COPE HIV
Communities Operationalizing People-centered HIV response

Experiences from the Pilot Implementation of the Philippines' HIV Community-Led Monitoring System

Insights and Opportunities for Community-Led Organizations and Key Stakeholders

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Table of Contents

Acknowledgments

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Executive Summary

The pilot implementation of the HIV community-led monitoring system (CLMS) in the Philippines was conducted from March to December 2023 where 11 facilities participated, eight (8) of which are government-owned clinics under the Quezon City Health Department, and three (3) are community centers under The LoveYourself, Inc. (TLY). During this phase, community-led organizations (CLOs) were also capacitated on the CLM process and two CLOs, HIV & AIDS Support House (HASH) and Team Dugong Bughaw (TDB), were able to fully implement the CLM system in their respective areas.

This study examines the experiences of PLHIV and KP communities and facilities during the pilot period, focusing on facilitating factors, challenges faced, and outcomes. Additionally, the study analyzes relevant policies and enabling factors supporting community and duty-bearer partnerships in the context of community engagement and community-led monitoring.

Data collection involved reviewing existing documents on the CLM implementation process, relevant HIV frameworks, policies and enabling mechanisms, and conducting key informant interviews and focus group discussions with the facilities and CLOs. Three types of case study designs were applied: 1) descriptive case study for detailing the experiences of the facilities and CLOs; 2) comparative case study for identifying the similarities and differences of their experiences; and 3) triangulation case study for analyzing and understanding the facilitating factors that surfaced from the multiple data sources.

Based on the results, the CLM pilot implementation yielded impactful outcomes for both the facilities and the CLOs such as addressing ARV stockouts, streamlining facilities' processes to reduce waiting times, engaging in dialogue with higher authorities to advocate for adequate infrastructure, developing a referral system to address unavailable services, and increasing awareness among clinic staff about client management standards, which has led to the delivery of better quality service.

The facilities and the CLOs also shared similar challenges during the CLM implementation, including a lack of human resources to collect data, a lack of gadgets or internet connectivity for some clients to access the CLM platform, and the tool needing to be shorter and clearer for some clients. CLOs are particularly impacted by the lack of resources, which poses a major concern given that CLMS is considered a community responsibility.

The effectiveness of CLMS implementation is essential, but support for it often diminishes after the development phase. To address the community's challenges in resources to sustain CLMS work, the community has opportunities to explore strengthening its partnerships or engagements through the Philippine National AIDS Council (PNAC)'s AIDS Medium Term Plan 7 (AMTP7), Local Government Units (LGUs) and Centers for Health Development's Program Implementation Review (PIR), quality improvement processes, and monitoring systems. These partnerships may not necessarily immediately address issues of lack of resources, but CLMS's adequate proof of concept may be a gateway.

In addition to the aforementioned, the Global Fund invests in CLM initiatives under its Resilient and Sustainable Systems for Health (RSSH) and through the RSSH components of disease-specific grants focusing on HIV, tuberculosis, or malaria. The communities must engage their Country Coordinating Mechanism (CCM), the concerned Principal Recipient (PR), and the Sub-Recipients (SRs) to understand their processes and ensure access to these resources.

The key stakeholders must understand that quality HIV programmes can only be achieved if community data is included in communities' and programme implementers' monitoring and quality improvement processes while maintaining the community's ownership of the system. Programme implementers, policymakers, governments, and response donors need to view CLM as a long-term investment in the quality of their health systems and adjust their cost-benefit models accordingly.

Given this conclusion, below are this case study's key recommendations:

1. For communities of PLHIV and KPs to mainstream CLMS data use at local, regional, and national levels, they should leverage the CLMS's inclusion in

AMTP7 and advocate within PNAC, encouraging the DILG to influence LGUs and the DOH to influence CHDs to incorporate CLMS process into their monitoring and quality improvement processes. Invest in social preparation by empowering community members and decision-makers about the importance of CLMS in shaping and improving HIV and AIDS response, emphasizing its role in identifying and addressing service-related issues.

Communities should also develop or strengthen their data appreciation, utilization, and solution recommendation skills, and build strong relationships with programme implementers through effective communication and coordination. Additionally, they should understand how to access Global Fund investments for CLM initiatives and engage with the PCCM. Given the limited resources for CLOs, adopt creative solutions like promoting CLMS feedback forms among community members to ensure continuous documentation and availability of feedback to decision-makers until more resources become available.

2. For key stakeholders and/or decision-makers to achieve its 95-95-95 targets strategically, their efforts should include fostering meaningful community engagement with PLHIV and key population communities by recognizing the significance of CLMS data in advancing national HIV programmes and assessing the preparedness, capacity, and resource needs for its effective utilization.

   They should collaborate with community-led organizations to develop strategies that bridge existing service-related and resource gaps, including ensuring the implementation and sustainability of CLM initiatives. In addition, the CLMS process and data should be embedded into the monitoring systems and quality improvement processes of facilities, service providers, CHDs, and LGUs and institutionalized by establishing policies that mandate the inclusion of community data in existing surveillance systems for the HIV response.

3. The existing HIV response donors in the country should equally prioritize supporting CLOs' implementation of the CLMS, ensuring continuous

support, and partnering with them in sustaining the system as part of their broader investment plans. Additionally, international or local corporations and foundations interested in public health, community mobilization, and accountability strengthening should support CLM initiatives to maximize the impact of their investments in health systems.

The CLM system proved that meaningful engagement can be achieved through the community's aspirations to drive HIV programmes to quality improvement and the enabling environment of their partner duty-bearers. By upholding community leadership and incorporating CLMS data into monitoring and quality improvement processes at all levels, it can be ensured that healthcare services meet the community's evolving needs and drive systemic improvements in the HIV and AIDS response.

List of Acronyms

AAAQ	Availability, Accessibility, Acceptability, and Quality
AIDS	Acquired Immunodeficiency Syndrome
AMTP7	7th AIDS Medium Term Plan
ARV	Antiretroviral
CBO	Community-Based Organization
CLM	Community-Led Monitoring
CLMS	Community-Led Monitoring System
CLO	Community-Led Organization
CQI	Continuous Quality Improvement
HIV	Human Immunodeficiency Virus
IEC	Informational, Educational, and Communication
KII	Key Informant Interview
KP	Key Population
LGU	Local Government Unit
M&E	Monitoring and Evaluation
NGO	Non-Government Organization
PEP	Post-Exposure Prophylaxis
PIR	Program Implementation Review
PLHIV	People Living with HIV

PQIP	Program Quality Improvement Process
PrEP	Pre-Exposure Prophylaxis
STI	Sexually transmitted infection
TB	Tuberculosis
VHSD	Violence, harassment, stigma and discrimination

Institutions and Organizations

ACHIEVE	Action for Health Initiatives Inc.
CDC	Centers for Disease Control and Prevention
CESU	City Epidemiology and Surveillance Unit
CHD	Center for Health Development
COPE	Community Operationalizing People-Centered HIV Response
DFAT	Department of Foreign Affairs and Trade of Australia
DOH	Department of Health
HASH	HIV & AIDS Support House
ITPC	International Treatment Preparedness Coalition
PCSAC	Pasay City STI, HIV and AIDS Council
PNAC	Philippine National AIDS Council
QCSAC	Quezon City STI, HIV and AIDS Council
RESU	Regional Epidemiology and Surveillance Unit
SDN	Service Delivery Network

TDB	Team Dugong Bughaw
TLF SHARE	TLF Sexuality Health and Rights Educators Collective, Inc.
TLY	The LoveYourself, Inc.
UNAIDS	Joint United Nations Programme on HIV/AIDS

Definition of Terms

Community-Based Organization	External entities or larger organizations often initiate community-based organizations to operate within a specific community and are established to provide services or support to that community. While they may involve community members in their activities, they are only sometimes led or governed by the community.
Community-Led Monitoring	An approach used by communities to take charge of routinely collecting quantitative and qualitative data or feedback on issues that matter to them, including but not limited to health services.
Community-Led Organization	Community-led organizations, groups, and networks, whether formally or informally organized, are entities in which the majority of governance, leadership, staff, spokespeople, membership, and volunteers, reflect and represent the experiences, perspectives, and voices of their constituencies, who have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups, and networks are self-determining and autonomous, and not influenced by government, commercial, or donor agendas.
Focus Group Discussion	A research method where selected participants

	contribute to open discussions for research.
HIV Community-Led Monitoring System (CLMS)	An accountability mechanism for HIV responses at different levels that is led and implemented by local community-led organizations of people living with HIV, networks of key populations, other affected groups, or other community entities. It uses a structured platform and rigorously trained peer monitors to systematically and routinely collect and analyze qualitative and quantitative data on HIV service delivery, HIV-relevant policies and investments, and incidents of violence, harassment, stigma, and discrimination.
Key Informant Interview	Qualitative in-depth interviews with people who know what is going on in the community.
Key Population	Men who have sex with men, prostituted persons, sex workers and their clients, transgender women, people who use or inject drugs and people in closed settings that are among the most likely to be exposed to HIV.
People Living with HIV	A person lives with HIV once infected with the virus, or progresses to having an AIDS diagnosis.
Redress Mechanism	Institutions, instruments, methods, and processes by which a resolution to a grievance is sought and provided.
Social Preparation	Refers to readying communities, organizations, and individuals to implement programs, projects, or initiatives. It involves various activities aimed at building awareness, fostering understanding, and ensuring active participation and collaboration among stakeholders.

Stigma and Discrimination	Refers to beliefs and/or attitudes that discredits an individual in the eyes of others. When stigma is acted upon, the result is discrimination, which refers to any form of arbitrary distinction, exclusion or restriction affecting a person, usually (but not only) because of an inherent personal characteristic or perceived membership of a particular group. It is a human rights violation. In the case of HIV, this can be a person's confirmed or suspected HIV-positive status, irrespective of whether or not there is any justification for these measures.

Introduction and Background

The conventional method for evaluating the efficacy of local or national HIV responses has involved program evaluations primarily conducted by managers to assess service quality and delivery. However, these evaluations often overlook the experiences of communities and key populations, who are the primary recipients of these interventions. This gap in understanding led to the recognition that the affected community's empowerment and engagement, through the production of community data, holds unique value in the HIV response *(1, 2, 3).*

Community empowerment and mobilization are increasingly acknowledged as essential strategies in fostering community-led HIV responses. A key aspect of this is social cohesion, which serves as a result and as a facilitator of effective community-led HIV response networks. This cohesion can potentially catalyze success by enabling marginalized or criminalized groups to consolidate influence and enact change locally *(4, 5).*

HIV community-led monitoring (CLM) is a community-led response focused on demanding accountability for HIV responses across various levels. It is led and implemented by local community-led organizations of people living with HIV (PLHIV), networks of key populations (KPs), other affected groups, or other community entities *(6).*

The HIV CLM system in the Philippines is a participatory, consultative, community-driven, and collaborative initiative that began development in 2022. The system is designed to be comprehensive and tailored to the specific data needs of PLHIV and KPs, aiming to empower and systematically involve them in the country's HIV response. Its monitoring processes include the collection, analysis, dissemination, and utilization of strategic information that is instrumental in advocating to improve the quality and scale of HIV service delivery, responsive HIV policies, equitable HIV financing and investments, and the eradication or reduction of violence, harassment, stigma & discrimination experienced by the PLHIV community, the key and affected, and vulnerable population. Notably, the data generated by the CLMS fills crucial gaps not typically covered by public health information systems, thereby enhancing HIV-related program data *(7).*

Following the roadmap and the CLMS development's initial completion in the first quarter of 2023, a pilot testing phase was implemented from March to December 2023. This phase aimed to evaluate the effectiveness of the system's processes and monitoring stages. Key activities during the pilot included a) conducting social preparations with the PLHIV, KP communities, and stakeholders, especially the eleven (11) pilot facilities; b) collecting data from clients of the 11 pilot facilities and processing and analyzing the same; c) utilizing the processed data to advocate and/or co-create solutions with stakeholders to address identified critical gaps during the pilot period; and d) documenting learnings from the pilot implementation and utilizing these learnings for the system's enhancements in preparation for its full roll-out in 2024 *(8).*

