THE GLOBAL FUND

Towards a Global Agenda for Community-Led Monitoring

Meeting Report

29 August – 1 September 2022
Bangkok, Thailand

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Acronyms and Abbreviations

ALMA	African Leaders Malaria Alliance
C19RM	COVID-19 Response Mechanism
CBM	Community-based monitoring
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CFCS	Challenge Facility for Civil Society
CLR	Community-led responses
CLO	Community-led organization
COE	Challenging operating environments
COP	Country Operational Planning
CRG	Community, Rights and Gender
CSO	Civil society organization
CSS	Community systems strengthening
DHIS	District Health Information Software
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
IRB	Institutional Review Boards
ISPs	Inadequately served populations
KPs	Key populations
KVP	Key and vulnerable population
M&E	Monitoring and Evaluation
MOH	Ministry of Health

MSM	Men who have sex with men
NFM	New Funding Model
NGO	Non-governmental organization
OUs	Operating units
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PLWHA	People living with HIV and AIDS
PR	Principal Recipient
RCF	Robert Carr Fund for Civil Society Networks
ROP	Regional Operational Planning
RSSH	Resilient and Sustainable Systems for Health
SI	Strategic Initiative
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
UHC	Universal Health Coverage
WHO	World Health Organization

1. Background

1.1 History and context

In February 2020, The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) convened the international meeting "Towards a Common Understanding of Community-based Monitoring and Advocacy" in Geneva, Switzerland. The meeting was a crucial first step in consolidating a vibrant community-led monitoring (CLM) community of practice: a place where donors, implementers, technical agencies and community-led networks convened to discuss the state of CLM. Just a month later, the COVID-19 outbreak curtailed the possibility of in-person convenings for the next two years, but during this time ongoing CLM and new programs were rolled out; in some cases, CLM was also deployed to respond to the new pandemic. Two years after the Geneva meeting, there was a need to reflect and assess progress made as well as collectively identify new opportunities.

In August 2022, the Global Fund together with other key partners convened the "Towards a Global Agenda for Community-led Monitoring" meeting in Bangkok, Thailand. The organizers, working with the local host Asia Pacific Council of AIDS Service Organisations (APCASO), invited 66 participants to Bangkok, Thailand for a three-day meeting. Participants included current CLM implementers and TA providers of the Global Fund, PEPFAR, UNAIDS and the Stop TB Partnership. The meeting's Steering Committee acknowledged that the limited budget resulted in a limited number of participants. Therefore, this meeting report is for public dissemination among the wider CLM community. This report captures key discussions and agreed actions from the meeting, and is intended for further discussion on strengthening CLM as a critical community accountability intervention for improved health outcomes.

As a supplement, a Google folder has been created which includes the presentations and resources from the meeting. The folder can be accessed HERE (https://drive.google.com/drive/folders/1ShO_cuJnr1hS7ogpAm_8eoC7bfQngl57).

1.2 Meeting purpose

The objectives of the August 2022 meeting were to:

- Reflect on progress made on CLM over the previous two years and how to advance CLM in the context of the national planning process, the Global Fund's next funding cycle and associated country dialogue, PEPFAR's COP and other opportunities.
- Increase understanding of implementation challenges, funding gaps, and TA needs for effective CLM programs, and identify ways to troubleshoot, expand available resources to meet the needs of CLM implementers.

- Identify priorities for a collectively owned action agenda to improve CLM systems, increase community leadership, in-country coordination and reinforce government engagement and donor alignment.

1.3 Pre-meeting survey

Twenty-six of the meeting participants completed a pre-meeting survey to inform the meeting agenda and working groups. Of the 26 respondents, 22 were CLM implementers. Topics of interest by respondents to be discussed during the meeting included:

Adaptation of CLM model beyond HIV
Affirming core CLM principles
Building community capacity for advocacy
Convincing national governments of CLM's value
Inadequate funding and funding delays
M&E of CLM cycles: how do we show CLM produces change?
Relationship building among CLM stakeholders
Sustainability in absence of donor funding

While key challenges noted in survey responses were:

CLM budgets inadequate and a lot is expected with few resources
Delays due to insecure contexts and political changes on the ground
Developing CLM models for malaria
Different stakeholders have different expectations of what CLM is
Evaluation of results
Funding for rigorous operational research of CLM
Lack of a shared global vision for CLM's long-term purpose
Low understanding of CLM tools, especially for offline communities

The results of the pre-meeting survey shaped the final meeting agenda. The full pre-meeting survey results report and presentation from the meeting are included in the Google folder.

2. Taking Stock: A Global Snapshot of CLM

The meeting kicked off with informative presentations from donors, technical partners and CLM implementers to share key learnings to date from CLM implementation, funding and technical assistance.

2.1 Disease-specific CLM

CLM for TB

The Stop TB Partnership's OneImpact tool has supported CLM development and implementation for the TB community. OneImpact has 30 CLM implementing partners around the world, and 26 adapted frameworks for 26 high TB high burden countries (HBCs). It was emphasized that OneImpact was an engagement approach and a process to empower the TB community to engage meaningfully in all aspects of the TB response. There were four significant key lessons learned through OneImpact:

- The process-driven approach facilitates a streamlined, iterative and ongoing learning and improvement process.
- Leveraging and aligning existing CLM efforts and existing community responses is advantageous to CLM and key to community systems strengthening.
- Aligning CLM efforts and indicators with national program priorities and targets is key to NTP uptake, CLM mainstreaming, generating actionable and complementary data, and thus improved people-centered care.

The presentation also reported gaps in scaling up OneImpact. These include STP CRG OneImpact TA, OneImpact processes, tools and technology, and STP Challenge Facility grants for civil society seed funding for orientation, adaptation and testing.

CLM for HIV

The UNAIDS team introduced a narrative of HIV CLM as an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of PLHIV, networks of KP and other affected groups or other community entities. In February 2021, UNAIDS published Establishing community-led monitoring of HIV Services – Principles and process reaffirming core CLM principles of the full CLM implementation cycle. While this guidance has been well received by partners, several challenges were presented as gaps for TA and CLM implementers, including:

- The interpretation of CLM principles differs on the ground.
- Communications around CLM implementation at all levels needs improvement.
- Long-term funding modalities and sustainability is an issue.
- Complex partner stakeholder dynamics need addressing.

