



A global exchange on the role of Community-Led Monitoring (CLM) in malaria programming

Meeting Report

June 1-2, 2023

Cape Town, South Africa



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Acronyms and Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality
ALMA	Africa Leaders Malaria Alliance
CATs	Community Accountability Teams
C19RM	COVID-19 Response Mechanism
CBM	Community-based Monitoring
CBO	Community-based Organization
CCM	Country Coordinating Mechanism
GC7	[Global Fund] Grant Cycle 7
CLAW	Community-led Accountability Working Group (CLAW)
CLM	Community-led Monitoring
CLM-SI	Community-led Monitoring Strategic Initiative
CLR	Community-led Responses
CLO	Community-led Organization
CRG	Community, Rights and Gender
CRSPC	Country/Regional Support Partners Committee
CS4ME	Civil Society for Malaria Elimination
CSO	Civil Society Organization
CHW	Community Health Worker
CSS	Community Systems Strengthening
DHIS	District Health Information System
EHRGE	Equity, Human Rights, Gender Equality (EHRGE) and Malaria
FBO	Faith-based Organization
ESA	Eastern and Southern African
HCW	Health Care Worker
HRH	Human Resources for Health
ITN	Insecticide-treated nets
IPTp	Intermittent preventive treatment of malaria in pregnancy
ITPC	International Treatment Preparedness Coalition

LGA	Local Government Areas
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NACA	[Nigeria] National Agency for the Control of AIDS
NMCP	National Malaria Control Programme
NSP	National Strategic Plan
NFM3	New Funding Model 3
NGO	Non-Governmental Organization
PHC	Primary Health Care
PR	Principal Recipient
SR	Sub-recipient
RCF	Robert Carr Fund for Civil Society Networks
RBM	RBM Partnership to End Malaria
RSSH	Resilient and Sustainable Systems for Health
TA	Technical Assistance
TB	Tuberculosis
ToR	Terms of Reference
TRP	Technical Review Panel
UHC	Universal Health Coverage
WDS	[Nigeria] Ward Development Committees
WHO	World Health Organization

1. Background

1.1 History and context

In 2020, there were an estimated 241 million malaria cases and 627,000 malaria deaths worldwide¹. Renewed global donor commitments to ending malaria offer a critical moment to finally bridge the gap in providing life-saving malaria services for high-risk and underserved populations through community-led, people-centred approaches such as community-led monitoring (CLM). Innovations to maximize progress toward and improve investment efficiency in this global goal are urgently needed.

As a significant donor to malaria, the Global Fund, providing 63% of all international financing for malaria programs, has raised the alarm on recent threats to malaria control, “one of humanity’s most significant public health successes.”². It notes that “funding has plateaued, drug and insecticide resistance are increasing, and climate change threatens to push malaria transmission into new regions. The new [Global Fund Strategy](#), as well as the [Community Systems Strengthening](#) and [Equity, Human Rights, Gender Equality \(EHRGE\) and Malaria](#) Technical Briefs, recognize that EHRGE-barriers further undermine an effective response to malaria and has acknowledged the importance of addressing the needs of high risk and underserved populations as we move toward ending malaria. These documents also underscore the critical role of communities and civil society, which are often best positioned to identify barriers to their health outcomes and guide and implement health programs to respond to their diverse needs effectively.

Community-Led Monitoring (CLM) for Malaria

Community-led monitoring is a powerful model for sustainably improving access to and quality healthcare services, including strengthening accountability for removing EHRGE-related barriers. Through CLM, healthcare service users/affected communities design and carry out routine data collection and analysis, leading to data-informed advocacy on barriers to healthcare that they have defined as priorities. CLM data is a critical complement to other monitoring and evaluation efforts conducted by governments. The CLM model builds on decades of global civil society advocacy efforts to improve the right to health. CLM is rooted in core principles of community ownership and independence in monitoring and advocating for people-centred solutions for equitable access to quality healthcare services while promoting accountability and more robust health systems at the government level. CLM enables an integral feature of the right to health: the active and informed participation of individuals and communities in health decision-making that affects them.

¹ World Malaria Report (2021), World Health Organization. Available at: <https://www.who.int/publications/i/item/9789240040496>

² Results Report (2022), The Global Fund. Available at: <https://www.theglobalfund.org/en/malaria/>

CLM has already proven to be an effective intervention. CLM for HIV and TB have catalyzed progress to improve programs and service delivery through strengthening the capacity of civil society to regularly engage with and advocate service providers on (a) what is deficient and (b) what is working well and should be scaled up. However, there are few examples of CLM implementation for malaria compared with HIV and TB, primarily due to differences in the historical evolutions of the disease response. Furthermore, CLM for malaria is often confused with community-based monitoring (CBM) and it is important to understand how they differ.

CBM is often led by community health workers (CHWs), services providers, and sometimes government-led initiatives, whereas CLM is intended to be led by independent affected populations. However, malaria typically affects whole communities according to geographical location; therefore, CLM can require entire malaria communities to be engaged, rather than the specific affected communities involved in driving CLM for HIV and TB.

Given the launch of the new Global Fund Strategy and the ongoing GC7 processes, as well as learning from CLM for HIV and TB services in recent years, now is an opportune time to reflect on how malaria CLM can be implemented in a way that strives towards globally adopted CLM principles.

A global exchange on the role of CLM in malaria programming

On June 1-2, 2023, the Global Fund with local host, the International Treatment Preparedness Coalition (ITPC) Global, organized the first-ever global exchange on community-led monitoring (CLM) for malaria. The meeting focused specifically on building a common understanding of how malaria CLM can be implemented in a way that is underpinned by globally adopted CLM principles, and to learn, share and explore how CLM can be a useful intervention to support better malaria outcomes in the current Global Fund grant cycle (GC7).

