Community-Led Monitoring

IAS

A guide to monitoring, evaluation, accountability and learning (MEAL) for community-led monitoring programmes

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International AIDS Society

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Contents

Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality
CLM	Community-led monitoring
FGD	Focus group discussion
HMIS	Health management information systems
IAS	International AIDS Society
MEAL	Monitoring, evaluation, accountability and learning
M&E	Monitoring and evaluation
MoU	Memorandum of understanding
PEPFAR	President's Emergency Plan for AIDS Relief
PPR	Pandemic preparedness and response
PrEP	Pre-exposure prophylaxis
TA	Technical assistance
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS

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Introduction

What is community-led monitoring (CLM)?

Community-led monitoring (CLM) is an accountability mechanism in which communities accessing services (such as health and education) and/or affected by specific issues (such as infectious diseases, inequities in access to health services, and environmental degradation) routinely gather, analyse and take advocacy action based on evidence about the service or issue in question.

CLM for HIV healthcare services centres the priorities of users of services at the monitored sites, including people living with HIV, key populations, young people and other highly impacted groups. It is independent from governments and donors and includes advocacy for better services. Communities own the data generated through CLM. At its core, CLM involves local community-led organizations, networks of key populations and other affected groups systematically monitoring health services. CLM can be thought about in a general cycle: gathering evidence; analysis and interpretation; engagement; advocacy; and monitoring (Figure 1)*.

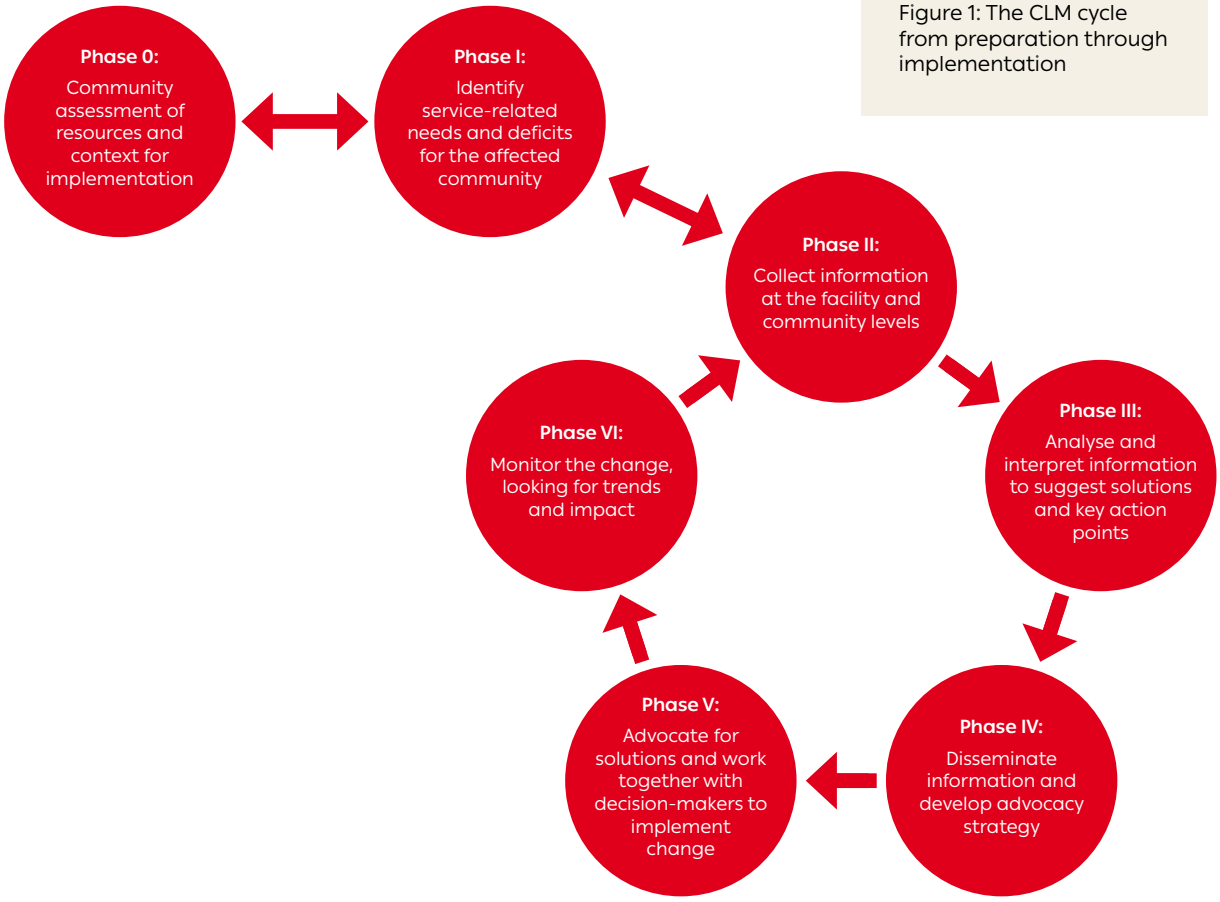

Figure 1: The CLM cycle from preparation through implementation

* The bidirectional arrows between Phase 0, I and II indicate that programmes may shift focus or priorities over time, and that these shifts can be supported by revisiting readiness and resources for new phases. Adapted from UNAIDS (2021) Establishing Community-Led Monitoring of HIV Services. Available here.

The CLM cycle is designed to ensure that health services are responsive to community priorities and experiences. Changes happen across the cycle as communities decide what indicators to monitor, gather and analyse data at health facilities, and discuss findings with various stakeholders.

CLM is one aspect of the HIV advocacy and activist ecosystem. While it can be used to monitor human rights abuses, stigma and discrimination that *prevent* people from coming to health facilities, it often focuses on experiences and conditions *at* health service delivery sites. It is important to bear in mind that CLM provides information on the availability, accessibility, acceptability and quality (AAAQ) of services - it is not the primary advocacy and accountability mechanism for ensuring that new products are developed to meet the needs of people living with and vulnerable to HIV.

CLM is also highly adaptable. During COVID-19, CLM programmes responded rapidly by developing tools to gather information about how lockdowns and other public health measures were affecting access to services. CLM is presently being explored in the context of pandemic preparedness and response (PPR) efforts in several countries.

What is MEAL?

MEAL stands for monitoring, evaluation, accountability and learning. It involves a set of activities and approaches that expand beyond monitoring and evaluation (M&E), which may be more familiar and already part of a CLM programme. This guidebook can support refinement of what a CLM programme is already doing as part of M&E, as well as the creation of new activities and indicators that contribute to programme strengthening through accountability and learning.

Here are some basic definitions of each component of MEAL:

Monitoring & evaluation is a process of collecting and analyzing data to assess the progress and effectiveness of a programme. It is often used to measure programme outputs and outcomes, identify areas for improvement, and inform decision-making. M&E typically focuses on evaluating a programme's performance against predefined indicators and targets.

Table 1: M&E core approaches

Monitoring	Evaluation
What	
◦ Observe, check ◦ Record	◦ Judge and value ◦ Assess
Why	
◦ Make day to day decisions ◦ Provides information for evaluation	◦ Make major decisions ◦ Provides information for planning
When	
◦ During implementation ◦ Continuous	◦ Before or after an activity ◦ Periodic

Accountability and learning bring additional depth to the project of understanding and improving a CLM programme.

Accountability involves ensuring that programme beneficiaries are involved in decision-making and that their feedback is used to improve programme effectiveness.

Learning refers to continuous improvement through periodic, timely reflection on programme objectives, strengths and weaknesses, and using that information to develop and implement innovative solutions.

Through collective reflection, a culture of accountability and learning can help organizations be more responsive, adaptive, and effective at achieving objectives, ultimately leading to stronger and more impactful programmes.

Table 2: A&L core approaches

Accountability	Learning
What	
◦ Engage programme benificiaries in evaluation ◦ Ask whether resources are being used according to original goals and plans	◦ Act on insights as they arise through creative problem-solving or action
Why	
◦ Ensure transparency ◦ Build trust and address concerns	◦ Continuous improvement
When	
◦ Before and during evaluation processes	◦ Ongoing across the programme or project lifecycle

Food for thought

M&E is like a basic meal that only focuses on the essentials. It's like a simple café that only monitors and evaluates the quality of the food, but doesn't care much about customer satisfaction or the overall performance of the restaurant.