UNAIDS presented examples of where CLM is making a difference:

- In **West Africa**, CLM across 11 countries supported KP demand creation for HIV treatment. At 16 health facilities, the number of new treatment initiations among men who have sex with men (MSM), sex workers, and people who inject drugs rose from 63 in the first six-month period of the project to 420 in the second and to 1,106 in the third – a 17-fold increase (ITPC).
- In **South Africa**, Ritshidze can now rank the best- and worst-performing clinics based on criteria such as waiting times, safety, adequate numbers of staff and the attitudes of personnel enabling it to track the quality of services over time and identify where best practices in top ranking clinics can inform struggling clinics to improve (South Africa UNAIDS report, internal, 2021).
- In **Togo**, CLM led to the development of social protection measures, including an emergency plan of 400 billion CFA to support the poorest households as part of a National Solidarity and Economic Recovery Fund (ITPC).

CBM[1] for Malaria

Models for CLM for malaria are generally limited. However, a community-based monitoring (CBM) approach by the African Leaders Malaria Alliance (ALMA), called the ALMA scorecard, has been used to strengthen accountability for malaria control and elimination across the continent. Key elements of the ALMA scorecards include:

- Country-owned color-coded management tools tracking the performance of priority indicators from Ministry of Health (MOH) strategic plans. Colors make it simple to identify problems to inform action planning with broad set of stakeholders, including communities.
- Optimizing the use of data from existing sources (e.g. DHIS2) for decision making.
- Objectives include action, accountability, advocacy, and resource mobilization.
- ALMA provides technical support and the country manages the scorecard independently on a “scorecard web platform”.
- DHIS2 interoperability allows for facility level (community level) monitoring.

Disease-specific scorecards can be used in community town halls, community dialogues and other community institutions to facilitate community responses to underperformance and allow communities to hold responsible parties accountable. ALMA shared that community scorecard actions have led to the donation of land for building new health facilities, resolving water supply issues, community advocacy to mobilize resources from the government to buy equipment and improving the availability and quality of home visits by community health workers. Key challenges noted in the scorecard approach include:

[1] Note: Community-based instead of community-led. In malaria programs, communities organize differently compared to HIV and TB; and malaria transmission and control interventions often target general populations. Thus, the community-led principle is more challenging to apply. For malaria programs, community-based monitoring is being explored.

1. Scale up of community scorecards requires training many communities which can be costly; high turnover of government staff also requires retraining.
2. Community level leaders (or facilitators) may have difficulty sustaining the initiative if there is no progress or feedback to motivate community members to participate.
3. Scorecards can draw visibility to problems/gaps in the health system which can bring resistance from those who will be held accountable (this is a good challenge).
4. Sometimes there are no functional community structures to rely on, which requires setting up a new process training community or traditional leaders.

2.2 Donor landscape

The Global Fund

The Global Fund shared how it is supporting effective implementation of CLM in HIV, TB, malaria, RSSH and C19RM grants. The core ways the Global Fund provides support is through two TA mechanisms:

- The CLM Strategic Initiative (SI) (2021 – 2023) has three CLM SI TA provider consortiums (18 partners representing five regions). Details were shared regarding the objectives, country focus, types of TA activities offered, achievements and learning to date of the CLM SI mechanism. The Global Fund highlighted the launch of this first-time, ambitious initiative amidst a pandemic.
- During COVID-19, the Global Fund also launched another TA program to support CLM in C19RM grants as well as support the development of CLM resources and tools in relation to pandemic preparedness.
- The Global Fund explained key resources developed by partners and new resources under development as well as other TA opportunities available in 2019-2022 allocation cycle.

The Global Fund shared resources and TA opportunities to support preparations for the 2023-2025 allocation cycle.

PEPFAR

PEPFAR presented on “Community-Led Monitoring Implementation: Funding and Opportunities within the PEPFAR Program”. The presentation went through the complex and nuanced mechanism of PEPFAR funding and implementation. Some key points:

- The PEPFAR COP/ROP 2022 Guidance recognizes the importance of engaging with communities in the development and implementation of HIV programming.
- Operating Units (OUs) are required to fund the development and implementation of community-led monitoring activities.

Under the guidance, PEPFAR must ensure its CLM activities include an explicit focus on key populations. This does not mean key populations are the only focus of CLM activities,

but rather that they must be involved in some way, and there are multiple ways of meeting this requirement.

3. Aligning CLM Principles to Practice

As noted in the pre-meeting survey, participants identified several challenges in aligning CLM principles with practice during CLM set up and implementation. These included sufficient and timely disbursement of funding; and donor and technical agency coordination of technical support. As a starting point for the discussion, a review of CLM definitions from different entities revealed strong similarities on key terms – **community-led, affected groups/communities, quantitative and qualitative data and accountability**. Organized around these four terms, participants were asked to discuss the applicability (or not) of related statements to CLM program implementation or technical support, and how participants' particular context (experience or environment) related. This exercise encouraged a rich discussion on how CLM principles are interpreted and implemented by communities.

3.1 Community-led

Statements:

1) Affected communities should be at the core of CLM processes regardless of who is funding them.

2) Governments, donors and/or technical partners can provide support to affected communities for convening and designing CLM programs, including collecting data.

- *Participant reactions:* The concept of community-led is theoretically important but is harder to achieve in practice. Emphasis was placed on involving communities earlier in the CLM process and making sure to bring CLM data back to communities. Areas of heated interest to governments, donors and technical agencies are indicator selection and site selection. Communities should be empowered to define what indicators to collect data on and sites that should be prioritized for monitoring.

3.2 Affected groups / communities

Statement: CLM programs should be managed and implemented by organizations of affected groups/communities, but if one does not exist in a country or geographic area, a CSO or CBO that is respected and credible to affected groups/communities can manage and implement the CLM program.

- *Participant reactions:* The CLM approach is very context specific especially for TB and malaria. Credibility is key. CBOs of affected communities may not want to do CLM. In

countries where there are different CLM programs with multiple systems and approaches, consider “groups of people” to implement CLM instead of an organization. The capacity of communities/CLOs to own and lead the CLM programs is important.

3.3 Quantitative and qualitative data

Statements:

1) CLM quantitative indicators can include those that public health facilities are monitoring; these indicators can be triangulated with qualitative data that can help explain what is behind the numbers.

2) CLM data should ideally be housed by the organization implementing the CLM. Access by other organizations and individuals outside the organization is at the discretion of the CLM implementer, but privacy, confidentiality and security need to be considered when deciding who has access to the data.

3) Involvement from the government or a donor does not compromise the independence of a CLM program as long as they are not deciding what data the CLM implementer should collect. The CLM implementer should be open to input on what to monitor but ultimately the decision rests with the implementer.

