Community-Led Monitoring

Mozambique -Country Report

In partnership with

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

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Acronym

ADPP	Aids For Development of People for People
AGYW	Adolescent girls and young women
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CCS	Health Collaboration Center (Centro de Colaboração para Saúde)
CLM	Community-led monitoring
CNCS	National AIDS Council (Conselho Nacional de Combate ao HIV)
COP	Country operational plan
CRG	Community, Rights and Gender
CSO	Civil society organisation
CSS	Community Strengthen System
DSD	Differentiated Service Delivery
EANNASO	The Anglophone Africa Platform on Communication and Coordination
FDC	Foundation for Community Development (Fundação para o Desenvolvimento da Comunidade)
FSW	Female sex worker
GF	The Global Fund
HIV	Human immunodeficiency virus

IEC	Information and educational materials
KP	Key population
KVP	Key and vulnerable population
LAMBDA	Mozambican Association for Sexual Minority Rights
LGBT	Lesbian, gay, bisexual and trans
MINJUS	Ministry of Justice
MOH	Ministry of Health
MSF	Doctors Without Borders
MSM	Men who have sex with men
N'Weti	Communication for health
NGO	Non-governmental organisation
NSP	National strategic plan
OST	Opioid substitution therapy
PEPFAR	The President's Emergency Plan For AIDS Relief
PLASOC-M	Mozambican Civil Society Platform for Health
PLHIV	People living with HIV
PWUD	People who use drugs
ROP	Regional operational plan
SOP	Standard operating procedures
TB	Tuberculosis
TG	Transgender

TSU Technical Support Unity

UNAIDS The Joint United Nations Programme on HIV/AIDS

UNDP The United Nations Development Programme

Background

The Mozambique CCM submitted a successful funding request to the Global Fund for the 2021-2023 cycle and included the community-led monitoring (CLM) component under the grant's CSS module.

CSS and PLASOC-M (Plataforma Da Sociedade Civil Para Saúde) will play an essential role in the designing, costing and integrating the CLM initiative into the new Global Fund grant, the latter building on the experience of implementing CLM for the PEPFAR-supported program.

To achieve the above goals, EANNASO, the Anglophone Africa Platform on Communication and Coordination, in collaboration with the Global Fund's CRG Department, Frontline AIDS and Mozambique country partners, hired an expert consultant to map out functional and ongoing CLM interventions in the country, informing the operationalisation of Global Fund funded CLM activities embedded in the various grants and under PLASOC-M coordination.

The scope of this technical assistance[1] included conducting an analytical assessment to understand the existing CLM capacity gaps for the current Global Fund grant, assessing PLASOC-M technical assistant needs to ensure effective implementation of the CLM component, and determining factors potentially contributing to the sustainability of CLM interventions, whilst bringing attention to approaches for risk mitigation to ensure successful scale-up.

[1] PLASOSC-M, ToR for Mapping out of community-led Monitoring systems in Mozambique

Executive summary

Mozambique is characterised by a generalised epidemic, with more than 2 million people living with HIV, including women and young girls. HIV prevalence is 13.2% among adults age 15-49 years. Poverty, harmful social practices, violence, harassment, and extortions, poor quality of care, long travel distances and wait times, limited privacy, and stigma from health workers are barriers to access to services, especially among the most vulnerable and marginalised population such as PLHV, AGYW, MSM, FSW, TG, PWUD and prisoners.[2]

In December 2019, Mozambique submitted a successful funding request to the Global Fund for the 2021-2023 cycle and included a CLM component under the grant's CSS module. The component built on the lessons learned from community-led monitoring models already implemented in the country, such as community scorecards (N'weti) and patient-provider feedback mechanism implemented as part of the Juntos pelo Acesso aos Medicamentos project (MSF) – both of which explored issues related to perceptions from recipients of care on the quality of ART-related services, accessibility of essential medicines, supply chains, human rights and medical ethics.[3] Therefore, the funding is prioritised various CLM models, including but not limited to community scorecards, performance cards and health, co-management, and community health committees. With the expansion of HIV prevention programs for key and vulnerable populations in the new grant, key populations networks, human rights defenders, AGYW focused organisations will be supported to place feedback and accountability mechanisms.[4]

The present report aims to inform operationalisation of Global Fund funded CLM activities embedded in the various grants and under PLASOC-M coordination.

