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Conflict of Interest in Community-led Monitoring programs

ACT THE ADVOCACY CORE TEAM

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HEALTH GAP GLOBAL ACCESS PROJECT

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1.0 Background and Purpose

1.1 Background

Community-led monitoring (CLM) is a forward-looking, state-of-the-art intervention to improve the quality and accessibility of health services, through data-driven monitoring and advocacy led by key and vulnerable populations (KVP), including people living with HIV (PLHIV) and people at risk for tuberculosis and malaria.

Key donors and partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), the President's Emergency Plan for AIDS Relief (PEPFAR) and UNAIDS, have supported the development of CLM and the rapid expansion of a proliferation of different models of CLM, implemented by different stakeholders.

However, given the unique requirement of CLM programs to remain independent and impartial in their monitoring work, an urgent need to address conflicts of interest has emerged.

1.2 Purpose

The purpose of this document is to guide CLM stakeholders to ensure a high standard of conduct in the design and implementation of CLM programs. This document aims to ensure that the fundamental principles of CLM are preserved while facilitating the identification, prevention, and management of actual and potential conflicts of interest (COI).

Maintaining the independence of CLM programs is a key priority. As new CLM projects are implemented, an urgent need has emerged to support countries to identify and mitigate COI in funding streams, implementer arrangements, and program design. Mitigating these conflicts is vital in ensuring that CLM remains effective, independent, and inclusive.

While the Global Fund's Policy on Conflict of Interest[1] is an important resource for identifying and preventing COI, CLM programs present unique challenges, such as funding streams passing through entities that are being monitored or non-independent organizations being chosen as CLM implementers, which require more targeted guidance.

[1] The Global Fund, Policy on Conflict of Interest. June 2020 https://www.theglobalfund.org/media/6016/core_ethicsandconflictofinterest_policy_en.pdf

Community-led monitoring focuses on generating political will to enact change and ensure accountability of decision makers and other duty bearers.

2.0 Key Definitions

2.1 Community-led monitoring (CLM)[2]

"Community-led monitoring trains, supports, equips, and pays members of directly affected communities to themselves carry out routine, ongoing monitoring of the quality and accessibility of treatment and prevention services.

Monitoring focuses on collecting quantitative and qualitative data through a wide variety of methods that reveal insights from communities about the problems and solutions to health service quality problems at the facility, community, sub-national, national, and even international levels.

Another key concept of community led monitoring—separating it from other modes of quality improvement— is the full integration of evidence-based advocacy into a cycle[3] that brings new information to the attention of decision makers and holds them accountable for acting on that information".[4]

2.2 CLM Principles

In contrast to other community-based monitoring initiatives, CLM is based on three key principles[5] which are consistently present across CLM definitions by the Global Fund,[6] PEPFAR[7] and UNAIDS[8]:

Community-led monitoring requires leading and ownership by independent communities/civil society.

People directly affected by weak, failing, or unaccountable HIV, TB, malaria, and recently, Covid-19 responses have the greatest stake in designing and monitoring health services and policies that aim to improve treatment and prevention outcomes. Communities are often the first to detect and diagnose problems.

CLM empowers communities with the institutional capacity and data to share what they know with decision-makers and to advocate to ensure their needs are met.

Community-led monitoring requires organized communities for effective monitoring.

The most effective community-led monitoring programs are led by organizations or coalitions with organized representation by directly impacted communities—bringing multiple voices at the local level together to create influence—and a central structure capable of managing the effort and connecting it with sub-national and national policy processes for systemic change. Funders willing to support community-led monitoring need to recognize the level of investment and

[2] Other definitions of CLM can be found on Annex 1. Annex 2 describes CLM actors and activities

[3] For CLM cycle see page 6

[4] Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality [white paper]. February 2020. Available online at: https://www.healthgap.org/wp-content/uploads/2020/02/Community-Led-Monitoring-of_Health-Services.pdf

[5] Community-Led Monitoring of Health Services: Building Accountability for HIV Service Quality [white paper]. February 2020. Available online at: https://www.healthgap.org/wp-content/uploads/2020/02/Community-Led-Monitoring-of_Health-Services.pdf