TLF SHARE Collective, Inc. (TLF SHARE), the lead organization in the CLM system's development and pilot testing, conducted different orientations, training, meetings, and planning with networks of PLHIV and KP-led organizations, including its pilot partner HIV & AIDS Support House Inc. (HASH) and the 11 pilot facilities to ensure that the entities involved in the pilot phase understood the essence of CLMS and the expectations relative to the pilot testing *(9).*

The CLM system operates through a cyclical process encompassing data collection, analyses, dissemination or communication, data utilization for advocacy and/or co-creation of solutions, and monitoring impacts or positive change effected by the CLM work. Central to this process is establishing feedback loops with stakeholders, enabling targeted solutions to identified issues, and fostering continuous improvement *(10).*

The pilot testing was strategically executed in eight (8) key facilities in Quezon City, with the active participation of the Bernardo Social Hygiene Clinic, Batasan Social Hygiene Clinic, AJ Maximo Social Hygiene Clinic, Project 7 Social Hygiene Clinic, Klinika Batasan, Klinika Bernardo, Klinika Project 7, and Klinika Novaliches. Quezon City, a local government unit supported by the Community Operationalizing People-Centered HIV Response (COPE), was a significant partner in this endeavor. COPE, a collaborative effort of Action for Health Initiatives, Inc. (ACHIEVE) in partnership with UNAIDS and funded by the Department of Foreign Affairs and Trade of Australia (DFAT), supported the development of the HIV CLM

system. The other three (3) facilities are community-based and owned by LoveYourself, Inc., namely LoveYourself Anglo, LoveYourself Victoria, and LoveYourself Welcome. LoveYourself, a non-government organization supported by the Global Fund, equally played a crucial role in the pilot implementation. While the pilot phase was ongoing, continuous training was also conducted to strengthen the community-led organizations' (CLOs) capacity for community-led monitoring, primarily localizing CLM work in their respective areas *(11).*

In line with the CLMS pilot's objectives, this study delved into the experiences of the communities and facilities involved in the pilot period, examining facilitating factors, challenges faced, and outcomes. Additionally, it explored the capacity-building efforts and challenges encountered by community-led organizations trained in the CLMS process. Furthermore, the study provides an analysis of existing policies and enabling factors supporting community and duty-bearer partnerships in the context of community engagement and community-led monitoring.

Literature and Methodology

I. Literature

A. **Community Engagement** is defined by the Centers for Disease Control and Prevention (CDC) as a Collaborative work with groups united by geographic proximity, shared interests, or similar circumstances to address issues affecting their well-being. Its overarching goals include fostering trust, mobilizing new resources and allies, enhancing communication, and ultimately improving health outcomes through sustainable collaborations *(12).*

In the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), the International Treatment Preparedness Coalition (ITPC), a global network of people living with HIV, community activists, and their supporters, defines community engagement as "a structured, supported, meaningful and accountable process that ensures that people living with HIV have a seat at the table and a voice in decision-making, planning,

implementation, and monitoring and evaluation (M&E) to achieve access to quality HIV care for all" *(13).*

In the Philippines, the country's National AIDS Council declared in its 7th AIDS Medium Term Plan (AMTP7) that community empowerment through participation is among AMTP7's guiding principles. It defined community participation as invoking the rights of citizens (communities, civil society organizations, and networks of people living with HIV) to actively participate in the response and to engage the state in addressing their needs and concerns *(14).*

B. **Community-Led Monitoring (CLM)** is a form of community engagement and one of community-led responses through monitoring of access to and quality of HIV services. It harnesses the agency of individuals living with HIV and key populations to convert insights on health systems into impactful advocacy initiatives. The emergence of CLM stems from the acknowledgment of the invaluable role of community data in tackling pressing issues, like high rates of antiretroviral treatment interruptions among individuals living with HIV. There's an escalating demand for HIV services to be more accessible and user-centric, particularly for those commencing treatment early and other marginalized groups often subjected to systemic exclusion or stigma within healthcare settings *(15).*

C. **Implementation Science Theory** is Per Nilsen's discussion on the importance of implementation science, with a focus on process models, determinant factors, and evaluated implementation, serving as a theoretical lens for this study. It provided a framework to understand how the Philippines' HIV CLMS process and cycle translated into practice, actionable insights, and identified the key factors influencing implementation outcomes, including those that facilitated or hindered implementation during the pilot period *(16).*

II. Methodology

A. Scope of Study

This study describes the HIV CLMS process and cycle experienced by the eleven (11) facilities involved in the pilot period from March 2023 to December 2023, including facilitating factors, challenges faced, and outcomes. It also examines

the implementation experiences of community-led organizations trained in the CLMS process and cycle. It explores their capacity, efforts, and challenges in localizing CLMS work within their respective areas.

Lastly, the study explores existing policies, strategic plans, and enabling mechanisms that communities of PLHIV and KPs can leverage to facilitate or strengthen community and duty-bearers partnerships relative to community-led monitoring in the context of the Philippine National AIDS Council, Centers for Health Development, and Local Government Units in the DFAT sites.

B. Study Overview

The study used mixed methods and a case study design, in which quantitative and qualitative data were collected, analyzed, and triangulated to respond to the scope of the case study objectives. The research began with a review of the literature on HIV frameworks, policies and enabling mechanisms, particularly those related to community engagement and participation and community-led monitoring.

This paper employed three (3) types of case study designs, as follows:

B.1. Descriptive Case Study. This focused on the detailed description of the piloted HIV CLMS process and cycle, including implementation experiences of LoveYourself, Quezon City, and Community-Led Organizations. This paper examined the processes, efforts, challenges, and outcomes encountered during the pilot stage. The data analysis focused on identifying themes, patterns, or key insights from the gathered qualitative data, offering an in-depth understanding of the pilot implementation experiences and their implications for localizing the HIV CLMS work.

B.2. Comparative Case Study. This study aimed to compare the implementation experiences of LoveYourself (as a non-government service provider) and Quezon City (as a government service provider), as well as compare the experiences of trained community-led organizations in implementing the HIV CLMS process

and cycle. The comparative focused on exploring similarities, differences, and variations in their implementation experiences to provide insights into factors influencing implementation outcomes and suggest community engagement strategies for the roll-out or expansion phase.

B.3. Triangulation Case Study. This design aimed to provide a comprehensive understanding of implementation experiences by triangulating multiple data sources explored from relevant literatures, interviews, focus groups, and document analysis to gather rich, descriptive data and validate findings, especially in relation to facilitating factors. It offers a nuanced understanding of the implementation experiences of LoveYourself, Quezon City, and community-led organizations (CLOs), and their implications for localizing CLM work.

Based on the literature, relevant policies, strategic plans, and enabling mechanisms were reviewed and analyzed and a semi-structured interview guide was developed to guide the data collection using key informant interviews (KIIs) and focus group discussions (FGDs).

C. Key Informant Interviews (KIIs)

Interviews were administered at the eleven facilities, eight (8) of which are social hygiene clinics and *klinikas* under the Quezon City Health Department, and three (3) are community centers or clinics under The LoveYourself, Inc. (TLY), they are as follows:

Facilities under the Quezon City Health Department	Facilities under The LoveYourself, Inc.
1. Klinika Batasan 2. Klinika Bernardo 3. Klinika Project 7 4. Klinika Novaliches 5. AJ Maximo Social Hygiene Clinic 6. Batasan Social Hygiene Clinic 7. Bernardo Social Hygiene Clinic 8. Project 7 Social Hygiene Clinic	1. TLY Anglo (Mandaluyong) 2. TLY Victoria (Pasay) 3. TLY Welcome (Manila)

Separate interviews were also conducted with the HIV & AIDS Support House (HASH) to highlight their experience communicating data results, advocating for and co-creating solutions with the 11 facilities, and with Team Dugong Bughaw (TDB) to demonstrate their experience facilitating the implementation of CLMS in Iloilo City.

D. Focus Group Discussions (FGDs)

FGDs were held for the CLOs trained on the HIV CLMS process and cycle. There were twenty-four (24) CLOs that attended the training but only ten (10) were able to participate in the FGDs, they are as follows:

1. Cebu United Rainbow LGBTIQ+ Sectors, Inc. (CURLS)
2. Dawaw-MAAI
3. Kagayan-PLUS
4. Pinoy Plus
5. Red Seahorse
6. Regional TB-HIV Support Network (RTHSN)
7. Tahas, Inc.
8. Ugat ng Kalusugan
9. Wagayway Equality, Inc.
10. Y-Peer Education Network Philippines

Results

This section presents findings relative to the experiences of involved stakeholders during the CLMS pilot period, the community-led organizations' experiences in efforts to localize the CLMS implementation, and key findings on relevant studies or documentation, policies, and enabling mechanisms in the context of the Philippine National AIDS Council, Centers for Health Development, and Local Government Units in the DFAT sites.

I. Pre-Pilot Preparation

This subsection outlines how the pilot phase was planned to be implemented. Relevant documents such as the CLMS roadmap, pilot protocol, pilot process

flow, and the pilot evaluation's documentation were particularly reviewed to have a comprehensive understanding of the pilot's process models, facilitating factors, and pilot implementation outcomes.

Pilot Site Selection

The results suggest that central to the pilot's success was the pilot protocol, which guided the pre-implementation phase. This involved active collaboration with various entities, including the local government unit, community-led organizations, advocacy leaders, community-led organizations, stakeholders, the PLHIV and key population communities. The final pilot sites were selected based on their receipt of support from key partners such as the Global Fund AIDS Project, FHI 360's Meeting Targets and Maintaining Epidemic Control (EpiC) Project, Australia's Department of Foreign Affairs and Trade (DFAT), or Centers for Disease Control and Prevention Philippines' International Centre for AIDS Care and Treatment Program (ICAP).

The selection of the pilot sites was a strategic process. Two sites in Metro Manila were identified, each with a unique service model. The first site was the Quezon City Local Government Unit (LGU), representing a local HIV service model in government facilities. The second site was LoveYourself (TLY), a non-governmental organization service provider offering a variety of HIV and STI services. The former was supported by Australia's Department of Foreign Affairs and Trade (DFAT) through ACHIEVE, while the latter was supported by the Global Fund AIDS Project.

Social Preparation

This study also found that the pilot protocol required that a social preparation must be conducted. Social preparation included a structured engagement and tailored orientation or learning sessions with parties involved in the pilot implementation, among others. The learning sessions included discussions on what CLM is, what HIV CLMS objectives are, its processes, monitoring indicators and tools and monitoring stages, and how CLMS data significantly contributes to HIV programme implementers' typical monitoring and evaluation data. Different learning session objectives were cascaded to ensure that the CLOs and service

providers involved in the pilot understood not just the CLMS' overall intentions but the purpose of the pilot testing.

Relevant CLMS documents show that the social preparation during the pilot centered on gaining stakeholders' buy-in and understanding their roles in the pilot stage, especially in terms of assisting clients who may potentially seek assistance for cases of serious incidents, which are defined by the Data Processing and Analysis Protocol as: breach of confidentiality, occurrence of antiretroviral (ARV) stockouts, and alleged experiences of stigma and discrimination during access to HIV services.

Pilot Process Flow

The process flow shown below was prepared before the pilot implementation began. It generally identified the roles of the parties involved during the pilot.

