SK PA·2

HEALTH EQUITY MATTERS

COMMUNITY-LED MONITORING OF HIV SERVICES TOOLKIT

A Guide for Key Populations

Updated August 2024

FOREWORD AND ACKNOWLEDGEMENTS

The *Community-Led Monitoring of HIV Services Toolkit* herein referred to as the toolkit presents a simple approach to measuring the quality of HIV services from the perspective of service users through Community-Led Monitoring[1] (CLM). The toolkit is designed to particularly address the needs of key populations, but it can be adapted to needs of any community accessing services.

Initially developed in August 2022 by Health Equity Matters (formerly AFAO) and its partners under the first *Sustainability of HIV Services for Key Populations in Asia (SKPA)* program (SKPA-1), funded by the Global Fund, the toolkit complements existing guidance on CLM (see Resources on page 38).

The original toolkit was piloted in Bhutan, Mongolia and Sri Lanka from November 2022 to June 2023 and, as result, it has been revised using the feedback and learning from CLM leadership and implementers in these countries. Updates to the toolkit include updates to the indicators, clarity on data analysis and use, additional tools to support establishment and management of feedback mechanisms, serious incident follow-up, case studies, and guidance on how to incorporate safeguarding approaches into the CLM process.

Health Equity Matters would like to express its gratitude to the Asia-Pacific Coalition on Male Sexual Health (APCOM), the Asia-Pacific Transgender Network (APTN), the Asia-Pacific Network of People living with HIV (APN+), the Asia-Pacific Network of Sex Workers (APNSW), and the Philippine NGO Pinoy + for their leadership in this area.

Health Equity Matters would also like to thank our partners who participated in the development of both toolkits: Save the Children Bhutan, the Family Planning Association Sri Lanka, the Community Health and Inclusion Association in the Lao People's Democratic Republic, the Youth for Health Center in Mongolia, the Burnet Institute in Papua New Guinea, Love Yourself in the Philippines, Estrela+ in Timor-Leste, and the Malaysian AIDS Council.

Thanks also go to the United Nations Joint Program on HIV and AIDS Regional Support Team for Asia and the Pacific (UNAIDS RST AP), the Global Fund, and the Seven Alliance, a consortium of seven regional networks, namely, APCOM, APTN, APN+, APNSW, the International Community of Women living with HIV Asia & Pacific (ICWAP), the Network of Asian People who use Drugs (NAPUD), and Youth Lead for their significant contributions. Finally, we would like to thank the Global Fund for their support.

We hope the toolkit will enable strong community leadership and improve HIV service delivery.

ACRONYMS AND ABBREVIATIONS

AAAQ	Availability, accessibility, acceptability, and quality
AFAO	Australian Federation of AIDS Organizations
APCOM	Asia-Pacific Coalition on Male Sexual Health
APN+	Asia-Pacific Network of People Living with HIV
APNSW	Asia-Pacific Network of Sex Workers
APTN	Asia-Pacific Transgender Network
ART	Antiretroviral therapy
CBO	Community-based organization
CLM	Community-led monitoring
CSO	Civil society organization
DHIS-2	District Health Information System Version 2
FGD	Focus group discussion
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
ICWAP	International Community of Women living with HIV Asia & Pacific
LGBT+	Lesbian, Gay, Bisexual, Transgender
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
M&E	Monitoring and evaluation
MOU	Memorandum of understanding
MSM	Men who have sex with men
MoH	Ministry of Health
NAPUD	Network of Asian People who use Drugs
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Fund for AIDS Relief
PLHIV	People living with human immunodeficiency virus
PrEP	Pre-exposure prophylaxis

QI	Quality improvement
QR	Quick response (QR) code
SIRRP	Serious Incident Response & Reporting Protocol
SKPA	Sustainability of HIV Services for Key Populations in Asia
SOP	Standard Operating Procedures
SPSS	Statistical Package for the Social Sciences
STI	Sexually transmitted infection
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UIC	Unique identifier code
UNAIDS	Joint United Nations Program on HIV and AIDS

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INTRODUCTION TO THE SKPA-2 CLM PROCESS

How to use this toolkit

- This toolkit is designed to provide a framework and a variety of tools to support your CLM efforts. Whether you are new to CLM or looking to enhance your existing practices, this toolkit is meant to be a flexible resource that you can adapt to meet your specific needs.
  - You are not expected to utilize every document, tool or resource in this guide.
- The toolkit provides an overview of planning, implementing, and data for decision making through strong community leadership.
  - The toolkit provides M&E tools and well-defined indicators that are linked to an internationally accepted service quality framework. These indicators can help community members advocate for changes with health facilities and providers.
- This toolkit includes suggestions on how to link service feedback and resulting action.
- Tools for serious incident follow-up and related indicators are included to help support those participants who may require individualized referrals to specialized services.
- CLM can take different forms in different country settings, and so the toolkit avoids being prescriptive about 'how to' implement CLM and focuses on presenting a process and general considerations for each stage of this process.
- The timeline for CLM data collection and analysis may vary depending on size of the program and budget availability.

WHAT IS CLM AND WHY IS IT IMPORTANT?

Community-led monitoring (CLM) is an important component of community engagement in program and service delivery. It involves activities that are carried out by community members to assess the quality, availability, accessibility and acceptability of the HIV and related health services they receive.

Although there are different definitions of CLM, they all share the following principles:

- CLM aims to collect and use information to advocate for improvements in HIV services for communities with a focus on key populations and people who are living with HIV.
- CLM is owned and led by communities whereby the communities decide what to monitor and how to use the data collected.

CLM shifts the dynamic from HIV service providers monitoring service quality to monitoring that is led by the people who use HIV services

This toolkit uses an adapted version of the most recent Global Fund definition of CLM applied to HIV-related health services[1]:

> Community-led monitoring is a systematic and routinely ongoing process designed and led by members of local community-led organizations to gather qualitative and quantitative information on health service delivery sites frequented by HIV-affected communities, and to analyze and use it to support quality improvement of HIV services, and accountability mechanisms and advocacy to increase uptake of and retention in HIV and related health services; thus, ultimately improving health outcomes for key populations.

[1] Information Note. Resilient and Sustainable Systems for Health (RSSH). Allocation Period 2023-2025. Date updated: January 2023. The Global Fund https://www.theglobalfund.org/media/4759/core_resilientsustainablesystemsforhealth_infonote_en.pdf. Accessed on May 5, 2024.

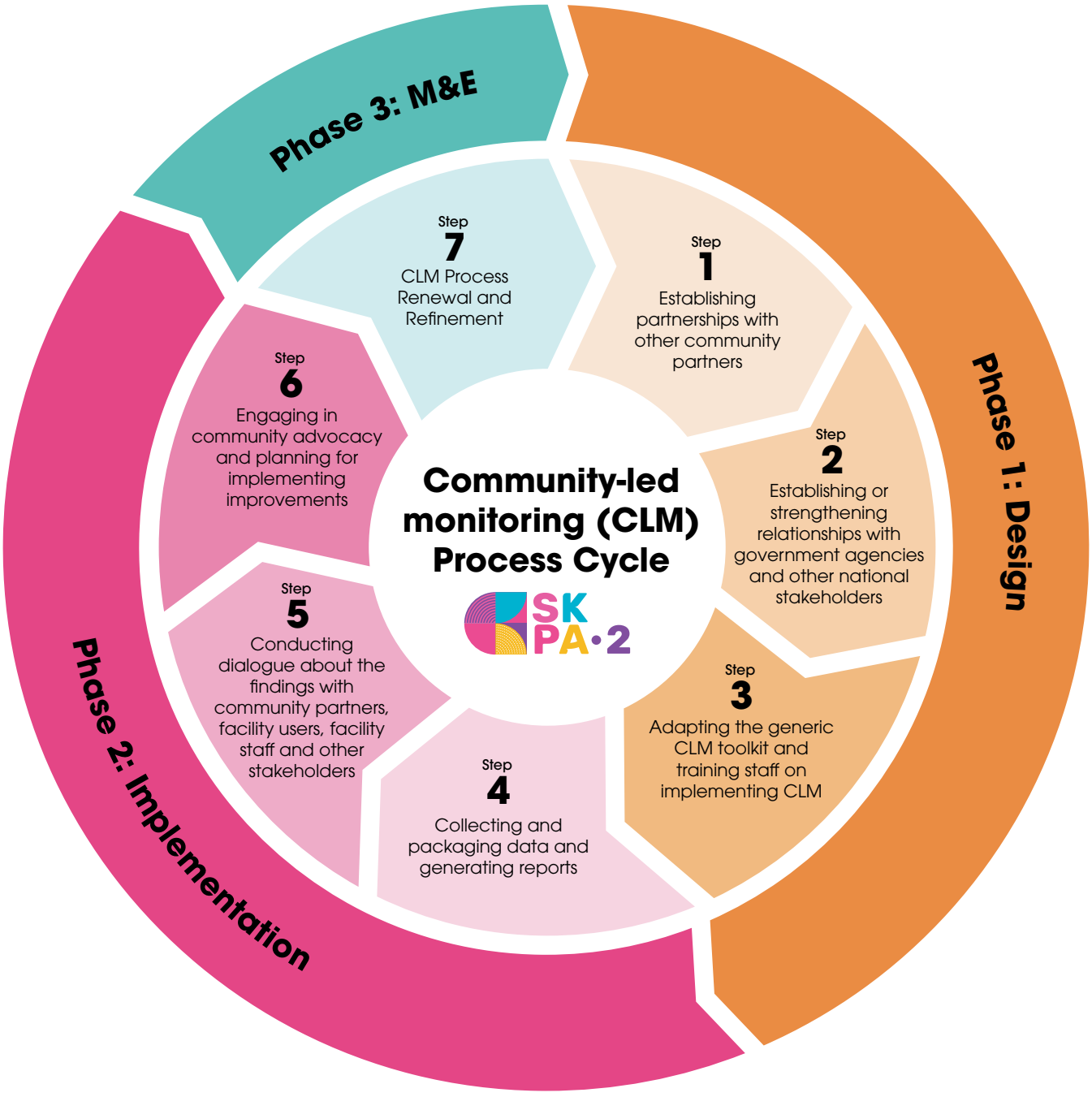
SKPA-2 CLM PROCESS: OVERALL FRAMEWORK & STEPS

The CLM process cycle

The CLM process is a continuous cycle with three phases (Design, Implementation, and M&E) and seven interconnected steps (see Figure 1). Each phase and step in the cycle is described below briefly.

A CLM Checklist has been developed to help implementers monitor their progress through each stage and step (Annex 1).

Figure 1: SKPA-2 CLM Process



PLANNING FOR MONITORING & EVALUATION OF CLM

Logical Framework

The logical framework in Figure 2 shows how CLM activities can contribute to improved HIV program outcomes and help to meet national targets. A logical framework is a tool that is used to describe how programs or activities are expected to contribute to desired results and outcomes.

Figure 2: Logical Framework for CLM[2]

Inputs and Processes	Outputs	Intermediate Outcomes	Outcomes
• Community Advisory and Technical Working Groups established • Safeguarding service and referral mapping completed • Agreements with HIV services in place • Serious Incident Response Protocol developed • Indicators agreed as per local context • Data collection survey tools finalized • Data management and analysis system established • Personnel trained and relevant equipment or supplies procured • Case managers recruited and trained • Data collection tools distributed • CLM demand generation/ awareness raising conducted	• Final TORs/SOPs • Stakeholder map, risk management assessment and referral linkages • CLM survey forms filled by respondents, data collected and analyzed • Attempts made to follow-up serious incidents • Serious incidents successfully followed up and referrals made • CLM indicators and results presented to HIV services • Dialogue and advocacy based on findings • Quality improvement action plans designed and implemented at facility/site level • Ongoing monitoring and refinement of quality improvement plans and AAAQ	• Improved availability of HIV services • Improved accessibility of HIV services • Improved acceptability of HIV services • Improved quality of HIV services • Increased satisfaction with HIV services	Improved utilization of key population HIV services and progress towards Global HIV and AIDS Targets[2]: • Increased access and use of appropriate, prioritized, person-centered, and effective HIV combination prevention options • Increased % of PLHIV who know their status • Increased % of PLHIV on ART • Increased % of PLHIV virally suppressed • Reduced prevalence of stigma and discrimination and other serious incidents in HIV service settings

[2] Global HIV and AIDS targets include: 95-95-95% HIV testing, treatment, and viral suppression; 95% access to prevention services for high-risk groups; 95% of women's sexual and reproductive health needs met; less than 10% stigma, discrimination, and punitive laws; and eliminating vertical transmission. (UNAIDS, 2022)

AAAQ Framework

The Availability, Accessibility, Acceptability, and Quality (AAAQ) Framework engages and empowers communities of people living with and affected by HIV to improve their health and hold decision-makers and service providers accountable for HIV service delivery. Definitions of availability, accessibility, acceptability and quality have been adapted for use in this toolkit to reflect the comprehensive package of HIV services for key populations and specific issues that are important for key population service users (Figure 3).

Figure 3: Availability, Accessibility, Acceptability, and Quality (AAAQ) Conceptual Framework

AVAILABILITY refers to the existence of HIV prevention and treatment health services. Countries may decide to include additional HIV-related services that are available and that communities want to monitor. See Figure 3 and the CLM client form (Annex 10) for a list of potential services.

ACCESSIBILITY refers to some or all of the following issues that can pose barriers to accessing services.

- Physical accessibility (whether the health facility is easy to reach/not too far)
- Opening times (whether opening days and hours are convenient/appropriate.
- Safety of the facility environment (sites free of violence and harassment in the surrounding environment and from staff)
- Financial accessibility (whether services are affordable)
- Administrative accessibility (whether it is easy to register and use the service or there are bureaucratic processes that prevent access)

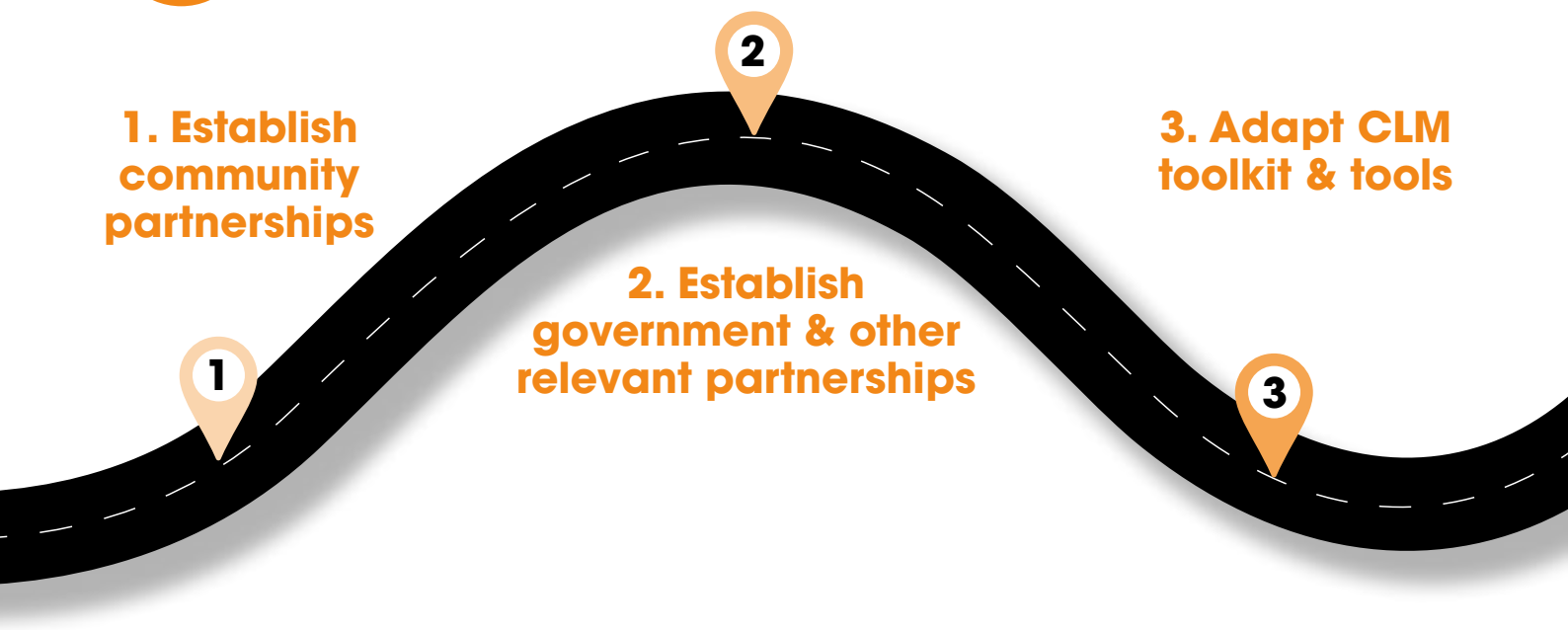
ACCEPTABILITY refers to how culturally and socially acceptable services are to users, based on some or all the following issues:

- Arrangements made for confidentiality and visual and auditory privacy of personal information during visit, and data security guaranteed after the visit
- Informed consent (whether informed consent is requested prior to clients receiving services)
- Equality, equity and respect for all service users (all are made welcome, with the same access to resources and services, and are treated fairly in addressing individual differences in needs, irrespective of culture, gender diversity, sexual orientation, age, or religion), and the use of appropriate pronouns by health care providers

QUALITY refers to the user's perception of service quality, based on some or all of the following issues:

- Knowledge, skills and professionalism of staff (the extent to which service users view staff as professional, qualified, confident, client-centered in their ability to answer questions simply and clearly and provide information options/alternatives and act on what clients need)
- Supplies (whether there is adequate supply of high-quality medicines, condoms, lubricants, other commodities)
- Comfortable environment that includes provision of suitable amenities, e.g., waiting room chairs, safe drinking water, clean toilets
- Timing (whether there are no long waiting times)
- Referral process is easy and streamlined
- Feedback options for clients at the facility such as a suggestion box, client satisfaction monitoring, exit interviews (ability to provide feedback about the service quality and confidence that it will be taken seriously)

PHASE 1: DESIGN



The design phase of the CLM cycle involves collaboratively developing a structured plan that outlines the stakeholders, process, tools and sites for monitoring and analysis.