[6] The Global Fund, Technical Brief: Community systems strengthening. October 2019 https://www.theglobalfund.org/media/4790/core_communitysystems_technicalbrief_en.pdf

[7] PEPFAR, Community-led Monitoring 2020 https://www.state.gov/wp-content/uploads/2020/07/PEPFAR_Community-Led-Monitoring_Fact-Sheet_2020.pdf

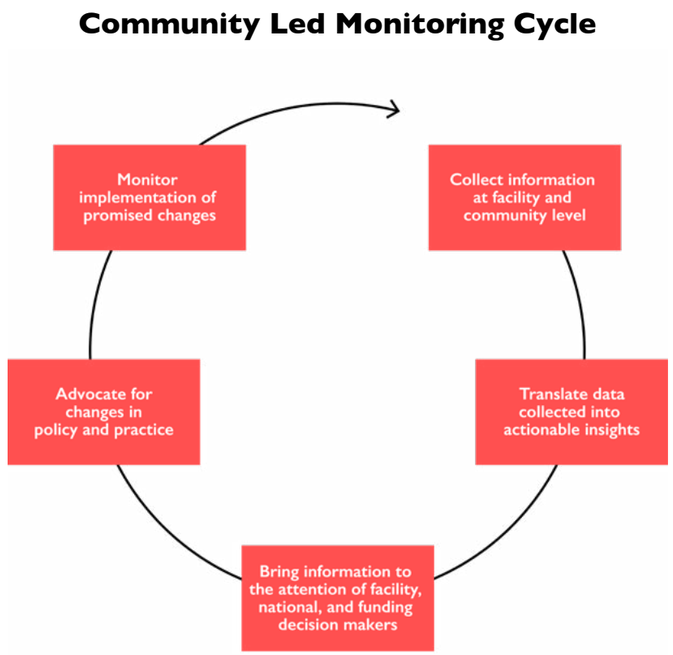
[8] UNAIDS, Establishing community-led monitoring of HIV services. 2021 https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf

resources (financial and technical) to build and sustain successful CLM programs.

Community-led monitoring focuses on generating political will to enact change and ensure accountability of decision-makers and other duty bearers.

Too often, decision-makers do not have access to critical information about the needs and gaps of health program recipients. Timely data and recommendations generated through CLM programs are an important way of bridging this gap. This data is then analyzed by communities and their findings are used to develop solutions to the problems their monitoring has uncovered using strategic advocacy and accountability.

It is necessary to ensure tools and resources are made available to service users to properly diagnose immediate service



delivery problems as well as the root causes of these issues that can be often linked to political, technical, budgetary and/or financial management challenges.

Proper political analysis and associated risk mitigation plans are needed to address these root causes, especially when CLM is conducted by marginalized and criminalized groups. CLM advocacy efforts need to focus on generating political will to resolve problems, reduce barriers and improve services.

2.3 Conflict of Interest

A COI is a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest.[9] In such a case, an individual or institution may, by act or omission, interfere with the performance of one interest by acting for the secondary interest in an official power, role, or function to the detriment of the primary interest. For example, there is a COI when an interview panel includes the relative of a person who is competing for a position the panel is interviewing for.[10]

Actual COI

A COI refers to the set of circumstances or relationships that create or increase the risk that the primary principles and goals may be neglected or undermined as a result of the pursuit of secondary interests. A COI exists whether or not a particular individual (or group) has yet acted unethically or taken inappropriate actions influenced by a secondary interest.

Clear and obvious examples[11] of actual COIs might include a person selecting an entity as a funding recipient on the basis of their personal financial ties to an organization; a contractor or supplier being involved in the design of the funding application; or an entity implementing a monitoring program in which it has a personal financial interest based on the outcome or findings of the monitoring.

Potential COI

A COI can be a result of bias or relationships even where no financial or other obvious relationship exists, but nevertheless serves to influence an individual's professional performance in a manner that is detrimental to the goals of the organization or project. Biases may exist even when individuals believe they are acting independently.

