

MILESTONE REPORT
**INTEGRATED CLM FOR TB,
HIV, AND HEALTH
EMERGENCIES:
A FEASIBILITY STUDY
DECEMBER 2025**



ACHIEVE

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MILESTONE REPORT

INTEGRATED CLM FOR TB, HIV, AND HEALTH EMERGENCIES: A FEASIBILITY STUDY

*Development of Integrated CLM
Mechanism for the Philippines (TB-HIV)*

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Acronyms and Abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality
ACHIEVE	Action for Health Initi
ARV	Antiretroviral (medication)
BHW	Barangay Health Worker
CAC	Community Advisory Committee
CHD	Center for Health Departments
CKL	CallKaLungs (Community Hotline)
CLM.	Community-Led Monitoring
C/MHO	City or Municipal Health Officer
C/MPDO	City/Municipal Planning and Development Officer
C/MDRM	City/Municipal Disaster Risk Management Focal Person
CQI	Continuous Quality Improvement
CESU	City Epidemiology and Surveillance Unit
DOH	Department of Health
DRRM-H	Disaster Risk Reduction and Management in Health Coordinator
EB	Epidemiology Bureau
FGD	Focus Group Discussion
HEMB	Health Emergency and Management Bureau
HIV	Human Immunodeficiency Virus
KII	Key Informant Interview
LDRRMC	Local Disaster Risk Reduction and Management Council
LGU	Local Government Unit
MEAL	Monitoring, Evaluation, Accountability, and Learning (as in MEAL plan)
NDRRMF	National Disaster Risk Reduction and Management Framework
NCR	National Capital Region (Pilot Site)
PMT	Project Management Team (as in PMT's Hotline)
PPPR	Pandemic Prevention, Preparedness, and Response
PrEP	Pre-Exposure Prophylaxis
SQ	Service Quality
TAG	Technical Advisory Group
TB	Tuberculosis
VHSD	Violence, Harassment, Stigma, and Discrimination
WHO	World Health Organization

Introduction

This feasibility study determines the optimal integration model—specifically, full integration versus an interoperable data system—for the Community-Led Monitoring (CLM) system covering Tuberculosis (TB), Human Immunodeficiency Virus (HIV), and Health Emergencies. The integrated CLM will monitor health service delivery across the four dimensions, including dimensions of violence, harassment, stigma, and discrimination (VHSD): Availability, Accessibility, Acceptability, and Quality (AAAQ).

The study is structured around three critical phases: Framework and Indicator Development (December 2024–April 2025), Data Collection and Usability Testing (April–August 2025), and Data Analysis and Feedback (September–October 2025). This process will generate robust evidence to assess the feasibility, functionality, efficiency, and sustainability of unifying existing CLM mechanisms.

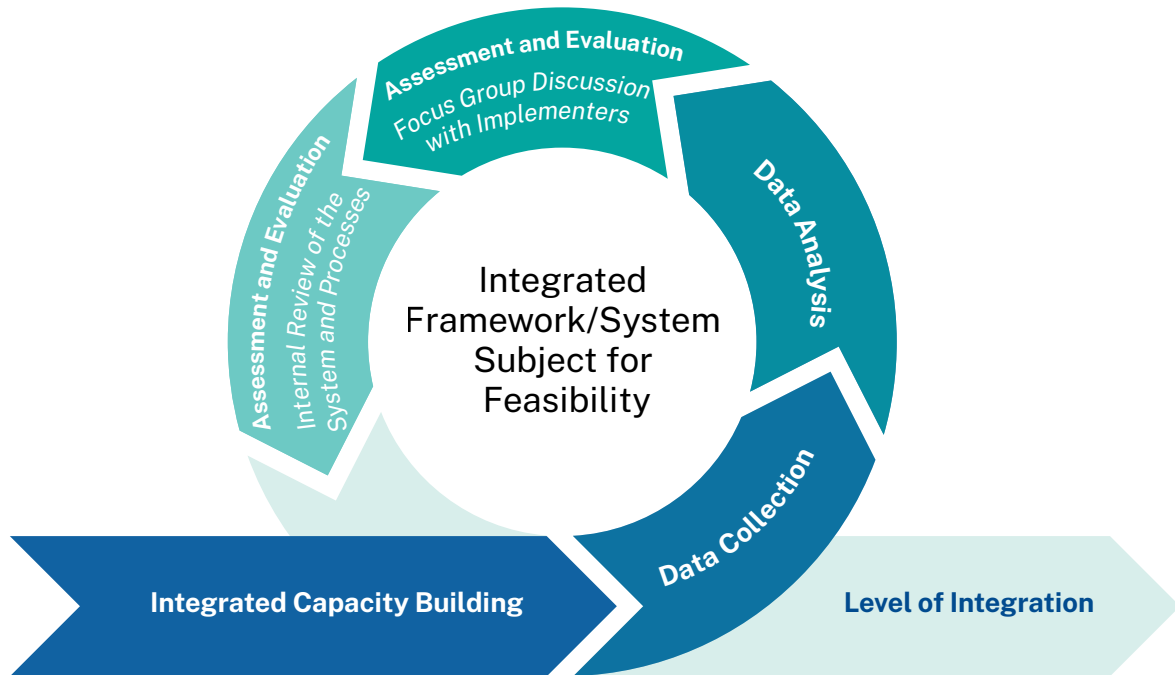


This initiative aligns with the Department of Health’s vision for a unified community monitoring mechanism, building on established collaboration among community-led organizations. ACHIEVE led the 2025 pilot implementation of the Integrated CLM Mechanism for TB and HIV within the framework of Pandemic Prevention, Preparedness, and Response (PPPR).

Ultimately, the pilot implementation seeks to establish a comprehensive framework for collecting, analyzing, and utilizing community-generated data. The goal is to strengthen accountability, connect community evidence directly to decision-making processes, and promote a sustainable and coordinated CLM practice in the Philippines.

Methodology

Figure 3: Integrated System Testing Phase



To assess the feasibility of the integrated framework, the system, tools, and processes underwent a pilot implementation across ten (10) regions and ten (10) cities. Grounded in the **AAAQ framework**, the integrated TB-HIV CLM was deployed through a dual-platform approach:

Self-Administered Survey - Utilized via the digital platform commusta.ph.

Integrated CLM Questionnaire

Your voice matters!
This survey is part of a collective effort to improve HIV and TB services by ensuring they are accessible, inclusive, and responsive to our communities' needs.

Note: For multiple choice questions, means only one answer can be selected and allows multiple answers.

*What is the name of the facility for which you're providing feedback?

*When did you last visit and receive services from this facility or organization?
 ↻

What services did you need or seek during that time?
 HIV Prevention & Testing
 HIV Treatment

Community Hotline - Managed under CallKaLungs (CKL).



Both platforms deployed the identical integrated TB-HIV monitoring tool, designed to accommodate and report feedback pertinent to both TB and HIV service delivery.

Table 1: Integrated Indicators for TB-HIV CLM	
SERVICE AVAILABILITY	Definition: Measures the extent to which clients were able to receive the services, commodities, human resources, and information they needed during facility visits.
SERVICE ACCESSIBILITY	Definition: Measures the extent to which clients find services accessible based on their perceptions of the facility’s location, safety, operating hours, and affordability of services during facility visits.
SERVICE ACCEPTABILITY	Definition: This is a composite indicator that integrates client perceptions to evaluate the extent to which TB and HIV services meet their needs and standards of care based on the three key dimensions of Accessibility, Acceptability, and Availability.
OUT-OF-POCKET EXPENSES	Definition: This indicator measures the minimum, maximum, and average costs incurred by clients for each specific service received.
VIOLENCE, HARASSMENT, STIGMA, AND DISCRIMINATION	Definition: An indicator to capture and document instances of VHSD experienced by TB and HIV clients due to their actual or perceived TB and/or HIV status

Indicators for the Health Emergency Component were developed based on the World Health Organization (WHO)’s One Health Framework and existing Philippine enabling mechanisms, specifically the National Disaster Risk Reduction and Management Framework (NDRRMF). This approach ensures a comprehensive, multi-sectoral, and community-based perspective on disaster risk reduction and management.

