

## COVID-19 RESPONSE MECHANISM-COMMUNITY ENGAGEMENT (MWI-C-MOH-SR-GF-2024-003)



## STANDARD OPERATING PROCEDURES FOR COMMUNITY-LED MONITORING OF HIV&AIDS, TUBERCULOSIS, MALARIA SERVICES

2024

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## Acknowledgements



## List of Acronyms

AAM	ActionAid Malawi
ADC	Area Development Committee
CBO	Community Based Organization
CCG	Community Consultative Group
CHAG	Community Health Action Groups
CLM	Community Led Monitoring
CSCP	Community Sputum Collection Point
CSO	Civil Society Organizations
DHMT	District Health Management Team
DHSS	Director of Health and Social Services
FSW	Female Sex Workers
HSA	Health Surveillance Assistants
HCMC/HFMC	Health Centre/Facility Management Committee
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IDSR	Integrated Disease Surveillance and Research
MoH	Ministry of Health
MSM	Men who have Sex with Men
NCHF	National Community Health Framework
NSP	National Strategic Plans
PLHIV	People Living with HIV
PR	Principal Recipient
SOP	Standard Operating Procedures
SR	Sub-Recipient



SSR	Sub-Sub-Recipient
UNAIDS	United Nations AIDS
VHC	Village Health Committee

## Executive Summary



## 1. Structure of CLM

### 1.1. The host organization or CLM implementer

To create a solid and sustainable foundation for CLM, it should be embedded in, and owned by, an existing organization.

### 1.2. Data collection sites



Data can be collected at public and/or private health facilities, community-based service delivery facilities and/or community service points (for example, community groups).

### 1.3. CLM Team

- 1.3.1. SR-SSR CLM Steering Committee:** To provide strategic oversight
- 1.3.2. SR CLM Team:** To provide technical oversight and backstops
- 1.3.3. SSR CLM Lead:** To provide oversight of CLM implementation.
- 1.3.4. SSR CLM M&E Officer:** To provide oversight of community data collection, management, analysis, and verification processes.
- 1.3.5. District CLM Assistant with support from District Health Office CLM Focal Point:** To supervise collection of data, conducting data verification and cleaning the data from all sites in the district.
- 1.3.6. Data collectors:** Collecting data from specific sites. Data collectors interact directly with health facilities or service delivery points to collect quantitative and qualitative data.
- 1.3.7. Technical Advisory groups:** Technical advisory groups support the host organization, CLM implementer and community network in implementing CLM. For example, UNAIDS.
- 1.3.8. Academic institution/External Experts:** Such a partnership for building capacity among community members who are implementing CLM.
- 1.3.9. Community/District/National Consultative Groups (CGs):** The CCG has 10-15 members, including a chair, a vice-chair, and members from these categories:
  -  **Normative agencies.** This can include UNAIDS and The Global Fund.
  -  **Government organizations.** This can include representatives from the national AIDS and/or TB programmes and other government counterparts.
  -  **Civil society organizations.** This can include strategic partners from civil society organizations.
  -  **Partners.** This can include target populations, members of key populations and national people living with HIV networks.
  -  **Research institute or independent expert.** People with relevant expertise can be invited to join the CCG. The host organization acts as the CCG secretariat.


















## 2. Community Monitoring Model

### 2.1. Collaborative Model

-  **Health Facility Management Committees:** Combine healthcare providers and community representatives to address grievances and provide feedback on solutions.
-  **Community Scorecards:** Develop performance indicators together, track health system quality, and create joint action plans.



### 3. Target Groups / Beneficiaries

Direct	Indirect
<ul style="list-style-type: none"> <li> The general population (Health service users)</li> <li> PLHIV and their support groups</li> <li> key populations (FSWs and MSMs)</li> <li> CBOs/ ADCs/CHAGs</li> <li> Youth and Women</li> </ul>	<ul style="list-style-type: none"> <li> Community surrounding the health facilities.</li> <li> Governance structures at different levels (ADCs, VHCs)</li> </ul>
Major Stakeholders	
<ul style="list-style-type: none"> <li> Health Sector (MOH depts, Offices of Ombudsmen, DHMTs, HFMCs and staff)</li> <li> Implementing Partners</li> <li> District Council staff</li> <li> Health &amp; Environment Committees</li> <li> Radio stations</li> </ul>	<ul style="list-style-type: none"> <li> Traditional leaders,</li> <li> Religious leaders</li> <li> Community based organizations</li> <li> Governance structures</li> <li> CSOs and their coordinating bodies</li> </ul>

### 4. CLM Steps

#### 4.1. Identify Service-Related Needs and Issues for CLM

This focuses on persistent community needs. Also considers the key aspects of service delivery such as availability, quality, access, appropriateness.

#### 4.2. Education

Training ensures that community members understand the services and treatment they are entitled to and are familiar with their national treatment guidelines. This provides the foundation for effective advocacy.

### **4.3. Evidence Generation**

- 4.3.1. Conduct baseline assessment.
- 4.3.2. Quantitative and Qualitative Data collection.
- 4.3.3. Data verification.
- 4.3.4. Data entry.
- 4.3.5. Data management and storage: Physical data collection tools to be stored in locked cabinets.  
Electronic data will be secured.
- 4.3.6. Data review and analysis.
- 4.3.7. Data quality audit (field visits)

### **4.4. Engagement and Advocacy**

CLM and related advocacy engagement is facilitated through consultative groups. Evidence-based advocacy uses targeted actions to change norms, guidelines, standards, and policies that directly affect the health of people living with and at risk for HIV.






## 5. CLM Standard Operating Procedures (SOP)

### 5.1. Planning meetings and site identification

#### 5.1.1. Purpose of the SOP

Provide a standardized approach for planning meetings and site identification with DHMTs and coordinators.



#### 5.1.2. Resources required

-  Projector and laptop
-  PowerPoint presentation
-  Refreshments and Lunch allowances for 20 people

#### 5.1.3. Application of SOP

The SOP will be used by all staff from SR and SSRs organizing and carrying out planning meetings


#### 5.1.4. Target participants

-  DHMT members
-  Program Coordinators







#### 5.1.5. Facilitators

-  SR
-  SSR
-  PR





#### 5.1.6. Duration/Frequency

-  2 Days

#### 5.1.7. Procedure

-  Send an email to the DHSS.
-  Follow it up with a phone call to agree on dates and venue for the meetings.
-  Meet the DHMT and Coordinators separately.
-  Meet DHMTs first then coordinators.
-  Where the DHMTs agree to combine with the coordinators, meet them at one place
-  Make the presentation as shared by SR.

### 5.1.8. Outcomes







-  Project sites identified.
-  District focal person identified.
-  DHMT commitment and support sought.
-  DHMT input and insights documented for consideration.

## 5.2. Development and Review of SOPs, manuals, and tools

### 5.2.1. Purpose of the SOP

Provide a standardized approach for the development of standard operation procedures






### 5.2.2. Resources required

-  Conference facilities
-  PowerPoint presentation on the project.
-  Project Budget
-  Fuel and transport
-  DSA for 40 participants
-  Reference materials: HSSP III, HIV NSP, 2020-2025, NCHF

### 5.2.3. Application of SOP

The SOP will be used by all staff from SR and SSRs


### 5.2.4. Target participants

-  SSR Program staff
-  Representatives from districts,
-  CSOs
-  MoH
-  Other agencies. E.g. UNAIDS






### 5.2.5. Facilitators





-  SR

### 5.2.6. Duration/Frequency




-  10 days

### 5.2.7. Procedure

-  Invite participants through email
-  Follow it up with a phone call to confirm participation.
-  Make the presentation of the project, emphasizing project activities, logical framework, CLM data flow and CLM indicator development.
-  Present draft SOPs
-  Divide the participants to groups to seek their input on the procedures.

-  Let the smaller groups present their recommendations to larger group to make a consensus on how the activities should be implemented.
-  When making consensus consideration should be given to purpose of the project, HR, finances, and time available to implement the project.
-  Agree on the resources needed to implement each activity.
-  Develop the tools and identify the resources necessary to implement each activity

#### 5.2.8. Outcomes







-  Detailed standard operation procedures for all project key activities
-  Tools developed to support implementation of key project activities.
-  Resources identified to support implementation of key project activities

### 5.3. Orientation of district CLM Assistants


#### 5.3.1. Purpose of the SOP

The purpose of this procedure is to ensure that district supervisors are oriented to their roles, responsibilities regarding the project


#### 5.3.2. Resources required

-  Power point presentation
-  Conference facilities
-  DSA for 20 people
-  Refreshments, transportation, and materials
-  Evaluation forms
-  Reference materials: HSSP III, HIV/TB/Malaria NSP, NCHF

#### 5.3.3. Application of SOP

-  The SOP will be applied by SR


#### 5.3.4. Target participants

-  District CLM Assistants

#### 5.3.5. Facilitators

-  SR

#### 5.3.6. Duration





-  5 days

#### 5.3.7. Implementation level

-  National level









#### 5.3.8. Procedure

##### a. Preparation:

-  Identify the individuals through SSRs who will participate in the orientation session.
-  Collaborate with SSR project coordinators to familiarize with orientation materials, including project objectives, methodologies, tools, and guidelines.
-  Schedule the orientation session at a convenient time and location, ensuring the availability of all participants. (Cluster at national level).
-  Allocate resources and budget for the orientation, including venue arrangements, refreshments, and materials.

