discussions to ensure CLM feeds into processes and decisions of the MoH-NTP. It was clarified that national disease programs can fund CLM, but to avoid conflict of interest, the principles of independence, community leadership and ownership across the different stages of the CLM cycle needs to be respected and supported.

2.3.4. Digital technologies

Additional concerns were raised regarding the growing adoption of digital technologies in CLM, with apprehensions that this trend might transform CLM into a specialized practice, potentially jeopardizing its capacity for robust community engagement. The ongoing development of technological applications in CLM introduces a variety of platforms and dashboards based on the specific context, requirements, and capacities of the communities involved.

A key consideration in the integration of technology into CLM is the critical aspect of digital safety and security, underlining the importance of implementing measures to safeguard the confidentiality and integrity of digital processes within CLM processes.

2.3.5. CLM data quality assurance

Some participants raised questions on CLM data quality, cleaning and verification. This was answered with the recognition that community-owned perspectives have its own credibility as it comes from the affected people whose lived experiences cannot be discounted. CLM results are not expected to be validated, nor are its mechanisms expected to be approved, by the government in the bureaucratic sense. The focus was directed to collaboration and mutual respect. Just the same, transparency on the operational framework, methods, process, and tools can help stakeholders see that CLM generates quality data. Ensuring that tools do not leave room for misunderstanding is a preparatory concern that, when done right, translates to recognizable and comprehensible feedback.

One participant raised their perspective that quality CLM implementation supports behavior change for TB KAP in the sense of encouraging health-seeking behavior. In terms of accountability, there are duty holders who have the obligation to make sure services pass the AAAQ criteria, then there are rights holders like communities who are entitled to receive these services against specific standards of care and medical ethics.

2.3.6. Different levels of community engagement

The primary challenge identified in the community building and engagement for CLM for TB stems from the fact that after a person under TB treatment complete their six to nine-month treatment, patients often return to their lives as they were before contracting TB. A distinction was drawn with HIV, where lifelong treatment is required, vs TB clients where there is completion to treatment and a cure. The differences in treatment for HIV and TB creates differences therefore, in the level of engagement of affected communities. For HIV, community engagement can more likely be sustained in the long term, whereas for TB, clients are less likely to remain engaged once treatment has been completed.

CLM is built on community structures that are community-led. Supporting these structures and organisations provides the foundation to sustain CLM as an approach and not only at the individual level. Supporting the organisations leading CLM is critically important and requires capacity-building and strengthening over time.

A misconception was noted in that people affected with TB who graduate from treatment also graduate from the needs and concerns of TB KAP. For example, a person who has had TB is more vulnerable to re-infections, and a person who has had multidrug resistant TB (MDR-TB) has to live with long-term side effects, requiring continuous use of health services. For these types of TB affected members, their interactions with service providers will continue. TB KAP, whether they are newly diagnosed or recurrent users of TB care services, are communities to be continuously engaged in CLM as they provide invaluable feedback. Including them in feedback loops to share CLM data and reports and outcomes of discussions with decision makers is equally important.

2.3.7. CLM-National M&E integration

The integration of CLM data in national M&E for TB or health in general was raised as a question. It is ideal to have CLM data clearly linked to show its complementarity to national disease M&E indicators, but to achieve this level of linkage requires coordination between CLM implementers and national M&E counterparts from the start especially during the process to agree on CLM indicators.

Although CLM is a separate, complementary source of data, there is a need to ensure that NTPs understand the valuable information that CLM can contribute to their own national M&E processes and ultimately to achieving NSP objectives and targets. The partnership framework of CLM intends to move away from the usual power dynamic with governments where they act in a supervisory manner toward communities. CLM data is owned by the community CLM implementer and raw data sits in a separate database outside the national M&E database; integration of CLM data could be most appropriate during discussions or regular reporting by health facilities to district health authorities. The timing of sharing and reporting of CLM data would be useful to map out to ensure this alignment and contribution to have the greatest impact.

Another point raised in response was the importance of sharing of CLM information with human rights actors and decision-makers from different government entities such as labor, education, human rights commissions, etc.

3. Key elements of a CLM program: Building blocks

3.1. Country experiences

Several CLM implementers were asked to share approaches in preparing CLM in their respective country especially in the context of community leadership and partnership and ensuring buy-in of government.

(a) Cambodia: Community responses led by TB peer support groups

In 2017, KHANA Cambodia, based on recommendations stemming from the CRG assessment, pilot tested OneImpact CLM in five operational districts. Key to its success and subsequent scale up was the establishment of peer support networks and a collaborative partnership with the National Center for TB and Leprosy Control (CENAT). These bi-directional support mechanisms facilitated community empowerment, mobilization and support, while securing strategic and national buy-in for CLM scale up and institutionalization. Today OneImpact CLM is being implemented in 17 Operational Districts. According to the 850 people with TB engaged in CLM and data available on the OneImpact dashboard, over 1000 barriers have been reported and 650 of them have been resolved. Furthermore, according to the OneImpact dashboard and analytic report, 50% of the challenges are being reported from three operational districts; Ou Raing Euv, Sa'ang, and Sen Sok and top three challenges being reported are: experiences of discrimination against people with TB, an absence of social protection and TB drug side effects, all of which are impacting quality of life and access to quality treatment and support. Knowing this has allowed KHANA to inform and work more intensely with the above-mentioned operational districts on ensuring support to those who reported and to work with CENAT on policy issues related to drug side effect management, and social protection for all people with TB. In 2024, KHANA will further scale up OneImpact CLM with a grant from the Stop TB Partnership's Challenge Facility for Civil Society (CFCS) and Global Fund support.