These indicators underwent rigorous review by the Technical Advisory Group (TAG) and subject matter experts, including technical representatives from the following Department of Health (DOH) bureaus:

- Health Emergency and Management Bureau (HEMB)
- Epidemiology Bureau (EB)

The indicators focus on four (4) key areas of preparedness:

Table 2 : Health Emergency Preparedness Indicators	
<p>Health emergency preparedness plan</p> <p>(Or equivalent plans: contingency plan, emergency plan, disaster management plan, business continuity plan)</p> <p>0: No 1: Yes</p>	<ul style="list-style-type: none"> • The existence of a plan/plans to address the risk assessment and prepare the facility, its staff, and the community to deal with a health emergency. <ul style="list-style-type: none"> ◦ The plan identifies accountable persons/institutions and clear roles and responsibilities. ◦ The plan is costed. ◦ The plan has a budget source earmarked for a possible health emergency.
<p>An early warning system is in place</p> <p>0: No 1: Yes</p>	<ul style="list-style-type: none"> • The existence of a system to inform the facility and the community of a possible health emergency. <ul style="list-style-type: none"> ◦ An early warning system includes community systems and the role of communities
<p>Community engagement in pandemic preparedness</p> <p>0: No 1: Yes</p>	<ul style="list-style-type: none"> • Plans are developed with input from affected communities <ul style="list-style-type: none"> ◦ Affected communities have specific roles identified in the plans to contribute to the pandemic or health emergency preparedness of the community. • Resources are available to support community-led and community-based pandemic or health emergency preparedness activities. • Communities are capacitated to engage in PPPR • Community systems for PPPR engagement established

To test the Health Emergency indicators, trained Community Monitors conducted Key Informant Interviews (KIIs) to identify and engage key health and non-health stakeholders at the project sites. Interviewees included, but were not limited to:

- City or Municipal Health Officer (C/MHO)
- Head, Social Hygiene Clinic
- Head, TB DOTS facility
- Supervising Nurse / Midwife / City / Barangay Health Worker (BHW)
- City/Municipal Planning and Development Officer (C/MPDO)
- C/M Disaster Risk Management Focal Person (C/MDRM)
- Community Representative in the Local Disaster Risk Reduction and Management Council (LDRRMC)
- Disaster Risk Reduction and Management in Health Coordinator (DRRM-H Coordinator)
- City Epidemiology and Surveillance Unit (CESU)



Data Processing

The collected data underwent a two-level analysis process to determine the integrated tool's efficacy in capturing data relevant to both TB and HIV, the community, and policymakers. The first level involved technical data processing, which focuses on ensuring data integrity and standardization. Data management officers performed cleaning and standardization using statistical software such as Stata and OpenRefine for data collected via commusta.ph and CKL. This process involved establishing and applying data validation rules to check for internal consistency, and subsequently conducting cross-validation by comparing the cleaned data against original sources or other relevant datasets to verify accuracy.

Data collected from the Key Informant Interviews (KIIs), which were designed to gather baseline information on the sites' level of emergency preparedness and community engagement, required a distinct approach. The interview data were analyzed side-by-side with the established Health Emergency indicators; the presence or absence of key indicators served as the metric to present initial information on the state of service delivery preparedness and community engagement of the city.

The second level focused on strategic utilization, involving collaborative data appreciation and preparation for advocacy with CLM implementers. Community coordinators, responders, and enumerators worked together with the data officers to make sense of the processed data and translated the technical findings into actionable insights for policy and program improvement.

Evaluation Process

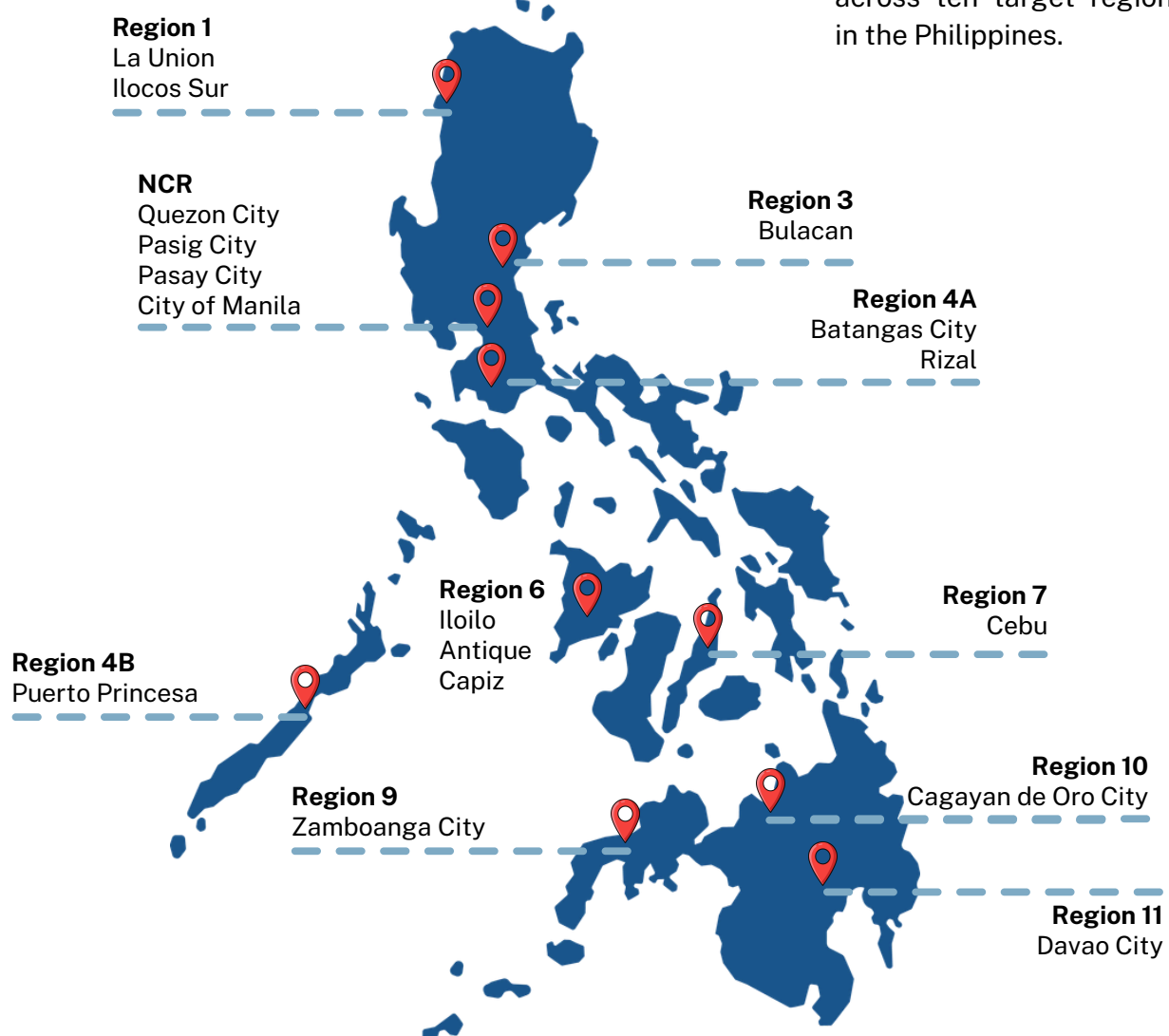
The integrated system was subjected to continuous evaluation and assessment throughout the pilot run to ensure iterative refinement.

Continuous monitoring was facilitated through monthly reports submitted by the implementing organizations promoting commusta.ph and structured monthly check-ins with CKL responders. To evaluate the usability and validity of the results, validation sessions were conducted with CLM implementers. Furthermore, to demonstrate utility, the collected data were presented as feedback to the Center for Health Departments (CHD) of each region and Local Government Unit (LGU) representatives. These sessions, led by community representatives, were crucial for sharing community advocacy and priorities based on the CLM data results.

Target and scope of the implementation

The scope of this pilot was designed to definitively determine the feasibility of the integrated CLM system. The pilot ran for a duration of ten months, from January to October 2025, and was geographically executed across ten target regions in the Philippines.

Figure 2: Pilot Sites



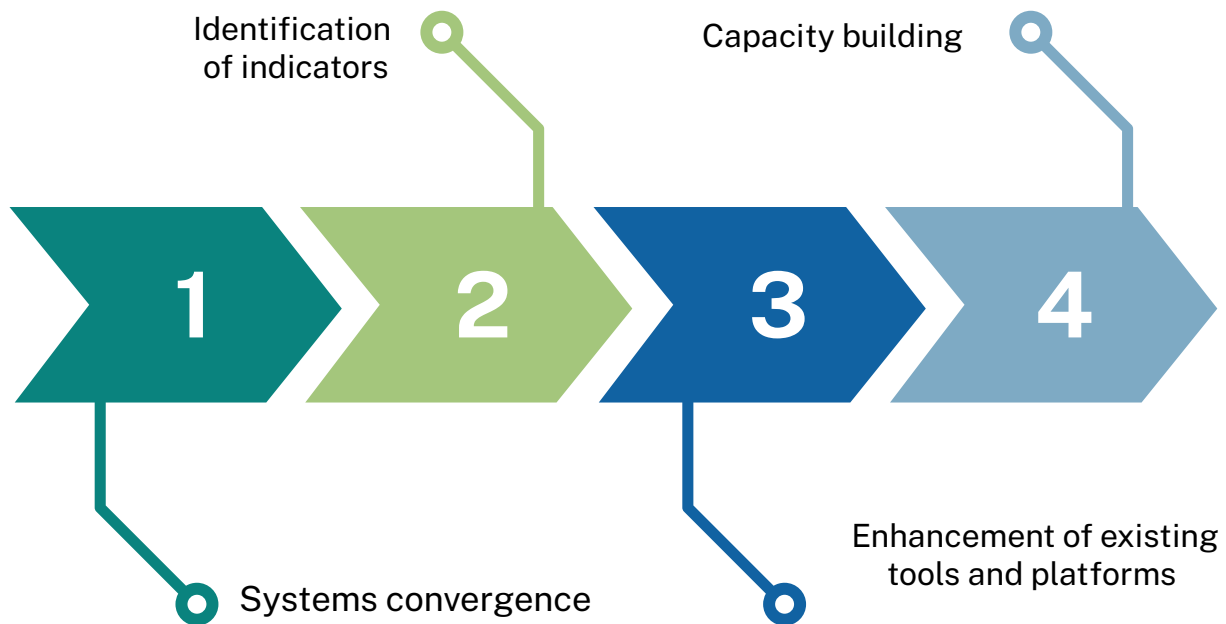
Operationally, the pilot encompassed four out of the six components of the complete CLM cycle: Identification of Priority Areas, Data Collection, Analysis and Interpretation, and Dissemination of Information. Due to the nine-month timeline for the feasibility study, the pilot necessarily excluded the final two stages of the full cycle: Co-creation of Solutions and Monitoring of Changes. These stages demand a longer implementation period and require sustained, continuous advocacy efforts from the community to successfully materialize and measure systemic impacts.

