PEPFAR Watch
Community-Led Monitoring webinar
COP23
Marineus Mwombeki, Tanzania KVP Forum
What is Community Led Monitoring and why is it important and Tanzania KP activists hopes for COP23?
What is Community led Monitoring?

Community-led monitoring (CLM) is systematic data collection at the site of health service delivery by community members that is compiled, analyzed, and then used by community organizations to generate solutions to problems found during data collection.

We do this by:

1. **Gathering evidence** about quality of services provided at clinics;
2. **Analysing the data** to identify challenges;
3. **Generating solutions** that respond to the evidence collected;
4. **Engaging duty bearers** on the challenges and proposed solutions; and
5. Where no improvement, **advocating for change**.
Why CLM?

Community-led clinic monitoring is one way to hold Donors e.g: PEPFAR and Global Fund and government accountable to communities of PLHIV and key population and improve overall HIV and TB service delivery.

CLM conducted by communities helps programs and health institutions, policy makers diagnose and pinpoint persistent problems, challenges, and barriers. For example HIV service uptake and retention at the community and facility level. This in turn, helps partners in improving service delivery and client outcomes by identifying data-driven solutions that will overcome barriers, and ensure beneficiaries access and receive optimal client-centered HIV services.

HIV programs are supposed to address these problems, but there has been limited responsibility across countries for how these funds are actually spent.
CLM Guiding principles

• Recognise, respect and embrace diversity.

• Actively fight for the rights of people living with HIV, women, queer people, young people, transgender people, sex workers, people who use drugs, migrants, and other marginalised populations.

• Actively fight and not tolerate any acts of racism, patriarchy, homophobia, transphobia or any other stigma or discrimination.

• Review your CLM to ensure critical communities eg: KP are not missing
Role of organisations under CLM

Grantees conduct the following standard activities:

- data collection and documentation of challenges and/or issues identified at facilities using standardized tools
- conduct monitoring of HTS; HIV treatment services (including retention and VL); service provider perceptions, attitudes, and practices; client satisfaction
- demand creation for HTS, VL testing
- participate in facility structure feedback meetings (e.g., health center committees)
- establish facility structure feedback meetings in facilities where none exist
- site-level advocacy (social contracts with duty bearers)
CLM Hopes for Tanzania’s KPs in COP23
Tanzania’s KVPs have worked on tools for KP data collection

KVP Forum was supported by UNAIDS and GF CRG to create teams for CLM data collection and digitalisation of tools for KVP specific CLM
CLM Hopes for Tanzania’s KPs in COP23

Going in to the 2-year COP we would like to ensure KP data collection to:

- Monitor structural barriers (criminalization of KVPs, police arrests, hatred speeches, gender based violence and stigma and discrimination that hinders smooth implementation of programs.

- Further the work of empowering KVP to ensure data collection by KVPs in addition to the PLHIV data collection currently on going

- Create space to advocate for KVP needs in HIV service delivery
Thank you
Community-Led Monitoring in the Draft COP 23 Guidance

Maureen Milanga, Health GAP
Community-led monitoring (CLM) remains a PEPFAR requirement, and a component of PEPFAR’s strategy. PEPFAR requires all OUs to fund the development and implementation of community-led monitoring activities.

- **CLM is a process initiated, led, and implemented by local community-based organizations and other civil society groups, networks of key populations, people living with HIV (PLHIV), and other affected groups or community entities.**

- These entities gather quantitative and qualitative data about HIV services and develop and advocate for solutions to the gaps identified during data collection, in collaboration with service providers and health care leadership.

- **CLM obtains input from recipients of HIV services**, including key populations and underserved groups, in a routine and systematic manner that will translate into action and change, building trusting and sustainable relationships with health care leadership and other stakeholders.

- **CLM is central to PEPFAR’s person-centered approach** because it puts communities, their needs, and their voices at the center of the HIV response.
CLM must be conducted by independent and local civil society organizations. CLM should be led by community organizations, not government institutions or multilateral bodies. Of note, PEPFAR IPs (including those that may be civil society organizations themselves) currently working on service delivery at the site level generally do not meet this requirement for CLM; this includes implementing partners who sub-contract/sub-grant to local civil society organizations. This helps maintain the objectivity and independence of CLM. OUs should consider the level of trust CSOs have among key communities and stakeholders when developing or refining CLM activities. However, in specific circumstances, a PEPFAR IP or subgrantee who does site-level service delivery may be included as a CLM partner if that organization meets the other requirements of a strong CLM partner, such as being community- or KP-led, and is not conducting monitoring of their own sites.

Whenever possible, a central, coordinated structure should implement CLM projects. PEPFAR OUs are encouraged to consider and select the funding mechanism most conducive to ensuring community leadership throughout each phase of the design, planning, implementation, and evaluation of the CLM activities. OUs should also consider partnership and award-management structures that meet the requirement and principles of objectivity, independence, and maximizing direct funding to community organizations. OUs may propose funding for additional staff support to oversee this CLM portfolio if they did not do so in prior COPs.

OUs should also consider and support the capacity building needs of implementing CSOs in health service monitoring, data collection and analysis, and evidence-based advocacy. This should include leveraging support from other multilateral organizations or others also supporting CLM efforts in-country.

