REPORT ON COMMUNITY-LED MONITORING (CLM) DATA COLLECTION ACTIVITY DECEMBER 2025

CLM Monitor conducting a Focus Group Discussion in Bison Health Centre III

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Name of the Sub recipient (SR)	**Uganda Development and Health Associates (UDHA)**	

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1.0 EXECUTIVE SUMMARY

This report documents the Community-Led Monitoring (CLM) data collection activity conducted by TDYAN YOVANU across eight health facilities in Tororo District. The activity was implemented as part of broader efforts to strengthen accountability, responsiveness, and quality of HIV, TB, and malaria services, particularly for adolescents, young people, and other vulnerable populations.

Grounded in a human rights and people-centred approach, the CLM process placed community voices at the heart of monitoring and learning. Trained community-based monitors engaged directly with service users and health workers through structured interviews, focus group discussions, and facility observations. The intention was not fault-finding, but listening carefully to lived experiences and translating them into credible, community-owned evidence that can inform service improvement.

A total of 119 beneficiary interviews, 40 health worker interviews, and 21 focus group discussions involving 257 participants were conducted across Merikit HC IV, Iyolwa HC III, Kisoko HC III, Bison HC III, Malaba HC IV, Paya HC III, Kirewa HC III, and Osukuru HC III. Participation was high, openness was notable, and communities demonstrated a clear willingness to engage constructively in conversations about service quality, access, and dignity.

While data analysis will be undertaken in the next phase, this activity successfully generated a rich body of primary data and strengthened trust between communities and health facilities. The experience reaffirmed that when people are listened to with respect and confidentiality, they are not only willing to speak, they are eager to contribute to better health systems.

2.0 INTRODUCTION AND ORGANIZATIONAL BACKGROUND

TDYAN Youth Voices and Action Network Uganda (TDYAN YOVANU) is a youth-led and child-centered organization founded in 2017 and registered to operate district-wide in Tororo District (Registration No. 6005, INDR157654939NB). The organization works to improve the health and wellbeing of vulnerable communities, with a strong focus on adolescents, young people, and youth.

TDYAN YOVANU prioritizes human rights protection and fulfilment, sexual and reproductive health and rights, education promotion, and skills development. Its work is grounded in collaboration with families, communities, cultural and religious institutions, government departments, and both local and international partners. Over the years, the organization has contributed to improved access to health information and services while promoting gender equality, equity, and meaningful youth participation.

The CLM initiative was designed in response to persistent community-level challenges in HIV, TB, and malaria service delivery, including commodity stock-outs, stigma and discrimination, long waiting times, and gaps in client-centred care. Through CLM, communities are supported to identify these barriers and engage health providers and district stakeholders in finding practical, locally relevant solutions.

The purpose of the CLM intervention is to strengthen the capacity of community-based and civil society organizations (CBOs/CSOs) to facilitate structured monitoring, evidence generation, and advocacy for improved health outcomes

3.0 BACKGROUND TO THE ACTIVITY

Community-Led Monitoring (CLM) is defined by the Global Fund as mechanisms through which service users and communities systematically gather, analyze, and use information to improve access to, quality of, and impact of health services, while holding service providers and decision-makers accountable.

CLM is a core component of the Global AIDS Strategy Framework 2021-2026 and the Global Fund Strategy 2023-2028, both of which emphasize people-centered, rights-based, and community-driven health systems. These frameworks recognize communities as essential partners in identifying service delivery gaps, addressing legal and social barriers, and strengthening sustainable and resilient health responses.

CLM is implemented by community-led organizations of people living with HIV, networks of key populations, and other affected community groups. It relies on trained peer monitors who routinely collect qualitative and quantitative data from both facility and community settings, including from individuals who may not regularly access health services. Findings are shared through rapid feedback loops with health facilities, district leadership, and program managers to support timely corrective action.

Importantly, CLM functions as a community accountability and surveillance mechanism. It is distinct from routine service delivery or internal program reporting and is designed to generate independent, evidence-based insights on what is working, what is not, and what needs to change.

4.0 JUSTIFICATION

Despite significant investments in HIV, TB, and malaria programming in Tororo District, persistent gaps remain between service coverage and actual health outcomes, particularly among adolescents, young people, and other vulnerable populations. Challenges such as delayed viral load suppression, inconsistent access to essential commodities, negative provider attitudes, long waiting times, stigma, and weak client feedback mechanisms continue to affect service uptake, continuity of care, and overall treatment success.

Routine health management information systems and facility report often capture service outputs but rarely reflect the lived experiences of service users or the contextual barriers faced by communities. As a result, critical issues affecting access, quality, acceptability, and equity of services may remain unaddressed, limiting the effectiveness and impact of existing interventions. This gap is especially pronounced for young people and marginalized groups, whose voices are frequently underrepresented in decision-making processes.