(b) Mongolia: Overcoming challenges to strong community engagement

Mongolia Anti-TB Coalition (MTC) faced significant challenges in promoting community leadership for CLM. One primary obstacle was the reluctance of individuals affected by TB

to engage due to stigma. Families often discouraged TB-related community work, fearing societal judgment. Addressing TB stigma was a key challenge, and a stigma assessment in 2019 highlighted its pervasive nature, even within healthcare facilities. Financial burden emerged as another barrier, affecting nearly 70% of individuals undergoing TB treatment. The transition back to work after successful treatment was hindered by the need to repay loans incurred during treatment, discouraging involvement in charitable or volunteer work.

To overcome these challenges, MTC took several initiatives. In 2019, after presenting stigma assessment results at a conference in India, they secured support from the Global Fund to address the issue in Mongolia. To initially provide a platform for engagement, MTC established a Facebook group, which, garnered 2,000 members. Many of these members, however, are currently using alternative or anonymous accounts to conceal their identities. In 2023, MTC together with APCASO facilitated a number of knowledge-building and capacity-building workshops among TB survivors and TB-affected community-led organisations and civil society organisations working on TB to address the lack of information and data platforms for CLM. They discovered a willingness among individuals and organisations, after several years post-treatment, to contribute to TB-related efforts including CLM, such as linking people diagnosed with TB to services.

When it comes to the concept of accountability within CLM, the reception in Mongolia was influenced by historical factors, particularly the rigidly vertical medical care system inherited from the previous political regime. People affected by TB tended to follow doctors' recommendations as strict rules, and one of the challenges was how to convey the importance of accountability when they might be accustomed to following medical directives without questioning. To respond to this, discussions around CLM as an intervention that supports long-term leadership strengthening of TB-affected communities towards establishing a national community-led TB network.

(c) Indonesia: Multistakeholder partnership ensures CLM success

In Indonesia, the stakeholders included in the CLM initiative were a mix of traditional and new partners. Key partners involved were the MOH, communities affected by TB, and human rights organizations. Facing challenges related to stigma, discrimination, and difficulties in accessing care, particularly for those with MDR-TB, the multistakeholder collaboration aimed to address these issues and improve services.

One notable aspect of the partnership was engagement with people with TB and survivor networks, with less than 15 organizations initially in 2022 expanding to more patient groups in 17 districts by 2023. Convincing the MOH was a key challenge, but the approach was collaborative, focusing on working together to enhance services rather than adopting a confrontational stance. The pivotal moment came in 2019 when community voices were gathered through OneImpact CLM, supported by a grant from the Stop TB Partnership's Challenge Facility for Civil Society (CFCS), leading to the government recognizing the importance of hearing and incorporating community perspectives.

From 2021 onwards, the Perhimpunan Organisasi Pasien TB (POPTB) became the Sub-Recipient (SR) for CLM under the Global Fund's GC6. Learning from the pilot, a web-based platform was created, but challenges arose due to limited digital literacy and accessibility issues for those without smartphones. To address this, efforts were made to ensure the CLM solution remained accessible to everyone. The web-based platform has seen success with

over 5,000 visitors and 876 users. POPTB continues to develop the platform with support from the Global Fund and Stop TB Partnership's CFCS grant.

The Indonesian experience showcases an expansion of local-level community groups, strengthened partnerships with human rights organizations, and collaboration with various partners to utilize tools, interpret data, and enhance the overall TB response. Overcoming challenges required a collaborative and inclusive approach, ensuring that the CLM solution is accessible and beneficial to all stakeholders.

(d) Pakistan: TB champions leading CLM

In 2022, the DOPASI Foundation in collaboration with the National TB Control Program Pakistan conducted the CRG assessment and subsequently developed a costed National CRG Action Plan. The CRG assessment findings and Action Plan were then integrated into the NSP for TB, thus institutionalizing CRG in the TB response. One of the recommendations of this assessment was the need to scale up OneImpact CLM as a means to systematically identify and overcome barriers to access. In 2021, DOPASI initiated CLM with the support of the NTP in Rawalpindi district. The program engaged 70 community champions to collect data from people with TB on experiences of barriers to access, stigma, and human rights violations. At first, community-raised barriers were directly reported to the national and provincial TB control programs instead of at the district level where the barriers needed to mostly be addressed. As a result, the district TB officer was encouraged to take leadership in being the first point of contact for sharing CLM data. This change in the CLM approach has facilitated a more rapid response and resolution to the barriers reported. A key success of OneImpact CLM has been the use of CLM data in the Joint Programme Review Mission (JPRM) in December 2022. Using the OneImpact App, DOPASI administered a survey to 1000 people with TB on the barriers they face. The results of this survey informed the JPRM and the subsequent CRG recommendations, which were included and validated in the final report. This simple survey thus allowed the voices and experiences of the TB affected community to be heard which resulted in programmatic recommendations and decisions being taken to strengthen CRG in the country's TB response. In 2024, OneImpact CLM will be scaled up in Pakistan with support from the Stop TB Partnership CFCS.

3.2. Group discussion on CLM building blocks

Participants rotated in groups to respond to specific questions related to the building blocks of CLM. Summaries of these discussions are described below.

