LEAP

Lead, Educate, Advocate, Partner

for Community-Led Monitoring in TB


APCASO
Strengthening community systems.
Advancing human rights.

LEAP

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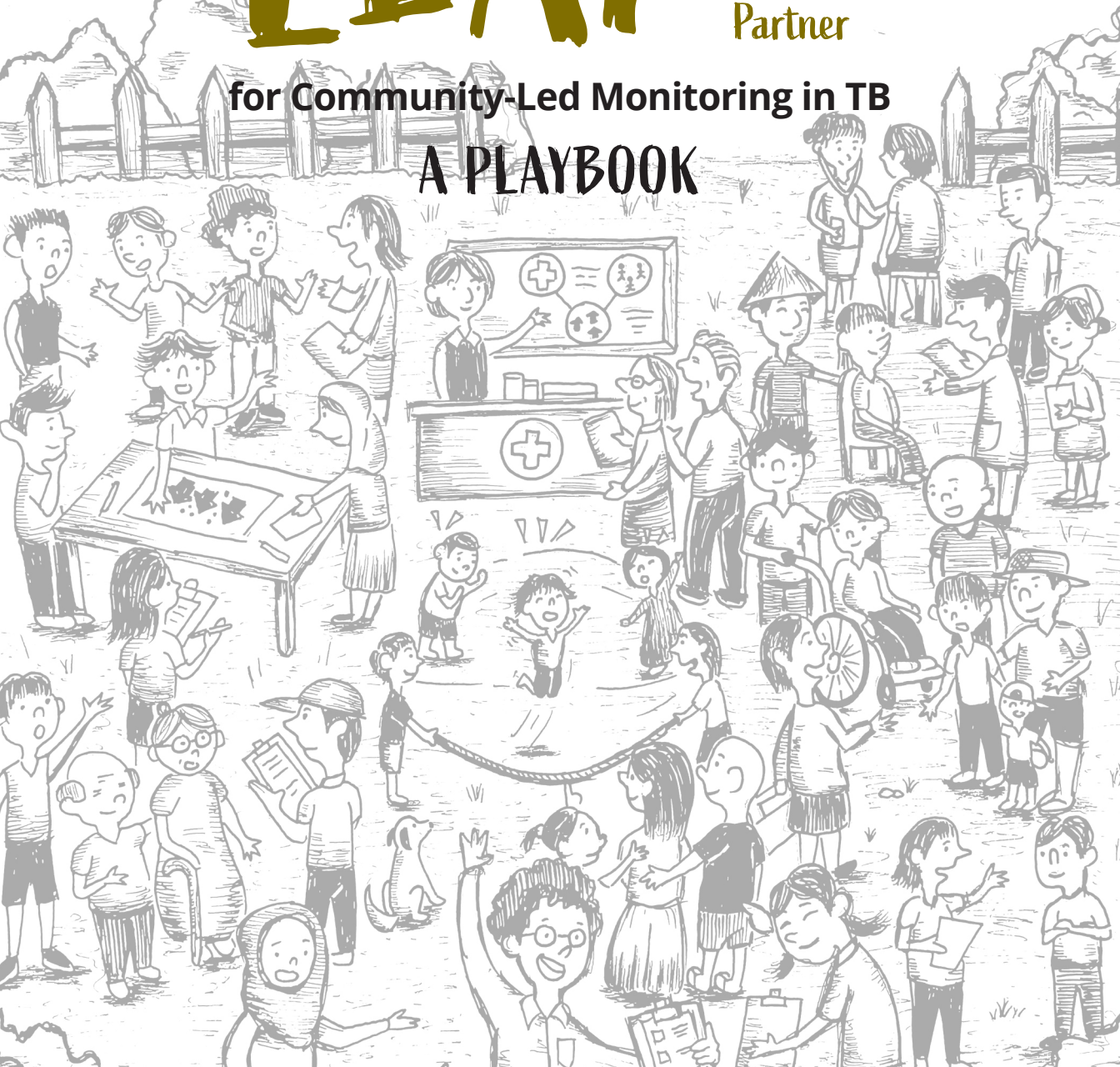
Educate,
Advocate,
Partner

for Community-Led Monitoring in TB

A PLAYBOOK



LEAP (Lead, Educate, Advocate, Partner) for Community-Led Monitoring in TB: A Playbook

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Acronyms and abbreviations

AAAQ	Availability, Accessibility, Acceptability, Quality
AAAQCE	Availability, Accessibility, Acceptability, Quality, Community Engagement
ACHIEVE	Action for Health Initiatives, Inc.
CBOs	Community-Based Organizations
CCM	Country Coordinating Mechanism
CE	Community Engagement
CLM	Community-Led Monitoring
CLM	SI Community-Led Monitoring Strategic Initiative
CLOs	Community-Led Organizations
CRG	Community, Rights, and Gender
CSOs	Civil Society Organizations
CS	Civil Society
CSS	Community Systems Strengthening
GFATM	Global Fund to Fight TB, AIDS, and Malaria
ITPC	International Treatment Preparedness Coalition
KHANA	Khmer HIV-AIDS NGO Alliance – Cambodia
KVPs	Key and Vulnerable Populations
LEAP	Lead, Educate, Advocate, Partner
MTC	Mongolia Tuberculosis Coalition
NSP	National Strategic Plan
NTP	National TB program
STP	Stop TB Partnership
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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Foreword

STRENGTHENING the meaningful engagement of HIV, TB and malaria key and vulnerable populations and communities remains a core work of APCASO under its 2021-2030 Strategy. However, pervading challenges to effective and equitable resourcing of health responses threaten the support towards ensuring that communities are engaged in decision-making at the country level. Community-led monitoring (CLM) has enabled APCASO to uphold our commitment to community systems strengthening (CSS), including in supporting country partners be steadfast in demanding for accountability from duty-bearers, especially in health service delivery, responding to stigma and discrimination, and access to life-saving medical countermeasures.

Through the Global Fund, APCASO, as a recognised technical assistance provider partner for the CLM Strategic Initiative, was given the opportunity to both learn from and support country partners in Bangladesh, Mongolia, the Philippines, and other countries outside of Asia-Pacific in the area of CLM. Our desire to capture and share the immense learning and insights from this work is the genesis for developing this Playbook. As nascent as the concept itself, CLM requires critical ingredients for setting up, implementation, and monitoring, hence we thought of using the analogy of the jumping rope game to characterise the fundamental requirements and steps needed to build strong foundations for CLM.

APCASO hopes that this playbook, “Lead, Educate, Advocate, and Partner (LEAP) for CLM in TB” becomes a companion to key and vulnerable populations and communities, community-

led organisations, civil society organisations, and broader stakeholders' partners, not only as they set up CLM in countries wherein CLM remains new, but also as they progress the agenda of strengthening the meaningful engagement of communities in HIV, TB, and malaria responses.

RD Marte
Executive Director
APCASO

Acknowledgment

THIS playbook will not be made possible without the inputs and insights from our country partners, especially colleagues from Action for Health Initiatives (ACHIEVE), Philippine Business for Social Progress (PBSP) in the Philippines; BRAC Foundation in Bangladesh, and Mongolia Anti-TB Coalition (MTC) in Mongolia. We also acknowledge the various stakeholders and partners that we worked with directly and indirectly across these three countries. From APCASO, we would like to acknowledge the technical guidance of RD Marte, Jeff Acaba, Natakorn Jittanonta, and Maria Leny Felix who also put these pieces of information into a concrete, scalable textbook. We would also like to acknowledge the work of our administrative and operations team as well as finance team at APCASO who worked tirelessly in making sure that our activities are contracts are processed timely and securely. Lastly, we would like to express our gratitude to the Global Fund Secretariat's CLM Strategic Initiative as well as the APCASO-EANNASO-ATAC consortium members, and the broader CLM technical assistance providers consortia that has vigorously fought to register our perspectives and voices as civil society organisations as more inclusive CLM mechanisms also develop globally.

How to use this playbook

Who are the users of this playbook?

THIS playbook on community-led monitoring for TB is a collection of reflections, stories, pointers and experiences of CLOs, KVPs and partners. The jump rope is used in this playbook as a metaphor for the concept and practice of CLM, with the rope symbolizing strength and resilience of community-led organizations. APCASO developed this playbook for leaders of TB-affected CLOs and partner implementers to aid them in strengthening meaningful engagement of TB-affected communities towards improvement in TB care and services. The design and operationalization of LEAP for CLM in TB is through their lens. Their perspectives resonate in each page of this playbook.

You are probably familiar with CLM concepts and cycle, and most likely have used some steps or tools in this playbook. You can then use this as an additional resource to guide you in designing, refining and implementing your CLM process and activities. This playbook is not stagnant but rather will evolve based on the progress of CLM strategy development and implementation. It intends to serve as a vehicle for dialogue and a platform for constructive CLM process in the TB program and communities.

What is the structure of the playbook?

The playbook is divided into six parts, each one underlining the meaning and principles of CLM

and structured in a linked and user-friendly way to effectively guide the users.

Part 1. Understanding the Framework of Community-Led Monitoring for TB provides a brief background on its evolution, definition, principle and process. It also discussed how CLM for TB evolved. This part essentially lays down the basis for developing APCASO's LEAP framework for CLM TB which serves as the CLM framework for this playbook.

Part 2. An Overview on the Characteristics and Leadership of Community-Led Organizations discusses the main features of community-led organizations, roles and responsibilities of CLOs in CLM for TB as lead implementer, educator, advocate and partnership-builder. It also explains the qualities of good leaders for CLM TB, and how to develop sustainable leadership of CLOs.

Part 3. Partnership-Building in Community-Led Monitoring for TB presents the context of partnership in CLM, and the roles and responsibilities of partners in key areas of partnerships in CLM for TB.

Part 4. Establishing and Implementing Community-Led Monitoring for TB provides details on preparation for the establishment and implementation of CLM for TB. Here you will find games, activities and tools that were adapted in the context of CLM process and activities.

Part 5. Evaluation and Documentation of CLM for TB includes discussions on how to conduct process and outcome evaluation of CLM implementation, as well as documentation of best practices and lessons learned.

Part 6. Pointers on Scale-up and Sustainability of CLM for TB serves as an end-note to remind CLM implementers and

users of this playbook on the importance of sustainability which needs to be considered in designing and implementing CLM for TB.

This playbook also includes steps on how to prepare for CLM establishment and conduct data collection, data quality assurance, data analysis, data visualization, data storage and management, and data utilization. Examples of templates and tools that can be used for some of the steps, and interactive activities or games with instructions as part of the steps are also included. As you walk through the playbook, you will see drawings and artworks to visualize ideas or concepts for each part.

Additional contents of the playbook are list of the tools and references.

Introduction

THE WHO report in 2022 stated that the "progress made in the years up to 2019 has slowed, stalled or reversed, and global TB targets are off track" as shown by the 1.6million estimated deaths due to TB in 2021[1]. At that time, access to TB diagnosis and treatment was problematic because of the COVID-19 pandemic.

This situation prompted APCASO to find innovative ways on how to further contribute in deepening and strengthening community engagement in TB response with partners at the national and local levels. APCASO saw that community-led monitoring is one of the mechanisms to engage TB-affected communities and partners.

In 2022, APCASO collaborated with the Global Fund through the Community Rights and Gender (CRG) Department umder the CLM Strategic Initiative (CLM SI) as technical assistance (TA) provider for Mongolia, Philippines and Bangladesh. CLM SI aims to provide technical support to increase the scale and quality of CLM mechanisms throughout the Global Fund's portfolio, and across the three diseases. The Global Fund noted that "while some countries have started to invest in CLM, most notably community treatment observatories and human rights monitoring mechanisms, CLM of prevention services across the three diseases remains largely unexplored"[2].

1 World Health Organization, "Global Tuberculosis Report 2022". https://www.who/int/teams/globak-tuberculosis-programme/tb-reports/global-tuberculosis-report=2022.

2 The Global Fund. Terms of Reference. CLM SITA provider support for the Mongolia Anti-TB Coaltion.

APCASO's collaboration with country partners on CLM establishment and implementation demonstrate the need to continue supporting their initiatives through capacity building and showcasing of good practices and lessons learned in CLM implementation. This is the reason for the development of *Lead, Educate, Advocate, and Partner (LEAP) for CLM in TB: A Playbook*.

Development of the community-led monitoring playbook

The goal and objectives of the LEAP on CLM for TB Playbook are in line with the mission of APCASO to bring together and support community and civil society organizations to improve advocacy and community systems in order to secure health, human rights, and social justice for key, vulnerable, and marginalized communities. This playbook was primarily developed for leaders of CLOs and CLM implementing partners so that they can effectively create a space for KVPs to meaningfully engage in improving the AAAQ of TB care and services.

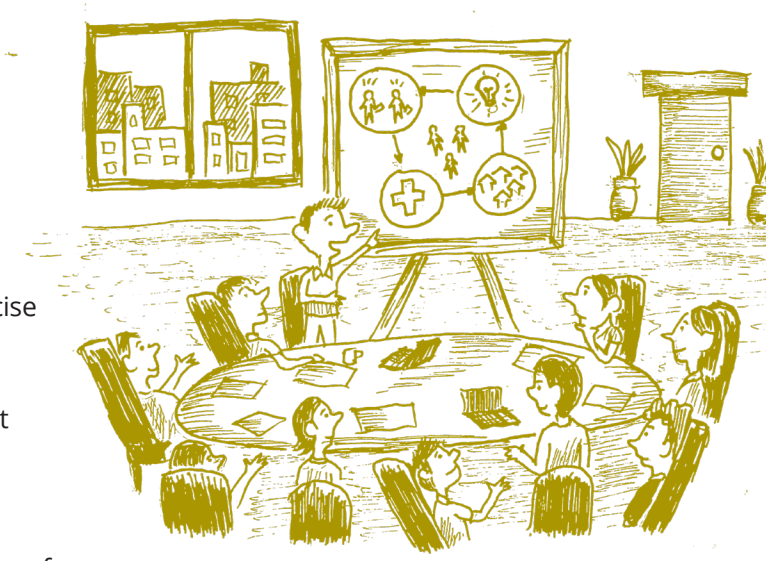
Specifically, this playbook aims to:

- Equip leaders of TB CLOs and communities with knowledge, skills, and attitudes in CLM concepts and process;
- Build the leadership capacity of TB CLO leaders in implementing CLM;
- Contribute to partners' understanding of CLM concepts and process;
- Share examples of country experiences in CLM;
- Facilitate learning exchanges on CLM among countries in the Asia-Pacific region.

Experiences of selected countries and program implementers were culled out from key CLM-related documents and key

informant interviews. The contents, methods, and tools of this playbook were developed through consultations with APCASO and selected partners. A validation meeting was conducted with APCASO for feedback and additional inputs. Relevant documents and publications were reviewed and utilized with appropriate modifications for this playbook. Interactive activities, illustrations, and infographics were used for easier understanding of its users, including the use of jump rope as a metaphor for CLM.

PART 1
Understanding the Framework of Community-Led Monitoring for TB



HAVE you played jump rope or saw people executing it to exercise their bodies? In this playbook, jump rope[1] is considered a useful metaphor for the concept and practice of community-led monitoring (CLM). The rope as the basic tool of this game can symbolize strength and resilience of community-led organizations (CLOs). The CLOs represent the rope holders or leaders with the ability to hold the CLM rope or process together. TB-affected communities epitomize the jumpers whose aim is to jump higher to win the fight against a disease. It can also represent connection or unity among partners in implementing the CLM process. Like jump

1 https://en.wikipedia.org/wiki/Skipping_rope. Skipping rope or jump rope.

rope, CLM requires strategy, coordination, agility and rhythm or regularity in the execution of the different steps.

When we use jump rope in sports work-out and ordinary exercise, it can improve our cardio health and strengthens the muscles[2]. Similarly, CLM can improve TB detection, care and treatment services for patients, survivors and affected communities. It can also strengthen the muscle of communities in TB response.

In this part, we will briefly discuss with you the evolution of CLM, its definitions, and process. Following this section is the discussion on the background of CLM for TB while the last section talks about APCASO's LEAP framework for CLM TB.

1.1 A brief background of community-led monitoring

1.1.1 How did community-led monitoring evolve?

The concept of CLM is not new. Some of the CLM processes and tools have been practiced in various forms by CSOs and communities though not yet structured and entirely led by organized community organizations. Monitoring tools such as scorecards and client exit interviews were already used in the past to collect data from project beneficiaries for advocacy activities[3].

We can say that CLM conceptualization is influenced by the development of participatory processes that began in the 1970s and flourished in the 1980s onwards along

2 *Healthline*. The Benefits of Jumping Rope Goes Beyond Weight Loss.
3 UNAIDS and KPAC. The CLM Recipe Book of PNG, "Komuniti Wok, Senis Kamap" August 2023. Final Report, p.9.

with the growth of civil society movements[4]. Community-based monitoring (CBM)[5] is one of the participatory tools developed in the early 1990s, and later on used by civil society organizations (CSOs), government, development partners and donor agencies such as The Global Fund, USAID, PEPFAR and UN Agencies in their HIV and AIDS, TB and Malaria programs.

Beginning 2018, the CLM framework was systematically formulated and slowly implemented due to the demand for meaningful engagement of key and vulnerable populations in monitoring of HIV and TB programs and services. Also, program planners and donors recognized the value of community data in improving delivery of services[6], addressing systemic barriers, gaps in prevention and treatment services, and identifying policy and legal constraints in the HIV and TB response.

1.1.2 What is community-led monitoring?

Let us first understand what is CLM through the following definitions of UNAIDS, Global Fund and PEPFAR. These definitions were outlined based on consultations with communities, CSOs, governments, development partners and donors in establishing and implementing CLM process:

- **UNAIDS[7].** HIV CLM is an accountability mechanism for HIV responses at different levels, led and implemented

4 Institute for Social Capital. Evolution of Participation Theory Part of 2004 Report "Designing Social Capital Sensitive Participation Methodologies". https://www.socialcapitalresearch.com/designing-social-capital-sensitive-participation-methodologies/evolution-participation-theory/.

5 Robino, Carolina. Community Based Monitoring System. International Development Research Centre, Canada. https://www.civicus.org/documents/toolkits/PGX_F_CBMS.pdf.

6 UNAIDS. Establishing Community-Led Monitoring of HIV services. 2021.

7 Ibid.

by local community-led organizations of people living with HIV, networks of key populations, other affected groups or other community entities.

Global Fund[8]**.** Models or mechanisms by which service users and/or local communities gather, analyze and use the information on an ongoing basis to improve access to, quality and impact of services, and to hold service providers and decision makers to account.

PEPFAR[9]**.** CLM is a process initiated and implemented by local community-based organizations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups or other community entities that gathers quantitative and qualitative data about HIV services.

In 2022, a consultative process of defining CLM was also conducted by CSOs that include **Community Data for Change (CD4C) Consortium, Community-Led Accountability Working Group (CLAW) Consortium and EANNASO-APCASO-ATAC Consortium**[10]. As a result of their consultations, they developed a White Paper reflecting their agreed definition and principles of CLM based on their collective experiences and reflections. The White Paper stated that:

8 The Global Fund. Community-led Monitoring for HIV, TB and Malaria programs and to address the impacts of COVID-19. CEECA regional webinar 07 December 2021 (https://eecaplatform.org/wp-content/uploads/2021/12/clm_ehra-webinar.07122021.pdf).

9 PEPFAR. PEPFAR 2022 Country and Regional Operational Plan (COP/ROP) Guidance for all PEPFAR-Supported Countries. Section 3.2.3, pp. 142-148.

10 COMMUNITY-LED MONITORING. Best practices for strengthening the model. White Paper. 2022. https://itpcglobal.org/resource/community-led-monitoring-best-practices-for-strengthening-the-model/. Community Data for Change (CD4C), Community-Led Accountability Working Group (CLAW) and EANNASO-APCASO-ATAC.

> "In the CLM model, service users and directly-impacted communities lead a systematic data collection effort, in which the community itself decides which issues should be tracked, creates indicators, and collects facility- and community-level data. These data are then analyzed and used to support advocacy directed at government and donors, with the aim of improving accountability and improving the quality of healthcare services"[11].

In the CLM definitions of UNAIDS, PEPFAR and Global Fund we can see three crosscutting principles[12]:

- Community-led monitoring requires leading and ownership by independent communities/civil society;
- Community-led monitoring requires organized communities for effective monitoring;
- Community-led monitoring focuses on generating the political will to enact change and ensure accountability of decision-makers and other duty bearers.

1.1.3 How does community-led monitoring work?

A review of the CLM process espoused by UNAIDS, Global Fund and PEPFAR and the White Paper will point to you these key steps:

11 Ibid.

12 HealthGap.Conflict-of Interest in Community-Led Monitoring Programs. February 2022, pp.5-6. https://healthgap.org/wp-content/uploads/2022/03/CLAW-Conflict-of-Interest-Feb-2022.pdf

Step 1. Assessment of local context or situation to learn about existing resources and capacities for CLM implementation;

Step 2. Planning, budget preparation, establishment of coordination mechanism and partnership-building;

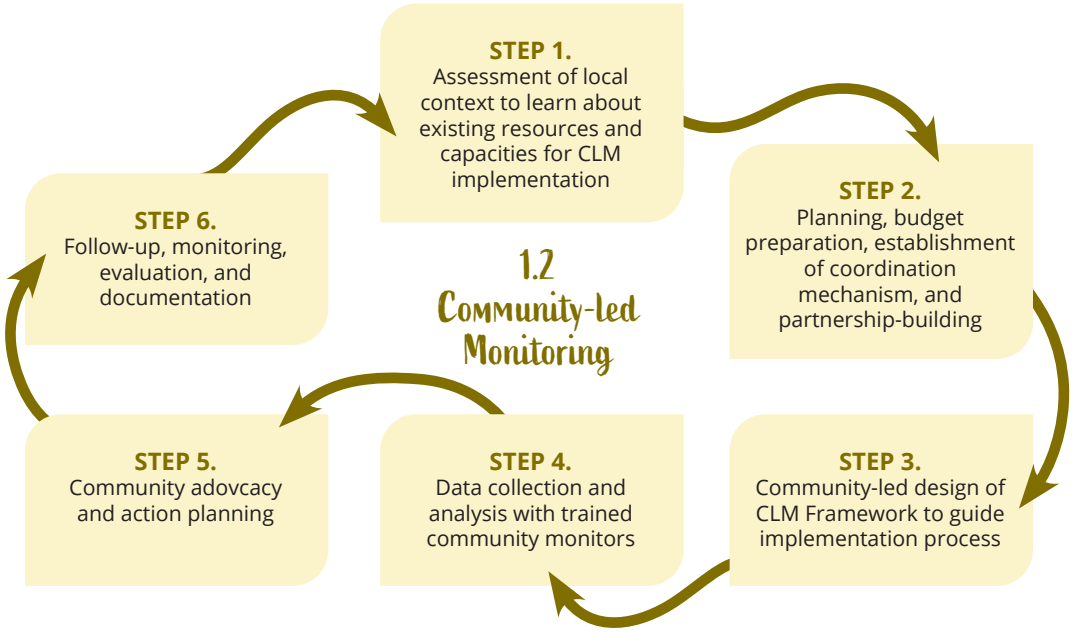
Step 3. Community-led design of CLM framework that will guide implementation process;

Step 4. Data collection and analysis with trained community monitors;

Step 5. Community advocacy and action planning;

Step 6. Follow-up, monitoring, evaluation and documentation.

Figure 1. Steps in the CLM Process



One of the early initiatives in CLM for TB is OneImpact which was launched by Stop TB Partnership in 2018, and currently being implemented in 26 countries[13]. It is a community engagement approach whose four building blocks are people, processes, technology and information for action. OneImpact is geared towards meaningful engagement in the TB response of people affected by TB. Its overall objective is "to ensure that quality TB care and services are available, accessible, acceptable to all and free from stigma and discrimination". Positive outcomes in the implementation of OneImpact were observed in Cambodia and Pakistan[14].

In November 2019, the Global Fund Board approved 19 workstreams totaling USD 343 million under the strategic initiatives' modality[15]. CLM is component #2 of Service Delivery Innovations in Strategic Objective 3: Promote and Protect Human Rights and Gender Equality. Despite the growing country initiatives on CLM in the areas of treatment and human rights monitoring, Global Fund noted that "CLM of prevention services across HIV and AIDS, TB and Malaria remains largely unexplored". The Community-Led Monitoring Strategic Initiative (CLM SI) was implemented by Global Fund to provide technical support to increase the scale and quality of CLM mechanisms throughout the Global Fund's portfolio, and across the three diseases[16].

The Global Fund's CLM SI included specific focus on TB in Bangladesh, the Philippines, and Mongolia. Initial results of CLM implementation in Mongolia led to completion of CLM strategy and workplan to design and launch a CLM program

13 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

14 Ibid.

15 Terms of Reference, CLM SI TA provider support for the Mongolia anti-TB Coalition (MTC).

16 Ibid.

in GC7[17]. In the Philippines, the launch of a TB hotline linked to a redress mechanism is gaining ground, while Bangladesh CLM is yet to take off due to some implementation challenges. APCASO served as technical assistance (TA) provider of Global Fund in implementing CLM SI in these three countries from June 2022 to December 2023.

