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Power to Communities

Community-Led Monitoring Toolkit

(Revised and updated version)

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Who can use this CLM Guide

This guide is written specifically for you – the key population communities and networks – who are carrying out this monitoring program. By using the broader 'key population community', this guide does not limit its use to a particular key population group. Whether you are a representative of MSM communities, transgender communities, sex worker communities or people who are using drugs, this guide allows you to develop a monitoring process that is appropriate and useful for your own community at a country level.

Design and layout: Vaness Silpakhon Kongsakul

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ABBREVIATIONS

AIDS	–	Acquired Immuno-deficiency Syndrome
ART	–	Anti-retroviral Therapy
BCC	–	Behavior Change Communication
CLM	–	Community Led Monitoring
CBOs	–	Community Based Organizations
CCM	–	Country Coordination Mechanism
FHI	–	Family Health International
HIV	–	Human Immuno-deficiency Virus
KP	–	Key Population
MSM	–	Men Having Sex with Men
PEPFAR	-	U.S. President's Emergency Plan for AIDS Relief
PLHIV	–	People Living with HIV
PWID	–	People Who Inject Drugs
SWOT	–	Strength, Weakness, Opportunities and Threats
TG	–	Transgender
The Global Fund	-	The Global Fund to Fight AIDS, Tuberculosis and Malaria
UN	–	United Nations
UNAIDS	-	United Nations Programme on HIV and AIDS

1 Background

The effectiveness of the HIV response is today highly variable—between populations and geographies. Some countries, communities, and populations are doing well against the 95-95-95 treatment targets, achieving high levels of community viral suppression, while others are far behind. At a global level neither deaths nor new HIV infections are on track to reach the 2020 UN goals. Key populations are, in most of the world, far behind in the treatment cascade. Hundreds of thousands of people living with HIV continue to die due to the disease each year.

"Loss to follow up" rates in most programs remain unacceptably high as people initiate treatment but are not effectively retained in care—either because they die or because they are not supported to sustain ART. The Asia and Pacific region was home to an estimated 5.8 million people living with HIV in 2019 [1].

The HIV epidemic is largely characterized by concentrated and growing epidemics in key populations in a variety of countries, particularly clients of sex workers and other sexual partners of key populations, people who inject drugs (PWID), and men who have sex with men (MSM). Low national prevalence masks much higher prevalence among these groups and in specific locations, particularly urban areas [2]. In 2019, 300,000 people became infected with HIV in the region. Three-quarters of these infections occurred among key populations and their partners [3]

It is increasingly clear that the Asia and Pacific region is falling behind regions the global trend in its HIV response. In 2019, 75% of people living with HIV in this region were aware of their status. Among those aware, 80% were on treatment of which 91% were virally suppressed. In terms of treatment coverage this equates to 60% of all people living with HIV being on treatment and just 55% being virally suppressed [4]

Political accountability deficits are a major reason quality of services differs so dramatically. It has long been shown that the provision of public goods is directly linked to the information and the accountability structures for officials making decisions about those goods. Given this context, community responses to HIV are the cornerstone of effective, equitable and sustainable HIV programmes. Community-led and community led efforts mobilize communities to demand services and exercise their rights; they also deliver services, support health systems and reach those most vulnerable to HIV where state facilities cannot. Moreover, communities act as barometers in their watchdog role, tracking what works and what does not with a local, contextualized perspective. In other words, communities give a voice to those who need services, provide feedback as to whether policies and programmes are working and suggest how they can be improved.

Communities were the first responders to HIV three decades ago, and they remain essential in advocating for a robust response to the epidemic, delivering services that can reach everyone in need and tackling HIV-related stigma and discrimination. Working alongside public health and other systems, community responses are critical to the success and sustainability of the HIV response. There is now wide recognition that community responses must play an increasing role in addressing and ending HIV the epidemic.

Global AIDS Strategy 2021-2026 "End Inequalities. End AIDS" [5] also identifies the importance of community engagement. It puts communities in the forefront of HIV response and suggests that communities must be empowered to play their crucial role in HIV service planning and monitoring. The Strategy aims to unite countries, communities and partners across and beyond the HIV response to take prioritized actions that will accelerate progress towards the vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. It seeks to empower people with the programmes, knowledge and resources they need to claim their rights, protect themselves and thrive in the face of HIV.

In HIV, decision-makers are rarely also users of the HIV and health services over which they exercise control and, in many cases, are not directly accountable to those who are. In many contexts people living with and affected by HIV are low in the priority list of decision-makers—particularly the users of public services and marginalized and criminalized populations. There is correspondingly little information about and accountability for delivering programs that work. In countries with the highest rates of HIV, aid agencies including PEPFAR and the Global Fund provide a significant portion, sometimes most, funding for HIV.

While the community led HIV responses at the local level support positive social transformation by strengthening health and social systems to reach the most marginalized in society. Local ownership, accountability and community leadership in the HIV response ensures greater substantive equality and helps to ensure health as a right for everyone. If we are to reduce HIV-related inequalities and get the response on-track to end AIDS by 2030, communities living with or affected by HIV must lead the way. Communities living with and affected by HIV have been the backbone of the HIV response at every level, from global to national to community. They advocate for effective action; they inform local, national, regional and international responses regarding communities' needs; and they plan, design and deliver services. They also advance the realization of human rights and gender equality, and support the accountability and monitoring of HIV responses. Communities give voice to people who are often excluded from decision-making processes. Effective community-led HIV responses must be adequately resourced and supported to enable communities to play their vital roles as equal, fully-integrated partners in national systems for health and social services.

1.1 Defining Community-Led Monitoring

Addressing continuing challenges in the quality of and access to services is inextricably linked to addressing this accountability deficit in the HIV response. Community-led monitoring offers an opportunity to address both. It trains, supports, equips, and pays members of directly affected communities to themselves carry out routine, ongoing monitoring of the quality and accessibility of HIV 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 to the concept of community-led monitoring—separating it from other modes of quality improvement— is the full integration of evidence-based advocacy into a cycle that brings new information to the attention of decision makers and holds them accountable for acting on that information.

Community-led monitoring is a technique initiated and implemented by local community-led 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 focus is on getting input from recipients of HIV services in a routine and systematic manner that will translate into action and change. Community-led monitoring is especially important for gathering crucial information and observations regarding HIV service delivery from and about key populations and other underserved groups.

Community-led monitoring shares important methodologies with research – and can generate research – ready information. But, it is distinct in that it is focused on improving service quality rather than generating generalizable knowledge. It can be thought about in a general cycle in five parts: data collection, analysis and translation, engagement and dissemination, advocacy, and monitoring.

According to PEPFAR, Community- led monitoring [6]: is a technique initiated and implemented by local community-led 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.

Community- led monitoring is a process by which service users or local communities gather and use the information on service provision or information on local conditions impacting on effective service provision, in order to improve the responsiveness, equity and quality of services and hold service providers to account."

1.2 Why is Community-LedMonitoring Important?

The core principle of community-led monitoring (CLM) is community systems strengthening; reinforced and sustained by systematic capacity building initiatives. Community actors require regular and systematic capacity enhancement to strengthen community-level strategic information development and advocacy capacities. An effective community-led monitoring system contributes towards service quality improvement, efficient crisis response mechanisms, and effective partnership engagement that acts upon service quality issues and/or human rights violations, and protects the safe space that the system has created for the intended beneficiaries. It is particularly important for key populations who are highly stigmatized and marginalized and lack the required data and information needed to participate meaningfully in decision-making that shapes programs and services that directly affect their lives and improve access to and quality of services.

There is a wide range of reports and case studies about community-led monitoring being implemented in several countries across the world. Regardless of the program being monitored, the community-led monitoring ***aims*** to improve the quality and availability/accessibility of services, increase the uptake of services, and enhance health outcomes.

There are a number of factors such as goals, objectives, geographic scope and target population in the implementation of community-led monitoring that contribute to improving quality of health services, uptake of services and health outcomes.

Different reference materials provide varying elements of successful community-led monitoring. They differ in terms of tools, models and approaches; training, skills and expertise needed and deployed; geographic range; type and extent of data and observations gathered; and partnership and collaboration arrangements, among many other factors. Yet despite the differences, all examples refer to efforts by communities to assess the scope and quality of health services and obtain information that can improve access, care and support for all in need. Often the emphasis is on highlighting gaps and challenges in health service delivery – and especially for the most vulnerable and stigmatized populations – and then using the data as the basis for advocacy activities to directly address those shortcomings. However, the following are the desired components of community-led monitoring:

- **Key population involvement in the CLM**. You, as the community of key population, should drive and lead the implementation of community-led monitoring, from the design of the tool to the presentation of your results. Your community's participation is an important part of any community led process. By involving your community leaders, the community service providers you work with and community beneficiaries to whom you reach out, collecting information will not only be easier but also be more valuable from the broader community's perspective.

- **Key population ownership of the CLM**. Your community's act of owning control, responsibility, and oversight is critical to the long-term sustainability of services. Community-led monitoring promotes ownership by offering your community a platform where you can keep track of issues that matter most.

- **Support and buy-in from program implementers**. Program implementers, such as the National AIDS Control Programs, have an important role to play in effective community-led monitoring. The program implementers may provide you with the technical support you need in data collection. It is recommended that you and your community involve the program implementers to promote transparency which may stimulate their buy-in into the community-led monitoring. Evidence-based advocacy will be more effective if program implementers are involved.

CLM is one aspect of the overall community engagement spectrum. It has a critical role to play in identifying and effectively addressing issues and bottlenecks in engaging and retaining people along the prevention and treatment continuums for HIV. This is done through mechanisms that monitor the availability, accessibility, acceptability, equity, and quality of services. Advocacy based on the evidence and observations gathered is an essential final activity of most community monitoring initiatives. The term 'community-led monitoring' has been used, and continues to be used, to refer to a wide range of activities and processes that differ substantially in areas such as what is involved, who is involved, and the purpose of the monitoring itself. At the broadest level, CLM is usually assumed to cover any type of monitoring that involves communities – whatever the monitoring activities, approaches and models comprise, and whether the monitoring consists of communities assessing their own activities or services and systems implemented by other entities. This heterogeneity is why there are many different definitions, even in regard to organizations and institutions focusing only on health-related CLM.

2 Introduction

2.1 Overview and Objectives of CLM

The working definition of community-led monitoring is:

"Community- led monitoring is a framework, which is designed, led and driven by key population community and their networks in identified health service delivery facilities to measure the quality of HIV services, document or gather data and report potential challenges affecting the service delivery chain, and assess the stigma and discrimination experienced by key population communities in health care settings. The gathered data can be used to improve the services and hold service providers to account".

Community- led monitoring should be aligned with organizational goals and objectives, respond to the needs of the community, engage with stakeholders in a meaningful manner and advocate for the improvement of the quality of the HIV services for key population groups. Whereas the objectives of the Community-led monitoring can be fully aligned with the country context and local needs, following broader goals and objectives should be considered:

1. It should enable community and key population networks to gather information, on an on-going basis, about the conditions of HIV services most especially on areas of accessibility (e.g., frequency, distance, convenience and cost) and availability, and quality of HIV services
2. Develop a simple, sustainable, community-friendly mechanisms to routinely collect information on barriers to services, potential policy issues, or any other issues which affect the quality or accessibility of services for KPs.
3. Train country partners (CBOs, community groups, etc.) to strategically use data collected to inform their advocacy and engagement with national authorities and/or other decision-making bodies (i.e. the CCM, National HIV Program, HIV Technical Working Groups, etc.).
4. Engage with national/local program managers and service providers to create a partnership for jointly improving availability, accessibility, and quality of HIV services for KP
5. Contribute to the redesign and improvement of HIV services using the data gathered;
6. Inform the next National AIDS Strategy or other guiding documents using knowledge of community and key population networks and the data gathered;

Goal of CLM:

Community members monitor the delivery of health services and resources that they regularly access. **The goal is to ensure availability, accessibility, quality and regularity of services.**

Additionally, communities can be engaged in monitoring of local conditions or barriers that undermine or hinder the access of health services. For example: incidents of human rights violation, stigma and discrimination within the healthcare settings, denial of services to key population groups etc.

By implementing the community-led monitoring, we are aiming to achieve the following results:

Goal of CLM

By the end CLM intervention programme, it is expected to have a meaningful participation of key populations, their communities, and/or their representatives at all levels in the decision making processes. In addition, the identified key population communities have developed or strengthened their capacities in terms of data collection and dissemination, engagement with national HIV program authorities and local service providers, prioritization of needs in relation to HIV, and advocacy capacity.

Expected tangible outputs from CLM

By the end of the project, we aim to deliver the following:

1. To establish a sustainable community-led feedback mechanism at a country level;
2. Community-level information about the availability, accessibility and quality of services of HIV services for key population communities and monitoring of local conditions or environments for key populations in their access to services;
3. Set of recommendations from the community-led monitoring in improving the HIV services through contributing to the development of National AIDS Strategies.
4. Facilitating synergies and collaborations at the Asia region level directed towards developing greater scope for engagement of regional key population networks for capacity strengthening and support to national networks and organizations for developing and implementing an effective CLM mechanism.

2.2 Approaches of CLM

Our guide outlines three (3) distinct approaches (or tools) for community- led monitoring, which is simple and replicable in your community. The approaches are:

I. Community Score Cards
II. Key Population Beneficiary Perception Survey
III. Community Feedback and Response Mechanism

These models are used by several countries in implementing the community-led monitoring for different purposes, depending on scope of monitoring and the capacity of the community. In implementing the community-led monitoring, it is important that you gather the members of your community and your partners to discuss and agree on which framework to use.