- *Participant reactions:* Communities’ perspectives should be considered and not just those of the CLM implementer. Consider who has access to the CLM data; data should be housed by the CLM implementer and data sharing agreements set up prior to data collection and advocacy efforts.

3.4 Accountability

Statement: Health authorities, other government officials and donors are usually the target of advocacy using the CLM data even if they are funding CLM activities.

- *Participant reactions:* Accountability is needed at different levels. It is important to target the right duty bearers, fund advocacy activities and remember that advocacy takes time.

4. Deep Dive into CLM Elements

Participants engaged in focused discussions around the following CLM topics which were selected based on actual experiences of participants and confirmed in the pre-meeting survey results. Discussions were guided by a set of questions for each topic but generally centered around how participants can improve and/or support processes, activities,

programs and strategies related to each topic. This session was intended to help create concrete actions by the end of the three-day meeting.

4.1 Improving in-country coordination, including governance and funding

Guiding Question	Key Responses
How do we overcome skepticism about CLM and lack of support from the Ministry of Health (and/or other government agencies)?	• Show value by sharing best practices and results from CLM to improve services. • Ensure rigor, reliability, and legitimacy of CLM data through triangulation with other government data. • Establish regular feedback and communication loops with government on CLM findings. • Be involved in government planning around national strategies to embed CLM, especially CLM data use for program improvement or decision making.
How do we cope with inadequate funding for CLM models, such as not paying data collectors?	• Identify additional sources of funding to support indirect costs related to operations and management. • Do not compromise CLM program due to reduction in funding envelope for intervention, instead consider reducing scope. • Ensure minimum basic costing of CLM programs, including remuneration of CLM monitors and adequate support and supervision during implementation.
How do we address funding gaps from large donors when delays in funding disbursements lead to CLM projects being unable to work for several months? Is this something other donors could assist with, or are larger changes possible to funding streams?	• PEPFAR should have 2-3 multiyear funding cycles. • Resource mobilization training for CLM implementers to help them diversify funding sources. • Need more realistic timelines for use of funds and reporting results. • Consider pooled funding mechanism for implementation/technical support with greater flexibility.

4.2 Evaluation of CLM, including documenting results

Guiding questions and key responses: [participants inserted the words in red during discussion]

Guiding Question	Key Responses
How do we best monitor and evaluate the impact of CLM and advocacy on the improvement of service delivery?	• The reason to include routine monitoring is to facilitate an ongoing engagement process to identify bottlenecks, take corrective action and improve operations in a timely manner so that it benefits improved health outcomes. • It is important to include advocacy using CLM data, which oftentimes is not always implicit or adequately funded. • Demonstrating change as a result takes time, emphasis on keeping logs of advocacy efforts and successes to monitor quality improvement trends over time. • Affected communities / CLM implementers should develop a theory of change/clear results chain that incorporates a broader monitoring and evaluation (M&E) framework that facilitates a continuous learning and improvement process. It should be developed during the inception phase and should include objectives and targets for CLM and advocacy, which will be: 1) monitored in the short-term (input and processes), 2) medium-term (output and outcomes), and 3) evaluated in the longer term (impact). • Technical partners should support or facilitate south-to-south TA to affected communities / CLM implementers to develop M&E frameworks for best practices of CLM and should disseminate them to promote CLM successes being cognizant of and incorporating realistic timelines to demonstrate change.
How, for whom do we document and share changes that occurred because of CLM and advocacy?	• Affected communities / CLM implementers: The M&E framework can use community methodologies (e.g., outcome harvesting / most significant change methodologies) to document change. Using these methodologies, communities can share individual stories, case studies etc. via social media, podcasts, etc. (platforms which communities have control over). These stories and case studies should be shared back with communities through embedded feedback loops, as well as with national programs, governance bodies (e.g., CCMs) and donors to build their understanding and appreciation of CLM. • Technical partners and donors should use their communications platforms to share and

	disseminate best practices to targeted audiences. They should also incorporate these best practices into relevant technical partner and donor documents and identify and create spaces and opportunities for communities / implementers to share these best practices. • All donors should include resource allocations for advocacy and M&E of advocacy in their CLM program budgets.
Advocacy processes are often non-linear and can take many years; pressure to "show results" of CLM within one or two years is short sighted and risks creating cynicism and disappointment in donors. Can we agree on some interim measures for impact which would provide a pathway for CLM implementers to show results?	• Affected communities / CLM implementers should lead regular CLM performance review meetings to monitor performance, against their M&E framework. • Communities / CLM implementers should lead subsequent regular multistakeholder CLM meetings to highlight success stories and challenges that require input and action from other decision makers: thus, working towards CLM mainstreaming in national programs for health and community systems strengthening. • Technical partners should encourage engagement and partnership across sectors in evaluating CLM, towards generating best practice examples.

4.3 Data collection, ownership and analysis

Meeting participants argued that the community doesn't need to perform data analysis. There should be a budget to outsource an expert data analyst and resources to train the CLM team to fully understand the data analysis process, the statistical results and meaning of each metric in the results, and how to use data for different purpose (e.g., advocacy, intervention design, capacity building, etc.). This also helps to increase the reliability of the data and ensure the consistency of the data.

Guiding Questions	Key Responses
A core challenge for CLM implementers is data analysis. What should be done to make data analysis more effective and rigorous?	• Develop a simple and smart tool for data collection and analysis which can easily clean data; automatically analyze and convert quantitative data into result tables/charts; and automatically transcribe qualitative data and recognize key words (i.e., scorecard, labeled data by color, etc.) • Build the capacity of person(s) in charge of data analysis in CLM teams on indicator selection, methodology, data cleaning and presentation. This person/ analyzing team need to be remunerated.

	• Provide continuous technical assistance and mentorship to CLM teams on data analysis; how to read and understand the data; and how to interpret the data.
How do we ensure collected data is credible / has a verification process?	• Validate/test and pilot the data collection tool(s) • Obtain IRB approval (where necessary) • Identify verification methods (photo of sites, record the interview, etc.) • Build a data management system to control the quality of data, storage and security of the data. • Select and train data collectors to ensure they are skilled – consider incentives carefully but ensure remuneration. • Provide supervision and TA during data collection • Organize community validation workshops to share the collected data and agree on common themes/priorities for advocacy.
How do we ensure communities own the data they collect?	• Develop data sharing agreements and principles from the outset on the roles of each party; the ownership of data by the community and how that is represented; and the compliance of the parties. These agreements and principles should be disseminated widely. • Develop a mechanism (possibly through a third party) to monitor compliance to the above agreements and principles and a process for understanding and ensuring compliance – why is the "party" having difficulty complying? How do they get support to better comply? • Capacitate the community on data storage and protection, on effectively presenting the data to their constituents, public, government, policy makers, etc. • Develop a process to regularly update the community on CLM progress, CLM data/findings, and then collect community feedback and respond to feedback received. • Organize dissemination workshops to share the CLM findings and results with the community and ensure the results are accessible to the community.

