COMMUNITY BASED MONITORING

A Technical Guide for HIV, Tuberculosis and Malaria Programming

eannaso

Regional Platform
for Communication and Coordination
on HIV/AIDS, Tuberculosis and Malaria
For Anglophone Africa

FRONTLINE AIDS

Stop TB Partnership

hosted by UNOPS

german cooperation
DEUTSCHE ZUSAMMENARBEIT

WHO CAN USE THIS GUIDE?

This technical guide may inform civil society organizations at the grassroots and other levels, communities, CCMs and consultants to design, cost and implement CBM mechanisms. The Guide may also be used by implementing partners including community groups and networks; civil society organizations and movements, activists, Principal Recipients (PRs), Sub Recipients (SRs) of Global Fund grants and PEPFAR implementing partners; diseases programs and the ministry of health, technical assistance providers and organizations; civil society advocates, Country Coordinating Mechanisms (CCMs), other oversight and decision-making bodies.

WHAT IS COMMUNITY BASED MONITORING (CBM)?

There are many definitions for community-based monitoring. This guide adopts the Global Fund's which defines CBM as:

> "Mechanisms that service users or local communities use to gather, analyse and use information on an ongoing basis to improve access to, quality and the impact of services, and to hold service providers and decision makers to account"[1].

CBM mechanisms avail service users and communities a platform to gather qualitative and quantitative data and use it to assess availability, accessibility, acceptability, equity, and quality of the services they receive, using that information to hold service providers and decision makers accountable. The value of CBM is summarized this short video from the Global Fund's website. https://www.theglobalfund.org/en/video/2020-04-15-community-based-monitoring/

WHO BENEFITS FROM CBM?

HIV related key[2] and vulnerable populations including PLHIVs, female sex workers, people living with disabilities, men who have sex with men, transgender, people who inject drugs (PWID) and their movements or networks, uniformed forces, women, adolescent girls, and young women (AGYW) and youth. Key affected populations under TB including miners, health care workers, prisoners, urban slum dwellers and the rural poor[3]. Populations at high risk of contracting malaria including expectant mothers, infants, children under 5 years of age, patients living with HIV, migrants, and mobile populations[4].

CBM IS NOT MONITORING AND EVALUATION

CBM should not be equated to routine monitoring and evaluation undertaken by implementing partners including PRs and SRs who engage communities to attain their perceptions and feedback on services rendered to them. Any other initiative that utilizes data collectors not drawn from the community of service users including PLHIVs, KPs, people affected by TB, communities affected by malaria does not constitute CBM.

1 Community-based monitoring: An Overview, The Global Fund, May 2020
2 https://www.theglobalfund.org/en/key-populations/
3 http://www.stoptb.org/assets/documents/communities/FINAL%20Declaration%20on%20the%20Right%20of%20People%20Affected%20by%20TB%2013.05.2019.pdf

PRINCIPLES OF COMMUNITY BASED MONITORING (CBM)

CBM IS ABOUT COMMUNITY EMPOWERMENT: CBM involves sensitizing and building capacity within communities to know their respective epidemics (know your epidemic) rights, ("Know your rights") and understand programs and grants; CBM is about equipping them with planning, monitoring, organizing, assertiveness, and advocacy skills in order to be effective change agents and duty bearers in their respective communities.

COMMUNITY BASED MONITORING IS COMMUNITY LED AND DRIVEN: UNAIDS defines community led organizations as those which, "are led by the communities and/or people they serve and are primarily accountable to them"[5]. "Community led and driven" means that either PLHIVs, people affected by TB, malaria communities, KP led and community-based organizations (CSOs) are an integral part of community led organizations.

CBM IS OBJECTIVE AND TRANSPARENT: CBM mechanisms uphold the principal of impartiality and neutrality. To avoid conflict of interest, community led organizations which are active implementers and or service providers do not qualify as potential CBM implementers.

CBM IS COLLABORATIVE WITH ACTIVE STAKEHOLDER ENGAGEMENT: CBM is a community led, objective and collaborative mechanism undertaken by communities either independently or in collaboration with service providers e.g. health facilities, clinics or civil society organizations undertaking community level service delivery and other possible partners such as researchers, academics and think tanks.