3.2.1. What is the added value of CLM for the national TB program?

Responses by participants on this aspect of CLM focused on the usefulness of data generated from CLM. CLM data can:

- Help to improve service delivery
- Support planning, budgeting and resource mobilization for the NTP
- Serve as an early warning or alert system for emerging pandemics or health emergencies due to natural disasters
- Contribute to joint monitoring missions and program reviews in terms of verifying findings
- Improve or encourage policies based on evidence and best practices
- Provide justification for the NTP in advocacy for resources and support at global level

3.2.2. What should the role of the NTP be in supporting CLM?

The support of the NTP is a critical building block for effective CLM as most monitoring activities target public health facilities. Participants' reflections on the role of the NTP went beyond just CLM to overall community engagement in the national program itself. The NTP's role includes:

- To encourage and support communities to contribute input to the national TB strategic plan (NSP)
- To support incorporation of CLM as a priority area in the NSP and integrate CLM indicators (as a complementary CLM module) in the NSP M&E framework
- To provide political and financial support for CLM
- To incorporate CLM data in TB program reviews, regular program meetings
- To act on CLM findings such as stockouts – e.g. lead collaboration with other departments in the health sector (beyond TB) to create and advocate for timely supply of commodities – and to improve TB service packages
- To advocate for community voices, engagement and use of CLM data at the local level and with other levels of decisionmakers and ministries, as relevant

3.2.3. How can communities be best prepared to start CLM?

Readiness of communities and feasibility to start CLM is a key component and needs to be assessed prior to the first phase of the CLM cycle – identification of issues to monitor. Funding for the CLM program would need to be secured for these preparation activities.

- Participants discussed the need to establish a shared understanding of CLM in the context of TB. This awareness-building and education involved in achieving a shared understanding should be designed and delivered in a community-friendly and culturally appropriate way (including language) to ensure comprehension and active participation. Outreach on this specifically to KVP is key to ensuring their participation.
- Understanding and clarification of roles and responsibilities of different community actors in CLM was also noted such as, identifying community-led organizations to lead the CLM and participation of different actors in monitoring activities.
- Participants shared that it would be helpful in the preparatory phase to explore different CLM mechanisms for collecting data that is comfortable, easy to administer and accessible (e.g., paper, digital).
- Participants agreed that identifying the decision-making structures at different levels (health facility, local, etc.) to share CLM data is important to do in the preparation stage.
- Engagement and buy-in of the NTP for CLM was discussed as a prerequisite for CLM especially at local level where the monitoring will be targeting specific health facilities.
- Assessing the level of knowledge of rights and disease literacy among those who have TB and are affected by TB can help inform the identification of issues to monitor.

3.2.4. What coordination structures, mechanisms or platforms exist where affected TB communities and CLM implementers interact with health decisionmakers (at different levels) to share concerns?

Participants offered country-specific examples of decision-making bodies and opportunities where CLM data can be shared. In all countries, there exists various types of national level technical working groups on TB and/or broader health, national coordinating committees with multistakeholders, and sub-national entities at provincial, district, local and health facility levels. The frequency of when meetings are held across the different levels also varies but mostly on a quarterly basis. It was emphasized that consultative bodies for CSOs to meet and plan for advocacy is important. Country-specific examples include:

Country	Structures for sharing CLM data
Bangladesh	NTP-led meetings with local authorities are critical to encourage them to accept CLM and act on its findings
Cambodia	National technical working group on health; district and provincial level meetings where CSOs can attend and participate
Indonesia	Legal institutions and organizations working on human rights to be able to act on and provide mediation on reported violations such as, instances of stigma and discrimination
Mongolia	NTP quarterly meetings with health providers (currently CSOs not yet involved so this is an area to work on)
Nepal	Health facility operational management committees
Pakistan	Private clinics quarterly review meetings
PNG	National strategic information working group with participation of government, development partners and CSOs
Philippines	TB technical working group which includes representation from key affected populations, local health boards, Department of Labor to address workplace-related TB stigma and discrimination, PhilHealth to address restrictive insurance policies
Thailand	National workforce committee meetings

4. Key Elements of a CLM program: Implementation and data use

4.1. Country experiences

Several CLM implementers were asked to share approaches in preparing CLM in their respective country especially in the context of community leadership and partnership and ensuring buy-in of government.

(a) Philippines

Action for Health Initiatives (ACHIEVE) leads TB projects and implements CLM initiatives through the Philippine Alliance to Stop TB (PASTB). They have developed CLM mechanisms like the Human Rights Scorecard and the CallKaLungs TB community hotline, engaging PASTB members as responders and coordinators.

In the first pilot of CallKaLungs, the hotline received an overwhelming 80% of calls related to TB information, 30% specifically concerning diagnostics, and an additional 20% revolving around prevention and symptoms.

Through the Human Rights Scorecard, funded by USAID through its TBLON project, ACHIEVE has identified critical issues within the community, with 14% reporting workplace discrimination and 11% of respondents facing challenges in finding employment. Notably, the data revealed that a portion of the community had difficulties securing jobs or were terminated due to TB. To address these concerns, ACHIEVE has established redress mechanisms, including retainer lawyers and mental health counselors for assessment, while simultaneously developing a mental health triage training for responders.

Advocacy efforts include translating Information, Education and Communication materials into local languages, utilizing local radio stations to disseminate information, and training facility staff, with resulting recommendations published in community reports to guide future action. Through these efforts, ACHIEVE is demonstrating its commitment to responding to and acting on community feedback.

(b) Papua New Guinea

In Papua New Guinea, the Key Population Advocacy Consortium (KPAC) is a platform representing key populations (KP), including sex workers, men who have sex with men (MSM), transgenders (TGs), People living with HIV (PLHIV), and youth.

For KPAC, CLM serves as a strategy for advocacy, ensuring data-driven change through active community involvement in all stages of the CLM cycle from indicator and tool development to advocacy to ensure that the CLM program is responsive to community issues and needs.

Key concerns relate to accountability and wellness. The absence of a facility grievance mechanism often poses challenges for clients, compelling proactive measures to establish a dedicated channel for communication. The approach to engaging clinic heads is marked by extensive sensitization, communication, and engagement, backed by governmental support.

Acknowledging the crucial role of community engagement, particularly in remote areas, underscores their unwavering commitment to bridging gaps and augmenting the overall efficacy of CLM initiatives.