The scope and scale of community-led monitoring should be determined by community members in each OU (in consultation with PEPFAR in-country staff) but should be based on need. For example, focusing on a geographic area, a limited number of sites, or access to treatment services among men within a specific community, etc. CLM has emerged as a solution to challenges with ART continuity and preventing interruptions in treatment; at a minimum, PEPFAR CLM should focus on these aspects of HIV service delivery, and communities may also prioritize other components of HIV services.
Core principles and considerations of CLM Metrics and Analysis in the guidance

- **PEPFAR teams must ensure a process that allows for community leadership of the specific metrics, measures, or tools to be used for CLM, with consultation and input from partner-country governments and PEPFAR teams.** Metrics or measures should be tailored to a given context and address the needs and concerns of community members.

- **Monitoring data should be additive and not duplicate data already available to PEPFAR through MER.** Additional monitoring data includes information from beneficiaries about their experience with the health facility; about barriers and enablers to access and sustained engagement in services; related to quality of services; related to the quality of interactions between clients and health workers (including ensuring stigma-free and confidential service delivery); verification of the implementation of national level policies (e.g., elimination of user fees) at the facility level, etc.

- **CLM activities can utilize SIMS tools as desired or deemed useful,** though there is no expectation to use them, or that data from community-led monitoring activities will be reported to S/GAC in DATIM.

- **CLM mechanisms must be action oriented.** It is **not enough to simply collect patient reports or descriptions of experiences, (i.e., client satisfaction surveys) but there must be an associated follow-up process with the health facility that is community-led (where safe) and that includes the involvement of USG staff, commitment to corrective public health action, and community advocacy to improve service outcomes.**

- **At minimum, community organizations should present CLM results and findings to in-country PEPFAR teams on a quarterly basis** (through a presentation or report followed by constructive discussion) in an environment that will foster honest and genuine discussion of results, including negative outcomes.

- **At a minimum, PEPFAR USG staff should share these findings with IPs on a quarterly basis.** Community members should not be tasked with sharing findings with service delivery partners or partner governments, though they may do so where it is safe. PEPFAR teams must be directly involved in necessary follow-up actions and oversight of IPs to strengthen the quality-of-service provision.
Core principles and considerations of CLM Metrics and Analysis

- **It's important that CLM results are shared with the partner-country government.** This could be in a direct manner through CLM (ideally and where safe) or from PEPFAR to the partner government. CLM results should ideally be immediately shared by CSOs at the level of collection where safe (e.g., health facility and district) to allow for immediate action at the local level by local leaders and IPs.

- **PEPFAR teams should triangulate CLM findings with other PEPFAR data sources, including MER results and SIMS scores, and use these data to both foster site-level improvements, and as part of their partner management approach.**

- **Implementers of CLM should coordinate and triangulate their activities with other multilateral organizations engaged in CLM (e.g., Global Fund) to facilitate information sharing and ensure efficient use of resources.**

- **CLM in COP/ROP23 should ultimately build upon CLM activities carried out in previous COPs; and the same should be ensured for subsequent COPs.** The intention should be to build a CLM program that is sustainable and contributes continually and tangibly to program improvement.

- **CLM systems should establish and articulate the routinized process for collecting, analyzing, and sharing of CLM data at the country level among all stakeholders.** As part of a commitment to transparency and accountability, community-led monitoring findings should be made as accessible as possible for use by all stakeholders while ensuring client safety and confidentiality.
The Global AIDS Coordinator may impose discretionary minimum, maximum, or exact budget requirements, in addition to the specific budget requirements listed in this guidance. These 3 budget controls ensure that programming meets specific requirements. These requirements will be communicated either in Planning Level Letters or supplemental guidance as well as suggested methods for meeting the requirement. Examples include budgeting for cervical cancer, **Community Led Monitoring (CLM)**, DREAMS, USAID condoms funding, and voluntary medical male circumcision (VMMC).
In the guidance CLM is not

- Is **not** simply adding some community-or client-focused indicators to already established government monitoring systems. This approach does not permit community leadership in design and implementation.

- Is **not** the same as patient satisfaction surveys. Patient satisfaction surveys may be very useful to improve the quality of services and the client’s experience of care, and there may be some overlap with CLM, but they are distinct from CLM. Patient satisfaction surveys are usually driven by health care providers, tend to focus on the effectiveness of services, and may not focus on the elements prioritized by communities.

- Is **not** a survey or study conducted to understand what communities experience. This type of assessment may be useful, but it is not community-led, nor is it routinized to drive change and ensure accountability.
To bolster KP Community Leadership, Collaboration and Empowerment Countries must ensure key populations community-led monitoring.

Since COP22, OUs are required to ensure their CLM activities include an explicit focus on key populations, where not already the case. This does not mean key populations are the only focus of CLM activities, but rather must be included. There can be multiple ways of meeting this requirement (e.g., ensuring KP-led organizations are among the funded monitoring organizations, ensuring KP-specific modules in monitoring tools, among others).