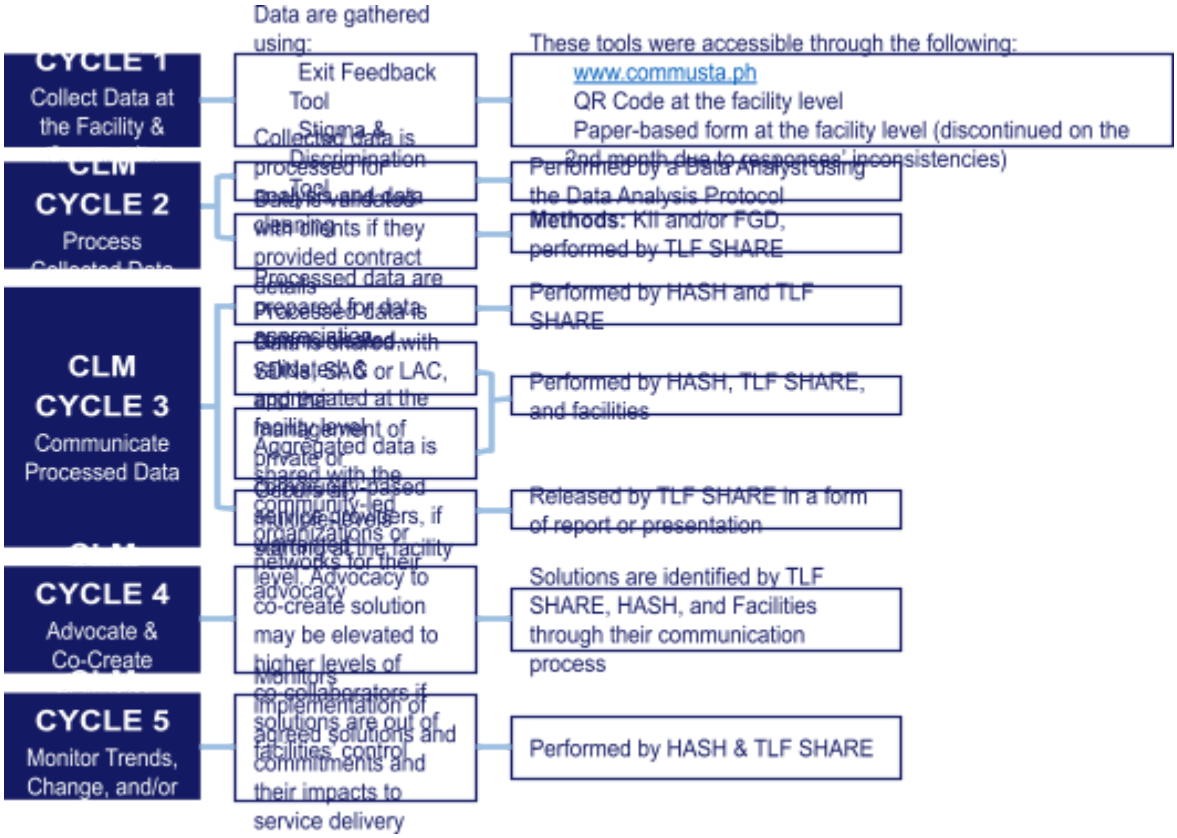

Figure 1. Pilot CLMS Cycle Process Flow.
Source: Copied from TLF SHARE's Pilot CLM Cycle & Serious Incident Process Flow

According to the pilot evaluation, all cycles were experienced from March 2023 to December 2023. However, it was also emphasized that while a few impacts were documented to have been achieved during the fifth stage, these were short-term impacts. Considering the pilot timeline, it is believed to be unrealistic to see long-term changes brought about by CLMS work, especially since the changes it aspires to contribute to are at a systemic level.

Apart from TLF SHARE and HASH, it is also found that while Team Dugong Bughaw's implementation of CLMS in two (2) HIV facilities in Iloilo City during the pilot stage was not originally part of the target pilot sites, TDB was able to implement CLMS in Iloilo using the same process flow.

II. HIV CLMS National Pilot Report

The HIV CLMS national report, accessible via the www.commusta.ph website, aggregates key findings from HIV service recipients' feedback during the pilot period. According to the report, 4,112 responses or feedback were received through the commusta.ph's exit feedback tool. The feedback came from clients of 62 healthcare facilities across the Philippines, extending beyond the 11 pilot sites *(17).*

The report finds that 3848 out of 4,112 responses said they received the HIV services and/or commodities they needed, while 264 said they did not receive the services and/or commodities they needed. The unavailable services or commodities were:

- Condoms
- Lubes
- Antiretroviral drugs
- Viral load testing
- CD4
- Self-test kits
- PEP
- PPP
- IEC materials on HIV
- TB drugs
- Hepa B test kit and Hepa B vaccine
- Flu vaccine
- Ascorbic acid
- PrEp
- Gonorrhea treatment
- Antibiotics such as metronidazole

Apart from the unavailable services and/or commodities, other concerns raised were:

- Some clients waited long during access to services;
- Some clients did not receive all the information they needed;
- Some clients reported that clinic or service providers' staff were unfriendly or unprofessional;
- Some allegedly experienced a breach of confidentiality; and
- Some allegedly experienced violence, harassment, stigma and discrimination (VHSD) during access to services.

The report also highlights a concerning fact: Some of those who provided details of their VHSD experiences did not seek a redress mechanism. This is interesting information that should prompt the community and duty-bearers to investigate further.

III. Pilot Implementation Experiences

The tables below present the results of descriptive analysis, which delved into the pilot experiences of the participants, encompassing the experiences of LoveYourself, Quezon City, and Community-Led Organizations (CLOs). The data focused on elucidating the processes, efforts, challenges, and outcomes encountered throughout the pilot stage. Based on the collected and analyzed information, themes, patterns, or key insights are identified.

Quezon City Facilities' Experiences

Data shows that prior to the CLMS pilot implementation in Quezon City, facilities had no clear process for the community to get directly involved in decision-making regarding HIV service delivery. Only one facility mentioned that they engage with community-based organizations and non-government organizations (NGOs) that are part of Quezon City's Service Delivery Network (SDN) and the Quezon City's STI, HIV, and AIDS Council (QCSAC). However, upon the implementation of CLM, all eight facilities were able to engage with the community by using the Exit Feedback Tool where their clients could voice out their concerns and issues about their experience in getting the services they need

in the facilities. While there is no evident outcome on the relationship of the facilities with their clients, the facilities have noted that they were able to appreciate the PLHIV community's insights better after implementing CLM.

The Quezon City Health Department's support to the CLMS pilot, especially requiring it to the eight facilities, helped in getting the cooperation of the facilities. Data culled from Quezon City facilities' interviews underscores the importance of social preparation as it allowed the facilities to clearly understand the CLM processes and the reassurance from the community that CLM will not be used negatively or destructively but a platform to ensure that feedback from service recipients is documented and used to improve service quality. Social preparation included conducting orientation at each of the facilities to explain the objectives and principles of CLM and its cycle and process before the implementation.

The facilities also had their own initiatives to prepare for the implementation. Delegating tasks among the staff ensured the integration of CLM into their workflow. The assigned staff promotes the Exit Feedback Tool to their clients in various stages of their visit, either during registration, consultation/treatment, or waiting time. Informational, educational, and communication (IEC) materials, such as flyers, promotional videos and standees of *commusta.ph's* mascot "Koko", were also posted around the vicinity. These strategies facilitated the collection of clients' feedback in the facilities. However, some clinics expressed that they lack human resources to accomplish data collection as their staff are already preoccupied with their primary functions. This became evident in the significant decline in the number of respondents during the latter stage of the pilot period when data collectors were no longer engaged. The facilities also experienced common issues in accessing the Exit Feedback Tool that hindered data collection. Since it is an online form, a device, such as a smartphone or tablet, is needed to access it along with an internet connection. Not all clients have these technical requirements and they cannot submit their feedback. Other concerns with the Exit Feedback Tool is its long and tedious format that causes confusion to the respondents that some do not have the time or patience to finish it. Clinic staff tried assisting their clients to clarify some of the questions or to instruct them on navigating the form.

For the communication of results, a major factor in its success is the transparent and comprehensive presentation of data. A few also appreciated the validation process that enabled the facility to explain their side. The established rapport and trust with TLF SHARE and HASH also contributed to the collaborative environment which is important in advocating for changes and co-creation of solutions. The periodic meetings of TLF SHARE, HASH and the facilities ensured that there is a regular assessment and monitoring of progress. However, one facility found the validation process still inadequate in considering their context and there is no way for the community to hear their side. A few also expressed that the Exit Feedback Tool became a complaint mechanism for clients to criticize or reprimand the staff.

A common outcome of the pilot implementation across the Quezon City facilities is the increase in awareness and consciousness of the staff in engaging with their clients. They practiced a more compassionate approach as they realized that they also impact their patient's experience. Other notable short-term outcomes of the pilot implementation include the streamlining service processes to decrease waiting time of the clients and improving the physical ambience in some clinics. The facilities appreciated CLM better after the pilot implementation as it increased their standard of quality service. They saw the value of CLM in getting transparent feedback from the PLHIV community to identify issues in their process, to assess challenges in their system, and to advocate for solutions to improve overall service delivery.

Table 1: Quezon City Facilities' Pilot Implementation Experiences

The table below shows the respondents' interview results, which were the basis for identifying thematic patterns using the descriptive case study design.

Theme		Quezon City Facilities							
		Klinika Batasan	**Klinika Bernardo**	**Klinika Project 7**	**Klinika Nova**	**AJ Maximo SHC**	**Batasan SHC**	**Bernardo SHC**	**Project 7 SHC**
Community Engagement	**Community involvement in HIV Service delivery decision-making pre-CLM Implementation**	There are no clear processes about the community's involvement in decision-making regarding HIV service delivery.	Community-based and non-government organizations are engaged through Quezon City's SDN and QCSAC. For example, QCSAC recommended the use of CLM in the facility.	There are no clear processes about the community's involvement in decision-making regarding HIV service delivery.					
Pilot Implementation Facilitating Factors	**Engaging with the community through CLM**	The Exit Feedback Tool became a platform for the community, particularly the HIV service recipients, to voice their concerns and for the clinic to respond to them, while the	1. The Exit Feedback Tool became a platform for the community, particularly the HIV service recipients, to voice their concerns and for the clinic	The Exit Feedback Tool became a platform for the community, particularly the HIV service recipients, to voice their concerns and for the clinic to respond to them, while the process of communicating CLM data results at the facility level served as a strategy to influence better decision-making and co-creating solutions at the facility level.			1. The Exit Feedback Tool became a platform for the community, particularly the HIV service recipients, to voice their concerns and for the clinic	1. The Exit Feedback Tool became a platform for the community, particularly the HIV service recipients, to voice their concerns and for the clinic	The Exit Feedback Tool became a platform for the community, particularly the HIV service recipients, to voice their concerns and for the clinic to respond to them, while the

Theme		Quezon City Facilities							
		Klinika Batasan	**Klinika Bernardo**	**Klinika Project 7**	**Klinika Nova**	**AJ Maximo SHC**	**Batasan SHC**	**Bernardo SHC**	**Project 7 SHC**
		process of communicating CLM data results at the facility level served as a strategy to influence better decision-making and co-creating solutions at the facility level.	to respond to them, while the process of communicating CLM data results at the facility level served as a strategy to influence better decision-making and co-creating solutions at the facility level. 2. Implementing the CLM process was required for the clinics.				to respond to them, while the process of communicating CLM data results at the facility level served as a strategy to influence better decision-making and co-creating solutions at the facility level. 2. Implementing the CLM process was required for the clinics.	to respond to them, while the process of communicating CLM data results at the facility level served as a strategy to influence better decision-making and co-creating solutions at the facility level. 2. Implementing the CLM process was required for the clinics.	process of communicating CLM data results at the facility level served as a strategy to influence better decision-making and co-creating solutions at the facility level.
Pilot Implementation Facilitating Factors	**Capacity on CLM Process**	The clinic understood the CLM process and greatly appreciated how systematic and efficient it is.	No facilitating factors mentioned	CLM's goal and purpose were clear to the facility.	CLM IEC materials were provided to the clinic.	1. Data enumerators were trained. 2. CLM IEC materials were provided to the clinic.	No facilitating factors mentioned	1. CLM's goal and the need to go through the process were clear to the facility. 2. The clinic focused on CLM's positive impact.	1. CLM's goal was clear to the facility. 2. TLF SHARE conducted a training workshop for the staff.
	Internal	Certain staff	1. CLM IEC	Certain staff	Tasks were	Certain staff	Tasks were	The clinic	Certain staff

