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How to Budget for Community-Led Monitoring



HEALTH GAP
GLOBAL ACCESS PROJECT

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GEORGETOWN LAW

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Abbreviations

C19RM	COVID-19 Response Mechanism
CAM	Community accountability meeting
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CLM	Community-led monitoring
CLO	Community-led organizations
CM	Community monitors
COI	Conflict of Interest
COP	Country Operational Plan
FTE	Full-time equivalent
KP	Key population
MOU	Memorandum of Understanding
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People/person living with HIV
TA	Technical assistance



Budgeting for Community-Led Monitoring

This guide is intended to be used by community-led organizations to develop a budget for a community-led monitoring, or CLM, program. The resource can be used by programs seeking funding for a new CLM program, or may be used by organizations seeking scaled-up resources for an existing CLM program (to scale up coverage, for example). This guide may additionally be used by technical consultants providing support to CLM programs.

What is Community-Led Monitoring?

CLM is a powerful model for improving the quality and accessibility of healthcare services, by empowering communities with data to advocate for change. Through a cycle of data collection and advocacy, CLM promotes rights-based and people-centered health systems, holds national and global duty-bearers accountable to the people they serve, and addresses power imbalances in global development by empowering communities to participate in decision-making and advocacy.

The cycle of CLM activities, as defined by UNAIDS,¹ CLM implementers, and technical assistance providers,² includes the following key stages of activities:

1. Pre-data collection: Identification of local community-based organization(s) to lead the CLM program; community and government orientation, community empowerment, and capacity building including community treatment literacy; relationship building, planning and conceptualization phase; identification of community needs and gaps from the affected community; and indicator development and pretest of data collection software and tools;

2. Data collection and analysis: Collecting qualitative and quantitative information at facility and community level from service users, healthcare workers, support staff, and other stakeholders; analyzing data; and conducting community meetings to analyze the information and translate data into actionable insights and advocacy priorities;

3. Developing solutions and conducting advocacy: Targeted action to bring information and proposed solutions to the attention of facility, national, and funding decision-makers (often through the establishment of Community Consultative Groups or leveraging other existing policy- and decision-making forums, or governance structures); and advocating for changes in policy and practice and work together with decision-makers to implement change, for example through Community Accountability Meetings, People's COPs, and more.

4. Follow-up and monitoring: Following up with duty bearers to monitor implementation of promised changes; analyzing the effectiveness of the CLM program and continually improving; providing feedback to the community regarding the outcome from advocacy or how data has been used; and monitoring the change, looking for trends and impact.

¹UNAIDS. [Establishing community-led monitoring of HIV services.](#)

²CD4C, CLAW, EANNASO-APCASO-ATAC consortia. [Community-Led Monitoring: Best practices for strengthening the model.](#) December 2022.

Recommendations for funding CLM

According to a global study of CLM programs, the largest donors to CLM programs are the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the United States government, primarily through PEPFAR and the Ambassador's Small Grants Program.³

Donors should fund CLM programs through mechanisms that are preferred by the community organizations implementing programs and that safeguard community independence. Donors often do not directly fund unregistered civil society organizations, particularly key population-led CLM implementers, due to policy restrictions—despite the fact that those groups might be best equipped to carry out CLM. During the last two years of CLM implementation, straightforward "pass-through" mechanisms that provided funding directly to civil society from other streams that do not have those restrictions, has helped mitigate this challenge to independence. Community systems strengthening support, and ensuring that community members and key populations are engaged in financial decisions related to CLM, can also be helpful.

Experience from technical assistance providers suggests that small grants to individual implementers are logistically challenging and hinder the ability of communities to deliver an independent, coordinated, coherent national program. Coalition or consortium proposals detailing the coordination, funding, and inclusion structures should be preferred, in order to avoid divisions in society and delays in disbursement and program roll-out.

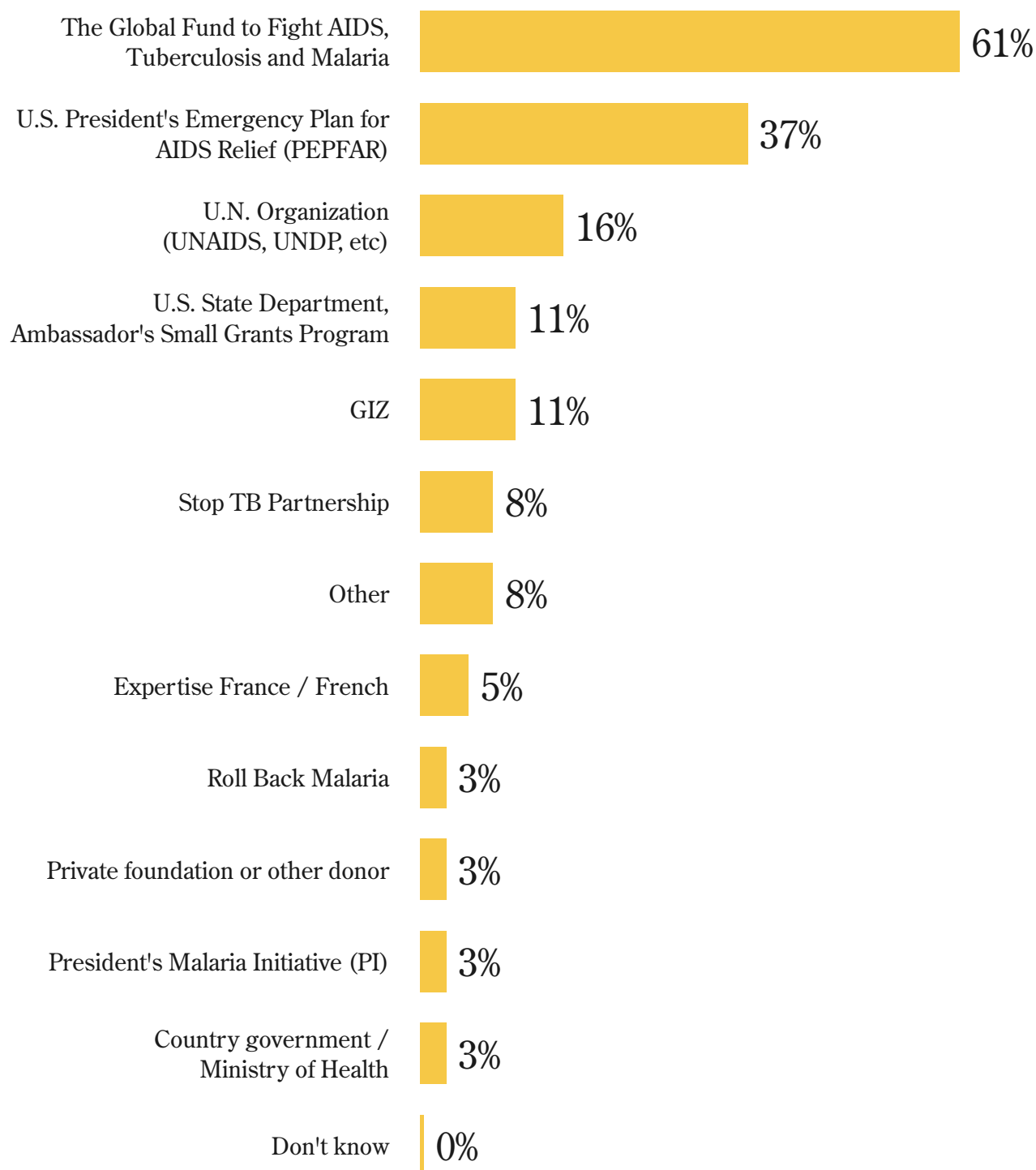
Funding mechanisms that limit the number of pass-throughs, avoid conflicts of interest (e.g. with governmental PRs), reduce overhead, and preserve project independence should be prioritized. Coordinated CLM donor and technical agency approaches, through funding mechanisms that pool resources from multiple donors, are recommended.



³ CLAW. [Best Practices for Community-Led Monitoring](#). September 2022.

Most commonly-reported funders of CLM programs

Source: global survey of CLM implementers.⁴



⁴CLAW. [Best Practices for Community-Led Monitoring](#). September 2022.

Why you need a CLM budget

Developing a budget is an essential part of requesting CLM funding from any donor. A well-detailed budget allows your CLM program to communicate to a donor unfamiliar with your work the types of activities you are planning to accomplish during the funding period. If you are applying for funding in a competitive process, such as an open call for proposals, being very clear in your budget can make you a more competitive applicant, because potential donors can easily see how funding will be used to do high impact, important activities.

Even if you already have funding, or if you are self-funding your CLM program, taking the time to develop a budget is important. Particularly for collaborative and community-led programs like CLM, your team will need to spend time together discussing and planning how you will accomplish your objectives. Breaking down those objectives into activities and costing those are critical, since it encourages important discussions about your planned activities, the division of roles of organizations and individuals, governance and management structures, and the scale of your program.

A budget is not only useful at the beginning of a program, but as a tool to refer to throughout the CLM cycle. By referring back to your original plan, your team can easily identify where costs are higher or lower than expected, which can allow the CLM program to course-correct to avoid running out of money or having unspent funds left over at the end. Remember that budgeting is about predicting how much your CLM program will cost, while costing is the process of describing your actual expenses after the activities are finished. A strong budget will prevent your CLM program from running out of funding faster than expected, failing

to consider inflation or price increases, and making sure the program is on track to achieve its milestones and deliverables.

Finally, having a budget will simplify reporting back to funders. Since your program will have a detailed picture of how the program plans to operationalize its funding, your finance team will be able to easily report your expenditures against those initial projections and show that you are on track. Your budget can also help you for both monitoring monthly and quarterly expenses, comparing actual expenses with approved budgets, and forecasting your program's expenditures, which can be useful when requesting disbursements of funds from donors. These analyses can also be used to ensure financial compliance with organizational policies, demonstrating accountability of funds used, and tracking value for money.



How to use this guide

First, take the time to ensure all those involved in the budgeting process know what CLM is. If you are starting a CLM program for the first time in your country or region, it is important to take time to make sure that all your colleagues and allies understand the core principles of CLM. Even for organizations that have done monitoring and evaluation (M&E) projects in the past, or that have implemented other programs for global donors, it can take time to understand the unique model of CLM—it is not a community-implemented M&E program.