At a minimum, there must be deliberate leadership of KP communities included in the design of the approach. Importantly, inclusion of a focus on key populations in CLM should not be limited to KP-specific sites or programs (which CLM may wish to monitor as well). CLM should gather data on KP service delivery in these sites as a priority.
CLM in Stakeholder Participation in COP/ROP23

CLM finding will be presented at the Global co-planning meeting in Johannesburg.

| Global Co-Planning Meeting in Johannesburg (Weeks 2–3) | Review materials and preparations with stakeholders
Share initial strategic vision
Prioritize equity: Discuss Pillar 1 first
Document stakeholder group feedback and PEPFAR response
Document areas of widest support for COP23 strategy | Attend Johannesburg Co-Planning Meeting
Stakeholders provide PEPFAR teams with recommendations for COP23 focus, based on (but not limited to) analysis of Q4 and national results and other observation or evidence of program performance, including findings from community-led monitoring activities
Stakeholders provide feedback on activities, targets, and approaches |
Thank you
Ndivhuwo Rambau, Ritshidze, South Africa
Background

- South Africa has nearly 8 million people living with HIV — yet remains dangerously off-track to meet the UNAIDS 95-95-95 targets.

- Too many individuals are lost before they initiate ART + once PLHIV do initiate treatment, there are severe ART continuity problems. Key populations face additional barriers accessing HIV prevention and treatment services.

- The failure to make sufficient progress towards the 95-95-95 targets can be directly linked back to the quality of public healthcare services. Ritshidze grew out of the need to identify + address challenges that cause PLHIV to disengage from care.

- As the flagship CLM programme — and largest CLM programme in the world — in the last 3.5 years Ritshidze has developed and scaled-up use of new, innovative tools for data collection, analysis and visualisation so Community Monitors can document, assess and address challenges to securing quality, accessible services and turned it into a system that can be scaled up.

**South Africa has the largest treatment programme in the world + poor quality services undermines not the HIV response.**
Where we work

+ Established in 2018 — Ritshidze was developed by people living with HIV. It unites the entire PLHIV sector in South Africa.

+ Ritshidze monitors over 400 clinics & community healthcare centres across 29 districts in 8 provinces in South Africa.

+ Ritshidze has a MOU in place with the National Department Of Health and authorisation letters from provinces and districts.

+ The objective of Ritshidze is to improve the quality of HIV and TB service delivery for people living with HIV in South Africa.
Several key indicators of healthcare quality have improved during Ritshidze implementation.
In 2022, 40% of public healthcare users said that there was “always” enough staff up from 35% in 2021.

In 2021, 83% of facility managers said that their facility did not have enough staff – this number dropped by 8% in 2022.

Staff also became friendlier in 2022. 4% more respondents said that staff were friendly and professional than in 2021.
Despite ongoing medicine stockouts, especially of contraceptives (reported by 41% of public healthcare users, 4% higher than in 2021), throughout the country, Ritshidze data has demonstrated that, overall, a smaller proportion of people were left without medicine as a result of stockouts (3% less in 2022).
Percent of people living with HIV getting refills for three or more months has increased from 33% to 44%.

In 2022, 49% of people living with HIV were collecting ARVs from pick-up points (either at the facility or external), up from only 36% in 2021.
More PLHIV understand U=U

+ There was a 7% increase in the proportion of people living with HIV who were aware of their viral load

+ Treatment literacy has also improved – in 2022, the proportion of people living with HIV who understood how viral load impacted their health increased by 4%

The proportion of people living with HIV who understood the relationship between viral load and transmission increased by 10%
Index testing and GBV

Have PLHIV been asked to participate in index testing?

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Patients Surveyed: 41,401

More people living with HIV are told they can refuse index testing (79% to 83%) and more people living with HIV provided with information on gender based violence (75% to 77%)
Improvement in waiting times

Do you consider the waiting time at this facility to be long?

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Patients Surveyed: 65,181

Waiting times dropped from four hours to 3.35 hours

Source: Patient survey
Ritshidze methodology — how we got to this impact
Where we work

Established in 2018 — Ritshidze was developed by people living with HIV and activists to hold the South African government and aid agencies accountable to improve overall HIV and TB service delivery.

It unites the entire PLHIV sector in South Africa.

Ritshidze monitors over 400 clinics & community healthcare centres across 29 districts in 8 provinces in South Africa.

It is one of the most extensive community-led monitoring efforts.

GATHER EVIDENCE

ANALYSE THE DATA

GENERATE SOLUTIONS

ADVOCATE FOR CHANGE

ENGAGE DUTY BEARERS
**Innovative data collection tools**

- **IMPROVED QUANTITATIVE SURVEYS**: quarterly data collection through: observational, patient/people living with HIV, adherence club member, Facility Manager, medicines, adherence club facilitator

- **IMPROVED QUANTITATIVE SURVEYS**: Sex workers, trans people, people who use drugs, men who have sex with men

- **IMPROVED QUALITATIVE INTERVIEW QUESTIONS**: Sex workers, trans people, people who use drugs, men who have sex with men, men, young people, individual testimony tool

**Technology for monitoring**

In order to streamline the monitoring process we set up + maintain “CommCare” — this allows us to capture the survey responses directly into the tablet that we provide monitors with, track site visits + analyse findings on the dashboard.