(c) Pakistan

In Pakistan, the Association for Social Development (ASD) has been working since 1995, engaging over 500 healthcare facilities to enhance the response to communicable and noncommunicable diseases. Their CLM initiative focuses on drug-sensitive TB (DSTB), drug-resistant TB (DRTB), diabetes, hypertension, mental health, malaria, HIV, and Maternal, Newborn, Child Health.

Using the OneImpact approach, CLM data has played a pivotal role in enhancing both service delivery and programmatic aspects of the NTP. At the first level, the data serves to enlighten program stakeholders about the primary challenges faced by people with TB, allowing for a targeted focus on specific facilities. In response, facility staff can then address the identified issues that has a concrete positive impact for people affected by TB.

This approach involves peer support groups actively informing healthcare providers and facilities about the challenges encountered by individuals with TB such as, treatment adherence, comprehensive care, and multiple facets of the patient experience. By putting together insights from individuals with TB, the program gains valuable perspectives from those directly impacted by the services which then is used to orient appropriate responses.

Regarding dissemination forums, ASD employs a structured approach with district-level forums and quarterly group meetings. These platforms serve as crucial avenues for sharing CLM data, facilitating open discussions, and ensuring that the insights derived from CLM are widely disseminated and absorbed. However, to date, opportunities to integrate CLM data into decision-making processes within the Country Coordinating Mechanism (CCM) have not yet materialized. This has been identified as requiring attention and effort.

(d) Indonesia

The Indonesian AIDS Coalition (IAC) is home to community-based organizations established in 2011. The IAC began CLM work for HIV in 2011, focusing on monitoring stock and prices of medication. Their work has expanded nationally to monitor other areas; their annual anti-violence against women report is now considered the official report on the issue.

The impact of community monitoring initiatives has invoked diverse responses from duty bearers, particularly within the MOH. When the CLM initiative commenced, it addressed a specific issue related to antiretroviral (ARV) prices, a topic entwined with sensitivities surrounding monopoly, corruption, and inefficiencies in government procurement. The MOH's initial response was marked by opposition, perceiving the advocacy as a challenge. However, through persistent efforts and collaboration, the MOH gradually understood the objective—to enhance procurement efficiency and promote local ownership of programs.

An essential turning point occurred during a meeting with the health minister, where IAC was fortunate to be invited for an engagement with the media. This encounter aimed to reinforce the validity, objectivity, transparency, and accountability of the data generated by CLM, making it amenable for acceptance by the government. The subsequent tripartite meeting involving IAC, MOH, and the national procurement agency resulted in a remarkable 48% reduction in ARV prices. The MOH, recognizing the positive intent of CLM to improve service delivery rather than cast blame, invited IAC to become the Sub-Recipient (SR) for the Global Fund grant to conduct CLM. While there are instances of varied responses from the government, the key lies in transparently explaining the intention of CLM—to enhance services and ensure people have access to the necessary resources—thus garnering government support for these initiatives.

4.2. Group discussion on CLM implementation and data use

Participants rotated in groups to respond to specific questions related to key service issues of TB KAP, feasibility of integration with CLM HIV, technology use, and readiness for scaling up.

4.2.1. What are the key service issues that TB-affected communities are most concerned about?

Drawing from their country experiences, participants shared which services should be targeted for monitoring in a CLM program:

1. Provision of TB information among communities to ensure awareness of issues such as service availability (including diagnostic tools, referral services, vaccines, treatment), cost of TB services, etc.
2. AAAQ of services (e.g. prescription issues, service turn-around, lack of human resources, gender-responsiveness extending beyond women to accommodate needs of people of diverse identities, hours of services, geographic access, availability of TB Preventive Therapy, quality of diagnostics, services, drugs)
3. Experiences of stigma and discrimination among people with TB and their families (including self and secondary stigma) - fear related to exposing TB status (e.g. people with TB seeking assistance at health facilities and been refused services for by staff for fear of being exposed), and potential violence
4. Catastrophic costs of TB – availability of social services (transportation, nutrition), and financial assistance on par with those offered to PLHIV
5. Availability of mental health support
6. HIV-related services for people with TB
7. TB-related job loss – financial security, system to support job re-negotiation, livelihood and empowerment support
8. Services for internal migrants and displaced persons
9. Prison-setting – lack of services and programs
10. Correct administration of DOTS at clinic and self-administered by people under TB treatment

4.2.2. Is it feasible to integrate CLM TB with HIV in your country / for your community?

Participants raised that even without a shared national strategy for HIV/TB in countries, CLM programs can monitor HIV/TB services such as provision of TPT for PLHIV, screening and testing for TB among PLHIV, HIV screening and testing for people suspected of/diagnosed with TB, etc. CLM TB and HIV can also be integrated in the later phases of the CLM cycle – CLM data sharing across CLM TB and HIV implementers for learning and joint advocacy, at various meetings with health officials at different levels, CCM meetings, multistakeholder meetings with government, development partners and CSOs. CLM TB and HIV implementers sharing reports at the same meetings can also reduce the number of meetings whilst providing opportunities for learning about the challenges to services for both diseases and where there are commonalities and differences in barriers identified. Below are reflections from participants on opportunities for CLM TB and HIV integration.

Country	Opportunities and challenges to integrate CLM TB with HIV
Bangladesh	The NTP works with the HIV program, but since CLM for TB is still in preparation stage and not yet implemented, CLM TB integration with HIV is tentative.
Cambodia	CLM data collection tools are different for HIV and TB – TB uses an app which is possible to add some HIV features.
Indonesia	Integration of CLM TB and HIV data is possible using a shared digital platform.