Take care to remind your team that community-led organizations must remain in the lead of programmatic decision-making, and committed to taking action using evidence-based advocacy. Remind them of the importance of avoiding conflicts of interest (COI) as much as possible, to preserve your program's independence⁵; oftentimes, requesting team members to declare and document potential COI can be helpful. Explain that the purpose of CLM is not just to gather data, but to use community-owned data to advocate for better healthcare services and to hold duty bearers accountable for providing those services.

Second, make sure you have the right people in the room. Although you definitely need to have your team's finance and grant management experts in the room, you can't make a CLM budget alone. You will need to bring in people with expertise in data collection, so they can give you reasonable estimates of how much it will cost to collect data and synthesize it into reports. You'll need to bring

in the organizations and consortia of community-led organizations that are part of your CLM program, so you can plan your advocacy strategy. It can help to include allies who have expertise in epidemiology and the health system, to respond to proposals from communities about which areas, levels of the health system, and/or clinics should be monitored first, along with the number and types of indicators you will be tracking – these facets of CLM will have an impact on the budget. If your organization does not have specialized staff with experience in finance and budgeting, you may find it helpful to hire an independent expert with experience in CLM as a consultant to provide your organization with technical assistance, particularly if this is your first time developing a CLM budget. Some donors and technical partners have TA mechanisms available and this should be investigated.

Third, walk through the questions in this guide and hold discussions. This guide doesn't tell you how to create a budget, but instead has some questions for you to discuss with your team. These questions should help to have the right kinds of discussions that will help you avoid unforeseen costs or challenges in the future. Some of the questions may not be relevant to your context, but most of them are useful for all CLM programs. Remember that you should also be developing your workplan at the same time, so that you are deciding not only how much you'll spend on activities, but also creating a detailed calendar of when you plan to do each phase of the work.

Finally, do the math and estimate a reasonable budget that is sufficient to achieve your program's goals. Be as accurate and realistic as possible. While it may seem like a good idea to overestimate costs, to make sure that the final budget isn't too small, this strategy can make it look like your CLM program hasn't planned well and can hurt your

⁵CLAW. [Conflict of Interest in Community-led Monitoring programs](#). February 2022.

chances of receiving funding. Depending on your donor, you will likely be asked to provide justification in writing for every item in your budget, which will be reviewed during the budget approval process. Indeed, writing out details for each budget line can be helpful in creating a picture of how the activities will be implemented. But make sure you budget enough resources, so that you don't run out of money midway through the year.

As you read this guide you can follow along with an example budget for a fictitious CLM program. This example budget is just that – an example – and is not meant to be the exact “correct” way of budgeting for CLM.

Adjusting budgets to available funds

The process of requesting funding will often involve several phases of review. At times, the amount of funding available for your CLM program may be less than what the actual need is. Or perhaps the available funds can change from year to year, resulting in your program needing to cut its budget. At times, advocates and their allies can counteract budget cuts by successfully negotiating to increase the envelope of available funding. However, sometimes CLM programs have no choice but to reduce budgets.

It can be challenging to identify which areas can be removed from budgets without impacting the CLM program's ability to succeed. However, several key strategies can help reduce the harmful impact of budget cuts.

Prioritize maintaining human resources. Once staff costs have been accurately estimated as a core cost, it is helpful to prioritize maintaining the funding in those budget lines. A common challenge

among CLM is high turnover, which can damage your staff's institutional knowledge and ultimately cost more due to the need to recruit, hire, and re-train new team members. In addition to terminating contracts, reducing salaries can also make CLM programs more likely to lose core team members and demotivate critical staff; as such, avoid reducing the pay for your community monitors and other staff.

Ensure that advocacy activities are fully funded. Advocacy efforts often are under-budgeted even before budget negotiations start. Watch out for an unrealistically limited set of accountability interventions: this risks leaving you with a large amount of data but without the ability to develop and implement community-owned solutions and action. Keep in mind that in the long term, cutting or reducing community engagement activities can also harm the program's ability to engage and collect data.

Develop modular data collection budgets. An important strategy when developing a budget is to make your budget as modular as possible; that is to say, make it very clear what the unit costs are for items, instead of describing high-level summarized costs. As an example, if you are collecting data in 30 health facilities, calculate the cost to monitor one health facility, and then in your budget show that amount and multiply it by 30. It's even better if you have recorded how you did the math for how you calculated travel costs, lodging, and other expenses.

By doing this, you can very easily increase or reduce the number of sites you monitor, just by changing your multiplier.

Take care with requests to add sites and indicators. You may find that your donor or other stakeholder may request changes to your CLM program, often by requesting that you collect data at more sites or by adding new indicators to your survey tools.

Input is valuable from all interested and informed

stakeholders. However, keep in mind that site selection and indicator selection criteria are at the heart of independent community program ownership. Ultimately, it is for communities to decide what is important for their CLM program to monitor, which facilities should be monitored, and why. If additional sites and questions are requested and agreed to by communities, there is almost always a budgetary implication, since more questions and more sites require more resources in terms of time, effort, and skills.

What about technical assistance?

Community-led monitoring can be a significant undertaking for small community organizations. CLM programs require significant staffing, technical capacity, and organization and sound financial management. Some organizations may never have received large grants before, and are therefore unfamiliar with the donor's financial and reporting requirements. As a result, many CLM programs decide to request additional support from partners with specific technical expertise.

If you decide to include technical assistance (TA) in your budget, remember to first think about what specific areas you would like support with. Since CLM must be led by local, community-led organizations, your TA providers can never be

responsible for planning the program's activities, developing tools, or deciding advocacy messages. For this reason, it can be helpful to define discrete pieces of work that you would like to outsource to your TA provider. CLM programs often request TA to develop the data storage and collection platform, or to help organize and prepare the data for analysis, or develop first drafts of reports. You may also want to request TA to help with developing your budget and workplan.

Since donors and governments are both the providers of services and the direct target of CLM advocacy, it is important to remember that these duty-bearers cannot act as TA providers.⁶ UN agencies like UNAIDS and UNDP can act as allies for the CLM program, including facilitating advocacy opportunities with duty-bearers. However, given the watchdogging purpose of CLM multilaterals such as UN organizations are not appropriate for provision of technical capacity building regarding CLM (for example, managing the program activities or developing data collection tools) and therefore should not be paid out of CLM budgets.

⁶CLAW. [Conflict of Interest in Community-led Monitoring programs](#). February 2022.



Project Activities

Project set-up and governance

The first phase of setting up a CLM program is creating an independent structure for project implementation and governance led by local, community-led and community-based organizations (CLOs and CBOs), people living with and impacted by the three diseases, key populations, and other service users.



Question for your team:

Which organization, or organizations, will be in charge of implementing the CLM program? Is this the same organization(s) that will be managing the funds for the CLM program?

Suggestions for how to think about this:

Community-led monitoring is most impactful when it is a collaboration between local community-led organizations, civil society groups, and advocacy networks. However, it can be very useful to have one organization manage the CLM funds on behalf of a consortium of organizations.

If you choose to have one organization receive the funds, it doesn't mean that that particular organization is in charge of the CLM program. What it means is that not every organization involved in CLM would have to do financial reporting to the donor. All participating organizations could then receive funding as sub-recipients and be paid out of this central pot of funds to implement their respective activities. Establishing norms among CLM collaborators

around partnership, collaboration, and information is critical from the start. Remember: the lead organization(s) should have a clear track record and established trust and credibility among civil society for being independent, and being willing and able to hold duty bearers accountable for the quality and accessibility of health service delivery.

As a way of coordinating and building buy-in, it's highly recommended that civil society consortia involved in the CLM program agree on the budgeting process of the funds at the outset. You may also want to create points of joint and individual budgeting to avoid budget inconsistencies that may be realized during implementation.

Example:

In our fictitious example, a brand new CLM program is planning to monitor healthcare quality for people living with HIV (PLHIV) and key populations (KP). There is already an existing network of organizations of PLHIV- and KP-led community organizations. The program decides that the one community organization, led by women living with HIV, will officially receive the funds for the program. This organization was chosen since it has experience managing large

grants from international donors, is eligible to receive funds from an international donor, and has experience successfully subgranting to community organizations. However, the entire network of organizations will participate in the program by serving on the governance committee, by sending their members to be hired as staff for the project, and by working as paid members of the advocacy team.



Question for your team:

Who will provide strategic guidance about the CLM program?

Suggestions for how to think about this:

Many CLM programs decide to set up a governance body that is in charge of strategic oversight. This governance body does not manage the program's funding, and it is not in charge of the day-to-day activities of the program. Instead, the governance body is tasked with work at a strategic level, making sure that the program activities are aligned with the CLM program's objectives and that the program is achieving its goals.

Oftentimes, this is an important way for a network of community organizations to help guide the CLM program, ensure that questions and monitoring relate to community and organizational priorities, and ensure equal power across the coalition. This body also ensures alignment on how funding will be used for implementing the CLM project while still supporting the administrative costs of the coalition organizations. Note that while representatives from government and funders can support the CLM project, they cannot be part of CLM governance bodies.⁷

For overall program decision-making, such as about division of labor and funding among implementing organizations, and day to day oversight of CLM implementation, it is helpful to establish a core program team with clearly defined expectations about decision making duties and responsibilities.

If you decide to set up a governance body, it is important to make sure that everyone is fairly paid

for their work. You also need to make sure that you are clearly defining how much time all members of the governance body will need to commit to the CLM program. Often this is achieved by developing Terms of Reference (TOR) for the governance body, which describe the process for electing members, eligibility to participate, term limits, rules around decision-making, and expectations around time commitments for members.

Will your governance meetings be held virtually, or in person? If they are in-person, you will need to also budget for meeting rooms and travel expenses if necessary.

Quick tip

If you're starting a new CLM program, it can be very helpful to visit an existing program. Many CLM programs report that shadowing another program's community monitors as they gather data, or participating in a public advocacy event helped them to deepen their understanding of the CLM model and avoid common pitfalls. Consider adding this activity into your travel budget!