MEAL is like a hearty, well-balanced meal that not only fills you up but also gives you all the nutrients you need to stay healthy – and that is prepared by someone who wants to be sure the food is served hot, all the helpers are content, and you're satisfied!

Why develop a MEAL framework for community-led monitoring?

Even though many CLM programmes are less than five years old, they have already shown impacts in many areas, including reducing levels of stigma and discrimination reported by clinic attendees who are members of key population groups (such as LGBTQI+ people, sex workers and people who inject drugs), increasing uptake of prevention methods, improving ART retention, and addressing stockouts. Because CLM programmes are centred on monitoring, they may be evaluated – by funders, implementers and government officials – based on shifts in these and other parameters.

However, a CLM programme can be well-designed and contribute to improvements in health service delivery without yet shifting the longer-term outcomes measured in HIV prevention and treatment cascades. During formative research conducted by the CLM programme of IAS – the International AIDS Society – many stakeholders involved in HIV-focused CLM expressed the need for a monitoring, evaluation, accountability and learning (MEAL) framework that captures programme strengths, intermediate outcomes and areas for improvement.

Specifically, stakeholders expressed the need for a framework that:

- Supports CLM programmes in addressing questions about the quality and validity of their data, the evidence that CLM itself has contributed to observed changes, and the rationale for continued support as an accountability mechanism
- Supports CLM programmes to build strong partnerships, ensure smooth-functioning programmes, and demonstrate sustained impact
- Supports funders, partners and governments to structure financial and technical support for CLM programmes that foster growth, independence and impact and manages expectations for all parties

In our formative research[1], the IAS heard about a range of MEAL approaches – from minimal to routine. Currently, MEAL is not a routine part of many CLM programmes.

This guide is a living document designed to meet the needs expressed by CLM implementers and partners during consultation and piloting sessions undertaken throughout 2024 and early 2025. It is meant to be adapted, adjusted and altered to further meet the needs of specific CLM programmes.

[1] This guidebook has been developed through a three-stage process. Phase 1 (March-April 2024) comprised a landscape review and key informant interview with CLM implementers and funders. Phase 2 involved in-depth regional consultations with CLM implementers (100+ participants, July-October 2024). Phase 3 focused on piloting the guidebook with CLM implementing organizations in Burkina Faso and Zimbabwe (December-March 2025). For further information, please contact clm@iasociety.org.

What does it mean to monitor community-led monitoring?

CLM has a lot in common with, but is not the same as, monitoring and evaluation. Every CLM programme chooses priority issues, identifies ways of assessing them, and then gathers and analyses that information to inform action. These are also the main steps in the MEAL approaches outlined in this guide. While CLM programmes monitor health facilities or services, MEAL for CLM looks at the programme itself, exploring the activities, actions and impacts.

Many CLM programmes produce reports and other documentation of the data collected, advocacy steps and changes over time. These are excellent resources for documenting CLM impact. For an established programme, MEAL can shed light on how the programme achieved its goals, bringing to the surface areas of strength and where to adjust. It can help answer questions about whether a given change was caused by CLM and what specifically led to the change. It can gather information on the political, policy and funding context that may explain why changes have been incremental or difficult to achieve. It can also help identify the sources of strength in CLM coalitions and teams, and opportunities for action for stronger partnerships. This kind of information may not be routinely gathered by your CLM programme itself. MEAL for CLM can help make the CLM programme even more effective over the long term.

Who is this guide for?

This guide is a practical tool for CLM implementers working on every aspect of the programme, from data collection to advocacy. You don't need to be a MEAL expert to read the guide or to build a MEAL approach. This is designed for MEAL newcomers and experts alike. It is also a resource for CLM funders and other stakeholders seeking to support CLM programmes with simple, robust MEAL approaches.

What's inside this guide?

Part 1 of the guide walks through five questions that CLM programmes should explore as they begin or refresh their MEAL approach.

Part 2 has sample MEAL frameworks for each phase of the CLM life cycle. In the framework for each phase, there are sample indicators and questions that can help you assess the process (Are you conducting activities in this phase as planned?) and the outputs (What's happening because of these activities?).

Depending on the answers to the questions in Part 1, you may or may not decide to use an indicator-based framework like those in Part 2.

Suggested basic steps using this guide to plan MEAL

1

Step 1: Lay the foundation for your CLM MEAL exercise – see Part 1

- Locate where your programme is in terms of development and CLM phase
- Discuss and revisit over-arching objective, strategy and theory of change
- Explore priority areas for using MEAL to support programme growth
- Consider different MEAL approaches
- Assess needs for conducting MEAL
- **Document your discussions and decisions in Worksheet 1 – or equivalent!**

2

Step 2: Design your CLM MEAL exercise – see Part 2

- Decide what specific programme aspect you'd like to focus on, what you'd like to learn, and how
- Develop approaches to gathering this information by identifying the sources, questions and potential indicators for your activity
- **Document your discussions and decisions in Worksheets 2 and 3 – or equivalent!**

3

Step 3: Finetune your CLM exercise - and develop a MEAL plan - see Part 3 and annexes

- Consider whether the sample indicators or approaches in this section offer ideas or directions for the activities you've designed
- Incorporate, adjust and validate your framework
- Estimate human and financial resource needs
- Map the plan, including resource mobilization if needed, to a timeline, looking for opportunities to integrate MEAL findings into grant reporting cycles or other planned activities

Part 1. Planning MEAL for CLM

Laying the foundation for your MEAL framework or activity

A strong MEAL process starts with clarity about what your programme is doing, how it is doing it, what it hopes to learn through MEAL, and how it wants to approach this learning. All these questions should be answered before any MEAL indicators are selected or tools developed.

In this way, MEAL for CLM is exactly like CLM itself. CLM programmes start with consultations that gather inputs, priorities and concerns from people using and affected by health services. The community issues and ideas shape the data collection, tools and advocacy. Similarly, MEAL of your CLM programme should start with discussion of a series of questions, which are outlined in this section.

Investing time in these questions will make it easier to decide what to measure, where to measure it, and who to involve in the MEAL process. *Worksheet 1: Laying the foundations for MEAL for CLM* (see Annex 1) is designed to capture inputs and insights in this phase of planning a MEAL activity. An example of a completed sample sheet is included at the end of this section.

1.1 Where is your programme currently in its development and CLM cycle?

CLM involves a cycle of activities (see Figure 1). CLM programmes also move through stages of growth and development, from launch and founding to early efforts to maturity. UNAIDS has developed a CLM "progression matrix" that delineates characteristics and capacities for each of these phases. This resource is currently being finalized.

While preparing to launch your MEAL effort, it can help to think about what stage of its evolution and growth the programme is in. How long has the programme been running? How established are its systems for data collection, analysis, advocacy and monitoring? You can also think about where your programme is in the CLM cycle. Defining where your CLM is in terms of activities and evolution can help you focus on what you want to learn through MEAL.

1.2 What are your overarching goals and how are you achieving them?

To answer this question, you are encouraged to consult – or create – your theory of change for your CLM programme. A theory of change is "an explanation of how a group of stakeholders expects to reach a commonly understood long-term goal" [2].

In general, a theory of change includes a long-term outcome, a set of intermediate outcomes, and steps you're going to take to try to achieve these outcomes. Some theories of change incorporate preconditions or prerequisites for achieving a goal. For example, a CLM programme needs the buy in of recipients of care and health facilities as a precondition for monitoring. Resources to support development of a theory of change for CLM are available in Annex 3, along with sample templates.

[2] Anderson, A. The Community Builder's Approach to a Theory of Change: A Practical Guide to Theory Development. (The Aspen Institute) https://www.theoryofchange.org/pdf/TOC_fac_guide.pdf.

Your theory of change and your MEAL activities can be mutually reinforcing: a strong theory of change will help you identify the activities or outcomes to measure with MEAL indicators, and a strong MEAL approach will help you test and affirm or adjust your theory of change.