The pilot implementation was structured across three sequential phases:

1. Framework and Indicator Development (December 2024–April 2025)
2. Data Collection and Usability Testing (April–August 2025)
3. Data Analysis and Feedback (September–October 2025)

Development Phase

Figure 3: Development Process



The Development Phase focused on creating the integrated CLM framework, including the addition of the Health Emergency component. This process entailed system convergence, indicator identification, tool enhancement, and capacity building for CLM implementers.

a. System Convergence and Mapping

System convergence began with mapping all existing TB and HIV CLM implementers across the country. This effort was critical for identifying potential areas of integration and for mapping existing enabling mechanisms relevant to the new Health Emergency component. The mapping exercise was a vital step in strengthening the Philippine HIV and TB CLM systems. It provided valuable insights into technical compatibility, potential interoperability, data-sharing mechanisms, and operational frameworks. By assessing commonalities, differences, gaps, and challenges across these monitoring processes, key integration points were pinpointed, facilitating streamlined data collection and enhancing overall system efficiency. Furthermore, the examination of enabling mechanisms for Pandemic Prevention, Preparedness, and Response (PPPR) supported the development of health emergency-related indicators, ensuring continuity of HIV, TB, and essential health services during public health crises. The mapping methodology employed a consultation meeting with implementers and a desk review of existing CLM reports and official presentations.

b. Indicator Identification, Validation, and Tools enhancement

TB-HIV Indicators

A review process was conducted to identify and consolidate similar indicators across the separate TB and HIV systems, resulting in a set of common indicators. Measurement adjustments were made to ensure these new indicators could cater to both TB and HIV CLM. These indicators were then presented to the Community Advisory Committee (CAC) for validation and approval, during which the weight of each indicator was determined.

Health Emergency indicators were developed through a separate series of reviews focusing on existing Philippine mechanisms for pandemic preparedness. The initial draft was based on the World Health Organization (WHO)'s One Health Framework and the National Disaster Risk Reduction and Management Framework (NDRRMF). This initial list went through a series of multi-stakeholder consultations until the final version was achieved.

During the consultation, the CAC has decided on the final measurement of the integrated indicators. Service Quality Score is the weighted average of the three dimensions and the VHSD indicator.

Following the validation of all integrated indicators, both the commusta.ph and CallKaLungs (CKL) tools underwent necessary enhancements to accommodate the resulting single, integrated monitoring tool. The computation $SQ = (0.3 \times \text{Accessibility Score}) + (0.2 \times \text{Acceptability Score}) + (0.3 \times \text{Availability Score}) + (0.2 \times \text{VHSD})$ yields a final score, which is then translated into a categorical rating or level based on the defined thresholds: Excellent (96-100), Good (90-95), Fair (80-89), Poor (79 below).

	Definition	Measurement	Weighted Average
SERVICE AVAILABILITY	Measures the extent to which clients were able to receive the services, commodities, human resources, and information they needed during facility visits.	Numerator: Number of reports indicating that clients received all the services and information they needed or came in for during facility visits within the reporting period. Denominator: Total number of responses received	30%
SERVICE ACCESSIBILITY	Measures the extent to which clients find services accessible based on their perceptions of the facility's location, safety, operating hours, and affordability of services during facility visits	Numerator: Total number of reports indicating that the facility... <ul style="list-style-type: none"> • was easy to access or conveniently located • was located in a safe area; • had suitable operating hours; and • offered affordable or free services. Denominator: Total number of responses received	30%

	Measurement	Weighted Average	Measurement
SERVICE ACCEPTABILITY	Measures the extent to which clients find services acceptable based on appropriateness of care, respectful treatment, informed consent, and facility sanitation & hygiene during facility visits.	<p>Numerator: Total number of reports indicating that clients:</p> <ul style="list-style-type: none"> waited for a reasonable amount of time were asked for consent prior to any procedure; were treated with respect; found the facility and its waiting area to be sanitary, hygienic, and well-ventilated; found staff to be professional received gender-affirming, age-appropriate, and culturally appropriate care. did not experience issues with breach of confidentiality <p>Denominator: Total number of responses received</p>	20%
VIOLENCE, HARASSMENT, STIGMA, AND DISCRIMINATION	An indicator to capture and document instances of VHSD experienced by TB and HIV clients due to their actual or perceived TB and/or HIV status	Any form of VHSD warrants a validation process for serious incidents and shall be communicated to the concerned HIV service facility if the incident happened within their vicinity	20%
SERVICE QUALITY	This is a composite indicator that integrates client perceptions to evaluate the extent to which TB and HIV services meet their needs and standards of care based on the three key dimensions of Accessibility, Acceptability, and Availability.	<p>The Service Quality Score is the weighted average of the three dimensions and the VHSD indicator.</p> $SQ = (0.3 \times \text{Accessibility Score}) + (0.2 \times \text{Acceptability Score}) + (0.3 \times \text{Availability Score}) + (0.2 \times \text{VHSD})$ <p>Excellent (96-100), Good (90-95), Fair (80-89), Poor (79 below)</p>	100%

Following the finalization of the integrated indicators, the integrated tools were developed. The commusta.ph webpage tool was enhanced, and a new CallKaLungs (CKL) tool was developed.

The enhanced commusta.ph tool was redirected to a new KoBoToolbox link, featuring streamlined questions and the seamless integration of out-of-pocket expenditure-related questions within the same questionnaire.

The CKL tool underwent extensive structural changes. Its previous process functioned primarily as an open feedback and inquiry hotline, where responders captured narratives in free-text only. The new CKL intake form transitioned to a structured questionnaire designed to systematically surface issues related to the Availability, Accessibility, Acceptability, and Quality (AAAQ) of services. Responders are now mandated to probe callers, regardless of the initial call purpose, to complete all questions related to service access.

Health Emergency Indicators

The Health Emergency indicators were initially developed through an internal writeshop following an extensive review of existing international and national frameworks on Pandemic Prevention, Preparedness, and Response (PPPR) in the Philippines. Guided by the National Disaster Risk Reduction and Management Framework (NDRRMF), these indicators underwent a series of multi-stakeholder consultations to ensure no duplication with existing government monitoring efforts.

Following extensive consultations, it was agreed that the CLM Health Emergency component would focus specifically on assessing the level of community engagement in prevention, preparedness, and response during health emergencies. A key outcome of this consultative process was the recommendation to only pilot the preparedness indicators. This decision was based on the practical difficulty of measuring and assessing the response indicators effectively in the absence of an active pandemic or health emergency during the project's nine-month pilot timeline.

Based on the final set of indicators, a technical recommendation was made to deploy a portion of the data collection via Key Informant Interviews (KIIs). Given that this represented the first community monitoring effort on a health emergency, the results from the KIIs were specifically designated to serve as baseline data for the integrated framework.

c. Capacity Building

To operationalize the integrated framework, a comprehensive capacity-building program was designed for all personnel, including enumerators, hotline responders, and community monitors. The training focused on using the enhanced TB/HIV tool and deploying the new Health Emergency KII tool.

Capacity building activities were conducted across four batches from February to June 2025, reaching a total of 169 trained CLM implementers: 17 enumerators, 6 organization leaders, 19 responders, and 120 community monitors.

Data Collection and Usability Testing Phase

Data collection started immediately following the capacity building activities, running from May 1 to August 31, 2025. By the cutoff date, both the enhanced commusta.ph tool and the new CKL hotline yielded a total of 5,451 reports across the ten pilot sites. Efforts to increase uptake focused on extensive promotion across health facilities, LGU activities, and social media boosting. CLM implementers first conducted social preparation to facilitate promotion within their areas. Separately, enumerators, under the leadership of their organizations, conducted courtesy visits to facilities and City Health Offices across the ten regions to arrange active promotion schedules, ultimately operating within 37 facilities throughout the implementation period.

Hotline Responders, aside from participating in LGU-led activities, actively promoted the hotline via their personal social media accounts. A notable and unintended source of reports emerged from social media messages. Following active boosting via the main CKL page in July 2025, the integrated chatbot was enhanced to link clients reaching out through the platform directly with responders. This functional enhancement resulted in a high yield of reports, establishing the social media platform as a significant third entry point for CLM data, augmenting the primary hotline and commusta.ph page. The active promotional of the CKL page and advertisement resulted in a total of 428.6K engagements from July to November. A total of 1000 messages were received and 341 were found actionable and were subsequently assigned to responders based on location for assistance.



Data collection for the Health Emergency component, which was qualitative, was conducted separately. Key Informant Interviews (KIIs) were executed with health facility and LGU representatives, focusing on pandemic preparedness, service continuity for TB and HIV, and health system resilience. These interviews took place between July and September 2025, involving a total of 64 respondents across 13 cities within the ten pilot sites.