⁷CLAW. [Conflict of Interest in Community-led Monitoring programs](#). February 2022.

Example:

The CLM program decides to create a governance committee, which it calls the CLM Governance Team (CGT). Since there are 23 organizations in the advocacy network, the CLM team decides to elect 10 rotating members to the CGT. Each voting member will be the executive director from an organization that is part

of the HIV advocacy network, and each member will be elected in one-year terms. Since the CGT will meet every two weeks for two hour-long meetings, the CLM budget will pay for 52 hours per year (2.5%) of the salary of each executive director during their time on the CGT.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
CLM Governance Team (CGT) compensation	52	Hours per year	X	\$10	X	10 CGT members	=	\$5,200
Meeting room for CGT	1	Room reserved	X	\$100	X	26 meetings per year	=	\$2,600
Travel expenses	26	Trips per year	X	\$5	X	10 CGT members	=	\$1,300





Question for your team:

Who are the core people that you will need to hire to run the program?

Suggestions for how to think about this:

It is important to make sure that your program has enough people to manage all the phases of the CLM cycle. This usually means that you will need one person who is the programmatic lead. For the day-to-day operations, you will likely need to hire at least one program officer. A good rule of thumb is to hire one person to lead each phase of the CLM cycle: one person to lead on data collection and one person to lead on advocacy activities.

Example CLM program staffing arrangement

Program Director

- Program Coordinator
- Program Officer: Data
- Program Officer: Advocacy
- Finance and Grant Management Officer

You will also need to pay for staff to do grant management activities. Depending on the capacity of the organization(s) receiving the funds, this could mean a finance or grant management officer. You may also find it helpful to have a project coordinator to support the project director and to keep the program activities organized.

Remember that not everyone needs to be working on the CLM program full-time. The project's director, grant management team, and others will usually only split their time between the CLM project and other organizational activities and priorities. By contrast, the team managing the day-to-day of the CLM project will usually need to be 100% (or nearly 100%) dedicated to CLM intervention.



Quick tip

CLM programs take a lot of person-power to run. On average CLM programs spend at least 25% of your budget on paying your staff, community monitors, and advocates. Depending on your program, this could reach 50% or higher. If your donor has guidelines or caps on human resource budgets, these can often be negotiated, or you may request a waiver. In some cases, paying community monitors is not considered an HR cost but rather an activity cost, so there are ways to organize the budget to adhere to donor guidelines.

Example:

The example CLM program decides that the executive director of the organization receiving the funding will serve as the project director. She will be spending one-quarter of her time on the CLM program, and will use the rest of her time on other

duties. Two program officers will be hired: one to manage the data collection efforts and the second to manage advocacy. The organization’s financial specialist will dedicate 20% of their time to manage the CLM program’s financial reporting.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Project Director	0.25	Full-time equivalent (FTE)*	X	\$20,000	X	1 (person per year)	=	\$5,000
Program Officers (Data, Advocacy)	1.0	Full-time equivalent (FTE)	X	\$10,000	X	2 (people per year)	=	\$20,000
Financial Manager	0.20	Full-time equivalent (FTE)	X	\$15,000	X	1 (person per year)	=	\$3,000

* 1.0 full-time equivalent (FTE) refers to the amount of time that an individual employee works in some amount of time (for example, per year). So if an employee normally works 40 hours per week, 1.0 FTE would be equal to 40 hours per week, while 0.5 FTE would be equal to 20 hours, 0.25 would be 10 hours, and so on.



Careful

The full cycle of community-led monitoring, including data collection and advocacy, can easily take up a good portion of the implementing organization(s) capacity and staff time. This can mean that organizations are not able to spend enough time on their other priorities or they may not have enough time to complete all the steps of the CLM cycle. It’s important to make sure that enough dedicated staff are assigned to CLM work. Be careful not to leave the day-to-day operation of the program to someone who is already leading many other projects!



Question for your team:

Does your program need to do activities to get “buy-in” from government and other stakeholders?

Suggestions for how to think about this:

It can be easy to forget that data collection is not the first step of a CLM program. First, you need to make sure that the right stakeholders understand your program and have given appropriate sign-off.

If your CLM is just starting for the first time, you may need to account for some activities to get buy-in. This could involve holding meetings with the Ministry of Health to explain CLM and securing a formal Memorandum of Understanding (MOU). It could mean holding a call with a district-level manager and a group of clinic managers to explain the purpose of CLM data collection. Perhaps you will need to request a formal letter of support from your provincial health department, which you will be able to share with health facilities when you start collecting data.

All of these set-up activities take time, and they also take budget. Make sure to include budget lines for meeting space, food and drinks during the meetings, travel expenses, and per diem to compensate people for their time. You may also want to budget for extra time from your program’s governance committee at the start of the project, so that they can participate in these meetings too.



Example:

The CLM program decides that it will request a meeting with national government officials to introduce the program, and they will invite representatives from three of the provinces where they plan to collect data. To prepare for the meeting, they will meet informally with government officials from

each of the three provinces to explain CLM and to answer any questions they may have. They will also invite the UNAIDS Country Director to attend, as well as the Chair of the Global Fund Country Coordinating Mechanism (CCM).

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Meeting Space (1 national meeting and 3 provincial)	1	Room reserved	X	\$100	X	4 meetings	=	\$400
Per diem for meeting participants	1	Per-person per diem	X	\$10	X	20 people	=	\$200
Travel and lodging (for participants from distant provinces)	1	Travel and lodging	X	\$75	X	10 people	=	\$750



Careful

Many new CLM programs are eager to start developing survey tools and start data collection as soon as possible. But it's important to spend time setting up your program's governance structure and making sure you have all the right people hired and trained first. You may also face challenges with your advocacy if you didn't spend enough time building buy-in from key duty-bearers like the Ministry of Health, National AIDS Council, National TB Control Program, or Malaria Elimination Program. Be sure to budget for this pre-data collection stage too!

Tool development and data systems

After a governance structure has been set up and the core staff have been hired, the CLM program is ready to develop data collection tools.



Question for your team:

Where will you collect data? How many sites will you monitor?

What are the criteria for site selection?

Suggestions for how to think about this:

When running a CLM program, it's important to strike a balance between monitoring too little and monitoring too much - both in terms of the number of sites and locations and the number of questions or indicators the project will collect data on. Monitoring too many sites or indicators may spread your resources too thin to do effective data collection, cleaning, analysis, feedback, and advocacy. Monitoring too few sites or indicators may make it difficult to convince district, provincial/regional, or national staff that the project findings are sufficiently noteworthy to require their attention.

Quick tip

Translation is especially important in CLM. Every data tool that you develop needs to be adapted into all of the languages spoken in the areas you will be monitoring, which means you'll need to budget for translators. It's also important to pilot or test your translated tools, to make sure that the translated questions are clear and appropriate for the target population.

Similarly, asking participants too many questions is time consuming and might compromise the quality of the data as a participant's focus fades. Asking participants too few questions misses an important data collection opportunity. To strike a balance, consider adding the minimum number of questions necessary to get the desired data. It is also important to pre-test all survey tools before implementation to ensure that actual survey implementation isn't taking too long in the field.

Importantly, the purpose of CLM is not to be everywhere, but to document and improve the quality of services at chosen sites and put the onus on duty bearers to resolve them in those sites that are monitored, as well as to develop systematic solutions for sites that are not being monitored by the CLM project. By attempting to conduct monitoring and evaluation in all sites there is a significant risk of over-extending your program (particularly at the beginning phases), which can prevent it from completing the full cycle of activities.

Deciding where to gather data will require holding meetings with the program's core team and a variety of community-led organizations, people living with and impacted by focus diseases, key populations, and other service users. This group should discuss the program's advocacy goals and decide which types of data will be useful to collect, and prioritize which objectives are the most urgent. The CLM program should also independently decide which sites should be monitored, and the criteria for site selection.

Nearly all CLM programs collect data in healthcare facilities and many also gather information outside of clinics. For example, monitors may interview

PLHIV accessing services through drop-in centers or community distribution sites, to understand the experiences and barriers for populations receiving services outside of clinics. In another example, some CLM programs may decide to gather data in the community, such as through door-to-door sampling, as a way of reaching people who are not receiving any healthcare services at all. This mix of respondents can be helpful in understanding the full range of experiences of PLHIV and KP both in, and out of, care.

Quick tip

When deciding which sites to monitor, there are several factors you can consider.

Epidemiological data and clinical outcomes are often helpful criteria. You could also choose sites in areas where CLM participating organizations have membership, CLM organizations are most easily able to begin monitoring, targeted populations are known to frequent, and where community networks have reported issues related to quality of care. Often this will also be an iterative process with sites being added or dropped as the project evolves.

Example:

A CLM program decides to gather survey data in HIV clinics. Since the program is in its first year of implementation, the team decides to focus on two provinces with the highest rates of loss to follow-up (LTFU) as measured by PEPFAR program data.

They decide to gather data in 20 clinics per province, and supplement those data with door-to-door interviews of PLHIV who have stopped taking their medications.



Question for your team:

How will CLM data be collected and stored?

Suggestions for how to think about this:

The way that CLM data will be collected and stored for analysis, reporting, and advocacy purposes will have significant implications for your program's budget. One of the key questions to ask when developing a budget is whether data will be collected on paper-based forms or electronically (i.e. on a phone or tablet). Your team should consider several considerations when making this decision.

First, keep in mind that regardless of which method you use to collect the data, all of your survey data will ultimately need to be converted into an electronic format (i.e. stored on a computer). This is because you will need to use computer software, like Microsoft Excel, to analyze your data and create tables and graphs that you can use in your reports.

This means there will be a trade-off in costs and effort. Electronic data collection will have higher up-front costs for things like tablets, mobile data, and license fees for the software used to collect data. By contrast, if you collect data on paper-based tools, you will need to pay for staff time to manually import data into a computer after the forms are filled out.