##### b. Orientation Session:








-  Begin by welcoming the participants.
-  Provide an overview of CLM project, including its objectives, and expected outcomes.
-  Explain the methodologies and tools used in the CLM process, such as focus group discussions, desk reviews and scorecards.
-  Clarify the roles and responsibilities of CLM assistant during capacity building, evidence generation, engagement, advocacy, and education.
-  Emphasize the importance of community engagement, transparency, and accountability in the monitoring process.
-  Review data collection, analysis, and reporting procedures, ensuring understanding and adherence to ethical guidelines and data privacy principles.
-  Encourage questions, discussions, and feedback to ensure clarity and engagement.
-  Gather feedback from participants to evaluate the effectiveness of the orientation process and identify areas for improvement.

#### **5.4. Orientation of DHMT, Research Committees, Ombudsmen, HMIS, and council representatives, and HEC**


##### **5.4.1. Purpose of the SOP**

The purpose of this procedure is to ensure that participants are effectively oriented to their roles, responsibilities regarding the project


##### **5.4.2. Resources required**

-  Power point presentation
-  Conference facilities
-  Refreshments, transportation, and materials
-  Evaluation forms
-  Reference materials: HSSP III, HIV/TB/Malaria NSP, NCHF







##### **5.4.3. Application of SOP**

-  The SOP will be applied by SRs and SSRs




##### **5.4.4. Target participants**

-  9 DHMT




-  Research committee members
-  District level Ombudsmen
-  Relevant council representative such as the District Commissioner, Director of Planning etc.,
-  Quality Management officer (QIST Coordinator)
-  HMIS officers
-  HEC members

#### 5.4.5. Facilitators

-  AAM
-  SSR
-  Community Health Services Department

#### 5.4.6. Duration





-  2 days

#### 5.4.7. Implementation Level




-  District







#### 5.4.8. Procedure

##### a. Pre-Orientation Preparation:

-  Identify the individuals through DHSS who will participate in the orientation session.
-  Collaborate with project coordinators to familiarize themselves with orientation materials, including project objectives, methodologies, tools, and guidelines.
-  Schedule the orientation session at a convenient time and location, ensuring the availability of all participants. (Cluster according by region).
-  Allocate resources and budget for the orientation, including venue arrangements, refreshments, and materials.

##### b. Orientation Session:

-  Begin by welcoming the participants.
-  Provide an overview of CLM project, including its objectives, and expected outcomes.
-  Explain the methodologies and tools used in the CLM process, such as focus group discussions, desk reviews and scorecards.





-  Clarify the roles and responsibilities of DHMT members, Ombudsmen, and other council staff during capacity building, evidence generation, engagement, advocacy, and education.
-  Emphasize the importance of community engagement, transparency, and accountability in the monitoring process.
-  Review data collection, analysis, and reporting procedures, ensuring understanding and adherence to ethical guidelines and data privacy principles.
-  Encourage questions, discussions, and feedback to ensure clarity and engagement
-  Evaluation:
  -  Gather feedback from participants to evaluate the effectiveness of the orientation process and identify areas for improvement.

## **5.5. Orientation with Health Facility Management Committees**


### **5.5.1. Purpose of the SOP**

The purpose of this procedure is to guide the orientation process for HFMCs regarding their involvement in a community-led monitoring and social accountability project. This orientation aims to inform HFMC members about the project's objectives, methodologies, roles, and responsibilities, ensuring their active participation and ownership throughout the project duration (2024-2025).



### **5.5.2. Resources required**

-  Power point presentation
-  Conference facilities
-  Refreshments, transportation, and materials
-  Evaluation forms

### **5.5.3. Application of SOP**

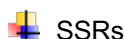
-  The SOP will be applied by the SR, SSRs staff organizing the training. It will also be applied by Facilitators of orientation

### **5.5.4. Target participants**

-  HFMCs (10-15)
-  TB, HIV, Malaria, IDSR

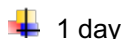
### **5.5.5. Facilitators**

-  DHMT and coordinators (TB, HIV, Malaria, IDSR)



SSRs

#### 5.5.6. Duration/Frequency



1 day










#### 5.5.7. Level of implementation




Facility


















#### 5.5.8. Procedure



##### a. Pre-Orientation Preparation:

-  Identify the HFMCs of the selected health facilities that will participate in the orientation session.
-  Collaborate with disease program coordinators to familiarize orientation materials, including project objectives, methodologies, tools, and guidelines tailored to HFMCs.
-  Schedule the orientation sessions clustered at the district level, considering the availability of HFMC members, and ensuring adequate time for discussion and interaction.
-  Allocate resources and budget for the orientation, including venue arrangements, refreshments, and materials.
  
-  Identify the HFMC, FHMT, program focal persons (TB, HIV, Malaria & IDSR, of the selected health facilities that will participate in the orientation session.
-  Collaborate with disease program coordinators to familiarize orientation materials, including project objectives, methodologies, tools, and guidelines tailored to HFMCs, FHMT, program focal persons (TB, HIV, Malaria & IDSR,
-  Schedule the orientation sessions clustered at the district level, considering the availability of HFMC members FHMT, program focal persons (TB, HIV, Malaria & IDSR, and ensuring adequate time for discussion and interaction.
-  Allocate resources and budget for the orientation, including venue arrangements, refreshments, and materials.
- 

##### b. Orientation Session:

-  Begin the session by welcoming HFMC members and introducing the facilitators and project coordinators.

-  Provide an overview of the community-led monitoring and social accountability project, including its objectives, significance, and expected outcomes.
-  Explain the methodologies and tools used in the monitoring process, such as desk reviews of registers, and community scorecards.
-  Clarify the roles and responsibilities of HFMC members in facilitating and participating in monitoring activities, ensuring accountability, and fostering community engagement.
-  Emphasize the importance of transparency, communication, and collaboration between HFMCs, health facility staff, and the community throughout the project implementation.
-  Review data collection, analysis, and reporting procedures, ensuring understanding and adherence to ethical guidelines and data privacy principles.
-  Demonstrate the use of monitoring tools and provide hands-on training if applicable.
-  Encourage questions, discussions, and feedback to ensure clarity and engagement.
-  Gather feedback from HFMC members to evaluate the effectiveness of the orientation process and identify areas for improvement.
-  Use feedback to refine future orientation sessions
-  Begin the session by welcoming HFMC members FHMT, program focals (TB, HIV, Malaria & IDSR, and introducing the facilitators and project coordinators.
-  Provide an overview of the community-led monitoring and social accountability project, including its objectives, significance, and expected outcomes.
-  Explain the methodologies and tools used in the monitoring process, such as desk reviews of registers, and community scorecards.
-  Clarify the roles and responsibilities of HFMC member, FHMT, program focals (TB, HIV, Malaria & IDSR, in facilitating and participating in monitoring activities, ensuring accountability, and fostering community engagement.
-  Emphasize the importance of transparency, communication, and collaboration between HFMCs, health facility staff, and the community throughout the project implementation.
-  Review data collection, analysis, and reporting procedures, ensuring understanding and adherence to ethical guidelines and data privacy principles.
-  Demonstrate the use of monitoring tools and provide hands-on training if applicable.
-  Encourage questions, discussions, and feedback to ensure clarity and engagement.

-  Gather feedback from HFMC members FHMT, program focals (TB, HIV, Malaria & IDSR, to evaluate the effectiveness of the orientation process and identify areas for improvement.
-  Use feedback to refine future orientation sessions














## **5.6. Training of CHAGS, ADCs, and other informal health service providers, on emergency and pandemic preparedness and response**

### **5.6.1. Purpose of the SOP**

The purpose of this standard operating procedure is to provide a systematic approach for conducting training sessions for CHAGs to enhance their knowledge and skills in emergency and pandemic preparedness and response. The training will enhance their knowledge, attitude and skills in emergency and pandemic preparedness and response. The training will allow few representatives from the above mentioned groups to attend the trainings. Then later there will be a follow to see if these representatives have briefed their fellow group members in their respective groupings.


### **5.6.2. Resources required**

-  Audio-visual equipment
-  Venue for training
-  Refreshments
-  Lunch allowance for facilitators and participants
-  Fuel for facilitators
-  Pre-test and post-test training
-  Transport reimbursement for participants
-  Stationary i.e., Markers, pens, shorthand note pad
-  Airtime for communication
-  Training manual for ADC/CHAGs
-  Reference materials: HSSP, NSPs, NCHF, training manual for CHAGs



### **5.6.3. Application of SOP**

The SOP will be applied by SR and SSR staff, disease program coordinators, and any other officers facilitating and supervising the training




### **5.6.4. Target participants**

-  ADCs, CHAGs

### **5.6.5. Facilitators**

-  IDSR coordinator
-  Disaster officer-council



-  Community Health Coordinator
-  CLM- District focal person
-  Emergency and Climate change Coordinator




Program coordinators

#### 5.6.6. Duration

- 2 days



#### 5.6.7. Procedure

##### a. Pre-training Preparation:


-  Identify suitable training venue(s) within the community (Health facility/TDC).
-  Assemble and familiarize necessary training materials, including presentations, handouts, and visual aids.
-  Confirm the availability of trainers/facilitators knowledgeable in emergency and pandemic preparedness and response.

##### b. Training Session Structure:




###### i. Introduction:

-  Welcome participants and introduce the purpose and objectives of the training.
-  Establish rapport and create a conducive learning environment.