The findings are based on desk and literature review about the subject, including the Country request and interviews of key informants, namely governmental institutions (CNCS, MoH), current CLM implementers (NAMATI, N'Weti, ADPP), GF partners (UNAIDS, PEPFAR).

The main findings are:

- Monitoring at the community level is not new; however, many ongoing initiatives are not community-led, rather than CSO or NGO-led. Additionally, they are health facility-based, geographically limited, and few monitor human rights violations.

[2] (CCM, 2020)
[3] (CCM, 2020), p.22 - 23
[4] (CCM, 2020), p.57

- The ongoing CLM initiatives are not harmonised into a coherent national strategy. Rather than being complementary or building on each other's lessons, experiences, and tools, they are isolated and have a lower impact in mobilising communities and stakeholders to engage in sustainable efforts towards policy changes.

- Many CSO and local KPV communities have limited knowledge about the CLM aims and principles, which, if not timely addressed, can heavily impact the design, implementation, and national alignment. For example, many interviewees described CLM as only watchdogging instead of a collaborative process between health providers and users. Also, some do not see any incompatibility between service delivery and community-led monitoring.

- The regional asymmetries on human development, access to tech devices and the internet pose a severe constraint to the upscaling of CLM initiatives.

- Stakeholders recognise PLASOC-M's leadership in the CLM initiative, therefore, have high expectation about its role in designing, implementation, and overall coordination; however, to fulfil those roles, the organisation will need technical and financial support.

- At all levels, groups, organisations, and networks led by key and vulnerable communities, namely people living with HIV, adolescent girls and young women, gay men and other men who have sex with men, people who use drugs, transgender people, and sex workers shown to have limited capacity to gather, analyse and use the information to improve the uptake of services or hold service providers (public or private) to account.

Key recommendations:

- To Strengthen the existing and tested CLM approaches by building consensus among stakeholders about the aims, principles, roles, and responsibilities. Also, by leveraging on the experiences, lessons, and tested tools.

- To ensure harmonisation of the CLM frameworks and coherent national strategy by involving all relevant stakeholders in defining the cornerstones of such social accountability mechanism.

- To strengthen the CLM and advocacy capacity to successfully scale up by investing in building technical capacity, community awareness campaigns, and knowledge sharing to engage in the advocacy initiatives to change policies meaningfully.

- To ensure that the scaling up of the CLM is sustainable

Context analysis

Community-led monitoring framework

Community-led monitoring (sometimes referred to as community-based monitoring) is part of the social accountability framework. It is defined as "mechanisms that service users or local communities use to gather, analyse, and use the information on an ongoing basis to improve access, quality and the impact of services and hold service providers and decision-makers to account" (The Global Fund, 2020)

For the Global Fund, the term "community" is not restricted to people who live in the same geographic area and includes those who share the same characteristics or vulnerabilities as living situations, health challenges, culture, gender, age, religion, identity, and sexual orientation. Communities are diverse and dynamic. A person may be part of more than one community (The Global Fund, 2019).

UNAIDS (2021) defines community-led organisations and their networks as entities for which most governance, leadership, staff, spokespeople, membership, and volunteers reflect and represent their constituencies' experiences, perspectives, and voices transparent of accountability to their constituencies (UNAIDS, 2021)

A community-Led mechanism is part of the social accountability framework. The Global Fund defines it as "mechanisms that service users or local communities use to gather, analyse, and use the information on an ongoing basis to improve access, quality and the impact of services and hold service providers and decision-makers to account" (The Global Fund, 2020).

PEPFAR defines it as a "technique initiated and implemented by local community-based organisations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups, or other community entities that gather quantitative and qualitative data about HIV service" (PEPFAR, 2020).

The monitored issues are primarily associated with the effectiveness and responsiveness of health service delivery, aiming to increase users' experience when accessing them either at health facilities or community settings and, therefore, contribute positively to services outcomes (CAFF, 2010) (Gofman, 2019).

For meaningful involvement in the process, users need to be empowered about what they are entitled to receive at health facilities or drop-in-centre. Secondly, all stakeholders involved must be aware that the

process is not about pointing out fingers. CLM is a solution-oriented process that links users to services providers to work together to find local solutions to their problems (Gofman, 2019).

CLM should be conducted by independent, local community organisation and tied to advocacy. In other words, non-service delivery CBO/CSO decide what to be monitored, thus, tailoring the intervention to respond to their communities' needs. Also, the collected data is owned by those communities and used for advocacy and programmatic purposes (Gofman, 2019) (UNAIDS, 2021). According to HealthGAP, funders' roles is to support KVP communities by training, equipping, and providing them with resources to cover the operational cost of implementation (HealthGAP, 2019).

