

The Community Led Monitoring (CLM) Playbook

An Easy Reference Guide



National AIDS Control Organisation
India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in



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Foreword



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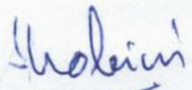
Foreword

In the past three decades, NACO has collaborated and ensured participation from communities of FSW, MSM, H/TG, PWID and PLHIV in the National HIV response. Efforts have been made to involve communities in the planning, designing and implementation of the National AIDS Control Programme (NACP) wherein communities helped in strengthening outreach, ensure service delivery, and in evidence generation activities.

In NACP V also, the strategy of Community System Strengthening (CSS) is to ensure a systematic approach to support the ongoing HIV interventions, by building communities capacities and their systems towards their meaningful participation in the HIV response. Community led monitoring under CSS, is an integral part to strengthen the existing community engagement systems, with the vision of institutionalising "Community Led Monitoring" as a viable mechanism for strategic engagement of HRG and PLHIV at grassroots level and service delivery points.

Hence, the Community Led Monitoring (CLM) programme piloted by Swasti funded by USAID under PEPFAR- a public health agency headquartered in Bengaluru, is a first of its kind within the National HIV Programme. Swasti has been able to pilot this programme, in two rounds, in three geographies - Telangana (5 districts), Maharashtra (2 districts) and Delhi (3 clusters of three districts) between May 2021 and Sep 2021.

I am happy that Swasti has been able to pilot this programme, and hope that this document will provide guidance and support for communities, community-based organisations and civil society organisations as CLM is scaled up across the country in the coming years. We believe that through the process of CLM, special emphasis will be given for identification of gaps and barriers in providing access to community centric services and for reduction of stigma and discrimination at the NACP facilities for our priority population. Thus, ensuring increase in access to HIV comprehensive services aligning with the global target to end the AIDS epidemic by 2030.


(Dr. Shobini Rajan)

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Background

The community has been at the center of India's HIV/AIDS response since the very inception of the National AIDS Control Programme (NACP) under National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare, Government of India.

The strategies led and adopted by NACO for prevention, treatment and care have predominantly been striving to keep the centrality of response with the key populations (KP) as well as the infected population such that the programme is in constant consultation and conversation with the community in planning, implementation and monitoring HIV prevention programmes and thus advancing the response.

Community System Strengthening (CSS) as an approach has been in consideration over the last few years and speaks to the commitments made towards ending AIDS by 2030.

CSS aims to achieve improved outcomes of the targeted interventions (TI) programme in India which is one of the main prevention strategies under the NACP. Evidence and experience suggest that the health outcomes can be enhanced by strengthening community based and community led systems for prevention, treatment, care, and support.

As the nodal organisation implementing the NACP, NACO has focused on capacity building of CSS at district, state, and national level. In the Indian context, mechanisms like

Technical Working Groups (TWGs) and Technical Resource Group (TRG) of NACO, the feedback drop box by VHS (Voluntary Health Services), and third party evaluations by Y. R. Gaitonde Centre for AIDS Research and Education (YRG CARE) has been set up to strengthen CSS.

The objectives for CSS are the development of a community resource pool, strengthening of Community Based Organisations (CSOs) and of India's response to HIV/AIDS, strengthening of Community Led Monitoring (CLM) and stakeholder linkages, while also ensuring the establishment of a Central Community Steering Committee to oversee implementation.

Another area which NACO has been focusing on is capacity building and leadership development under CSS including the development of a training needs assessment module as well as the Training of Trainers (ToT) for community engagement to ensure that gaps identified are addressed accordingly.

Furthermore, CSS will also be focused on community mobilisation on health and social issues, the development of linkages between communities and service providers and collaboration with all services under NACP, as well as ensuring smooth coordination amongst all stakeholders from different vertical ministries relevant to Key Population Groups[1]."

[1] National Consultation on Community System Strengthening, 18 February 2021.

A quick note on the

National Consultation on Community System Strengthening, 2021

The National Consultation on Community System Strengthening, 2021 saw the active participation and contribution of community representatives, coalitions, associations, civil society organisations and bilateral partners.[2]

NACO's focus is to ensure CSS and CLM leads to the achievement of the overall 95:95:95 goals of the SDG by 2024.

The participatory sessions (facilitated break-out sessions) provided inputs on four important areas of CSS which included: Steering mechanism and Community Resource Group (CRG) in district level; Capacity building and CBO engagement; Selection and engagement of community champions; and CLM tools, process and timelines.

It was summarised that the Steering mechanism and CRG at district level needs to include 80% community persons significantly and mechanisms to maintain confidentiality with well-defined roles and responsibilities. It was observed that representation has to be ensured from new emerging sub groups like youth and hard-to-reach populations based on geographies.

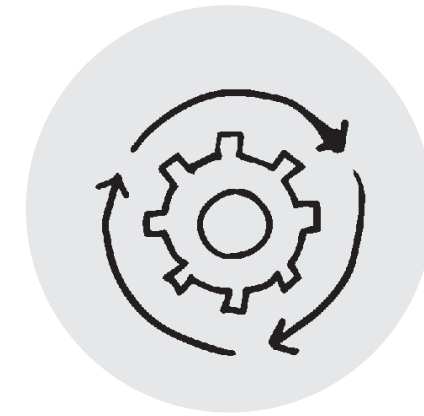
Emphasis was laid on empowerment and capacity building plans for system strengthening which ensure updated knowledge, community sustainability and resource mobilisation for long term. Furthermore, creation of enabling environment by tackling barriers like stigma and discrimination, legal and structural barriers was articulated.

And lastly, for CLM to be a sustained approach, it was recommended that it should be owned by the community and the government jointly with access down to the district level. Emphasis was placed on transparent and clear communication between stakeholders to ensure service quality and acceptability.

[2] The consultation was actively participated in by community leaders from IDUF, AMAANA, TG Welfare Board, AASTHA, NCPI+, NNSW, AINSW, Taaras Coalition, DMSC, Ashodhaya, Sangram and from Targeted Intervention programmes. The consultation workshop was funded by PEPFAR USAID and supported by Swasti, The Health Catalyst and involved the active participation of bilateral partners and civil society organizations - CDC, UNAIDS, HLPPT, TISS, VHS, SAATHI, Humsafar Trust, India HIV Alliance, FHI 360, I-Tech India and ACCELERATE Project-JHU.

What is a Playbook?

A playbook includes “process workflows, standard operating procedures, and cultural values that shape a consistent response—the play.”



Executive Summary

This Community Led Monitoring Playbook - An Easy Reference Guide is a result of critical learnings surfaced by Swasti, a global public health agency during the Community-Led Monitoring (CLM) pilot across three geographies. The CLM pilot was carried out from May 2021 to Sep 2022, in Telangana (five districts), Maharashtra (two districts) and Delhi (3 clusters in 3 districts). CLM is an initiative of the National AIDS Control Organization (NACO), with the pilot supported by USAID-PEPFAR and Swasti.

This Playbook describes how Community Led Monitoring can be adapted by taking the reader through each step of all the 5 stages - including the thinking that went behind the design, experiences from the pilot and key learnings.

It is intended for scalability and replication.

Community Networks, Community Organizations, Civil Society Organizations, Governments, International Aid Agencies may use the lessons learned and integrate them into future interventions and programs.

The **annexe** provides a range of Tools and Notes that cover Checklists, Forms, and Training Documents.



Community Led Monitoring (CLM) provides a first-hand perspective of the community's experience of HIV services.

CLM is an important strategy to strengthen programme impact, efficiency, effectiveness, and accountability through a better collaboration between civil society, KP, PLHIV and national state and district level decision makers.

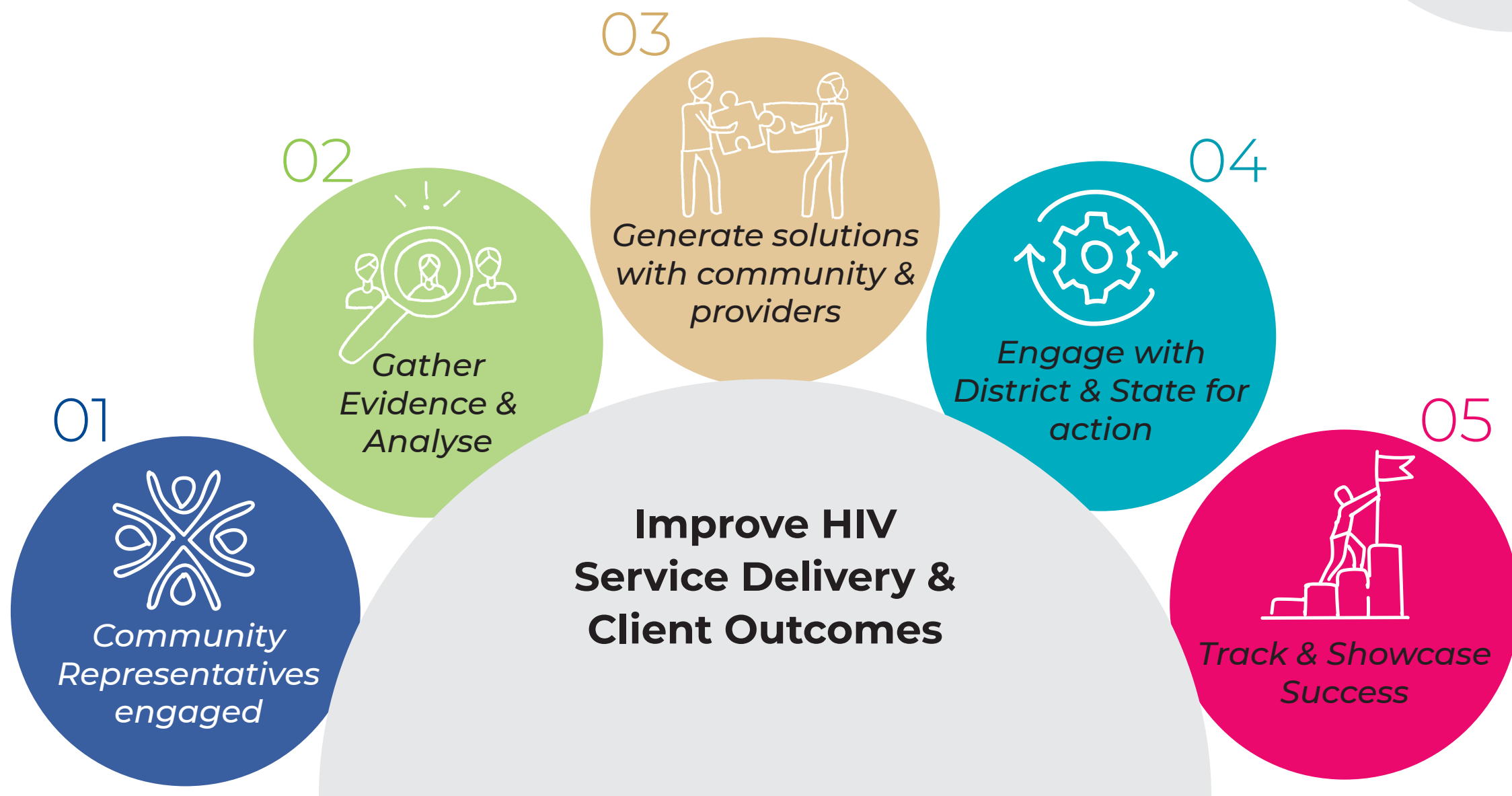
It is important at this juncture to dwell on what CLM is not. **CLM is not monitoring of people; it is not an established government monitoring and evaluation system that includes some community centered indicators.** It is not periodic check-ins by facilities to ensure that services intended to serve communities are doing so effectively.

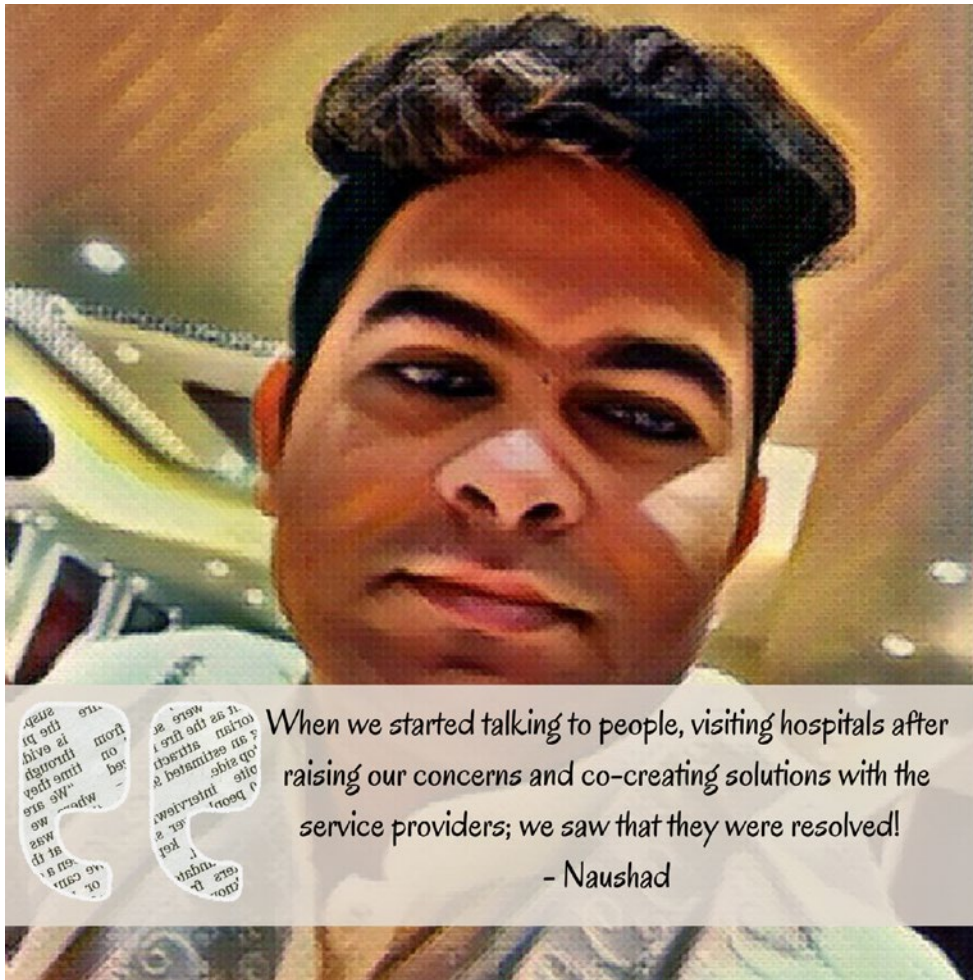
CLM contributes to the assessment of performance and service quality, the identification and addressing identified barriers such as access, stock outs, and stigma and discrimination. It ensures that the community's experience is integrated in the monitoring systems and response time is minimal, through systematic and regular analysis of community inputs and joint problem solving and action.



Community Led Monitoring (CLM) is a technique initiated and implemented by local community-based organisations and other civil society groups, networks of KP, people living with HIV (PLHIV), and other affected groups and community entities that gather quantitative and qualitative data about HIV services. The CLM focus remains on getting input from recipients of HIV services in a routine and systematic manner that will translate into action and change (PEPFAR, 2020)

Goal of CLM: To generate input from recipients of HIV services in a routine and systematic manner, translate that into action through co-creating solutions with all stakeholders. to address gaps in service delivery.

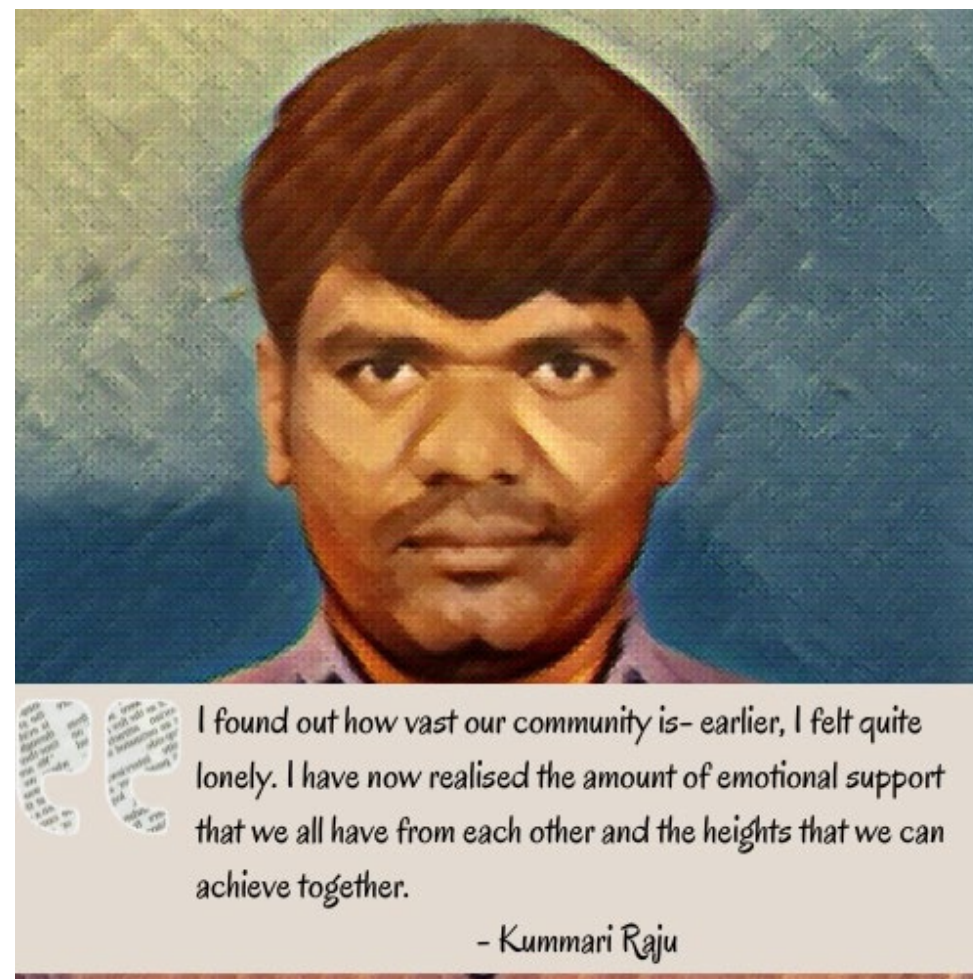




When we started talking to people, visiting hospitals after raising our concerns and co-creating solutions with the service providers; we saw that they were resolved!
- Naushad

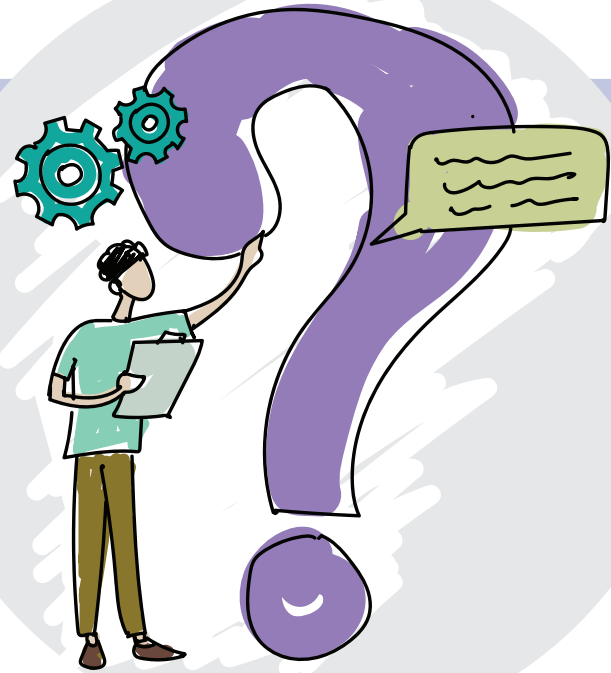


If a doctor is seeing 100 patients and 10 of them are from the community then there is an impact there as well. Either the counselor is not giving all the information because of which our community members do not get to know everything. If our 10 patients are taught and told properly, they can make the 10 into 50. But the other 90 will remain around 80-90 only because more than half the patients tend to forget everything they talked about in counseling or learned. But community patients are more proactive and they realize that things are affecting their community.
-Komal Tyagi



I found out how vast our community is- earlier, I felt quite lonely. I have now realised the amount of emotional support that we all have from each other and the heights that we can achieve together.
- Kummari Raju

4 Unique Contributions of CLM

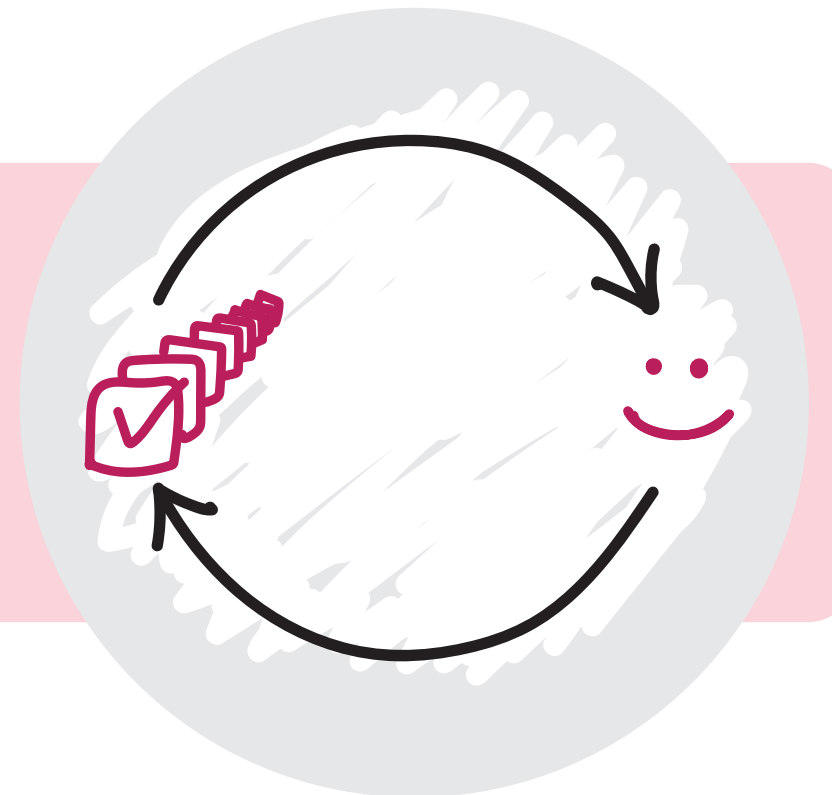


1. Insights:

CLM can bring about a valid and nuanced understanding of the, needs, and contexts of KPs, PLHIV, and other affected communities in accessing HIV services

2. Responsiveness:

CLM can help ensure that action is taken through short feedback loops that engage the appropriate service providers, program managers, and other decision makers. With greater autonomy, communities can initiate improvements with the help of service providers without waiting for external approval.





3. Empowerment:

Training, support, and other capacity-building measures are necessary for the implementation of CLM. The skills that are developed equip communities to capture and use valid data that apply to the service-related issues that matter to them. In turn, this motivates greater engagement with, and greater use of, the available services, for their benefit.

4. Joint problem-solving:

Relationships based on trust and respect foster the generation of solutions. CLM can contribute to a multidisciplinary approach to service-quality improvement, based on responsibility, accountability, and joint problem-solving. CLM practices can be adopted for other health services as well such as SRHR and TB.





HOW DOES CLM MAKE THIS HAPPEN?

Roles Of Stakeholders

In each stage of the process various stakeholders will have to play their role in order for the CLM process to deliver the intended results. We describe the role of the Facilitating Organisation first.

Facilitating Organisation

The facilitating organization is the entity/agency that facilitates the Community Led Monitoring Process on ground and is the single point of contact with SACS.

This organization is tasked with:

- ⌘ **Operationalizing the Standard Operating Procedure** to facilitate the roll out of the Community Led Monitoring process end to end.
- ⌘ **Actively partnering with stakeholders in the process** - NACO, SACS, TSU, DAPCU, Community Organizations, Targeted Intervention programme teams, Community Representatives, the Community Resource Group (CRG), Service providers - ICTC, ART, STI clinic personnel.
- ⌘ Undertaking **Capacity Building** of community representatives / key population representatives to implement the Facility Assessment Tool
- ⌘ Undertake the **data analysis** from the data collected in the forms.
- ⌘ Undertaking **Monitoring and Learning** for the CLM process
 - All the Monitoring and Learning from the process will be aligned to relevant NACO's guidelines. The facilitating organization will ensure this alignment is maintained
 - Regular updates to NACO and all stakeholders on the progress of the CLM process



- Record strengths, limitations, opportunities and threats to the process and resolve hurdles and incidences that are flagged by either of the stakeholders or by the Facilitating Organization themselves.
- Process documentation including photos, Audio/ Visuals
- Maintaining statutory documentation - filled and signed informed consent forms where applicable, workshop documentation, filled in tools.

- ⌘ **Actively support solution driven actions** to be taken and **celebrate changes**





Service Providers: The service provider will provide the information to the community representatives on the various services available.



