Community-Led Monitoring for Increased **Community Engagement** in DSD Decision-Making and Programming

Results from a field rollout of the Community Engagement Tracking Tool in 20 African countries—July-Nov 2022

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ITPC
INTERNATIONAL TREATMENT PREPAREDNESS COALITION

About

About ITPC

The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- Intellectual property and access to medicines (#MakeMedicinesAffordable)
- Community-led monitoring and accountability (#WatchWhatMatters)
- Activism and capacity building (#BuildResilientCommunities)

To learn more about ITPC and our work, visit. itpcglobal.org.

About Watch What Matters

Watch What Matters is a community monitoring and research initiative that gathers data on access to and quality of HIV treatment globally. It fulfills one of ITPC's core strategic objectives: to ensure that those in power remain accountable to the communities they serve.

Watch What Matters aims to streamline and standardize treatment access data collected by communities. It helps ensure that data is no longer collected in a fragmented way and reflects the issues and questions that are most important to people living with and affected by HIV. It relies on a unique model that empowers communities to systematically, routinely collect and analyze qualitative and quantitative data on access barriers, and use this data to guide advocacy efforts and promote accountability.

To learn more about **Watch What Matters** and our work, visit WatchWhatMatters.org.

About Build Resilient Communities (BRC):

The progress we have seen in access to treatment and improvements in quality HIV services are based on communities self-organising and demanding their right to health. ITPC understands the importance of creating meaningful partnerships within the movement, in order to form broader coalitions to fight for social justice.

Visit **Building Resiliient Communities** to learn more about our work.

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*To download this report from the ITPC website, click **here.***

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Acronyms

ART	Antiretroviral therapy
CAN	Community advocacy network
CE	Community engagement
CLM	Community-led monitoring
CQUIN	HIV Coverage, Quality, and Impact Network
CSO	Civil society organization
DRC	Democratic Republic of Congo
DSD	Differentiated service delivery
HF	Health facilities
ICAP	International Center for AIDS Care and Treatment Program
ITPC	International Treatment Preparedness Coalition
LibNeP+	Liberia Network of People Living with HIV and AIDS
M&E	Monitoring and evaluation
MANET+	Malawi Network of People Living with HIV/AIDS
NACOPHA	National Council of People Living with HIV/AIDS in Tanzania
NAFOPHANU	National Forum of People Living with HIV/AIDS Networks in Uganda
NAP+	Ghana Network of Persons Living with HIV/AIDS
NEP+	Network of Networks of HIV Positives in Ethiopia
NEPHAK	National Empowerment Network of People living with HIV/AIDS in Kenya
NEPWHAN	Network of People Living with HIV and AIDS in Nigeria
NEPWU	National Empowerment of Positive Women United
NETHIPS	Network of HIV Positives in Sierra Leone
NZP+	Network of Zambian People Living with HIV/AIDS
PLASOC-M	Civil Society Platform for Health in Mozambique
PLHIV	People living with HIV
RBP+	Réseau Burundais des Personnes Vivant avec le VIH/SIDA
RéCAP+	Réseau Camerounais des Associations de Personnes vivant avec le VIH/SIDA
RIP+	Réseau Ivoirien des organisations de Personnes vivant avec le VIH
RNP+	Réseau National des Associations de PVVIH
RoC	Recipients of care
RRP+	Rwanda Network of People Living with HIV/AIDS
TWG	Treatment working group
UCOP+	Union Congolaise des Organisations des PVVIH
ZNNP+	Zimbabwe National Network of People Living with HIV

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Executive Summary

Differentiated service delivery (DSD) is a person-centered approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with and vulnerable to HIV and optimize available resources in health systems[1]. Since DSD relies on people-centered practices, community engagement (CE) is central to its success.

CE is a process of developing relationships that enable stakeholders to work together to address health-related issues and promote wellbeing to achieve positive health impact and outcomes[2]. However, there is a lack of tools to assess CE, both in general and specifically regarding DSD.

In response to this gap, the Community Engagement Community of Practice and a community advocacy network (CAN) were formed, supported by the International Center for AIDS Care and Treatment Program (ICAP) at Columbia University and the HIV Coverage, Quality, and Impact Network (CQUIN), with funding from the Bill & Melinda Gates Foundation.

In collaboration with the International Treatment Preparedness Coalition (ITPC), the CAN developed a Community Engagement Framework and a monitoring tool to track and enhance CE in DSD policy development, program design, planning, implementation, monitoring, and evaluation.

The results from a pilot of the CE tracking tool in Kenya and in the Democratic Republic of Congo (DRC) in 2021 provided insightful results and sparked interest in the broader CQUIN network. The Excel-based CE tracking tool containing 19 quantitative indicators was then translated from English into French and Portuguese, data collectors were trained, and the tracking tool rolled out in 20 countries[3] between July and November 2022.

Approximately 120 people across the 20 countries were involved in the data collection process and engaged mainly with ministry of health officials and civil society representatives. Supporting evidence was sourced from various places, such as meeting records, health facility records, and, in some cases, verbal recollections. Site selection was mainly based on the ease of access to data at the sites.

Average scores for each indicator were ranked, and trends and insights were extracted from the tracking tool and country reports. Feedback from working sessions and meetings were consolidated into the report. Results were shared with CAN members and a wider audience during the ICAP CQUIN 6th Annual Meeting in 2022 and will be presented at the 2023 International Aids Society Conference.

This assessment seeks to answer if and how communities are engaged in DSD design and implementation, as well as monitoring and evaluation (M&E) across the policy, program, and community levels. The key findings and corresponding recommendations bring further insight into levels of engagement and how to strengthen meaningful CE in countries rolling out DSD programs.

1

Key findings

Communities are most often involved in the design of DSD policies and programs and far less in the M&E of DSD programs.

Strong engagement at policy and community levels within the design levels was linked to decision-makers understanding the need to involve Recipients of Care (RoC) in DSD for its success when compared with the historical involvement of RoC in HIV service delivery.

Low levels of CE were linked to M&E activities across all three levels (policy, program, and community) that have not started or have been con-

ducted in-country, weaker engagement at sub-national levels due to geographic concerns, structural issues where DSD has not yet been institutionalised, and low capacities of RoC to engage in DSD design, implementation, and M&E.

Recommendations

Develop, implement, and monitor advocacy action plans, focusing on understanding the underlying causes of low CE.

Countries are advised to disseminate the results of the CE tracking tool among local stakeholders and develop, implement, and monitor an action plan on the areas for advocacy, including the prioritization of RoC in ensuring the quality of activities not yet implemented.

Countries should seek to understand why communities are primarily engaged the early stages of program and policy development but far less engaged at the end of the implementation cycle.

2

Key findings

Fifty percent of countries report strong or satisfactory community engagement in DSD and low scores are mainly linked to activities not yet conducted.

Liberia, Cote d'Ivoire and DRC scored meaningful engagement of communities in DSD activities. Rwanda, Zambia, Zimbabwe, Ghana, Ethiopia, Mozambique, and Nigeria scored satisfactory CE. Sierra Leone, Tanzania, Eswatini, South Sudan and Kenya scored minimal CE, but low scores are mostly linked to M&E-stage activities not being conducted yet. Lower scores are linked to Cameroon and Burundi being in the early stages of DSD implementation. Senegal's DSD program is not yet decentralised. Malawi and Uganda report challenging local contexts regarding CE.

Recommendations

Promote country-to-country learning and capacity building to incentivise action.

The experiences of each of the 20 countries currently tracking CE is a rich source of learning practices and country-to-country learning should be promoted to build capacity on successful strategies and incentive action in countries where CE is low or activities have not been conducted.

3

Key findings

The data collection process fostered relationships with duty-bearers, leading to opportunities for further CE.

As a result of the ongoing discussions and cooperation required to complete the CE tool, relationships were fostered with authorities such as district health bodies and ministerial agencies, and several CAN members were subsequently invited to join writing teams on DSD and CE, and potentially even writing teams for applications to the Global Fund's GC7.

Recommendations

Nurture developed relationships with duty-bearers, monitoring their impact while further exploring how to create more opportunities for CE and targeted advocacy.

It is recommended that countries sustain the dialogue, nurture the fostered relationships, and consider developing formalised collaborative

frameworks with duty-bearers and local authorities for future data collection. It is also recommended they follow up on the impact of these developed relationships and explore how thepcomingg round of data collection can be used to further create opportunities for CE, as well as identify dysfunctions hindering strong CE for more targeted and collaborative advocacy actions.

4

Key findings

Gaps in understanding of DSD, CE and the role of RoC in DSD need to be addressed to improve DSD.

The rolling out of the CE tracking tool pushed all the stakeholders involved in data collection to better define CE and understand the role of RoC in DSD. However, this highlighted gaps related to these aspects both at government and community level.

Recommendations

Raise awareness and build capacity on CE and DSD.

All countries acknowledge the need to raise awareness on CE among stakeholders and to build capacity regarding DSD among communities. It is recommended that countries receive guidance on who specifically should be targeted by the capacity-building initiatives, differentiating between awareness raising for large groups of RoC for them to understand their role in DSD, and smaller groups of RoC representatives (community leaders, networks of people living with HIV [PLHIV], and RoC advocates) that would most probably require more technical expertise to be able to engage with local authorities and duty-bearers.

Background

As countries work to achieve HIV epidemic control, the scale-up of high-quality **DSD** is a promising approach to improving both the quality and efficiency of HIV services. DSD is a person-centred approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with and vulnerable to HIV and optimize available resources in health systems[4] . Since DSD relies on people-centered practices, **CE** is central to its success. CE is a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes[55]. Over the past two decades, research and practice in health promotion have increasingly employed CE, defined as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people"[6]. Based on the Greater Involvement of People Living with HIV principle, CE considers that a higher level of involvement of communities in program design, implementation and M&E as well as policymaking will improve the relevance, acceptability and effectiveness of programmes[7]. However there is an absence of tools to assess CE, both in general and specifically with regards to DSD.

In response, ICAP at Columbia University launched CQUIN in March 2017, with funding from the Bill & Melinda Gates Foundation. CQUIN is a learning network designed to accelerate DSD scale-up by fostering joint learning, country to country exchange, and targeted technical assistance for its member countries.

CQUIN network countries identified CE as a pillar for successful DSD programs. The participation of PLHIV, including RoC and their advocates, in the design, implementation, and evaluation of DSD initiatives is critical to assure both demand from PLHIV and supply of high-quality, contextually appropriate services. CQUIN member countries also recognize that their efforts towards meaningful CE are sometimes suboptimal.

The CQUIN project supported the formation of the **Community Engagement Community of Practice**, and later, in collaboration with the African Society for Medicine, a CAN. The CAN and the CAN advisory group seek to identify and address common barriers and challenges and to co-create solutions for meaningful engagement of PLHIV in DSD initiative, at national and global levels. The CAN also reached consensus to develop a **CE framework and a monitoring tool**[8] to be used by PLHIV networks and communities in efforts to improve CE in DSD policy development, program design, planning, implementation, monitoring, and evaluation.

In 2020, in collaboration with ICAP CQUIN and ITPC, the CAN finalized a monitoring framework including indicators for CE across agreed upon levels (policy, program, community) and areas (design, implementation, M&E) *(see Annex I for list of indicators)*. Subsequently, in 2021, a 19-indicator tracking tool was finalized to collect data across these levels and areas *(see Annex II for a snapshot)*. The tracking tool included a five-colour coded scale linked to each indicator score; this ranged from red for the lowest engagement scores (0-20%) to green for the highest engagement (81-100%) *(see Annex III for colour code)*. Data collectors from the national networks of PLHIV in DRC and Kenya were trained on the principles of the CE framework and the tracking tool, and collected data between July and August 2021 to assess CE across the established indicators for the June 2020 to May 2021 period. DRC and Kenya were selected as pilot countries based on language (Kenya / anglophone and DRC / francophone) and prior experience in community mobilization.