The Global Fund does not prescribe the CLM model; however, any model adopted should be part of the national monitoring system. There are various models and tools, e.g., community scorecards, user satisfaction surveys, user service charters, complaints, and grievance mechanisms, yet they must be used according to the local context (The Global Fund, 2020) (The Global Fund, 2019).

The concept of community-led monitoring is not new in Mozambique. Several NGOs have been collecting data on health services aiming to increase the user experience. Using various tools such as community scorecards, user service charter, user satisfaction surveys, user report cards, they also aim to empower citizens in monitoring public services and hold service providers to account.

CSO and NGO actors

N'weti

N'weti – Comunicação para Saúde, is a Mozambican nonprofit organisation founded in 2008 focused on communication for health that aims to contribute to better health for Mozambican citizens and communities. It engages in social mobilisation and advocacy and governance monitoring, particularly on gender and human rights violations (N'weti, n.d.).

Since 2008 N'weti has been implementing CLM using the community scorecard tools to increase the quality, efficiency and accountability of services offered at health facilities and empowering the local communities to monitor public service delivery, fostering dialogue and collaboration between health providers and the end-users to find local solutions. Recently, COP20 focussed on monitoring the HIV treatment service delivery at the health facilities.

With PEPFAR support, N'weti covers 75 health facilities - 14 in Maputo Province, 15 in Gaza, 4 in Inhambane, and 42 in Zambézia; N'weti's model engages co-management committees and health

committees in issues about the availability of ARVs, health facility cleanness, confidentiality, health care workers attitudes, patient DSD knowledge, services fees, stockouts and the quality of the information provided to patients on viral load. Seven hundred community groups and 7.000 community members participated in the activities, including AGYW, women and men living with HIV.

The data collected at the health facility and community level is presented at an interface meeting between the community and the health providers. After discussions and negotiations, a joint action plan is developed and implemented. Regular meetings are held to assess the implementation of the plan.

The data gathered is also sent to the N'weti database. Regularly, the MOH5 receives a metadata file, which is feed into their system. It is worth mentioning that N'weti and MOH use the same software, which facilitates integration and data sharing.

NAMATI

NAMATI is an international NGO which operates in Mozambique since 2013, building grassroots health advocates to put the power of health policy in people's hands, bridging the gap between policy and practice by strengthening the accountability of services to poor and vulnerable communities.

The organisation has been implementing CLM using Barriers Assessment Tool based on Community Scorecard methodology, aiming to increase awareness of fundamental rights and health policy, facilitate dialogue between communities and health facilities to proactively identify and address violations, and pursue solutions to specific grievances cases. Since then, it has helped solve 4,800 grievances, and over the past two years, NAMATI has seen an average reduction of 43% of violations at health facilities.

With PEPFAR support, NAMATI covers 67 health facilities, 14 in Maputo province, 10 in Maputo City, 1 in Gaza, 30 in Inhambane and 12 in Zambezia.

Its CLM interventions consist of identifying patients' rights violations and support redressing through community dialogues involving the community health committees and co-management committees. Besides, it strengthens the committees by training human rights and patients' rights, providing IEC materials to communities and clients.

[5] Departamento de Humanização

The CLM topics focus primarily on the availability of medical equipment and supplies, patient privacy, and health worker attitudes towards clients. The data and information gathered are then used to draft policy briefs about patients' rights.

As pointed out, NAMATI follows the community scorecard methodology, approaching clients and health providers to find a solution to local problems jointly. The data collected at the health facility is used to develop a local joint plan of action, which is then monitored every three months. At the central level, the data from all implementing sites is collated, analysed, shared with the donors, MoH and other stakeholders in the printed form.

CCCS

The CCS- Health Collaboration Center, a local nonprofit organisation, founded in 2010 as part of the transition from PEPFAR international partners to local implementers. The CCS works on health promotion, disease prevention and improving the quality and equity of access to care and treatment of common diseases in Mozambique, focusing on the health of women, children, and other vulnerable groups (CCS, n.d.).

CCS is part of NAMATI's Health Justice Program and implements the same CLM model and tools to increase the quality-of-service delivery at health facilities. The tools assess the barriers faced by PLHIV to access HIV services such as prevention, testing, linkages, care and treatment, adherence, viral load suppression. The innovation is the linkage between HIV service delivery and monitoring (and follow up) of Human Rights violation (NAMATI, n.d.).