###### ii. Icebreaker Activity:

-  Conduct an icebreaker to familiarize participants and encourage interaction.

###### iii. Overview of Emergency and Pandemic Preparedness:


-  Present key concepts related to emergency and pandemic preparedness, including risk assessment, early warning systems, and response planning.
-  Role of ADCs, CHAGs, and VHCs:
-  Discuss the specific roles and responsibilities of ADCs, CHAGs, and VHCs in emergency and pandemic response.

###### iv. Training Modules-Deliver interactive sessions covering topics such as:

-  Disease transmission and prevention measures
-  Surveillance and reporting of infectious diseases.
-  Community mobilization and communication strategies.
-  First aid and basic medical care.
-  Psychological support and mental health awareness.










**v. Practical Exercises and Demonstrations:**

-  Facilitate hands-on activities, simulations, or role-plays to reinforce learning and build practical skills.

**vi. Case Studies and Best Practices:**

-  Share relevant case studies and success stories from other communities or regions.

**vii. Question and Answer Session:**












-  Allocate time for participants to ask questions and seek clarification on any topics covered.
-  Conduct knowledge assessments or quizzes to gauge participants' understanding.
-  Ask the committees to develop pandemic community disaster and pandemic preparedness plans.
-  Summarize key takeaways and reinforce the importance of preparedness and collaboration.
-  Express gratitude to participants and trainers.
-  Gather feedback from participants regarding the training content, delivery, and effectiveness.
-  Evaluate the achievement of learning objectives and identify areas for improvement.

## **5.7. Training of data collectors, data clerks, coordinators, journalists, (TB, HIV, Malaria, IDSR), service providers, (AEHO Nurses, clinicians on the Community Led Monitoring**

### **5.7.1. Purpose of the SOP**

The purpose of this standard operating procedure is to outline the systematic approach for conducting training sessions for supervisors, Health Surveillance Assistants (HSAs), and data collectors on CLM project. The training aims to equip participants with the necessary knowledge, attitude, and skills to effectively support CLM initiatives.



### **5.7.2. Resources required**

-  Training materials
-  Stationary i.e. Flip chart, pens, markers, note pads
-  Transport reimbursement for participants
-  Fuel for facilitators
-  Pre-test and post-test
-  Airtime to facilitators for communication
-  Logical framework
-  Audio-visual equipment
-  Venue for training
-  Refreshments
-  Reference materials: HSSP, NSPs, NCHF, CLM Library



### **5.7.3. Application of SOP**

The SOP will be applied by SR and SSR staff, disease program coordinators and any other officers facilitating and supervising the trainings

### **5.7.4. Target participants**


-  EHO, HSAs, Journalists, Health Education Officers
-  Nurses, clinicians, data clerk, and Data collectors

### **5.7.5. Facilitators**

-  SSR
-  District staff: IDSR, Community health Coordinator, CLM- Focal person, Program coordinator







#### 5.7.6. Duration

 3 days




#### 5.7.7. Procedure

##### a. Pre-training Preparation:


-  Identify suitable training venue(s) (clustered)
-  Prepare training materials, including presentations, manuals, handouts,
-  Arrange for audio-visual equipment, flip charts, markers, etc.
-  Confirm the availability of trainers/facilitators. (SSR, DHMT)

##### b. Training Session Structure:


###### i. Introduction:

-  Welcome participants and provide an overview and objectives of the training
-  Set expectations and establish a participatory learning background.
-  Present an overview of the CLM project, its goals, and significance in promoting community engagement and accountability.


###### ii. CLM Methodology:

-  Explain the principles and methodologies of CLM, including participatory monitoring, community scorecards, and social audits.


###### iii. Data Collection Techniques:

-  Provide training on effective data collection techniques, including surveys, interviews, focus group discussions, and observation.


###### iv. Community Engagement Strategies:

-  Discuss strategies for engaging communities in CLM initiatives, building trust, and fostering active participation.

###### v. Reporting and Documentation:


-  Review procedures for data recording, analysis, and reporting, emphasizing accuracy, timeliness, and confidentiality.

###### vi. Quality Assurance and Supervision:


-  Outline mechanisms for quality assurance, including regular supervision, feedback loops, and corrective actions.

###### vii. Practical Exercises, Role-plays, and case studies:

-  Conduct hands-on activities, simulations, or role-plays to reinforce learning

-  Share examples of successful CLMSA projects and lessons from previous implementations.

**viii. Roles and Responsibilities:**

-  Clarify the roles and responsibilities of supervisors, HSAs, and data collectors in implementing CLM activities, including data collection, community mobilization, and monitoring.

**ix. Evaluation:**

Assess participants' understanding through quizzes, group discussions, or practical assessments.

Gather feedback from participants to evaluate the training content, delivery, and effectiveness.










Review learning outcomes and identify areas for improvement in future training sessions

## **5.8. Training of CLM assistants, data clerk, and Data collectors on Automated CLM System**

### **5.8.1. Purpose of the SOP**

The purpose of this standard operating procedure is to outline the systematic approach for conducting training sessions for supervisors, Health Surveillance Assistants (HSAs), and data collectors on CLM project. The training aims to equip participants with the necessary knowledge, skills, and tools to effectively support CLM initiatives


### **5.8.2. Resources required**

-  Training materials
-  Logical framework
-  Audio-visual equipment
-  Venue for training
-  Refreshments
-  Airtime to Facilitators for communication
-  Fuel
-  Lunch
-  Reference materials: HSSP, NSPs, NCHF, CLM Library







### **5.8.3. Application of SOP**

The SOP will be applied by SR and SSR staff, disease program coordinators and any other officers facilitating and supervising the trainings

### **5.8.4. Target participants**


-  CLM assistants, data clerk, and Data collectors

### **5.8.5. Facilitators**

-  SR
-  SSR
-  Community coordinator,
-  IDSR
-  Disaster And Climate Change Coordinator
-  Program coordinators





### **5.8.6. Duration/Frequency**



 3 days




### 5.8.7. Procedure

#### a. Pre-training Preparation:


-  Identify suitable training venue(s) (clustered)
-  Prepare training materials, including presentations, manuals, handouts,
-  Arrange for audio-visual equipment, flip charts, markers, etc.
-  Confirm the availability of trainers/facilitators. (SSR, DHMT)

#### b. Training Session Structure:


##### i. Introduction:

-  Welcome participants and provide an overview and objectives of the training
-  Set expectations and establish a participatory learning background.
-  Present an overview of the CLM project, its goals, and significance in promoting community engagement and accountability.


##### ii. CLM Methodology:

-  Explain the principles and methodologies of CLM, including participatory monitoring, community scorecards, and social audits.


##### iii. Data Collection Techniques:

-  Provide training on effective data collection techniques, including surveys, interviews, focus group discussions, and observation.


##### iv. Community Engagement Strategies:

-  Discuss strategies for engaging communities in CLM initiatives, building trust, and fostering active participation.



##### v. Reporting and Documentation:

-  Review procedures for data recording, analysis, and reporting, emphasizing accuracy, timeliness, and confidentiality.


##### vi. Quality Assurance and Supervision:

-  Outline mechanisms for quality assurance, including regular supervision, feedback loops, and corrective actions.




##### vii. Practical Exercises, Role-plays, and case studies:

-  Conduct hands-on activities, simulations, or role-plays to reinforce learning
-  Share examples of successful CLMSA projects and lessons from previous implementations.

**viii. Roles and Responsibilities:**

-  Clarify the roles and responsibilities of supervisors, HSAs, and data collectors in implementing CLM activities, including data collection, community mobilization, and monitoring.

**ix. Evaluation:**







-  Assess participants' understanding through quizzes, group discussions, or practical assessments.
-  Gather feedback from participants to evaluate the training content, delivery, and effectiveness.
-  Review learning outcomes and identify areas for improvement in future training sessions

## 5.9. Identification of issues and indicator development

### 5.9.1. Purpose of the SOP

The purpose of this standard operating procedure is to provide a structured approach for the identification of issues and the development of CLM indicators at health facilities. The SOP aims to facilitate collaboration between project coordinators, Health Facility Management Committees (HFMCs), and selected community representatives to address gaps in HIV, TB, Malaria, and other public health indicators through community-led monitoring.







### 5.9.2. Resources required

-  Meeting venue(s) at identified health facilities.
-  Necessary materials such as flip charts, markers, notepads, and pens.
-  Relevant data and reports on HIV, TB, Malaria, and other public health indicators.
-  Facilitators or moderators knowledgeable in community engagement and participatory approaches
-  Issue prioritization
-  IDSR guidelines, EBS guideline



### 5.9.3. Application of SOP

The SOP will be applied by SSRs, Project Coordinators, CLM assistants' data collectors, Facilitators and staff organizing and supporting the session

### 5.9.4. Target participants

-  HCMCs
-  Data collectors
-  Community representatives
-  Facility focal persons i.e. Malaria, TB, HIV
-  Other representatives from community structure
- 

### 5.9.5. Facilitators

-  SSR
-  CLM Focal person




-  Community Health coordinator

-  IDSR Coordinator




-  Disease program coordinators

#### 5.9.6. Duration/Frequency

-  1 day



#### 5.9.7. Procedure

##### a. Pre-Activity Preparation:




-  Schedule a planning meeting with SSR CLM officers, HFMC members, and community representatives (CBOS, Support groups, CSCPs)
-  Prepare necessary materials, including flip charts, markers, notepads, and pens.
-  Ensure the availability of relevant data and reports on HIV, TB, Malaria, and other public health indicators for reference during the activity.