COMMUNITY BASED MONITORING IS ACTION-ORIENTED AND TRANSFORMATIONAL: The goal of CBM is to stimulate positive and corrective action that improves access, uptake, and the quality of health services. CBM assesses current health practices to identify, document and communicate identified gaps within a short time to inform advocacy and corrective action.

CBM PROMOTES ACCOUNTABILITY FOR HEALTH INVESTMENTS AND RESULTS: Through continuous monitoring, corrective action, and improvements, CBM mechanisms promote accountability for investments and value for money at community level.

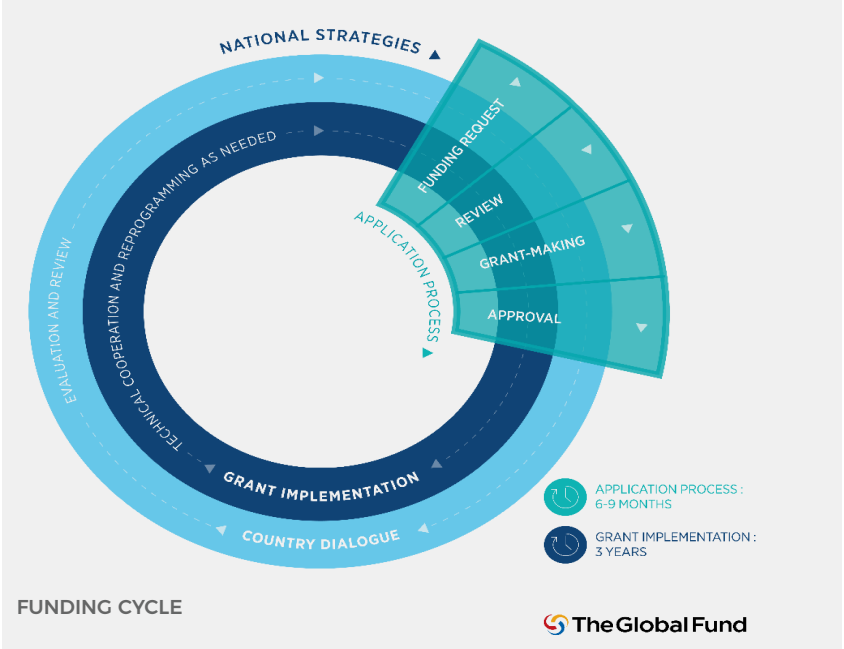
CBM PROVIDES A COMPLEMENTARY SOURCE OF INFORMATION: CBM mechanisms provide and generate alternative and complementary information through a structured process that entails routine data collection and monitoring of the availability of tools, equipment, materials, supplies and stock of medicines, and health workers with the required competencies and skills mix to match community health needs; the accessibility of health facilities and services including the gender and human rights barriers to HIV, TB and malaria services.

5 https://www.unaids.org/sites/default/files/media_asset/what-is-a-community-led-organization_en.pd

INTEGRATING CBM INTO FUNDING REQUESTS TO THE GLOBAL FUND

THE FUNDING CYCLE

Global Fund processes are easily predictable because they are guided by a sequential funding cycle. It is important to take note of entry points for integrating CBM. These include national program reviews, strategic planning processes, CCM oversight processes and various interactions with the Global Fund such as funding requests, grant-making, TRP iterations, interactions with the Grant Approvals Committee and if approved as a reprogramming measure during grant implementation, among others.