See: [https://ritshidze.org.za/category/tools/](https://ritshidze.org.za/category/tools/)
Gathering evidence in COP21

In COP21 Ritshidze interviewed

+ 65,906 public healthcare users
+ 41,877 people living with HIV
+ 13,659 young people (under the age 25)
+ 1,193 Facility Managers
+ and conducted 1,617 observations

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<tr>
<td>Case studies written up</td>
<td>25 case studies</td>
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<tr>
<td>Community member testimonies filmed</td>
<td>200+ stories</td>
</tr>
<tr>
<td>Community members videos edited, subtitled + produced</td>
<td>100+ videos</td>
</tr>
<tr>
<td>Photography + filming at clinics</td>
<td>50+ clinics</td>
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Extremely bad attitudes towards key populations

“I use Ext 4 Clinic. It’s not easy to say if the staff are friendly and professional towards us because we don’t disclose that we are sex workers. You only end up disclosing if you have a serious issue, like when you have recurring STIs, so they ended up asking me where is my partner because he needs to be treated as well, so I had to disclose the nature of work that I do, that I am a sex worker, at the end I had to disclose.” — A sex worker who uses Embalenhle Ext 4 Clinic, interviewed in May 2022

“We don’t get lubricants there but they have condoms, the staff will always complain about us taking too much” — a sex worker using Empangeni CHC interviewed in October 2022.

“The challenge is that at the Clinic there is no privacy, they just tell you everything in front of everyone. They discuss sensitive issues in front of all patients. They judge us. They will ask you how you have sex. I stopped going to the clinic after a nurse who knows me spoke about my status in public. She also met me at the park and said you are here and you know that you take treatment and alcohol is not good for you. I asked why you take issues of the clinic to the public and I stopped going to the clinic and defaulted for 2 years after 2017 when my status was disclosed in public. I started to feel sick and went back to the Clinic, I was assisted by a lesbian nurse from Aurum who said I must not go to those nurses but to her, since then she is the one who assist me.” — A gay man using Grace Mokgomo CHC, interviewed in May 2022

“We use Ext 4 Clinic. It’s not easy to say if the staff are friendly and professional towards us because we don’t disclose that we are sex workers. You only end up disclosing if you have a serious issue, like when you have recurring STIs, so they ended up asking me where is my partner because he needs to be treated as well, so I had to disclose the nature of work that I do, that I am a sex worker, at the end I had to disclose.” — A sex worker who uses Embalenhle Ext 4 Clinic, interviewed in May 2022

“Lubricants are not always available but they have them in the store room and do not keep them outside. In addition… there is a stigma attached to lubricants.” — A gay man using Bophelong Clinic, interviewed in August 2022

“I was using Stanford Terrace Clinic Mthatha. I went there to collect my PrEP and also for STI treatment. The nurses were very rude to me. Firstly, they assumed the STI was on my penis, but it was on my behind (anus). It was itching on the back and this happened after I had unprotected anal sex. I told them that the STI is not in front but they were plain rude, saying “why would you say the STI is not in front, are you a male or a female.” — A queer man using Stanford Terrace Clinic, interviewed in August 2022.
Between July and September 2022, a large scale quantitative data collection effort took place, across 21 PEPFAR supported districts in 7 provinces. Monitoring tools were updated after consultation with KPs.

A team of more than 146 KP data collectors were recruited to support the data collection effort, including mobilisation and implementation of tools.

KPs who were interviewed were identified through snowball sampling where initial participants were asked to refer those they know, who in turn refer those they know, to participate in the survey.

9,137 quantitative surveys were collected:
- 2,349 GBMSM
- 3,353 PWUD
- 2,200 Sex Workers
- 1,145 Trans* people

KP quantitative data in COP22
Additional quantitative data related to stockouts and shortages of medicines and other health products was collected between May and June 2022 in the North West — led by the Treatment Action Campaign (TAC), Stop Stockouts Project (SSP) and Ritshidze.

Data collection took place at 57 sites across four districts: 12 sites in Bojanala Platinum, 15 sites in Dr Kenneth Kaunda, 10 sites in Dr Ruth Segomotsi Mompati, and 20 sites in Ngaka Modiri Molema.

Data were collected by talking to Facility Managers and pharmacists or pharmacist assistants, where available. Where unavailable, the team engaged with anyone tasked with oversight of the pharmacy.

All data are available at https://bit.ly/NWstockouts2022
ANALYSE THE DATA
Automated Facility, District + Provincial Reports

+ **Individual facility reports:** look at data from one particular site and compare across district, province and national.

+ **District reports:** take the data from the district level and show an aggregated score for each indicator and compares with the national and provincial pictures, as well as the best and worst districts. The 5 best and worst performing sites in the district are also revealed to allow for district duty bearers to take corrective action.

+ **Provincial reports:** take the data from the provincial level and show an aggregated score for each indicator and compares with the national and provincial pictures, as well as the best and worst provinces. The 5 best and worst performing sites in the province will also be revealed to allow for provincial duty bearers to take corrective action (launched in COP21).

+ The reports analyse data from indicators across a number of categories including: facility waiting times, staffing, clinic conditions, stockouts, ARV collection, access to viral load testing and information, index testing, and TB infection control.

Automated Reports

Individual facility reports:

+ **1,410 facility reports were generated in COP21** that analyse data from an individual facility.

District reports:

+ **29 district reports were generated in each quarter** that aggregate and analyse data from a district.

Provincial reports:

+ **7 provincial reports were generated in each quarter** that aggregate and analyse data from a province.

Note: The reports showcase the **GOOD and the BAD** in provinces. They align the best and worst clinics and show where a clinic scores in the district, province and country. They are not only showcasing poor performance.

GENERATE SOLUTIONS
After analysis, Ritshidze monitors talk to PLHIV sector members, patients, staff, and community members to generate solutions for the biggest problems uncovered.

