



COMMUNITY LED-MONITORING GUIDE FOR KEY MALARIA PROGRAMS FOR CIVIL SOCIETY ORGANISATIONS

CS4ME

CIVIL SOCIETY FOR MALARIA ELIMINATION

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LIST OF ABBREVIATIONS AND ACRONYMS

ACT	Artemisinin-based Combination Therapy
ACOMIN	Civil Society in Malaria Control, Immunization and Nutrition
CHW	Community Health Worker
ET	Educational Talk
CS4ME	Civil Society For Malaria Elimination
DHIS2	District Health Information Software 2
HF	Health Facility
IRA	Acute Respiratory Infection
ISA	Impact Santé Afrique
CDI	Community Directed Interventions
CSO	Civil Society Organization
NGO	Non-governmental organization
WHO	World Health Organization
NMCSP	National Malaria Control Strategic Plan
M&E	Monitoring & Evaluation
TB	Tuberculosis
RDT	Rapid Screening Test
ITP	Intermittent Preventive Treatment
HV	Home Visit
HIV	Human Immunodeficiency Virus

INTRODUCTION

According to the latest World Health Organization (WHO) World Malaria Report (2021), there were 241 million cases of malaria in 2020 compared to 227 million in 2019, an increase of nearly 14 million cases. Malaria deaths increased by 69,000 to 627,000 deaths in 2020 compared to 558,000 in 2019.. In addition, the WHO Africa Region continues to pay the highest burden of malaria with 96% of all malaria deaths in 2020. Children under 5 years of age are the primary victims of the disease (80% of all malaria deaths in the region). On the other hand, after a significant reduction in the number of cases and deaths observed between the years 2000 and 2015 in the world, most of the countries with a high malaria burden (the vast majority of which are on the African continent) have experienced a worrying increase. As an illustration, 24 countries have experienced an increase in malaria-related mortality since 2015¹. This situation has worsened with the COVID-19 pandemic, which has further weakened the health systems of these already globally weak states.

Globally, the 11 countries with the highest incidence of the disease recorded a moderate decrease between 2000 and 2015.. Malaria cases in High Burden to High Impact (HBHI) countries reduced from 155 million to 150 million from 2000 to 2015. But the malaria cases in those countries reached 163 million in 2020. Deaths from malaria decreased from 641,000 to 390,000 from 2000 to 2015. But in 2020, the trend is up with 444,600 deaths from malaria².

Pregnant women and children under five are among the groups most biologically vulnerable and affected by malaria. Social groups with very low incomes are also vulnerable to malaria insofar as they are unable to access paid services and care.

In order to better address their needs, community-led monitoring is an important activity.

In order to ensure that the needs of populations vulnerable to malaria related to the «Community, Rights and Gender» are better taken into account in malaria policies and have a strong influence of civil society on decision-making bodies in the fight against malaria, it is essential that the capacities of civil society organizations (CSOs) be strengthened in strategic areas such as Community-Led Monitoring (CLM). The aim is to improve their contribution to quality community monitoring of key malaria interventions in vulnerable communities..

During a literature review, it was noted that unlike the HIV and TB pandemics which have a long list of community-led monitoring tools, malaria has very few tools to monitor malaria interventions. Organizations implementing community led monitoring of malaria interventions have had to adapt existing tools to the context of their respective countries. This is the case of the ACOMIN network in Nigeria, which has done so as part of its community monitoring project financed by the Global Fund. . This means that CSOs involved in the fight against malaria do not have enough tools to conduct good and quality community-led monitoring of interventions. This observation makes it clear that CSOs, major actors in the fight against malaria, need to have a guide and tools that will allow them to properly conduct community-led monitoring of malaria control activities.

The efforts made so far for community-led monitoring tools available in the field of HIV/TB are generally government-led/sponsored, which takes away their decision making choice, voices and responsibility from the communities. In addition, the community-led monitoring driven by the government generally has a very high budget and do not reflect the actual meaning of community owned process of monitoring interventions while that initiated by the community has a better quality/price ratio. It should be noted that in most cases, community-led monitoring in the areas of HIV/TB is conducted by community identity organizations. These community identity organizations were born because of the stigma/discrimination related to these two pandemics, which pushed patients who suffer from them to organize themselves into identity groups. However, malaria does not have

¹ Angola, Bolivia (Plurinational State of), Botswana, Brazil, Comoros, Democratic Republic of the Congo, Djibouti, Ecuador, Eritrea, Guinea Bissau, Guyana, Haiti, Liberia, Madagascar, Namibia, Nigeria, Papua New Guinea, Philippines, Solomon Islands, Sudan, South Sudan, Uganda, Venezuela (Bolivarian Republic of), Yemen

²Source: WHO - World Malaria Report 2021

these identity groups and this may, to a lesser extent, explain the little community-led monitoring conducted for malaria interventions far. In addition, malaria-affected communities are not yet well informed that community-led monitoring exists and is their responsibility.

The vision of WHO and partners involved in the fight against malaria is a world free of malaria by 2030. To achieve this, a Global Technical Strategy (GTS) has been developed, adopted, and contextualized for each country to make this vision a reality. Thus, to achieve malaria elimination, it is essential to put in place a combination of national strategies adapted from the global technical strategy, based on the realities of each malaria-endemic country. These strategies include distribution and use of treated mosquito nets, Chemoprevention, timely diagnosis, effective treatment of simple or complicated malaria cases, antimalarial treatment, Intermittent Preventive Treatment (IPT), Malaria surveillance. , All of these strategies are implemented during key interventions for which quality community led monitoring must be carried out. In addition, WHO has launched the «High burden high impact» objective, which will increase country ownership, political will, strategic information, better guidance and a coordinated response.

Community led-monitoring is based on the principle that **«Nothing that is done for us should be done without us»**. The combination of this principle with evidence shows that community-led monitoring is an important driver of improved service delivery and health outcomes that needs to be re-emphasized. Thus, the community must participate at all stages of the fight against malaria. This guide will be useful to CSOs working in the field of malaria in the conduct of community-led monitoring of activities efficiently and allow these CSOs to know their role and responsibilities in this exercise at each key stage. This guide will also provide CSOs and communities affected by malaria with templates of monitoring tools adapted to key malaria programs.

This document aims to encourage the inclusion of community-led monitoring approach particularly to malaria funded programs in Global Fund grants to complement national Malaria monitoring systems, identify barriers to improved service delivery, and respond to community preferences regarding access, affordability, quality, and acceptability of services.



OBJECTIVES

The overall goal of this guide is to strengthen capacities of CSOs in community-led monitoring so as to improve their contribution to quality monitoring of malaria interventions in communities.

This guide is driven by the following specific objectives:

- ① To provide an understanding of the definition, characteristics, and importance of Community-Led Monitoring;
- ① To enable mastery of the processes of data collection and data analysis;
- ① To enhance mastery of data quality assurance and the processes of using up-to-date information to improve decision-making;
- ① To improve understanding of the steps to implement Community-Led Monitoring in communities, with the community as the leader.



CHAPTER I: MALARIA SITUATION IN “HIGH BURDEN TO HIGH IMPACT» COUNTRIES

This chapter provides a brief overview of the epidemiological status of malaria in HBHI countries, the WHO-recommended strategy, and the need to align community monitoring with national malaria control strategic plans.

1. Summary of the malaria situation in High Burden to High Impact (HBHI) countries

World Health Organization (WHO) estimates that 627,000 people died from malaria in 2020, compared to 558,000 in 2019, an increase of 69,000 deaths. Nearly two-thirds (47,000) of the additional malaria deaths are caused by disruptions in malaria prevention, diagnosis, and treatment services during the COVID 19 pandemic.

In 2020, 95% of malaria cases (228 million of estimated cases) and 96% of malaria deaths (602,000) occurred in the WHO African Region, which bears a large and disproportionate share of the global malaria burden. Children under 5 years of age accounted for 80% of all malaria deaths in the Region. In sub-Saharan Africa, the estimated number of malaria deaths increased by 12% in 2020 compared to 2019. This figure highlights the impact of even moderate disruptions to malaria control services in an at-risk population.

The WHO South-East Asia region accounted for nearly 2% of global malaria cases, with approximately 5 million cases and 9,000 deaths in 2020. India alone represented 83% of malaria cases in the region. The six countries of the Greater Mekong Sub-region (Cambodia, China, Myanmar, Lao PDR, Thailand, and Viet Nam) reported a peak of 650,000 malaria cases in 2012. This prompted the launch of targeted efforts to fight antimalarial drug resistance in the sub-region, which resulted in a significant decline in case numbers. In 2020, there were 82,000 cases of malaria in the sub-region, including some 19,000 cases of *P. falciparum*. Most cases are in Myanmar and Cambodia.

The 10+1 HBHI countries (Burkina Faso, Cameroon, Ghana, India, Mali, Mozambique, Niger, Nigeria, Uganda, Democratic Republic of Congo (DRC), and United Republic of Tanzania), accounted for nearly 70% of cases and 71% of deaths globally in 2020.