These include less obvious examples of COIs that might arise where an individual - despite no longer having any financial, family, or personal relationship with a previous employer - specifically designs evaluation frameworks that are skewed to show that employer in a good light.

[9] Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice; Lo B, Field MJ, editors. Washington (DC): National Academies Press (US); 2009. Principles for Identifying and Assessing Conflicts of Interest. https://www.ncbi.nlm.nih.gov/books/NBK22937/

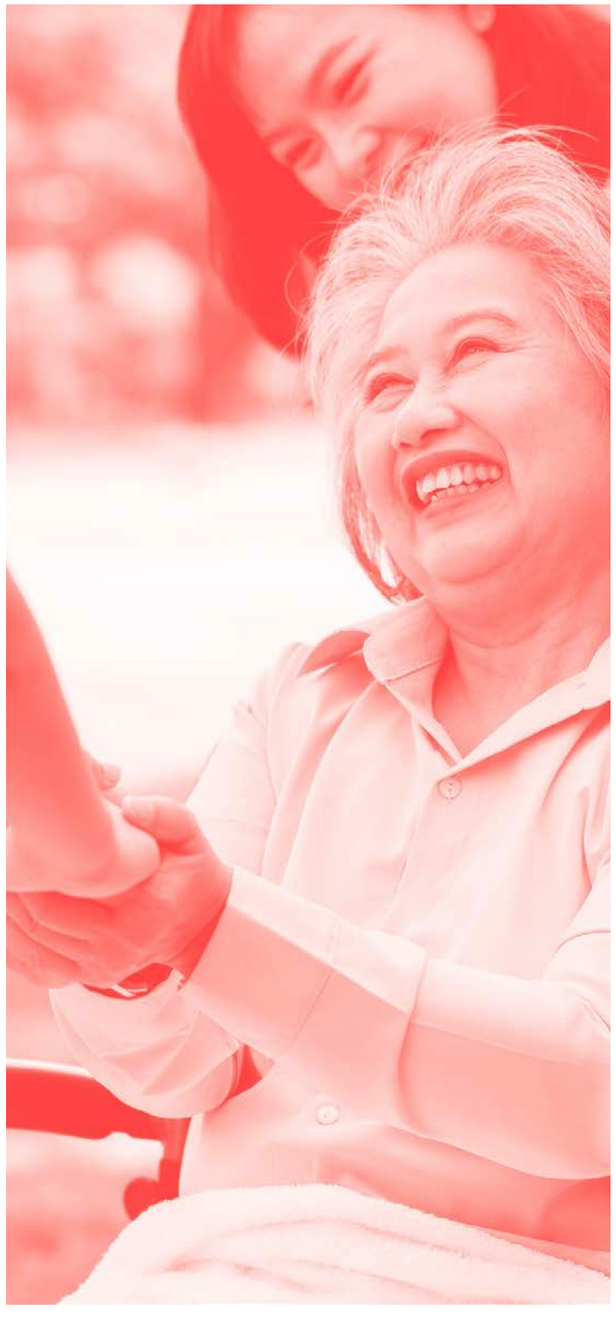
[10] The Global Fund Policy on Conflict of Interest. June 2020 https://www.theglobalfund.org/media/6016/core_ethicsandconflictofinterest_policy_en.pdf

[11] Specific COIs in CLM are compiled in the session 3.

Perceived COI

COI can also be perceived in a situation when one of the parties may appear, according to a reasonably neutral third-party observer, to have a COI, even if it is not an actual or potential COI.

The claim that a COI exists is based on common experience and social science research, which indicate that, under certain conditions, there is a risk that professional judgment may be influenced more by secondary interests than by primary ones.[12]



[12] Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice; Lo B, Field MJ, editors. Washington (DC): National Academies Press (US); 2009. Principles for Identifying and Assessing Conflicts of Interest. https://www.ncbi.nlm.nih.gov/books/NBK22937/

3.0 Guidance on avoiding or minimizing conflict of interest in CLM

As a community-led initiative, CLM programs are vulnerable to several key areas of potential COI. Due to the unique requirement that CLM programs be owned and led by community-led organizations, special attention is needed to ensure that the institutions and individuals conducting the monitoring are protected from interference by those being monitored. It is important for CLM to be as free as possible from the perception of COI that can arise regardless of whether actual changes are made.