There may also be trade-offs in data quality. When using paper-based tools, you are likely to experience higher rates of human error: monitors may lose

the paper reports or the data clerks may make mistakes when copying the paper surveys into a computer. Computer-based surveys also can include more sophisticated tools like “skip logic”, which can make some questions mandatory to fill out, or may make some questions only asked to some respondents on the basis of how they responded to other questions.

When starting a new CLM program, you may choose to start a pilot using paper-based tools, and then migrate to an electronic process over time. It's also possible to use a mix of paper and electronic tools, often because there is not sufficient funding for all monitors to be supplied with a device. Even in a fully electronic CLM program, you will want to have some paper versions on hand, in case your monitors need to collect data in a clinic where it's not safe to carry tablets.



Careful

With so many other CLM programs operating worldwide, it may also be useful to learn from the survey tools created by other programs (adapting them to the country's context through workshops with civil society). But keep in mind that the purpose of collecting data in CLM is to use it to advocate for change. This means it's very important for community-led organizations, advocates, and service users to discuss the program's advocacy priorities before creating data collection tools. Make sure to only gather data that are relevant to the needs of your community!

Quick tip

In general, small-scale projects monitoring only a few health facilities or community perspectives that are relatively close to each other may be able to function adequately with paper-based forms. However, any large-scale project monitoring across multiple districts or provinces/regions, or with more than 20 sites, will find that paper-based data collection is extremely burdensome and time-consuming.

Example:

A CLM project is just starting and only plans on conducting monitoring at 10 facilities that are all located in the same city. Because it will be relatively easy to transport forms around a small group of nearby facilities, the project elects to use

paper-based surveys for the time being. The program decides to budget for the printing of paper forms, staff to input the data onto a computer, laptops, and online back-up data storage using Dropbox.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Printing forms	10	Pages of printing, per page	X	\$0.50	X	10 Facilities	=	\$50
Data Clerks	0.25	FTE Salary	X	\$10,000	X	2 people	=	\$5,000
Laptop	1	Computers for data clerks	X	\$400	X	2 people	=	\$800
Dropbox	1	Monthly subscription	X	\$10	X	12 months	=	\$120

Example 2:

After implementing for one year, the example CLM project decides to scale up to monitor 60 facilities across three districts. The project opts to collect data electronically in order to free up staff time and to reduce manual effort. They also decide that electronic data collection will

allow their program coordinator to track monitoring progress in real-time and to do some quality checks. This means the project will have to budget for devices for all data collectors, and hosting costs for the electronic forms/data.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Tablets for data collection	1	Tablet	X	\$150	X	20 monitors	=	\$400
Wi-Fi hotspot at headquarters for syncing tablet data	1	Month of Wi-Fi	X	\$10	X	12 months	=	\$120
Computers for analysis	1	Computer	X	\$400	X	2 computers	=	\$800
Software for tablet-based data collection	1	Month of license	X	\$250	X	12 months	=	\$3,000



Quick tip

There are several companies and software platforms that are available. Examples of open source hosted solutions include [CommCare](#) by Dimagi, [DHIS2](#), and [KoboToolbox](#). Keep in mind that some of these are free but will have more advanced services that cost money. If you're planning on self-hosting, you must consider the cost of servers (including back-up servers) and IT staff qualified to manage the systems. Remember CLM data should never be owned by, or hosted by, government- or donor-owned systems!



Question for your team:

What kinds of data will your CLM program collect?

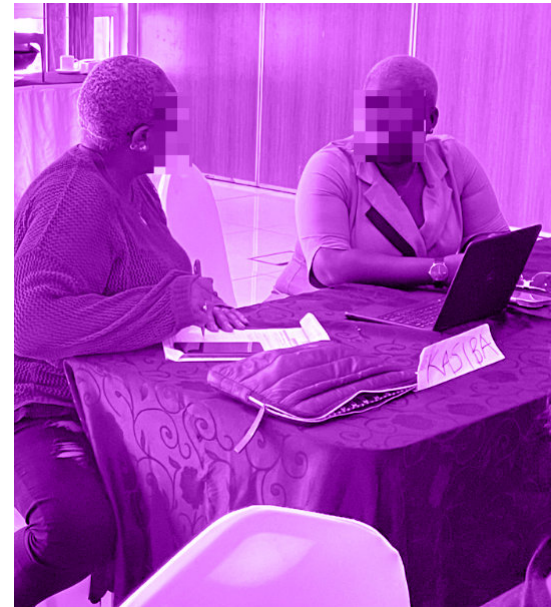
Suggestions for how to think about this:

CLM programs generally collect two types of data: quantitative and qualitative data. Quantitative data are those that have a universal fixed value, where the results can be analyzed as numbers. For example, a survey could ask a facility manager if PrEP is available in the clinic, with the respondent being given the option to reply “Yes” or “No”. This indicator is quantitative: you can add up the “Yes” values and calculate a percentage. Other examples of quantitative questions would be asking when a clinic opens on weekdays, or how many patients are waiting in line at a clinic; in both cases, you can calculate averages, minimums, maximums, and evaluate the findings mathematically.

By contrast, qualitative data are focused on answering questions about the “how” or the “why,” and the interpretation of these data is much more subjective. An example of qualitative data would be asking a respondent to describe the reasons why they stopped taking their medication. The data collected using this type of question would be a long paragraph of text that is not easily broken down into numbers, but instead would need to be analyzed qualitatively and descriptively to understand the respondent’s perspective.

Both types of data are used to measure the quality of healthcare services, but each has different strengths. Quantitative data are the easiest to analyze quickly and can produce helpful, real-time statistics, such as “32% of clinics do not offer PrEP.” By contrast, qualitative data can give immensely informative and nuanced perspectives that can’t be gathered from a multiple-choice question, as well as producing compelling quotes and short testimonies

that complement quantitative data. However, qualitative data always take more manual effort to analyze, since someone has to read through text and summarize what the respondents are saying.



Quick tip

You may find it easiest to focus primarily on gathering quantitative data, while complementing your survey data with a small number of qualitative interviews or focus groups. This approach will help you to not get overburdened by analyzing large amounts of qualitative data, while still contextualizing the findings.



Careful

There are two common criticisms that CLM data can face. The first is that the community-owned data do not align with the M&E data gathered by governments and donors. The second is that the sample size (i.e. number of sites monitored) of the CLM program is too small, making the findings scientifically unreliable.

Remember that CLM programs are not doing traditional M&E and they are not running scientific studies. Instead, CLM is focused on gathering data on a set of indicators that are important to communities. CLM programs should not be monitor the same exact indicators as do other monitoring programs, like the Ministry of Health or donors like PEPFAR – unless there is a concern with their methodology and it would help your advocacy to measure the same metrics.

CLM programs also don't need to gather data on every patient in the country: if even one patient reports abusive practices or treatment interruption due to stock-outs, those findings are important and must be taken seriously by governments and donors. Presenting both quantitative survey data and powerful interview testimonies can reinforce the gravity and urgency of patient experiences.

Trainings and refresher courses

Gathering CLM data requires having a team of people who are trained on data collection and comfortable with the data collection tools, software, and methodologies.



Question for your team:

Who will be in charge of gathering the CLM data, and who will train and supervise the data collectors?

Suggestions for how to think about this:

In many CLM programs, the data collectors, or Community Monitors (CM), are people who are service users and/or people living with the same diseases being monitored. Particularly among stigmatized groups like key populations, respondents often feel more comfortable sharing personal information with someone who is also a member of the same population.

The people that your program hires as CM will have varying levels of background and experience with data collection. In some CLM programs, applicants to become CM are screened to make sure they have the skills needed for community

monitoring. As a result, it is important for your CLM program to develop a clear Terms of Reference or job description for the CM and discuss the balance between qualifications, skills, and personal characteristics of the people hired as CM during recruitment and selection.

Finally, your CLM program should consider how they will supervise CMs. Many CLM programs find it helpful to also hire CM supervisors, or coordinators, who are responsible for the work of CM in a particular region (such as province or district). This role is particularly helpful in programs with many CM, where the sites that are being monitored are very far apart, or where many sites are monitored. These coordinators are in charge of making sure that CM have monitored all

their sites, doing some quality assurance on the data being collected, and responding to CM questions and needs during data collection. It is often helpful to have a capacity-building plan in

place to ensure the coordinators build all the necessary skills for data collection and advocacy.

Example:

The example CLM program decides to hire three Provincial Coordinators, who will be charged with supervising the work of the Community Monitors (CM) and providing support during data collection. Although the program will be monitoring 20 clinics in each of the three provinces, they decide to hire four CM in the first province, five in the second, and three in

the third, to account for differences in how spread out the sites are in the three regions. Each CM candidate is either a PLHIV or KP, and candidates are screened using a short practical test.





Question for your team:

*How, and how often, will the data collectors be trained
(and re-trained)?*

Suggestions for how to think about this:

Gathering data for CLM can be challenging, particularly for those who have never participated in a facility monitoring project before. It's important for all the CM and support staff involved in data collection to have a good understanding of best practices, including ethical data collection, protecting privacy and confidentiality, sample sizes, and consent. The team will also need to understand how to use electronic data collection tools (like tablets or mobile phones) or how to fill out the paper-based tools. The CM supervisors, if your program has them, will also need to be trained so that they can troubleshoot issues faced by the CM, including issues with technology, communications with facility staff, and how to respond to issues identified during data collection that require immediate attention. Onboarding new CMs at the start of a program can require extended training, but it's absolutely essential to ensure understanding. In-person mentorship of new CMs is also key.

In general, you should expect to re-train your staff regularly. CLM is a living process, and even established programs are learning lessons constantly. Having budget flexibility for ongoing support supervision and hands-on skills building, including south-south knowledge transfer, is a key aspect of building the capabilities of a CLM program. This is because even the best-trained CM will benefit from a refresher, particularly if long periods of time have passed since the last round of data collection. Tools and data systems often evolve over time, so it's important to make sure everyone is up to date. Turnover of CM is often high in CLM programs, so it's likely that you will have brand new

CM in each data collection cycle. Lastly, refresher trainings give the CLM program an opportunity to identify challenges from the previous cycle and reinforce best practices for future rounds of data collection.