2. WHO recommended strategy

To reverse this trend, WHO introduced the High Burden to High Impact (HBHI) approach in 2020, which aims to put the world back on track toward reaching the milestones of the Global Technical Strategy for Malaria Control 2016-2030. To achieve this, WHO recommends:

- Accelerate the reduction of malaria incidence and mortality in the 11 countries (Burkina Faso, Cameroon, Democratic Republic of Congo, Ghana, India, Mali, Mozambique, Niger, Nigeria, Tanzania and Uganda) contributing to 70% of the malaria burden through increased political will, use of data for action, and improved guidance and coordination;
- Learn from success and expand to other high-burden countries.

The Global Technical Strategy is based on the following elements:

Pillar 1: Ensure access to malaria prevention, diagnosis and treatment as part of universal health coverage.

The main WHO recommendations focus on vector control, chemoprevention, diagnosis, testing and treatment, with the aim of significantly reducing morbidity and mortality.

Pillar 2. Accelerate efforts to eliminate malaria and achieve malaria-free status.

In addition to prevention, diagnosis and treatment as part of primary health care, the strategy will focus on targeting parasites and vectors at transmission sites, based on active case detection and investigation as part of a malaria surveillance and response programme. In addition, the development and adoption of innovative solutions will be essential to address the spread of insecticide resistance and residual transmission, and to target *P. vivax* hypnozoite reservoirs.

Pillar 3. Make malaria surveillance a key intervention.

All malaria-endemic countries and those at risk of re-establishing malaria need an effective health management information system to help national malaria control programmes direct resources to the most affected populations, identify gaps in programme coverage, detect outbreaks, and assess the impact of interventions to guide national strategic planning and implementation.

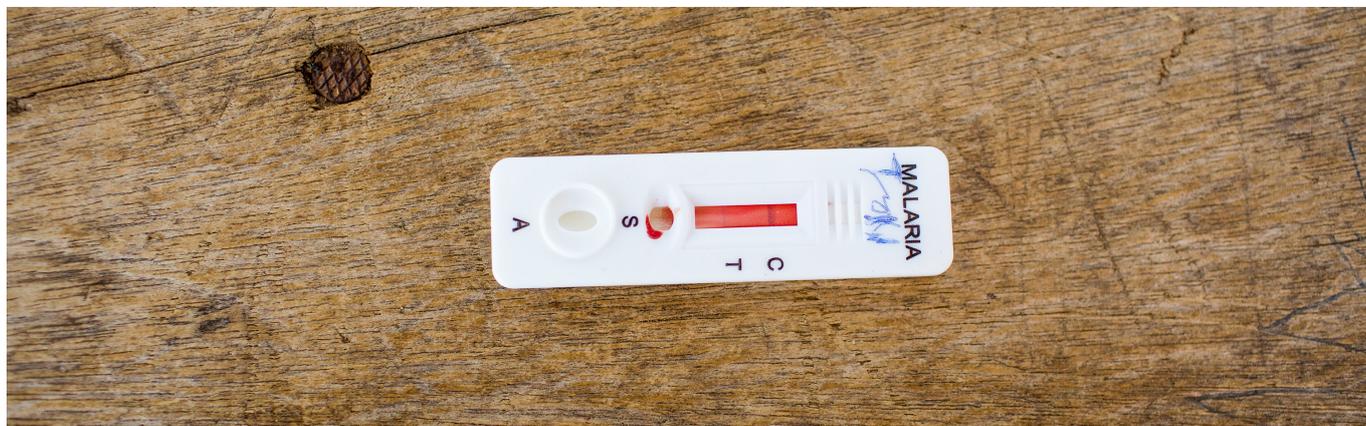
Supporting element 1: Harnessing innovation and developing research.

To support these three pillars, malaria-endemic countries and the global malaria community need to harness innovation and increase their engagement in basic, clinical and implementation research.

Supporting element 2. Strengthen the enabling environment for more sustainable and equitable outcomes.

Malaria interventions must be embedded in and supported by an enabling environment. Accountable and trusted national leadership in sustainable and equitable societies with resilient and well-functioning health systems, supported by a gender-sensitive, equity-focused and human rights-based approach, with the goal of leaving no one behind, is essential for success.

Indeed, funding for malaria control has fallen from US\$3.7 billion in 2017 to less than US\$3 billion in 2018, according to WHO, rising to just over US\$3 billion in 2019 and 2020. The main contributors are the Global Fund, PMI (USA), National Malaria Control Programs (NMCPs), and the United Kingdom.



3. Importance of national malaria control programs and strategic plans

To fight against malaria, each country has a National Strategic Plan for Malaria Control (NSPMC) and a National Malaria Control (or Elimination) Program (NMCP/NMEP). The NSPMC is the country's political vision to solve this problem while the NMCP/NMEP is the institution that coordinates daily malaria control interventions in the country. In general, the NSPMC is initiated by the NMCP/NMEP which involves all partners in its implementation.

It is very important that all activities carried out by the various stakeholders to fight malaria in a country are linked to this vision and coordinated by the NSPMC.

Therefore, community led monitoring for key malaria programs must be aligned with the NSPMC. In this perspective, Community Led-Monitoring can be used to monitor the budget and prioritization of operational plans.



CHAPTER II: MALARIA CONTROL STRATEGIES

Malaria control strategies are those that can have the greatest impact on reducing the number of cases and/or curing patients. Given the scarcity of funding, donors are focusing their priorities on key programs. The most commonly used strategies include vector control such as the use of Insecticide-Treated Nets (ITNs), chemoprevention, Indoor Residual Spraying (IRS); hospital and community-based malaria management.

1. Methods of malaria prevention

Malaria is prevented through several approaches. In some countries, these different ways are combined to achieve better prevention. To conduct community-led monitoring, it is essential to be aware of the national and global malaria control plans and targets (as well as your country's guidelines) to track progress. Below are some common malaria prevention methods used in many countries around the world. Each CSO involved in the fight against malaria can find those specific to their country in the National Malaria Control Strategy, generally available from the NSPMC.

..... 1.1 The chemo prevention

Malaria is prevented through several approaches. In some countries, these different ways are combined to achieve better prevention. To conduct community-led monitoring, it is essential to be aware of the national and global malaria control plans and targets (as well as your country's guidelines) to track progress. Below are some common malaria prevention methods used in many countries around the world. Each CSO involved in the fight against malaria can find those specific to their country in the National Malaria Control Strategy, generally available from the NSPMC.

..... 1.2 Distribution and use of ITNs

One of the best-known and most widely used methods is the distribution of Insecticide-Treated Nets (ITNs), of which some are LLINs, because of the varied wash and integrity resistance. The Long Lasting Impregnated Mosquito Net (LLIN) not only protects against mosquito bites, but also reduce lifespan of mosquitoes. LLINs can also kill or repel other insects such as bedbugs, lice and fleas.

The LLINs, which can release insecticides about three years, can be washed more than 20 times over the course of three years, retaining all their effectiveness. The method of use is simple: before placing the LLIN, it should be aired, if outside in the shade or to the open air for 24 hours, then it must be placed over the bed.

Most countries prioritize pregnant women and children under 5 years of age, as these are the most vulnerable segments of the population.

..... 1.3 Larval source management

The most important cause of morbidity and mortality in sub-Saharan Africa and other third world countries is poor environmental sanitation. This factor plays a major role in transmission of multiple vector-borne diseases, including malaria. The malaria vector (the female Anopheles) thrives and breeds in generally clean not organically polluted water. When these are few and findable, destroying larvae through environmental management, using larvicides or predators of mosquito larvae can reduce malaria.

..... 1.4 Indoor spraying

Indoor residual spraying (IRS) is an operational procedure for vector control that involves applying insecticides with residual efficacy and to which mosquitoes are susceptible to the inner surfaces of the structures used by humans and, sometimes, those for tethering animals if adult vectors are likely to rest in these during a significant part of their lifecycle. The aim of IRS is to kill vectors before they are able to transmit a parasitic disease to another human being. The specific residual insecticide persist on the wall for several months.

..... 1.5 The vaccine

The malaria vaccine available today can reduce by 30% the severe forms of the disease and requires four doses starting at 5-7 months of age.

To fight against malaria effectively, mixes of interventions are needed and adapted to different contexts, in particular patient management, vector control and chemoprevention. With strong health systems and programmatic capacity malaria has already been eliminated from several countries in Europe and America.



2. Malaria management

..... 2.1 Community-based management of malaria

The management of simple malaria cases is generally done in the community through Community Health Workers (CHW). CHWs are trained in the management of febrile patients, and are equipped with malaria RDTs and Artemisinin-based treatments (ACT). The role of CHWs in the community management of malaria is central. They distribute simple malaria control drugs and ensure that the drugs are taken correctly. The duties of CHWs sometimes extend to promote LLIN use and checking that the LLIN is properly attached. They are also responsible

for referring cases of severe malaria in children and pregnant women to the health facility. Most countries are promoting integrated community case management (iCCM) of malaria, pneumonia, diarrhea and malnutrition in children under five.