Step ❶ Establish community partnerships

- Identify a lead organization that is trusted by key populations and has funding and staff available. To avoid a conflict of interest and bias in CLM findings, it is important that the selected organization is not involved in service delivery at the health facilities where CLM will be conducted.
- Establish a CLM Committee or Technical Working Group with key population representation. The committee, supported by the lead organization, should build partnerships with community organizations to ensure CLM is community-driven, inclusive of all key populations, and not monopolized by a single group.
- The development of a Stakeholder Map may help support identifying the appropriate organizations to engage (see Annex 2).

Step ❷ Establish or strengthen partnerships with government agencies and other relevant stakeholders

- Involve government agencies from the outset and secure their support for CLM. As CLM activities focus on health facilities, which are usually managed by government health authorities or operate under regulations defined by the government, it is critical to gain their support at the start.
  - Use the stakeholder mapping to help identify which organizations you should engage in the CLM.
- Other relevant national stakeholders and health authorities at sub-national level should be engaged, to ensure that CLM findings are accepted and used.

Step 3 Adapt the CLM Toolkit

This step outlines important considerations for tailoring the CLM toolkit to the local context, including identifying the focus population, selecting appropriate sites, addressing ethical concerns, planning for serious incidents, choosing suitable data collection methods, and selecting relevant indicators to measure outcomes. This toolkit includes adaptable templates for setting up your CLM program, such as:

- Annex 3: CLM Training Agenda
- Annex 4: Safeguarding Recruitment Checklist
- Annex 5: Informed Consent Form
- Annex 6: Code of Conduct for people involved with CLM activities

Focus Population and Eligibility Criteria

This toolkit is designed to address the specific needs of key populations, who face unique challenges related to HIV. In many countries, HIV remains concentrated within these groups.


ANNEX 10: CLM CLIENT FORM

Section 1: HIV/health service details and visit date

CLM form number

1. Today's date: Day / Month / Year
2. Location of the facility: Ward/Village; Town/District; Province/Region
3. Name of the facility
4. Date of clinic visit that you are providing feedback about: Day / Month / Year

Section 2: Feedback on the health service/s:

Availability of services:

5. Which service(s) did you seek at your clinic visit?

Sought service	Did you receive it? Yes	No
5a. Condom and lubricant supply	✓	✓
5b. HIV screening test	✓	✓
5c. HIV counseling	✓	✓
5d. HIV confirmation test	✓	✓
5e. Receive HIV test result report	✓	✓
5f. Anti-retroviral therapy (ART) initiation	✓	✓
5g. Anti-retroviral therapy counseling	✓	✓
5h. Anti-retroviral therapy (ART) refill, follow-up multi-month dispensing	✓	✓
5i. Viral load testing	✓	✓
5j. Post-exposure prophylaxis (PEP)	✓	✓
5k. Pre-exposure prophylaxis (PrEP)	✓	✓
5l. STI testing/diagnosis and treatment	✓	✓
5m. Opportunistic infection (OI) management and medicine	✓	✓

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Key Populations include:

- People living with HIV
- Men who have sex with men
- Transgender women and men
- Sex workers
- People who use or inject drugs

On the CLM client form (Annex 10), the key population of a client can be identified through the following:

- Gender (Q22)
- Organizational affiliation (Q23)
- Risk group (Q24a-h)

If none of the boxes from Q24a to Q24h are checked, it may be unclear whether the respondent belongs to a key population. This can make data analysis and advocacy targeting more challenging.

Key Considerations:

- It is generally better to exclude feedback from non-key populations in the analysis to ensure data accuracy.
- Some individuals may prefer not to disclose their behaviors or key population status on the feedback form.
  - One option is to analyze feedback from these individuals separately, as it may still offer valuable insights for service quality improvement.

For key populations who have not attended an HIV service in the last six months, conducting focus group discussions or key informant interviews can help understand their reasons for not accessing services, including prevention efforts.

Health Facilities and Site Selection

It is advisable to pilot the tools at two to four service delivery points before scaling up. Key aspects to consider during the pilot include:

- Types of facilities: A facility can be a public, private, or community-based site where key populations access HIV prevention, testing, or treatment services.
  - The CLM team and health facilities or National AIDS Control Programs should develop an agreement or partnership to support advocating for changes using the CLM results.
- The size and scope of the CLM program should be defined by various factors including:
  - Available funding
  - Capacity of CLM implementers
  - Location and prevalence of HIV and HIV services
  - Other locally relevant factors as agreed by the CLM Technical Working Group

Number of Services Visits vs. Number of Service Users

Each CLM client form corresponds to a single visit to an HIV service, meaning the denominator for most indicators is based on the number of service visits within a specific timeframe. This differs from the number of unique service users, as one individual may visit multiple times and complete several forms during the same period.

While it is possible to calculate the number of unique individuals receiving services through the use of a unique identifier code (UIC) on the CLM client form (Q23), challenges exist. Some countries have standardized UIC systems, but clients may struggle to remember their codes or prefer to remain anonymous, which can reduce participation.

For these reasons, the recommended unit of analysis for CLM is service visits rather than individual service users. This approach ensures feedback from every visit is captured, as each visit represents a unique experience and an opportunity for service improvement.

Ethical Considerations

Although CLM is a program activity and not research the following ethical principles should apply to all CLM activities:

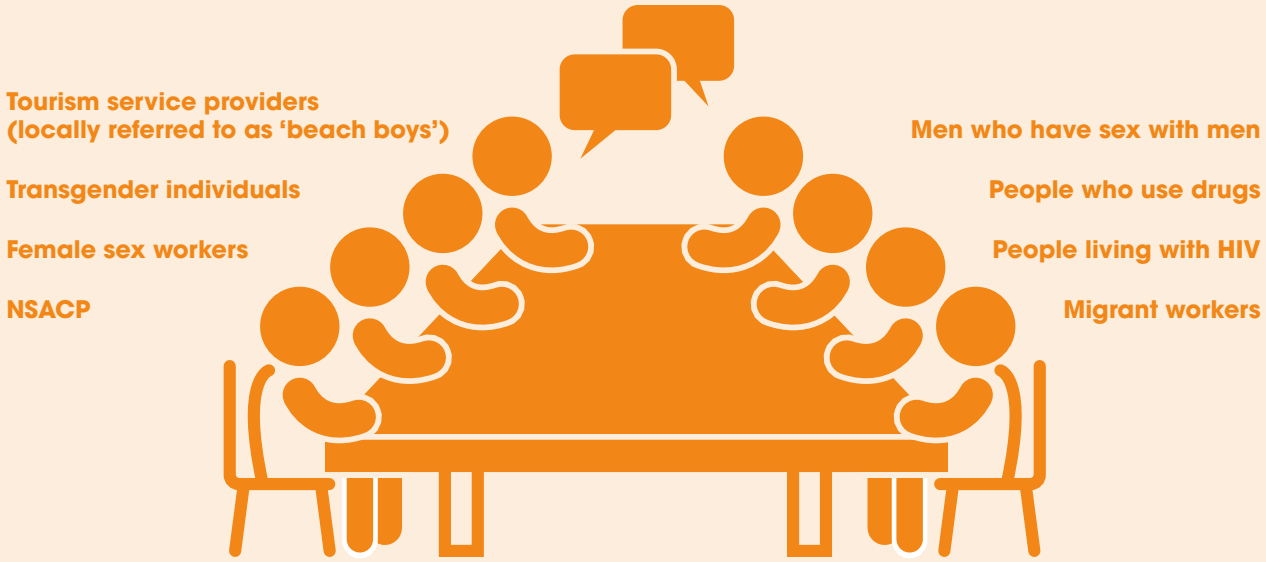
Ethical Principal	Description
Voluntary participation	Participation in CLM must be free from coercion, and participants can withdraw at any time without affecting their access to services.
Informed Consent	Informed consent is a voluntary agreement based on a clear understanding of the facts and implications, without threat or coercion. Before participating in CLM, individuals should understand the objectives, funding, time commitment, risks, and follow-up, enabling them to make an informed decision without penalties.
Confidentiality	Personally identifiable information should not be collected. Identifying information, such as telephone numbers in the case of serious incident reporting, must be stored securely and only used for service follow-up and referral purposes.
Anonymity	Protect participants' anonymity by not collecting names and addresses; only minimal identifiers (e.g., nickname, phone number) should be collected for follow-up on serious incidents.
Privacy	Ensure data collection and management protect participants' visual/auditory privacy and confidentiality, preventing any feedback from being linked to individuals.
Safeguarding	Safeguarding refers to the measures an organization puts in place to prevent it from doing harm to people in the delivery of its services or programs. Safeguarding in CLM involves implementing processes to prevent harm and addressing any safeguarding risks for participants.
Do No Harm	Everything should be done to ensure that individuals involved in CLM are safeguarded from any form of harm or abuse that could result from their participation.

CASE STUDY SRI LANKA

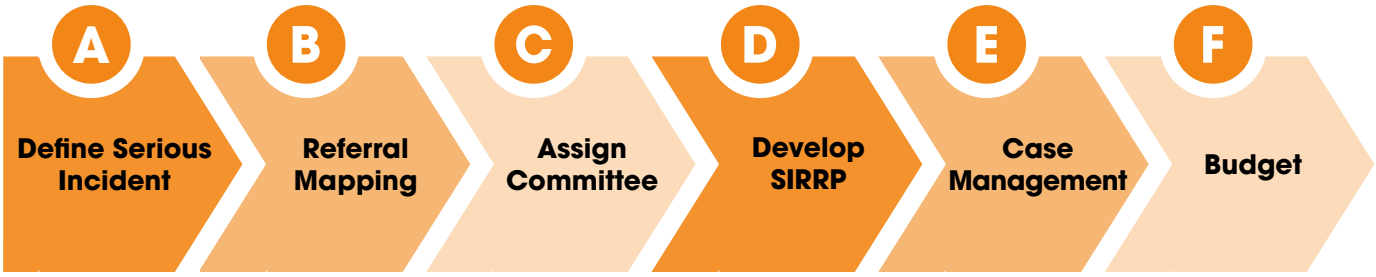
A Dynamic Community-Led Technical Working Group Guides CLM In Sri Lanka

In Sri Lanka, CLM activities began in November 2022, led by the Family Planning Association of Sri Lanka in collaboration with key stakeholders, including civil society organizations and the National STD/AIDS Control Programme (NSACP). A Technical Working Group (TWG) with 15 members was formed in February 2023, representing key populations such as men who have sex with men, female sex workers, people who use drugs, transgender individuals, migrant workers, tourism service providers (sometimes known as "beach boys"), and people living with HIV. The group meets regularly and is chaired by an HIV and LGBTQ+ rights activist, with each key population member having a vote in decisions.

The TWG played a crucial role in developing CLM guidelines, including the Terms of Reference for the coordinating organization and a Serious Incidents Management Committee. They also meticulously reviewed the translation of the CLM client form into Sinhala to ensure it reflected grassroots language and cultural relevance. The CLM pilot launched in June 2023, focusing on men who have sex with men, at three government clinics and one community clinic run by Heart to Heart, a Colombo-based LGBTQ+ organization. Feedback from field researchers from Lanka Plus and Heart to Heart indicated that the form was easy to use, though a few Tamil speakers faced difficulties. Future CLM scale-up will include a trilingual online questionnaire to accommodate all languages in the country.



Planning the Serious Incident Follow-Up



The CLM client form specifically asks for information about serious incidents. Consequently, systems must be set up in advance to respond to any serious incidents that are reported. Key steps in planning for this are:

Defining a Serious Incident

The CLM Committee or Technical Working Group (TWG) should clearly define what constitutes a serious incident. This ensures a shared understanding of violations related to service delivery for key populations. Categories of rights violations can be included on the CLM client form where clients report serious incidents.

Examples of Serious Incidents:

- Stigma and discrimination
- Violence experienced during service delivery
- Sexual harassment from staff or other clients
- Breach of privacy or confidentiality
- Denial of services based on gender, identity, race, or risk behavior
- Undue physical pain or distress

Referral and Reporting Mechanisms

The TWG should map referral and reporting pathways for serious incidents, considering local laws and mandatory reporting requirements. Annex 7 provides an example structure to conduct the mapping.

Key Steps:

- Identify survivor-centered services for referrals
- Ensure services are inclusive, stigma-free, and trusted (medical, psychosocial, legal, etc.)
- Establish agreements with service providers (MOUs) to ensure cooperation
- Provide access to free legal services for clients who experience discrimination, where available

A **Serious Incident Management Committee** should be formed to manage responses and reporting. The committee should be composed of members from the TWG and/or relevant medical or social welfare experts.

The committee should draft and develop a **Serious Incident Response and Reporting Protocol** (see template in Annex 8). The Serious Incident Response and Reporting Protocol (SIRRP) should be in place before CLM commences and clearly outline the following processes:

- Responding to serious incidents, including the initial response, follow up, referrals and reporting steps
- Ensuring a survivor-centered approach, which means following the following principles::
  - Respect: all actions are guided by respect for the survivor's choices, wishes, rights and dignity
  - Safety: the safety of the survivor is the number one priority
  - Confidentiality: survivors have the right to choose to whom they will or will not tell their story and maintaining confidentiality means not sharing any information with anyone
  - Non-discrimination: providing equal and fair treatment to anyone in need of support[14]
- Clear referral pathways to support services, ensuring informed consent
- Guidance on mandatory reporting to authorities, addressing any conflicts between privacy and reporting obligations

A **Case Manager** should be appointed to handle serious incidents. This individual, typically from a key population organization, should have experience in addressing issues affecting key populations. The CLM TWG or Serious Incident Management Committee should define the qualifications required and the roles and responsibilities of this position.

Allocate a **budget** to support the management of serious incidents and provide assistance to affected individuals. Pre-determined funding limits may be set for this purpose by the CLM TWG.