1.3 APCASO's LEAP framework for CLM TB

1.3.1 What is the basis for developing APCASO's LEAP framework for CLM TB?

In developing the Lead, Educate, Advocate and Partner (LEAP) framework for CLM TB, we took note of the following challenges[18]:

- Lack of appropriate CLOs to lead work on CLM for TB;
- Limited knowledge and skills on CLM of TB-affected communities;
- Inadequate understanding of CLM from country partners;
- Varied understanding of the concepts of community-led and community-based;
- Clarity on the role of communities in each stage of the CLM cycle;
- Knowledge of ways to integrate human rights indicators (i.e., stigma, discrimination and other violations happening beyond the facilities) in the overall CLM TB approach and framework;
- Limited resources for CLM.

17 Ibid.

18 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming
Meeting Report. October 18-20, 2023 Manila, Philippines.

APCASO has adopted the White Paper definition of CLM in the LEAP framework which states that, "In the CLM model, service users and directly-impacted communities lead a systematic data collection effort, in which the community itself decides which issues should be tracked, creates indicators, and collects facility- and community-level data. These data are then analyzed and used to support advocacy directed at government and donors, with the aim of improving accountability and improving the quality of healthcare services".

The principles[19] guiding this framework affirm that CLM will:

- Be led by directly-impacted communities including people living with HIV, TB, malaria and key populations;
- Maintain local leadership and independence, protecting against programmatic interference from other actors including donors, national government, 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 'do not harm' principle;

19 CD4C, CLAW, EANNASO-APCASO-ATAC. COMMUNITY-LED MONITORING Best practices for strengthening the model. White Paper. https://itpcglobal.org/resource/community-led-monitoring-best-practices-for-strengthening-the-model/.

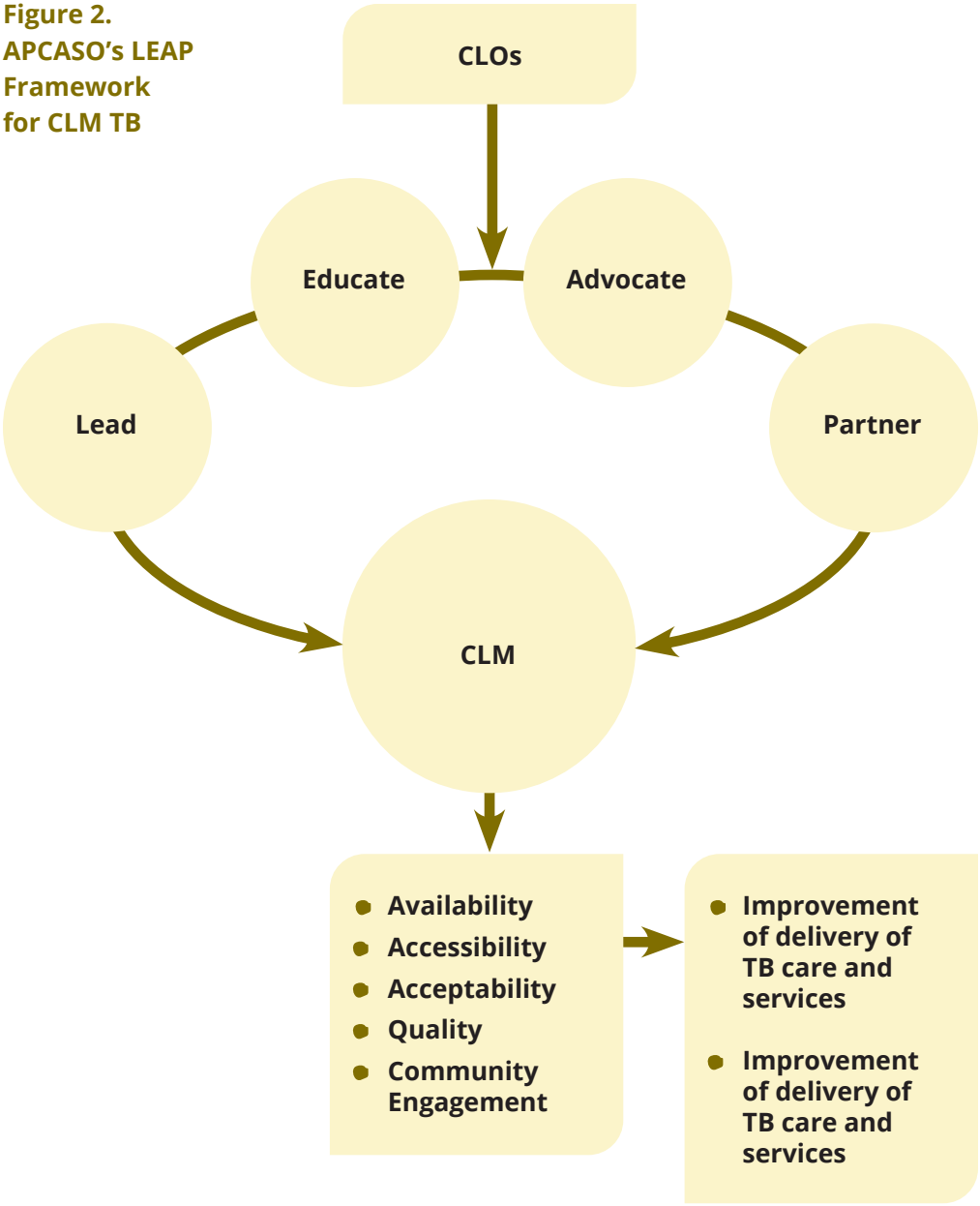
- Ensure that data are owned by communities, with programs empowered to share CLM data publicly and at their discretion. CLM programs should not be made to re-gather, replace, or duplicate M&E data from existing systems;
- Ensure community monitors are representatives of service users, and that they 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 the programmatic, financial, and human resource components of the program.

1.3.2 What is APCASO's LEAP framework for CLM TB?

The LEAP framework for CLM TB as shown diagrammatically in Figure 2 represents the guide that we will use in facilitating the establishment and implementation of CLM with TB-affected communities. It is anchored on our belief that TB response should be based on and led by the communities and based on the principles and values that strengthen community engagement. This means empowering TB-affected communities and survivor groups to create an enabling and non-stigmatizing environment that can support their treatment journey and beyond and meaningful engagement in TB response through advocacy, capacity building, and community mobilization.

LEAP framework is focused on improving the TB services that TB-affected communities and TB survivors receive, as well as the policy and program environment where these services operate based on indicators selected by the communities. Where appropriate and applicable, CLM will also be integrated in TB programs/projects of CLOs but guided by Conflict of Interest (COI) Policy.

Figure 2.
APCASO's LEAP Framework for CLM TB



We ground this framework on the understanding that to improve the delivery of TB care and services and achieve meaningful engagement of communities, CLM should be driven by CLOs. **CLOs are "led by the people who they serve and are primarily accountable to them"**[20]**.** In the TB response, CLOs include organizations by and for TB patients, TB survivors and affected communities.

We say that CLOs will serve as leaders, educators, advocates, and partnership-builders in the CLM process. The assumption of this framework is that the lead CLO has been identified, with basic leadership capacities and willing to:

- **Lead** the establishment and implementation of CLM process;
- **Educate** TB-affected communities, service providers and other key stakeholders on CLM;
- **Advocate** for better TB policies and programs including the adoption of CLM strategy;
- **Partner** with key stakeholder in operationalizing CLM for TB.

Within this LEAP framework, CLM data collection and analysis cycle is focused on TB care and services' **Availability, Accessibility, Acceptability, Quality and Community Engagement (AAAQCE)**. These CLM indicators are linked to the overall TB response and goal to end TB. Thus, CLM results on AAAQCE will be utilized for evidence-based advocacy and meaningful engagement of communities in TB response.

20 UNAIDS. What is a Community-Led Organizatin. 2019. https://www.aidsdatahub.org/sites/default/files/resource/unaids-what-community-led-organization-2019.pdf.

These AAAQCE[21] indicators for CLM TB are described as:

Availability requires that services and facilities for Tuberculosis Detection and Treatment be available in "sufficient quantity" in the health facility or other facilities in the country.

Accessibility includes the absence of stigma and discrimination, physical, economic, and information barriers to accessing of TB services.

Acceptability requires that TB services, including health facilities are culturally appropriate, gender sensitive and ethical.

Quality of TB services requires that they be "scientifically and medically appropriate", with professional competence or administered by skilled health workers, and patient-centered.

Community engagement in tuberculosis response requires empowering TB-affected communities and survivor groups to create an enabling and non-stigmatizing environment that can support their treatment journey through advocacy, capacity building and community mobilization. Specifically, this is about the quality of the interactions created for communities, the relevance of the engagement activities, and the value of engagement results for the communities.

21 Brian Citro, Viorel Soltan, James Malar, Thandi Katlholo, Caoimhe Smyth, Ani Herna Sari, Olya Klymenko, and Maxime Lunga. 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, Volume 23/2, December 2021, pp. 253-267 | PDF. https://www.hhrjournal.org/2021/12/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/

The APCASO's LEAP Framework for CLM is geared towards ensuring that TB-affected communities:

- Decide the TB care and delivery issues to be addressed
- Decide how to address the TB care and delivery issues
- Decide what resources to use and where to use them the most
- Design the actions
- Implement the actions
- Conduct its own evaluation of the actions implemented
- Strengthen their capacity to meaningfully engage in TB response
- Exemplify high levels of community ownership
- Promote inclusive, participatory and gender responsive processes in the TB response

PART 2
An Overview of the Characteristics and Leadership of CLOs

WE emphasized in part one of this playbook that CLOs are the rope holders or leaders of CLM. To continue our discussion, we shall now describe in this part the characteristics of CLOs, their roles and responsibilities in CLM for TB, qualities of good CLO leaders and ways to develop sustainable leadership of CLOs.

2.1 Characteristics of community-led organizations in TB response

In the TB response, we refer to three distinct groups as key and vulnerable populations[22] that include:

22 APCASO. People Affected By TB Matter, A Playbook on Community Engagement. December 2023.

a. **People at increased risk of TB because of biological and behavioral factors that compromise immune function** (e.g PLHIV, people with pre-existing medical conditions, people with a certain unhealthy lifestyle, and people who use drugs).

b. **People who have increased exposure to TB bacilli** (due to where they live or work — overcrowding, poor ventilation, e.g. health care workers, contacts of TB patients, incarcerated persons, and mining-affected population).

c. **People who have limited access to health services** (due to gender, geography, limited mobility, legal status, stigma, e.g. women and children in settings of poverty, remote populations, homeless, migrants, refugees, and internally displaced people, indigenous peoples and ethnic minorities, sex workers and victims of sex trafficking, people who use drugs, and men who have sex with men).

In this context, we can say that:

- **TB patients-led organizations and networks** are led by people infected with TB bacteria and undergoing treatment;
- **TB survivors-led organizations and networks** are led by people who survived tuberculosis;
- **TB-affected community-led organizations and networks** are led by people who have limited access to health services and resources due to poverty, geographic location, stigma and discrimination, thus at risk of being infected with TB.

2.1.1 What are the main features of CLOs?

As a whole, TB patients, survivors and TB-affected community organizations, groups and networks that are community-led whether registered or not registered as a legal body exemplify the following characteristics[23]:

- Majority of governance, leadership staff, spokespeople, membership and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies;
- Promote group leadership and responsibility;
- Inclusive and participatory;
- With transparent mechanisms of accountability to their constituencies;
- Self-dtermining and autonomous, and not influenced by government, commercial, or donor agendas.

2.2 Roles and responsibilities of CLOs in CLM for TB

2.2.1 What are the roles & responsibilities of lead implementer, educator, advocate and partnership-builder?

Based on the LEAP framework for CLM TB, we suggest the following roles and responsibilities of CLOs:

Lead Implementer

- **Initiate situation analysis.** CLOs are responsible for assessment of community needs and gaps in service provision, availability of resources and capacities for establishing the CLM mechanism and operationalizing it;

23 UNAIDS. What is a Community-Led Organization? 1 December 2019. https://www.aidsdatahub.org/sites/default/files/resource/unaids-what-community-led-organization-2019.pdf. CLO characteristics were adopted from this document with modifications and additional insights on their main features.

- **Takes charge of the organization's CLM program.** The CLOs are responsible for setting-up of the structure/mechanism for CLM operationalization. They will undertake the phase of planning, program conceptualization, effectively managing, implementing, monitoring, maintaining and evaluating the CLM program. Resource mobilization and fund-raising is also part of their responsibility. Also included here is the identification and finalization of CLM indicators;
- **Put in place the systems and procedures** for data collection, data processing and analysis. This responsibility also includes formulation of policies and standard operating procedures for data storage and management;
- **Direct the data collection, processing and analysis with trained community monitors and partners.** As Lead Implementer, they will be responsible for guiding the community monitors and partners in collecting data, processing and anlyzing them according to agreed procedures;
- **Implement the CLM data utilization plan.** They are responsible for making decisions on how data will be used for advocacy, planning and programming of TB services;
- **Conduct follow-up monitoring, evaluation and documentation of CLM process.** They will be responsible for tracking the progress of CLM activities, assessing immediate results and gaps, and documenting the CLM outputs, outcomes and impact on TB response;
- **Ensure that Conflict-of-Interest (COI) policy is adhered to by CLM stakeholders.** They are responsible for raising COI issues and addressing COI in conducting CLM along with other relevant stakeholders.

Educator

- **Conduct CLM orientation among TB key stakeholders.** They are responsible for providing the members of TB-affected communities, service providers and other key

stakeholders with concise and accurate information about its concepts, principles and process to make them better understand why they need to engage and own CLM;
- **Train community monitors** on data collection, processing, and analysis;
- **Build CLOs' knowledge and understanding of CLM** through practice, observations, reflections and discussions;
- **Assess TB-affected communities' participation in CLM** as a way to monitor their meaningful engagement in TB response;
- **Provide regular feedback to TB-affected communities** about the CLM process, implementation issues and results;
- **Foster productive learning environment on CLM** among TB-affected communities and key stakeholders based on data gathered, lived experiences and community practice of CLM.

Advocate

- **Providing a voice for TB-affected communities in demanding for improvement in TB care and services based on CLM data.** The CLOs are responsible for ensuring that the TB patients, survivors, and affected communities' views and experiences are heard and respected. This is also a way to assist TB patients, survivors, and affected communities to access and understand appropriate information and services;
- **Ensuring that TB-affected communities are fully informed about their rights** based on legislations and policies as basis for analysing gaps in services gathered through CLM and in making informed decisions;
- **Analyze, monitor, and advocate for policy changes and formulations if necessary for improvement in TB services based on CLM results.** This includes budget proposals, and administrative policies and regulations;
- **Work with local and national government for integration**

of CLM indicators and data/results in National TB Strategic Plan, TB Guidelines and National M & E Plan;

- **Promote the institutionalization of CLM strategy** in the National TB Program and other key planning and policymaking bodies, including allocation of budget for CLM data collection and analysis.

Partnership Builder

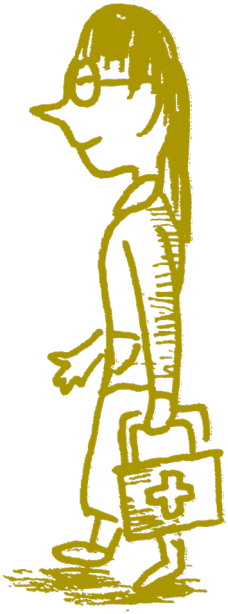
- **Set clear goals and expectations for the partnership in CLM TB.** The CLOs are responsible for defining what they hope to achieve from the partnership, what will the partners gain from CLM partnership and how the CLM process will benefit from partners' contributions;
- **Mapping of potential partners for CLM TB.** CLOs are responsible for dentifying key stakeholders that can contribute in setting-up the mechanism for CLM TB and in conducting the different steps in CLM implementation, and will benefit from the partnership with CLOs representing TB-affected communities;
- **Enter into formal agreement with identified partners on areas of partnership in the CLM process.** It is their responsibility to come up with a Terms of Reference (ToR) or Memorandum of Understanding (MoU) that will guide the CLM collaboration between and among partners;
- **Coordinate and work with partners in implementing the different steps in the CLM process.** CLOs will ensure that there is a good coordination and working arrangements with different partners from setting up of the mechanism for CLM, data collection, processing and analysis and other aspects of CLM implementation;
- **Communicate and conduct regular meetings/ feedbacking sessions with partners on CLM status.** They are responsible for initiating assessment of the CLM results, achievements and gaps that can be addressed by the partners;

- **Secure the support of partners in carrying out advocacy activities based on CLM data** for improvement of TB services, legislations and policies that are supportive of TB-affected comunities, budget allocations, and institutionalization of CLM in the national TB program;
- **Obtain technical assistance from partners in establishing and implementing CLM.** It is the responsibility of CLOs to seek TA from partner-donors, development partners, and CSOs on how to set up mechanisms for CLM operationalization, conceptualization of the CLM strategy, development of tools for data collection, processing and analysis, systems and procedures for data quality assurance, data storage, management and utilization of CLM data.

2.3 Qualities of good CLO leaders for CLM TB

2.3.1 What makes a good leader for CLM TB?

We ask this question because the success of CLM for TB is highly dependent on the qualities of CLO leaders. Communities envisage their leaders to be at the forefront of CLM establishment, implementation, and monitoring. CLO leaders are expected to ensure interactions within their TB-affected communities in the course of conducting the different steps and activities in the CLM process. They can help communities and partners connect and exchange skills, ideas, experiences and resources.



Let us share with you essential qualities that CLO leaders must have or develop to make CLM TB work. Good CLO leaders demonstrate these qualities:

Ability to inspire TB-affected communities and partners

Leaders of CLOs must be able to motivate members of TB-affected communities and partners to imagine the benefits of CLM, act, and invite others to work together to achieve its function and purpose. Embedded in this ability to inspire are traits of integrity, trustworthiness, positive energy, and self-awareness that can facilitate effective implementation of CLM.

Capacity to develop a sense of community responsibility
Good leaders build an organization or network's long-term capacity for self-reliance to sustain CLM implementation. This is anchored on their capacity to develop a sense of community responsibility that results in strong ownership of CLM process and results.

Readiness to learn, adapt and act

The complex environment of CLM TB is challenging for CLOs because there are various players or partners, existence of contradictory perspectives and the outcomes or impact of CLM results are not known in advance despite the identified indicators. While CLM systems and procedures are defined beforehand, they might change according to the interpretation and execution of the CLM players. So even if CLO leaders have knowledge, expertise in CLM, and supported by partners, what they anticipate may or may not happen given the complexity of the environment.

Thus, we say that good leaders must be ready to constantly learn and quickly adapt to changes when needed to make progress in CLM implementation. Remember that like jump rope, CLM requires agility of its players. In this sense, good CLO leaders are:

- Willing to listen to the voices, ideas and proposals of key stakeholders and change course as long as these will benefit the TB-affected communities;
- Ready to learn, adapt, and take action based on the feedback from communities and partners, CLM data and overall situation of TB response.

Consensus-builder

We emphasized in the LEAP framework that CLOs have to partner with key stakeholders to ensure effective CLM implementation. Good leaders in CLM for TB build consensus to ensure that ideas, decisions and actions are supported with ownership and accountability by communities and partners. This means giving each of them an equal chance to be heard and to influence the outcome.

Good leaders understand that consensus-building is important in CLM because through this, a collaborative team environment is created and a consistent approach to decision-making is put in place. They know that consensus in the CLM process cannot be reached quickly and unanimously. They are aware that community members and partners need to be consulted and engaged in a thorough discussion before they agree to support the course of action most community members and partners want to take.

Accountability

Fundamental to the CLM definitions of UNAIDS, Global Fund, PEPFAR, and the CLM implementers from CSOs is the element of accountability. We have noted that one of the cross-cutting themes in their definitions state that community-led monitoring focuses on generating the political will to enact change and ensure accountability of decision-makers and other duty bearers.

In CLM leadership, we also embrace the value of accountability. Leaders are considered accountable when they make it a point to:

- Accept responsibility for mistakes, not just successes in CLM implementation;
- Submit regular CLM reports;
- Solicit and provide prompt feedback to community members and partners;
- Account for the status of entrusted funds for CLM operations;
- Facilitate sharing of CLM implementation progress and results;
- Focus on fixing issues and problems in CLM implementation.

2.4 Developing sustainable leadership of CLOs

In our jump rope metaphor for CLM, we stressed that CLOs hold the ropes. This implies that the lifeline of CLM depends on the strength and capacity of CLOs to plan, effectively implement and manage the processes, monitor, maintain, document, and evaluate its operations. Therefore, developing sustainable leadership of CLOs is a key component of CLM for TB.

2.4.1 What is sustainable leadership?

The concept of sustainable leadership is generally referred to as, **"an approach to leadership that seeks to promote the long-term well-being and sustainability of both organisations and society as a whole"**[24]. In the realm of

24 Nicky D. https://www.linkedin.com/pulse/sustainable-leadership-nicky-dare-.

CLM TB, sustainable leadership provides opportunities for shared leadership and developing a pool of leaders among TB-affected communities with long-term decision-making ability and commitment.

Leadership of CLOs is not the domain of just one or few individuals, and not at all personality-centered[25]. By all means, it is not a one-shot deal. Leaders are expected to come up with a leadership succession plan and proactively implement it to sustain CLOs' leadership of CLM for TB. They are also responsible for sustained capacity-building of future leaders.

During implementation of the CLM cycle, it is anticipated that community leaders will make decisions that take into account their impact on the well-being of TB-affected communities and the society as a whole, along with the future of TB response. Promoting a culture of sustainable leadership among CLOs resonates with the joy of working together, sustaining, and celebrating community empowerment[26].

2.4.2 How to develop sustainable leadership of CLOs?

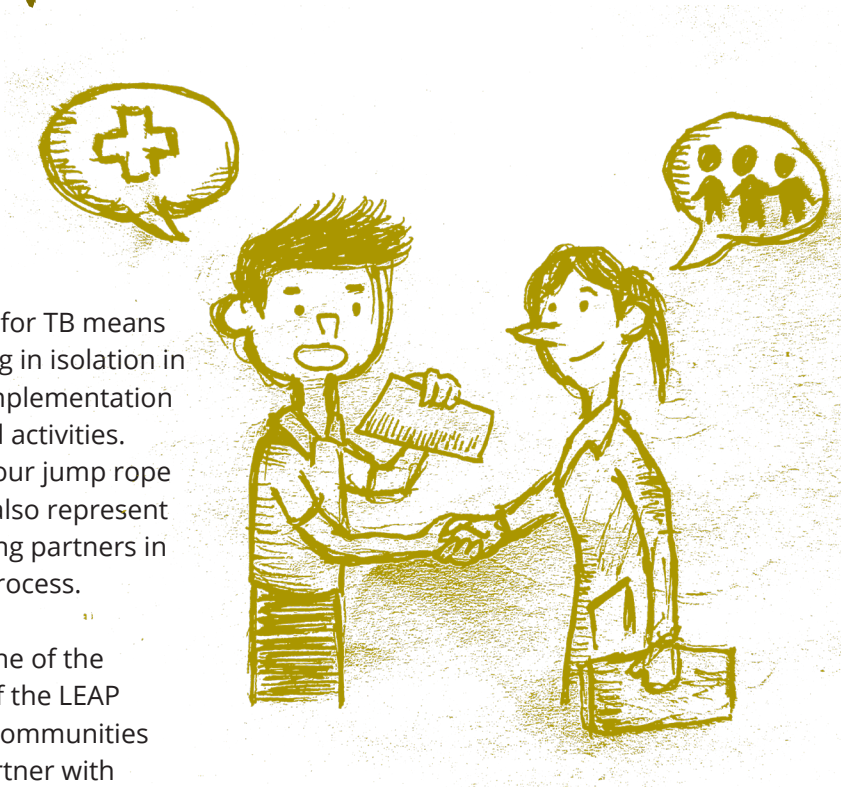
Developing and sustaining leadership of CLOs in CLM for TB is not an easy task. They need ongoing support such as technical assistance, funding/resources and enabling policies. It also requires methodical capacity-building of leaders and evaluation of leadership in CLM.

You may consider the following suggestions in developing sustainable leadership of CLOs in CLM for TB.

25 ACT! ACT and APCASO. People Affected by TB Matter. A Playbook on Community Engagement. December 2023. p.24.
26 Ibid.

- Develop a sustainable leadership program on CLM for CLO leaders and community monitors;
- Identify potential leaders from TB-affected communities—exemplifying motivation/willingness to learn, basic skills in research and advocacy, and passion for CLM work;
- Provide systematic mentoring and training for CLO leaders and community monitors;
- Create space for CLO leaders and community monitors to apply or practice their CLM knowledge, skills and experiences;
- Create opportunities for continuing education, learning and advancement through study visits in countries with best practice in CLM for TB, short course on use of technology for CLM, specialized trainings on data collection and analysis, data sstorage and management, and utilization of data for advocacy, programming and mobilization;
- Celebrate CLM achievements - reward and recognize the contributions of communities, leaders and community monitors in CLM implementation;
- Monitor and evaluate progress in leadership development for CLM TB;
- Document lessons learned and best practices in CLM establishment and implementation.

PART 3
Partnership-Building in Community-Led Monitoring for TB



HAVING partners in CLM for TB means that CLOs are not working in isolation in the establishment and implementation of the different steps and activities. This is what we mean in our jump rope metaphor that the rope also represent connection or unity among partners in implementing the CLM process.