Community Representatives: The community representatives will lead the process by planning and implementing the CLM process.

Stakeholders and their roles in each stage of the Community Led Monitoring process:

Stage	Stakeholders involved and roles
Planning for CLM	SACS and TSU team - for selection of districts and identifying timelines, communication about CLM process and identifying the Facilitating organisation for CLM (e.g. Swasti in MH and TS)
	Facilitating organisation to translate necessary tools and detailed micro-plans
Engaging Community Representatives	Facilitation Organisation: outreach to different community networks and CSOs to identify community representatives; conduct orientation meetings
	CBOs, service providers, SACS and DAPCU will need to provide their known lists of community representatives so that the pool is large enough and opportunity is available as many interested community members to join the process
	Community Advisory Board: to participate in discussions and endorse the final selection of community representatives
Gather Evidence and Analyse	Facilitating organisation: To support training of community representatives and ensure tools are available in local languages; to analyse the data collected with the community representatives
	SACS & TSU: to communicate with all service providers and request cooperation
	Service Providers: to participate and share their perspective
	Community representatives: to collect information from the service providers and the community members

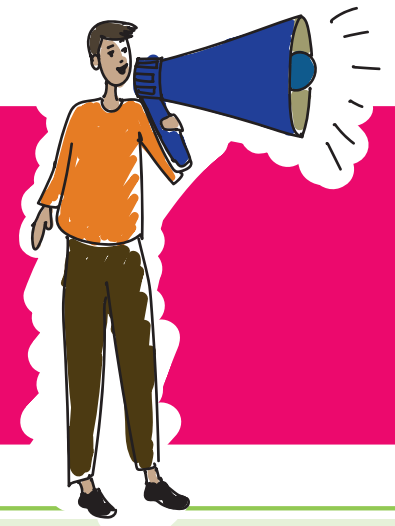
Generate solutions with Community Representatives	Facilitating organisation: Convene all service providers and community representatives; facilitate the discussions with support of the community representatives
	SACS & TSU: Participate in the discussions and support solution identification
	Service providers: Participate in the discussions, reflect on the findings and contribute to solution finding
	Community Advisory Board: Participate in the discussions and identify opportunities for follow through at State level forums, if necessary.
	Community representatives: Facilitate the discussion and share findings from the process
Engage with District and State for Action	Facilitating organisation: Present the results as well as the solutions identified; identify specific follow up action required at district and state level
	SACS & TSU: Identify the actions that will be followed through and communicate with all relevant stakeholders, with timelines for action. Also establish follow-up mechanisms
	Service providers: Follow through on the actions agreed upon and communicate back with all stakeholders
	Community Advisory Board: Monitor the follow-up actions and work closely with all stakeholders
	Community Representatives: Follow through on the actions agreed upon and communicate back with all stakeholders
Track and showcase success	Facilitating organisation: Based on results of CLM and or progress on actions taken, identify the organisations for recognition/showcasing. Organize forums for recognition and communication
	SACS & TSU: Convene the forums and use them to reinforce the importance of community participation and community focused interventions
	Service providers: Use the forum to learn and share best practices
	Community Advisory Board: Monitor the follow-up actions and work closely with all stakeholders to ensure best practices are highlighted
	Community Representatives: Use the forum to learn and share best practices



DECODING THE 5 STAGES OF CLM

Stage 1

COMMUNITY REPRESENTATIVES ENGAGED WHY COMMUNITY REPRESENTATIVES?



Community-led monitoring requires that community is not just “part” of the process but “led” by the Community. All communities are diverse - people in the community are of various age and their journey with the National AIDS Control Program varies widely, as does their lived experience in society and their daily engagements.

There are leaders within the communities who have been engaged with the National AIDS Control Program (NACP) at various levels over many years and across different initiatives. Community-led monitoring offers an opportunity to expand the pool of people who connect with and represent the needs of Key Population members and People Living With HIV; strengthening NACP and the outcomes we all desire

While all community representatives may not get involved in all the processes and initiatives, which is natural, their presence in the community with increased knowledge and skills than before, will continue to help improve access to services for the community, as well as influence the shaping of services and policies alike.



The first stage in CLM involves engaging community representatives. “Engaging” is about working in partnership with the Community Representatives (CRs) throughout the CLM process - this includes identifying CRs, onboarding them - helping them understand what CLM is, what is expected of

them, finding resonance on why CLM is important and getting CRs ready to play their role fully and independently - this includes Capacity Building and handholding on the NACP and CLM processes.



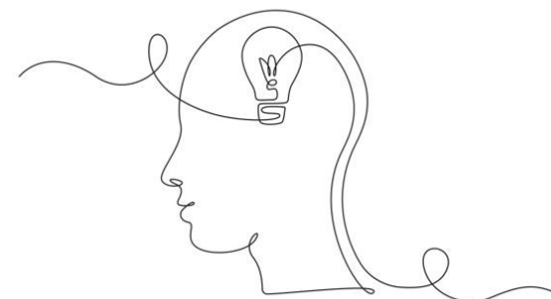
The following steps are crucial in identifying and engaging with community representatives:

Step 1: a. Mapping of stakeholders and service delivery facilities with services

Identification of stakeholders having presence in the district. This effort is required to create a robust roster of organisations who work with the community at the district and state level. This also ensures the detailing of the functional stakeholders, the products and services provided by them in a certain area. This process might take about 1-2 months for the completion of this step. The mapping is important because all of these stakeholders will help in nominating community representatives.

Who are the “stakeholders” being mapped?

This step is important to list the stakeholders who provide products and services to the community persons as well as networks and platforms accessed by community persons. In this step, the facilitating organisation will identify the current service providers in the community such as ICTC, TI, ART, DIC, STI/RTI Clinics, OST etc., community based organisations, Non-Government Organisations, Networks, Community Representatives working directly with women in sex work, men who have sex with men (MSM), transgender person, PLHIV, people who inject drugs (PWID), KP, DAPCU, SACS.



b. District Level Consultations

Once the list of service providers is finalised and rapport is built with them, district level consultations with stakeholders will be conducted. The chief purpose of the district level consultation is to have discussions with the service providers and come up with indicators for CLM. Indicators here signifies the aspects which will be observed in the CLM process.

The identified organisations and community representatives in the field will be invited for discussion about the community monitoring process that will be conducted. They will be provided with an overview of the principles, the process, and timelines.

Feedback will be invited so that the whole process is co-created with the community. Specific actions will be identified and timelines for reconvening will also be agreed.



Learning Vignette

Whom did we map?

♦ **Service providers Service delivery facilities**

Service delivery facilities such as integrated counseling and testing centers (ICTCs), anti-retroviral treatment (ART) centers, designated microscopy centers (DMCs), TB treatment (DOTS) centers, prevention of parent-to-child transmission of HIV (PPTCT), targeted intervention (TI), drop-in centers (DICs), and designated STI/ RTI clinics (DSRCs), were mapped in all the five districts in Telangana and two districts in Maharashtra.

♦ **Stakeholders**

The stakeholders consisted of the following:

- ⌘ SACS, DAPCU, TSU
- ⌘ CBOs in the district, which are owned and managed by the community itself.
- ⌘ Non governmental organizations (NGOs)/ civil society organizations (CSOs) in the district, which are working with various KPs (FSW, MSM, TG, IDUs, PLHIV), and other state lead partners (such as Alliance India, JHU, YRG Care, FHI360, SAATHII), which are providing any service related to HIV/AIDS.
- ⌘ Networks in the district such as the PLHIV network.

Why did we map?

- ⌘ To gather information on the number of services providing facilities and the service providers and stakeholders that existed in the five districts in Telangana and two districts in Maharashtra.
- ⌘ To get details on the facility-wise service providers and the stakeholders in all the seven districts.

Later, the stakeholders were contacted by phone to seek nominations for CRs and to request them to provide their own lists of candidates so that the pool of CRs would be large enough and there would be ample opportunity for the CRs to implement the CLM pilot project.

How did we map?

The state team possessed a good working knowledge of HIV/AIDS. Their experience of working with HIV/AIDS programs and their good rapport with state players enabled the state team to introduce the CLM pilot project to the stakeholders smoothly in the districts. The state teams used the following methods for mapping:

- ⌘ Desk review of the NACO and SACS websites to gain initial information and background knowledge on the existing service-providing facilities.
- ⌘ Formal meeting (in-person and virtual) on the CLM pilot with all the service providers and stakeholders.
- ⌘ Tapping the NGOs and CBOs working in the seven districts in both states.
- ⌘ Establishing contacts with other state lead partners such as JHU, FHI360, YRG Care, HIV Alliance, SAATHII.
- ⌘ Linking with PLHIV networks in the states and districts.

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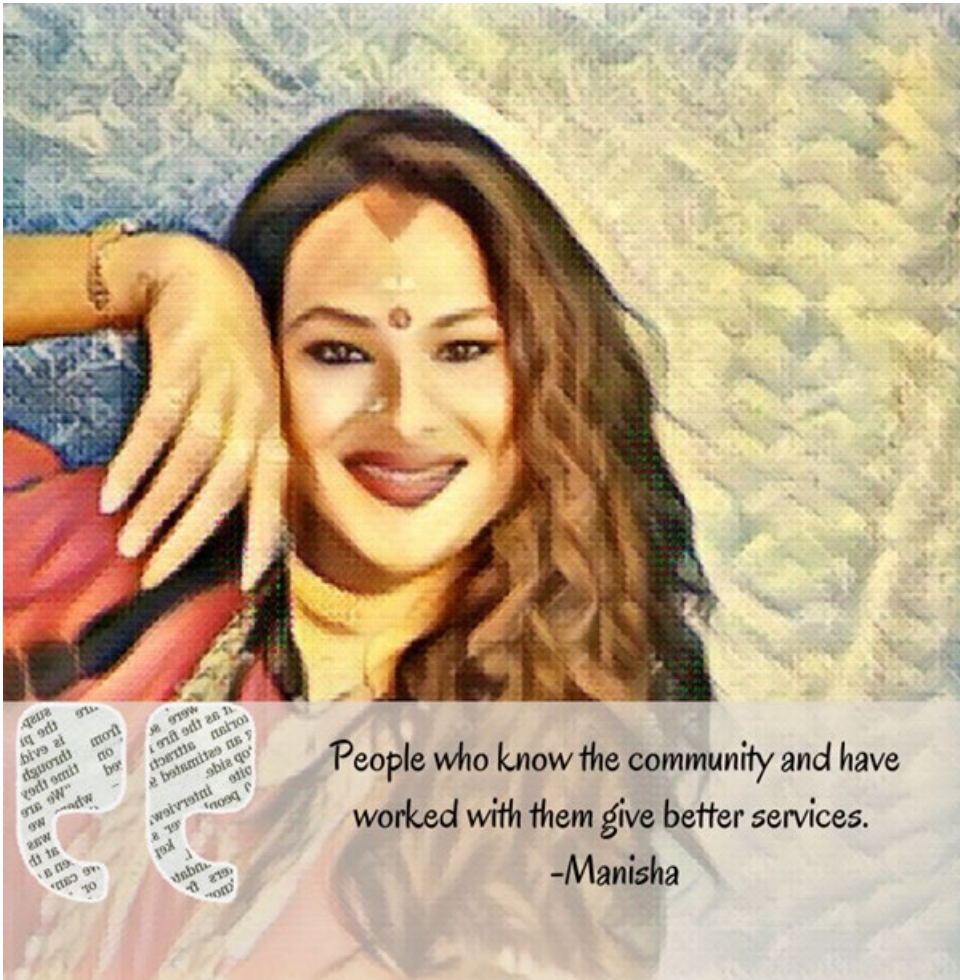
We included all the fields of information in the directory, such as basic information, geographical areas and KPs, services and products, contact details of key contact persons, level of engagement with the contacts/service providers, and information on service-providing facilities and stakeholders. The existence of already functioning data-collection mechanisms (by the stakeholders, if any) from communities (about their experiences, barriers, or enablers) was also explored.

We mapped potential stakeholders in their respective districts who worked directly with female sex workers (FSW), men who have sex with men (MSM), transgenders (TG), people living with HIV (PLHIV), and people who inject drugs (PWID). After the identification of the service providers, the next step was building rapport with the service-providing facilities and the stakeholders (such as NGOs, CBOs, CSOs, networks of PLHIV, and the concerned staff from DAPCU and TSU) in all the districts. Initially, the discussions were held in-person and later, due to COVID-19 restrictions, the discussions were conducted over the phone or virtually.

- **Vishnu**

Note: The team informed the stakeholders that this was not a policing or data-verification exercise. The team oriented the service providers and stakeholders on the goals of Swasti as an organization and its experience in the HIV sector and also on the concept of CLM.





People who know the community and have worked with them give better services.

-Manisha



If I say it in Farsi, 'koti koti ma pet' - it means that we are sons of the same mother. We understand each other. Like, if you are a female and I am a female, then I will understand you because we are going through the same journey and struggles. In the same way, when I am MSM and the other person is also MSM so when I am making him understand, he knows I am doing it for his well-being so he will understand, no matter how long it takes.

-Aakash



I feel like my participation is worthy and I'm able to bring about some very necessary changes in the system and help my community members.

-Kiran

Step 2: Identifying and On Boarding Of Community Representatives

Finalisation of Community Representatives

After the deadline for receiving nominations, all names received will be reviewed against the criteria agreed upon previously. A list of community representatives for each district, who will be involved in the CLM process, will be finalised. The community persons who are chosen will then be oriented on CLM.

At the district level, a team of approximately 10 community representatives will be selected. While forming this team, special care will be taken to have a buffer of nominations as there might be instances of drop-outs at this stage. For example to come to a nomination of 10 persons, it is suitable to nominate 40 community persons.

If the number of nominations happen to be fewer, then individuals from the roster/directory created, who meet the criteria, will be contacted, and onboarded.

To know more about the criteria followed in the CLM Pilot Project, go to page 23.



Going beyond NACP roles: Community Representatives who are currently not part of NACP initiatives.

While CLM is not a livelihood opportunity but a platform for community to support their network of peers with NACP/ HIV services; it does require focused effort at different times

of the year for activities such as - information collection, training, monitoring action plans and more. This means, it is critical to have Community Representatives who are not involved in current NACP service delivery initiatives involved in the CLM process. This way, there is expansion of community capacity in terms of access to services and more while also an opportunity of welcoming fresh perspective.

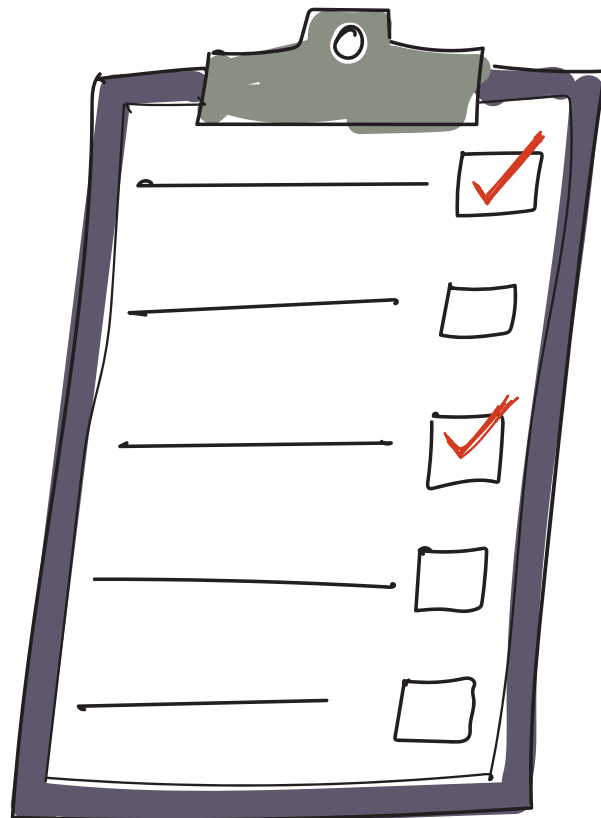
Learning Vignette

We reached out to all stakeholders to identify potential CRs in each of the districts.

The team conducted independent verification to ascertain that these CRs were:

- ⌘ From the key population community;
- ⌘ Acceptable to the community as their representative;
- ⌘ Did not have any criminal records or legal cases against them and
- ⌘ Willing to support the CLM process

The nominated CRs were oriented on CLM. The list of Community Representatives were provided to NACO, SACS and the CSS National Working Group. Nominations from the CSS National Working Group were incorporated and included for in-person training.



Criteria for finalisation of Community Representatives

- ✓ Not employed full time or part-time with any current HIV intervention, on remuneration
- ✓ Represent one of the KP groups in the district (FSW, MSM, PLHIV, TG)
- ✓ Can read and write in the local language – are able to follow and complete tools developed
- ✓ Are willing to give time for the CLM process and are interested in learning and contributing to the community empowerment process.

Orientation cum Capacity Building of Community Representative who agreed to volunteer

- ⌘ The nominated Community Representatives were then given an orientation on the CLM pilot.
- ⌘ Followed by orientation workshop, capacity building of the CR who agreed to be part of the CLM pilot initiatives were undertaken.
- ⌘ A detailed training were provided on the following:

The role of the CRs throughout the five stages of the CLM pilot were undertaken.

HIV program service delivery facilities (ICTC, PPTCT, DSRC, DMC/DOTS, ART, OST and TI-DIC) and a brief overview of each component was provided to them

The CRs were also trained on the process of installation and usage of the CommCare app on Android-based mobile phones, use of the CFT, and to seek feedback on the CFT.

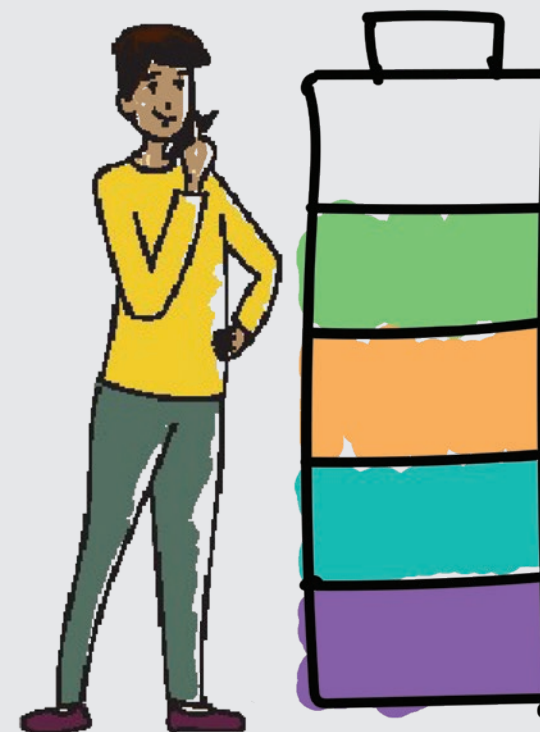
Capacity building of teams including Community Representatives on the CLM tools

Structure of the training

The Community Representatives were divided into three batches that undertook the gathering of information from different

Facilities:

- ♦ Batch 1 to gather information from the ICTC and PPTCT
- ♦ Batch 2 to gather information from the ART Center and the DMC
- ♦ Batch 3 to gather information from the TI, DIC and the DSRC



The batches were selected based on the interest and experience of the Community Representatives in working in specific HIV/AIDS program components or on their general interactions with the different facilities.

Each batch was trained on a different day as per the theme for which it had been selected.

From the Capacity Building Sessions: What went well?

1



Coordination - The teams repeated internal discussions, held mock sessions to build the capacities of the state teams, engaged in regular communication with Community Representatives, SACS, TSU, DAPCU, CBO/NGO, and PLHIV networks, and visualized all possible obstructions and options for addressing these barriers. Most importantly, the easing of Covid-19 restrictions allowed the teams to move from the virtual to the physical mode of meetings and getting connected with actors in the field.

Use of regional language as a medium of training - The state teams used regional languages for the training and ensured that each participant understood the concepts well.



2

3



Quality of Sessions - All the sessions went well. The key enabling factors were pre-planning, preparation, and engaging the Community Representatives in such a manner that their interest was sustained. No session was kept beyond 45 minutes. The teams also used in-between session energizers. They employed simple language and used only a few technical words, and these too were explained in detail to aid understanding.

4

Use of simple terminology for training - The teams engaged in thorough preparation, used simple words to explain technical terms and phrases, engaged the participants, limited the number of sessions to around ten or less each day, and concluded each session with summary points.

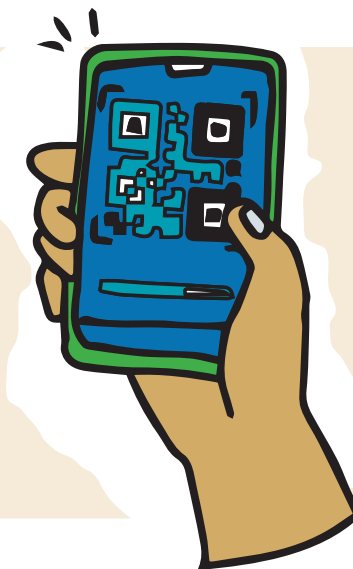


5



Training Methodology - Many Community Representatives were not fully aware of the various services that were being provided under NACP; their understanding was superficial at best or was limited to the extent of their own experience. For the training of Community Representatives, this means that the training methodology can include more games or other participatory methods (instead of lectures), so that retention of information by the Community Representatives and the transmission of information to their peers is better and more effective.

Use of the App - The Community Representatives were very comfortable using the app. They readily grasped the use of emojis and the purpose behind their deployment.



6

7



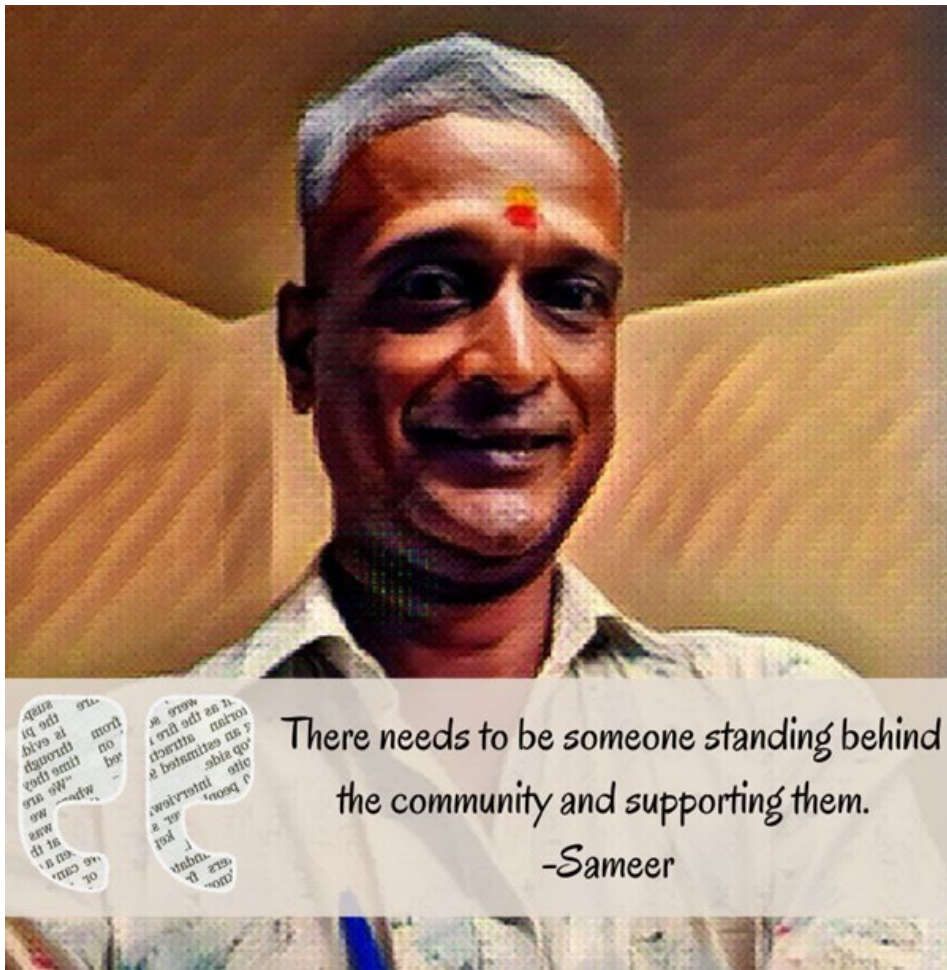
Incorporation of Feedback from Community Representatives into the CLM tools As a part of the training, feedback was also taken from the Community Representatives. The Community Representatives suggested the inclusion of COVID-19-related matters and the use of more colloquial terminology. These recommendations were later added by the team to the CLM tools.

Letter of Engagement - The state teams also provided a letter of engagement and an identity card for each Community Representatives who had been onboarded.