I. Community Score Cards

A community scorecard is a service monitoring tool which enables you to assess and monitor the availability, accessibility and quality of HIV services in consultation with community and stakeholders. It enables community members and health care providers to facilitate collective agreement and action with the goal of improving the quality of the service. It allows the community to meaningfully engage with healthcare and deliberately and positively encourage improvement of service quality, efficiency and accountability. This is achieved by providing space for these two groups to engage in a participatory dialogue that is action based and accountability focused.

Using this approach of CLM, the beneficiaries from your key population community who are accessing HIV services will give a score to a particular HIV service that they have accessed. The scores which may be a figure, facial expression or a numerical value which presents a scale 'very dissatisfied' to 'very satisfied' in relation to user's experience in using the HIV services.

Community members and healthcare providers will collaboratively develop indicators and evaluation criteria for evaluating the services which are captured in your scorecard. Collaboration is crucial to the successful design and implementation of the scorecard. By working together all stakeholders understand "why" for each score. Then community members and service providers gather in an interface meeting to create an action plan for carrying out those improvements.

A scorecard approach provides communities and health workers with data that they can use to measure trend over time and use to advocate for measures to improve service delivery from governmental and nongovernmental stakeholders. This approach facilitates community members to provide feedback directly to their catchment health facility as the scorecard acts as a vehicle for systematically sharing feedback in a transparent and structured manner that enables action and accountability. The strength of this monitoring tool and process is that it emphasizes immediate response to the scores and joint decision making and action among all stakeholders. Service providers receive immediate feedback in a space that allows for mutual dialogue between community members and providers around the indicators and scores. Similarly, improvement actions are identified together and both groups take responsibility for implementing and monitoring them. By working together, the scorecard seeks to create a collaborative and constructive dynamic between all stakeholders that result in action, accountability, and positive change.

This is a participatory approach that is conducted at micro/local level and uses the community as the unit of analysis. It generates information through focus group interactions and enables maximum participation of the local community.

A sample template of a community score card is included with this guiding document, which you can replicate and use with your community to assess the HIV services in your area. Using the template provided at the Annexure, you and your community need to prioritise the issues and agree on the most important and urgent relevant issues to deal with. From these priority issues, develop the indicators and list the issues related to each indicator. Everyone in the key population community must be clear about the process and what has been done so far and what the next steps are.

Some of the benefits of using the community score cards are as follows:

1. Solicits direct engagement and feedback from the community members.
2. Community level data collection allows for engagement of key stakeholders from various groups; the consensus process for determining the score on regular intervals creates a space for dialogue.
3. Flexible methodology that allows for a focus on critical issues for a particular cascade of services or location. For example, at one point score card can be developed and implemented to assess the quality of HIV prevention services, HIV treatment services, health worker behavior toward patients and stigma toward key populations.
4. Action planning process at the end of the scorecard data collection promotes the use of data for decision making, with specific actions identified with timelines and persons responsible (which may include escalating an issue up to the levels of policy makers).

Following steps have been identified to help you and your community for designing and implementing the community score cards:

Step 1: Defining the Scope of Community Score Card means, in consultation with the community you need to decide what will be assessed using the score card. While identifying the scope of the community score card identify,

- HIV services such as prevention (HIV testing, condoms, BCC etc.) Treatment (ART, CD4 and Viral Load tests, TB testing etc.) that the scorecard will focus on
- Overall goal of using the scorecard e.g. assessing availability, access or quality of HIV services or assessing all the aspects
- Geographical coverage and health facilities within those geographies where the assessment will be conducted
- Defining the process of healthcare provider engagement for example conducting orientation meeting, finalizing indicators and deciding a dissemination process
- Define the population and sub-populations within the key community that need to be represented as a part of the assessment process
- Budget considerations, if any

Step 2: Designing the score card needs to be a collaborative process. It is the foundation of the scorecard approach and it needs to be designed strategically so that it effectively monitors and informs improvement in desired areas. Following components need to be completed at this stage:

- Finalizing and defining the scorecard indicators – Indicators are the metrics that provide information to monitor the performance, measure achievements and determine accountability. Indicators should be finalized and defined in consultation with the community and healthcare providers. These indicators will depend on the goal and capture the assessment areas which you have already identified in your step-1
- Deciding and defining the scorecard scales – Scales should be defined in such a way that it is easy for your community to understand and score the quality of the services. There can be different ways of defining the scores for example 1 to 5 or 1 to 10 numbering (1 being lowest and 5 or 10 being highest), other options can be using faces. Select the scale most commonly used and understood within the culture and context of those participating. This will ensure that indicators are scored confidently and consistently by all involved. Designers should also be particularly attuned to literacy rates. If a community is less literate then scales using 'faces' may be more suitable. Most commonly, a scale of 0 to 10 is used with 0 being "not at all/never" and 10 being "completely/all the time." In the scorecard template attached in this guiding document, a system of both numbering and faces has been used on a 10 point scale (0 to 10) which can be adopted based on the requirements and community needs.
- Development of an action plan template - The action plan is the lever of change within the scorecard concept, and it enables communities and healthcare facility providers to better work together to improve service delivery. An action plan should include, required actions to be taken to improve the quality of the services, person(s) responsible for implementing the action, timelines and name of the person who will supervise the action taking process.

Step-3: Designing the score card standard operating procedures ensures that the scorecard is implemented in a consistent, transparent manner, a clear process needs to be defined. Ultimately, this process is captured in a SOP format and it is described in detail in the next section of this toolkit: Process of implementing an effective CLM.

II. Key population Beneficiary Perception Survey

This approach allows you and your community to reach out to the key population who are accessing the health services at your local clinics. You and your community may collect quantitative or qualitative data through a survey tool. The community data collectors may identify key population beneficiaries who may be respondents to the survey and proactively approach them to gather information. Your community may also decide to conduct online or offline surveys to interview users and non-users of services to compare the factors that influence the uptake of testing and to find out about the conditions of testing. Interviewing key informants to obtain information about policies, programmes and services related to testing, counseling, confidentiality and consent can also be considered. This approach will also allow you to understand the motivations, behaviors and experiences of key populations related to access to testing, treatment.

The survey tool used in this approach combines quantifiable open-ended and closed-ended questions to gather information about attitudes, perceptions and experiences of the users. This is a client-focused instrument that can be administered at health facilities. You and your community may follow the stages in designing this approach for community-led monitoring.

Step-1: In agreement with your community, identify the scope of your mechanism. Once agreement is reached, you may design your questionnaire.
Step-2: You may decide if the questionnaire involves quantitative questions or qualitative questions or both.
Step-3: Identify a set of questions according to the scope or service that you have decided to monitor. You can monitor key areas that affect KP and their access to services. In consultation with your community, prioritize and reduce the number of questions, or revise the questions accordingly.
Step-4: Pilot the questionnaire with a small group within your respective community. This will allow you to discern whether you get the information you need from the questions, or how they are asked.
Step-5: Based on the pilot, revise the questionnaire accordingly.

III. Community Feedback and Response Mechanism

The Community Feedback and Response Mechanism enables you and your community, as the beneficiaries, to provide feedback and seek responses in relation to the provision of HIV services in a manner that is human-rights based, non-discriminatory and accessible. An effective community feedback and response mechanism will contribute to the achievement of national program's targets and goals. Most especially, it promotes key population community's meaningful engagement to the implementation of national grant, as well as, increases KP ownership of, and accountability to, HIV programs.

In implementing a Community Feedback and Response Mechanism, a more formalized system needs to be in place. This includes a system of soliciting responses, receiving responses or feedback, processing of feedback gathered and responding to the feedback received. Your community may follow the following stages in designing your community feedback and response mechanism.

Step-1: In agreement with your community, identify the scope of your mechanism. Once agreement is reached, you may design your questionnaire.

Step-2: Decide on a preferred channel. These may include a hotline number set up for the communities to call or an internet-based platform to report feedback or responses in accessing services. This can be identified through a communication needs assessment as different groups or individuals may prefer different channels.

Step-3: Set up your channel. The Community Feedback and Response Mechanism must use your community's preferred communication channel. For example, if your community prefers a local hotline, a mobile phone or locally-operated telephone must be in place.

Step-4: Promote or disseminate information to key populations about this mechanism.

Unlike the previous two approaches, data is acquired when a key population beneficiary or user decides to call your hotline or decides to access your channel to report an incident. In implementing this approach, information needs to be disseminated as widely as possible. This is to inform the key population community accessing services the available platforms for them to report complaints or recommendations to improve the quality of services.

Gathering information at the time of reporting is a crucial element of the process. The report should be objective and precise, focusing on the facts and relevant information that will help to identify necessary actions.

Monitoring from your organizational perspective

One critical step in community-led monitoring is understanding your country's context in relation to HIV epidemiology and the priority needs of your key population community. In understanding these, you can identify the kind of information you will collect and other stakeholders that you need to get involved.

You have to remember that countries are different in terms of key demographic data, HIV epidemiology, and the behaviors of key populations that put them at risk of HIV. Priority areas of service delivery and levels of financing are also different from each country. Each country also has its own set of data or strategic information where the programming is based.

But it is critical for you and your community to understand the prevalence or the most recent number of HIV infections to a particular key population and the service coverage in your own country. Specifically, you and your community must be aware of the following country-level information:

- Provisions for services and commodities under HIV prevention cascade
- Provisions for services and commodities under HIV treatment cascade
- Percentage of people living with HIV who know their status
- Percentage of PLHIV on ART
- ART coverage among those aware of HIV status
- Key structural barriers to access for HIV prevention and treatment services

When you have figured out what your community wants to monitor, the next step is to decide on an approach to monitoring or identify the monitoring tools. Below are models with sample tools that you can consider and adopt in implementing the CLM in your country.

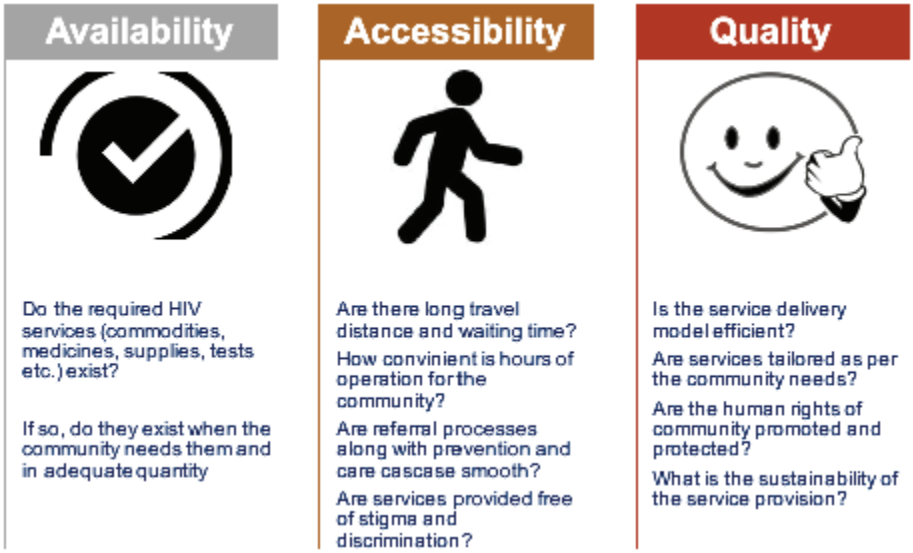
Having focused and targeted Indicators for Community-led Monitoring

The Community-led Monitoring assesses three main areas: the availability of services, the accessibility of services and the quality of services. Your community may want to only focus on one or two or all areas during the process of community-led monitoring. However, it is ideal to include indicators on all three aspects to develop a comprehensive monitoring mechanism that can provide feedback on these aspects. Decisions on which areas to be focused need to be taken in consultation with the community and the stakeholders. The templates of the community score card and key population beneficiary perception survey attached in this guide have provided sample indicators for these areas. However, additional indicators on certain other aspects can be added in consultation with the community and stakeholders, depending upon the needs and availability of the additional services for any particular community e.g., access to social entitlement services for HIV positive clients.

In selecting the model of your community-led monitoring, it is essential that it is targeted and focused. This means that you and your community is encouraged to specify or limit the following:

Scope for Monitoring. The cascade of HIV services at country levels consists of outreach, prevention, HIV testing, pre-test and post-test counseling, and anti-retroviral treatment and care, retained on treatment and achieved viral suppression. Ideally, you and your community may wish to monitor the entire cascade. However, you must also consider the availability of resources and level of program capacity of your community. Having a focused scope for your monitoring will make the implementation more realistic and provide impactful results.

However, the scope of monitoring of HIV services is centered on three aspects i.e. Availability, Accessibility and Quality of the services, as mentioned earlier. While designing the monitoring mechanism for your country, the prevention and treatment cascade can be adopted as per these three areas and indicators can be developed based on the need and availability of such services in national programs.



Target key population. This guide does not make you to choose a key population over the other in the implementation of community-led monitoring. The key populations are identified by the World Health Organization as the most at risk and most affected by the HIV epidemic, hence, they need to be at the center of the response. However, each country's epidemiology is different from the other. One country's HIV epidemic may be driven by people who use drugs, whereas, the others may be by men who are having sex with men or female sex workers. Your target key population, and the services provided for them, for your community-led monitoring will depend on your country's context.

Accessibility. Similarly, the factors that define your and your communities' accessibility is encouraged to be limited in implementing a cycle of community-led monitoring. The accessibility is defined by the quality of services, affordability of servicers, the level of stigma and discrimination, or the local conditions or barriers that prohibit the delivery of health services to your community.

2.3 Development history of CLM Toolkit

APCOM has been working on community monitoring since 2018, with APCOM providing technical support for CLM under the Global Fund's Sustainability of HIV Services for Key Populations in Asia (SKPA) project, which AFAO is the principal recipient.

For the development of this CLM guide a consultation was conducted with country level CLM implementers, stakeholders and other experts and their opinions and suggestions were gathered. Furthermore, desk review of CLM tools (developed by PEPFAR, UNAIDS) was conducted with an intention to make this CLM guide comprehensive and user friendly.