Example:

The CLM program in the example is planning to do two rounds of data collection per year, so they plan to hold two rounds of data collection. In the first round, the supervisors will be asked to travel to the capital city to participate in an in-person training session. The supervisors will then return to their respective provinces and conduct in-person trainings of all the CMs. In the CM trainings, the supervisors guide the CM

through practical exercises using the data collection tablets, participate in scenarios about challenges that may be faced during monitoring, and receive presentations on CLM data collection. In the second round of data collection, the supervisors participate in a refresher training that is held virtually, while the second CM training will again be in person.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Initial Provincial Coordinator training: meeting room	1	Meeting room	X	\$1,000	X	2 (days)	=	\$2,000
Initial Provincial Coordinator training: hotel	2	Hotel room nights	X	\$200	X	3 Provincial Coordinators	=	\$600
Initial Provincial Coordinator training: per diem	3	Daily per diem (days)	X	\$20	X	3 Provincial Coordinators	=	\$180
Initial Provincial Coordinator training: travel costs	2	Flights	X	\$100	X	3 Provincial Coordinators	=	\$600
Community Monitor trainings (2x): meeting room	3	Meeting room	X	\$700	X	6 (days, 3 day per meeting)	=	\$12,600
Community Monitor trainings (2x): per diem	8	Daily per diem (days, 4 per meeting)	X	\$20	X	12 (Community Monitors)	=	\$1,920
Community Monitor trainings (2x): travel costs	6	Roundtrip travel (days, 3 per meeting)	X	\$20	X	12 (Community Monitors)	=	£1,440



Question for your team:

How will you train members of the advocacy team?

Suggestions for how to think about this:

In parallel with the training of the CM before data collection, the advocacy team can also benefit from training. If you plan to employ advocates and community partners to develop solutions, participate in solutions visits in the clinics, and to be a part of advocacy events and activities, you may decide to hold trainings after each round of data collection. You may also want the CM to be involved in these sessions, both to share their perspectives on the data and to provide support to the advocates (particularly if you are using electronic tools to track the proposed solutions and the commitments made). Much like for the CM, the turnover and the time gap between rounds of advocacy activities mean even mature CLM programs benefit from regular refresher trainings.

Much like the CM, CLM programs may be able to reduce turnover and improve engagement by making sure that advocates are fairly compensated for their work. Particularly for advocates with other competing priorities and workstreams, it's important to make sure that their time and travel to trainings are appropriately reimbursed.



Data collection

After the CLM program has been set up, the data collection tools have been developed, and the team has been trained, your CLM program is now ready to start gathering data.



Question for your team:

How many Community Monitors will you need to hire?

Suggestions for how to think about this:

There are several questions to ask yourself when deciding how many Community Monitors (CM) you will need to hire. The first is how long it will take for one CM to gather data in one facility. This will depend on the number of respondents you will be surveying in each facility (i.e. the sample size), since it will take more time to survey 15 patients than to survey 5. You'll also want to think about the length of the surveys, since long surveys take longer to complete.

Are there days or times when eligible participants are more likely to be in the clinics? For example, if you are trying to survey PLHIV, finding enough participants would be easier if you visit the clinic when an HIV-focused event will be taking place. Sometimes, medication pick-up or adherence club meetings may only happen in the morning or

evening. If you are interviewing any of the clinic staff, you may also need to take into account staff availability. If the CM enters a clinic and the clinic manager or other staff are not available, the CM may need to come back to the clinic the next day in order to complete their survey.

It's important to also consider whether the CM should work alone, in pairs, or in groups. For safety reasons, many CLM programs prefer not to deploy CM to clinics or communities by themselves.

Remember when hiring your CM and coordinators to consider additional costs, such as health insurance and other benefits. Depending on the country context and laws, as well as how you employ the CM (i.e. as staff versus as consultants) these additional benefits may be legally required or necessary for safety reasons.

Example:

The program will be doing two rounds of data collection: one in January and one in June. To manage workload and ensure the team’s safety, the CM will visit the health clinics in pairs. They decide that each pair will spend two full days monitoring in each site, so they budget for 160 days of work

(20 sites X 2 days per site X 2 monitors per site X 2 rounds of visits per year per site = 160 days), with each CM being paid for an average of 13 days per year (160 days / 12 monitors = 13 days).

Days of CM pay = Sites * Days to monitor 1 site * CM per site * Rounds of data collection per year

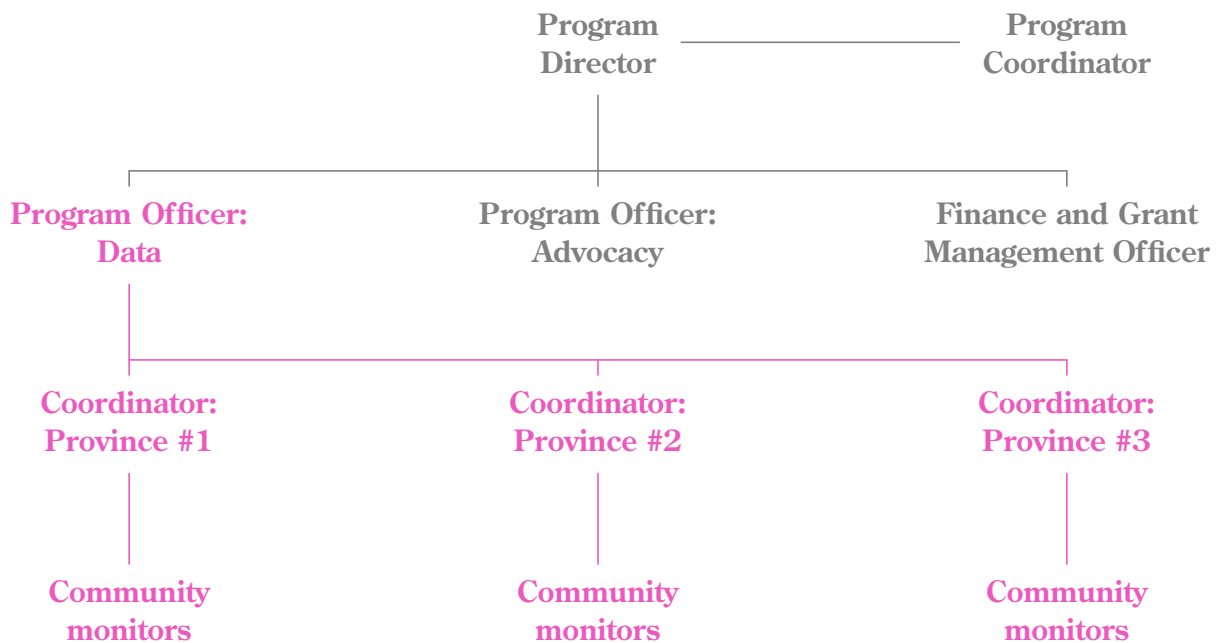
Days of pay per CM = Days of CM pay / Number of CM hired

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Province Coordinator	0.50	Full-time equivalent (FTE)*	X	\$7,000	X	3 (people)	=	\$10,500
Community Monitors	13	Days of work	X	\$100	X	12 (people)	=	\$15,600

* 1.0 full-time equivalent (FTE) refers to the amount of time that an individual employee works in some amount of time (for example, per year). So if an employee normally works 40 hours per week, 1.0 FTE would be equal to 40 hours per week, while 0.5 FTE would be equal to 20 hours, 0.25 would be 10 hours, and so on.



Example of staffing structure for data collection:



Careful

It is important that everyone who is working on the CLM program be compensated for their time and work. This includes the Community Monitors, any supervisors, and the advocacy team. Many CLM programs struggle with high staff turnover, which means the CLM program has to spend a lot of effort continuously bringing new staff up to speed. To minimize turnover, make sure the CM are being given compensation that not only reimburses their time, but also the extra costs that can be incurred during monitoring (i.e. transportation costs, lodging, etc.). This can mean paying different CM different stipends, to account for differences in travel-related costs.



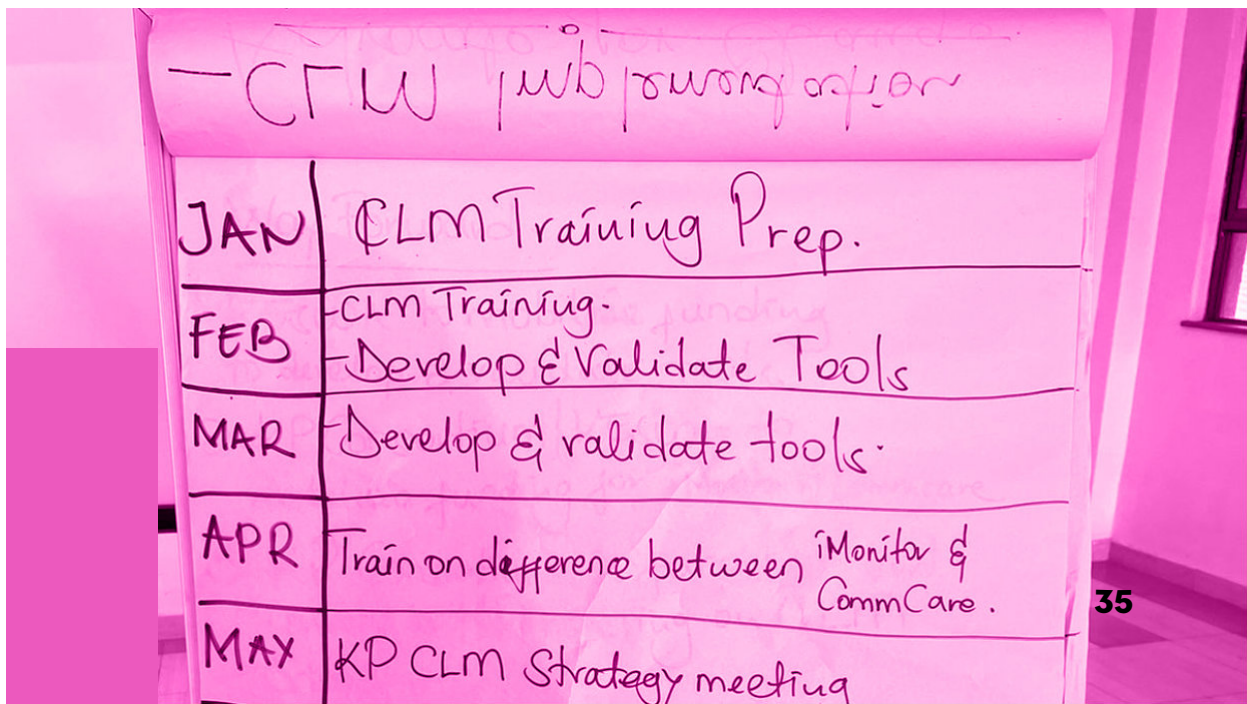
Question for your team:

How will you transport Community Monitors to the data collection sites?