Partnership-building is one of the underlying component of the LEAP framework for CLM TB. Communities lead but they need to partner with key stakeholders in the TB response to make CLM work and achieve its purpose of (a) improving the delivery of TB services and (b) facilitate meaningful engagement of communities in the TB response.

In this part of the playbook, we shall share insights on the context of partnership, roles and responsibilities of partners and the areas of partnerships in CLM for TB.

3.1 Context of partnership in CLM for TB

3.1.1 Why is partnership-building important in CLM for TB?

"KHANA Cambodia noted that key to its success and subsequent scale up in pilot-testing OneImpact CLM in five operational districts 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"[27].

We noted from the reports of Stop TB Partnership and Global Fund[28] that CLM for TB in Asia-Pacific region is not yet mature or still being developed. Also, CLOs in the TB response are still learning, developing their skills, and gaining experience in operationalizing CLM process[29]. Given this situation, it is crucial to build partnerships in establishing and implementing CLM for TB.

27 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report, p.13. October 18-20, 2023 Manila, Philippines.

28 Ibid, p.6.

29 Ibid, p.7.

Partnership in CLM for TB matters because:

- Each partner can provide/complement/or gain experience, expertise and knowledge on CLM;
- Partners can pool resources, technology and finances to ensure successful CLM implementation;
- CLOs' visibility can increase that may result to broadening reach among TB-affected communities;
- It improves collaboration, trust, and shared decision-making on implementation of CLM process and utilization of data for evidence-based advocacy;
- It creates opportunities for CLM scale-up;
- It fosters a culture of accountability among partners for performing their roles and responsibilities in CLM for TB;
- It can facilitate institutionalization of CLM strategy in National Strategic Plan, National TB Guidelines and National Monitoring and Evaluation Framework for TB;
- CLM indicators and data can be integrated in the national reporting system for TB.

3.1.2 Who are the partners of CLOs and TB-affected communities?

The following entities are viewed as partners in CLM establishment and implementation:

- Government bodies at the national and local levels—usually the Ministry of Health, National TB Program, TB programs/offices at the provincial and district governments, National Human Rights Commissions, and other relevant government institutions;

- Multilateral and bilateral donor agencies for CLM TB—for example, Stop TB Partnership, Global Fund, USAID/PEPFAR and DFAT;
- United Nations agencies such as the World Health Organization and UNAIDS;
- Civil society organizations that supports CLOs and CLM—includes INGOs, national and local NGOs, research organizations and academic institutions;
- Key population and other CLOs who can support the education, advocacy, and partnership with broader sectors;
- Private sector—health facilities, IT companies and communication agencies.

3.1.3 What are the principles of partnership in CLM for TB?

We consider the principles of partnership in the box below as appropriate to guide CLOs and partners in establishing and implementing CLM. This is based on our own experiences with country partners and in the work of other organizations that are engaged in partnership building in the TB response.

Principles of Partnership in CLM for TB

1. **Equality in CLM partnership.** This is premised on the belief that while CLOs lead CLM for TB, partners should agree on the objectives and process together and work as a team to implement the steps and activities toward achieving the goals. Each partner values the inputs, perspectives and ideas of other partners in the CLM process.

2. **Build trust with partners by promoting transparency in CLM partnership.** CLOs and partners must clearly communicate their expectations in the partnership, in particular their objectives, what they can bring and what they cannot do.

3. **Result-oriented approach as cornerstone of CLM partnership.** Without negating the importance of process, partners' focus must be on the outcomes of CLM goals and objectives. They should track the progress in achieving results of CLM indicators and data utilization.

4. **Commitment to undertaking one's responsibility in the CLM partnership.** Partners must keep their commitments (TA, expertise, resources, funds, etc.) and deliver accordingly and promptly.

5. **Ensure complementarity in the CLM partnership.** Duplication of contributions must be avoided. Each partner should be able to bring resources and capacities that other partners cannot contribute. Complementarity strengthens collaboration and maximize the use of available resources and expertise from each of the partner.

6. **Make space for a safe CLM partnership environment.** Dialogue and emphatic listening must be present and valued. Partners must feel comfortable, secure, and at ease to voice out dissent, new ideas and propose changes.

3.1.4 What are effective strategies for building partnership in CLM TB?

Here are examples of strategies that CLOs may explore and adapt in building partnership:

a. **Define the goals and expectations from the partnership.** CLOs need to clearly define what they hope to achieve in the short-term and long-term. What are the roles and responsibilities of each partner in the CLM process? What resources, expertise and time will each partner contribute?

b. **Mapping of potential partners to identify the right partners for CLM TB.** Identifying the right partners is an important step in building partnership. In the mapping activity, you must look for organizations, institutions, companies, and individuals that share your principles, complement your strengths, influencers and can help you overcome limitations in operationalizing CLM. The identified goals and expectations from the partnership must guide the mapping of potential partners.

c. **Enter into formal partnership agreement with the right partners.** Based on the mapping results, contacts can be made with selected partners to discuss the prospects of partnership with them, and if successful formalized the partnership agreement.

d. **Develop a CLM partnership plan with the partners.** This outlines the goals and objectives of the partnership agreed on by the partners. It also includes the resources, activities and indicators that will be used to measure the achievements of the partnership vis a vis the overall goals and objectives of CLM for TB.

e. **Establish communication strategy in the CLM partnership.** The methods of communication, content/ themes and regularity or frequency of communication must be put in place to guide the partners way of communicating with each other.

f. **Collaborate in implementing the CLM process and activities.** All partners must be given opportunities to participate through sharing of knowledge, skills, expertise and resources. This includes encouraging introduction of new ideas and innovations in the CLM process.

g. **Maintain the CLM partnership.** Follow-through is important once the action plan is implemented because this is the way to maintain the momentum of partners' enthusiasm and commitment. Remember that each of the partner has its own priorities so we need to actively do a follow-through. Here, effective communication is key which may take the forms of regularly providing feedback and holding formal or informal events to celebrate gains or successes in CLM implementation.

3.2 Roles and responsibilities of partners in key areas of CLM for TB

The table on the next page shows the areas of partnerships in CLM, roles and responsibilities of each partner.

Table 1. Areas of partnerships in CLM, roles and responsibilities partners

Areas of Partnerships	Responsible/ Main Partner(s)	Roles	Responsibilities
Situation Analysis (SA)	CLOs (leaders & community members)	Lead implementer	Develop the SA plan, tools, conduct SA & prepare SA report
Planning & Conceptual-ization of CLM Strategy	CLOs (leaders)	Lead implementer	Guide the planning & conceptualization process (including selection of indicators), provide inputs on tools development for data collection, analysis, quality assurance and use of technology
	CSO partner	Facilitator	Facilitate or co-facilitate the planning & strategy conceptualization process
	Donors & devel-opment partners	TA provider, funder	Provide consultants, funding & resources
	Government	Resource person(s)	Provide technical inputs on NSP, M&E indicators, share data on situation of TB
Setting up of coordination/ collaboration mechanism	CLOs (leaders)	Lead implementer	Guide the process and activities for setting up the CLM organizational structure/mechanism
	CSO partner	Facilitator & TA provider	Facilitate or co-facilitate the establishment of CLM organizational structure/mechanism
Partnership-building	CLOs (leaders)	Partnership-builder	Guide the establishment, operationalize partnership activities, maintain partnerships
	CSO partner	Facilitator	Facilitate the establishment of CLM partnership and participate as partner
	Donors	TA provider, funder	Provide TA, funding, inputs and participate as partner
	Development partners	TA provider	Provide TA, inputs and participate as partner
	Government	Resource person(s)	Serve as resource persons and participate as partner
	Private sector	Resource person(s)	Serve as resource persons and participate as partner

Areas of Partnerships	Responsible/ Main Partner(s)	Roles	Responsibilities
Resource Mobilization	CLOs (leaders)	Lead implemented	Preparation of grant proposals on CLM, resource mobilization plan, fund-raising activities
	Donors	Funder	Provide information on fund-generation, allocate funds for CLM
	Government	Funder	Allocate funds for CLM
Capacity-building	CLO (leaders)	Educator	Conduct orientation on CLM, train community monitors, provide mentoring and coaching support
	CSO partner	Facilitator	Facilitate orientation on CLM, training of community monitors, mentoring and coaching support
	Donors	TA provider	Provide TA and funds for capacity-building program
	Development partners	TA provider	Provide TA for capacity-building
Data collection	CLO leaders & community monitors	Lead implementer	Collect data based on defined indicators
Data analysis	CLO leaders & community monitors	Lead implementer	Guide the data analysis process
	CSO partners	Co-implementer	Facilitate the analysis & interpretation of data collected
	Private sector partners		Provide support on use of technology for data analysis
Data quality assurance	CLO leaders	Lead implementer	Guide the implementation of data quality assurance protocol
	CSO partners	Co-implementer	Facilitate process for data quality assurance
	Development partners	Co-implementer	Provide support to data quality assurance
Data storage & management	CLOs	Lead implementer	Put in place systems & procedures, maintain and manage storage of data
	Development partners	TA provider	Provide technical and material support for data storage & management

Areas of Partnerships	Responsible/ Main Partner(s)	Roles	Responsibilities
Use of CLM data for Advocacy	CLOs (leaders)	Advocate	Develop advocacy plan, use CLM data to advocate for improvement in the delivery of TB services, policy changes, meaningful engagement of TB affected communities in TB response
	CSO partner	Advocate	Support and./or develop as well as implement advocacy activities based on the advocacy plan that was developed
Use of CLM data for program-ming and reporting (NSP, TB programs)	CLOs	Advocate	Initiate dialogue with government, donors and other partners for the integration of data in the national reporting system, NSP, M&E and other; institutionalization of CLM strategy in TB programs
	Government	Facilitator / Recipient	Integration of data in the national reporting system, use of data in NSP and institutionalization of CLM in the national M & E framework
	Private sector	Facilitator / Recipient	Use of CLM data for improvement of TB services
	Donors	TA provider, funder	Provide technical, human and material support to government for CLM data utilization
	Development partners	Lobbyist	Lobby for government adoption of CLM indicators, data and process
Use of CLM data for community mobilization	CLOs (leaders)	Advocate	Mobilize TB affected communities to advocate for improvement in TB services based on CLM results
	CSO partners	TA provide	Provide support to CLOs in mobilizing communities based on CLM data
Evaluation of CLM process, outcomes & impact	CLOs (leaders)	Lead implementer	Guide the evaluation process
	CSO partner	Facilitator	Facilitate the participatory evaluation process
	Donors	TA provider, funder	Provide technical support to the evaluation of CLM implementation
	Private sector	Resource provider	Provide support on use of technology for evaluation
Documentation of best practices & lessons learned	CLOs (leaders)	Lead implementer	Guide the documentation process & activities
	CSO partners	Facilitator	Provide technical support in the documentation process
	Donors	TA provider, funder	Provide consultants, funds & other forms of support in the documentation process

PART 4
Establishing and Implementing Community-Led Monitoring for TB

HOW do we actually establish and implement community-led monitoring for TB? This a good question to continue our conversation. In the preceding parts, we provided the framework that will guide the establishment and implementation of CLM for TB. We clarified the characteristics of TB-affectd CLOs, their roles and responsibilities, the qualities of good CLO leaders and emphasized the need for sustainable CLO leadership. We also pointed out that partnership-building is a key element in the LEAP CLM framework for TB.

Going back to our jump rope metaphor, we said that like this game, CLM requires strategy, coordination, agility and rhythm

or regularity in the execution of the different steps. Now, we will further elaborate this context by discussing how to make CLM for TB work in line with the LEAP framework from preparation, implementation of data production process and management, and utilization of data.

4.1 Preparation for CLM establishment and implementation

Key questions[30] to be asked at this point in the preparation phase for establishing and implementing CLM for TB include:

- Do you have support from the NTP for your CLM activities/ program?
- Are communities organized to be able to lead CLM activities/programs?
- Have CLM implementers been selected?
- Have sites been selected to monitor TB services?
- Do you have a CLM strategy or operational framework?

Considering that CLM readiness is crucial to making CLM for TB work, TB affected-CLOs with their partners have to devote substantial efforts, time and resources in undertaking these activities: 1) situation analysis, 2) conceptualization of CLM strategy, 3) setting up collaboration mechanism, 4) development of CLM action plan, 5) resource mobilization, and 6) capacity-building of TB-affected CLOs and partners on CLM. The diagram on the opposite page illustrates the overall preparation steps and activities:

30 CLM Cycle and Country Frameworks. Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

Figure 3. Preparation Steps in Establishing and Implementing CLM for TB

4.1.1 Situation analysis for CLM TB

What is situation analysis, and why is it so important in CLM for TB?

Situation analysis (SA) is a systematic process of assessing the prevailing environment of CLM for TB as basis for strategy development and planning. It looks at the current epidemiological status of tuberculosis to understand the burden of disease in terms of incidence, prevalence and mortality. It examines the conditions of TB care and service delivery for key and vulnerable populations, policies that impact TB response, and the engagement of TB-affected community-led organizations. In short, situation analysis answer the question, "Where are we now in TB response?".

Performing a situation analysis can help TB-affected CLOs:

- Understand the internal and external factors influencing TB response that have implications to CLM implementation at the national and local levels;
- Get a detailed picture of the gaps, issues and challenges in TB care and services that will benefit from CLM implementation;
- Identify strengths and weaknesses of TB CLOs in CLM for TB implementation;
- Identify opportunities and threats in the implementation of CLM for TB;
- Determine key community data to be collected through CLM;
- Devise an appropriate CLM strategy and plan.

What are the responsibilities of community leaders in situation analysis?

- Guide the members of TB-affected CLOs in defining the objectives and selecting the methods for situation analysis;
- Develop a work plan for situation analysis;

- Conduct of the steps in situation analysis;
- Prepare the situation analysis report.

What are the steps and activities in conducting situation analysis?

Step 1. Outline the plan for situation analysis. In this step, you may facilitate the activities below:

a. Conduct a meeting with members of TB-affected CLOs to review with them the definition of CLM, principles and its process, orient them on the importance of situation analysis for CLM TB, jointly define the objectives and choose the methods for situation analysis (for example SWOTAnalysis)

   You can conduct the following fun activity to identify the objectives of situation analysis:

Activity 1. Make a TB-affected CLO-Family Bucket List of Objectives for Situation Analysis

Objective — To get community members' consensus on the objectives of situation analysis.

Duration — 45 minutes to 1 hour

Requirements — Lead facilitator, documentor, flipcharts and markers.

Instructions —

1. Explain the purpose of the activity;

2. Divide the TB-affected CLO family into small groups (5-7 members). Ask each group to choose their facilitator and note-taker;

3. Draw a bucket where you will put your list of objectives in conducting situation analysis. The following are example of questions that may guide you in listing your SA objectives:
   - What do you intend to find out about TB response?
   - What are the types of TB care and services available in your community?
   - What are the gaps in TB service delivery and the needs of TB patients?
   - Why is it difficult to access isoniazid?
   - What would you like to know about the perceptions, views, and experiences of TB patients on the services they received?
   - How do people in the community feel towards TB survivors? Towards people who are affected by TB (e.g. people living with HIV, people in households with someone who had TB, children of TB survivors and those who are undergoing treatment, people who use or inject drugs, people who live in slums or those considered urban poor)
   - How are key and vulnerable populations accessing information about TB disease and services they can avail?
   - How are TB-affected CLOs engaged in TB response at the national and local levels?
   - What are the best practices of TB-affected CLOs in monitoring and evaluation of TB service delivery?

4. Brainstorm a list of your specific objectives in conducting situation analysis and fill-up the bucket;

5. The lead facilitator will ask the CLO family members to identify common themes in the bucket list of objectives for situation analysis and summarize the identifies objectives;

6. Where necessary, the lead facilitator will suggest relevant objectives that need to be included in the bucket list. To conclude, he/she will ask the CLO family to decide by consensus on the list of objectives for situation analysis.

b. Develop a work plan for situation analysis. This will include the objectives, activities, team responsibilities, key outputs, required resources, timelines and budgets. Below is a sample work plan template for situation in CLM TB.

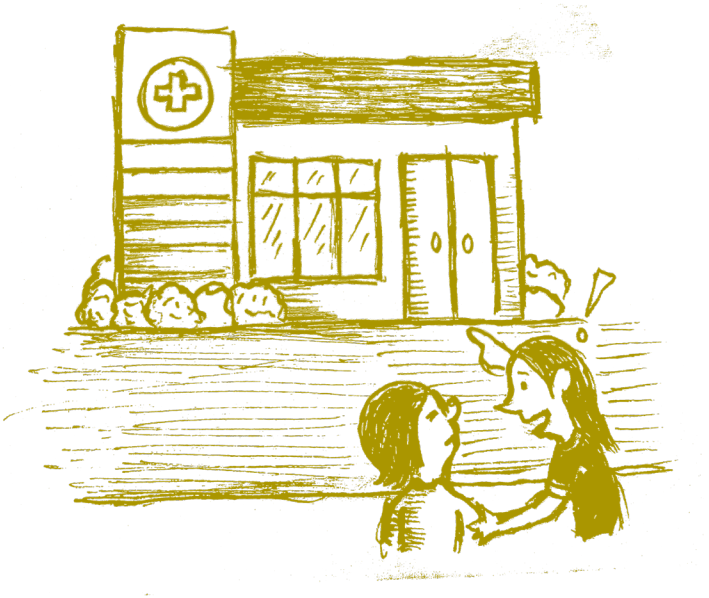


Table 2. Sample Work Plan for Situation Analysis in CLM TB

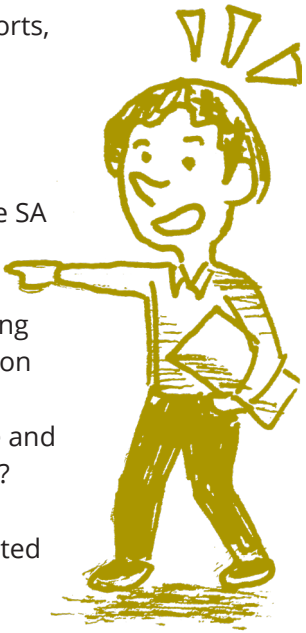
Consortium of TB-Affected CLOs for CLM Program
Work Plan for Situation Analysis in CLM TB, January-June 2024

Objectives of Situation Analysis:
1. To examine the internal and external factors influencing the TB response that have implications to CLM implementation at the national and local levels;
2. To assess the gaps, issues and challenges in TB care and services that will benefit from CLM implementation;
3. To identify TB-affected CLOs' strengths and weaknesses of TB CLOs in implementation of CLM for TB;
4. To identify opprotunities and threats in the implementation of CLM for TB;
5. To determine key community data to be collected through CLM.

Tasks	Activities	Responsible	Required Resources & Budgets	Schedule and Due dates Jan-June 2024	Key Outputs
1. Prepare the logistical requirements for SA	List the logistics needed Set-up/ready the logistics	CLO leaders & staff	Expertise in logistics & budget planning Funds & logistics TA in SA	01/ 1-13 Due: 01/ 14	Operational Plan for Logistics Budget Ready to mobilize/ utitlize logistics Available TA
2. Finalize the SA frameworks	Formulate, refine & finalize the frameworks for (e.g. SWOT Analysis, interviews, desk review)	CLO leaders	TA in SA Funds	01/ 15-20 Due: 01/20	Final version of SA frameworks
3. Develop the data collection & analysis methods/tools					
4. Gather data					
5. Analyze the data gathered					
6. Prepare the SA report					
7. Use the SA findings in CLM strategy conceptualization & planning					

Step 2. Data Gathering. This entails putting into action the methods you have chosen for the situation analysis. Qualitative, quantitative or combination methods may be used to collect information. Data should be collected from different stakeholders of the TB response using appropriate methods like desk review, interviews, surveys or focus groups. In the interest of time and resource limitations, we suggest that in the pilot stage of CLM implementation, TB-affected CLOs may initially use desk review, SWOT Analysis, focus groups, and key informant interviews for data gathering.

a. Conduct **desk review**. This is the first step in data gathering for situation analysis. Sources of data may include but not limited to documents on TB epidemiology, TB program reviews, assessments and evaluations, national strategic plan, monitoring and evaluation reports, progress reports on TB care and service delivery, TB-affected CLOs organization development documents, community engagement reports and CLM materials. Through desk review, you can already collect key information to answer these five main questions of the SA in CLM for TB:



- What are the internal and external factors influencing TB response that are relevant to CLM implementation at the national and local levels?
- What are the gaps, issues and challenges in TB care and services that will benefit from CLM implementation?
- What key community data should be collected?
- What are the strengths and weaknesses of TB-affected CLOs in implementing CLM for TB?
- What are the opportunities and threats in the implementation of CLM for TB?

b. Conduct **SWOT analysis** to examine the organizational strengths or assets of TB CLOs that will facilitate CLM

implementation, and their weak areas that need improvement. With this tool you will also be able to gauge opportunities and risks or threats that may affect CLM implementation. The data gathered from desk review can provide initial insights on the strengths and weaknesses of TB CLOs, and existing opportunities and threats in the external environment of TB CLOs. See the box below for an example on how to do SWOT Analysis in CLM for TB through focus groups[31].

Activity 2. SWOT Analysis in CLM for TB

Purpose — a. identify the strengths and weaknesses of TB CLOs in CLM implementation; and b. Identify opportunities and threats in the implementation of CLM.

Duration — 1 hour and 30 minutes

Requirements — Lead facilitator and co-facilitator, supplies (flip charts, Post-it notes, pens, masking tape, etc.). SWOT Analysis Template as visual aid.

Instructions —

1. Explain the objective and mechanics of SWOT Analysis framework.

2. Divide the community members into small groups. Ask each group to choose their group facilitator and notetaker. Provide each group with a set of supplies.

31 APCASO. People Affected by TB Matter, A Playbook on Community Engagement. December 2023. This was used as reference in developing the SWOT Analysis framework in CLM for TB

3. Draw the four quadrants on the flip chart: Strengths, Weaknesses, Opportunities, Threats.

4. Ask the community members to brainstorm on these questions:
   Strengths—What are the strengths or strong points of your TB CLOs that can facilitate effective implementation of CLM for TB?
   Weaknesses—What are the limitations or weak points of your TB CLOs that need to be improved in order to effectively lead the implementation of CLM for TB?
   Opportunities—What are the opportunities in the external environment of TB-affected CLOs that can facilitate effective implementation of CLM for TB?
   Threats—What are the threats in the external environment of TB-affected CLOs that might affect the implementation of CLM for TB?

5. Each group will write on Post-it notes their answers for strengths, weaknesses, opportunities and threats, then place them in the assigned quadrant in the flipchart.

6. Ask the community members to reflect on the results of SWOT Analysis. After their reflection, consolidate both positive and negative results and ask the community members to rank by consensus the strengths, weaknesses, opportunities, and threats according to their importance in implementing CLM for TB.

7. Summarize the results of the activity on SWOT Analysis framework.

The summary results of SWOT Analysis can be presented in the following template:

SWOT Analysis Template

INTERNAL	**STRENGTHS**	**WEAKNESSES**
INTERNAL	**OPPORTUNITIES**	**THREATS**

Step 3. Data Analysis. When data collection has been completed, your next task is to organize and analyze the information gathered. Content analysis can be used to examine the relationships, patterns, trends, meanings, etc. in the data and draw conclusions based on the objectives of situation analysis.

Step 4. Preparation of situation analysis report. The report should be able to capture in a concise way the necessary information and recommendation that will be used in conceptualizing the CLM Strategy for TB. Usually, the main contents of situation analysis report include the context of situation analysis, objectives, methodology, key findings and recommendations. Data sources are also included in the report.

An example of template to present the summary of key findings by objectives and recommendations is shown on the next page.

Table 3. Tool 2 - Summary Template of Situation Analysis Findings and Recommendations

SA Objectives	Key Findings	Recommendations
1. To examine the internal and external factors influencing the TB response that have implications to CLM implementation at the national and local levels.		
2. To assess the gaps, issues and challenges in TB care and services that will benefit from CLM implementation.		
3. To identify TB-affected CLOs' strengths and weaknesses in CLM implementation.		
4. To identify opportunities and threats in the implementation of CLM for TB.		
5. To determine key community data to be collected through CLM.		

4.1.2 Conceptualization of natural CLM strategy for TB

In the previous section, we said that the key findings and recommendations of situation analysis will be the basis for conceptualizing the National CLM Strategy. At this point in our conversation, we will unpack the concept of CLM strategy, how to design or develop based on situation analysis and some examples of CLM in the TB response.

What is CLM strategy for TB, and why is it important?

Our understanding of strategy in general is associated with a game plan for winning or achieving goals. From this perspective, we say that **CLM strategy for TB is a game plan that outlines the strategic direction and plan for achieving the CLM goals at the national level in a systematic and sustainable way**.

Developing a national strategy for CLM TB can help TB-affected CLOs:

- Focus their monitoring efforts;
- Make the best use of available or limited resources;
- Engage in long-term planning and development of action plans;
- Prioritize and align CLM activities;
- Define accountabilities in CLM process;
- Enhance CLM buy-in and communication among partners at the national and local levels.

How to develop the CLM strategy for TB?

The national CLM strategy for TB is guided by the LEAP framework and situation analysis results. In designing the strategy we suggest that you keep in mind the key questions on the opposite page[32].