The results from the pilot were insightful and generated interest among the community partners

as well as the wider CQUIN network. To explore CE further, the tracking tool was translated into English, French and Portuguese, and 18 additional countries were selected. The 18 additional countries provided geographical diversity (east, west, central, and southern Africa) and also language. diversity (English, French, Portuguese).

This report presents the findings from the data collected in 2022 with this larger set of countries[9], and offers recommendations for further improving the CE tool and its use.

Methods

Context

The roll out of the CE tool was used in 20 countries, namely Burundi, Cameroon, Côte d'Ivoire, DRC, Eswatini, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe, as illustrated in Figure 1 below.

Figure 1: Countries leading the CE tool roll-out

Stakeholder engagement

Stakeholder engagement varied among countries and depended on the nature of their relationship with the relevant authorities. Some countries such as Sierra Leone formalised stakeholder engagement with a memorandum of understanding with local authorities. Others reached out to their DSD coordinator or another ministry of health representative to obtain data for the CE framework.

Site and participant selection

Countries were requested to collect data that was nationally representative, either by obtaining data covering all geographical regions where DSD was being rolled out, or by selecting a relevant sample of regions/sites that could provide a solid snapshot of CE in DSD rollout in the country. Each country then identified the ministry of health officials who needed to be contacted to gain access to the data/sites and decided on the scope of data collection based on what was feasible – a representative national sample, or a certain number of sites in each region/district. Site selection was made mainly based on the ease of access to data regarding the sites. In some cases, countries requested the information from the national aids control programs (or equivalent) and obtained available data without any coverage of specific sites. The data was obtained in diverse ways: interviews with officials/RoC/civil society organisations (CSOs); meetings minutes and facility registers; interviews at health facility level; and verbal confirmation from DSD coordinators. The following table provides this information for each country:

Table 1: Snapshot of CE roll-out by country

COUNTRY	IMPLEMENTING ORGANIZATION	DATA COLLECTION TEAM	SITES/INSTITUTIONS PROVIDING DATA	CHARACTERIZE SCOPE OF DATA
BURUNDI	Réseau Burundais des Personnes Vivant avec le VIH/SIDA (RBP+)	Two members of RBP+	National AIDS and STI Control Program; CQUIN coordinator	Nationally representative
CAMEROON	Réseau Camerounais des Associations de Personnes vivant avec le VIH/SIDA (RéCAP+)	Five from RéCAP+	National AIDS and STI Control Committee ; Department of Disease Control and Epidemics ; regional delegates of RéCAP+	Not nationally representative
CÔTE D'IVOIRE	Réseau Ivoirien des organisations de Personnes vivant avec le VIH (RIP+)	Four from RIP+ (director, program manager, M&E manager, and technical advisor care & support)	Community advisors from the 4 sites: Agefosyn ; Dispensaire Sœur Catherine ; HG Yopougon Attié, Centre de Prise en charge, de recherche et de Formation ; National Aids and STI Control Program	Nationally representative
DRC	Union Congolaise des Organisations des PVVIH (UCOP+)	Five PLHIV from UCOP+	National AIDS and STI Control Program; Ministry of health; Two health facilities (one supported by the Global Fundand the other by President's Emergency Plan for AIDS Relief); two community associations	Not nationally representative
ESWATINI	Dream Alive Eswatini	Three from Dream Alive (executive director, M&E officer, and program officer)	Ministry of Health: Swaziland National AIDS Program	Nationally representative

COUNTRY	IMPLEMENTING ORGANIZATION	DATA COLLECTION TEAM	SITES/INSTITUTIONS PROVIDING DATA	CHARACTERIZE SCOPE OF DATA
ETHIOPIA	Network of Networks of HIV Positives in Ethiopia (NEP+)	Six from NEP+ (executive director, M&E manager, M&E officer, project officer, program manager, and PR and communication manager)	Health facilities; CSOs; regional health bureaus; the Federal Ministry of Health Regions: Oromia, Addis Ababa, Amhara, and Southern Nations, Nationalities, and Peoples' Region	Nationally representative
GHANA	Ghana Network of Persons Living with HIV/AIDS (NAP+)	Five board members/ administrators of NAP+ as the core team and 14 data collectors who were RoC and members of NAP+	70 health facilities in nine out of 15 regions had rolled out HIV DSD training in Ghana; the National Aids Control Program; the Christian Health Association of Ghana	Nationally representative
KENYA	National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK)	Three data collectors from networks affiliated to NEPHAK representing adolescents and young people, women living with HIV, and key populations	No details provided	Not nationally representative
LIBERIA	Liberia Network of People Living with HIV and AIDS (LibNeP+)	Three data collectors (one man who has sex with men, one transgender person and one PLHIV)	National AIDS Commission; the Ministry of Health	Not nationally representative

COUNTRY	IMPLEMENTING ORGANIZATION	DATA COLLECTION TEAM	SITES/INSTITUTIONS PROVIDING DATA	CHARACTERIZE SCOPE OF DATA
MALAWI	Malawi Network of People Living with HIV/AIDS (MANET+)	Five data collectors from MANET+ network (executive director, two coordinators of the National Association for Young People Living with HIV, an IT officer, and the chairperson of the Coalition of Women Living with HIV and AIDS)	Ministry of Health; the Department of HIV DSD section Districts: Salima, Lilongwe and Blantyre	Not nationally representative
MOZAMBIQUE	Civil Society Platform for Health in Mozambique (PLASOC-M)	One supervisor and three data collectors	Ministry of Health: Coordinator of the disease surveillance department; national director of the HIV program; and the care and treatment coordinator. Health facilities: clinical directors of Mavalane General Hospital, three organisations of PLHIV: Associação Hixikanwe, Amovapsa, and Associação Kindlimuka	Information not provided
NIGERIA	Network of People Living with HIV and AIDS in Nigeria (NEPWHAN)	Four data collectors from NEPWHAN: three state coordinators and one secretary	Ministry of Health; National Agency for the Control of AIDS; health facilities and support groups in four states: Cross Rivers, Ekiti, Nasarawa and Lagos	Not nationally representative

COUNTRY	IMPLEMENTING ORGANIZATION	DATA COLLECTION TEAM	SITES/INSTITUTIONS PROVIDING DATA	CHARACTERIZE SCOPE OF DATA
RWANDA	Rwanda Network of People Living with HIV/AIDS (RRP+)	Three from RRP+	Three districts and the city of Kigali; health facilities; Ministry of Health; Rwanda Biomedical Center; UNAIDS; RoC; 15 implementing partners of community DSD	Not nationally representative
SENEGAL	Réseau National des Associations de PVVIH (RNP+)	RNP+: The data collectors were presidents of organisations of PLHIV across 14 regions in the country	Data managers in the districts; health zones; state agencies at the decentralized level (governorates and county)	Nationally representative
SIERRA LEONE	Network of HIV Positives in Sierra Leone (NETHIPS)	NETHIPS M&E officer and two community monitors	National Aids Control Program; health facilities; community antiretroviral therapy (ART) groups in the Western Area/ Freetown Peninsula	Not nationally representative
SOUTH SUDAN	National Empowerment of Positive Women United (NEPWU)	Six data collectors from NEPWU (M&E lead, program officer, liaison officer, community counsellor, community volunteer, mentor mother)	Ministry of Health; South Sudan Aids Commission; Network of Aids Service Organizations in South Sudan (umbrella CSO)	Nationally representative

COUNTRY	IMPLEMENTING ORGANIZATION	DATA COLLECTION TEAM	SITES/INSTITUTIONS PROVIDING DATA	CHARACTERIZE SCOPE OF DATA
TANZANIA	National Council of People Living with HIV/AIDS in Tanzania (NACOPHA)	Fifteen PLHIV guided by four NACOPHA secretariat staff	National Aids Control Program and Ministry of Health (via a four-day meeting); 300 RoC in four districts: Morogoro, Dar es Salaam, Dodoma and Mbeya	Nationally representative
UGANDA	National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU)	Three data collectors supervised by the executive director	DSD coordinator; district PLHIV coordinators; sampling of health facilities in 29 districts of all four regions of the country	Nationally representative
ZAMBIA	Network of Zambian People Living with HIV/AIDS (NZP+)	Mainly NZP+ staff members	Ministry of Health: public health specialist; DSD national M&E focal point partners: Clinton Health Access Initiative, Howard University, Center for Infectious Disease Research in Zambia, and the Aids Healthcare Foundation; Community: RoC from CSO; Health facilities: ART in-charges and community adherence support supervisors	Nationally representative
ZIMBABWE	Zimbabwe National Network of People Living with HIV (ZNNP+)	Provincial coordinators	Ministry of Health and Child Care; National AIDS Council; Zimbabwe National Family Planning Council; local health facilities	Nationally representative

Data collection

On 29 and 30 June 2022, ITPC led a training session with five representatives from the national PLHIV networks in all 20 countries *(see Annex VII for the list of national PLHIV networks trained)*. The training covered the principles of CE as detailed in the framework, a walk-through of how to collect data using the CE tracking tool, and tips on collecting, analysing, and advocating using the data (a copy of the agenda can be accessed here).

Between July and November 2022, following small grant disbursements, the country teams collected data for all indicators for the period 1 June 2021 to 31 May 2022. Fifty-two members of the PLHIV networks were involved in the data collection process. These were mainly either staff or members of the PLHIV networks or affiliated networks.

The data collection tool was an Excel CE tracking tool *(see Annex 2 for a snapshot of the tool)*. The tracking tool contained a list of 19 quantitative indicators *(see Annex 1 for the list of indicators)* classified by policy, program, and community level. The instructions on how to complete it include descriptions of numerators and denominators, as well as examples of data sources/evidence. Data collectors either sent the tool via email for the respondents to fill in, or filled it in themselves on their computers following interviews in which the quantitative data was gathered. Most evidence was sourced from invitations, attendance registers and reports from meetings organized by local HIV/AIDS authorities and/or public health sectors, as well as health facility records and verbal recollections from DSD coordinators. The most common community-sourced data were for indicators related to community-level platforms, thematic working groups and supportive supervision visits. There was no formal and systematic process for the validation of results once all the data was collected.

The following table lists the most common data sources for each indicator:

Table 2: Illustrative data sources per indicator

INDICATOR	ILLUSTRATIVE DATA SOURCE
POLICY LEVEL	
% of treatment working group (TWG) on DSD where RoC participated	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
% of policy validation exercises where RoC participated	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
% of online DSD platforms that include RoC, policy makers, program implementers and health providers	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
# of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments	Communication materials obtained from CSO and health ministry
% of M&E meetings that include RoC	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry

INDICATOR	ILLUSTRATIVE DATA SOURCE
% of impact assessment exercises where RoC participated	Impact reports obtained from health ministry
PROGRAM LEVEL	
% of meetings focused on DSD program design where RoC participated	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
% of DSD planning meetings where RoC provided recommendations on prioritization of DSD models	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
% of DSD health facility (HF) trainings that include RoC as planners and facilitators	CSO reports/databases, HF records/training registers
% of DSD supportive supervision visits that include RoC leaders	Joint supervision reports from CSO and health ministry
% of DSD M&E tools development meetings where RoC participated	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
% of DSD M&E activities where RoC participated	Reports from health ministry and verbal accounts from health ministry
% of self-assessments where RoC participated and led on CE domain	Reports obtained from CSO and health ministry
COMMUNITY LEVEL	
# of community-level platforms established aimed at gathering RoC views on DSD models	Reports and verbal accounts from CSO
% of thematic working groups where RoC participated	Invitations, attendance lists, minutes/reports of meetings obtained from health ministry
% of DSD sensitization/demand creation activities led by or actively involving RoC	HF records, reports, obtained from health ministry and CSO
% of HF with DSD where RoC work as service providers	HF records and CSO program reports
# of trainings organized for peer educators (PE) and RoC	Training registers from CSO and health ministry
% of DSD facilities where community scorecards and/or client satisfaction surveys are implemented	Completed scorecards and records obtained from HFs

Following the quantitative data collection, ITPC sent out country reports to be completed by the networks of PLHIV. These reports documented the country specificities of the data collection process, the key lessons learnt during roll-out, main challenges encountered, additional scoring on the three numerical indicators (details in the details analysis section below), how they used the results of the CE tracking tool, and recommendations to improve the tool and CE. The content of the country reports also aims to guide countries in developing their advocacy plans.