In COP21, 1,225 solutions documents were generated to be taken in conjunction with individual facility reports to feedback meetings with facility staff.
Community dialogues

+ At times solutions are not always easily identified at the individual or facility level — it is then often most appropriate to turn to the community to help generate solutions.

+ **Community dialogues to generate solutions that are community-based and owned were held in 37 communities.**
ENGAGE DUTY BEARERS

1. Gather evidence
2. Analyse the data
3. Generate solutions
4. Advocate for change

Engage Duty Bearers
Engaging duty bearers

+ Quarterly meetings took place with facility staff, district, and provincial health teams on the evidence gathered and the recommended solutions.

+ **1,213 facility meetings** took place with Facility Managers in COP21.

+ The teams go through each aspect of the reports, both the **GOOD** and the **BAD** results so that facility staff know where they are doing well and where improvements are needed.

+ Most Facility Managers reacted positively to the feedback and welcomed the detailed reports.
Engaging duty bearers

+ **7 State of Health reports** produced providing detailed analysis of provincial data (including disaggregation by district and site) + recommended solutions

+ So far, **7 community accountability meetings** held with national, provincial and district duty bearers in which we **present data** from Ritshidze that highlights problems at our local clinics and **offer solutions** to fix the challenges found. PLHIV, KPs and other healthcare users in the province have the opportunity to talk directly to those in power
RITSHIDZE
SAVING OUR LIVES
WWW.RITSHIDZE.ORG.ZA
社交平台
Facebook
Instagram
Twitter
RitshidzeSA
Joanne Hyppolite
Isidor
Haiti’s Community-Led Monitoring
Housing Works
These data were collected from 41 facilities during the second quarter of 2022. We interviewed 1,526 patients, including 1,344 PLHIV, 38 facility managers, and 38 professional nurses. This data can be used in the COP23 to help civil society advocate for better services in the clinics.
Waiting Times: out of 1500 patients surveyed 23% of patients think the facility's queue is long.

Patients explain why waiting times are long: (24% think there are not enough staff and 45% think the staff is slow, and the rest give other reasons)
Staffing

According to the 38 facility directors surveyed, 74% report that there are not enough clinical and non-clinical staff.

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Do you think there are enough clinical and non-clinical staff at the facility?

- Yes: 26%
- No: 74%

Source: Facility Manager Survey
Staffing:
Cadre Understaffed: The majority of facilities surveyed are understaffed, especially for doctors (50%), Professional Nurse (54%) psychologists (46%). The main reason is that there are not enough funds to pay the salaries of new employees.
Stigma, Discrimination, and Privacy: According to the facility directors surveyed, 89% of clinical staff have received training on stigma and discrimination, but according to 41 patients surveyed, the most discriminating staff remain professional nurses (49%) and Doctors (27%).
Stigma, Discrimination, and Privacy: 78% of facilities separate PLHIV from other patients, 22% of patients receive colored cards that identify them as a PLHIV or Key population.
Acceptability of services: the main reasons why patients stopped taking ARVs were: lack of food (38%); and forgetting to take them (41%).
Soeurette Policar
OCSEVIH

How do we advocate using CLM in Haiti?
Here is a picture of the way the CLM is making Advocacy

1st Step
Training on Advocacy

2nd Making an Advocacy plan with the 11 CSO by identify the activities and region

3rd Making Action based on the Advocacy plan in each sector

- Youth
- Sex Workers
- Women
- Trans-gender
- PLHIV
- KP
- Faith

All those activities are based on the results coming from the sites, focus group and interviews
Importance of project set-up and governance structure:

- Legitimacy of the Steering Committee and the GCC.
- Clarification of the role of each Committee
- Data collection and analysis are done by members of KPs and PLHIV organization
- Importance to have quarterly meeting with the Minister of Health and donors to present the finding not to wait at the end of the year.

*It's important to have a leadership that can mobilize diverse community voices*
Advocacy is powerful

Advocacy actions take the color of the cultural context

Victories

CLM – Haiti victories are:
1- PEPFAR, Global Fund, UNAIDS, UNDP, and the CCM Better understand the work of the CLM.
2- Now PEPFAR- USAID accept to fund directly the CSOs and to avoid 38% of overhead.
3- Increase the participation of the CLM in several conference and webinar to present and to share reports and to promote better services for PLHIV and KPs
4- Increase Media intervention National and International

ACCEUIL | Ocsevih-Observatoire (observatoirevih-haiti.org)
Importance to work Globally with the Activist

What the CLM –Haiti really understand is to keep contact closely with the Global Activist this is why we have:

1- Technical Assistance from Housing Works, Health GAP and O'Neil Institute.
2- Working with CLAW to reinforce the CLM Mechanism.
3- Member of CLAW
4- Participate in several meetings with the Global Activists.
5- Sharing and raise the issues so the Global Activist can help the local team to solve the problem.

Advocacy with the Global Activists: A Fundamental way to Leverage Power
Naike Ledan
Health GAP
Budgeting for CLM
Budgeting for CLM

A fundamental
All stages:
Project set-up and governance
Tool development and data systems
Training and refresher courses
Data collection
Data analysis and reporting
Advocacy

What should your budget cover?
Important!