Theme		Quezon City Facilities							
		Klinika Batasan	**Klinika Bernardo**	**Klinika Project 7**	**Klinika Nova**	**AJ Maximo SHC**	**Batasan SHC**	**Bernardo SHC**	**Project 7 SHC**
Pilot	**Preparations to Offer CLMS' Exit Feedback Tool to Clients**	were assigned to facilitate parts of the survey to the clients.	materials were posted in visible areas of the clinic. 2. Peer Educators were assigned to endorse the Exit Feedback Tool to their patients.	were tasked to engage with their clients and to encourage them to answer the Exit Feedback tool.	delegated among the staff.	were tasked to engage with their clients and to encourage them to answer the Exit Feedback tool.	delegated among the staff.	physician oriented the team about the process and incorporated CLM into their workflow.	were tasked to engage with their clients and to encourage them to answer the Exit Feedback tool.
	Collecting Clients' Feedback	Clients are approached individually and informed of the Exit Feedback Tool's purpose and process.	Clients are approached individually and assisted by data collectors or volunteers to answer the Exit Feedback Tool. In the absence of a volunteer, a staff member assumes the responsibility of promoting the form.	Koko's video promoting commusta.ph was continuously played on the clinic's TV. They used this strategy to encourage the clients to fill out or answer the form.	Clients are asked to answer the Exit Feedback Tool while waiting after blood extraction.	1. Clients would be grouped at the reception as staff explained the CLM feedback mechanism and encouraged them to answer. 2. Staff promoted CLM by talking to clients individually, providing CLM flyers, and promoting the	Informed patients or clients about commusta.ph's Exit Feedback Tool and its purpose of improving service delivery.	1. Made the Exit Feedback Tool's QR code visible to clients. 2. Promoted commusta.ph' s Exit Feedback Tool as a safe space to express clinic feedback. 3. Staff lent their gadgets to the clients so they could answer the online form.	1. The clinic's doctor encourages patients or clients to accomplish commusta.ph' s Exit Feedback Tool during the consultation period. 2. The clinic also played the commusta.ph' s video using their TV. 3. Staff lent their gadgets to the clients so they could answer

Theme		Quezon City Facilities							
		Klinika Batasan	Klinika Bernardo	Klinika Project 7	Klinika Nova	AJ Maximo SHC	Batasan SHC	Bernardo SHC	Project 7 SHC
Implementation Facilitating Factors						CLM process through social media. 3. Data enumerators were trained and deployed to help gather data			the online form.
	CLOs' Communication of Results	No facilitating factors mentioned	Transparency in the delivery of the report.	Incidents are validated from the clinic's perspective.	Data statistics presented were comprehensive.	1. Trust in TLF SHARE in managing the data. 2. Transparency in the delivery of the report. 3. Incidents are validated from the clinic's perspective.	Established rapport with TLF SHARE.	1. Established rapport with TLF SHARE and HASH. 2. Transparency in the delivery of the report. 3. Incidents are validated from the clinic's perspective.	1. Transparency in the delivery of the report. 2. Incidents are validated from the clinic's perspective. 3.
Pilot Implementation Facilitating Factors	Data Utilization for Advocacy and Co-Creating Solutions	No facilitating factors mentioned	No facilitating factors mentioned	No facilitating factors mentioned	1. Best practices from other clinics are shared by TLF SHARE. 2. Periodic meetings both with the internal clinic team and with TLF SHARE and HASH paved the way for assessing	Periodic meetings both with the internal clinic team and with TLF SHARE and HASH paved the way for assessing and monitoring the quality of clinic services.	No facilitating factors mentioned	Periodic meetings both with the internal clinic team and with TLF SHARE and HASH paved the way for assessing and monitoring the quality of clinic services.	No facilitating factors mentioned

Theme		Quezon City Facilities							
		Klinika Batasan	Klinika Bernardo	Klinika Project 7	Klinika Nova	AJ Maximo SHC	Batasan SHC	Bernardo SHC	Project 7 SHC
					and monitoring the quality of clinic services.				
Challenges	Engaging with the community through CLM	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned
	Capacity on CLM Process	No challenges mentioned	Not all staff, including managers, were oriented about the CLM process.	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned
	Internal Preparations to Offer CLMS' Exit Feedback Tool to Clients	No challenges mentioned	The clinic lacks human resources to accommodate data collection.	The clinic lacks human resources to accommodate data collection.	CLM IEC materials lacked instructions on how to access and answer the Exit Feedback Tool.	No challenges mentioned	No challenges mentioned	No challenges mentioned	The clinic lacks human resources to accommodate data collection.
	Collecting Clients' Feedback	The facility does not have wi-fi internet.	1. Clients get confused by the questions and/or the format of the Exit Feedback Tool. 2. Some clients are not knowledgeab	1. Clients get confused by the questions and/or the format of the Exit Feedback Tool. 2. The form is too long that some clients	1. Clients get confused by the questions and/or the format of the Exit Feedback Tool. 2. Some clients do not have a smartphone and/or	Some clients do not have a smartphone and/or internet data to access the Exit Feedback Tool.	1. Some clients do not have a smartphone and/or internet data to access the Exit Feedback Tool. 2. The form is too long that some clients	Some clients do not have a smartphone and/or internet data to access the Exit Feedback Tool.	1. Some clients do not have a smartphone and/or internet data to access the Exit Feedback Tool. 2. The form is too long that some clients

Theme		Quezon City Facilities							
		Klinika Batasan	Klinika Bernardo	Klinika Project 7	Klinika Nova	AJ Maximo SHC	Batasan SHC	Bernardo SHC	Project 7 SHC
			le about how to use a tablet. 3. Some clients do not own a smartphone or tablet to access the Exit Feedback Tool.	do not finish it.	internet data to access the Exit Feedback Tool. 3. The commusta.ph site would be down in some instances making the Exit Feedback Tool inaccessible.		do not finish it.		do not finish it.
	CLOs' Communication of Results	No challenges mentioned	Comments by the clients that were not validated were reported to the SDN and it became a way to reprimand the staff.	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	Some clients used the Exit Feedback Tool to complain about the staff.
	Data Utilization for Advocacy and Co-Creating Solutions	No challenges mentioned	1. Some issues are not reported and addressed on time. 2. The context of the clinic is not taken into consideration . 3. Instead of	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	No challenges mentioned	The community still cannot hear the side of the facility.

Theme		Quezon City Facilities							
		Klinika Batasan	**Klinika Bernardo**	**Klinika Project 7**	**Klinika Nova**	**AJ Maximo SHC**	**Batasan SHC**	**Bernardo SHC**	**Project 7 SHC**
			finding solutions, CLM became a way to reprimand staff.						
Outcome	**Relationship with communities of PLHIV and key populations, especially their patients, after experiencing the CLM process**	No evident outcome	No evident outcome	No evident outcome	No evident outcome	Both the community and the facility had the opportunity to express their concerns.	No evident outcome	The community had an opportunity to express their concerns and appreciation to the clinic. This enabled the clinic staff to appreciate the community's insights.	No evident outcome
	Improvement, Positive Change, or Short-Term Impact of CLM Work as a Result of Data Utilization, Communication of Results, and Advocacy	Data was used to allot a budget for internet wi-fi in the facility.	1. Streamlined their processes to be more efficient and to reduce waiting time for the patients. 2. Clinic staff became more conscious of how they dealt with their patients.	1. Staff practiced a more compassionate approach to engaging with their clients. 2. The clinic increased their standards in delivering quality service to their clients.	Streamlined their processes to be more efficient and to reduce waiting time for the patients.	The clinic increased their standards in delivering quality service to their clients.	Staff practiced a more compassionate approach to engaging with their clients.	1. Staff practiced a more compassionate approach to engaging with their clients. 2. The clinic improved the ambiance of their facility to make their clients more comfortable in their space.	1. Streamlined their processes to be more efficient and to reduce waiting time for the patients. 2. Staff practiced introducing themselves to the patients for better recognition.

Theme		Quezon City Facilities							
		Klinika Batasan	**Klinika Bernardo**	**Klinika Project 7**	**Klinika Nova**	**AJ Maximo SHC**	**Batasan SHC**	**Bernardo SHC**	**Project 7 SHC**
Perception	**CLM's Value for LGUs or HIV Programme Implementers**	No insight mentioned	1. CLM facilitates immediate discussion of issues with clients. 2. CLM becomes a reminder that they are public servants and they should serve well.	CLM serves as an assessment tool to identify the facility's weaknesses and actively work on resolving the issues.	No insight mentioned	CLM is an effective tool for getting transparent feedback from clients to improve service delivery.	No insight mentioned	CLM is a feedback mechanism that helps the facilities improve services delivered to the patients.	CLM served as an assessment tool to identify the facility's weaknesses and actively work on resolving the issues.

LoveYourself Facilities' Pilot Experiences

The LoveYourself, Inc. (TLY) is a community center and their services were primarily triggered by the needs of the community even before they participated in the CLM process. Their established rapport with the PLHIV community made it easier to endorse CLM to them. Following LoveYourself Anglo, Welcome, and Victoria's CLM orientation and training, the facilities did internal preparations such as orienting their staff and delegating tasks in promoting commusta.ph and the Exit Feedback Tool to their clients.

LoveYourself also has an existing feedback mechanism and their clients are familiar with the routine of submitting their comments and suggestions. When they incorporated CLM into their system, LoveYourself observed that the community felt more empowered as they realized they were contributing data that could be used as evidence to advocate for better services from the facilities and the government. However, LoveYourself also shared the same challenges with the Quezon City facilities when it came to the technical requirements of the online form that made it inaccessible to some clients. While the Anglo branch involved volunteers to aid in the data collection, the Victoria branch lacked human resources to accommodate the additional task.

Based on the LoveYourself's pilot experience, trust, transparency, and non-biased or non-judgmental ways of communicating CLM data results are identified strengths of the monitoring stage. However, the turnaround time for the results is the main concern of LoveYourself as some issues could not be resolved immediately for they currently receive the reports every quarter only. One facility also expressed that collaboration is still not prominent in the advocacy and co-creation of solutions stage.

One notable outcome of the pilot implementation is the use of CLM data as evidence on the ARV stockout to demand the supply needed. CLM also enabled a referral system to be established for clients to access their other needs. Similar to the Quezon City facilities, the staff of LoveYourself also became conscious of how they interact with their clients. After the pilot implementation, LoveYourself now

sees CLM as a tool that collects precise data to assess their services and ensure that a standard quality is met.

Table 2: LoveYourself Facilities' Pilot Implementation Experiences

The table below shows the respondents' interview results, which were the basis for identifying thematic patterns using the descriptive case study design.

Theme		LoveYourself Facilities		
		Anglo	**Welcome**	**Victoria**
Community Engagement	**Community involvement in HIV Service delivery decision-making pre-CLM Implementation**	TLY was established by the community and its services are primarily triggered by the needs of the community.		
Pilot Implementation Facilitating Factors	**Engaging with the community through CLM**	1. Incorporated the exit feedback tool to their existing process for feedback mechanism 2. Established rapport with the community		
	Capacity on CLM Process	TLF SHARE conducted a series of orientation and training where the roadmap, objectives and the Exit Feedback Tool were clearly explained to them.		
	Internal Preparations to Offer CLMS' Exit Feedback Tool to Clients	1. The staff were oriented and tasks were delegated. 2. Volunteers were involved to do data collection.	1. The staff were oriented and tasks were delegated. 2. Incorporated the Exit Feedback Tool's QR code to their card for easier access.	The staff were oriented and tasks were delegated.
	Collecting Clients' Feedback	Staff emphasized the value of CLM in improving overall HIV services.	Promoted commusta.ph to their clients, promotional and campaign materials were used.	A staff is assigned to endorse the Exit Feedback Tool to their clients.
	CLOs' Communication of Results	Trust, transparency, and non-biased or non-judgmental ways of communicating results were exhibited during the presentation.		
	Data Utilization for Advocacy and Co-Creating Solutions	No facilitating factors mentioned	No facilitating factors mentioned	No facilitating factors mentioned

Theme		LoveYourself Facilities		
		Anglo	**Welcome**	**Victoria**
Challenges	**Engaging with the community through CLM**	No challenges mentioned	No challenges mentioned	No challenges mentioned
	Capacity on CLM Process	Value of the CLM process is not clear to all the staff.	No challenges mentioned	No challenges mentioned
	Internal Preparations to Offer CLMS' Exit Feedback Tool to Clients	No challenges mentioned	No challenges mentioned	The clinic lacks human resources to accommodate data collection.
	Collecting Clients' Feedback	1. System breakdown of the site prohibits submission at times. 2. The form is too long that some clients do not finish it. 3. Some clients are not knowledgeable about how to use a tablet.		
	CLOs' Communication of Results	1. Turnaround time of feedback is too late making it hard to recall details of the incident. 2. Some issues are not reported and addressed on time.		
	Data Utilization for Advocacy and Co-Creating Solutions	Collaborating for co-creation of solutions seemed to be lacking.	No challenges mentioned	No challenges mentioned
Outcome	**Relationship with communities of PLHIV and key populations, especially their patients, after experiencing the CLM process**	Clients got more encouraged in sharing their feedback knowing that they can use the data to lobby for better services to the government.	The community felt more empowered seeing that their feedback leads to improvement.	The community got more involved and they also evolved. More people are aware of the fight against HIV.
	Improvement, Positive Change, or Short-Term Impact of CLM Work as a Result of Data Utilization, Communication of Results, and Advocacy	1. Data was used as evidence for the ARV stockout and lobbied for more supplies. 2. A system of referrals was also established. 3. Staff became more conscious of how they serve their clients.		
Perception	**Value of CLM for LGUs and**	CLM serves as an assessment tool to see	CLM ensures that the standards of service	CLM allows a more precise collection of data.