##### b. Activity Implementation:



###### i. Introduction:

-  Welcome participants and provide an overview of the purpose and objectives of the activity.
-  Explain the importance of community-led monitoring in addressing gaps in public health indicators.


###### ii. Identification of Issues:

-  Facilitate a discussion to identify key issues and challenges related to HIV, TB, Malaria, and other public health indicators at the selected health facility.
-  Encourage participants to share their perspectives and experiences regarding existing gaps and barriers to improvement.
-  Limit to 5 indicators at a time to be reviewed every 6 months

###### iii. Prioritization of Issues:

-  Collaboratively prioritize the identified issues based on their severity, impact on the community, and feasibility of addressing them through CLM.
-  Use consensus-building techniques to ensure all stakeholders' input is considered in the prioritization process.

###### iv. Development of CLM Indicators:

-  Guide participants in formulating specific, measurable, achievable, relevant, and time-bound (SMART) indicators to monitor the identified issues.

- ✚ Ensure that CLM indicators are aligned with the goals and objectives of the CLM project and are feasible to track over time.

**v. Documentation:**

- ✚ Record the identified issues, prioritized areas, and developed CLM indicators on flip charts or digital platforms for reference and future monitoring.
- ✚ Assign responsibilities to project coordinators, HFMC members, and community representatives for implementing and monitoring CLM indicators.

**vi. Action Plan:**

- ✚ Develop an action plan outlining the steps, timelines, and responsible parties for implementing CLM indicators and addressing the identified issues.
- ✚ Ensure that the action plan includes mechanisms for regular data collection, analysis, reporting, engagement, dissemination, advocacy to ensure progress towards achieving the set objectives.

**c.Post-Activity Follow-up:**







- ✚ Share the outcomes of the activity, including identified issues, prioritized areas, CLM indicators, and the action plan, with relevant stakeholders.
- ✚ Monitor the implementation of CLM indicators and the progress made in addressing the identified issues.
- ✚ Conduct monthly follow ups on activities before actual reviews to ensure implementation of the planned activities
- ✚ Advise the committee members to take pictures when carrying out activities as a means of evidence for actual implementation
- ✚ Committees to include HSAs or Volunteers who can give evidence of activity implementation
- ✚ Trainings must be done according to hierarchical arrangements
- ✚ Conduct periodic reviews and evaluations to assess the effectiveness of CLM interventions and make necessary adjustments as needed

## 5.10. Monthly quantitative data collection

### 5.10.1. Purpose of the SOP

The purpose of this standard operating procedure (SOP) is to establish guidelines for the systematic monthly quantitative data collection conducted at a targeted health facility as part of the Community Led Monitoring (CLM) project. This SOP aims to ensure the accurate and consistent collection of relevant data from TB, HIV Testing, Antiretroviral Therapy (ART), Malaria registers, and other relevant sources to assess the impact of CLM interventions on the uptake and delivery of health services.






### 5.10.2. Resources required

-  Monthly consolidated reports, observation, from the registers
-  Data collection tools: Tablets, Interview guides, checklists, Consent forms, Recording devices., Supervisory support and guidance from project coordinators or facilitators
-  Monthly consolidated reports and registers.
-  Data collection tools: Tablets, checklists, Consent forms, , push bikes/motorcycle, locable cabinets, files, Supervisory support and guidance from project coordinators or facilitators.
-  Support from district staff.
- 



### 5.10.3. Application of SOP

The SOP will be applied by Data collectors, District Based CLM assistants, Project coordinators and District staff supporting the data collection

### 5.10.4. Target participants

-  Data collectors
-  Facility Data clerk
-  DSCA/HSA added for sustainability
- 
-  Youth, women, PLHIV etc

### 5.10.5. Facilitators/Supervisors

-  CLM assistants
-  SSR









 District staff

#### 5.10.6. Frequency

 Ongoing



#### 5.10.7. Procedure

##### a. Pre-Data Collection Preparation:



-  Schedule and coordinate with trained data collectors to ensure their availability for monthly data collection.
-  Notify the Health Facility Management Committee (HFMC) and relevant health facility staff about the upcoming data collection activity.
-  Prepare necessary materials, including data collection forms/templates, data collection guidelines, and any other relevant documents.
-  Ensure access to the relevant TB, HIV Testing, ART, Malaria registers, and other health facility records for data extraction.
-  Conduct refresher training for data collectors to review data collection protocols, techniques, and ethical considerations.
-  Ensure the availability of a designated space at the health facility for data collection activities.

##### b. Data Collection Process:



###### i. Register Review:

-  Review the relevant TB, HIV Testing, ART, Malaria registers, and other health facility records to identify the required data elements for collection.
-  Ensure data collectors are familiar with the format and content of the registers to facilitate efficient data extraction.




###### ii. Data Extraction:

-  Extract the required quantitative data from the registers, including but not limited to patient demographics, service utilization, diagnostic tests conducted, and treatment outcomes.
-  Ensure data collectors adhere to standardized procedures for recording and documenting extracted data to minimize errors and inconsistencies.

###### iii. Quality Assurance:







-  Implement quality assurance measures, such as double-checking of extracted data and data validation checks, to ensure data accuracy, timeliness and completeness.
-  Provide ongoing supervision and support to data collectors throughout the data collection process.

**iv. Ethical Considerations:**

-  Ensure confidentiality of patient information and compliance with data protection regulations during data extraction and recording.
-  Obtain necessary permissions or approvals from health facility authorities before accessing and extracting data from registers.
-  Make sure the data collector has a binding agreement with the Health facility to maintain confidentiality .



**c. Post-Data Collection Procedures:**










-  Compile and organize the collected quantitative data in a structured format for analysis and reporting.
-  Conduct data validation checks to identify any discrepancies or inconsistencies in the collected data.
-  Analyze the quantitative data to assess trends, patterns, and changes in health service utilization and outcomes over time.
-  Prepare summary reports or dashboards presenting key findings, performance indicators, and trends to assess the impact of CLM interventions on health service delivery.
-  Share the findings with relevant stakeholders, including HFMC members, health facility staff, and community representatives, for review, discussion, and decision-making.
-  Store the reports and recommendations in locable cabinets for safekeeping and future use.

## 5.11. Quarterly qualitative data collection and consolidation

### 5.11.1. Purpose of the SOP

The purpose of this standard operating procedure is to establish guidelines for the quarterly qualitative data collection conducted by community data collectors as part of the Community Led Monitoring (CLM) project at the health facility. This SOP aims to ensure the systematic collection of relevant qualitative information to monitor and evaluate the performance of the health facility and identify areas for improvement based on community feedback.



### 5.11.2. Resources required

-  Tablets
-  Data collection tools,
-  Interview guides, -Acceptability/stigma, interview service providers
-  Consent forms.
-  Transportation
-  KII/Exit interview questionnaire-
-  Recording devices.
-  Designated space interviews and FGDs
-  Supervisory support and guidance from project coordinators or facilitators.






### 5.11.3. Application of SOP

The SOP will be applied by Data collectors, District Based CLM assistants, Project coordinators and District staff supporting the data collection

### 5.11.4. Target participants

-  Data collectors-women, youth, PLHIV etc.
- 

### 5.11.5. Facilitators-SUPERVISORS

-  SSR
-  Data collectors
-  District staff
-  Data clerks
-  HSA

### Frequency















Ongoing




#### 5.11.6. Procedure

##### a. Pre-Data Collection Preparation:



-  Schedule focus group discussions
-  Prepare necessary materials, including data collection tools, interview guides, consent forms, and any other relevant documents.
-  Notify the Health Facility Management Committee (HFMC) and relevant health facility staff about the upcoming data collection activity.
- 
-  Ensure the availability of a designated space at the health facility for conducting interviews and data collection activities.
-  Schedule focus group discussions
-  Conduct Exit interviews
-  Notify the Health Facility Management Committee (HFMC) and relevant health facility staff about the upcoming data collection activity.
-  Prepare necessary materials, including data collection tools, interview guides, consent forms, and any other relevant documents.
-  Ensure the availability of a designated space at the health facility for conducting interviews and data collection activities.

##### b. Data Collection Process:

###### i. Community Engagement:





-  Explain the purpose of the data collection to the FGD target audience.
-  Encourage their participation.
-  Ensure confidentiality and respect for participants' rights.

###### ii. Qualitative Interviews:



-  Conduct qualitative interviews with community members using semi-structured interview guides to gather feedback on their experiences and perceptions of health services.
-  Encourage open-ended responses and probe for detailed insights into specific aspects of health service delivery, satisfaction levels, and suggestions for improvement.

###### iii. Data Recording:





-  Record qualitative responses accurately and comprehensively using standardized data collection tools.
-  Ensure proper documentation of participant demographics, interview details, and verbatim responses.
-  Ensure functionality of data recording gadgets and storage devices.
- 






#### **iv. Quality Assurance:**

-  Implement quality assurance measures, such as spot-checking of data collection activities and reliability checks, to ensure data accuracy and consistency.
-  Provide ongoing supervision and support to community data collectors throughout the data collection process.