Data management and data quality assessment

Following data collection, the country partners underwent several rounds of data quality checks with the ITPC team to finalize their data sheets. Country DSD coordinators and data collectors were consulted to respond to ITPC comments and queries. This data informed their in-country activities and summary report write-ups. ITPC also conducted quality control on the reported results when consolidating all country data into a one multicountry scoring sheet, cross-checking that all results were properly scored.

The different versions of the CE tracking tool and final results were all stored online in a Dropbox folder and classified by country.

Data analysis

Once the final country tracking tools, including all responses to ITPC comments and questions, were received, the country data was consolidated into a single scoring sheet. The percentage results for each indicator were translated into the equivalent scoring, as illustrated below. Numerical indicators were not included in the overall scoring analysis since they were reported in numbers and could not be proportioned into percentages. Countries were asked to self-assess the scores on the numerical indicators in their country reports *(see Annex IV for self-assessment of numerical indicators)* and these scores were not used to calculate country scores. It was also decided to differentiate all zero scores between either keeping them red (no CE) or shading them grey (activity not yet started in country) or shading in grey with N/A (data unavailable) to improve analysis of the low scores. The table below illustrates the scoring level and definitions.

Figure 2: Scoring levels and definition

SCORING LEVELS & DEFINITIONS (DSD DASHBOARD 3.0)						
COLOR SCORE	**0 OR N/A**	**0-20%**	**21-40%**	**41-60%**	**61-80%**	**81-100%**
CE scoring descriptions (DSD Dashboard 3.0)	0 means that the activity is not developed / planned N/A data source not noted, available, accessible)"	Representatives from the community of people living with HIV (PLHIV) and civil society organizations (CSO) are not involved in any activities related to DSD and there are currently no plans to engage these groups*	PLHIV and CSO are not currently engaged in DSD activities, but engagement is planned or meetings and discussions are ongoing	PLHIV and CSO are meaningfully engaged in DSD implementation	PLHIV and CSO are meaningfully engaged in implementation and evaluation of DSDM	PLHIV and CSO are meaningfully engaged in implementation and evaluation of DSD, as well as oversight of DSD policy (e.g., through inclusion in DSD task force or other group)
If % is between		**0-20%**	**21-40%**	**41-60%**	**61-80%**	**81-100%**
Score points	0	0	1	2	3	4

*use this color score if: 1) activity not developed / planned and therefore no CE or plans to engage communities; 2) data source not noted, available, accessible

The quantitative CE scores were analysed by level of DSD roll-out (policy, program and community) and stage of DSD roll-out (design, implementation and M&E). The average scores for each indicator,

based on the results of 20 countries and 16 indicators (excluding numerical ones), were ranked and reasons for these trends were extracted from the tracking tool and the country reports. Considerations around the lessons learnt and benefits, as well as challenges, were discussed with countries and among the ITPC team members who documented them. Feedback from the working sessions during the pre-meeting to the CQUIN 6 th Annual Meeting in December 2022 were also consolidated into this interim report.

Data dissemination

The results of the CE tool roll-out in the seven CQUIN countries were shared with the CAN countries during the CQUIN 6th Annual Meeting (Durban, South Africa, December 2022) and at a CQUIN pre-meeting (Nairobi, Kenya, March 2023). The results of the 20-country roll-out will also be shared via an e-poster at the International Aids Society Conference in July 2023 and included in other dissemination platforms such as webinars when relevant. The lessons learnt and best practices were also incorporated into the development of a Community Engagement Monitoring Tracking Tool that is currently being used as a guide during the 2023 roll-out.

Limitations

The main limitations regarding the first process of data collection and analysis are:

- Eight countries[10] report that the data did not have a **national scope**. These countries collected data from data sites that were accessible and did not use a sampling that was nationally representative of CE in DSD roll-out nationwide. Three countries[11] specifically highlighted that financial resources were insufficient to collect data representative of the whole country. Mozambique has not confirmed if the data is nationally representative or not.
- Seven countries[12] reported **data not being available for certain indicators** in their tracking sheets[13]. This was mainly due to the indicator not being tracked by authorities and/or authorities informing them that data was not available – without detailing the reason. The unavailability of data was a factor that caused disengagement of data collectors in some countries.
- Most countries could not provide all the **documentation required as evidence** for all the 19 indicators. Limited accessibility of registers to confirm that RoC did attend meetings/activities and poor recording within registers was also noted, as in some instances there was no actual evidence that RoC attended, and countries relied on verbal confirmation by DSD coordinators. Supporting documentation was also sometimes harder to obtain at decentralised level. Poor monitoring of activities at community level was also noted. CE assessments are still relatively new and CE data are not expected to be available as part of routine HIV M&E systems. However, this is an opportunity for local stakeholders to co-create a solution to ensure CE is documented.
- The **newness of DSD and the lack of understanding of DSD** was a challenge leading to data collectors and health facilities having a hard time understanding all the indicators. During the CQUIN pre-meeting in December 2022, it was noted that RoC are positioned within various DSD approaches, and they do not know where they belong within these models. Countries also faced issues such as a lack of willingness and availability of health authorities to provide the requested data, the need for administrative permissions to engage with stakeholders, thus collecting or providing the data in a timely manner was a challenge.
- The **CE indicators were open to different understandings and interpretation**, leading to potentially misinformed results in some cases. For example, the indicator "% of self-assessments where RoC participated and led on community the engagement domain" was not understood as the indicator meant to document CE in the

CQUIN Capability Maturity Model self-assessment exercises that are led by the ministry of health. In some countries data collectors who were involved in the roll-out were not involved in the training, which also led to a gap in the standard way of understanding the tool.

- Most countries faced challenges with completing **disaggregation of data in indicators** with sub-disaggregation (% of DSD M&E activities where RoC participated and # of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments), which led to poor quality results.
- **Numerical indicators** (# of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments; # of community-level platforms established aimed at gathering RoC views on DSD models; and # of trainings organized for peer educators and RoC) could not be proportioned into percentages and were omitted from the scoring analysis.
- The CE tracking tool effectively reported on the involvement of RoC in various stages of DSD design, implementation, and M&E stages, but their **level of engagement could not be established**. For example, RoC were invited and attended meetings, but there is no way of establishing if they actively participated in the meeting, if their suggestions were taken on board and, consequently, if this engagement led to an effective impact on DSD programming. There is an opportunity for local stakeholders to co-create a tracking solution to effectively measure meaningful engagement rather than only participation in DSD roll-out, including exploring the CE tracking tool with other existing community-led monitoring (CLM) initiatives to show the added value and impact of CE in DSD.

Result

The main finding is that CE is generally stronger in the early stages of policy and program development of DSD (policy validation, planning and program design meetings, thematic working groups), as well as implementation (demand creation, RoC as service providers), but there is far less engagement at the end of the implementation cycle (M&E meetings and activities). In the following sections, results have been ranked by country and by indicator, and an in-depth analysis per level of DSD roll-out (policy, program and community) highlights the specificities of each country.

Overview of results

Among those countries that have begun CE efforts in DSD, the results are mostly encouraging. As illustrated in the Table 4 below, 39% of reported CE results were in the 81-100% achievement rate (meaningful engagement) – meaning that nearly 40% of those countries that are implementing CE are doing it well. These countries include Rwanda, Zimbabwe, DRC, Liberia, and Côte d'Ivoire. A further 10% of results are in the 61-80% achievement rate (satisfactory engagement), mainly in Nigeria, Kenya, Sierra Leone, and Zambia. In short, a full 50% of results are in the "meaningful engagement" or "satisfactory engagement" achievement rate – an important baseline for this first year of monitoring on CE.

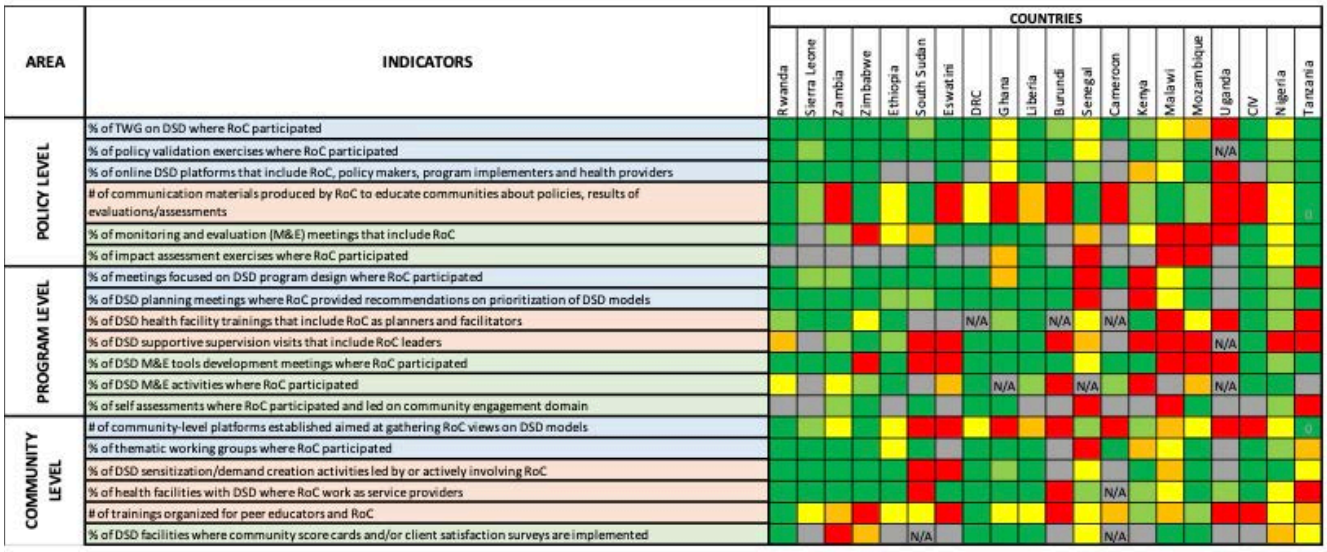
With regard to less than satisfactory scores, 30% of reported results described no CE whatsoever for two reasons.

First, 16% of reported results are in the red score, indicating no CE in specific areas, mainly in South Sudan, Eswatini, Burundi, Senegal, Malawi, Uganda, and Tanzania. This suggests that CE activities have been planned but not enacted, meaning clear opportunities to initiate CE for the first time.

Second, 14% of reported results are found in the grey score, which represents activities that have not been conducted yet, involving 16 countries. The countries with seven or more indicators that are related to activities not yet been conducted are Burundi, Cameroon, and Uganda. These grey scores are opportunities to enquire more deeply about why no planning has taken place, and to facilitate steps toward timely planning of activities with full CE.

Three percent of results are related to data not being available due to in-country monitoring systems not capturing this type of data anywhere in South Sudan, DRC, Ghana, Burundi, Senegal, Cameroon, and Uganda, which is an opportunity to make sure that the data is made available in the next reporting period. This is illustrated as shaded in grey marked N/A in Table 3.

Table 3: Comparative scores of CE across 20 countries



Overview of country ranking

Table 4 illustrates the average score of each country based on the 16 CE indicators (excluding numerical indicators) and is followed by an analysis of trends common to a majority of countries found in the same scoring description.