Community-Led Monitoring (CLM) provides a practical and evidence-based approach to bridging this gap by placing communities at the center of accountability and quality improvement. By systematically

collecting and analyzing feedback from service users and health care providers, CLM generates independent, community-owned evidence on what is working, what is not, and why. This evidence is essential for informing timely corrective actions at facility, district, and national levels, in line with the Global AIDS Strategy Framework 2021-2026 and the Global Fund Strategy 2023-2028.

Implementing CLM in the eight targeted health facilities in Tororo District is therefore both timely and necessary. These facilities serve large catchment populations, including adolescents and young people who are disproportionately affected by HIV, TB, and malaria-related vulnerabilities. Through structured Key Informant Interviews, Focus Group Discussions, and facility observations, the activity will captured diverse perspectives on service delivery, including barriers related to availability of medicines, human resources, service organization, provider-client interactions, and stigma.

TDYAN YOVANU's position as a trusted, youth-led, and community-rooted organization uniquely enables it to facilitate this process effectively. The use of trained community-based CLM monitors enhances trust, openness, and data credibility, while fostering constructive dialogue rather than blame. The resulting findings will strengthen accountability between communities and service providers, support data-driven quality improvement, and contribute to more responsive, equitable, and people-centered health services.

Ultimately, this activity is justified as a critical step toward moving from service coverage to real impact by ensuring that HIV, TB, and malaria services in Tororo District are not only available, but accessible, acceptable, and effective for the populations they are intended to serve.

5.0 OBJECTIVES OF THE ACTIVITY

5.1 General Objective

To improve the accessibility, availability, and quality of HIV, TB, and malaria services in Tororo

District, with particular attention to adolescents, young people, and other affected populations.

5.1.1 Specific Objectives

1. To collect and document community and client experiences, concerns, and satisfaction with HIV, TB, and malaria services in targeted health facilities.
2. To identify systemic gaps in service delivery that affect access, quality, equity, and health outcomes.
3. To generate credible community-led evidence to inform facility-level, district-level, and national-level corrective actions and advocacy

6. METHODOLOGY OF IMPLEMENTATION

6.1 A. Preparatory Phase

The Project Officer formally engaged the District Health Office and issued notification letters to in-charges of the eight selected health facilities. Community VHTs and facility peer mobilisers were also engaged early to support mobilization, scheduling, and informed consent.

Seeking an introduction letter from the CAO's office addressed to facility managers

Introductory Letter.pdf

CLM monitors jointly developed facility-specific schedules with in-charges to minimize disruption to routine service delivery. Interview tools were reviewed collectively, and clear targets were set for health workers, clients, and FGDs. Community-based monitors, familiar with local languages and context, were deployed to enhance trust and openness.

CLM SCHEDULE Monitor 1.docx

CLM schedule Monitor 2.pdf

Data collection was conducted by trained CLM monitors drawn from local communities within the district. These monitors were equipped with skills in participatory monitoring, ethical data collection, and community engagement. Their familiarity with the local context and trust within communities is expected to enhance openness, accuracy, and depth of responses.

The CLM process emphasized constructive dialogue between service users, health workers, and community members, focusing on availability, accessibility, acceptability, equity, and quality of HIV, TB, and malaria services.

The team engaged with the district on the community led monitoring program. They also used data collection tools that were provided by TASO.

6.2 B. Implementation Phase

The team visited 8 health facilities which included Merikit H/C IV, Iyolwa H/CIII, Kisoko H/CIII, Bison H/CIII, Malaba H/CIV, Paya H/CIII, Kirewa H/CIII and Osukuru H/CIII.

A mixed-methods approach was used to ensure triangulation and comprehensive analysis, including:

- Structured questionnaires administered to patients and health workers
- Key Informant Interviews (KIIs) with facility in-charges and selected frontline health workers

- Focus Group Discussions (FGDs) conducted separately with HIV, TB, and malaria clients
- Facility observations to assess infrastructure, availability of essential medicines and commodities, staffing, and client flow

The interviews were purposive basing on the thematic illness like TB, HIV and malaria focal persons, clients and the health in charges with the knowledge to respond to the questions asked. The targets were pre-determined by TASO and being that team wasn't mobilizing clients from communities but talking to clients who are existing the facility and selected by the facility peer mobilizers.

The interviews were one on one with assurance of consent, privacy and confidentiality and also withdrawal of the interview when the clients feel that can no longer proceed with the interview.

The interviews also aimed at service delivery improvement, looking about clients satification, access to service, availability and quality of services. The interviews were taking 20 minutes per client.