#### **v. Ethical Considerations:**

-  Obtain informed consent from all participants before conducting interviews and ensure their voluntary participation in the data collection activity.
-  Maintain confidentiality of participant information and anonymize data during analysis and reporting.

#### **c. Post-Data Collection Procedures:**

-  Compile and organize the collected qualitative data for analysis, including transcription of interviews if necessary.
-  Conduct data validation checks to identify any inconsistencies or discrepancies in the collected data.
-  Analyze qualitative data to identify emerging themes, patterns, and insights relevant to the performance of the health facility and the CLM project.
-  Prepare summary reports or presentations highlighting key findings, community feedback, and actionable recommendations for health facility improvement.
-  Share the findings with relevant stakeholders, including HFMC members, health facility staff, and community representatives, for discussion and decision-making.



- Store the reports and recommendations in locable cabinets for safekeeping and future use.










## **5.12. Consortium level review meeting**

### **5.12.1. Purpose of the SOP**

The purpose of this SOP is to share project progress, feedback and success within our consortium and relevant stakeholders (Government and CLM CSOs)







### **5.12.2. Resources required**

-  Meeting agenda
-  Budgets
-  Conference package -Audiovisual equipment
-  Refreshments and lunch, stationery, and venue
-  Conference package (Audiovisual equipment, Refreshments, Stationery, and lunch)
-  Transport reimbursement/Fuel
-  DSA for participants

### **5.12.3. Application of SOP**

This will be applied by AAM, SSRs and relevant stakeholders (Government and CLM CSOs)


### **5.12.4. Target participants**

-  PR
-  SR
-  SSR
-  MoH departments
-  District staff
-  stakeholders

### **5.12.5. Facilitators**

-  SR



### **5.12.6. Duration**



-  5 days

### **5.12.7. Procedure**





#### **5.12.8. a. Procedure**

##### **a. Preparatory meeting**

-  Invite all participants (SSRs) involved in the project through an email
-  SSRs to invite relevant stakeholders Government and CLM CSOs to the meeting through email a week prior to the meeting date and follow up with phone calls

-  (SR)Secure venue for the meeting
-  SSR to prepare PowerPoint presentation

**b. Actual meeting**





-  Welcome all participants conduct introductory session and explain the agenda of the review meeting and logistics
  -  Sharing of project updates/ progress by SSRs focusing on activities done, challenges encountered, successes registered, and lessons learnt, Plans for next reporting period
  -  Plenary discussions and feedback from audience
  -  Presentation by SR
- Summarizing key issues and next steps

### 5.13. Conduct facility baseline assessment

#### 5.13.1. Purpose of the SOP

The purpose of this SOP is to establish current status of the identified indicators to be monitored which will serve as a reference point and basis for periodic review

#### 5.13.2. Resources required

-  Data collection forms, tablets consent forms, stationery
-  Identified facility
-  Identified space for FGD and interview
-  Supervisory support and guidance from project coordinators or facilitators

#### 5.13.3. Application of SOP

This will be used by SSRs, SR, Consultant and district staff supporting data collection

#### 5.13.4. Target participants

-  HCMCs
-  CHAGS
-  ADCs/VHCs
-  Religious leaders,
-  Traditional leaders
-  Data collectors





#### 5.13.5. Facilitators






-  SSR
-  District staff

#### 5.13.6. Duration

-  3 days per facility

#### 5.13.7. Procedure

-  Preparatory meetings with district stakeholders (coordinators district CLM focal person, district research lead, Facility in charge and facility focal person)
-  Prepare necessary materials including data collection forms /template, consent forms data collection guidelines and any other relevant documents
-  Obtain necessary permissions or approvals from necessary authorities
-  Preparatory meetings with district stakeholders (coordinators district CLM focal person, district research lead, Facility in charge and facility focal person)






-  Set dates for the study
-  Familiarize and adapt data collection tools
-  Training of data collectors
-  Pretesting of data collection tools
-  Actual baseline assesment
-  Commence data collection
-  Data analysis and report writing
-  Familiarize and adapt data collection tools
-  Training of data collectors
-  Obtain necessary permissions or approvals from necessary authorities
-  Pretesting of data collection tools
-  Set dates for the study
-  Prepare necessary materials including data collection forms /template, consent forms data collection guidelines and any other relevant documents
-  Actual baseline study
-  Commence data collection
-  Data analysis and report writing
-  Dissemination to proper structures-research committees

## 5.14. Data Quality Analysis


### 5.14.1. Purpose of the SOP

To standardize and guide SR to conduct data audits





### 5.14.2. Resources required

-  Transport
-  Allowances
-  Data collection tools
-  Transport/Fuel
-  Lunch Allowances/DSA

### 5.14.3. Application of SOP

-  To be used by SR


### 5.14.4. Target participants

-  SSR
-  Data collectors
-  CLM assistants
-  Facility representative responsible for particular issue e.g Malaria, TB, HIV

### 5.14.5. Facilitators

-  SR

### 5.14.6. Duration



-  5 days

### 5.14.7. Frequency

-  Quarterly



### 5.14.8. Procedure

#### i. Define Goals and Indicators:



-  Determine the purpose of the analysis. What aspects of data quality are you most concerned about (completeness, accuracy, etc.)?
-  Identify specific data points (indicators) relevant to your goals. These could be patient demographics, treatment records, or medication adherence data.

#### ii. Gather Information:





-  Collect existing documentation on data collection procedures, data storage systems, and data quality standards followed by the healthcare institution.
-  Interview staff involved in data entry and management to understand their processes and potential challenges.



**iii. Assess Data Collection and Management Systems:**

-  Evaluate the design of the data collection system. Are there clear guidelines and protocols for data entry?
-  Analyze the data management system for security measures, data backup procedures, and accessibility.





**iv. Review Implementation and Operation:**

-  Observe real-world data collection practices. Are staff following established procedures?
-  Investigate the effectiveness of data validation checks and error correction processes.

**v. Data Verification and Validation:**

-  Sample actual data entries and compare them against source documents to verify accuracy.
-  Use data analysis tools to identify inconsistencies, missing values, or outliers that might indicate errors.

**vi. Compile a Data Quality Report:**









-  Summarize your findings, highlighting strengths and weaknesses in data quality.
-  Include specific examples of data quality issues encountered.
-  Propose recommendations for improvement, such as data cleaning procedures, staff training, or system upgrades.
-  Provision of feedback and Dissemination of findings

## **5.15. Quarterly data dissemination, engagement and advocacy targeting Community, district, and national consultative groups**

### **5.15.1. Purpose of the SOP**

To standardize and guide SR, SSRs to properly engage duty bearers and conduct advocacy






### **5.15.2. Resources required**

-  Meeting agenda
-  Budgets
-  Conference package -Audiovisual equipment
-  Refreshments and lunch, stationery, and venue
-  Meeting agenda
-  Conference package (Audiovisual equipment, Refreshments, Stationery, and lunch)
-  Transport reimbursement/Fuel
-  DSA for participants

### **5.15.3. Application of SOP**

To be used by SSR, HCMCs, data collectors, CLM Assistants

### **5.15.4. Target participants**

-  HCMCs
-  Data collectors
-  Health service providers
-  Decision makers at decision level
-  Community members

### **5.15.5. Facilitators**

-  SR

### **5.15.6. SSR**

### **5.15.7. Duration**

### **5.15.8. 1 day**

### **5.15.9. Frequency**

-  Quarterly

### **5.15.7. Procedure**

- i. **Pick Your Advocacy Priorities**





 Analyze your CLM data to identify the most pressing issues.


 Choose no more than five priorities to maintain focus and avoid appearing scattered.

**ii. Rank Your Priorities**


 Order your priorities based on importance and urgency.

 Provide a clear rationale for each priority, using evidence from your CLM data.

**iii. Set SMART Objectives**

 Break down your advocacy priorities into achievable goals with specific timelines:

- Short-term (next few months)
- Medium-term (within a year)
- Long-term (within a few years)


 Make your objectives SMART (Specific, Measurable, Attainable, Relevant, and Time-bound).


**iv. Establish Your Target Audience**

 Identify who you want to hear your message and take action:


- Government
- Civil society
- Media
- Private sector
- Donors
- Technical partners
- Academia
- Consider both primary and secondary audiences.
- General population

**v. Identify Friends and Foes**

 Recognize potential allies who can amplify your voice or provide support.

 Identify potential opponents who might hinder your efforts.

**vi. Map Entry Points**

 Look for opportunities to advance your agenda:

- Upcoming meetings or conferences
- Report launches
- Regular technical working group meetings


**vii. Plan Activities and Expected Results**

 Develop specific actions to push your advocacy agenda:

- Advocacy briefs
- Presentations
- Conference submissions
- Phone calls
- Meetings with decision-makers
- Media outreach

 Define the desired outcome for each activity.


**viii. Consider Available Resources**

 Assess the human resources, financial resources, and time needed for your plan.

 Explore funding opportunities and identify team members with the necessary skills.

 Explore opportunities for collaboration


**ix. Determine Measurements of Success**

 Establish criteria to measure the success of your advocacy efforts.

 Utilize ongoing CLM data collection or conduct separate assessments.

**x. Practice Your Elevator Pitch**

 Imagine encountering a key decision-maker in a brief elevator ride.

 Practice explaining your advocacy agenda and convincing them to act within one minute.

## 6. Annexes

### Annex 1: CLM Issues Prioritization Matrix

#### SECTION A: PARTICULARS OF SITE

Name of Health Facility:.....