The meeting brought together 60 diverse participants from 15 countries.³ Participation included government officials from National Malaria Control Programmes (NMCP), representatives from development and technical partners, members from civil society organisations (CSOs), frontline community health workers and affected communities working in malaria programming.

³ Burkina Faso, Cameroon, Central African Republic, Côte d'Ivoire, Democratic Republic of the Congo, Indonesia, Malawi, Ghana, Kenya, Rwanda, Tanzania, Thailand, Uganda, Venezuela, Zambia

As a supplement, a Dropbox folder has been created with all of the meeting [presentations, recordings and photos](#).

1.2 Meeting purpose

The objectives of the June 2023 meeting were to:

- Build an understanding of CLM principles and approaches among implementers, TA providers and regional partners, including sharing of experiences of CBM/CLM implementation in malaria contexts.
- Define how to apply CLM principles to the malaria context and build an understanding of its relevance to optimize national and community responses towards malaria control and elimination.
- Share CLM tools/resources/guides to support CLM strategy development and implementation of CLM interventions in GC7 malaria grants.

1.3 Expected outcomes

- Gain a shared understanding of applying CLM principles into practice in the context of malaria programs.
- Increase knowledge of successes and challenges to CLM for malaria implementation.
- Identify priorities for a collectively owned action agenda to support the piloting and implementing of a malaria specific CLM model, including opportunities for learning among implementers.
- Identify funding opportunities for implementation and technical assistance (TA) to establish, improve and/or scale up CLM for malaria activities/programs/mechanisms.

2. Day 1: Thursday, June 1, 2023

2.1 Participant expectations

The meeting opened with participants sharing their expectations for the two days. Participants shared that with CLM being a new concept in the malaria response, it required socialisation around: (i) the definition and overall understanding of CLM; (ii) appreciation of the differences between CBM and CLM. (iii) learning from existing CLM modalities in HIV and TB; and (iv) need for immediate sharing on CLM with other stakeholders in their respective countries given that some countries had already submitted their GC7 funding requests which did not include any CLM interventions or budget.

2.2 Global Fund support for CLM in malaria programming

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

The Global Fund presented global malaria trends, Global Fund malaria allocations (current and past grant cycles), its malaria investment areas and program essentials, and opportunities for CLM malaria programs. The Global Fund has aligned its investments to support the [Global Technical Strategy for Malaria 2016-2030](#), which targets a 90% reduction in malaria incidence and mortality by 2030.

Key features of the presentation included the Global Fund's efforts to support countries through their malaria planning, funding request development, target setting, programming, and technical assistance. The presentation highlighted the importance of malaria programming requiring a multisectoral response – especially in low-resourced, high-burden and elimination settings.

When reviewing how the Global Fund could support countries improve their response to malaria, key elements focused on the evolution of trends and the need for new ways of working. This included:

- **Innovation:** Innovation in products and service delivery models is needed to address the emerging challenges. Malaria programs should be more responsive and community centred, as well as include the five essential human rights programmatic areas that are a pre-requisite in the Global Fund's EHRGE and Malaria Technical Brief.
- **Funding:** The Global Fund contributes 63% of donor funding for malaria. This is implemented through national, regional and multi-country grants. The Global Fund allocation for malaria is \$4.1 billion between 2023-2025.
- **Opportunities under the GC7 funding requests:** The current GC7 process was noted as a window of opportunity for countries to apply for funding to design and implement CLM. Even those countries that did not incorporate CLM interventions into their GC7 funding requests still have an opportunity to generate a case for the inclusion of CLM during grant-making. Countries under future application windows have an opportunity to prioritise CLM in funding requests to respond to the program challenges. National programs are encouraged to apply to RBM's CRSPC for CLM technical assistance.

The presentation highlighted the four Global Fund Malaria Investment Areas. These include: i) evidence-based decision making, ii) prevention (vector control, preventive therapies), iii) case management, and iv) malaria elimination. Across these areas are 10 cross-cutting considerations. The investment areas and cross-cutting considerations provide countries with opportunities for iteration and responsive programming to ensure supportive environments including addressing structural barriers to access.

CLM was discussed as promoting participatory community engagement by gap-filling the missing qualitative information that national malaria programs may have not explored in detail. Identified benefits of CLM for malaria programs included:

- Increased community engagement – through consistent interaction and sharing of data between CLM implementers, communities and decision-makers.
- Increased understanding of heterogeneity in malaria transmission at national and sub-national levels – data collected through CLM can support further identification of barriers to services for at-risk, hard-to-reach and underserved populations.
- Improved surveillance: data validation or triangulation of data with reports from communities – for example, evidence collected through CLM can be used for shadow reports to share with decision-makers to complement other national program monitoring and surveillance.
- Improved quality of care: giving a voice to affected communities on malaria prevention and treatment services.
- Improved quality of national malaria programs – CLM data can inform design of strategically focused and optimal mixes of interventions that are cost-effective and tailored to community needs. CLM can also help stakeholders to understand what services are needed where, when, and how best to deliver the services to the targeted individual/populations in a way that will maximize impact and address barriers to access.
- Differently from HIV and TB, CLM for malaria will need to involve whole communities in malaria-endemic areas in high burden contexts. In low burden contexts and humanitarian crises, specific populations may need to be addressed (forest goers, miners, migrants, internally displaced, etc.)