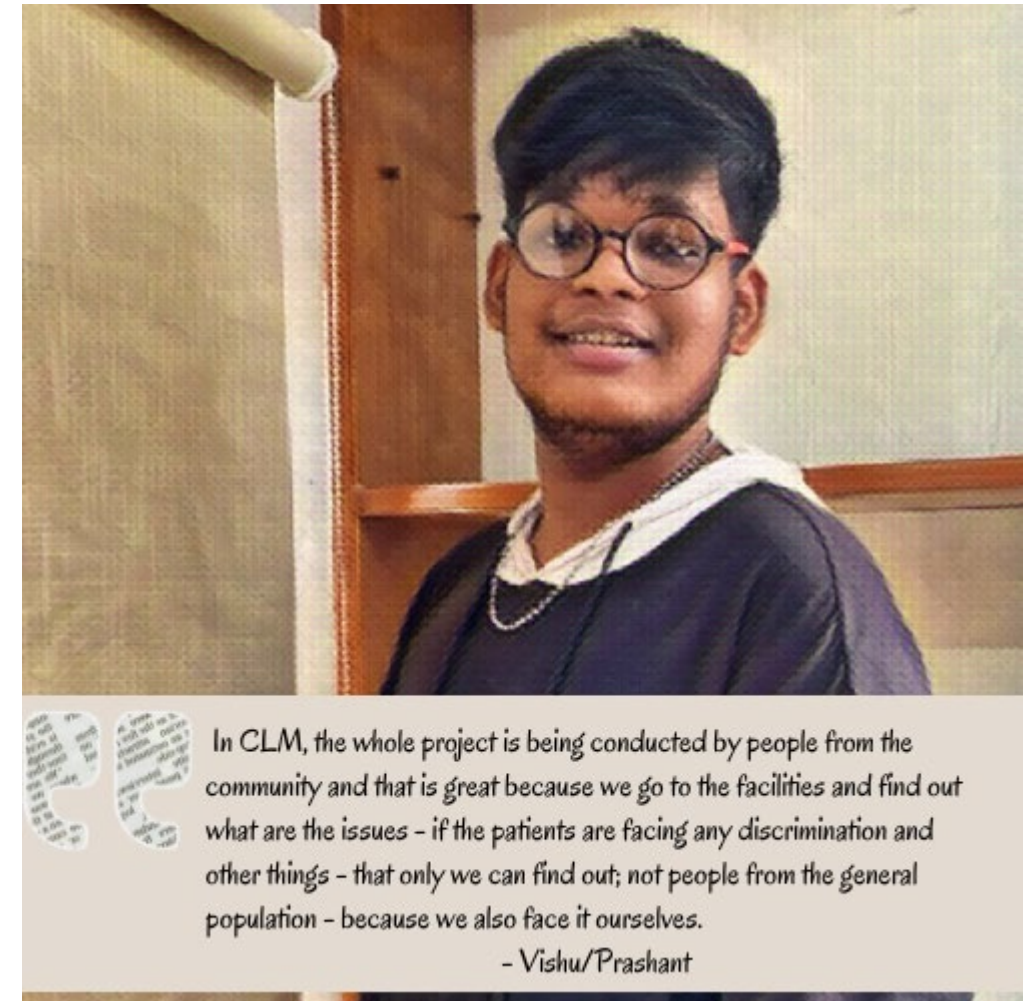


8





There needs to be someone standing behind the community and supporting them.
-Sameer

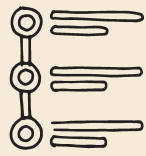


In CLM, the whole project is being conducted by people from the community and that is great because we go to the facilities and find out what are the issues - if the patients are facing any discrimination and other things - that only we can find out; not people from the general population - because we also face it ourselves.
- Vishu/Prashant



Involvement of the community is essential. Otherwise who will bring light to the community's issues and problems? We know what we need and we know where we don't have access to what. If we are involved, then all the policies and schemes will make sense
-Hemalatha

Key Learnings!



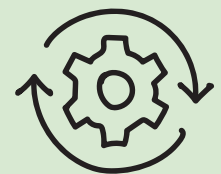
Orientation of all the key stakeholders on CLM and involvement of all the key stakeholders right from the initiation of the CLM pilot process added value in terms of making timely nominations of Community Representatives as well as the acceptance of the Community Representatives who worked at the field level, by the KPs, the service providers, and the community network.



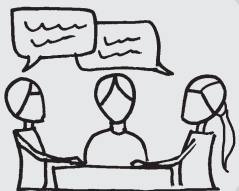
Since CLM is a new initiative, the pilot project elicited a great deal of interest as well as questions across the board, from the service providers, the KPs, and the core community and related networks.



The orientation of key stakeholders, as well as the community, on CLM also provided clarity.



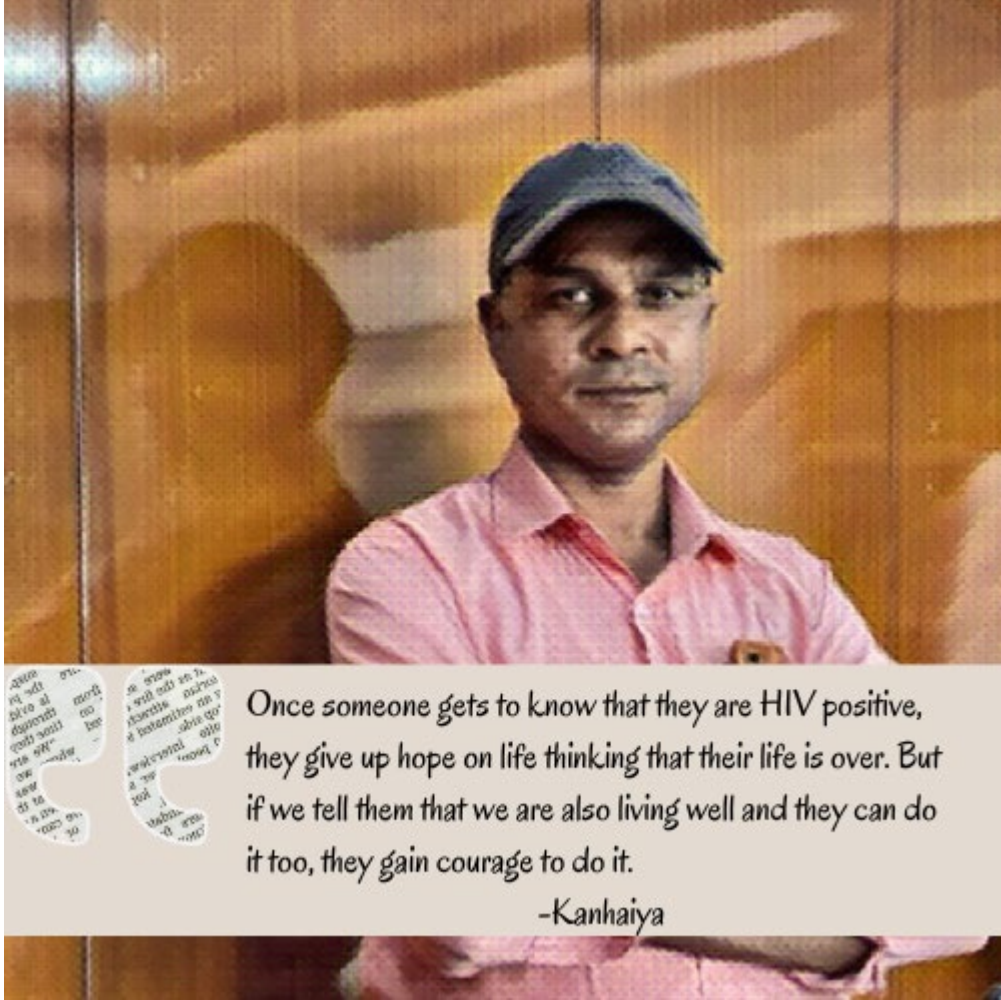
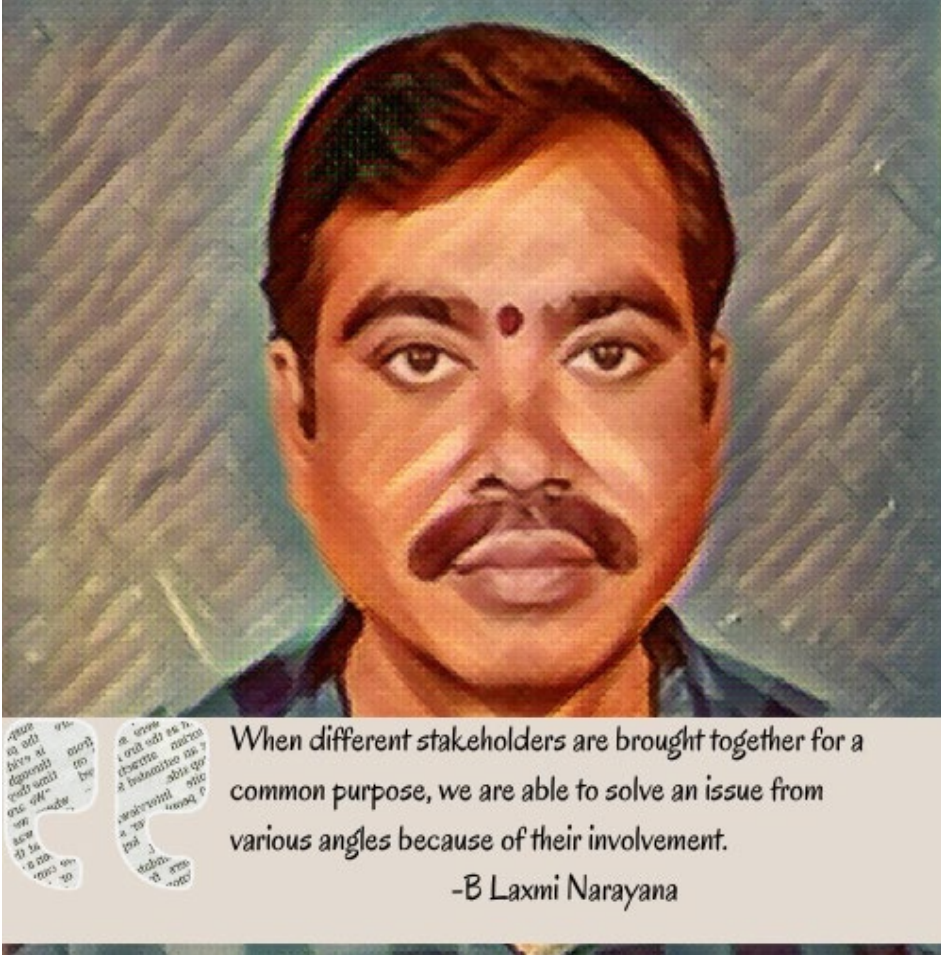
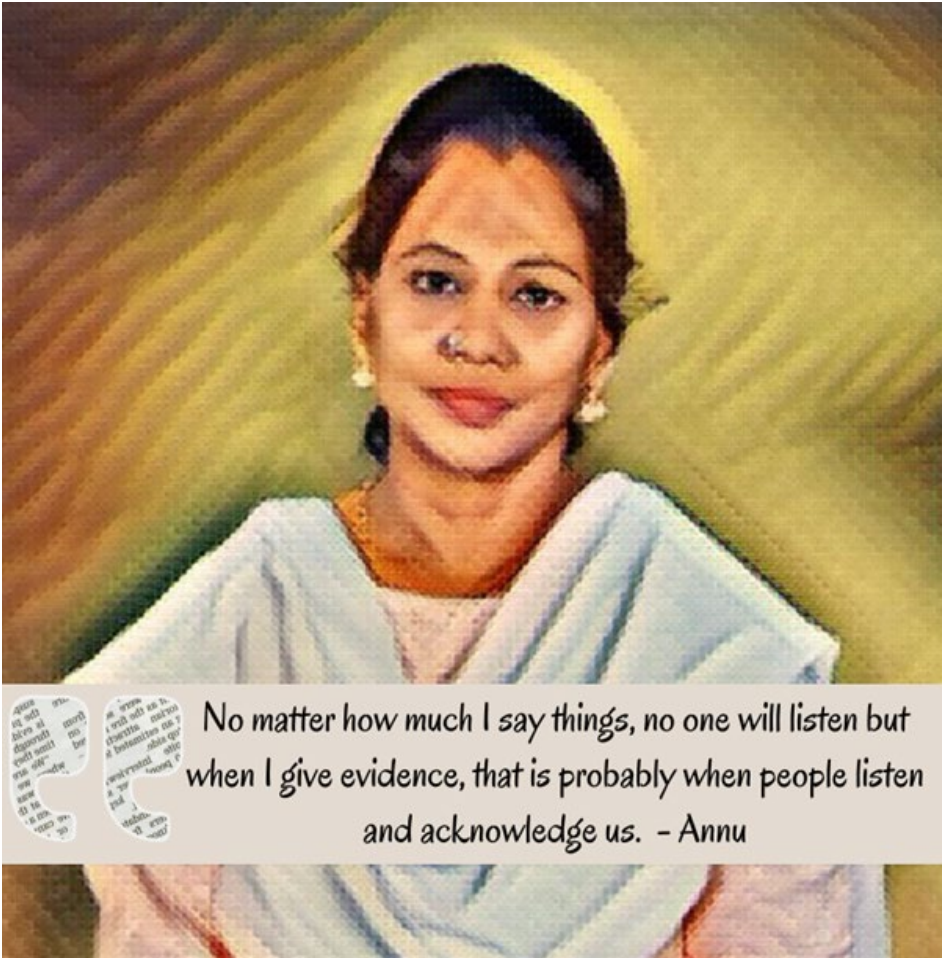
Training of the Community Representatives on the process and tools provided a platform for the Community Representative in having a better understanding and knowledge on each key thematic area under the NACP. Besides, through this training, the Community Representative who has always been service beneficiaries gained perspectives on how they could potentially contribute towards the enhancement of the HIV programme service delivery.



Through the training, the Community Representative were also capacitated on how they should conduct the interview at the facility level as an interviewer ensuring that they adhere to the standard quality of an interviewer.


Stage 2

GATHER INFORMATION & ANALYSE



Step 1: Gathering Information

The following table describes the scope of the information collection to be done in this phase

Prevention and treatment services and products	Aspects monitored
<p>Services:</p> <ul style="list-style-type: none"> ♦ TI services [Drop-in center (DIC) and outreach] ♦ HIV testing and screening (at facility and community-based) ♦ STI treatment (at PHC/DH as well as TI/referral STI care) ♦ Opioid Substitution Therapy (OST) ♦ Antiretroviral Treatment (ART) including CD4 test. ♦ Opportunistic Infections (OI) & Viral Load testing, Prevention of mother-to-child transmission (PMTCT) counselling ♦ Link to other health services [Directly Observed Treatment Short Course (DOT) centers for TB] 	<ul style="list-style-type: none"> ♦ Acceptability (stigma, violence) ♦ Accessibility (location, timing, client friendliness) ♦ Affordability (out of pocket expenses) ♦ Appropriateness ♦ Availability (waiting time) ♦ Accountability ♦ Responsiveness ♦ Utilisation
<p>Products:</p> <ul style="list-style-type: none"> ♦ Condoms ♦ Lubricants ♦ Needles/syringes ♦ Sexually transmitted infection (STI) drugs ♦ OST ♦ ART drugs ♦ OI drugs 	

The Tools for Gathering Information

After the initial trial process, one of three tools has been suggested for collecting information at scale. The table below provides an overview of the tools that were trialed.

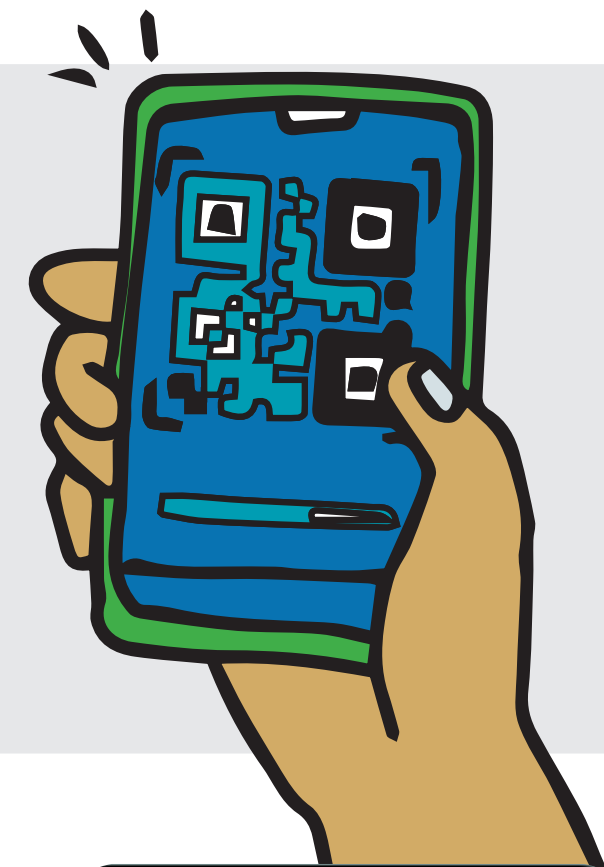
Name of Tool	Tool type	Aspects covered	Tool administered by	Place of administration	Frequency
Client feedback forms (Qualitative)	Questionnaire	-Accessibility -Availability -Responsiveness	Self administered by Key Population / Community Members availing the services	At the facility	Each CLM round (bi-annually or quarterly as determined by NACO)
Facility assessment (Quantitative & qualitative)	Semi- structured questionnaire & checklist	-Accessibility -Availability -Utilisation -Responsiveness	Trained community representatives	At the facility	Each CLM round (bi-annually or quarterly as determined by NACO)
Community feedback (Qualitative)	Focus group discussion	-Accessibility -Acceptability -Availability -Affordability -Appropriateness -Accountability -Responsiveness -Utilisation	Facilitating organisation and trained community representatives	Any place convenient to community	Each CLM round (bi-annually or quarterly as determined by NACO)



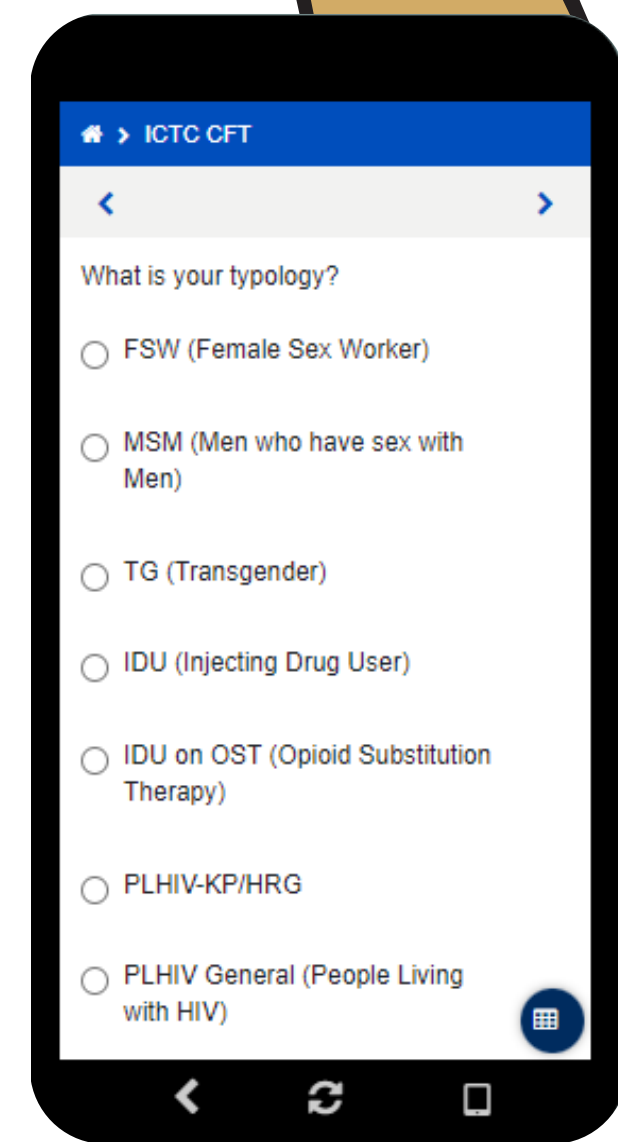
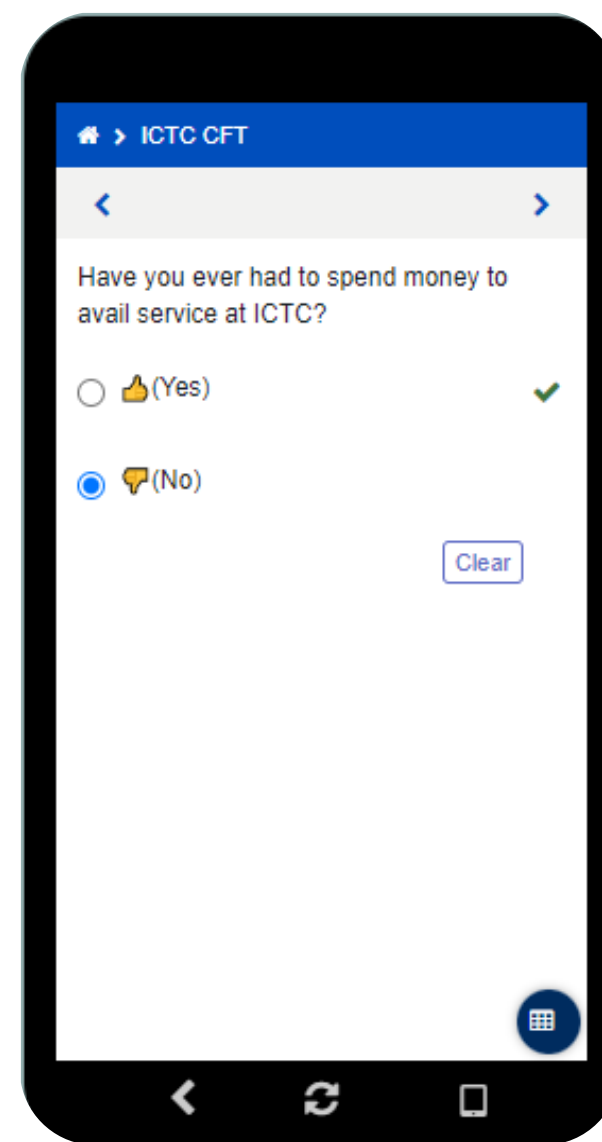
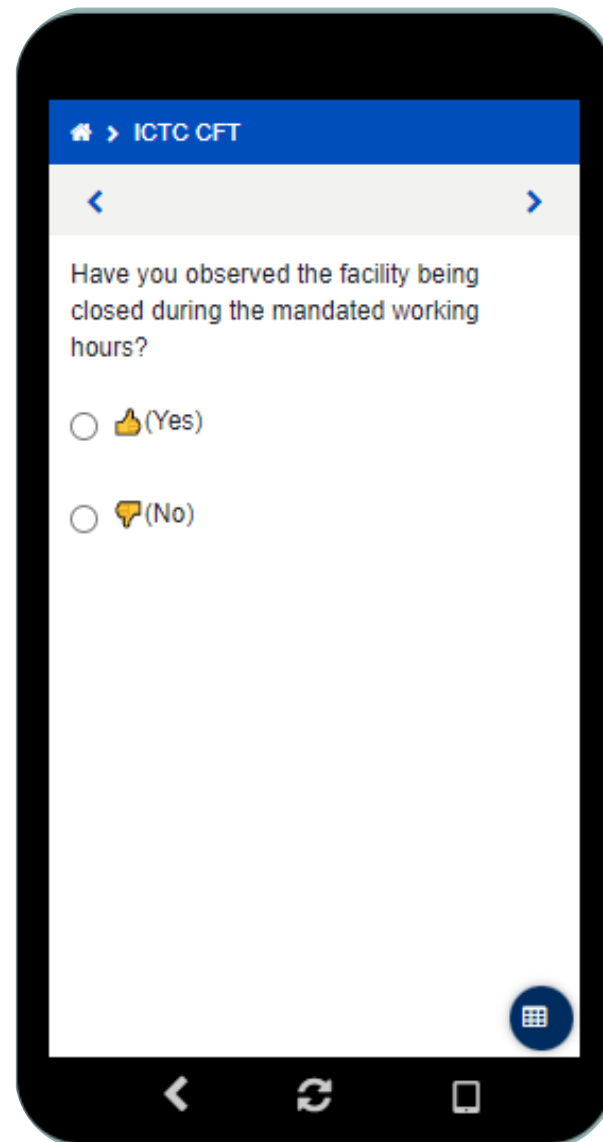
Information Collection through the Commcare App

It is an open source platform used to build android based mobile applications that are designed to support frontline workers across a variety of sectors in low-resource settings.

*developed by Dimagi



Scan to know more about Dimagi



Benefits of Commcare:

- ♦ Automates information collection
- ♦ Minimize Errors
- ♦ Customizable
- ♦ Ease of use for CCs
- ♦ Translation into local language is easy
- ♦ Tracking of field teams
- ♦ Option of adding emojis as options
- ♦ Can be used offline/ low data mode (CCs are able to use personal android smartphones)
- ♦ Both multiple choice and open-ended questions

TI-DIC CFT

< >

Have you ever been screened for HIV (CBS) without your consent?