..... 2.2 Malaria management in hospitals

This management in a hospital setting is generally based on parenteral treatment of severe cases. Since 2010 injectable artesunate has become the standard of care for severe malaria. Partial resistance to artemisinin has emerged in Latin America, Southeast Asia and more recently in Africa. This has not affected the efficacy of ACT, as long as the partner drug remains effective.

3. Mosquito resistance to insecticides

The increasing physiological resistance of Anopheles mosquitoes to insecticides is recognized as a major threat that requires an urgent and coordinated response. To monitor this threat and inform country responses, WHO launched the Malaria Threat Map in 2014. In addition, all malaria-endemic countries are required to develop and implement insecticide resistance surveillance and management plans to monitor and manage insecticide resistance. There are also new generations of LLINs, «Interceptor G2» and «PBO», which combine the following chemicals : Permethrin + PBO; Deltamethrin + PBO; Alpha-cypermethrin + PBO; Alpha-cypermethrin and chlorfenapyr.

4. People most vulnerable to malaria

Generally, the most vulnerable populations to malaria are:

- Children from 0-5 years old;
- Pregnant women.

Community led monitoring of key malaria programs should therefore pay special attention to these most vulnerable populations, as they should be the focus of all interventions.



5. «Key populations» in malaria

For a given disease, the key populations are those that are difficult to reach because of certain local specificities related to their social status or their living environment. The Global Fund (which is one of the main donors to fight malaria) is gradually starting to talk about the notion of a key population for malaria, as is already the case with HIV and TB. But this notion is not yet very precise. The key populations identified for malaria are mobile populations (refugees, migrants, internally displaced, travelers, fishermen, rangers, hunters), sex workers (because a good number of them work at night in the open air), people living with HIV/AIDS, non-immune groups,⁵. Also, indigenous peoples in malaria-endemic areas are often at higher risk of transmission and generally have limited access to care and services. At present, malaria control activities do not reach key populations in all countries. But this marginalization of key populations in the fight against malaria raises the problem of equity in access to care against this disease. Community-led monitoring must highlight this lack of equity so that actions can be taken to correct it.

In conclusion, the concept of «key populations» cannot be used at this time to define populations vulnerable to malaria as presented in the previous section.



⁵Malaria matchbox tool, page 11,



CHAPTER III: COMMUNITY-LED MONITORING

The Global Fund defines Community-Led Monitoring in the CSS Technical Brief (2019) as «**models or mechanisms by which service users and/or local communities continuously collect, analyze and use information to improve access, quality and impact of services, and hold service providers and policymakers to account.**» In addition, for the Ritshidze program (HIV, TB) Community-Led Monitoring is «**a data collection and monitoring system developed and maintained by the community at the service delivery site, monitoring the development and implementation of advocacy solutions to respond to the evidence generated**». These two definitions reflect the central place of the community in this exercise and the purpose of generating programmatic evidence.

1. Characteristics of community-led monitoring

Community-Led Malaria Monitoring is therefore an accountability mechanism aimed at improving the quality of services and access to them. It is led and implemented by local community organizations of people suffering from this disease and other relevant groups.

Unlike monitoring led or carried out by health systems, CLM activities essentially result in awareness-raising/advocacy based on evidence and observations collected. CLM is undertaken through mechanisms whereby, depending on the specific objectives of the monitoring, service users and communities gather quantitative and qualitative observations and data to assess the availability, affordability, accessibility, acceptability, equity, and quality of services received and use this information to hold service providers and decision-makers to account.

CLM is not vertical like project monitoring conducted by project staff. It must be conducted by independent civil society organizations (and not vendors) on a periodic regular basis. The data produced is used strategically by the community. The following story represents a good example.

“Activity began in 2008, in a context where people experienced disrupted care. You had to pay for treatment and it wasn’t always available, there was a high prevalence rate and high levels of stigma. Patients had to navigate testing and accepting the disease, and then tackle treatment. Many did not accept the disease: for us, it was unacceptable that people who did accept it faced treatment stock-outs and/ or additional charges [...]. We then began to document the first cases of stock-outs in hospitals. It started to annoy people and we were asked where the proof is? But at the same time people were telling us “do not say that it was me who said that”. This is where the idea of an observatory to collect information in a structured way came from. The idea was there, but we didn’t have the resources to pay people to collect at specific times. We identified people who were likely to have information and we got them to contribute: users, support group members, the community health workers and the caregivers [...] Given the lack of financial resources to pay informants, we opted for a simple, flexible, inclusive mechanism that empowered patients to monitor their access to care”.

LOUIS TSAMO, Secretary General of Positive Generation (Cameroon)

For a CLM project to be effective, it must reflect the main concerns of the care recipients and prioritize them from the beginning. The importance of the effective participation of the community in order to highlight the needs, rights, and barriers to services should be emphasized here. Thus, the design of CLM will differ depending on many factors, such as context, goals and objectives, geographic scope, and target population. It is important to begin by introducing the community to the benefits of CLM; explaining why it is needed and how it fits into broader participatory governance; and then introducing the role of CSOs in helping communities engage.

CLM initiatives assess a wide range of issues related to effective and accountable malaria services, with many activities focusing on the quality of the patient experience in facilities, the quality of systems (clinical management), the quality of programs, the availability of essential medicines and rights violations.

CLM can thus take several forms:

- community outcome sheets used in health facilities,
- patient satisfaction surveys,
- complaint and complaint mechanisms,
- treatment observatories,
- social audits,
- monitoring and control of the budget and resources,
- Reporting human rights violations.

COMMUNITY LED MONITORING	
WHAT IT IS	WHAT IT IS NOT
Actions focused on community priorities	Actions focused on priorities defined by external stakeholders (donors, governments, research institutions).
Another type of project monitoring	Monitoring/evaluation of the project
Recurring and routine data collection	Single survey or report, a single "sample".
Data can be measured by numbers (quantitative) and by descriptions of citizens' lived experiences (qualitative).	The resulting data is published but "sleeps on a shelf". data collection is the "end point"
This is repeated	Rigid definition of the type of data that "counts" or doesn't count" that tends to favor quantitative data and dismiss qualitative data as anecdotal"; priority given to epidemiological trends (prevalence rates, screening targets) with little interest in the lived experiences underlying these figures
The involvement of the community in the follow-up of the project	Basic study of the project
Another facet of the community response	Mid-term evaluation of the project
A contribution to the triangulation of project data	Final evaluation of the project
	Budget monitoring of the project
	Project audit

2. Functions of Community Led Monitoring

Structures implementing Community-Led Monitoring must have rigorously trained peers to collect and analyze qualitative and quantitative data on malaria service delivery systematically and regularly. CLM brings together data that highlights what works properly, what doesn't and what needs to be improved while suggesting targeted actions to improve results. CLM allows to:

- Verify that the commitments made to solve these problems are implemented and effectively improve the quality of malaria control services;
- Contribute to empowering decision-makers. In short, the community is both responsible for the management and execution of CLM, which contributes to the improvement of the services it receives;

- Implement the community response to malaria, and it provides an opportunity for community networks and groups to play their surveillance role;
- Ensure that priorities should be set through community consultation, instead of being set only by entities and programs outside the communities.

3. Importance of the Community Led Monitoring

Community Led Monitoring **contributes directly to the achievement of the Global Fund's strategic objectives for the period of 2023-2028:**

1. *Ending malaria;*
2. *Maximize integrated, people-centered health systems for greater impact, resilience and sustainability;*
3. *Maximize the engagement and leadership of the most affected communities so that no one is left behind;*
4. *Maximize health equity, gender equality and human rights;*
5. *Mobilize more resources.*

CLM **supports the collection, evaluation and triangulation of data and observations (quantitative and qualitative) that are essential for program oversight and the improvement of policies and procedures.** Data collected by communities in the form of information and observation from independent monitoring activities are valuable, but not always recognized as such. In some countries, this type of data is subject to much controversy because they often differ from the results of monitoring carried out or monitored by health systems, other government agencies, academic entities and other stakeholders outside the civil society sector. To get all stakeholders to accept the results of Community-Led Monitoring, the data that leads to it must be collected and analyzed with the greatest possible rigor. To do this, the Community Led Monitoring budget should allow for inputs by resource persons according to the field (demographer, statistician, economist, public health expert, etc.).

In CLM, **care recipients speak with more freedom** about the quality of services received to members of their community. This is because they feel close and trust the members of their communities who are their peers.

It is essential to note that CLM is not a substitute for other systems such as DHIS2 but complements them and must be used in addition to these systems to control the quality and accessibility of services.

CLM **supports the collection of essential data that the health system does not have access to, particularly among marginal populations and other unserved groups:** this is an entrenched advantage that is expected to gain prominence in the future, as recent trends show that national malaria epidemics in all contexts are increasingly concentrated among or closely linked to marginalized populations and groups.