Table 4: Ranking of countries per scoring of CE

RANK	COUNTRY	AVERAGE SCORE
1	LIBERIA	**93%**
2	CÔTE D'IVOIRE	**81%**
3	DRC	**81%**
4	RWANDA	**79%**
5	ZAMBIA	**76%**
6	ZIMBABWE	**72%**
7	GHAHA	**70%**
8	ETHIOPIA	**64%**
9	MOZAMBIQUE	**64%**
10	NIGERIA	**63%**

RANK	COUNTRY	AVERAGE SCORE
11	SIERRA LEONE	**55%**
12	TANZANIA	**52%**
13	ESWATINI	**45%**
14	SOUTH SUDAN	**43%**
15	KENYA	**42%**
16	SENEGAL	**36%**
17	MALAWI	**33%**
18	BURUNDI	**30%**
19	CAMEROON	**30%**
20	UGANDA	**5%**

Liberia, Côte d'Ivoire and DRC are the three countries that scored within the range of RoC being meaningfully engaged in the DSD activities. All countries obtained a 100% score on all their indicators, apart from Liberia scoring 80% on CE in M&E activities, the unavailability of data for DSD health facility trainings in DRC, and activities that have not yet been conducted (online DSD platforms in DRC and Côte d'Ivoire, impact assessments in DRC, self-assessments in Liberia and Côte d'Ivoire and community scorecards/client satisfaction surveys in DSD facilities in Côte d'Ivoire).

Rwanda, Zambia, Zimbabwe, Ghana, Ethiopia, Mozambique and Nigeria scored within the range of satisfactory engagement of RoC in DSD activities. Although individual country results vary, the following trends are common to a large proportion of this group:

- Strong CE at community level, with a majority of 100% CE scores in DSD sensitization/demand creation activities, DSD health facilities where RoC work as service providers and thematic working groups with RoC participation.
- Lower levels of CE in M&E activities, including M&E meetings, self-assessments, and community scorecards/client satisfaction surveys in DSD facilities. The impact assessments obtained low scores in a majority of countries because it has not been conducted as yet.

Sierra Leone, Tanzania, Eswatini, South Sudan and Kenya scored minimal CE in DSD activities. Most of the low scores reported by the countries are related to activities not being conducted yet, mostly in the M&E stage – impact assessments, DSD, M&E activities, self-assessments and community scorecards/client satisfaction surveys in DSD facilities. The indicators with the lowest levels of CE were at the implementation level of DSD, more specifically supportive supervision visits and DSD sensitization/demand creation activities.

Planned activities and ongoing discussions will address scores reflecting no engagement in DSD activities across Senegal, Malawi, Burundi, and Cameroon.

Cameroon and Burundi report seven or more indicators where activities have not yet started. Cameroon indicated that it had not yet developed a national DSD policy and they are currently working on a situation analysis to inform the development of a DSD policy and guiding documents.

Burundi has only recently started DSD implementation with a DSD action plan developed in 2021, which does not include some of the activities monitored by the CE tracking tool (such as online platforms and thematic working groups). Implementation started in pilot sites as from mid-2022 and the integration of communities in the implementation is not yet rolled out (including training of RoC and peer educators, DSD sensitization/demand creation activities, and community scorecards).

Malawi, on the other hand, is rolling out its DSD program and noted that there are generally low levels of CE, and that "most of the work in the design and planning of DSD approaches is done by the Ministry of Health without much regard to the input from recipients of care. RoC are not involved in most critical decision-making stages due in part to the lack of platforms for engagement." Senegal is also rolling out its DSD program, but it noted that DSD is not yet decentralized in the whole country and that CE is lower at policy and program levels, which requires advocacy and corrective measures.

Uganda, which scored the equivalent to zero CE and has no plans to engage these groups reported CE only in terms of health facilities with DSD where RoC work as service providers. All other indicators were either scored as data not available (three indicators), activity not yet started (seven indicators) or no CE (five indicators). The country reported challenges in understanding and using the CE tracking tool, as well as obtaining information to populate the indicators. It also noted that the country reported having five DSD approaches, but that "there has been no deliberate action to tell RoC in which approach they belong to."

Overview of indicator ranking

Table 5 illustrates the eight indicators that are rated as satisfactory CE, the three indicators that have minimal CE and the five indicators that have a very low scoring on CE. The calculations are based on 20 countries and 16 indicators; numerical indicators have not been used in this analysis.

Table 5: Ranking of all indicators by score

RANK	CE INDICATOR	SCORE
1	% of policy validation exercises where RoC participated	**80%**
2	% of TWG on DSD where RoC participated	**77%**
3	% of DSD planning meetings where RoC provided recommendations on prioritization of DSD models	**74%**
4	% of meetings focused on DSD program design where RoC participated	**71%**
5	% of health facilities with DSD where RoC work as service providers	**71%**
6	% of thematic working groups where RoC participated	**66%**
7	% of DSD M&E tools development meetings where RoC participated	**66%**
8	% of DSD sensitization/demand creation activities led by or actively involving RoC	**64%**
9	% of online DSD platforms that include RoC, policymakers, program implementers, and health providers	**53%**
10	% of M&E meetings that include RoC	**49%**
11	% of DSD health facility trainings that include RoC as planners and facilitators	**47%**
12	% of DSD M&E activities where RoC participated	**39%**
13	% of DSD facilities where community scorecards and/or client satisfaction surveys are implemented	**38%**
14	% of DSD supportive supervision visits that include RoC leaders	**37%**
15	% of self-assessments where RoC participated and led on CE domain	**33%**
16	% of impact assessment exercises where RoC participated	**24%**

The indicator achievement rates will be further analysed in this following section.

Analysis of CE per level and stage of DSD roll-out

According to the scoring of indicators (Table 6), RoC are satisfactorily engaged in the design stage of DSD roll-out and are minimally engaged in the implementation and M&E stages. All levels of DSD roll-out are scored as RoC having minimal engagement at community, policy, and program levels.

Table 6: Average scoring of stages and levels of DSD (all countries)

LEVEL	AVERAGE SCORE
COMMUNITY	**60%**
POLICY	**56%**
PROGRAM	**53%**

STAGE	AVERAGE SCORE
DESIGN	70%
IMPLEMENTATION	55%
M&E	42%

The three highest CE indicators are all in the design stage:

Table 7: Three highest CE indicators

INDICATOR	EXPLANATION
80% of policy validation exercises saw the participation of RoC	19 countries are conducting this activity: 14 have 100% CE and five have more than 40% CE
77% of treatment working groups on DSD included the participation of RoC	19 countries are conducting this activity: 11 with 80-100% CE and seven with more than 40% CE
74% of DSD planning meetings on prioritization of DSD models included the participation of RoC	18 countries are conducting this activity: 12 have 80-100% CE and four have more than 40% CE

The lowest CE indicators are in the M&E and implementation stages:

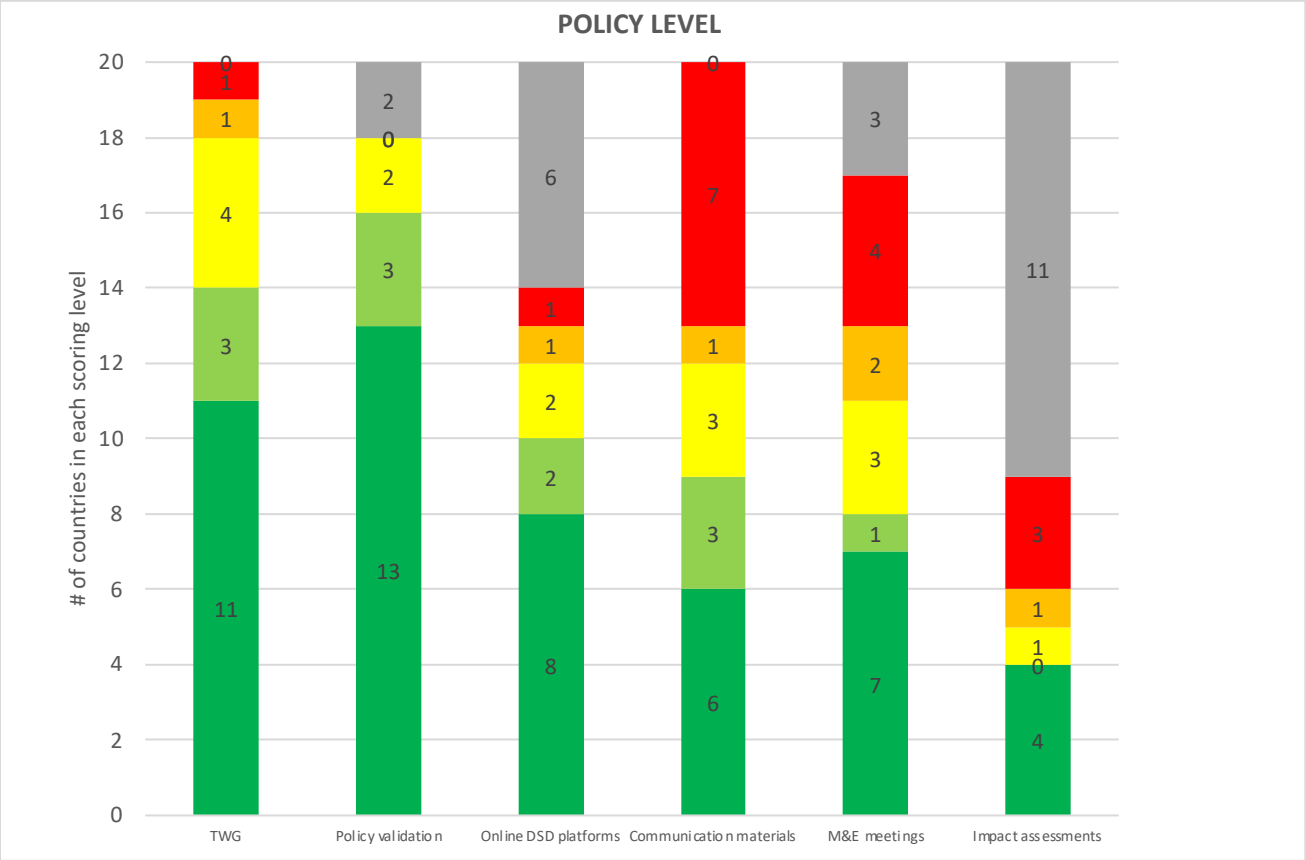
Table 8: Three lowest CE indicators

INDICATOR	EXPLANATION
24% of impact assessments exercises reported RoC participation	10 countries have not yet conducted impact assessments, one country does not have this data, three countries report no CE in the process, and two countries have 33% and 54% CE
33% of self-assessments where RoC participated and led on CE domain	Nine countries have not yet conducted self-assessments, four countries report 0-20% CE, and seven countries report 61-100%
37% of DSD supportive supervision visits included RoC leaders	10 countries report low CE (0-39%), two report 21-60% CE, data are not available for one country, and this activity has not started in two countries

The levels of DSD roll-out (policy, program, community) are analysed in more detail in the following section.

Results of CE in DSD roll-out at policy level

Figure 3: Policy level scoring of all indicators by number of countries



As illustrated in Figure 3, at policy level, more than half the countries reported meaningful CE in DSD policy validation exercises and TWGs on DSD. Half of the countries reported meaningful or satisfactory CE in online DSD platforms that include RoC, policymakers, program implementers and health providers.