Moreover, CLM should be adaptable to community needs; as such, there is no one way to organize, finance, and govern CLM programs. However, the following best practices describe principles of independence and community ownership in CLM programs that need to be adhered to in order to minimize COI. While it is unattainable to eliminate all possible situations of COI, this guidance aims to draw clear lines on the best forms of engagement by the main actors involved in establishing and implementing CLM in three main areas where COI most often occurs:

3.1 COI in funding streams

In many cases, donors do not provide CLM funding directly to small, local civil society organizations (CSO) and community-based organizations (CBO). Instead, funding streams typically pass through an intermediary entity, which may be the country government, a United Nations agency, an international non-governmental organization (INGO) or a national CSO. In the case of CLM, in which entities are charged with conducting independent oversight of the quality and accessibility of health services that could be owned and operated by the same entity that oversees the funding streams for CLM, COI in funding streams is a key consideration.

Depending on the country and the services being monitored, the array of CSOs that are financially independent of all potential COI may be extremely limited. Often, funding streams for CLM are disbursed through the organization/institution being monitored.

For example, Global Fund funding for CLM could pass through a government Principal Recipient (PR). Since the CLM program monitors primarily the public healthcare system, this financial arrangement may challenge the program's ability to independently evaluate public sector health facilities. In such a case, governments have a responsibility to ensure that they protect the autonomy and independence of a CLM program's governance and operations.

Minimizing COI in funding arrangements

As a best practice, financial arrangements should be pursued where donor funds do not pass through an entity that delivers the same services being monitored. For instance, donors should prioritize funding directly to the CSOs implementing CLM programs.

Where direct funding is not feasible, donors should prioritize funding CLM programs through a CSO or other independent entity. In the absence of direct funding from donors

to CLM implementers, the practice of flowing funds through an independent entity is likely to reduce the COI in the funding streams.

Depending on the country and the services being monitored, the array of civil society organizations that are financially independent of all potential COI may be extremely limited.

In situations where funding is already being channeled through a third non-independent entity, the donors may develop clear guidelines clarifying the role of this entity. In such cases, the entities, PRs, implementing partners (IPs), government or otherwise, may only inquire on fiscal responsibility and not about CLMs' programmatic spending priorities.

3.2 COI and CLM implementers

CSOs and CBOs play a key role in global health programming, often serving an important role in the delivery of a range of health services, including Global Fund-supported services. Given that CLM is community-led, these same organizations are often the best places to develop and lead CLM programs. In such situations, a potential COI may emerge if the same organization providing a healthcare service is also charged with implementing a CLM program to monitor its own service.

For example, a CBO operates a Drop-In-Centre (DIC) providing HIV services for key populations (KP), and is a member of a community coalition supporting improved

services for KP groups. In this case, while the CBO can be part of the coalition, the monitoring of its own services needs to be done by another member of the coalition in order to avoid COI.

Minimizing COI in selection of CLM implementers

CLM implementation must be led by independent, trusted, local, and community-led organizations with no financial or personal ties to the organizations delivering healthcare services. In such a scenario, the risk of COI within the program governance structure is minimal.

Recognizing that in some contexts, the best or only candidates for CLM implementation may also be those already funded to deliver services, care should be taken to both identify and monitor for potential COI. In contexts where there is a lack of CLM capacity among CSOs and CBOs, the preferred option may be to pause the CLM effort while capacity is built. In these instances, a UN organization, INGO, or national CSO with CLM knowledge and expertise may be asked to support CLM capacity-building of eventual CLM implementers.

3.3 COI and Community Health Workers

Similar to COI and CLM implementers, a COI arises when Community Health Workers (CHWs) are tasked with aspects of community monitoring. CHWs are not in a position to monitor the quality of their service delivery to communities considering their role as health service providers, but rather this task should be carried out by an independent CLM implementer.