🙅(No) ✓

🙋(Yes)

Clear

☰

< ↻ □

TI-DIC CFT

< >

Who has referred you to TI- DIC?

Through the PE/ORW

Referred by ICTC

Referred by DSRC

Voluntary

Through Peer Network

☰

< ↻ □

TI-DIC CFT

< >

Did you get to meet the ORW and PEs at the hotspot area on a periodic basis?

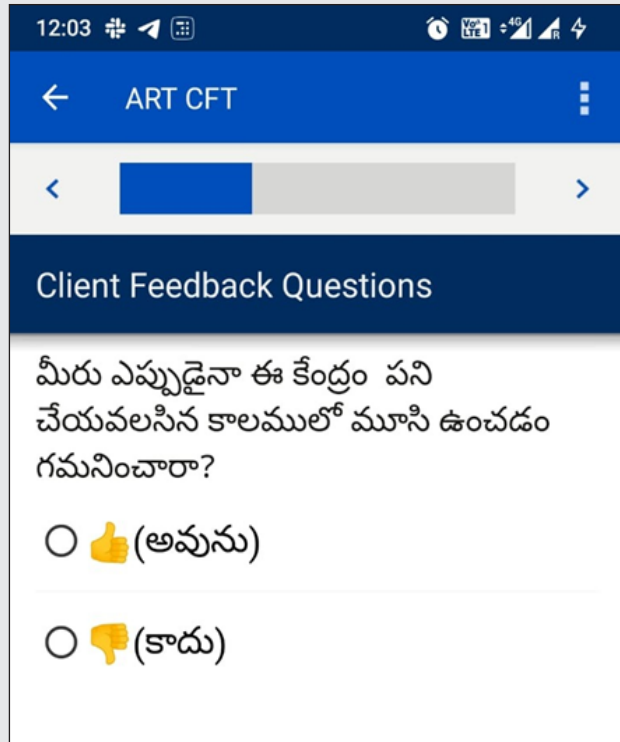
🙋(Yes) ✓

🙅(No)

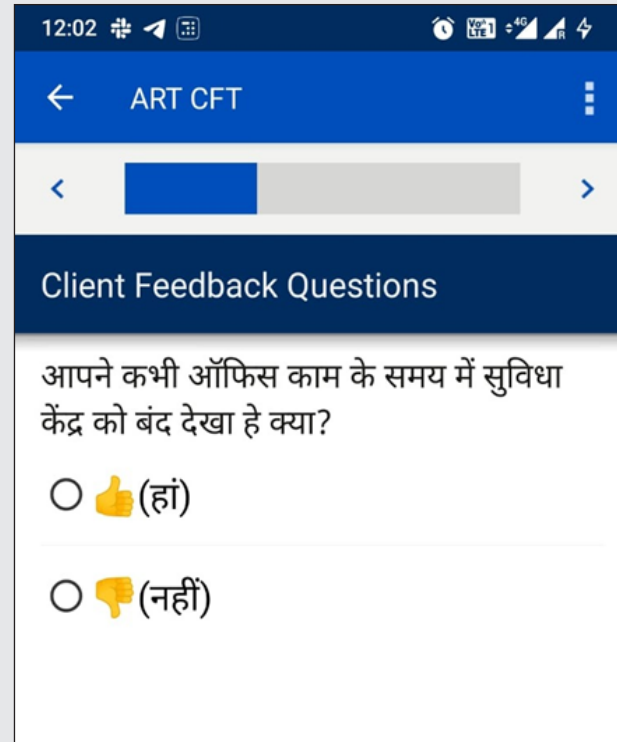
Clear

☰

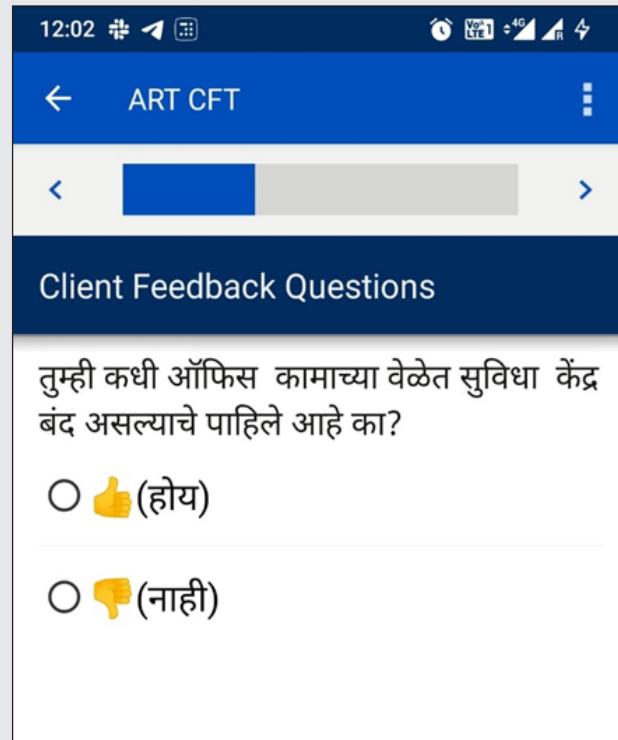
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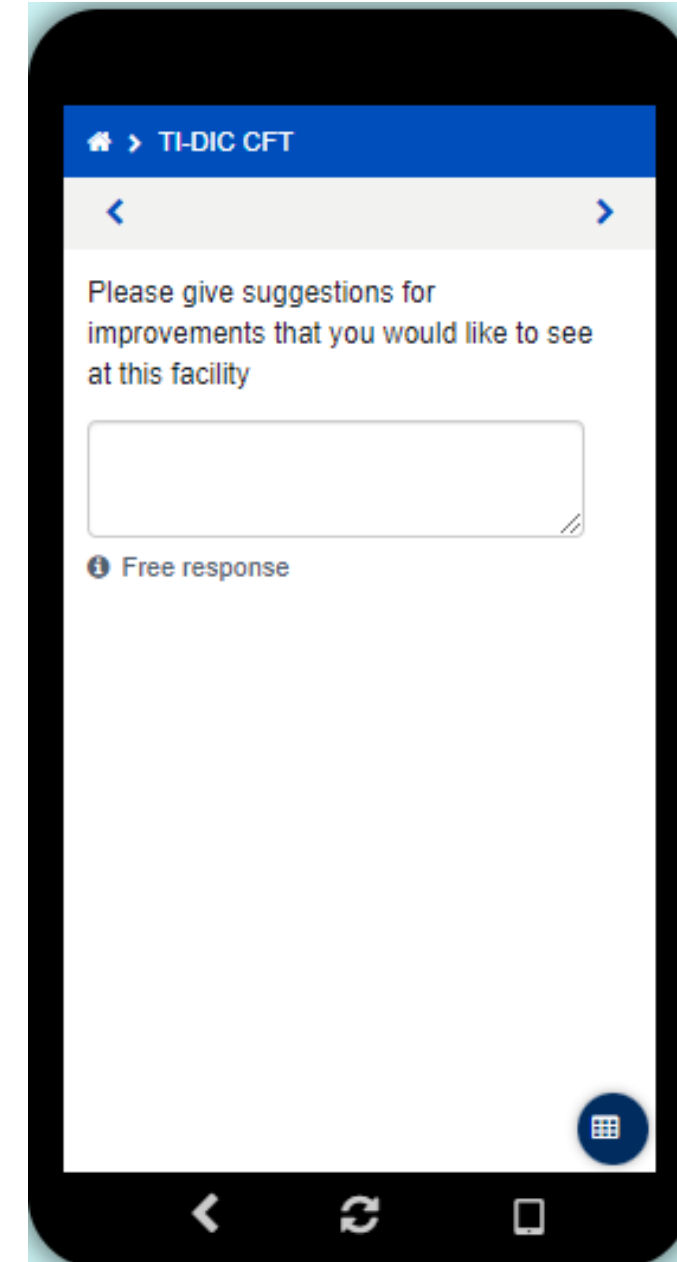
Telugu



Hindi

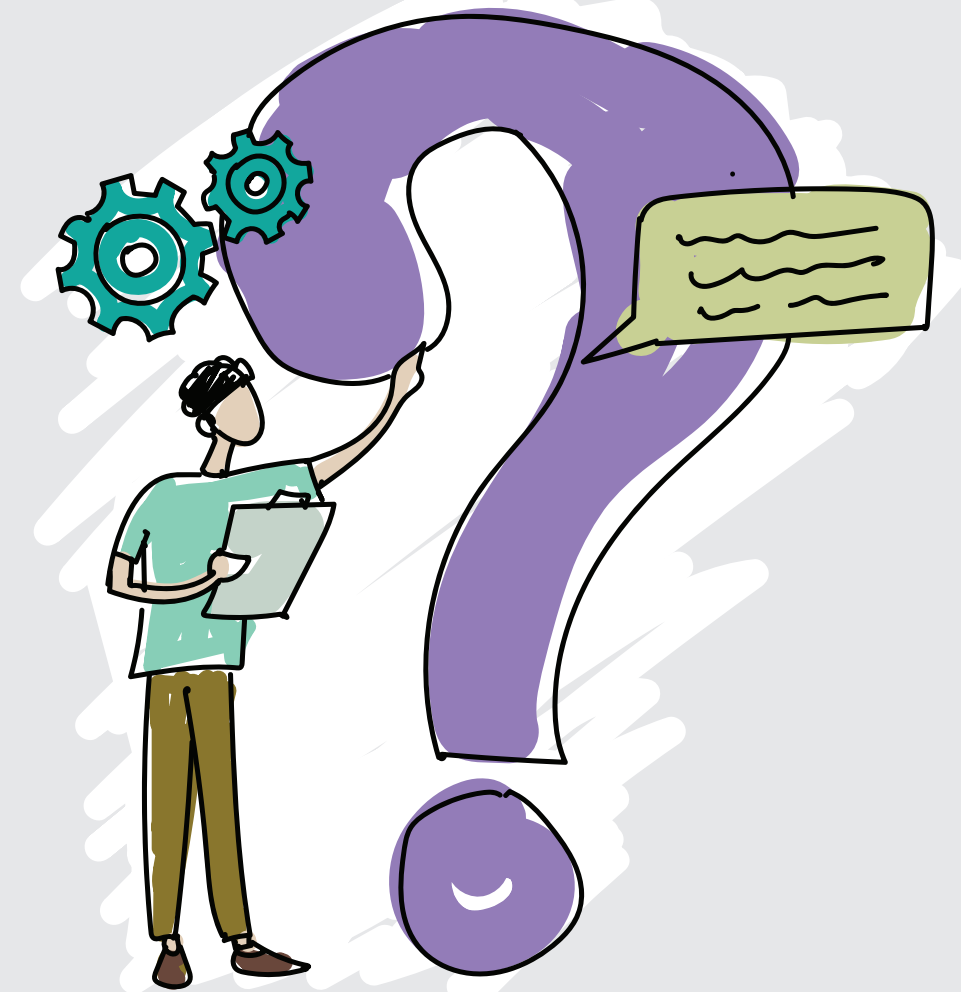


Marathi



How will information be analysed?

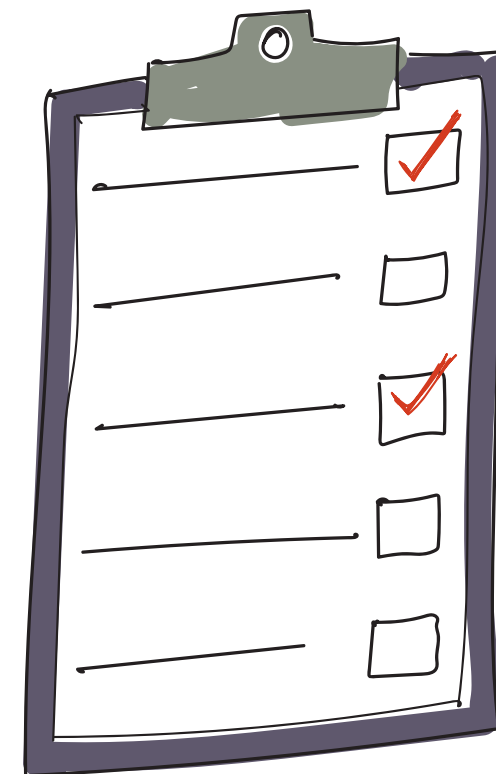
Programme Lead will do the data compilation for district, state and national level. Under the pilot project compilation will be done by the Result Impact Officer (RIO) in-charge of the district. The pilot will help us to understand the different levels which the team need to further analyse.



Training Community Representatives on the Use of the Community Report Card

All community representatives will be trained to use the Community Report Card through sessions conducted at the district level by the facilitating organisation (e.g., Swasti in Maharashtra and Telangana). The CRG will be invited to these sessions so that they are oriented towards using the Community Report Card to ensure improved services.

The translated Community Report Card, in local languages, will be made available and community representatives and CRG persons will participate in mock-sessions to become familiar with the Community Report Card and process during the training.



The Story Of The Community Report Card

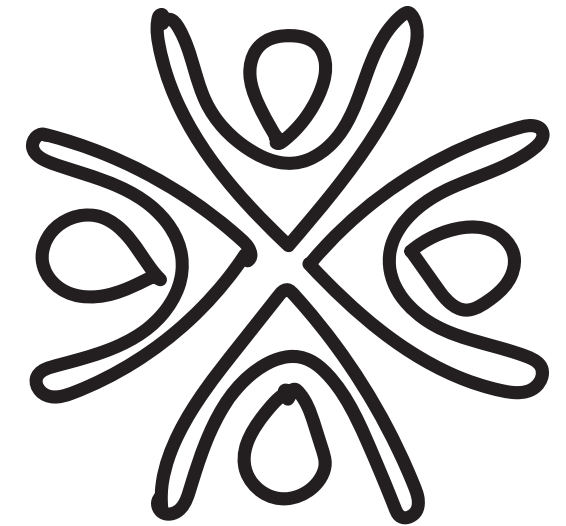
Pioneered by CARE in 2002 (Kwantu, 2016), the Community Score Card (CSC) is a five-phase process focused on constant improvement and facilitates continuous and enhanced dialogue between clients and health care providers. It provides a detailed snapshot of multiple issues, such as HIV prevention services, treatment and care, and stigma and discrimination.

It thus is a performance improvement tool that helps in participatory, community-led quality improvement routinely used for assessment, planning, monitoring, and evaluation of health services. Through the Community Score Card - communities can provide feedback directly to facilities, facilities get a direct link to communities and together they partner to identify and implement improvement actions.

Based on the Consultation held in Feb 2021, it was decided

to use the term “Community Report Card” instead of the Community Score Card, while the process remains largely the same (CARE, 2002) and will be adapted as we learn from implementation in India.

The Community Report Card adapts the tools developed by NACO in 2021, but goes beyond the collection of information to look at how the information collected is analysed, presented and used.



Planning a District-wide Implementation of Community Led Monitoring

After the training, the community representatives in each district along with the facilitating organisation will develop a work-plan/timeline for coverage of the facilities and how client feedback will be solicited.

Once the work-plan has been developed, this will be shared with the service providers to inform them of the schedule and solicit their cooperation. The DAPCU officer will be requested to make this communication to ensure that the CLM process goes smoothly. A copy of this work-plan / timeline will also be shared with the CRG.

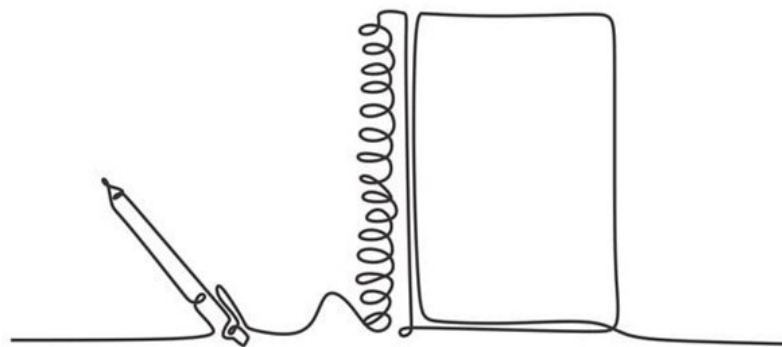
You can find a sample indicative work plan in **Annexures**.



Collection of Information

The community representatives will use the tools provided to complete the monitoring process of services and products in their districts. It is expected that the monitoring process in each district will be completed in approximately 8 weeks or less. This is based on the sampling proposed in the table ahead:

SN	Facility/Service Provider	Facility/Service Provider
1.	ICTC	ICTC
2.	ART	ART
3.	TI office	TI office
4.	DIC	DIC
5.	OST	OST
6.	STI /RTI clinics	STI /RTI clinics



Step 2:

Information Analysis

Data Analysis and Compiling the Community Report Card Results

The information collected through the client feedback form is analyzed and each facility is given a score. The CFT includes a list of qualitative questions which are scored through the use of emoticons for ease of understanding at the community level.

Each emoticon option is assigned a particular weighted score which is used to calculate the individual scores per facility.

Subsequently, the scores calculated for each facility are converted into grades.

Learning Vignettes

Aspects & Scoring:



Scoring:

An example for a question related to Acceptability

Question		Score
Have the staff behaved rudely with you?		
	Very Rude	0
	Rude	1
	Average/Okay	2
	Good	3
	Very Polite	4

Analysis of Information Gathered

Sample Snapshot of Report Card Generated

Facility	Accessibility	Availability	Acceptability	Affordability	Awareness
ICTC	B+	C+	A+	A+	B
ART	B+	B	A	A	C
DSRC	C+	C	A+	A	C
DMGDOTS	A	D+	A	A	C+
TI-DIC	C+	C	A+	A+	B
OST	A	C+	A	B+	C+

Grade	Score
A +	90% - 100%
A	80% - 90%
B+	70% - 80%
B	60% - 70%
C+	50% - 60%
C	40% - 50%
D+	30% - 40%
D	20% - 30%

Issues Identified:

1. Condom Stockout
2. Non availability of toilets
3. Medical officer not present
4. No lubricants available



Key Learnings

Before sending the Community Representatives (CR) directly to the facility, the State Team should ideally meet the service providers, introduce the designated representatives to the service providers so that the CR does not face issues like not being allowed to conduct interviews, the service providers not willing to cooperate with the CRs, etc.

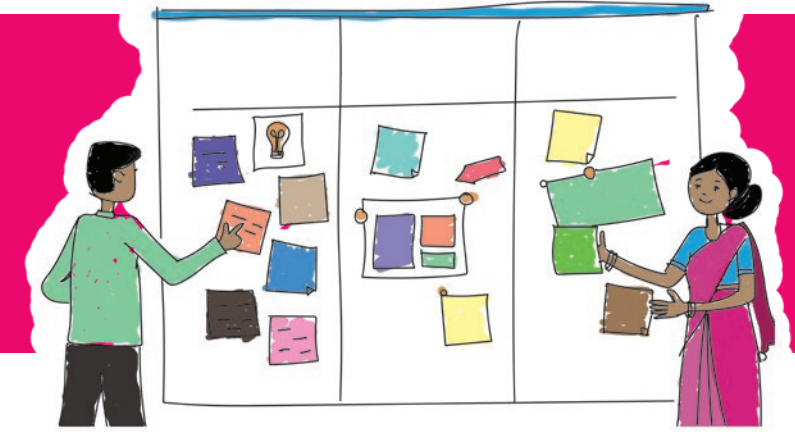


The State Team to have a discussion with the Service providers to discuss the daily HRG/KP footfall at the centre so that field planning for data collection can be planned accordingly.



Stage 3

GENERATE SOLUTIONS WITH COMMUNITY & PROVIDERS



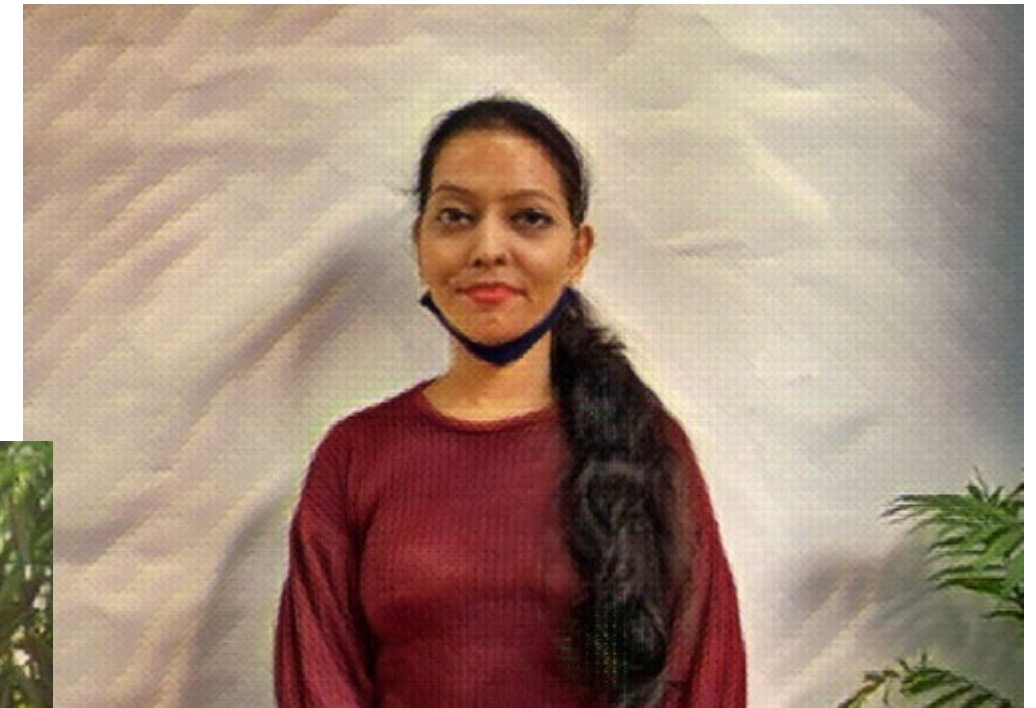
Our community only shares thoughts, feelings and problems with each other and not with outsiders. CLM helped me identify, discuss and address our struggles and I was finding solutions directly with service providers!

-Sana



This project works since it comes from the community itself. The community people know better about the usage and about the community that are into usage and thus vulnerable to HIV and other diseases as well.

-Bobby



This is the most important thing - how to guide the patients and whatever we were not aware of - we have learned all of it through this process. Information has been our biggest gift.

-Mukta

Step 1: Conduct workshop

After generation of the report cards, workshops will be organised with the following objectives:

- ⌘ To share the CLM findings with community groups and service providers
- ⌘ To identify the problems and solutions to the existing barriers involving the community groups, service providers and other stakeholders (CRG, DAPCU, partners etc)



4 Things to remember when facilitating workshops to generate solutions alongwith Community Members and Service Providers

- 1 Choose a facilitator who is well-accepted** by both the Community Members and the Service Providers and can speak the vernacular language.
- 2 Set the context** by specifically co-creating ground rules that aim towards creating a safe space. Here are some examples of the ground rules that work towards creating a safe space in workshops

Facilitator seeks permission from the group to

- ⌘ Keep conversations on track
- ⌘ Invite people who have not spoken
- ⌘ Request that conversations are inclusive
- ⌘ Ask clarifying questions

The facilitator helps the team to remember

- ⌘ That they can ask questions any time and no question is a right or wrong question. There are no value judgments
- ⌘ Invite co-participants into the conversation if they know that they may offer deeper insight
- ⌘ Ask for extra time on each topic
- ⌘ Share their stance on an issue fearlessly. No value judgments.
- ⌘ Express concerns that have not been addressed

3

Here are norms for making the workshop a safe space for honest conversations and solution finding:

- ⌘ Start with open conversations
 - Ask about 3 things the community and the service providers are proud of
 - Ask about 3 things the community and service providers feel they need to change
 - Ask about what can enable this change and what could be hurdles to it
- ⌘ The participants will frame responses and questions in a manner that is respectful, polite and non-judgmental

4

Set norms for creating emotional safety

- ⌘ Declare it as a “no-secrets” workshop
- ⌘ Specify that only time keepers, presenters and minute takers can use their devices. Request that everyone keep aside their devices in the duration of the meeting
- ⌘ Treat every participant with positive regard
- ⌘ Assure that there will be time to take photos during the breaks.
- ⌘ Request the participants to devote their complete attention to whoever is speaking
- ⌘ Each person takes their time to complete their thought
- ⌘ The facilitator will summarize the key highlights after each conversation segment - this will reinforce that participants are being listened to
- ⌘ The facilitator will acknowledge the quality of conversations and express gratitude to the participants

Results Reviewed with Community Groups and CRG

The results from the data collection phase, i.e., the Community Report Card, will be presented to community organisations and their partners/stakeholders working closely with them (previously identified) and the CRG. Any further insights from the community persons will be recorded and brought into the Community Report Card.

The CRG will be invited to be part of these discussions-share insights and guide actions.

This will also provide an opportunity to identify service providers and specific personnel in those facilities who are supportive towards the community and can partner in addressing the issues highlighted by the community.