Similarly, **CLM solves problems that cannot be detected during follow-up by health facilities:** in HIV programs, for example, Community Led Monitoring is ideally placed to find people who have dropped out of care and to provide information on how to improve patient retention efforts. Thus, Community-Based/Led Monitoring focuses on the community, removing barriers to service utilization to improve patient outcomes and ensure sustainable change.

The value for money of the implementation of CLM is moderate compared to investments in data collection and strengthening; therefore, the CLM resource optimization proposal indirectly contributes to the fourth strategic objective (mobilizing increased resources). In particular, the results of CLM interventions should be used to advocate for additional financial resources for health from governments and other donors, in case coverage gaps or inequities are documented.

Community Led Monitoring data is used to establish rapid feedback loops with program managers and health sector decision-makers. This includes collecting data from people living in communities who may not have access to health care.

Community Monitoring	Monitoring & Evaluation	Baseline/mid-term/final studies
Help with data triangulation	Help with data triangulation	Help with data triangulation
Beneficiaries feel very free in front of their peers and talk to them with confidence	Recipients are not facing their peers and may be shy	Recipients are not facing their peers and may be shy
Horizontal approach	Vertical approach	Vertical approach
Led by the community	Led by the project staff	Led by government or external firms
High value for money	Very expensive	Very expensive
Ability to target marginalized populations	Difficulty in targeting marginalized populations	Difficulty in targeting marginalized populations
Fast feedback	Medium feedback	Slow feedback

4. Differences between Community Led Monitoring and Monitoring & Evaluation

Community Led Monitoring is different from program/project monitoring and evaluation (M&E) systems. The two systems are actually complementary. Malaria M&E, as a national or local strategy (or as part of specific programs), follows a standardized set of indicators to report on progress and quality of services against targets, based on data usually collected on a regular basis by implementers.

CLM provides unique data and information generated by the community, which reflects what matters to the community and those using health services. For example, where regular M&E focuses on the number of patients who have received services, CLM provides information on wait times, stigma or discrimination experienced, services that do not or do not work well, targets not covered, activities not performed, or why patients choose not to use services. In its evolution, CLM has understood the need to leave populations easily achievable to monitoring/evaluation in order to focus more and more on those that are difficult to access or left behind. Community Malaria Monitoring aims to fill the gaps in many M&E systems, from the perspective of patients and the community.

CLM is generally done at a slower frequency (quarterly, semi-annual, annual) than monitoring/evaluation (daily, weekly, monthly).

DIFFERENCES		
	COMMUNITY MONITORING	MONITORING & EVALUATION
Indicators	Standardized	Non-standardized
Data collection tool	Standardized for the entire project	Variables by activity and/or community
Responsible	Community or its representatives	Project Team
Frequency of data collection	quarterly, semi-annual, or annual	Daily, weekly or monthly
Recipients	Project Manager and Decision Makers	Funders and partners

However, both Community Led Monitoring and M&E are part of the national M&E strategy, and they complement and provide each other with information to create a more complete picture that contributes to improving the quality of services and access to them.

Community Led Monitoring shares important methodologies with research and can generate research-ready information. However, community-led monitoring is distinct in that it focuses on improving the quality of services rather than generating generalizable knowledge. Community-led monitoring can be thought of in a general cycle in five parts: data collection, analysis and translation, engagement and dissemination, advocacy, and monitoring.



5. The five main stages of Community Led Monitoring

The conduct of Community Led Monitoring of Malaria interventions can be summarized in five main steps, namely: (i) information collection, (ii) data analysis and interpretation, (iii) dissemination and engagement, (iv) advocacy and (v) monitoring. Each step has activities.

..... 5.1. Collection of information

This first step consists of collecting data on the activities chosen for Community-Led Monitoring. This data collection is conducted by community members, after some initial trainings. These data are usually collected in the field, in the localities targeted by the project for which the monitoring is implemented. In some cases, this monitoring may, apart from the collection of data in the field, have a collection of reported data (reading of project activity reports, evaluation reports, supervision reports, etc.). It is important to note that field and reported data should not be used separately, but rather complementary.

..... **5.2. Data analysis and interpretation**

Once the data has been collected, the CSO or its members in charge of Community-Led Monitoring must analyze and interpret the available data. The analysis varies according to the available data: it can be qualitative data (which cannot be measured and defined with numbers such as color or will) or quantitative (which can be measured and defined with numbers such as age, weight, height). Whatever the type of data, the analysis must be able to identify gaps in the implementation of activities, bottlenecks, activities that are poorly conducted or not conducted, and that the beneficiaries are not satisfied. The analysis of Community-Led Monitoring data tends to focus more on activities that do not work (or not well) rather than those that work, because its strategy is precisely to highlight what is not working so that it is corrected. The interpretation of the data will consist in providing one or more possible explanations for the results obtained. This can be done by the CSO, with the participation of some community members. It is these explanations that will guide the decisions to be made to solve the problem. For example, CLM found that children under 5 years of age are not cared for in the community for simple cases of malaria. The interpretation of the data can be the drugs stock shortage in the community, the unavailability/lack of motivation of CHWs.

..... **5.3. Use and commitment**

One of the duties of the CSO that is involved in Community Led Monitoring is to report, by making the results of this CLM available to the community. This can be done through small, simplified workshops in which these results are explained to the community. The CSO also has a duty to commit to advocating for relevant decision-makers or stakeholders to correct the gaps observed in the implementation of activities.

The CSO and all project stakeholders need to be able to understand the main performance indicators used in the project's performance monitoring and have access to high-quality data to monitor these indicators on a regular basis. With such data (such as from Community Monitoring), stakeholders can ensure that the project is on track to rapidly scale up malaria control approaches. Similarly, stakeholders should use this data at regular intervals to constantly adjust the program strategy and the implementation and management of that strategy. Reliable data from CLM can also be a compelling case for advocating for the resources needed to fight malaria. They can also guide decision-making when certain sites are likely to be dropped from the project.

Thus, it is essential that CSOs use data and transform it into information to impact their daily lives, through the creation of data frameworks for action (C2DA).

..... **5.4. Action plan**

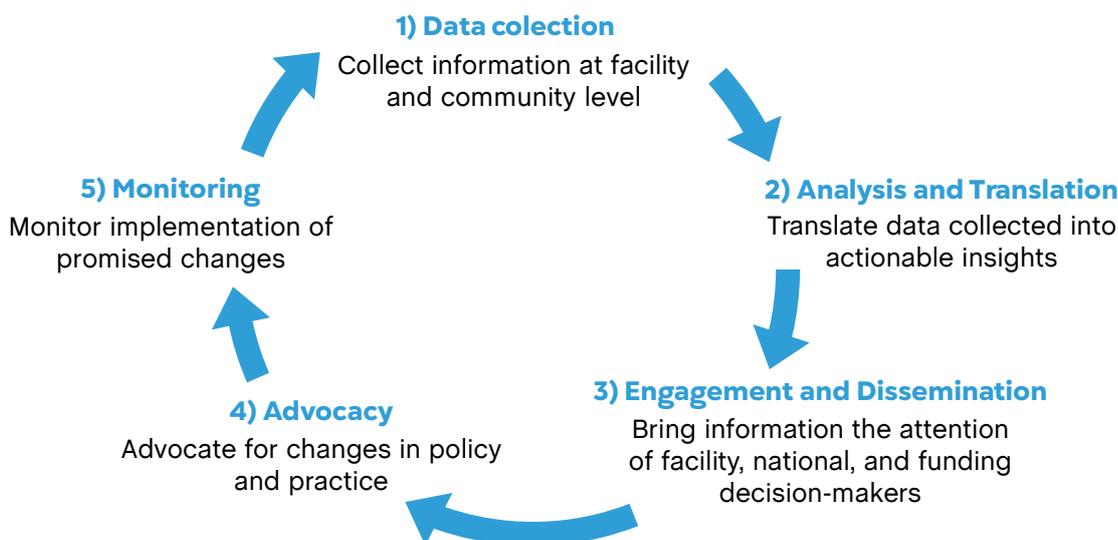
A Community Led Monitoring that does not lead to the correction of the observed gaps in the implementation of malaria control activities is an incomplete follow-up. Therefore, the CSO conducting the follow-up should plan realistic activities and target the appropriate decision makers for that purpose.

..... **5.5. Follow-up**

The CSO must also follow up to ensure that its advocacy based on the recommendations has borne fruit. Indeed, the institutions responsible for implementing those recommendations have other priorities and the follow-up to those recommendations in this case constitutes a kind of reminder. In addition, following up on the recommendations protects the CSO from conducting a second Community-Led Monitoring on issues that have already been resolved, which would be a waste of time and resources.

These five main stages of Community-Led Monitoring are actually a cyclical process and can be summarized in the figure below:

Figure 1. Five stages of the Community-Led Monitoring cycle



Community Led Monitoring and current M&E are not interchangeable, and they do not need to feed a single database.