FUNDING CYCLE

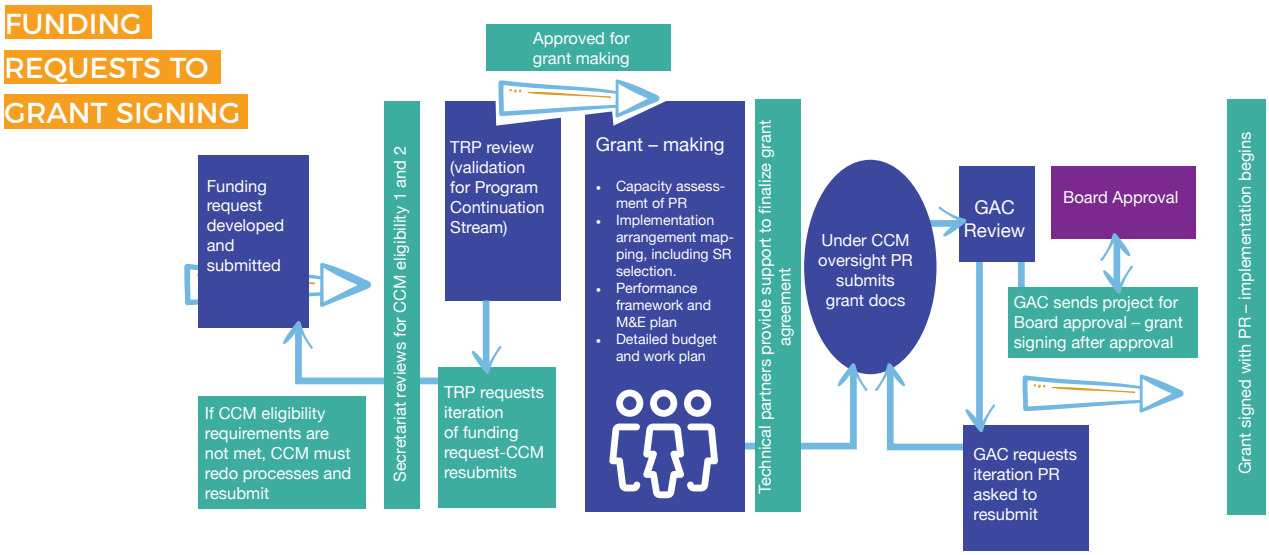
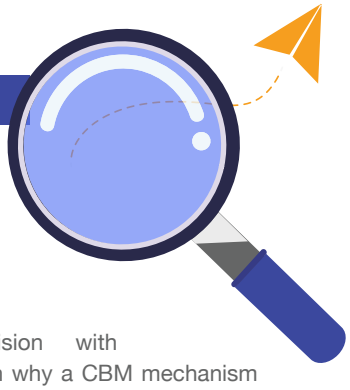


TABLE 1: ENTRY POINTS FOR INTEGRATING CBM INTO FUNDING REQUESTS TO THE GLOBAL FUND

National Program Reviews	Development of National Strategic Plans (NSPs)	FUNDING REQUEST DEVELOPMENT	Technical Review Panel (TRP) Iteration Requests:	Grant Making Stage:	Grants Approval Committee (GAC) Iteration Requests
National strategic plans (NSPs provide two primary entry points for integrating the CBM mechanisms into Funding Requests. These are midpoint midterm reviews (MTRs) and end term program reviews. Civil society and communities should ensure that the reviews include specific objective on community systems and human right barriers; and that relevant key and vulnerable populations for each of the disease have opportunity to engage and provide their respective feedback for the reviews.	Civil society and communities should ensure that their respective disease specific NSPs identify community systems strengthening and CBM mechanism are among the prioritized interventions.	• Every three years, the Global Fund announces a new funding cycle. The cycle begins when the Global Fund communicates allocation ceilings to country coordinating mechanisms (CCMs) and advises on areas to focus/ emphasize on funding requests. • Civil society and communities should familiarize themselves with the Global Fund's modular framework. The current modular framework modules on RSSH CSS and reducing gender and human rights barriers to HIV/ TB services provide for CBM interventions and activities.	Civil society and communities, especially those on the CCM should follow up on the TRP comments to ensure that where CBM related comments and questions are raised, comprehensive and adequate feedback is provided, and that the Funding Request is strengthened.	Civil society and communities including those on the CCM need to ensure that: • Implementation arrangements include community led organizations as implementers i.e. either as sub recipients (SRs) or sub-sub recipients (SSRs) of CBM mechanisms. • Detailed workplans and budgets adequately fund all components of the CBM mechanism. • Civil society and communities' representatives on the CCM advocate for adequate funding to CBM mechanisms and safeguard them from programming during grant implementation.	Civil society and communities, especially those on the CCM should follow up on the GAC comments to ensure that where CBM related comments and questions are raised, comprehensive and adequate feedback is provided to enable Funding Requests proceed to the Board for review and approval.

