

# THE REALITIES OF COMMUNITY-LED MONITORING: OUR EXPERIENCE FROM ZIMBABWE SO FAR!



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## BACKGROUND

People-centeredness and putting communities in the lead in HIV and AIDS response have become buzzwords in recent times. Thus, **Community Led Monitoring (CLM)** gained prominence as an avenue to make it a reality. The United Nations Joint Programme on AIDS (UNAIDS) defines HIV CLM as, "... an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups or other community entities. FACT Zimbabwe, with financial support from the Global Fund to Fight AIDS, TB, and Malaria (GF) through the United Nations Development Program (UNDP) is among the pioneers of CLM in Zimbabwe.

### Context

- Zimbabwean culture is predominantly Christian and African traditions. The above set the social norms with a bearing on legal, policy, and social environment on sexuality. Marital heterosexuality is considered the 'norm', & any deviation is derided.
- Notable progress was made on HIV with 96% of people living with HIV knowing their status, of which 97% are on ART and 95% of those on ART have viral load suppression (MoHCC, 2022). Other sub-populations are still lagging like children and key populations (KP) e.g., Lesbian, Gay, Bi-Sexual, Transgender, Intersex, and Queer (LGBTIQ). According to the 2022 Zimbabwe People Living with HIV Stigma Index 77.7% of sex workers reported HIV status-related stigma and 17.9% of people living with HIV discontinued antiretroviral treatment (ART) in the preceding year due to stigma-related reasons.
- It is in this context that various CLM programs are being implemented in Zimbabwe to enhance prevention, treatment, and care as well as fostering inclusion and communities' voices in the HIV and AIDS response. CLM's objective is to monitor accessibility, availability, affordability, acceptability, appropriateness, and quality of HIV prevention, treatment and care services, and related health services.

## DESCRIPTION

- Since 2021 FACT Zimbabwe implemented CLM in 20 largely rural and remote districts of Zimbabwe where particular sub-populations are not organized, are sparsely spread and not yet socially embraced like sex workers, men who have sex with men (MSM), and LGBTIQ.
- Data was collected in 199 facilities by 600 volunteer community health monitors (CHM) representing people living with HIV, sex workers, etc. Data collection, analysis, and dissemination are done quarterly at the facility and district levels. Advocacy issues are shared with networks of CSOs & CLM national steering committee for escalation.