For conducting consultation, three separate discussion guides were developed by consultant and it was approved by APCOM. These discussion guides were particularly used for following category of the respondents:

1. CLM mechanism implementing partners
2. CLM mechanism non-implementing partners
3. Country stakeholders

These discussion guides were divided into separate section which covered aspects of stakeholder and community involvement in the CLM mechanism development and implementation, process of feedback collection from community and data collectors, overall utilization of the CLM mechanism for improved service delivery and community led advocacy, in addition to partner experiences of CLM mechanism development and implementation. A SWOT analysis was conducted with partners during the discussion in order to understand the difficulties faced by them and opportunities available for improved process outputs. The discussion guides used for the consultations can be seen at *Annexure*.

These discussions were facilitated by APCOM where the consultant was introduced to the implementing and non-implementing partners. Consultant coordinated with the partners initially by providing them 3-4 options for holding the discussions through Doodle polls. Every country partner selected a time suitable to them and the discussions were scheduled as per the details provided on table-1. APCOM team supported the consultant to organize the calls on Zoom platform.

The below table provides the details of the schedule for virtual consultations conducted with above mentioned key informants.

Country	SR/ SSR/ Stakeholder Name	Person Contacted
CLM Tool Implementing organizations		
Bhutan, SR	Save the Children	Jamyang Norbu, Project Officer
Bhutan, SSRs	Pride Bhutan	Tenzin Gyeltshen, Executive Director
	Lhak Sam	Dhanraj Rai, IT/Programme Manager
		Deyon Phuntsho, Programme Manager July 27, 2021
	Chithuen Phendhey Association	Dawa Penjor, Programme and Admin Officer
Laos	Community Health and Inclusion Association (CHIas)	Vongphachanh Temmelath, Community Base Support Officer
Mongolia	Youth For Health	Galsanjamts Nyampurev, Project Officer
PNG	Burnette Institute	Maura Elaripe, Project Officer
Sri Lanka	Family Planning Association	Sriyal Nilanka Marasinghe, Programme Officer
		Ranaka Siriwardana, Content Specialist
CLM Tool Non-Implementing SRs and SSRs		
The Philippines	Love Your Self	John Oliver Corciega, Programme Manager
Country Stakeholders		
Bhutan	National HIV/Hepatitis & STIs Control Program, Ministry of Health, Bhutan	Mr. Lekey Khandu, Program Manager (written response collected)
Laos	FHI360	Phayvieng Philakone, Country Representative
		Oudone Souphavanh, Program Officer

2.4 How to use this CLM Toolkit

The community- led monitoring processes are divided into three major categories (fig-1). The below sections of the document provide a detailed understanding of processes involved in establishing, managing and using the CLM results to do evidence-informed advocacy for improved service delivery at the country level. The suggested processes have been divided into three primary sections namely processes involved in designing an effective CLM mechanism, processes involved in implementing an effective CLM mechanism and processes involved in effective use of CLM results for service improvement, in addition to sample tools and formats. These processes have been defined based on the country context, level of CLM implementation in these countries under CLM intervention programme and prior experiences and capacities of community led organizations in the context.

Figure 1: Three stages of effective CLM mechanism

Every step has been briefly explained in the document for ease of understanding. While each of these steps can be further segregated into smaller steps for an orientation to a much detailed planning and implementation process, it is important to note that these processes and steps are essential yet indicative. Country implementing partners have the flexibility to introduce additional steps which might be helpful according to their country's situations.

Among the many issues and opportunities found, there are opportunities for communities to build their capacity to participate in monitoring health services and local conditions

Based on several existing practices on community-led monitoring, this material provides you and your community with an overview of the community-led monitoring process, the purpose for community-led monitoring, and the steps required for its implementation.

3 Process of Developing an Effective CLM Mechanism

3.1 Setting up a multi-stakeholder technical committee

A multi-stakeholder technical committee includes critical and important stakeholders which are essential to ensure that the HIV services in the country are delivered as per the community needs. These stakeholders may include important government officials from the national HIV program/response, officials from other government departments such as social welfare and/or social justice, as the case may be, community leaders, community and/or non-community members from community based organizations and civil society organizations and CCM members etc. among the others.

While the primary objective of setting up the technical committee is to establish a formal mechanism for collecting the inputs and suggestions on each stage of CLM mechanism development and implementation, the scope of this committee can be extended to include other aspects of the effective strategy implementation including providing the recommendations to the government for improving the quality of service as a result of the overall CLM processes.

A detailed ToR for such a committee, explaining the purpose, scope of work and other aspects of management of the committee has been appended at ***Annexure***. Please note that the ToR appended with this guidance toolkit is indicative and it can be modified as per the needs and country context, in order to ensure the most suitable use of the committee's expertise. However, it is strongly recommended that the committee's expertise and position should be used at every step of the CLM implementation process including, but not limited to, deciding the CLM mechanism to be used in your country, finalization of the tools, training of the data collection teams, monitoring of the CLM process implementation and more importantly, for providing the recommendations to the government to facilitate the improvement of the service quality.

3.2 Development and Finalization of the CLM tool

Once the CLM mechanism for the country has been decided in consultation with partners, community, technical committee and other stakeholders, it is advised to formally engage with the national HIV program about the mechanism to be used and also explain the process of deciding the mechanism. The next step after that is development of the CLM tools. The development and finalization of the tools have been divided into following sub tasks:

I. Tool Development

Development of an effective and appropriate tool is one of the essential and most important aspects of establishing a useful CLM mechanism in the country as well as advocating for the changes in the quality of services. It is the data collected from the tool which provides appropriate insights for the availability, accessibility and quality of the services provided to the community. It is important to include these aspects of the service provisions viz. availability, accessibility and quality for all the HIV services available in the country. Inferences and recommendations can be provided to the government for improvement in each of these three aspects separately, based on the feedback received from the community as part of the CLM process.

Specimen of the tools suggested to be used namely Community Score Card, Key Population Beneficiary Perception Survey and Community Feedback and Response Mechanism have been provided at Annexure, separately for both HIV prevention, care and support services. However, these tools can be customized to incorporate the country contexts in terms of available services and need for monitoring certain services.

However, while developing the tools following steps need to be completed before starting tool development process:

- Review epidemic and response situation of the country
- Review different services provisions within the national HIV response
- Identify the scope of the CLM for your country (this can change over the period of time depending upon the relevant changes and improvement in the services)
- Select the CLM approach(es) to be used (among the three approaches of community-led monitoring) in consultation with technical committee
- Select and agree upon the service/s to monitor by CLM in consultation with technical committee and other stakeholders
- Define indicators to monitor the services
- Review and adapt the specimen of tools to serve the country needs

II. Collecting and incorporating suggestions from Community and Stakeholders

Once the draft tools have been developed, it is advised to collect feedback and suggestions from community as well as other stakeholders, in addition to the stakeholders which are part of the technical committee. Collecting and incorporating the community and stakeholder feedback will not only strengthen the tool but it is also one of the essential steps to ensure the engagement of both in the entire process. While the stakeholder feedback can be collected through virtual mechanisms, it is suggested to collect community feedback in a more physical manner. A meeting with important community leaders and members who are accessing the services, can be organized, the draft tools can be presented to them, and feedback can be collected and incorporated. Although, there is no ideal order to collect the feedback between these two important players, however, it is better to first collect community feedback and share the near to final version of the tool to government and other stakeholders in order to avoid multiple rounds of feedback collection.

III. Pilot testing of tools

Pilot testing of the tools will provide the practical and concrete insights into various important aspects such as following:

- Time taken to administer the tool with the community
- Flow of the questionnaire and positioning of certain questions
- Comfort or difficulty faced by interviewers in explain the questions in the tool
- Comfort or difficulty faced by the respondents in understanding the questions in the tool
- Appropriateness of the language used in the tool
- Comfort or difficulty in explaining or understanding the response options provided in the tool
- Comprehensiveness in terms of information coverage
- Skipping, additional instructions etc. for field interviewers
- Testing of the language used and appropriateness of translations

Things to remember:

1. Near to final tool should be used during pilot, which has been finalized after incorporating community and stakeholder feedback

2. Pilot interviews should be conducted by same level of data collectors as for the main survey

3. Respondents selected for pilot testing should be representative of the respondents as for the main survey

4. Feedback from the pilot should be compiled and incorporated in the tool

Although there is no ideal sample of interviews for a pilot testing exercise, it is advised to take a representative of the sites and respondents for pilot exercise so that the inputs from all such sites where main survey will be conducted, can be incorporated.

IV. Finalization of tools

After the pilot testing exercise collect and incorporate the feedback in the tool in order to finalize it. A sample format for collecting the feedback from pilot exercise has been provided at ***Annexure***. The same can be used after customization, for collecting feedback from different sites and/or different interviewers who have conducted the pilot testing of the tools.

3.3 Sample Size Determination and Sampling Procedure

Although there is no ideal sample size for collecting the feedback from the community on the availability, accessibility and quality of the services, however, the efforts should be made to collect a reasonable sample size considering the representation of geographies and community sub-groups, in order to be able to analyze the data and present the substantial results in an effective manner.

The minimum Sample Size is 100

A good maximum sample size is usually 10% as long as it does not exc

There are a few simple approaches with which the sample size for community led monitoring can be determined:

Minimum sample size to get any kind of meaningful result is 100. If your population is less than 100 then you really need to survey all of them. A good maximum sample size is usually around 10% of the total population, as long as this does not exceed 1000. For example, in a population of 5000, 10% would be 500. In a population of 200,000, 10% would be 20,000. This exceeds 1000, so in this case the maximum would be 1000. Even in a population of 200,000, sampling 1000 people will normally give a fairly accurate result. Sampling more than 1000 people won't add much to the accuracy given the extra time and money it would cost.

You can also choose a number between the minimum and maximum depending on the situation. Suppose that you want to assess a facility or a province which has 6000 community members enrolled. The minimum sample would be 100. This would give you a rough, but still useful, idea about their opinions. The maximum sample would be 600, which would give you a fairly accurate idea about their opinions.

Choose a number closer to the minimum if:

- You have limited time and financial resources.
- You only need a rough estimate of the results.
- You don't plan to divide the sample into different groups during the analysis, or you only plan to use a few large subgroups (e.g. MSMs / Transgender).
- You think most people will give similar answers.
- The decisions that will be made based on the results do not have significant consequences.

Choose a number closer to the maximum if:

- You have the time and financial resources to do it.
- It is very important to get accurate results.
- You plan to divide the sample into many different groups during the analysis (e.g. different age groups, socio-economic levels, duration of registration in prevention/ treatment facilities etc.).
- You think people are likely to give very different answers.
- The decisions that will be made based on the results of the survey are important, expensive or have serious consequences.

In practice, most people normally want the results to be as accurate as possible, so the limiting factor is usually time and financial resources. In the example above (between minimum and maximum), if you had the time and resources to survey all 600 clients, that will give you a fairly accurate result. If you don't have enough time or resources and/or other limiting factors then just choose the largest number that you can manage, as long as it's more than 100.

In order to sample the participants for the interviews selection can be of either all or some of the beneficiaries visiting the health facilities on any given day(s) in the week during the period of the data collection. In a facility visited by a limited number of community members, selecting all clients on any given day will be an ideal process of ensuring the adequate sample size. However, in facilities which has relatively higher number of the clients, a mechanism can be devised to select the clients scientifically. For example, once the interviewer reaches to the facility at the time of opening, 1st, 3rd, 5th, 7th, 9th and so on number of clients who visit the facility can be selected to be interviewed. However, if this approach is being followed, important considerations are that you need to roughly know how many clients are registered in the facilities being assessed and on any normal day how many clients visit the facility, so that you can estimate the overall sample for the assessment based on which planning will be done.

However, important aspects to note in any of these sampling techniques is that the facility in-charge needs to be informed about the client sampling process to be followed. It is also essential to collect the list of all registered beneficiaries from the facility in-charge, especially if the number of registered clients is greater than what you need. For one round of data collection, a mix of both selecting all registered clients and sampling the clients on the day of visit, can be used depending upon the number of clients to be found in any facility/site. Sample size and sampling process for the CLM should be finalized in consultation with the multi-stakeholder technical committee and information regarding the same should be shared with the relevant officials in government.

3.4 Approvals and Consent from Government and Other Stakeholders

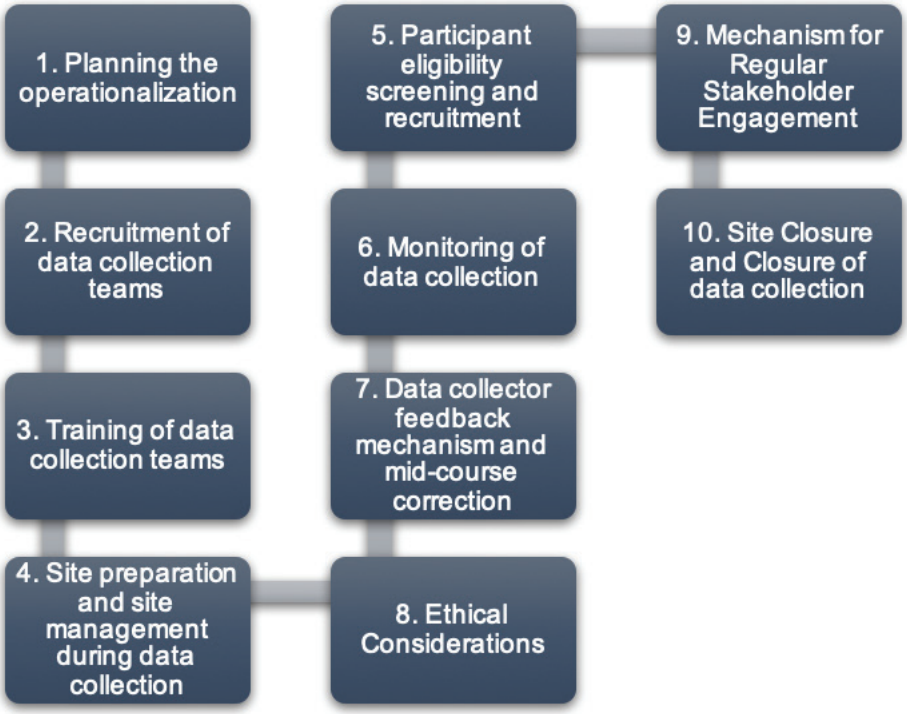
A formal approval and engagement with the National AIDS Control Program should be initiated, before setting up the multi stakeholder technical committee. This final approval can include the tools finalized for the survey, selection of the sites, data collection dates and mechanism among others should be sought before starting the data collection process. At this stage only a formal request should be submitted to the National AIDS Control Program for the approval of tools, data collection sites and for intimating the facilities and their in-charge about the CLM data collection processes. A written communication from the national program can be facilitated by providing a draft intimation letter, as explained in the next paragraph. Ensuring a written communication from the national program will not only ensure smooth data collection process but will also determine the authenticity of the whole process and the interviewers collecting the data.