Data Analysis and Feedback Phase

Immediately after the cut-off of the data collection, data cleaning and processing were done at the data management officer level to ensure that the data collected is free of duplicates and is validated. This was also the first level of assessment on the kind of data received. Data analysis and data appreciation workshop was done together with community leaders and CLM implementers for them to have a better understanding of the data they have collected. This is also in preparation for the feedback that happened in October.

From October 1, a series of regional feedback sessions was arranged for community leaders to present the regional data and their community priorities in response to the CLM reports they collected.

Integrated TB-HIV CLM Key Findings



This section presents the results of the implemented integrated CLM tool for TB and HIV, as well as the baseline data of the health emergency component. A detailed report on the results is discussed in the 2025 Integrated CLM Pilot Report.

The integrated CLM was able to capture TB and HIV AAAQ concerns across the ten (10) regions. With the CLM, reports on TB and HIV stockouts and shortages were reported immediately and were validated by coordinators. Reports of the shortages on treatments were resolved as soon as we received reports through CLM. This showcases that the established coordination and reporting process for serious incidents during social preparations with the regions and LGUs was effective. Presentation of the results and key findings is presented below.



AVAILABILITY
91.78%

ACCESSIBILITY
94.66%

ACCEPTABILITY
93.02%

VHSD-FREE
99.59%

*This is a summary of service quality monitoring results from April to August 2025 in the 10 regions, covering Availability, Accessibility, Acceptability, and VHSD-Free indicators. The overall Service Quality score is a weighted average of these dimensions, with weights of 30% each for Availability and Accessibility, and 20% each for Acceptability and VHSD-Free.

A total of 5,451 responses were recorded between April 1, 2025, and August 31, 2025. The Overall Service Quality Score derived from these responses was 94.45% (Good), with the following performance breakdown across the AAAQ dimensions:

Indicators	Score	Key Findings
Availability	91.78%	High degree of service receipt, but significant stockouts identified.
Accessibility	94.66%	The majority reported no issues, but safety and convenience were flagged as barriers.
Acceptability	93.02%	High satisfaction, yet notable gaps in consent, respect, and facility standards.
VHSD-Free Facilities	99.59%	Nearly all facilities reported being free from violence, harassment, stigma, and discrimination

Availability

Of the 5,451 clients surveyed, 5,002 (91.78%) reported receiving all necessary services during their visit. Despite this high rate of service receipt, critical gaps exist, as specific commodities and services were commonly reported as unavailable.

The unavailability of key services is particularly concerning. HIV Testing (93) and PrEP (97) topped the list of absent services. The lack of HIV Testing presents a significant barrier to case identification and subsequent enrollment in treatment, directly impeding the effort to reach undiagnosed individuals. Similarly, the unavailability of PrEP undermines essential prevention measures critical for stemming the increase of infection among key populations.

The data further revealed that services were not offered at facilities that clients accessed, highlighting a systemic issue requiring attention. For instance, a report was received from a client in Batangas who was unable to access PrEP because the service was not offered in the facility. The purchase of prevention commodities remains the top community recommendation during feedback sessions, particularly in Region 9 and Region 6. Another critical example involved an ARV stockout reported by a client in Region 10 and Region 4A who attempted to access ARV at a facility that was not yet accredited as a treatment hub. These examples underscore the urgent need for all facilities to be capacitated to offer a comprehensive array of services and will serve as key evidence for targeted community advocacy moving forward.

Top 5 Reported Unavailable Services	
Service/Commodity	Number of Reports
PrEP	97
HIV Counseling	94
HIV Testing	93
Lubricants	63
HIV Information	49

Top Reason/s for Service Unavailability	Number of Reports
Unavailable medicines/commodities	82
Additional tests were required	54
Services were not offered	49

Acceptability

While the acceptability score was high (93.02%), the data revealed systemic issues related to patient rights and facility standards.

One hundred thirty-four (134) clients reported that facilities were not sanitary, hygienic, or well-ventilated, with reports on unhygienic comfort rooms being particularly prevalent in the received data. This concern is substantiated by a critical regional finding: in Western Visayas, all clients reported facilities and waiting areas as not sanitary, hygienic, or well-ventilated, highlighting a complete regional failure in upholding these basic standards. Furthermore, the cleanliness and sanitation of facilities emerged as the top priority concern for the community in Region 1 and Region 4B.

Issues undermining client trust included failure to seek patient consent (83 clients) and instances where clients were not treated with respect (37 clients). Furthermore, 30 clients alleged a breach of confidentiality. Staff conduct was also noted as an area for improvement, with reports of unprofessionalism (31) and a lack of sensitivity (6 for gender, 5 for cultural).

Regarding wait time, reports were highly subjective; some clients considered a four-hour wait reasonable, while others deemed a wait of less than one hour unreasonable. This suggests that the perceived reasonableness of the wait time is highly dependent on the client's individual context and expectations.

A notable recommendation stemming from feedback from both CLM implementers and clients themselves was the need to create a dedicated space within the monitoring tool, allowing clients to detail or elaborate on th

Accessibility

Accessibility was found to be strong overall (94.66% score), with 5,056 clients reporting no issues related to location, safety, operating hours, or affordability of services.

Despite this, localized barriers and operational concerns were identified. A significant access barrier concerned the client environment, as 130 clients reported not feeling safe in or around the facility. Other minor barriers included inconvenient location (89) and unsuitable operating hours (79). Regarding financial access, while the vast majority reported services were free, 15 clients who paid for services reported them as unaffordable.

In the context of operational factors influencing access and experience, waiting hours were reported as one of the top concerns across the pilot sites, particularly in Region 1. The Region 1 community partner provided specific recommendations to address this issue, including deploying additional personnel, improving time management, and proactively setting client expectations on waiting time.

VHSD

The CLM data for the pilot run yielded a high percentage for VHSD-free facilities, achieving a score of 99.59%. However, there are still 22 clients (0.41% of total respondents) who alleged experiencing any form of violence, harassment, stigma, or discrimination while accessing services.

Despite the low overall incidence, the reports detailed serious violations of dignity and safety. The most common types of alleged incidents included bullying (6), verbal insult/ridicule (5), and being ignored (5). Other severe incidents reported included threats, sexual violence, being gossiped about their HIV/TB status, physical harassment, physical abuse, and sexual harassment (each reported by 2 to 3 clients). These findings indicate that while widespread institutional stigma may be low, isolated yet critical incidents of hostility and abuse persist, demanding targeted intervention.

A notable and unintended finding with the new CLM tool was capturing reports of VHSD concerns outside the facility setting. Both the CKL hotline and commusta.ph received reports detailing VHSD incidents that occurred in other settings, specifically within households and workplaces. This finding suggests that the integrated CLM mechanism holds unexpected utility in monitoring social and environmental determinants of health beyond the healthcare facility. The addition of this specific purpose for the tool is still up for discussion and consultations to determine proper coordination and management.

Serious Incidents



Reports of stockouts and shortages are still one of the most important purposes of the CLM. The data documented several critical incidents that compromise patient care and safety:

- **ARV Stockouts**
 - A total of 41 clients reported incidents of ARV shortage, with 13 clients not receiving their refill. Of the 28 who received less than a three-month supply, stock levels were cited as the primary issue.
- **TB Medication Stockouts**
 - Sixteen (16) clients reported stockouts for key TB medications, including Quadmax (10), Duomax (4), and ITR Meds (2).
- **Confidentiality Breaches**
 - Beyond the 30 incidents in the Acceptability dimension, specific critical breaches included the disclosure of personal information (16) and HIV status (13).

Originally, the scope of serious incident reporting for stockouts or shortages was restricted to treatment-related supplies. However, consistent reports revealed shortages and stockouts of prevention and screening-related supplies, directly impeding eventual enrollment in treatment. Consequently, the Community Advisory Committee (CAC) recommended and agreed to expand serious incident reporting to officially include stockouts and shortages of prevention and screening-related supplies.

Health Emergency Community Monitoring Key Findings

The project also conducted a baseline assessment of selected LGUs within the 10 regional sites on their preparedness for health emergency events that may occur moving forward, following the unprecedented experiences during the COVID-19 pandemic. Key informant interview (KII) was the main methodology, along with a desk review of relevant documents emanating from the national and local levels. The project trained 124 community monitors on the assessment methodology to enable them to conduct the KIIs. The areas of study were: Pasig, Pasay, Quezon City (NCR); City of San fernando (R1); San Jose del Monte (R3); Antipolo City (R4A); Batangas City (R4A); Puerto Princesa (R4B); Janiuay (R6); Cebu (R7); Zamboanga (R9); Cagayan de Oro (R10); and Davao City (R11).

This baseline assessment looks at the status of health emergency preparedness of 12 local government units in 10 regions of the country where the integrated TB-HIV community-led monitoring is being conducted under a broader feasibility study.