The CLM definition in the [RSSH Info Note](#) was shared with participants as “an accountability mechanism that uses an independently structured and planned process designed and led by equipped, trained and paid members of community-led organizations of affected communities, to systematically and routinely collect and analyze quantitative and qualitative data from health service delivery sites (i.e., facility-based and beyond) and affected communities either for a specific disease component (i.e., HIV, HIV/TB, TB, malaria) or broader primary health care.” Effective CLM also ensures that feedback loops are established and engrained into the mechanism from the start so that issues raised by communities are resolved for better services.

CLM can collect data on many aspects, including monitoring commodities, quality of service delivery, and improvement of facilities and malaria posts where services are received. Further, the mechanism can be leveraged to monitor the usage of ITNs, stockouts, quality of care, workforce issues, and equity- human rights-, and gender-related barriers to care.

This would ensure more comprehensive coverage of persons who are often unable to access appropriate healthcare, including (but not limited to) women and children, forest goers, people who work nightshifts, those who live close to rivers, etc.

CLM does not replace CBM which is useful and valuable where CLM may not be feasible or appropriate.

The difference between CBM and CLM was explored, and discussions made clear that existing CBM can be adapted to CLM as needed.

CBM (broader)	CLM (specific)
Any type of monitoring that involves communities <ul style="list-style-type: none"> - Designed by CBOs, CSOs that work in communities - Designed by governments - Designed by donors 	Monitoring that is entirely designed and led by CLOs, CBOs and CSOs coupled with advocacy to act upon the CLM data and results to improve access to and the quality of health care
Monitoring BY any type of community member, including CHWs	Monitoring BY affected communities themselves
Community members serve as data collectors and can be recruited by community-, donor-, government-designed CBM programs	Affected community members serve as data collectors for community-designed and led programs
Data can be integrated directly into the national M&E system	Communities own the data they collect; data is outside of the national M&E system (complement)

2.3 Introduction to CLM for malaria by CS4ME

CS4ME presented its [CLM Guide for Key Malaria Programs](#) which aims to strengthen capacities of CSOs in CLM to improve their contribution to quality monitoring of malaria interventions in communities with a focus on inclusion of CLM in Global Fund malaria grants. This guide forms one of many available tools developed by different partners to support implementers with operationalizing CLM.

The specific objectives of CS4ME's guide are to:

- Provide an understanding of the definition, characteristics, and importance of CLM;
- Enable mastery of the processes of data collection and data analysis;
- Enhance mastery of data quality assurance and the processes of using up-to-date information to improve decision-making; and
- Improve understanding of the steps to implement CLM in communities, with the community as the leader.

While CSOs involved in the fight against malaria are the main audience for the CS4ME guide, it is also intended for CSOs/CBOs working in health more broadly, CCMs, NMCPs/MoH, technical and funding partners involved in malaria elimination. It was highlighted that this guide filled a much-needed gap because there had been no tools for community monitoring of malaria interventions.

The presentation walked participants through the CS4ME CLM Guide. It also summarised the distribution strategy to promote the guide since its launch early in 2023. The launch took place both virtually and face-to-face. The latter took place in Madagascar, Cameroon, Nigeria and DRC.

During its piloting phase, CS4ME learnt that some problems could be easily solved, such as navigating the issue of stock-outs, by working with the government and other partners. At the same time, some are more long-term and structural challenges. Documentation is important to be able to share with governments which helps them to think about how to remedy the problems. CLM is an independent and affected community-led mechanism, which adds value through the collection of qualitative “lived experiences” information and not just quantitative data.

The CLM guide developed by CS4ME may be revised following learning from country-level implementation and based on the key outcomes and principles agreed at this meeting.

2.4 Country examples

During this session, several country presentations were given on community involvement in national malaria programs, malaria in GC7 and CBM/CLM for malaria. It was acknowledged that for malaria, countries are mostly implementing CBM which was viewed as an opportunity for reflection on adaptation to a CLM approach. In some countries, CLM is being implemented for another disease and therefore could be used as an entry point for integration of malaria.

Thailand: Benefits of CBM for hard-to-access & border populations

Thailand has a long history and strong performance of its malaria program services through malaria clinics since 1965. The country aims to be malaria free by 2024 as described in its National Malaria Elimination Strategy 2017-2026. A key challenge is the rise in malaria cases along its border with Myanmar. Community capacity strengthening is part of the country’s adopted *1-3-7 strategy: real-time notification/ investigation/ response*. Existing community-based activities include:

- In endemic areas, at village level, Malaria Post Workers (MPW) & Village Health Volunteers (VHV) provide malaria test and treat services.

- Migrant Health Volunteers (MHV) provides information about access to malaria test and treat services to non-Thai or ethnic minority populations.
- Volunteers monitor treatment adherence, observe effects of drugs, gather data on net use and prevention behaviors, give health education, and assist with net distribution.
- Regular meetings with partners at community levels with Health Promoting Hospitals, Malaria Posts, Malaria Clinics, VHV, MHV, community leaders, and local authority are conducted to monitor and verify bottlenecks.
- Quantitative data from key interventions are collected and can be monitored online.

The presentation was a good example of community-based monitoring mainly to increase coverage of test and treatment services at community levels where target populations can access services, and to improve active case detection at border areas to increase coverage and convenience for those living in remote areas and at migrant work sites/shelters.

Thailand will leverage the CLM intervention under GC7 to address these challenges by establishing more malaria posts at the border where the malaria outbreak occurs and utilising data to see how best CLM can contribute to the effectiveness and sustainability of the overall national response.