Mongolia	There is a national TB CLM strategy and a CLM Coordinating Committee (CCC) although data collection will not start until 2024 under the GC7 grant; an HIV representative has been included in the CCC.
Nepal	There is a policy of screening for both diseases, but these services are provided separately.
PNG	CLM for HIV and TB can use the same tools and implementers. There are common pathways for sharing information during semester meetings.
Philippines	Government is pushing for HIV/TB integration so willingness is there; lack of HIV understanding among TB services providers is a challenge; services for HIV and TB are located at different facilities so it would be more effort to monitor

4.2.3. How can technology used to support CLM?

The role of technology in CLM is dependent on several factors – available budget to support technological approaches in CLM, skills and comfort of CLM implementers and programs to use technology in different phases of the CLM cycle, and need for CLM programs to be more efficient and effective. Technology has been most used in data collection, data management, analysis and report generation. Overall, participants shared perspectives on the role of technology in CLM.

- Can support real-time reporting and action
- Online databases are capable of storing large amounts of data that can be analyzed via different types of dashboard platforms, and can generate reports and visual presentations of analyzed data
- Facilitates ease of retrieving data when and as needed in different formats and for different purposes (i.e. audiences)
- Builds in data privacy and security
- Transforms ability to communicate and educate the public (e.g. faster, wider reach, diversity of visuals, languages), therefore closing the knowledge gap
- Can create cost efficiencies – less workforce and time needed for specific tasks that technology can do

4.2.4. What is the criteria for CLM scale up readiness?

Criteria for readiness of a CLM program to scale up was discussed in terms of community readiness, government acceptance and support, and CLM program readiness.

Criteria 1: Community readiness

- Overall CLM public visibility and promotion by communities and government
- Community preparedness - mobilization by affected communities, community understanding, acceptance, engagement in current CLM program

Criteria 2: Decisionmakers' acceptance and support

- NTP – inclusion of CLM In national policy, NSP, national guidelines, programmatic frameworks; CLM focal person in NTP; capacitated NTP staff at all levels on CLM understanding of the CLM program including service providers; commitment to use CLM data in a standardized way; inclusion of CLM indicators in national health system; buy-in from NTP to empower communities to implement CLM and engage in the CLM program
- CCM sensitization on and interest in CLM program

- Engagement with other decisionmakers, policymakers, ministries and departments responsible for social welfare system, health system strengthening

Criteria 3: CLM program readiness

- Overall scale up plan with targets and commitment to monitor changes and impact (long-term plan)
- Digitization of CLM to maximize reach for local ownership, IT infrastructure for consolidation of data, communications platform for information sharing, adherence to data laws
- Evidence of pilot results documented, shared and acted on by health facilities and decisionmakers
- Secured and sufficient financing from external and domestic sources (public and private) to support scale up and sustainability of the CLM program
- Agreement among communities and government on CLM indicators for scale up phase
- Identified data collection tools to support scale up

5. Lessons from the CLM TB experience in the Philippines

The Global Fund-supported CLM program in the Philippines is actively implemented Principal Recipient (PR) for TB, PBSP, with ACHIEVE contracted for CRG components on capacity building, advocacy, and CLM.

CallKaLungs, a hotline initiative, serves to provide accurate TB information, gather feedback, document stigma and discrimination experiences, and refer individuals to service providers. The hotline engaged responders from PASTB members who are TB survivor and/or TB affected community-led and PLHIV-led organizations across the country, who received a total of 646 calls, primarily from the Visayas region. Notable topics of inquiry included TB-related information (84%), prevention and symptoms (28.6%), and treatment-related concerns (25.5%). Data analysis revealed insights into gaps in service delivery, particularly regarding AAAQ.

Protocols for responders were established, and the 'CallKaLungs' dashboard was created, providing modules for intake forms, referral tracking, client information, and call history. The dashboard aids in quick response, tracking, and monitoring of hotline activities, contributing to efficient data utilization.

TB Health Education And Livelihood Support (TB HEALS), a TB-affected community-led group supporting people who are diagnosed with DRTB, was introduced to CLM in 2019 but faced challenges due to poor community participation. Capacity-building efforts were made with TB HEALS to improve community engagement, and this included various aspects, from advocacy and data utilization to social media engagement and public speaking.

Cavite Positive Action Group (CPAG) emphasized the critical role of partnerships in CLM, engaging Centers of Health Development, local government units, non-government organizations and other entities. Building strong partnerships requires trust, effective communication, shared goals, and mutual benefits, contributing to the success of CLM

activities in Cavite Province. The CLM efforts in Cavite led to improved accountability, enhanced service delivery, policy influence, sustainability, and data-driven decision-making. Notable outcomes include increased accountability of public officials, improvements in healthcare services, policy reviews, and informed decision-making based on community feedback.

Implementation challenges included technical issues, reluctance from some government partners, and negative perceptions of CLM among health workers and health officials. Key lessons learned emphasized the importance of promotion, understanding data privacy laws, engaging local government units, and mental health triage training for responders. Future plans involve sustained advocacy, partnerships with national bodies, and further refining CLM tools based on ongoing feedback.

6. Operationalizing CLM TB in Asia-Pacific countries

Participants from each country worked together in a group to complete two templates designed to support operationalization of CLM in their respective country.

The first template was aimed at countries with an existing CLM program to assess the status of implementation across the CLM cycle – Cambodia, Indonesia, Pakistan, Philippines. The CLM cycle checklist covered the stages of: i) CLM readiness; ii) identifying TB-service related needs from the affected community; iii) collecting data; iv) analyzing and interpreting CLM data; v) disseminating information; vi) advocating for solutions to improve TB services; vii) monitoring changes and improvements. Bangladesh, Mongolia, Nepal, PNG, and Thailand were only able to complete the first two stages of the CLM cycle given that they are in the process of or have just started to initiate a CLM TB-specific program.