Objectives of the assessment

1. Assess the capacity and preparedness of primary health facilities, as well as TB and HIV facilities in delivering their services during health emergencies
2. Identify gaps and challenges in pandemic preparedness and response at the facility level
3. Provide data-driven recommendations for improving service continuity, particularly for key and vulnerable populations
4. Strengthen community engagement in health governance by empowering trained monitors to gather and analyze facility-level data



Overall, the assessment shows that several local government units (LGUs) demonstrate strong preparedness and responsiveness across the five (5) focus areas of the health emergency assessment. Seven (7) LGUs—San Fernando, San Jose del Monte, Quezon City, Pasig, Batangas City, Puerto Princesa, and Zamboanga City—consistently scored high across all indicators, reflecting well-established systems, planning mechanisms, and coordination structures.

Among these, Batangas City stands out as having the most comprehensive and well-articulated health emergency preparedness plan. Its 2020–2025 Disaster Risk Reduction and Management–Health (DRRM-H) Plan integrates key lessons from the COVID-19 pandemic and applies a human-centered and mental health-focused approach for both responders and clients. The plan emphasizes psychosocial support for healthcare workers, systematic assessment of infrastructure damage, livelihood restoration, and the continuation of social protection services. Priority areas include post-disaster rehabilitation, livelihood recovery, and support for affected families and communities.

Batangas City also prioritizes continuous safety and preparedness training across departments, with capacity-building activities conducted both before and after the pandemic and adapted to evolving risks. The LGU is currently developing standardized local protocols and client-centered response algorithms to further strengthen future emergency responses. Community engagement is actively practiced, with meaningful participation from key populations, women's groups, senior citizens, and the private sector.

Despite these positive findings, the assessment also identified gaps in community involvement, with 42% of assessed sites demonstrating limited or no community participation in planning processes related to pandemic prevention, preparedness, and response (PPPR). Cebu City recorded the lowest scores in community engagement among the sites assessed, indicating the need to strengthen participatory mechanisms.

Several LGUs with relatively strong resource bases—including Cebu City, Cagayan de Oro City, and Davao City—would benefit from technical assistance in strengthening and refining their DRRM plans, particularly in aligning them with health emergency and PPPR considerations. Similarly, the municipality of Janiuay in Iloilo Province requires technical support to review and finalize its draft DRRM plan.

At the lower end of the spectrum, Pasay City and Antipolo City provided no documentary submissions and showed limited engagement with community monitors despite repeated follow-ups. As a result, no substantive data could be gathered on their level of preparedness for health emergencies during disasters, calamities, or disease outbreaks. For Pasay City in particular, findings across all five (5) focus areas remain nil due to the absence of information.

In general, however, the assessment indicates that all baseline sites exhibit some form of health emergency-related activities. These efforts, while present, remain largely fragmented and informal and would benefit from further systematization and institutionalization to ensure sustainability and effectiveness in future health emergencies.

In view of the findings the following recommendations are put forward:

1. For the Department of Local Government and Development (DILG) to require LGUs to have completed DRRM plans and the local health reforms and responsiveness since these are major indicators for the Seal of Good Local Governance (SGLG).
2. For the Department of Health Centers for Health Development (DOH-CHDs) to provide technical assistance to LGUs in developing their plans for Health Emergency Preparedness.
3. For civil society organizations (CSOs) community-led, community-based, or peoples' organizations to strengthen their ranks in order to meaningfully engage in the planning, implementation, and monitoring of health emergency prevention, preparedness, response and recovery (HEPPRR)
4. For the NGOs, government, and the private sector to assist communities to comprehend the various aspects of health emergency preparedness, how it impacts their lives, and how they can formulate their collective and appropriate response
5. For civil society, peoples' organizations, and community-led organizations to mount a strong advocacy for participation in HEPPRR to enable the LGUs to be conscious of the significant role the communities play in disaster risk management, particularly in involvement in health emergency interventions.

Implementation Performance and Assessment Results

The Integrated TB-HIV CLM followed a project MEAL plan. This particular assessment is part of the whole evaluation that will determine the project's feasibility, effectiveness, efficiency, and outcomes, and identify areas for improvement.

The review was conducted through the triangulation of field reports, activity documentation, and a series of focus group discussions with commusta.ph enumerators, CallKaLungs (CKL) responders, and the community monitors for the LGU health emergency preparedness assessment. The results surfaced the good practices, shortcomings, and the challenges faced by all actors in the course of the implementation with a view towards improvement. The field assessment ran from mid-October- mid-November 2025 across the 10 regional sites. The period that was evaluated was from April to August 31, 2025, to coincide with the cut-off period for data inclusion gathered from the integrated TB-HIV CLM.

In the face of challenges both at the national and local implementers' levels, the ground implementers strived to function optimally, resolving issues as they occur, in the default mode of flexibility without prejudice to scientific processes so as not to disrupt implementation. The data managers were always in touch with the responders and enumerators for validation of data received and to assist them in times of difficulties or uncertainties.

Objectives of the assessment

1. To assess the following facets of project implementation to determine the facilitating factors and the challenges to CLM implementation and how the latter were managed at ground level.
2. To determine the areas for improvement for application in the next phase of the Integrated CLM implementation.



The assessment attempted to answer the following:

1. Was the scope of work of CKL responders, commusta.ph enumerators, and Health Emergency Baseline assessment monitors fulfilled?
2. Were the activities conducted as scheduled during the project implementation on the ground?
3. What challenges, and bottlenecks were met by the field personnel during the project implementation?
4. How were these challenges managed?
5. Did the ground team perform at the optimum level?
6. What were the causes in instances when the responder/enumerator fell short in his/her duties?
7. What are the areas for improvement in efficiency and effectiveness?

Community Participation

Twenty three (23) community organizations across the 10 regional sites were engaged to implement CLM using the commusta.ph and CallKaLungs platforms. These are:

Location

Region	City	Community -Led Organization
1	La Union Ilocos Sur, Ilocos Norte	iECHO Support Advocacy Inc. AyatLakas Yakap Foundation
3	Malolos	TB Heals
4 A	Batangas City Cavite	Batangas KP Group TB League of Volunteers
4B	Puerto Princesa	Tandikan
NCR	Quezon City, Pasig, Pasay, Manila	Babaylanes Breathe Free Ph Positibong Pasigueno Association of Positive Women Advocates, Inc. (APWAI) HIV and AIDS Support House (HASH)
6	Iloilo, Janiuay, and Antique	Rajah kag Diwata
		ChillLungs
7	Cebu	IDUCARE Cebu KP Group
9	Zamboanga	MACAHAZ Mujer LGBT Organization
10	Cagayan de Oro	Kagay-an Plus NORMAA
11	Davao	Dawaw Mindanao Advocates Association Inc. (Dawaw MAAI) TBAI Dabaw TAHAS, Inc

Two (2) schemes of community engagement were applied for effective, efficient, and inclusive implementation of the CLM at the ground level. Community-led/based organizations were engaged for HIV that uses the existing but enhanced commusta.ph platform. A memorandum of agreement (MOA) that spells out roles and responsibilities between individual organizations and ACHIEVE was forged. Funds were downloaded to the organizations for CLM implementation during the period of the feasibility study. Meanwhile for TB, ACHIEVE engaged responders individually as a result of their performance evaluation during the previous implementation of CKL

Scope of Work of Community Organizations

The community organizations were responsible for the following tasks in their respective areas:

1. Identify and manage enumerators who will be responsible for ground implementation
2. Participate in all relevant capacity-building activities, including training sessions, simulations, coordination meetings, or refresher workshops organized by ACHIEVE or its partners.
3. Ensure ethical data collection, specifically in the areas of confidentiality, informed consent, and respectful engagement.
4. Supervise field operations, including observing data collection sessions as necessary, tracking progress.
5. Conduct feedbacking and regular coordination with local HIV facilities, networks, and other stakeholders to facilitate access for enumerators and promote data utilization through feedback loops and dialogue.
6. Submit monthly reports to ACHIEVE, highlighting enumerator activities, challenges encountered during data collection including concerns raised clients about CLM.
7. Submit reports on CLM-specific advocacy activities, including meetings with stakeholders and activities beyond data collection.

Ground Implementers

There were three (3) categories of the integrated CLM ground implementers who are members of the HIV, TB, or HIV/TB affected communities, namely:

1. Enumerators for HIV commusta.ph. The 11 enumerators who were engaged by their own organizations to serve as are responsible for collecting client feedback using the Integrated CLM tool, and ensuring adherence to eligibility criteria, data ethics, and project guidelines.
2. Responders for CKL. Recommended by their respective organizations, the 19 responders were engaged individually for the feasibility study to respond to calls through the CKL platform.
3. Monitors in the 10 regional sites. The 13 lead monitors (who in turn trained another 108 monitors in their respective stations) are the ones focusing on data gathering pertaining to health emergency matters during the occurrence of disease outbreaks, disasters, and calamities.

From among the current ground implementers, a Regional Coordinator was assigned for each region.

Terms of reference of ground implementers

Due to budget constraints as well as most of them also have jobs, all the ground implementers work on a part-time basis. Their role and functions are:

1. Commusta.ph Enumerators

Essentially, it was left to the HIV community organizations to assign their respective enumerators in the regions where they are assigned. The enumerators take on the responsibilities reflected in the MOA. The training of the designated enumerators also followed the training provided to the CKL responders.