Results Reviewed with Service Providers

All service providers assessed during the monitoring process will be invited for a discussion on the results at the district level. Community representatives who led the monitoring will share the results and discuss their findings. Furthermore, consensus will be built on priority actions with local solutions to be undertaken.

Any actions that require changes at the state level or district level (with the public health system) will also be identified for the next level of discussions.



Learning Vignettes

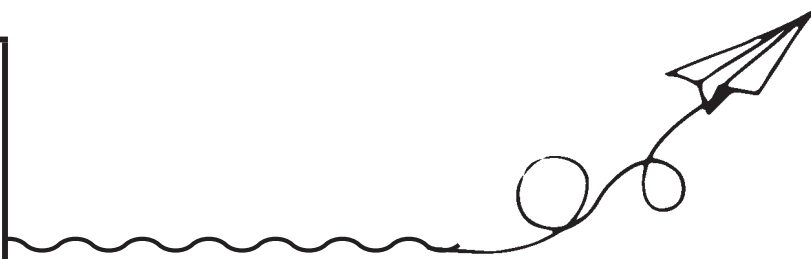
After the analysis of the findings, a workshop on Co-creating of Solution using the SOLVE approach in all the 7 districts was conducted.

Objectives of the workshop:

- ⌘ To share the observations made by the Community Representatives using the Client Feedback Tool (CFT) and the Facility Assessment Tool (FAT) to all the stakeholders.
- ⌘ To co-create solutions for issues identified in the CLM pilot in consultation with all concerned Service providers and Community Representatives
- ⌘ To share the action plans with district and state-level authorities and CRG to initiate actions to address the issues identified and solutions generated.



SOLVE



The SOLVE Approach

The SOLVE approach is used for problem-solving at various management and community levels. A set of cards are created and each card has a root cause. It is a part of an **integrated** approach to facilitate **accountability, decision making, and actionable insights** with the providers and managers at the different administrative levels using existing data and limited resources. The SOLVE cards are based on the **WHO framework** that describes health systems in terms of six core components or “building blocks”:

(i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance

The SOLVE card process follows 5 key steps:

- ♦ **S**elect your key problem
- ♦ **O**bstruction identification (root cause)
- ♦ **L**ocate solution
- ♦ **V**olunteer key person and deadline; Take photo
- ♦ **E**xecute (and evaluate)

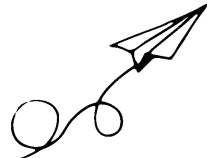
Objective:

The Objective of the SOLVE card process is to **assist in the outline and implementation of an integrated response that links management and community action**; is informed by data, and is focused on strengthening the HIV service delivery platform at facility and community levels.

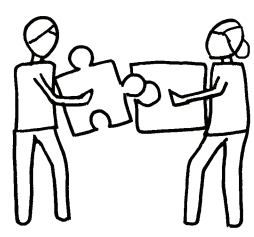
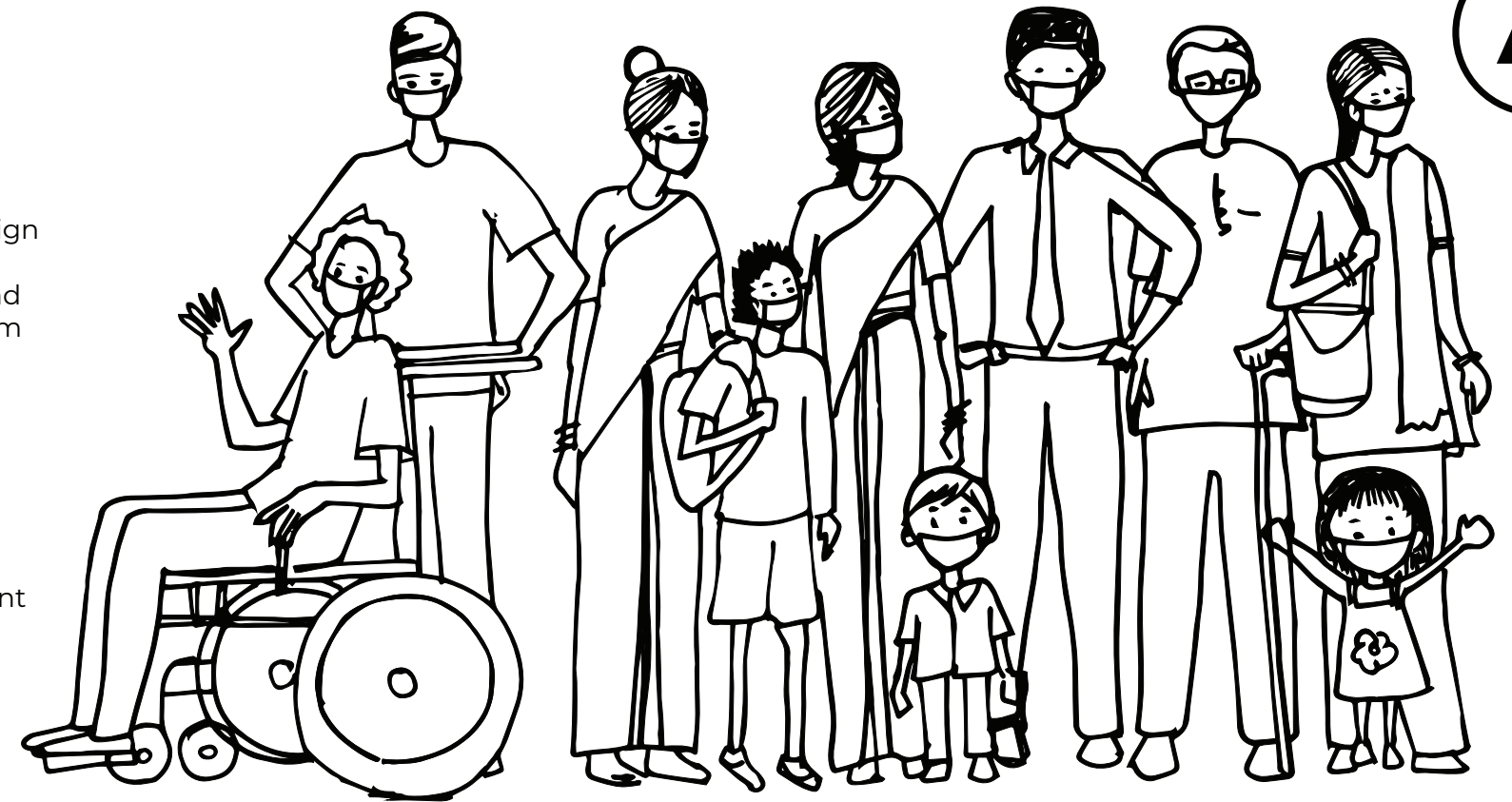
- ⌘ Service facilities: ICTC, ART, PPTCT, DMC/DOTS, DSRC, and TI/DIC
- ⌘ Service user and service providers

The primary focus of SOLVE cards is to **identify root causes of issues** that exist in the system and **generate consensus on implementable solutions**, vetted by the community.

SOLVE



A



Objective:

The purpose of the SOLVE Card process is to support the design and implementation of an integrated response that links management and community action; is informed by data; and is focused towards strengthening the service delivery platform at facility and community levels.

- ⌘ Service facilities include: ICTC, PPTCT, ART, DMC/DOTS, DSRC, TI/DIC and OST
- ⌘ Service beneficiaries and service providers

The key objective is to identify root cause/s to issues in HIV service delivery and generate implementable solutions, in joint consultation with service providers and service consumers vetted by the larger community.



SOLVE

Here is a SOLVE process guide:

Step 1

Select your key problem

WHAT: The first step is to pinpoint the key problem that the cards will help address.

WHEN: This step can be undertaken before the implementation begins or during the implementation, at the review meeting.

WHERE: At a review meeting or a stakeholder meeting. In case neither is happening, the team could call for a meeting involving all stakeholders.

LEVEL: This is applicable at all administrative levels (Facility, Ward, LGA and State)

WHO: This step may be done by the point person facilitating the administrative level meeting or the manager of that unit level

How?

The first step is identifying the problem. This can be done through multiple methods. Please choose one or a combination of methods that might be helpful.

- ⌘ The visual scorecards give an overview of the indicators that need prioritization.
- ⌘ Discussion with the relevant stakeholders in the form of review meetings to identify key issues.

Step 2

Obstruction identification (root cause)

WHAT: Once the problem is identified, the next step is breaking down the problem to get to the root cause of the problem. *I feel this needs elaboration so that one reaches the root cause. Digging deeper and deeper till you reach a stage where there are no further causes are identified*

WHEN: After problem identification. It could happen on the same day or another day.

WHERE: Administrative unit level review meetings, for eg: Ward level reviews, or a sentinel event review. In case neither is happening, the team could call for a meeting involving all stakeholders. **LEVEL:** This is applicable at all administrative levels (Facility, Ward, LGA and State)

WHO: This step must include all attending stakeholders.

SOLVE

How?

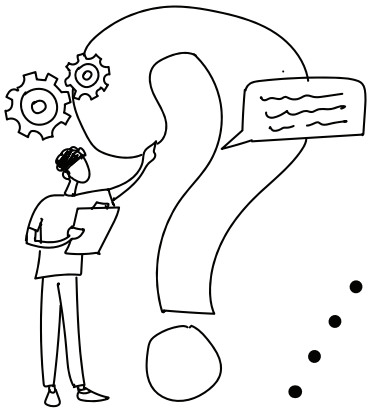
For identifying the root cause, use one or more of the tools mentioned.

The SOLVE cards are multifunctional and may be used in the review meetings to identify the cause. To use it

- ⌘ Lay the cards on a table with the problem side facing up.
- ⌘ Convene the team, discuss the agenda.
- ⌘ Go around the room to pick up cards that are most relevant.

SOLVE

B



SOLVE

Step 3

Locate solution

WHAT: Use the root cause to identify one or more potential solutions.

WHEN: This should happen on the same day when root cause analysis happens.

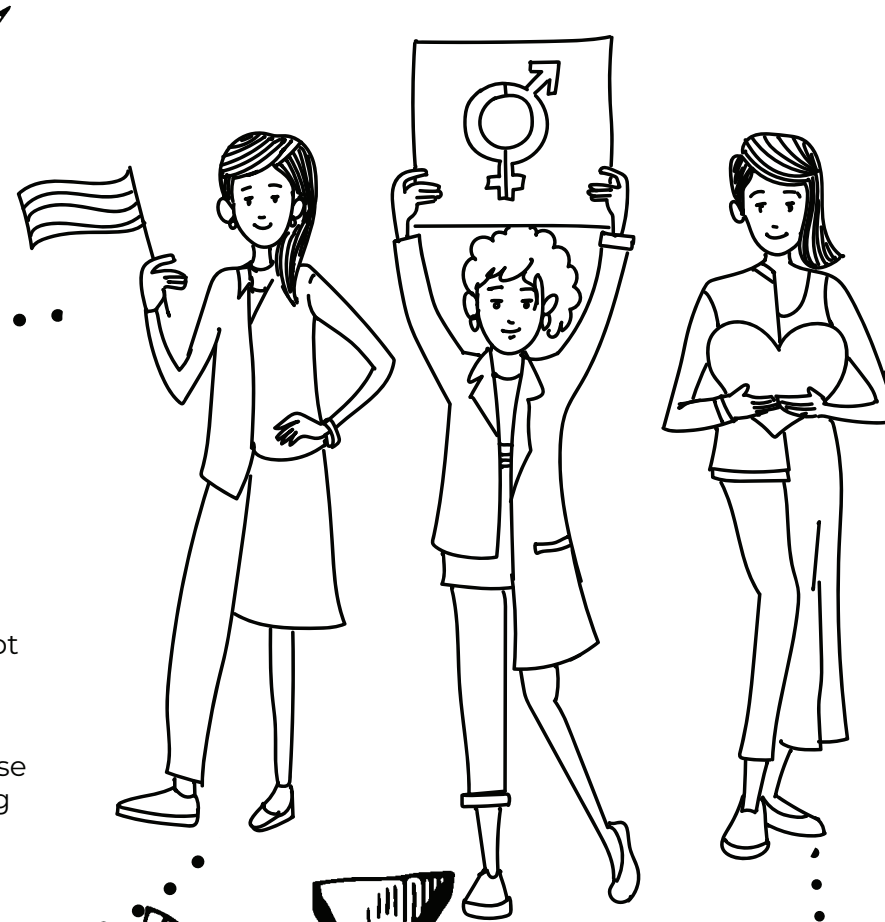
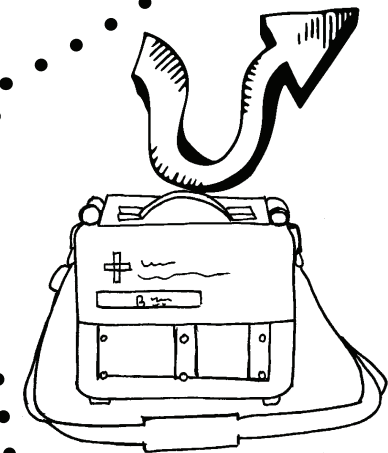
WHERE: Administrative unit level review meetings, for eg: Ward level reviews, or a sentinel event review. In case neither is happening, the team could call for a meeting involving all stakeholders.

LEVEL: This is applicable at all administrative levels (Facility, Ward, LGA and State)

WHO: This step must include all attending stakeholders.

How

Look up the solutions in the Solve cards provided to you by turning the card around. If none of the solutions are relevant to your problem, you can add your own unique solution to the cards.



SOLVE

Step 5

Execute (and evaluate)

WHAT: Once the solution is identified, a deadline and a point person to be assigned to implement the solution.

WHEN: This should happen as per the timelines assigned to a particular task. Evaluation of the progress of the task should happen at a stipulated frequency (to be decided by the manager or as per review meeting frequency)

WHERE: Administrative unit level review meetings, for e.g. Ward level reviews, or a sentinel event review. In case neither is happening, the team could call for a meeting involving all stakeholders.

LEVEL : This is applicable at all administrative levels (Facility, Ward, LGA and State)

WHO: This step must include all attending stakeholders. However, the person undertaking any task is responsible for resolution. And the manager or authority in concern oversees taking stock of progress.

How?

The work plan needs to be executed and evaluated periodically. Use the scorecard periodically to analyze improvements in the indicators identified.

Problems either get resolved or they evolve. Therefore, the regular use of the cards will help in institutionalizing a system of problem solving and self reliance.

How

- ✂ Assign key person
- ✂ Design a work plan based on the Solve Solutions Mix/Validate the solutions by assigning timeline and date for review.
- ✂ Take a picture and share with the relevant authority.

Checklist for workplan:

- ✂ The manager/facilitator can use stickers/tick-marks to identify relevant and contextual solutions.
- ✂ Based on the Solve Mix of solutions, the manager will assign a timeline for the implementation plan.
- ✂ Develop a plan of implementation taking into consideration available resources and efforts.
- ✂ Develop a schedule for review meetings for progress.

Step 4

SOLVE

Volunteer key person and deadline; Take photo

WHAT: Once the solution is identified, a deadline and a point person to be assigned to implement the solution through a work plan.

WHEN: This should happen the same day when root cause analysis and SOLVE solutions are identified.

WHERE: Administrative unit level review meetings, for eg: Ward level reviews, or a sentinel event review. In case neither is happening, the team could call for a meeting involving all stakeholders.

LEVEL: This is applicable at all administrative levels (Facility, Ward, LGA and State)

WHO: This step must include all attending stakeholders. However, the assigning of tasks may be done by the person/manager in authority

To know more about SOLVE cards and how it has been used in CLM, write to helloswasti@catalysts.org

Key Learnings!

Involvement of key service providers, DAPCU and CRG in the process of the workshops makes solutioning and action planning effective

Co-creating of solutions was a good method to share insights for effective implementation

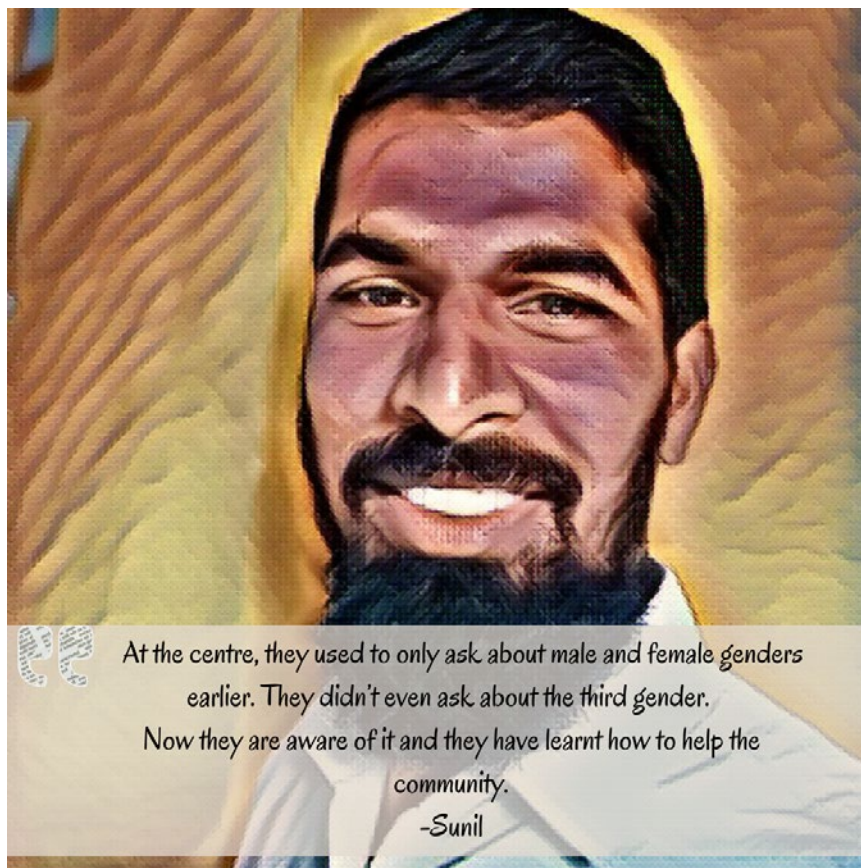
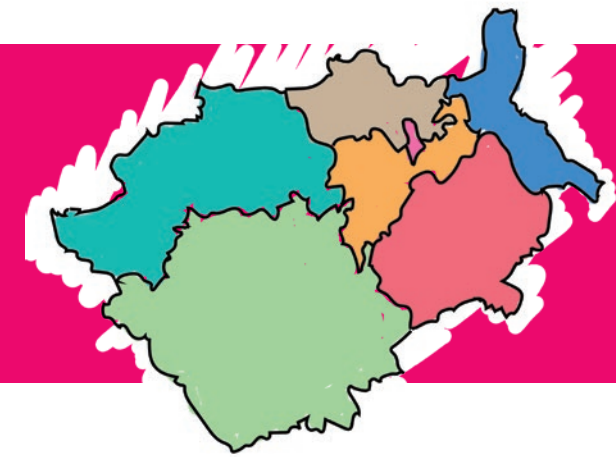
There was active participation of the CRG and CC's in the group discussions and their ability to articulate issues and problems with service providers helped in identifying better solutions

The workshop created a platform for the CR and CRG to interact with the service providers, and express their concerns and vice versa. Hence, a platform for building trust with the Key Populations (KPs) and services providers.

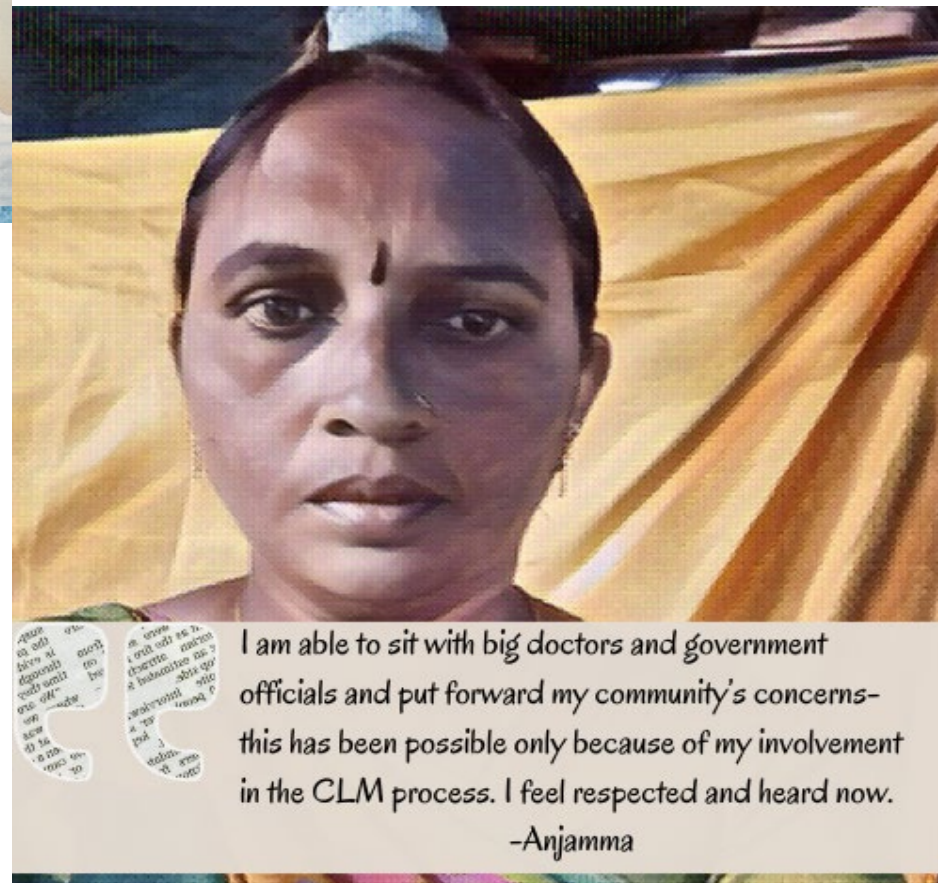
SOLVE process provided scope for brainstorming amongst service providers and KPs, to track the program performance and re-program accordingly, to achieve desired goals and objectives.

Stage 4

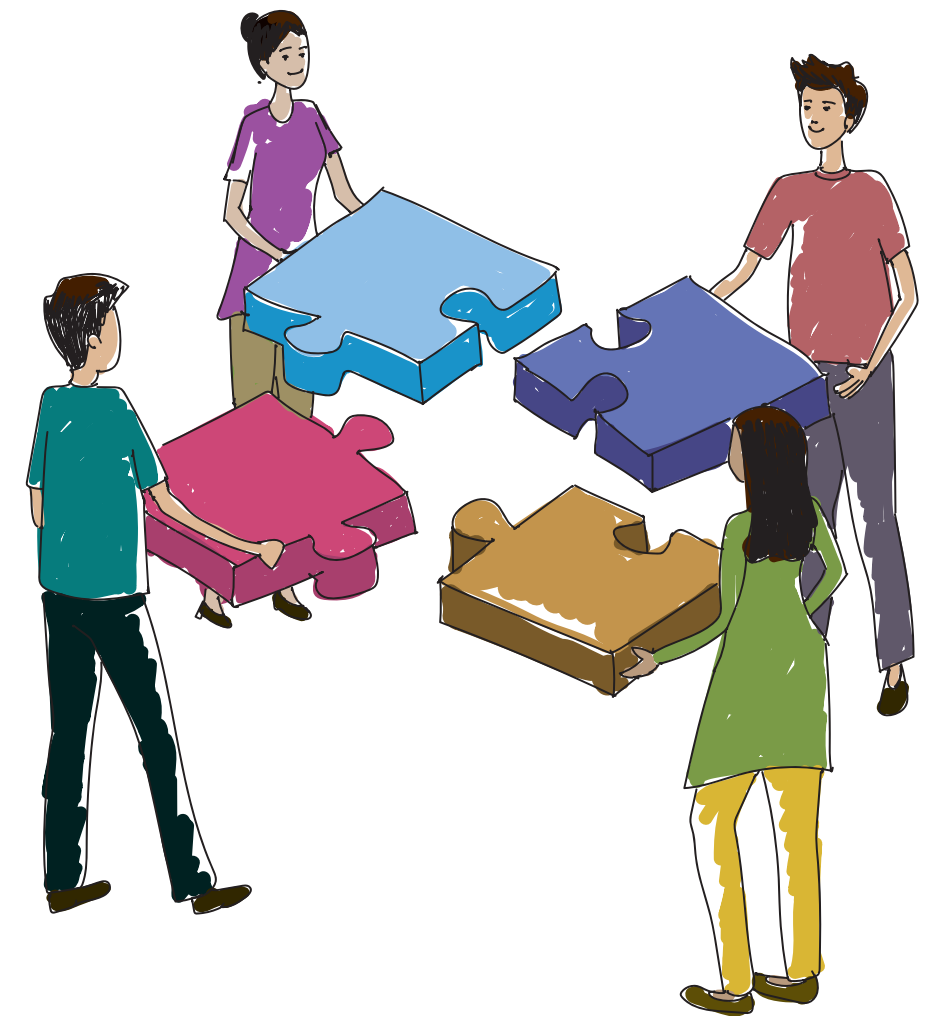
ENGAGE WITH DISTRICT & STATE FOR ACTION



At the centre, they used to only ask about male and female genders earlier. They didn't even ask about the third gender. Now they are aware of it and they have learnt how to help the community.
-Sunil



I am able to sit with big doctors and government officials and put forward my community's concerns- this has been possible only because of my involvement in the CLM process. I feel respected and heard now.
-Anjamma



Engage with the District and State for Action

The results from the district level discussions, including identified actions/solutions are discussed with SACS. Community representatives as well as persons of the CRG are part of these deliberations.