3.5 Site Preparation before Launch

It is suggested to establish a formal way of communicating to the service sites and service providers about the CLM data collection launch. To facilitate this process, information should be communicated to HIV service sites through a circular, cover letter or other formal communication by the national AIDS program. The monitoring team should further hold meetings or undertake other formal engagements with all district site-level officials to explain the project and ensure easy access to facilities in each geography. Data collectors should be equipped with evidence of these authorizations or understandings as they are dispatched to the field and given appropriate guidance on introducing themselves to the service sites and communities.

4 Process of implementing an effective CLM mechanism

The process of implementing an effective CLM mechanism is divided into ten (10) sub sections.



4.1 Planning the operationalization

After completing the tasks suggested at the level of setting up a CLM mechanism, the implementation of the community-led monitoring should be operationalized. At this stage of the planning, entire implementation plan can be developed. Developing a detailed implementation plan will facilitate the control over the stages and activities involved in the implementation processes. For planning the operationalization, a simple timeline format can be used which can include activities mentioned below such as recruitment and training of the field teams, timeline for data collection, timeline for collecting data collector field back and mid-course correction, if any and timeline for sharing the initial results with stakeholders in addition to development of the report and other advocacy materials. It is advised to involve all team members in the planning process who are associated with the CLM implementation in your organization. Team members can have a detailed discussion about the processes and a detailed plan with the possible timelines can be developed.

4.2 Recruitment of data collection teams

Depending upon the available resources and total sample of the assessment, adequate number of data collection team members should be recruited for the main field work phase, with some provisions of buffer. Before recruiting the data collection team members, program managers need to decide the selection criteria.

Before recruiting the data collection team members, a thorough screening process should be followed to assess their suitability on above aspects. Recruitment of those suitable for the data collection should be done from a resource pool of such suitable individuals.

A minimum qualification criteria such as 10+2 or graduation, a certain number of years of experience in the field of HIV, experience of doing a certain number of similar nature of assignments, and connections with the local community members can be set as criteria for selecting the data collection individuals. While all these aspects can be defined and decided depending upon your local context, it is essential to recruit potential interviewers to collect good quality data.

While it is advised that the data is collected from the same community members for which the survey is being conducted i.e. MSM, Transgender, Female Sex Worker or People who use Drugs, other non-community individuals who have prior experience of working with the key population communities can also be recruited, depending upon the need and situations.

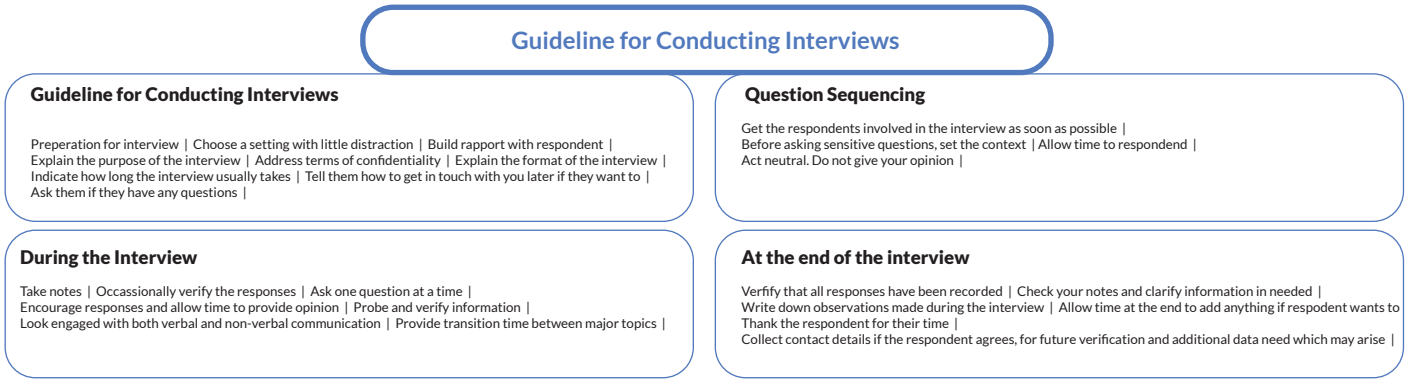
Ideally, a team of 2-3 interviewers should be formed and facilities/sites should be assigned to a team or pair so that the team members can manage the site efficiently and data collected by team members can be verified. It also makes data collection easier and there is another person to reflect with on the challenges encountered.

Many times, especially in case of limited resource availability for CLM, you will need to use the CBO staff or other community volunteers to collect the data. It is advised to develop a pool of such resources who can be used to for CLM data collection. Capacity of this pool of community and CBO human resources can be developed over time to collect the data and implement CLM mechanism.

4.3 Training of data collection teams

Appropriate training of the data collection teams is one of the essential aspects of the CLM implementation process which ensures the accuracy of the data collected through the process without major challenges. Training of these teams should be planned in a thorough and detailed manner involving all stakeholders and team members concerned. While conducting the training of the data collection teams, support should be taken from the multi-stakeholder technical committee and community leaders.

Under the community led monitoring mechanism, it is suggested to plan and conduct a three (3) day training of the data collection teams Or Based on the available resource, the number of training days should be determined. A specimen training agenda for the data collector's training (Appended at Annexure) and training outline has been attached with this guiding document which can be customized and used at the time of data collector training



4.4 Site preparation and site management during data collection

It is important that the facility/site in-charge understands the details of the project and the importance of working together. The project team needs to build a good working relationship with the facility. To do this, data collectors will need to introduce themselves properly before they start any interview or conversation, present the copy of letter of support sent by the national program and explain the purpose of the visit. Before the data collector goes to the clinic, they should familiarize themselves with this guidebook and the data collection tool and have all the information they need to discuss the purpose and details of the project.

Data collectors should contact the clinic to set up a meeting with the facility/site in-charge to introduce the project. During the meeting, data collectors should describe the background of the project, the monitoring cycle, and the specific surveys they will undertake. They should explain that there is permission from the relevant authorities and show the facility in-charge evidence of the permission. They should also explain that the exercise feeds back findings and potential solutions on a regular basis at a time to be arranged and convenient for the facility in-charge. If data collectors have any challenges accessing the clinic and/or the clients, they should contact the supervisor or data collection manager.

4.5 Participant eligibility screening and recruitment

All data collectors should screen the eligibility and recruit the respondents before starting the data collection. The client eligibility and recruitment process should be explained in detail to the data collection team members at the time of their training. Additionally, a note on client recruitment and an eligibility screening tool can also be developed before the launch of the data collection. The recruitment note should be available with the data collection team members at all times of data collection and the eligibility screening tool can be appended at the beginning of the main survey tool. The recruitment note should explain the process of client recruitment and selection as explained under the “Sample Size Determination and Sampling Procedure”.

4.6 Monitoring of data collection

The program team can establish a system of data collection monitoring. Ideally this system should be in place before the launch of the data collection. Different methods of monitoring can be followed such as deploying a supervisor for a team of data collectors, introducing community monitors which can be community leaders, members of the technical committee and program staff. While the team supervisor should accompany them during the field work and supervise the data collection processes, a regular frequency of the monitoring visits by other possible monitors can be decided.

During the monitoring visits, the monitors need to assess the data collection of following aspects:

1. Whether the processes defined for data collection are followed by the team members?
2. Whether the local stakeholders and facility/site in-charge have been communicated and are part of the process?
3. Whether the data collection teams are interviewing the right respondents?
4. Whether the questions are asked in the intended manner?
5. Whether the answers are recorded appropriately?
6. If there is any provision of client compensation, whether the clients are provided the appropriate compensation?

Additionally, both team supervisors and monitors should conduct a certain percentage of the back checks and scrutiny of the data in order to determine the accuracy of the data. The percentage for the back checks and scrutiny should be defined at the time of establishing the monitoring mechanism.

4.7 Data collector feedback mechanism and mid-course correction

Although appropriate planning, effective training and detailed explanation of the procedures and protocols will reduce the chances of issues at the time of data collection, still the data collectors may face certain issues during data collection. These issues can be related with both the survey tools and/or processes involved in the data collection. A regular feedback mechanism should be in place to collect the interviewer feedback. The same can also be facilitated through the team supervisors where they can collect regular feedback from the interviewers can share the same with project team at the national level. The issues faced by them should be resolved on priority in order to continue the data collection and complete it as per the timelines. However, in some instances the mid-course correction may require more time such as changes in the data collection tool, in that case appropriate measures should be taken to ensure the accuracy of the data as well as completion of the data collection within the timelines.

4.8 Client Safety and Security Protocols: informed consent, potential risks, benefits and mitigation strategies

There are certain safety and security protocols to be followed especially during the data collection and analysis processes. These protocols include obtaining consent from respondents before data collection, ensuring confidentiality of their information, providing independence to the respondent to refuse to answer any question or section and leave the interview at any point they don't feel comfortable and mitigation of risks for respondents if there are any such as fear of identity disclosure. Therefore, before starting the data collection and analysis a list of such protocols should be developed and all individuals involved in the community-based monitoring processes especially data collection and analysis should be aware about such protocols to be followed. A detailed understanding of the ethical protocols should be developed for the interviewers and other members of the data collection teams during the training. Additionally, they should be aware about the mitigation strategies to be followed in case of any adverse events during the data collection processes.

Informed consent refers to giving people all the information they need to decide if they want to answer your questions or not before you interview them. This means that they will need to know:

a) Who you are and why you want to talk to them
b) What information you want and what you will do with it
c) That participation is completely voluntary and they can skip or refuse to answer any questions
d) That we will never share their name or personal information unless they give us permission to do so.

Written informed consent should be taken from all recruited and interviewed respondents. During the consent process the respondents should be explained all possible risks, benefits and mitigation strategies available at disposal. Every client interviewed should be provided an opportunity and time to read the consent form developed for the study. A copy of the consent form should be provided to the respondents and a signed copy should be obtained by the interviewers.

4.9 Mechanism for Regular Stakeholder Engagement

At the time of CLM implementation it is also necessary that the stakeholders are regularly engaged and informed about the progress made in the field and any issues or adverse events. While it is important to keep the stakeholders informed and engaged it is essential to provide regular updates and feedback to the government officials about the progress of the CLM implementation. These updates can be in the form of issues faced by the field teams, status of data collection and preliminary findings, depending upon the stage of the data collection. While updates on issues in the field and status of the data collection has different purpose, the purpose of sharing the preliminary findings is to provide an indication to the government officials about the nature of the overall findings. This doesn't only keep them engaged in the processes but also prepares them for the results of the monitoring.

4.10 Site Closure and Closure of data collection

Site closure is an important activity for a particular site whereas the closure of the data collection is for the entire process of data collection. At both the stages of site closure and completion of the data collection, relevant officials such as facility/site in-charge, national program officials, members of the technical committee etc. should be informed about the completion of the data collection. For site level data collection it is extremely important as the implementation of the community led monitoring is a regular activity and the data collection will require to visit the facility/site again and building a cordial relation with the in-charge will be helpful for future stages of data collection.

Minimizing Risk of COVID-19

During COVID pandemic it would be usually difficult to conduct the face to face data collection as prevention and safety protocols are put in place by the government on gatherings. However, in this situation, it is advised to review the local prevention and safety protocols laid down by the government and follow the same during data collection. Both interviewers and study participants need to follow the prevention protocols applicable in local context. Interviewers need to carry prevention commodities such as masks, sanitizers etc. at all times of data collection, in addition to maintaining social distancing. Instructions for both interviewer and client prevention and safety aspects need to be provided to the interviewers during the training and the same need to be monitored at the time of field visits by monitoring teams.

Considering the pandemic situation, a set of strategies have to be listed out to prevent the transmission of COVID-19 among the investigators and the respondents. These strategies should includes list of instructions under selection of geographical area, selection of investigators and respondents as well as steps to be followed during interview and group discussion.

Selection of Geographical Area

- The selection of geographical area should be done considering the COVID-19 situation in the region.
- Any facility/site falling under the containment zone should be avoided for the study.
- A provision of back up arrangement has to be made for replacement of facilities/sites considering the COVID-19 situation.