[14] How to support survivors of gender-based violence. A Step by Step Pocket Guide. https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_PocketGuide021718.pdf

CASE STUDY MONGOLIA

Successful Online Launch of CLM in Mongolia

Mongolia was the first country to pilot CLM with a self-administered online SKPA-2 Toolkit CLM Client Form in 2023. The transition from the earlier phase of community-based monitoring in the country using a face-to-face data collection method was made for several reasons. It allows greater confidentiality of responses, which is a major concern for clients fearing identification or retribution for their responses. The feedback can be provided online at the clients' convenience rather than when they are under time pressure. It also helps to avoid biased responses that may result when data is collected in the presence of key population service providers or at health facilities. In the long-term an online CLM tool will be lower cost and hence more financially sustainable than a survey requiring interviewers.

The online CLM client form was made available on a dedicated website. The availability of the CLM tool online to collect feedback on health services was promoted through field mobilizers and outreach workers of the implementing organizations, Youth for Health Center (YFHC) and Perfect Ladies, to their members. YFHC was the first non-governmental organization established in Mongolia for men who have sex with men and transgender people. Perfect Ladies started as a self-support group for female sex workers, and since it became a sub-recipient of the current Global Fund National HIV Grant it has expanded its reach throughout the country as an umbrella organization working with nine community-based/non-governmental organizations in the provinces.

To prepare for the pilot testing of the online tool, a demonstration video was created and made available on what CLM is, how to complete the online CLM form, and how CLM will be linked to advocacy to improve health services. Posters were displayed at the 25 clinics where the services for key populations would be monitored in the pilot. These served to advertise the availability of the client forms, and provided the QR code link to the website that clients could reach on a computer or through their smartphones.

About 200 males who have sex with males, transgender people and female sex workers responded to the online form, some of whom reported the occurrence of serious incidents during service utilization. Based on analysis of the feedback collected, YFHC prepared an action plan with 12 recommendations to share with national stakeholders. An acknowledgement of the success of the CLM pilot is that the Ministry of Health has integrated the indicators into the National Monitoring and Evaluation Framework.

YFHC is preparing to launch the online client form on a larger scale to get more key population members to respond, thus strengthening the reliability of the data collected. To reach this goal, in addition to promotion through key population organizations, the link to the online website will be shared widely through various social media platforms such as the community-based organizations' websites, Facebook pages and Instagram accounts, on dating apps, and through posters at key population hotspots and social gathering sites.

"Community led monitoring seemed to be an easy way to express how we feel about HIV health care service without any worries."

– Community member quote from Mongolia

Data Collection Methods

The CLM client form and the CLM client follow-up form are the proposed tools to collect data. This can be done through a self-completed online questionnaire, through interviews conducted by data collectors or using other methods. In addition, teams may want to include Focus Group Discussions (FGDs), key informant interviews (KIIs), or supplemental methods to better understand key population experiences both in using HIV services and what may be preventing them from using HIV services.

Data Collection Methods	Description	Considerations
 Online Survey	Clients complete a survey via mobile phone, tablet, or computer.	Requires a cloud-based application or website (e.g., Google Forms, SurveyMonkey). May need a paid subscription. Consider data confidentiality and storage. Survey links can be shared via email, SMS, QR code, or embedded in other systems.
 Suggestion Box	A physical box where clients can submit paper-based forms.	Forms should be easily accessible, with instructions and writing materials provided. Boxes should be placed in private locations, locked, and managed by the organization overseeing CLM activities.
 Face-to-Face Interview	Volunteers or outreach workers conduct brief interviews with clients.	Suitable for clients who cannot read/write or prefer not to fill out forms. Data can be recorded on paper or online. Ensure informed consent, privacy, and confidentiality are maintained during interviews.
 Phone Call or Social Media Interview	Clients provide feedback through phone or social media interactions with CLM staff or volunteers.	Contact details should be promoted for clients to reach out. Volunteers/staff can record responses on paper or online. As with face-to-face interviews, ensure privacy and confidentiality.
 Qualitative Methods	Methods such as FGDs or KII to gather in-depth feedback.	FGDs involve 6-12 participants, facilitated by a moderator. Useful for exploring reasons behind survey findings or to interview those who have not attended a health facility visit in the last 6 months.

Critical considerations:

Deciding which data collection methods to use will be determined by the country context and capacity and needs of clients. One critical factor to consider is digital literacy and accessibility. Using an online survey may not be appropriate in a context where digital literacy and access are low.

Even with high digital literacy, it is recommended that clients have the option to fill in paper forms or to be interviewed to maximize participation in CLM.

Another critical factor to consider is disability, which can present a barrier to participating in CLM. Data collection methods should take account of the need for inclusion of people with disabilities in CLM, to ensure that the most marginalized can participate. Partnering with disability people's organizations (DPOs) in country, including those with diverse and female leadership, is important to ensure the voices and needs of people with a disability are incorporated.

Data Management Considerations

Data management involves all the processes required to collecting, manage and use data securely, efficiently and cost-effectively. During the CLM design phase it is important to consider the intended purpose and the choices available when selecting tools for data storage and collection that ensure security and confidentiality, and to plan for subsequent data analysis and presentation. Crucial questions such as data ownership and access also need to be considered. There are several comprehensive resources available on these topics in the Resources section.[17]

[17] See references: 1) International Treatment Preparedness Coalition: Data Management Tools. Considerations for choosing tools for data collection, analysis, and presentation for Community-Led Monitoring, 2023; 2) International Treatment Preparedness Coalition: How to Implement Community-Led Monitoring: A community Toolkit, 2021; and 3) EpiC Project (FHI): LINK Technical Guide. An Electronic Client Feedback System for HIV Programs,. 2021.

What Indicators and data collection tools can be used for CLM?

Indicators are the specific measures that are used in CLM to collect data to assess HIV and related health services. The following two pages include a list of potential indicators to use. The full list of indicators and how to calculate them can be found on Annex 9.

SKPA-2 CLM indicators fall into two categories:

A Key population CLM indicators:

These indicators and data are collected from all persons participating in CLM and can be administered via a simple questionnaire. Data for these indicators is collected using the CLM client form (Annex 10: CLM Client Form). There are 27 questions in total and the form should take around 15 minutes to complete if self-administered and 20-30 minutes if clients need assistance.

There are eight proposed indicators:

- One for CLM participation (A1)
- Five linked to the AAAQ framework (A2-A6)
- Two for reporting of serious incidents (A7 and A8)

B Key population CLM serious incident follow-up indicators:

These indicators and data are related to management, follow-up and support to serious incidents. There are five proposed indicators although CLM programs are open to determine the best approach to adapt the tool and measure relevant follow-up. Data should only be reported and collected from people who meet the following criteria:

1. Have recorded a serious incident in the CLM client form; AND
2. Have consented to be followed-up by a trained staff member.

There are five proposed indicators although CLM programs are open to determine the best approach to adapt the tool and measure relevant follow-up.

- Two indicators measuring serious incident follow-up attempts and success (B1-B2)
- One indicator on accuracy of reporting/validation of serious incident (B3)
- Two indicators related to case management and referrals (B4-B5).

Data for these indicators is collected using the CLM client follow-up form (Annex 11), which is filled in by the person responsible for follow-up of serious incidents (case managers, CLM focal points). A new form should be filled in for each serious incident follow-up attempt. To assess the quality of follow-up, a client satisfaction follow-up form should be sent out. A template is provided in Annex 12.

CLM Indicators

Indicators = 2 ← Numerator / 3 ← Denominator

NAME	INDICATOR	FORMULA
A1. CLM Participation	Number (#) of CLM client forms	CLM Participation = Number of CLM client forms
A2. HIV Service Availability	Proportion (%) of clients who found services available	HIV Service Availability = Total forms where all services sought were received / Number of CLM client forms
A3. HIV Service Accessibility	Proportion (%) of clients who found services accessible	HIV Service Accessibility = Yes to ALL accessibility questions / Number of CLM client forms
A4. HIV Service Acceptability	Proportion (%) of clients who found services acceptable	HIV Service Acceptability = Yes to ALL acceptability questions / Number of CLM client forms
A5. HIV Service Quality	Proportion (%) of clients who found services of good quality	HIV Service Quality = Yes to ALL quality questions / Number of CLM client forms
A6. HIV Service Satisfaction	Mean (average) of the satisfaction score (from 1 to 5)	Mean Satisfaction Score = Total of all satisfaction scores / Number of CLM client forms
A7. Prevalence of Serious Incidents	Proportion (%) of clients who reported experiencing serious incidents	Prevalence of Serious Incidents = Yes to serious incident / Number of CLM client forms
A8. Prevalence of Stigma & Discrimination	Proportion (%) of clients who reported experiencing stigma and discrimination	Prevalence of Serious Incidents = Yes to stigma and discrimination / Number of CLM client forms

NAME	INDICATOR	FORMULA
B1. Follow-up of serious incidents	Proportion (%) of client serious incidents reports during the CLM cycle followed up	Serious Incident Follow-up = Yes to follow-up / Total # of serious incidents
B2. Successful follow-up of serious incidents	Proportion (%) of client serious incidents reports during the CLM cycle successfully followed up	Successful Follow-up = Yes to successful follow-up / Total # of clients followed-up with
B3. Accurately reported serious incidents	Proportion (%) of client serious incidents reports during the CLM cycle deemed as accurate	Accurate Reporting = Yes to accurate reporting / Total clients responding to accuracy question
B4. Serious incident referrals	Proportion (%) of clients referred to other services based on serious incidents follow-up successfully	Referrals = Yes to referral / Total clients with accurate reporting of serious incident
B5. Serious incident timely resolution	Proportion (%) of client serious incidents reports resolved within 30 days of report	Timely resolution = Yes to case resolved within 30 days / Total clients with accurate reporting of serious incident

CASE STUDY BHUTAN

Building Capacity of Key Populations in Bhutan to Independently Conduct CLM

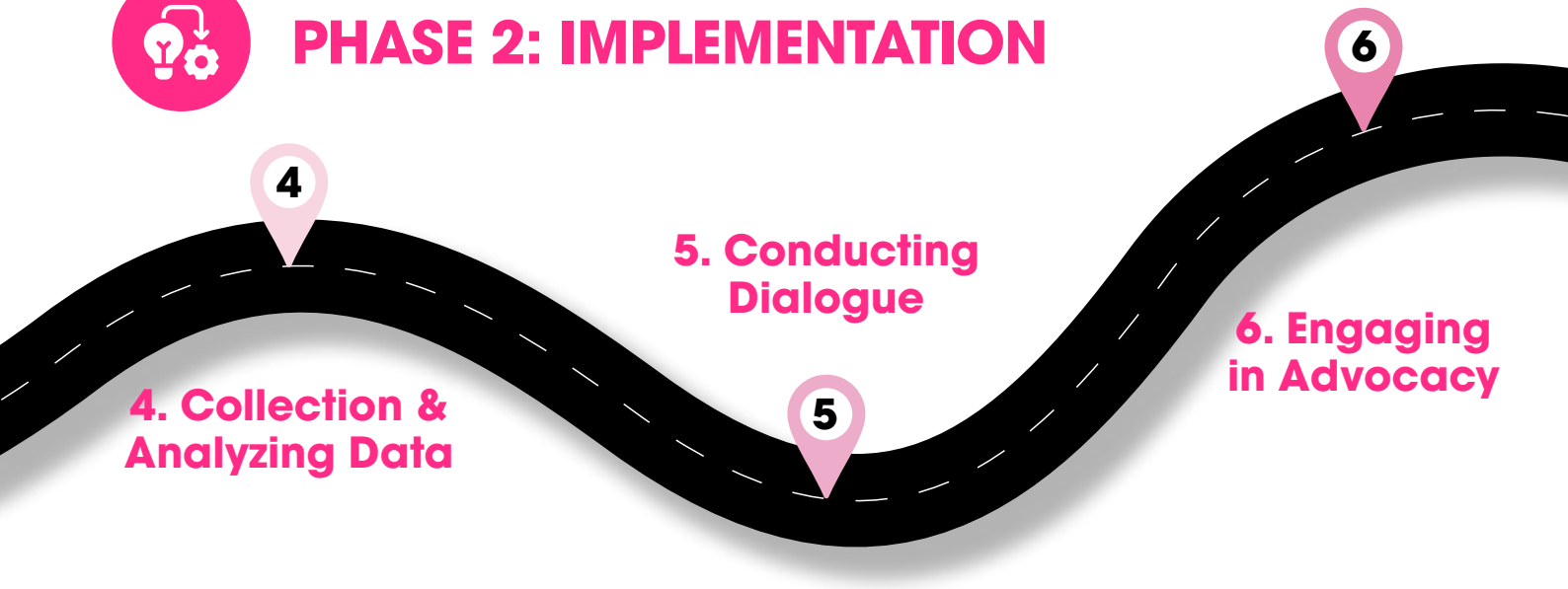
In Bhutan the SKPA-2 Toolkit CLM pilot was conducted during April and May 2023. Three key population organizations were chosen as implementers to recruit members to respond to the client form questionnaire: Lhak-Sam, a civil society organization (CSO) of people living with HIV; Chithuen Phendhey Association, a CSO working with people who use drugs and alcohol; and Pride Bhutan, a community-led non-profit organization working with LGBT+ and sex worker communities. A team from each of the CSOs consisting of a supervisor and 7-8 trained enumerators was involved in the implementation, assisted by QVoB, an LGBTQIA+ advocacy network and Red Cross Network for female sex workers, to promote CLM and aid in recruitment of LGBTQI+ individuals and sex workers. Data were collected through face-to-face interviews at 50 facilities countrywide using the CLM client form and entered directly into a computer–assisted personal interview application.

What was striking about the pilot in Bhutan was that a significant capacity-building effort of participating key population and civil society organizations was integrated into the process. They were involved at every step of the pilot from initial planning to the final development of an advocacy plan. To prepare for implementation, a national consultant in consultation with the CLM TWG, which included key population representatives, reviewed the toolkit and adapted it for use in Bhutan. Using the SKPA-2 Toolkit, a consultant trained the supervisors and enumerators through two workshops on data collection using the CLM client form, data cleaning of the responses, and analyzing the data with the statistical software package Stata. They reported finding Stata difficult to master (although some had prior experience with SPSS) but welcomed the learning opportunity. There was also a 5-day report-writing training workshop held for the implementers.

Once the final CLM report was written, a meeting was held with key population members to validate the findings and develop recommendations. At the meeting an advocacy plan was also developed focused on dissemination of the findings and recommendations to various national stakeholders and health service providers, so that it would lead to changes being made and improved services for key populations at HIV and other health facilities.

The TWG and key population organizations aim to further simplify the toolkit and tools so that the CLM client form can be shared online as a self-administered questionnaire that key population members can use more easily. The goal is to widen the reach of CLM and make data collection routine, ongoing, and led solely by communities independent of consultants.

PHASE 2: IMPLEMENTATION



Step 4 Collection, Analysis and Presentation of Data

Following the AAAQ framework, responses on the CLM client form are analyzed for indicators of availability, accessibility, acceptability, and quality of HIV services for key populations. The mean score for each indicator should be calculated to give an overall rating. Sub-indicator analysis is needed to identify specific areas for improvement, such as non-availability of STI services, issues with opening hours, or confidentiality concerns.

Further analysis is required to understand differences in the experiences of various key populations, types of facilities (public, private, community-based), or age groups. Findings can then be presented appropriately to stakeholders, either collectively or by specific population, facility, or age group.

Figures 4-6 show sample data from a fictional facility, Beach Health Center, illustrating how indicators can be calculated and presented. For example, across all key populations, service availability data from Q2 at Beach Health Center can track overall experience and satisfaction.

For examples of the specific analyses and results from the CLM pilots in Bhutan, Mongolia and Sri Lanka, see the Technical Briefs
available at: https://healthequitymatters.org.au/publications/international/

- **Across all key populations:** This allows the overall experience and satisfaction of key populations using HIV services in the area/country to be assessed and tracked over time. To illustrate how to calculate and present data across all key populations, we include a tally sheet of service availability data (indicator A.2.) from quarter 2 (Q2) for the Beach Health Center.

Figure 4 shows that 70% of key population CLM participants received all the HIV services they sought in Q2 at the Beach Health Center. This includes services such as HIV confirmatory testing, ART initiation, and ART refill. One client (ID #12) visited twice in the quarter, and both visits were included in the calculation. Another client (#107) sought two services in one visit, but since only one was available, the overall rating for availability was marked as 'no,' as all services sought must be available for a positive rating.