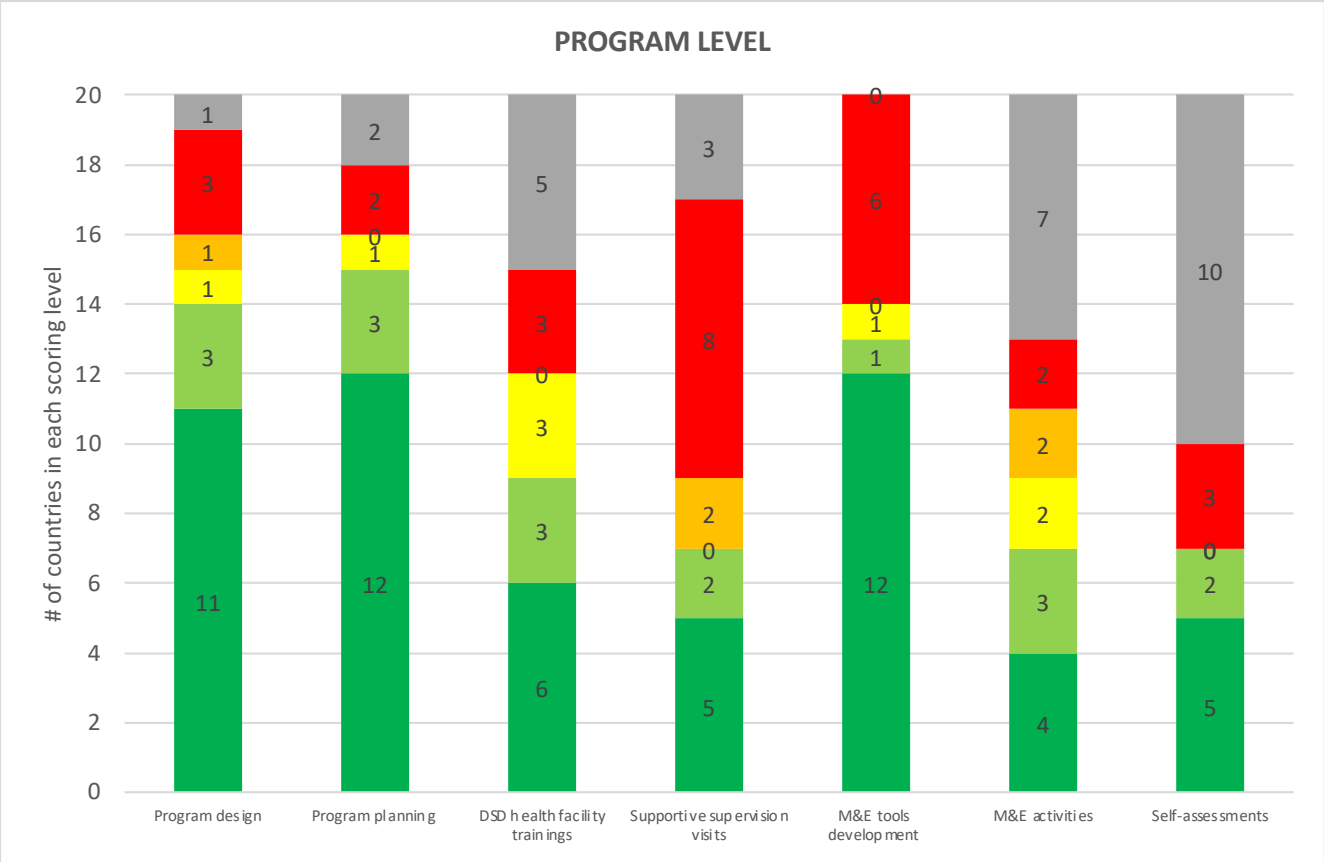
Half the countries reported that there were either no communication materials produced on DSD during the reported period and that this is a gap or that there was no CE in the process of producing DSD communication materials. This indicator was self-rated by countries in their country reports.

Half the countries reported that impact assessments have not yet been carried out and 45% of countries report that M&E meetings on DSD that include RoC were either not happening or that there was no CE.

Results of each indicator by country are detailed in Annex V.

Results of CE in DSD roll-out at program level

Figure 4: Program level scoring of all indicators by number of countries



As illustrated in Figure 4, at program level, more than half the countries reported meaningful CE in meetings focused on DSD program design, M&E tools development and planning/prioritisation of DSD models.

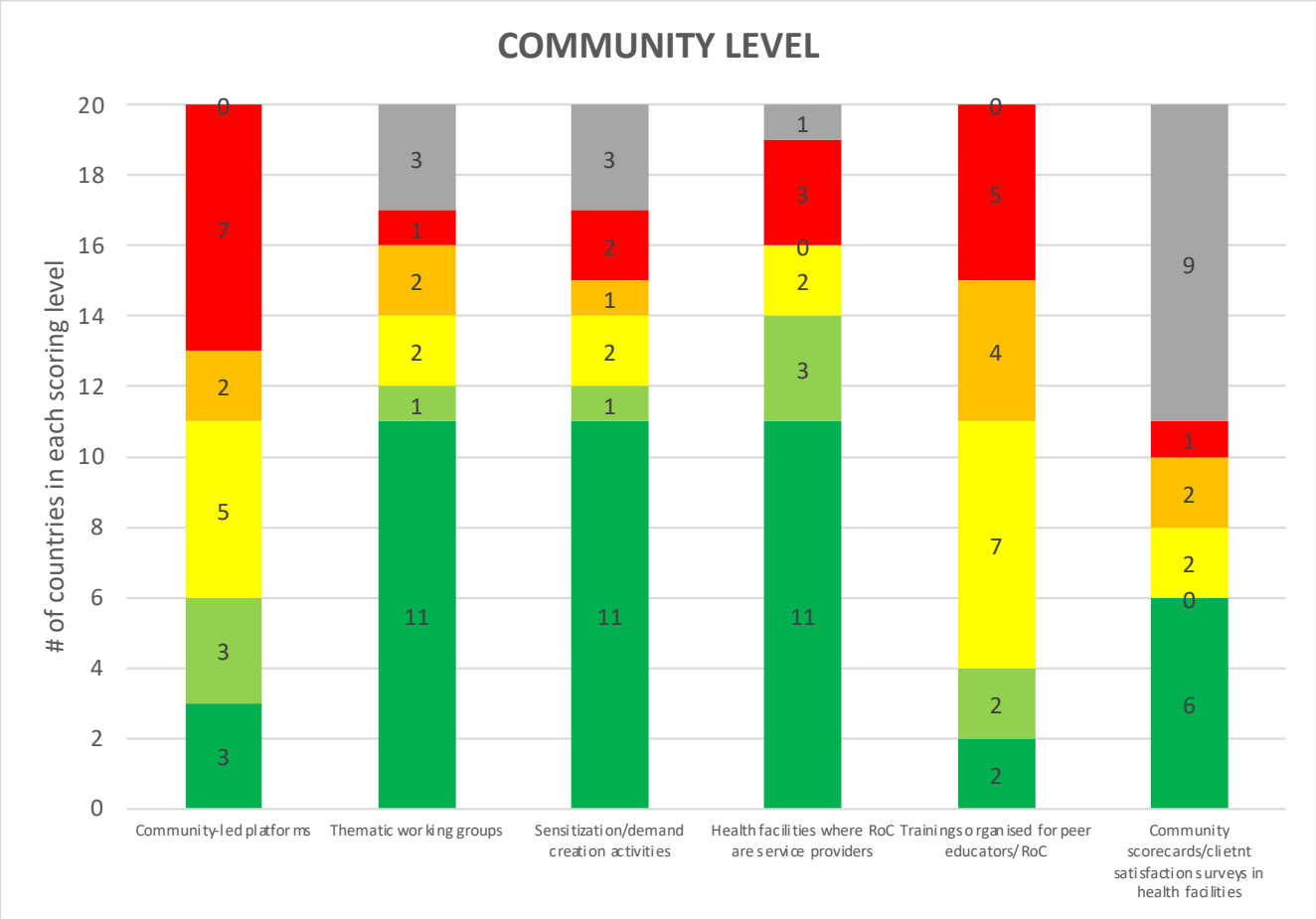
40% of countries report that there is no CE in supportive supervision visits and 25% of countries report meaningful engagement. Results for CE in health facility trainings are more varied: 30% of countries report meaningful CE, 10% report no CE, 15% report satisfactory CE, while another 15% report minimal CE, and the last two subsets of countries of 15% either could not provide data or did not conduct this activity.

Half the countries report that self-assessments were not conducted. Twenty percent of countries report that DSD M&E activities are not being conducted, 20% report extremely low to no CE in M&E activities, and 15% could not provide data for this indicator.

Results of each indicator by country are detailed in Annex V.

Results of CE in DSD roll-out at community level

Figure 5: Community-level scoring of all indicators by number of countries



As illustrated in Figure 5, at community level, more than half the countries report meaningful CE in DSD thematic working groups, DSD sensitization/ demand creation activities and health facilities with DSD where RoC work as service providers.

The two following indicators were self-rated by countries in their country report. Thirty-five percent of countries report that there were no community-level platforms established during the reporting period and this is a gap in their DSD, and 25% reported that that existing community-level platforms were either not organized enough or representative enough to ensure RoC views on DSD models were fully gathered.

Thirty-five percent of countries report that there were training sessions organized for peer educators and RoC during the reporting period, but the amount of training session was insufficient compared to the DSD plans, and 25% reported that there were no training sessions organized for peer educators and RoC during the reporting period and this is a gap in their DSD.

Results of each indicator by country are detailed in Annex V.

Discussion

The following section analyses the immediate benefits and challenges faced while rolling out the CE tracking tool, the factors that resulted in strong CE or that caused low CE, and how countries are using or plan to use the results of this first roll-out.

Benefits resulting from rolling out the CE tracking tool

All countries report that the rolling out of the CE tracking tool enabled all the stakeholders involved to have a better idea on defining CE in relation to DSD. Communities themselves better understood the different levels they should be engaged in and how best they could be engaged. Cameroon reported that the process clearly showed the difference between engagement being considered as RoC participating in meetings versus meaningful participation in all levels of DSD. Kenya reports that RoC are now also requesting to join other forums/platforms apart from DSD in an effort to increase their engagement in other sectors of the HIV response.

Ghana, for example, reports that PLHIV who were involved in the process and have a better understanding of how DSD aims to improve the accessibility and quality of care are now more interested in being virally suppressed. As a result of meeting RoC during the data collection process, groups called Positive Health and Dignity were created to encourage peer-to-peer support in treatment adherence.

All countries also report having obtained a clear picture of the level of CE currently happening in their local settings and which levels (policy, program and community) had to be strengthened. Countries also found out which activities were not yet implemented in their countries and, up to a certain extent, when these activities were planned to be rolled out. This was an opportunity to better prepare and advocate for CE in the forthcoming activities.

During the CAN pre-meeting at the CQUIN Annual Conference convened by ITPC on 5 December 2022, **multiple CAN participants shared that the data collection process fostered relationships between data collectors and duty-bearers, such as district health bodies and ministerial agencies.** As a result of the ongoing discussions and cooperation required to complete the CE tool, several CAN members were subsequently invited to join writing teams on DSD and CE, and potentially even writing teams for applications to the Global Fund's GC7. More exploration about the role of data collection in creating opportunities for CE and ongoing advocacy as a result of carrying out the CLM process should be carried out in subsequent work.

Reasons for strong and poor CE

Strong engagement at community level seems to be related to how much CSOs, and thus RoC, were historically involved in the implementation of HIV services. For example, Ghana, Mozambique, Senegal, Sierra Leone and Eswatini noted that strong CE at the level of HF is due to RoC being previously engaged in service delivery as peer educators to offer psychosocial counselling as expert clients and by helping track PLHIV who miss their appointments and/or ART. In these countries, DSD roll-out was done with the engagement of RoC since they were already integrated in service delivery. This most likely accounts for the fact that in 71% of DSD HFs in all 20 countries, RoC are service providers and 64% of demand creation activities are led or involve RoC. However, some countries, like Burundi and Côte d'Ivoire, note that the community response in DSD is lagging.