Theme		LoveYourself Facilities		
		Anglo	Welcome	Victoria
	Private Organizations	weaknesses and help improve services.	quality are met.	

Community-Led Organizations' Pilot Implementation Experiences

The experiences of CLOs differ significantly from those of Quezon City and LoveYourself's pilot experiences due to their distinct roles. According to the essential elements of the CLMS, CLOs are responsible for owning and leading the CLMS processes, as well as collaborating with stakeholders to advocate for changes or improvements in the HIV response.

This section presents data on the CLOs' experiences in applying CLMS processes within their local contexts after undergoing training, along with the results of their CLMS implementation. The experiences of the CLOs are further categorized: HIV & AIDS Support House Inc. received training on the CLMS process and shadowed TLF SHARE during the pilot implementation, while the remaining CLOs were trained and attempted to implement the CLMS independently.

TLF SHARE mentored HIV & AIDS Support House Inc. (HASH) to observe how CLOs would handle various stages of the CLM cycle, particularly in communicating results and co-creating solutions. During the pilot period, HASH involved five staff members and volunteers, who were tasked with promoting CLM, collecting data in facilities, presenting results, and facilitating advocating for improvements and co-creating solutions with Quezon City and LoveYourself facilities. To promote CLM, HASH distributed IEC materials, posted on social media, and spread the word through direct interactions. For data collection, they approached clients individually or in groups during their waiting time, initiating conversations with questions about what improvements they thought were needed in the facilities. This approach encouraged clients to express their concerns more freely on the Exit Feedback Tool.

HASH initially observed TLF SHARE during the data presentation and co-creation of solution stages and then took on these roles independently. Before visiting the facility, their team conducted internal meetings to discuss and thoroughly understand the data results. They consulted TLF SHARE for any questions or clarifications. With a clear grasp of the data, they compared the results against the action plan and brainstormed potential recommendations for the facility. They also strategized on presenting feedback that would not make the facilities feel

destructively criticized or reprimanded. Effective communication of the data was crucial to ensuring the facility's positive response and that the comments were taken seriously.

During their initial meetings with facilities, HASH encountered challenges with word choice, which posed communication hurdles. However, TLF SHARE's guidance helped prevent miscommunication. HASH took proactive steps to address feedback on specific individuals, initially a difficult task, by redacting names during presentations. Specific feedback was discreetly communicated solely to the clinic head, ensuring staff were informed privately. HASH's ongoing concern revolves around alleged cases of stigma and discrimination that couldn't be probed further due to respondents not leaving contact details or ignoring follow-up messages, leaving these issues unaddressed or not referred to redress mechanisms.

HASH claimed that most facilities were collaborative, and they were curious whether their actions led to any changes. Overall, the availability of the Exit Feedback Tool has made facilities more cautious and sensitive to their clients' needs.

On the other hand, Team Dugong Bughaw (TDB) participated in the CLM capacity strengthening workshops and subsequently implemented CLM in two facilities in Iloilo City: the Western Visayas Medical Center and the Iloilo Social Hygiene Clinic. Their social preparation involved separate meetings with the local government unit (LGU) and the facilities to explain the CLM's objectives, tools, and methodologies. Their ongoing engagement with these facilities facilitated an agreement to implement CLM. Additionally, TDB received technical assistance from a member of the Family Planning Organization of the Philippines-Iloilo, who helped coordinate with the LGU.

To begin with data collection, TDB assigned two community monitors to visit the facilities twice a week to promote CLM and encourage patients to complete the Exit Feedback Tool. They developed a standard pitch explaining the goal of CLM—to improve HIV services for the community—and assured clients of the system's confidentiality. The volunteers interacted with clients in a friendly manner and used local dialects, including Bisaya, Hiligaynon, and Tagalog, based on client

preference. They also distributed IEC materials containing the CLM QR code at the facilities.

Although the community monitors were provided with transportation and meal allowances, TDB deemed this approach unsustainable for the coming months due to the strain on their operational funds. They anticipate a decline in respondent numbers when this initiative is suspended. While the facilities have integrated CLM into their workflow by encouraging clients to fill out the form while waiting, this is not feasible when the facilities are busy accommodating many patients. TDB also encountered issues similar to those faced by QC facilities and LoveYourself regarding data collection, including connectivity problems, clients without smartphones, and occasional website outages.

In December 2023, TDB presented the data results to the two facilities. They first requested processed data from TLF SHARE and prepared their presentation based on this information. To ensure clear delivery, they reminded the facilities of the CLM implementation objectives before showing the results. During the presentation, they solicited the facilities' perspectives, identifying what the data revealed and what it did not, including issues and potential solutions. TDB practiced co-creating solutions with clinic staff, discussing recommendations and next steps. They agreed to hold quarterly meetings to monitor progress on the agreed solutions. Given the facilities' tight schedules, these meetings were kept short, detailed, and comprehensive.

One major issue that surfaced was the long waiting time. The facility agreed to display posters of their policies with corresponding waiting times to manage clients' expectations. However, most issues pertained to infrastructure insufficiencies which are beyond the facilities' control. At the Western Visayas Medical Center, the main concern was a lack of privacy due to a small space, which was addressed by providing the HIV team with a separate area. The Iloilo Social Hygiene Clinic faced similar space constraints, leading TDB to accompany clinic heads in presenting CLM data to their executives, thereby justifying their request for a larger facility. TDB also presented CLM to the city mayor and plans to implement CLM in other facilities.

Both HASH and TDB observed increased community engagement during CLM implementation, as community members had a platform to voice their concerns. Facilities appreciated the community's insights, which affirmed their good performance and motivated them to improve further.

Table 3: Community-Led Organizations' Pilot Implementation Experiences

The table below shows the respondents' interview results, which were the basis for identifying thematic patterns using the descriptive case study design.

Theme		Community-Led Organization	
		HASH	**TDB**
Pilot Implementation Facilitating Factors	**Capacity on CLM Process**	Training on understanding data and how to present them	Capacity development training on CLM and communication Hearing experiences and best practices from other CLOs during the training
	Strategies Employed	1. Spread CLM through word of mouth 2. Engaged in friendly conversation with the client first before endorsing CLM.	1. Engaged in a personal conversation with the client first before endorsing CLM. 2. Spread CLM through word of mouth
	Internal Preparations and Resources to Implement CLMS	1. Volunteers were involved in implementing CLM. 2. The implementation was guided by TLF SHARE. 3. IEC materials were distributed to the facilities.	1. Groundwork and social preparations with LGU and facilities were conducted 2. Volunteers were involved in data collection 3. Established rapport with the facilities 4. The coordination with LGU was guided by FPOP-Iloilo
	Collecting Community/Clients' Feedback	1. IEC materials were distributed both on-site and on social media pages. 2. Clients were approached individually or in groups in the waiting area to discuss CLM and the Exit Feedback Tool.	Two volunteers (community monitors) were deployed to the facilities twice a week to collect data.
	Data Appreciation/ Analysis	Identified critical gaps, advocacy points, and recommendations to the facilities regarding solutions	
	Communication of Results	Preparations were made beforehand – reviewing the data and discussing the manner of delivery.	1. Preparations were made beforehand 2. Kept the presentation short but precise
	Data Utilization for Advocacy	1. Reviewed action plans and checked in with facilities	Staff was participative and engaging

Theme		Community-Led Organization	
		HASH	TDB
	and Co-Creating Solutions	2. Collaboration with facilities was practiced	
Challenges	**Capacity on CLM Process**	No challenges mentioned	No challenges mentioned
	Strategies Employed	No challenges mentioned	No challenges mentioned
	Internal Preparations and Resources to Implement CLMS	No challenges mentioned	1. Lack of tools and policies to guide the implementation (e.g. client management) 2. Deploying volunteers is financially constraining
	Collecting Community/Clients' Feedback	Some clients do not have a smartphone and/or internet data to access the Exit Feedback Tool.	1. There were instances when the site would be down and inaccessible. 2. Some clients do not have a smartphone and/or internet data to access the Exit Feedback Tool.
	Data Appreciation/ Analysis	No challenges mentioned	No challenges mentioned
	Communication of Results	1. Encountered challenges with word choices. 2. Some of the alleged cases of stigma and discrimination couldn't be probed further due to respondents not leaving contact details or ignoring follow-up messages, leaving these issues unaddressed or not referred to redress mechanisms. 3. Facilities denied some complaints of stigma and discrimination.	
	Data Utilization for Advocacy and Co-Creating Solutions	No challenges mentioned	
Outcome	**Relationship with communities of PLHIV and key populations after experiencing the CLM process, especially the social preparation at the community level**	The community has been made aware of CLM and it encouraged them to voice out their concerns.	The community felt more empowered that they could give feedback confidentially.

Theme		Community-Led Organization	
		HASH	TDB
	Relationship with stakeholders (facilities, SDN, or SAC/LAC) after experiencing the CLM process with them	Staff appreciated the data when they got affirmed of their work.	Staff appreciated CLM as it helped them identify the root causes of their issues and they were also affirmed of their performance.
	Improvement, Positive Change, or Short-Term Impact of CLM Work as a Result of Data Utilization, Communication of Results, and Advocacy	Clinic staff practiced a more compassionate approach to dealing with their patients.	Issues were raised with the management and are now looking into options for relocating the clinics to a bigger facility to accommodate the needs.
Organization's Possible CLM Implementation Counterpart	**Internal Preparations and Resources to Implement CLMS**	Providing volunteers	Nothing mentioned
	Other Commitments	No commitment mentioned	Raising awareness and education

Other Trained Community-Led Organizations' Pilot Implementation Experiences

The capacity-strengthening efforts on CLM for CLOs included a session on developing localized work plans for each organization or area. However, out of the 24 trained CLOs, only one, Team Dugong Bughaw, was able to fully implement CLM in their area. Most of the trained CLOs limited their initiatives to introducing CLM to local government units (LGUs), facilities, and communities, without completing the actual CLM cycle.

Four of the interviewed organizations engaged in groundwork by promoting CLM to local officials or lobbying for its inclusion in local ordinances. Those who initiated social preparation already had existing partnerships with their LGUs and facilities. In contrast, other organizations struggled with social preparation due to a lack of established rapport with their LGUs. One organization noted their LGU's conservative views on HIV and the absence of testing centers in some areas, complicating CLM implementation. Social preparation efforts focused on duty-bearers, such as local government and facilities, but there was little evidence of efforts directed toward proper social preparation for the community. In some areas, low understanding of HIV and lack of awareness made communities apprehensive about sharing their experiences regarding HIV service delivery.

A common challenge among the interviewed CLOs was the absence of a designated focal person for CLM within their organizations. The staff attending the training sessions often varied depending on availability, and even when the same representative attended, there was often no internal knowledge sharing or proper turnover of information, leading to inadequate dissemination of CLM knowledge among staff. Furthermore, CLOs faced difficulties in starting CLM implementation due to limited human resources, as existing projects and programs took priority. Financial constraints also posed challenges, as organizations had limited budgets and required funds to mobilize their members for data collection and presentation. As seen in the experiences of the Quezon City facilities, LoveYourself and Team Dugong Bughaw, data collectors are crucial for encouraging clients to use the Exit Feedback Tool, and data collection is a key task that CLOs need to commit to for successful CLM implementation.

Table 4: Other Trained Community-Led Organizations' Pilot Implementation Experiences

The table below shows the respondents' interview results, which were the basis for identifying thematic patterns using the descriptive case study design.