Figure 4: Example of how to calculate service availability

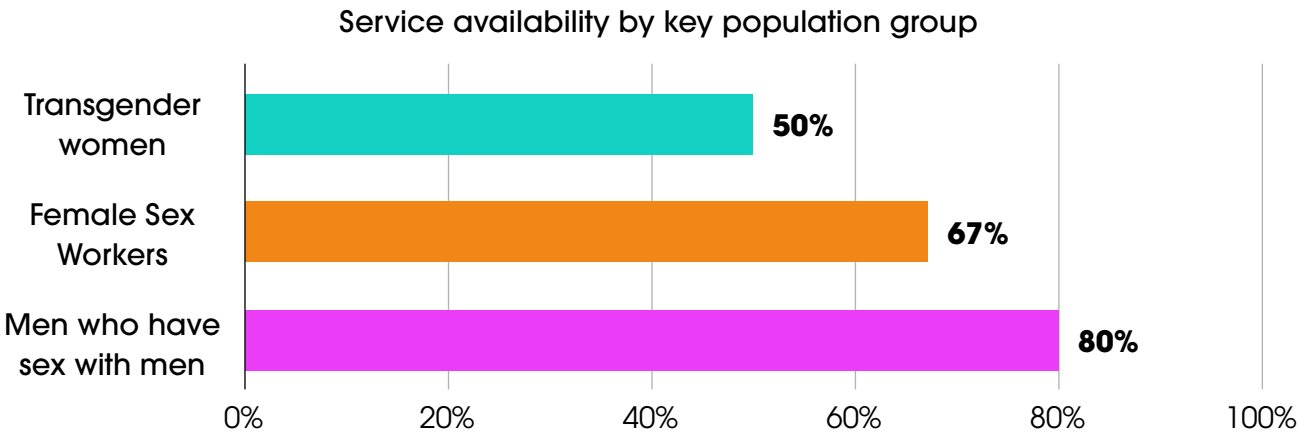
Service visits during Q2		A2. Service Availability Tally Sheet						All Services Available (Yes/No)
		HIV confirmatory test (5b.)		ART initiation (5h.)		ART refill (5i)		
Client #	KP Group	Sought?	Received?	Sought?	Received?	Sought?	Received?	
101	Men who have sex with men	Y	Y					Y
107	Transgender women	Y	Y	Y	N			N
85	Men who have sex with men					Y	N	N
143	Men who have sex with men					Y	Y	Y
156	Transgender women	Y	Y					Y
162	Men who have sex with men			Y	Y	Y	Y	Y
84	Transgender women	Y	N					N
12	Female Sex Workers	Y	Y					Y
15	Men who have sex with men					Y	Y	Y
12	Female Sex Workers			Y	Y			Y
Total Client visits: **10**		Total visits where ALL services were available: **7**						
							Availability score (7/10)	**70%**

- **By key population:** This allows visits to HIV services to be compared for different key populations across facilities. This may highlight differences in service availability, accessibility, acceptability or satisfaction between key population groups.

Figure 5 below shows the same tally sheet as in Figure 4, this time with the data disaggregated by key population and transformed from a table (top) into a bar chart (bottom). This makes it easier to identify differences in service availability by key population group. In this example, men who have sex with men were the most likely to find services available (80%), while transgender women were the least likely (50%). As there were only two transgender women clients during the quarter, and only one did not receive all the services they sought, this number is not sufficient to draw any meaningful conclusions (including calculating percentages) of service availability for this key population group. In cases like this with very low numbers, it may be best to use a longer time period (e.g. combine a whole year's worth of data) or combine data from several facilities for analysis.

Figure 5: Service availability by key population group

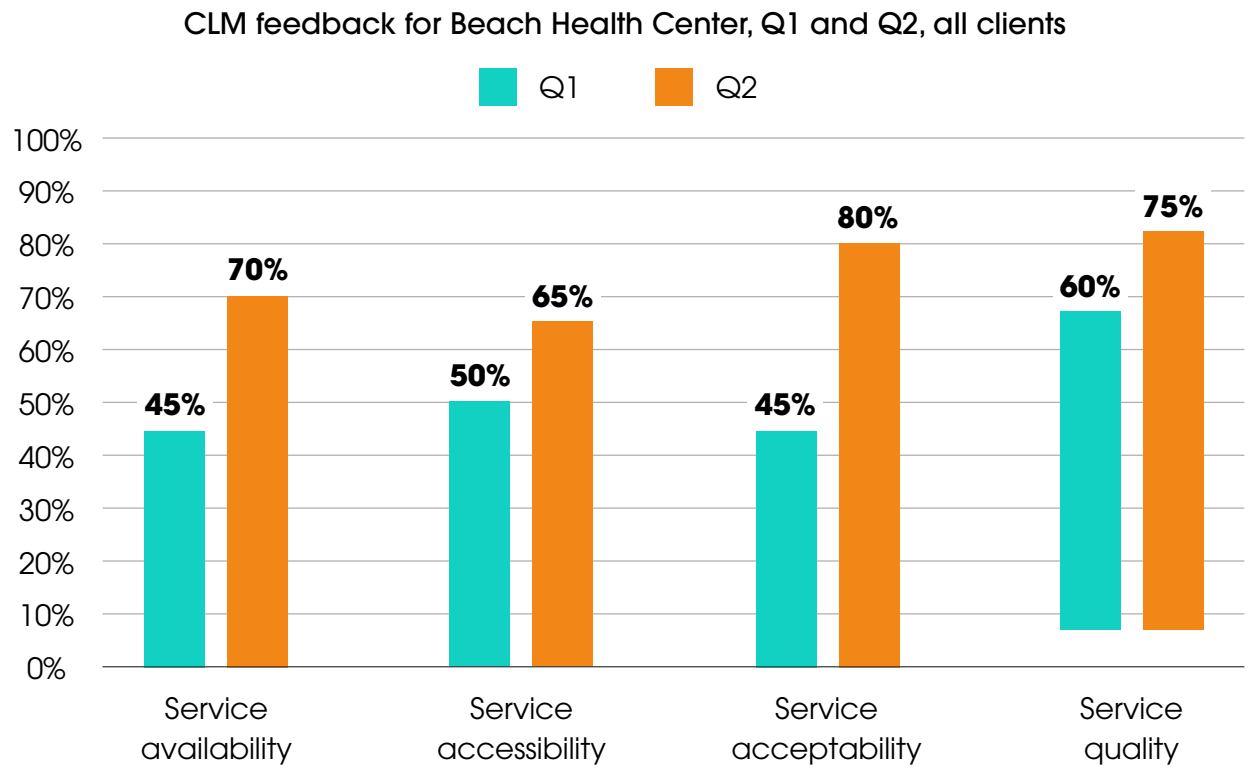
Service availability by KP group	# visits where services were available	# visits during quarter	Service availability score for each group
Men who have sex with men	4	5	80%
Female sex workers	2	3	67%
Transgender women	1	2	50%



- **By facility, rural/urban or district/province:** This allows services at different facilities or sub-national geographical units to be compared. This can be done with data from individual facilities, but can also be done using a cluster approach, for example, comparing all government facilities with all private/CBO facilities, or comparing facilities in urban areas with facilities in rural areas, or all facilities in one province with those in a different province.
- **By age group:** This enables the experience of service visits among younger key populations to be compared with those of older key populations (generally expressed as less than or more than 25 years of age). It is important to define in years any age group being used for comparisons. Countries may choose to use age ranges for analysis that are aligned to facilitate comparisons to UNAIDS Global AIDS Monitoring and Global AIDS update indicators, to align with national M&E data systems, or to meet other global or national standards.
- **By gender:** The experience of service visits can also be compared for cisgender men and women, transgender men and women, and non-binary persons. Consistently lower scores for one gender at a facility compared to scores for other genders could indicate a systematic bias, or a gap in service provision or staff training that needs to be addressed.

- **By trends over time:** Scores for the same indicator are compared over time to assess whether service ratings are improving, stable or worsening. This can be done at facility level, district level, provincial or state level, or national level. Figure 6 presents data for selected CLM indicators at two points in time (quarter 1 (Q1) and quarter 2 (Q2)) for the Beach Health Center. This shows improving scores for all indicators between Q1 and Q2. Trend analysis can measure the success of advocacy and action plans.

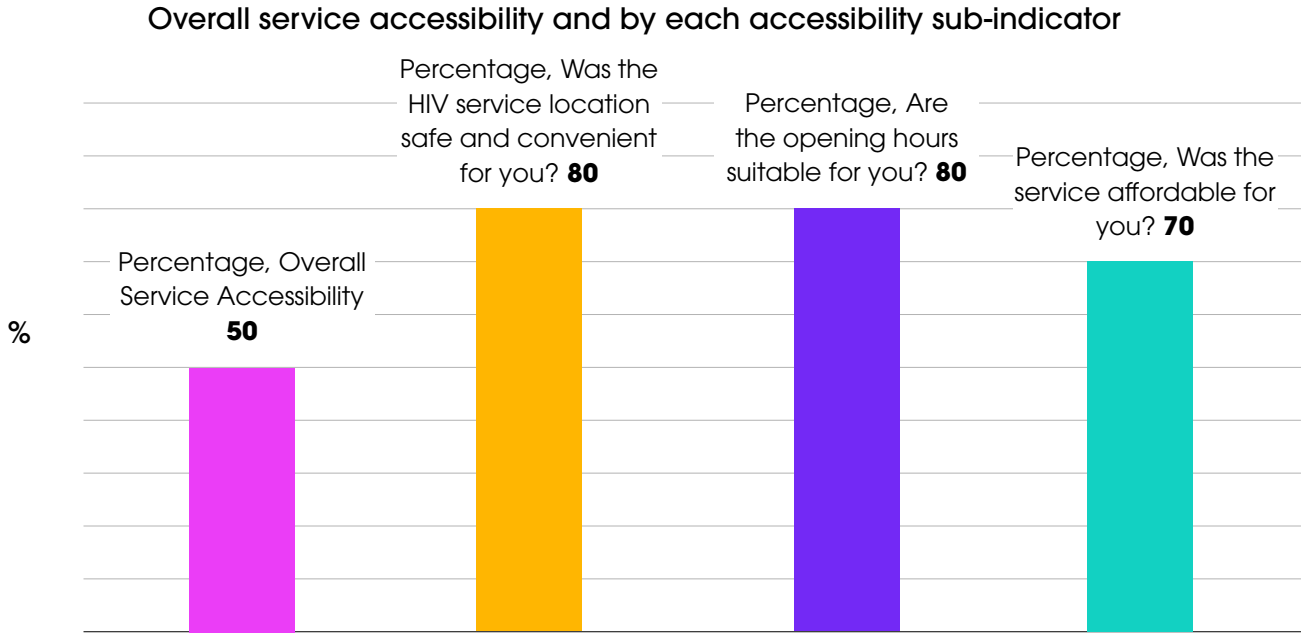
Figure 6: Example of how to present CLM trends over time



- **By sub-groups of key populations:** If the number of responses is large enough, it may be possible to calculate mean scores for key population sub-groups, such as scores for young female sex workers, compared to older female sex workers, across different states or provinces.
- **By sub-indicator:** Understanding health service accessibility, acceptability, and quality by sub-indicator helps identify which aspects meet or fall short of client needs. Figure 7 illustrates an example for accessibility: among 10 respondents, 80% found the service location safe and convenient, 80% found the hours suitable, and 70% found the service affordable. However, only 50% found the service fully accessible based on all three criteria. With a larger sample, sub-analysis could reveal which key populations or facilities face issues like unaffordability or higher out-of-pocket costs.

Figure 7: Example of calculation of service accessibility disaggregated by each criterion

Client responses to accessibility questions	Q6: Was the HIV service location safe and convenient for you?	Q7: Are the opening hours suitable for you?	Q8: Was the service affordable for you?	# Clients who found health service accessible based on all 3 questions
Client 1	Y	Y	Y	1
Client 2	Y	N	N	0
Client 3	N	Y	Y	0
Client 4	Y	Y	Y	1
Client 5	Y	Y	Y	1
Client 6	Y	N	N	0
Client 7	Y	Y	Y	1
Client 8	Y	Y	N	0
Client 9	N	Y	Y	0
Client 10	Y	Y	Y	1
Total # client responses	**8**	**8**	**7**	**5**
% Accessibility	**80%**	**80%**	**70%**	**50%**



Sharing findings from data analysis is crucial to improving HIV service availability, acceptability, accessibility, and quality.

- Data presented in graphs are recommended.
- Findings can be shared through reports, presentations, social media, and other outlets.
- Tailoring information to the audience is key—CBOs focused on transgender health or LGBTI rights may prioritize data on serious incidents, while HIV service managers may focus on AAAQ indicators for all key populations or by facility.

Analyzing serious incidents by category and the effectiveness of resolutions can provide valuable insights for policymakers and service providers. **Personal identifying information MUST be removed before sharing.** Serious incident data can reveal the types of incidents affecting HIV service access or retention and assess whether these issues are being effectively addressed. It can also identify specific service locations that need support to improve safeguarding.

Step 5 Conducting Dialogue

In many countries, Quality Improvement (QI) of HIV services is already an important area for health ministries, and facility-level QI efforts are underway. Positioning CLM as a tool to strengthen QI can help gain buy-in and support from the government.

However, collecting, analyzing, and sharing data does not automatically lead to service improvements. Dialogue with decision-makers, clinical management, and service providers is required to address gaps and drive change. Capacity building of service providers and managers may also be required to improve attitudes and skills, or address misconceptions held by service users.

- Partner with community organizations, networks, and health facility staff to identify specific service improvements.
- Prioritize issues based on importance and ease of resolution, distinguishing between short-term and long-term goals.
  - For example, adjusting opening hours to improve accessibility might be a quick fix at the facility level. More complex issues, such as access to PEP or PrEP or services for young key populations, may require broader policy changes and additional planning.

A meeting with facility management to present CLM data and proposed solutions can lead to immediate changes. Preparing for the meeting by assigning roles and documenting commitments is crucial. Progress should be monitored and followed up at future meetings.

A sample corrective action plan template, detailed in Annex 13, outlines micro-level (facility) and macro-level (advocacy/policy) actions. The plan should specify organizations, desired outcomes, responsible parties, and timelines.

CASE STUDY TIMOR-LESTE

Case Study: Making Use of CLM Data

In 2019, Estrela+, an independent association of people living with HIV in Timor-Leste, established a response feedback mechanism (RFM) using multiple channels, including suggestion boxes, social media (Facebook and WhatsApp), a hotline, and face-to-face feedback with peers at health facilities, to routinely capture experience from clinic visits. This activity was supported by the Asia Pacific Network of People Living with HIV (APN+) and the Global Fund-supported SKPA program, with technical support provided by PINOY Plus Association in the Philippines.

Estrela+ built a network of partners and stakeholders including the Ministry of Health, referral governmental hospitals in Dili and at municipality level, private clinics, key population-led organizations, and legal and mental health services. The RFM monitors human rights issues, HIV treatment services, factors affecting the accessibility of HIV services and commodities, and demand for HIV-related information. Each report is analyzed and an appropriate response is provided, for example, online or face-to-face counseling, referral to HIV, mental health or legal services, and distribution of ART through community-based differentiated service delivery (DSD) models. During 2019-2021, about 50 people living with HIV who had disengaged from HIV treatment services contacted Estrela+ and were counseled and successfully linked to services, and 15 cases of stigma and discrimination or breach of confidentiality were resolved.

Step 6 Engaging in Advocacy

For more complex or systemic issues identified by CLM data, advocacy will be needed to influence broader policy decisions. An advocacy action plan should be developed with clear goals and should consider the regulatory framework and planning processes managed by the government.

- Develop an advocacy action plan in collaboration with stakeholders.
- Focus on maintaining constructive engagement to avoid conflict with government stakeholders and health service managers.
- Use examples of successful improvements to demonstrate what can be achieved through collaboration.

Advocacy should be a collaborative effort, emphasizing positive engagement with government and health services. Documenting good practices and sharing areas where improvements have already been made will strengthen the case for change.