Minimizing COI among CHWs

While CHWs may not be the best placed to serve as a CLM implementers, given their front-line service delivery role, program collaboration between CHWs and CLM implementers are important especially where CHW monitoring and CLM is taking place in the same communities and health facilities. For example, collaboration can include sharing of CLM data, identifying issues at the health facility, and organizing joint meetings with the health facility to present data and carry out advocacy activities. This partnership can be helpful in addressing service barriers.

3.4 COI in CLM design

Governments, implementing organizations, and donors play leading roles within aspects of health systems related to national health sector monitoring and evaluation (M&E) activities. However, it is critical to differentiate a CLM program which specifically monitors service access and quality by CBOs and CSOs from that of a national M&E system which monitors the performance of system elements and the results and outcomes of that performance. Therefore, while CLM and national M&E both generate important and critical data about the functioning of the health system overall, the data generated by each is complementary yet distinct.

For example, a CLM program designed as 'M&E provided by the community,' placed within the national (i.e., government) health system structure, automatically fails to fulfill the core CLM principle of independence, which is essential to be able to advocate for change. More subtle examples arise when governments assume a lead technical role in designing data collection tools or make decisions around advocacy activities.

Minimizing COI in CLM design

While local and independent CSOs and CBOs will lead every stage of the CLM cycle, there are several important roles for other actors to provide relevant input at different stages of the CLM cycle.

Governments, international non-governmental organizations, academic institutions, and UN family organizations may serve an advisory role at the request of the program. Examples of this may include providing information on service delivery barriers, which communities and populations are facing the greatest obstacles to accessing quality health services, guidance on information technology, or providing analytical support. The types of support needed should be defined by the CLM program. Note that while non-governmental organizations may provide technical assistance, they may not do so in cases where they are implementing the same programs being monitored. In order to ensure CLM is truly community-led, these entities would not be tasked with a leadership or decision-making role in project implementation. While challenging, documenting COI in CLM will assist in finding nuanced and appropriate measures to mitigate or eliminate them.

Table of roles

The table aims to address primary areas on how each actor could be involved in the CLM activities in order to minimize the risk of COI. In general, roles and activities that are not defined should be reserved for CBOs or delegated by the CLM governing body. *(see page 14)*