Name of the District: .....

Name/s

Facilitators.....

Date: .....

#### SECTION B: SCORE GUIDE

CLM Issues with higher total scores are generally prioritized over those with lower scores. However, it's essential to remember that the matrix is just one tool in the decision-making process, and other factors such as political context, stakeholder input, and available resources should also be considered.

#### SECTION C: ACTUAL SCORES (On a scale of 1-5)

No	Issue	Scores				
		Importance (how crucial the issue is to the organization or cause).	Feasibility (how achievable it is to address the issue given the resources, support, and constraints).	Impact (Reflects the potential effect of addressing the issue on the target population or cause)	Urgency (Represents the immediacy or time-sensitivity of the issue).	Total
2						

3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

15						

**FINAL ISSUES MONITORING/ADVOCACY/ COMMUNITY ENGAGEMENT/ SENSITIZATION**

No	Issue	Final Score
1		
2		
3		
4		
5		



## Annex 2: Baseline/ Analyzed Data Template

Name of Health Facility: District name: Name of the facilitators/Data collector			Date:		
Category	Advocacy Priority	Indicator	Baseline	Target	Achievement
HIV Testing	Increase demand for HTS through communication campaigns	Percentage increase in people tested for HIV			
Care and Treatment	Enhance linkage and retention in care, especially for key populations	Percentage of key populations linked to and retained in care			
Viral Load Testing	Ensure effective treatment monitoring through faster turnaround times for results	Turnaround time for results			
Malaria	Increase access to prevention measures	Long-lasting insecticidal nets (LLINs) distributed			
Malaria	Improve diagnostic capabilities	Rapid diagnostic tests (RDTs) performed			
Tuberculosis	Early detection of TB cases	New smear-positive TB cases notified			
Tuberculosis	Prevent the spread of drug-resistant TB	# of patients diagnosed with drug-resistant TB			
Surveillance and Early Warning Systems	Strengthen surveillance and early warning systems	Number of actions taken to address a detected threat			
		Percentage of the public informed about threats and appropriate actions to take			

Workforce Development and Training	Increase knowledge among workers in the health sector	Number of health workers trained			
Mental Health and Psychosocial Support	Increase awareness on mental health issues Improve mental well-being of the populations	Percentage of people reached by Mental health and psychosocial support			

## Annex 3: Training/Orientation Evaluation Form

Name of Trainer/s:

.....

Date: .....

Name of Training/Orientation:.....

SR/SSR conducting the training:

.....

Location:

.....

	Item	KEY Poor=1 Average=2 Good=3 Excellent=4			
		1	2	3	4
	<b>Facilitator</b>				
1	Was the facilitator audible and precise?				
2	The instructor was knowledgeable about the topic				
3	Instructor involved participants in learning activities				
	<b>Content &amp; Methodology</b>				



4	Quality of training aids				
	Time against content				
5	The workshop was useful and provided new information				
	The training delivery method was appropriate				
	The presentation style was effective				
	<b>Venue</b>				
7	The room and amenities were conducive to learning				
	<b>Overall impression</b>				
11	The workshop met the learning objectives				

The part I liked about the training session

.....

.....

.....

13. If I could change something about the training, It could be

.....

.....

.....

14. Any other important feedback related to the training:

.....

.....

.....





Annex 4: FGD Interview Guide

1. **Project:** Community-Led Monitoring of HIV/AIDS, Malaria, Tuberculosis, and Pandemic Preparedness

2. **Target Services (Please tick relevant box based on module being assessed):**

☐ HIV&AIDS

☐ Malaria

☐ Tuberculosis

☐ Pandemic Preparedness

1. **Date (Enter date of data collection DD/MM/YY):**

2. **Facility:** (Facility name)

3. **Instruction:** 10-15 participants (separately according to focus group-Youth, Women, Men)

1. **Welcome, Quick Introductions and Opening (10 minutes)**

- The facilitator welcomes participants and introduces themselves and the project.
- An explanation of the FGD/interview methodology and purpose is provided.
- Informed consent is obtained from participants.

2. **Focus Group Discussion: Facilitated Discussion on (45 minutes)**

- The facilitator asks pre-determined questions to gather feedback on the project's objectives.
  - i. Positive aspects (probes for details and reasons)
  - ii. Areas for improvement (probes for details and reasons)
  - iii. Key message for the project team (probes for details and reasons)

3. **Closing (5 minutes)**

- The facilitator thanks participants for their time and participation.



- Confidentiality of the discussion is reiterated.
- Information on next steps, including access to the final report, is provided.



**Additional areas of assessment during FGDs: Service Provider Checklist**

<b>Category</b>	<b>Description</b>	<b>Data Sources</b>	<b>Yes (1)</b>	<b>No (2)</b>	<b>Comments</b>
<b>Presentation</b>	Wears relevant identifiable attire?	Observation			
<b>Communication</b>	Speaks clearly and respectfully to patients	Observation			
	Listens attentively to patients' concerns	Observation			
	Explains procedures clearly and answers questions patiently	Observation			
	Maintains patient confidentiality	Observation			
<b>Time Management</b>	Arrives on time for scheduled appointments	Observation			
	Minimizes patient waiting times	Observation			
<b>Professional Conduct</b>	Avoids distractions during patient interactions	Observation			
<b>Others (write any other observation)</b>					

## Annex 5: Health Facility Exit Interview Survey

3. **Project:** Community-Led Monitoring of HIV/AIDS, Malaria, Tuberculosis, and Pandemic Preparedness

4. **Target Services (Please tick relevant box based on module being assessed):**

☐ HIV&AIDS

☐ Malaria

☐ Tuberculosis

☐ Pandemic Preparedness

4. **Date (Enter date of data collection DD/MM/YY):**

5. **Facility:** (Facility name)

6. **Instructions:** For each question, write the most appropriate answer. Ask 20 respondents per month.

**Introduction:** Thank you for using our health facility today! We would appreciate a 5 minutes of your time to answer some questions about your experience. Your responses are confidential and will be used to improve our services.

Question	Answer Options	Comments
How satisfied were you with the waiting time to see a healthcare provider today?	Dissatisfied=1 Satisfied=2	
How easy was it for you to understand the explanation you received about your condition or treatment?	Difficult=1 Easy=2	
Did the healthcare provider treat you with courtesy, and respect?	Yes=1 No=2	



Was your privacy respected?	Yes=1 No=2	
Overall, how satisfied are you with the services you received today?	Dissatisfied=1 Satisfied=1	
Do you have any other comments or suggestions for improvement?		

- **Consider availability of service charters in all facilities in baseline assessment**
- **Also consider bill of rights**

#### Annex 6: Service-User Assessment Checklist

5. **Project:** Community-Led Monitoring of HIV/AIDS, Malaria, Tuberculosis, and Pandemic Preparedness

6. **Target Services (Please tick relevant box based on module being assessed):**

☐ HIV&AIDS

☐ Malaria

☐ Tuberculosis

☐ Pandemic Preparedness

7. **Date (Enter date of data collection DD/MM/YY):**

8. **Facility:** (Facility name)

9. **Instruction:** To be used by service provider quarterly.

#### SectionA:

Category	Rate on the scale of 1-5 1=Very Bad 2=Bad 3=Average 4=Good 5=Very Good
Active participation in health education sessions	
Prior communication of needs and concerns	
Adherence to appointment times	
Respectful interaction with other service users and staff	



Utilization and care of healthcare facility property	
Unsupervised children within the facility	
Unsanitary practices within the facility (littering, improper waste disposal)	

**Section B: Other challenges faced and how were they resolved**

Challenge	Rating: Rate on a scale of 1-5 1=Very Bad 2=Bad 3=Average 4=Good 5=Very Good	Solutions

Annex 7: Consent form

**Project:** Community-Led Monitoring of HIV/AIDS, Malaria, Tuberculosis, and Pandemic Preparedness

**Target Services (Please tick relevant box based on module being assessed):**

- ☐ HIV&AIDS
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Pandemic Preparedness

**Date (Enter date of data collection DD/MM/YY):**

**Introduction**

My name is ..... I am part of a team implementing community-led monitoring (CLM) interventions in ..... This form explains the project and your role as a participant.

**Before We Begin**

May I proceed with explaining the project and answering any questions you have?

**Project Description**

- CLM gathers information from health facilities and users to identify gaps in service access and quality. This information is used to advocate for improvements.
- You were chosen because you accessed services at this facility.

**What is Involved in Your Participation?**

- You might also participate in a group discussion for about an hour
- Feel free to ask questions throughout the process.

**Are There Any Risks?**





- This project is anonymous. No identifying information will be recorded.
- Some questions may be personal or touch on sensitive topics like HIV, sex, or stigma.
- If you feel uncomfortable with a question or the discussion, you can skip it or stop participating altogether. Full participation is voluntary.

### Are There Any Benefits?

- Your participation will help improve access and quality of HIV, TB, Malaria prevention, services, and treatment, and pandemic preparedness in your community and Malawi.

### Statement of Consent

I have reviewed and understood this information. All my questions have been answered. I voluntarily agree to participate.

Name	Designation	Phone	Signature



## Annex 8: Service Provision Checklist

7. **Project:** Community-Led Monitoring of HIV/AIDS, Malaria, Tuberculosis, and Pandemic Preparedness

8. **Target Services (Please tick relevant box based on module being assessed):**

☐ HIV&AIDS

☐ Malaria

☐ Tuberculosis

☐ Pandemic Preparedness

10. **Date (Enter date of data collection DD/MM/YY):**

11. **Facility:** (Facility name)

12. **Instructions:** For each question, write the most appropriate answer.