2. CKL Responders

1. Capacity Building Participation - Engage in training and capacity-building activities related to the Community-Led Monitoring (CLM), including but not limited to:

- Fundamentals of CLM-m CLM Cycle and Social Preparation
 - Human Rights and Gender
 - TB-related Laws and Policies
 - Tuberculosis 101
 - HIV 101
- TB Advocacy and Communications
 - CallKaLungs 101 -Hotline Protocols, Data Management and Utilization, Probing Skills and Report Writing, Mental Health Triage
 - Orientation on the DOH-NTP Manual of Procedure

2. **Client Interaction and Support**

- Answer incoming calls and messages from clients, providing accurate information and support.
- Ensure that the intake information regarding the client's concerns is accurately recorded into the CallKaLungs database on a weekly basis, with no delays exceeding one month.
- Follow up on clients' situations to ensure ongoing support and services.
- Make appropriate referrals to relevant service providers.

3. **Partnerships and Linkages**

- Develop and strengthen partnerships with service providers and stakeholders in the assigned region.
- Promote and raise awareness about the CallKaLungs Hotline within the assigned region.
- As needed, participate in the monthly or quarterly meetings presided by the LGUs, PHOs, CHDs, and other CLM-related discussions, events, and activities.

4. **Reporting of cases**

- Report directly to the CallKaLungs Regional Coordinator, and Community Coordinators of ACHIEVE. Maintain a journal to ensure accurate intake of calls and ensuing processes.
- Report serious cases or critical incidents received through the CallKaLungs hotline to the Community Coordinators of ACHIEVE.

5. Monitoring and Evaluation - Participate in monitoring, evaluation, and learning activities related to the CallKaLungs TB Hotline to ensure the quality and effectiveness of the service.

6. **Equipment Management**

- Take responsibility for the proper use, care, and maintenance of assigned equipment.
- Ensure that the assigned CallKaLungs TB Community Hotline number is exclusively used for CallKaLungs-related purposes.

3. Community Monitors (Health Emergency Preparedness)

The community monitors went through a different training tailored to their terms of reference.

1. The Lead Community Monitor shall:

- Attend and complete the 5-day training on June 5–9, 2025, in Pasig City;
- Assist ACHIEVE in coordinating and setting up interview schedules;
- Conduct Key Informant Interviews with:

- Health facility managers or designated officers, and LGU officials responsible for health emergencies, TB, or HIV response;
- Ensure interviews are conducted ethically, with informed consent and sensitivity.
- Submit required documentation (notes, recordings, forms), per ACHIEVE's guidance;
- Refer escalated issues (e.g., serious service gaps or violations) to ACHIEVE;
- Participate in reflection, data validation, and advocacy messaging workshops.

2. Their deliverables include:

- Attendance and completion of the June training;
- Provide KII orientation to at least 4 other community members who could provide support during the interviews.
- Submit post-activity report (Annex 5), photographs, and profiles of each community member oriented using the Community Profile Form (Annex 3).
- Conduct of 10-12 completed and documented interviews using the KII tool (Annex 1);
- Timely submission of interview documentation, including attendance sheets, consent forms, notebook, photographs, and recordings.
- Participation in validation and feedback activities.

5. Treatment Hubs/Clinics Monitored

- For HIV services, a total of 82 facilities (47 primary care clinics and hospitals plus 35 champion clinics run by The Love Yourself) were monitored for feedbacks from clients for purposes of the feasibility study. For TB services, the calls were coming from even beyond the 10 regional sites.

Key Findings of the Assessment

The findings presented below were generated from focus group discussions (FGDs) conducted with 35 ground implementers across 10 regional sites, comprising 16 commusta.ph enumerators, 15 CKL responders, and 8 community monitors.

1. Comprehensive understanding of the CLM cycle by ground implementers

Overall, ground implementers demonstrated strong operational familiarity with key components of the CLM process, particularly in data collection and client interaction. Responders were adept at handling calls under the CKL modality, while enumerators showed confidence in administering the web-based commusta.ph tool. Community monitors involved in the baseline Health Emergency Preparedness Assessment also showed a clear understanding of their roles, as the tasks assigned for this activity were straightforward and well-defined.

At the same time, the assessment indicates that a comprehensive understanding of the full CLM cycle—including its theoretical foundations, principles, and end-to-end processes—remains a work in progress for many implementers. Despite multiple orientations and training sessions, several participants were unable to immediately recall the complete CLM cycle during the FGDs and required probing questions to trigger their recollection, particularly regarding social preparation and community-level promotion. This may be partly attributed to the short intervals between capacity-building activities, which may have resulted in cognitive overload given the range of knowledge and skills required by their roles.

While implementers demonstrated strong competencies in data gathering, further capacity strengthening is needed in data analysis and the translation of findings into actionable advocacy objectives. Strengthening these competencies is critical to fully realizing the value of CLM as a tool for evidence-based advocacy and systems improvement.

2. Work performance

Across regions, ground implementers showed high levels of engagement with health facilities for both TB and HIV, investing considerable effort in securing buy-in and approval

approval from facility staff and the Department of Health Centers for Health Development (DOH-CHDs). This reflects a strong orientation toward institutional coordination and formal entry points within the health system. However, as the Integrated CLM shifts toward a more community-centered and integrated approach, the assessment highlights the need to rebalance promotional efforts toward affected communities—the primary users of CLM mechanisms. In many sites, promotion relied heavily on health facilities to disseminate information, rather than engaging communities directly through community-based organizations. This was evident in areas such as Zamboanga, Palawan, and Bulacan, where posters, flyers, or QR codes were often ignored or discarded, and where long QR-based surveys were abandoned midway due to connectivity constraints.

While promotional materials were available, these were largely displayed or distributed within health facilities and government offices. Direct community-level promotion was limited, and the potential role of community organizations—particularly those working with key and affected populations—was not fully leveraged by either CKL responders or HIV-focused community organizations. Strengthening community-led promotion remains a critical area for improvement as part of the integration process.

Implementation challenges also affected performance in specific sites. In Cagayan de Oro, the responder was unable to deliver outputs due to organizational challenges and psychosocial distress, resulting in no calls received and limited promotional activities. In Cebu, difficulties in scheduling meetings with key stakeholders, including the DOH, City Health Office, and TB DOTS facilities, constrained implementation. These experiences highlight the importance of organizational support and well-being in sustaining frontline CLM work. In some cases, implementers who also serve as healthcare providers experienced challenges in maintaining role boundaries. A few responders tended to immediately resolve client concerns by facilitating access to services—such as screening, medication, or referrals—rather than documenting cases through the CLM system. While this reflects strong client-centered values, it underscores the need to clarify role distinctions to ensure that service provision and monitoring functions complement rather than replace one another.

Responders reported spending 10 minutes to up to two (2) hours per unique call and receiving multiple calls from the same clients. The length and timing of calls—some occurring late at night or early in the morning—posed challenges for timely case encoding, compounded by occasional gadget lag. Enumerators, meanwhile, required 3 to 7 minutes to administer the CLM tool. Assisted administration was generally faster (2–3 minutes) than self-administration (5–7 minutes). Despite the relatively short completion time, some clients declined participation due to their desire to leave facilities immediately after receiving services, pointing to the need for more flexible and client-friendly engagement strategies.

3. Integrated CLM Tool

Both responders and enumerators expressed general agreement that the integrated CLM tool represents a significant improvement, particularly in terms of clarity and ease of understanding compared to previous versions. This indicates positive progress toward harmonized and user-friendly tools as part of the integration process. Nevertheless, certain items continue to present challenges during administration. Clients showed hesitancy in responding to sensitive questions, such as those related to income, and confusion was observed when clients were asked to identify the group to which they belong. These findings suggest opportunities for further refinement of question phrasing and additional guidance for implementers to support clearer client understanding.

4. Gadgets

During the preparation for the feasibility study, ACHIEVE submitted to the principal recipient – the Philippine Business for Social Progress the number and tailored specifications of the digital gadgets required in order to optimally and efficiently implement the integrated CLM. The specifications were specifications are critical for ensuring that the team can efficiently handle all aspects of the TB-HIV CLM project, from data processing to documentation, reporting, and collaboration, without interruptions or delays.

Original Request	Provided by PBSP
Computer/LaptopProcessor: 13th Gen Intel Core i7-13620HOS: Windows 11 HomeGraphics: Intel Arc Graphics A370M, 4GB GDDR6Memory: 16 GB DDR5Storage: 1 TB, M.2, PCIe NVMe, SSDDisplay: 15.6-in. display Full HD+ (1920x1200)Quantity: 10 units	Computer/LaptopProcessor: Intel i7 12th GenRAM: 16GBSSD: 1TBWIFI: WIFI 6 with ethernetconnection or adaptorOS: Windows 11 ProMS Office: OEMPerpetual (with license) Quantity: 8 units
Computer/LaptopProcessor: 13th Gen Intel Core i7-13620HOS: Windows 11 HomeGraphics: Intel Arc Graphics A370M, 4GB GDDR6Memory: 8 GB DDR4Storage: 5gb, M.2, PCIe NVMe, SSDDisplay: 15.6-in. display Full HD+ (1920x1200)Quantity: 16 units	Computer/LaptopLaptops i5 Specifications:Process: i5 12thRAM (Memory): 16 GBStorage: 1 TBDisplay: 14 inchesOS: Windows 11 ProSoftware: MMSOffice: OEM Perpetual (withLICENSE)Network: Wifi 6 with ethernetconnection or adaptor Quantity: 10 units
Mobile PhoneProcessor and Storage: Octa-core Snapdragon 750G processor and 8GB of RAM. 128GB of internal storageBattery - 5,000Mah (typical) battery with a 25W of Super Fast ChargingDisplay: 6.6-inch Display with Full HD+ technology. Super smooth 120Hz displayQuantity: 15 units	Mobile Phone6.7" FHD+ Super AMOLED 90Hz display, runs Android 14, powered by a MediaTek Dimensity 6300 or Exynos 1330 chip with 4-8GB RAM, 50MP main camera, 13MP front camera, 5000mAh battery with 25W charging, and IP54 dust/splash resistance, with storage up to 256GB expandable via microSD Quantity: 12 units (against 19 units required)

The project provided 11 tablets for enumerators and 12 mobile phones, and 12 laptops for CKL responders to support Integrated CLM implementation. These devices enabled data collection, call handling, and documentation across sites.