4.4 Data sharing and link to advocacy

Guiding Questions	Key responses

A core challenge for CLM implementers is community involvement in data presentation and using the data for advocacy. What needs to happen for CLM implementers to be able to present data to decision-makers?	• Identify what is needed by who (decision makers), when and how (different communication and engagement methods might be required). • Ensure adequate skills, capacity and experience to compile, synthesis, analyze multiple data sets from multiples sites and multiple indicators. • Agree on messages and visuals that best "tell the story" at different levels – local/facility, district, provincial/state and national.
What needs to happen for CLM implementers to be able to conduct evidence-driven advocacy more effectively?	• Have a plan, structure, process for data control, reporting and use. • Build capacity around data analysis, communications and advocacy. • Conduct a stakeholder mapping to be able to target advocacy and CLM data use more strategically and effectively. • Ensure adequate budgets for advocacy-related activities.
How can implementers best document the advocacy actions they take, to later show results?	• Track the process (i.e., "how" advocacy was done) around planning, coalition-building, communications methods used, meetings where data is presented, reactions to data and time needed for each step. • Track the outcomes and actions – immediate actions and resolutions as well as long-term processes leading to impact.

4.5 Value for money technical assistance

Guiding Questions	Key Responses
How can TA better support implementers facing challenges carrying out data analysis, using data for advocacy, and tracking advocacy results?	• Conduct an assessment to understand capacity and subsequent TA needs. • TA needs should include – support for development of advocacy frameworks to put CLM data to use, skills transfer plans for sustainability; quality assurance and data management, differentiate between advocacy and health promotion/education.
How can we structure longer-term TA funding?	• TOR can be staged and/or reflect phases of CLM implementation with corresponding technical support needs identified for each phase. • Mobilize domestic funding and support budget advocacy at the local level.

	• Get full funding up front for long-term TA that allows for flexibility to determine and adjust activities and deliverables based on the evolving needs.
How can TA reach and support communities who are not online / need offline tools and support?	• Design TA for the context (i.e., disease, population, etc.). • Link capacitated community organizations with others who may need additional support

4.6 Turning principles to practice

Guiding Questions	Key Responses
In many countries, CLM is being implemented in a manner that is out of step with the guidance set out by UNAIDS and other partners. What solutions can we propose to remedy this?	• The UNAIDS guidance should be understood and agreed to by all CLM stakeholders from the start and adherence to the principles in the guidance should be monitored as the CLM program evolves. • All stakeholders – donors, technical agencies, CLM implementers, TA providers, governments – are responsible for monitoring that they are adhering to / supporting / enabling adherence to the principles. Develop a "diagnostic" tool to monitor routinely if on track. • Ensure course corrections are made if not on track – revisit implementation arrangements, workplans, budgets, processes, etc. • Improve transparency among partners at the national level.
How do we address challenging operating environments where it is hard to implement according to the core CLM principles? For example, when there are not independent community-led networks or organizations who can take the lead as is the case in some countries or in some disease contexts (i.e., malaria).	• Set an aspirational goal for CLM centered around community leadership – do this in incremental phases, monitor milestones and develop a roadmap for the goal. • In settings where there is no civil society space, and/or the political context criminalizes specific populations, identify how to get government buy-in by learning from other countries (south-to-south learning), sharing across diseases. • Address structural problems that contribute to inequality; invest in the enabling environment for CLM uptake.
How do we support contexts where communities are partially, but not fully, leading to become in charge and independent?	• Bring together groups to share experiences – establish a community accreditation model. • Develop a check-in mechanism to assess CLM quality. • Build capacity of community to be independent and empowered by improving skills, helping

	create financial sustainability and mentoring (country, region) via a community of practice model.

4.7 Community-led solutions: CLR, CSS

Guiding Questions	Key Responses
What other community-led responses should be invested in, in addition to CLM?	• Other issues that impact communities such as GBV, maternal health, SRHR. • Broaden scope of CLM to monitor other sectors beyond health (e.g., human rights, socioeconomic issues, education – promoting health in schools via curricula with students at all levels.
What is the combination of community-led responses (including CLM) to enable the communities to truly lead on addressing their health, human rights and funding needs?	• Need to invest in community structures for monitoring – it's a long-term endeavor. • Funding is needed for advocacy. • Be intentional about strengthening community leadership and institutions. • To be ready to implement CLM, communities need skills, training, tools and human resources.
How can we build "ecosystems" for CLM and other community-led responses to take root, grow and be brought to scale?	• Reach out to other groups for advocacy – women's, men's, churches/faith-based communities, human rights groups, agriculture and environmental groups (e.g., forest, indigenous groups), service organizations (e.g., Rotary), research and academic institutions to support community-driven research. • Ensure diverse community representation on health committees.

5. Funding Opportunity Updates

5.1 Robert Carr Civil Society Networks Fund (RCF)

Robert Carr Fund presented on "10 Years Stronger Networks, Stronger Communities." The Robert Carr Fund is an international pooled funding mechanism working to strengthen regional and global civil society and community networks; empower, involve and serve inadequately served populations (ISPs); and achieve results on HIV, health, inclusion and wellbeing. The fund was named after Dr. Robert Carr to honor his memory and to recognize his contributions to the global HIV response. RCF holds civil society and communities at the center of its vision and mission as a Fund.

Most of the RCF budget is allocated to advance human rights, improve access to and quality of services, and resource accountability. The presentation showed RCF support for CLM implementation within the 2019 – 2021 core funding round timeline including:

- 24 grantees in 60 regional and global civil society and community-led networks.
- RCF support for CLM implementation under the COVID-19 mitigation funding round as a short-term initiative. The objective of the short-term initiative was to mitigate the impact of COVID-19 on the HIV response for inadequately served populations, with PEPFAR and UNAIDS support to conduct CLM programs that strengthen community systems, programmatic capacity building, including CLM, advocacy, TA for community-led implementers of GF-funded programs, and addressing programmatic needs and gaps.