Selection of Investigators and Respondents

- All individuals should be assessed for COVID related symptoms before participation in the study as respondents or investigators.
- A dedicated area should be pre-arranged in the facility/sites for conducting the interviews, in case of face to face data collection.
- The facility in-charge should be informed and the dedicated area should be sanitized before the interviews.
- In case of discussions and/or group gatherings, the total number of individuals should not exceed from 5-6 at any given point of time.
- All members of the data collection team as well as respondents should follow social distancing at all times

Steps to be followed on field during conducting an Interview and/or discussion

- Health Monitoring for all investigators should be done on daily basis. This includes daily recording of body temperature using infra-red thermal scanner prior to going on field, looking for COVID-19 Symptoms like cough, cold, body ache, difficulty in breathing etc.
- 2 Masks and 1 small bottle of Sanitizer should be given to the investigators on a daily basis for usage during the data collection.
- It should be mandatory for investigators to wear mask during the data collection process.
- A bottle of hand sanitizer should be kept in the designated space for interview / group discussion which would be used for all the respondents coming to participate in the study.
- All respondents should be instructed to wear masks and maintain social distancing during the duration of interview and discussion.

However, if physical data collection is not allowed due to the surge in COVID infections in the country and/or any particular geography where the data collection need to happen, other data collection mechanisms need to be explored. In such situations the possible options can be telephonic interviews or online surveys such as Google Forms, Typeform, SurveyMonkey, SoGoSurvey, Qualaroo, ProProfsSurvey Maker and Survey Planet which are available without any additional cost involved. However, it is important to customize data collection tools, monitoring mechanisms and stakeholder engagement mechanisms as per the data collection method.

5 Process of Generating Insights for Evidence Informed Advocacy

5.1 Data Storage and Management

The community led monitoring process yields significant data and this data must be managed accurately to ensure that analyses and, ultimately, decisions that result from analyses are accurate and representative. It is suggested to develop a data management plan, a formal document that states how data will be collected and managed, by whom, and who has access to the data. It also defines:

A. Who is responsible for collecting the CLM data?
B. What tools will be used to collect the data?
(E.g. hard copy questionnaire, software, google form, etc.)
C. Where and how the data will be saved?
D. Who all have access to data collected through the CLM process?
E. How to protect the client privacy and confidentiality?
F. Process for data cleaning and data scrutiny

This data storage and management plan should be developed soon after the start of the data collection process. This management should be comprehensive to be able to refer to for all processes related with the data.

5.2 Steps and stages to design the analysis template

Following steps can be followed for designing an analysis template:

i. Data cleaning and treatment of outliers
ii. Defining variable labels and value labels as per the questionnaire
iii. Development of a detailed analysis plan.
iv. Syntaxes development and table generation

It is important to note that for the providing community feedback on the quality of HIV services, no sophisticated analysis is required. Whereas, the data should be analyzed in a manner which is easy to explain to the stakeholders and the community. For that purpose simple statistical analysis such as means (average or the most common value) can be provided. The idea here is to provide the insights on the quality of services delivered to the community. Which can be done by simple frequency and percentages as well. However, what is important to explain through the data is the reason behind an occurring phenomenon and possible solutions.

5.3 Development of Report other advocacy materials

Once the data is analyzed and tables are prepared, the report should be developed. A report structure should be finalized in consultation with the technical committee and the report should be developed on the same structure. However, in addition to the detailed report other useful material can also be developed using the CLM data. These materials such as 2-3 page advocacy note can be easily used to provide the key findings from the survey along with the recommendations. In the detailed report as well, it is important to segregate the data and the inferences for site/facility level findings to understand the differences.

Important thing to note is that higher level policy change is a long term process and will require consistent networking and advocacy with government including strategic use the community and stakeholders. However, you need to look at simpler interventions addressing service delivery issues such as facility opening time, staff attitude, waiting times, availability of commodities etc. Some of these might take direct intervention with service providers or program managers. While designing the tools as well as advocacy materials you need to focus on such smaller issues to start with in order to build credibility of the CBM systems for both community and stakeholders.

5.4 Procedures for Dissemination of results

Findings of the community- led monitoring process can be shared in a dissemination event involving the stakeholders and the community. These dissemination events can be online and offline events where the government, community and other stakeholders are present. Findings from the CLM data along with the recommendations should be presented and the government should be provided with simple and easy to implement solutions for the issues which matter to the community. You can also invite community members to share their personal experiences about the major areas of concerns which are emerging from the CLM. The multi-stakeholder technical committee should be used to forward the recommendations of the monitoring processes to the government. The dissemination of the findings can be multiple events in order to ensure that the findings of the monitoring are adopted by the government and action is taken to facilitate the appropriate changes.

While a formal dissemination event is advised to be organized for sharing the results, it is not necessary that the results of the CLM should always be shared in a formal dissemination event only. You should look for opportunities where the required officials from government and other stakeholders will be available and such gatherings should be used to discuss the CLM findings in an organized manner. Since you and your organization closely work with the government and will receive intimation of such meetings/events/gathering prior to the event, discussion on findings of the CLM can also be included in such events in consultation with the government. In a situation where there won't be enough financial resources available for regularly conducting the CLM, such opportunities will be helpful to facilitate the dissemination and share recommendations.

5.5 Substantiating Results for Desired Changes

Although it is advised to use standard tools and process to the extent possible, at the same time it is recommended to use other methods of data collection and mechanisms of collecting insights to substantiate the results which have been gathered as part of CLM mechanism. For example, if the quantitative data has been collected through a community score card method the results can be substantiated for each facility by collecting the qualitative data through key informant interviews and semi-structured questionnaires from the service providers in order to understand the processes which are followed. By doing so a logical explanation can be provided for the better services delivery at some centers and possible recommendations for improving the services for centers which are not performing well. It is also easier for the government to understand the differences when the comparison is drawn in such a manner between two health facilities and action points can also be clearly defined by the government.

5.6 Usefulness of Insights and Recommendations

Usefulness of the insights and the entire processes of the CLM as a whole can be ensured when the recommendations to the government are provided in such a way which can be implemented. These recommendations need to be clear, community specific and need to explain the adverse impact on the community.

It is ideal to start focusing on smaller changes. Once these mechanism are set up on the country level, government is on board with the entire mechanisms and involved processes then the bigger issues and more serious aspects can be picked up. Idea is to gain the government's confidence in the whole process of CLM as well as community's feedback on the provided services.

5.7 Follow through on the recommendations and suggestions

One of the most important aspects of the whole process is follow through the suggestions and recommendations. Once the CLM mechanism is set up, data is collected and recommendations are shared along with the results and insights, it is not only essential but necessary to develop mechanisms to follow through the suggestions and recommendations which have been provided to the government. It is easier to do so through the multi-stakeholder technical committee.

5.8 Sustainability of CBM Processes

For the CLM to be successful, it needs to be a continuous process in which all participants are engaged and committed to implementing the action plans. The CLM process does not end after the first set of meetings, a first round of feedback, and an initial action plan. It is an iterative and continual process. CLM meetings lead to action plans, action plans should be implemented, the group should reconvene to evaluate progress against the action plan and recollect the data to monitor progress, and identify additional areas to work on – and so on. Continually repeating the CLM process institutionalizes the practice of working together to identify and solve issues. This process of continuous improvement will yield results which, in turn, will motivate stakeholders and keep them committed to ensuring that all community members can access quality services.

Similarly, institutionalization of the CLM at your organizational level is also important.. Being the national networks of key population communities and civil society organizations working with the key populations, it is essential that the community led monitoring of the services should be performed and your organization should engage with the government on regular basis for improving the services for key populations. In order to institutionalize the CLM in the national HIV response led by your organization, following aspects need to be ensured.

Government and Stakeholder Commitment:

The CLM process will work only if it is fully adopted by the community and stakeholders. This concept is most successful when each group is fully contributing and ensuring their voices and expectations are heard and represented in designing and implementing the CLM. Inviting diverse populations to participate in designing the CLM guarantees that it is not only relevant but that it encapsulates the knowledge and capacity of those living in and seeking care from the system in order to best understand and ultimately resolve the issues.

Commitment to Action Plans:

Action plans are the crux of the CLM concept. They are where ideas translate into action. Action plans direct 'change,' but their effectiveness depends on commitment to the community, follow through by those implementing them and actions facilitated with the government for implementing the recommendations. By enacting action plans, you will enable improvements and see the value of CLM.

Locally Relevant:

In order for the CLM to be effective in facilitating positive change, it must measure attributes of the health system that communities want to see improved. This principle is also applicable to the action plans. Prescribing actions makes the process less community driven and reliant on the community's advantage in understanding what actions are likely to address issues uncovered by the CLM within a particular context. In fact, it might have a negative effect on the problem, which could, in turn, disempower the community and undermine the overall process. Community members have unique and intimate experience with the health system, including knowledge of specific obstacles to access to care and various other's willingness and capacity for making improvements.

Support of Decision Makers within Government System:

Ensuring commitment to the senior officials is essential. Whether reviewing CLM data analysis or approving resources needed to enact action plans, senior stakeholder support will propel efforts forward. The CLM has a greater chance of success when the system and processes are properly vetted and approved by decision makers (community leaders, health facility directors, National AIDS control Program director ministry policy directors etc.). This reduces the likelihood of experiencing major challenges in implementation.

6 Sample Tools, Templates and Other resources

6.1 Annexure-1: Terms of Reference for Multi-Stakeholder Technical Committee:

Purpose

The Multi-stakeholder Technical Committee is an independent ad-hoc committee constituted to provide inputs for effective implement of community led monitoring mechanism in the country. The committee will also monitor the implementation of the CLM and will be used to advocate for the changes based on the recommendations of the overall CLM process for improving the quality of the HIV services in the country. The purposes of the committee are as follows:

1. Provide technical input for the development and implementation of community- led monitoring mechanism
2. Support the CLM tool development process by providing inputs as per the community needs and experiences
3. Provide training to data collection teams on the use of monitoring tools.
4. Sensitize and/or train relevant stakeholders and decision makers on CLM systems and processes.
5. Facilitate, supervise and participate in pilot testing of tools with target populations; and document lessons learned from the pilot tests.
6. Oversee the roll-out of CLM tools as per implementation work plan.
7. Ensure that key populations and beneficiary feedback is a central consideration in all aspects of tool development and implementation.
8. Advocate with the government and policy makers for the changes in the availability, accessibility and quality of the HIV services, based on the results and recommendations gathered as part of the CLM processes.

Scope of Work

1. Collate existing community-led monitoring tools which has been utilized to collect information regarding stigma and discrimination, quality of service delivery, human rights violations, treatment and inventory stock-out etc. which has been implemented for HIV programme.
2. Analyze content of tools and select sections of the tools which are relevant and can be utilized.
3. Deliberate on the strengths and weaknesses of the tools; taking into consideration lessons learned from the implementation of those tools.
4. Review available tools from the region (and global) for adaptation as the committee sees fit.
5. Agree on a set of tools and mechanisms to support the CLM strategy to include a comprehensive client satisfaction survey with standard questions on availability, accessibility and quality of services.
6. Develop standard operating procedures, terms of references for data collectors, and training implementation manuals for CLM system.
7. Conduct monitoring and supervision of the data collection process and provide inputs to the data collection teams on appropriateness of the processes followed during data collection, including stakeholder engagement

8. Support and provide inputs in report development and development of other useful advocacy materials which can be used to inform the government and policy makers about the results and recommendations of the CLM processes
9. Support the community networks and CBOs in planning and designing dissemination processes and protocols post development of the report
10. Advocate with the government and policy makers for changes in the availability, accessibility and quality of the HIV services based on the finalized set of recommendations as part of the CLM processes

Selection Criteria for Committee Membership

The Multi-stakeholder Technical Committee members shall collectively fulfil the following criteria:

1. Individuals representing key populations, key affected populations or persons living with HIV
2. Individuals representing academic institutions and research institutions with knowledge on public health and community research methodologies.
3. Individuals representing HIV intervention implementation agencies from government, technical partners and non-government organizations
4. Community leaders and advocates with experience of engagement with community and government on improvement of HIV services in the country
5. Individuals from community based organizations and civil society organizations with experience of working in HIV program at the national or regional levels
6. Members of the community coordination mechanism representing the HIV programs and communities

The total number of committee members may differ as per the needs and country context, however, it is advised to include 10-12 individuals, with fair representation of gender, sexual diversity and people working in the field of HIV.

Frequency of Meetings and Reporting

The Multi-stakeholder Technical Committee can meet as and when there is a need, especially during the time of CLM development and implementation in the country. However, on a regular basis a quarterly meeting is advised to review the progress of CLM in the country and plan way forward.

Deliverables

1. Set of community-led monitoring tools.
2. Standard operating procedures, terms of references for data collectors, and training and implementation manuals for CLM system.
3. Data collection monitoring visit reports and inputs
4. Dissemination plan and evidence of advocacy with government and policy makers for desired changes in the service provisions
5. Quarterly meeting reports

6.2 Annexure-2: Sample CLM Tools: Community Score Card

Community Score Card:

Name of the Person Collecting Data:	
Name of Health Centre Servicing the Community:	
Name of Community:	
District/Province Name:	
Date of data collection:	

Instructions:

Ask your community group each question.

Allow them to discuss and then score their answer using the scale below.

Please note –
if the question is not applicable or there is no available information, or the respondent do not have an answer to the question - select "0".