Suggestions for how to think about this:

Will you expect your Community Monitors to find their own transportation to the data collection sites, or will you be providing it for them? The answer will be very different if you are monitoring in a city center where the clinics are near to each other, or if you are monitoring in an extremely rural area where moving between sites requires multiple forms of transportation. You should also take into consideration where the CM you hire live, since transporting people long distances is more expensive than hiring CM who already live in the region where monitoring will take place.

If you do decide to provide transportation for the CM, you'll have to discuss whether you would prefer to use a vehicle owned by the CLM program or whether you will hire transportation. It may be that the organization(s) implementing the CLM have a vehicle that can be used for data collection; if this is the case, make sure to budget for petrol, the costs of regular maintenance, and the pay for a driver.



Example:

The CLM program is primarily collecting data in an urban center, where none of the data collection sites are more than 3 hours apart. Since none of the organizations involved in the CLM program have a vehicle, the program decides to hire a driver during data collection to transport

the CM from site to site. The program calculates 80 days of work (20 sites X 2 days per site X 2 rounds of visits per year per site = 80 days). The number of kilometers driven is calculated assuming 250 km driven per day of monitoring and a fuel efficiency of 7 km per liter of petrol.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Hired vehicle	1	Vehicle	X	\$30	X	80 (days)	=	\$2,400
Driver	1	Person	X	\$20	X	80 (days)	=	\$1,600
Petrol	1	Liter	X	\$1	X	2,857	=	\$2,857



Careful

Many new programs get a lot of advice about sites to add, requests to accompany monitors, and indicators to change and/or add. Often these requests come with no commitment of additional funding. Independent community ownership of CLM is critical – CLM is for communities to develop and use. You can always say 'no' to these requests when you do not agree with them. A justification can help you explain your rationale. For instance, sometimes funders want to accompany monitors during a site visit. You can share with your donor that this practice can inadvertently compromise the independence of your program, since it's impossible for monitors to gather impartial and accurate data (often about donor practices!) while funders are in the room. Clinic users will also see this dynamic and it could compromise their willingness to share accurate and forthright information for fear of retaliation targeting them or the program.



Data analysis and reporting

Once the data have been collected, the next step for CLM programs is to analyze the findings for trends and patterns, and to adapt these findings into actionable demands for duty-bearers.



Question for your team:

Who will be in charge of data analysis and management?

Suggestions for how to think about this:

It is important for CLM programs to not only budget for regular rounds of data collection, but also to ensure that the team has the capacity to quickly turn those data into solutions and recommendations. In general, there are two important strategies to make sure that the data analysis phase is manageable: hiring a strong team to analyze data and to find ways of automating and simplifying the reporting process.

Many CLM programs find it helpful to have at least one staff member dedicated to data analysis and reporting. This data lead acts as the focal point for the regional supervisors, by making sure data are being collected and properly uploaded and/or shared, leading on data quality assurance, and

developing tables and graphics that can be easily understood and interpreted by the entire CLM team.

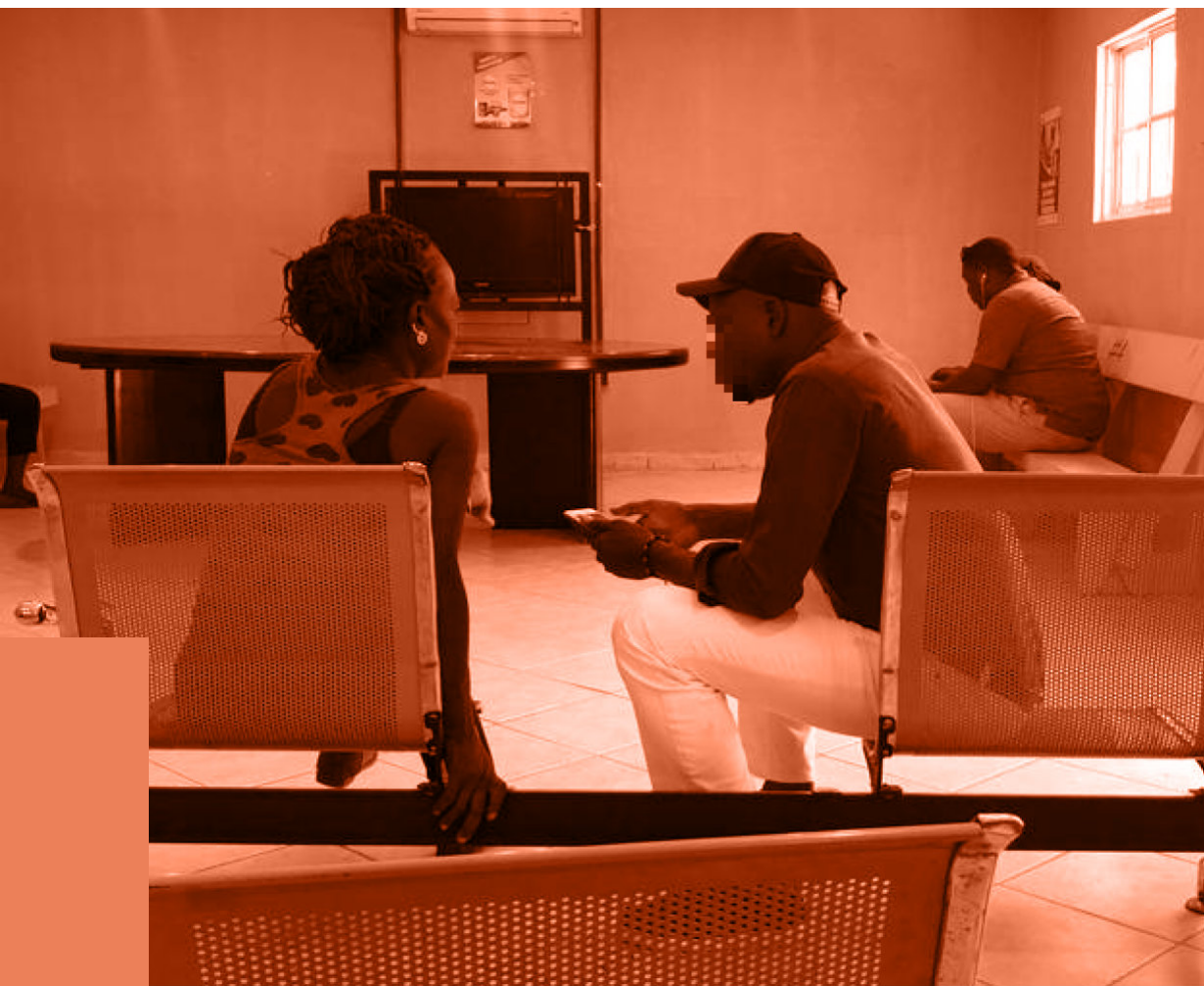
There are several options for automating data analysis, in order to reduce the manual effort for the data team. CLM programs often report that shifting from paper-based tools to electronic data collection is critical for streamlining analysis. Depending on which software is used for data collection, you may be able to create some simple visuals and charts directly in the program. You may also be able to use data analysis programs like Excel to develop reports that can be automatically updated (make sure to budget for any software licenses and laptops). Several CLM programs have developed entire websites that automatically display up-to-date CLM data, organized into visuals and

downloadable reports. The option you choose for your program will depend on the scale of your program, the technical skills of your data staff, and potentially the technical assistance your program receives.



Careful

In the CLM model, it is important to collect data on a regular basis, in order to identify where services are improving or worsening. However, it can be easy to collect data on a too frequent schedule and run out of time to fully analyze the data, share the analysis with communities, generate solutions, and take action based on the evidence before the next cycle begins. In general, new CLM programs may find that planning more than 2-3 cycles per year is too fast of a pace at the beginning. In time, as the data team gains more experience and as some parts of analysis are automated, the number of rounds of data collection can gradually be increased.





Question for your team:

What kind of platform for data visualization do you want to build?

Suggestions for how to think about this:

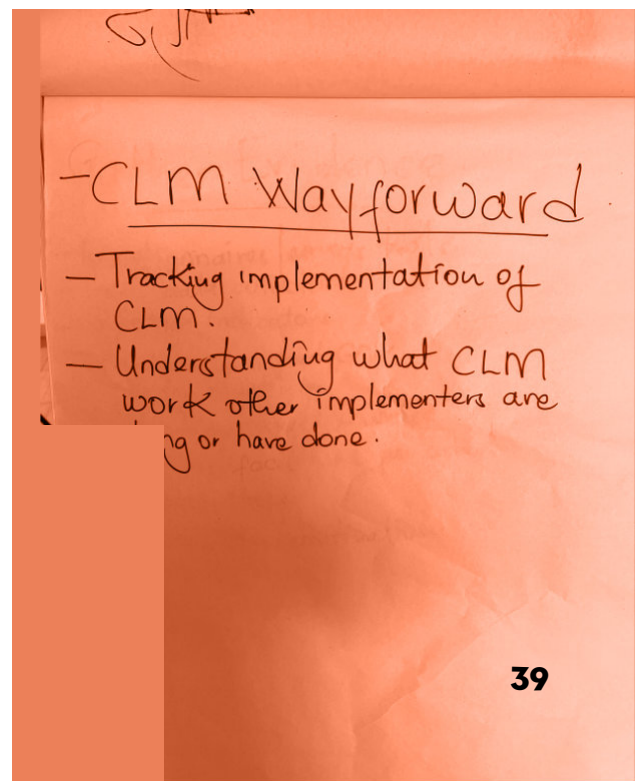
The goal of CLM data collection is to make actionable data available to advocates so they can take appropriate action. As a result, it's vitally important to make a plan for how your data will be shared with both the CMs and advocacy team members, so the entire program has coordinated visibility into what findings are coming from monitoring.