	Community Led Organizations	Private Health Facilities	Government Entities	CCM	Donors	Multilateral Agencies	International NGOs
Governance and Coordination	Responsible for technical reporting to funder and oversight of all decision-making processes and project implementation Engage in collaborative development of a governance structure to coordinate the CLM program/implementation Participate on the governance board on on-going basis Coordinate activities with other CLM or CLM-like program in the country	Be involved in CLM governance roles	Provide input and advice on CLM implementation and coordination, at the invitation of CLM governance body Be involved in CLM governance roles nor have voting rights on any CLM governing body	Conduct general oversight of Global Fund funded CLM activities (no different than CCM's oversight role of all GF grant activities) Develop CLM proposals as part of GF concept note development	Be involved in CLM governance roles	Develops CBO's organizational capacity to implement CLM program Ensure cooperation and cohesion between the different actors involved in the CLM programs since agencies, specially UNAIDS, UNDP and the Stop TB Partnership, are often part of a coordinating body	
Data Management	Identifies the main priority areas of concern for monitoring data collection Develop survey tools defining indicators to monitor Develop a data management protocol Develop process for data dissemination and use Clean, inspect and analyze data to uncover useful information to support conclusions and decision-making Management of data dashboard; responsible for data download and reporting	Conduct secondary analysis of publicly released CLM data Review and provide suggested feedback on data tools Require staff to respond survey/ interview requests Provide input on the development of main areas of concern Provide input on data properties for ensuring CLM data can be used alongside with government data systems for analysis Be involved in the primary data analysis for every period of the CLM project Be involved in data warehousing		Support with resources		Participate on the development of main areas of concern Review and provide suggested feedback on data tools Be involved, due its neutral instance, in data warehousing	Be involved, at the request of the CLM programme, in data analysis and data warehousing when its own services are not being monitored
Project Management and Delivery	Delivers all 5 steps of the CLM cycle Convene and engage with duty bearers at all levels using evidence from the CLM cycle to drive improvements in identified issues Responsible for ensuring that community is provided with the science behind the diseases and normative standards for optimal prevention, treatment, care and support interventions Establish open channels of communication with all actors involved in CLM programmes Develop targeted advocacy tools and media resources to disseminate challenges and findings regarding access to care in the communities Leverage findings to win change Implement CLM programs in sites in which they are also providing health services	Facilitate/Allow access to its facilities Receive and respond to the findings of the CLM program Participate in feedback meetings	Ensure access to public health facilities and participate by public health officials and medical staff (e.g. through MOU and permission letters) Participate in feedback (report back) meetings Promote health education to ensure community understanding about the science behind the diseases and normative standards for optimal prevention, treatment, care and support interventions Receive information collected and analysed by CBOs Conduct further analyzes based on publicly released CLM data	Support CBOs with network sharing, mobilization and dissemination of findings Participate in project management	Support CBOs advocacy to win change in access to health care Hold CLM implementer accountable to their own project planning Respond to CBOs feedback of needs and improvements Follow up with donor funded facilities on CLM findings	Support CBOs with network sharing, mobilization and dissemination of findings	
Financial Management	Develop a workplan and hire staff and monitors according to available funds Report on fiscal accountability directly to the donor or to another entity depending on the funding flow	Get involved in CLM financial management	Be the PR and strictly participate in allocating and financial reporting Be involved in the development of the workplan and staffing requirements within the available budget	Oversees financial management of GF grants, including CLM program Guide suggest resource allocation on grant development	Hold CBOs financially accountable to their own programming Prioritize funding directly to CBOs implementing CLM program Prioritize dual track financing with funding flowing through PR CSOs to the implementing CBO Develop clear guidelines clarifying that PRs, IPs, government or otherwise, may only inquire on fiscal responsibility and not about CLM programmatically spending priorities	Only involved in financial management if involved as donor (see above)	Be the entity from which funding flows to the CBO implementing CLM. In this case it can strictly participate in allocating and financial reporting

Key:

Lead | Can | Cannot

Annex 1:
Other CLM definitions

Despite slightly different CLM definitions by UNAIDS, Global Fund and PEPFAR, the key three principles of a) community led and ownership; b) community organization for effective monitoring and; c) community focus on enacting change and ensuring accountability, is consistently present in all definitions.

UNAIDS[13]	HIV community-led monitoring (CLM) is an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups or other community entities. CLM uses a structured platform and rigorously trained peer monitors to systematically and routinely collect and analyze qualitative and quantitative data on HIV service delivery—including data from people in community settings who might not be accessing health care—and to establish rapid feedback loops with program managers and health decision-makers. CLM data builds evidence on what works well, what is not working, and what needs to be improved, with suggestions for targeted action to improve outcomes.
Global Fund to Fight AIDS, Tuberculosis and Malaria[14]	The Global Fund defines CLM as models or mechanisms by which service users and/or local communities gather, analyze and use information on an ongoing basis to improve access to, quality and impact of services, and to hold service providers and decision makers to account.
PEPFAR[15]	Community-led monitoring (CLM) is a technique initiated and implemented by local community-based organizations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups, or other community entities that gather quantitative and qualitative data about HIV services. The CLM focus remains on getting input from recipients of HIV services in a routine and systematic manner that will translate into action and change.

[13] UNAIDS, Establishing community-led monitoring of HIV services. 2021
https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf

[14] The Global Fund, Technical Brief: Community systems strengthening. October 2019
https://www.theglobalfund.org/media/4790/core_communitysystems_technicalbrief_en.pdf

[15] PEPFAR, Community-led Monitoring 2020
https://www.state.gov/wp-content/uploads/2020/07/PEPFAR_Community-Led-Monitoring_Fact-Sheet_2020.pdf

Annex 2:
CLM Actors and Key Activities

Key actors and key activities are necessary for the success of CLM. They are important to understand as they are oftentimes the source of COI.