At policy level, the highest levels of CE are seen in meetings related to the design of DSD policies and plans. **Some countries report that networks of PLHIV are consistently included in policy meetings because decision-makers understand the relevance of including them to better meet the**

needs of RoC in the service delivery of HIV services. An example of this is Burundi, where the technical DSD committee is co-chaired by the network of PLHIV, so they are actively involved in every phase of DSD roll-out. However, other countries, like Cameroon, Malawi, and Mozambique, report the opposite – that policy formulation is considered to be a domain reserved for government officials only and RoC are typically not implicated in this activity.

Part of the reason for low scores in some areas is because activities have not been started or have not been conducted in-country. All M&E indicators, apart from the development of M&E tools, are among the lowest ranking in the list of indicators. This is mainly due to countries reporting that these activities have not been conducted yet (11 countries for impact assessments, 10 countries for self-assessment and seven countries for community scorecards/client satisfaction surveys). Six countries (Ethiopia, South Sudan, DRC, Burundi, Cameroon, Côte d'Ivoire) have not yet set up online DSD platforms. Cameroon and Uganda have not yet started activities in nearly half of the monitored indicators.

Geographical concerns also affect levels of CE. Differences in CE are noted at national and sub-national levels. For example, Nigeria notes that some networks of PLHIV at state level do not know and demand participation in state-level policy formulation due to irregular dissemination of DSD and CE information across all states of the country. South Sudan notes that due to financial constraints, sub-national consultations are not held, and decisions automatically exclude RoC from county or district levels.

Structural issues also affected the level of CE. Sierra Leone noted that DSD is done on an ad hoc basis, and not properly institutionalised as national guidelines and operational plans are yet to be developed. Poor engagement at program and community levels reported by Rwanda and Kenya were due to lack of a structured and coordinated mechanism for CE. Kenya reports an unharmonized way of engaging with communities, which is at the discretion of the leadership of each health facility or community-based organization. Rwanda further highlights that 67% of DSD sites are not included in coordination meetings and do not benefit from funding for joint M&E visits. Community-based DSD models are also missing from the national policy dashboards of DSD for HIV treatment.

Twelve countries, namely Zimbabwe, Zambia, Uganda, Tanzania, South Sudan, DRC, Nigeria, Mozambique, Malawi, Kenya, Eswatini and Cameroon, highlighted the need to empower RoC in their countries on DSD and their role in DSD roll-out. South Sudan, Eswatini and Rwanda specifically highlighted that the lack of regular training for peer educators, including on DSD models, is a factor that creates low levels of engagement at community level. **It can be deduced that low capacities of RoC to engage in DSD design, implementation and M&E is one of the factors that contributes to low levels of engagement.**

Current and planned use of findings from CE tracking tool

All countries have planned to use the data to inform advocacy for better CE in DSD. Some countries have already initiated actions:

- Burundi has developed an advocacy plan based on the gaps, and activities have started, including setting up a community observatory within the network of PLHIV.
- Rwanda will advocate for an annual regional coordination meeting with key partners of DSD including representation of PLHIV, local authorities, health providers, the biomedical centre, and ministries in all facilities to discuss the achievements and gaps that may remain for DSD improvement.
- Zambia, Zimbabwe, and DRC have already started to engage with the relevant authorities from policy and program levels around CE in DSD.

- Cameroon and Malawi have started discussing advocacy on how to increase CE in DSD in CSO forums, and how the findings can be used in country funding requests to the Global Fund. Cameroon will be advocating more specifically for a more structured approach to DSD, a unified data collection tool bringing on board all DSD actors and include CE in policy documents such as the National Strategic Plan.
- Côte d'Ivoire used the findings to better plan their fundraising to cater for the internal capacity building needs for more comprehensive engagement and advocacy.
- Mozambique integrated the findings in their advocacy plan and successfully obtained funding from the International Aids Society for activities at the level of health units.
- Ghana has sensitized regional health executives on DSD and plans to hold a training session on DSD.
- Tanzania has used the findings to support their annual engagement plan and integrated the CE findings in their CLM feedback meetings with the President's Emergency Plan for AIDS Relief, the Ministry of Health and RoC. Tanzania is also using the findings in relation to their CLM systems, especially to inform the upcoming community scorecard.
- Kenya has also started using the data to advocate, leading to the National Aids and STI Control Program to hold sensitization and training sessions on the revised ART guidelines, which also included RoC. This was used as a forum for advocacy for more CE. The program also committed to supporting CE during the national ART Guidelines TWG meetings and an assessment of DSD is planned, which will enable more advocacy around CE. The Kenyan network of PLHIV has disseminated information on the results of the CE framework in its weekly bulletin in an effort to reach out to community members.
- In Ghana, NAP+ is working on empowering their members on treatment literacy and adherence for a higher engagement in and accountability towards their treatment. The PhD groups, created as a result of the data collection process, will be supported to have a line of communication with regional and national Ministry of Health executives, with other community members, and for focus group discussions in view of strengthening the DSD programs.
- In Sierra Leone, NETHIPS is using the findings to review its position and role in the DSD roll-out, assessing the need to reinforce strong CE in DSD, as well as considering how the CE data can be linked to other CLM initiatives.

It will be important to establish with the countries how they will be tracking whether these actions lead to the desired changes. Post-CE assessments should consistently include the dissemination of the results of the assessment with local authorities, the development and validation of an action plan to address challenges, and the implementation and monitoring of the action plan.

Recommendations

This section details the eight main recommendations that apply to countries in general to support future tracking of CE and to ensure that levels of CE in DSD roll-out improve.

Making the data collection process more user-friendly

Countries all reported that the data collection process was hard, time consuming and intense. They suggested that the tracking tool could be more user-friendly. At the time of finalisation of this report, an updated tracking tool and user manual has been developed by ITPC, a refresher training course has been conducted and a data collection plan for 2023 has been developed based on the recommendations which can be found in Annex VI.

Ensuring the scope of data collected is nationally representative

Networks that cannot access data from all geographical zones in their country should ensure that their sampling is representative enough to provide a national estimation that will give a solid snapshot of CE in DSD. This will also enable countries to conduct evidence-based advocacy where lower CE is noted at sub-national levels.

Raising awareness and building capacity on CE and DSD

Cameroon, DRC, Ghana, and Kenya acknowledge that sensitization, training and empowerment of RoC is required for a better understanding of DSD in the countries to encourage more RoC to take ownership of their treatment, and use the DSD facilities that are patient-centered and can better respond to their needs. This would also enable RoC involved in DSD services to provide higher quality support and guidance to PLHIV. Many countries also highlight the need for institutional capacity building of RoC organisations so that they can be more proactive at fostering partnerships to promote CE in DSD. Raising awareness on DSD models so that RoC know what the approaches are and create demand is most probably an activity that will benefit all countries. It is recommended to guide countries on who specifically should be targeted by the capacity building initiatives, differentiating between awareness raising for large groups of RoC for them to understand their role in DSD, and smaller groups of RoC representatives (community leaders, networks of PLHIV, RoC advocates) that would most probably require more technical expertise to be able to engage with local authorities and duty-bearers.

Fostering relationships with duty-bearers and co-creating joint action plans

All countries note that they need to sustain the dialogue, nurture the fostered relationship with duty-bearers and local authorities that started around the data collection process, and supplement this with advocacy based on the findings. It is important to follow up on the impact of these relationships built, invitations to join writing teams and planning bodies, as well as track the planned advocacy actions. It is advised to also explore with countries how the upcoming round of data collection can be used to further advocate and narrow down which dysfunctions are hindering strong CE, so that more targeted and collaborative advocacy actions can be defined and carried out.

Developing formalised collaborative frameworks with duty-bearers

In terms of data sourcing and availability, the main recommendation is related to the data source being primarily from local HIV/AIDS authorities and/or public health sectors. It is recommended to consider developing formalised collaborative frameworks (such as memorandums of understanding) to facilitate future data collection, with reporting periods and tools that are agreed on between all local stakeholders (including from community level, where there is also a challenge to track activities).

Issues regarding the unwillingness of authorities to collaborate in data collection or regarding the unavailability of data or supporting documentation can be addressed with duty-bearers and systems to ensure this data is available and can be co-created. National networks should, together with government stakeholders, develop remedial plans to ensure that the subsequent data collection is smoother. For example, ensuring that they obtain a copy of the meeting register after every meeting. Networks can also track some of this information on an ongoing basis. In other words, taking note of all invitations to participate in DSD related activities, their attendance and whether they meaningfully contributed. They should also take note of activities that they discover happened without their knowledge or invitation.

Tracking meaningful CE

One of the issues raised during this first data collection process was the fact that community participation rather than meaningful CE was being tracked. Networks should engage with duty-bearers to co-create a tracking solution to effectively measure meaningful engagement. Discussing how the CE tracking tool could be linked or integrated into other CLM initiatives could also open more perspectives on tracking the impact of CE on clinical outcome data. This can be done during the refresher training in 2023 and during the pre-arranged support meetings to be held during the 2023 data collection period.

Advocating for higher levels of CE in DSD roll-out

Countries are advised to disseminate the results of the 2022 CE tracking tool with local stakeholders and develop an action plan on the areas for advocacy. The implementation and monitoring of this action plan is essential to track if the desired changes in the levels of CE are being realized.

Countries should seek to understand why communities are primarily engaged the early stages of program and policy development (such as planning and demand-creation) but far less engaged at the end of the implementation cycle (M&A, satisfaction surveys, and so forth). Noting that a majority of countries indicated their lower reporting rates are a result of these M&E activities not having been conducted yet, it is still enormously important for RoC to be prioritized in evaluating the quality of the services aimed at meeting their needs.

Some potential advocacy areas are listed below:

RECOMMENDED ADVOCACY THEME	COUNTRIES
Advocate for the planning of timely impact assessments with strong CE	Rwanda, Sierra Leone, Zambia, Zimbabwe, Ethiopia, Eswatini, Burundi, DRC, Cameroon, Uganda, and Kenya
Advocate for higher CE in existing impact assessments	Ghana, Malawi, Mozambique, and Senegal
Advocate for CE in CQUIN Capability Maturity Model self-assessment exercises that are led by the ministry of health every year	Rwanda, Sierra Leone, Ethiopia, Eswatini, Liberia, Burundi, Cameroon, Uganda, Côte d'Ivoire, Kenya, Malawi, Tanzania, and Senegal
Advocate for the inclusion of community scorecards and/or client satisfaction surveys led by communities	Sierra Leone, Ethiopia, Eswatini, Burundi, Uganda, Côte d'Ivoire, and Kenya

RECOMMENDED ADVOCACY THEME	COUNTRIES
Advocate for higher CE in community scorecards and/or client satisfaction surveys	Zambia, Zimbabwe, and Nigeria
Advocate for higher CE in M&E DSD activities	Burundi, Kenya, Mozambique, and Eswatini
Advocate for availability of data on CE in M&E DSD activities	Ghana, Uganda, and Senegal
Advocate for higher CE regarding DSD supportive supervision visits	South Sudan, Rwanda, Burundi, Eswatini, Senegal, Malawi, Mozambique, Nigeria, Tanzania, and Kenya
Advocate for higher levels of health facility trainings that include RoC	Malawi, Uganda, and Tanzania

Promoting country-to-country learning and capacity building

The experiences of each of the 20 countries currently tracking CE is a rich source of learning practices that should be shared in a joint forum to build on successful strategies. For example, Ghana, Mozambique, Senegal, Sierra Leone and Eswatini could share how historical involvement in implementation of HIV services can be used to promote CE in DSD roll-out in countries like Burundi and Côte d'Ivoire where the community response is lagging. Cameroon, Malawi, and Mozambique could learn from Burundi on what strategy enabled the network of PLHIV to co-chair the technical DSD committee, ensuring strong engagement in design of DSD policies.