Theme		Other Trained Community-Led Organizations									
		Wagayway Equality	**Ugat ng Kalusugan**	**Y-Peer**	**Dawaw-MAAAI**	**Kagayan-Plus**	**Pinoy Plus**	**Tahas**	**RTHSN**	**Red Seahorse**	**CURLS**
Initiatives on CLM	**Social Preparation**	No initiative mentioned	Promoted CLM to the City Health Office and social hygiene clinics.	Promoted CLM to community organizations in different regions.	1. Promoted CLM to the community in social media pages and chat groups. 2. Introduced CLM to the facilities. 3. Proposed for a CLM ordinance in Davao City.	1. Promoted CLM and commusta.ph during World AIDS Day. 2. Introduced CLM to social hygiene clinics.	Promoted CLM to the community through word of mouth and social media.	1. Promoted CLM to their members. 2. Lobbied for amendments with the Local AIDS Council on various ordinances.	Promoted CLM to the community through social media.	Included CLM in their HIV lectures.	1. Introduced CLM to city councilors, City Health Office and social hygiene clinics. 2. Included CLM in their HIV lectures.
Facilitating factors		No facilitating factors mentioned	Established rapport with the LGU, facilities and the communities	No facilitating factors mentioned	No facilitating factors mentioned	SHC Head saw the value of CLM	No facilitating factors mentioned	Has a champion in the Sangguniang Bayan	On-going project with ACHIEVE to anchor CLM on	No facilitating factors mentioned	Established rapport with the LGU, facilities and the communities
	Capacity on CLM Process	1. Representatives of the CLM	Not yet equipped to use the tool	Lack of knowledge and skills on M&E	1. Lack skill on data analysis 2. Facilities	No challenges mentioned	No challenges mentioned	Lack skill on data analysis	No challenges mentioned	Still lack knowledge on CLM	Still lack knowledge on CLM

Theme		Other Trained Community-Led Organizations									
		Wagayway Equality	**Ugat ng Kalusugan**	**Y-Peer**	**Dawaw-MAAAI**	**Kagayan-Plus**	**Pinoy Plus**	**Tahas**	**RTHSN**	**Red Seahorse**	**CURLS**
Chal-lenges		training were not able to cascade the informa-tion 2. Lack of knowl-edge and skills on data collection			still have apprehen-sion on CLM						
	Internal Prepara-tions and Resour-ces to Imple-ment CLMS	1. Lack of human resources 2. Lack of CLM focal person in the organiza-tion 3. Lack of database of facilities and their scope and services	1. Lack of CLM focal point in the organizatio n (in the case of Tandikan) 2. The organizatio n has other priority projects 3. Lack of IEC materials to be distributed	1. The organiza-tion has other priority projects 2. Lack of financial resources for mobiliza-tion 3. LGU and communit y has conserva-tive perspectiv e on HIV 4. No HIV testing centers in	Lack of technical resources to collect data (tablets, internet).	1. Lack of CLM focal person in the organizatio n 2. Lack of financial resources for mobilizatio n	1. Lack of financial resources for mobilizatio n 2. Lack of technical resources to collect data (tablets, internet) 3. Have not established rapport with 4. LGU	1. Lack of human and technical resources to collect data (tablets, internet) 2. Lack of CLM focal person in the organizatio n 3. Lack of financial resources for mobilizatio n 4. Lack of IEC materials to	1. Lack of technical resources to collect data (tablets, internet) 2. Lack of CLM focal person in the organizatio n 3. Lack of financial resources for mobilizatio n 4. Lack of IEC materials to be	1. Lack of human resources 2. Lack of technical resources to collect data (tablets, internet) 3. Lack of financial resources for mobilizatio n	1. Lack of human resources 2. Lack of technical resources to collect data (tablets, internet) 3. Lack of financial resources for mobilizatio n

Theme		Other Trained Community-Led Organizations									
		Wagayway Equality	**Ugat ng Kalusugan**	**Y-Peer**	**Dawaw-MAAAI**	**Kagayan-Plus**	**Pinoy Plus**	**Tahas**	**RTHSN**	**Red Seahorse**	**CURLS**
				some areas				be distributed	distributed		
Organi-zation's Possible CLM Imple-mentation Coun-terpart	**Role on CLM**	1. Data collection 2. Communi-cation of results 3. Advocacy and Co-Crea-ting Solutions	1. Data collection 2. Communi-cation of results	Data collection Communi-cation of results Advocacy and Co-Crea-ting Solutions	1. Data collection 2. Advocacy and Co-Creatin g Solutions	1. Data collection 2. Communi-cation of results 3. Advocacy and Co-Crea-ting Solutions	Data collection Communi-cation of results Advocacy and Co-Crea-ting Solutions	Advocacy and Co-Creating Solutions	Advocacy and Co-Creating Solutions	Data collection Communi-cation of results Advocacy and Co-Crea-ting Solutions	3. Data collection

IV. Relevant HIV Frameworks, Studies or Documentation, Policies, and Enabling Mechanisms

No less than the 1987 Philippine Constitution enshrined citizen participation, protecting the rights of individuals and civil society organizations to ensure "effective and reasonable participation at all levels of social, political, and economic decision-making" *(18).* The State is mandated by law to establish adequate consultation mechanisms. This commitment to citizen involvement was further strengthened by the 1991 Local Government Code of the Philippines and other legislative documents that promote the rights of the people and their organizations to participate in decision-making across all social, political, and economic domains. Engaging citizens in local governance has consistently demonstrated significant benefits for individuals, communities, and organizations, while also providing greater value to governments.

Different pieces of literature on community-led monitoring suggest that its framework and principles seem to be a progressive accountability mechanism due to its collaborative and transformative nature. CLM can be an integral component of community empowerment, mobilization, and meaningful engagement. This transformative potential of CLM instills hope and optimism for a more participatory and inclusive governance.

While the pilot implementation experiences exhibited clear support from select programmatic implementers to include community perspectives in their monitoring systems for HIV and AIDS, this research highlights findings of progressive stakeholders, policies, and enabling mechanisms where the CLM is directly supported and/or promoted, including opportunities that communities of PLHIV and Key Populations can leverage to engage duty-bearers meaningfully.

The Philippine National AIDS Council and the 7th AIDS Medium Term Plan

The Philippine National AIDS Council (PNAC) oversees the country's HIV and AIDS Response with a rights- and accountability-based framework. This framework stresses the state's responsibility to uphold human rights and the community's

duty to exercise those rights responsibly, ensuring transparency and responsiveness to community needs *(19).*

PNAC's seventh AIDS Medium Term Plan (AMTP7) prioritizes community empowerment through active participation, recognizing the rights of communities and civil society organizations, including networks of people living with HIV, to engage with the state. It aims to target a person-centered focus, emphasizing dignity and equality regardless of HIV status or socio-economic background, to provide tailored, respectful, and quality services. It also advocates for gender-affirming and transformative approaches, aiming for the recognition of individual rights free from stigma or discrimination based on sexual orientation, gender identity, or expression. The same plan also conveys that by ensuring equitable resource distribution and harmonized coordination among HIV programme implementers, PNAC aims for a unified, inclusive, and effective HIV response nationwide.

Monitoring and evaluation (M&E) are critical to the national HIV response and a core function of PNAC. A robust M&E plan and system are crucial to the success of the comprehensive strategic plans outlined in AMTP7, enabling PNAC and other stakeholders to effectively track progress, outcomes, and impacts. While PNAC acknowledges the country's success in developing a robust HIV surveillance and response monitoring system through the Department of Health-Epidemiology Bureau, it emphasizes that a comprehensive approach to M&E requires more than epidemic surveillance and health sector program monitoring. AMTP7 specifies that the national HIV M&E system must include three main components: (a) the health sector, (b) the non-health sector, and (c) the community-led monitoring system. These components will collectively gather strategic information from all sectors to support the Philippine HIV and AIDS response.

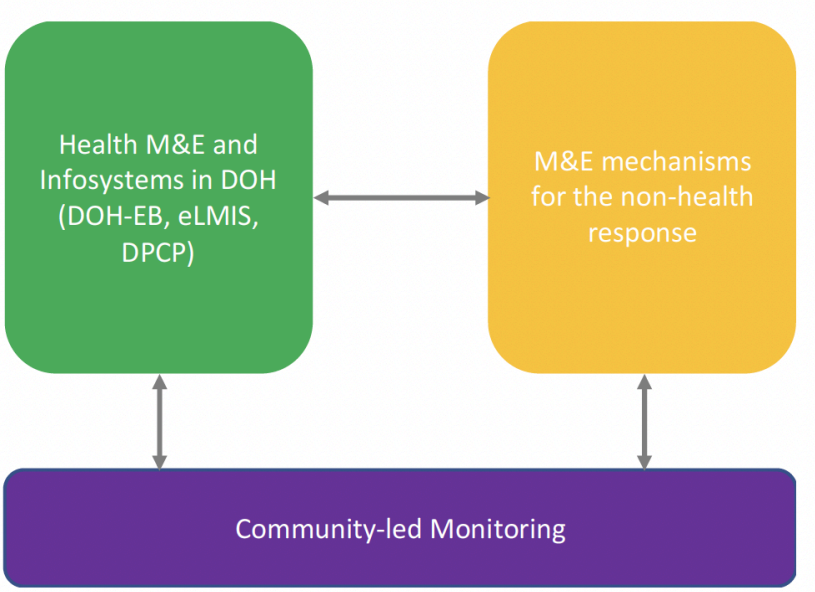

Figure 2. National HIV M&E System Components
Source: Copied from PNAC's 7th AMTP 2023 to 2028 | Philippines: Fast Tracking Towards 2030

Upon delving deeper into PNAC's monitoring indicators articulated in its AMTP7, this study finds that the core indicators for monitoring and evaluating AMTP7's strategy pillars were developed by referencing previous M&E plans from past AMTPs, the Department of Health (DOH) Health Sector M&E plan, the CLM Roadmap, and the Human Rights Roadmap. PNAC intends to monitor the HIV situation and response in five domains, with cross-analysis providing a holistic measurement: Epidemic, Service Delivery and Quality, Stigma and Discrimination, Policies, and Financing.

The Epidemic domain tracks reported HIV cases, estimates of people living with HIV, new infections, AIDS-related deaths, demographics, and burden levels through the DOH-Epidemiology Bureau. Service Delivery and Quality assess the type, quality, accessibility, and availability of services for those affected by HIV. Stigma and Discrimination indicators measure levels of stigma and discrimination among PLHIV and key populations. Policies track enabling or hindering policies and the implementation status across areas and sectors. Financing monitors HIV investment needs, actual spending versus needs, and the cost-effectiveness of interventions *(20)*. Data for many of these indicators are gathered through the HIV CLMS, as shown in the figures on the succeeding page:

Table 6.4 INDICATORS FOR STRATEGY PILLAR 3: PROTECT

	Indicator	Source
13	**Discriminatory attitudes towards PLHIV** Percentage of women and men 15–49 years old who report discriminatory attitudes towards people living with HIV	NDHS
14	**Internalized stigma reported by people living with HIV** Percentage of people living with HIV who report internalized stigma	Stigma Index
15	**Stigma and discrimination experienced by people living with HIV and key populations** • 15.1 Percentage of people living with HIV who report experienced stigma and discrimination in the last 12 months – per 6 settings • 15.2 Percentage of people who are members of a key population who report having experienced stigma and discrimination in the last 6 months • 15.3 Percentage of key populations who avoided health care because of stigma and discrimination	Stigma Index *Survey among KP, CLM*
16	**Violence towards KP and PLHIV** • 16.1 Percentage of key populations who experience physical or sexual violence • 16.2 Percentage of people living with HIV experience physical or sexual violence	*Survey among KP, CLM*
17	**People living with HIV seeking redress for violation of their rights** Proportion of people living with HIV who have experienced rights abuses in the last 12 months and have sought redress	*Survey among PLHIV or case reports*
18	**Social Protection** Percentage of people living with HIV with access to one or more social protection benefits	*Survey among PLHIV or case reports*