Dimension	Question	Data Sources	Yes (1)	No (2)	NA (3)	Comments
<b>General</b>	Are there adequate sanitation and hygiene supplies and facilities (soap, water, disinfectant, toilets, bin)?	Observation				
<b>Approachability</b>	Is there information on who can utilize the services and how?	Posters, Service-Charter Reception desk/security personnel				

<b>Acceptability</b>	Is the service provided with anonymity/confidentiality (if applicable)?	Observation				
<b>Availability</b>	Is the service ready when needed (medicines, equipment, personnel available)?	Observation Stock book Inventory books				
	Do location, opening hours, opening days, meet standards?	Observation Ask Posters				
	Is the waiting time long?	Observation				
	Are there any stockouts of essential medicines, equipment, supplies for this service?	Monthly reports (Pharmacy, Service)				
<b>Affordability</b>	Is the service free of charge?	Service- Charter, observation				
	Does the facility provide outreach services for hard-to-reach areas?	KII, observation				
<b>Appropriateness</b>	Is the service provided with privacy?	Observation				
	Are the services offered in appropriate language?	Observation				
<b>Others (Provide any additional notes)</b>						



## Annex 9: Community Sensitization checklist

## INSTRUCTIONS

This checklist will help the user (SSR and government stakeholders) to plan and execute an effective community sensitization program.

Please tick the areas covered during sensitization meetings

- ☐ HIV/AIDs
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Pandemic preparedness

This checklist will be filled out before and after sensitization meetings.

Area for sensitization	Key questions to reflect on	Yes(1)	No(2)	N/A(3)	Comment
<b>Pre-Sensitization checklist (To be used by SSR)</b>					
Needs assessment	Has the team analyzed the needs of audience?				
Approach	Has the team identified appropriate approaches for sensitization?				
Audience segmentation	Has the team have specific messages for different audience groups (youth, men women, community leaders)				
Cultural sensitivity	Is the team mindful of the religious and cultural beliefs of targeted community?				
Gender sensitivity	Is sensitization gender sensitive?				

Partnerships	Has the team identified other stakeholders to do the sensitizations with?				
Logistics	Has the team arranged a venue for the meetings?				
Communication materials	Does the team have communication materials in different languages?				
<b>Post Sensitization evaluation (to be assessed by SSR)</b>					
Facilitation	Was the facilitator clear in giving out the messages?				
	Was the content clear to the targeted audience?				
	Did the team address any ongoing questions or concerns?				
Meeting objectives	Were the community members encouraged to utilize the health services?				
Sustainability	Does the team have plans for ongoing sensitizations to foster behavior change?				

## Annex 10: Data Verification/Quality Assessment Tool

NO	PROCESS/ITEM	Yes	No	Comments	Action Taken
	<b>ACCURACY</b>				
1	Is the data free from errors, inconsistencies, and inaccuracies?				
2	Are there any discrepancies between different data sources?				
3	Is the data validated against known standards or benchmarks?				
	<b>COMPLETENESS</b>				
5	Does the dataset contain all the necessary fields and records?				
6	Are there any missing values or gaps in the data?				
7	Have all relevant data sources been included				
	<b>CONSISTENCY</b>				
11	Is the data consistent across different systems or periods?				
12	Are there any contradictions or conflicts within the dataset?				
13	Have data entry standards been consistently applied?				
	<b>TIMELINESS</b>				
15	Is the data up-to-date and relevant for the intended purpose?				
16	Are there any delays in data collection, processing, or reporting?				
17	Is there a defined schedule for updating or refreshing the data?				
	<b>VALIDITY</b>				
18	Does the data conform to predefined formats, rules, or constraints?				
19	Are there any outliers or anomalies that need to be addressed?				

20	Has the data been reviewed and approved by relevant stakeholders?				
	<b>RELEVANCE</b>				
21	Does the data align with the objectives and requirements of the analysis?				
22	Are there any irrelevant or extraneous fields that can be removed?				
23	Have data quality dimensions been prioritized based on relevance?				

## Annex 11: MIS System monitoring checklist

**9. Project:** Community-Led Monitoring of HIV/AIDS, Malaria, Tuberculosis, and Pandemic Preparedness

**10. Target Services (Please tick relevant box based on module being assessed):**

☐ HIV&AIDS

☐ Malaria

☐ Tuberculosis

☐ Pandemic Preparedness

**13. Date (Enter date of data collection DD/MM/YY):**

**Facility:** (Facility name)

Category	Description	Indicator	Action
<b>System Availability</b>			
Uptime	Percentage of time system is operational	Outages or downtime	Investigate cause of downtime and implement corrective actions.
Response Time	Average time to respond to user requests	Response times impacting user experience	Analyze system load, optimize database queries, or consider hardware upgrades.





Data Integrity			
Data Validation	Review data quality reports for inconsistencies or errors	Data errors suggest data entry issues or system configuration problems	Investigate source of errors, implement data validation rules, or provide user training.



## Annex 12: Logical Framework

	PROJECT SUMMARY	INDICATORS	TARGET	MOV	RISKS AND ASSUMPTIONS
IMPACTS	Enhanced quality of health services (availability, acceptability, timeliness, accessibility)	% increase in the availability of skilled healthcare providers in targeted HF		QR, health center reports	
		Reduction in stockouts of critical medicines and medical supplies		Health center reports, QR	
		% reduction in delays for diagnostic test results		QR, Health center reports.	
		% increase in the utilization of health services by underserved and vulnerable populations		QR	
OUTCOMES	Communities able to monitor and report stock-outs, quality of services, and health rights violations.	Number of cases of stock-outs, poor service quality, and human rights violations reported to traditional and district health authorities		QR, VCPC Reports, Police reports	Active participation by the community. Data accuracy and reliability

	<ul style="list-style-type: none"> <li>Service providers and authorities able to respond more effectively to community needs and feedback.</li> </ul>	<ul style="list-style-type: none"> <li>% of reported issues resolved within a defined timeframe by health and or leaders and authorities</li> </ul>		QR, Assessments, Focus groups (Supervisions)	Willingness of service providers/duty bearers to resolve reported issues. Data accuracy and reliability
	<ul style="list-style-type: none"> <li>Enhanced knowledge among community members on HIV, TB, Malaria, COVID-19,</li> </ul>	<ul style="list-style-type: none"> <li>% of community members with improved knowledge of HIV, TB, Malaria, COVID-19, and pandemic preparedness</li> </ul>		QR, baseline, assessments	Willingness of community members to attend awareness sessions
	<ul style="list-style-type: none"> <li>Enhanced knowledge of disaster and pandemic preparedness among community</li> </ul>	<ul style="list-style-type: none"> <li>% of ADCs/community structures with disaster/pandemic response plans</li> </ul>		QR, Baseline, assessments	willingness of ADCs and communities to develop plans
		<ul style="list-style-type: none"> <li>% of ADCs/Community structures able to detect and report possible outbreaks/epidemics/pandemics for investigations to health authorities</li> </ul>		QR, Baseline	willingness of ADCs and community structures to report possible

					epidemics/ pandemics
	<ul style="list-style-type: none"><li>Increased uptake of health services</li></ul>	<ul style="list-style-type: none"><li>% increase in community members with knowledge of preventive healthcare measures</li></ul>		QR, assessments, baseline	Availability of health services and baseline data
		<ul style="list-style-type: none"><li>% increase in the # of people using health services</li><li></li></ul>		QR, Baseline	
OUTPUTS	<ul style="list-style-type: none"><li>36 program sites identified &amp; specific CLM issues &amp; indicators identified for the sites</li></ul>	<ul style="list-style-type: none"><li># of program sites identified with a comprehensive list of CLM issues relevant to their context.</li></ul>		MR, Assessments	Availability of HFMC, volunteers and funds
	<ul style="list-style-type: none"><li>SOPs, manuals, and tools developed</li></ul>	<ul style="list-style-type: none"><li># of SOPs, manuals, and tools developed</li></ul>		M/ AR	Availability of stakeholders
	<ul style="list-style-type: none"><li>72 Data collectors, 12 supervisors, and 216 HSAs trained</li></ul>	<ul style="list-style-type: none"><li>% of data collectors, supervisors, and HSAs trained</li></ul>		M/ AR	Availability of the facilitators, participants and funds

	<ul style="list-style-type: none"> <li>36 CCGs and 12 DCGs established.</li> </ul>	<ul style="list-style-type: none"> <li># of CCGs and DCGs established</li> </ul>		M/ARs	The willingness of duty bearers to participate in CCGs and DCGs
	<ul style="list-style-type: none"> <li>Community-led awareness sessions conducted based on the knowledge gaps identified during data collection</li> </ul>	<ul style="list-style-type: none"> <li># of community-led awareness sessions conducted based on the knowledge gaps identified</li> </ul>		M/ARs	Availability of HPOs, volunteers & PA systems
	<ul style="list-style-type: none"> <li>Community structures trained on pandemic preparedness.</li> </ul>	<ul style="list-style-type: none"> <li># of community structures trained on pandemic preparedness.</li> </ul>		M/ARs	Availability of volunteers and funds
	<ul style="list-style-type: none"> <li>Reports on issues and service gaps and issues disseminated to</li> </ul>	<ul style="list-style-type: none"> <li># of reports on issues and service gaps disseminated to CCGs, stakeholders, and authorities</li> </ul>		M/ARs	Availability of CCGs and stakeholders