5.2 The Global Fund

The new Global Fund Strategy 2023-2028 includes scaling-up enhanced community-led monitoring (CLM) approaches to generate, utilize and share data to inform strategic, financial and programmatic decision-making at national and sub-national levels. The strategy will ensure accountability for results, including by supporting programs to systematically monitor and report on health service availability and quality, and human rights and gender-related barriers to services.

The Global Fund has undertaken several changes to help facilitate funding for CLM in the next allocation period, including revisions to the Global Fund Modular Framework and Community Systems Strengthening Technical Brief, updated core disease and RSSH information notes. These include:

- Changed intervention name from “Community-based monitoring” to "Community-led monitoring" in line with global guidance.
- Name and scope of intervention updated to align with new technical guidance, including: "UNAIDS (2021) Establishing community-led monitoring of HIV services — Principles and process" and "Stop TB (2021) OneImpact Community-Led Monitoring Framework Empowering Communities to End TB."
- Updated main description of intervention to align with the latest guidance (UNAIDS 2021; Stop TB 2021) and specifically mentioned examples of what CLOs are (e.g., networks of TB survivors; key population networks, etc.).
- Clear definitions and examples of what "community-led organizations" mean are added directly in the scope text.

There have also been several additions:

- Specifies that CLM should be done in public health facilities and community settings.
- Added "Development of national community-led monitoring frameworks" to intervention scope.
- Community engagement in oversight mechanisms to be much more about CLM data use for decision-making and advocacy in these spaces.

- The revised modular framework also emphasizes community-led data storage and use.

5.3 PEPFAR

PEPFAR acknowledged the importance of engaging with communities in the development and implementation of HIV programming from COP20 and continuing onward to future COPs. PEPFAR defines CLM as 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 that gather quantitative and qualitative data about HIV services. CLM has been central to PEPFAR's client-centered approach because it puts community needs and voices at the center of the HIV response. While total PEPFAR CLM funding decreased slightly from COP21 to COP22, USAID and CDC allocations increased. The top six funded PEPFAR CLM programs were in Africa.

Recent PEPFAR changes that are supportive of CLM for upcoming funding include:

- A reimagined strategy that includes five pillars: Health Equity for Priority Populations, Sustainability, Health Systems and Security, Partnerships, and Science. The three enablers of these pillars are Community Leadership, Innovation, and Leading with Data.
- New PEPFAR guiding principles include Respect/Humility, Equity, Accountability/Transparency, Impact and Sustained Engagement.

Funding challenges: The U.S. government cannot directly fund non-registered entities, which can impact CLM implementers such as KP networks. However, one solution is that UNAIDS has relatively more flexibility, and the ability to fund non-registered organizations. If needed, UNAIDS can be an intermediary between PEPFAR and small, community-based and -led organizations.

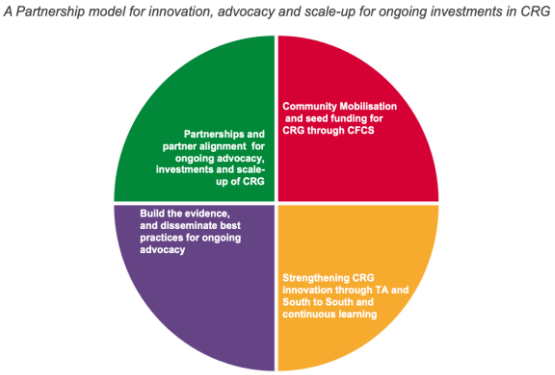
5.4 Stop TB Partnership

The Stop TB Partnership presented its Challenge Facility for Civil Society (CFCS).

CFCS is the leading grant mechanism for CRG TB for grassroots and affected TB community organizations. It also supports affected TB communities and civil society working at the national, regional and global levels to transform and focus the TB response on community-led engagement, human rights and gender equality to end TB.

Within rounds 1 to 10, 230 grants in 47 countries have delivered USD 13,540,000. In the new CFCS 11, 332 proposals from 29 countries have requested USD 10.5 million. The expected outcomes are the mobilization of affected TB Communities and key and vulnerable populations for engagement and advocacy. OneImpact is a CLM platform that is currently pilot testing in 26 countries and two regional community networks to expand and scape up CLM.

The CFSC model:



6. Building our Toolbox

Many participant organizations' have produced CLM resources over the last few years on a range of topics related to CLM and advocacy. During this session, a marketplace was organized where organizations were given an opportunity to share their CLM guides and respond to specific questions from participants. These resources* included the following and can be found in the CLM Toolbox.

NAME OF ORGANIZATION	NAME OF CLM GUIDE
Australian Federation of AIDS Organizations (AFAO) and partners in Asia Pacific under the Global Fund SKPA Program	Sustainable Community-Led Monitoring of HIV Services: A Toolkit for Key Populations
Community-led Accountability Working Group (CLAW)	Conflict of Interest in Community-led Monitoring Programs Rough Guide to Influencing and Monitoring PEPFAR Country Programs
EANNASO-ITPC Global-Health Gap-CRG Regional Platform for Anglophone Africa	Integrating Community-Led Monitoring into C19RM Funding Requests

FHI 360 EpiC Project	Community-Led Monitoring Technical Guide
Frontline AIDS	Gender REAct User Guide REAct User Guide A Practical Guide: Implementing and Scaling Up Programmes to Remove Human-Rights Related Barriers to HIV Services
ITPC Global	From Insights to Evidence: A guide for translating program and policy priorities into qualitative and quantitative measures for Community-Led Monitoring How to Implement Community-Led Monitoring: A Community Toolkit Precision in a Pandemic: A Data Quality Assurance Guide for Community-led Monitoring During COVID-19
Stop TB Partnership	Community-Led Monitoring Framework: Empowering Communities to End TB
UCOP+ DRC	Data collection tools for the HIV-TB observatory in DRC
UNAIDS	Establishing community-led monitoring of HIV services Frequently asked questions: Community-led Monitoring
U.S. Centers for Disease Control (CDC)	Four Models of CBM

**This is not an exhaustive list of all CLM guides and resources available globally but represents those that have been developed by participant organizations of the meeting.*

Additional guides and resources are currently in development. These were shared during the meeting by the organizations:

- Impact Santé and CS4ME - Community-Led Monitoring Guide for Key Malaria Programs for Civil Society Organizations
- UNAIDS Progression Matrix for CLM
- International AIDS Society - Community-Led Monitoring (CLM) of programs and policies related to HIV, tuberculosis, and malaria: A guide to support inclusion of CLM in funding requests to The Global Fund