DESIGNING COMMUNITY BASED MONITORING (CBM) MECHANISMS



A CBM mechanism comprises of seven inter linked phases as depicted below.
Conceptual Framework for a CBM Mechanism

I. COMMUNITY EMPOWERMENT PHASE

This is a foundation stage when developing a CBM mechanism and it capacitates communities as 'right holders' on their respective rights, on prevention and treatment for HIV, TB and malaria and their effective health service delivery and equips them with organizational and advocacy skills.

II. PLANNING AND CONCEPTUALIZATION PHASE

During this stage, the entire CBM mechanism should be well thought out and summarized into a project concept note ready for implementation. Key questions to answer during this phase include:

What are the primary objectives for your CBM mechanism? i.e. Which barriers do we want to monitor and why? Which population (s) and interventions will we focus on? Will our CBM mechanism monitor issues in one disease or will it adopt an integrated approach? For example, will it monitor the quality of HIV services by PLHIVs; or will it monitor quality of HIV, TB, and malaria services amongst PLHIVs?

Will ethical clearance and approvals be required from government to ensure that the CBM mechanism is conducted in a responsible, ethical and an accountable manner?

How will the CBM mechanism ensure data privacy, and confidentiality to ensure the rights and protections of key, marginalized and vulnerable populations?

What experience does the organization have with respect to CBM? How will it be implemented? Will it be more practical to pilot for a few months or a year before going to scale (growing it to cover entire programs or other national locations?) What strategy will the community use to implement the actual CBM mechanism? The strategy should define the following.

- The nature and type of civil society and community-led organizations that qualify and are positioned to implement the CBM mechanism.
- The human resource needs of the CBM implementers. These main implementers include a CBM Coordinator, M & E Reporting and Learning Officer, Program Support Assistants and data collectors drawn from communities and service users.
- The objectives and populations of focus for the CBM mechanism. Consider adapting a CBM mechanism model that integrates the monitoring of HIV, TB, and malaria.
- The geographical scope should be informed by the needs, availability for funding and the objectives of your CBM mechanism. It is important that an evidence-based decision with justification is made on why a CBM mechanism is recommended for each specific location.
- How will your stakeholder mobilization and engagement be undertaken? During this phase, key stakeholders will be identified and mobilized, influenced, or advocated to, to support the CBM mechanism.
- Who will perform data collection? Data collectors must be drawn from community level beneficiaries / service users who access these at community level. What will the eligibility criteria for data collectors be? What renumeration and incentives will they receive? What are the direct costs related to data collection?
- Which digital and mobile solutions will be used? Have the relevant Ministries of Health and Information been engaged, and approvals received?
- What will be the mode and frequency of data collection – paper or digital? web-based or mobile? Will the data be collected on a weekly or monthly basis?
- The strategy should also detail whether the electronic and or mobile platforms are readily available for adaptation; or if they will need to be designed and customized to the context.
- Who will analyze and synthesize data collectors' findings to generate the report?
- What software will be used for data analysis? What capacities will be required to support data analysis?
- Who will be the target audience for the findings of the CBM mechanism? Who will use these reports? and for what purposes? What type of reports will be generated?
- Who will follow up on each of the identified issues to ensure that corrective action is taken to improve access and quality of services?
- For how long will the CBM mechanism be implemented? Will it be a one, two- or three-year project?
- How will the project be sustained following this period?
- How much is it likely to cost? How can savings be made?

It is recommended that civil society and communities do not rush into implementing CBM mechanisms; but first plan and invest first in their own empowerment and design of these mechanisms before initiating the implementation phase.

III. STAKEHOLDER ANALYSIS AND ENGAGEMENTS.

To be more inclusive, a rapid mapping of key stakeholders and service providers is done. This will help identify the focal persons at all levels including the Ministry of Health at facility, divisional, district/ county, regional/state levels and on the CCM. It is also important to:

- Determine the roles of each group of stakeholders
- Form a steering committee with clear terms of reference. The membership should be balanced, strategic including high-level health and political leadership to support advocacy.
- Have a formal launch of the CBM mechanism to generate awareness at community level.