As implementation progressed, some operational constraints emerged. Several responders reported that older mobile phones, including seven units retained from previous project cycles per PBSP requirements, were prone to lag and had weak battery performance, limiting real-time case encoding during calls. Responders also noted the need for mobile data support, as calls were often received while they were in transit.

To manage these limitations, some implementers used personal laptops or mobile phones to ensure continuity of work. While this demonstrated adaptability, it highlights the need to standardize, upgrade, and adequately support digital devices as part of the ongoing strengthening of the Integrated CLM system.

5. Challenges encountered and how such were overcome

Overall, the implementation experience demonstrates that Integrated CLM is feasible, with several sites showing the ability to adapt and sustain operations despite initial challenges. Strong collaboration between enumerators, responders, and facility staff enabled smoother implementation in sites such as Zamboanga CHO, Iligan, Cagayan de Oro, and selected facilities in Davao and Iloilo, where personnel actively referred clients, shared QR codes, and assisted with tablet use, resulting in higher participation.

Some challenges encountered reflect the early stages of integration and institutional alignment. In Cebu, Davao, and Cagayan de Oro, delays in scheduling appointments with facilities affected CLM start-up. In Quezon City, delays were attributed to the absence of a memorandum of understanding between ACHIEVE and the City Health Department, an issue that appears linked more to individual operational understanding than a systemic barrier. In La Union, some facility staff initially perceived CLM as a form of scrutiny, a concern heightened by unrelated issues such as 8888 cases, leading to increased caution among enumerators. Additionally, certain facilities – including Batangas Medical Center – required ethics clearance prior to CLM entry, further extending timelines. In some sites, facilities also exercised control over the number or type of clients allowed to participate in CLM. These experiences highlight the need for continued engagement, clearer communication, and trust-building, all of which are critical as integrated CLM processes mature.

Operational constraints were also noted. Enumerators – many of whom balance CLM work with other day or night jobs – were typically able to conduct facility visits once or twice a week. Responders received calls at varying times, including late at night or early in the morning, and often prioritized answering calls despite personal inconvenience, reflecting a strong commitment to community support. Challenges related to gadgets and data encoding were addressed through adaptive practices. Responders reported that encoding data using project-issued mobile phones could take an average of 30 minutes, prompting the use of note-taking during calls and encoding immediately afterward or the following day, often using personal devices. These adaptations ensured continuity of operations while pointing to areas where additional technical support could improve efficiency.

Finally, concerns regarding personal safety and security were raised, particularly in facilities located in perceived high-risk areas such as Pasay City, underscoring the need for clearer safety guidance as CLM implementation expands.

6. Support from their own and other allied organizations

Support from community organizations varied across sites. In several cases, enumerators reported limited engagement from their affiliated organizations, either because active support was not sought or because the need for assistance was not immediately recognized. Similarly, TB community-based organizations were less visible in CLM promotion, despite the presence of allied organizations under the Philippine Alliance to Stop TB (PASTB).

Rather than indicating a lack of interest, these findings point to a capacity and coordination gap within community networks as they adjust to integrated CLM approaches. Strengthening these networks presents an important opportunity to deepen community leadership, expand outreach, and enhance collective ownership of CLM for both TB and HIV. Addressing these gaps will be essential to sustaining integrated CLM and ensuring that community systems evolve alongside formal health structures.

7. Support from ACHIEVE

The implementers were unanimous in praising the support they received from ACHIEVE. The training and the logistical support were cited as excellent.

“Isang tawag lang naming sa ACHIEVE, andyan na si Kuya Robert, o si Sir Alain at Sir Jerome”

“Mentoring was very good. Very patient” “Response is instant”

8. Most enjoyed in their work

Most stressed the joy and fulfillment they feel about being able to help others, and being able to relate with the journey the clients were going through, having been in the same situation before.

Responders welcome being appreciated by callers who expressed such through follow-up calls, updating the responders with the progress of their cases.

Being able to build good working relationships with clinic staff and sometimes with the City Health Offices also afford the ground implementers satisfaction and a sense of raised self-esteem.

9. Self-assessment scoring

Majority scored themselves high-between 7 to 9 on a scale of 1 to 10. They said that in spite of the difficulties, they tried their best to deliver what is expected of them. A few, three (3) said they feel they should be given a grade of 5 or 6.

10. Their own recommendations for improvement of the integrated CLM

Foremost among their recommendations is the conduct of a robust, periodic promotion of CLM among the targeted users, in acknowledgement of their shortcomings in this aspect. Another is a the provision of more powerful and efficient gadgets to cope with the demands of the job.

The role of responder should be a full-time job.

CLM Governance Structure

The governance of the Integrated CLM system is anchored on three interlinked structures that ensure the mechanism remains community-led, technically sound, and accountable. Throughout the implementation there are three main governance structures that ensure the successful implementation of the integrated system.

The CAC, TAG, and PMT demonstrated effective complementarity, ensuring that both community and technical perspectives informed major decisions. The PMT reviewed existing CLM indicators in 2022-2023 for both the TB and HIV response. The CAC validated the integrated indicators and surfaced community priorities; TAG members provided technical assurance and alignment with national systems; and the PMT managed coordination, timelines, and follow-through across stakeholders.

1. Community Advisory Committee (CAC)

The CAC serves as the primary advisory and decision-making body representing community voices. The project implementation team refer to the CAC important decisions in terms of what the CLM will include such as the indicators, its measurements, the utilization of data, and the recommendations to be made.

In particular, since this was a pilot for the first integrated system it is important to ensure that community ownership of the CLM remains. In addition, the active participation of CAC members in national and regional social preparation and feedback sessions strengthened the legitimacy of CLM activities and findings. Their involvement enhanced trust and encouraged greater engagement from health facilities, CHDs, and LGUs in addressing identified service delivery issues.

2. Technical Advisory Group (TAG)

The TAG provides specialized technical guidance and alignment of the integrated framework with the existing government systems.

The TAG's multi-sectoral composition that includes representatives from the Department of Health's (DOH) TB and HIV Program, from the DOH Epidemiology Bureau (EB), ensured that the integrated TB-HIV-Health Emergency indicators were aligned with existing DOH.

In particular, the TAG played a great role in the development of the PPPR/health emergency indicators. This ensured that the CLM for health emergencies will complement the existing government efforts on PPPR whilst ensuring that community monitoring will be able to look at the existence of community engagement in government processes. One important factor that the TAG provided inputs on was since PPPR and health emergency is pretty new for communities to look into, the technical guidance of the TAG made it possible to ensure the soundness of the health emergency component of the CLM.

3. Project Management Team

ACHIEVE, served as the PMT responsible for overall project management, coordination, and implementation oversight. The PMT provided consistent logistical, administrative, and technical oversight. Despite a highly compressed implementation timeline, the PMT maintained project momentum through timely coordination, troubleshooting, and structured support to implementing organizations.

Areas for improvement regarding CLM implementation

The pilot implementation confirms that the Integrated CLM model is functional and effective. The call-based modality was validated as a strong mechanism for capturing detailed client concerns, while the integrated CLM tool represents a clear improvement over previous versions. FGD findings further suggest that, with intensified promotion, client feedback can increasingly be generated directly through CLM platforms, potentially reducing the need for facility-based enumeration.

Building on these strengths, promotion of Integrated CLM remains the foremost priority to increase utilization and broaden community feedback. Greater engagement of TB and HIV-affected networks and allied CSOs is needed to position CLM as a trusted platform for vulnerable populations to raise service-related concerns across all levels of care.

Ongoing capacity strengthening of ground implementers is essential as the system matures. Priority areas include deeper familiarity with TB and HIV service protocols, improved identification and handling of serious incidents as defined in the CLM playbook, and strengthened digital competencies. While the integrated tool is significantly improved, further refinements to enhance ease of use have been identified and are planned for the next iteration.

Operational learnings point to the need for stronger digital support as utilization increases. More powerful and standardized gadgets will be required to manage higher call and data volumes. While enumeration can support early uptake, the call modality has proven more effective, though labor-intensive, indicating the need for a dedicated cadre of well-trained, full-time responders, preferably fluent in local languages. Centralizing call handling while maintaining strong regional support may improve efficiency.