Many new CLM programs are eager to start developing survey tools and start data collection as soon as possible. But it’s important to spend time setting up your program’s governance structure and making sure you have all the right people hired and trained first. You may also face challenges with your advocacy if you didn’t spend enough time building buy-in from key duty-bearers like the Ministry of Health, National AIDS Council, National TB Control Program, or Malaria Elimination Program. You make face conflict within civil society questioning the legitimacy of the CLM if you did not take time to include all voices, report back and establish a community-approved leadership. A leadership that mobilizes diverse voices of the community is a recipe for success!

Be sure to budget for this pre-data collection stage too!
• **Question for your team:** Which organization, or organizations, will oversee implementing the CLM program? Is this the same organization(s) that will be managing the funds for the CLM program?

• **Question for your team:** Who will provide strategic guidance about the CLM program?

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**Quick tip**

If you’re starting a new CLM program, it can be very helpful to visit an existing program. Many CLM programs report that shadowing another program’s community monitors as they gather data, or participating in a public advocacy event helped them to deepen their understanding of the CLM model and avoid common pitfalls. Consider adding this activity into your travel budget!

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### Stage 1 - project set up/ governance

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<td>Travel expenses</td>
<td>26</td>
<td>Trips per year</td>
<td>$150</td>
<td>10</td>
<td>$3,900</td>
</tr>
</tbody>
</table>
Stage 1 - project set up/ governance

- **Question for your team:** Who are the core people that you will need to hire to run the program?
- **Question for your team:** What offices will the program use?
- **Question for your team:** Does your program need to do activities to get “buy-in” from government and other stakeholders?

---

**Careful!**

The full cycle of community-led monitoring, including data collection and advocacy, can easily take up a good portion of the implementing organization(s) capacity and staff time. This can mean that organizations are not able to spend enough time on their other priorities or they may not have enough time to complete all the steps of the CLM cycle. It’s important to make sure that enough dedicated staff are assigned to CLM work. Be careful not to leave the day-to-day operation of the program to someone who is already leading many other projects!

---

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Space (1 national meeting and 3 provincial)</td>
<td>1</td>
<td>Room reserved</td>
<td>$100</td>
<td>4 (meetings)</td>
<td>$400</td>
</tr>
<tr>
<td>Per diem for meeting participants</td>
<td>1</td>
<td>Per-person per diem</td>
<td>$10</td>
<td>20 (people)</td>
<td>$200</td>
</tr>
<tr>
<td>Travel and lodging (for participants from distant provinces)</td>
<td>1</td>
<td>Travel and lodging</td>
<td>$75</td>
<td>10 (people)</td>
<td>$750</td>
</tr>
</tbody>
</table>
Tool development and data systems

• **Question for your team:** Where will you collect data? How many sites will you monitor? What are the criteria for site selection?

• **Question for your team:** How will CLM data be collected and stored?

• **Question for your team:** What kinds of data will your CLM program collect?
  
  - Budget for translation
  - Already existent survey tools
  - Discuss the program’s advocacy priorities before creating data collection tools

---

**Quick tip**

Any large-scale project monitoring across multiple districts or provinces/regions, or with more than 20 sites, will find that paper-based data collection is extremely burdensome and time-consuming. There are several companies and software platforms that are available. Examples of open source hosted solutions include CommCare by Dimagi, DHIS2, and KoboToolbox. Keep in mind that some of these are free but will have more advanced services that cost money. If you’re planning on self-hosting, you must consider the cost of servers (including back-up servers) and IT staff qualified to manage the systems. Remember CLM data should never be owned by, or hosted by, government- or donor-owned systems!

---

**Quick tip**

You may find it easiest to focus primarily on gathering quantitative data, while complementing your survey data with a small number of qualitative interviews or focus groups. This approach will help you to not get overburdened by analyzing large amounts of qualitative data, while still contextualizing the findings.
### Tool development and data systems

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graphic designer</td>
<td>10</td>
<td>Days of work</td>
<td>$120</td>
<td>1 (person)</td>
<td>$1,200</td>
</tr>
<tr>
<td>Translator</td>
<td>5</td>
<td>Days of work</td>
<td>$100</td>
<td>3 (people)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Photographer</td>
<td>2</td>
<td>Days of work</td>
<td>$120</td>
<td>1 (person)</td>
<td>$240</td>
</tr>
<tr>
<td>Short-term consultant</td>
<td>20</td>
<td>Days</td>
<td>$100</td>
<td>1 (consultant)</td>
<td>$2,000</td>
</tr>
<tr>
<td>IT staff</td>
<td>0.5</td>
<td>Full-time equivalent (FTE)</td>
<td>$40,000</td>
<td>1 (person per year)</td>
<td>$20,000</td>
</tr>
<tr>
<td>Server and web hosting services</td>
<td>1</td>
<td>Months</td>
<td>$50</td>
<td>12 (months)</td>
<td>$600</td>
</tr>
<tr>
<td>Transcribers and translators</td>
<td>14</td>
<td>Days of work</td>
<td>$80</td>
<td>3 (people)</td>
<td>$3,360</td>
</tr>
<tr>
<td>Qualitative researcher</td>
<td>5</td>
<td>Days of work</td>
<td>$200</td>
<td>1 (person)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
### Question for your team:

Who will be in charge of gathering the CLM data, and who will train and supervise the data collectors?