Rewarding good quality and success

While advocacy often focuses on weaknesses and gaps that need to be addressed, it is important to also use successes and achievements for advocacy purposes. Praising a clinic that has achieved high satisfaction ratings, and the reasons for this, may be more effective than highlighting the weaknesses of the worst-performing clinic. 'Positive' advocacy could include giving awards to facilities that have seen the greatest improvement in satisfaction ratings over the past 12 months. The highest scoring facilities could be acknowledged and provided with a medal, certificate or reward of some kind (e.g. "Transgender-friendly Facility of the Year", "Sex-worker-supportive Clinic of the Year", "Appreciation Award by Young MSM 2024"). Criteria for such awards should be determined by the committee that is overseeing CLM and awards could be presented at a special event organized around World AIDS Day or another auspicious occasion.

[19] For more on advocacy, see for example: 1) Advocacy in Action: a toolkit to support NGOs and CBOs responding to HIV/AIDS. International HIV/AIDS Alliance (2002). Accessed at https://pdf.usaid.gov/pdf_docs/pnacs577.pdf, and 2) Frontline AIDS (formerly International HIV/AIDS Alliance): EMPowerment for ADvocacy The EMPAD Policy Framework for national advocacy by and with key population

If several areas for improvement are discovered as part of the CLM analysis, it is important to prioritize issues that are the most important and easiest to fix, and to identify short-term and longer- term goals.

- For example, changing opening hours to open on Friday and Saturday evenings may be a relatively easy and quick fix to improve accessibility, if this can be decided at the facility level.
- Other issues, such as the availability of PEP or PrEP or the lack of access to HIV testing for young key populations may not be so easy to change, as they are related to broader policy decisions.

In many cases when areas for improvement at certain facilities are identified, a constructive meeting or workshop to present CLM data and the proposed solutions to the facility's senior management, who are in a position to respond on behalf of the facility and to make commitments, and other key staff can lead to immediate changes. A pre-meeting of the CLM team who will attend the facility meeting to outline roles and approach, such as who will discuss which findings and solutions, who will note commitments, is a useful preparatory step. The agreed actions and commitments should be documented. Subsequently, the CLM team should monitor progress with implementing QI and action plans, and follow up at subsequent meetings with facility management and staff.

A sample template for documenting the corrective CLM action plan is given in Annex 13. Since action plans will target different levels of stakeholders, the template has two sections: A. Micro-level: Facility Level, Quality Improvement Actions, and B. Macro-level: Advocacy, Policy Systems Level Actions. After prioritization discussions, the action plan template can be adapted to document short-term and long-term actions. Actions plans should clearly state which organizations developed the plan, the desired outcomes, and which health facility/service or agency is responsible for implementing actions, with a timeline.

PHASE 3: MONITORING & EVALUATION

Step 7 Monitoring and evaluation

The CLM process and feedback mechanisms should be reviewed and adapted to ensure community leadership and that CLM will lead to improvements in HIV services for key populations. SKPA-2 has developed a CLM Quality-of-Care (QoC) Benchmark tool that can be used to analyze and assess the quality of CLM programs. The summary can be found in Table 1 and the full tool can be found as Annex 14.

The QoC Benchmark tool can be utilized annually or biannually to assess the CLM program's strengths and weaknesses. Each benchmark may be given a score of 1-4 and can be done internally or via an external independent consultant depending on budget. Table 1 provides an overview of the categories for each area of concern included in the full QoC benchmark tool. Full details and explanations can be found in Annex 14 and in a separate upcoming CLM Quality of Care Technical Guidance Note, expected to be published in early 2025.

Table 1: Benchmarks to assess CLM Feedback Mechanisms

Phase	Area of Concern
DESIGN	Ensuring community leadership
	Routinization
	Duty of Care
	Confidentiality and data security
IMPLEMENTATION	Collect and package data, generate reports, and respond to serious incidents
	Conduct dialogue about the findings with community partners, facility users, facility staff and other stakeholders to identify and agree actionable recommendations
	Engagement in advocacy for change
MONITORING & EVALUATION	CLM Renewal and Refinement
	M&E – Stakeholder Feedback
	M&E – Capacity Building

RESOURCES

In addition to the references indicated in the footnotes of this document, we recommend the following CLM-related documents for further reading:

- Advancing Partners & Communities, 2018. Community Scorecard Toolkit: Empowering Communities and Healthcare Providers to Partner in Leading Change. Arlington, VA
- EpiC Project (FHI 360), July 2021. Community-led Monitoring Resources
- EpiC Project (FHI 360), August 2021. Community-Led Monitoring Drives Tailored Solutions and Improves Focus on Client-Centered Services: Success Story
- EpiC Project (FHI 360), 2021. LINK Technical Guide: An Electronic Client Feedback System for HIV Programs
- Initiative 5% - Expertise France, October 2019. Collective Learning: Community health observatories
- International Treatment Preparedness Coalition (ITPC), 2021. How to Implement Community-Led Monitoring: A Community Toolkit
- International Treatment Preparedness Coalition (ITPC), 2019. The Community Treatment Observatory (CTO) Model Explained¬–How Communities can Collect and Analyze Health Data to Ensure Accountability and Drive Change(Summary brief can also be downloaded)
- International Treatment Preparedness Coalition (ITPC), 2023. Data Management Tools. Considerations for Choosing Tools for Data Collection, Analysis, and Presentation for Community-Led Monitoring
- International Treatment Preparedness Coalition (ITPC). CLM Hub (Multiple guides available on CLM indicators, data analysis and management)
- Community-Led Accountability Working Group (CLAW), 2022. Best-Practices-in-Community-Led-Monitoring
- Swasti, The Health Catalyst, September 2022. The Community-Led Monitoring (CLM) Playbook. An Easy Reference Guide. Version 2.0
- Frontline AIDS (formerly International HIV/AIDS Alliance), 2014: Advocacy in Action: a toolkit to support NGOs and CBOs responding to HIV/AIDS
- Frontline AIDS (formerly International HIV/AIDS Alliance): EMPowerment for ADvocacy The EMPAD Policy Framework for National Advocacy by and with Key Populations
- Nimesh Dhungana, LSE, Flora Cornish, LSE, Morten Skovdal, University of Copenhagen, Gitau Mburu, International HIV/AIDS Alliance (report commissioned by the Community, Rights and Gender Department at the Global Fund to Fight AIDS, Tuberculosis and Malaria), 2016. Four models of community- based monitoring: a review
- RITSHIDZE, 2020. Activist Guide - Community-Led Clinic Monitoring in South Africa
- Stop TB Partnership | UNOPS, 2020. Community-Based Monitoring of the TB response, using the OneImpact digital platform (Investment Package – community, rights and gender)
- The Global Fund, May 2020. Resources for Community-Based Monitoring

- The Global Fund, February 2020. Towards a Common Understanding of Community-based Monitoring and Advocacy
- U.S. President's Emergency Plan for AIDS Relief (PEPFAR), 2020. Fact Sheet on Community-Led Monitoring
- UNAIDS, 2021. Frequently asked Question on Community-led Monitoring
- UNAIDS, 2021. Establishing community-led monitoring of HIV services
- UNAIDS, 2019. Rights-based monitoring and evaluation of national HIV responses
- IASC Gender-Based Violence (GBV) Guidelines, 2022. How to Support Survivors of Gender-Based Violence when a GBV Actor is not available in your area – A step-by-step Pocket Guide for humanitarian practitioners (version 2.0)
- PSEA Network. Protection from Sexual Exploitation and Abuse From A to Z
- Inter-agency Standing Committee, 2016. Guidelines. Inter-agency Community-based Complaints Mechanisms. Protection Against Sexual Exploitation and Abuse
- Australian Government Department of Foreign Affairs and Trade, 2021. Disability Inclusion in the DFAT Development Program. Good Practice Note

ANNEX 1: CLM CHECKLIST

This checklist includes key tasks that can be completed under each step to help CLM implementers. Feel free to use this as a worksheet in helping you establish and implement CLM. This checklist may be adapted.

Phase 1: Design

STEP 1 Establish Community Partnerships

- [ ] Identify a lead organization for CLM implementation
- [ ] Develop a CLM committee or TWG
- [ ] Complete Stakeholder Mapping
- [ ] Conduct a mapping of relevant policies and legislation, services and referral system

STEP 2 Establish Partnerships with Government

- [ ] Engagement with government agencies

STEP 3 Adapt the CLM Toolkit

- [ ] Review and update the toolkit
  - [ ] Update the CLM Client Form
  - [ ] Update the CLM Serious Incident Follow-Up Form
  - [ ] Develop Key Information Interview Template (if applicable)
  - [ ] Develop Focus Group Discussion Template (if applicable)
- [ ] Translate the toolkit into local languages
- [ ] Develop CLM Budget
- [ ] Update Code of Conduct
- [ ] Develop job descriptions and recruit CLM staf
- [ ] Develop Serious Incident Response and Reporting Protocol (SIRRP)
- [ ] Develop Demand Generation Materials
- [ ] Develop CLM Training Materials
- [ ] Organize relevant CLM trainings
- [ ] Develop data collection and management protocols

Phase 2: Implementation

STEP 4 Collect, Analyze and Package Data & Generate Reports

- [ ] Collect CLM Data
- [ ] Analyze CLM Data
- [ ] Develop CLM Report

STEP 5 Conduct Dialogue

- [ ] Develop CLM Action Plan
- [ ] Conduct Quarterly CLM Dialogue Meeting

STEP 6 Engage in Advocacy for Improvements in HIV Services

- [ ] Develop CLM Advocacy Plan

Phase 3: Monitoring & Evaluation

- [ ] Review and update the CLM process annually, including tools, partnerships, and reporting templates.
- [ ] Obtain feedback from key stakeholders to improve CLM data usage and advocacy.
- [ ] Identify and address capacity development and training needs
- [ ] Review and update training materials for CLM implementers
- [ ] Review and utilize the QoC Benchmark Tool

[2] Using the Stakeholder Mapping may help to identify which organizations to engage in the process.

ANNEX 2: STAKEHOLDER MAPPING[3]

Stakeholder mapping is a process that helps to identify what the context for what project stakeholders exist, their level of influence, which key players are responsible for decision-making, and that provides a visual representation of how these all connect into a larger engagement strategy. Stakeholder mapping is especially important for CLM as it helps to map out the different stakeholders you would like to collect data from (key populations and organizations working with them and representing them) along with decision makers such as the Ministry of Health, health facilities providing HIV services, and others who can help support and ensure the success of CLM.

Step ❶ Stakeholder Identification

Community leadership and program implementers who are leading the CLM initiative should come together to list all relevant stakeholder groups that may need to be engaged in the CLM process. This may include Primary, Secondary and Tertiary stakeholders.

Primary Stakeholders	Secondary Stakeholders	Tertiary stakeholders
• Key population led organizations • Key population community members • People living with HIV • Specialized HIV healthcare providers • Community health workers • Key population outreach workers • National AIDS Control Program • NGOs leading HIV programs	• Technical Assistance providers • International donors (Global Fund, PEPFAR, etc.) • Policy makers • General health providers • Research institutes	• General public • Police • Education institutions • Legal and justice systems • Lawmakers

Examples may include:

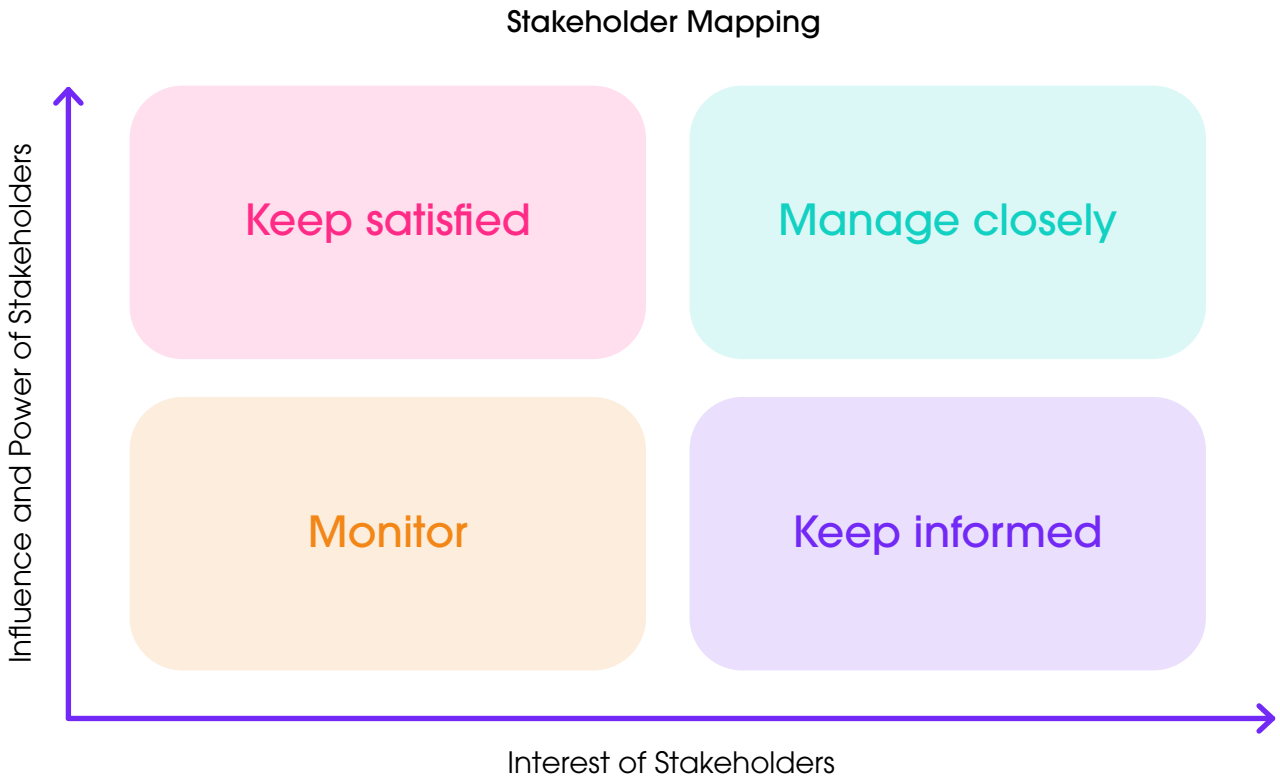
Step ❷ Map out Stakeholder Interest and Influence

This will help to identify and prioritize who to actively engage with to ensure CLM is a success in your context. Special attention should be given to ensure that key population communities are in the leadership position and that engagement with government authorities and stakeholders with high levels of influence are not leading the process.

The stakeholders can be mapped out using Mendelow's Matrix as in the Figure below.

[3] Additional examples of how to conduct a stakeholder mapping can be found here.

Figure 1: Stakeholder Map



This may be done using post-it notes for each stakeholder and mapping them along the Y axis for their level of influence and along the X axis for their interest in the CLM process. You may color code the post-it notes based on Primary, Secondary and Tertiary stakeholder groups.

Next Steps:

- Develop a stakeholder engagement plan based on the analysis and ensure partnerships and engagement are made with relevant groups through the process
- Integrate these stakeholders throughout the CLM process
- Regularly review and update the stakeholder mapping in case of major changes that might impact the CLM process and decision makers to ensure success

ANNEX 3: CLM TRAINING AGENDA

It is important that individuals involved in all aspects of the CLM receive training to enhance their skills and motivation.

Training can include a range of topics, based on the context of the CLM. Suggested topics are listed below. It can be helpful to conduct a training needs assessment to determine which topics are needed. Training could then be modularized, depending on the training needs of the individual.

Training can also include providing clear education materials (such as fact sheets, how-to guides or toolkits).

About CLM

What is it? Why is it important.
Key inputs and expected outcomes

The CLM Process

Establishing, adapting collecting, reporting, findings, advocacy

Ethics of CLM

Including safeguarding and doing no harm. Expected Codes of Conduct.

Data Management and Security

Collection, privacy, confidentiality and data sharing.