The second template provided countries an opportunity to reflect on the current status of CLM for TB activities, possible scale up and related TA needs to realize the overall plan. The template was organized into three sections with specific questions for each section. If the country does not currently have CLM for TB activities/program, the questions were discussed in the context of how the country would introduce/design a CLM for TB program.

1. What is the status of your existing CLM for TB activities and program?
2. Are there plans for improvement, scale up/expansion of the CLM for TB activities/program?
3. Completed country CLM cycle checklists and operational plans can be found here.

6.1. Operationalizing CLM for TB in countries

Each country presented the results of the CLM cycle checklist and operational plan which are briefly summarized below. These detailed plans can be accessed here.

(a) Bangladesh

Bangladesh is relatively new to CLM, with a well-established TB program achieving success rates of over 90%. However, the current TB program operates as a one-way road with programming activities, and there is a lack of insight into community needs. The country is now looking to adopt CLM practices, starting with a pilot in six districts. In hard-to-reach areas, existing community structures will be leveraged, while in more accessible areas, community

health workers will be engaged. The focus includes TB communities, AAAQ, stigma, discrimination, human rights, and gender. The plan is to assess the feasibility over a year, emphasizing collaboration with existing structures and learning from other countries' experiences.

(b) Cambodia

Today Cambodia (CENAT and KHANA) is focusing on scaling up and institutionalizing OneImpact CLM in the TB response, with the support of the Stop TB Partnership Challenge Facility for Civil Society and the Global Fund. Key priority areas of focus include a nationwide communication strategy on OneImpact and the systematic analysis, use and dissemination of CLM data and reports for action and evidence-based advocacy. To this end, OneImpact CLM Cambodia will actively engage health facility staff, a sub-technical working group for TB, and OneGroup a national oversight body for CLM in Cambodia, which is currently being constituted. With these structures in place, Cambodia aims to demonstrate the importance of partnership, country ownership, community empowerment and engagement for effective CLM in TB.

(c) Indonesia

Indonesia, having completed stages 0 and 1, is well-advanced in implementing CLM for TB. The country emphasizes the importance of cycles in program implementation and highlights the engagement of TB survivors as key actors. POPTB, established for TB survivors, plays a crucial role in advocacy, feedback collection, and addressing stigma and discrimination. The country plans to expand CLM implementers, coverage, and indicators. Identified gaps include support at the district level, sustainability of tools, and the need for technical assistance in updating CLM strategy and operational documents.

(d) Mongolia

Mongolia is in the planning phase for CLM integration into its TB program, starting from GC7. Advocacy efforts are underway, including the inclusion of CLM in national TB guidelines. A support body for CLM has been established, involving various stakeholders. Mongolia plans to pilot CLM in selected districts and provinces, utilizing community health workers and existing community networks. The focus includes reducing stigma and discrimination, monitoring treatment outcomes, and addressing reinfection. The country aims to establish a TB network, peer support groups, and utilize an app-based survey for data collection.

(e) Nepal

Nepal has included CLM in its TB National Strategic Plan for community activities, primarily driven by local government-led initiatives. While not explicitly practicing CLM, Nepal has implemented community-based activities led by local governments. The country is working on CLM readiness, conducting CRG assessments, and addressing barriers to information dissemination. The plan includes initiating platforms for KAP discussions, learning from HIV CLM experiences, and empowering community health volunteers. Piloting is aimed at addressing issues like loss to follow-up, and scaling up involves advocating for CLM at the national level.

(f) Pakistan

Pakistan recognizes the need for scaling up and institutionalization of CLM across the entire country and the public sector. Designated field staff and TB champions are being engaged in

CLM promotion, but challenges in TB knowledge, reporting of barriers, and peer support require technical assistance. The country emphasizes the importance of increased funding support and of scaling up its CLM efforts.

(g) Philippines

See Section 5.

(h) Papua New Guinea

Under the banner of the KPAC, Papua New Guinea is preparing for TB CLM, leveraging experiences from HIV interventions. The country has identified three provinces to lead the CLM response, emphasizing advocacy with the Department of Health. PNG's operational framework includes pilot sites, financial and technical support from the NTP, and collaboration with CLM for HIV. The country seeks support for CLM implementation and resource mobilization to integrate TB CLM in and/or coordinate with existing HIV CLM initiatives.

(i) Thailand

Thailand is in the early stages of planning for TB CLM, having experience with CLM for HIV. Community readiness, data collectors, and operational frameworks are being developed. Challenges include obtaining buy-in from the NTP and the need for further tool development. The country's next steps for TB CLM are expected to align with activities during GC7.

6.2. Key reflections from countries

The overarching theme across countries, in discussions related to their operational plans for TB CLM, involves the challenges and opportunities in implementing CLM: engaging communities, securing funding, and addressing specific contextual issues such as political attention, budget constraints, and the impact of the COVID-19 pandemic.

The discussions underscored the need for comprehensive, community-led strategies to monitor and address TB and related issues. Challenges related to funding, political support, and coordination were acknowledged. Still, countries were actively seeking innovative solutions and advocating for the integration of CLM into broader health programs. Coordination, collaboration, and community engagement remain central to the success of CLM initiatives in the fight against TB.

6.2.1. Support and promotion of CLM

Challenges discussed related to CLM readiness and implementation include limited scope of CLM, lack of buy-in from NTP, and gaps in political attention and budgetary support for CLM. Countries emphasize the need for a joint dialogue between civil society, the Global Fund, and other stakeholders to promote CLM initiatives.