Zimbabwe, Zambia, Uganda, Tanzania, South Sudan, DRC, Nigeria, Mozambique, Malawi, Kenya, Eswatini and Cameroon highlighted the need to empower RoC in their countries on DSD and their role in DSD roll-out. Networks from Ghana and Sierra Leone could share how they are reviewing their strategic position in relation to DSD and empowering RoC to reinforce CE in DSD programs.

Conclusion

The strengths of this unique project to track CE in DSD are that it fills important knowledge gaps on CE – whether for RoC themselves to better understand their role in DSD (and more broadly the country's HIV response) or for local authorities to better understand the added value of CE in DSD. Since the tracking tool looks at the different levels and stages of DSD roll-out, it gives specific feedback on where exactly RoC need to be more proactive to be engaged and play a more active role. Best practices and successful strategies for CE can also be documented through the tracking tool. The tool is also relatively straight forward to replicate in other countries and can be used to inspire other networks of PLHIV and RoC to assess and improve levels of engagement in their countries.

Despite the importance of CE across all boards of DSD for its success, this assessment showed CE was quite variable, both from domain to domain and from country to country. However, the general trend is that CE is higher at the design stage of DSD and strongest at the community level. CE is lowest at the M&E stage and at the program level. The assessment has provided a solid baseline from which to work to improve levels of CE and has created new perspectives to explore to strengthen CE. Some outcomes of the assessment such as countries realising the added value of CE and the role of communities in HIV responses, having a clear picture of gaps in CE and building new relationships with authorities and partners have created potential opportunities to have an impact on their institutional frameworks.

This first assessment has also provided guidance on what to advocate for and, if done regularly, this process will be refined. In the future, the assessments could provide more specific insights on systemic dysfunctions and the relevant strategies to adopt to ensure that RoC are at the heart of differentiated HIV service delivery.

Annexes

Annex I: Community engagement tracking tool – list of indicators

POLICY LEVEL (SIX INDICATORS)
% of TWG on DSD where RoC participated
% of policy validation exercises where RoC participated
% of online DSD platforms that include RoC, policymakers, program implementers and health providers
# of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments
% of M&E meetings that include RoC
% of impact assessment exercises where RoC participated
PROGRAM LEVEL (SEVEN INDICATORS)
% of meetings focused on DSD program design where RoC participated
% of DSD planning meetings where RoC provided recommendations on prioritization of DSD models
% of DSD HF trainings that include RoC as planners and facilitators
% of DSD supportive supervision visits that include RoC leaders
% of DSD M&E tools development meetings where RoC participated
% of DSD M&E activities where RoC participated
% of self-assessments where RoC participated and led on CE domain
COMMUNITY LEVEL (SIX INDICATORS)
# of community-level platforms established aimed at gathering RoC views on DSD models
% of thematic working groups where RoC participated
% of DSD sensitization/demand creation activities led by or actively involving RoC
% of HF with DSD where RoC work as service providers
# of training sessions organized for peer educators and RoC
% of DSD facilities where community scorecards and/or client satisfaction surveys are implemented

Annex II: Community engagement tracking tool – a snapshot

	HOW TO ENGAGE	INDICATOR	INDICATOR DESCRIPTION	NUMERATOR # of TWG mtgs on DSD w/RoC participation	DENOMINATOR # of TWG mtgs organized by MOH where DSD discussed	% RESULT	CONFIRMED DATA SOURCES / EVIDENCE	EXAMPLES OF DATA SOURCES / EVIDENCE	NOTES / COMMENTS ON DATA SOURCES
POLICY LEVEL	"PL.D1. Consult with recipient of care (RoC) leadership to facilitate information-sharing re: differentiated service delivery (DSD) models described in DSD policy documents PL.D2. Include RoC/community members in policy and guidelines formulation task teams and treatment working groups (TWGs)"	% of TWG on DSD where RoC participated	To determine the %, take # of TWG meetings where RoC participated divided by the # of TWG organized by the government where DSD was discussed					National program listserv for TWG meeting invitations National DSD TWG meeting reports National policy frameworks/ guidelines documents with list of contrtibutors/ participants	
		INDICATOR	INDICATOR DESCRIPTION	# OF DSD POLICY VALIDATION MTGS WHERE ROC PARTICIPATED	# OF DSD POLICY VALIDATION MTGS ORGANIZED BY MOH	% RESULT	CONFIRMED DATA SOURCES / EVIDENCE	EXAMPLES OF DATA SOURCES / EVIDENCE	NOTES / COMMENTS ON DATA SOURCES
	PL.D3. Include recipients of care (RoC)/community members in policy validation exercises	% of policy validation exercises where RoC participated	To determine the %, take # of DSD-related policy validation meetings where RoC participated divided by the # of DSD-related policy validation meetings organized by the government			#DIV/01		National program listserv for policy validation meeting minutes National policy validation meeting reports	

Annex III: Community engagement tracking tool – colour code

SCORING LEVELS & DEFINITIONS (DSD DASHBOARD 3.0)						
COLOR SCORE	**0 OR N/A**	**0-20%**	**21-40%**	**41-60%**	**61-80%**	**81-100%**
CE scoring descriptions (DSD Dashboard 3.0)	0 means that the activity is not developed / planned N/A data source not noted, available, accessible)"	Representatives from the community of people living with HIV (PLHIV) and civil society organizations (CSO) are not involved in any activities related to DSD and there are currently no plans to engage these groups*	PLHIV and CSO are not currently engaged in DSD activities, but engagement is planned or meetings and discussions are ongoing	PLHIV and CSO are meaningfully engaged in DSD implementation	PLHIV and CSO are meaningfully engaged in implementation and evaluation of DSDM	PLHIV and CSO are meaningfully engaged in implementation and evaluation of DSD, as well as oversight of DSD policy (e.g., through inclusion in DSD task force or other group)
If % is between		**0-20%**	**21-40%**	**41-60%**	**61-80%**	**81-100%**
Score points	0	0	1	2	3	4

*use this color score if: 1) activity not developed / planned and therefore no CE or plans to engage communities; 2) data source not noted, available, accessible

Annex IV: Self-assessment of numerical indicators (extract from country report template)

Further analysis of numerical indicators. Please tick the most relevant response for the following indicators from the tracking tool:

# of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments

There were no communication materials produced during the reporting period and this is a gap in DSD	There were no communication materials produced during the reporting period, but the country already has sufficient communication materials	There were communication materials produced during the reporting period but not by RoC/with their full participation	There were no communication materials produced by RoC during the reporting period, but this is planned and discussions are ongoing	There were communication materials produced during the reporting period by RoC or with their full participation

# of community-level platforms established aimed at gathering RoC views on DSD models

There were no community-level platforms established during the reporting period and this is a gap in DSD	There were no community-level platforms established during the reporting period, but the country already conducted these prior to the reporting period	There were community-level platforms established during the reporting period but either (i) not enough were organized to ensure RoC views on DSD models were fully gathered; or (ii) the platforms were representative enough to ensure RoC views on DSD models were fully gathered	There were no community-level platforms established during the reporting period, but this is planned and discussions are ongoing	There were community-level platforms established during the reporting period that ensured RoC views on DSD models were fully gathered

# of training sessions organized for peer educators and RoC

There were no training sessions organized for peer educators and RoC during the reporting period and this is a gap in DSD	There were no training sessions organized for peer educators and RoC during the reporting period, but the country already conducted these prior to the reporting period	There were training sessions organized for peer educators and RoC during the reporting period, but they were number of sessions were insufficient compared to the DSD plans	There were no trainings organized for peer educators and RoC during the reporting period, but this is planned and discussions are ongoing	There were training sessions organized for peer educators and RoC during the reporting period and the number of sessions were sufficient for the DSD plans

Annex V: List of detailed results per indicator and per country

Results of CE in DSD roll-out at policy level

Treatment working groups on DSD where RoC participated	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Zimbabwe, Ethiopia, Eswatini, DRC, Liberia, Cameroon, Côte d'Ivoire, and Tanzania	Meaningful CE
South Sudan, Burundi, and Kenya	Satisfactory CE
Ghana, Senegal, Malawi, and Nigeria	Minimal CE
Mozambique	Extremely low levels of participation, so currently RoC are not described as engaged
Uganda	No CE

Policy validation exercises where RoC participated	
COUNTRIES	**LEVEL OF CE**
Rwanda, Zambia, Zimbabwe, Ethiopia, South Sudan, Eswatini, DRC, Liberia, Burundi, Kenya, Mozambique, Côte d'Ivoire, and Tanzania	Meaningful CE
Nigeria, Sierra Leone and Malawi	Satisfactory CE
Ghana and Senegal	Minimal CE
Cameroon	Activity did not happen in country
Uganda	Data not available

Online DSD platforms that include RoC, policymakers, program implementers and health providers	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Zimbabwe, Eswatini, Liberia, Mozambique and Tanzania	Meaningful CE
Senegal and Nigeria	Satisfactory CE
Ghana and Malawi	Minimal CE
Kenya	Extremely low CE
Ethiopia, South Sudan, DRC, Burundi, Cameroon, and Côte d'Ivoire	Activity does not exist in country
Uganda	No CE

Communication materials produced by RoC to educate communities about policies, results of evaluations/ assessments	
COUNTRIES	**LEVEL OF CE**
Rwanda, Zimbabwe, South Sudan, Senegal, Malawi, and Tanzania	Full participation of RoC in the communication materials produced
Sierra Leone, Kenya, and Mozambique	Communication materials including RoC participation is planned and discussions are ongoing
Ethiopia, DRC, and Nigeria	Communication materials were produced, but these did not include full RoC participation
Zambia, Eswatini, Ghana, Burundi, Cameroon, Uganda, and Côte d'Ivoire	No communication materials produced during the reporting period and this is a gap in DSD
Liberia	Although there were no communication materials produced during the reporting period, there are sufficient communication materials, so this is not a gap

M&E meetings that include RoC	
COUNTRIES	**LEVEL OF CE**
Rwanda, Eswatini, DRC, Ghana, Liberia, Côte d'Ivoire, and Tanzania	Meaningful CE
Zambia	Satisfactory CE
Ethiopia, Kenya, and Nigeria	Minimal CE
South Sudan and Senegal	Extremely low CE, considered as none
Zimbabwe, Malawi, Mozambique, and Uganda	No CE at all
Sierra Leone, Burundi, and Cameroon	Activity is not happening in country

Impact assessment exercises where RoC participated	
COUNTRIES	**LEVEL OF CE**
South Sudan, Liberia, Côte d'Ivoire, and Tanzania	100% participation of RoC in impact assessments
Nigeria	Minimal CE in the impact assessments carried out
Ghana	Extremely low levels of CE
Rwanda	Impact assessment carried out before reporting period
Senegal, Malawi, and Mozambique	No CE in the impact assessments carried out
Sierra Leone, Zambia, Zimbabwe, Ethiopia, Eswatini, DRC, Burundi, Cameroon, Kenya, and Uganda	Impact assessments have not yet been carried out

Results of CE in DSD roll-out at program level

Meetings focused on DSD program design where RoC participated	
COUNTRIES	**LEVEL OF CE**
Rwanda, Zimbabwe, Ethiopia, South Sudan, Eswatini, DRC, Liberia, Burundi, Cameroon, Mozambique, and Côte d'Ivoire	Meaningful CE
Sierra Leone, Zambia, and Nigeria	Satisfactory CE
Malawi	Minimal CE
Ghana	Extremely low CE
Uganda	Activity was not conducted in country
Senegal, Kenya, and Tanzania	No CE