Local CBO community researchers collect the data using printed forms. The forms are submitted to the district supervisor, who then collates them in a single monthly report. The finds are also shared with the Community and decision bodies – community health committees and co-management committees- during the joint meetings. Based on the discussions and negotiations, an action plan is developed and implemented. Regular meetings are held to assess the implementation of the plan.

CCS district supervisors share the monthly printed reports with the district and provincial health authorities. Concurrently, it is also shared with CSS internal structures, which forward to MoH quarterly.

ADPP

ADPP Mozambique is a Mozambican non-governmental association established in 1982 working in quality education, health and well-being and environment and sustainable agriculture. In 2019, the organisation,

supported by The StopTBPartnership, implemented a one-year CLM initiative in partnership with the National TB program (ADPP, n.d.).

The initiative aims to empower TB patients and people affected by the disease by providing them with information, encouraging them to report TB challenges and related barriers when accessing services, such as reporting human rights violations and providing peer support services to encourage treatment adherence.

Though an e-tool app dubbed "OneImpact", the model tackles the central challenges of responding to TB both at the individual and the community level while generating essential information in digital data to better programming. The generated data is shared with the National TB program officer at MoH, local governments and CCM. Moreover, it is made available to community groups and response teams to identify and solve local bottlenecks (ADDP, 2020).

The implementation involved 116 TB patients, seven case managers and targeted five health facilities. Nine in ten patients reported challenges when accessing services; in the same period, 703 barriers were reported (ADPP, n.d.).

FrontlineAIDS

Rights, Evidence ACTion (REAct) was community-led human rights monitoring project implemented in Mozambique and two other countries in the region, namely, Uganda and Kenya. In Mozambique, the implementation began in December 2019 and ended in September 2020. It involved twelve local CBOS/CSOs, and LAMBDA coordinated it with the financial and technical support from FrontlineAIDS. It recorded 54 human rights violations against PWUD, PLHIV, FSW, MSM and LGBT (FrontlineAIDS, 2020).

The model aims to support people experiencing human rights-related barriers to accessing HIV health services while building an evidence base to inform programme improvements and policy and legal reforms.

The community members most affected by the barriers were people who use drugs (67%), men who have sex with men (16%) and people living with HIV (8%). The most common types of violations recorded were emotional harm, denial of services and violence/physical harm. The most frequent perpetrators were the police/law enforcement and public health care workers - the very stakeholders that should support and protect marginalised populations.

Overall, 690 REAct cases were resolved, while many more are in the process of resolution. Three-quarters of responses (76%) were provided directly by REActors (trained local activists) and REAct Implementing

Partners, with the remaining quarter (24%) provided through referral networks. The most common types of services provided were legal support and emotional and psychological counselling.

At the national level, cases collected through REAct have served as evidence to build a dialogue with the government on legislative changes. In Mozambique, in some cases, REActors and Implementing Partners have had to take on a new role and be negotiators with the police to allow people who use drugs to take supplies of needles and OST medicines home the risk of arrest.

REAct can be modified to be managed in collaboration with different stakeholders, implemented at different levels, and funded by different donors. Besides, it can also be modified to respond to crises such as COVID-19, including addressing growing needs for specific types of support, such as to address increased levels of gender-based violence.

PLASOC-M

PLASOC-M is an umbrella organisation of the local TB patients, PLHIV, KP, AGYW civil society organisations that advocate quality health services delivery.

In its effort to hold service providers to account, PLASOC-M has requested UNAIDS technical assistance to develop and pilot a CLM model, which combines social audit, mystery client and exit surveys. The model relies on observations and interviews of managers, patients and PLHIV accessing services at health facilities. All the information, long waiting hours to men's engagement, can be gathered using a printed form or a tablet/smartphone. The data is collected with an App; the CommCare is then collated, analysed, and shared with the health facility managers, MoH and donors. The piloting was implemented at five health facilities and interviewed 638 patients. Some of the findings included high health care workers absenteeism, long waiting hours, lack of TB LAM stockouts (PLASOC-M, UNAIDS, 2021).