If you do not have a theory of change or if you are seeking to check the fit between your MEAL approach and your overall approach, you can spend time reflecting on the changes you most want to achieve through CLM and consider whether the MEAL approach you're developing will help you achieve programme objectives.

1.3 Why are you doing MEAL right now and what do you hope to learn?

There's usually a simple answer to the question, "Why are you doing MEAL?". It might be because you want to make your programme better or because a partner requires it. At this stage, you're invited to develop a more detailed answer to the question by focusing on the aspects of the programme you'd like to improve or perhaps on the environment in which CLM is operating. As Box 1 shows, MEAL can do a lot of different things: sharpen strategy, evaluate processes, document the conditions that may be creating challenges or opportunities beyond the control or scope of the CLM programme – and more. Take the time to go beyond the simple answer to be as specific as possible about why you are doing MEAL right now and what you hope to learn. Identifying the learning purpose(s) for your exercise will help prioritize your resources, make sure you are involving the right people, and set the schedule for your activity.

Box 1: Monitoring and evaluation purposes

Refining strategy and direction: Are the steps we're taking to achieve change producing the results we want? Are there places to shift or revisit our approach to improve outcomes?

Supporting and strengthening governance: Is our programme organized in a way that gives all team members a voice and the opportunity to contribute? Do the people with decision-making responsibility have access to the information they need? Do the people with information have the mandate to make decisions and shifts?

Supporting efficient, useful programme outputs: Are the data reports, dashboards and reports we're producing having the intended impact? And is the time and effort allocated to them enough, too much or insufficient? Are there too many indicators or too few? How much of the collected data is used for advocacy?

Documenting and understanding intended and unintended outcomes: What are our programme's successes and setbacks? Why did they happen? Were there unanticipated successes or positive outcomes? Why and how did they emerge?

Assessing accountability: Does the CLM programme have robust systems in place for financial management, addressing conflict of interest issues, mediating disagreements and disputes, and ensuring that affected communities are informed, engaged and centred in the work?

Mapping the context in which CLM is taking place: What is the political, economic and social context in which our programme is operating? How is it changing? And how do these changes impact our programme's ability to effect change?

1.4 What is the right MEAL approach for your goals and priorities?

MEAL can take many different forms. Understanding your learning purpose can help you pick the approach or approaches that will give you the information you want most. MEAL types include:

- Participatory evaluation: Involves the key stakeholders in a programme or project in the design and implementation of the evaluation
- Process evaluation: Determines whether the activities outlined in an action plan or work plan have been implemented as proposed
- Outcome evaluation: Focuses on what happened during a given period of CLM implementation, usually the changes in health service availability, accessibility, acceptability and quality brought about by the programme

Practical examples and activities for developing each of these types of evaluations can be found in the LEAP (Lead, Educate, Advocate) for Community-Led Monitoring in TB playbook developed by APCASO. Participatory evaluation and process evaluation can be potent tools for assessing and understanding how recipients of care engaged with and impacted by CLM feel about the programme and for identifying best practices and areas for improvement in building partnerships with government at local and national levels.

As the LEAP playbook and other analyses of CLM needs and principles note, MEAL should support and reflect realistic expectations about what CLM can deliver. An excellent and established CLM programme can struggle to secure service improvements if ministries of health and other partners do not take on recommendations. Nascent CLM programmes should not be expected to deliver concrete shifts in short time periods, though some may arise. Outcome or impact evaluations that focus on improvements should be considered in this context.

As you reflect on the learning purposes for your MEAL and these approaches, you may notice a natural fit between a given learning purpose and MEAL approach. For example:

- If you're seeking to strengthen governance, you might undertake a process evaluation looking at the involvement and roles of affected communities at various stages of the CLM process.
- If you are seeking to understand how your CLM programme has achieved success in improving health services, you might want to combine process and outcome evaluation approaches, looking at how various activities were conducted in a cycle that did (or did not) lead to substantive change.

It is important to remember that participatory evaluation approaches can be used to design and implement both process and outcome evaluation. To home in on your MEAL approach/es, you may want to explore these reflection questions:

- Do you, your funders or other partners have questions about the extent to which changes or improvements in health services can be attributed to CLM or the degree to which CLM improved the knowledge, skills and attitudes of health providers and the communities?
- Do you, your funders or other partners have questions about how affected communities perceive or experience CLM implementation?
- Do you have questions about how you might improve relationships and ensure equitable distribution of power and decision making between programme planners, implementers and beneficiaries?

There is no "right" way to do MEAL, but there is often a "best-fit" approach for the purpose and question you are prioritizing. You can reflect with your team on which questions are most important and feasible and whether you have the resources (see next section) to address them.

1.5 What do you need for your MEAL to succeed?

After clarifying why you want to conduct MEAL, what you want to learn, and how you want to learn it, you can map out a plan that includes financial and human resources, tools and training curricula, convenings and timelines. Key things to think about are:

- How often you're going to conduct the MEAL activity
- How intensive it will be (in terms of coverage of your CLM sites, types of data collected and analysed, and duration of the exercise)
- How much it will cost

Many CLM programmes do not currently have dedicated budgets for MEAL, so this needs assessment process may reveal resource gaps that should be filled before you can commence the activities. Figuring out your optimal, desired approach is still beneficial – it can be shared with funders and other partners, including other CLM programmes, to mobilize additional resources to do MEAL.

Worksheet 1 (see Annex 1 for a template) is designed to capture the "big picture" information that is the foundation for your activity. The questions on this sheet are the same as those used in the preceding section. Here is an example of a filled-in worksheet:

Worksheet 1 sample: Laying the foundations for MEAL for CLM

Question 1: Where is your programme currently in its development and CLM cycle?

(Prompt: How long has your CLM programme been running and what activities are you engaged in at present?)

The programme was established two years ago. We just finished the data collection phase in (x) health facilities in (x) regions and are moving into data analysis and validation, which will take place over the next 1-2 months.

Question 2: What is your overarching goal and your plan for achieving it?

(Prompts: What is the long-term objective? Do you have a theory of change for achieving this objective that lays out the steps in the plan? Is now the time to create or revisit one?)

Our long-term objective is to improve the quality of health services for people living with and vulnerable to HIV. We aim to get there by gathering and analysing data from health facilities on key issues and working collaboratively with duty bearers to identify possible solutions. To succeed, we need a strong coalition, buy in from government and health facility partners, sustainable funding, and trust and leadership from recipients of care.

Worksheet 1 sample: Laying the foundations for MEAL for CLM

Question 3: Why are you doing MEAL right now and what do you hope to learn?

(Prompts: What aspects of your programme are you curious or concerned about or especially proud of? How would understanding these aspects help your programme?)

We are interested in securing long-term funding and building confidence in CLM from various stakeholders, including recipients of care, government and funders. We hope to learn more about where our programme is succeeding and why so that we can build a strong case for our work to different audiences. Because we are only two years into our CLM work, we want to focus on short-term outcomes, e.g., over 1-2 years, that support our ultimate goal of contributing to health service improvements.

Question 4: What is the right MEAL approach for your goals and priorities?

(Prompts: Do you have a clear sense of how participatory, process and outcome methodologies can be used to gather different types of information? Are there other MEAL approaches you have encountered or worked with or tools you have been asked to use by funders that you want to consider?)

We want to use a participatory design process so that recipients of care shape the MEAL questions asked and the ways we ask them. We are focused primarily on process evaluation because we want to understand how well we are building buy in and confidence from stakeholders (e.g., recipients of care, government, other key actors).

Question 5: What do you need for your MEAL to succeed?

(Prompts: Do you have funding and staff time available for MEAL activities? Do you have the time in your programme calendar to design and conduct your activities? Do you have the expertise you need? What are the conditions in the external context that could impact your MEAL?)

We have a budget that will allow us to develop a focused activity looking at one or two key areas of our CLM programmes. The available budget will cover time for an M&E officer, convenings, tool design and analysis. To support this MEAL activity, we have strong collaborative relationships in two of the five districts we are working in.