IV. CAPACITY BUILDING, DEVELOPMENT & PRETEST OF SOFTWARE & TOOLS

Communities should be mobilized and empowered on the package and quality of services to expect from health facilities and other service providers. Data collectors and other staff should be trained on CBM objectives, tools and required monitoring and reporting skills.

It is important that training content and/ or data collector's curriculum is developed to inform this process. This training should include pretesting of tools and practical simulation exercises on the use of electronic technologies and tools that will be adopted. If using digital solutions, the Stop TB Partnership OneImpact or Frontline AIDS REAct can be adapted and used.

V. DATA COLLECTION, ANALYSIS AND REPORTING

Data will be analyzed using procedures defined in the project concept note. Data analysis software may be required, and staff trained on their use. Validation meetings should be planned (and budgeted earlier) to relay information to community members and other stakeholders, summarize an advocacy agenda and discuss how to use findings for advocacy and triangulation (offer CBM as an additional source) of information available to decisionmakers.

During the design and planning stage, each CBM mechanism should define the nature and type of report to be produced, and their frequency of reporting. Reports generated consistently and at regular intervals throughout the lifespan of the CBM mechanism have proven to be more effective than one--off assessments and scorecards.

VI. INFLUENCING AND ADVOCACY

Influencing and advocacy should be undertaken using an elaborate approach which should entail:

- Sifting and listing urgent and priority observations and bringing them to the attention of the health facility or implementer, the district level steering committee of the district health management team and the CCM where applicable. Relevant feedback should be relayed back to the target community so they may implement necessary behavioral change and other corrective measures.
- A brief advocacy agenda, preferably in bullet points that identifies priority issues, key messages, audiences and communication and timelines should be developed and agreed at this stage, to ensure community members pass the same messages so that the collective energy of communities is targeted towards the right changemakers.
- CBM reports should also be disseminated and considered as integral sources of information when conducting oversight visits, routine supervisions, reviewing implementer performance, assessing principal, or sub recipients, undertaking mid and end term reviews and during development of NSPs, guidelines and funding requests.
- The dissemination and advocacy forums for the reports should provide space for the audience to respond to the key issues and define when corrective action will be taken.

VII. FOLLOW UP, MONITORING AND CLOSURE

Implementing organizations should take note of commitments, timelines and follow up to ensure that:

- Corrective action is initiated immediately; and if not, some formal and verbal communication (letter, email, or traceable oral communication) or meeting is quickly convened to inform relevant authorities on gaps that threaten health service delivery
- Corrective action is completed within agreed timelines.
- Acknowledgement and appreciation notes and emails are written to the relevant authorities highlighting that previously identified challenges have been resolved and that service delivery is efficient.

VIII. REVIEWS

Periodic (monthly, quarterly, and annual) reviews of the CBM mechanism should be used to monitor implementation progress, identify, and resolve challenges and continue to adapt the CBM mechanism. Participatory reviews by CBM implementing organizations and service users are particularly recommended as they provide opportunity to document best practices, lessons learned and inform future programming for CBM mechanisms.

XI. COSTING OF CBM MECHANISMS

Detailed costing of CBM mechanisms is important since it will ensure adequacy of funding. Ultimately, the costing will be informed by the nature, type, and scope of the mechanism. The CBM conceptual framework described in this section may be used as a reference for what should be costed. Specific guidance for costing CBM mechanisms is detailed in the table below.