Finally, based on their experiences, participants identified several other guides and resources that would be useful to develop in the future:

- Directory of all CLM guides and resources for quick reference by new consultants, writers, and people working on CLM
- Guide on how to engage communities in CLM implementation
- Brief on the role of CLM within health systems
- Guide on getting CLM into National Strategic Plans and budgets
- Guide on how to expand CLM funding to the private sector

7. CLM and Sustainability

Sustainability of CLM activities and programs was raised in the pre-meeting survey also by participants prior to the meeting as a discussion topic despite CLM being a relatively new community intervention. As such, a dedicated session on CLM and Sustainability was included in the agenda. A framing presentation provided context for the discussion as to generally what is needed to achieve sustainability of CLM:

1. Majority of funding for CLM is from external donors. Government political will needs to exist prior to donor disengagement.
2. Fully funded CLM programs are necessary in the fight for genuine sustainability in HIV, TB and malaria overall.

Participants were divided into two groups and were assigned questions to discuss.

Questions	**GROUP A** **Securing sustainability of CLM programs**	**GROUP B** **Ensuring CLM programs increase the sustainability of HIV, TB, malaria and KP response**
What is possible or desirable?	-Increased and more predictable funding (move away from "trickles" of funding) for CLM programs from diversified sources (e.g., private sector, GF leveraging relationships with other donors, etc.) -Evidence of government buy-in through inclusion of CLM in countries national strategic plans -Common understanding of CLM principles -CLM mainstreamed across the health and community systems	-Connection with budget monitoring groups -Broaden CLM scope beyond the three diseases and target universal healthcare agendas, health security, pandemic preparedness and other community-led concerns -Identifying various funding sources (e.g., mechanisms by local government to fund local CSOs to plan and implement CLM

		with sustainability in mind at the beginning)
Threats	-Changes in the government that could influence buy-in (positive or negative) -Changes in donor priorities -Strength of a CLM program – is it structured and implemented solidly enough to generate credible data about the experiences of affected communities?	-CLM data not valued as an important contribution to the overall health information system -Limited or reduced space for CLOs to engage with decision makers to share CLM data and have it acted on
Vision for 1-2 years from now	-Better understanding of CLM at all levels starting at the local level -Greater involvement of affected communities in CLM overall (not just as CLM implementers, but as advocates for using CLM data for change)	-Support for a type of "CLM Center of Excellence" or "CLM Resource Centre" to support CLM stakeholders to set up, improve and scale up CLM programs -CLM considered integral to universal access to health, health security, pandemic preparedness and not just for the response to the three diseases -Increased government commitment to CLM (no more resistance)

8. Actions by CLM stakeholders over the next two years

Meeting participants represented different types of CLM stakeholders, including 1) CLM implementers; 2) CLM TA providers; 3) donors of CLM programs and or TA; 4) technical agencies supporting CLM. Based on the discussions over the first two days, each stakeholder group presented the actions they committed to. These were presented at the meeting and are intended to encourage further discussion within and across stakeholder groups to continue to support the future evolution of CLM.

8.1 CLM Implementers

- ✓ **Improved use of CLM data for advocacy**; organize more events to promote CLM and its valuable contribution to improving health services.

- ✓ Support the design of and **contribute to a CLM Center of Excellence** / Research Center / Repository of Resources – ensure resources can be accessed locally and regionally, consider languages used in different countries to make it accessible.
- ✓ Enhanced **advocacy coordination** with all CLM implementers in a country.
- ✓ Plan for and **mobilize resources** for introducing or scaling up CLM to cover geographic areas, and across diseases.
- ✓ Establish partnerships with CLM implementers working on other diseases across countries.
- ✓ Work with the **GF CCM/PR to ensure that CLM is integrated** into grants and sufficiently budgeted including payment for data collectors.
- ✓ Write **success stories from CLM programs** from the community perspective; document testimonials on CLM – community leadership strengthened through CLM, community empowerment as a result of CLM, advocacy victories (i.e., improved policies and services; increased and/or re-directed funding).
- ✓ Engage more in documenting, planning, requesting TA based on identified needs (in a timely manner).
- ✓ Take advantage of opportunities for GF re-programming to solidify or expand CLM budgets when funds for implementation are insufficient to appropriately implement, scale up and/or improve the CLM program.

8.2 TA Providers

- ✓ Utilize existing spaces and/or create a new focused online and offline space where TA providers can **exchange information and troubleshoot challenges to TA** set up, implementation, budgeting and documentation; consider if these spaces are internal for TA providers only or accessible to CLM implementers and communities.
- ✓ Document **emerging learning**, particularly around south-to-south sharing of expertise.
- ✓ Strengthen TA offerings around the unmet needs of CLM implementers, such as **working in conflict settings, challenging operating environments** (COE) and/or on diseases not well covered such as malaria.
- ✓ Leverage the power of TA provider networks and broader global community networks to ensure **TA can be deployed rapidly and flexibly** to address issues as they arise.
- ✓ Document TA needs during TA implementation and identify potential funding to support these needs.

A joint position statement was also presented by the CLM TA providers during the meeting which recommended important areas for donors to consider in how they support and fund CLM implementation and TA going forward.

8.3 Donors

- ✓ Conduct exploratory analysis into **pooled funding options**, including establishing new pooled funding mechanism(s), expanding/diversifying existing pooled and funding mechanisms, among other opportunities.

- ✓ Where possible/appropriate, **increase direct funding to PLWHA/KVP community-led partners**, reducing overhead costs associated with "pass-through" mechanisms.
- ✓ Funding and strategy development updates: **Points of contact at donor agencies** will provide updates on upcoming funding opportunities (Global Fund, Robert Carr Fund) and ways of engaging in the PEPFAR COP and guidance development process.
- ✓ Rapid Response: Points of contact at donor agencies working on CLM will routinely meet to discuss challenges raised internally and through community and implementing partners with the goal of rapidly responding to these events in a coordinated manner.
- ✓ Streamline and better **coordinate the availability of technical support** to and by CLM implementers.
- ✓ Convene annual/biennial CLM meeting: **Support an annual or bi-annual CLM convening** to follow up on progress on CLM community roadmap; share lessons learned, tools and resources; address implementation, coordination and other challenges; and expand and deepen the CLM community of practice.
- ✓ Change organizational mindsets and practice: **Build internal capacities on CLM,** principles, results and process through knowledgeable donor staff, engagement with governments and others to reduce skepticism and support buy-in.
- ✓ **Capture and communicate results**: Support implementers to more consistently document results/impact to increase evidence base for CLM implementation and enhance peer-to-peer learning.