Part 2. Designing your MEAL activity

In Part 1 of this guide, you laid the foundation for a MEAL activity. The content in this section and Part 3 aims to help you design the activity or set of activities that are the best fit for your learning purpose and overall goals. Community-led monitoring teams already have a lot of experience with developing tools for assessing different aspects of a programme and with the selection and design of indicators. This section supports teams to be thoughtful and intentional about decisions on what to monitor and why.

2.1 Activity design worksheet

Worksheet 2 (see Annex 1 for a blank template) is designed to flow from the work done in the planning phase, which you may have captured in *Worksheet 1*. By the time you start to think through these questions, you know why you are doing MEAL right now and what you hope to learn. You've oriented yourself to where your programme is in terms of its growth and the CLM cycle. Now, it is time to get even more specific. In the sample sheet for this section, a programme that has previously decided it wants to do MEAL to support and strengthen governance and partnerships prioritizes specific aspects of this topic for further investigation. Review the questions and the sample answers – which are short, specific and focused – and then try it yourself!

Worksheet 2 sample: Designing your MEAL activity

Question 1: What do you want to prioritize for MEAL with this activity?

(Prompt: Of the aspects of your programme that are of interest, which ones will be most feasible and impactful to look at with a MEAL approach?)

We want to understand the effectiveness the approaches we are using to build buy in and support for CLM from recipients of care and local health workers. We are prioritizing this because buy in and support for CLM from recipients of care and local health workers is a key precondition for progress to intermediate outcomes in our theory of change.

Question 2: Why do you want to learn this?

(Prompts: How will you use the information from the activity? Will it inform strategy, budgeting, communications activities or other aspects of the programme?)

We have tried several different approaches, including meetings, one-on-one outreach and posters at clinics, but we don't know which ones are most or least effective. We'd like to make the best use of our resources, and having this information can help us plan and budget.

Worksheet 2 sample: Designing your MEAL activity

Question 3: What will you do with the information?

(Prompt: Does the timing of your MEAL activity align with the timing of the processes you would like to inform, such as budgeting or planning?)

We will use it to inform our next budget and planning cycle. We may also use it to make changes in our ongoing activities.

Question 4: Are there any terms you need to define in order to plan with clarity?

(Prompts: Who needs to be involved in defining these terms? Have we represented the points of view of our key constituencies?)

We need to define what "effective" means. In this case, we think an effective approach is one that increases enthusiastic participation in CLM work, and we think "enthusiasm" means people are interested, positive and engaged with questions, ideas and feedback.

Question 5: What could you measure or count to help you get the answer to your question?

(Prompts: Which types of measurable or countable information are easy to access or readily available? Are there confidentiality or ethics considerations? Which types of information will be most useful to help you answer your key questions?)

# of one-on-one outreach meetings

# of multistakeholder or coalition meetings

# of one-on-one outreach meetings that resulted in further engagement with the CLM programme (time, coalition support, personnel who might be trained as data collectors, etc.)

# of participants attending multistakeholder or coalition meetings that became engaged in CLM (time, coalition support, personnel who might be trained as data collectors, etc.)

Programme costs associated with different outreach approaches (staff time, convening costs, airtime, fuel, etc.)

# of memoranda of understanding with relevant groups (i.e., health facilities, government, coalition partners)

Worksheet 2 sample: Designing your MEAL activity

Question 6: What could you review or analyse to help you get the answer to your question?

(Prompts: Which types of documentation are easy to access or readily available? Are there confidentiality or ethics considerations? Which types of information will be most useful to help you answer your key questions?)

Meeting notes and follow-up items to see what questions, concerns or ideas were generated – and by whom

Changes in meeting participation or level of engagement with CLM programme over time

Question 7: What questions could you ask to inform your activity?

(Prompts: What do we want to learn that isn't available from existing programme information? Which questions are key to supporting our MEAL objective?)

How do the meetings and engagements feel to participants? Does it feel like a collaborative space with shared decision making? Do recipients of care feel empowered to speak and engage? Why or why not?

What is motivating our coalition partners to take on follow-up activities related to the CLM programme? What do they experience as challenges?

How do local health facility staff and officials feel about the ways that they are engaged? What is working and what can be improved?

Question 8: How will you get the answers to these questions?

(Prompts: What types of spaces and approaches will make our partners feel comfortable and safe in sharing frank information? What is feasible for our budget and schedule?)

We will use focus group discussions and one-on-one interviews. But first, we will review the meeting minutes and other records of engagement to identify groups and individuals that did or did not get involved or become partners with our programme so that we can hear a range of opinions.

2.2 Indicator design worksheets

Worksheet 3a and *3b* (see Annex 1 for template) helps you move from the detailed vision for your activity to the practical decisions about what you will measure, gather and analyse to realize this vision. Here, you begin to look at the indicators you will use in your activity.

An indicator is something that can be measured to determine progress toward an intermediate or overarching goal or objective (that may also be captured in a theory of change). An indicator can be qualitative or quantitative. There are many ways to think about what makes a "good" indicator (see Box 3).

As outlined below, MEAL indicators are different from the indicators that the CLM programme uses to assess health services! You may want to spend some time with your team reviewing these differences before you move to activity design and indicator selection.

Community-led monitoring programme indicators focus on the following aspects of **health services**:

- ✓ **Availability** - Is the service provided? Are there trained staff? Are the supplies on the shelves?
- ✓ **Accessibility** – Are there fees to receive the service? What is the wait time? Can the people who need it get it without excessive travel?
- ✓ **Acceptability** – Do people receiving the service receive the information they need to make decisions about their health care? Are they treated with respect? Are all groups who need the service treated in the same, respectful and rights-based way?
- ✓ **Quality** – Are commodities (vaccines, treatments, etc) unexpired and quality-assured? Do staff have up to date training?

CLM monitoring, evaluation, accountability and learning indicators focus on aspects of the programme that is monitoring the health services, such as:

- ✓ **Processes** – Is data collection happening smoothly, supported by memoranda of understanding with facilities? Does analysis and validation happen efficiently?
- ✓ **Partnerships** – Is the coalition of groups supporting or impacted by the CLM programme representative, inclusive and effective?
- ✓ **Impact** – How and why are the findings from CLM programmes making changes at health facility or policy level? If changes are not happening, what are contributing factors?

Table 3: Compare and contrast examples of CLM indicators and CLM MEAL Indicators

CLM programme activities	MEAL	
Question or indicator	**Question or indicator**	**Which part of MEAL does this support?**
What percentage of staff received quarterly support supervision visits to reinforce best practices in treating TB and HIV coinfection?	Percentage of CLM teams who conducted their data collection on schedule	**Monitoring:** This is an example of an aspect of programme performance that can be tracked on an ongoing basis, in real time, with action taken to address challenges as soon as they arise.
How many people who need TB treatment are receiving it when they need it?	Percentage of surveyed sites that provided information about clients served, drug stocks and other requested data	**Evaluation:** This is an example of an indicator that allows a programme to assess whether it met key targets (in this case securing necessary information from sites) after the activity has been completed. This can inform what further actions may be needed to improve performance on the indicator.
What do the members of the community think about the TB services?	Percentage of surveyed community members representative of the most-impacted groups in terms of age, gender, KP status or other demographic category	**Accountability:** This is an example of an indicator that allows a CLM programme to reflect on whether it is reaching the community it is committed to serve.
What is the turnaround time for test results?	What factors contributed to improvements in turnaround time?	**Learning:** This is an example of a question focused on understanding why CLM is working. It could be answered through interviews and/or by listing and exploring the contributions of steps taken such as accountability meetings, data presentations or other advocacy activities.

Once you feel confident in the kinds of indicators or measures used for CLM MEAL, you can move on to *Worksheet 2* (see sample on page 15).

The sample frameworks and approaches in Part 3 can help with your planning process – but remember, the best indicator will always be the one that emerges from your knowledge and priorities.

There are many ways to think about what makes an effective indicator. Here are some basic definitions of different kinds of indicators (you can find more detail in the glossary in Annex 2):

- A quantitative indicator is expressed in numerical terms, like a percentage or an absolute count. A quantitative indicator could help you determine programme efficiency (how long data analysis takes or what percentage of data are analysed within a specified time), reach and pace of growth (how many people are participating) and other measurable aspects of the programme.
- A qualitative indicator captures quality, perceptions, insights and experiences of an activity or project. A qualitative indicator can give detailed descriptive information about how your programme is performing (how involved recipients of care feel in data analysis, how strong the collaboration with health facility staff is, and so on).