32 Adapted in CLM strategy for TB context from 'Components of Monitoring Strategy'. http://www.qualityplanning.org.nz/node/1027.

Key questions in the design of CLM strategy for TB

- What is your purpose in designing the CLM strategy for TB?
- What are the goals and objectives of your CLM for TB? Why are these CLM goals and objectives important and what will they be used for?
- What mechanisms will you use to ensure effective feedback between CLM and decision-making process?
- How will you decide what TB issues to monitor and when? What criteria will you use to decide priority TB issues?
- What framework and criteria will you use to select indicators/measures for the issues?
- How will you collect and analyze data?
- How will you manage and store CLM data to ensure it is of good quality and will be consistent over time? How will you ensure you can retrieve it in a usable form for analysis and reporting at the times you need it?
- What methodologies and tools will you use in data collection and analysis?
- How will you use the results of CLM to influence policy and other decision-making process?
- Who will you be reporting the CLM results to?
- Hw will you utilize the information in CLM reports?
- What forms of reporting will you use to ensure it is effective?

Steps in developing the CLM strategy for TB

In line with the LEAP framework for CLM, you may consider these four steps in developing the strategy:

Step 1. Define the purpose, goals and objectives of the CLM strategy for TB

The first step in the design of the strategy is to define the reason or intentions of TB-affected CLOs in implementing CLM for TB. The purpose influences the articulation of your goals and objectives, and serve as basis for determining desired results from the CLM process. From the stated purpose, you should state the goals or what you aspire to achieve in the future. Objectives, on the other hand, are the concrete actions that you need to do to achieve the goals for CLM TB, or the steps that you will take to realize your aspirations.

Example of purpose, goals, and objectives:

> **Purpose—**"Operationalize a CLM for TB to monitor progress in the delivery of services and advancement of community engagement in the TB response."
>
> The **goal** of CLM strategy is to: "Improve TB care and services and achieve meaningful engagement of TB-affected communities in TB response."
>
> The **objectives** are:
>
> - Implement the CLM indicator framework to assess progress and outcomes of TB services and community engagement using community data;
> - Conduct routine collection and analysis of community data based on agreed CLM indicators;

- Strengthen the capacity of TB-affected CLOs to lead and manage the CLM process and activities; which includes:
  - Building the capacity of community monitors for routine data collection and analysis based on CLM indicators;
  - Improve the capacity of TB-affected CLOs in utilization of CLM results for advocacy to influence policy and foster accountability of decision makers on TB;
- Outline and implement specific steps and activities for strengthening partnership to conduct effective CLM;
- Integrate CLM indicators and results in the national reporting system to ensure greater utilization of community data for improving the availability, accessibility, acceptability and quality of TB care and services.

Step 1. Identify key areas to be monitored

Using the results of your situation analysis, your next step is to identify the key areas to be monitored. For example, these may include low detection of TB cases, high rate of reinfection after completion of treatment, stigma and discrimination, awareness about TB and services, etc. Priority geographic areas for CLM data collection and analysis will be selected based on disease burden and key community data that needs to be collected. Other considerations include presence of already-established TB community network in a particular area.

Step 3. Develop the indicator framework

Once the purpose, goals and objectives are defined, and key areas to be monitored have been identified, your next task is to outline the indicator framework and select indicators

(quantitative, qualitative) for tracking progress towards achieving those goals.

Indicator as defined in the Compendium of Indicators for Monitoring and Evaluating National Tuberculosis Programs is a "specific measurement of program performance that is tracked over time by the monitoring system"[33]. Indicators are specific, observable, and measurable changes that shows whether progress has been made or not toward particular objectives. The type of indicators are shown in the box below[34]:

- **Input indicators:** human and financial resources, physical facilities, equipment, clinical guidelines, and operational policies that are the core ingredients of a program and enable delivery of health services;
- **Process indicators:** the multiple activities that are carried out to achieve the objectives of the program. It includes both what is done and how well it is done. For example, if the goal of the program is to train 100 service providers (output) in sputum smear microscopy, process-level indicators could include the development of a curriculum, the implementation of the training courses, and the quality of slides;

33 PATH. Guide to Monitoring and Evaluation of Advocacy, Communication, and Social Mobilization to Support Tuberculosis Prevention and Care. March 2013. https://www.path.org/resources/guide-to-monitoring-and-evaluation-of-advocacy-communication-and-social-mobilization-to-support-tuberculosis-prevention-and-care/.

34 WHO/HTM/TB/2004.344. Compendium of Indicators for Monitoring and Evaluating National Tuberculosis Programs. August 2004. https://apps.who.int/iris/handle/10665/68768.

- **Output indicators:** the results of program-level efforts, such as the number of activities conducted in areas such as service delivery, including commodities and logistics, management and supervision, or training. Service delivery outputs may measure the volume of services provided to the target population, as well as the adequacy of the service delivery system in terms of access, quality of care, and program image/client satisfaction. In many cases, M&E is limited to outputs because these data are collected on a routine basis;
- **Outcome indicators:** refer to the changes measured at the population level, some or all of which may be the result of a given program or intervention. Outcomes may refer to specific results—such as improvements in case detection and treatment success rates—that are clearly related to the program;
- **Impact indicators:** program results achieved among the target population and to what extent these achievements can be attributed to the intervention (e.g., reducing morbidity and mortality as a direct result of introducing effective public–private partnerships).

The ***indicator framework*** is an organized way to view data from different sources. It is a simple and concise way to present gathered data and help show the relevance and connection between different indicators. In a framework, data can be grouped or categorized and are often shown alongside detailed descriptions of associated measures and methods of calculation[35]. It is a way to organize

35 https://health-infobase.canada.ca/datalab/indicator-framework-blog.html.

and systematize indicators for making them consistent, transparent and end-user oriented.

As a component of the CLM strategy for TB, it provides you a set of indicators and structure to guide the CLM process, particularly data collection and analysis. It is important to note that the CLM indicator framework intends to:

- Contribute to achieving the national strategic objectives as stated in the Country's National Strategic Plan for TB;
- Provide TB-affected CLOs with a tool to organize and systematize indicators that they will use to monitor progress of TB care and services;
- Establish the indicators, measurement and source of data from the perspective of key and vulnerable populations;
- Support an assessment of community engagement in the TB.

The CLM indicator framework for TB consists of strategic themes and indicators pertaining to: a. availability, b. accessibility, c. acceptability, d. quality of TB services, and e. community engagement. Details on sources of quantitative and qualitative data that will be collected by community monitors, including suggested methods are presented in the framework. You can apply the entire indicator framework to each of the five indicator and can form the basis for the data collection process, analysis and use of the information to improve quality of services and accountability of decision makers. The TB-affected CLOs take the lead in developing and implementing the indicator framework.

Following are brief descriptions of the AAAQCE indicators for CLM TB:

a. **Availability** requires that services and facilities for Tuberculosis Detection and Treatment be available in "sufficient quantity" in the health facility or other facilities in the country.

b. **Accessibility** includes the absence of stigma and discrimination, physical, economic, and information barriers to accessing of TB services.
c. **Acceptability** requires that TB services, including health facilities are culturally appropriate, gender sensitive and ethical.
d. **Quality** of TB services requires that they be "scientifically and medically appropriate", with professional competence or administered by skilled health workers, and patient-centered.
e. **Community engagement** in TB response requires empowering key and vulnerable populations to create an enabling and non-stigmatizing environment that can support their treatment journey through advocacy, capacity building and community mobilization. Specifically, this is about the quality of the interactions created for them, the relevance of the engagement activities, and the value of engagement results for the communities.

Frequency of data collection and responsibility. Once decision has been made on what data will be collected and how it will be collected, the TB-affected CLOs need to decide how often data will be collected and who will collect. An example is shown in the tables on the next page:

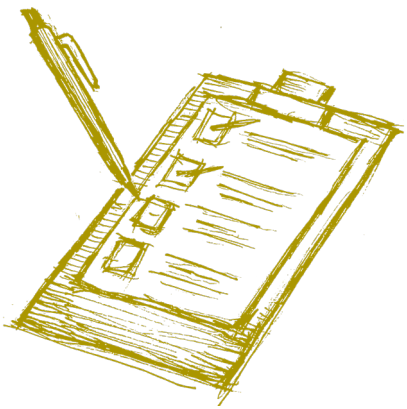


Table 4. Example of NSP indicators for 2024-2030 and potential indicators for CLM process[36]

No	Criteria	Unit of measurement	Foundation		Target level							Frequency of data collection	Responsible organization	Potential alignment with a CLM indicator in selected sites identified in the National CLM Strategy
			Level	Year	The year 2024	The year 2025	The year 2026	The year 2027	The year 2028	The year 2029	2030 year			
Goal: To meet the Sustainable Development Goals-2030, Global TB Eradication Strategy indicators, and by 2030 to reduce TB-related deaths per 100,000 people compared to 2015 by 90% reduce;														
1	Mortality due to tuberculosis	per 100,000 population	6	2022	6	6	5.5	5	4	3	2	Once a year	NCSC	
2	Prevalence of Rifamycin (RR-TB) and/or OETS among new cases of tuberculosis	Percentage	5.4	2022	5.4	5.4	5.4	4.5	4	3.5	3	Once a year	NCSC	
3	Tuberculosis incidence rates	per 100,000 population	428	2022	428	428	428	Estimates will be calculated after National Prevalence Survey -II.				Once a year	NCSC	
4	Treatment success in rifamycin resistance and OETS	Percentage	76.5	2022	78	79	80	85	86	87	90	Twice a year	NCSC	

36 This draft CLM Indicator Framework was drafted by APCASO for Mongolia during the development of the national CLM strategy for TB. This is subject for discussion of the CLM Coordinating Committee, finalization and endorsement.

5	Tuberculosis treatment coverage	Percentage	20.02	2022	45	50	63	70	75	85	90	Once a year	NCSC	Ö
6	Number of cases of all forms of tuberculosis registered	Real numbers	2803	2022	6689	7545	9641	8500	7000	6500	5000	Twice a year	NCSC	Ö
7	Successful treatment of all forms of tuberculosis	Percentage	89.7	2022	90	91	91	92	93	94	95	Twice a year	NCSC	Ö
8	Percentage of patients with new and recurrent tuberculosis diagnosed by rapid diagnostic methods rec-ommended by WHO	Real numbers	82.2	2022	85	87	90	93	94	95	99	Twice a year	NCSC	Ö
9	Number of cases of rifampicin-re-sistant and/or OETS	Real numbers	158	2022	388	436	551	400	300	200	100	Twice a year	NCSC	
10	Proportion of rifampicin-re-sistant and OETS cases treated with second-line TB drugs	Percentage	91	2022	94.8	96.1	97.1	98	99	99	99	Twice a year	NCSC	

No	Criteria	Unit of measurement	Foundation		Target level							Frequency of data collection	Responsible organization	Potential alignment with a CLM indicator in selected sites identified in the National CLM Strategy
			Level	Year	The year 2024	The year 2025	The year 2026	The year 2027	The year 2028	The year 2029	2030 year			
Goal: To meet the Sustainable Development Goals-2030, Global TB Eradication Strategy indicators, and by 2030 to reduce TB-related deaths per 100,000 people compared to 2015 by 90% reduce;														
11	Number of people enrolled in contact prevention treatment for tuberculosis patients	Real numbers	608	2022	2119	3346	4886	5000	5300	5500	6000	Twice a year	NCSC	Ö
12	Reported cases of tuberculosis (all forms) among prisoners	Real numbers	63	2022	134	151	193	150	130	100	50	Twice a year	NCSC	
13	Number and percentage of HIV/TB co-infected patients receiving EBV during TB treatment	Percentage	0	2022	100	100	100	100	100	100	100	Twice a year	NCSC	Ö
14	Proportion of HIV-infected persons enrolled in EBV who received TB ACE	Percentage	0	2022	100	100	100	100	100	100	100	Twice a year	NCSC	Ö

15	Proportion of diagnoses with community involvement out of total reported cases	Percentage	10.9	2022	12	14	16	20	23	25	30	Twice a year	NCSC	Ö
16	Percentage of reported cases of RIF/OET referred to 2nd-line primary care	Percentage	79.5	2022	80.2	83	85	88	92	95	96	Twice a year	NCSC	
17	Number of MOET precursors and MOET cases treated	Real numbers	6	2022	10	12	15	10	10	5	5	Twice a year	NCSC	
18	Percentage of units reporting records and reports using full electronic information systems	Percentage	50	2022	80	85	90	93	95	100	100	Twice a year	NCSC	
19	Number of TB patients receiving community-based TB treatment	Number	488	2022	600	700	800	850	900	950	1000	Twice a year	NCSC	Ö

Table 5. Example of a Draft CLM Indicator Framework for TB in Mongolia[37]

	CLM indicators	Source for Data Collection	Method of Data Collection (Quantitative and Qualitative)	Frequency of Data Collection	Responsible unit	Link to the NSP Strategic Objectives and NSP Indicators (2024-2030)
1a	**Availability of rapid diagnostic methods recommended by WHO in the health facility or other facilities for new and recurrent tuberculosis.**					
	% of patients with new tuberculosis in the 4 CLM sites diagnosed by rapid diagnostic methods. % of patients with recurrent tuberculosis in the 4 CLM sites diagnosed by rapid diagnostic methods. % of patients from the 4 CLM sites who received information about rapid diagnostic methods. % of new TB patients who are aware of the availability of rapid diagnostic methods.	Health facility Patient/ client	Interview or questionnaire Client Exit interview or focus group discussion	Quarterly	TB-affected CLOs, community monitors	#To increase the participation of public and private health organizations in order to increase the detection of tuberculosis among adults. #To improve the effectiveness and efficiency of active TB detection. #To improve the uptake of TB diagnostic innovations. #Expand rapid TB testing methods. #Improve TB program registration and reporting system. **Indicator no. 8 Percentage of patients with new and recurrent tuberculosis diagnosed by rapid diagnostic methods recommended by WHO**

37 Ibid.

	% of patients with recurrent TB who are aware of the availability of rapid diagnostic methods.					
1b	**Availability of treatment services for all forms of tuberculosis.**					
	Number of cases of homeless, undocumented and mentally ill people in high-risk populations in the 4 CLM sites who availed of TB care and treatment. Number of TB patients in the 4 CLM sites receiving community-based TB treatment.	Health facility Patient/ client	Interview or questionnaire Client Exit interview or focus group discussion	Quarterly	TB-affected CLOs, community monitors	#Improve the legal regulations for high-quality, effective, and patient-centered treatment of tuberculosis. #Improve the effectiveness of TB care and treatment for homeless and mentally ill people in high-risk populations. #To improve the effectiveness and coordination of community-based tuberculosis treatment. Indicator No. 5 Tuberculosis treatment coverage **Indicator no. 19 Number of TB patients receiving community-based TB treatment**
2	**Accessibility of diagnosis, care and treatment services for people with TB in the 4 CLM sites.**					
	% of people with TB who are able to access TB services. % of people with TB who experience human rights barriers that prevent access to TB services.	Health facility Patient/ client	Interview or questionnaire Client Exit interview or focus group discussion	Quarterly	TB-affected CLOs, community monitors	#To strengthen the joint activities of TB and HIV/AIDS programs and to improve care services during co-infections.

	% of people with TB who cannot access TB services due to geographical barriers. % of people with TB who cannot access TB services due to financial barriers. % of people with TB who cannot access TB servies due to gender-related issues/barriers Number of TB/ HIV co-infected patients who are able to access TB services % of people who have knowledge about the TB services in the health facility or other facilities.					#To reduce the social factors affecting the incidence of tuberculosis. #To improve social care Indicator No. 6 Number of cases of all forms of tuberculosis registered for TB patients. Indicator No. 13 Number and percentage of HIV/TB co-infected patients receiving EBV during TB treatment **Indicator 7. Successful treatment of all forms of tuberculosis**
3	**Acceptability of TB services for people with TB in the 4 CLM sites.**					
	% of people with TB who find the TB services in healthcare facility acceptable. % of people with TB who find the TB services community-based treatment facility acceptable.	Health facility Patient/ client	Interview or questionnaire Client Exit interview or focus group discussion	Quarterly	TB-affected CLOs, community monitors	#To improve the knowledge, attitudes and practices of TB among decision makers, policy makers and the public through TB advocacy, influence, information and promotion. #Reduce TB stigma and discrimination.

	% of people with TB who experience stigma in health care settings. % of people with TB who experience stigma in community -based care settings. % of people with TB who experience discrimination due to TB. % of people whose right to confidentiality was violated.					**Indicator No. 11** Number of people enrolled in contact prevention treatment for tuberculosis patients
4	**Quality of TB care and services.**					
	% of people with TB in the 4 CLM sites who found the TB treatment, care and support services good. % of people with TB in the 4 CLM sites who found the TB services they receive in the healthcare setting unsatisfactory. % of people with TB in the 4 CLM sites who found the TB services they receive in community-based treatment facility unsatisfactory?	Health facility Patient/ client	Interview or questionnaire Client Exit interview or focus group discussion			#Improve monitoring, analysis and evaluation of TB care. #Ensuring sustainability of tuberculosis care during public emergencies. #To improve the cooperation and coordination of other sectors in the fight against tuberculosis. #Ensuring the stability of funding for public health care and services. Create and implement evidence and response mechanisms to address challenges in providing accessible and quality TB care and services.

						Indicator 14. Proportion of HIV-infected persons enrolled in EBV who received TB ACE
5	**Community Engagement in TB response.**					
	# Established and functional CLM Coordinating Committee. — Level of demonstrated ability of civil society and community representatives to carry out CLM strategy and workplan # Established and functional TB network — Level of demonstrated ability to carry out action plans. — Community leaders' ability to advocate for policy changes in the TB response. #Level of knowledge and skills to implement CLM process #Leveraging CLM results in the national M & E framework and national reporting system.	TB affected communities and survivor groups Family of TB patients TB CSO support groups	Interview or questionnaire or focus group discussion	Quarterly	TB-affected CLOs, community monitors	#To support the new financing system for the health sector. #Community-led monitoring council (CMC) to work. #Build, empower and strengthen community networks affected by TB. #To create a legal environment for the creation of the system of the National Security Agency. **Indicator No. 15** Proportion of diagnoses with community involvement out of total reported cases

	#Engagement of civil society and communities with parliamentarians, Ministry of Justice, Interior, Corrections, religious and community leaders, among others, for advocacy and sensitization on TB. #Level of capa-city in monitoring of laws and policies, including compliance of TB guidelines. #Level of capacity in community-led monitoring of TB service delivery quality, including stigma, discrimination, confidentiality and privacy and informed consent . % of people with TB who receive support from TB network during treatment					

Step 4. Outline the implementation arrangement

Structure and process for strategy implementation. The implementation of the CLM strategy for TB will be driven by TB-affected CLOs through a consortium or network depending on country context. The creation of a coordinating mechanism composed of CLM partners should be initiated by TB-affected CLOs to support the implementation of the CLM process and activities.

You may consider implementing the CLM strategy for TB in three phases: **a. pilot phase, b. rollout phase, and c. sustainability phase**, as explained in the box below:

Phases in CLM Strategy Implementation: The Experience in the Philippines[38]

PILOT phase: is a short-term trial usually done by organizations before implementing a rollout of program or project to learn how it might actually operate. Organizations that implemented CLM for TB and HIV piloted it in a few sites before they embarked on roll-out of the program.

The Philippine experience in CLM for TB also went through the pilot stage, wherein an implementation guidelines and mechanisms were drafted as basis for the trial. With technical support from APCASO, ACHIEVE proceeded with the pilot after developing the draft national CLM guidelines, the redress

38 Based on ACHIEVE Philippines' presentations during the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines; and interview with Jeffry P. Acaba, Senior Programme Officer of APCASO, December 7, 2023.

mechanism guidelines, and the CallKaLungs TB hotline. Simultaneously, a system was put in place while the trial is being undertaken.

ROLLOUT phase: this is done after assessing the results of the pilot stage. Once the potential for successful implementation has been established, organizations launch a roll-out of the program or project. At this stage, sites and resources are prepared, and refinements are done on the systems and procedures for full-scale implementation.

With reference to the CLM for TB implementation in the Philippines, ACHIEVE plans to rollout from the pilot five regions to all 17 regions under Global Fund's Grant Cycle 7. This entails finalising the guidelines and providing support in the rollout of these guidelines to all regions in the country.

SUSTAINABILITY phase: this is a part of organizations' vision to have the ability to maintain or sustain the program over time. Thus, a sustainability plan is developed and used by organizations to guide them in this phase.

In the case of ACHIEVE Philippines, there is a plan on how to sustain CLM implementation which will be further refined as they implement the rollout. Central to their sustainability plan is building the leadership and management capacity of their TB CLOs for CLM, government buy-in of CLM process towards its institutionalization in NTP, national M & E framework and national reporting process, and partnership-building for CLM sustainability.

Take note that an evaluation of CLM launching, piloting, rollout, achievements and failures/gaps needs to be conducted and documented after each phase or before proceeding to the next phase. You also need to develop an action plan to set into motion the CLM strategy for TB and mobilize resources to operationalize the strategy.

Roles and responsibilities. A Terms of Reference (TOR) should be developed at the onset to define the specific roles and responsibilities of each TB-affected CLOs and the partners in the CLM process. It is envisioned that the TORs that will be developed will not only cover the TB CLO implementers but also partners who will be participating in the implementation of CLM. This includes government, donors, development partners, CSOs and private sector. All members will be selected against criteria for membership and guided by the Conflict of Interest (COI) Policy.

As defined by CLAW, "COI is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest"[39]. It may be an actual COI, for example, "an entity implementing a monitoring program in which it has a personal financial interest based on the outcome or findings of the monitoring; a potential COI such as an individual — despite no longer having any financial, family, or personal relationship with a previous employer - specifically designs evaluation frameworks that are skewed to show that employer in a good light.; or a perceived COI in a situation when one of the parties may appear, according to a reasonably neutral third-party observer, to have a COI, even if it is not an actual or potential COI"[40].

39 CLAW. Conflict-of-Interest in Community-Led Monitoring Programs. February 2022.. https://healthgap.org/wp-content/uploads/2022/03/CLAW-Conflict-of-Interest-Feb-2022.pdf.

40 Ibid, pp.7-8.

The COI Policy should be included as an annex to the TOR, and relevant provisions are applied when needed during selection of members and in defining roles and responsibilities in the coordinating/collaboration mechanism. In the Philippines, for example, "there were decisions made around ensuring that among CLOs, it is not the service provider who conducts the CLM especially if it is within the same organisation. For instance, in Iloilo, the Family Planning Organization of the Philippines (FPOP) acts as both the service provider and the CLM implementer in the province"[41], which falls into the definition of actual COI]. This kind of situation became a learning experience for CLOs on how to collectively discuss and agree on ways to address actual, potential and perceived COI in CLM implementation.

Timeline for strategy implementation covers the preparatory activities, pilot phase, roll-out phase and sustainability phase. The indicative period of implementation, for example three or five years is subject to the decision of the TB-affected CLOs and the partners in the coordinating mechanism for CLM TB.

41 Based on interview with Jeffry P. Acaba, Senior Programme Officer of APCASO. 7 December 2023.

4.1.3 Setting-up CLM collaboration mechanism

"Promoting CLM in Mongolia was not easy.
We had to secure buy-in from key stakeholders in the country by creating a mechanism for collaboration. This was a key solution to our predicament and a vehicle for finalizing the draft National CLM Strategy for TB. The purpose of Mongolia's CLM Coordinating Committee (CCC) is for TB-affected communities, civil society organizations, government, private sector, and development partners to collaborate and participate in the process of implementing community-led monitoring in the national TB program[42]."
— Mongolia TB Coalition

"In Indonesia, the multistakeholder partnership ensures CLM success.
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. 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.

42 Based on the presentation of Mongolia TB Coalition (MTC) during the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming. October 18-20, 2023 Manila, Philippines.

Overcoming challenges required a collaborative and inclusive approach, ensuring that the CLM solution is accessible and beneficial to all stakeholders[43]."
— Perhimpunan Organisasi Pasien TB (POPTB)

What is collaboration in CLM, and why it is important?

When TB-affected CLOs and partners work together to achieve the purpose, goals and objectives of CLM for TB, we call that collaboration. Effective collaboration is key to successful achievement of target CLM outcomes. The creation of collaboration mechanism for CLM TB should be initiated by TB-affected CLOs once the draft strategy has been conceptualized. This collaboration mechanism which may be referred to as a CLM coordinating committee, council, CLM partnership forum, etc is beneficial because it can:

- Accelerate buy-in for CLM establishment and implementation in the country;
- Facilitate achievement of CLM goals and objectives;
- Serve as vehicle for sharing of knowledge, skills and resources in implementing CLM process and activities;
- Enhance communication, collaboration, information sharing, and accountability among CLM implementers;
- Increase efficiency in conducting the different steps and process in CLM operations;
- Enhance TB-affected CLOs visibility in the TB response.