6. Roles of each stakeholder in Community Led Monitoring of malaria control interventions

Community Led Monitoring involves several stakeholders whose roles need to be clarified for a harmonized process.

..... 6.1. Role of the community and CSOs

- CSOs are primarily responsible to facilitate the joint designing and implementation of community monitoring design and implementation of Community Monitoring. In other words, the CSO together with the community members that develops the Terms of Reference of the CLM that it wants to implement.
- Community decides on the activities that will be followed among all those that are implemented in the community.
- CSOs are also responsible for the design of the tools that will be used in this follow-up and the drafting of the report that will be sent to the relevant stakeholders. The CSO may not have staff with the expertise to design data collection and analysis tools. In this case, the CSO may consider recruiting if it has several projects that can support their salary or hiring ad hoc consultants for this activity. In all cases, budgetary provisions must be made, so that CLM becomes a classic activity of CSOs.

Subsequently, they must include in their planning and budget a workshop to report to the members of the community they represent.

The results produced by CSOs in the framework of CLM must be related to the indicators of the National Malaria Control Strategy so that these results constitute the contribution of CSOs to this national strategy.

Communities' voice through Community Monitoring

The conduct of Community Led Monitoring is a good opportunity for the community to make its voice heard in the fight against malaria. It is true that it is already doing so with the strong involvement of CSAs. But this involvement of CHWs remains for the moment an enforcement role, generally entirely subject to the existing health system. The conduct of Community Led Monitoring must be from the bottom up and not the other way around. In other words, Community Led Monitoring must be designed and carried out by the CBOs representing the community. The results obtained will be brought to the highest levels by the various reporting and advocacy techniques. Community Led Monitoring is therefore an opportunity to show and enhance Community know-how. It is not a question for Community Led Monitoring to do something competing or opposed to the health system, but rather to bring different and complementary perspective to contribute to the good health of populations.

..... 6.2. Role of the National Malaria Control Program

The National Malaria Control Program (NMCP) is responsible for the design of the national malaria control policy in the country. It is therefore this institution that draws up the relevant national documents and designs the implementation strategy. All malaria control actors, including CSOs, should refer to the national documents developed by the NMCP. CLM should also follow the activities set out by the NMCP. The NMCP is responsible for the implementation of recommendations of CLM or ask relevant stakeholders to implement these recommendations. It is therefore advisable that NMCP leads/supervises the CLM implementation.

..... 6.3. Role of decision-makers (Municipalities, Parliamentarians, Government)

The District Health Management Teams (DHMT), Municipalities, Parliamentarians and Government are also the recipients of the Community Led Monitoring reports. They are also the targets of the advocacy resulting from this follow-up. The DHMTs and Municipalities can take into account the recommendations of the follow-up at the local level, while Parliamentarians and Government do so at the national level.

..... 6.4. Role of the partners and donors

Partners and donors can use the findings of Community Led Monitoring to increase or better direct funding for malaria control activities.

7. Next step after CLM

Through Community-Led Monitoring, communities work with service providers and policymakers to propose solutions to barriers to access and other issues that affect the quality of malaria services. This second major part, which follows the CLM, involves empowering the community in planning and decision-making with local authorities.



CHAPTER IV: IMPLEMENTATION OF COMMUNITY LED MONITORING OF KEY MALARIA PROGRAMS

The implementation of Community Led Monitoring goes through several stages. These steps are preceded by a few prerequisites that must be taken into account before starting. Subsequently, this Community Led Monitoring must lead to proposals for solutions to the problems identified.

1. Prerequisites for Community Monitoring

All the following preparatory steps should be discussed in advance with the project implementation team that houses the Community Led Monitoring and within the community, so that the community can maintain leadership.

..... **1.1. Community Led Monitoring Approach by Communities**

The CSO who act as a facilitator of the implementation of CLM on behalf of the community, should make sure that the entire community is well informed and implicated at each level of the implementation. Understanding the community's approach to Community Led Monitoring helps to ensure community commitment and enables the community to contribute effectively.

..... **1.2. Budget adequacy**

It is also important that CLM have a budget that takes into account all of its components. The budget should take into account the additional resources that the CSO will need to recruit and that it does not have to conduct CLM.

..... **1.3. Scope of Community Led Monitoring in relation to available resources**

The design of CLM must seek a balance between the resources available (staff, budget, equipment) and the scope of the related activities. If the CSO has a small size in terms of resources, it will simply conduct small-scale CLM, even if it means making several passages. Conversely, a CSO with a high resource capacity can invest in large-scale CLM.

..... **1.4. Understanding of target populations/local context for community monitoring**

Any CSO that aspires to work in a community must have ownership of that community. Understanding the target populations is essential in CLM. Indeed, it is this population that must answer the questions during the follow-up. CLM officials need to know what the availability of this target population is, the traditions and customs to be respected, the language and level of language to be used, who are the key informants of the community, which segments of the population are difficult to access, what are the cultural constraints specific to each community and which influence the fight against malaria, etc. The CSO's mastery of these details facilitates the deployment of Community-Led Monitoring.



2. Community Led Monitoring components

..... 2.1. Identification of interventions to monitor

It is important to emphasize that each indicator must be backed by one or more project interventions. Therefore, knowledge of the interventions/activities of the project is essential for good Community-Led Monitoring. To do this, CLM actors must reassure themselves that they have the same understanding of the activities as those responsible for the project. A thorough reading of the project document and/or discussions with the project manager will help to understand these activities. This is important so that when the results of the CLM are reported, the results are related to the project activities. It should be borne in mind that the results of the CLM will be used to make decisions either on the project activities or on the management/direction of the project.

..... 2.2. Identification of the sites and targets concerned by Community Led Monitoring

Once the Indicators of CLM have been set, the next step is the designation of the localities in which the Community Led Monitoring will take place as well as the targets. This takes into account the time and budget constraints available. At the same time, the allocated budget must be able to cover as many sites as possible to see all facets of the project. It is therefore necessary to find a balance between the need to cover as many sites as possible and budgetary and time constraints. The targets must be the beneficiaries and stakeholders of the project. The inclusion of beneficiaries is important to bring out their views in the implementation of the project. For some themes, the beneficiaries feel more comfortable talking with members of the community than with people from outside.

2.3. Identification of indicators to be monitored

For CLM to be effective, it is important that the indicators to be monitored are well defined at the very beginning.

In a project, an **indicator** is an observable and measurable quantity used to show changes achieved or progress towards achieving a specific effect. The indicators of a project are usually set at the beginning of the project, with details of their meanings and how to collect and measure them. The indicators of CLM will not necessarily be those of the project, but it is important that there is a relationship between the two. CLM actors will identify the project's indicators and set their own so that the two are complementary.

CLM is independent and community-centered. The community chooses its own indicators of what to track and where to work, prioritizing the things that matter most to them.

Examples include the availability of medicines, the nature of interactions between community members and health workers, user fees, quality of services, barriers to accessing services, and experiences of stigma and discrimination.

Example of some indicators for Community Led Monitoring of Interventions

For Cameroon, the Global Fund-funded malaria project selected the indicators in the following table:

Program/ Objectives	Interventions	Expected results	Indicators
Objective 1: Test 100% of suspected malaria cases in the community with rapid diagnostic tests	Community case management	All identified suspected malaria cases undergo community RDT	Proportion of suspected malaria cases tested parasitically in the community
Goal 2: Properly treat 100% of confirmed simple malaria cases with ACTs in the community.	Community case management	Reduction of malaria cases Reduction of malaria-related mortality	Proportion of confirmed simple malaria cases receiving first-line antimalarial therapy in the community

RSS/ Transversal aspect			
Objective 1: Oversee and coordinate the implementation of ISDCs	Capacity-building	CHWs monitoring is improved	- Proportion of community health workers who received at least one formative supervision during the reporting period (quarter)
Goal 2: Pay monthly for the motivation of all functional multi-purpose CHWs	Capacity-building	CHWs are motivated	- Percentage of operational CSAs who received their motivation

On the basis of these project indicators, CLM can use the same indicators, and/or formulate the following complementary indicators:

- Proportion of confirmed simple malaria cases who did not receive first-line antimalarial therapy in the community;
- Proportion of community health workers (CHWs) who received at least one formative supervision during the reporting period (quarter);
- Percentage of operational CHWs who have not received their motivation;
- Percentage of operational CHWs who received their motivation more than two months late;

- Number of patients cared for at home and lost to follow-up;
- Proportion of people not satisfied with home-based malaria care;
- Proportion of people not satisfied with malaria management at Health Facility;
- Number of Home Visits carried out by the CHWs;
- Number of Educational Talks carried out by the CHWs.

With the indicators developed, the means of verification (calculation methods, reports, records, etc.) should be specified.