Box 2: Approaches to indicator design

There are many ways to think about what makes an effective indicator. The three approaches outlined here serve different purposes, but they are not mutually exclusive categories or criteria. For example, the SMART approach considers time as a key factor in strong indicator development, whereas the SPICED approach focuses on how indicators are used, rather than how they are developed. These criteria can support you in approaching and evaluating your indicators in ways that align with your principles and practices as a CLM programme.

SMART indicators:	Specific, Achievable, Realistic and Time-bound
CREAM indicators:	Clear, Relevant, Economic, Adequate, Monitorable
SPICED indicators:	Subjective, Participatory, Interpretable and communicable, Cross-checked and compared, Empowering, Diverse and disaggregated

Worksheet 3a sample: Quantitative indicator design

To develop quantitative indicators:

We are consulting these information sources ...

MoUs with groups in our coalition

Formal invitations to join the coalition issued over the previous year

We are counting and tracking ...

Number of groups that joined the coalition

Number of groups that were invited

We are calculating ...

The percentage of invited groups that joined the coalition

We will use this information to understand ...

How our outreach efforts worked in terms of creating a robust and diverse coalition

We are calculating ...

The percentage of groups invited who joined CLM

So that we can understand ...

How effective our outreach and coalition-building approach was

And (if we measure it again) how it changes over time

Keep in mind:

In the example above, there is a numerator (the top number in a fraction) and a denominator (the bottom number in a fraction) for the indicator. In this case, it is the number of groups that joined your CLM coalition (numerator) and the number of groups invited to join (denominator). A fraction can also be expressed as a percentage. Tracking changes in percentage is an effective approach for tracking change over time.

Worksheet 3b sample: Qualitative indicator design

To develop quantitative indicators:

We are consulting these information sources ...

Meeting minutes from stakeholder engagement sessions

Survey to field staff (data collectors) to hear about positive or negative feedback on data collection days or in the community

Focus group discussions conducted for this MEAL activity

We are assessing ...

How recipients of care view the CLM programme

We are building our understanding of ...

Levels of satisfaction, ownership on the part of recipients of care, including from those who might not be interested in joining a focus group discussion

So that we can report back and take action on ...

The extent to which the programme is viewed as accountable to and engaged with recipients of care, since this is a crucial precondition for the changes we are aiming for

Keep in mind:

Qualitative information can be collected retrospectively (for example, looking at the comments left in a suggestion box and asking data collectors to share feedback) and prospectively (for example, through interviews and focus group discussions). You may get different insights from these approaches. The people who volunteer for a focus group may be more likely to support or have complaints about a programme or may be more available for in-person meetings than other people.

Part 3. Sample MEAL frameworks across the CLM cycle

In this section, you will find sample indicators and approaches for each phase of the CLM cycle. A brief description of each phase is provided so that you can see the assumptions about what is happening at this stage, which are then reflected in the table. Each programme operationalizes activities slightly differently. Reading the section, "What's happening in this phase", will show you which activities are being discussed, even if your programme has a different way of thinking about the phases. Next, each section includes a table with sample indicators and qualitative questions. The types of indicators included are:

- Impact indicators: These measure a change directly related to the overarching objectives of the programme or project.
- Output indicators: These measure direct results and products, such as meetings held, sites visited, training materials developed and people engaged.
- Outcome indicators: These measure intermediate programme-level changes or impacts, such as the representativeness or inclusivity of various stakeholders and their engagement with data and reports.

See the glossary in Annex 2 to learn more!

Phase 0: Community assessment of resources, context and implementation

What's happening in this phase

In this phase, the groups and individuals who want to do CLM take stock of their readiness and resources. Readiness can include building, setting and seating partners at the table. This phase addresses several questions. What is the coalition structure for the work? What are governance needs and approaches? Are the right people involved? It also includes finding out what issues matter most to communities so that priorities are reflected in the earliest stages of planning.

Looking at context during this phase is key. Do the health facilities or services in question have established connections to community organizations? Is CLM known and practiced in other parts of the country? Are there strong relationships or past conflicts or concerns that could impact CLM implementation, including developing memoranda of understanding (MoUs) to support activities?

Much like constructing a building, assessing CLM readiness can be likened to putting together a list of required building materials, including the quantity and quality, as well as thinking about what sort of skills and equipment will be needed for successful completion of the structure. An engineer may even have to study the construction site and assess its suitability for the type of building they are planning to build. Going into a construction project before adequately considering these important factors can have dire consequences. The project may fail to take off, the project may be faced with a myriad of challenges, or the project may be partially completed or even abandoned on the verge of completion. On the other hand, with proper planning, it could turn out to be the most beautiful building in its location! The outcome is largely dependent on how well implementers of the project are prepared for the construction. Similarly, prioritizing an in-depth assessment of CLM readiness is key to the success of your programme. Sample indicators for this phase are provided in Table 3.

Table 4: Sample indicators for MEAL in Phase 0

Sample impact indicator/goal	**Networks or groups of people living with HIV and key populations are recognized by CLM stakeholders as the principal decision makers on CLM at the local, sub-national and/or national levels** **Insights into the barriers, enablers and prospects of implementing CLM are evaluated and plans are drawn to address the barriers.** **Community capacity to implement CLM is evaluated, capacity gaps are identified, and capacity-building plans are drawn.**
Sample output indicators	# of CLM stakeholders introduced to CLM (disaggregate by type of stakeholder, for example: a) national disease programme managers and staff; b) affected community members; and c) country-level funders # of CLM stakeholders from affected communities involved in: a) establishing CLM coordinating body or committee; b) contributing to development of criteria for selection of lead CLM implementers; and (c) selection of implementers # of key documents developed to support CLM programme including work plans, cooperative agreements and MoUs between coalition members and between CLM and health services, capacity assessment reports, capacity-building plans # of health service sites and/or types of services identified as the focus for the CLM programme % of CLM programme budget secured (disaggregate by funder) # or % of CLM implementers with funding secured for more than one year # of months from introduction of CLM to government to gaining government buy in, as evidenced by approvals for CLM programme to monitor public health facilities
Sample outcome indicators	% of activities in this stage led and carried out by the CLM programme (and not by an external technical assistance [TA] provider) % or # of health service sites approached that establish partnerships with CLM implementers and cowmmit to using CLM data % of CLM governance structure and workforce representing affected communities' members # of MoUs signed between government bodies and CLM implementers # and category of capacity gaps identified and strategies set to address them
Sample qualitative monitoring questions	How were affected community members involved or engaged in CLM preparatory activities? How did they participate in these activities? How were decisions about sites, topics, implementing partners and other governance issues made? Who was included before, during and after planning with funders and in initial outreach with government and health facilities? What processes were in place for managing conflict of interest, disagreement or other issues that can challenge coalitions? What challenges or strengths of the coalition emerged during the planning process? What are the likely barriers to CLM implementation at: a) community level; b) facility level; and c) national level? What are the enablers for CLM implementation at: a) community level; b) facility level; and c) national level? What are the prospects for CLM implementation at: a) community level: b) facility level; and c) national level?
Examples of programme outputs to review or gather	Introductory materials developed to build understanding of, and buy in for, CLM Meeting agendas, minutes and participant lists from informational, preparatory and decision-making meetings CLM coordination committee terms of reference, governance structure, conflict of interest and dispute resolution procedures documented Letter of authorization for CLM implementer(s) to monitor health service sites CLM protocol developed and ethical approval obtained (if needed or desired) and/or documentation of decision making not to pursue IRB approval CLM programme operational plan finalized; activities, including advocacy, are costed Contract(s) for CLM implementer(s) MoUs with health facilities and local government structures Capacity assessment report(s)