### Question for your team:

How, and how often, will the data collectors be trained (and re-trained)?

### Question for your team:

How will you train members of the advocacy team?

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Provincial Coordinator training:</td>
<td>1</td>
<td>Meeting room</td>
<td>$1,000</td>
<td>X</td>
<td>$2,000</td>
</tr>
<tr>
<td>meeting room</td>
<td></td>
<td></td>
<td></td>
<td>2 (days)</td>
<td></td>
</tr>
<tr>
<td>Initial Provincial Coordinator training:</td>
<td>2</td>
<td>Hotel room nights</td>
<td>$200</td>
<td>X</td>
<td>$600</td>
</tr>
<tr>
<td>hotel</td>
<td></td>
<td></td>
<td></td>
<td>3 (Provincial Coordinators)</td>
<td></td>
</tr>
<tr>
<td>Initial Provincial Coordinator training:</td>
<td>3</td>
<td>Daily per diem (days)</td>
<td>$20</td>
<td>X</td>
<td>$180</td>
</tr>
<tr>
<td>per diem</td>
<td></td>
<td></td>
<td></td>
<td>3 (Provincial Coordinators)</td>
<td></td>
</tr>
<tr>
<td>Initial Provincial Coordinator training:</td>
<td>2</td>
<td>Flights</td>
<td>$100</td>
<td>X</td>
<td>$600</td>
</tr>
<tr>
<td>travel costs</td>
<td></td>
<td></td>
<td></td>
<td>3 (Provincial Coordinators)</td>
<td></td>
</tr>
<tr>
<td>Community Monitor trainings (2x):</td>
<td>3</td>
<td>Meeting room</td>
<td>$700</td>
<td>X</td>
<td>$12,600</td>
</tr>
<tr>
<td>meeting room</td>
<td></td>
<td></td>
<td></td>
<td>6 (days, 3 day per meeting)</td>
<td></td>
</tr>
<tr>
<td>Community Monitor trainings (2x):</td>
<td>8</td>
<td>Daily per diem (days, 4 per meeting)</td>
<td>$20</td>
<td>X</td>
<td>$1,920</td>
</tr>
<tr>
<td>per diem</td>
<td></td>
<td></td>
<td></td>
<td>12 (Community Monitors)</td>
<td></td>
</tr>
<tr>
<td>Community Monitor trainings (2x):</td>
<td>6</td>
<td>Roundtrip travel (days, 3 per meeting)</td>
<td>$20</td>
<td>X</td>
<td>$1,440</td>
</tr>
<tr>
<td>travel costs</td>
<td></td>
<td></td>
<td></td>
<td>12 (Community Monitors)</td>
<td></td>
</tr>
</tbody>
</table>
**Data collection**

**Question for your team:** How many Community Monitors will you need to hire?  
**Question for your team:** How will you transport Community Monitors to the data collection sites?

---

### Example of staffing structure for CLM

![Staffing Structure Diagram]

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### Careful!

It's important that everyone who is working on the CLM program be compensated for their time and work. This includes the Community Monitors, any supervisors, and the advocacy team. Many CLM programs struggle with high staff turnover, which means the CLM program has to spend a lot of effort continuously bringing new staff up to speed. To minimize turnover, make sure the CM are being given compensation that not only reimburses their time, but also the extra costs that can be incurred during monitoring (i.e. transportation costs, lodging, etc.). This can mean paying different CM different stipends, to account for differences in travel-related costs.

---

### Table 1: Staffing Costs for Province Coordinator and Community Monitors

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Province Coordinator</td>
<td>0.50</td>
<td>Full-time equivalent (FTE)*</td>
<td>$7,000</td>
<td>3 (person)</td>
<td>$10,500</td>
</tr>
<tr>
<td>Community Monitors</td>
<td>13</td>
<td>Days of work</td>
<td>$100</td>
<td>12 (people)</td>
<td>$15,600</td>
</tr>
</tbody>
</table>

---

### Table 2: Transportation Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hired vehicle</td>
<td>1</td>
<td>Vehicle</td>
<td>$30</td>
<td>80 (days)</td>
<td>$2,400</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
<td>Person</td>
<td>$20</td>
<td>80 (days)</td>
<td>$1,600</td>
</tr>
<tr>
<td>Petrol</td>
<td>1</td>
<td>Liter</td>
<td>$1</td>
<td>2,857</td>
<td>$2,857</td>
</tr>
</tbody>
</table>
**Data analysis and reporting**

*Question for your team:* Who will be in charge of data analysis and management?

*Question for your team:* What kind of platform for data visualization do you want to build?

*Question for your team:* What kinds of advocacy reports or other materials should you generate using CLM data?

*Question for your team:* How will you manage your qualitative data?

---

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term consultant</td>
<td>20</td>
<td>Days</td>
<td>$100</td>
<td>1 (consultant)</td>
<td>$2000</td>
</tr>
<tr>
<td>IT staff</td>
<td>0.5</td>
<td>Full-time equivalent (FTE)</td>
<td>$40,000</td>
<td>1 (person per year)</td>
<td>$20,000</td>
</tr>
<tr>
<td>Server and web hosting services</td>
<td>1</td>
<td>Months</td>
<td>$50</td>
<td>12 (months)</td>
<td>$600</td>
</tr>
</tbody>
</table>

---

**Quick tip**

Building and managing a dashboard can be a challenging task for a new CLM program. If you decide to budget for external technical assistance to support dashboard development and data management, discuss how your data will remain owned by and accessible to the community.