When working within a coalition to implement CLM, writing a data sharing agreement in the program planning stage is one way to ensure data is owned by and accessible to all partners. This agreement should outline who can access data, how they will be able to, and in what forms (for example, can all implementing organizations access the raw data? Or only after data cleaning and quality assurance?). You may also find that your advocacy efforts will be strengthened by giving the duty-bearers themselves access to the data, so that governments and donors can triangulate CLM data with their own data.

Many CLM programs decide to build public, web-based dashboards that visualize CLM data in real-time. These dashboards also help you routinely identify problems, trends (good or bad) over time, and support accountability measures focused on duty bearers. Without a data visualization platform such as a dashboard, it can be extremely challenging to quickly analyze the data you collect, share the data, and generate solutions based on your evidence.

Quick tip

Building and managing a dashboard can be a challenging task for a new CLM program. If you decide to budget for external technical assistance to support dashboard development and data management, discuss how your data will remain owned by and accessible to the community.



Example:

After initially sharing data through paper-based reports, the example CLM program decides that they want to share the data more broadly. After exploring several options, they decide that using DHIS2 is the best data visualization option for their needs. They hire a short-term consultant

to help with setting up a system that visualizes real-time data on a website. To support the consultant and to do ongoing maintenance of the website, the program hires an IT lead to work in the core team. They additionally budget for hosting the server and for the webpage domain.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Short-term consultant	20	Days	X	\$100	X	1 (consultant)	=	\$2,000
IT staff	0.5	Full-time equivalent (FTE)*	X	\$40,000	X	1 (person per year)	=	\$20,000
Server and web hosting services	1	Months	X	\$50	X	12 (months)	=	\$600

* 1.0 full-time equivalent (FTE) refers to the amount of time that an individual employee works in some amount of time (for example, per year). So if an employee normally works 40 hours per week, 1.0 FTE would be equal to 40 hours per week, while 0.5 FTE would be equal to 20 hours, 0.25 would be 10 hours, and so on.



Careful

It is normal for dashboard establishment to take many months. Once a strong foundation is set up, maintenance and improvement becomes more straightforward. It is important to develop an interim plan in the beginning for how you will review and analyze your data while a more robust visualization system is being built.



Question for your team:

What kinds of advocacy reports or other materials should you generate using CLM data?

Suggestions for how to think about this:

Community-led monitoring is a powerful accountability tool because it equips advocates with real-world data on what service users are experiencing in clinics and the community. As such, using CLM data to generate community solutions is a critical stage in the CLM cycle.⁸ These solutions should, over time, help improve concrete health outcomes by improving the quality and accessibility of essential clinical services.

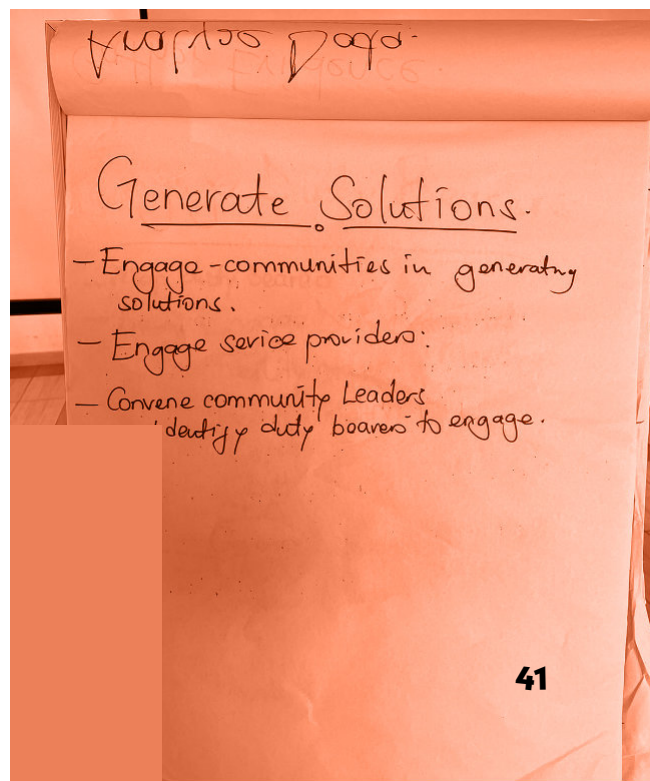
Quick tip

CLM teams can benefit from developing an advocacy workplan, which defines the kinds of activities your program will do each year. As part of this workplan, you can decide which types of reports and analyses of CLM data will be the most useful for advocacy.

In general, it can be valuable to develop two types of reports. The first is a facility-level report, which can be used when conducting visits to clinics to share findings and recommendations. These reports are also useful for the advocacy team to use when developing the solutions that will be advocated for.

The second type of report is one that aggregates facility-level data into a broader report. Depending on the scope of your project, this could be a national report or it could be focused on the specific region that you are monitoring. These higher-level reports are often used to conduct advocacy with the Ministry of Health or provincial government and are also useful when making recommendations to donors.

The types of outreach and data sharing that your CLM program does will need to be adapted to your country's context. Regardless of what type of reports your CLM program will produce, it is important to include enough budget to create useful, clear reports, and deciding how to disseminate the reports in order to communicate clearly with duty bearers. This could include paying for a graphic designer, one or more translators, and a photographer and videography with access to quality equipment.



⁸ CLAW. [Community Evidence to Create Change](#). September 2022.

Example:

An example CLM program decides it will develop a report at the end of each cycle of data collection, which it will use in advocacy with donors and the government. The team decides to pay for a graphic designer for these reports and a translator so that the report can be translated into each of the three regional

languages. They decide to hire a photographer to participate in a few days of community monitoring, in order to have high-quality images for the report. The program will also make facility-level reports for their visits to clinics, although these will be developed by the team’s data lead.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Graphic designer	10	Days of work	X	\$120	X	1 (person)	=	\$1,200
Translator	5	Days of work	X	\$100	X	3 (people)	=	\$1,500
Photographer	2	Days of work	X	\$120	X	1 (person)	=	\$240





Question for your team:

How will you manage your qualitative data?

Suggestions for how to think about this:

Qualitative data, such as from interviews or focus groups, will need to be carefully factored into your budget. In many cases, the effort needed to analyze qualitative data is much higher than for quantitative data: interviews need to be recorded, transcribed, translated, coded, and analyzed. Each of these steps can be time-consuming and require a special skill set that your program’s data team may not have. Likewise, qualitative data can be extremely important in conveying evidence about the accessibility and quality of health services in a way that complements the purely quantitative data.

To ensure that you are able to use the findings from your qualitative data, you may find it helpful to build this need into your budget and staffing decisions. You may be able to hire a data lead that has both quantitative and qualitative skills. Otherwise, and particularly if your program is conducting many interviews, your program could consider hiring a dedicated qualitative researcher to lead this work. You may also need to hire a team to transcribe the interviews so that they are usable by your qualitative lead.

Example:

In order to complement the findings from the surveys, the example CLM program decides to conduct a total of 20 interviews with community members who have stopped visiting the clinic. The interviews will happen in two batches, one in April and a second in October. The CLM program identifies a group of three consultants who will be contracted to

transcribe the audio recordings from the interviews. Since the interviews will be conducted in multiple languages, the transcription team will also transcribe into the language that will be used for analysis. The program decides to partner with a nearby university and contract a qualitative researcher to analyze the data.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Transcribers and translators	14	Days of work	X	\$80	X	3 (people)	=	\$3,360
Qualitative researcher	5	Days of work	X	\$200	X	1 (person)	=	\$1,000

Advocacy

The ultimate goal of Community-Led Monitoring is to advocate with duty-bearers like governments and donors to improve the quality of healthcare services in your community. This phase is the final phase of the cycle.



Question for your team:

Who will lead the advocacy phase of the cycle?

Suggestions for how to think about this:

Much like for the data collection phase of the cycle, hiring a dedicated advocacy lead can be helpful in managing the last phase of the cycle. Depending on what advocacy goals your program has decided on, this phase of the CLM cycle can be very intensive,⁹ and is critical to the success of the program, particularly for addressing the complex and systemic issues identified through CLM that are difficult to resolve at the level of a health facility.

However you decide to staff the advocacy work, your advocacy lead(s) can be in charge of the development and management of the program's advocacy workplan, leading outreach to duty-

bearers, supporting the generation of community-owned solutions, tracking advocacy demands and successes, and organizing the participation of the advocacy team in planning sessions and advocacy activities. The advocacy team should also develop a flexible and appropriate plan for key population-focused advocacy, particularly in contexts with a difficult political environment. Keep in mind that public community accountability meetings, in which both community members and duty-bearers are invited to participate in CLM events, can require a considerable amount of coordination to ensure their success.

⁹ CLAW. [Community Evidence to Create Change](#). September 2022. ITPC. [How to Implement Community-Led Monitoring: A community Toolkit](#). December 2021



Question for your team:

How will your CLM program identify priority issues for advocacy, develop community-owned solutions to those issues, and hold duty bearers accountable?

Suggestions for how to think about this:

The data collected by your CLM program are likely to highlight important challenges and gaps in healthcare delivery. It is important to discuss what process your team will use to develop proposed solutions to these issues, call for duty bearers to implement those solutions, and to track whether the solutions are having the desired effect.

In most contexts, this process should be done collaboratively, where a combination of service users, civil society organizations, community members, and advocates should partner with the CLM program's data team to review the data, routinely track issues, develop proposed solutions, and advocate for implementation of those solutions.

When budgeting for this process, you may need to pay for a meeting space where convenings can take place. Remember to take into consideration travel costs and per diem for the individuals that are invited to participate in these meetings. You may also need to budget for printing costs, if you decide to distribute hard copies of the facility-level data reports.