8.4 Technical Agencies

- ✓ Advocate for the core **principles and models** of CLM to be adhered to by:
  - (Re)committing to these principles and models
  - Advocating for other UN agencies, technical partners, funders, TA providers, global, regional and national networks and community organizations to sign-on
  - Leading an effort towards a routine recommitment and adherence to these CLM principles as demonstrated by a published and endorsed internationally agreed CLM consensus on principles
- ✓ Foster discussions towards the articulation of how to "**define success" of CLM** in the context of:
  - Mobilization and strengthening of community-led and civil society networks and organizations which is essential to CLM
  - Building a shared understanding of the nuance that is needed to fully capture work and progress; and
  - Work done to date from UNAIDS on the CLM progression matrix that articulates CLM progress from the identification of inputs, output, outcomes and/or process milestones towards
- ✓ Convene and/or improve existing **CLM communities of practice** at the country, regional and global levels that enable communities to participate – being mindful of language needs, time zone issues and cost.

9. Annex

9.1 Models of CLM Implementation

During all days of the meeting, CLM implementers were asked to share their experiences, lessons, successes and challenges. Brief summaries of these models of CLM implementation are highlighted below.

(a) Haiti

L'Observatoire Communautaire des Services VIH (OCSEVIH) from Haiti started the presentation of Haiti's Community-Led Monitoring to share their best practice for models of CLM implementation in the country. The successful implementation was seen from data rooted in the information, including facilities surveyed, observation surveys, patient surveys, facility manager surveys, nurse surveys, departments visited and arrondissements. OCSEVIH noted progress through several success stories in advocacy and strengthened the capacity of its members to execute CLM. A key challenge was data collection in hard-to-reach areas controlled by armed gangs. Despite civil society having been committed to good governance to form solid CLM; evidence of rapid changes; and advocacy at all site and community levels, the PEPFAR local team showed consistent unwillingness to embrace CLM and the empowerment of the community. Several highlighted issues were related to budget and time mechanisms for disbursement. There has been no increase in the budget for CLM activities, and the budget disbursement was late by six months. Despite the success stories, its CLM was unfunded, defunded, and at risk of having to stop its activities.

(b) Uganda

The International Community of Women living with HIV Eastern Africa (ICWEA) from Uganda presented its CLM journey through one of the darkest times in the HIV response. Data indicated that in sub-Saharan Africa, Uganda's incidence was high, with 7% HIV prevalence and incidence being over 40, and PLHIV lost from care. The ICWEA team engaged with PEPFAR processes and invited stakeholders to connect with civil society to identify PLHIV, KPs and vulnerable populations, including migrant populations and persons with disabilities. The process was designed to build a review mechanism for collecting data and information and giving feedback in ten action plan points. During the process, civil society realized the power of data and capacity building through a pilot project to build a coalition for health promotion and social development between the KPs and stakeholders. PEPFAR has supported the pilot phase of a CLM engagement framework for CLM community capacity building to prepare the community to be both "enabled and an enabler." The pilot phase also included citizen education and mobilization. CLM coordination was established between partners: UNAIDS, PEPFAR, CDC and CLM consortium partners held monthly management meetings. An innovative method used during the CLM pilot was an advocacy issue tracker, especially during clinic monitoring. When an issue was identified, it

was documented in an issue tracker to make available a tracking mechanism that would record who resolved it, when, and how it has been measured. CLM in Uganda has strengthened the healthcare system and access to ART treatment for different subpopulations.

(c) India

Swasti from India explained their best practices for CLM implementers. The definition of success was defined as the completion of five stages of the CLM cycle in just five months, starting from identifying and onboarding community champions; collection of information by community champions and analysis; co-developing solutions and action-based plans on the community report card; doing a follow-up action on the strategic plans, and tracking and showcasing success. The success practices were followed by the implementation of availability, accessibility, acceptability, affordability, and appropriateness of the documentation in compliance with various guidelines and protocols. There have been systematic routines set up by the community and a robust community system to train champions. The factors that create pride are community leadership and the ability to demonstrate community-led collaboration.

(d) Malawi

The Civil Society Advocacy Forum reported that the HIV and AIDS response in Malawi has benefitted from PEPFAR investments since 2004 to accelerate the achievement of 95-95-95 targets and sustain epidemic control. The Civil Society Advocacy Forum (CSAF), made-up of over 40 organizations working in the HIV and AIDS sector from Malawi, presented the implementation of community-led monitoring projects in the country. CLM was defined as a process through which community members collect and analyze data on issues that affect them and use it to organize, campaign and advocate for their rights. The engagement process was bottom-up from the district to the national level, including PEPFAR, the Global Fund, the government and even parliament. Commitments because of CLM have been made at different levels, such as the construction of a new ART clinic, training of female nurses and service provision through mobile clinics. CSAF are in the middle of implementing an acceleration for data collection, generating evidence for improvement of PEPFAR programming and strengthening CSO's capacity to conduct CLM. Some setbacks noted from the presentation include delayed funding and limited on-sight support from UNAIDS and CDC due to COVID-19.

(e) Myanmar

The Myanmar Positive Group started the presentation by explaining there was a concentrated epidemic among key populations (FSW, MSM, TG, PWID) with an estimated number of 270,000 PLHIV as of March 2022. More than 90% of HIV prevention and linkage to care services are provided by CSO partners such as I/LNGOs and CBOs and nearly 80% of the ART cohort receive care in public health facilities and the rest by CSO partners. The success story was explained in relation to implementation and partnership. Community

Network Consortium (CNC) (HIV) is a coalition of eight national-level community networks including three KPs networks, a national PLHIV network, a women's PLHIV network, a YKP network, a national NGO network and an interfaith network. Myanmar Positive Group (a PLHIV network) takes the lead in the implementation. CNC and technical partners, donor representatives, and CSO partners representatives function as a community consultative group (CCGs).