Table 1 CLM interventions and annual costs

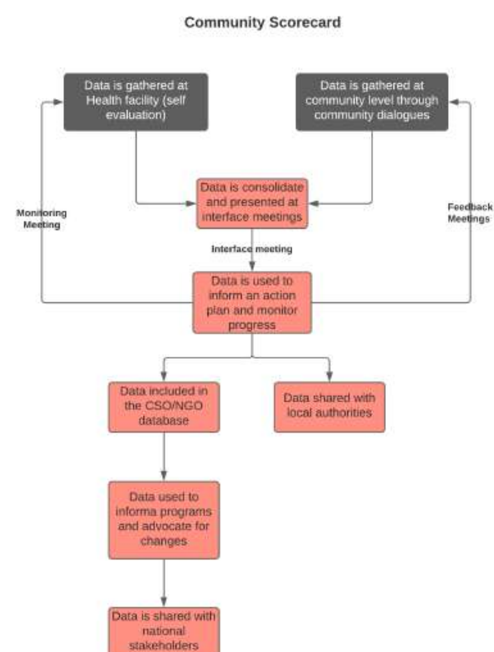
Implementer	Year	Funder	CLM-Tool	E-tool	KP focus	Annual cost	# sites
N'WETI	2008	The World Bank PEPFAR	Community scorecard	None	PLHIV, TB patients	$ 1.376.000[6]	75
NAMATI	2013	PEPFAR	Barriers Assessment[7]	None	PLHIV, general populations	$ 1.658.000[8]	67

[6] PEPFAR COP20 Grant
[7] Base on the community scorecard methodology
[8] PEPFAR COP20 Grant

CCS	2017	PEPFAR	Community scorecards	None	PLHIV, general populations	N/A	125
ADPP	2017	Stop TB Partnership	Client's anonymous feedback	OneImpact	TB patients	$ 90.000	20
LAMBDA	2019	FrontlineAIDS	Survey	Wanda/DHIS2	KP Human Rights Violations	$ 790,750.00	N/A
CNCS/PLASOC-M (piloting)	2020	PEPFAR	Patient survey Health care provider survey	CommCare	PLHIV	N/A	20

Data systems

With few exceptions, the data systems in Mozambique are characterised by being fragmented. The MoH relies on several data systems, some of them based on DHIS2. Many CSOs/NGOs use Excell spreadsheets or foreign e-tool such as OneImpact, Wanda/DHIS2, CommCare, Salesforce and others.



The digital penetration in the country is at 20.9 % of the population. A meagre number compared to other countries in the region, such as Kenya's 87 %. Only 6.5 million people have internet access, and the majority cannot afford computers or smartphones.

Data gathering at the local level is primarily paper-based. The information is collated and shared with the local stakeholders - e.g., co-management committees and community health committees - via interface meetings and regular monitoring sessions. The information is also shared with the local authorities depending on the issues reported; presented at district consultation councils. After sharing with local authorities is inserted in the implementers' databases, which may or may not share with the national authorities.

It is worth mentioning that N'weti's CLM system is the only one in the country that is compatible with the MoH's DHIS2, allowing them to regularly share metadata files fed into the national monitoring health system.

The fragmentation of national data systems, the siloed CLM interventions and the low access to tech devices and the internet poses a significant challenge to roll out and sustain a unified CLM model.

Findings and conclusions

- **The political will to evidence-informed HIV programming**: Both MOH and CNCS are committed to evidence-informed HIV programme planning, an opportunity for a high-level buy-in of CLM initiatives. Moreover, local authorities and health facility managers are already engaging with communities to monitor the quality of services.

- **Conducive legal framework**: The legal frameworks prohibit discrimination of PLVHIV and others seeking public services.

- **Limited geographic coverage**: The ongoing CLM initiatives are health facility-based, covering only 330 out of 1.651 health facilities, corresponding to 20% of the total units.

- **Health-facility focused:** The majority of the ongoing CLM initiatives are health facility-based and do not encompass services being delivered in community settings such as drop-in-centres, hotspots and other spaces.

- **Availability of tested CLM tools and models**: CLM models and tools are ready to be adapted from existing programs such as the PLASOC-M/UNAIDS piloting, ADPP -OneImpact or FrontlineAIDS-REAct. Although they were developed to respond to certain areas and needs, namely, improve PLHIV, TB, and other KPs up taking of services, if necessary, they could be swiftly adapted to other diseases such as Malaria[9].

- **Limited capacity**: Technical capacity limitations at the community level. Any model that may be adopted will require technical capacity at all levels to gather, analyse, interpret, and act upon the data. Many CSO and CBOs do not have adequate capacity, which could negatively impact the CLM initiative's scale-up.