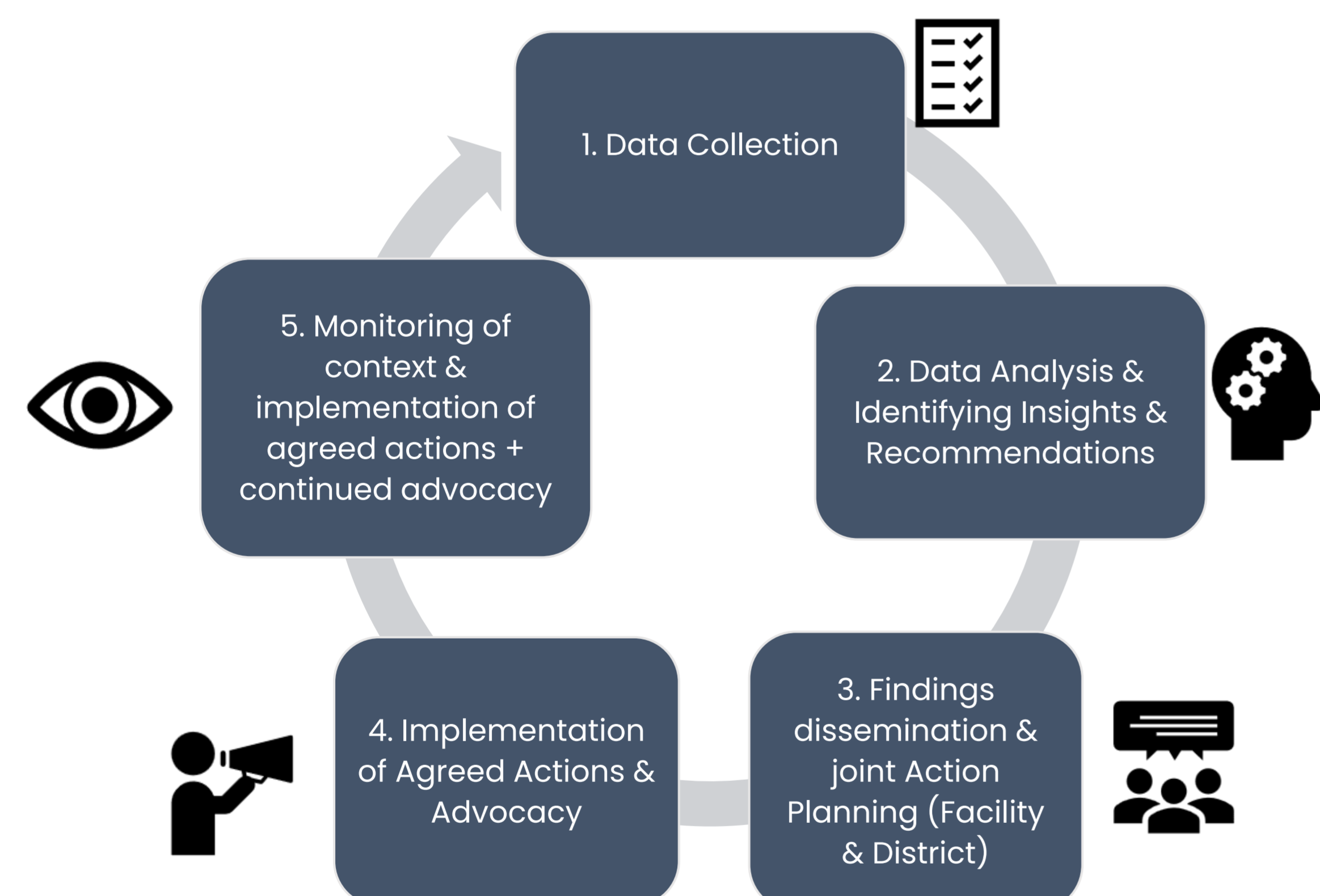


Figure 1. FACT Zimbabwe Quarterly CLM Cycle

### Insights from CLM Data

- **Inadequate healthcare workers** which manifest in staff burn-out, negative attitudes, attrition, and long waiting times e.g., 92% of CLM respondents between October and December 2023 mentioned understaffing as a reason for long waiting times.
- **Negative Attitudes** towards people living with HIV and key populations by nurses.
- **Non-availability of medicines and stock-outs** of essential medicines e.g., painkillers and antibiotics for sexually transmitted infections for instance, which was reported by 44% of respondents in the 4<sup>th</sup> quarter of 2023.
- **HIV testing kits** – the confirmatory testing kits are intermittently unavailable or expired, derailing HIV testing services (HTS).
- **Non-availability of key services for HIV co-morbidity and non-communicable diseases at the local level.** Of the 5,186 respondents during the 4<sup>th</sup> quarter of 2023, 50% noted that cervical cancer services are needed but not available in their local facilities.
- **Long distance to facilities** – limits access to HTS, condoms, and treatment. Facilities in rural areas are sparsely distributed often resulting in additional costs on transport leading to treatment disruptions.

### Achievements

- **Treatment follow-up:** CHM actively follows up on loss to follow-up ART clients to ensure continuity of treatment & care.
- **Resolving stock-outs:** Communities to report drugs and commodities stock-outs to district health executives (DHE) and quickened their response turnaround.
- **Staff attitudes:** CLM demystified negative attitudes of nurses towards ART clients and KPs through dialogues.
- **Bridging communication gaps between communities and facilities:** CHM relays information from facilities to communities and vice versa and creates awareness and demand for HIV services like HTS, PrEP, PEP
- **Decentralization of services: Health Posts** are set up at the furthest points to mitigate traveling costs and time.
- **CLM fostering differentiated service delivery (DSD) for young people:** For example, designated rooms and days exclusively for youth service provision give assurance of confidentiality and non-judgmental service.

## LESSONS LEARNED

### Key lessons thus far:

- CLM can reduce stigma & discrimination through continuous dialogues between service providers and recipients of care. CLM also bridges information gaps between facilities and communities.
- Community health monitors can be foot soldiers for following up and re-connecting ART recipients to treatment hence minimizing cases of defaulting and loss to follow-up.
- CLM is applicable beyond HIV and can foster communities' participation and social accountability in public health delivery. In our experience, CLM brought general health issues to the attention of duty-bearers.
- We observed that CLM is effective where government authorities are responsive. Variations were noted across districts and are correlated to how CLM was embraced locally.
- Community capacities on CLM also plays a major factor on its effectiveness. The limited capacities of communities to organize and advocate are limiting CLM's impact in Zimbabwe.
- The greatest controversy remains on the definition of communities. There have been contestations around who are the **'true communities'** causing latent dissonance often stalling CLM progress.
- Thus, efforts to enhance CLM in Zimbabwe like the development of a CLM strategic plan are hampered by contestations centered on the legitimacy and definition of **CLM**.



Community Volunteers at Chironde Clinic, Shurugwi district.  
 (PHOTO CREDIT: Makomborero Nzwatu, Jointed Hands Welfare Organization)

## CONCLUSION

- CLM is increasing access to HIV health services by resolving localized access barriers, reporting on medicines and commodities stock-outs, re-connecting recipients of care to treatment, cascading health information in communities, and building rapport between healthcare workers and communities.
- CLM is generating undeniable evidence for informed policy advocacy.
- CLM can put people in the lead in HIV and AIDS response, but only if duty bearers are responsive and communities have the necessary skills and capacities.
- CLM is not yet fully understood and embraced in Zimbabwe resulting in low prioritization and both overt and covert resistance by some key stakeholders
- CLM is often confused with ordinary M&E, yet it is a social accountability & public health intervention.
- An inclusive CLM approach may be more impactful in the Zimbabwean context than exclusionary group-specific approaches due to generalized health challenges and that some KP groups are not yet socially and politically embraced.
- Particularly mentioning specific groups in authoritative definitions of CLM is problematic and has stalled some key CLM processes in Zimbabwe. This is so because:
  1. Sub-population-specific CLM are less impactful where the general health system is constrained.
  2. Exclusive CLM interventions received mixed reactions from the public in Zimbabwe, inherently risking resentment.
  3. Whilst treatment & care is important to avoid treatment disruptions equal attention is needed on prevention.

## NEXT STEPS

- Contextualize CLM to local realities for impact rather than a one-size-fits-all approach.
- Increase funding to build strong communities and for sustained advocacy at different levels.
- Apply CLM beyond HIV as a social accountability mechanism in wider health delivery.
- We ought to place equal emphasis on primary prevention as with treatment for total epidemic control.
- Revisiting the definition of CLM.



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