What is collaboration in CLM, and why it is important?

a. Review the situation analysis report to assess the country's level of readiness for a CLM mechanism. The data will

43 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

guide the TB-affected CLOs on how to approach its establishment;

b. Identify and recruit potential members of the CLM mechanism;
c. Organize a buy-in meeting for establishing CLM mechanism;
d. Conduct a workshop to orient the partners on CLM and the purpose of the collaboration mechanism. The draft CLM strategy for TB should also be discussed in this workshop. **Activity 3 below may be used as a team building activity**[44];
e. Assess with the partners the resources needed for operationalizing the CLM strategy for TB, including operations of the collaboration mechanism;
f. Define with the partners the structure of the collaboration mechanism and develop a Terms of Reference for CLM collaboration with the following example parts:

- Background of the CLM coordinating committee
- Purpose
- Term of office
- Composition and officers
- Roles and responsibilities
- Meetings
- Rules and procedures
- Amendment, modification or variation
- Conflict of interest

g. Develop a communication strategy that will guide the partners on how they will communicate, share information and provide feedback within the group and to the external environment;

44 Adapted from APCASO's People Affected by TB Matter. A palybook on Community Engagement. December 2023, p.93-94.

h. Agree on and develop an Action Plan for CLM implementation (to be explained further below);
i. Conduct regular assessment and documentation of the collaboration's status, achievements and lessons learned.

Activity 3. The Human Knot Game

A collaboration game for getting partners' involvement in CLM

Objective—To motivate partners to participate in CLM establishment and implementation

Duration — 30 - 45 minutes

Requirements — Lead facilitator and co-facilitator, and visual aid for the Human Knot Game

Goal — Undo the knot without letting go of hands (20 minutes)

Instructions —

1. Get partners into a circle. Everyone stands shoulder to shoulder. You can also do this in smaller groups and add a competition aspect;
2. Everyone lifts their right hand;
3. Everyone grabs the hand of someone else in the circle. They cannot hold hands with the person next to them;
4. Everyone lifts their left hand;
5. Everyone grabs the hand of someone else in the circle (not the same person as with the right hand). They cannot hold hands with the person next to them;

6. The group has to untangle the knot without letting go of anyone's hand;
7. Repeat the exercise and this time instruct partners that they can't talk. All communication has to be nonverbal;

What to observe and do during the exercise:

- See who's comfortable working together and who's not. Identify who among the community members are leaders, followers, those who do not like to be in close proximity to others, and those who do not consider others in an activity;
- Try not to come up with solutions for your group, but do offer encouragement;
- Remind partners not to let go of hands. Also, remind them not to shove or tug;
- Everyone has to be aware of their surroundings and the consequences of sharp movement;
- Ask partners how their actions affect others;
- Decide what you'll do if someone breaks the chain or if the exercise goes beyond the time limit. Will you have partners start over? Will there be a penalty (some partners become blindfolded)?

Reflection Questions in relation to getting the involvement of partners:

Reflect on the exercise — what is the value in playing a game like this at the beginning of CLM establishment and implementation? Did anyone try to take control of the exercise? Did it work? Did anyone give up? What caused them to do so? Were you able to undo the knot? Why or why not? If you did, were you surprised at your success? Why or why not? What strategies did you use to undo the knot? What could have been done differently?

4.1.4 Development of CLM Action Plan

Once the CLM collaboration mechanism has been created, the TB-affected CLOs should initiate with the partners the development of CLM Action Plan with a define period of implementation. A planning workshop with the members of the collaboration mechanism may be conducted for this purpose. Below is an example of an Action Plan Template for CLM with objectives:

Table 6. Example of Action Plan Template for CLM TB Establishment and Implementation, January 2024 - December 2026

Objectives	Activities	Responsibility	Resources Needed	Indicative Timeline	Notes/ Assumptions
Strengthen partnerships with government towards CLM institutionalization in MOH/ NTP/appropriate agencies.	Obtain partners' endorsement of CLM Strategy for TB.	Chair, Co-chair/Team Lead for CLM TB Strategy	TA for the finalization of CLM Strategy for TB	2nd quarter of Year 1	Contents of the strategy document have been vetted by CLM partners
	Meetings to finalize the CLM Strategy for TB that will be submitted for endorsement. Production of the final strategy document. Forum to endorse the CLM Strategy for TB.				
Finalize CLM Indicator Framework in line with NSP, National M & E and National Reporting System.					
Develop resource mobilization plan and budget for CLM.					

Objectives	Activities	Responsibility	Resources Needed	Indicative Timeline	Notes/ Assumptions
Develop and implement data collection and data analysis tools.	Conduct community monitors with knowledge and skills in data collection and analysis.				
Set up systems and procedures for data quality assurance, storage and management					
Enforce meaningful community engagement through CLM.	Equip TB-affected CLOs with knowledge and skills on leadership and management of CLM process and activities.				
Operationalize a systematic & sustainable CLM data production and management process, and data utilization.					
Utilize CLM results for advocacy, programming and community mobilization.	Develop guidelines for utilization of CLM data.				
Build CLM capacity of partners.					
Carry out periodic assessment & evaluation of CLM implementation.	Document best practices & lessons learned in CLM establishment & implementation.				

4.1.5 Resource Mobilization

Substantial resources are needed to establish and implement CLM process and activities in a sustainable way. Thus, resource mobilization should be one of your main focus in operationalizing CLM for TB.

What is resource mobilization, and how to undertake it?

Resource mobilization pertains to all activities designed for securing new and additional resources from resource providers[45] that includes funds, expertise, equipment, facilities, etc. It also involves identification and making use of effective practices in resource mobilization of TB-affected CLOs and partners. Budget preparation for CLM is also a component of resource mobilization. Having resources means that the CLM strategy for TB and Action Plan for CLM can be implemented, continued, and scaled up. Through this, there is a likelihood of increasing opportunities for creativity and capacity in resource generation for CLM implementation.

You may consider the following steps and activities in mobilizing resources for CLM:

Step 1: Develop a resource mobilization strategy to implement the CLM strategy for TB and Action Plan.
You should involve communities of key and vulnerable populations and partners in developing the strategy, particularly in:

- Determining resource mobilization targets;
- Identifying internal and external resources;
- Mapping resource providers, including relevant government agencies to fund CLM;

45 The section on resource mobilization in APCASO's, People Affected by TB Matter, A Playbook on Community Engagement, published in December 2023 was used as reference but modified in the context of CLM.

- Identifying mechanisms for accessing the resources;
- Clarifying the right ways to use resources;
- Developing a budget for CLM

Step 2: Form a resource mobilization team within your CLM collaboration mechanism. This is a team effort, thus the team should include skilled resource mobilizers from TB-affected CLOs, communities and partners. The tasks of the team consist of:

- Planning for resource mobilization;
- Managing the resource mobilization process;
- Reviewing resource providers' histories;
- Serving as contacts for resource providers;
- Leading the implementation of resource mobilization plan and activities;
- Updating or developing new resource mobilization strategies.

Step 3: Put in place the systems and procedures for resource mobilization. This includes operational guidelines, monitoring, and evaluation mechanisms.

Step 4: Implement the resource mobilization plan in a sustained manner. It is worth remembering that at the onset, the TB-affected CLOs and partners in the collaboration mechanism commit to sustained intiatives in mobilizing resource for CLM.

You may conduct the start-up orientation activity below and use the example forms on defining resources and action plan as references in undertaking resource mobilization for CLM. The template on defining resources is used for the purpose of identifying the resources that you need for CLM. Out of these resources you prioritize the resources that are critical to CLM implementation during the pilot, rollout and sustainability phases. Then you identify the resources on

hand or available and not available but urgently needed for CLM. The outputs of this exercise on resource identification may be used as inputs in developing the action plan for resource mobilization.

Activity 3. Collage on Resource Mobilization

Meaning, importance and elements

Objective — To facilitate understanding of the meaning, importance and elements of resource mobilization plan in CLM by members of TB-affected CLOs

Target audience — Members of TB-affected CLOs (partners may be invited as resource persons)

Duration — 45 minutes

Requirements — Lead facilitator and co-facilitator, supplies (flip charts, Post-it notes, pens, masking tape, scissors, etc.), and old newspaper and magazines; resource persons from partners in the collaboration mechanism

Instructions —

1. Explain the objective and mechanics of collage-making on resource mobilization;
2. Divide the community members into small groups. Ask each group to choose their group facilitator and notetaker. Provide each group with a set of supplies
3. Ask each group to brainstorm on the following questions in relation to establishing and implementing sustainable CLM process and activities:

- What is resource mobilization? Why do we need to mobilize resources?
- Why do we need to come up with a resource mobilization plan?
- What are the elements of a resource mobilization plan?

4. Explain to the community members that after their brainstorming, they will cut or rip pictures from the old newspapers and magazines that represent the ideas/ answers to the above questions. Then, they will paste the pictures in the flipcharts according to their categories and post them on the wall or board;
5. The community members will do a gallery viewing of the pictures and mark the pictures that best represent the ideas/answers to the questions (emoticons may be used to mark the pictures);
6. The Lead Facilitator will facilitate a reflection session on the output of the community members based on the marks made on the pictures;
7. A synthesis of the group output on the definition, importance, and elements of the resource mobilization plan after the reflection session. The discussion also includes the component process of resource mobilization

Table 7. Example of Form for defining resources, priority resource needs, resource needs and gaps for CLM TB

DEFINING RESOURCES		
Resource category: What are the kinds of resources that might be relevant to CLM for TB?	Resource needs: What are your organization's specific needs for implementing CLM TB?	
PRIORITY RESOURCE NEEDS		
Organization		
Priority resource need #1		
Priority resource need #2		
Priority resource need #3		
RESOURCE NEEDS AND GAPS		
Priority resource needs	Currently available resources to meet this need	Resource gap Current resources that you have available – what you will need to meet your need = resource gap

Table 8. Sample template of Resource Mobilization Action Plan for CLM TB

Purpose:					
Strategic Priorities:					
Goal:					
Objectives					
Item	**Action Steps**	**Responsible**	**Support Needed**	**Priority Level**	**Deadline**
Objective 1					
Objective 2					
Objective 3					

Finally, you may consider the following strategies to jumpstart your resource mobilization endeavor:

- Collaborate with local health authorities, academic institutions, and other CSOs to pool resources and share responsibilities for CLM operationalization;
- Seek donations of goods or services that support CLM activities, such as meeting spaces, technology, or printing services;
- Mobilize volunteers from the community or professional networks to contribute their time and skills to CLM activities;
- Launch promotional campaigns or engage in community fundraising events to gather financial support for CLM activties;
- Invest in training and development programs for staff and volunteers, enhancing their skills and making the TB-affectd CLOs more attractive to potential funders.
- Advocate for including CLM initiatives in government health budgets or seek grants from government programs supporting community-led initiatives.;
- Identify and apply for grants from international organizations, foundations, or donor agencies that align with the goals of CLM;
- Implement rigorous budgeting practices, prioritize activities, and ensure efficient financial management to maximize limited resources for CLM operations.

4.1.6 Capacity-building on CLM

Conducting capacity-building on CLM is important to ensure that TB-affected CLOs, community members and partners have the knowledge, skills, competencies and resources to implement its process and activities on a sustainable basis. The concept of building capacity also involves empowering

TB-affected CLOs and communities to solve their issues and problems towards improvement in the delivery of services and their meaningful engagement in the TB response.

With this in mind, your capacity building during the preparation phase should take into account these three aspects: a) types of capacities that should be prioritized, b) capacity needs at the organizational and individual levels, and c) development and execution of capacity-building plan, for example outputs should include tools for data collection and analysis.

What types of capacities in CLM for TB should be prioritized?

At the organizational level, the following should be prioritized:

a. Leadership capacity building of TB-affected CLOs in the areas of:
   - CLM strategy conceptualization and operationalization
   - Setting up, maintaining and sustaining CLM collaboration mechanism;
   - Development and implementation of multi-year CLM Action Plan
   - Resource mobilization planning and implementation
   - Crafting and execution of systematic CLM capacitiy-building plan.

b. Management capacity of TB-affected CLOs in planning, staff development, organization development, financial management and communication;
c. Capacity-building of TB-affected CLOs and CLM collaboration mechanism in developing and implementing the CLM process and activities on data production, data management and utilization;
d. Capacity-building of TB-affected CLOs and CLM collaboration mechanism on CLM evaluation, and documentation of best practices and lessons learned;

e. Capacity-building of CLM collaboration mechanism on shoring up sustainability of CLM for TB.

Capacity-building at an individual level should focus on:

a. Knowledge, skills and attitude building of community leaders on how to perform their roles and responsibilities to lead, educate, advocate and partner for CLM TB establishment and implementation;
b. Knowledge, skills and attitude building of community monitors on data collection and analysis;
c. Knowledge, skills and attitude building of CLM partners on how to effectively strengthen collaboration and advocacy for data utilization of data produced from CLM TB. For example, in the Philippines, the CLM data will be used by the Philippine Alliance to Stop TB (PASTB) for advocacy with DOH as well as through its members to do advocacy at the provincial/site level[46].

How do you determine the capacity needs on CLM for TB?

Your immediate task is to assess the existing capacity at the organizational and individual levels based on the **required capacities** to successfully implement CLM for TB. With the information on **what capacities you currently have**, you then look into **what capacities you do not have** and **what possible strategies** should be utilized applied to fill the gaps. You may organize your assessment results in the example template shown below:

46 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

Table 9. Example Template of Capacity Needs Assessment for CLM TB

CLM Capacity Requirements	Existing Capacity	Capacity Gaps	Possible Strategies
Organizational level: TB-Affected CLOs			
CLM strategy conceptualization and operationalization			
Seeting up, maintaining & sustaining CLM collaboration mechanism			
Development and implementation of multi-year CLM Action Plan			
Resource mobilization planning and implementation & Budgeting for CLM.			
Crafting and execution of systematic CLM capaci-tiy-building plan			
Management capacity (planning, staff development, organization development & financial management)			
Developing and implementing data production, data management and utilization of data for advocacy, programming & community mobilization			
CLM evaluation, and documentation of best practices and lessons learned			
Organization level: CLM Collaboration Mechanism			
Developing and implementing data production, data management and utilization of data for advocacy, programming & community mobilization			
CLM evaluation, and documentation of best practices and lessons learned			
Sharing up sustainability of CLM for TB			
Individual level: Community Leaders			
Knowledge, skills and attitude building on roles and responsibilities to lead, educate, advocate and partner for CLM TB establishment and implementation			
Individual level: Community Monitors			
Knowledge, skills and attitude building on data collection and analysis.			
Individual level: Community Partners			
Knowledge, skills and attitude building on effectively strengthening collaboration and advocacy towards data utilization for CLM TB			

What are the components of capacity building plan for CLM TB?

After you have completed the capacity needs assessment, you can now initiate the development of CLM capacity building plan for TB with the partners in the collaboration mechanism in consultation with communities of key and vulnerable populations. The setting of timeframe should be led by TB-affected CLOs with the CLM collaboration mechanism. The capacity building plan should target the TB-affected CLOs, CLM collaboration mechanism, community leaders, community monitors and partners. You may include the following components or other aspects as necessary:

- Objectives
- Capacity needs
- Activities
- Expectd outputs
- Targets
- Responsible unit/person
- Timeline
- Resource requirements

On the opposite page is an example template which you may use as reference in developing and executing the capacity building plan for CLM TB.

Table 10. Example Template of Indicative Capacity Building Plan for CLM TB, 2024-2026

Capacity Needs	Activities	Expected Outputs	Targets	Responsible unit/ person	Timeline	Resource requirements
Objective: Build CLM capacity at organizational level						
TB-affected CLOs need appropriate knowledge, skills and attitude to perform their leadership role and responsibilities in operationalizing CLM for TB.	Training on development and implementation of multi-year plan on CLM operationalization to facilitate structured and sequenced CLM process and activities; Workshops and training on CLM tools development; Workshops on guidelines for data processing, management, storage & data ulitizatin.	Training on development and implementation of CLM operationalization conducted Workshops and training on CLM tools conducted Workshops on guidelines for data processing conducted Training on fundraising and resource mobilisation conducted	Two trainings (1 main, one booster) on development and implementation of CLM conducted Two trainings (1 main, 1 booster) on CLM tools conducted One training on fundraising and resource mobilisation conducted Finalised version of operational guidelines for CLM	Lead TB-affected CLOs (consortium/ network) with the CLM collaboration mechanism	2nd quarter of Year 1 2nd quarter of Year 1 2nd quarter of Year 1 3rd and 4th quarter of Year 1	Budget, TA
	Training on fundraising and resource mobilization.		Resource mobilisation plan developed and improved Finalised guidelines for data processing, management, storage & utilization ready for implementation.			

Capacity Needs	Activities	Expected Outputs	Targets	Responsible unit/ person	Timeline	Resource requirements
Objective: Build CLM capacity at organizational level						
TB-affected CLOs need management skills, competencies and resources I operationalizing CLM process and activities.	Training and mentoring on planning, staff development, organization development, budget preparation, financial management and communication.					
CLM Collaboration mechanism need partnership abilities in shoring up sustainability of CLM process and activities.	Training on forging partnerships with other organizations for CLM TB.					
Objective: Build CLM capacity at individual level						
Community leaders need appropriate knowledge, skills and abilities to lead, educate, advocate and partner in executing their roles and responsibilities in CLM process and activities.	#Training and mentoring on sustainable leadership of CLM #Training and mentoringon advocacy using CLM results #Exposure/exchange visits. #Internships					

Capacity Needs	Activities	Expected Outputs	Targets	Responsible unit/ person	Timeline	Resource requirements
Objective: Build CLM capacity at organizational level						
Community monitors need to be equipped with knowledge, akills and attitudes in data collection and data analysis.	#Training on administration of CLM tools (interviews, scorecard, etc) Coaching, mentoring #Training of Trainiers (TOT)					
CLM partners need techniques in supporting collaboration and leadership of TB-affected CLOs.	#Training on techniques for sustaining partnerships in CLM process.					

In summary, good preparation matters in CLM implementation. Our jump rope metaphor also imparted that players need to be prepared so they can endure and win the game. An example of this is the experience of Mongolia in preparing for CLM implementation.

Preparation Matters in CLM Implementation: Insights from Mongolia TB Coalition

Good preparation and perseverance are key to the success of Mongolia Anti-TB Coalition (MTC) in facilitating CLM implementation for TB in the country. Early on, "We knew that we need to prepare well, be patient, and focus on solutions instead of problems", said Dr. BazraTsogt and Ganzorig Munkhjargal of MTC[47].

TB incidence rate in Mongolia is 428 per 100,000 population, and TB treatment is among the lowest in the world at 31%[48]. Based on the review of TB program, TB detection is low, wherein about 80% of TB cases are missed, and the prevalence of TB is high, including drug-resistant tuberculosis. MTC pointed out that one primary obstacle was the reluctance of individuals afftected by TB to access diagnostic and treatment services due to fear of stigma and discrimination. Aside from this, financial burden is a barrier, affecting nearly

47 Based on interviews and discussions with Dr. BazraTsogt and Ganzorig Munkhjargal of MTC, and their presentation during the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB ProgrammingMeeting Report. October 18-20, 2023 Manila, Philippines.

48 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9386240/pdf/bmjopen-2022-061229.pdf.

70% of individuals undergoing TB treatment. Their transition back to work after successful treatment was hindered by the need to repay loans incurred during treatment, thus discouraging involvement in charitable or volunteer work, such as joining TB survivor groups These issues were highlighted in the Mongolia Stigma Assessment Report that was presented at a conference held in India in 2019.

As a result of the stigma assessment report, MTC was able to secure support from the Global Fund to address TB issues. Ganzorig narrated that, "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". MTC thought that a strategic approach needs to be done to address the gaps in TB care and treatment. Hence, in 2023 they sought the supportof Global Fund through the CLM SI mechanism with APCASO as TA provider.

Together with APCASO, the following steps were facilitated by MTC:

- A number of knowledge-building and capacity-building workshops among TB survivors and TB-affected CLOs and civil society organizations working on TB to address the lack of information and data platforms for CLM. Through these initiatives, "We discovered that there are individuals and organisations who are willing to contribute to TB-related efforts including CLM, such as linking people diagnosed with TB to services;
- Drafting of a National CLM Strategy for TB which was discussed by stakeholders and now in the process of finalization;

- Drafting of CLM interventions for GC7 which will be implemented in 2024-2027;
- Creation of the Working Group tasked to initiate the establishment of CLM Coordinating Committee and drafting of the Terms of Reference;
- Creation of the CLM Coordinating Committee (CCC) with the responsibility to facilitate CLM implementation, including support to building of TB network in Mongolia which will eventually lead CLM process and activities.

MTC noted that, "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 given that they are accustomed to simply following medical directives. It was important for us to emphasise that CLM as an intervention supports long-term leadership strengthening of TB-affected communities towards establishing a national community-led TB network, and partnership with government and other key stakeholders are critical to its success".

MTC said that their preparation for CLM implementation matters because now, they have completed the Final Draft of National CLM Strategy for TB, CLM interventions are now part of the National Strategic Plan and included in the TB Guidelines, and piloting of CLM process and activities will be conducted under GC7.

4.2 Implementation phase of data production and management process

Once you have completed the groundwork for the establishment of CLM for TB, then you may now jump to the implementation of data production and management process. Your CLM implementation cycle begins by implementing your data collection and analysis tools according to the implementation plan.

The CLM implementation plan outlines the necessary steps that TB CLOs and CLM collaboration mechanism should take to accomplish the goal and objectives. Among the questions that are generally responded to in the CLM implementation include:

- What are the tasks related to: a. data collection, b. data quality assurance, c. data analysis, d. data visualization, e. data storage and management, and f. data utilization?
- Who is/are responsible for each task?
- When will you start and complete the tasks?
- What resource do you need?

In this phase, you will also undertake capacity building on an ongoing basis through mentoring and coaching of community leaders and community monitors. Maintaining and sustaining partnerships in the CLM collaboration mechanism is also a part of this phase.

4.2.1 Data Collection

Remember that in the CLM strategy for TB and capacity building plan, we have indicated that the methods and tools for data collection should be selected, agreed on, and developed during the preparation phase based on key areas

to be monitored, selected indicators and sites. The pre-testing, refinements and finalization of tools are also conducted in this phase. In monitoring the availability, accessibility, acceptability, quality of TB services, and community engagement (AAAQCE) in TB response, we suggest that you collect both quantitative and qualitative data.

Quantitative Data = numerical data that can help TB-affected CLOs and partners assess the progress, effectiveness, outcomes and impact of TB care and services. For example: Availability of treatment for all forms of tuberculosis ● Number of cases of homeless, undocumented and mentally ill people in high-risk populations in the 4 CLM sites who availed of TB care and treatment. ● Number of TB patients in the 4 CLM sites receiving home-based TB treatment.	**Qualitative Data** = focuses on the narrative that can help TB-affected CLOs and partners understand people's feelings and atitutdes. The information gathered through qualitative methods can provide valuable insights into key and vulnerable populations' preferences, needs and issues which can complement quantitative data in the process of making decisions and improving TB programs and services. **For example: Availability of treatment for all forms of tuberculosis** ● Reasons for homeless and mentally ill people in high-risk populations in the 4 CLM sites not availing TB care and treatment (e.g. stigma, lack of information, economic hardships, negative attitude of service providers, etc). ● Factors influencing TB patients in the 4 CLM sites not availing of home-based treatment (e.g. geographic location, preference/ bias for health facilities – hospitals or clinics, etc.)

What are examples of methods and tools for data collection in CLM for TB?

Based on the experiences of TB-affected CLOs and partners, there are some examples of effective data collection tools

that have been utilized in the course of implementing CLM for TB such as the CallKaLungs of ACHIEVE, Inc. in the Philippines and OneImpact[49]. There are also examples ot data collection tools in CLM HIV that can be adapted to TB like the CLM Recipes of KPAC in Papua New Guinea.

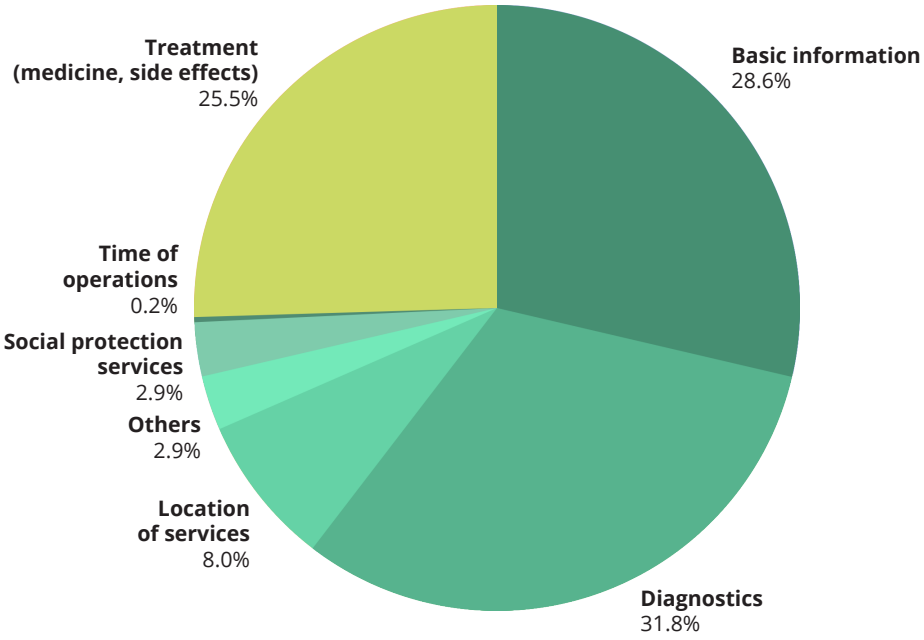
CallKaLungs TB Community Hotline in the Philippines

Action for Health Initiatives (ACHIEVE) in TB response is implementing CLM mechanisms[50]. One helpful mechanism is the CallKaLungs TB Community Hotline which started in October 2022 with the development of guidelines and protocols, followed by a training on data and information management in November 2022. In connection with data collection, the objectives of CallKaLungs are: a) collect feedback on experiences related to TB information, availability, accessibility, acceptability, and quality of services (AAAQ); and b) document TB-related stigma and discrimination experience by TB-affected communities. There are 33 indicators for data collection. A total of 15 hotline responders from 6 organizations in Luzon, Visayas, and Mindanao are in-charge of receiving calls from various individuals seeking assistance and information on TB. Initial report shows that from December 2022 to September 2023, a total of 646 calls were received by the TB Community Hotline. The nature of calls and types of TB information asked are shown in the figure on the next page:

49 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming
Meeting Report. October 18-20, 2023 Manila, Philippines. Pp. 18-19.