- **Coordination and information sharing**: Data access and dissemination are significant problems since the data collected at the community level end up in the implementer's databases; some of these repositories are not accessible to communities. There is no centralised data repository.

[9] Noting that other CLM tools and models should be explored or designed to suite the different needs.

- **Community leadership**: the methodologies are structured to rely heavily on external facilitators hired by the NGOs to mobilise the local community, monitor, and report the findings. Little evidence shows that the most vulnerable and affected communities (PLHIV, MSM, FSW, TG, PWUD, and prisoners) lead the processes of design and oversight of CLM.

Recommended CLM tools – Strengths and challenges

Based on stakeholder consultations, all CLM approaches have their strengths and challenges. The following analysis was based on the local context and the current interventions.

Table 2 CLM tools-strengths and challenges

CLM tools	Strengths	Challenges
Community Dialogues **Current implementers:** NAMATI, ADPP, CCS **Periodicity** Every quarter	• Amplify marginalised voices (KVPs) • It is cost-effective compared with other CLM tools and can easily be integrated into the GF grant • It can be implemented to monitor the three diseases in different spaces and community settings • Fosters mutual understanding between service providers and their clients/Beneficiaries • Can quickly generate qualitative data about people's experiences when seeking services • Build up and taps into local knowledge and resources	• Mobilise the disproportionately affected and marginalised groups to participate • Participation may not be meaningful/can be tokenistic • Participation of those who cannot effort transportation fees or who face logistical challenges can be sub-optimal. • Prepare all stakeholders to engage in an open, collaborative dialogue[10]. • Lack of capacity in qualitative data collection and analysis at the community level.
Provider-Client feedback loop **Current implementers:** ADPP (OneImpact) **Periodicity** An ongoing process of data collection Every month joint analysis and planning review	• Empowers individuals to act • Generates information that can quickly be (e-tool) acted upon • Creates service demand- clients can see which facility has better services in real-time • Linked with service provision and peer support: clients in distress can get peer support	• Access to technology equipment (smartphones) and internet connectivity can be a barrier. • Social and cultural norms that prevent clients from certain KVP from voicing their honest opinion (e.g., Women, children) • Fear from reprisals of HCP and fear of hurting provider-client relationships • Safety: may put vulnerable clients at risk

[10] CSO and the leadership would have to be trained to engage in constructive dialogues with their beneficiaries/clients. Cultural aspects should be taken into consideration.

		• Timely coordination and support between clients and supervisor • Access to health facilities' premises and records (service utilisation, people on treatment) • Data privacy and data security
Community scorecards **Current implementers:** N'Weti, NAMATI, CSS **Periodicity** Every six months (data gathering and joint planning) Every three months (plan monitoring)	• It empowers communities and health providers to get involved. • Under-represented and marginalised groups can use the opportunity to voice their concerns and educate other members • Create synergies and builds collaboration between other stakeholders and KVP communities • It can be applied to one or several sites simultaneously. • Progress can be compared over time by any stakeholder. (if data available)	• Creating an environment of respect, trust, the collaboration between stakeholders (government, HCP and community members and funders) due to power differentials. • Clients may not be aware of the service standards, and "quality" may vary according to context. • Different level of literacy among members of the health committees • Participation may not be meaningful/can be tokenistic • Involvement of community members and clients. Some clients may not want to participate in the interviews due to fear of reprisal or being outed (KPs) • Availability of technical capacity to facilitate discussions, collect and analyse data. • Coverage limitations: Because the model is very localised, it cannot be applied to large geographical areas • Coordination and collaboration among different implementers
Community-led research **Current implementers:** PLASOC-M/UNAIDS *(piloting)* **Periodicity** Every six months	• Create local capacity, empowering activists and CSOs to take the research further • Quickly generates data that can be used to inform advocacy actions. •	• Clients may not be aware of the service standards, and "quality" may vary according to context • Availability of technical capacity to collect and analyse data, considering that the country has high levels of illiteracy • Coordination and collaboration among different stakeholders (implementers, government, CSOs) • Continues need of training and updates on data gathering and management

- Access to technology and the internet (some parts of the country have limited access to the internet)
- Mobilise the community to take part – requires investment in community awareness campaigns

CLM sustainability factors

The sustainability of the CLM in Mozambique is contingent on the following factors:

- **Cooperation of key government actors such as MoH, CNCS and MINJUS at all levels**: without government actors' cooperation, implementers will not access health or closed settings facilities to collect data among beneficiaries accessing the facilities. Therefore, groundworks need to be done at the national, provincial, and district levels to develop ways of working between CSO implementing CLMs and relevant government institutions and jointly agree on the value of CLMs before its implementation.