Key CLM Actors

Community-based organizations or CLM implementer

First and foremost, CLM should be led by organizations that have a long-standing, trusted relationship with the communities in their respective locations to be effective . This means that community-based organizations (CBO), Civil Society Organizations (CSO), key population (KP) networks and organizations, faith-based organizations (FBO) and youth organizations should be at the center of all activities including conceptualizing CLM programs; developing its tools; implementing; and coordinating with other CLM programs.

Community health workers

Community health workers function in a range of activities from service delivery, such as community DOTS workers, finding lost-to-follow-up (LTFU) cases, adherence services, to community sensitization, mobilization and promoting community empowerment and social justice. As mainly health service providers, this category of workers generally cannot be CLM implementers.

Country Coordination Mechanism (CCM)

The core function of these national multi-stakeholder committees is to submit funding applications to the Global Fund and oversee grants on behalf of their countries.

Donors

The majority of CLM programs monitor government health services that are in part funded by international donors, such as the Global Fund and PEPFAR. Likewise, the majority of CLM programs are also funded by the same international donors.

Government entities

Other important actors in the CLM context include government ministries and departments, district health management teams, oversight committees, national AIDS councils and public health facilities. These actors are primarily providers of services that are being monitored by the community.

[16] https://itpcglobal.org/wp-content/uploads/2021/06/Integrating-Community-Led-Monitoring-into-C19RM-Funding-Requests.pdf

International organizations (INGOs) and Implementing partners

Similar to private health facilities, INGOs and PEPFAR implementing partners (INGOs and non-profit organizations such as university institutes) are primarily health service providers that are monitored by communities. However, these actors often engage in capacity building and training of CBOs.

Multilateral agencies

Especially UNAIDS, UNDP and the Stop TB Partnership, are often involved in CLM programs as donors, providers of technical assistance and/or in coordination bodies supporting government health goals and independent CSOs to carry out a range of health promotion activities.

Networks of people living with HIV, TB, Malaria

Networks of PLHIV, TB and Malaria should lead the design and implementation of CLM programs. In some instances, the networks may not have capacity to carry out the program themselves. Nevertheless, as the main recipient of these health services, their experiences and feedback should be at the center of CLM programs.

Private health facilities

Similar to government entities, private health facilities are primarily health service providers that are being monitored by communities.

List of activities in which COI may occur

Communications

Establishing open channels of communication with all actors involved in CLM programs; Developing targeted tools and media resources to disseminate challenges and findings regarding access to care in the communities.

Coordination

Ensuring cooperation and cohesion between the different actors involved in the CLM programme, including sharing best practices among the CLM programs in a determined area/ region/country, addressing challenges faced by the programs and documenting progress.

Data Analysis

Cleaning, inspecting, and modeling data to uncover useful information to support conclusions and decision-making.

Data Warehousing

Securing electronic and paper storage of information collected by CLM programs.

Education

Learn and ensure understanding about the science behind the diseases and normative standards for optimal prevention, treatment, care and support interventions.

Facility/Community Monitoring

Seeking approval to access health facilities, generating appropriate information by collecting data in the facilities and documenting challenges and barriers faced to access care in a determined facility.

Financial Management

Planning, organizing, directing and controlling the financial activities of CLM programmes.

Follow-up and Advocacy

Leveraging findings to win change. This includes: educating the public, developing briefs and policy papers, speaking out, lobbying.

Governance

Ensuring that actors involved in all activities related to a CLM program follow appropriate and transparent decision-making processes and that the interests of the CLM program are prioritized.

Project Management

Ensuring the delivery of all 5 steps of the CLM cycle from data collection and analysis, to translation into actionable insights, delivery of information to relevant decision makers, advocacy for change and finally monitoring of promised changes.

Tools Development

Identifying priority areas of concerns for monitoring which aims to ensure minimal standards in health services, while addressing structural enablers and barriers to accessing them. This includes site selection, indicator development, training of data collectors, obtaining ethical clearance when required among others.

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