6.2.2. Innovative approaches and tools

Innovations such as web-based platforms, QR codes, and artificial intelligence are being explored for CLM implementation, reflecting a tech-driven approach. These tools are not only for data collection but also for health literacy, legal support, and raising awareness about rights.

6.2.3. Social protection and policy advocacy

Issues related to social protection were discussed, with efforts to engage government officials, conduct policy research, and participate in global meetings to address gaps. Advocacy for the inclusion of CLM in policy frameworks and leveraging support from various funding sources, including the Global Fund and STP, was highlighted.

6.2.4. Organization and coordination of TB affected communities

Many countries acknowledge the strength of organized communities in the HIV sector but note the absence of dedicated networks for TB survivors. Therefore, efforts have been made to establish TB survivor networks and engage TB affected communities through CLM. The importance of coordination among different stakeholders, including CSOs, was also emphasized to prevent fragmentation and competition for resources.

6.2.5. Funding challenges and solutions

Countries face challenges related to funding gaps, especially for scaling up CLM initiatives beyond the pilot phase. Suggestions include leveraging funds from the Global Fund's C19 Response Mechanism, advocating for CLM as part of CSS in the context of Pandemic Preparedness and Response (PPR), and making strong business cases for CLM in grants.

6.2.6. Community engagement and autonomy

Community engagement was a central theme, with efforts to involve TB survivors, community-elected leaders, and other key stakeholders. Discussions revolved around the autonomy of CLM, with calls for developing frameworks that are owned by TB-affected communities.

6.2.7. Opportunities for collaboration

Collaborative opportunities, such as engaging with UNAIDS, WHO and other international organizations, are recognized as essential for the success of CLM initiatives.

6.2.8. Lessons learned from HIV CLM

Lessons learned from the HIV sector, such as the importance of political attention, leadership, and clear frameworks for CLM, are considered valuable for TB initiatives. Best practices include utilizing existing structures, conducting thorough assessments, and establishing partnerships for successful CLM implementation.

7. Funding and TA opportunities to support CLM TB country plans

7.1. Global Fund

The Global Fund's CLM SI that been providing technical assistance for CLM in HIV, TB and Malaria grants since January 2021 ends in December 2023. The decision to end support is attributed to the outcomes from the Global Fund's replenishment campaign.

The implementation period for COVID grants has been extended until December 2025, with initial investments and technical assistance provided across 22 assignments in 13 countries. Participating countries are encouraged to prioritize C19RM resources for CLM to measure COVID-19 impact on services, human rights, social protection in terms of TB.

A new investment case is being developed, and it will be presented to the Global Fund's C19RM investment committee in the coming weeks, seeking additional funding for supporting CLM technical support and generating evidence and learning for CLM in PPR. Negotiating GC7 budgets should consider changes in scope, strategy development, and the inclusion of CLM frameworks, aligning with the Revised Modular Framework that supports framework development, integration approaches, piloting and innovation of CLM and technical assistance.

7.2. L'Initiative

L'Initiative supports Global Fund grants, as part of France's commitment and pledge to the Global Fund addressing specific priorities and portfolios in certain countries. L'Initiative focuses on providing technical support, strengthening enabling environments, generating and sharing knowledge, and supporting French-speaking countries, among others.

In the Asia-Pacific region, eligible countries include Myanmar, Cambodia, Laos, Thailand, and Vietnam, to support implementation challenges and high impact interventions. L'Initiative offers demand-based technical assistance covering grant preparations, implementation support, and ad hoc on-demand assistance. Technical assistance involves multiple stages, and the process begins with eligible partners submitting requests through French embassies. The process involves a call for proposals, similar to grant-making organizations, allowing countries to submit requests for specific projects.

7.3. Stop TB Partnership

The Stop TB Partnership approach to technical assistance is led by communities. Those that receive grants through the Challenge for Civil Society (CFCS) learn by doing, which in turn informs the regional and global CRG initiatives. The package of support to countries, provided through CFCS consists therefore of; grants, tools and the mobilization of additional expertise, should this be required. The CFCS is supporting OneImpact CLM in 36 countries, by providing grants, technology and technical assistance to support CLM scale up and institutionalization. Stop TB Partnership OneImpact CLM is a CLM approach for TB – with a focus on TB key and vulnerable populations and identifying and overcoming the specific barriers to access they face. It relies on people, notably partnerships between communities and national TB programmes, processes, data and technology as its key building blocks towards scalability and institutionalization. The OneImpact technology addresses the common challenges faced by CLM programmes; the generation of actionable data, the analysis of large amounts of data, the integration of all data collection tools into one space, and CLM scale up and institutionalization.

The OneImpact platform is an engagement platform for all people implicated in the TB repsonse; those with TB and those engaged in the response at different levels, enhancing accountability in the TB response. It consists of an App for people with TB, a Response Dashboard for first responders and an Accountability Dashboard for key decision makers in the TB response. The App has different modules which allow people to access the latest information on TB, information on their rights as people affected by TB, to connect with each

other and to report barriers to access anonymously. Facilitating interactive information sharing, users can access TB-related information, share experiences, and engage in discussions, with options to “like”, “comment”, and actively participate in the community. Notably, the App incorporates a mapping services feature, enabling users to map TB and support services in their region, promoting community empowerment. The OneImpact Response Dashboard then allows first responders to view and to take immediate action on the challenges being reported in real time. It serves as a communication hub between those reporting issues and first responders, guided by a resolution protocol, while the Accountability Dashboard aggregates the CLM data to identify the top challenges per province / facility / KVPs/ Genders/ Age groups so that communities and programmes alike can prioritize the action required to overcome the majority of challenges reported. OneImpact, fundamentally, empowers communities by facilitating issue reporting, engagement in discussions, and responses to the challenges reported, thereby establishing a feedback loop that promotes accountability in the TB response. Through this platform countries can maximize community engagement, analyse large amounts of data in real time and download analytic reports for action and advocacy and can integrate various data collection methods into the platform, thus supporting CLM scale up and institutionalization.