Venezuela: CLM is possible among indigenous communities

Malaria is concentrated in the country's south in four endemic states. Risk factors vary considerably across communities and situations: ecosystems, water bodies, dwelling types and locations, domestic space organization and usage, sleep habits, work habits, and human population mobility. Venezuela's malaria response faces many challenges, including: 1) diagnostic network, the main pillar of the national malaria program, lacks resources; 2) weak connectivity and deficiencies in equipment make it difficult to send data online and communicate; 3) non-existent or limited transportation for medical staff and equipment to reach people most affected; and 4) lack of basic equipment to operate and function sufficiently (scales, furniture, billboards, educational material).

In Venezuela, community participation is enshrined in the Constitution. The national malaria program relies on municipal and county level structures that interact and are based at the community level. Groups such as HAWAPO, whose work was presented, originated in the communities themselves and carry out monitoring of the malaria cases in their communities. As such, they explicitly meet the definition of community-led and could be considered as an appropriate CLM implementer. They identified the need for CLM training to support them to improve qualitative and quantitative data collection, and provision of printed data collection tools and pens/pencils as they have no access to technology. Issues to monitor include improving case detection, especially among the most hard-to-access and at-risk

populations, and ensuring better quantification of self-test kits so that the mining sector does not have to procure diagnostics tools by using 'gold' as a commodity.

Malawi: Potential to adapt existing HIV CLM for malaria

Malawi's experience in CLM has primarily been focused on HIV rather than malaria. The country's Principal Recipient (PR), World Vision, has been implementing HIV CLM under the RSSH grant for the past three years with six HIV-focused civil society organisations. CLM approaches under this program include: (i) a community scorecard and (ii) interface meetings. Other CLM approaches implemented in the HIV sector include the Community Treatment Observatory (CTO model) and Stop TB Partnership's OnelImpact tool. CLM has nearly national coverage for HIV, however several challenges were noted:

- No proper plans for coordinated engagement of stakeholders in CLM
- No coordinated CLM platform for sharing best practices
- No proper stakeholder mapping for engagement in CLM
- No detailed analysis of issues being monitored
- No packaging of findings for advocacy
- Lack of recommendations of advocacy issues

The GC7 funding request proposes to expand CLM to five additional districts and to expand the focus areas to include malaria.

Tanzania: Community Score Card integrated CLM

There is no standalone malaria CLM currently being implemented in Tanzania, however community monitoring is carried out through the Community Score Card (CSC) approach which is a community-led governance tool that brings the community, health care facilities and local government structures together to promote accountability and responsiveness to community needs; CSC integrates malaria with maternal, newborn, reproductive and child health.

Through funding from the Global Fund, the CSC approach has been piloted in five regions (Kigoma, Katavi, Geita, Simiyu and Dodoma), and is currently implemented in one additional region through other funding sources. With technical assistance from ALMA, the Tanzania team (Mainland and Zanzibar) visited Ghana to learn about implementation of the CSC and how can it be implemented in Tanzania.

As an example, findings from the CSC have helped to correct community misunderstandings on the use of mosquito nets among male partners, such as "sleeping under mosquito nets causes impotence", and "mosquito nets attract bed bugs". Overall, challenges to the CLM program to be addressed in GC7 include: (i) ensuring a common understanding of what is

CLM is at different levels; (ii) need for additional resources - both time and human resources; and (iii) support and agreement on the CLM data sharing system. The country will continue to seek technical assistance from ALMA to improve implementation of the CSC.

Nigeria: An advanced CLM malaria program

Nigeria is implementing two wide-scale CLM programs supported by the Global Fund through the malaria grant and C19RM/RSSH grants. These programs focus on two key approaches: (i) accountability via use of client exit interviews, key informant interviews and focus group discussions, and (ii) evidence-based and results-focused advocacy led by Community Accountability Teams, which, if needed, escalate issues to State Accountability Teams and the media. The malaria CLM program is being implemented by 208 CBOs across 13 states (out of 36 states), covering a total of 852 facilities. The CLM C19RM/RSSH program is being implemented by 135 CBOs in nine states, and a total of 270 facilities. CLM data collection has migrated from a paper-based system to electronic and real-time data entry on a CSO-created system, ACCOMIS, which has made data collection seamless and easy to analyze.

Several key achievements from the CLM programs include:

- Construction of new facilities/extensions and renovation of dilapidated health facilities (including toilet facilities, bore holes, wells, signposts, perimeter fences, electrification, windows and doors) as well as donation of IPTp, equipment and furniture)
- Government redeployment and redistribution of health workers
- Improved supply of malaria commodities and reduction of stockouts
- Reactivation of Ward Development Committees and formation of Comprehensive Health Centers
- Improved emphasis on gender sensitivities to service providers and community members

Challenges noted through CLM include:

- Persistent stock outs of LLINs and malaria treatment (SP) in PHCs discourages pregnant women from accessing services in the health facilities;
- Lack and inadequacy of road networks / infrastructures making it difficult to access and deliver services to rural and hard-to-reach communities;
- Inequitable distribution of skilled health workers between rural and urban health facilities;
- Significantly inadequate funding for CSOs to support hard-to-reach areas due to the continuous increase in cost of fuel and transport costs; and
- Increased insecurity and banditry leading to difficulties in timely implementation in some hard-to-reach areas.

Pakistan presentation: A sophisticated community feedback approach

The Empowerment, Voice & Accountability for Better Health & Nutrition (EVA-BH) program and implementation framework was presented as a community feedback approach. The process is citizen-led, branded and owned. It starts with community feedback via community groups and then escalates issues to district and provincial advocacy forums who then relay community feedback directly to health facilities, district and provincial governments. Over the last five years, there have been 390 active community groups which use observation checklists and exit interviews as their data collection methods. Examples were given on perspectives from outpatients, pregnant women and mothers with children under two years of age about their experience receiving services at health facilities. Some observations have focused on age-friendly and disability supportive services, infrastructure and equipment such as ramps and steps with railing or grab bars, railing or grab bars on patient beds, available wheelchairs, and wheelchair accessible toilets.