Table 6.5 INDICATORS FOR STRATEGY PILLAR 4: STRENGTHEN

	Indicator	Source
19	**Service quality** Percentage of clients who received quality service during their last access of HIV services Quality defined through a) service availability, commodity availability, wait time, staff demeanor, provision of HIV information	CLM
20	**Service availability** Percentage of clients who received needed services (per type of service)	CLM
21	**Service accessibility** Percentage of KP who were able to access needed HIV services in the past 6 months/12 months	CLM
22	**Service continuity** • 22.1 Percentage of clients who receive HIV testing, treatment, and other services during the period of crisis or conflict • 22.2 Number of reports of stock outs within a reporting period	DOH, CLM, Special surveys
23	**Integration of HIV services** Percentage of people living with HIV linked to people-centered and context-specific integrated services for other communicable diseases, noncommunicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being	*PLHIV Survey*

Table 6.6 INDICATORS FOR STRATEGY PILLAR 4 & 5: STRENGTHEN & SUSTAIN

	Indicator	Source
24	**Implementation of the RA 11166** Percentage of completion of mandated policies stipulated in RA 11166	PNAC, CLM
25	**Implementation of Political Commitment to End AIDS by 2030** Percentage of recommended global policies adopted	PNAC-NCPI, CLM
26	**Local HIV Response Implementation** • 26.1 Percentage of LGUs with local AIDS ordinances aligned with RA 11166 • 26.2 Percentage of LGUs with anti-discrimination ordinances • 26.3 Percentage of LGUs with active local AIDS councils • 26.4 Percentage of LGUs with established societal enablers *Societal enablers including programmes to reduce/eliminate HIV-related stigma and discrimination, advocacy to promote enabling legal environments, programmes for legal literacy and linkages to legal support, and reduction/elimination of gender-based violence	PNAC, CLM
	• 26.5 Percentage of LGUs with effective HIV response Effective response defined through a combination of sub-indicators on ordinance implementation, quality services, HIV care cascade accomplishments,	
27	**Community-led services** • 27.1 Percentage of service delivery for HIV prevention programs for key populations to be delivered by community-led organizations • 27.2 Percentage of testing and treatment services to be delivered by community-led organizations	*PNAC, CLM*

Quezon City STI, HIV, & AIDS Council (QCSAC)

News accounts celebrate Quezon City as one of the few multi-awarded and progressive cities in the Philippines in terms of enacting people-centered policies. In the context of HIV and AIDS advocacy, its comprehensive ordinance on STI, HIV, and AIDS prevention and control encourages stronger partnerships between the community and the Quezon City LGU. It outlines provisions to enhance the program by involving key actors such as representatives from PLHIV communities, the Quezon City Pride Council, and NGOs working with key populations to improve collaboration and service delivery. The ordinance also emphasizes monitoring and evaluation to identify best practices and address city response gaps. It mandates the establishment of an integrated service delivery network to ensure access to essential health, social, and legal services, especially in combating stigma, discrimination, and rights-based barriers faced by PLHIV, key populations, and vulnerable communities *(21)*.

To advance its HIV governance structures at the local level, the QCSAC's Strategic Plan 2023-2027 and Operational Plan 2024-2025 express the Council's commitment to include the PLHIV and KP communities in its process of championing good governance and in its work towards a more inclusive and equitable decision-making process. Thus, participating in the community-led monitoring system is included in its plans, specifically under its Protect and Strengthen pillars *(22).*

Pasay City STI, HIV and AIDS Council (PCSAC)

Similar to QCSAC, the PCSAC is mandated to implement Pasay City's Comprehensive STI, HIV, and AIDS Prevention and Control Program through the city's health office. The Ordinance defines PCSAC as a multi-sectoral organization committed to unifying responsive efforts on the prevention, care, and control of

STI, HIV, and AIDS among the general population, especially marginalized groups, and reducing its impact on the community.

Its membership rule requires two (2) representatives from organizations of PLHIVs, one (1) representative from the Pasay Pride Council, one (1) representative from a private organization or NGO with expertise in standard setting and service delivery, and six (6) representatives from different NGOs actively working for the welfare of identified key populations in Pasay City, among others. This reflects express opportunities for community-led organizations and Pasay LGU partnerships. One of the Ordinance's interesting provisions includes community-led monitoring as PCSAC's function and responsibility. Specifically, it requires PCSAC to conduct community-led monitoring of the implementation and evaluation of the city's STI, HIV, and AIDS Prevention and Control Action Plan, undertake mid-term assessments, including spending assessments, and evaluate its impact every five years *(23).* CLOs are a step ahead in mainstreaming CLMS in Pasay by including the implementation of CLMS as PCSAC's function. However, while the PLHIV and KP communities are represented in the council, both communities and local government should ensure that the CLMS remains a community-owned and community-led mechanism for it to truly serve its essence.

Opportunities in Centers for Health Development (CHD) and other LGUs

To understand the importance of CHDs' roles in community engagement through the CLMS, it is significant to have a better sense of the Department of Health's mandates concerning implementing the Republic Act (RA) No. 11166, otherwise known as the Philippine HIV and AIDS Policy Act. Article V, Section 43 of the said law mandates that, at the national level, the Department of Health (DOH) shall maintain a comprehensive HIV and AIDS monitoring and evaluation program that shall help the national government in determining whether the HIV prevention and treatment programs being employed are adequate and effective, among others. Through its Secretariat, the Department must also submit an annual report to the Philippine National AIDS Council (PNAC) containing the findings of its monitoring and evaluation activities in compliance with this mandate.

The CHDs are DOH's regional centers that oversee the implementation of policies and programs both regionally and within retained health facilities. They also

directly engage with Local Government Units, Non-Government Organizations, People's Organizations, and the private sector to enforce health regulatory policies and develop local health systems, including extending technical and other forms of assistance in the health field.

Since surveillance, monitoring systems, and program quality improvement processes are critical functions of the DOH, CHDs' M&E data must include a complete picture of the regions' situation, including service recipients' perspectives on accessing HIV and AIDS services.

This study reviewed the results of the Scoping of HIV Monitoring, Evaluation, and Program Quality Improvement Processes of Local Government Units and DOH Centers for Health Development conducted by Natasha Montevirgen et al. in DFAT sites in 2022. It revealed that the respondent regions' regular PQIP and monitoring of data revolves around the following:

- HIV Care Cascade, progress towards 95-95-95 targets;
- Program indicators for HIV, TB, and maternal and child health;
- Compliance with DOH standards and service capability;
- Budget for HIV;
- Implementation of activities cited in the work and financial plan (WFP);
- Facility accreditation; and
- Workforce in respective LGUs.

These data are gathered through the region's quarterly meetings to discuss issues and concerns, annual Program Implementation Review (PIR), Regional Epidemiology and Surveillance Unit (RESU) facility monitoring, and monthly inventory reporting. Based on this finding, Montevirgen et al *(24)*. emphasized that some of the critical data gaps in the regions' M&E data are an opportunity for communities of PLHIV and KPs to address through the CLMS. These are:

- Real-time reporting of data on stockouts/ unavailability of services;
- Potential reasons for loss to follow-ups (can be a special/supplemental CLM study);
- Feedback from the community on their access to services;

- Baseline assessment on recipients of HIV services on how they were before and if there are changes in quality of life after reach/ treatment (can be a special/supplemental CLM study); and
- Data on stigma and discrimination cases/incidents.

The same scoping looked into the M&E and QI process of select LGUs. To understand LGUs' roles in health, Republic Act (RA) No. 7160 or the Local Government Code of 1991 mandates the devolution of basic services to the LGUs. It establishes a system that delineates the powers of provincial, city, municipal, and barangay governments. The law transfers control and responsibility for delivering basic services, including health, to LGUs, and it seeks to enhance service provision, improve local resource allocation efficiency, and broaden decision-making opportunities by encouraging stakeholder participation.
During the scoping described above, it revealed that the respondent LGUs' regular PQIP and monitoring of data revolves around the following:

- Outputs of prevention activities (i.e.number of clients reached, condoms distributed, and outreach conducted);
- Number of individuals tested for HIV;
- HIV Care Cascade, progress towards 95-95-95 targets;
- Clients with STIs;
- Clients on PrEP;
- HIV commodities; and
- Budget plan and expenditure.

Similar to the CHDs, the data mentioned above are gathered through the LGUs' Program Implementation Review (PIR), monthly staff meetings, local planning (investment and annual operational planning), and the City Epidemiology and Surveillance Unit (CESU)'s monitoring of priority program indicators. Parallely, the scoping showed that some critical data gaps in the LGUs' M&E are an opportunity that communities of PLHIV and KPs can address through the CLMS. These are feedback from individuals about the service received and the Performance of CBOs providing services.

Funding or Support Opportunities

The Global Fund is on a mission to combat AIDS, tuberculosis, and malaria while building robust and sustainable health systems worldwide. With a three-year funding cycle, the Global Fund secures financial commitments from governments, the private sector, and foundations, ensuring consistent support for long-term health initiatives. This powerful global health partnership collaborates across public and private sectors to harness insights and innovations.

Countries benefiting from Global Fund investments play a central role in identifying priorities and developing tailored responses within their unique contexts. They submit funding applications for rigorous review. Once grants are approved, Principal Recipients and Global Fund Country Teams work together to implement them collaboratively. Continuous monitoring and evaluation ensure effectiveness and transparent reporting of results maintains accountability to donors.

The Global Fund has developed a Modular Framework with a standardized set of components, modules, interventions, budgets, and performance indicators. This framework aims to ensure consistent monitoring and reporting across different regions and over time. All funding requests to the Global Fund must use this Modular Framework to show how proposed program activities and costs align with and contribute to a specific set of indicators and outcomes.

Upon review, it was found that CLM can receive funding through Global Fund grants directed toward Resilient and Sustainable Systems for Health (RSSH) as well as through the RSSH components of disease-specific grants focusing on HIV, tuberculosis, or malaria *(25)*.

Within RSSH, CLM activities are supported as part of community systems strengthening (CSS). In the 2023-2025 funding cycle, the Global Fund has highlighted CLM as one of CSS's fundamental aspects. Specifically, they are:

- Community-led monitoring
- Community-led research and advocacy
- Community capacity building and leadership development
- Community engagement, linkages, and coordination

Meanwhile, the modular framework also identified examples of CLM activities:

- Development of national frameworks and strategies for CLM
- Development of CLM tools and equipment, including appropriate technologies for data collection, management, and storage
- Technical support and training for CLM, such as for indicator selection, data collection, data management and security, data analysis, or use of CLM data to improve programs
- Piloting and implementation of CLM to identify and address barriers to health

The HIV CLMS in the Philippines have already established and started accomplishing all of the suggested activities mentioned, which should give the CLOs opportunity to be supported for the expansion phase.

Discussion

Global data on community-led monitoring efforts and practices suggest that enabling factors are extremely important for communities, stakeholders, and donors to optimize the added value of CLM to the universe of HIV surveillance data. While this paper's findings show that there are many entry points to optimizing CLMS's full potential in the Philippines, these facilitating factors need strengthening, and the uncovered challenges in this study need to be addressed collectively.

The succeeding subsections digest and discuss the current contexts, based on all the data reviewed and studied, and how communities of PLHIV, networks of KPs, and key stakeholders can mutually gain from enabling factors.

Pre-Implementation Preparation

The interviews and FGDs conducted in this study highlighted the importance of social preparation, which is designed to prepare people involved in the implementation to cope with and accept the changes brought about by the CLMS. The activity consists of understanding the CLMS framework and processes. It addresses the reservations or discomfort of those subjected to monitoring. This

process is warranted to form deeper connections and partnerships with duty-bearers or the recipients of CLMS data.

In addition, the community-led organizations prepared for this data-driven advocacy by undergoing rigorous training, including learning to practice diplomatic, solution-focused data presentations and respectful feedback. The stakeholders who are targets of their advocacies should then be genuinely open and ready to co-develop solutions with the community. HIV programme implementers or service providers can manifest the same by voluntarily embracing their roles in the implementation.

HIV CLMS Report

The HIV CLMS report gives a better picture of the system's methodologies, including how the data it collects is being processed and analyzed, which are essential to understand from the data user's perspective. It also does not only present critical gaps reported by clients of HIV and AIDS services since it also presents good performance indicators of the concerned providers. This shows how programme implementers generally perform their duties, especially in service availability, accessibility, acceptability, and quality (AAAQ) framework, which are the basic standards of healthcare service provision.