50 ACHIEVE, Inc. An Overview of the CLM Data So Far. Presented during the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.. Ppt presentation.

Figure 4. Asking for TB Information44



OneImpact Approach in Pakistan

The CLM initiative in Pakistan of the Association for Social Development (ASD) focuses its data collection on the areas of drug-sensitive TB (DSTB), drug-resistant TB (DRTB), diabetes, hypertension, mental health, malaria, HIV, and Maternal, Newborn and Child Health[51]. They are using the OneImpact approach to CLM implemented by the Stop TB Partnership (STP)[52] which uses an innovative mobile app to collect data

51 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.. Ppt presentation. P.18.

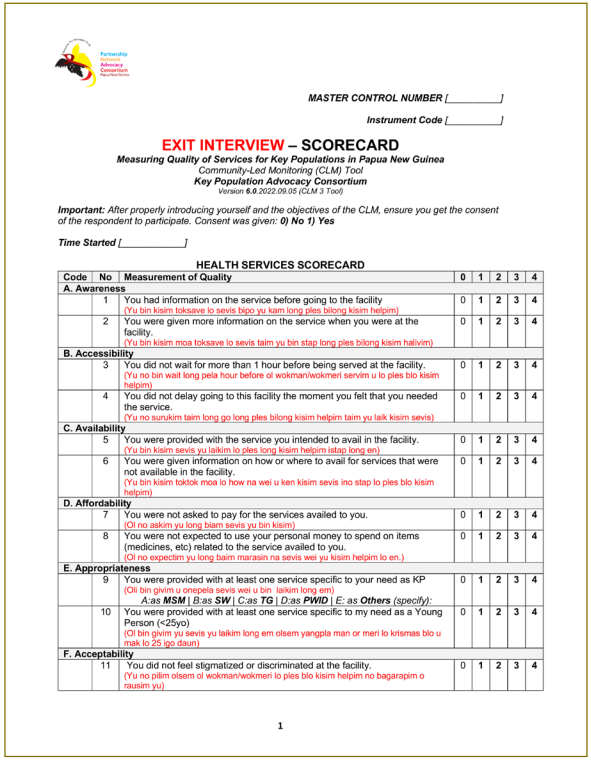
52 Stop TB Partnership. OneImpact. Community-Led Monitoring Framework, Empowering Communities To End TB. https://stoptbpartnershiponeimpact.org/resources/Conceptual%20Framework/OneImpact%20CLM%20Conceptual%20and%20Implementation%20Framework%20FN.pdf.

from TB-affected communities that report TB challenges such as human rights violations, TB stigma, Barriers to TB health services and barriers to TB support services. Depending on resource availability and type of work being done by the implementing organization, the Data collection may be passive (relies on word of mouth to encourage people affected by TB to download the app and use it to report TB challenges) or active (creates structured times and spaces for people affected by TB to download the OneImpact App and use it to report TB challenges. This might include dedicated time on the agenda during treatment literacy sessions, during active case finding outreach, or in other community gatherings), or both.

By using the OneImpact approach, ASD was able to collect CLM data which has played a pivotal role in enhancing both service delivery and programmatic aspects of the NTP. The OneImpact platform is shown below.

CLM Recipe 3 of KPAC Papua New Guinea for HIV – Facility Exit Interview

The Key Population Advocacy Consortium (KPAC) of Papua New Guinea began implementing its CLM Recipes for HIV in 2021. One of its recipes provide a good example of how to collect data at the facility level which KPAC plans to adapt in the TB Program[53]. CLM Recipe 3 is for Facility Exit Interview with five tools, one of which is the Exit Interview – Scorecard. This is a tool for measuring quality of services for key populations in Papua New Guinea. The seven categories of service quality are awareness, accessibility, availability, affordability, appropriateness, acceptability of services, and accountability of service providers. The four (4) page-scorecard is used during facility exit interviews among members of key populations and people living with HIV that are conducted every four months by Community Champions acting as community monitors. Below is a section of the 4-page Exit Interview Scorecard.



MASTER CONTROL NUMBER [_____]

Instrument Code [_____]

EXIT INTERVIEW – SCORECARD

Measuring Quality of Services for Key Populations in Papua New Guinea

Community-Led Monitoring (CLM) Tool

Key Population Advocacy Consortium

Version 6.0 2022.09.05 (CLM 3 Tool)

Important: *After properly introducing yourself and the objectives of the CLM, ensure you get the consent of the respondent to participate. Consent was given:* ***0) No 1) Yes***

Time Started *[_____]*

HEALTH SERVICES SCORECARD

Code	No	Measurement of Quality	0	1	2	3	4
A. Awareness							
	1	You had information on the service before going to the facility (Yu bin kisim toksave lo sevis bipo yu kam long ples bilong kisim helpim)	0	1	2	3	4
	2	You were given more information on the service when you were at the facility. (Yu bin kisim moa toksave lo sevis taim yu bin stap long ples bilong kisim halivim)	0	1	2	3	4
B. Accessibility							
	3	You did not wait for more than 1 hour before being served at the facility. (Yu no bin wait long pela hour before ol wokman/wokmeri servim u lo ples blo kisim helpim)	0	1	2	3	4
	4	You did not delay going to this facility the moment you felt that you needed the service. (Yu no surukim taim long go long ples bilong kisim helpim taim yu laik kisim sevis)	0	1	2	3	4
C. Availability							
	5	You were provided with the service you intended to avail in the facility. (Yu bin kisim sevis yu laikim lo ples long kisim helpim istap long en)	0	1	2	3	4
	6	You were given information on how or where to avail for services that were not available in the facility. (Yu bin kisim toktok moa lo how na wei u ken kisim sevis ino stap lo ples blo kisim helpim)	0	1	2	3	4
D. Affordability							
	7	You were not asked to pay for the services availed to you. (Ol no askim yu long baim sevis yu bin kisim)	0	1	2	3	4
	8	You were not expected to use your personal money to spend on items (medicines, etc) related to the service availed to you. (Ol no expectim yu long baim marasin na sevis wei yu kisim helpim lo en.)	0	1	2	3	4
E. Appropriateness							
	9	You were provided with at least one service specific to your need as KP (Oli bin givim u onepela sevis wei u bin laikim long em) *A:as* ***MSM*** *| B:as* ***SW*** *| C:as* ***TG*** *| D:as* ***PWID*** *| E: as* ***Others*** *(specify):*	0	1	2	3	4
	10	You were provided with at least one service specific to my need as a Young Person (<25yo) (Ol bin givim yu sevis yu laikim long em olsem yangpla man or meri lo krismas blo u mak lo 25 igo daun)	0	1	2	3	4
F. Acceptability							
	11	You did not feel stigmatized or discriminated at the facility. (Yu no pilim olsem ol wokman/wokmeri lo ples blo kisim helpim no bagarapim o rausim yu)	0	1	2	3	4

1

An array of data collection tools that you may use for CLM TB depending on your need and country context are provided in the table on the next page:

53 KPAC CLM Recipes. https://www.kpacpng.org/.

Table 11. Examples of Potential Data Collection Tools for CLM TB

Data Collection Tools	Types of Data to be Collected	
	Quantitative Data	**Qualitative Data**
Hotline/Response Center	Number of inquiries about TB information, or AAAQ Number of calls about discrimination complaint	Knowledge on available TB care and other services; Issues encountered in accessing TB services
Facility Exit Interview Scorecard	Quality and coverage of services for TB key and vulnerable populations in terms of AAA	Quality of service provided
Community Scorecards	Performance of TB care and other health services	Performance of TB care and other health services
Surveys	Gathering feedback on the AAAQ of the service received by TB key and vulnerable populations Health-seeking behaviour Stigma and discrimination Health provider attitudes	
Focus Group Discussions		Information on issues affecting service delivery among TB key and vulnerable populations, including changes over time
Facility Observations through Mystery Clients using a scorecard		Responses to be collected in visiting facilities are focused on indicators for services availed and health services scorecards (needs of KVPs met or unmet and facilities' performance in delivering high-quality, inclusive, and responsive services.
Observations		Information about how a TB program actually operates, particularly about processes.
Interviews		TB KPV's impressions or experiences in accessing TB care and services using semi-structured questionnaires.

Data Collection Tools	Types of Data to be Collected	
	Quantitative Data	Qualitative Data
Case Studies		KVPs experiences in a TB program and in engagement in TB response
Desk/documentation review review	Numerical insights and impressions of how TB programs and services operate. Preliminary information on community engagement in TB response.	Initial insights and impressions of how TB programs and services operate. #Preliminary information on community engagement in TB response.
Social Media Platforms	Number of issues posted related to accessing TB services Number of referrals made through social media platforms Kinds of information needs raised via social media messenging app	Issues in accessing TB services. Referral needs of TB patients. Information needs of KVPs.

4.2.2 Data quality assurance

What is data quality assurance, and why is it important in CLM TB?

Recalling our jump rope metaphor, before using the rope for the game, we look at its quality to ensure that the length is appropriate, there are no broken yarn filaments, looped or pulled strands and other defects to ensure that it is sturdy and will not put the players at risk or create accidents. Data quality assurance is similar to this.

Data quality assurance is a process that involves checking inconsistencies, verifying and validating accuracy through data cleaning before doing data analysis. This process is important for CLM TB to ensure that what you have gathered are high-quality data that will be useful for advocacy, programming and

community mobilization. In the OneImpact approach, this is what they said about data quality assurance:

> *"Each reported TB challenge is captured and electronically stored in the First Responder Inbox, which is managed by the CLM data manager or managers (who have signed confidentiality agreements). For data accuracy and quality purposes, data managers must validate or decline each reported challenge, based on a country-specific protocol. This might include checking if the person reporting the challenge is registered and linked to a health facility (to screen for people who are not registered at a health facility using the app) or if they reported the challenge more than once within a defined timeframe (that is, to screen for duplication errors)[54]."*
> — Stop TB Partnership

The box below is an example of summary steps that KPAC implements in doing data quality assurance for HIV CLM[55]. You may use this as reference in developing your own data quality assurance protocol for CLM TB:

Summary of Steps in Data Quality Assurance – KPAC PNG

Step 1. Downloading Data. The analyst downloads all the data from Kobo into Excel for further analysis and quality assurance.

54 Data Quality Assurance. Stop TB Partnership. OneImpact. Community-Led Monitoring Framework, Empowering Communities To End TB, p.30. https://stoptbpartnershiponeimpact.org/resources/Conceptual%20Framework/OneImpact%20CLM%20Conceptual%20and%20Implementation%20Framework%20FN.pdf.

55 Discussed by Lesley Bola, KPAC Executive Director during his presentation at the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines. The contents of his presentation are based on the KPAC CLM Documentation Report, June 2023. https://www.kpacpng.org/

Step 2. Reviewing Data. The analyst carefully examines the downloaded data to identify any discrepancies, errors, or inconsistencies. This includes checking for missing information, spelling mistakes, incorrect dates, or contradictions within the responses.

Step 3. Addressing Quality Control Checks. If any quality control issues are identified during the review, the analyst takes necessary actions to address them. This may involve investigating conflicting information, clarifying discrepancies with the supervisor and monitors, or making corrections to the data.

Step 4. Finalizing the Excel File. Once all the quality assurance checks have been completed, the analyst downloads a final version of the Excel file that incorporates all the necessary quality control adjustments and corrections.

Step 5. Creating Tables and Visuals and Analyzing Variables. With the finalized Excel file, the reviewer creates tables and performs data analysis on different variables of interest using MS Excel pivot tables or MS Power BI Dashboards. This step involves organizing, visualizing, and presenting the data in a structured format to gain insights and draw conclusions.

4.2.3 Data analysis

How do you analyze data in CLM for TB?

After you have processed the data gathered, your next task is to analyze them. Data analysis is a crucial stage in CLM for TB

because this is where you convert the raw data into useable information. At this point, you interpret and organize the data and findings rationally and logically. Triangulation is also done during data analysis to make data more reliable which can be done through the use of different data sources, data collectors, methods and others as necessary.

In data analysis, you may use quantitative (focus is on numbers) and qualitative (focus is on narratives - e.g. quotes, cases, tarnscripts, phrases, reports, stories and even images) methods. You may refer to the following guide from International Treatment Preparedness Coalition (ITPC) on qualitative and quantitative approaches to analysis of CLM data[56]:

Table 12. Methods and Types of Data Analysis in CLM (ITPC)

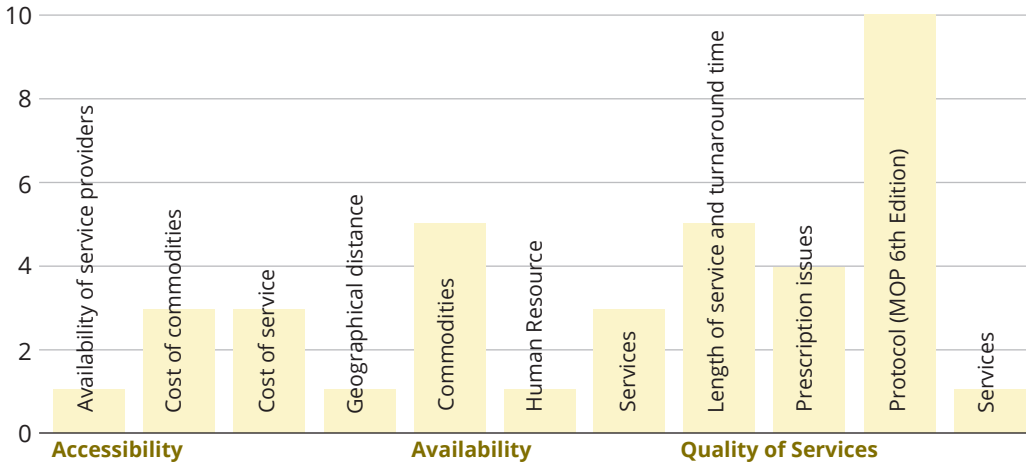
Methods of Data Analysis	Types of Analysis	Description and Examples
QUALITATIVE	Content Analysis	Content analysis looks at the presence of certain words, emerging concepts, and subjects. >For example, a CLM implementer may intentionally look for the presence of stigma, drug stock-outs, or long distances to the facility as some of the emerging words and concepts from the data set.
	Thematic Analysis	Thematic analysis involves searching the entire data set to identify, analyze, and report repeated patterns and themes in the data set. > For example, a CLM implementer can use thematic analysis if the intention is to understand a set of experiences, thoughts, and behaviors across the data set, such as recurrent stigmatizing interactions with healthcare providers, prohibitively high user fees, or a lack of health information tailored to the needs of young people.
	Narrative Analysis	Narrative analysis uses people's stories to describe human experience and action. > For example, a CLM implementer may use stories or testimonials shared by recipients of care (RoCs) to draw conclusions about the experiences of RoCs with access to health services.

56 ITPC. A Guide to Data Analysis Methods in Community-Led Monitoring. https://itpcglobal.org/resource/a-guide-to-data-analysis-methods-in-community-led-monitoring/.

Methods of Data Analysis	Types of Analysis	Description and Examples
QUANTITATIVE	Descriptive Statistics	Used to describe your raw data using statistics, graphs, and tables to help you understand the details about your sample population. >For Example: suppose we have a set of raw data that shows treatment defaulter rates of 600 health facilities in country X. We might be interested in the average defaulter rate, along with the distribution of all the defaulter rates. Using descriptive statistics, we can find the average score and create a graph that helps us visualize the distribution of the defaulter rates. This allows us to understand the defaulter rates of the different health facilities much more easily than just staring at the raw data.
	Inferential Statistics	Use a small sample of data to draw inferences about the larger population that the sample came from. >For Example: we might be be interested in understanding the preference of millions of people for health facility opening hours in a country. However, it would take too long and be too expensive to survey every individual in the country. Instead, we would take a smaller survey of say, 1,000 community members and use the results of the survey to draw inferences about the entire population.

An example of disaggregated data based on CallKaLungs TB Community Hotline data analysis is shown in the following figure:

Figure 5. ACHIEVE CallKaLungs TB Community Hotline Disaggregated AAAQ



As suggested by ITPC, different software and tools can be used in your data analysis. Examples of these include Excel, SPSS, Phyton, MAXODA, NVVivo, and STATA[57]. For example, in data analysis, KPAC uses Excel pivot tables to analyze and report on various aspects of the collected data, with a focus on key population groups and their distribution among the visited facilities[58].

4.2.4 Data visualization

What is data visualization, and why is it important in CLM for TB?

When you start translating analyzed data into a visual context, such a map, graph, dashboard or pictures, then you are doing the data visualization process. Its main objective is to make it easier for the TB-affected CLOs and partners to identify patterns, trends, and outliers in CLM data sets or to understand what the data is showing. In the capacity building plan on CLM, one of the target activities include training and mentoring on visualization process of CLM results

Aside from graphs and charts in Excel, a number of quantitative visalization are available in the internet which you may choose from to visualize your CLM data. These include Piktochart, Venngage, Tableau and Power BI. For qualitative visualization, you may explore Nvivo, ATLAS.ti and Wordstat[59].

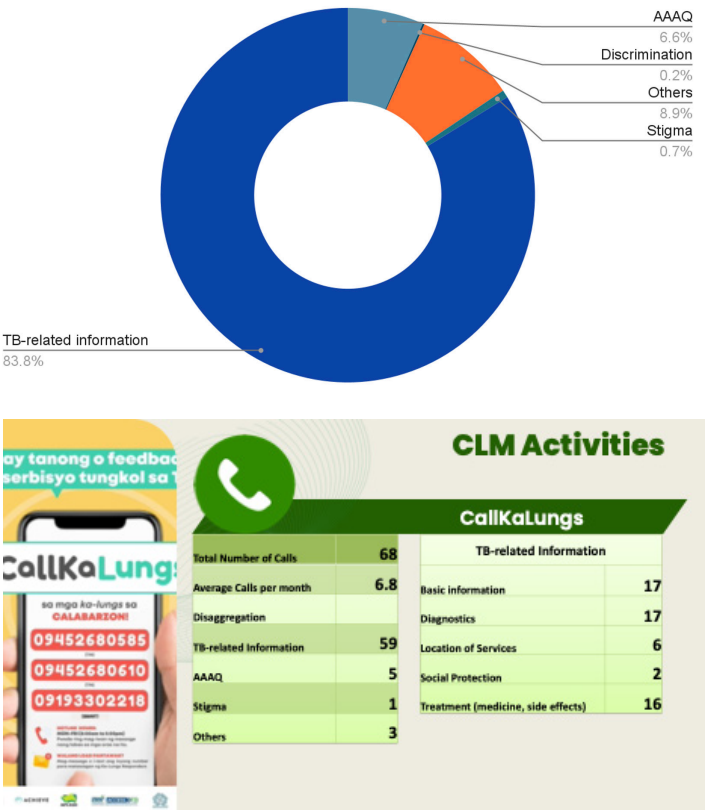
57 ITPC provided these Links to software for Data Analysis. https://monkeylearn.com/blog/qualitative-data-analysis-software/; https://www.thoughtco.com/quantitative-analysis-software-review-3026539.

58 ITPC provided these Links to software for Data Analysis. https://monkeylearn.com/blog/qualitative-data-analysis-software/; https://www.thoughtco.com/quantitative-analysis-software-review-3026539.

59 Refer to this Link for details https://tools4dev.org/blog/data-visualization-and-its-role-in-me/.

Currently, the common practice of most CLM pratitioners is to use Microsoft PowerPoint for data visualization. For ACHIEVE, they hired a local designer to develop a dashboard that instantly develops calls collected into visual data (See Figure 4). In KPAC CLM Recipe 3 – Facility Exit Interview, Microsoft Power BI software is being used for the Online Dashboard that visualized the analyzed data in the Exit Interview – Scorecard into coherent and interactive insights[60].

Figure 6. Nature of calls in ACHIEVE's CallKaLungs Community TB Hotline



60 Refer to KPAC https://www.kpacpng.org/

4.2.5 Data storage and management

How to store and manage your CLM data?

"CLM projects are meant to be replicated, repeated, and realigned over the years, and CLM implementers may need to reassess and reanalyze old data sets to explore new themes of analysis. Therefore, it is recommended that you opt for a database that is easy to explore,search, and filter, and one that can store data for a long period of time."
— International Treatment Preparedness Coalition

Data Storage. What should you do with your large sets of data? How do you ensure their safety? Who can access these data? These are important questions in implementing CLM for TB. In the preparation phase, we said that the Action Plan should include development of guidelines for data storage and management to ensure proper handling, security and confidentiality of the data. Essentially, data storage in CLM for TB means that files and documents containing the information gathered, analyzed, and visualized are recorded and saved in a storage system for future use.

Physical and digital storage are currently in use for CLM implementation, although many are now going digital in storing their data. For digital storage, data may be stored in physical hard drives, disk drives, USB drives or virtually on iCloud, Google Drive, or Dropbox. Whatever you choose for in data storage, better to keep in mind the following:

- Ensure that it is easy to create back up files for safekeeping and that you can quickly recover your data in the event of an unexpected computing crash or cyberattack; and
- Apart from reliability and robust security features, you have to consider the cost to implement and maintain the data storage system.

Data management. When you practice collecting, organizing, and accessing data for advocacy, programming, and community mobilization, you are doing the data management process. In CLM for TB, we should strive to undertake the following tasks and procedures as part of data management:

- Gather, process, validate, and properly store data;
- Ensure integration of different types of data from different sources;
- Make data available for key users in their times of need, ensuring that they are safe from potential disasters (natural and manmade) and unwanted intruders and compromises (especially for digital data);
- Ensure that data governance is implemented according to the established guidelines on how to identify, organize, handle, manage and use the data collected through CLM process and activities;
- Effectively protect security and confidentiality of the data.

An overview of the data storage and management process practiced by KPAC PNG that you may use as reference is shown in the box below[61]:

Storage of Hard Copies. Hard copies of the data are stored at the KPAC office. The data is kept in a sealed container, ensuring its physical security. The purpose of storing hard copies is to have a backup in case of errors or there is a need for verification.

Data Entry into Kobo. Data entry into the Kobo online platform is performed at the KPAC office (but when

61 Discussed by Lesley Bola, KPAC Executive Director during his presentation at the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

there are power outages, at the UNAIDS office where power generators are available). This is done by a KPAC officer who reviews the hard copies and directly uploads the information into Kobo. This step allows for the conversion of physical data into a digital format.

Data Analysis on Laptop: Once the data is uploaded into Kobo, it is downloaded onto a KPAC CLM laptop for further analysis. The analysis is carried out by an analyst who uses the downloaded data to perform various data analysis tasks. The laptop serves as a dedicated workspace for data analysis.

Data Privacy and Confidentiality: Access to both the digital data in Kobo and the hard copies of the survey is restricted to authorized personnel only. This includes UNAIDS, the KPAC team, and the KPAC analyst. Data privacy and confidentiality are prioritized to protect the sensitive information collected during the survey.

4.2.6 Data utilization

How to use CLM results?

Putting into use the CLM results is your next challenging and exciting task. In accord with the LEAP framework for CLM, you may focus the utilization of data for **awareness-raising** on the state of TB response and **advocacy** to bring about changes in policy and improvements in TB care and services. Some actions to consider before undertaking these two aspects in data utilization:

- **Develop action plan for data utilization, including communication strategy** that will guide the use of data for awareness raising and advocacy. This should be guided by the overall guidelines for data storage and management;
- **Conduct community-level dissemination of CLM data.** Before embarking on data use for education and advocacy among your partners and other stakeholders, the immediate action that you should do is to widely disseminate the CLM results to the KVPs. This is consistent with the principle that the results of CLM process and activities are owned by communities, thus the data must be made available to them first. To do this, community meetings, community dissemination forums, and other community-centered platforms should be organized and sustained to present and discuss the CLM findings;
- **Define responsibilities in the dissemination of CLM data.** This include all the related tasks from preparation, conduct and assessment of dissemination events;
- **Understand the CLM data that you have gathered and analyzed.** Be prepared to engage with critical feedback and answer queries that may arise in relation to the credibility of your data;
- **Iteration of the frequency, timing, and mode of data dissemination** that have been outlined in the CLM guidelines for data utilization to ensure that expectations on receiving of feedback from CLM are met. Timing of dissemination or feedback may be done immediately or same day, for example after the conduct of exit interview, same month or within three months. Depending on the target group of data dissemination, the modes of dissemination may be conducted through face-to-face verbal feedback, community meetings or forums, workshops, and feedback to national CLM or other multistakeholder platforms (e.g. CCM meetings, technical working group meetings, or national program implementation reviews).