The recommendations and agreements arrived at during previous meetings with service providers and community groups and the CRG will also be discussed.

Agreements arrived at with SACS and district officials, through one or more discussion(s), will be documented and made available to community groups as well as on the CLM website/portal.



Pages from Delhi CLM Field Diary : An Excerpt

Service Providers speak:

Dr. Sachin, Medical Officer, ART, Lok Nayak Hospital

Dr. Sachin believes that the CLM process is integral to bridging the gaps in HIV service delivery and that service delivery providers can help strengthen the care continuum. CLM has allowed patients to be much more comfortable sharing their experiences and grievances, whether big or small, as these are issues that often go unattended. This is of importance because the patient's convenience is key to the patient. "The rectification of these issues will enhance the patient's experience and improve health outcomes. Hopefully, the 95:95:95 goal will be achievable through CLM and whatever is best for the patient will be done. Through 50 percent of the community's efforts and 50 percent of the system's efforts, we will be able to bridge the gaps in the care continuum," Dr Sachin said.



Mr. Jai Prakash Varma, Counselor, ART, Dr. Baba Saheb Ambedkar Hospital

Mr. Jai Prakash Varma believes that the CLM process is important in the race to eliminate HIV/AIDS. He said that it is his personal contribution in strengthening the community's awareness of the disease and removing the stigma attached to it. He acknowledges the importance of his role as a counselor. He encourages beneficiaries to ask questions about the disease and educates them on the modes of transmission and on the importance of ART adherence. As a propagator of the right information to the community, he believes that CLM will allow the community to come forward and speak about the issues that concern them the most. This exchange paves the way for a two-way communication wherein the counselor educates the beneficiaries and the beneficiaries share their concerns and provide feedback for improving the system.

Ms. Shikha, Counselor, ICTC, Dr. Baba Saheb Ambedkar Hospital

Ms. Shikha said that she and her colleagues are providing, and will continue to provide, their full support to efforts aimed at meeting the community's needs and in including and representing the community members' voices and concerns in the CLM process. Since safeguarding the patient's health is important to her and her colleagues, they are determined to handle the challenges they face and manage these issues head on.



Ms. Pushpa Nagar, Counselor, TI, TG/DIC

Ms. Pushpa believes that the community is an integral part of CLM. Because she works directly with the community, she understands that the identification of barriers and gaps, and what the community needs, must come directly from the community because they know these issues best. When the community identifies gaps in service delivery, they are able to provide a solution that comes from a non-judgemental standpoint, especially when we are talking about HRGs such as TGs. This direct approach will yield a more meaningful dialogue, encourage deeper deliberation, and produce better health outcomes for the clients, which is the key objective of CLM. Since the lifestyles of various HRGs are unique to them, their problems will also have unique solutions which can only come directly from the people.

Ms. Pushpa believes that if the source of the problem is the 'people', then the solution must also come from the people. Community members help each another and with the help of quality caregivers and health care providers, she and her colleagues can reduce the burden of HIV in time. The 2030 goal is a big push to accelerate the efforts in achieving the goal, but she thinks the disease can be eliminated in the next 20 years. "Even a 10 percent improvement is an achievement, which means that the intervention is working for some. If this is replicated, the 95:95:95 goal is very much achievable through the help of CLM initiatives," Ms. Pushpa said.

Learning Vignettes

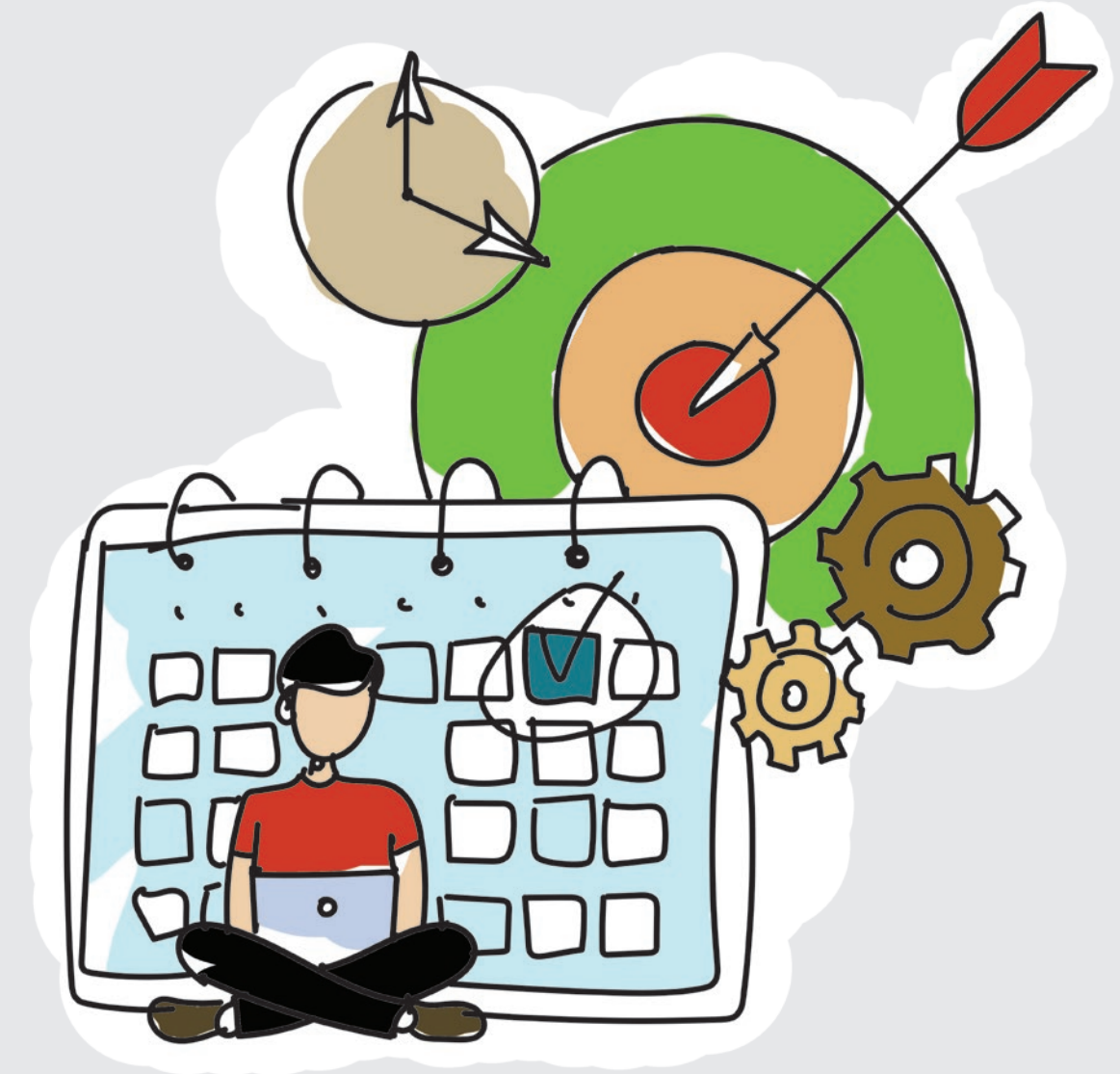
Microplan on field visit developed

As a result of the 3 day workshop conducted, the key action points were developed in agreement with all the stakeholders with timelines and key responsibilities set forth by each centre service provider. The team then initiated the follow-up visit with the concerned key stakeholders at the field. The micro plan on field visits was developed based on the action points across the facilities in the districts, covering the following aspects-



In both states, the follow up visits were done in 2 rounds, to share the implementable action points in Round 1 and to verify progress and identify best practices in Round 2 each.

Based on the key observations made in reference to the agreed recommended action points in Stage 3, a monthly report was to be developed to be sent and apprised the SACS, TSU as well as DAPCU on the milestone achieved.



Stage 5

TRACK & SHOWCASE SUCCESS

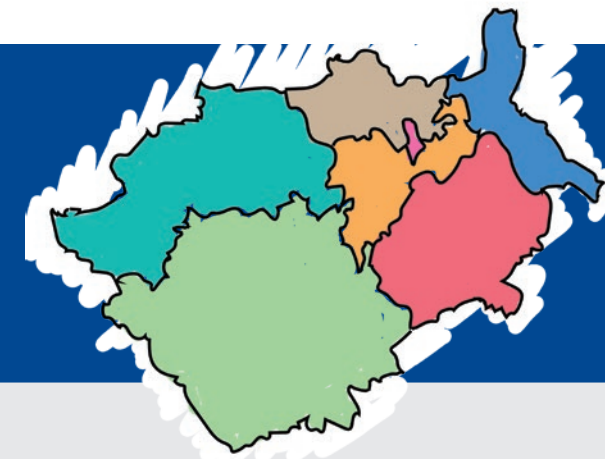
As this stage closes the loop in the framework of CLM, therefore, emphasis will be laid on taking stock of achievements of the HIV programme and improvements achieved as a result of actions in stage 3 and 4.

Following steps are important in this stage:



Award Ceremonies to Recognise and Appreciate Service Providers

Service providers who receive community support for delivering quality services and going above and beyond, will be felicitated at district/state level events. This public recognition is important to motivate others and to express gratitude to those who go beyond the call of duty.



The facilitating organisation along with the community representatives in the district will monitor the actions that had been agreed upon in discussion in the previous quarter. This will be done through a simple listing of the actions and whether work has been initiated or not. These will be reviewed monthly at the DAPCU level and at least quarterly at SACS. The status of actions made available on a website/portal enables transparency and increases trust with the community.

Learning Vignettes

CLM Action Tracker

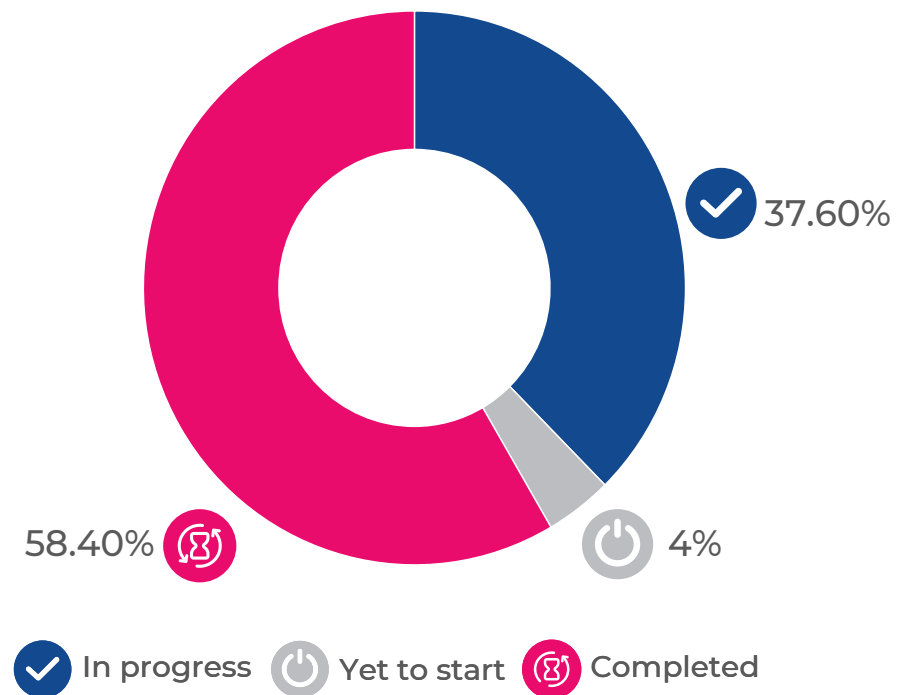


CLM Round	State	District	Type of Facility	Level of Resolution	Name of facility	Issue Identified	Action/Solution Identified	Aspect of Action/Issue	Timeline	Responsibility	Progress (From 1st follow up)
Round 1			ART	Facility Level		No suggestion box	Arrange a temporary box with proper labelling.	Availability	15 Days	Counsellor, MO	Completed
Round 1			ICTC	Facility Level		No redressal committee	Grievance/Redressal committee should be enforced.	Accountability	15 Days	Counsellor, MO	Completed
Round 1			ART	Facility Level		No redressal committee	Grievance/Redressal committee should be enforced.	Accountability	15 Days	Counsellor, MO	Completed
Round 1			ART	Facility Level		No Suggestion Box	Arrange a temporary box with proper labelling.	Availability	15 Days	Counsellor, MO	Completed
Round 1			ART	Facility Level		Low Awareness of the HIV/AIDS ACT 2017	Request DAPCU to conduct awareness program on HIV/AIDS ACT 2017	Awareness	1 Month	DAPCU, PO-TSU and SACS	Completed
Round 1			ART	District Level		Inappropriate communication by the ART staff towards clients	Regular coordination meeting with TI-NGO/CBO	Acceptability	1 Month	Counselor, MO and PM-TI-NGO/CBO	In Progress
Round 1			DSRC/ST I	Facility Level		No Display of Signages	Arrange temporary sign boards at strategic locations by consulting the Hospital superintendent	Accessibility	Immediately	Counsellor, MO	Completed
Round 1			DSRC/ST I	Facility Level		Suggestions box not available	Arrange a temporary box with proper labelling.	Availability	15 Days	Counsellor, MO	Completed
Round 1			DSRC/ST I	Facility Level		Inappropriate communication by the staff towards clients	Regular coordination meeting with TI-NGO/CBO	Acceptability	1 Month	Counselor, MO and PM-TI-NGO/CBO	In Progress
Round 1			DMC/D OTS	Facility Level		Multiple Visit due to Stockouts	Ensure regular provision of stock and timely indent of stock.	Availability	1 Month	TBHV, STLS, PPSA	Deferred/P ostponed
Round 1			DMC/D OTS	Facility Level		Redressal box Old/ damaged	Arrange a temporary box with proper labelling and Request to be raised for a new box with a lock key.	Availability	1 Week	TBHV, STLS, PPSA	Deferred/P ostponed
Round 1			DMC/D OTS	Facility Level		All Sign boards removed during hospital refurbishment.	Arrange temporary sign boards at strategic locations by consulting the Hospital superintendent	Accessibility	1 Month	TBHV, STLS, PPSA	Deferred/P ostponed
Round 1			DMC/D OTS	Facility Level		Congested waiting area and no adequate seating arrangement	Provision of adequate seating arrangement by maintaining physical distance.	Appropriateness	1 Month	DTO, CTO, Hospital Administration	Deferred/P ostponed

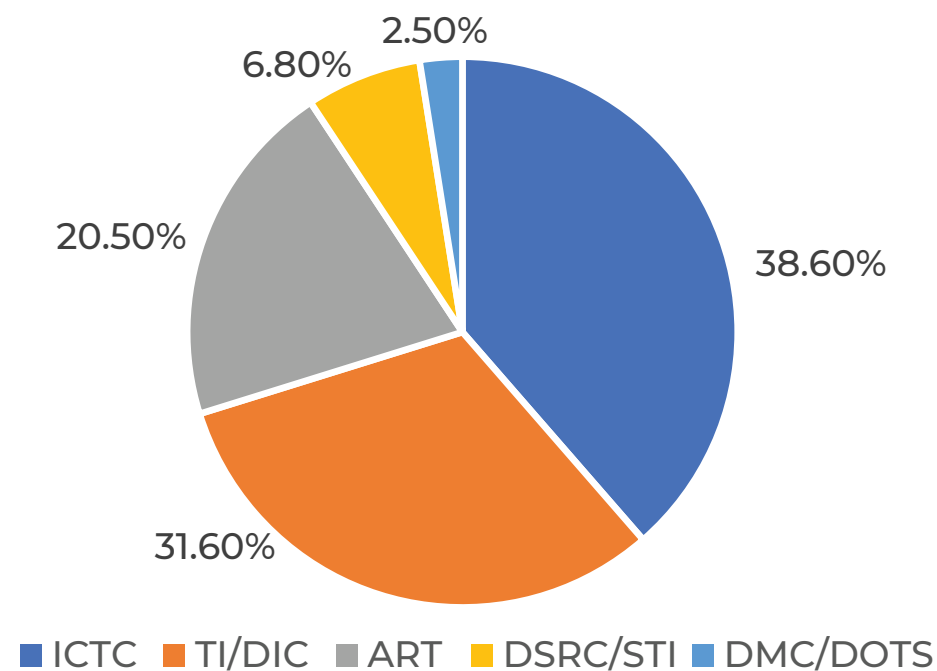
CLM Dashboard Snippets

Sample:
Tracking Progress
 State Wise
 (Maharashtra)
 Dashboard to
 Track Progress
 of Action Points

Maharashtra Progress of Action Points

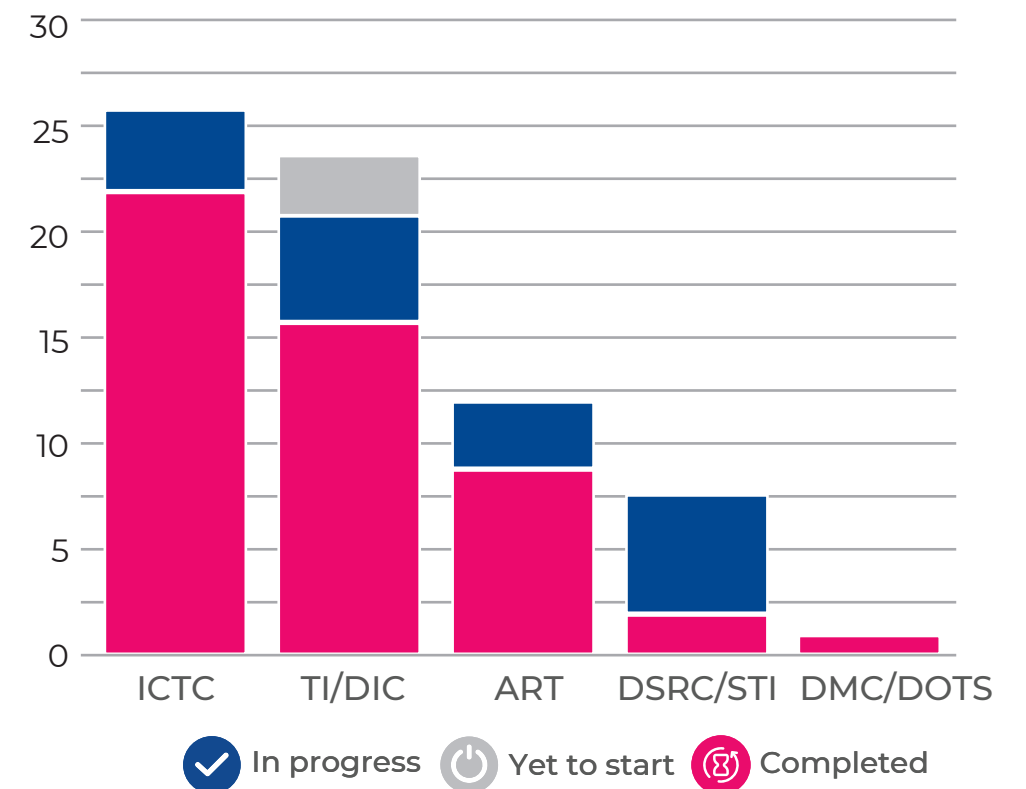


Type of Facility - Number of Action Points



Maharashtra By Type of Facility
 Total Actions (Progress)

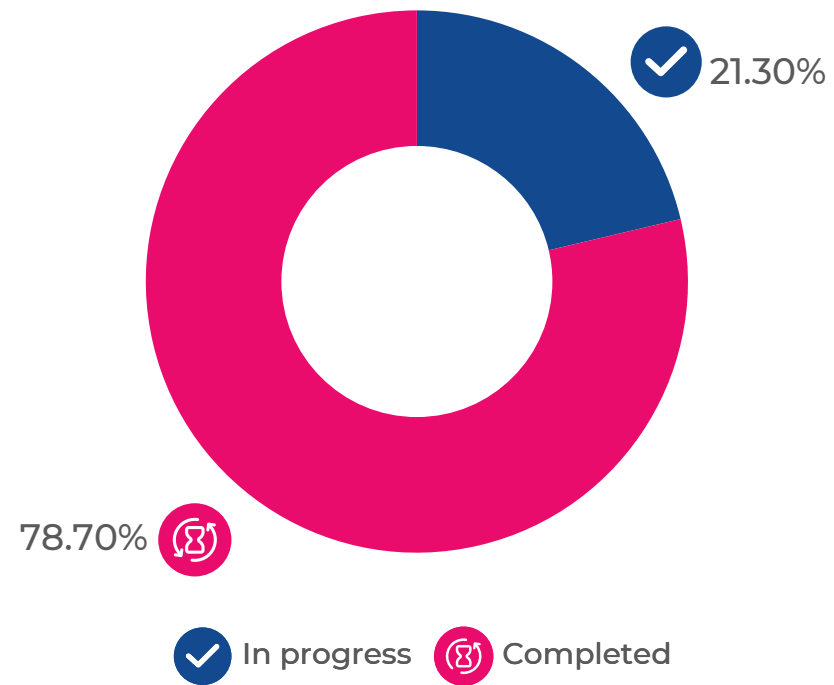
Facility Wise Progress of Action Points



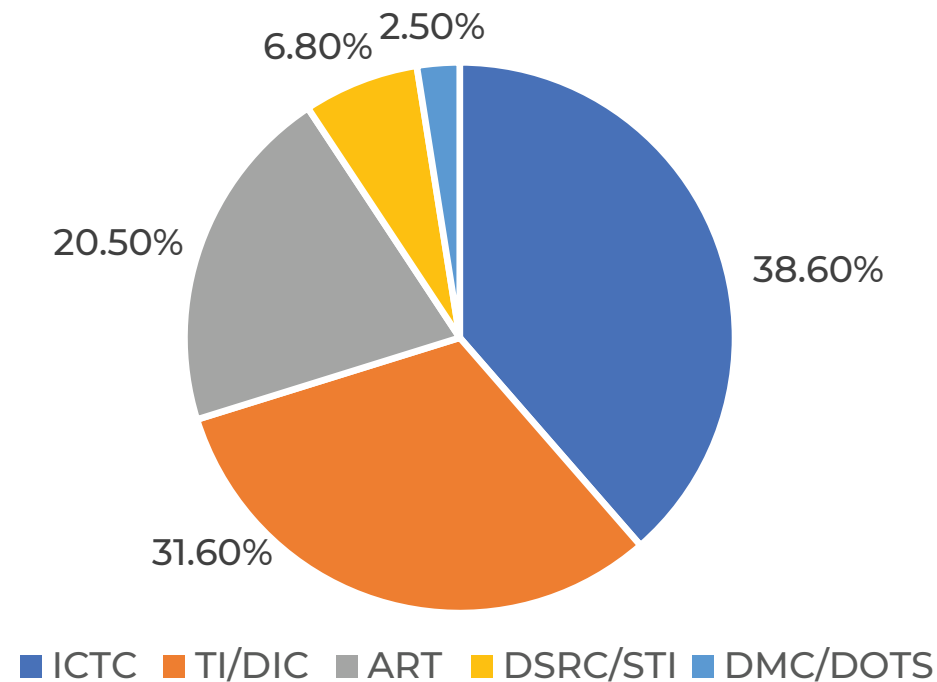
Sample:
Tracking Progress
State Wise (Thane)
Dashboard to Track Progress of Action Points

*Thane By Type of Facility
 Total Actions (Progress)*

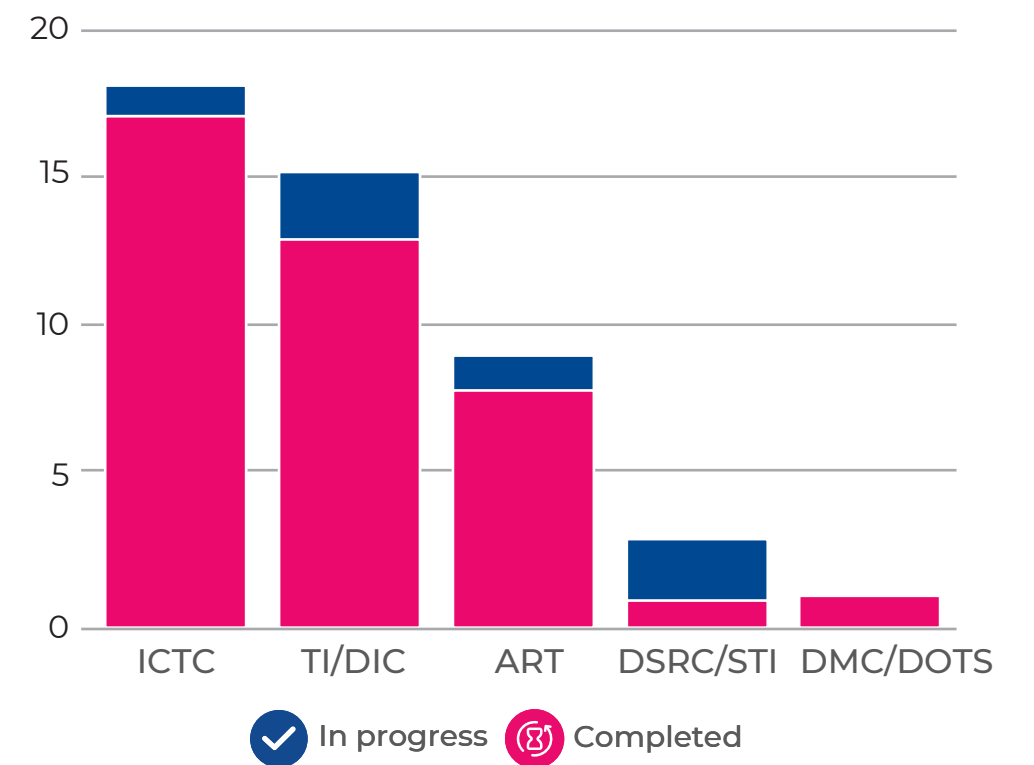
Maharashtra Progress of Action Points



Type of Facility - Number of Action Points

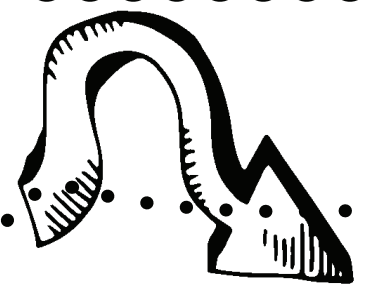


Facility Wise Progress of Action Points



Three things to remember when embarking on the Learning & Dissemination Workshop

A



1. The Community Leads

Just like the entire programme of Community Led Monitoring, the Community also leads the Learning & Dissemination Workshop.