During this time, a total of 6725 demands have been raised and 4078 resolved (61%). The program includes many other aspects to ensure its effectiveness and impact such as monitoring of the time from demand raised to resolved, assessment and rating of the performance of community groups, as well as a sophisticated policy environment mapping. The program has engaged with media and trained journalists on rights-based reporting.

2.5 Part 1: Defining a CLM malaria approach

During this session, participants were divided into groups and rotated to six different flip charts to reflect on and respond to pre-assigned questions. A facilitator guided discussions for each question and recorded responses. Consolidated feedback for each question is summarized below.

Question 1: What could be good examples of CLM, and how this type of accountability has caused meaningful engagement and change?

Participants provided examples of community feedback and community engagement in monitoring (not specifically CLM). Several are highlighted below.

- Maasai huts in Tanzania are round but dwellers were provided with square-shaped nets. This led to incorrect or no use of the nets. This example underscores the importance of consulting communities during planning and design.
- An example from India was given on the value of community-based verbal autopsies in strengthening mortality surveillance to understand the cause of death. This approach uses trained, non-physician data collectors – i.e. community members – providing important skills needed for CLM.

- Mozambique and Nigeria use three levels to escalate issues to the national level if needed, which facilitates community interaction and accountability of government at different administrative levels.
- In Cameroon and Malawi, community monitoring found that orphanages did not fit the criteria of a “house” for the distribution of ITNs, representing a clear need to revise this definition. This was addressed with a letter to the NMCP and advocacy to ensure that orphanages were included in the distribution plan.
- In Ghana, there was low uptake of IPT3 due to the lack of maternity waiting rooms at the health facility. Advocacy targeted the district councils to secure funding to resolve this.
- In humanitarian contexts, such as northern Mali and parts of Nigeria, security challenges make it difficult to provide services and health commodities. Ongoing feedback from communities in these areas is critical to finding safe and consistent ways to meet their health needs.
- In Uganda and Venezuela, community dialogues and assemblies serve as important events for gathering feedback.

Question 2: Can existing CLM models from HIV and TB be used for malaria? What adaptations are needed for malaria?

Participants agreed that CLM models for other diseases can be adapted and used for malaria. CLM principles and the main activities for each phase of the CLM cycle (e.g. indicator selection, data collection, data analysis, etc.) are the same regardless of the disease or health issue. There is no “one size fits all” model to CLM, but rather different approaches depending on the need, context and barriers to access that the CLM is addressing. Different CLM approaches considered for adaptation can include PEPFAR-supported CLM, the Community Scorecard (CSC), Community Treatment Observatory (CTO), mystery client / secret shopper, Stop TB Partnership’s OnImpact, among others. Main points from the discussions are below.

- In the education component of the ITPC CLM model, the content can be adapted to focus on malaria transmission, prevention, intervention packages, country and globally adopted commitments.
- Malaria issues and indicators can form the basis of a standalone CLM program or be integrated into an existing CLM program.
- Malaria can affect anyone in areas where malaria has not been eliminated, but there are also specific at-risk and underserved populations for malaria such as pregnant women, children under five, migrants, forest workers, night workers, and sometimes entire villages where malaria burden is high. CLM would need to be adapted based on whether it focuses on the general population or targeted populations or a geographic location.

- Affected malaria communities are typically not organized as individual organizations, therefore the selection of a CLM implementer to financially manage a program would likely be a broader health-focused organization. In the absence of a CLO to financially manage the CLM program, it will be important to engage affected malaria communities throughout the CLM cycle to maintain the principle of “community-led”. This includes affected malaria community members actively involved in the identification of issues and indicators to monitor, serving as members of the CLM team (e.g. data collectors, analysts, coordinators, supervisors), carrying out advocacy, monitoring resolution of issues, documenting improvement in services.

Question 3: What are the key service issues that affected malaria communities are most concerned with in both a malaria control and malaria elimination context?

Organized by the Availability, Accessibility, Acceptability, and Quality (AAAQ) of services framework⁴, participants shared the following key service issues that they believe affected communities may be most concerned about. It was recognized that affected communities were not participating in the meeting, and therefore this would be an indicative list for further consultation.

Availability of services:

- Underserved at-risk communities – these include displaced persons, migrants, persons with disabilities, children, nightshift workers, etc.
- Adequate and timely supply of ITNs, Rapid Diagnostic Tools (RDT) and medicines
- Insufficient human resources at health facilities
- Limited services beyond malaria – in some countries CHWs only provide malaria services and are therefore missing opportunities to help care for other health issues.
- Lack of choice of healthcare facilities – the private sector was raised as an alternative but not everyone can afford to pay for a private sector service (accessibility)

Accessibility of services:

- Timeliness of services – for example, the Thailand government committed to providing services in 1 to 3 to 7 day which was reported to work well, and reported to reduce delays in services and referrals.
- Lack of ability to pay for transportation to a health facility.
- Difficulty reaching the health facility due to environmental disasters, conflicts, etc.

Acceptability of services:

⁴ AAAQ framework (2019), UNICEF. Available at: <https://gbvguidelines.org/wp/wp-content/uploads/2019/11/AAAQ-framework-Nov-2019-WEB.pdf>

- Health care worker attitudes and attitudes of those working outside of the health system, such as teachers and employers - multisectoral responsibility to create a friendly environment for key and vulnerable populations.