Data Analysis and Follow Up

Responding to and reporting serious incidents

Self Care

Safety, avoiding burn-out, mental health

Communication & Advocacy

Community engagement, organizing advocacy and influencing change

Training may also include areas such as HIV transmission, prevention, testing and treatment and treatment adherence. However, that will require different training materials not included in this toolkit.

Training could be delivered in-person or online. It could be delivered over a set timeframe, enabling capacity and skills to build upon each other.

ANNEX 4: SAFEGUARDING RECRUITMENT CHECKLIST

This checklist is provided as guidance to support transparent and consistent safeguarding processes in the recruitment of staff engaged under the CLM.

It should complement existing recruitment practices (not replace them).

It is a general list and should be adapted to suit.

- [ ] Assess the safeguarding risks related to the role.
- [ ] Reference safeguarding and code of conduct requirements in job announcements or advertisements.
- [ ] As part of the application process, include a requirement for applicants to self-declare or disclose prior safeguarding misconduct.
- [ ] Include questions about safeguarding in the application process.
- [ ] Include questions about safeguarding in the interview process.
- [ ] Include questions about safeguarding in the reference checking process.
- [ ] Consider the safeguarding skills and experience of the people conducting shortlisting, interviewing and reference checking. It is helpful to include people with safeguarding experience in this process.
- [ ] Consider the need for criminal history checks.
- [ ] The consequences for breaching safeguarding requirements and the Code of Conduct should be made clear in the contract.
- [ ] Include training about safeguarding at induction and then again as a refresher at regular intervals.

ANNEX 5: INFORMED CONSENT FORM

Note: this is a template that should be adapted to reflect the local context. If the CLM Client Form is provided through an online survey, then this Consent Form should be incorporated into the first page of the electronic form. It may be modified.

Informed Consent Template for Client Form

You are invited to provide feedback on the quality of HIV services received during your last visit at one of the health facilities that is part of community-led monitoring efforts. The feedback is being conducted by (name of your organization) in collaboration with (include the name of the agencies collaborating with this project, including Ministry of Health). This feedback should take around 10 minutes to complete.

Your participation is voluntary and you will receive no direct benefits from participating in this survey. However, the findings are intended to help improve the quality of services provided by the health facility. There are no anticipated risks involved in participating in this survey, except for the small risk that you may experience some discomfort or anxiety from recounting and reporting an unpleasant experience.

All your responses are transmitted to (add where data are sent such as Google survey) where data are stored and safely encrypted. You do not need to provide any identifying information about yourself; your responses remain anonymous. Only if you identify a serious issue that is in need of follow-up, will you be asked to leave contact details (phone, email, or social media) with us. In that case, your responses may no longer be anonymous to us, as a case manager will be asked to contact you directly to learn more about the issue and discuss potential follow-up actions (that may include referrals to additional services). No names or identifying information would be included in any presentations based on these data, and your responses to this survey remain confidential.

If you have questions or concerns, you can contact our coordinator at this following number (add full name(s), telephone number and/or social media username) from (add operating day/time). You may print a copy or take a screenshot of this consent for your records. Please indicate below whether you agree or disagree to participate in this survey:

a. You have read and understood the above information

b. You are (add legal age) years old or older

c. You voluntarily agree to participate

○ Agree ○ Disagree

ANNEX 6: CODE OF CONDUCT FOR PEOPLE INVOLVED WITH CLM ACTIVITIES

This code of conduct must be signed by any individual (employee, volunteer, data collector, case manager, consultant, or any others) involved in CLM activities before they commence.

I, undersigned, certify that I will comply with the following principles during the preparation and implementation of any of the CLM activities in (name city, country).

The principles of this code of conduct are:

- All individuals, regardless of their age, ethnicity, religion, gender or sexual orientation, involved in CLM activities should be treated with respect and without a discriminatory or judgmental attitude.
  - Written Informed consent should be obtained from every participant prior to collecting information from them (including acknowledging through digital consent when data is collected online).
  - The only identifier that should be collected is a first name or nickname, telephone number, email, or social media username, if the key population service user wishes to initiate a follow-up contact after reporting a serious incident, this information is collected only after obtaining consent. No other identifiers such as full name, date of birth, or address will be collected from any participants.
  - Information about any individual involved in CLM activities will be maintained confidentially. Information will only be shared in line with the Serious Incident Response and Reporting Protocol.
  - Data must never be fabricated or altered to replace missing data (i.e., questions not answered by the participant) or to suit a desired outcome.
  - No collected or transcribed data (e.g., field notes, transcripts, questionnaires, recorded tape, dataset, etc) should ever be shared with outside persons who are not involved in data collection or analysis, unless in accordance with the Serious Incident Response and Reporting Protocol and in accordance with local law, including the prior approval of the CLM coordinator.

When conducting my duties under the CLM I must always:

- Treat all individuals involved in CLM activities fairly and with respect and dignity and without a discriminatory or judgmental attitude, regardless of their age, ethnicity, religion, gender identity, sexual orientation, HIV status, marital status, or any other factor.
- Demonstrate the highest professional and ethical standards.
- Create and maintain an environment which prevents any form of abuse, including sexual exploitation, abuse or harassment and any form of child abuse.
- Be mindful of and proactively seek to challenge discrimination and stigma of key populations.
- Complete the required CLM training.
- Follow the Serious Incident Response and Reporting Protocol established as part of the CLM.
- Raise any concerns about my own safety and security.

- Where there is a serious incident, adopt a survivor-centered approach. This means putting the needs, wishes, dignity, rights, safety and wellbeing of the survivor at the forefront of the decisions made to follow up and respond to the incident.

When conducting my duties under the CLM I must never:

- Be under the influence of alcohol or use, or be in possession of illegal substances.
- Engage in sexual relationships with clients since they are based on inherently unequal power dynamics.
- Engage in sexual activity with children (persons under the age of 18). Mistaken belief in the age of a child is not a defense.
- Exchange money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behavior.
- Engage in any commercially exploitative activities with children or vulnerable adults including child labour or trafficking.
- Physically, sexually, or emotionally abuse any adult or child.

I have read and understood the above principles and agree to abide by them

Name and Surname:

Organization:

Position:

Date:

/ /

Day Month Year

Place:

Signature:

(2 copies: 1 for the individual signing the document and one kept in the CLM file of the organization)

ANNEX 7: SERVICE AND REFERRAL MAPPING

The CLM should map the following areas:

Brief of International Instruments, such as the UN Conventions or Covenants, that the country is signatory to	UN Conventions and Covenants are written legal agreements between countries and the UN. They describe the human rights people have, and what the country must do to make sure that people's human rights are supported. After a country signs a Covenant or Convention, they have a legal obligation to respect, protect and fulfill the rights written in it. This may help in advocacy at the national level. There are 9 core international human rights instruments[4]
The Age of Majority & The Age of Consent	The age of majority is the threshold of legal adulthood as recognized or declared in law. It is the moment when a person ceases to be considered a minor and assumes legal control over their person, actions, and decisions, thus terminating the control and legal responsibilities of their parents or guardian over them. The Age of Consent is the legal age at which an individual is considered mature enough to consent to sex. Sexual relations with someone aged under the Age of Consent is a criminal offense. The Age of Majority and the Age of Consent are not always the same.
Relevant Legislation	• Relevant aspects of a Country's Constitution or Criminal Code, which outlines which behaviors are criminalized. • Child Protection Legislation, which defines how the child protection system is managed and delivered. • Family and Domestic Violence Legislation, which defines how the social welfare system is managed and delivered. • Other relevant legislation that outlines any mandatory reporting of child abuse, gender based or family and domestic violence.
Relevant country or regional level plans	Relevant National Action Plans or Strategies
Reporting Pathways	• Voluntary vs. Mandatory Reporting requirements to law enforcement/police • Reporting information for statutory protection agencies (child protection, social welfare, human rights)
Referral Pathways	• Local health and medical services • Child support or child protection • Counseling services • Legal services • Social welfare services • Relevant services for key populations Services and referral pathways should include providers that are specific to people's age, gender, culture and physical abilities. Special attention should be given to providers whom have been sensitized and provide quality care to key populations. It is important to ensure that information is accurate and up to date.

See here for links to country mapping examples: Prevention of Sexual Exploitation and Abuse (PSEA) Country Mapping of Known Context, Legislation, Reporting and Referral Pathways — All Countries

Note that these mapping documents are examples only and are relevant to sexual exploitation and abuse and would need to be expanded.

ANNEX 8: SERIOUS INCIDENT RESPONSE AND REPORTING PROTOCOL (SIRRP)

The purpose of CLM is to collect and use information to advocate for improvements in HIV services for key populations. This includes information about any reported serious incidents.

The communities and community-led organizations who are leading and implementing the CLM must decide how data about serious incidents gained through follow up discussions will be managed, recorded, shared, and used to help make referrals, or reported.

This should be outlined in a Serious Incidents Responding and Reporting Protocol. The purpose of the Protocol is to help the CLM manage and address serious incidents consistently, prioritising the safety and wishes of clients, in a clear and transparent process.

Below is a general outline and guidance about what to include in the Protocol. This guidance should be informed by service and referral mapping (see Annex 7) and adapted to your context.

Outline	Example and Guidance
Introduction	Include information about the CLM, including the communities and community-led organizations that are leading, implementing and participating. This section could also include information about the experience, skills, and qualifications of the CLM Case Manager.
Define a serious incident	This toolkit defines a serious incident as a violation of someone's human rights, including incidents involving: • stigma and discrimination; • experiences of violence linked to receiving the service; • experiences of sexual harassment from service staff or other clients; • breach of privacy or confidentiality regarding the client's personal information; • refusal of service because of gender, identity, race, risk behavior or other; • any form of physical, sexual, or emotional abuse or harm; or • experience of physical pain or distress. The Protocol should outline in detail the definitions applied in the local CLM.
Feedback forms	Include a description of the CLM feedback system, including its data recording and follow up forms.

Roles and responsibilities	The Protocol should outline roles and responsibilities for managing serious incidents, including the roles and responsibilities of case managers. • Review the case, including the information received on feedback forms. • Provide follow-up to the client (if consent has been provided). • Explain confidentiality, and its limits, to the client. • Gather additional information. • Complete risk assessment and an assessment of the client's current safety. • Discuss and provide remedy, where possible. • Refer the client, if required and consented, to support services. • Report the incident (or support the client to report), if required and consented, to other authorities. • Ensuring the client remains informed about the case throughout. • Case closure. • Completing client Follow Up Forms. • Secure records management. De-identified (anonymized) reporting of CLM Serious Incident Indicators. The Protocol should outline in detail these responsibilities, including any required timelines and decision-making points. The Protocol should also outline the process of appointing case managers, along with any additional experience, qualifications, training, and support required for the role. Ideally, case managers have relevant child protection, child safeguarding, gender-based violence, family welfare or other relevant skills and experience. The Protocol should also outline how cases might be escalated, and to whom, if case management is delayed or complex. This may include escalation to a Serious Incident Management Committee. The Protocol should outline who is part of the committee, how they are selected, their term, and key roles and responsibilities. The committee should include a representative with safeguarding skills and experience. It should also outline when and how information can be shared between the Case Manager and the Committee, including the process of seeking the client's consent for this to occur. It is important that the Protocol clearly outlines roles and responsibilities for determining and making any external reports to police, social welfare or child protection (or other relevant authorities). It is important that the Protocol clearly outlines roles and responsibilities for follow-up actions with facility managers or health care providers that are the subject of the serious incident.
Follow up to a reported serious incident	The client does not give consent for follow up. **No follow up with client** Anonymized data (i.e. de-identified data) from the client form is collated for analysis. This ensures the CLM can analyse, track trends, and learn from the number of serious incidents occurring, as well as the percentage of serious incidents where clients decline follow up. Sharing this anonymized data is a critical step to ensure that CLM leads to improvements in the availability, acceptability, accessibility, and quality of HIV services. The client gives consent for follow up. **Follow up with client by a trained CLM case manager, using the client's preferred mode of contact**

Confidentiality and its limits	
Assessing risk	
Gathering additional information	**The Protocol should outline how the case manager will explain confidentiality, and any limits to confidentiality.** This should be done before the Monitor asks for further information about the serious incident. Confidentiality does not mean never sharing information. Confidentiality means that you do not share information unless you have the client's informed consent to do so.[6] At the beginning of the follow up with the client, the client should be informed of any limits to confidentiality. These can relate to mandatory reporting, and to the provision of information for referrals to support services. Other limits that could apply include if there is a risk to life, or if a child has been sexually or physically abused. When a child is a survivor of abuse, it may be necessary to break confidentiality to protect them. These limits should be explained in a way that is easy for clients to understand, including the level of detail about what information will be shared or reported, who will have access and what form follow-up actions might take. This will help the client to understand and assert their right to confidentiality, which may help them decide what aspects of their case they want to disclosure or not.
	The Protocol should include information about assessing safety risks. Providing feedback, making a complaint or seeking support is difficult. In some cases, clients will be considering the risks and benefits before consenting to the next steps. Risks can be many things, for example they can include other people finding out what happened which can lead to the client being stigmatized. There may be a risk of retaliation from alleged perpetrators, the community, or the service providers. Client risk behaviors may be illegal or culturally unacceptable, and there may be risks with reporting to other services or the authorities that further criminalize or marginalize the client. Clients may also be considering the risks of not taking next steps, such as imminent risks to health and safety. There are also benefits. For example, the client may benefit from interventions that prevent further harm, provide access to health or medical care, or access to other services that support longer term recovery. The overall intended benefit of a CLM is to use information to advocate for improvements in HIV services for key populations. The purpose of safeguarding is to do no harm and it may be necessary to discuss with clients the risks and benefits of next steps before they are able to make informed consent. The Protocol should provide guidance if there are concerns about the safety of referral or reporting pathways.

[6] To be provided

Records	**The Protocol should provide guidance about what records to include on the Form.** The monitor should record relevant details about the serious incident on the Follow Up Form to assist understanding or resolving the serious incident. The record should not include personal or identifying information. No record or information should ever be shared with outside persons who are not involved in data collection or analysis, unless informed consent is provided for referrals or reports to authorities.
Referrals	**The Protocol should outline how referrals should be offered or provided.** Clients that report a serious incident through CLM have the right to information and referrals to relevant support services that can provide follow-up support and assistance from qualified, skilled and competent service providers. The Protocol should include information obtained through service mapping (Refer Annex 7 for more information). This will include up-to-date information about functional, reputable service pathways for medical, health, social, child support/ protection, counselling, legal and social welfare services. available including opening hours, location, contact and services. The Protocol should outline how these pathways will be discussed and provided to the client. The client has the right to choose which service they would like to be referred to. The Protocol should outline the process for seeking the client's consent for the referral to be made, including explaining what information will be shared and how.
	The Protocol should include information about client consent for referrals. **If the client consents:** The protocol should provide detailed information about the available resource / service including how to access it, relevant times and locations, focal points at the service, safe transport options etc. If referrals are made, the referrals should only include basic information about the client's support needs. Referrals should not include information about any alleged perpetrator or organizations of the alleged perpetrators. Verbal referrals are preferred to avoid risks to confidentiality. **If the client does not consent** Provide the client with information about services that they can access if they change their mind. It is helpful to check with the client that they have someone to talk with, a friend, family member, caregiver, or someone they trust for support.

External Reports	**The Protocol should include information about external reporting, including reports to authorities.** **Reporting the serious incident to authorities** If a complaint constitutes a criminal offence under local or national law, the authorities have an interest in investigating separate from the follow up process of the CLM. The protocol should outline what information will be shared, how and by who. In addition, certain types of alleged offenses may require mandatory reporting to authorities. For example, this can include allegations about child abuse that should be reported to the child protection or welfare authorities. The Protocol should outline what serious incidents would require a mandatory report, including what information will be shared, how and by who. Where it is safe to do so, child abuse (sexual abuse or exploitation, physical abuse, emotional abuse or neglect) should be reported to the authorities, regardless of whether the law mandates it. **If the client consents** The Protocol should outline the timeline for external reporting. The referral to the authorities should occur after the client has consented and as soon as it is recognised that a crime may have occurred. The Protocol must identify the person who has the authority to make this referral to the authorities. The Protocol should also outline what, if any, support will be provided to the client to help and guide them with the process of working with the authorities. The safety of the client should be paramount, and the Protocol should outline any further risk assessment and safety planning during the reporting stage. **If the client does not consent.** The protocol should outline the steps CLM will take when the client does not consent to reports to authorities. The Protocol should outline what steps will be taken if the wishes of the client are in conflict with reporting requirements, such as mandatory reporting. For example, if the client does not consent to a report to the authorities and the serious incident indicates a crime may have occurred. The consent of the client needs to be balanced with mandatory reporting laws and obligations. The Protocol should also outline what steps, including any formal reporting, will be taken to inform the facility or health care facility about the critical incident. The Protocol should clearly identify the person who has the authority to do this, and the process of seeking consent from the client. The Protocol should identify the person who has the authority to make decisions about any form of external reporting without the client's consent and under what basis this might occur. The first step to avoid this conflict is to ensure that the client understands the limits to confidentiality at the beginning of the follow up (see above).