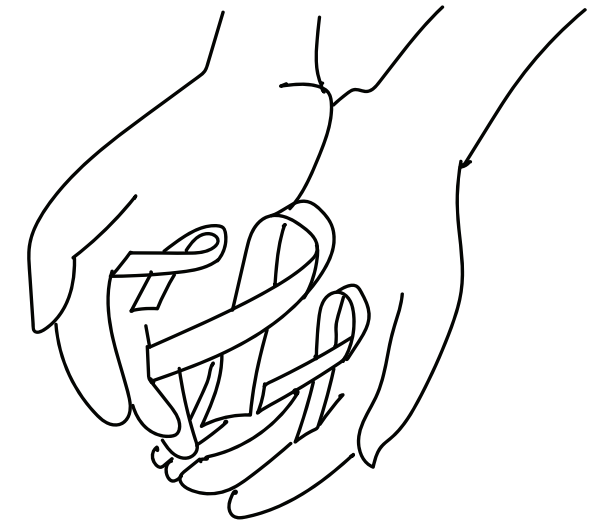
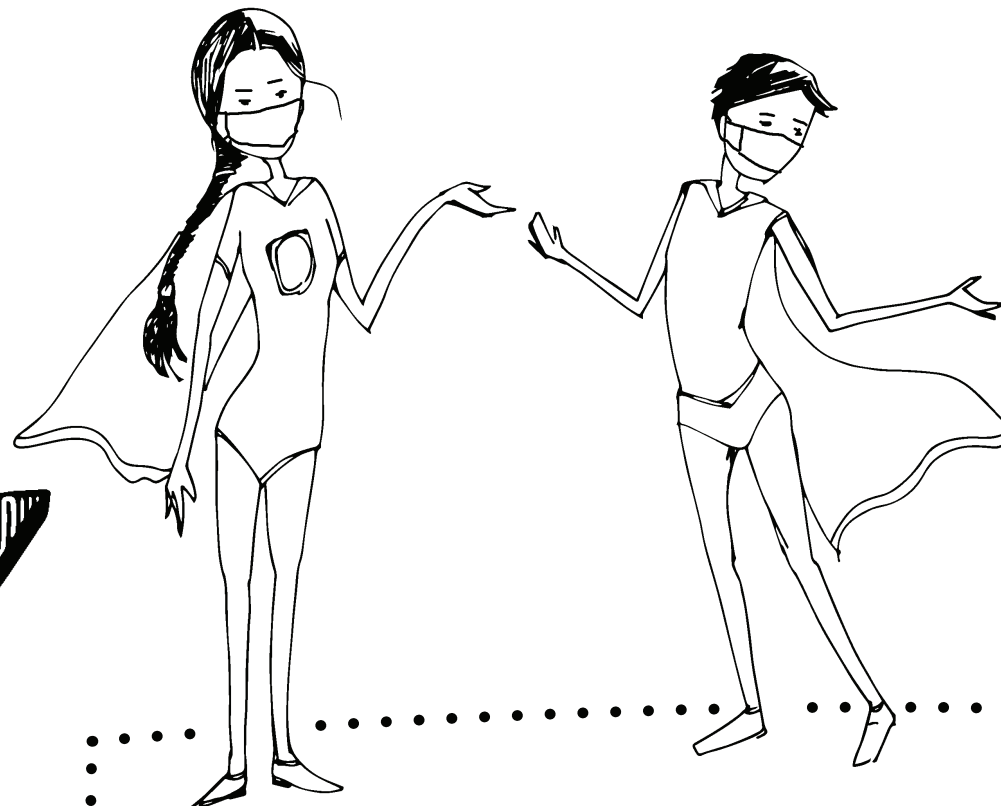
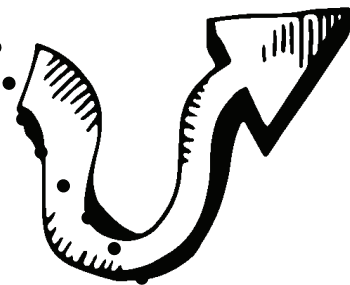
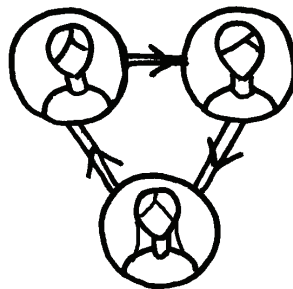
This means:

1. The Community Representatives co-create

- ⌘ The Guest List
- ⌘ Look & feel of the event
- ⌘ Order of Activities / Showflow

2. Community Representatives are the main speakers and take the roles of

- ⌘ Exhibition guides and speakers who explain the Process of and the Learnings from their work on Community Led Monitoring (CLM)
- ⌘ Panelists who discuss their Point Of View
- ⌘ Speakers who take the audience / participants through the insights around CLM



3. Community Representatives and their community's experiences of CLM is the central voice and spirit of the Learning and Dissemination Workshop. This is represented through

- ⌘ Giveaways that are designed to represent them and their work
- ⌘ Publications of their experiences in the form of Story Books

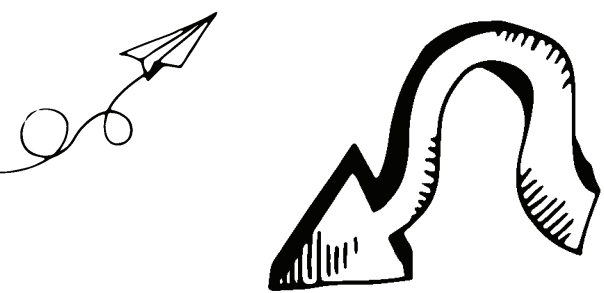
Note: Additionally, service providers are welcomed as

- ⌘ Speakers
- ⌘ Panelists



Three things to remember when embarking on the Learning & Dissemination Workshop

B



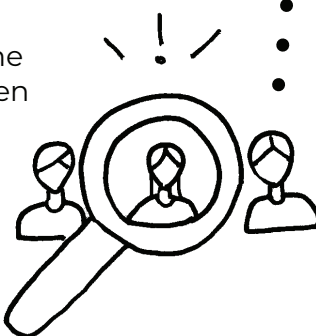
2. Evidence based, grounded showcase of CLM activities meeting its' goals, sharing learnings and celebrating successes is the central focus of the event.

It is imperative to showcase the following when designing the Learning & Dissemination Workshop:

Empathy in Action: On how CLM guided a deep understanding of the problem that both service providers and people from the Key Population and PLHIV communities face and empathizing with them.

Ideation in Action: Representing how the many ideas were developed and solutions co-created by Community Representatives and Service Providers; including sharing of what worked and what did not.

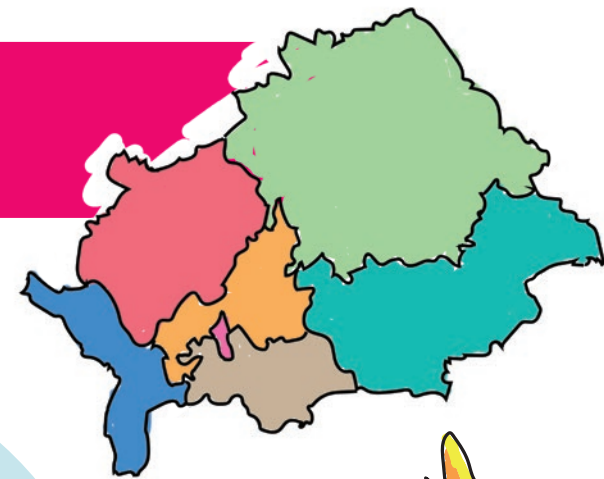
Prototyping in Action: By virtue of elements like Exhibitions, Storytelling, Data Maps and the release of a range of artifacts - such as Process Documents, Storybooks and Playbooks - showing the prototype of potential solutions and then testing it with real users.



3. Adoption of 4 spatial design elements to ensure the event is friendly, festive and engaging.

What?	How?
Easy to read content displays with data maps and visual guides so Community Representatives can use the same to spur their storytelling.	Consider large sized panels / posters with illustrations and pictures instead of closed booths and pamphlets to help Community Representatives navigate better and not be confined within a space.
Inclusion of audio/visual elements	Consider photo galleries and video introduction of products
Multilingual interaction throughout the programme	Ensure that the host / emcee of the programme is multilingual and able to converse with ease with all present.
Space for ALL community representatives to participate during the programme	Logistically, ensure that the showflow allows for participant / audience interaction - not just in Q&A but also in terms of remarks and comments; that there are enough hand mics to go around the room and the room has aisle spaces created for swift movement if any participant wishes to come on stage to speak about their lived experiences.

STORIES FROM CLM, MAHARASHTRA



DISTRICT: THANE



Good Practice#1:

Community taking lead in enhancing the HRG clinic footfall at the ICTC-IGM Bhiwandi ICTC-ART-DMC-TI

Background:

During the process of client feedback, it was observed that the KP/HRG clinic footfall across ICTC, ART, DSRC and DMC was considerably low. This issue was highlighted by the Community Representatives during a feedback session. In the subsequent Solve Card Co-Creation Workshop, it was discussed with all key stakeholders involved and was recommended that coordination meetings across the facilities needed to be enhanced, to resolve the issues to achieve the overall 95-95-95 goal at the district level by 2030.



Key Observation:

Low clinic footfall at IGM Bhiwandi ICTC-ART-DMC-TI

Learnings:

Enhancement of programmes and addressing of field level issues does not need SACS or NACO intervention at every step per se, but it was the ownership and leadership of the district authorities in escalating field level issues on time, by involving the service beneficiaries and service providers that actually enhances quality of service delivery.



Key stakeholders:

Service providers of TI, ART, ICTC & DMC, DSRC and Community Representatives, DPM, CBO

Replicability and Sustainability:

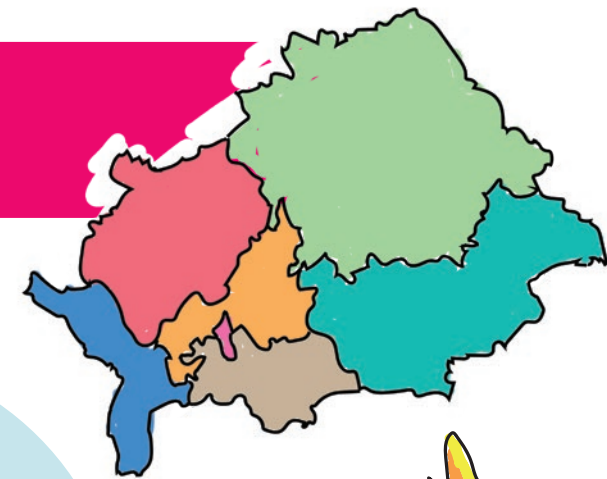
It can be replicated across the districts through DAPCU/CRG (CRG) by involving all the concerned stakeholders on a monthly basis through regular meetings or communication as well as proactive participation of the TI NGOs.

Impact:

Real-time field level issues faced by the HRG/KP were addressed and then escalated on time at the local level. This was possible due to the regular monthly meetings that were conducted by the service providers, which led to increased footfall across the facilities. A 100% confirmatory test at the ICTC was ensured by the TI NGO CBOs in coordination with ART staff, for those HRG KP's who were screened reactive during the CBS camp.



STORIES FROM CLM, MAHARASHTRA



DISTRICT: THANE



Good Practice#2:

Pre-post test counselling enhanced at ICTC and ART centre-Rajiv Gandhi Hospital -Kalawa and Chaya Hospital Ambernath ICTC

Background:

This issue was highlighted by the Community Representatives during the Co-creation of solution Workshop held in December 2021 and it was recommended that coordination meetings across the facilities need to be enhanced to ensure quality service delivery.

Key Observation:

Due to a heavy client load, lack of pre and post test counselling at the ICTC and ART centre at Rajiv Gandhi Hospital -Kalawa and Chaya Hospital Ambernath ICTC.

Learnings:

MO is taking lead and ownership to supervise and monitor the quality of pre and post test counselling and adherence counselling at ground level.

What people have to say:

Gulab (TG Community) Counseling gives the platform and opportunity for clients to express all their questions and eliminates the fear of taking the HIV test. In the Kalwa Hospital, all the required information related to HIV during pre and post-testing counseling has been initiated by facilities. Now we don't hesitate to do HIV testing hence, we encourage and motivate other clients to get tested as well.

Key stakeholders:

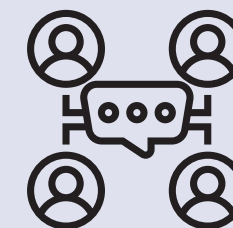
ART, ICTC, Vihaan, Network, CRG

Replicability and Sustainability:

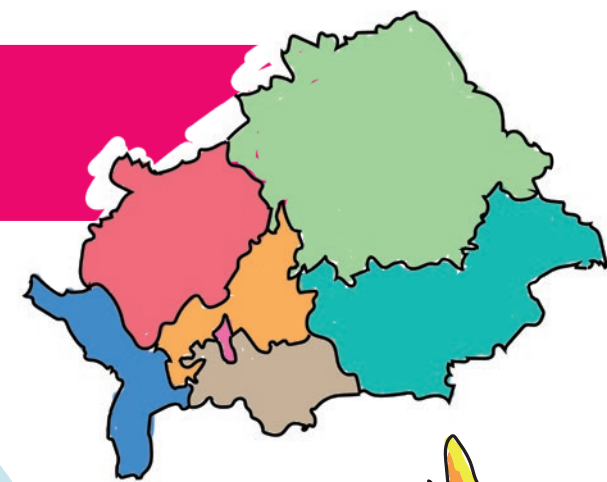
It can be replicated across the districts through DAPCU by involving all the key stakeholders on a monthly basis.

Impact:

Adherence counselling has been initiated by the ART with handholding support from other stakeholders who provide counselling for ART programs e.g. Networks, VIHAAN, etc. One to One Counselling with FSW/KP and Counselling timings has increased as per the KP/HRG population's availability.



STORIES FROM CLM, MAHARASHTRA



DISTRICT: THANE



Good Practice#3:

Increased community mobilisation activities at the field level resulting in better footfall- TI/DIC: Sankalp Rehabilitation Trust, Action Research Centre, Ekta Equal TG, Alert India - Turbhe FSW, Kinnar Asmita 1, Aastha Pariwar

Background:

This issue was highlighted by the key service beneficiaries and Community Representatives during the Solve Card Co- Creation Solution Workshop held in December 2021 where it was discussed with all key stakeholders involved and it was recommended that community mobilisation activities were taken up while following COVID 19 protocol to increase the KP/HRG footfall at the TI+DIC.

Key Observation:

There was minimal Community Mobilisation activities at the hotspot level leading to low TI+DIC footfall.

Learnings:

Community Mobilisation activities are now being introduced in hotspots. HIV testing camps have been initiated with ICTC. Also, most of the events are scheduled as per community convenience.

Feedback from the field:

The community program did not take place in the area for about 1.5 years as it was very important to maintain social distance during COVID-19. There were also no HIV testing camps, and ICTC's coordination was also reduced.

"The coordination with ICTC was newly established in Thane. Now, testing camps and community programs have been started at the field level. This community program has helped to increase the HRG/KP footfall". - Shaukat Ali, Sankalp IDU TI NGO, Mumbai, Thane

Key stakeholders:

TI+DIC, CRG, CC, Community, TSU-PO

Replicability and Sustainability:

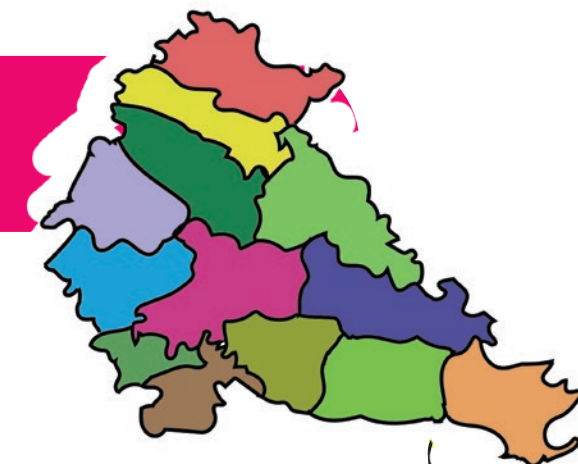
This practice has been initiated at all TI+DIC in Thane district along with ICTC centre coordination. Also DAPCU involves all the key stakeholders on a monthly basis.

Impact:

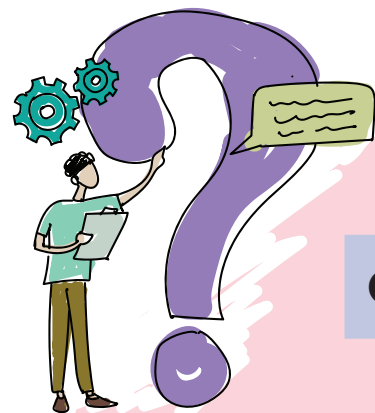
Community events have been conducted by TI+DIC. The coordination meetings have increased among ICTC centres and TI+DIC.



STORIES FROM CLM, MAHARASHTRA



DISTRICT: PUNE



Good Practice#4:

Regular condom demonstrations with the KP's at the Centre-Bharat Ratna Indira Gandhi Hospital, Mira Road DSRC

Background:

This issue was highlighted by the Community Representatives during the Solve Card Co-Creation Solution Workshop held in December 2021, where it was discussed and recommended that condom demonstration in a scientific manner needs to be carried out at TI+DIC and ICTC centre in order to educate the KPs/HRGs.

At the ICTC centre, the models were made available by co-workers, and training was given on carrying out a scientific demonstration by colleagues. The concerned DPM was informed and advised to leverage the existing functioning TI-NGOs to conduct staff refresher training on a periodic basis for continuous advocacy to undertake maximum condom demonstrations.

Key Observation:

There were hardly any condom demonstrations taking place at the centre.

Learnings:

Enhancement of programs and addressing field-level issues need ownership and leadership of the facility and district authorities in escalating field-level issues on time by involving the service beneficiaries and service providers.

Feedback from the field:

"Blind condom demonstration was very helpful for TG community to conduct a sexual activity during night as most of the clients refused to use condom during sexual activity". -Kiran (Banti) TG from Pune

Key stakeholders:

TI+DIC, ICTC

Replicability and Sustainability:

It can be replicated across the districts through DAPCU by involving all the key stakeholders on a monthly basis to maximise the Scientific condom demonstration at TI and CTC level and advocate safe sex practises.

Impact:

Scheduled onsite periodic training for the staff and the shared importance of condom promotion is critical in prevention programs for the KPs/HRGs initiated. It is observed that the footfall of KP and HRG has increased.



STORIES FROM CLM, TELEGANA



DISTRICT: HYDERABAD



Good Practice#1:

Setting up of a redressal mechanism at the Area Hospital Golconda - ICTC, DSRC, LAC, and PPTCT

Background:

The facility had a suggestion box, but it was not used by the KPs/HRGs to raise any issues or to lodge any complaints while they were accessing the services at the facility.

Feedback from the field:

Dilip, ICTC and LAC Counselor says, *"The process initiated helped us to understand the gaps in the program. It also gave us the platform to rectify matters and make changes for better service delivery and for building trust between the community and us."*



Key Observation:

There was no redressal mechanism at the facility level.

Learnings:

The overall process enhanced the quality of service delivery and also established trust between the service providers and the clients.

Prem, MSM says, *"We are happy that our issues and problems are solved very quickly. Now we feel happier about visiting the facility."*



Key stakeholders:

Area staff, hospital management, CAB



Replicability and Sustainability:

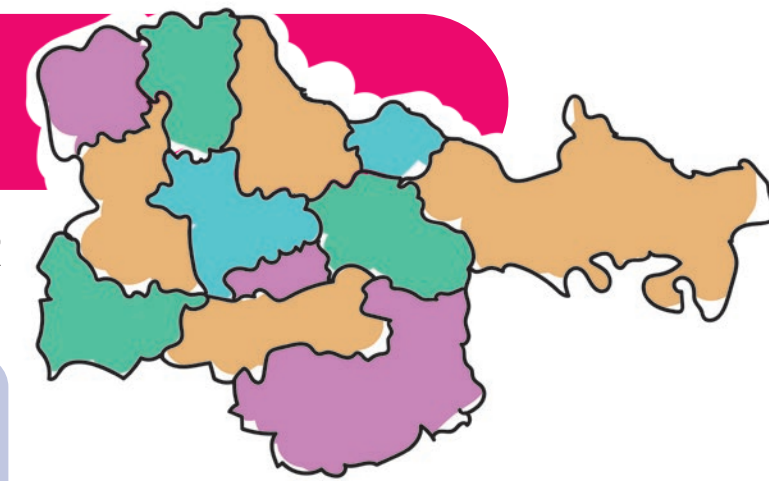
As this practice was implemented by the facility staff, it can be easily replicated across other facilities as well, because it requires minimal effort, making this a sustainable practice.



Impact:

Issues related to the KP/HRG accessing the facility were addressed on a periodic basis. Consequently, the clients were happy that their concerns were addressed and changes were made at the facility level by the service providers. Due to the implementation of solutions, the number of clients accessing the services increased, and the quality of the services also improved.

STORIES FROM CLM, TELEGANA



DISTRICT: KARIMNAGAR



Good Practice#2:

Developed a regular follow-up mechanism for PLHIV to ensure adherence to treatment.

Background:

During the stage two process of information gathering in various ART centers, it was observed by the CRs that HIV-positive individuals were not coming to the center regularly every month. So, to reduce skipping of visits by clients and to bring back missing clients, the Huzurabad LAC counselor developed a technique to ensure that all the clients were easy to track and follow up. The counselor developed a single biodata format so that the name and contact details of the client, as well as the names and contact details of all the family members of the client were entered into the sheet. This made it easy to track and follow up with the clients every month and facilitated the counselors in tracking who was accessing the services and who was missing them.

Similarly, all client deaths were also recorded following the same criterion. As a result, the clients started visiting the centre regularly and getting ART drugs from LAC. More than 95 percent of the clients are now taking medicines from this LAC.