Quality of services:

- Properly trained health facility staff providing professional, scientifically sound services, and to provide referrals for other health issues.
- Health facility infrastructure – for example, lack of working toilets, gender-specific bathrooms to allow for privacy, no waiting rooms.

Other key concerns that can benefit from CLM included:

- **Government commitments:** If communities know there is a commitment to build a new facility, for instance, and this does not happen, CLM can document the reasons why, and use advocacy to hold governments accountable.
- **Level of community engagement in design of health services:** Active participation in decisions affecting peoples' health was seen as crucial, especially in the design of services.
- **Vector control:** CLM could assist in monitoring changes to mosquito breeding sites and highlighting where there have been no efforts to eliminate breeding sites. (e.g., ponds in communities, potholes, stagnant waters).
- **Gender-based violence and human rights violations:** CLM could assist in recording incidences and set standards for all stakeholders to adhere to.

Question 4: What structures, mechanisms or platforms exist where affected malaria communities could interact with health decision-makers and to share their concerns?

Participants shared the various types and levels of existing community feedback mechanisms to health decision-makers. These included opportunities for feedback via organized meetings while other models relied on experienced CSOs and/or CSO platforms that had established direct linkage with decision-making bodies. Examples included:

- In Ethiopia, Client Councils organize and facilitate the community feedback meetings as well as present the communities' feedback to the health facility management and broader community. These are used in the implementation of the ALMA community scorecard.
- In Tanzania, CSOs can engage with Ward Development Committees (WDC) at the local government level which have links to the President's Office – Regional Administration and Local Government (PO-RALG).

- In Kenya, they have “barazas” which are large community gatherings or assemblies intended to facilitate the sharing of information and concerns, elicit feedback on issues and hold decision-makers to account.
- Ghana has opinion leaders and elected community representatives who report through the health facility platform comprised of health facilities, CBOs and FBOs.
- In Venezuela, states are stratified in health clusters. Each cluster has a supervisor who meets with the communities weekly.
- Zambia has Village Health Councils – independent community health groups interacting monthly with the health facilities to channel community concerns on health services.
- In Thailand, Migrant Health Volunteers report back to health care workers on the concerns of the communities.
- In India, Accredited Social Health Activists (ASHA), primarily female community health workers, are connected to local government bodies and able to report on the community's concerns and needs.
- In Uganda, there are Community Health Dialogues. Health care workers report the outcomes of the dialogues to the focal persons at health facilities.
- In Burkina Faso, a Village Health Assembly meets every six months and reports back to the health facility, district and regional level authorities.
- In CAR and DRC, CSO platforms focused on the three diseases channel any complaints to the Ministry of Health.
- In Rwanda, malaria scorecards influence the allocation of resources from the central government to the sub-national health facilities.

Question 5: Who are community-led organisations for malaria? What organizations exist that represent and/or support affected malaria communities?

In many countries, there are no malaria-specific civil society/community-based/community-led organizations. Malaria is usually integrated in the work of CSOs, CBOs, and CLOs that work on a range of health issues. During the group rotation, a distinction was made between CSOs and CBOs with CSOs being mostly those that are legally registered operating at a regional or national scale, and CBOs as often informal (not registered) groups and associations, based in a specific geographic area and seen as credible to the community where they work. Participants discussed that in a Global Fund grant implementation arrangement, it is possible that a grant has a civil society PR with CSOs/CBOs/CLOs as SRs to provide malaria services as well as SRs to carry out CLM. It was discussed and agreed that organizations implementing services cannot be CLM implementers because it represents a conflict of interest (i.e. cannot monitor your own services).

Groups discussed identifying organizations that work with internally displaced people, refugees, undocumented migrants, communities that work at night, and women and children living in poverty as potential organizations to engage on CLM as they have established connections with these communities. In the absence of known organizations supporting these communities, it was proposed that undertaking a mapping of organizations and groups supporting these communities and where they operate could be helpful.

Other potential groups to engage in CLM include those who have been affected directly or been touched by an experience related to malaria (e.g. malaria survivors, family or friends of someone who died from or survived malaria).

Finally, the Africa Media Research Network was shared as a potential platform to disseminate best practices in malaria including CLM for malaria.

Question 6: What community monitoring structures exist that CLM can build on (including those relating to PHC and not limited specifically to malaria)?

Participants shared many different government-organized and community-based structures that exist in their countries. Some of these structures are important for sharing of CLM findings because they have the authority to make or influence decisions, others can be used to identify community respondents for the monitoring itself, while others are valuable as platforms for disseminating CLM findings and results of advocacy to demonstrate the usefulness of CLM to improving services.

Structures with decision-making authority or influence

- Community Legal Clinics
- Health Defence Committees (Nigeria)
- Health Center Advisory Committees
- Health Surveillance Assistants
- Health and Welfare Centers
- Neighborhood Health Committees
- Community-based health planning services (CHPS) and Community health management committees (CHMC) (Ghana)
- Parish Development Committees (i.e. Parish Development Model) (Uganda)
- Village Health Committees that bring information to the traditional leaders
- Chief/Cultural/Elders Council
- Ward Development Committees

Structures useful in recruiting respondents and/or sharing results of CLM

- Social Media: (i) FB groups, (ii) WhatsApp Groups, (iii) Neighbourhood watch
- Parent Teacher Associations

- Parents groups
- Political caucus groups
- Labor unions
- Water point community groups
- Agricultural cooperatives
- Beach communities
- Mining and fishing unions
- Volunteer Control and Diagnostic Focal Points for Malaria (Venezuela)
- Community Health Worker cooperatives
- Faith-based groups
- Youth groups and clubs

Another issue that was discussed was the resourcing, remuneration and incentivisation of these existing structures to be partners in ensuring CLM's success.