DSD planning meetings where RoC provided recommendations on prioritization of DSD models	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Zimbabwe, Eswatini, DRC, Ghana, Liberia, Burundi, Mozambique, Côte d'Ivoire, and Tanzania	Meaningful CE
Ethiopia, South Sudan, and Nigeria	Satisfactory CE
Malawi	Minimal CE
Cameroon and Uganda	Activity was not conducted in country
Senegal and Kenya	No CE

DSD health facility trainings that include RoC as planners and facilitators	
COUNTRIES	**LEVEL OF CE**
Sierra Leone, Zambia, Ethiopia, Liberia, Kenya, and Côte d'Ivoire	Meaningful CE
Rwanda, Ghana, and Nigeria	Satisfactory CE
Zimbabwe, Senegal, and Mozambique	Minimal CE
South Sudan and Eswatini	Activity was not conducted in country
Malawi, Uganda, and Tanzania	No CE
DRC, Burundi, and Uganda	Data is not available

DSD supportive supervision visits that include RoC leaders	
COUNTRIES	**LEVEL OF CE**
Zimbabwe, DRC, Ghana, Liberia, and Côte d'Ivoire	Meaningful CE
Zambia and Ethiopia	Satisfactory CE
Rwanda and Senegal	Minimal CE
Sierra Leone and Cameroon	Activity does not exist in country
South Sudan, Eswatini, Burundi, Kenya, Malawi, Mozambique, Nigeria, and Tanzania	No CE
Uganda	Data is not available

DSD M&E tools development meetings where RoC participated	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Ethiopia, DRC, Ghana, Liberia, Burundi, Cameroon, Kenya, Côte d'Ivoire, and Tanzania	Meaningful CE
Nigeria	Satisfactory CE
Senegal	Minimal CE
Zimbabwe, South Sudan, Eswatini, Malawi, Mozambique, and Uganda	No CE

DSD M&E activities where RoC participated	
COUNTRIES	**LEVEL OF CE**
Ethiopia, DRC, Côte d'Ivoire, and Nigeria	Meaningful CE
Zimbabwe, Liberia, and Cameroon	Satisfactory CE
Rwanda and Zambia	Minimal CE
Eswatini and Mozambique	Extremely low CE
Sierra Leone, South Sudan, Malawi, and Tanzania	Activity not being conducted in country
Burundi and Kenya	No CE
Ghana, Senegal, and Uganda	Data not available

Self-assessments where RoC participated and led on CE domain	
COUNTRIES	**LEVEL OF CE**
Zimbabwe, South Sudan, DRC, Ghana, and Mozambique	Meaningful CE
Zambia and Nigeria	Satisfactory CE
Rwanda, Sierra Leone, Ethiopia, Eswatini, Liberia, Burundi, Cameroon, Kenya, Uganda, and Côte d'Ivoire	Activity has not been conducted in country
Senegal, Malawi, and Tanzania	No CE

Results of CE in DSD roll-out at community level

Community-level platforms established aimed at gathering RoC views on DSD models	
COUNTRIES	**LEVEL OF CE**
Rwanda, Zimbabwe, and Tanzania	There were community-level platforms established during the reporting period that ensured RoC views on DSD models were fully gathered
Sierra Leone, Senegal, and Kenya	There were no community-level platforms established during the reporting period, but this is plannedand discussions are ongoing
Zambia, Ethiopia, DRC, Mozambique, and Nigeria	There were community-level platforms established during the reporting period but either (i) not enough were organized to ensure RoC views on DSD models were fully gathered; or (ii) the platforms were representative enough to ensure RoC views on DSD models were fully gathered
Liberia and Malawi	There were no community-level platforms established during the reporting period, but the country already conducted these prior to the reporting period
South Sudan, Eswatini, Ghana, Burundi, Cameroon, Uganda, and Côte d'Ivoire	There were no community-level platforms established during the reporting period and this is a gap in DSD

Thematic working groups where RoC participated	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Zimbabwe, South Sudan, DRC, Ghana, Liberia, Cameroon, Mozambique, and Côte d'Ivoire	Meaningful CE
Nigeria	Satisfactory CE
Ethiopia and Malawi	Minimal CE
Kenya and Tanzania	Extremely low CE
Eswatini, Burundi, and Uganda	Activity not conducted in country
Senegal	No CE

DSD sensitization/demand creation activities led by or actively involving RoC	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Zimbabwe, Ethiopia, DRC, Liberia, Kenya, Mozambique, Côte d'Ivoire, and Nigeria	Meaningful CE
Ghana	Satisfactory CE
Senegal and Tanzania	Minimal CE
Malawi	Extremely low CE
Burundi, Cameroon, and Uganda	Activity not conducted in country
South Sudan and Eswatini	No CE

Health facilities with DSD where RoC work as service providers	
COUNTRIES	**LEVEL OF CE**
Rwanda, Sierra Leone, Zambia, Zimbabwe, Ethiopia, Eswatini, DRC, Ghana, Liberia, Mozambique, and Côte d'Ivoire	Meaningful CE
Senegal, Kenya, and Uganda	Satisfactory CE
Malawi and Nigeria	Minimal CE
South Sudan, Burundi, and Tanzania	No CE
Cameroon	Data not available

Trainings organized for peer educators and RoC	
COUNTRIES	**LEVEL OF CE**
Rwanda and DRC	There were training sessions organized for peer educators and RoC during the reporting period and the number of sessions were sufficient for the DSD plans
Kenya and Mozambique	There were no training sessions organized for peer educators and RoC during the reporting period, but this is planned and discussions are ongoing
Sierra Leone, Ethiopia, South Sudan, Ghana, Liberia, Senegal, and Nigeria	There were training sessions organized for peer educators and RoC during the reporting period, but the number of sessions were insufficient compared to the DSD plans
Zambia, Cameroon, Malawi, and Tanzania	There were no training sessions organized for peer educators and RoC during the reporting period, but the country already conducted these prior to the reporting period
Zimbabwe, Eswatini, Burundi, Uganda, and Côte d'Ivoire	There were no training sessions organized for peer educators and RoC during the reporting period and this is a gap in DSD

DSD facilities where community scorecards and/or client satisfaction surveys are implemented	
COUNTRIES	**LEVEL OF CE**
Rwanda, DRC, Ghana, Liberia, Malawi, and Mozambique	Meaningful CE
Senegal and Tanzania	Minimal CE
Zimbabwe and Nigeria	Extremely low CE
Sierra Leone, Ethiopia, Eswatini, Burundi, Kenya, Uganda, and Côte d'Ivoire	Activity not conducted in country
Zambia	No CE
South Sudan and Cameroon	No data available

Annex VI: List of detailed recommendations to improve data collection tools and processes

Recommendations to make the tracking tool more user-friendly:

- Separate policy, program, and community levels in different Excel tabs so that the tool is less bulky.
- Include one separate tab for instructions, FAQs, a glossary and scoring details.
- Include an example of a filled in tracking tool with correct and complete details in each column as a guide.
- Define indicators more precisely to clarify any misunderstanding, such as if networks of PLHIV or CSO are also representative of RoC, self-impact exercises are specifically CQUIN annual self-assessments and so on.
- Predefine the scope of the data (national, sub-national, health facility level) to guide data collectors.
- Streamline indicators by removing sub-disaggregation in the indicators % of DSD M&E activities where RoC participated and # of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments.
- Clarify in the tool the period for data collection and dates of submission.

It is also recommended to either remove the following numerical indicators, transform them into % indicators or keep them as country self-assessments in future data collection if they cannot be proportioned, which renders them difficult to score:

- # of communication materials produced by RoC to educate communities about policies, results of evaluations/assessments
- # of community-level platforms established aimed at gathering RoC views on DSD models
- # of trainings organized for peer educators and RoC

The colour-scoring methodology could also be improved by differentiating between activities that have no CE, activities that have not yet started in a country, and indicators where data is not available to better understand the nuances between low levels of engagement. Integrating the grey option to the scoring system (activity not started or information unavailable) in the tracking tool would facilitate future data collection and analysis, as well as reduce back and forth between ITPC and countries during the data review. Furthermore, integrating an option in the tool where countries can clearly specify if the activity is currently being implemented in a country was already implemented before the reporting period or whether it is planned after the reporting period would facilitate the feedback process between countries and ITPC.

The training on the CE data collection process in 2023 should cover any updates made to the tracking tool and address all the areas where there was not enough clarity to ensure a common understanding of all indicators, scope of data collection, and level of detail required for supporting evidence.

Lastly, more frequent communication prior to and during data collection could help address challenges and track progress before the submission deadline. This would also be an opportunity to address the question of whether participation in activities always implies meaningful engagement and gather input from countries on how they suggest this nuance be identified. A suggestion would be to have pre-arranged support meetings during the data collection process.

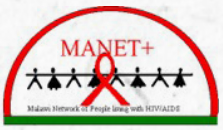
Annex VII: List of countries trained for leading the CE tool roll-out

COUNTRY	NAME OF PARTICIPATING ORGANISATION
BURUNDI	*Réseau Burundais des Personnes Vivant avec le VIH/SIDA* (RBP+)
CAMEROON	*Réseau Camerounais des Associations de Personnes vivant avec le VIH/SIDA* (RéCAP+)
CÔTE D'IVOIRE	*Réseau Ivoirien des organisations de Personnes vivant avec le VIH* (RIP+)
DRC	*Union Congolaise des Organisations des PVVIH* (UCOP+)
ESWATINI	Dream Alive Eswatini
ETHIOPIA	Network of Networks of HIV Positives in Ethiopia (NEP+)
GHANA	Ghana Network of Persons Living with HIV/AIDS (NAP+)
KENYA	National Empowerment Network of People living with HIV/AIDS in Kenya (NEPHAK)
LIBERIA	Liberia Network of People Living with HIV and AIDS (LibNeP+)
MALAWI	Malawi Network of People Living with HIV (MANET+)
MOZAMBIQUE	Civil Society Platform for Health in Mozambique (PLASOC-M)
NIGERIA	Network of People Living with HIV and AIDS in Nigeria (NEPWHAN)
RWANDA	Rwanda Network of People Living with HIV/AIDS (RRP+)
SENEGAL	*Réseau National des Associations de PVVIH* (RNP+)
SIERRA LEONE	Network of HIV Positives in Sierra Leone (NETHIPS)
SOUTH SUDAN	National Empowerment of Positive Women United (NEPWU)
TANZANIA	National Council of People Living with HIV/AIDS in Tanzania (NACOPHA)
UGANDA	National Forum of People Living with HIV/AIDS Networks in Uganda (NAFOPHANU)
ZAMBIA	Network of Zambian People Living with HIV and AIDS (NZP+)
ZIMBABWE	Zimbabwe National Network of People Living with HIV (ZNNP+)

Endnotes

1 WHO, Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring, July 2021
2 WHO, Community engagement: a health promotion guide for universal health coverage in the hands of the people, October 2020
3 Burundi, Cameroon, Cote d'Ivoire, DRC, Eswatini, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe
4 WHO, Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring, July 2021
5 WHO, Community engagement: a health promotion guide for universal health coverage in the hands of the people, October 2020
6 Centers for Disease Control and Prevention (CDC), 1997, p. 9
7 UNAIDS, The Greater Involvement of People Living with HIV (GIPA) policy brief, March 2007
8 CAN/CQUIN, Community Engagement Framework, November 2019, available here
9 Burundi, Cameroon, Cote d'Ivoire, DRC, Eswatini, Ethiopia, Ghana, Kenya, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.
10 Cameroon, DRC, Kenya, Liberia, Malawi, Nigeria, Rwanda, and Sierra Leone
11 Nigeria, Kenya, and DRC
12 Burundi, Cameroon, Ghana, Senegal, South Sudan, Uganda, and DRC
13 Health facility trainings that include RoC, DSD facilities where RoC work as service providers, DSD M&E activities where RoC participated, supportive supervision visits and implementation of community scorecard and/or client satisfaction.







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