..... **2.4. Community Led Monitoring tools for malaria control interventions**

Community Led Monitoring must be done with tools developed for this purpose. Monitoring tools should be broken down according to the activities and indicators identified for monitoring. These tools can take several forms:

activity tracking sheets (see annex 1);

- community outcome sheets used in health facilities;
- patient satisfaction surveys;
- complaint and grievance mechanisms;
- treatment observatories and social audits;
- budget and resource monitoring and control;
- responding to human rights violations.

Each of the forms listed above will be chosen for Community Led depending on the purpose of the monitoring and the activities involved

..... **2.5. Community rights and gender in Community Led Monitoring of malaria interventions**

It is important to highlight respect for Gender in Community Monitoring. Malaria affects and weighs more on the most vulnerable groups of the population. As much as possible, it is important to include these vulnerable groups in the target population of the CLM and in the team that will conduct the monitoring. For example, pregnant women and providers of care for children under five years of age could be included (if possible) in the monitoring targets and team.

Project activities must in principle respect the rights of communities. It is up to the CLM to check whether these rights have been respected. These rights of the community may relate, for example, to the respect of the customary or agricultural calendar in the implementation of activities, respect for the local culture. Interviews with community members/leaders will verify compliance with these rights.

4. Conduct Community Led Monitoring of Malaria Control Interventions

Community Led Monitoring is conducted primarily at the project activity site. It also looks at the facilities and environment of the project site, access to services, and social, cultural, and other conditions that exacerbate challenges or compromise service delivery, whether related to gender, geographic/remote challenges, language issues, criminalization, etc.

While some of the work related to this monitoring may be done away from the field, it is recommended that the evidence read in the documents be compared to that observed directly in the field.

5. Community Led Monitoring Team

Conducting Community Led Monitoring requires a team to oversee and facilitate its implementation. At a minimum, the team should include:

- **The Leader or Focal Point.** This person is responsible for supervising the implementation of Community-Led Monitoring. The focal point will also facilitate Community Advisory Group (CAG) meetings, dialogues with sites, work with health officials to ensure that formal agreements for data collection are in place and ensure project visibility and national ownership of the project, and that ideas from the data are used for targeted advocacy.
- **The Monitoring and Evaluation Officer** oversees the processes of community data collection, management, analysis, and verification. The M&E Officer is also responsible for overseeing capacity building, providing technical support on data collection and management processes for supervisors and data collectors, developing and reviewing reports generated from community data before they are disseminated to project managers and external stakeholders, distilling data from national reports to the macro level, and overseeing overall data management.
- **The Data Supervisor:** The data supervisor is responsible for data collection at all collection sites, data verification, and data cleanup. Depending on the number of data collection sites, there may be multiple data supervisors, each managing a team of data collectors and the data collection of the corresponding sites.
- **The Data Collectors:** Each data collector is responsible for collecting data from specific sites. Data collectors interact directly with healthcare facilities or service delivery points to collect quantitative data. They also collect qualitative data by conducting key informant interviews and organizing group discussions with care recipients, community members and other stakeholders. One data collector per site is usually sufficient, but this varies depending on the volume and frequency of data collection. For example, in cases where data collectors are only required to visit data sites once a month for quantitative data, it may be feasible and more efficient to have one data collector cover multiple sites.

6. Reporting on Community Led Monitoring of Malaria Control Interventions

The development of the Community Led Monitoring report must be thought out in advance. It is important to identify who will receive the report and how it will be presented. If the recipient is the project manager, you should take the time to give him or her all the details of the facts presented before you come to your conclusions. If the audience is the community, funders/decision makers, only the most salient facts will be presented to illustrate the conclusions. Similarly, the language type should be chosen according to the audience: low language to be understood by beneficiaries, medium language for other audiences. Furthermore, emphasis should be placed on the appropriation of the problems raised by the report as well as by its recipients. Indeed, it is when the recipient takes ownership of a problem that it becomes quick to solve it.

See annex 2 for an example of the outline CLM report



7. Some existing Community Led Monitoring models

The Community Led Monitoring approach has been implemented for several years in various contexts around the world. There are several models, the most commonly used of which are listed above. It is up to each OSC to modify them so that they are appropriate to their situation. Below are a few examples of these models.⁶

Health Facilities Committee: Health care providers and community representatives meet in health facility committees, monitor and review grievances raised by health care recipients, and then provide regular feedback on how they were handled.

Citizen Scorecards: These scorecards track the quality of health services based on metrics that communities have identified and prioritized. Progress on these metrics can be measured in comparison to a national standard or the performance of other local health facilities. To address these issues, it is best to discuss the assessments in meetings between health care providers and communities.

Community dashboards: These are based on indicators that have been developed in collaboration with community representatives and health care providers. These indicators are used to monitor the performance and quality of health systems and are translated into an action plan that is jointly evaluated by communities and health care providers

Health advocates: They have been the channel for addressing grievances of health care recipients in some situations. In addition to educating communities about local health policy standards and their rights, health advocates also collect grievances and track their resolution. Health advocates work with health care providers to develop solutions to the problems they have identified and establish a timeline for action.

Community-based observatories: Community-based observatories regularly and systematically collect quantitative (from health facility records) and qualitative (from care recipients) data on the quality of services throughout the malaria prevention, detection, care, and treatment pathway. Trained community representatives collect data, monitor trends against a baseline, and advocate for changes as needed.

Community health observatories: Similarly, community health observatories rely on health monitors, community representatives, or community health workers, who report deficiencies and/

⁶https://itpcglobal.org/wpcontent/uploads/2021/12/1205_ITPC_CLM_Design_FullReport06_compressed.pdf

or dysfunctions in service delivery in health facilities to the observatory facilitators, using telephone applications or in face-to-face meetings.

Notes: It is not necessary for a community/CSO to use all of these models at once, but rather to adopt the one that best suits its needs and capabilities.

8. Use of Community Led Monitoring results

In addition to its use for informing project stakeholders, the Community Led Monitoring report can serve several other purposes:

- Programmatic decision-making: the project manager uses the results of CLM to improve project implementation.
- Accountability: CLM provides accountability to all parties involved in the project.
- Advocacy: CLM may, for example, identify gaps in project implementation and advocate for these gaps to be filled. It may also involve using these results to advocate for change in the country's health policy or aspects of it.

See Practical Training Guide - Advocacy Technical Support Toolkit (By Impact Santé Afrique, 2021)

9. Resources for Accessing PEPFAR's Community Led Monitoring Tools

PEPFAR has already developed a set of tools for CLM of its projects/programs. It is worthwhile to consult these tools and use them as inspiration to develop your own for malaria. Of course, they need to be adapted to the needs and context of each project. To do so, please consult:

PEPFAR CLM tools:

<https://www.pepfarsolutions.org/resourcesandtools-2/2020/3/12/community-led-monitoring-implementation-tools>

10. Some examples of case studies of CLM for Malaria interventions

Community diagnosis to identify and address the priority needs of vulnerable populations to malaria in Cameroon, Niger and Nigeria

Background: The Global Fund supports civil society to better address the needs of communities affected by the three diseases, including malaria. It was noted that despite the fact that communities are at the core of all malaria interventions, the voices of the vulnerable are still not taken into account in the design and implementation of national malaria control strategies. As a result, many of the priority needs of people in vulnerable communities are not reflected in national malaria policy development. Since March 2021, Component 2 of the Global Fund's strategic initiative «Community Rights and Gender (CRG)» has been implemented in 3 countries: Cameroon, Niger and Nigeria. One of the objectives of this project is to strengthen the participation and voice of key and vulnerable populations in policy and decision-making forums, as well as in the governance and management of responses to the three diseases. In order to achieve this objective, it is essential to identify the priority needs of populations vulnerable to malaria. To this end, Impact Santé Afrique (ISA, Cameroon), the "Organisation Nigérienne des Éducateurs Novateurs" (ONEN, Niger), and the Civil Society for Malaria Control, Immunization and Nutrition (ACOMIN, Nigeria), implemented a community diagnosis between June and July 2021. Both quantitative and qualitative data were collected, using the quantitative tool with more than 100 indicators relevant for assessing the overall quality of service delivery. In each country, the activity was carried out in the form of a literature review and focus groups conducted by 10 CSOs in Nigeria, 05 CSOs in Cameroon and 02 CSOs in Niger.

Results:

Nigeria: The community diagnostic was implemented in 10 states, covering the six geopolitical zones of the country. These states are Adamawa, Anambra, Delta, Imo, Kebbi, Kwara, Niger, Ogun, Ondo and

Oyo. In these states, follow-up visits were successfully conducted in all 30 communities.

From this diagnosis, the following priority needs of vulnerable populations were identified:

- Environmental sanitation with community environmental management to prevent malaria through larval source management, waste management leading to blocked drainage, community environmental management and community fumigation
- The improvement of health care services with the creation of new health facilities, the reduction of distances to reach health facilities, the improvement of equipment and technical facilities (access to electricity, water and sanitation, etc.), the need for qualified health personnel.
- The need for LLINs in the communities
- The reduction of ACT and SP costs in health facilities
- Reduction of malaria management costs in health facilities
- Reduction in the cost of malaria control services in health facilities
- Raising awareness about malaria treatment and the use of malaria control products

Cameroon: Data were collected in the Far North, West, South, Central and North West regions.