CNC holds monthly meetings, and it promotes trust, communication, and accountability among community networks, who can prioritize and agree on advocacy issues. ITPC has provided technical assistance. CLM was conceptualized in the country as Community Feedback Mechanisms (CFM), established in 2017 and acknowledged by MoH in 2019, as these two are based on the same principle of a community-based approach. Through repeated meetings and discussions, UNAIDS led collaboration with different funders and convinced the different implementers to work on the same CLM platform. The Global Fund, UNAIDS and PEPFAR collaborated technically, programmatically and financially to set up a single CLM system for monitoring HIV service facilities around the country. As a result of CLM, there had been improvement in the health facilities in terms of expansion of health services sites and collaboration from the community. Several challenges for the pilot phase included safety and security concerns for data collectors and respondents due to political crisis and conflict areas. COVID-19 prevention measures have been a concern by the data collectors, respondents and facility sites. The next steps that the organization will take include reviewing the pilot phase and improving CLM tools and methods, strengthening community networks and its consortium to maintain CLM, promoting CLM in existing sites and scaling up the sites in January 2023 based on available funding.

(f) Namibia

The Society for Family Health (SFH) from Namibia presented on "Namibia CLM Model Process and Achievement to Date." The presentation explained the support from the U.S. for Namibia in pushing and accomplishing a cycle of CLM stages from data collection; analysis and translation; engagement and dissemination; advocacy; and monitoring to fight TB in the country. In 2021, there were a total of 77 health facilities covered by CLM. The success story includes a high level of government buy-in, especially through the data collection methodology and data sharing. Data methods utilized were focus group discussions and individual interviews through referrals for young people, KPs from PLHIV networks and Community Adherence Groups (CAGs) and health care providers, including pharmacists and nurses.

The CLM key findings revealed that there was a disruption during the COVID-19 situation in the availability of services, including the inability to use multi-month dispensing and facilities stocked out of adult ARV 1st line and family planning commodities due to poor monitoring and procurement, poor quantification, late deliveries and human resources capacity. Moreover, the community also reported that 15% of the population had missed at least one HIV-related clinical appointment in the last three months, indicating a higher HIV-related

stigma. The presentation offered several recommendations, including strengthening the capacity of health facilities/districts on logistic management to prevent stock-outs, ensuring all facilities consistently roll out differentiated service delivery (DSD) model, scaling up community education on PEP and PrEP, establishing more CAGs and outreach points in communities that are far from health facilities, continuing to promote a friendly environment for PLHIV including KPs, and strengthening the capacity of health staff to be KP competent in the provision of comprehensive services.

(g) Sierra Leone

In Sierra Leone, the Civil Society Movement Against Tuberculosis (CISMAT) brought together CSOs from the TB community to serve as a watchdog for facility level CLM. There were immediate results including improvements from national service delivery. There was a successful intervention to invite more people to come out against the social stigma of TB and a surge in knowledge about TB prevention and rights. The knowledge gap has been far reduced, and the issue of human rights for TB communities was highlighted with the government and parliament. The challenges that still linger include limited funding and independence of CLM. There has been inadequate technical support to scale up CLM programs.

(h) Vietnam

Lighthouse from Vietnam showcased best practices for CLM in the country in terms of KP-friendly models that highlight the collaboration between the community, health providers under the support of technical organizations, including the Ministry of Health and other technical partners. CLM activities included capacity-building training to provide mentorship and technical assistance to improve the quality of health facilities with consensus from multi-stakeholders. There were also toolkits and methodology to conduct client surveys. The data collection process was reliable, and the data were stored in one portal for further analysis and access to the health facilitators. There has been a reduction in clinic waiting time from 60 minutes to 16 minutes, and an increasing percentage of client awareness of the viral load – from 48% to 85%. However, the real challenge is maintaining this success model and expanding to serve more people from the affected populations.

9.2 List of Invited Organizations

CLM Implementers	
Jamaican Network of Seropositives (JN+)	Jamaica
Jamaica Forum for Lesbians, All-Sexuals and Gay (J-FLAG)	Jamaica
Civil Society for Malaria Control Immunisation, and Nutrition (ACOMIN)	Nigeria
Civil Society Movement Against Tuberculosis Sierra Leone (CISMAT-SL)	Sierra Leone
Alliance Cote d'Ivoire (CIV)	Cote d'Ivoire
L'Union Congolaise des Organisations des Personnes Vivant avec le VIH (UCOP+)	Democratic Republic of Congo
International Community of Women living with HIV Eastern Africa (ICWEA)	Uganda
Treatment Action Campaign (TAC), PLHIV Sector, Ritshidze Project	South Africa
Society for Family Health (SFH)	Namibia
Malawi Network of AIDS Service Organisations (MANASO)	Malawi
Myanmar Positive Group (National Network of People Living with HIV)	Myanmar
L'Observatoire Communautaire des Services VIH (OCSEVIH)	Haiti
Lighthouse Social Enterprise	Vietnam
Thai Network of People Living with HIV/AIDS (TNP+)	Thailand
SWASTI	India
Pyi Gyi Khin (PGK)	Myanmar
Associação Mocambicana para a Ajuda de Desenvolvimento de Povo para Povo (ADPP)	Mozambique
Khmer HIV/AIDS NGO Alliance (KHANA)	Cambodia
CLM Technical Assistance Providers	
International Treatment Preparedness Coalition (ITPC) Global	

Health GAP (Global Access Project)
O'Neill Institute at Georgetown University
Eastern Africa National Network of AIDS and Health Service Organizations (EANNASO)
Asia Pacific Council of AIDS Services Organizations (APCASO)
Alliance for Public Health Ukraine (ATAC)
CLM Donors and Technical Partners
The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
Joint United Nations Programme on HIV/AUDS (UNAIDS)
United States Agency for International Development (USAID)
Centers for Disease Control and Prevention (CDC)
Office of the U.S. Global AIDS Coordinator and Health Diplomacy (S/GAC)
Bill & Melinda Gates Foundation (BMGF)
International AIDS Society (IAS)
Stop TB Partnership (STP)
Robert Carr Fund (RCF)
Aidsfonds
Love Alliance – East African Sexual Health and Rights Initiative (UHAI EASHRI)
Frontline AIDS
Bangkok-based Partners
Asia Pacific Coalition on Male Sexual Health (APCOM)
UNAIDS Regional Support Team (RST)
Embassy of France to Thailand
Family Health International (FHI 360) – Meeting Targets and Maintaining Epidemic Control (EpiC) Project

USAID Thailand
Australian Federation of AIDS Organisations (AFAO) – Global Fund Multi-country Grant / Sustainability of Services for Key Populations in Asia (SKPA-2)
Malaria Free Mekong – Global Fund Multi-country Grant / Regional Artemisinin-resistance Initiative (RAI3E)