3. Day 2: Friday, June 2, 2023

3.1 Part 2: Building country CLM implementation frameworks

Following a recap of Day 1 discussions, the moderator asked participants to group themselves by country and shared a CLM implementation template for each country group to complete. The template outlined key aspects of the development of an implementation plan. Some countries have existing CBM or CLM activities or programs and so guidance was given to use these to integrate malaria. These frameworks, once completed, were intended to be shared further with their organizations and colleagues to generate discussion and interest in CLM for malaria. Key areas and related questions in the template included:

1. LEAD ORGANISATION(S)	What types (and names) of CSOs/CBOs/CLOs are best placed to host a CLM program?
2. ISSUES:	What services should communities monitor as complementary to national M&E?
3. INDICATORS	What indicators (quantitative, qualitative) are essential for CLM to monitor?
4. TARGET POPULATIONS	What affected malaria communities are we most concerned about their access to services?
5. SITES	What type of and which health service delivery sites should be monitored in a CLM program?
6. DATA COLLECTION	1) Who can be recruited as CLM malaria data collectors? What are the essential background and skills needed? 2) How will data be collected (e.g. paper-based, use of an app on a tablet or smartphone)?
7. PRIVACY & CONFIDENTIALITY	What considerations need to be in place to ensure the privacy and confidentiality of data?
8. DATA USE	How have NMCPs, or how can NMCPs use CLM data?

At the end of the group work, each country presented their initial CLM malaria framework. A compilation of country frameworks can be found [here](#).

3.2 CLM guides, resources and tools to support design and implementation

Global Fund CLM-SI TA provider and local meeting host, ITPC Global, presented a collection of CLM resources that have been compiled into one website called the [CLM Hub](#). ITPC led participants through the website to show the range of different available informational resources, guides and toolkits and also translated into several languages. These included those developed by ITPC, such as:

- How to Implement CLM: A Community Toolkit
- Quantitative and Qualitative Measures for CLM (CLM indicator development)
- Data Quality Assurance for CLM
- Data Management Tools for CLM
- Data Analysis Methods in CLM
- CLM Data Use in Decision-making

The Community-led Accountability Working Group (CLAW) also presented several resources that they have developed to support CLM stakeholders which can also be found on the [CLM Hub](#).

- Conflict of Interest in CLM Programs
- How to Budget for CLM
- Best Practices for CLM
- Community Evidence to Create Change (advocacy)

3.3 Opportunities for advancing a CLM malaria approach

This session focused on funding and available technical assistance opportunities.

The RBM Partnership to End Malaria (RBM)

RBM presented on their work, including the critical role of the Country and Regional Support Partner Committee (CRSPC), which was described as a platform to coordinate support to countries and regions as they execute their malaria control and elimination programmes. The CRSPC support is based on country demand tailored to suit needs, does not compete with or duplicate existing effective mechanisms, and uses consultants from within the region where they work for south-south collaboration. The three main roles of the CRSPC are to: i) support countries in the design of quality, prioritized programmes; ii) facilitate timely access

to implementation support to address bottlenecks and gaps; and iii) support countries with mobilizing and prioritizing domestic and other resources.

To ensure timely submission of high-quality GC7 funding requests, and to avoid gaps in implementation, the CRSPC provides a comprehensive package of support to countries starting with an orientation meeting on the Global Fund Funding Request to inform countries on the differentiated application approach and prepare detailed TA plans. TA can support in the development of funding requests, carry out implementation and/or financial gap analyses, help address TRP comments including issues around CRG/malaria matchbox implementation and updating of MPRs/NSPs (in collaboration with WHO). In addition, funds are available to countries to organize country consultations, country dialogue and recruit local consultants. Mock TRP meetings are also held to facilitate country peer review of draft Funding Requests and remote expert review of final draft Funding Request will be provided by CRSPC members. While to date, CLM has not been part of the provision of TA under the CRSPC, participants were encouraged to reach out with specific TA requests.

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, and 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”. (sub-objective A.2.2). The Global Fund has undertaken several changes to help facilitate funding for CLM in the next round, including revisions to the [Global Fund Modular Framework](#) and updated information notes and technical briefs.

There are a few ways that partners access funding for CLM. This primarily is through the inclusion of high-quality CLM component in GC7 funding requests. Engagement in funding request development (via country dialogue, community-specific prioritization meetings, writing teams) is important to ensure that CLM is included and budgeted sufficiently. This includes for actual CLM implementation activities but also for TA, given that in GC7, the Global Fund will no longer offer a standalone TA program (i.e. CLM-Strategic Initiative (CLM-SI))⁵ to support eligible countries that is additional to grant budgets. In addition, countries should also consider including other cross-cutting CSS interventions that support elements of CLM for effective implementation:

⁵ The CLM SI is a three-year initiative, 2021-2023. Its objectives are to: 1) improve uptake and use of CLM; 2) strengthen integration of CLM into disease responses and national strategies; and 3) generate evidence on the impact of CLM on service delivery. TA is provided by three approved TA provider community consortia.

- a) Community-led research and advocacy (same as GC6)
- b) Community engagement, linkages and coordination (formerly social mobilization in GC6)
- c) Capacity building and leadership development (formerly institutional capacity building in GC6)

The Global Fund presented very limited opportunities to seek TA through the current CLM-SI for Windows 1 and 2 that are going through grant-making and for Window 3 submissions. During GC7 implementation, there could be opportunities for TA and additional budget for CLM during periods of grant revision during the grant lifecycle.