Other vital parts of the report surround specific recommendations to address the presented critical gaps and outcomes or results of the HIV CLMS advocacy. However, since it is a national report, it must still provide tailor-fit recommendations to address issues. It must also include other CLMS data, such as reports on VHSD gathered from other HIV CLMS monitoring tools.

Nevertheless, CLMS data complements other data decision-making authorities use for program planning, monitoring, and improvement. It adds value to local, regional, and national health information systems by filling a gap in understanding the underlying and diverse barriers that prevent the response from achieving its targets.

Pilot Implementation Experiences

Programme Implementers or Service Providers

Quezon City and LoveYourself generally have the capacity to promote CLMS' purpose to their clients, but they face unique challenges that could affect all if left unaddressed. Issues such as a lack of human resources to collect data, some clients lack gadgets and internet connectivity to access the exit feedback tool, and the tool being long and confusing for some clients are important hurdles that CLMS should address. Whilst community-led monitors should step up in leading the CLMS promotions and data collection, they must be supported by key stakeholders to perform their CLMS functions effectively.

Regarding principal facilitating factors, government-owned or controlled service providers have different motivations compared to community-based providers like LoveYourself. For Quezon City facilities, the requirement from administrators or managers to engage with the PLHIV and KP communities through CLMS has been a key factor for successful pilot implementation. This requisite led to their internal preparations, leveraging lessons from the social preparation stage, and designating focal persons to promote CLMS' purpose and the exit feedback tool to their clients. Their engagement with CLOs during advocacy stages and the co-creation of solutions demonstrated the city's commitment to partnering with the community and addressing gaps.

In contrast, community participation and engagement are among LoveYourself's core values, which served as the primary basis for fully embracing CLMS. Nonetheless, unlocking CLMS's full potential demands unwavering political determination and a steadfast commitment to accountability from those driving the HIV programme forward.

Community-Led Organizations

The national baseline study on CLM for HIV, conducted in 2022 by Bilon et al., highlighted several barriers that, once addressed, can pave the way for a more effective CLM system. These barriers encompass factors related to systems and tools, knowledge, attitudes, and values, equipment and infrastructures, skills, and partnerships *(26).*

Two of the barriers identified by the baseline study that this paper found to be highly important to address were the lack of understanding among respondent organizations about community-led monitoring, its purpose, and methodology, and the lack of financial and human resources limiting their ability to conduct monitoring. Post-pilot implementation, the system could only address the first problem. The issue of lack of resources appears to be still the primary culprit in the CLOs' inability to implement the HIV CLMS fully. This has limited their implementation to CLM promotion and minimal social preparation only. While TDB appeared to be an exception due to its ability to implement, it also noted that the implementation is already straining its organizational funds.

Stories of Change

Although the people involved in the pilot implementation faced challenges, the collection and analysis of CLMS data and the community's advocacy efforts to find solutions still resulted in addressing issues such as ARV stockouts, streamlining facilities' processes to reduce waiting times, engaging in dialogue with higher authorities to advocate for adequate infrastructure, developing a referral system to address unavailable services, and increasing awareness among clinic staff about client management standards, which has led to the delivery of better quality service. Albeit not at a systemic level yet, these outcomes are impactful and would not have been possible without the community's aspirations to drive HIV programmes to quality improvement, and the enabling environment of their partner duty-bearers, which prove that meaningful community engagement through CLM is attainable.

Relevant HIV Frameworks, Studies or Documentation, Policies, and Enabling Mechanisms

CLMS is a community-led initiative that offers impartial and ongoing data on HIV service recipients' and impacted communities' experiences to decision-making bodies. Its data helps remove biases in health system reporting brought about by hierarchies, organizational interests, political, or professional interests and opens

the door to improvements by involving patients in quality improvement assessments of services and identifying ways to overcome impediments.

The incorporation of CLMS into the Philippine National AIDS Council (PNAC)'s national HIV monitoring system represents a significant stride towards fostering genuine community engagement with individuals living with HIV and key population networks. PNAC, with its oversight functions, holds a strategic position to help the community mainstream the CLMS at local and regional levels. While PNAC is enhancing community participation through its collaboration with CSOs and its monitoring and evaluation system, it should also provide robust support to empower community-led organizations (CLOs) in conducting monitoring activities in their respective areas. Given that CLMS is institutionalized in its AMTP7, PNAC stands to gain substantial benefit from community-generated data, emphasizing the crucial need to address the resource constraints faced by the community.

Quezon City and Pasay City have demonstrated commendable moves for supporting CLMS by recognizing and including its implementations in their local monitoring systems, showcasing their commitment to meaningful engagement. Based on reviewed documents, both LGUs also intend to evaluate how CLM is carried out or implemented in their respective jurisdictions, an opportunity that should be welcomed by the community since the intended evaluation may include whether the institutions enabled CLM's purpose.

The support for CLMS has been increasing since its establishment, opening up new opportunities for potential collaborations within the community and key stakeholders. As cited in this study, the CHDs and LGUs within and outside the DFAT sites that are in need of comprehensive surveillance data will hugely benefit from the CLMS. By recognizing and providing appropriate support, community-led monitors can help complement CHDs' and LGUs' programmatic data, ultimately bridging critical gaps and strengthening community initiatives and partnerships.

In relation to sustaining the actual work being done for CLM initiatives, the Global Fund invests in CLM initiatives under its RSSH as well as through the RSSH components of disease-specific grants focusing on HIV, tuberculosis, or malaria. Majority, if not all CLOs involved in the implementation of CLMS should

understand how to access this support by engaging with the principal recipient on HIV, and the Philippine Country Coordinating Mechanism (PCCM). Further, it is paramount for CLOs to actively seek out other partnerships. This includes exploring potential funding sources like the President's Emergency Plan for AIDS Relief (PEPFAR), investments from the Australian government, or foundations investing on community mobilization. These partnerships can significantly contribute to the CLMS's long-term sustainability.

Conclusion

As we approach 2025, addressing critical gaps in access to and uptake of healthcare services is imperative to achieving the 95-95-95 global AIDS targets. The community-led monitoring system (CLMS) is a vital strategy for closing accountability gaps by empowering communities, holding duty-bearers accountable to the needs of healthcare service users, and formulating actionable improvements and recommendations based on holistic and comprehensive HIV and AIDS data that include community experiences. This approach fosters accountability and ensures that healthcare services are continuously aligned with the community's needs.

The preceding sections of this paper discussed the facilitating factors that enabled the CLMS pilot period, the challenges faced, the outcomes of the pilot implementation, and opportunities to support the expansion or roll-out. Understanding all this information is essential to determining what needs to be sustained and improved to fulfill the CLMS's promise.

This study concludes that social preparation, requiring the facilities to participate in the CLMS process, the presence of community data collectors in service providers, data validation, and the transparent and solution-focused communication of data and advocacy are predominantly the facilitating factors that enabled the pilot implementation. These factors, among others, are necessary to sustain participation in the process.

Regarding challenges, service providers and community-led organizations commonly face issues such as some clients lacking access to gadgets and internet

connectivity to use the exit feedback tool. The tool can be long and confusing for some clients, and more human resources are often needed to collect data or manage the entire CLMS process. It is important to note that community-led organizations are particularly impacted by the lack of resources, given that CLMS is considered a community responsibility. Addressing resource gaps will also address the other issues mentioned, as more data collectors can be deployed to assist clients in giving feedback.

The effectiveness of CLMS implementation is essential, but support for it often diminishes after the development phase. Despite the problems in resources to sustain CLMS work, the community still has windows or opportunities to strengthen their partnerships or engagements through the PNAC's AMTP7, CHDs' PIRs, and LGUs' monitoring systems. These partnerships may not necessarily immediately address issues of lack of resources, but CLMS's adequate proof of concept may be a gateway. Both the community and key stakeholders must understand that impact can only be achieved if CLM is included in communities and program implementers' monitoring and quality improvement processes while maintaining the community's ownership of the system. Advocacy actions should be routine and consistent to realize systemic change, though evidence of impact may only be evident several years later.

Program implementers, policymakers, governments, and response donors need to view CLM as a long-term investment in the quality of their health systems and adjust their cost-benefit models accordingly. In the case of local governments, they are expected to benefit from the Mandanas-Garcia ruling penned by the Philippine Supreme Court. This ruling will give LGUs more opportunities and flexibility to carefully plan, execute, and oversee programs, projects, and activities, including health. The increased devolution of resources through their access to a larger share of national funds under the National Tax Allotment is part of the government's broader decentralization initiative. This is relevant information because community engagements at the LGU levels can now be heightened by looking into how LGUs appropriate local funds and how inclusive their planning and budgeting are to community involvement, which may include a potential allocation for CLMS by means of social contracting, with emphasis that social contracting shall not mean compromising community-ownership and leadership of the CLMS.

The CLMS program aims to help drive long-term and systemic improvements in the HIV and AIDS response across the country, necessitating sustained meaningful and impactful engagement between affected communities and various duty-bearers such as the government, HIV programme implementers, technical support providers, and funding entities. While community-led monitors themselves cannot directly ensure the enhancement of monitored services, this duty rests with entities such as the Department of Health and its Centers for Health Development, the Local Government Units, the Philippine National AIDS Council, and the donor-funded programmatic implementing partners, who are the primary subjects of CLMS advocacy.

Finally, to achieve the 95-95-95 global AIDS targets, a robust and sustainable community-led monitoring system is essential. This system is not a one-time solution but a continuous process that requires ongoing support, active stakeholder participation, and a commitment to long-term investment and advocacy. By upholding community leadership and incorporating CLMS data into monitoring and quality improvement processes at all levels, we can ensure that healthcare services meet the community's evolving needs and drive systemic improvements in the HIV and AIDS response.

Recommendation

Considering the results of this study, the following are recommended:

1. For Community-Led Organizations

- Leverage the inclusion of CLMS in the AMTP7 and advocate within the PNAC to help mainstream CLMS data use at local and regional levels. The Department of Interior and Local Government (DILG), which has significant influence over LGUs, can encourage them to incorporate CLMS into their local monitoring and program quality improvement processes. Greater or the same level of influence is accurate for the DOH relative to its CHDs.
- Invest in social preparation using CLMS data. Educate and inform community members and decision-makers about CLMS to highlight its

importance and added value in shaping and improving program policies, guidelines, planning, and monitoring. Emphasize how CLM helps identify and address issues related to the availability, accessibility, acceptability, and quality of HIV and AIDS services.

- Upskill or master the CLMS skills, particularly in data appreciation, utilization, and recommending solutions. Building strong relationships with program implementers is crucial for co-developing solutions, and this can be achieved through diplomacy, effective communication, and better coordination, among others.
- Understand how to access the Global Fund's investments for CLM initiatives and engage with the country's principal recipients for the prevailing global fund grants and the Philippine Country Coordinating Mechanism (PCCM).
- As resources for CLOs engaged in or preparing for CLM implementation remain limited, creative solutions are needed to conduct CLMS work without compromising organizational health. At the minimum, promoting CLMS feedback forms among community members may suffice until more resources become available. This will ensure continuous documentation of community feedback, which should be routinely available to decision-makers.

2. For Government and Non-Government-Owned Programme Implementers, Service Providers, and/or Policymakers

- Foster meaningful community engagement with PLHIV and key population (KP) communities by recognizing the significance and impact of CLMS data in advancing national HIV programs. Assess the preparedness, capacity, and resource needs for effectively utilizing the CLMS process and data to identify and address gaps.
- Collaborate with community-led organizations (CLOs) to develop strategies that bridge existing resource gaps, ensuring effective implementation and sustainability of CLM initiatives.
- Embed the CLMS process and data into the monitoring systems and quality improvement processes of facilities, service providers, CHDs, and LGUs. Institutionalize this initiative by establishing policies that mandate the inclusion of community data in existing surveillance systems for the HIV response.

3. For Funders and Donors

- The existing HIV response donors in the country should also prioritize support for CLOs' implementation of the CLMS. To maximize donors' investments in developing CLM initiatives and see fruitful impacts, continuous support to CLOs while helping them figure out how to sustain the system should be part of their more extensive investment plans.
- International or local corporations and foundations interested in investing in public health, community mobilization, and accountability strengthening should support CLM initiatives.

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