Case closure and records management	The Protocol should include information about closing the follow up. The Monitor's role ends once the client has been referred to the appropriate service providers for assistance and the incident has been reported to authorities (if required and where the client consents). The Protocol should include information about how clients will be updated throughout the case management process, including at case closure. This includes ensuring that they are updated about case closure steps, ensuring they understand what has occurred and what the proposed next steps include. The Protocol should outline how data and information relating to the follow up, any referrals and reports will be safeguarded, including how it will be stored, processes for hard and electronic copies, who has access, and for how long it will be retained. Storage should be restricted to those with the authority to access.

ANNEX 9: SKPA-2 CLM INDICATORS

Table 2. SKPA-2 CLM indicators

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
A. Key population CLM Indicators				
A1.	CLM survey participation	Number of key population CLM client forms collected	A measure of key population participation in CLM within a certain period of time. A high number of CLM client forms collected indicates high numbers of service users chose to participate in CLM questionnaire. However, it is important to remember that some clients may visit a particular facility several times and complete client form each time. Analyzing this indicator by risk group (Q24), gender (Q22) and age (Q21) (see client form in Annex 10) will provide more detailed information about who is participating in CLM. The total key population size would be needed to use this data to assess coverage or the proportion who are participating.	The number of CLM forms collected from key population HIV service users within a certain period of time (e.g. month, quarter) where a defined HIV service was received, or sought but not received, indicated by a 'yes' OR 'no' box checked next to any service in Section 2 Q5, of the CLM client form.
A2.	HIV service availability	Number and percentage of HIV service visits where the services were reported as available[5] [6]	A measure of whether key populations are able to successfully receive the HIV service(s) they are seeking. 'Availability' here only covers whether or not the service key population clients sought was received. High levels of unmet demand could be used to advocate for the expansion of certain services.	Numerator: The number of CLM forms filled in by key populations where there is a 'yes' checked next to **every** service sought in the 'did you receive it' column on the client form Section 2 Q5a - Q5t.6 Denominator: The number of CLM forms filled in with one or more boxes checked under the service sought column Section 2 Q5a-Q5t.[6]

[5] For indicators where "number and percentage" is indicated, the number is the same as the numerator in the definition column. The percentage is calculated by dividing the numerator by the denominator

[6] It will be important to analyze HIV service availability based on the specific service clients are seeking, e.g. contrast the availability of HIV testing services (5b.) compared to anti-retroviral therapy initiation (5f.).

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
A3.	HIV service accessibility	Number and percentage of HIV service visits where the services were reported as accessible	A measure of how affordable and convenient it is for key populations to access the HIV services they are seeking. Accessibility here covers: (1) convenience for clients to reach the location, (2) suitability of opening hours and (3) affordability of the service(s). ALL conditions need to be met to report the service visit as accessible. High percentages indicate that key populations overall view the HIV services they use as accessible. Further analysis is encouraged including constructing indicators for each of these three criteria individually so the analysis can help identify specific access barrier(s).[7]	Numerator: The number of CLM forms filled in by key populations where there is a 'yes' checked next to every accessibility-related question on the client form (Q6, 7, 8). Denominator: The number of CLM forms filled in with an entry in the 'yes' OR 'no' column for every accessibility-related question on the client form (Q6, 7, 8).
A4.	HIV service acceptability	Number and percentage of HIV service visits where the services were reported as acceptable	A measure of how acceptable key populations found the HIV service they received. Acceptability here covers: (1) perception that the client was treated respectfully by staff at the facility, (2) whether their consent was sought for any procedures and (3) privacy and confidentiality. ALL conditions need to be met to report the service visit as acceptable. High percentages indicate that key populations overall view the HIV services they use as acceptable. Further analysis may be helpful (see A3 above and footnote 7).	Numerator: The number of CLM forms filled in by key populations where there is a 'yes' checked next to every acceptability-related question on the client form (Q9, 10, 11). Denominator: The number of CLM forms filled in with an entry in the 'yes' OR 'no' column for every acceptability-related question on the client form (Q9, 10, 11)

[7] This will help pinpoint specific barrier(s) to quality services, such as affordability or inconvenient opening times, rather than just concluding services are not 'accessible' or 'acceptable'. It may also be useful to disaggregate the analysis to identify whether there are particular groups, such as young people or women, that experience accessibility differently.

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
A5 a.	HIV service quality	Number and percentage of HIV service visits where the services were reported as good quality	A measure of the quality of the HIV service key populations received. Quality here covers: (1) whether the client received items or commodities (e.g. medicine, condoms, lubricants) and information they needed, (2) whether a comfortable environment was provided – seating, drinking water, clean toilets, etc. BOTH conditions need to be met to report the service as good quality. High percentages indicate that key populations overall view the HIV services they use as good quality. Further analysis may be helpful (see A3 and footnote 6).	Numerator: The number of CLM forms filled in by key populations where there is a 'yes' checked next to every quality-relatedquestion on the client form (Q12, 13). Denominator: The number of CLM forms filled in with an entry in the 'yes' OR 'no' column for every quality- related question on the client form (Q12, 13).
A5 b.	HIV service wait	Average waiting time for HIV service	How long client had to wait to see the health care provider as a measure of health service efficiency.	Recorded in minutes. Mean (average) waiting time from Q14 can be calculated from all CLM client forms.
A6.	HIV service satisfaction	Mean (average) overall satisfaction score	A subjective measure of overall satisfaction with the service through a score between 1 and 5. A high score indicates a high level of general satisfaction and likely willingness to refer peers to the service. A low score indicates a low level of satisfaction.	The mean (average) of scores on all CLM client forms entered in Q15.

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
A7.	Prevalence of serious incidents	Number and percentage of key population service visits where a serious incident is reported[8]	A measure of the prevalence of "serious incidents" (e.g. human rights violations such as breach of confidentiality, stigma and discrimination, violence or sexual harassment) reported by key population HIV service users. This indicator will be disaggregated by the type of serious incident, namely: • Stigma and discrimination • Violence • Sexual harassment • Breach of privacy or confidentiality • Refused service because of gender, race, identity, risk behavior, or other • Undue pain or distress Any serious incident report needs to be followed up with the client, and potentially the service provider/manager in line with response protocols.	Numerator: The number of CLM forms filled in by key populations where there is a 'yes' checked next to **one or more** of the serious incident pre- defined categories on the client form (Q16a – 16f. Denominator: The number of CLM forms collected from key population HIV service recipients within a certain period of time (e.g. month, quarter) where a defined HIV service was received, or sought but not received (Q5a – 5t) as indicated through a **'yes' OR 'no'** box being checked next to any service in Section 2 Q5 on the client form.

[8] Care must be taken in interpreting a high percentage of serious incidents, particularly when making comparisons across facilities or other geographic units. It may be that in some areas key populations are more likely to fill the form in only when they experience a serious incident, while in others they are more likely to provide general feedback. This may be related to how the CLM tools are introduced. A consistent approach to introducing CLM tools within a country will help make these comparisons more meaningful. The same consideration applies to indicator A8.

[9] The list of serious incidents included in the data collection tool can be edited following country level stakeholder consultation.

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
A8.	Prevalence of stigma and discrimination	Number and percentage of key population HIV service visits where stigma and discrimination was reported[9]	A measure of the prevalence of stigma and discrimination reported by key population HIV service users who participated in CLM. This is a subset of indicator A7. Any stigma and discrimination incident needs to be followed up with the client, and potentially the service provider/manager.	Numerator: The number of CLM forms filled in by key populations where there is a 'yes' checked next to stigma and discrimination in the serious incident section of the client form (Q16a). Denominator: The number of CLM forms received from key population HIV service recipients within a certain period of time (e.g. month, quarter) where a defined HIV service was received, or sought but not received (Q5a – 5t) as indicated through a **'yes' OR 'no'** box being checked in Section 2 Q5 on the client form.
B. Key population CLM serious incident follow-up indicators				
B1.	Serious incident follow-up attempts	Number and percentage of serious incident reports followed up	A measure of efforts to follow-up serious incidents. This is the number and percentage of CLM follow-up forms where at least one attempt has been made to reach the client.	Numerator: The number of CLM follow-up forms filled in with one or more attempts made to contact the client (a 'yes' OR 'no' checked in Q14 on the follow-up form). Denominator: The number of CLM client forms filled in with one or more serious incidents indicated (Q16a – 16f)[10]

[10] An alternative source of data for this denominator is section 3 (Q15) on the follow-up form – only if the data is consistently transferred from Q15 on the client form to here.

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
B2.	Successful client follow-up of serious incidents	Number and percentage of serious incident reports where a successful contact with a key population HIV service client was made for follow-up	A measure of successful follow-up of serious incidents. The numerator measures the number of serious incidents with a successful follow-up attempt, while the percentage measures the relative success in contacting clients to review the incident and plan follow-up actions. A low percentage could highlight a lack of contact details on the follow-up forms, low intensity of follow-up efforts, lack of interest from client for follow-up or a combination of these reasons.	Numerator: The number of CLM follow-up forms where the individual making the follow-up attempt successfully contacted the key population HIV service user reporting a serious incident (a 'yes' checked in Q14 of the follow-up form). Denominator: The number of CLM follow-up forms with a serious incident indicated and one or more attempts were made to contact the client (a 'yes' OR 'no' checked in Q14 on the follow-up form).
B3.	Accurate reporting of serious incidents	Number and percentage of serious incidents correctly recorded	A measure of accurate reporting of serious incidents on the CLM client form. This is generated during the client follow-up process where the case manager or HIV service supervisor conducting follow-up will discuss the nature of the serious incident' with the client in a confidential and supportive manner. The case manager will then use their best judgement (based on relevant national guidelines) to determine whether the incident was correctly categorized and reported on the form. This is a data validation process, as well as forming an important part of client follow-up and case management.	Numerator: The number of CLM follow-up forms with a 'yes' next to Q16 on the follow-up form ('was this a serious incident?'). Denominator: The number of CLM follow-up forms with a 'yes' OR 'no' next to Q16 on the follow-up form ('was this a serious incident?').

[11] A case manager could be an outreach worker, counsellor, or other trained CBO staff/volunteer tasked with following up CLM serious incident reports. It could also be an independent staff member of the health facility (someone other than the HIV service provider who served the client) or a member of a district or local government health team.

[12] Case managers need information about referral services before they speak to the client - including alternate HIV or health services, counseling services, social welfare, legal and other relevant services.

Indicator number	Indicator short name	Indicator long name	What the indicator tells us	Definition/computation
B4.	Referrals to services following a serious incident	Number and percentage of serious incidents referred to services	A measure of case management of serious incidents. Following the validation of a serious incident by case managers (see B3) referrals to follow-up services may be needed. These follow-up services include: (1) HIV/ health services, (2) counseling services, (3) legal services, (4) social welfare services including gender- based violence, (5) child protection, and (6) other[12].	Numerator: The number of CLM follow-up forms with the 'yes' box ticked under one or more of the services listed in Q18 referrals (Q18a – 18f). Denominator: The number of CLM follow-up forms with a 'yes' next to Q16 on the follow-up form ('was this a serious incident?').
B5.	Successful and timely resolution of serious incidents	Number and percentage of serious incidents resolved within 30 days[13]	A measure of the successful resolution of serious incidents in a timely manner.	Numerator: The number of serious incidents successfully resolved within 30 days from reporting the incident (Q20b). The time taken to resolve the incident can be calculated by counting the number of days in between Q4 (date of the CLM report) and Q5 (date of this follow-up) on the client follow-up form. Denominator: The number of CLM follow-up forms with a 'yes' next to Q16 on the follow-up form ('was this a serious incident?')

It is important to only collect data for indicators that are relevant and actionable, and to adapt this set of core indicators (and terminology) as necessary, so that they are appropriate to the country context. Countries may choose to monitor additional AAAQ indicators included in the framework in Figure 3. However, it is important to keep in mind that key population respondents are more likely to take the time to answer a short, streamlined survey.

[13] 30 days is used as a benchmark for timely resolution of serious incidents, recognizing that complex cases (e.g. those involving the legal system) may take longer to resolve. Analysis by type of serious incident will help identify those that can usually be resolved in a timely manner. An indicator for successful resolution of serious incidents can also be constructed from 18b, by ignoring the time taken to resolve the incident.

ANNEX 10: CLM CLIENT FORM

Section 1: HIV/health service details and visit date

CLM form number

1. Today's date

Day / Month / Year

2. Location of the facility

Ward/Village | Town/District | Province/Region

3. Name of the facility

4. Date of clinic visit that you are providing feedback about

Day / Month / Year

Section 2: Feedback on the health service/s:

Availability of services:

5. Which service(s) did you seek at your clinic visit?

Sought service	Did you receive it? Yes	No
5a. Condom and lubricant supply	○	○
5b. HIV screening test	○	○
5c. HIV counseling	○	○
5d. HIV confirmation test	○	○
5e. Receive HIV test result report	○	○
5f. Anti-retroviral therapy (ART) initiation	○	○
5g. Anti-retroviral therapy counseling	○	○
5h. Anti-retroviral therapy (ART) refill, follow-up multi-month dispensing	○	○
5i. Viral load testing	○	○
5j. Post-exposure prophylaxis (PEP)	○	○
5k. Pre-exposure prophylaxis (PrEP)	○	○
5l. STI testing/diagnosis and treatment	○	○
5m. Opportunistic infection (OI) management and medicine	○	○

	Yes	No
5n. Other HIV case management	○	○
5o. TB services	○	○
5p. Reproductive health service (family planning, contraception) (Optional)	○	○
5q. Obstetric/ Gynecological diagnosis and care (Optional)	○	○
5r. PMTCT (Optional)	○	○
5s. Harm reduction services for people who use drugs (opioid substitution therapy, needle and syringe exchange (Optional)	○	○
5t. Other (specify)	○	○

Accessibility of service

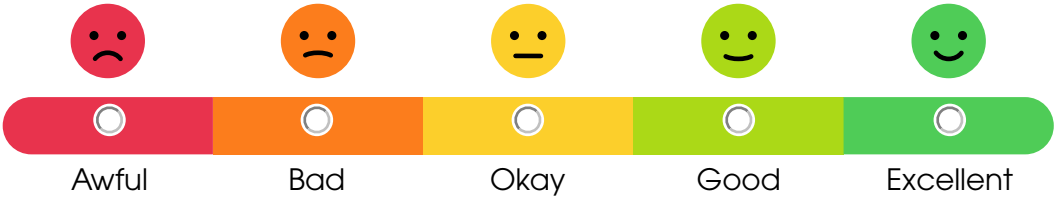
	Yes	No
6. Was the HIV service location convenient for you? (distance, ease of transportation, etc.)?	○	○
7. Are the facility opening hours suitable for you? (know/ask facility opening & closing timings (weekdays & weekend))	○	○
8. Was the service affordable for you?	○	○

Acceptability of service

	Yes	No
9. Were you treated respectfully by the staff, regardless of your gender, sexual orientation, age or religion?	○	○
10. Did the staff seek your consent for any procedures (examinations, tests, etc.)?	○	○
11. Was there privacy and confidentiality provided for your consultation during the visit?	○	○

Quality of service

	Yes	No
12. Did you receive any items (medicine, condoms, lubricant, etc.) or information you need (were all your questions answered)?	○	○
13. Was the facility comfortable for you? (chairs in waiting room, drinking water availability, clean toilets, etc.)	○	○
14. How long did you have to wait to see the health care provider? (Record in minutes, if the waiting time was in hours multiply by 60; enter 0 if did not have to wait)		
15. Please give a score from 1 to 5 for how satisfied you were with the service (where 1 is awful to 5 is excellent)		



Section 3: Reports of any serious incidents experienced:

	Yes	No
16. Did you experience any serious incidents at or linked to the service visit?	○	○
16a. Stigma and discrimination (Negative attitude or negligence towards you or unfair treatment at health facility during your visit because of your appearance, identity, or profession)	○	○
16b. Violence during or due to your visit to health facility (Verbal or physical harm or sexual abuse)	○	○
16c. Harassment (including sexual) from the service staff or other clients (Inappropriate or offensive attitudes, words or behavior towards you)	○	○
16d. Abuse, either emotional, physical or sexual, from service staff or other clients.	○	○
16e. Breach of privacy or confidentiality (Lack of space to discuss your health matters privately or your personal information or HIV status was not kept confidential)	○	○
16f. Refused service because of gender, identity, race, risk behavior or other reason	○	○
16g. Undue physical pain or distress caused by rough or unkind treatment at facility	○	○

16f. Other

17. Can you please provide some more details to assist our follow-up?

18. Do you consent to having a trained staff member or volunteer contact you to help resolve this?

19. If yes, please let us know how to contact you

Name/Nickname of contact person

Email

Phone/WhasApp

Other social media

Section 4: Client profile

20. When did you last complete this form for this health facility?

21. What is your age in years?

years old

22. What is your gender?

23. Which organization do you associate with?

24. Please select any of these population groups that you identify with (you may select more than one)

24a. Men who have sex with men

24b. Sex worker

24c. Person who uses recreational drugs[1]

24d. Person who injects recreational drugs

24e. Client of sex workers

24f. Transgender woman

24g. Person living with HIV

24h. None of above

24i. Do not want to disclose

[1] Recreational drugs such as heroin, cocaine, amphetamines and amphetamine type stimulants - MDMA, ecstasy, ice, etc.