Using CLM data for awareness-raising

Based on CLM data, you can raise awareness about the state of TB care and services among communities, health service providers, program planners, policy makers, development partners, donors, private sector and the public. The table below provide some examples of TB-related data that you may gather through CLM process and can be used to inform and turn awareness into actions (some of the contents were adapted in the context of TB from the document of Stop TB Partnership)[62].

Table 13. Examples of CLM Data from Stop TB Partnership

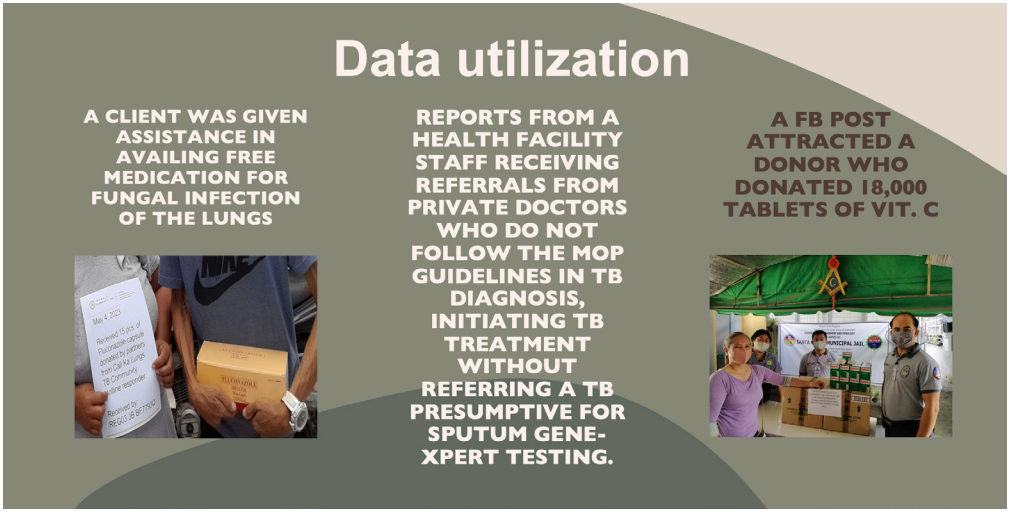
Examples of CLM data topics	Examples of insights that can be gathered
AVAILABILITY	
Availability of services and products	*"I have MDR TB and I do not have access to MDR-specific drugs"*
Availability of comprehensive and accurate health information	*"The local health center did not have molecular testing for HIV or TB, and I did not receive a referral".*
Discrimination or denial of services based on various factors	*"I am a migrant worker and the designated treatment center denied me an appointment"*
ACCESSIBILITY	
Physical accessibility (e.g. distance, safety)	*"I am not able to get tested for TB because my health facility is far away and the route is not safe."*
Financial accessibility (e.g. user fees or other expenses)	*"I was asked to pay for a TB rapid diagnostic test but it should be available free of cost."*
Opening hours and administrative procedures	*"I am a sex worker. I am moving to a new district and my TB treatment center has not transferred my file."*
Other barriers such as inadequate access to social protection, stigma, discrimination, violence	

62 Stop TB Partnership. Community-Led Monitoring. Guide to Support CLM Data Use in Decision-Making. Adapted to TB context. https://www.stoptbpartnershiponeimpact.org/resources/Training%20Tools/0113_CLM_NewTool_full_B2.pdf

ACCEPTABILITY	
Experiences of stigma, discrimination or human rights violations	*"My health centre is staffed by male health workers only, which makes me uncomfortable to seek care"* *"I did not receive information in a language I understand."* *"The service provider told my family about my TB diagnosis without my consent.*
Reasons people do not seek or utilize the health services they need, such as gender norms and social acceptability of male/female health care providers	
Preferences of users and affected communities in relation to the patientprovider interaction, such as the language used, cultural beliefs, etc.	
QUALITY	
Relative wait times or turnaround times to receive test results	*"It has been more than 2 weeks since I tested for TB but have not received the test results yet."* *"I have a drug side effect from my TB treatment but my service provider does not have the knowledge and resources to manage my condition."* *"Medicines are not being stored properly at my health centre."* *"The nurses are rude and make me feel uncomfortable when I go to pick up my TB medicines, because I am transgender."*
Referral mechanisms to other services	
Skills and competencies of providers	
Respect of clinical protocols	
Respect of hygiene, infection control and safety standards	
Experiences of stigmatizing or disrespectful treatment by service providers	
Use of services from unlicensed providers	
Individual health outcomes in relation to information and services received	

Awareness-raising techniques on CLM results that you may consider include: issuing press release and CLM results briefings; disseminating CLM reports (including visualized data), studies and publications in social media and other platforms; dialogue with policymakers and legislators; working with media and influencers; and conducting public awareness meetings and forums.

Figure 7. Example of ACHIEVE's CLM data utilization in the Philippines[63]



Using CLM data for advocacy in CLM for TB

Evidence-based data[64] is key to effective advocacy in CLM for TB. Having evidence, however, is not enough to be truly effective in advocacy. It should have a specific purpose, targeted, with clear visualization of the data and purposeful delivery to generate positive results from advocacy efforts.

The following insights on how CLM data can be used for advocacy are good points for your reflection[65]:

63 ACHIEVE, Inc. "Promoting Community-led Monitoring & Utilizing CLM Data. Presented by Florita D. Dalida, RN during the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

64 Ibid. This infographic is used as an example of how to provide evidence-based data in CLM.

65 Stop TB Partnership. Community-Led Monitoring. Guide to Support CLM Data Use in Deceion-Making. Adapted to TB context, pp. 47-48.

"Provide insights for potential advocacy priorities. For example, CLM data can document disparities in access, human rights violations in health care settings, the role of social determinants in access, and potential improvements to be made in the accessibility, affordability, and quality of programs, thereby shaping priorities for advocacy about program improvements;

Help to focus discussions with program implementers. For example, advocates can attend regular CLM data review meetings at health facilities and use CLM data to work with health workers to improve service availability, accessibility, acceptability, and quality;

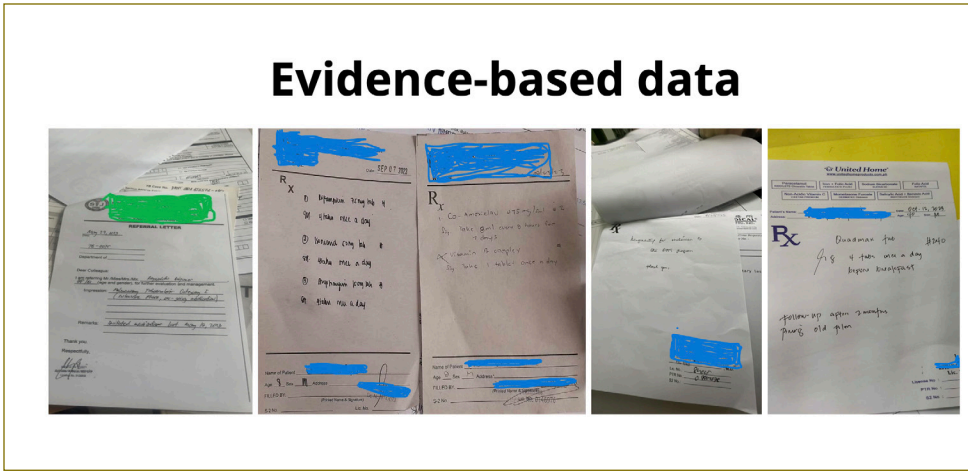
Engage communities and build constituency support for issues and actions. For example, where CLM data reveals needs to improve programs and services for specific key and vulnerable populations, that data can bring new visibility and allies to advocacy efforts;

Help to frame and support arguments for changes in policies and laws, and can help to convince international donors of the need for increased and targeted funding. For example, advocates can use CLM data findings in meetings of national health programs, national legal and human rights groups, and CCMs."

— Stop TB Partnership

Using evidence to inform policy. If you intend to influence policymaking in TB response from the perspective of KVPs, you need to provide community data based on evidence gathered. Experiences of TB-affected CLOs demonstrate that evidence-based policymaking helps in making decisions about how to improve the AAAQ of TB care and services, and engage communities.

Figure 8. Example of ACHIEVE's CLM evidence-based data



In the advocacy approach that you will implement to inform policy of CLM results, there is a need to pay attention to the following aspects[66]:

- Mapping the stakeholders and creating an open line of communication with them. This may include public officials in MOH, NTP, Ministry of Finance, Commission on Human Rights and other government bodies at the national and local levels, think tanks of government, legislative bodies, etc.;
- Complement quantitative data with qualitative evidence and utilise both in communicating key messages. Human stories, for example, have proven effective in making stakeholders understand better the situation of KVPs;

66 The insights in this section was based on Evidence for Advocacy: A Practical Guide Guidance on the generation and use of evidence in charity advocacy campaigns authored by Brian Lynch, et.al. https://hrci.ie/wp-content/uploads/2019/09/6013-Evidence-for-Advocacy-Guide_WEB.pdf

- Present the evidence in an accessible and concise way. This is where your data visualization plays an important role such as infographics. “Policy-makers need to know more than just the solution, they need to know specific details – the how, why, who and when,’
- Use national and local media as a tool for advocacy, such as newspapers, radio, television, social media, online blogs, and other media platforms. Ensure that your issue is worthy of media attention.

Using CLM data to advocate for government support. Here, you intend to advocate for including CLM initiatives in the national strategic plan, national TB programs, government health budgets or seek grants from government programs supporting community-led initiatives. For this strategy on data use for advocacy, it will help if you conduct the following activities:

- Collect data and case studies showcasing the positive impact of CLM initiatives on TB care and services, as well as community health;
- Engage with key stakeholders in government health agencies, policymakers, and champions of CLM in NTP;
- Create compelling materials highlighting the benefits of CLM initiatives for TB care and services, and overall TB response;
- Organize workshops to educate government officials about the CLM model, best practices and outcomes;
- Develop a comprehensive proposal outlining the need for government support and the potential impact of CLM initiatives;
- Use media channels to raise awareness about the CLM initiatives and garner public and government attention.

One example of advocacy for government support worth learning from for CLM TB is the experience of Indonesia AIDS Coalition (IAC):

"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 fo 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." — from the Global Fund Report[67]

67 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines. https://www.theglobalfund.org/media/13600/crg_2023-community-led-monitoring-asia-pacific-tb-meeting_report_en.pdf

On a final note, let us reflect on the meaning of advocacy in the context of CLM:

> *"Advocacy is the active promotion and defense of an opinion, a cause, a policy and/or a group of people. It is, at its essence, an effort to communicate with and influence those who hold power, and not only creating and defining obligations but also holding those in power to be accountable to those obligations."* — Stop TB Partnership

PART 5
Evaluation and Documentation of CLM for TB

THE fundamental objective of CLM evaluation is to discover what happened, and use the findings to advocate for improvements in the delivery of TB services and meaningful community engagement in TB response. At the organizational level, evaluating and documenting your experience in establishing and implementing CLM for TB will help you understand where you are, and what you are doing right or wrong in relation to your CLM purpose, goals and objectives. Like our jump rope metaphor, there is also qualitative and quantitative criteria to assess

whether the executions are done by players accordingly[68], and the subsequent modifications made on the traditional game was a result of its evaluation as a sports and physical fitness program[69].

This part of the playbook provides you with insights on evaluation of the CLM process and outcomes; and documentation of best practices and lessons learned in the establishment and implementation of CLM for TB. These two aspects serve as guidepost on how to leap or jump to the next level in CLM implementation.

5.1 Evaluation of CLM process and outcomes

"The goals of CLM programs are long-term and require sustained engagement with a variety of duty-bearers over time. Fundamentally, CLM implementers are not in control of whether the services being monitored actually improve; rather, that power lies with the ministries of health and donor-funded programmatic implementing partners that are often the targets of CLM advocacy.

Requiring impact evaluation as a measure of success at this nascent stage of global rollout is not realistic nor justified, even while early results are seen in some countries. Imposing impact evaluations and tying funding decisions to such evaluations are counterproductive at this stage. Instead, we recommend jointly defining what success looks like in the short- , medium- and long- term phases of CLM evolution and working together on progress assessment approaches that could be defined and measured, bearing in mind significant

68 https://www.edapp.com/blog/fun-training-games-for-employees/

69 Based on the study of Heppy Zakiatun Nissa, Mustaji Jump Rope Games Modification: Enhancing Children's Motor and social skills. 2018. https://www.atlantis-press.com › article.

variations in context[70]*."* — From the White Paper of CD4C, CLAW and EANNASO-APCASO-ATAC.

It is important to underline from the quote above that CLM is in its nascent stage in its rollout globally. This is, in fact, a good opportunity for civil society and TB-affected CLOs to take ownership on how CLM can be evaluated, and take lead in telling the narrative from the perspective of those who are affected by TB and those who represented them. One of your responsibilities is to lead the evaluation of CLM with the partners in the collaboration mechanism. This is aligned with the LEAP framework where you are expected to educate KVPs, partners and other stakeholders on CLM process and outcomes. CLM evaluation is also a component of the action plan. Logic Model is shown in Figure 7 and Table 13 that may be used as reference for process and outcome evaluation in CLM for TB as appropriate.

70 CD4C, CLAW and EANNASO-APCASO-ATAC. COMMUNITY-LED MONITORING. Best practices for strengthening the model, White Paper. https://www.amfar.org/wp-content/uploads/2022/12/CD4C-CLAW-EANNASO-ATAC-APCASO-Community-led-Monitoring-Best-practices-for-strengthning-the-model.pdf.

Figure 9. Example of a Logic Model on Process and Outcome Evaluationin the Philippines
(may be used for CLM TB)

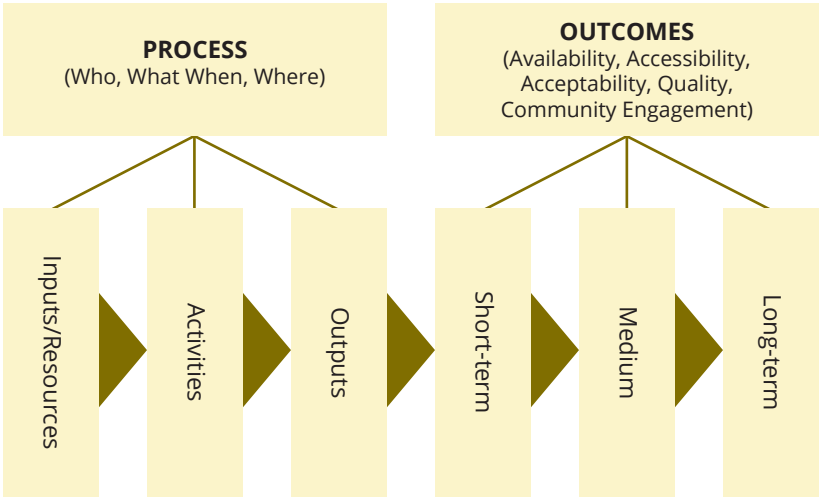


Table 14. Sample Template for Logic Model

PROCESS (Who, What When, Where)			OUTCOMES (Availability, Accessibility, Acceptability, Quality, Community Engagement)		
Inputs	**Activities**	**Outputs**	**Short-term**	**Medium-term**	**Long-term**

It is envisioned that the conduct of evaluation will contribute to:

- Validating whether you are doing what you said you will do in your CLM Action Plan;
- Determining the AAAQCE outcomes of your CLM process and activities;
- Building evidence that is relevant to TB-affected CLOs CLM goal to improve the AAAQ of TB care and services;
- Enhancing KVPs knowledge and understanding of CLM;
- Concrete assessment of progress in TB-affected CLOs leadership of CLM and meaningful engagement in TB response;
- Providing feedback to key stakeholders in government, healthcare service providers (public and private) development agencies and donors;
- Foster productive learning environment on CLM among TB-affected CLOs, KVPs and partners on CLM evaluation results;
- Finding evidence to support replication or expansion of CLM to other sites;
- Defining what successful CLM for TB means in the short-term, medium-term, and long-term based on AAAQCE indicators.

5.1.1 Concept of participatory evaluation, and its importance to CLM for TB

What is participatory evaluation, and why use this approach in CLM for TB?

Participatory evaluation is an approach that involves the key stakeholders of a program or project in the design and implementation of the evaluation, including preparation of the report and dissemination of the findings[71]. In this approach, the stakeholders/beneficiaries are:

71 Participatory evaluation. https://www.intrac.org/wpcms/wp-content/uploads/2017/01/Participatory-evaluation.pdf.

a. Given the opportunity to identify their own objectives or indicators of change,
b. The role of the evaluator is to facilitate discussions and guide the stakeholders in assessing their situation;
c. Tools and methodologies such as Venn diagram, SWOT Analysis, mapping, focus group discussion, case study and in-depth interview are designed to facilitate stakeholder participation within the evaluation process;
d. Reports may be developed in collaboration between the evaluators and beneficiaries or stakeholders.

It is considered beneficial to use participatory evaluation when there is a need to[72]:

- Empower communities or programme beneficiaries;
- Improve relationship between program planners, implementers and beneficiaries to achieve goals and objectives;
- Improve the quality of information collected and analyzed through the evaluation, and to maximize the potential for findings to be used;
- access a wide range of perspectives, rather than attempting to acquire a single viewpoint from an outside evaluator or team of evaluators;
- Encourage buy-in and ownership of the programs or projects.

In keeping with the CLM principles, you should ensure that CLM evaluation is jointly conducted with the KVPs, CLOs, and partners. Thus, you may consider participatory evaluation as your main approach in assessing the process and outcomes in CLM for TB.

72 Ibid.

Through participatory evaluation, the KVPs, CLOs and partners will be involved in[73]:

- Setting up frameworks for measuring and reporting on CLM results:
  - What will be evaluated in CLM implementation?
  - Who will be involved in the evaluation among the KVPs, CLOs and partners?
  - When activities will take place and be completed?
  - What data collection and analysis methods will be used?
  - How findings in the evaluation of the CLM implementation for TB will be consolidated and results shared?

- Reflecting on progress of CLM implementation, proposing solutions/directions to respond to issues/challenges.
- Helping with the implementation and sharing of CLM evaluation results.

You may consider the following steps in conducting the participatory evaluation:

1. Agree on which stakeholders should be involved and the reasons for their involvement;
2. Develop a Terms of Reference for the CLM evaluation — may include specific responsibilities and deliverables of evaluators, evaluation team, communities and reviewer of evaluation findings;
3. Conduct appropriate training for all those involved in the evaluation — data collection, analysis, report writing, dissemination and use of evaluation findings (See Activity 5);
4. Develop a design of the CLM evaluation — that includes goals and objectives to be addressed, logic model or

73 Adapted from the paper of CIDA, How to Perform Evaluations. Participatory Evaluation. https://www.oecd.org/derec/canada/35135226.pdf.

evaluation framework, questions to ask or data to collect, and best ways to ask the questions or methods and tools for data collection and analysis, schedule and responsible team member for the tasks;

5. Conduct the evaluation based on the design with timelines — collecting information about the CLM program;
6. Organize the data and prepare the evaluation report — includes analysis of key findings, conclusions and main recommendations;
7. Disseminate and use the evaluation findings.

Activity 5. Example of Training on Developing Basic Skills in Participatory Evaluation for CLM TB

Objective — To equip the leaders and members of TB-affected CLOs with basic knowledge and skills on how to conduct participatory evaluation in CLM for TB, particularly process evaluation

Duration — 1 hour

Requirements — Lead facilitator and co-facilitator, supplies (flip charts, Post-it notes, masking tape, colored pens, etc.)

Instructions —

1. Explain the objective and mechanics of this activity.
2. Orient the participants on the basic concept of participatory evaluation as context to the tasks that they will do in this activity.

3. Divide the community members into small groups. Ask them to choose their group facilitator and rapporteur;
4. Let them review the objectives and activities incorporated in the CLM Strategy for TB and Action Plan;
5. Tell the groups to brainstorm on the reasons for process evaluation, and let them develop the evaluation objectives and questions for evaluation;
6. Let the groups identify the information sources that will answer the evaluation questions, schedule of data gathering, and processing of data. Allow them to decide who will do the gathering of information and related tasks;
6. Ask the group representative to present their output within 5-10 minutes;
7. After each presentation of outputs, the Lead Facilitator will facilitate a discussion session among the rest of the participants on (a) their feedback on the outputs, (b) reflecting on the gaps, and (c) imagining themselves already in the field, the feasibility of implementing the identified outputs and identifying potential challenges / fears that they will encounter. If the time allows, they can conduct a fishbowl exercise wherein they can act a scenario of being in the field and conducting the evaluation of the CLM implementation.
8. A synthesis follows after the reflection session with additional discussion linking the group outputs with concepts and process of participatory evaluation and its relevance to CLM purpose, goals and objectives as discussed in section 5.1.1.

5.1.2 Process evaluation in CLM for TB

Why evaluate the process?

In community-led monitoring, process is as important as the outcomes. Process evaluation determines whether the CLM activities outlined in the action plan have been implemented as proposed. It is important for you to evaluate the process because through this, you will be able to ascertain the quality of your ongoing CLM implementation, and what outputs have you produced, for example, completed CLM trainings or workshops, CLM infographics disseminated, feedback points/hubs installed for CLM data collection, or CLM results briefs shared with NTP, donors and other key stakeholders.

How to conduct process evaluation?

The conduct of process evaluation takes place within the CLM implementation cycle. It can be conducted periodically throughout the life of CLM for TB, but the timing should be agreed on during the establishment of CLM and indicated in the action plan. For example, it can be conducted after the pilot phase to identify areas for corrections and improvement that will improve CLM operations, and should be repeated in an agreed periodic interval throughout the life cycle of your CLM implementation.

Basic steps to remember when you conduct process evaluation in CLM for TB:

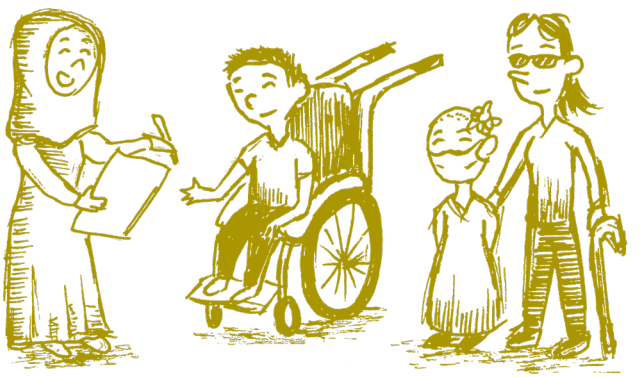
Step 1. Engage the assigned members of CLM evaluation team in preparing the plan, design and logistics needed for process evaluation;

Step 2. Draft, finalize, and endorse the evaluation questions. This step ensures that the KVPs, TB-affected

CLOs, and partners are on the same page with respect to the evaluation questions. These questions should keep in mind the CLM Strategy that you have developed in the beginning.

Example of process evaluation questions:

- What activities are being done in the implementation of CLM for TB?
- When are CLM implementation activities being done?
- Where are the CLM activities being conducted?
- Who implements the CLM activities?
- To whom are the CLM activities and efforts directed?
- How are these components the same or different from the planned CLM design?
- What are some successes in CLM implementation?
- What are the key barriers in implementing CLM for TB?
- How are these key barriers being addressed?
- Is what is being done helping achieve CLM goals?



Step 3. Conduct the data collection and analysis. Once evaluation questions are finalized, you can now collect data using the tools that you have developed to find out whether the intended design of CLM implementation has actually been executed or not. You may use the tools in the following table as reference in developing the process evaluation tools for CLM:

Table 15. Examples of Participatory Process Evaluation Tools for Data Collection

Data collection tools for process evaluation	Purpose of the Tool (Indicative)	Types of Data to be Collected (Indicative)
Story telling	Understand how KVPs, CLOs and partners experience and perceive how CLM implementation is working.	Insights into the contextual factors that influence conduct of the CLM process and activities. KVPs, CLOs, and partners experiences in CLM data collection, analysis and utilization, shedding light on strengths and weaknesses in the design of CLM implementation. Initial insights and impressions of KVPs on what CLM has produced or contributed in the TB response.
Case studies	Capture examples of CLM processes or experiences within specific stages in the cycle.	Functionality of CLO leadership in CLM for TB. Interactions and dynamics among partners in the collaboration mechanism Preliminary information on community engagement in data utilization for advocacy.
Focus group discussion	Elicit perceptions of the CLM implementation	Status of objectives: Are CLM implementation objectives and activities in the action plan met? If so, how? If not, why not? Functionality of CLM: How is CLM operations functioning from administrative, organizational, and/or personnel perspectives? CLM outputs: What do they think of the CLM activities and what it has produce? Are they satisfied?

Data collection tools for process evaluation	Purpose of the Tool (Indicative)	Types of Data to be Collected (Indicative)
Observations	Data gathered by observing people, physical objects, events, processes, behaviours, actions and interactions.	Involvement of KVPs in CLM activities Observed behaviors of CLM implementers in the field Observed behaviors and dynamics of KVPs, TB CLOs, and other CLM partners during collaboration or advocacy-related activities
Historical Timeline[74]	Understand the evolution of CLM process and record important events over time from its establishment and implementation of its cycle from the perspective of CLOs, KVPs and partners.	The evolution of CLM may be described by drawing a historical timeline, recording the most important developments, and key milestones and dates. For example, achievements in advocacy work may be indicated in the timeline. This method can collect data through an interactive process. CLM partners can organize their thoughts and history and focus on important events related to the goals and objectives of CLM implementation.