From this diagnosis, the following priority needs of vulnerable populations were identified:

Among pregnant women:

- Free treatment of malaria for pregnant women
- Free treatment (diagnosis and treatment) of malaria
- Reduction in the price of malaria drugs
- Reduction in the cost of malaria management
- Sufficient availability of anti-malaria drugs in health facilities
- Improvement of the service offer (reception and management of patients) in the health facilities
- Increase in the number of CHWs for the management of malaria in communities
- Increase in the number of health personnel in the health facilities

For children under the age of 5 :

- Effective free management (diagnosis and treatment) of malaria ;
- Sufficient availability of RDTs for malaria diagnosis in the health facilities;
- Supply of RDTs and drugs for the fight against malaria to CHWs;
- Effectively fight against counterfeit drugs;
- Free distribution of anti-malaria drugs in communities;
- Set up local complaint cells against abuses observed in the health facilities;
- Valuation of traditional pharmacopoeia for the treatment of malaria.

For internally displaced persons, refugees and nomadic peoples, priority needs have not been formally identified, such as for pregnant women and children under the age of 5. However, it was noted in the diagnosis that these populations have difficulties to benefit from malaria control services at lower costs.

Niger: Data was collected in the regions of Agadez, Tahoua, Maradi, Tillabéri and Zinder.

From this diagnosis, the following priority needs of vulnerable populations were identified:

Among pregnant women:

- Availability of LLINs in households and for pregnant women;
- Improvement of the environment;
- Reduction in the cost of treating malaria cases;
- Insufficient resources for IRS;
- Free Intermittent Preventive Treatment.

For children under 5 years of age:

- Reduction of the costs of treating children;
- Rapid access to health facilities;
- Effective implementation of free malaria treatment.

Conclusion: In a context where the real priorities of the most affected communities are not always taken into account, the elements resulting from the results of this community diagnosis carried out by community actors have therefore constituted solid arguments for advocacy in favor of the integration of representatives of vulnerable communities in decision-making bodies to ensure that their priority needs are better taken into account.

Community consultations to identify priority needs of vulnerable populations and inclusion of the identified needs in the concept notes in Cameroon, Niger and Nigeria

Context: During the process of drafting concept notes for the fight against malaria, HIV/AIDS and tuberculosis, very little effort is generally devoted to identifying the real needs of populations and communities vulnerable to these three diseases. In addition, civil society, the voice of the communities, is poorly represented in the process of developing country concept notes. It is therefore essential that civil society organizations (CSOs) be better involved in the decision-making process in the fight against these three diseases, particularly malaria. Malaria CSOs need to be well-coordinated and act together with their respective governments to end malaria, especially in the current context of the severity of COVID-19. CSOs members of the CS4ME platform in Cameroon, Niger and Nigeria were among the 10 selected beneficiaries of a sub-grant to implement a Global Fund project. The project aimed at improving the quality of malaria civil society contribution and participation in the development of the Global Fund 2021–2023 country concept notes to mitigate the impact of COVID-19 on malaria interventions, the so-called COVID-19 Response Mechanism (C19RM). CSOs from Cameroon (Reach Out Cameroon), Niger (ONEN) and Nigeria (ACOMIN) conducted community consultations to identify priority needs for vulnerable populations and collaborated in proposing revisions to the country concept notes that took these opinions into account.

Implementation: Throughout the process, Impact Santé Afrique (ISA), the CS4ME secretariat, provided technical support to the ten CSOs involved in the implementation of the project. This support took the form of capacity building through information and experience sharing webinars, technical monitoring of the implementation of activities and ongoing mentoring. Partners thereby strengthened their capacities on the C19 response mechanism itself as well as how to conduct community dialogues, identifying the priority needs of populations vulnerable to malaria, and advocating for the inclusion of these needs in the concept notes. In addition, tools developed or adapted by ISA, the Global Fund and other partners were made available to CSOs in French and English, for example, National social dialogue to guarantee the participation of civil society and communities used to conduct a community diagnosis. The **COVID-19 Information Note: Consideration for Global Fund Support for Malaria** and **COVID-19 Guidance Note: Community Rights and Gender**, were two tools appreciated and used by civil society during the process of the development of their concept notes in the three countries. ISA also organized training sessions on how to use these tools. CSOs received quality technical assistance from the CS4ME secretariat, which was always available via email or phone to answer questions or provide clarifications.

Results: The advocacy efforts conducted by CSOs namely ISA, Reach Out in Cameroon, ONEN in Niger and ACOMIN in Nigeria, and other CS4ME members in these three countries have resulted in the inclusion of eligible community related malaria activities in the C19RM concept notes of their respective countries. Following the identification of priority needs during the national consultations, civil society led advocacy actions for the inclusion of these reformulated needs into eligible activities for the concept notes of the three countries. CSOs in these three countries conducted consultation workshops with civil society actors in order to define the activities that require funding in the concept notes; they also held working sessions with health and government authorities to finalize the concept notes. The CSOs in the three countries held working sessions with the CCM partners to define the role and responsibilities of civil society in the process of developing the C19RM concept note for that country.

Conclusion: The C19RM 2021 - 2023 Global Fund concept note development process was an excellent opportunity for malaria civil society to provide their contribution to the design of this note and to include the real needs of communities as identified through community consultations. The impact was felt by the different communities, whose needs were included in the concept notes.

11. Some specific activities of Community Monitoring

Specific activities eligible under the CLM generally include⁷:

- Development, support and strengthening of community structures that monitor the availability, accessibility, compliance and quality of services (e.g. observatories, alert systems, dashboards); health policies, budgets, resource monitoring and decisions on the allocation of health funds; and/or complaint and complaints mechanisms;
- Community-based monitoring of barriers to access to services (e.g., human rights violations, including stigma, discrimination and confidentiality, age and gender inequalities, geographical and other barriers) for emergency response, redress, research and/or advocacy to improve programmes and policies;
- Tools and equipment for Community Led Monitoring (including appropriate technologies);
- Technical assistance and training on community monitoring: data collection, compilation, processing and analysis; and use of community data to inform programmatic decision-making as well as advocacy for social responsibility and policy development;
- Community engagement and representation in appropriate governance and oversight mechanisms;
- Monitoring by CSOs/CBOs of the impact of COVID-19 with health service providers in their communities;
- Support communities to track and report stock-outs, quality of services and human rights violations.



⁷<http://www.rame-int.org/wp-content/uploads/2021/06/Int%C3%A9gration-du-Suivi-Communautaire-dans-le-C19RM-1.pdf>

12. Community Led Monitoring in brief

Responsible	Purpose of the follow-up	Method
Independent and local community organizations.	Systematic and routine, with follow-up and continuous improvement. Ad hoc evaluations are not enough.	Community Led Monitoring is productive, collaborative, respectful and solution-oriented
Malaria project implementation partners currently working on service delivery at the site level	<ul style="list-style-type: none"> • It is triangulated but not duplicated with other data streams in the project. • Community Led Monitoring data should reflect «added value» and not duplicate routine data collection already available for the project through monitoring, evaluation and reporting indicators. • «Value added» monitoring data includes beneficiaries' information on their experience with the health facility, information on barriers and enablers to access and retention in services, etc. • Can use Site Improvement Through Monitoring System (SIMS) tools as needed. • SIMS tools can be used for specific and selected SIMS essential elements (or standards) that evaluate the patient-provider experience. • SIMS tools are publicly available. 	<p>Action-oriented with a follow-up process associated with the health facility supervised by government staff</p> <p>Committed to corrective public health actions</p> <p>Involving community advocacy to improve service performance</p>





CHAPTER V: COMPETENCES REQUIRED FOR GOOD COMMUNITY LED MONITORING

Several skills must be put together to conduct Community-Led Monitoring. Some requirements need to be met up at the level of the community as well at the level of CSOs. These skills must be sought both within CSOs and in communities.

1. Competencies at the level of CSOs

Good knowledge of the activities to be monitored

It is essential that CSOs and/or its members in charge of Community Led Monitoring of malaria control activities have a good knowledge of the activities concerned by the monitoring. Indeed, it is difficult to keep track of activities that are little or poorly known. The easiest way to get there is to do a thorough research of these activities before starting the follow-up. It is also advisable to ask questions to the project manager concerned to improve this understanding. In many cases, these will be activities familiar to the CSO, as a malaria CSO has the necessary (background and staff) to understand these activities.

Capacity to develop Community Led Monitoring tools

This manual provides guidance and examples of CLM tools. It is a question for each CSO to be inspired by them to adapt them as best as possible to its context or to the specific project so the activities are the subject of Community Monitoring.