COST ITEMS / ACTIVITIES	UNITS	NUMBER OF UNITS	UNIT COST IN $	TOTAL COST IN $
I – COMMUNITY EMPOWERMENT				
I - Planning and Conceptualization				
2.1 Planning and conceptualization meetings CBM mechanism	days	4	XX	XX
2.2 Technical support	days	15		
2.3 Travel, & DSA for representatives of communities and key stakeholders				
2.4 Conceptualization 3-day residential retreat with select representatives of communities and key stakeholders and TA for 20 pax				
SUB-TOTAL				
6III - HUMAN RESOURCES [1]				
3.1 Program Coordinator – for the duration of the CBM mechanism				
3.2 CBM Support Officers – 1 for each CBM site				
3.3 M & E and Reporting and Learning Officer				
3.4 IT support				
[7]3.5 Data collectors [2] monthly stipend				
SUB-TOTAL				
IV – STAKEHOLDER MAPPING AND ENGAGEMENT				
4.1 Rapid mapping of key stakeholder in each CBM site location (s)				
4.2 Constitute and make function steering committee				
4.3 Steering committee orientation workshop				
4.4 Monthly Steering committee and communities' meetings				
4.5 Launch materials				
4.6 Community Launch – tents, refreshments & transport where applicable				
SUB-TOTAL				
V - CAPACITY AND BUILDING, DEVELOPMENT OF TOOLS				
5.1 In-depth orientation of all staff and data collectors				
[8]5.2 Development / procurement of real time data collection software/apps [3]				
5.3 Purchase of data collection gadgets & their configuration				
5.4 Training of data collectors and simulation exercises for the software/apps and gadgets				
5.5 Ongoing Technical support for the software (6 months				
SUB-TOTAL				
VI – DATA COLLECTION, ANALYSIS AND REPORT				
6.1 Stipends for data collections				
6.2 Communication and internet connectivity costs for data collectors				
6.3 Ongoing technical support provided by software/app developers (4.5), IT support (2.4) and CBM support assistants (2.2).				
6.4 Procure data processing computers and their respective software				
6.5 Monthly data review meetings to triangulate and validate the reports (select data collectors, CBM support assistants, coordinators)				
6.6 Design and layout/ desktop publishing for reports and Printing of info graphs of quarterly reports				
6.7 Quarterly Steering committee meetings to share quarterly reporting and agree on an advocacy strategy				
6.8 Design and layout and printing of annual reports				
SUB-TOTAL				

VII - INFLUENCING AND ADVOCACY				
7.1 Community /facility level dissemination and feedback meetings and meetings to agree on an advocacy agenda				
7.2 Quarterly dissemination and feedback meetings				
7.3 Dissemination of quarterly reporting to all stakeholders as listed in 2.7				
7.4 Budget to support the follow up and implementation of agreed upon corrective actions				
7.5 Budget for multi-level advocacy meetings				
SUB-TOTAL				
VIII- REVIEWS				
8.1 Quarterly review meetings				
8.2 Annual review meetings and report				
8.3 TA for annual report				
8.3 End of project evaluation and report				
SUB-TOTAL				
GRAND TOTAL				

FURTHER READING

A Practical Guide to Implementing and Scaling Up Programmers to Remove Human Rights Related Barriers to HIV Services, Frontline AIDS, April 2020

Building Resilient and Sustainable Systems for Health (RSSH) Information Note, The Global Fund, August 2019

Community-based monitoring: An Overview, The Global Fund, May 2020

Community-Led Monitoring and Advocacy for Health (PDF) [Source: International Treatment Preparedness Coalition (ITPC)]

French 5% https://www.initiative5pour100.fr/sites/default/files/ressource-doc/2019-10/Community-health-observatories-capitalization_0.pdf

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

http://www.stoptb.org/assets/documents/communities/FINAL%20Declaration%20on%20the%20Right%20of%20People%20Affected%20by%20TB%2013.05.2019.pdf

https://www.unaids.org/sites/default/files/media_asset/what-is-a-community-led-organization_en.pd

Modular Framework Handbook, The Global Fund, October 2019

PEPFAR Community Led Tools https://www.pepfarsolutions.org/tools-2/2020/3/12/community-led-monitoring-implementation-tool
ITPC's Regional Community Treatment Observatory in West Africa and the Missing the Target
ITPC, Community-Led Monitoring and Advocacy for Health (PDF)
Frontline AIDS: REACT User Guide for Documentation and Monitoring of Human Rights

EANNASO

Plot # 1 Olorien, Kijenge | Off Njiro Road
P.O Box 6187 Arusha, Tanzania

+255 739 210598 | eannaso@eannaso.org | www.eannaso.org

eannaso.org | Instagram: eannaso.org | eannaso