Phase I: Identifying service-related needs and deficits

What's happening in this phase

In this phase, communities affected by the health issues and services that will be monitored are engaged to discuss priority issues, needs and deficits, which are collectively referred to as indicators. As in the preparatory Phase 0, many activities will involve meeting and making decisions with affected communities. It is crucial to ensure that all stakeholders understand what CLM aims to do and the kinds of issues it can address. MEAL for this stage may focus on how decisions are made, who is engaged, how they are prepared, and how different types of expertise and different points of view are weighed and reflected in outcomes. Activities might include:

- Identifying existing affected community platforms/structures and mechanisms to support gathering feedback on service needs
- Preparing, organizing and carrying out community consultations to identify and agree on issues and indicators to monitor
- Strengthening M&E knowledge and skills among affected community members
- Developing and validating a set of issues and indicators that will be used by the CLM programme

Table 5: Sample indicators for MEAL in Phase I

Sample impact indicator/goal	**CLM programmes that are relevant to and valued by affected communities and are aligned with community needs** **CLM implementers are recognized and respected partners to government and other stakeholders to support data generation of quality of services and respect for rights in the country**
Sample output indicators	# of consultations organized with community-led organizations and/or affected community members to identify and agree on issues to monitor # of affected community members participating in workshops to build understanding and skills in M&E for indicator selection # of existing community platforms identified for gathering feedback on service needs
Sample outcome indicators	% of activities in this stage led and carried out by the CLM programme implementers (not by an external TA provider) # or % of consultations to identify and agree on issues and indicators to monitor led by affected communities % of trained affected community members applying M&E skills to CLM or other monitoring activities, including non-HIV (disaggregate by type of affected community and type of M&E skill)
Sample qualitative monitoring questions	What was the process to identify and select issues along with indicators? What kind of decision-making process was used (consensus-based or majority, for example)? Did the participants engaged in decision making have similar levels of familiarity with CLM or with monitoring approaches? What kinds of expertise were valued or foregrounded in the decision-making process (for example, lived experience with health services in a given facility)? How were topics determined for the meetings/trainings How were community participants selected for the M&E trainings? What measures were put in place to ensure that there was inclusion and representation of affected groups, including key populations in meetings and trainings?
Examples of programme outputs to review or gather	Outreach materials Meeting agendas, minutes and participant lists Documentation of decision-making processes Decision-making criteria List of issues and indicators proposed by and agreed to by communities Training manual and tools for communities, focused on basic M&E for CLM

Phase II: Collecting information at the facility and community levels

What's happening in this phase

Phase II of CLM is focused on gathering information at facility and community levels. A lot of the data collected in this phase may be used in documentation, which can also be reviewed for the MEAL process, including numbers of people interviewed, numbers of focus groups and quantitative data. MEAL at this stage can explore the processes that supported this work, including the tools used and approaches taken to selecting and training data collectors. MEAL in this phase can also collect information on how communities, health workers and other stakeholders asked to provide or share data felt about the process. This includes whether people who were interviewed felt prepared to provide feedback and share their experiences honestly and without feeling prejudiced. It can also look at the experiences of data collectors in terms of training, implementation, remuneration and other topics related to strengthening workforce development. Activities at this stage might include:

- Developing, adapting and/or revising data collection tools (paper or digital/app)
- Piloting data collection tools
- Identifying, recruiting and training community data collectors
- Introducing CLM to health service site directors
- Conducting CLM awareness-raising sessions with health service site staff
- Conducting data collection (for example, through observations, interviews, and/or focus group discussions)

Table 6: Sample indicators for MEAL in Phase II

Sample impact indicator/goal	**Robust, feasible, representative and ethical data collection efforts that support the CLM programme's ability to improve health services in partnership with communities and health service duty bearers**
Sample output indicators	# of data collectors for CLM programme # of affected community data collectors trained in M&E and data collection processes # of health service site observations conducted (disaggregate by health service site) # of completed data collection forms, questionnaires and reports submitted on time # of health service sites that were introduced to the CLM programme # of interviews held. Disaggregate by type of informant: a) health service site staff; or b) affected community member user of services # of FGDs held
Sample outcome indicators	# of individuals completing data collection training and/or data collection activities who report increased health literacy, skills or other strengthened capacity (could be gathered by pre- and post-action surveys and disaggregated by gender, age, key population, HIV status if relevant or desired) # of health service staff who report sustained or increased understanding of CLM purpose and process after site visits (could be gathered by survey and disaggregated by site and service type if relevant or desired) # or % of sites at which data collection teams report collaborative discussions with staff that lead to unintended or unanticipated shifts (for example, changes in signage, seating arrangements, client flow that may be made after a conversation or exchange between data collectors and staff, even before formal engagement takes place) # of % of data collection activities that uphold ethical principles and processes, such as confidentiality and consent (could be gathered by random sampling and review)
Sample qualitative monitoring questions	Do data collectors feel supported with training, tools, logistics support, etc.? What can be done better? What is working well? What was data collectors' experience of conducting health service site observations and using tools? And how can this experience be used to modify approaches if needed? What are challenges or successes of site observations? Did the data collection phase start and end as scheduled? If yes, what supported this? If no, why not? How did the health service site react to introduction of the CLM programme? How were informants selected for interviews at facility and community levels?
Examples of programme outputs to review or gather	Data collection plan, with details on: assignment of data collectors to sites; timing of data collection and submission of forms; flow chart for supervision and management; and collection methods to be used Final data collection tools (paper or digital/app) Piloted versions of data collection tools Database of trained data collectors Modules developed for CLM awareness-raising sessions CLM awareness-raising sessions conducted with health service site staff Health service site directors introduced to CLM CLM data collected (observations, interviews, FGDs, other)

Phase III: Analysing and interpreting information to suggest solutions and action points

What's happening in this phase

Phase III is after CLM data are collected and stakeholders gather to review, analyse and interpret the findings. This phase usually involves engagement with different parts of the CLM team, including data collectors and programme leadership, as well as members of the CLM coalition, community members, health facility staff and local or national health officials. The analysis can look for trends and expected or unexpected changes. Review and discussion of observed changes might lead to insights and explanations that were not documented as part of data collection, such as a new policy or a weather event that affected services during the time period in question. Key activities include:

- Implementation of a data analysis process (data cleaning, anonymizing and validating)
- Clarification of roles and responsibilities for affected community members involved in data analysis
- Training for, and support to, community members to conduct data analysis
- Execution of data analysis
- Preparation of data analysis reports
- Triangulating CLM data with data from other sources, including PEPFAR, the Global Fund, government health records like the health management information systems (HMIS), and facility reports

Case study: CLM MEAL in action

During a pilot project using this guidebook, one CLM organization decided to assess the knowledge levels about CLM among groups of community health monitors and adolescent girls and young women involved in the programme. From the data collected, the organization learned that, in one district, 8 out of 10 community health monitors interviewed defined CLM as demand generation and understood their main responsibility to be community education and referrals. Assessing knowledge of CLM goals and purposes among communities helped the organization identify a gap that the programme could fill with training, meetings and continued support. Asking communities involved in CLM whether they understand its purpose is an example of assessing accountability. The organization found out that it needed to adapt in order to strengthen partnerships with groups impacted by health services.