Needs urgent attention	Needs improvement					Meets expectation			Exceeds expectations	
0	1	2	3	4	5	6	7	8	9	10
No / Never / Not available or Does Not Exist Or respondent is not aware	Very Poor	Poor	Well below average	Below average	Average / Sometimes	Above average	Well above average	Good	Very good	Yes / Always / Excellent

	Indicators/Questions	Score (0-10)	Reasons / Comments
1	**Accessibility of the health facility**		
1.1	It is easy for me to reach the health facility		
1.2	Facility timing is convenient for me		
1.3	Facility was open during my last visit		
1.4	Facility was fully functional during my last visit		

2	**Availability of basic physical infrastructure**		
2.1	There is basic cleanliness at the health facility		
2.2	Usable toilet facility is available at the health facility		
2.3	Designated waiting area with proper seating arrangements is available at the health facility		
2.4	Drinking water facility is available at the health facility		
2.5	Separate counselling room is available at the health facility		
2.6	All staff members *(doctor, counsellor, community liaison person etc.)* were available at the time of my visit		

3	**HIV Service Availability and Accessibility**		
3.1	HIV testing facility was available at the health facility		
3.2	I was provided information on availability of HIV commodities such as condoms and lubricants		
3.3	I was provided information on additional prevention services such as PrEP and PEP		
Applicable to PLHIV Community			
3.4	CD4 reagent and kits were available at the health facility		
3.5	ART medicine was available at the health facility		

4	**Quality of Health Centre Services**		
4.1	I was able to access HIV testing and counselling services		
4.2	Pre- and post-test counselling was provided during HIV testing		
4.3	I was given counselling on STI management or signs and symptoms		
4.4	HIV/AIDS educational and IEC materials were displayed at the facility		
4.5	Information provided on additional prevention services such as PrEP and PEP, was useful for me		
Applicable to PLHIV Community			
4.6	ART initiation counselling was effective and useful for me		
4.7	Adherence counselling was effective and useful for me		

5	Prevention Commodities Availability and Accessibility (Discuss as per specific need of KP)		
5.1	Condoms were available at the health facility		
5.2	Condoms were provided to me at the time of my visit		
5.3	Lubricant was available at the health facility		
5.4	Lubricant was provided to me at the time of my visit		
5.5	Needles and syringes were available at the health facility		
5.6	Needles and syringes were provided to me at the time of my visit		
5.7	OST was available at the health facility		
5.8	OST was provided to me at the time of my visit		

6	Stigma and Discrimination – HIV/AIDS-related		
6.1	I was treated respectfully ICTC/ART centre		
6.2	Facilities staff keeps my information private and confidential		
6.3	My records (such as test results and documents) are kept confidential and private at the health facility		
6.4	Healthcare providers do not judge me because of my sexual and gender identity		
6.5	Healthcare providers do not judge me because of my HIV status		
6.6	Healthcare providers do not deny me services because of my sexual and gender identity		
6.7	Healthcare providers do not treat me differently because of my sexual and gender identity		
6.8	Healthcare providers treat me like any other client		
6.9	Healthcare providers treat me with respect		

7	Local Communities Attitudes Towards Key Population		
7.1	Local community is respectful towards **female sex workers**?		
7.2	Local community is respectful towards **men who have sex with men**?		
7.3	Local community is respectful towards **people who inject drugs**?		
7.4	Local community is respectful towards **Transgender persons**?		
7.5	Local community is respectful towards **PLHIV community**?		
7.6	My community members do not face stigma and discrimination by general population		
7.7	My community is treated with respect by general population		
7.8	My community members are accepted by their family		

8	COVID-19 related prevention protocols		
8.1	I was satisfied with the COVID-19 prevention protocols followed by the health facility staff		
8.2	I was satisfied with prevention protocols laid down for me		
8.3	Healthcare providers have access to sanitizer, masks, face shield etc.		
8.4	Healthcare providers were using the prevention materials such as sanitizer, mask and face shield		
8.5	Health facility staff practices social distancing		
8.6	I was provided with prevention materials such as sanitizer		
8.7	I was informed about the prevention protocols to be followed at the health facility		
8.8	Others visiting the health facility were informed about the COVID prevention protocols to be followed		
8.9	Other visiting the health facility were following the prevention protocols such as wearing masks, using sanitizer and practising social distancing		

6.3 Annexure-3: Sample CLM Tools: Key Population Beneficiary Perception Survey Tool

Prevention Services			
S. No.	**Questions**	**Options**	**Code**
1.	What is the approximate distance between the health facility and your residence?	In Kms	
2.	What modes of transport do you user to reach to the health facility? (Multiple Choice)	Walk	1
		Public transport	2
		Personal Vehicle	3
		Other	4
3.	Is public transport easily available from your place of residence to health facility?	Yes	1
		No	2
4.	Is the timing of the health facility convenient for you?	Yes	1
		No	2
5.	If "Not", why?		
6.	Is the facility open and functional when you visit during its working hours (As per the programme guidance)?	Yes	1
		No	2
7.	Are following facilities available in the health facility premises? (Checklist/Multiple choice)	Waiting Area	1
		Usable Toilet	2
		Seating (Chairs, sofa etc.)	3
		Closed room for counselling	4
		Drinking water facility	5
		Complaint box	6
8.	Are the following items available (on request) during visit?	Condoms	1
		Lubricants	2
9.	Is the health facility premises found clean during the visits?	Yes	1
		No	2
10.	Were the staff helpful during your visit to the health facility?	Yes	1
		No	2
11.	If "Not", why?		
12.	Have the staff behaved rudely to you?	Yes	1
		No	2
13.	If "Yes", provide the details of the incident		
14.	Were the staff present practicing Covid-19 safety precautions such as the following:	Hand Sanitiser,	1
		Face mask	2
	(Checklist/MCQ)	Face shield	3
		Social Distancing	4
15.	Were you provided with Pre-Test Counselling	Yes	1
		No	2
16.	If yes, was the information provided during the pre-test counselling useful?	Yes	1
		No	2
17.	What all was discussed during the pre-test counselling?	Recoverd Verbatim	
		Do not remember	99

18.	Did the counsellor demonstrate correct condom usage?	Yes	1
		No	2
19.	Was the counsellor in a hurry to finish the session?	Yes	1
		No	2
20.	If "Yes", why do you think that the counsellor was in a hurry?	Recoverd Verbatim	
21.	Did the counsellor give you the time you needed?	Yes	1
		No	2
22.	Were you able to talk freely with the counsellor?	Yes	1
		No	2
23.	If "Not", why?		
24.	Did you still have any question that you could not ask?	Yes	1
		No	2
25.	If "Yes", what questions you could not ask and why?		
26.	Do you remember the average waiting time before the counsellor calls you in? **(Multiple choice Question)**	More than 30 minutes	1
		15-30 minutes	2
		5 - 15 minutes	3
		Less than 5 minutes	4
		No Time	5
27.	Did the counsellor ever visit you in the field?	Yes	1
		No	2

28.	Have you been sent away without testing because of non-availability of the following: **(Multiple choice Question)**	Lab technicians	1
		Test kits (1st)	2
		Test Kits (2nd and 3rd)	3
		Not been sent away for these reasons	4
		N/A	5
29.	Did you give blood for testing at the same center?	Yes	1
		No	2
30.	If not, did you go to another location to give blood?	Yes	1
		No	2
31.	If Yes, Did the counsellor guide you on how to reach there?	Yes	1
		No	2
32.	Were you referred to other OPD's or service delivery points for additional services?	Yes	1
		No	2
33.	If Yes, Did you get any guidance to the other essential OPD services?	Yes	1
		No	2
34.	If Yes, did you finally reach the other essential OPD services?	Yes	1
		No	2
35.	If YES, Did you receive a referral slip?	Yes	1
		No	2
36.	Was it given in the language you understood?	Yes	1
		No	2
37.	Was it legible/ could you understand what was written?	Yes	1
		No	2
38.	Did you need to ask for help to understand what was written?	Yes	1
		No	2
39.	Were there visible signage present at the center?	Yes	1
		No	2
40.	If yes, Was it easy to follow?	Yes	1
		No	2
41.	Did you collect the report by yourself?	Yes	1
		No	2
42.	If yes, did you receive post-test counselling before receiving the report?	Yes	1
		No	2
43.	If yes, Did you receive the report on the same day?	Yes	1
		No	2

44.	If no, Did someone collect the report on your behalf?	Yes	1
		No	2
45.	Have you ever been asked to buy any of the following?	Syringe	1
		Needles	2
		Cotton	3
		Spirit	4
		Medicine	5
		Stationary Items	6
		None/ Have not been asked to buy	7
46.	Have you ever been asked to pay for any services in the health facility?	Yes	1
		No	2
47.	If yes, for what services were you asked to pay?	(TEXT)	
48.	If yes, what was the amount that you paid?	(TEXT)	
49.	If yes, to whom did you pay the amount to?	(TEXT)	
50.	Did you face any issues while getting the service?	Yes	1
		No	2
51.	If YES, what issues did you face?	(TEXT)	
52.	If YES, who did you contact to solve the issue?	(TEXT)	
53.	If Yes, through what means did you communicate your problem?	(TEXT)	
54.	If YES, was the problem solved?	Yes	1
		No	2
55.	Please share any specific area / issue in the facility that needs improvement – (in areas of facility, services, staff attitude, commodity, any other)		

Treatment Services			
1.	Do you know how frequently you should undergo Viral Load testing?	Yes	1
		No	2
2.	According to you what is the frequency?		
3.	Do you know how frequently you should undergo CD4 testing?	Yes	1
		No	2
4.	According to you what is the frequency?		
5.	Were you ever informed by the health facility staff about frequency of viral load and CD4 testing?	Yes	1
		No	2
6.	Were you examined by a Medical Officer during every visit to ART Centre?	Yes	1
		No	2
7.	If "Not", why?		
8.	Were necessary medicines administered at the centre?	Yes	1
		No	2
9.	Have you ever taken half-doses of ART medicine to overcome the possibility of limited supply?	Yes	1
		No	2
10.	Were you aware that there is multi month dispensation of ART medicines for some PLHIVs?	Yes	1
		No	2
11.	Has the health facility staff ever informed about about the multi-month dispensing?	Yes	1
		No	2
12.	Were you provided information on testing for opportunistic infections such as TB?	Yes	1
		No	2
13.	Did you give the sample for TB testing?	Yes	1

		No	2
14.	Was the report collected by you?	Yes	1
		No	2
15.	If yes, were you provided post-test counselling?	Yes	1
		No	2
16.	Was the post-test counselling helpful for you?	Yes	1
		No	2
17.	If "Not", why?		
18.	Were your doubts cleared during the post-test counselling, if you had any doubts?	Yes	1
		No	2

Other Tests			
1.	Availability of STI Testing and management of STI?	Yes	1
		No	2
2.	Was the report collected by the respondent?	Yes	1
		No	2
3.	Pre and post-test counselling provided?	Yes	1
		No	2
4.	If "Not", why?		
5.	Where was the blood sample given for STI testing?	Yes	1
		No	2
6.	If not in the same premise, was the client provided adequate information and guidance to access the other health center?	Yes	1
		No	2
7.	Issues and difficulty faced by the client while going for other tests	Yes	1
		No	2

Stigma and Discrimination			
1.	Has any of the health facility staff treated you differently during your visits?	Yes	1
		No	2
2.	At any point did you feel that you were not given the respect that you deserved?	Yes	1
		No	2
3.	Were you called by offensive names at any point during your visit to the health facility?	Yes	1
		No	2
4.	Were you stared by any of the health staff during your visit to the health facility?	Yes	1
		No	2
5.	Were you ever made to wait unnecessarily during your visit to the health facility?	Yes	1
		No	2
6.	Were you told that any of the facility is not available even though the same service was provided to others at the time of your visit?	Yes	1
		No	2
7.	Have you ever reported any such incident of being unequally treated to anyone within or outside the health facility?	Yes	1
		No	2
8.	If yes, was any action taken on your complaint?	Yes	1
		No	2
9.	If "Not", why?		

6.4 Annexure-4: Sample CLM Tools: Community Feedback and Response Mechanism Tool

General Information (Common for both)						
A1	Name of the organization/ network reporting the incident:		A2	Partner Network(s):		
A3	City/ district/ province		A4	Name of the person reported incident:		
A5	Implementation Period:		A6	Unique identity code (if available):		
A7	Date of feedback or response:	DD/MM/YYYY	A8	Incident reported by "Self"?	1. Yes	2. No
A9	Key Population Category		A10	Address and contact details		
A11	Feedback and Response Category	1. Stigma, discrimination, human rights violation 2. Quality of services 3. Recommendations for service improvement 4. Other (specify) _____				

Incident Reporting of stigma, discrimination and other cases of human rights violation		
Date of the incident	DD/MM/YYYY	
Date on which incident was reported	DD/MM/YYYY	
Has the client given consent to document the incident?	1. Yes	2. No
Place of the incident	Provide possible options with an additional option of "Other" to record the open ended responses	

Type of incident	1. Discrimination and/or denial of services	2. Verbal Abuse	3. Physical Assault/Harassment	4. Violence
	5. Denial of rights such as right employment, education, health and right to property	6. Outing status or disclosing identity	7. Mental abuse	98.Other (specify)

Nature of the perpetrator	1. Family members	2. Friends/community members	3. Local gundas	4. Employers
	5. Regular Partner/Husband	6. Health care settings	7. Community leaders	98.Others____
Did the crisis involved any physical injury?			1. Yes	2. No
If Yes, was medical assistance taken?			1. Yes	2. No
If No what was the reason for not seeking any medical assistance	1.Fear of stigma		2.Didn't want to disclose	3.Was not aware if the help is available
	4.Didn't feel any assistance was required		5.It is not easy to get any support from health facilities	98.Other (specify)
Did you seek any legal assistance			1. Yes	2. No
If Yes, was a police complaint filed?			1. Yes	2. No
What is the current status of the case in legal system?	1.Case has been resolved	2.Case is pending		3.Status is not known

Incident Reporting for Quality of Services		
Facility/Site name and location		
Date of the incident	DD/MM/YYYY	
Date on which incident was reported	DD/MM/YYYY	

Has the client given consent to document the incident?	1. Yes	2. No
Place of the incident	Provide possible options with an additional option of "Other" to record the open ended responses	
Quality of services incident is reported for?	1. HIV prevention services	2. HIV treatment services
Details of the incident		
Suggestions for improvement		
Was the incident reported to someone else before?	1. Yes	2. No
If yes, was any action taken?	1. Yes	2. No

6.5 Annexure-5: Sample CLM Tools: Key Population Beneficiary Perception Survey Tool (Qualitative)

Note: *This Discussion Guide includes participatory processes required for understanding the community's perspective, key barriers, and enablers to accessing HIV care and treatment services from different service providers. The process for the discussion suggested in this guide ensures active participation that generates interest and involves the community. This is designed, besides meeting information needs, to build rapport and to facilitate active engagement of the community members. It is aimed to facilitate total participation of the community in the process.*

Criteria for Discussion:

The main purpose of discussion during the CLM process is to understand the community's perspective, key barriers, and enablers to accessing HIV care and treatment services from different service providers. This exercise will be done after completing the client's perception survey in quantitative tool. This tool can be used for different KPs i.e. Female Sex workers, MSM, (Men having Sex with Men), TG (Transgender) PLHIV and PWIDs. However, questions need to be customized based on the local context, service provisions in the country and specific needs of the particular community.