8. Practical CLM resources and guides

The Community-led Accountability Working Group (CLAW), on behalf of the three technical assistance consortium providers under the CLM SI, gave a presentation to showcase various resources and guides developed over the last few years. These resources offer practical guidance across various stages of CLM design, implementation and advocacy.

These include:

- Conflict of Interest in CLM Programs
- How to Budget for CLM
- Best Practices for CLM
- Community Evidence to Create Change
- CLM Quantitative & Qualitative Measures
- Data Quality Assurance for CLM
- Data Management Tools for CLM
- Data Analysis Methods in CLM
- CLM: Guide and Training Materials to support CLM Data Use in Decision-making
- SKPA2 Sustainable CLM of HIV Services: A Toolkit for Key Populations

These resources can be found here (https://drive.google.com/drive/folders/1cq0q8bl0SBo_-crjVRol8TmzxHBpFAbF)

9. Cross learning and collaboration

Technical assistance providers offered valuable insights and strategies for CLM. Hands-on learning and insights sharing, synchronous and asynchronous learning, centralized organization of information, real-time data sharing through publicly available CLM dashboards, and international platforms and initiatives were highlighted in the discussion. Integration of coordination into existing and upcoming projects was also raised as an

important part of enhancing the synergy among the range of CLM implementers and stakeholders.

CLAW underscored the importance of recognizing diverse experiences, emphasized the necessity for a cross-learning platform, and encouraged countries to allocate funds for such intercountry learning exchanges. They advocate for coordinated efforts through regional organizations like APCASO to facilitate knowledge exchange among various stakeholders.

APCOM shared their role in a regional consortium supporting CBOs and CLOs in CLM at the country level. They highlighted their roles in providing TA support, organizing workshops, and fostering cross-learning. Collaboration with ITPC Global and CLAW as TA providers for the CLM SI has led to important sharing of TA experiences, tools and support for the development of CLM resources and guides.

Sustainability of HIV Services for Key Populations in Asia (SKPA2), delved into regional mechanisms for CLM, including working groups, a knowledge management hub, and learning series. They propose collaboration with UNAIDS and the launch of a Community of Practice while introducing the idea of a Technical Assistance Fund (TAF) for exchange visits. Various contributors collectively stress the importance of a Community of Practice, knowledge-sharing, and webinars, highlighting the establishment of a learning hub and real-time data dashboards.

The Global Fund highlighted the effectiveness of exchange visits and drew parallels with successful practices in HIV, recommending online sessions like the Link and Learn sessions used by the Global HIV Prevention Coalition.

STP focuses on the role of the CFCS as a space for civil society training and learning. Country implementers expressed the positive impact of cross-learning experiences with communities in India and Indonesia, advocating for strategic planning to amplify efforts at regional and international levels.

Significant strides have been celebrated in the realm of CLM for TB, showcasing the emergence of a robust regional community of practice. The commitment, tools, and technical expertise within these communities were emphasized, with a dedicated pledge to advocate for crucial funding for CLM initiatives. The importance of CLM extends beyond TB; CLM is proving to be a vital pathway for addressing broader health issues and fostering collaborative health and disease-specific partnerships in the region.

Annex: List of Participants

Country Partners (32)		
Country	Organization	Name
Bangladesh	National TB Program	Dr Rupali Sisir Banu
Bangladesh	National TB Program	Dr Shahira Sharwat Chowdhury
Bangladesh	BRAC	Dr Ferdous Wahid
Bangladesh	BRAC	Riaj Mahmud
Cambodia	National TB Program	Dr Long Neth
Cambodia	KHANA	Sok Chamreun Choub
Cambodia	KHANA	Phorng Chanthorn
Indonesia	POP TB	Budi Hermawan
Indonesia	PBSTPI	Liza Pratiwi
Indonesia	IAC	Aditya Wardhana
Indonesia	Stop TB Partnership Indonesia	Thea Hutanamon
Mongolia	National TB Program	Dr. Purevsuren Yanjindulam
Mongolia	Mongolian anti-TB Coalition	Bazra Tsogt
Mongolia	Mongolian anti-TB Coalition	Ganzorig Munkhjargal
Nepal	National TB Program	Deepak Dahal
Nepal	Jantra	Sharan Gopali
Papua New Guinea	KP Advocacy Consortium	Lesley Bola
Pakistan	National TB Program	Dr Abdul Wali Khan
Pakistan	DOPASI Foundation	Kinz Ul Eman (online)
Pakistan	Association for Social Development	Farah Zafar
Philippines	Philippine Business for Social Progress	Eric Camacho
Philippines	Philippine Business for Social Progress	Arnyl Araneta
Philippines	Philippine Business for Social Progress	Maricar Arroyo
Philippines	Pilipinas Shell Foundation	Loyd Norella
Philippines	ACHIEVE	Mara Quesada
Philippines	ACHIEVE	Shyne Catedral
Philippines	ACHIEVE	Jerome Ernest Santos
Philippines	TB HEALS	Florita Dalida
Philippines	Cavite Positive Action Group	Oliver Barrameda
Thailand	Raks Thai Foundation	Wasurat Homsud
Thailand	Raks Thai Foundation	Praphaporn Choowech
Asia-Pacific	AFAO/SKPA	Matthew Kusen

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Global Fund to Fight AIDS, TB and Malaria	Keith Mienies
Global Fund to Fight AIDS, TB and Malaria	Susan Perez
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Global Fund Technical Assistance Providers (7)	
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