6.2.1 Sample Size Determination

Each health facility targeted 5 health workers, totalling 40 health workers and beneficiary interviews targeted 120 clients, categorized under HIV, Malaria, and TB. A total of 8 FGDs were planned (one per health facility) but the monitors managed to collect data from 119 clients. 257 participants / clients involved in the focus group discussions

The sample size was determined based on facility client flow, availability of disease category specific clients

1. The M&E officer also visited the monitors at their respective facilities to ensure quality data was collected and the target numbers were reached.

6.3 C. Documentation Phase

The monitors used approved DHIS data set that is entered through a tablet provided by TASO through UDHA.

7.0 ACHIEVEMENTS / RESULTS OBTAINED

7.1 A. Descriptive Analysis

The team hasn't done data analysis and its planned as for the next activity

7.2 B. Quantitative Summary Table 1 bellow

Indicator	Target	Achieved	% Achievement
Beneficiary interviews	120	119	99%
Health worker interview	40	40	100%
FGD	24 (of 8-12people in each FGD)	21	87.5%
Number of HF enrolled	08	08	100%

The total number of clients reached during the FGDs were 257 clients

(Malaria had 141 clients, HIV had 94 clients and TB had 22 clients)

7.3 Table 2 indicating Total Number of Participants Who Took Part in the Exercise Disaggregated by Facility, Sex and Age,

Facility	AGE	MALE	FEMALE	TOTAL
Malaba H/CIII	10-19	00	03	03
	20-24	02	09	11
	25 above	11	28	39
	Total	**13**	**40**	**53**
Merikit H/CIII				
	10-19	01	02	03
	20-24	00	12	12
	25 above	08	34	42
	Total	**09**	**48**	**57**
Osukuru H/CIII				
	10-19	02	04	06
	20-24	02	28	30
	25 above	03	19	22

	Total	**07**	**51**	**58**
Bison H/CIII				
	10-19	02	01	03
	20-24	03	14	17
	25 above	09	27	36
	Total	**14**	**42**	**56**
Paya H/CIII				
	10-19	00	13	13
	20-24	00	09	09
	25 above	13	17	30
	Total	**13**	**39**	**52**
Kisoko H/CIII				
	10-19	01	02	03
	20-24	02	11	13
	25 above	15	23	38
	Total	**18**	**36**	**54**
Kirewa H/CIII				
	10-19	00	00	00
	20-24	00	00	00
	25 above	13	38	51
	Total	**13**	**38**	**51**
Iyolwa H/CIII				
	10-19	02	02	04
	20-24	00	01	01
	25 above	11	41	52
	Toal	**13**	**44**	**57**
TOTAL PARTICIPANTS		**100**	**338**	**438**

8. CHALLENGES ENCOUNTERED

1. Low TB client volumes made it difficult to achieve targeted FGD numbers in some facilities.
2. Lack of dedicated note-takers placed a heavy burden on monitors during FGDs.

9. LESSONS LEARNED & BEST PRACTICES

1. Morning hours were more suitable for client interviews than afternoons.
2. Ensuring privacy, confidentiality, and informed consent created a safe space for honest feedback.
3. Excluding health workers and mobilisers from FGDs encouraged openness.
4. Early engagement of facility in-charges significantly improved coordination.

5. Using monitors from the same communities helped overcome language and trust barriers.

10. RECOMMENDATIONS

1. Need to recruit note takers because its hectic asking questions, recording and taking photos.
2. For the target of TB FGD, number is not realistic for the low volume facilities because they don't make the number of an FGD like Malaba, merikit and osukuru had 1 client for TB making it hard to hold FGD, however we can merge them with the HIV FGD since the discussion is comprehensive and covers on the discussion.
3. Facility in-charges should be provided with a project timeline so they can be aware of each CLM data collection period
4. Health facility in-charges should be informed early about the data collection activity to ensure better preparedness
5. Providing facility in-charges with the CLM project timeline so they are aware of each project activity

11. ACTION PLAN / STRATEGY FOR NEXT ACTIVITY.

- Data cleaning of the data collected.
- Analysis and report writing meeting which involves CLM monitors, biostatcticians, CBO staff, HMIS focal person and facility in charges.

12. CONCLUSION

This CLM data collection activity demonstrated that communities are not only willing, but deeply invested in improving the health services they rely on. When given safe and respectful spaces to speak, service users provided thoughtful, practical insights grounded in daily experience.

While data analysis will follow, the process itself has already generated value by strengthening trust, improving dialogue, and reinforcing the

13. PHOTO GALLERY **(at 6 photos)**


On the right hand is an interview with a health worker in Paya and on the left is FGD in Iyolwa


On the left hand is FGD in Kisoko while on the right hand is patient interview


On the right hand is an interview with health worker interviews in Merikit Health Centre III

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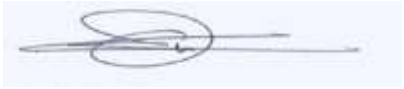
Signature: 

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