Alternate question if country team decide it is more suitable[2]

24*. *In the past 12 months have you engaged in any of the behaviors listed here? (tick all the boxes that apply)*

24a. *Male to male sex* ☐

24b. *Received money or goods in exchange for sex* ☐

24c. *Paid money or goods in exchange for sex* ☐

24d. *Use of recreational drugs* ☐

24e. *Injected recreational drugs* ☐

24f. *None of the above* ☐

24g. *Do not want to disclose* ☐

25. Do you have a unique identifier code (anonymous client code) that you are willing to share?

Yes, here it is ☐

No or unsure ☐

Section 5: General Feedback and follow-up

26. What did you particularly like about your experience at this HIV service?

27. Do you have any advice, recommendations or requests for this HIV service?

Thank you for taking the time to provide feedback on your HIV service experience.
Your feedback is important!

[2] This alternate question 24* can be used in the CLM Client Form instead of question 24, if county stakeholders are more comfortable with this option due to local sensitivities about asking respondents directly about their population group.

ANNEX 11: CLM FOLLOW-UP FORM

Section 1: Follow-up details

The details for Q 1 – 10 can all be obtained by staff from the Client Form and there is no need to repeat asking the client. For online forms they can be autogenerated from electronic database.

1. CLM form number

2. Name of the facility

3. Location of the facility

Ward/Village | Town/District | Province/Region

4. Date of the CLM report

Day / Month / Year

5. Date of this follow-up

Day / Month / Year

6. Details of individual following up report

Name

Designation (position) e.g. Outreach worker

Organization

Contact details

7. Client age in years

years old

8. Client gender

9. Client Unique identifier code (if known)

Yes, here it is

No or unsure

10. Please select any of these population groups that you identify with (you may select more than one):

Men who have sex with men	☐	Transgender woman	☐
Sex worker	☐	Person living with HIV	☐
Person who uses recreational drugs	☐	None of above	☐
Person who injects recreational drugs	☐	Do not want to disclose	☐
Client of sex workers	☐		

Alternate question if country team decide it is more suitable:

10* Client risk behaviors in last 12 months (tick all that apply)

10a. Male to male sex	☐	10d. Use of recreational drugs	☐
10b. Female to female sex	☐	10e. Injected recreational drugs	☐
10c. Received money or goods in exchange for sex	☐	10f. None of the above/did not disclose	☐

11. Did client consent to having a trained staff member or volunteer contact them for more information on this?

Yes ○ No ○

If no, *then go to section 20b and enter 'client refuses to continue the case' under final result*

If yes, *please continue, using the client's preferred mode of contact and details on their CLM form*

Section 2: Follow-up attempts

12. Is this the first contact related to this complaint or a follow-up? Yes ○ No ○

13. How are you following up the client?

Phone call/ WhatsApp/etc	Email	Face-to-face	Other, please specify
☐	☐	☐	☐

14. Did you reach the client?

Attempt 1		Attempt 2		Attempt 3	
Yes	No	Yes	No	Yes	No
○	○	○	○	○	○

If you were not able to reach the client after 3 attempts, skip to section 20b and enter 'could not reach client'

Section 3: Recap of serious incident(s) to be followed up

15. Is this the first contact related to this complaint or a follow-up? Yes ○ No ○

	Yes	No
15a. Stigma and discrimination	○	○
15b. Violence linked to visiting the service	○	○
15c. Sexual harassment from the service staff or other clients	○	○
15d. Abuse, either emotional, physical or sexual, from service staff or other clients	○	○
15e. Breach of privacy or confidentiality	○	○
15f. Refused service because of gender, identity, race, risk behavior or other	○	○
15g. Undue physical pain or distress	○	○

15h. Other, explain

16. After discussing with the client, was this a serious incident as above? Yes ○ No ○

Enter any more relevant details here to assist understanding or resolution of the issue

Section 4: Information following successful contact with client

17. After discussing with the client, was this a serious incident as above? Yes ○ No ○

18. If yes, did you refer the client to any of the following services (tick box)

18a. HIV or health services ☐

If yes, which health facility?

18b. Counseling services ☐

18c. Legal services including police ☐

18d. Social welfare services including GBV ☐

18e. Child protection services ☐

18f. Other, please specify

18g. Please provide detail of the referral made (organization, contact point, etc.)

19a. Is there a mandated requirement to report the incident, or does the incident relate to criminal conduct? Yes ○ No ○

19b. If yes, does the client consent to a report being made to the authorities? Yes ○ No ○

19c. If yes, did you make any reports to the following authorities (tick box)

Police	Child Protection Authorities	Social Welfare Authorities	Other
☐	☐	☐	☐

19d. Please include details about the report, including the date and what was reported.

Section 5. Final result from this follow-up attempt

20. Is the case still ongoing or is it now resolved/closed?

20a. Ongoing Yes ○ No ○

20b. Case resolved or closed because:

- Could not reach client ☐
- Successful resolution accepted by client ☐
- Client refuses to continue the case ☐
- Could not successfully resolve the case ☐
- Client successfully referred to external agency ☐
- Other situation, please specify

21. Please explain in a few words the nature of the follow-up contact, your recommendation for any follow up actions for the client and the KPO or health centre, and the result:

Thank you for taking the time to provide feedback on your serious incident follow-up experience. Your feedback is important!

ANNEX 12: CLIENT SATISFACTION TOOL FOR SERIOUS INCIDENTS

Name

ID #

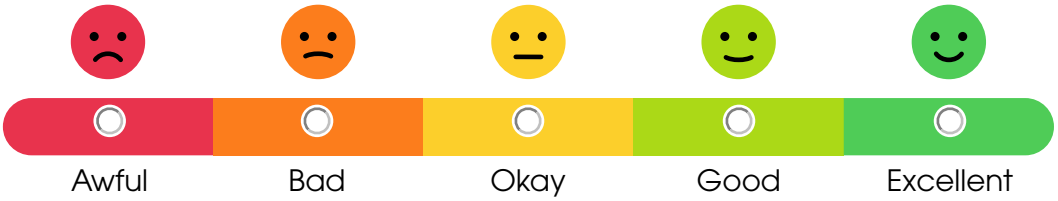
Today's Date

Day / Month / Year

Date of Serious Incident Follow-up by CLM Staff

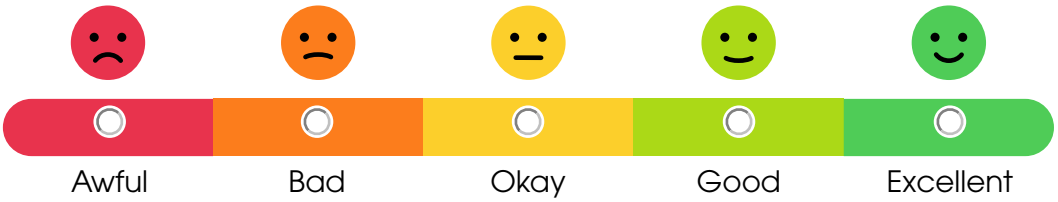
Day / Month / Year

A. Please rate below your overall feeling about the resolution by trained staff of the Serious Incident you reported:[5]

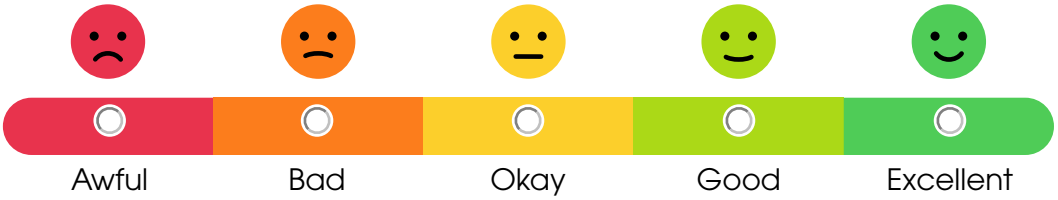


B. Please rate below your feelings about follow-up by trained staff on the following:

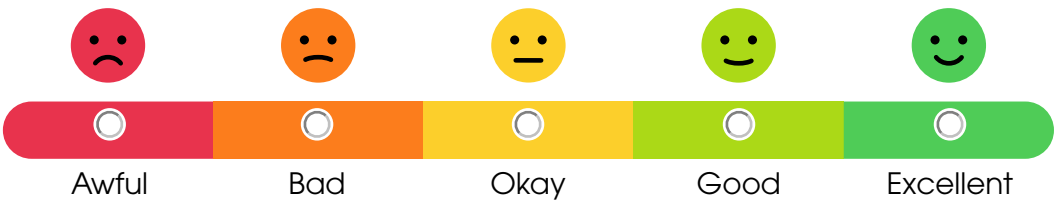
i. Staff clearly explained the reason for follow-up:



ii. Staff communicated clearly and spoke to me in a respectful manner:



iii. Staff provided adequate information and/or referral options to relevant services that I may need to address my serious incident issue:



[5] Note for CLM implementers: For analysis purposes to derive a mean score on these indicators of client satisfaction with the resolution of serious incidents, the 'Awful' to 'Excellent' emoticon ratings may be scored from 1 to 5 or 0 to 4, respectively.

C. Improvement Suggestions

Kindly provide any suggestions you have so that we may better follow up and respond to your detailed serious incident in the future. This information will be analyzed and used by management staff to try and make changes to the process to improve it.

D. Any other comments

Thank you for your feedback to help us improve

ANNEX 13: TEMPLATE FOR CLM ACTION PLAN

A. Micro-level: Facility Level / Quality Improvement Actions

Facility

District/Province

Date

Day / Month / Year

Name and affiliation (organization) of members of the working group developing the CLM action plan:

Name

Affiliation (organization)

Issue description (note: one issue/form)

Desired Outcome

Plan

Planned Action(s)		
1.	Responsible	Resources needed
	Indicator(s)	Date due
2.	Responsible	Resources needed
	Indicator(s)	Date due
3.	Responsible	Resources needed
	Indicator(s)	Date due
4.	Responsible	Resources needed
	Indicator(s)	Date due
5.	Responsible	Resources needed
	Indicator(s)	Date due

B. Macro-level: CLM Advocacy, Policy Systems Level Actions

Agency

Disctrict/Province/Location

Date

Day / Month / Year

Name and affiliation (organization) of members of the working group developing the CLM action plan:

Name

Affiliation (organization)

Issue description (note: one issue/form)

Desired Outcome

Plan

Planned Action(s)		
1.	Responsible	Resources needed
	Indicator(s)	Date due
2.	Responsible	Resources needed
	Indicator(s)	Date due
3.	Responsible	Resources needed
	Indicator(s)	Date due
4.	Responsible	Resources needed
	Indicator(s)	Date due
5.	Responsible	Resources needed
	Indicator(s)	Date due

ANNEX 14: QUALITY OF CARE (QOC) BENCHMARK TO ASSESS FEEDBACK MECHANISMS

Area of Concern		Standard (benchmark)	Score (1-4)
Identification		Serious incidents clearly defined so that they are easily identifiable in CLM data	
		Clear roles and responsibilities and qualifications defined for the case manager	
		Clear roles and responsibilities and composition defined for the serious incident management committee	
		Serious incident management committee established	
		Budget ringfenced for funding to support responses to serious incidents and support individuals if needed (pre-determined limits by coordinating committee)	
		CLM data reviewed regularly / routinely to identify any serious incidents for follow-up timeously	
Follow-up		Contact made with individual to follow-up to establish further details regarding serious incident	
		Informed consent sought for follow-up	
		Communication channels clearly defined, and secured, including for responding to issues requiring rapid response	
		Script followed for follow-up interview, further details documented about the incident - template form completed	
		If serious incident confirmed, further follow-up and response needed by case manager and committee	
		Serious incident management / review committee notified of incident and review findings	
		Resolution noted / documented if no further follow-up required (consent not given) or if incident no longer deemed to be serious	
Response	At individual level	Case Manager responds immediately through provision of support and/or referral to assist the individual	
		Allocate funding to support individual if needed	
		Referral form completed and/or response to incident documented in CLM Follow up Form by Case Manager	
		Accompanied referral offered / provided as needed	
		Follow up completed with client with the Client Satisfaction Tool after the referral to understand whether the issue is successfully resolved	
		Ensure all implementing staff are aware of the procedure for handling serious incidents and that new colleagues are trained on the Serious Incident Response and Reporting Protocol	

Area of Concern		Standard (benchmark)	Score (1-4)
Response	At clinical / institutional level	Serious Incident Management / review committee to further investigate if needed and/or inform clinic management	
		Stakeholders kept up to date with reports of and responses to serious incidents. Stakeholders include communities, ministries of health, CLM implementers, donor agencies and others	
		A remediation plan should be developed by Serious Incident Management/ review committee to address serious incident(s). Stakeholders should discuss the plan and report back to the community and the facility.	
		Senior clinic management notified of serious incident	
		If a serious incident is reported against a staff member, they are referred to the National AIDS Programme/Ministry of Health disciplinary committee or other appropriate agency for follow up investigation and their duties re-allocated	
		Response received from senior clinic management and solutions to address / prevent serious incident included in improvement /action plan	
		Ongoing professional development for providers on inclusive, stigma-free and quality care	
		Document agreed actions and commitments made to address and prevent similar future serious incident(s)	
		Risk mitigation strategy informed / updated based on CLM data and serious incidents reported	
	At structural level	Identify any advocacy issues arising from serious incidents reported	
		Mechanisms established for reporting cases of discrimination in health-care settings, and serious incidents reported through relevant national channels where applicable, e.g. to National AIDS Program managers or MoH officials.	
		Awareness raising on patient rights	
		Identify if / any technical support needs for preventing similar serious incidents in the future	
		Identify if / any training needs for healthcare providers to respond to, and prevent future, serious incidents	
Monitor	At individual level	Check in after 6 months to check resolution / redress achieved	
	At clinical / institutional level	Check in during next (quarterly) clinic review meeting on progress re actions / solutions identified	
	At structural level	Monitor CLM data mindful of any trends in serious incidents documented, and if so, elevate for advocacy and systems level intervention	