General Instructions:

- Be sure to make the location and time of the discussion clear to all participants.
- At any point in time do not club the KP from different categories into one discussion
- If you anticipate some participants not showing up, invite 10-20% extra participants. However, be careful to not create too large of a group.
- An ideal size of the group should include 6-8 community members
- Always try to conduct one discussion in one area. This will help you to ensure geographical spread.
- It is critical to complete the process well and gather all these crucial information as per the checklist
- Be sure that the discussion is in a public place that is convenient for participants
- Consider the location's proximity to public transportation
- If the discussion must happen out in the field, make it as comfortable and convenient for participants as possible
- Make sure that the setting does not bias the information being collected

Preconditions to FGD

Ensure that you have all the materials you require.

- Adequate place for group discussion
- FGD checklist
- Other material required for conducting the group discussion

Suggested time for discussions for each group discussion is 45 minutes to 1 hour. But the facilitating team may decide to terminate early/ later than the suggested time based on the comfort levels and willingness of participants.

Dos and don'ts of Discussion

- Remember that you must **only facilitate the discussion** among the respondents based on the questions. Ask a broad question and allow the respondents to contribute with all the various issues under that question.
- Guide the flow when you feel that the discussion is getting irrelevant to the discussion objectives. Keep the pace brisk to keep energy levels high.
- Ensure that **all the probe questions are covered**.
- Encourage and invite participation by all respondents. Ensure that you look around at all the respondents while talking, especially those who are not contributing. Allow them to express their opinions before the confident ones do.
- Yet recognize that all respondents do not have to answer every question.
- Summarize group views on each topic before proceeding to the next topic. Remember we are looking for different views & opinions – it is not necessary for all the participants to have the same view & opinions. DO NOT TRY TO ACHIEVE A CONSENSUS OR AN AGREEMENT ON ISSUES WHERE PARTICIPANTS MAY HAVE DIVERSE VIEWS & OPINIONS
- Keep time for every section - if there is disagreement on any one topic and it takes too much time, agree to disagree, and move on!
- Be careful about potential hijackers/ deviating respondents. If the group is getting out of control due to the presence of one, have one of the peer educators gently take her aside and conduct a separate interview.
- Do not start providing information to or correcting any respondent during the discussions. Does it after the discussion if you feel it is essential?
- **DO NOT MAKE VALUE JUDGEMENTS ON THE VIEWS OF ANY RESPONDENT OR ENGAGE IN ARGUMENTS**

Important consideration for documentation

- Keep a separate record of each discussion with date/ venue/ target group etc.
- Note down points during the process of discussion. If some proverbs/statements are unique and need to be captured verbatim, do so in first person.
- If crucial points are getting missed out, make a note of it, and ensure they are noted as soon as the discussion is over.

Introduction of Participants

Initiate the discussion with formal introduction of participants. Once the introduction is completed, explain the purpose of the group discussion.

Hi everyone! My name is _____ and I work with _____ We are conducting Community led Monitoring in _____ (mention geography/facility name). I thank all of you for making time to participate in this exercise. We are conducting these focus group discussions as part of the CLM process. Purpose of this discussion is to have a better understanding about your experiences while accessing the HIV care and Treatment services from the health facility. This will help us to share the key barriers with the stakeholders and develop an action plan to improve the efficiency of the HIV service delivery and client outcomes.

During the process of the discussion, if you do not understand something, you can always stop us and ask us to explain it and we shall do the same. For any questions that you may have later, you can contact me or one of my team members.

Consent Process

Consent process should be verbally explained and recorded. (Purpose of the study explained above) I hope you understand what this exercise is about! I assure you that no harm of any nature will occur to you by participating in this discussion. Your participation in this process is entirely voluntary. You alone have the sole capacity to decide whether to participate in these discussions.

The responses you give will be confidential. Your name will be recorded for the consent process only. The data will be anonymous, and it will be stored securely to protect it from people who might want to see it. Despite the discussions being audio recorded, I assure you that the information provided by you will be kept anonymous. Knowing all the above, do you agree to participate in this discussion?

If you agree please say yes.

Section 1: Service Accessibility

1. Do all of you know/heard about ICTC (Integrated Counselling and testing centers)?

Probe for following points:

- How many of them visited ICTC in the last three months?
- How often do they visit ICTC?
- Generally what percentage of community members visit ICTC?
    - Collect reasons for visiting?
    - Collect reasons for not visiting?
- What comes to their mind when they think about ICTC? (Collect all the responses mentioned by most of the group members)
- Is it easy to access the ICTC center?
- Is the timing of the ICTC working hour convenient?
- What services have they received from the ICTC?
- Are they happy to access the service?
    - If they say yes - Collect the reasons?
    - If they say No - Collect the reasons?

Repeat these questions to understand the accessibility to following services as well.

- ART center. OST and STI/RTI Clinics

Note: *We can make this process more participative by using chart papers, scoring, and rating sheets and pictures (smiley faces) to express their feelings*

Section 2: Availability, Responsiveness and Stigma

2. When you visited ICTC, were the staff present?

Probe for following points:

- How many staff members were present?
- Probe to check presence of Doctor, Lab technician and Counsellor?
- How did the staff members respond to community members?
    - Are they sensitive towards members' needs?
- How did they feel during the Counselling session, while drawing the blood, meeting with the doctor?
- Are they satisfied with the service they received during the visit?
    - Did they face any problem while receiving the services?

Repeat these questions to understand the accessibility to following services as well.

- ART center. OST and STI/RTI Clinics

Section 3: Acceptability, Affordability, and Appropriateness

3. Are you all happy with the services you received in ICTC?

- If they say yes - Collect the reasons?
- If they say No - Collect the reasons?

Probe for following points:

- Are the services received in ICTC appropriate for community members?
- Are the services received adequate?

  (Ex, Medicines, Condoms, Syringes....etc. - Use these examples while discussing about the service)
- Are the relevant products available in the center during their visit?
- Is the information shared by the center staff relevant and useful?
- Are they able to avail and afford the services frequently based on their requirements?
- Did the staff members meet your expectations?
- What changes do they want to introduce to make the services more appropriate?
- What new services do they want to include?

Repeat these questions to understand the accessibility to following services as well.

- ART center. OST and STI/RTI Clinics

Section 4: Accountability

4. How did you find the environment at the center during your visit?

- If they say the environment is fine/good/ satisfactory...etc. - Collect the reasons?
- If they say the environment is not fine/ not good/ unsatisfactory...etc. - Collect the reasons?

Probe for following points:

- Are the staff members responsible?
- Are they interested in supporting community members?
- Are the community members serious about availing the available service?
  - If Yes - Collect the reasons
  - If No - Collect the reasons

Repeat these questions to understand the accessibility to following services as well.

- ART center. OST and STI/RTI Clinics

Ask if an online tool would be most useful for Client feedback and Facility Assessment.
If yes, what would the ideal online tool contain?

6.6 Annexure-6: Pilot Test Report Format

Date of pilot testing:
Location:
Total Interview conducted:

General Observations:

1.

Question wise Feedback:

S.no	Section	Question No.	Feedback	Solution
1				
2.				
3				
4				
5				
6				
7				
8				
9				
10				

6.7 Annexure-7: Sample Workshop Outline for Individuals Collecting Data

Training Objectives: By the end of the training sessions, the data collection team members will be able to develop clarity on following.

- Community-Led Monitoring (CLM) concept,
- Understand the processes involved in implementing the CLM in your country viz. field operation and management, data collection, stakeholder engagement and communication
- Understand the questions and scales: indicators an scales and its way of implementing

Notes:

- The below session plan is for a two-day training.
- Training days are to be planned for eight hours, with a maximum 6-7 sessions each day
- Tea and lunch breaks can be added, as appropriate
- Participatory sessions may need more time compared to presentations and planning sessions
- Energizers, sum-up sessions and recap sessions to be added, as appropriate
- Pre and post assessments to measure the increase in participant knowledge level and training evaluation to assess the quality of the training and its methodology, to be included

Materials Required:

- Stationary such as markers, flipchart, white board, notebook, pads, pen/pencil etc.
- Projector to present the PPT slides
- Final CLM tools for each participant

Estimated Time	Session Title	Objectives	Methodology
30 minutes	Session – 1 Welcome and Introduction	• Welcome participants • Review Objectives and Agenda • Participant introduction • Gather the team's expectations • Set ground rules • Collect pre assessment responses	Participatory methodology Lecture
30 minutes	Session – 2 Overview of Community Led Monitoring	• Define community led monitoring • Describe why community led monitoring is important • Describe the purpose, goals and objectives of community led monitoring • Define how it can generate positive changes at the community level • Provide examples how community led monitoring results in improved service delivery for the community	Lecture Discussions Question and Answers
30 minutes	Session – 3 Community Led Monitoring mechanism	• Describe the CLM overview and its objectives • Define different approaches of CLM • Describe how service availability, accessibility and quality will be monitored using CLM	Lecture Discussions Question and Answers
30 minutes	Session – 4 Process of CLM mechanism development for your country	• Provide a brief history of what has led to the day of training • Connect with previous rounds of CLM implementation • Describe how the current round is different/similar to previous rounds of CLM in your country *(if implemented)*	Lecture Discussions Question and Answers
30 minutes	Session – 5 Role of data collection team in Community Led Monitoring	• Define steps in CLM implementation • Define the role of data collectors in overall CLM implementation – its importance • Define how their engagement with community and service providers at the filed level enables the CLM implementation • Describe the importance of good quality data in CLM implementation and evidence informed advocacy	Lecture Discussions Question and Answers
40 minutes	Session – 6 Overview of the CLM tool developed for your country	• Provide a detailed overview of the tool to be used in the country • Describe different aspects to be monitored using the tool • Define how the indicators collected using the tool impacts the service delivery and life of community individuals	Lecture Discussions Question and Answers

Estimated Time	Session Title	Objectives	Methodology
90 minutes	Session – 7 Review of CLM tool: Defining Indicators	• Review the CLM tool with the data collection team members – connect with the aspects explained in previous session • Define each indicator included in the tool • Develop clarity on the service quality indicators	Participatory methodology – using team members to read questions and explain their understanding Providing clarity by facilitator by lecture method
90 minutes	Session – 8 Practice Session: Review of CLM tool and Defining Indicators	• Practice administering the tool and conduct a review meeting at the end of the session	Group work Presentation by team members Discussion
40 minutes	Session – 11 Site preparation, management, stakeholder communication during data collection	• Define the process of site preparation • Define the process of site management • Describe the process and importance of communication and intimation with stakeholders (site/facility in-charge) • Describe the process of approval and intimation from national program • Provide details about approval/intimation letter, identity documents for data collectors etc.	Lecture Discussions Question and Answers
30 minutes	Session – 12 Participant Eligibility Screening and recruitment	• Define the client eligibility • Define client eligibility screening process • Practice session on administering eligibility tool	Lecture Discussions Question and Answers Practice on tool
30 minutes	Session – 13 Monitoring of Data Collection Processes	• Define team composition and role of supervisor and during data collection • Define the process of monitoring from national team • Define the role of multi-stakeholder technical committee members in data collection monitoring • Define communication protocols for monitoring purposes	Lecture Discussions Question and Answers
45 minutes	Session – 14 Ethical Consideration, risks and mitigation strategies	• Define process of taking informed consent from clients • Define documentation for consent process • Practice session on consent form developed for the CBM implementation • Define possible risks and mitigation strategies	Lecture Discussions Practice using consent form Question and Answers

Estimated Time	Session Title	Objectives	Methodology
30 minutes	Session – 15 Data collector feedback mechanism and mid-course correction	• Define the scope for data collector's feedback during CLM implementation • Define communication protocols for sharing feedback • Define the course of action and possible scenarios for action based on feedback provided by teams	Lecture Discussions Question and Answers
180 minutes	Session – 16 Mock exercise: Practice session on tools (2 practice sessions using different team members can be done based on available time)	• Provide clarity on each question • Practice each question in the tool • Define intended meaning and implications of the questions • Describe how the questions are intended to be asked • Describe ways of recording responses based on respondent answers • Define service provisions and related standard practices as per the guidelines	Practice session Divide team members in a pair One team member acts as interviewer and other acts as respondents Team members conduct the interviews Supervise the interviews and take notes on feedback to be provided Provide feedback on aspects which went well Provide feedback on aspects which require improvement
30 minutes	Session – 17 Site closure, communication and stakeholder intimation	• Define site closure protocols and steps • Define importance of communication with stakeholders at the end of data collection • Describe things to be ensured before the closure of the site	Lecture Discussions Question and Answers
30 minutes	Session – 18 Site team formation, distribution of sites, planning operationaliza-tion	• Form to teams for data collection at different sites • Distribute sites/ geographical locations / facilities among the team members • Define the data collection operationalization and timelines	Practical session engaging team members
30 minutes	Session – 19 Development of site team's field movement plan	• Develop overall movement plan, segregated for each team • Distribute the movement plan and provide clarity to the teams	Practical session engaging team members
30 minutes	Session – 20 Question and answer, closure	• Address team's doubts and provide clarity • Collect post assessment and training evaluation responses • Final remarks and closure	Lecture and discussions Question and answer

6.8 Annexure-8: Templates for Collating Findings and Action Plans

I. Community Score Card

Name of Community:	
Name of Health Facility:	

No	Problem Areas	Gravity of the issue *(Mild/ Medium / Serious)**	Priority of Action *(urgent / not urgent)*	Steps to be taken	Who will do it? *(Responsible Person/ Group)*	When will they do it *(Timing)*	Who will supervise the action?
1	Example-1 Condom stock out						
2.	Example-2 Non-availability of HIV test						
3	Example-3 Community being discriminated by health facility staff						
4	Example-4 Services such as NSP, OST, ART etc. not available						
5	Example-5 Other tests such as CD4, Viral Load etc. are not available						

** Scales (mild/medium/serious) for the gravity of the issue can be defined by implementors on various aspects. Such as if an issue is reported by 50% or more (percentage changeable) community members then it can be considered serious. Similarly, if the same issue is reported by less than 10% community members, it can be dealt on less priority.*

II. Key Population Beneficiary Perception Survey Tool

(N=945)	
Questions	**Responses**
Sex assigned at birth	
1. Male	516 (54.60)
2. Female	235 (24.87)
3. Intersex	194 (20.53)
Marital Status of Respondents	
1. Never married	811 (94.74)
2. Currently married	27 (3.15)
3. Divorced/Separated/Widowed	18 (2.10)
4. Other (Specify)	0 (0.00)
Availability of prevention commodities	
1. Condoms	349 (84.10)
2. Lubricants	66 (15.90)
Availability of Pre-Test Counselling	
Yes	461 (57.91)
No	335 (42.09)
Note: Under the responses column both numbers and percentages of the responses have been mentioned. However, the same can be changed as per the need. Either of the two can also be presented.	