Finally, the pilot highlights the importance of streamlined coordination mechanisms, particularly for reporting and responding to serious incidents. Variations in coordination protocols across regions created complexity during implementation. Establishing a uniform coordination process, as also noted by Region VI CHD, will be critical as Integrated CLM moves toward scale and institutionalization.

Areas for Strengthening regarding governance structure

The project benefited from the active participation of the Community Advisory Committees (CAC), Technical Advisory Groups (TAG), and the Project Management Team (PMT), enabling timely responses to implementation needs and supporting adaptive decision-making.

As the integrated CLM governance model continues to mature, coordination between the CAC and TAG is often reactive to immediate project needs rather than guided by a regular consultation schedule, limiting opportunities for deeper joint review and strategic planning.

Similarly, role boundaries among advisory (CAC), technical (TAG), and management (PMT) functions were still being clarified during the early stages of implementation, occasionally resulting in overlaps or delays in decision-making.

Documentation and communication practices also present opportunities for strengthening. Records of decisions and follow-up actions were maintained inconsistently, affecting institutional memory and feedback flows between CAC members and their community networks.

Finally, high workloads and competing responsibilities contributed to variable participation across governance structures. In some cases, CAC and TAG representatives were replaced mid-implementation, requiring additional coordination and underscoring the need for structured onboarding, capacity-building, and succession planning as governance systems become more established.

Conclusions and Recommendations

Contributions to Health Systems strengthening and ensuring stakeholder buy-in

Social preparation activities conducted at the start of implementation proved to be a critical foundation for building trust and shared understanding among government stakeholders. These engagements helped position CLM as a constructive mechanism for improving programs and service delivery, rather than as a compliance or monitoring exercise alone.

1 Shifting Perception of Government on CLM

Across sites, Local Government Units (LGUs) quickly recognized the unique value of CLM data as a client-centered feedback mechanism that complements existing Continuous Quality Improvement (CQI) metrics of the Department of Health (DOH). CLM was seen as filling an important information gap by capturing lived client experiences that are often not fully reflected in routine facility-based data. For example, Pasig City emphasized that CLM provides essential context to better assess service quality. Development partners similarly acknowledged CLM as a necessary input in evaluating services supported through international funding.

Following initial feedback sessions, a clear shift in perception was evident. The earlier view of CLM as a tool for policing systems gave way to an appreciation of CLM as a resource for understanding community needs and informing responsive program improvements.

2 Commitment and CLM Integration to Programming

This shift in perception translated into concrete commitments and early integration efforts across pilot sites. In Region IV-A, CLM was identified as highly feasible for integration into quality audit cycles. Cebu City viewed CLM as a critical bridge between policy and client experience. In Western Visayas, CLM data began to function as an early warning system for monitoring commodity supply issues, prompting openness to policy and ordinance-level solutions. In Northern Mindanao, CLM findings directly informed decisions on infrastructure upgrades and resource reallocation. In Region I, the Center for Health Development (CHD) committed to promoting CLM hotline numbers and validating confidentiality-related cases reported through the platform. Collectively, these developments demonstrate growing government ownership and institutionalization of integrated CLM data.

3

Translating CLM Data to System Improvements

While it is still early to comprehensively measure system-wide impact, CLM data has already prompted several timely and actionable responses from government partners. These early changes highlight both strong stakeholder buy-in and the practical utility of CLM in translating community feedback into operational and policy-level decisions at the local level.

4 Infrastructure and Personnel Enhancements

As a direct result of client feedback indicating the need to travel elsewhere for specialized services, the San Jose del Monte (SJDM) City Health Officer (CHO) (Region 3) decided to hire a pulmonologist. Additionally, the office is committed to hiring additional nurses and medical technologists to bolster local service provision. To address the frequently reported issue of inadequate facility space, Iligan City is currently planning the transfer of the facility to a significantly larger space.

Policy and Commodity Access **5**

At the policy and access level, CLM findings on condom and lubricant availability in Zamboanga City were elevated to the agenda of the next Local AIDS Council (LAC) meeting. In Cebu City, the LGU committed to improving access to Post-Exposure Prophylaxis (PEP) through community centers and initiated efforts to fast-track the development of PEP and PrEP guidelines to support non-occupational PEP regulation and distribution.

Forms of CLM Integration

The pilot implementation demonstrates that integrating TB and HIV community-led monitoring is both possible and feasible, even while the two programs continue to use different access platforms. Integration is effectively achieved across three core areas: harmonized indicators and measurements, a common integrated tool, and an interoperable dashboard.

Because both TB and HIV CLM systems were already grounded in the AAAQ framework, harmonizing indicator definitions and measurements for the integrated system proved workable. The integrated TB-HIV CLM tool further enabled this process, as it is generally effective, user-friendly, and capable of capturing actionable data across both disease areas. Administration time ranges from 2–7 minutes for enumerator-assisted surveys and 15 minutes to up to two hours for hotline calls, reflecting the depth of concerns raised through the call modality. As implementation progresses, refinements are being considered to address areas where some clients experience difficulty, such as identifying key population categories or answering sensitive items (e.g., gender identity and income).

Integration has also expanded reporting options for TB and HIV clients. Individuals may now choose between a self-administered web-based form or a hotline, improving accessibility and client comfort. Notably, HIV clients can access the hotline even prior to visiting a facility, allowing them to seek information and guidance earlier in their care pathway.

Overall, the feasibility study confirms that the improved operational definitions and the integrated tool effectively capture critical dimensions of health service delivery for both TB and HIV, supporting the validity of a unified monitoring approach.

A key integration question addressed by the study was whether a single platform could present both TB and HIV data in a coherent and usable manner. Following each data collection cycle, information from the hotline and web-based tool is consolidated by the CLM Data Management Team through systematic cleaning and validation. This process ensures data accuracy and consistency prior to integration into a central master database.

The master database feeds into the Integrated Community-Led Monitoring Dashboard, an interoperable platform that enables community organizations, service providers, decision-makers, and the public to access and explore processed CLM data. The public-facing dashboard enhances transparency and accountability in TB and HIV service delivery, strengthens community participation in health governance, and supports timely, evidence-informed responses to emerging issues—further reinforcing the feasibility and value of an integrated CLM system.

Pathways for Sustainability

The sustainability of the integrated CLM system remains a priority for community leaders as the final framework and system structure continue to be refined. Findings from the feasibility study affirm that the core foundations for sustainability—community ownership, peer-led promotion, and government engagement—are already in place. While integration is still evolving, the challenges identified reflect a system in transition rather than structural limitations, pointing to clear and actionable pathways for strengthening long-term viability.

1. CLM Funding

Discussions on CLM financing are actively progressing. Community leaders recognize the need to diversify funding sources while safeguarding the independence and integrity of CLM data. In the context of declining international funding, communities are exploring complementary support from the Department of Health (DOH) and Local Government Units (LGUs), particularly for discrete operational components such as feedback sessions, stakeholder engagements, and the reproduction of promotional materials. These discussions are guided by agreed safeguards to ensure that data credibility and community trust are maintained.

At the subnational level, a promising financing pathway has emerged from Region VI through the proposed social contracting of CLM implementers. This model would allow community-led organizations (CLOs) to access LGU or Center for Health Development (CHD) funds to support localized promotion and increase uptake, while retaining centralized data processing and management under the CLM host organization to preserve independence.

From an efficiency standpoint, the Community Advisory Committee (CAC) reviewed future hosting arrangements and recommended retaining the current CLM host beyond 2026. The CAC emphasized that transferring hosting would require significant additional resources for system migration, new rounds of capacity building, and institutional onboarding. Maintaining

the current host is viewed as the most cost-effective and operationally efficient option, allowing resources to be focused instead on improving implementation quality and addressing the gaps identified in this feasibility study.

2. Institutionalization of CLM

Institutionalization remains a central objective for ensuring long-term sustainability. Increasing and formalizing the use of CLM data by government stakeholders positions CLM as a critical input to national and local planning and programming processes. Potential mechanisms include a joint memorandum from the DOH and the Department of the Interior and Local Government (DILG) encouraging LGUs to integrate CLM data into routine planning cycles.

More sustainably, legislative and regulatory pathways are being pursued. The ongoing amendment of the TB Law presents an opportunity to formally include CLM as a mandated mechanism, while the inclusion of CLM provisions in Local AIDS Ordinances (LAOs) – already realized in some LGUs – offers another viable pathway. Embedding CLM in legislation provides a strong legal basis for long-term government funding and institutional support. In addition, formalizing the participation of CLM implementers in Local Health Boards (LHBs) and Service Delivery Networks (SDNs) is essential to ensure that CLM findings are consistently reported, reviewed, and acted upon by key governance bodies.

3. Capacity Building for Civil Society Organizations (CSOs)

The development and hosting of the CLM system have historically been undertaken by organizations with strong technical capacity. A long-term goal of the integration roadmap is the eventual transition of full CLM system management to a dedicated community organization capable of overseeing database management, data analysis, and coordination with partners. Building this level of capacity is recognized as a gradual and resource-intensive process.

Consistent with the CAC's efficiency recommendation, the feasibility findings support phasing this transition rather than accelerating it. Retaining the current host in the near term ensures operational continuity while allowing structured capacity-building investments for the future community host. The coming period will therefore focus on strengthening systems, documenting processes, and gradually preparing for a well-planned transition – ensuring that integration gains are consolidated and sustained rather than disrupted.



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