You will need to think about your system for tracking issues, proposed solutions and their implementation, along with commitments by duty bearers, as something assigned to the data team. Without this it can be impossible to have clarity

about program-wide trends and problems, or to develop relevant advocacy strategies. This feedback loop is also essential for CMs who are returning to facilities over and over and meeting the same facility staff so they can refer to data in order to hold them accountable. For emergency issues such as rights violations and stock outs, such a tool is particularly valuable.¹⁰

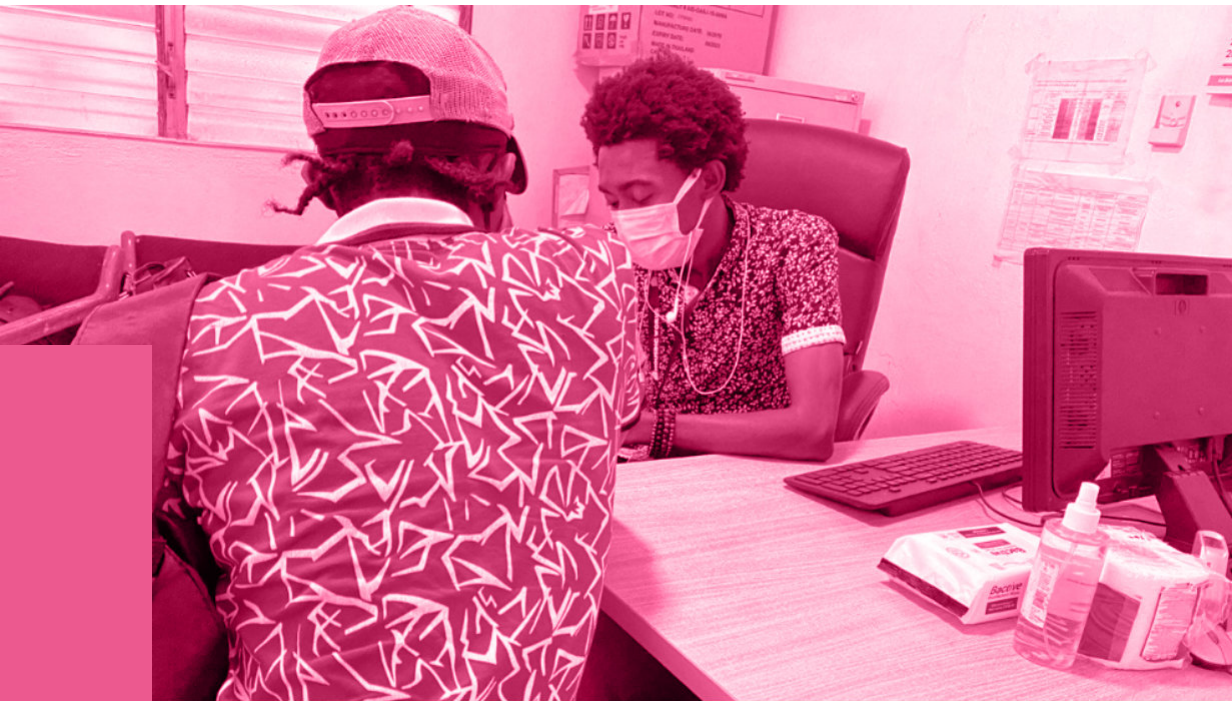
¹⁰Honermann B, Rutter L, Rambau N, Sharp A, Sherwood J, and Lankiewicz E. Data for action - developing a multi-country CLM dashboard for visualization, reporting, and program management [e-poster]. International AIDS Conference 2022, 29 July – 2 August, 2022. Montreal, Canada.

Example:

After each round of data collection, the example program decides to hold a solutions retreat with all of the organizations involved in the program, the Community Monitors, and the core CLM team. The meetings are to be held in the capital in a hotel, which will also be used to house the out-of-town participants. The CLM team will present to the group on the

high-level findings of the round of data collection and then the participants will be broken into small groups to develop facility-specific solutions. The CM will provide additional facility-specific information as needed to support the deliberations. The meeting will generate a detailed advocacy strategy that will be taken forward by the Advocacy Lead(s).

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Meeting space	2	Meeting rooms (one per meeting)	X	\$1,000	X	2 (days)	=	\$4,000
Hotels for out-of-town participants	4	Hotel room nights	X	\$200	X	15 (people, out of 20 total participants)	=	\$12,000
Per diem	4	Days of per diem	X	\$10	X	20 (people)	=	\$800
Printing	1	Page	X	\$0.05	X	40 (20 facility reports per meeting)	=	\$2





Question for your team:

Who will participate in feedback sessions with clinic managers and other duty-bearers? How will commitments generated during feedback sessions be documented and followed up?

Suggestions for how to think about this:

ImmEDIATE and ONGOING feedback to facility managers plays an important role in CLM. These feedback sessions are often the first step in the advocacy phase of CLM, with advocates acting at the most local level. In general, these meetings involve your advocacy team sharing facility-specific data, identifying areas where the clinic is performing well or facing challenges, and soliciting concrete commitments from the most immediate decision-makers responsible for health service quality. These are also important opportunities for the CLM program to build relationships with clinic staff and allies in the improvement of health services.

When planning your feedback sessions, make sure to budget for the staff time of your advocacy team, as well as the travel and accommodation costs. It's also important to think about how you will keep track of these commitments, since you may want to budget for a data collection tool or form. Some CLM programs develop survey tools where they store both the solutions developed by community members and the commitments made by facilities, which allows the CLM program to both hold duty-bearers accountable and track the outcomes of the advocacy work.



Quick tip

Some CLM programs document the outcomes of the feedback sessions by writing a document sharing commitments made, with signatures by both the clinic in charge and the CM team. You may also find it helpful to create advocacy logs, which are used to track changes over time and the triggers (such as a conversation or meeting) that led to each turning point. This formal agreement can form the basis of follow up, including escalation if needed.

Example:

The example CLM program decides to hold facility feedback meetings with every facility one month after data collection finishes. This gives the team enough time to analyze the data, develop facility-level reports, and hold a meeting with the civil society network to review the data and develop solutions. They decide that the advocacy team will include community advocates, as well as the community monitors, who will be able to share their

perspectives on the data. All of the CLM participants in the meetings are compensated for their time. The team develops an electronic data collection survey that they use to record the proposed solutions for each facility, as well as to record the commitments that the managers make. The CM will be responsible for entering all of the data into the survey forms.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Hired vehicle	1	Vehicle	X	\$30	X	20 (days)	=	\$600
Driver	1	Person	X	\$20	X	20 (days)	=	\$400
Petrol	1	Liter	X	\$1	X	700	=	\$700
Printing	2	Pages of printing	X	\$0.20	X	20 (facilities)	=	\$8





Question for your team:

What types of accountability interventions will your CLM program do?

Suggestions for how to think about this:

In addition to direct feedback to the clinics where the data were collected, many CLM programs find it useful to conduct public-facing events to share the program's findings and to advocate for change. Community mobilization, public outreach, media engagement, and other efforts to hold duty bearers accountable can have the benefit of creating additional pressure, particularly if duty bearers have been resistant during direct engagements or where the team has faced roadblocks at lower levels. Public events also have the benefit of disseminating the CLM program's findings to the community and to the broader advocacy community. These events can also be a powerful means to showcase what CLM can do, what has been achieved, to share stories, and to celebrate victories.

Public events, sometimes referred to as community accountability meetings (CAMs), take a lot of logistical planning. While you can keep these events relatively small, they can also be quite large and have many expenses to plan for.^{11, 12} You may decide to hold a national event in a city, in order to be closer to national government officials and donors. If you choose this approach, remember that you will need to reimburse the travel and lodging expenses for your team. Alternatively, you could hold a series of local events in the regions where you are monitoring.

These events require not just a venue, but also refreshments, snacks or meals, and the equipment to share video, audio, and stream to virtual participants. If you are planning to use the meeting to disseminate a report or analysis, make sure to account for the costs of printing multiple copies to distribute.



¹¹ CLAW. [Community Evidence to Create Change](#). September 2022

¹² ITPC. [How to Implement Community-Led Monitoring: A Community Toolkit](#). December 2021

Example:

After conducting solutions visits in clinics, the CLM program reviews the feedback they received. The team decides that some interventions can't be implemented by the clinics themselves but will need buy-in from the provincial government and the Ministry of Health. They plan on two strategies: first, they decide to share CLM findings and recommendations during PEPFAR's quarterly Oversight

Accountability Response Team (POART) meetings.¹³ In addition, they plan to hold a public community meeting, where they will share a report with CLM data and recommendations and present live testimonies with government officials, donors, and the public. To amplify the messages from the event, the team plans to live stream the event and also invites several media contacts to join.

¹³ Health GAP: [Rough Guide to Influencing and Monitoring PEPFAR Country Programs](#). 2019.

Description	Units	Unit Description		Unit Cost		Count		Total Cost
Travel of CLM team to capital	1	Flights	X	\$100	X	10 (people)	=	\$1,000
Hotels for out-of-town participants	1	Hotel room nights	X	\$200	X	10 (people)	=	\$2,000
Per diem	1	Days of per diem	X	\$10	X	30 (people)	=	\$300
Meeting space	1	Meeting space	X	\$1,000	X	1 (day)	=	\$1,000
Refreshments (lunch and beverages)	1	Lunch and beverage per person	X	\$5	X	30	=	\$150
Audio and visual equipment	8	Hours	X	\$30	X	1 (day)	=	\$240
Printed reports	10	Pages	X	\$0.20	X	30 (copies)	=	\$60

How to Budget for Community-Led Monitoring



Generic Template

A generic Excel-based template for CLM budget planning is a tool that allows individuals and groups to plan and track their expenses for monitoring projects. It provides a detailed list of potential expenses and a column for users to input their estimated costs. This template will likely need to be adapted to countries' contexts, the requirements of funders, and the planned activities in each CLM program; however, CLM implementers may use this resource as a user-friendly and organized way for community organization to plan and manage their CLM budgets.

How to Budget for Community-Led Monitoring

Led by the Community-Led Accountability Working Group (CLAW)

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