**Quick tip**

CLM teams can benefit from developing an advocacy workplan, which defines the kinds of activities your program will do each year. As part of this workplan, you can decide which types of reports and analyses of CLM data will be the most useful for advocacy.
### Data analysis and reporting

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graphic designer</td>
<td>10</td>
<td>Days of work</td>
<td>$120</td>
<td>1 (person)</td>
<td>$1,200</td>
</tr>
<tr>
<td>Translator</td>
<td>5</td>
<td>Days of work</td>
<td>$100</td>
<td>3 (people)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Photographer</td>
<td>2</td>
<td>Days of work</td>
<td>$120</td>
<td>1 (person)</td>
<td>$240</td>
</tr>
<tr>
<td>Transcribers and translators</td>
<td>14</td>
<td>Days of work</td>
<td>$80</td>
<td>3 (people)</td>
<td>$3,360</td>
</tr>
<tr>
<td>Qualitative researcher</td>
<td>5</td>
<td>Days of work</td>
<td>$200</td>
<td>1 (person)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>
**Advocacy**

**Question for your team**: Who will lead the advocacy phase of the cycle?

**Question for your team**: How will your CLM program identify priority issues for advocacy, develop community-owned solutions to those issues, and hold duty bearers accountable?

**Question for your team**: Who will participate in feedback sessions with clinic managers and other duty-bearers? How will commitments generated during feedback sessions be documented and followed up?

**Question for your team**: What types of accountability interventions will your CLM program do?

<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Unit Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting space</td>
<td>2</td>
<td>Meeting rooms (one per meeting)</td>
<td>$1,000</td>
<td>2 days</td>
<td>$4,000</td>
</tr>
<tr>
<td>Hotels for out-of-town</td>
<td>4</td>
<td>Hotel room nights</td>
<td>$200</td>
<td>15 people</td>
<td>$12,000</td>
</tr>
<tr>
<td>participants</td>
<td></td>
<td></td>
<td></td>
<td>20 people</td>
<td></td>
</tr>
<tr>
<td>Per diem</td>
<td>4</td>
<td>Days of per diem</td>
<td>$10</td>
<td>20 people</td>
<td>$800</td>
</tr>
<tr>
<td>Printing</td>
<td>1</td>
<td>Page</td>
<td>0.05</td>
<td>40 reports</td>
<td>$2</td>
</tr>
</tbody>
</table>

**Quick tip**

Some CLM programs document the outcomes of the feedback sessions by writing a document sharing commitments made, with signatures by both the clinic in charge and the CM team. You may also find it helpful to create advocacy logs, which are used to track changes over time and the triggers (such as a conversation or meeting) that led to each turning point. This formal agreement can form the basis of follow up, including escalation if needed.
<table>
<thead>
<tr>
<th>Description</th>
<th>Units</th>
<th>Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hired vehicle</td>
<td>1</td>
<td>Vehicle</td>
<td>$30</td>
<td>20 (days)</td>
<td>$600</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
<td>Person</td>
<td>$20</td>
<td>20 (days)</td>
<td>$400</td>
</tr>
<tr>
<td>Petrol</td>
<td>1</td>
<td>Liter</td>
<td>$1</td>
<td>700</td>
<td>$700</td>
</tr>
<tr>
<td>Printing</td>
<td>2</td>
<td>Pages of printing</td>
<td>$0.20</td>
<td>20 (facilities)</td>
<td>$8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Unit</th>
<th>Description</th>
<th>Unit Cost</th>
<th>Count</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel of CLM team to capital</td>
<td>1</td>
<td>Flights</td>
<td>$100</td>
<td>10 (people)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Hotels for out-of-town participants</td>
<td>1</td>
<td>Hotel room nights</td>
<td>$200</td>
<td>10 (people)</td>
<td>$2,000</td>
</tr>
<tr>
<td>Per diem</td>
<td>1</td>
<td>Days of per diem</td>
<td>$10</td>
<td>30 (people)</td>
<td>$300</td>
</tr>
<tr>
<td>Meeting space</td>
<td>1</td>
<td>Meeting space</td>
<td>$1,000</td>
<td>1 (days)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Refreshments (lunch and beverages)</td>
<td>1</td>
<td>Lunch and beverage</td>
<td>$5</td>
<td>30</td>
<td>$150</td>
</tr>
<tr>
<td>Audio and visual equipment</td>
<td>8</td>
<td>Hours</td>
<td>$30</td>
<td>1 (days)</td>
<td>$240</td>
</tr>
<tr>
<td>Printed reports</td>
<td>10</td>
<td>Pages</td>
<td>$0.20</td>
<td>30 (copies)</td>
<td>$60</td>
</tr>
</tbody>
</table>
What to prioritize when having adjust budget to available funds?

Prioritize project setup and governance.
Prioritize maintaining human resources.
Ensure that advocacy activities are fully funded.
Develop modular data collection budgets.
Beware of requests to add sites and indicators.
Tools to help you out!
Upcoming COP23 Webinars — to support the development of activist recommendations to PEPFAR

Sign up at: bit.ly/PEPFARWatchWebinars2023
PEPFAR Watch
Community-Led Monitoring webinar
COP23