Ability to collect and analyze data

It is not enough simply to collect data as part of Community Monitoring, it is also a question of analyzing them to draw relevant conclusions to guide advocacy. We are not necessarily talking about statistical analyses with software. To achieve this, it is necessary to collect the data by following an objective process, with data collection tools that meet the standards in this area. This requires the capacity building of CSO staff, who in general are not sufficiently equipped for this type of activity. It is therefore important to think about the costs related to this capacity building when budgeting for Community Monitoring. The data collection itself should be as objective as possible:

- Obtain the necessary permissions to collect the data;
- Seek Informed Consent from respondents;
- Do not direct responses;
- Remain neutral;
- Do not frustrate respondents;
- Respect the confidentiality of respondents.

Perform a baseline assessment: It may be useful to collect baseline data if monitoring will be a continuous process over time and involves the same indicators. Over time, the data they collect can be compared to baseline assessments to track trends and identify improvements (or decreases) in treatment access and quality of services.

Specify the periodicity of data collection: The CSO must specify the periodicity of Community Led Monitoring data collection, depending on the objectives pursued.

Data verification: The data collected must be subject to verification of its completeness, and consistency before being analyzed. This data verification will have the same periodicity as the data collection.

Data entry: Once the data has been verified, the data supervisors hand it over to the focal point manager or another designated team member who enters it into the database. Increasingly, android tablets are being used for data collection, saving time and money. Management procedures should ensure that such data is recorded and stored in standardized formats to ensure consistency in order to facilitate access, review, analysis and reporting.

Data review and analysis: After entering the data into the database, the focal point manager performs a first-level analysis to verify the timeliness, completeness, clarity and consistency of the data. If no issues require further review, the focal point manager (and/or monitoring and evaluation specialist, if part of the implementation team) can start conducting a more in-depth analysis. Key considerations for the analysis include: Does the data demonstrate progress towards the objectives? Is it possible to link the data to any outcome? What is the most useful data for advocacy? Are there indicators for which data are not available? If so, why? Is the indicator still relevant? Are there any data or trends in the data that raise questions? If so, what are the next steps to address them?

Depending on the capacity of the body responsible for implementing Community Monitoring, a consultant/research firm or other experts may provide assistance in analyzing the data and/or carrying out data quality audits to ensure their validity. A consultant/research firm or other experts have often assisted CLM implementers in developing data analysis frameworks, training and performing data analysis, and/or conducting data quality audits to refine indicators and/or data collection methods.

After data collection, the data must be analyzed using one method: content analysis, literature review and statistical analysis. It is important to specify the type of analysis used in the report. This analysis should lead to useful conclusions for advocacy with decision-makers. For example, data analysis may show that beneficiaries are not satisfied with project activities because project actors do not respect local customs: then project management will make decisions aimed at respecting local customs by project actors. The analysis can highlight areas/targets not covered by the project when possible. Then decision-makers can decide to take these areas/targets into account.

Ability to prepare the Community Led Monitoring report

The analysis of the data should lead to a CLM report. The objective of such a report is first and foremost accountability, but also that it should lead to decision-making; to achieve this, the report must not be very long, but rather short and very explicit. It must include the precise facts, with some photos if necessary and equally highlight the problems encountered with proposals for solutions. These proposals must be realistic. For example, a municipality cannot be offered the purchase of a medical aircraft to evacuate people suffering from acute malaria, because in general, the purchase of medicalized aircraft is expensive and is not the prerogative of the municipalities.

2. Competencies at the level of communities

The community is responsible for both the management and delivery of the CLM, which contributes to the improvement of the services it receives.

It is the responsibility of the community to select the partner (CSO/CBO) who will implement the CLM. Groups of populations vulnerable to malaria can therefore be established as surveillance committees to ensure effective and efficient implementation of CLM activities.

In this way, the community, together with the CSO, will be able to put in place mechanisms for monitoring and controlling the quality of activities implemented under the CLM.

It is also important that the community establish mechanisms to ensure local ownership of the CLM, which is necessary for the sustainability of the intervention. For the CLM to be sustainable, it must also be owned by the community and valued, and therefore supported, by the government.

Thus, building technical capacity in the communities will promote its sustainability.



CONCLUSION

The place of Community Led Monitoring is central to the malaria control process and is based on the need for community participation. From its preparation to its recommendations, through its implementation, this process highlights the ownership of the fight against this disease by the beneficiaries. The different tools proposed are indicative models that will have to be contextualized according to the different projects to which they are applied. It is an important source of data for programmatic decision-making and accountability.

This guide will only be effective under two conditions: first, that those who have been trained share this knowledge with the members of their team who will be involved in the Community Led Monitoring of activities. Secondly, the monitoring of these activities be effective.

The writing team of this Guide remains available to support the various users in its implementation.



WHAT YOU NEED TO KNOW

<p>Definition : « ...models or mechanisms by which service users and/or local communities collect, analyze, and use information on an ongoing basis to improve access, quality, and impact of services, and to hold service providers and policy makers accountable. »</p>	<p>Goal: Improved quality of and access to services</p>
<p>Implementers: The community (beneficiaries) or their representatives (CSOs).</p>	<p>Steps: (i) Information collection ; (ii) Data analysis and interpretation; (iii) Use and engagement (iv) Advocacy (v) Monitoring</p>
<p>Community Monitoring Team: Focal Point, M&E Officer, Data Supervisor, Data Collectors</p>	<p>Stakeholders: NMCP, Ministry of Health, Communes, Partners, Donors</p>
<p>Relationship with stakeholders: Collaboration, but not dependency.</p>	<p>Method: productive, collaborative, respectful and solution-oriented</p>
<p>Value-added of Community Monitoring data:</p> <ul style="list-style-type: none"> • Additional data for triangulation • Information on beneficiaries' experiences • Highlighting bottlenecks and enablers in access to health services 	<p>Some Community Monitoring tools: Activity monitoring sheets; Community scorecards used in health facilities; Patient satisfaction surveys; Complaint and grievance mechanisms; Treatment observatories and social audits; Budget and resource monitoring and control; Responding to human rights violations</p>
<p>Skills for good community monitoring: (i) Mastery of the activities to be monitored; (ii) Ability to develop the tools; (iii) Ability to collect the data; (iv) Ability to write the report</p>	<p>Use of Community Monitoring Data</p> <ul style="list-style-type: none"> • Programmatic decision making • Accountability • Advocacy
<p>Identification of indicators to be monitored: Linkage of indicators to activities, independence from project indicators.</p>	<p>Scope of Community Monitoring: Number of sites, indicators, and duration of monitoring consistent with the size and budget allocated to this activity</p>
<p>Some models of Community Monitoring: Health Facility Committees, Citizen Report Card, Community Scorecards, Health Advocates, Community Health Observatories</p>	<p>Knowledge of target populations and local context: Consider the availability of the target population, their customs and practices, their language level, their key informants, segments of the population that are difficult to access, and the cultural constraints of each community</p>

ANNEXES

ANNEX 1: EXAMPLE OF A TOOL FOR MONITORING INTERVENTIONS UNDER COMMUNITY DIRECTIVES

Country: _____ Region: Health _____ District: _____

Health Area: _____ Period: _____

I. MISSION OBJECTIVES:

- a)
- b)
- c)

II. AVAILABILITY OF LLINs IN THE COMMUNITY

Topics	Number	Observations
Number of households in the community		
Number of households with LLINs in the community		
Number of households with pregnant women		
Number of households with pregnant women with LLINs in the community		
Number of households with children aged 0-5 years		
Number of households with children aged 0-5 years with LLINs in the community		
Number of CHWs raising awareness about the proper use of LLINs		

III. AVAILABILITY OF ACTS IN THE COMMUNITY

Topics	Number	Observations
Number of CHWs in the community		
Number of CHWs in the community with a stock of ACT		
Number of CHWs in the community with an unexpired stock of ACT		

IV. MALARIA MANAGEMENT

Topics	Number	Observations
Number of health centers in the community		
Number of suspected malaria cases and number of consistent tested cases in the health center		
Number of health centers managing severe malaria cases		
Number of health centers that meet the stages of severe malaria management		
Number of health centers with consistent number of confirmed malaria cases and number of treated cases		
Number of health centers that fill all malaria cases in the Monthly Activity Report		

V. SYNTHESIS OF FEEDBACK GIVEN TO EACH COMMUNITY

VI. POINTS TO BE NOTED

- a- Strengths (Indicate the communities concerned)
- b- Areas for improvement (Indicate affected communities)
- c- Threats (Indicate the communities concerned)
- d- Recommendations and conclusion (Indicate the communities concerned)

ANNEX 2: COMMUNITY LED MONITORING REPORT OUTLINE

- 1- Introduction
- 2- Composition of the team
- 3- Sites and targets
- 4- Activities followed
- 5- Monitoring indicators
- 6- Specificities of each work site
- 7- Challenges encountered and solutions
- 8- Team Evaluation
- 9- Suggestions
- 10- Conclusion

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