- **It is critical to build a rapport and trust with duty bearers (e.g. public officials, health providers, law enforcement agents) to ensure constructive dialogue**: Effective CLM initiatives build trust, promote collaboration, empower citizens and health providers. In general, it considers the context and the stakeholders' needs, not just the users/clients. The critique should be evidence-based and the discussion solution-oriented rather than solely highlighting problems; therefore, all stakeholders should be readied to embark on a constructive national CLM initiative.

- **Funding availability**: ideally, the CLM initiatives should be funded with public funds and implemented by independent community-led organisations; therefore, advocacy actions for structural changes, which involves significant investments, should be aligned to national budget cycles. However, Mozambique is a donor-dependent country, and funding social accountability initiatives may not be at the top of the government's priorities. Consequently, communities will have to rely on donor funding, for the time being, aligning their advocacy for the improvement of health service delivery with these primary grant-making cycles, The Global Funds' and PEPFARs'.

- **Achievement of tangible results**: Any social accountability mechanism is sustainable when it has an added value to communities affected, government, funders, and other stakeholders; in other words, it must archive the desirable results and create lasting changes. Therefore, continuous monitoring, evaluation and result dissemination should be part of the Mozambican CLM strategy.

Recommendations

Strengthening the existing CLM approaches

- To conduct a series of meetings and consultations with national stakeholders, funders (PEPFAR, The Global Fund and UNAIDS) seek/build consensus on aims and principles, funding mechanisms, CLM approaches coordination and joint outcomes.
- Once consensus is built across partners, organise a consultation with key and vulnerable populations (KVP) to agree on areas of monitoring by proposing aims, objectives, and key considerations for independent monitoring of services (e.g. management of conflict of interest, ethical standards for collecting clients' feedback, data usage and dissemination). The involvement of government authorities and other stakeholders in its design and facilitation should be ensured.
- Based on the analyses of the existing tools and the consultations with KVPs, revise/amend a simple methodology/SOP, which could be easily adapted and used by local community groups and organisations working on different CLMs initiatives, if necessary, leveraging the existing and tested tools for a swift implementation.
- For the HIV-related prevention services, recommend approaches that can be integrated into low-threshold services implemented by community-based organisations. Also, it may include, but not limited to, the introduction of client feedback mechanism at drop-in centres through peer educators, regular anonymous online surveys, or community dialogues. Service implementers will have to develop a practice of analysing and using data for program improvement (e.g., integrating such an approach into the SoPs for Drop-in centres, roles and responsibility of case managers re-assigning peer educators monitoring quality survey feedback, among others).
- In the gaps, explore piloting of new community-based monitoring approach(s) that can support insight gathering among KVP, for instance, mystery clients (or mystery shoppers), which are known to be effective in confidentially highlighting the needs of underserved populations.

Ensuring harmonisation framework and coherent national strategy

- To support MoH, CNCS and KPV communities to review/develop a unified Humanisation Guidelines to address the three diseases (HIV, TB and Malaria) service delivery at public and community-based health facilities. The reviewed document would serve as a baseline to assess the

quality of services, avoiding any ambiguity on the communities' end and informing the health providers about what the communities expect.

- To design and develop Code of Ethics and National Strategy for CLM, support implementation via PLASOC-M to avoid conflict of interest between service provision and monitoring conducted by the same group or organisation.

- To sensitise all national stakeholders about the concept and models of linking CLM to national health outcomes to avoid siloed initiatives and build local capacity.

- To support MoH, CNCS and KVP communities and their networks to identify an effective mechanism, strategic opportunities, or platforms to discuss data analysed through CLMs and implications for health service improvement. Mapping of CLM indicators against health service indicators might be required.

- To support KVP and Ministry of Justice, National Human Rights Commission, and relevant authorities to identify a mechanism of linking Community-led human rights monitoring indicators to Human Rights national indicators, taking learned lessons from South Africa REAct implementation.

- To support the development/adaptation of a unified CLM national e-tool that will enable data gathering, analysis, dissemination, readily accessible by all stakeholders.