Table 7: Sample indicator for MEAL in Phase III

Sample impact indicator/goal	**Analysis and validation of CLM data that is efficient, inclusive and effective at generating reports that support health literacy in the community, advocacy and action** **Triangulation of CLM data with data from other existing sources, including PEPFAR, the Global Fund, government HMIS and health facility reports**
Sample output indicators	# of affected community members participating in training on data analysis skills and processes % of individuals involved in data analysis who represent affected communities and % representing TA providers # of data reports prepared on time per pre-specified schedule Documentation of steps taken to secure, anonymize and clean data, including standard operating procedures and/or reports from each data analysis cycle Time elapsed between completion of data collection and generation of reports # of affected community data collectors trained in M&E and data collection processes # of other data sources with which CLM data has been compared and validated
Sample outcome indicators	% of activities in this stage led and carried out by the CLM programme (not by an external TA provider) % of trained affected community members applying data analysis and management skills to CLM or other monitoring activities, including non-HIV (disaggregate by type of affected community, type of data analysis and management skill)
Sample qualitative monitoring questions	How is the process of data analysis and validation contributing to relationships with coalition members and affected communities? How does the process feel to those involved in it? Is it rushed, slow, labour intensive, frustrating or exciting? How was CLM data validated for accuracy?
Examples of programme outputs to review or gather	Data analysis process plan Data analysis report template Database of community members participating in analysis Documentation of and infrastructure for secure data storage – physical (for example, locked filing cabinets), digital (secure cloud-based storage) or both

Phase IV: Disseminating information and developing advocacy strategies

What's happening in this phase

In Phase IV, CLM programmes share their findings from data reports with various stakeholders and use these engagements to identify issues and potential solutions. Key steps include:

- Mapping stakeholder groups and forums for sharing data analysis reports
- Convening affected community members to review data reports and prioritize issues to bring forward to duty bearers
- Preparing presentations and reports
- Developing or updating the programme's dissemination and advocacy plan
- Identifying case stories that align with key findings

Case study: CLM MEAL in action

When a CLM implementing organization piloted this guidebook, it held a two-day long workshop during which participants worked in small groups to develop indicators for Phase IV and V. After comparing results, the organization decided to adapt the indicator table above to include additional relevant information, including the organization or stakeholder group responsible for collecting data, and the information sources to be used. The tailored template helped the CLM partners capture core elements of their MEAL activity plan for easy reference and tracking.

Table 8: Sample indicators for MEAL in Phase IV

Sample impact indicator/goal	**CLM data reports and analysis on issues of relevance to affected communities are routinely requested, viewed as valuable and valid, and used to inform management of the health system at every level**
Sample output indicators	# or % of affected community members participating in meetings to prioritize and decide issues to share with decision makers based on CLM data # of findings reports produced (compared with original CLM programme plan) # or % of committees and/or platforms' data that are shared. These include: (a) health service decision makers; (b) affected communities; and (c) potential or current allies, such as coalition members working in related fields, political candidates and funders # of community-prioritized issues presented to duty bearers with the ability to make changes to address or contribute to the issue (that is, does the committee or working group that received the update have the power to make a change?) # of case stories identified and presented to duty bearers in alignment with issues prioritized
Sample outcome indicators	% of activities in this stage led and carried out by the CLM programme (not by an external TA provider) # of requests for CLM data presentations or reports at government, civil society or multistakeholder committees, working groups and/or platforms # of CLM reports regularly requested by other sectors (that is, non-health ministries and sub-national entities)
Sample qualitative monitoring questions	How is the engagement planning and preparation process contributing to relationships with coalition members and affected communities? What CLM data has been of most interest in these committees? How has the relationship changed between affected community members and members of these committees because of regular engagement? Does the process of information dissemination change over time? That is, do routine engagements with specific stakeholders emerge? Are the groups that were involved in Phase I also involved in this phase? What's changed and why?
Examples of programme outputs to review or gather	Public presentations and briefs Public and/or stakeholder-specific report templates Meeting agendas, minutes and attendance lists

Phase V: Advocate for solutions

What's happening in this phase

During Phase V, CLM implementers collaborate with and advocate to duty bearers and decision makers, using CLM data as the basis for discussions. These meetings may happen at health facility, sub-national and national government levels, and may also involve donors. Activities may include:

- Meetings to share CLM data with duty bearers and decision makers
- Convening and collaborating with advocacy organizations to amplify key messages
- Developing action agendas and documenting commitments based on meetings
- Updating of online resources for CLM data, including dashboards, and dissemination of advocacy messages through digital channels (websites, social media and chat groups)

Table 9: Sample indicators for MEAL in Phase V

Sample impact indicator/goal	**Increased community engagement in national health and/or disease-specific decision making and programme reviews, Global Fund Country Coordinating Mechanism decision making, PEPFAR Country/Regional Operational Plan processes, joint external monitoring missions** **Improved collaboration with key decision makers and increased buy in of the CLM model**
Sample output indicators	# of attempts made to have meetings with duty bearers and other decision makers # of actual meetings held with duty bearers and other decision makers # or % of community members participating in meetings to advocate for change # of advocacy messages drafted and informed by evidence-based solutions suggested earlier # of materials developed for advocacy (such as PowerPoint presentations, fact sheets, reports and policy briefs) # of platforms used for advocacy # of follow-up activities conducted to ensure that commitments are honoured # of community-based organizations, civil society organizations and non-governmental organizations involved in collaborating for strong and impactful advocacy
Sample outcome indicators	% of activities in this stage led and carried out by the CLM programme (not by an external TA provider) % increase in uptake of HIV services at CLM sites (disaggregate by site, type of service, age, gender and type of key and vulnerable population group) # of policies and/or protocols improved because of using CLM data (disaggregate by geographic region and type of policy or protocol) # of documented improvements in the AAAQ of services at CLM sites, including improved behaviour by health services and staff behaviour towards people living with HIV and key and vulnerable populations (disaggregate by geographic region, site and AAAQ type of service) % of stakeholders accessing the CLM online dashboards. Disaggregate by: (a) CLM dashboard if there is more than one (for example, one per CLM implementer); and (b) type of stakeholder (for example, health service providers, government and affected communities)
Sample qualitative monitoring questions	How receptive and willing were duty bearers and other decision makers to engaging CLM implementers and the community? Were relevant and appropriate duty bearers and other decision makers participating in discussions? To what extent are duty bearers engaged throughout the project cycle? To what extent were the advocacy messages relevant and community-owned?
Examples of programme outputs to review or gather	PowerPoint presentations Policy briefs Fact sheets Reports (facility, district, regional, provincial) Meeting agendas Meeting registration forms

Phase VI: Monitor implementation

What's happening in this phase

During this phase, CLM implementers are doing three things: a) consistently monitoring and following up commitments made by duty bearers and other decision makers; b) identifying trends and impact made as a result of the CLM project; and c) evaluating project performance to ensure that implementation is still on track and that the project remains impactful. This process involves reviewing and revising data collection tools to ensure their relevance and effectiveness in capturing the actual community needs and priorities. It also involves drafting, reviewing and revising advocacy strategies and plans to ensure appropriateness, relevance and alignment with the project goals.

Once advocacy initiatives have been conducted and commitments are made by duty bearers and other decision makers, CLM implementers provide feedback to the community on what transpired during the advocacy efforts, the outcomes of these engagements, and whether data collected was effectively utilized.

Table 10: Sample indicators for MEAL in Phase VI

Sample impact indicator/goal	**Improved health outcomes because of duty bearers following through on the commitments they made as a result of advocacy and engagement** **Progress towards 95-95-95 targets** **Lower rate of new HIV acquisitions** **Reduction in HIV-related deaths** **Improved health status of people living with HIV and key and vulnerable populations (also for non-HIV-related health issues)** **Affected communities know their health rights**
Sample output indicators	% increase in number of essential health services and supplies % reduction in reported gaps at facility and community levels % increase in number of community members reporting satisfaction after project implementation % of commitments made by duty bearers and that have been fully or partially addressed # of monitoring visits conducted during the project cycle # of meetings convened to plan for and execute monitoring events
Sample outcome indicators	% of activities in this stage led and carried out by the CLM programme (not by an external TA provider) % increase in uptake of HIV services at CLM sites (disaggregate by site, type of service, age, gender and type of key and vulnerable population group) # of policies and/or protocols improved as a result of using CLM data (disaggregate by geographic region and type of policy or protocol) # of documented improvements in the AAAQ of services at CLM sites, including improved behaviours by health services and staff behaviour towards people living with HIV, key and vulnerable populations (disaggregate by geographic region, site and AAAQ type of service) % of stakeholders accessing the CLM online dashboards. Disaggregate by: (a) CLM dashboard if there is more than one (for example, one per CLM implementer); and (b) type of stakeholder (such as health service providers, government and affected community)
Sample qualitative monitoring questions	How have different CLM stakeholders responded to the changes the CLM programme has achieved? How easy or difficult is it to monitor change? Are you satisfied with the progress the CLM programme is making to achieve change? How has the CLM programme been able to track who is accessing the CLM dashboard? For what purpose are various people accessing the dashboard? What has the feedback been from those accessing the CLM dashboard?
Examples of programme outputs to review or gather	Health services monitoring tools Gap analysis tools Client satisfaction survey tools Advocacy strategies and plans Monitoring reports Evaluation reports Meeting reports

Conclusion

CLM programmes have experience with collaborative development of learning objectives, data collection and analysis approaches. This is core to what these programmes do each day. This skill set is highly relevant to the development and conduct of MEAL for CLM programmes. The expertise to use monitoring to learn and effect change is already a part of these programmes. This guidebook is a starting point for CLM implementers and their supporters who want to strengthen and sustain this crucial accountability mechanism. It is a tool to be adapted, iterated and evolved for different contexts and conditions. A MEAL activity is most effective when it meets the needs of the programme team that has developed it and has sufficient resources for execution and completion. Currently, funding for MEAL is not uniformly included in CLM grants. By using this guidebook or other resources to test MEAL as a tool for increasing impact and understanding of CLM, CLM implementers can develop a sense of what their MEAL needs are and what is needed to support them.