Key Observation:

No suggestion box was available at the center, and there was no display of the timings at the facility. Gap in uptake of ART services by the PLHIV who belong to the HRG /KP

Learnings:

Regular coordination meetings of the NACP facility staff will help in addressing and resolving issues in improving the quality of services promptly and effectively



Key stakeholders:

ICTC, LAC – staff, hospital management, CRs, CAB members, KPs, HRGs

Replicability and Sustainability:

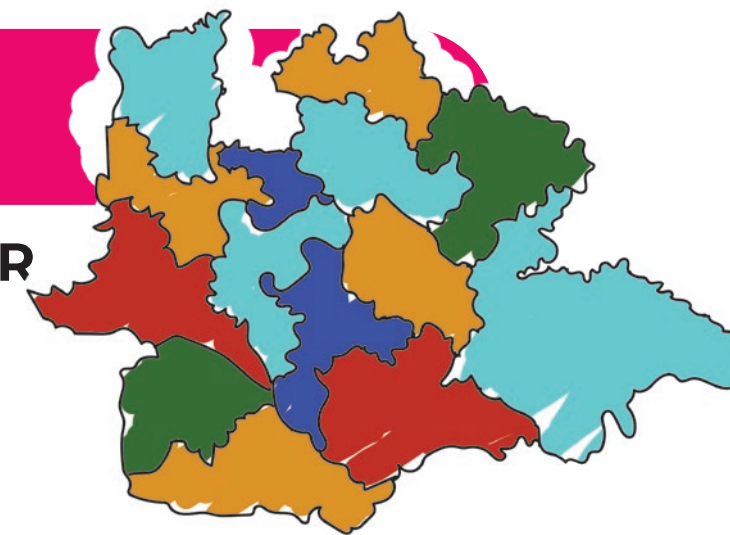
The follow-up mechanism / process pertaining to clients, KPs, and HRGs can be replicated in other facilities (i.e., ARTs and DMC-DOTs) by the concerned counseling staff without much difficulty. Also, the hospital management and the service providers need to continuously monitor and evaluate progress at every coordination and review meeting.

Impact:

The KP / HRG populations are now accessing the facilities and are getting services like quality counseling, access to waiting areas, toilets, etc. Illiterate PLHIV clients are prioritized and are continuously followed up by the counselors. They are called to avail ART from the LAC



STORIES FROM CLM, TELEGANA



DISTRICT: MAHBUBNAGAR



Good Practice#3:

Sense of ownership of the program by the district officials, DAPCU Mahabubnagar resulted in a positive impact on the overall program outcome.



Key Observation:

Lack of structured coordination and program review at the district level.

Key stakeholders:

DAPCU, facility staff (service providers), TUS PO, TI PMs, CRs, Swasti RIO

Replicability and Sustainability:

This practice can be replicated by DAPCU by taking ownership of the issues identified through the SOLVE card approach and by monitoring the progress of the resolution process. The continuation of this process of review, evaluation, and implementation by DAPCU has proved to be an efficient and sustainable approach.

Learnings:

Coordinating and collaborating with all key stakeholders, sharing responsibilities and highlighting achievements, and planning activities for the coming months are part of a systematic approach to the management of the CLM process at all levels.

Impact:

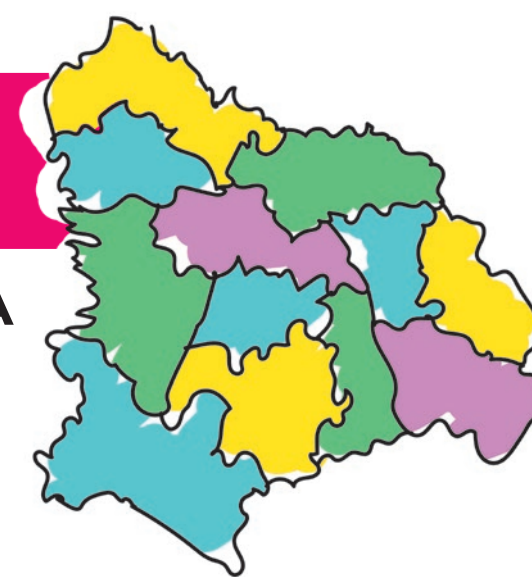
Ownership of any new initiative launched under NACP by DAPCU (ADMHO and DPM) was seen in the district. This was a major achievement in the district where DAPCU was leading the process alongwith the TSU / TI team. DAPCU reviews the recommended action points as one agenda item and brings them up for discussion during their review/coordination meetings at the district level. Progress in adopting solutions and in implementing the SOLVE card approach was observed and monitored by ADMHO and DPM. This indicates the ownership of the change by these stakeholders. During these review meetings, district-level stakeholders like TSU PO, TI PMs, the staff of local facilities, and Swasti RIO were also involved.

Background:

CRs visited different facilities in the district and identified various issues that impede, prevent, or discourage the KPs / HRGs from seeking access to the services at the facilities. This matter was brought up for discussion during the co-writing of solutions workshop by the CRs, CAB, and service providers. The issue was documented and submitted to DAPCU for escalation.



STORIES FROM CLM, TELEGANA



DISTRICT: NALGONDA

Good Practice#4:

Arranging of amenities at the ART Center through self-funding



Key Observation:

No seating arrangement and no drinking water facility.



Learnings:

When essential services — such as arrangements for a proper waiting area and drinking water facility — are provided at the ART center, the clients gain more trust in the counselors and in the system, which motivates them to adhere to ART and take their medication on time.



Key stakeholders:

ART staff, MO, counselors, hospital administration, DAPCU, PO-TSU

Replicability and Sustainability:

This practice can be replicated across the other facilities, as it requires proactive participation and a spirit of ownership on the part of the facility staff to enhance service delivery. The centers collectively mobilized funds, resulting in improved facilities and in more efficient services for the clients.

Background:

During the CLM pilot Stage 2 information-collection process, the CRs received feedback from the HRG/KP. The CRs also observed that the center had no proper seating arrangement and no proper drinking water facility.

The MO and the counselors coordinated activities, collected funds with the help of the local people, made seating arrangements for clients, provided three fans, and arranged for drinking facilities at the center.



Feedback from the field:

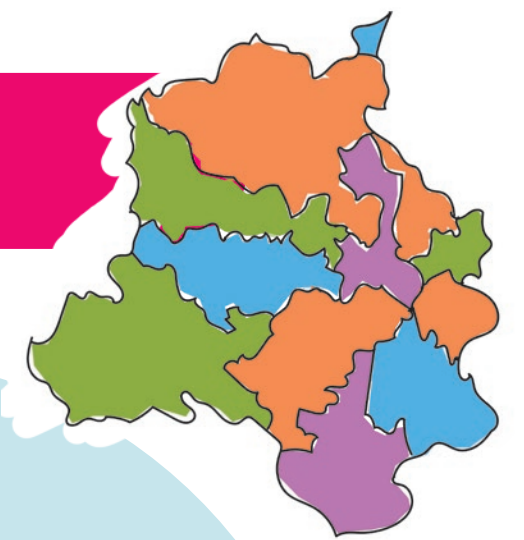
“The community recognized that the facility staff was working beyond their mandate to ensure that the clients were satisfied with the services provided to them.” **Community Representatives**

Impact:

With the provision of proper waiting facilities and arrangements for drinking water, the footfall at the center increased, the service uptake by clients rose, and the clients' trust in the counselors also increased.



STORIES FROM CLM, DELHI



Good Practice#5:

At the ART Center, Treatment Preparedness, Adherence counseling is diligently conducted so that the PLHIV who are on ART treatment can take their medications diligently as prescribed, the clients are able to discuss their concerns pertaining to the treatment with the counsellor leading to better awareness about treatment side effects.

Impact:

This has led to treatment adherence, less loss to follow up and better treatment outcomes for the clients.



Good Practice#6:

At DSACS, NACO conducted a two-day training for DSACS staff on the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Act, 2017. As a follow-up to this, trained staff from DSACS will conduct a training for the staff.



Good Practice#7:

At LNH, a designated room is provided for the CRs to conduct interviews, ensuring privacy at all times.

Impact:

The clients (KP's) were able to have an open conversation with the Community Representatives and could voice their concerns in private, comfortably after a designated room was provided to carry out the process of information collection. It provides a secure environment for the interviewee and emphasizes the importance of respect for the client (KP's).



Impact:

During CLM data collection, it was found that 90% of the patients and service providers were unaware of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Act, 2017. For them, it is very important to be aware of the legal and human rights of persons infected with and affected by HIV and AIDS. It also seeks to protect the rights of healthcare providers.



Good Practice#8:

At TI DIC, GB Road, the staff are supportive and receptive. They said that the TI is always open to the community during the mandated hours, especially in times of crisis. Clients are generally comfortable sharing their problems with the staff.

Impact:

The TI- DIC has high footfall at the centre, it is a safe space for the Female Sex Workers as it has created an enabling environment for the FSW.

ANNEXURES

Annexure 1: Month-wise timelines for CLM Round 1

	TELANGANA	MAHARASHTRA
Stage 1	January 22 – July 27, 2021	January 22 – July 28, 2021
Stage 2	July 9 – September 22, 2021	June 24 – December 29, 2021
Stage 3	December 12, 2021 – January 20, 2022	December 21 – 29, 2021
Stage 4	February 10 – 23, 2022	January – April 2022
Stage 5	Ongoing	Ongoing

Annexure 2: Definitions of the six As

- 1. Availability:** Availability is defined in this Community Report Card in terms of availability of commodities/ services, including condoms, lubricants, and lab tests. Availability here means readily available products/ services at the facility.
- 2. Accessibility:** Accessibility is defined in this Community Report Card primarily in terms of location and time. Accessibility measures the ease of reaching the facility and of gaining access to the services. Accessibility in terms of location is defined in this Community Report Card as convenience in terms of the placement or location of the facility from the residence of the client. It is scored based on travel time and distance from the client's residence (considered in Round 1) and on the ease of reaching the facility. It also covers timing accessibility, which is defined in terms of the timings of the facility being reported as convenient and the waiting time being reasonable as reported by the client community members.
- 3. Acceptability:** Acceptability is defined in this Community Report Card in terms of the behavior, conduct, or attitude of the facility staff toward the client community members in terms of bias, stigma, and discrimination. This includes if the client was treated with respect and if the facility offered a safe environment during the time of the visit.
- 4. Affordability:** Affordability is defined in this Community Report Card in terms of whether the client was asked to buy or pay for commodities or services at the facility.
- 5. Accountability / Responsiveness:** Accountability is defined in this Community Report Card as the client community members reporting that the issues that they had faced and reported (or shared) have been resolved. It also refers to the accountability of the staff to provide accurate and relevant information to the client community members in any given situation and when required. It also covers the components required for high-quality service delivery that are the responsibility of the service provider.
- 6. Awareness:** Awareness is defined in the Community Report Card as the understanding that the client has about the various services being provided. This includes knowledge of the HIV/AIDS Act 2017, along with the client's experience of providing consent before availing a service at the facility.

Annexure 3: CommCare app - It's uses and benefits

The CommCare application (app), which is an Android-based app, was adapted by Swasti to aid the gathering of information at the facility and client levels by the CRs.

CommCare is an open-source platform used to build Android-based mobile apps that are designed to support frontline workers across a variety of sectors in low-resource settings. Frontline workers use CommCare to track and support clients with registration forms, checklists, SMS reminders, and multimedia messages, all on Java-enabled phones or on Android smartphones and tablets.

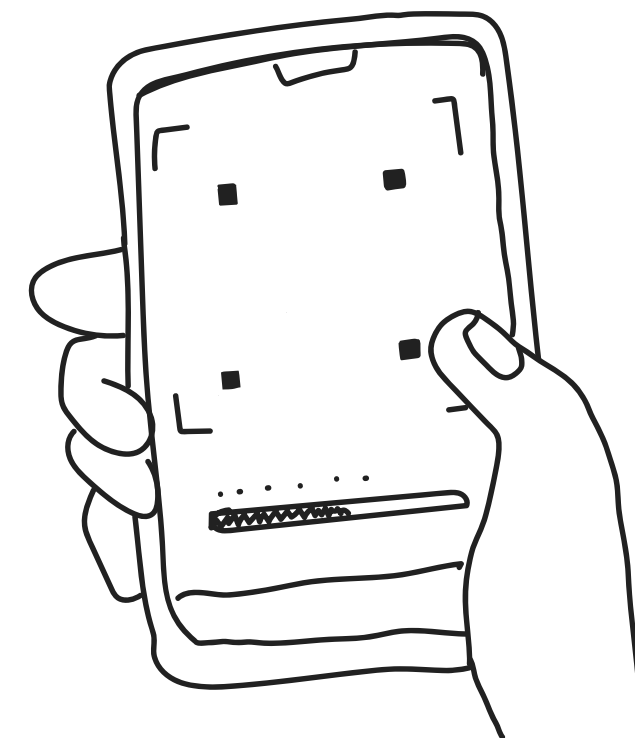
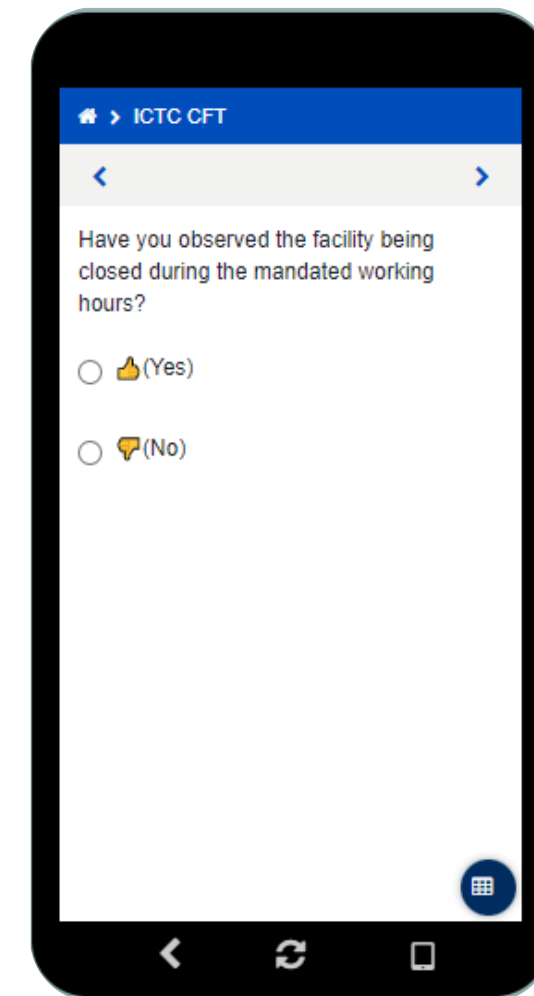
CommCare automates data collection from the field, minimizes errors that occur when collecting and processing data by hand, and expedites evaluation of data. The CommCare platform is customizable to the specific monitoring and evaluation needs of the CLM pilot project. For the program team, it was important to finalize the questionnaires before building the app, since even small changes to the questionnaire would require major adjustments to the app.

Even though there were challenges in designing a customized tool, the advantages of doing so far outweighed any potential roadblocks: the CommCare system dramatically reduces the time devoted to data collection, data transfer, and report production. The system facilitates data usage and analysis through the automatic transmission of data from the field to the monitoring, evaluation, research and learning (MERL) team at Swasti.

The CLM tools were translated into three languages, i.e., Hindi, Telugu, and Marathi. The translated tools in Telugu and Marathi were uploaded to CommCare.

Benefits of using the CommCare app

The app is downloadable on Android phones. It can be used in offline mode, as the Internet is used mainly for the installation of the app and for syncing the information gathered.



Annexure 4: Grading scale

The CFT includes a list of qualitative questions that are scored with the use of smiley faces for ease of understanding at the community level. Each smiley face option is assigned a particular weighted score that is used to calculate individual scores per client. In addition, there is also a list of questions in the FAT, similar to a checklist, on the availability and accessibility of specific products and services. A score of the service is calculated on the basis of the accumulated scores of each questionnaire, as explained below.

The responses to the questions were bucketed into two scoring patterns. This was because there were mainly two types of questions.

First, the answers to questions have two options: 'yes' (👍) and 'no' (👎). Second, some questions offer multiple choices as answers which range on a 5-point Likert Scale, represented by emojis, depending on the hierarchy of the choices.

To avoid any contradiction in the yes/no questions (e.g., yes, the medicine was available), we have maintained a 0 score for the worst option (e.g., very unhelpful).

and the worst choice for the 5-point question, we have maintained a 0 score

For example, the question 'Were the timings of the faculty convenient for you?' offers the following options: Very Inconvenient **(1)**, Inconvenient **(2)**, Average/Okay **(3)**, Convenient **(4)**, Very Convenient **(5)**.

In this example, even the worst possible choice. i.e., "Very Inconvenient" (Score – 1) is added to the final score and has the same scoring as that of a yes (👍) choice.

To make the distinction clear, we would rather score the answers on a scale of 0 to 4 so that negative choices do not have a positive impact on the score.

Explanation of the scale:

Scoring	(0)	(1)	(2)	(3)	(4)
Type 1	👍	👎			
Type 2	🙄 (score 0)	😞 (score 1)	😐 (score 2)	😊 (score 3)	😄 (score 4)

Annexure 5: Facility Report Card

TELANGANA

Example of a report card: | District: Mahabubnagar | Facility: ICTC

Facility name	Accessibility	Availability	Appropriateness	Acceptability	Awareness	Affordability
ICTC – CHC -SHADNAGAR	A	B	A	B	A	A
ICTC – DH - MAHABUBNAGAR	A	A	A	A	C	A
ICTC - SVS MEDICAL COLLEGE	B	A	B	D	A	A
SA – AH – ICTC -MAKATHAL	B	B	B	B	B	A
SA AH – NARAYANPET (V)	A	A	A	B	A	A
SA AH ICTC -GADAWAL	B	B	B	B	D	A
SA AH ICTC -NAGARKURNOOL	A	A	B	D	C	A
SA AH ICTC -WANAPARTHY	A	B	A	A	B	A
SA CHC – BADEPALLI (V)	A	B	B	B	A	C
SA CHC - ICTC KODANGAL	B	B	B	A	D	A
SA CHC ICTC -AMANGAL	A	B	B	B	A	A
SA PVT – MC – SVS HOSPITAL & MEDICAL COLLEGE (P)	B	A	B	A	A	A
SA – ICTC – CHC - ACHAMPET	B	A	B	B	A	A
SA - CHC ICTC - KALAWAKURTHY	A	B	B	A	C	A
SA - CHC ICTC -KOLLAPUR	B	A	B	A	B	A
SA – ICTC – CHC - ALAMPUR	A	B	B	B	C	A
Total	A	B	B	B	B	A

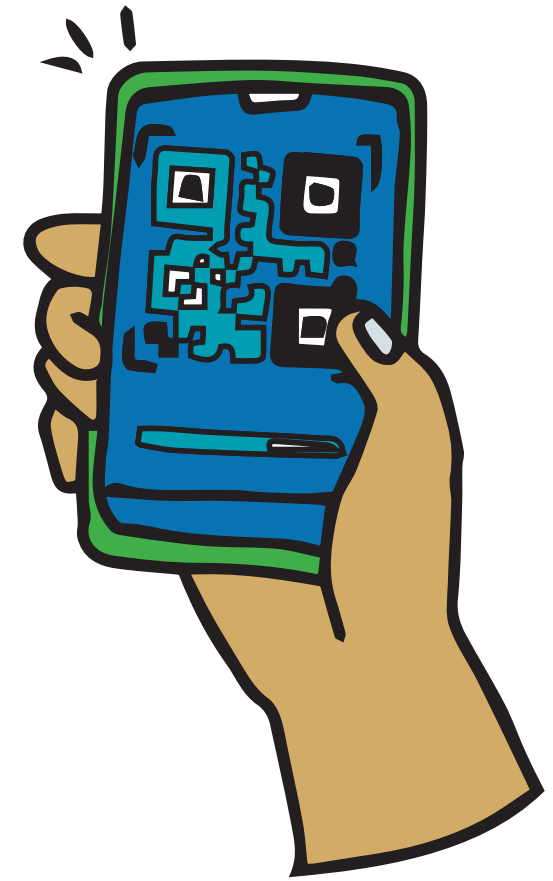
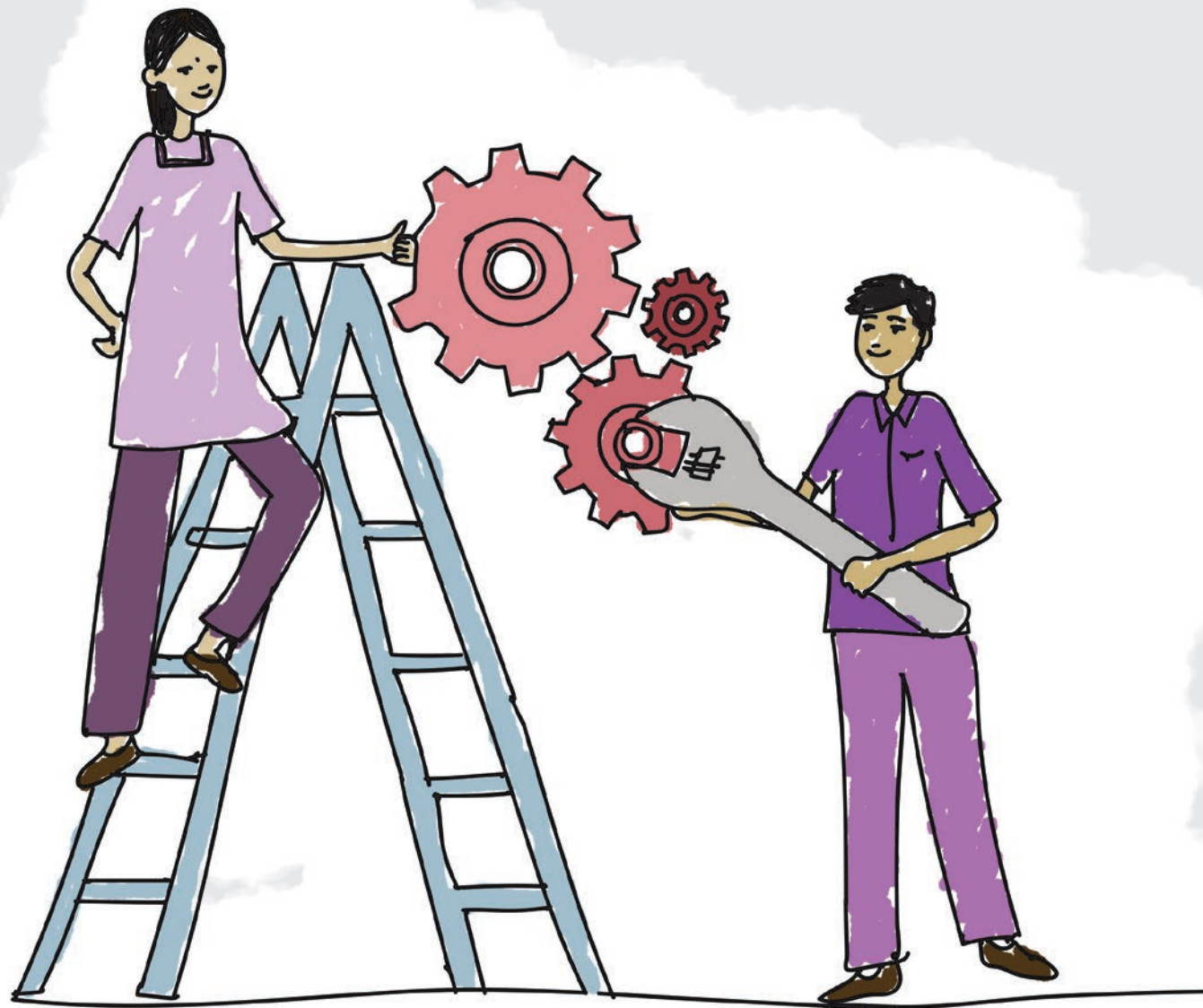
A	75% to 100%	C	25% to 50%
B	50% to 75%	D	0% to 25%

Annexure 6: Facility-wise action points – Telangana

Districts: Hyderabad, Mahabubnagar, Nalgonda, Ranga Reddy, Karimnagar

Annexure 7: Facility-wise action points – Maharashtra

Districts: Pune, Thane



Scan to access CLM tools



Closing Note

We at Swasti are grateful for the opportunity to support NACO in piloting the Community Led Monitoring initiative, with support from USAID/PEPFAR.

Swasti has over 18 years of experience with key population groups, PLHIV and affected groups and have been involved in the response to HIV across various countries. I am glad we were able to bring our lessons and expertise to this co-developing this methodology with all partners, especially the CSS National Working Group and have been able to demonstrate it in different geographies.

My gratitude to the teams at Swasti who worked through different waves of the Pandemic, especially wave 2, to ensure not just the achievement of results but also keeping all community representatives and themselves safe.

This playbook is our attempt to share our thinking and methodology with anyone who seeks to replicate or adapt CLM. Please do reach out to us at hello@swasti.org if you have questions and we look forward to working with you to end AIDS.

Shama Karkal
CEO, Swasti



@ShamaKarkal





About Swasti, The Health Catalyst

Swasti (Wellbeing in Sanskrit) is a global public health organization committed to adding 100 million 'wellthy days' for Vulnerable Communities. Our mission is to upgrade the discourse from health to wellbeing and bring the missing pieces in wellbeing together (social, behavioral, management and technology) around the technical/medical aspects, with a strong focus on Health Systems Strengthening for equity, and Community systems strengthening. Swasti is a registered not-for-profit organization and part of the Catalyst Group of institutions, having worked across 25 countries in South Asia, South East Asia, and parts of East Africa.

Swasti, The Health Catalyst is a global public health agency headquartered in Bengaluru, India.

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