- To establish and support the country CLM Committee comprised of independent, certified CLM experts, TSU members, MoH (Malaria, HIV and TB National Programs representatives), CNCS (CSO coordination representative) and CCM that would regularly evaluate the CLM strategies and results, provide recommendation for improvement and alignment.

- To integrate human rights violations as part of adopted CLM model(s), seeking integration and harmonisation with existing ones. Consider involving the Ministry of Justice, UNDP, which currently supports legal reforms and other initiatives to document human rights violations, Department of Prisons, National Human Rights Directorate, the ombudsman's office, and other relevant state institutions in defining the indicators and data sharing systems.

Strengthening CLM and Advocacy Capacity

- To invest in PLASOC-M' capacity strengthening to coordinate CLM high-level advocacy efforts. Consider supporting in the following areas: data analysis and problem identification, and strategic communication for advocacy.

- To ensure proper orientation/sensitisation around the developed SOP for all communities of KVP involved, paying specific attention to the Code of Ethics as part of the orientation process.

- To develop a cadre of local certified CLM trainers and experts who will support KVPs' organisations in adapting the tools to their local needs, conduct training, supervise data gathering and develop their problem identification and prioritisation skills.

- To develop and implement community awareness campaigns drawing lesson from the FDC "Know your rights" initiative to mobilise KVP communities further to participate in CLM initiatives as volunteers or data collectors actively, noting that those involved in data collection would have to be trained.

- To develop and implement an organisational capacity strengthening package, which should include, but not limited to, training or mentorship in good governance, financial management and reporting, CLM and advocacy. The package should be accompanied by financial support or seed funding.

- To support legal literacy, advocacy, leadership, negotiation skills development to strengthen the capacity of KVP organisations to engage with the local and national human rights bodies such as the ombudsman's office, parliamentary commissions, and the national human rights commission.

- To support knowledge and skills sharing initiatives among national and local stakeholders. The events could take the form of annual CLM conferences where results, lessons learned could be presented. Also. It could be an excellent opportunity to recognise CLM champions in the local governments publicly.

Scaling up and CLM Sustainability

- To expand the CLM health facility-based to other geographic areas in coordination with PEPFAR to avoid duplication of efforts. To set a target of 60% of health facilities are covered by 2023[11]. Consider also investing in expanding client's feedback mechanisms such as community dialogues on community-based service delivery. For the expanded geographical areas, a formal feedback loop

[11] Note that currently only 20% of the health facilities are covered by PEPFAR's CLM initiatives.

needs to be established between communities conducting monitoring and service providers, i.e. Through collaborative formalised agreements,

- To sensitise the government authorities at all levels, national, provincial and district, about the CLM aims and objectives and its importance to archive the national health and human rights indicators. Additionally, central level authorities and officials should be involved in sensitisation and orientation efforts targeting provincial and district government authorities and officials.

- To create community ownership of CLM initiatives by strengthening communities decision-making bodies such as the co-management committees, the health committees, community advisory boards and districts AIDS Council. The operationalisation could include, but not limited to, the definition of roles and responsibilities, provision of training and refreshments on CLM aims and objectives, information sharing, linking funders to these bodies.

- To support KVP to advocate on the CLM data with funders and government officials in decision-making processes and planning, e.g. COP/ROP, GF in-country portfolio optimisation/re-programming, and NSP review.

- To conduct a comprehensive evaluation of CLM implementation and present findings and conclusions to the KVP communities, government, and funders.

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Annexes

Implementation costs of different CLM Models

Table 3 CLM models costs

CLM models	Y1	Y2	Y3	Total	# Sites	Avg Cost/site
Community dialogues	$ 3,510.00	$ 3,580.20	$ 3,651.80	$ 10,742.00	1	$ 3,580.67
Provider-Client feedback loop (KVP)	$ 28,810.00	$ 29,386.20	$ 29,973.92	$ 88,170.12	3	$ 9,796.68
Provider-Client feedback loop (TB) with e-tool	$ 157,186.00	$ 111,129.72	$ 113,352.31	$ 381,668.03	20	$ 6,361.13
Community-led research (PLASOC-M/UNAIDS)	$ 410,000.00	$ 405,900.00	$ 414,018.00	$ 1,229,918.00	20	$ 20,498.63
Paper-based client satisfaction surveys		$ 63,400.00	$ 64,668.00	$ 128,068.00	1	$ 64,034.00
Community Led Human Rights Monitoring (REAct)	$ 474,698.00	$ 523,933.40	$ 530,510.84	$ 1,529,142.24	42	$ 12,136.05