	CCGs and stakeholders.				
	<ul style="list-style-type: none"> <li>volunteers provided with enablers</li> </ul>	<ul style="list-style-type: none"> <li>% of volunteers provided with bicycles, backpacks and</li> </ul>		M/ARs	Availability of transport
<b>ACTIVITIES/ PROCESSES</b>	<ul style="list-style-type: none"> <li>Planning meetings and site identification with DHMT and coordinators in 12 districts</li> </ul>	# of planning meetings held with DHMTs and coordinators	DHMT and Coordinators	A/MR	Availability of DHMTs and funds
	<ul style="list-style-type: none"> <li>Community engagement and sensitization</li> </ul>	# of community engagements and sensitization campaigns held  # of people reached at the community engagements and sensitization campaigns.	The general population, key populations, traditional leaders, religious leaders, PLHIV, TB Patients, and survivors.	A/MR	Availability of HPOs, volunteers & PA systems
	<ul style="list-style-type: none"> <li>Development of SOPs, manuals, and tools</li> </ul>	# of SOPs development workshops conducted	SSR staff, District health staff, and	A/MR	Availability of DHMT and SSRs

			stakeholders		
	<ul style="list-style-type: none"> <li>Orientation of DHMT, Ombudsmen, and other relevant council staff</li> </ul>	# of orientation sessions conducted	DHMT, Ombudsmen, and relevant council staff	A/MR	Availability of DHMTs, ombudsmen, and funds
	<ul style="list-style-type: none"> <li>Orientation Health Facility Management Committees</li> </ul>	# of orientation sessions of HF Management Committees conducted	Traditional and religious leaders, CBOs, and Health Workers making up HFMC	A/MR	Availability and willingness of HFMCs and funds
	<ul style="list-style-type: none"> <li>Identification of issues and indicator development</li> </ul>	# of HF meetings held	Health Workers, HFMC, PLHIV support groups and CBOS	A/MR	Availability and willingness of HFMCs and volunteers
	<ul style="list-style-type: none"> <li>Monthly and quarterly data collection and consolidation (</li> </ul>	# of Monthly and quarterly data collection and consolidation sessions held	PLHIV, CBOS, service users	A/MR	willingness of the DHMTs, HFMCs & volunteers

	quantitative)				
	<ul style="list-style-type: none"> <li>Quarterly data collection and consolidation ( qualitative )</li> </ul>	Number of Quarterly data collection and consolidation sessions conducted ( qualitative )	PLHIV, CBOS, service users	A/MR	willingness of the DHMTs, HFMCs & volunteers
	<ul style="list-style-type: none"> <li>Procurement of enablers ( bicycles, tablets, laptops</li> </ul>	# of materials procured on each category	TB volunteers ( Community Health	A/MR	Availability of market supply and resources
	<ul style="list-style-type: none"> <li>Procurement of consultancy services to develop and automate and data collection system</li> </ul>	# of consultants procured  Functionality of the automated and data collection system		AR	Availability of consultancy services and resources
	<ul style="list-style-type: none"> <li>Training ADCs on emergency and pandemic preparedness and response</li> </ul>	# of training sessions for ADCs on pandemic preparedness conducted	ADC	A/MR	Availability of facilitators and resources



	<ul style="list-style-type: none"> <li>• Refresher training of supervisors' HSAs, and data collectors (</li> </ul>	# of training sessions conducted  # of people trained	HSAs, data collectors, and supervisors	A/MR	Availability of participants and funds
	<ul style="list-style-type: none"> <li>• Review of SOPs, manuals, and tools</li> </ul>	# of review sessions held	SSR staff, District health staff, and stakeholders	A/MR	Availability of stakeholders and funds
	<ul style="list-style-type: none"> <li>• Consortium level review meeting</li> </ul>	# of review meetings held	SSR, SR, Coordinating bodies, DHMTs, MOH dpts.	A/MR	Availability of stakeholders and funds
	<ul style="list-style-type: none"> <li>• Supporting community representation in governance &amp; oversight mechanisms</li> </ul>	# of meetings Supporting community representation in governance & oversight mechanisms	Community representatives in various governance structures at different levels	A/MR	Availability of stakeholders and funds
	<ul style="list-style-type: none"> <li>• National level Consultative meetings</li> </ul>	# of national-level Consultative and advocacy meetings conducted	NCCs, SRs and SSRs	A/MR	Availability of stakeholders and funds

	& advocacy				
	• Training data collectors, supervisors & HSAs	# of training sessions conducted # number of data collectors, supervisors & HSAs trained in...	Data collectors, HSAs, and supervisors	AR	Availability of participants and funds
	• Data dissemination engagement and advocacy at district consultative groups	# of data dissemination engagement and advocacy conducted at district consultative groups	DCGs and district authorities	A/MR	Availability of DCGs and funds
	• Quarterly data dissemination, engagement, and advocacy at HF level	# of data dissemination, engagement, and advocacy at HF level	CCG and HFMC	A/MR	Availability of CCGs and funds
	• Quarterly data verification by external consultants	# of quarterly data verification by external consultants conducted.		A/MR	Availability of consultants and funds
	• DQA and analysis by AAM	# of DQAs conducted	HFM and	A/MR	Availability of stakeholders and funds

## Annex 13: Comprehensive Program Checklist (bi-annually)

Component	Description	Yes (1)	No (2)	Evidence	Comment
Education Capacity Building	Offers training to ensure knowledge & competence			<ul style="list-style-type: none"> <li>• Clear materials on standards &amp; measurement.</li> <li>• Documented training completion.</li> <li>• Evidence of ongoing knowledge updates (discussions, briefings).</li> </ul>	
	Provides informational & educational materials on standards & measuring effectiveness.				
	Provides avenues for continuous learning & knowledge exchange.				
Evidence Data Collection & Storage	Establishes a system for community-generated, independent, & ethical data collection.			<ul style="list-style-type: none"> <li>• Evidence submitted by community members.</li> <li>• Data from multiple perspectives.</li> <li>• Documented ethical data collection procedures.</li> <li>• Consistent data collection over time.</li> <li>• Data from various locations.</li> <li>• Structured &amp; validated data.</li> <li>• Data used for recommendations &amp; advocacy.</li> </ul>	
	Ensures routine, continuous, widespread, rigorous, & actionable data collection.				

Ethical Clearance & Consent	Acquires written or verbal consent from respondents.			<ul style="list-style-type: none"> <li>Documented consent from respondents.</li> </ul>	
Capacity of Data Collectors	Has sufficient trained data collectors.			<ul style="list-style-type: none"> <li>Documented qualifications of data collectors.</li> <li>Documented data collection oversight.</li> </ul>	
	Oversees data collection processes.				
Data Capture & Entry	Regularly transmits data to a secure database.			<ul style="list-style-type: none"> <li>Documented data transmission procedures.</li> </ul>	
Data Quality	Performs quality audits on collected data.			<ul style="list-style-type: none"> <li>Documented data quality audits.</li> </ul>	
Data Analysis	Analyzes CLM data systematically & accurately.			<ul style="list-style-type: none"> <li>Documented data analysis procedures.</li> </ul>	
Advocacy	Builds people's skills for advocacy & provides resources for sustained work.			<ul style="list-style-type: none"> <li>Documented advocacy actions using CLM data.</li> <li>Evidence of advocacy skills development &amp; resource provision.</li> <li>Evidence of functional advocacy structures.</li> </ul>	
	Uses CLM data for advocacy efforts				
	Establishes community structures for advocacy				

	communication & collaboration.				
Communications	Increases visibility & promotes work at local, national, regional, & global levels.			<ul style="list-style-type: none"> <li>Communication strategies &amp; materials for various audiences.</li> </ul>	
Ownership	Demonstrates community ownership, innovation, & adaptation in implementation.			<ul style="list-style-type: none"> <li>Evidence of community involvement in design &amp; implementation.</li> </ul>	
Academic/external Institution	Partners with academic institutions or hires skilled personnel for data analysis.			<ul style="list-style-type: none"> <li>Documented partnerships or hiring agreements.</li> </ul>	
Community Consultative Groups	Maintains a functional community consultative group overseeing CLM data & advocacy.			<ul style="list-style-type: none"> <li>Documented group formation &amp; activities.</li> </ul>	
National Integration	Integrates into the national context, establishes partnerships to avoid duplication, & participates in relevant forums.			<ul style="list-style-type: none"> <li>Documented partnerships &amp; participation in national forums.</li> </ul>	
Good Governance & Accountability	Practices good governance &			<ul style="list-style-type: none"> <li>Documented governance structures &amp;</li> </ul>	

	ensures accountability.			accountability mechanisms.	
Policies	Establishes policies governing operations.			Documented organizational policies.	
Transparency	Demonstrates transparency in decision-making & operations.			Documented communication of decisions & activities.	
Leadership	Maintains a clear leadership & management structure.			Documented organizational structure.	
Personnel	Has sufficient skilled staff for core functions (program, finance, M&E).			Documented staffing levels & qualifications.	
IT & Technology	Possesses appropriate technology for CLM implementation.			Documented IT infrastructure & applications.	
	<b>Total Score</b>				