Worksheet 1: Laying the foundations for MEAL for CLM

Question 1: Where is your programme currently in its development and CLM cycle?

(Prompt: How long has your CLM programme been running and what activities are you engaged in at present?)

Question 2: What is your overarching goal and your plan for achieving it?

(Prompts: What is the long-term objective? Do you have a theory of change for achieving this objective that lays out the steps in the plan? Is now the time to create or revisit one?)

Question 3: Why are you doing MEAL right now and what do you hope to learn?

(Prompts: What aspects of your programme are you curious or concerned about or especially proud of? How would understanding these aspects help your programme?)

Question 4: What is the right MEAL approach for your goals and priorities?

(Prompts: Do you have a clear sense of how participatory, process and outcome methodologies can be used to gather different types of information? Are there other MEAL approaches you have encountered or worked with or tools you have been asked to use by funders that you want to consider?)

Question 5: What do you need for your MEAL to succeed?

(Prompts: Do you have funding and staff time available for MEAL activities? Do you have the time in your programme calendar to design and conduct your activities? Do you have the expertise you need? What are the conditions in the external context that could impact your MEAL?)

Worksheet 2: Designing your MEAL activity

Question 1: What do you want to prioritize for MEAL with this activity?

(Prompt: Of the aspects of your programme that are of interest, which ones will be most feasible and impactful to look at with a MEAL approach?)

Question 2: Why do you want to learn this?

(Prompts: How will you use the information from the activity? Will it inform strategy, budgeting, communications activities or other aspects of the programme?)

Question 3: What will you do with the information?

(Prompt: Does the timing of your MEAL activity align with the timing of the processes you would like to inform, such as budgeting or planning?)

Question 4: Are there any terms you need to define to plan with clarity?

(Prompts: Who needs to be involved in defining these terms? Have we represented the points of view of our key constituencies?)

Worksheet 2: Designing your MEAL activity

Question 5: What could you measure or count to help you get the answer to your question?

(Prompts: Which types of measurable or countable information are easy to access or readily available? Are there confidentiality or ethics considerations? Which types of information will be most useful to help you answer your key questions?)

Question 6: What could you review or analyse to help you get the answer to your question?

(Prompts: Which types of documentation are easy to access or readily available? Are there confidentiality or ethics considerations? Which types of information will be most useful to help you answer your key questions?)

Question 7: What questions could you ask to inform your activity?

(Prompts: What do we want to learn that isn't available from existing programme information? Which questions are key to supporting our MEAL objective?)

Question 8: How will you get the answers to these questions?

(Prompts: What types of spaces and approaches will make our partners feel comfortable and safe in sharing frank information? What is feasible for our budget and schedule?)

Worksheet 3a: Quantitative indicator design

To develop quantitative indicators:

We are consulting these information sources ...

We are counting and tracking ...

We are calculating ...

We will use this information to understand ...

We are calculating ...

So that we can understand ...

Worksheet 3b: Qualitative indicator design

To develop qualitative indicators:

We are consulting these information sources ...

We are assessing ...

We are building our understanding of ...

So that we can report back and take action on ...

Annex 2: **Glossary**

AAAQ framework: The Availability, Accessibility, Acceptability and Quality framework, which was developed by the World Health Organization, considers access to healthcare from a human rights perspective. According to this framework, there must be adequate and efficient health services (Availability) that are physically accessible and affordable to all without discrimination (Accessibility). Similarly, health services must be ethically and culturally appropriate for people from different backgrounds (Acceptability). Furthermore, health services must be scientifically sound and of high quality (Quality).

Indicator: An indicator is used to show the presence or state of a situation or condition. In the context of monitoring and evaluation, an indicator is a quantitative or qualitative metric that provides information to monitor performance, measure achievement and determine accountability. Indicators can also be used to provide data on the quality of an activity, project or programme.

> **Quantitative indicator:** This metric provides information to monitor performance, measure achievement and determine accountability. It can be used to provide data on the quality of an activity, project or programme – expressed as either numbers (#) or percentages (%). Number indicators are used to determine the baseline of activities and/or set targets; show progress or changes over time or for programme reporting of processes and outputs. Percentage indicators are used to indicate status at a point in time, monitor progress or changes over time, and require data sources for the numerator[3] and denominator[4]. For example, % of health service sites selected for the CLM programme is calculated by taking the # of health service sites selected divided by the # of health service sites (in the district, region, state or country, or that provide HIV services).
>
> **Qualitative indicator:** This metric provides information to monitor performance, measure achievement and determine accountability through non-numerical data. These indicators capture the quality, experiences, perceptions and insights of an activity, project or programme – expressed either as descriptive or narrative information. Qualitative indicators often involve methods such as interviews, focus groups and open-ended survey questions to gather detailed and descriptive information about, for example, the level of satisfaction of participants with a health service, the perceived impact of a programme on community well-being, and the challenges faced by stakeholders in implementing a project.

Output: An output is the immediate result of programme activities. This term relates to the direct products or deliverables of programme activities, such as the number of counselling sessions completed, the number of people reached, and the number of materials distributed. Higher numbers do not necessarily mean better results; they should be compared with established targets to assess effectiveness.

Outcome: Outcomes are the intermediate changes that result from a programme's impact on target audiences or populations, such as changes in knowledge, attitudes, beliefs, skills, behaviours, access to services, policies and environmental conditions.

Impact: Impacts are the longer-range, cumulative effects of programmes over time on what they ultimately aim to change. Often, this effect will be a population-level health outcome, such as a change in HIV acquisition rates, morbidity and mortality. Impacts are rarely, if ever, attributable to a single programme, but a programme may, with other programmes, contribute to impacts on a population. Assessing the impact of a CLM programme to improve health results as detailed in the national health programme, specifically the M&E framework, would likely be carried out in a separate evaluation.

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[3] The top number of a common fraction, which indicates the number of parts from the whole that are included in the calculation.

[4] The bottom number of a common fraction, which indicates the number of parts in the whole.

Annex 3: **Additional resources**

There are many available resources on developing theories of change and monitoring and evaluation frameworks. This brief list includes documents that informed the development of this guidebook and where additional information about various topics, as indicated, can be found.

LEAP for Community-Led Monitoring in TB

(APCASO Foundation)

Includes templates for different theories of change, participatory exercises for developing MEAL activities and detailed explanations of different MEAL approaches, such as process and outcome evaluation.

https://apcaso.org/clm-playbook/

The Community Builder's Approach to Theory of Change

(The Aspen Institute)

Includes simple, accessible and advocacy-oriented explanations of the "what" and "why" of theories of change.

https://www.theoryofchange.org/pdf/TOC_fac_guide.pdf

Monitoring and Evaluating Advocacy

(UNICEF)

Includes detailed frameworks for identifying learning purposes and approaches.

https://www.betterevaluation.org/sites/default/files/Advocacy_Toolkit_Companion_%25281%2529.pdf

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How to Design a Monitoring and Evaluation Framework for a Policy Research Project

(The Method Lab)

Includes detailed explanation of the importance of moving from a theory of change through learning purposes – before arriving at indicator selection and activity design.

https://media.odi.org/documents/10259.pdf