III. Community Feedback and Response Mechanism Tool

District/Province:				
Key Population Category:				
Nature of incident reported by community *(Stigma discrimination / Quality of Services)*	**Place of Incidnet**	**Details of the incident**	**Action Plan**	**Timeline**

6.9 CLM Report Structure

Acknowledgement
Abbreviations

1. **Executive Summary and Key Findings**
2. **Rationale and Background**
3. **Introduction**
4. **Objectives and Scope of CLM in the country**
5. **Geographical Coverage and Population Reached**
6. **Process of Data Collection from the Community**
7. **Detailed Findings**
8. **Recommedations**
9. **Action Plan**
10. **Conclusion**

6.10 Annexure 9: Other Resources on CLM

https://www.theglobalfund.org/media/9622/core_css_overview_en.pdf

https://www.theglobalfund.org/media/9632/crs_2020-02cbmmeeting_report_en.pdf

https://gate.ngo/wp-content/uploads/2021/04/Four-models-of-CLM-a-review.pdf

https://www.pepfarsolutions.org/resourcesandtools-2/2020/3/12/community-led-monitoring-implementation-tools

https://www.state.gov/wp-content/uploads/2020/07/PEPFAR_Community-Led-Monitoring_Fact-Sheet_2020.pdf

http://www.stoptb.org/assets/documents/communities/CRG%20Investment%20Package_OneImpact%20Community%20Based%20Monitoring_10.02.2020.pdf

https://itpcglobal.org/our-work/watch-what-matters/

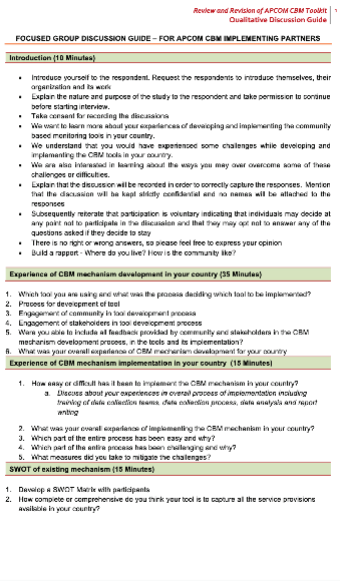
https://static1.squarespace.com/static/5a29b53af9a61e9d04a1cb10/t/5e6a93950073e27da32e9cd8/1584042902866/ITPC+PEPFAR+Mtg+CLM_Nov+2019.pdf

https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf

https://apps.who.int/iris/bitstream/handle/10665/246178/WHO-HIV-2016.05-eng.pdf

6.11 Annexure 10: Discussion Guides used for country consultations

Discussion Guide for Partners Implementing CLM



Review and Revision of APCOM CBM Toolkit | 1
Qualitative Discussion Guide

FOCUSED GROUP DISCUSSION GUIDE – FOR APCOM CBM IMPLEMENTING PARTNERS

Introduction (10 Minutes)

- Introduce yourself to the respondent. Request the respondents to introduce themselves, their organization and its work
- Explain the nature and purpose of the study to the respondent and take permission to continue before starting interview.
- Take consent for recording the discussions
- We want to learn more about your experiences of developing and implementing the community based monitoring tools in your country.
- We understand that you would have experienced some challenges while developing and implementing the CBM tools in your country.
- We are also interested in learning about the ways you may over overcome some of these challenges or difficulties.
- Explain that the discussion will be recorded in order to correctly capture the responses. Mention that the discussion will be kept strictly confidential and no names will be attached to the responses
- Subsequently reiterate that participation is voluntary indicating that individuals may decide at any point not to participate in the discussion and that they may opt not to answer any of the questions asked if they decide to stay
- There is no right or wrong answers, so please feel free to express your opinion
- Build a rapport - Where do you live? How is the community like?

Experience of CBM mechanism development in your country (35 Minutes)

1. Which tool you are using and what was the process deciding which tool to be implemented?
2. Process for development of tool
3. Engagement of community in tool development process
4. Engagement of stakeholders in tool development process
5. Were you able to include all feedback provided by community and stakeholders in the CBM mechanism development process, in the tools and its implementation?
6. What was your overall experience of CBM mechanism development for your country

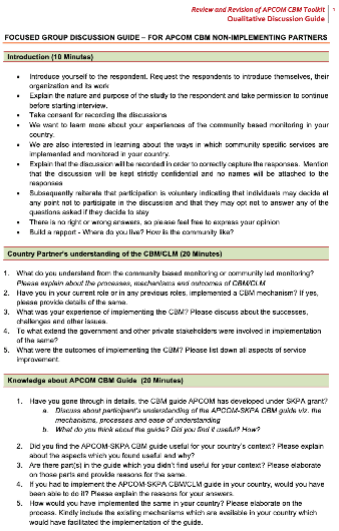
Experience of CBM mechanism implementation in your country (15 Minutes)

1. How easy or difficult has it been to implement the CBM mechanism in your country?
   a. *Discuss about your experiences in overall process of implementation including training of data collection teams, data collection process, data analysis and report writing*
2. What was your overall experience of implementing the CBM mechanism in your country?
3. Which part of the entire process has been easy and why?
4. Which part of the entire process has been challenging and why?
5. What measures did you take to mitigate the challenges?

SWOT of existing mechanism (15 Minutes)

1. Develop a SWOT Matrix with participants
2. How complete or comprehensive do you think your tool is to capture all the service provisions available in your country?

Discussion Guide for Partners NOT Implementing CLM



Review and Revision of APCOM CBM Toolkit | 1
Qualitative Discussion Guide

FOCUSED GROUP DISCUSSION GUIDE – FOR APCOM CBM NON-IMPLEMENTING PARTNERS

Introduction (10 Minutes)

- Introduce yourself to the respondent. Request the respondents to introduce themselves, their organization and its work
- Explain the nature and purpose of the study to the respondent and take permission to continue before starting interview.
- Take consent for recording the discussions
- We want to learn more about your experiences of the community based monitoring in your country.
- We are also interested in learning about the ways in which community specific services are implemented and monitored in your country.
- Explain that the discussion will be recorded in order to correctly capture the responses. Mention that the discussion will be kept strictly confidential and no names will be attached to the responses
- Subsequently reiterate that participation is voluntary indicating that individuals may decide at any point not to participate in the discussion and that they may opt not to answer any of the questions asked if they decide to stay
- There is no right or wrong answers, so please feel free to express your opinion
- Build a rapport - Where do you live? How is the community like?

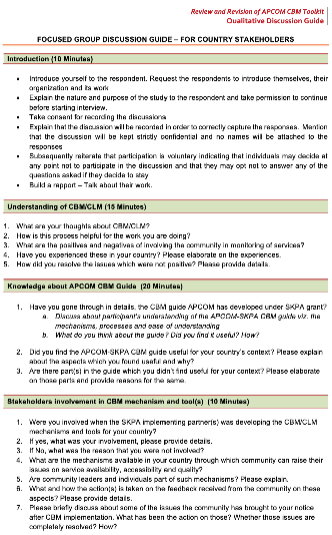
Country Partner's understanding of the CBM/CLM (20 Minutes)

1. What do you understand from the community based monitoring or community led monitoring? *Please explain about the processes, mechanisms and outcomes of CBM/CLM*
2. Have you in your current role or in any previous roles, implemented a CBM mechanism? If yes, please provide details of the same.
3. What was your experience of implementing the CBM? Please discuss about the successes, challenges and other issues.
4. To what extend the government and other private stakeholders were involved in implementation of the same?
5. What were the outcomes of implementing the CBM? Please list down all aspects of service improvement.

Knowledge about APCOM CBM Guide (20 Minutes)

1. Have you gone through in details, the CBM guide APCOM has developed under SKPA grant?
   a. *Discuss about participant's understanding of the APCOM-SKPA CBM guide viz. the mechanisms, processes and ease of understanding*
   b. *What do you think about the guide? Did you find it useful? How?*
2. Did you find the APCOM-SKPA CBM guide useful for your country's context? Please explain about the aspects which you found useful and why?
3. Are there part(s) in the guide which you didn't find useful for your context? Please elaborate on those parts and provide reasons for the same.
4. If you had to implement the APCOM-SKPA CBM/CLM guide in your country, would you have been able to do it? Please explain the reasons for your answers.
5. How would you have implemented the same in your country? Please elaborate on the process. Kindly include the existing mechanisms which are available in your country which would have facilitated the implementation of the guide.

Discussion Guide for Country Stakeholders



Review and Revision of APCOM CBM Toolkit | 1
Qualitative Discussion Guide

FOCUSED GROUP DISCUSSION GUIDE – FOR COUNTRY STAKEHOLDERS

Introduction (10 Minutes)

- Introduce yourself to the respondent. Request the respondents to introduce themselves, their organization and its work
- Explain the nature and purpose of the study to the respondent and take permission to continue before starting interview.
- Take consent for recording the discussions
- Explain that the discussion will be recorded in order to correctly capture the responses. Mention that the discussion will be kept strictly confidential and no names will be attached to the responses
- Subsequently reiterate that participation is voluntary indicating that individuals may decide at any point not to participate in the discussion and that they may opt not to answer any of the questions asked if they decide to stay
- Build a rapport – Talk about their work.

Understanding of CBM/CLM (15 Minutes)

1. What are your thoughts about CBM/CLM?
2. How is this process helpful for the work you are doing?
3. What are the positives and negatives of involving the community in monitoring of services?
4. Have you experienced these in your country? Please elaborate on the experiences.
5. How did you resolve the issues which were not positive? Please provide details.

Knowledge about APCOM CBM Guide (20 Minutes)

1. Have you gone through in details, the CBM guide APCOM has developed under SKPA grant?
   a. *Discuss about participant's understanding of the APCOM-SKPA CBM guide viz. the mechanisms, processes and ease of understanding*
   b. *What do you think about the guide? Did you find it useful? How?*
2. Did you find the APCOM-SKPA CBM guide useful for your country's context? Please explain about the aspects which you found useful and why?
3. Are there part(s) in the guide which you didn't find useful for your context? Please elaborate on those parts and provide reasons for the same.

Stakeholders involvement in CBM mechanism and tool(s) (10 Minutes)

1. Were you involved when the SKPA implementing partner(s) was developing the CBM/CLM mechanisms and tools for your country?
2. If yes, what was your involvement, please provide details.
3. If No, what was the reason that you were not involved?
4. What are the mechanisms available in your country through which community can raise their issues on service availability, accessibility and quality?
5. Are community leaders and individuals part of such mechanisms? Please explain.
6. What and how the action(s) is taken on the feedback received from the community on these aspects? Please provide details.
7. Please briefly discuss about some of the issues the community has brought to your notice after CBM implementation. What has been the action on those? Whether those issues are completely resolved? How?

FOOTNOTES:

1. http://aidsinfo.unaids.org/
2. https://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf
3. UNAIDS data 2019
4. http://aidsinfo.unaids.org/
5. https://www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf
6. 2016. FOUR MODELS OF COMMUNITY BASED MONITORING: A REVIEW. A report prepared for the Global Fund to Fight AIDS, Tuberculosis and Malaria
7. https://www.afaoskpa.org/
8. Key populations, or key populations at higher risk, are groups of people who are more likely to be exposed to HIV or to transmit it and whose engagement is critical to a successful HIV response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender people, people who inject drugs and sex workers and their clients are at higher risk of exposure to HIV than other groups. However,
9. 'Downward Accountability' means that you and the members of your key population communities, as services users, can provide feedback on the accessed services and can expect actions from the service providers.

We are united in advocating for issues around HIV and those that advance the rights, health and well being of people of diverse sexual orientation, gender identity, gender expression and sex characteristics.

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APCOM Secretariat | 48 Soi Udomsuk 13,
Bangna Bangkok 10260 Thailand
+66 2399 1145 / +66 2399 1146
www.apcom.org | apcom@apcom.org

/apcom.org @APCOM /APCOMorg /APCOMorg /apcom