Once data collection is completed, you may now proceed to analysis of the data based on the evaluation questions. You may use a combination of quantitative and qualitative methods, although generally qualitative methods are used in participatory process evaluation. Some examples of tools for analysis of process evaluation are provided in Table 16. You may also refer to the discussion in Table 12 in section 4.2.3 on methods and types of data analysis because they can also be adapted in analyzing the data collected for process evaluation. It is also important to take note of what participatory data analysis means in the context of participatory evaluation.

74 Meg Gawler.Useful Tools for Engaging Young People in Participatory Evaluation. UNICEF CEE/CIS Regional Office. December 2005, p.21. Use as reference in adapting Historical Timeline in the context of CLM for TB.

> "Participatory data analysis can involve quantitative or qualitative data analysis, and is often treated as a separate case. This is because participatory data analysis follows different rules, and is usually based on stakeholders' sensemaking and consensus rather than rigorously applied methods. The purpose of participatory analysis may also be quite different — encouraging stakeholders to analyze their own situations rather than coming to a conclusion based on an external viewpoint".

Table 16. Some examples of tools for analysis of CLM process evaluation data

Process Evaluation Data Analysis Methods/tools[75]	Purpose of the Tool (indicative)	Types of Data that can be Analyzed (indicative)
1. Trend Analysis	To track changes in CLM implementation parameters over time.	Graph of the key parameters showing the evolution of CLM since its establishment. Examples of CLM parameters that could be graphed: number of community monitors trained in data collection and analysis, number of CLM champions in NTP and other relevant government agencies, number of advocacy activities launched using CLM results, with NTP.
2. Force-Field Analysis	Analyze why implementation of CLM cycle has evolved as it has. Discover positive factors, and what obstacles have had to be overcome.	List of the positive and negative forces in CLM implementation is useful for analysis, especially for its phase or cycle.

75 Meg Gawler.Useful Tools for Engaging Young People in Participatory Evaluation. UNICEF CEE/CIS Regional Office. December 2005. Use as reference in adapting Trend Analysis and Force-Field Analysis in the context of CLM for TB.

Process Evaluation Data Analysis Methods/tools[76]	Purpose of the Tool (indicative)	Types of Data that can be Analyzed (indicative)
3. Text Analysis[77]	May be used to analyze insights from storytelling or documents. involves extracting insights from textual data. It analyzes large volumes of text, such as social media posts, customer reviews, or documents. Text analysis can uncover sentiment, topics, and trends, enabling organizations to understand public opinion, customer feedback, and emerging issues.	Can be used to uncover trends in CLM implementation, help CLOs understand KVPs and partners behaviors, relationships, and feedback on CLM activities, and emerging issues in the different cycle or phase of CLM.
4. Causal flow charts[78]	Use to depict sequences of events, revealing how things work or how processes occur by representing actions and events with boxes, circles and arrows.	Data on CLM process may be analyzed by looking at how CLOs, KVPs, and partners interpret the results of data collection or advocacy using the CLM data. Data on the kinds of CLM decisions and priorities chosen by CLOs and partners that affected the implementation of activities can also be analyzed through this method.

Step 4. Prepare the process evaluation report. In this stage, you will prepare a comprehensive report which both documents the experience in conducting the process

76 Meg Gawler.Useful Tools for Engaging Young People in Participatory Evaluation. UNICEF CEE/CIS Regional Office. December 2005. Use as reference in adapting Trend Analysis and Force-Field Analysis in the context of CLM for TB.

77 https://www.simplilearn.com/data-analysis-methods-process-types-article.

78 https://www.measureevaluation.org/resources/training/capacity-building-resources/data-quality-portuguese/AD_1.pdf.

evaluation, the findings and recommendations. Based on this report, It will be helpful to prepare an audience-specific synopsis or briefer of findings and recommendations for each CLM stakeholder. For example, what key findings and action points would you like to share to the KVPs, NTP/government or donors.

Step 5. Disseminate and utilize the process evaluation findings. Meetings, forums and other types of dissemination activities should be conducted to provide feedback among key stakeholders on the progress of CLM operations, with a focus on initial successes and key barriers to its successful implementation. The findings should be used to make adjustments, modifications and improvements in CLM implementation. This should also include reflection on the strengths, weaknesses, opportunities and challenges encountered during the implementation of your process evaluation of CLM.

Everything considered, remember to make the process evaluation fun and a way to strengthen participation, collaboration and innovation. Similar to our jumping rope metaphor wherein spectators of the game are also part of ensuring that the swinging of the rope reaches the expected height and that the rope remains sturdy throughout the game; the CLM process evaluation assures that the CLM implementation is being conducted as planned. You may introduce games during orientation on process evaluation, data collection, dissemination and utilization of findings for CLM stakeholders to enjoy and learn more. One example is the Scavenger Hunt that is adapted in the context of CLM TB as shown in the box on the opposite page:

Activity 6. Photo Scavenger Hunt to Strengthen Collaboration and Innovation in CLM Process Evaluation

Objective — To let each of the participants express their resourcefulness, creativity and coordination in performing activities related to process evaluation

Duration — 30 - 45 minutes

Requirements — smart phone or camera, computer, projector, lead facilitator, documenter, list of items to find or list of simple acts that can be performed for this activity (see no. 5 below)

Instructions —

1. Explain the objectives, mechanics of Scavenger Hunt and its relation to CLM process evaluation.
2. Divide participants equally into two or more teams based on the overall number of participants. Each team should select their facilitator/leader and documenter.
3. Then, ask each team to assign one "process evaluator" from within their team. Once assigned, they will swap with those in the other team. The purpose of this process evaluator is to observe the scavenging process of the team that they are assigned to.
4. Show them a list of items to find, or perform acts and take pictures along with a deadline to perform the activity.

5. Teams will share the items/pictures by screen sharing during the plenary session.

   Examples of a list of items for scavenger ideas can include (but not limited to):
   - Data collection tool
   - Interviewing a KVP informant
   - Participatory process
   - Dissemination meeting/forum
   - Community leaders having fun during data analysis
   - Sites for data gathering
   - Funniest object you can find during your scavenger hunt
   - Items that symbolizes AAAQ of TB care and services

6. During the plenary session, ask teams to share what facilitated their collection of pictures, and what were the challenges.
7. Ask each of the process evaluators on how they performed their role throughout the scavenger hunt. Identify how the teams that they are "monitoring" has followed the procedures of scavenger hunt. They can then relate these reflections to conduct of CLM process evaluation.
8. To make the activity more fun, prepare some gifts beforehand and award the team / members with the following:
   a. Most obedient (in following directions) team or member
   b. Most resourceful team or member
   c. Most punctual team or member

9. The lead facilitator will summarize the activity and link it with process evaluation.

5.1.2 Outcome evaluation in CLM for TB

Earlier, we took note of the recommendation in the White Paper on CLM developed by Community Data for Change (CD4C), Consortium Community-Led Accountability Working Group (Consortium (CLAW) and EANNASO-APCASO-ATAC Consortium regarding CLM evaluation. In their perspective, since the achievement of CLM goals may take time given the complexities of its process, "requiring impact evaluation as a measure of success at this nascent stage of global rollout is not realistic nor justified, even while early results are seen in some countries". Thus, "jointly defining what success looks like in the short- , medium- and long- term phases of CLM evolution" and implementation is considered more appropriate and relevant. This is essentially the take off point of our discussion with you about outcome evaluation in CLM for TB. Outcomes refer to your desired results in CLM implementation, or simply said what you want to achieve.

What are the key characteristics of outcome evaluation and why conduct it in CLM for TB?

- Focus is on what actually happened after CLM implementation, for example after three or five years timeframe;
- An assessment conducted to measure the final results of CLM implementation in line with AAAQ of TB services and community engagement in TB response. A way to see if your CLM is making meaningful changes in the short, medium, and long-term periods;

- Mostly focuses on inputs from KVP and how CLM process and activities affected them or brought any change on them;
- Allows you to understand whether CLM implementation has made any difference on the TB-affected CLOs and KVPs;
- Provide you with the opportunity to define measures for CLM successes in the short, medium, and long term periods;
- Makes you embrace implementation failures or gaps and consider them as opportunities to improve CLM operations in the future;
- An accountability measure on the part of decision makers, program planners, and implementers in the TB response at the national and local levels.

How to conduct outcome evaluation in CLM for TB?

In conducting the outcome evaluation for CLM TB, you may refer to these steps:

Step 1. Joint definition of measures of CLM successes in the short, medium, and long term. TB-affected CLOs and partners in the CLM collaboration mechanism should facilitate a participatory process in determining qualitative and quantitative measures of what can be considered as successful outcomes.

Step2. Engage the assigned members of CLM evaluation team in preparing the plan, design, and logistics needed for outcome evaluation.

Step 3. Determine what information the evaluation must provide based on the overall AAAQCE CLM indicators. This step ensures that the KVPs, TB-affected CLOs, and partners are on the same page with respect to the types of data that will be collected and analyzed.

Example of outcome evaluation questions:

- How well did CLM implementation work throughout x number of [defined period – the year, 3 years, 5 years]?
- Were the intended outcomes of CLM implementation in the **short (immediate effects), medium (mid-term effects) and long term (desired CLM results vis a vis goal)** attained?
- Did the implementation of CLM result in changes in knowledge, skills, and attitudes among the TB health service providers (for example in relation to stigma and discrimination, waiting times?
- To what extent can changes or improvements in availability, accessibility, acceptability and quality of TB care and services can be attributed to CLM implementation?
- Did TB-affected CLOs leadership of CLM process and activities made a difference in meaningful community engagement in TB response?

Step 4. Conduct the data collection and analysis. Once evaluation questions are finalized, you can now develop the instruments, and collect and process data. Then analyze the processed data based on the evaluation questions. You may use a combination of quantitative and qualitative methods, but ensuring that the principles of participatory process evaluation are adhered to. Some examples of tools for analysis of outcome evaluation are provided in Table 17. You may also refer to the discussion in Table 12 in section 4.2.3 on methods and types of data analysis because they can also be adapted in analyzing the data collected for outcome evaluation. Similar to process evaluation, it is important to take note in outcome evaluation what participatory data analysis means in the context of participatory evaluation.

Table 17. Some examples of data collection cools for outcome evaluation

Data collection tools for outcome evaluation[79]	Purpose of the Tool (Indicative)	Types of Data to be Collected (Indicative)
Questionnaires, Surveys, Checklists	To quickly gather information from people in a non threatening way.	Changes or Improvements in availability, accessibility, acceptability and quality of TB care and services received by patients
Interviews	Use to fully understand someone's impressions or experiences, or learn more about their answers to questionnaires administered.	Example question for data to be collected: Did our CLM process and activities produce the changes that we wanted in the delivery of TB services?
Observation	Gather accurate information about how a CLM cycle actually operates, for example quarterly data collection, analysis, storage and utilization.	Waiting time in health facilities, attitude of health providers to TB patients, presence of TB support groups, etc.
Documentation review	Appraise how CLM operates through a review of documentation reports, finances, minutes, guidelines, protocols, applications, etc.	Changes in patient or provider knowledge, attitudes, beliefs, or behavior; An increase in patient adherence to treatment that shows progress toward completion of treatment.
Focus group discussions	A tool use to explore a topic indepth through group discussion led by a facilitator with checklist of questions.	
Case studies	Capture examples of CLM outcomes after 3 or 5 year implementation.	May be used to analyze long-term outcomes pertaining to positive changes in CLO leadership of CLM, successful evidence-based advocacy, or Systemic changes that occur as a result of your CLM process and activities.

79 TB Program Evaluation Handbook: Introduction to Program Evaluation. Tuberculosis Evaluation Work Group Division of Tuberculosis Elimination National Center for HIV, STD, and TB Prevention Centers for Disease Control and Prevention Department of Health and Human Services, Winter 2006.Use as reference in adapting tools for outcome evaluation in CLM for TB.

Table 18. Some examples of data analysis tools for outcome evaluation

Outcome Evaluation Data Analysis Methods/tools	Purpose of the Tool (indicative)	Types of Data that can be Analyzed (indicative)
Venn Diagram	Analyze important institutions/organizations in CLM, engagement of different partners and stakeholders in CLM or access and availability of TB care and services.	Levels of partners and stakeholders' engagement in CLM process and activities; Access and availability of redress mechanisms for cases of stigma and discrimination.
Descriptive statistics	Describe the general characteristics of a set of data. Descriptive statistics include frequencies, counts, averages and percentages.	Can be used to analyze data from process evaluation and outcome evaluation that have been quantified. For example, increase in adherence to TB treatment as a result of CLM process and activities; or changes in knowledge, attitudes and skills of KVPs in dealing with stigma and discrimination as a result of CLM implementation.
SWOT Analysis	Use to analyze internal strengths and weaknesses of implementing organizations; and the opportutnities and threats in the external environment.	Analyze organizational strengths of TB CLOs that helped in achieving CLM objectives and the of TB CLOS weakness that affected CLM results. Evaluate the opportunities and threats surrounding CLM implementation.

Outcome Evaluation Data Analysis Methods/tools	Purpose of the Tool (indicative)	Types of Data that can be Analyzed (indicative)
Most Significant Change (MSC)	"A form of participatory evaluation. It is participatory because many project stakeholders are involved both in deciding the sorts of change to be recorded and in analyzing the data. It is a form of monitoring because it occurs throughout the program cycle and provides information to help people manage the program. It contributes to evaluation because it provides data on impact and outcomes that can be used to help assess the performance of the Initiative as a whole"[80].	The degree to which CLM implementation is having an effect on AAAQ of TB services; or extent of change in TB CLOs leadership skills, knowledge and behaviors in CLM implementation.

Step 5. Prepare the outcome evaluation report. In this stage, you will prepare a comprehensive report which both documents the experience in conducting the outcome evaluation, the findings and recommendations. Based on this report, It will be helpful to prepare an audience-specific synopsis or briefer of findings and recommendations for each CLM stakeholder. For example, what key findings and action points would you like to share to the KVPs, NTP/government or donors.

Step 6. Disseminate and utilize the outcome evaluation findings. Meetings, forums and other types of dissemination activities should be conducted to provide feedback among key stakeholders on the outcomes of CLM implementation,

80 Tamarack Institute. Most Significant Change Tool.

with a focus on short, medium and long term (where applicable) successes and key barriers to its successful implementation. Most Significant Change Stories may be shared during the dissemination. A reference on MSC steps is shown in the box below[81]. The findings should be used as basis for CLM continuation, replication or expansion. This should also include reflection on the strengths, weaknesses, opportunities and challenges encountered during the implementation of your outcome evaluation of CLM.

10 Steps for Most Significant Change (MSC) Implementation	
1. Raise interest amongst key stakeholders and get their commitment to participate	
2. Define the domains of change	What has broadly changed in people's lives?
3. Determine the reporting period – over the past year, six months, three months etc.	
4. Collect the significant change stories from participants	During the last six months, in your opinion, what was the most significant change that took place for participants in this program?
5. Select the most significant stories. Every time stories are selected, record criteria used to select them.	From among the stories selected, what do you think was the most significant change of all?
6. Feedback the results of the selection process. Include stakeholders to review the process, stories selected and assess the domains of stories	From among the stories selected what do you think was the most significant change of all?
7. Verify the stories	Who told the story? Who captured the results? When and where did the story take place?
8. Quantify the results	
9. Conduct a secondary or meta-monitoring analysis	You may use analysis methodologies as presented in Tables 12 or 18
10. Revise the system based upon lessons learned	

81 Source: http://mande.co.uk/docs/MSCGuide.pdf.

5.2 Documentation of best practices and lessons learned

In jumping rope games, we usually remember who is considered the most valuable player (MVP) everytime we play. Some of us looks up to, and sometimes emulate the style and the gameplay of that player. At the same time, we keep track of our individual gameplay, adjust our movements, and train our jumps to make it stronger and higher. Similar to jumping rope, in CLM, these steps are important in making sure that we identify the best practices (the MVPs) and the lessons learned to better our LEAP.

What are best practices, and why document them?

When your CLM activity or process yield success, meaningful results, or a game changer that is worth replicating and sustaining, that can be considered as a best practice. In many instances, best practices are innovations or sets of tasks and procedures that are cost efficient, effective, and replicable course of action. The CLM experience in India was documented as one of the best practices on how CLM data was used to inform and resulted in a positive outcome.

> "In India, CLM data revealed that large decreases in TB diagnoses were due to misinterpretation of recent government guidelines, resulting in patients being incorrectly required to test for COVID-19 before TB screening. The CLM team held dialogues to address the misinterpretation, with mandatory COVID-19 testing ultimately removed as a barrier to access[82]".

82 CLAW. Best Practices for Community-Led Monitoring. September 2022.

You need to document best practices in CLM for TB because it can:

- Help TB-affected CLOs improve their leadership of CLM process and activities;
- Generate buy-in from partners in government and donors;
- Inspire and motivate CLM partners;
- Inspire and mobilize communities;
- Replicate similar practices with relative success; and
- Build or contribute to a growing evidence that is relevant to KVPs and TB-affected CLOs advocacy work on improvement of TB services and meaningful community engagement in TB response.

WHO-Africa points out that, "the main rationale for documenting and sharing "Best Practices" is to enable persons and organizations working in the health sector to avoid "re-inventing the wheel"; to "learn in order to improve performance" and; to "avoid the mistakes of others"[83].

Here are some pointers on how you can document best practices in CLM implementation:

- Develop and agree on your own criteria for best practices in CLM establishment and implementation;
- Involve CLM KVP, TB-affected CLOs, civil society organisations, partners, and other key stakeholders in identifying best practices based on results of process and outcome evaluations;
- Create a documentation plan for CLM best practices;
- Seek support in conducting the documentation of best practices in CLM for TB, e.g. TA, funds, expertise, among others;
- Produce a concise and creative documentation report.

83 WHO, Regional Office in Africa. Guide for Documenting and Sharing"Best Practices" in Health Programmes. https://www.afro.who.int/sites/default/files/201706/Guide_for_documenting_and_Sharing_Best_Practice_-_english_0.pdf

What are lessons learned, and why document them?

Reflecting on what work and did not work in CLM implementation is one way to cull-out lessons learned. The lessons highlight knowledge based on experience, which are seen as valuable insights that can help you prevent future mistakes and improve CLM operations. Aside from repeating mistakes, these lessons also facilitates identification of your strengths and weaknesses in CLM implementation, and a vehicle for dialogue among communities and partners. Thus, you need to systematically document them and share to CLM stakeholders.

You may consider the following pointers in documenting lessons learned in CLM implementation:

- Develop or use a simple template in documenting lessons learned that can be shared easily within TB-affected CLOs, communities and partners. You may refer to the sample template below for documenting lessons learned;
- Start lessons learned identification by discussing what went well, what did not went well, and what improvements are needed;
- Solicit feedback on the above ideas;
- Develop those feedback into insights as lessons learned;
- Analyze the lessons learned;
- Put into writing, and if needed, prioritize key lessons learned.

Table 19. Sample template for documenting lessons learned

LESSONS LEARNED IN CLM IMPLEMENTATIONFOR TB	
Implementing TB CLOs:	
Location:	
Date/Timeframe:	
Goals:	
LESSONS LEARNED	
What went well or worked in CLM implementation? Lesson #1 Lesson #2 Lesson #3 Lesson #4	How would you improve the process for next time, if applicable?
What did not work in CLM implementation? Lesson #1 Lesson #2 Lesson #3 Lesson #4	How would you improve the process for next time, if applicable?
Further Comments: — What would you do differently in future CLM implementation? — What surprises did theTB CLOs and partners encounter during CLM implementation? — What CLM implementation circumstances were not anticipated? — Were the CLM implementation goals attained? If not, what process and/or technical changes need to be made to meet goals in the future?	

Below is example of lessons learned from ACHIEVE and PASTB' CLM experience[84]:

CLM: the ACHIEVE and PASTB Experience LESSONS LEARNED

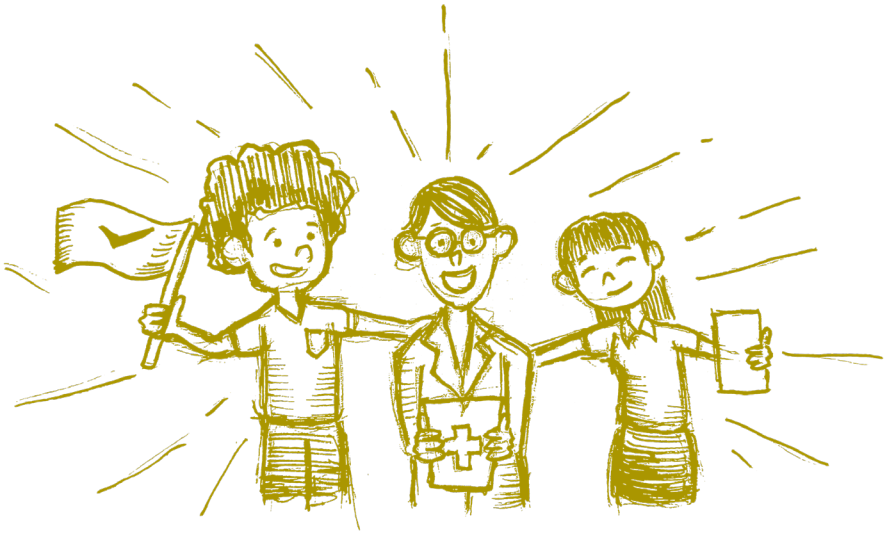
- Promotion is crucial to the success and sustainability of CLM;
- Ensure that there is consideration to your country's data privacy laws (e.g. Data Privacy Commission in the PH);
- Local government units/cities may require formal partnerships; will have to undergo bureaucratic processes towards a MOA;
- Partners should have more appreciation/understanding of CLM for them to be more engaged;
- Triage training for responders must be conducted especially for mental health issues and legal issues;
- Role delineation: clarity on when CLM responder role ends and when community-led organisation responding to a client need begins;
- CallKaLungs respondents have to be trained on probing for real issues;
- The dashboard will have to undergo several improvements and there must be regular feedbacking to continuously improve it.

In summary, through documentation of best practices and lessons learned in CLM for TB, you are able to capture and

84 ACHIEVE, Inc. CLM: the ACHIEVE and PASTB Experience, presented by Florita D. Dalida, RN during the Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

record the insights and experiences vividly and systematically. You can use them as reflection material on how to apply the lessons, learn from others, and foster a learning culture among the TB-affected CLOs, KVPs and CLM partners.

PART 6
Pointers on Scale-up and Sustainability of CLM for TB



FOR a leap further, let us take you to two important concerns in CLM, namely: Scale-up and Sustainability. The essential question is, "how do you scale-up and sustain CLM for TB?" The discussion in this part is based on the collective insights and experiences of countries in Asia-Pacific Region that are currently operationalizing CLM in TB and HIV according to their country context[85].

85 Global Fund. An Asia-Pacific Exchange on the Role of Community-Led Monitoring in TB Programming Meeting Report. October 18-20, 2023 Manila, Philippines.

6.1 Tips for CLM Scale up

What is CLM scale up, and when to do it?

Scaling in CLM involves expanding its effect and influence beyond its initial scope, for example increase in sites and targets. But before embarking on scale up, there is a need to first assess the readiness and capacity of TB-affected CLOs and partners to do so. Once you have done an assessment of the readiness of implementing CLM in your country or locality, subsequent steps would be the selection of strategy for scale up, development of the scaling plan, capacity building on scaling up, risk management of scale up initiative and sharing of lessons in scaling up[86].

According to CLM implementers, the criteria of a CLM program to scale up include[87]:

1. **Community readiness** – pertains to overall CLM public visibility and promotion by communities and government, and community preparedness where there is mobilization by affected communities, community understanding, acceptance and engagement in current CLM program.

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;

86 https://www.linkedin.com/advice/0/how-do-you-scale-up-your-program-impact.
87 Ibid.

- 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.

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; and
   - Identified data collection tools to support scale up.

6.2 Sustainability Pointer

What are the opportunities and challenges to CLM sustainability?

Sustainability of CLM is also a major concern among CLM implementers. For example, the question about how to compensate community members who render their efforts and time in CLM work is a recurring theme. Although the national disease programs can fund CLM, there is the

issue on conflict of interest. In this context, COI has to be managed to ensure that the principles of independence, community leadership and ownership across the different stages of the CLM cycle are respected and supported[88].

Some of the suggestions on CLM sustainability are:

- Facilitate continued conversation with governments, ensuring the inclusion of CLM as a social accountability tool in national and community health responses and strategic frameworks.
- Ensure CLM receptiveness of decision makers.
- National level discussions on CLM to ensure that its data feeds into processes and decisions of the MoH-NTP.
- Strengthen integration of CLM TB with existing diseases such as with HIV. The table below provides insights on opportunities and challenges to integrate CLM TB with HIV.

88 Ibid.

Table 20. Opportunities and Challenges to CLM TB Integration with HIV

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.
Papua New Guinea	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.

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