Participants were encouraged to share the information with their country partners and act quickly to develop and submit a TA request if needed given the time it would take to process the request, finalize a TOR and assign a TA provider. These TA requests can come from CSOs, CCMs and Global Fund Country Teams.

4. Common principles for a CLM malaria approach

The meeting ended with a presentation of agreed CLM principles that came out of the two-day meeting. While these principles mirror those in existing CLM guidance, it was important to gain general consensus among the participants as malaria stakeholders and fairly new to CLM. These principles are intended to guide malaria stakeholders in the design, implementation and sustainability of CLM malaria activities and programs.

CLM should be:

1. Inclusive and representative
2. Community-led, bottom-up design
3. Rights-based and non-discriminatory, respecting privacy, confidentiality and consent
4. Cyclical (i.e. CLM cycle) and routine
5. Action- and results-oriented and responsive
6. Complementary and avoid duplication (i.e. CLM findings should add value to existing data)
7. Collaborative and mutually beneficial to communities, health facilities and decision-makers
8. Context-specific, differentiated based on need for specific information and populations
9. As simple as possible to allow for different types of communities to carry out CLM successfully

10. Independent and set up in a way that avoids potential conflicts of interest (i.e. CSOs/CBOs/CLOs that are providing services cannot monitor their own services, therefore they cannot be CLM implementers)

Annex: List of Participants

Country Partners (26)		
Country	Name	Organization
Burkina Faso	Ousseini Ouedraogo	Secrétariat permanent pour l'élimination du paludisme
Burkina Faso	Tounaba Boukary Belem	ONG Progettomondo
Cameroon	Paul Patrick Endeke	Treatment Access Watch
Central African Republic	Sibelle Balanga	Seni Na Maingo
Democratic Republic of the Congo	Barth Kibonge Muyengo	ONG Racoj
Ghana	Selina Danso	National Malaria Elimination Program (NMEP)
Ghana	Anthony Yankee	Keba Africa Foundation
Indonesia	Yohanes Ari Hermawan	Perdhaki
Kenya	Beatrice Machini	Division of National Malaria Program, Ministry of Health
Kenya	Francis Onditi	AMREF Health Africa
Malawi	Alvin Chidothi Phiri	Health Education Services, MOH
Malawi	Thokozani Malifa Chapomba	Malaria Youth Army Champions
Nigeria	Owoya Samuel	NMEP
Nigeria	Fatima Kolo (online)	ACOMIN
Rwanda	Seraphina Gahigana	Society for Family Health
Rwanda	Nooliet Abanyana	Rwanda NGOs Forum on HIV/AIDS and Health Promotion
Tanzania	Leah Ndekuka	National Malaria Control Program (NMCP)
Tanzania	Gesonko Paul Nyasuguta	Civil Society/Non-State Actors
Thailand	Rungrawee Tipmontree	Department of Disease Control, MOH
Thailand	Korakod Intaphad	Raks Thai Foundation
Uganda	Catherine Maiteki	National Malaria Control Division, MOH
Uganda	Mary Mbidde	TASO Grants Management Unit
Venezuela	Brenda Garcia	Ministerio del Poder Popular para la Salud (MPPS)
Venezuela	Eglee Zent	Hawapo with the Yonomami indigenous population
Zambia	Donald Mukumbuta	National Malaria Elimination Centre, MOH
Zambia	Madrine Mbuta	Planning and Budgeting Department, MOH

Donors & Technical Partners (10)	
Organization	Name
Global Fund to Fight AIDS, TB and Malaria	Kate Thomson
Global Fund to Fight AIDS, TB and Malaria	Keith Mienies
Global Fund to Fight AIDS, TB and Malaria	Susan Perez
Global Fund to Fight AIDS, TB and Malaria	Alistair Shaw
Global Fund to Fight AIDS, TB and Malaria	Maisoon Elbukhari Ibrahim
WHO AFRO	Taiwo Oyelade
RBM	Daddi Wayessa
RBM	Marsha Deda
RBM - CReMA working group	Jessica Rockwood
ALMA	Diego Duque
Global Fund Technical Assistance Providers (11)	
Organization	Name
Impact Santé Afrique (Host of CS4ME)	Olivia Ngou
Impact Santé Afrique (Host of CS4ME)	Fidele Bemadoun
HR SI EHRGE-Malaria TA Provider / MECA Data SI TA Provider	Shampa Nag
HR SI EHRGE-Malaria TA Provider	Fayaz Ahmad (online)
HR SI EHRGE-Malaria TA Provider	Sayson Meya
MECA Data SI TA Provider	Rutazaana Damian
CLM SI TA provider (CD4C-ITPC Global)	Solange Baptiste
CLM SI TA provider (CD4C-ITPC Global)	Jelena Bozinovski
CLM SI TA provider (CLAW-ZAN)	Walter Chikanya
CLM SI TA provider (CLAW-HEPS Uganda)	Kenneth Mwehonge
CLM SI TA provider (EANNASO)	Onesmus Mlewa Kalama
Rapporteur & Facilitator (2)	
Role	Name
Rapporteur	Lynette Mtimkulu-Eyde
Facilitator / HR SI EHRGE-Malaria TA Provider	Denise NJama-Meya
Translators (2)	
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Hilda Poulter	Info2@ctlanguages.co.za
Laurence Peillex-Delphes	latranslationsa@gmail.com
Logistics Support (3)	
Organization	Name
ITPC Global	Larissa Donald
Take Note	Dionne Collett
Take Note	Ayanda Phakathi