Community-Led Monitoring Training Manual

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NEP+ and Ministry of Health

Contents

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
AYLHIV	Adolecent and youth Living with HIV
CBO	Community Based Organization
CLM	Community Led Monitoring
CLO	Community Led Organization
CSOs	Civil Society Organizations
EDHS	Ethiopian Demographic and Health Survey
MoH	Ministry of Health
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Service
KP	Key Population
KPP	Key and priority populations
OIs	Opportunistic Infections
OPD	Out- patient Department
OST	Opioid Substitution Therapy
MAT	Medically Assisted Therapy
MOH	Ministry of Health
NEP+,	Networks of Networks of HIV Positives in Ethiopia
NGOs	Nongovernmental Organizations
NNPWE	National Networks of HIV Positive Women In Ethiopia
PEP	Post-Exposure Prophylaxis
PWID	People Who Inject Drugs
PLHIV	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV
RHBs	Regional Health Bureaus
S&D	Stigma and Discrimination

STIs	Sexually Transmitted Infections
TWGs	Technical Working Group

Introduction

Background

Community-led monitoring (CLM) is a process through which communities systematically and routinely collect and analyse data at policy and strategy, programming, and service delivery levels to identify key bottlenecks and barriers. The CLM data collected at the policy and programme level will help to ensure accountability and address barriers. When implemented at the health facility level, community-led monitoring can provide deep insights on targeted action to improve patient experience and the overall quality of care, resulting in better health outcomes for individuals and the broader community [1].

The strength of CLM rests in that it is owned and conducted by people living with HI, key populations, and civil society organizations. CLM uses the power of people living with HIV and key populations to transform information on health systems into life-saving advocacy campaigns. It rapidly generates data on HIV prevention and treatment services and empowers communities to use their findings to identify and advocate for solutions that break down barriers to human rights, better health and higher quality of life [2].

A strong governance structure is key for enabling CLM programs to solicit funding, manage staffing and other start-up steps, and ensure the successful implementation of the project. implementation and governance led by local, community-led organizations, people living with and impacted by the three diseases, key populations, and other service users [3].

Globally, most CLM programs (82%) monitor indicators related to HIV, and 74% include TB indicators. Less commonly, 62% monitor indicators related to human rights, and 49% monitor COVID-19 indicators. Only 28% of programs include monitoring of malaria indicators [3].

Practice in 30 counties documented that, CLM created increased capacity for local organizations to conduct advocacy collect and analyze data and advocacy [3]. CLM helps to reduce stigma and human rights violations and increase access to and quality of HIV prevention, care, and treatment services [4, 3].

Ensuring quality of care has been a continued challenge to HIV, TB and Malaria services in Ethiopia [5]. The Second Stigma Index Survey in 2021 reported that 30% of PLHIV and key populations in Ethiopia face stigma and discrimination in healthcare settings. A bout 20% of PLHIV reported HIV testing without proper informed consent and 7% of PLHIV reported HIV status disclosure without consent in the healthcare settings [6]. Though there is significant stigma, unconsented care, and disclosure in healthcare settings there were limited mechanisms

to monitor stigma and human right violations in healthcare settings [7]. CLM could play a very critical role in monitoring quality of HIV, TB, and Malaria services and stigma and human rights violations in healthcare and community settings.

NSP 2023/24-2026/27 identified the following activities to be implemented to strengthen community-led monitoring in Ethiopia during the strategic period [1]:

- Establish a CLM task force at national and regional levels which will oversee the conceptualization and design of the CLM and review and act on CLM findings.
- Develop CLM national strategy, guidelines, and data collection and compilation tools to monitor, identify and address policy, programme, and service gaps and barriers.
- Avail digital tools and technologies for data management and storage.
- Build community capacity including training on CLM including digital CLM tools, human resource (staffing), technical (training) and technological and financial capacity.
- Adopt, implement and monitor a digital CLM platform.
- Provide technical assistance to CSOs leading CLM for the development of a data warehouse to bring CLM data from multiple sources.
- Provide a real-time CLM dashboard and response module for multiple stakeholders to take prompt action on the ground and to promote evidence-based decision-making.
- Perform an annual assessment of needs, issues, and impact of CLM activities.

CLM will be complementary to national health management information systems (HMIS). Together, the data can inform national strategic and operational planning for HIV programmes to improve overall implementation and mitigate programmatic risks. CLM data can also be compiled and triangulated with government data over time for a more comprehensive picture of access to and quality of services [1].

In Ethiopia, community-led monitoring has been piloted with support from PEPFAR and US state department small grant to improve quality and friendliness of HIV services for key populations (KPs) and PLHIV. The Global Fund NFM3 and GC7 grants has funding to support implementation of CLM.

However, CLM implementation was challenged with lack of CLM training manual to train CLM implementers in the country. Therefore, this CLM manual was developed with review of existing literature and consultation with stakeholders including affected communities CSOs and networks, GF, PEPFAR, UN agencies and other stakeholders.

The purpose of this training manual

The primary purpose of this training manual is to build capacity of affected communities, their organizations, and networks to apply the concepts, principles, methods and tools of CLM to collect, analyses, interpret and use data to co-create solutions and advocate to improve access to and quality of health care, protect human rights of affected communities particularly PLHIV and Key populations.

Objectives: By the end of the training participants will be able to

- Describe the concepts, goal, guiding principles, components, thematic and population priorities and governance structure of CLM in Ethiopia
- Discuss the steps to set up CLM.
- Design and collect, analyze and present CLM data.
- Engage stakeholders to co-create solutions and advocate for access to and quality of services.
- Discuss the use of technology in CLM.
- Describe strategy and interventions of combination HIV prevention, HIV testing, treatment and care, clients' rights including stigma free care, informed consent and confidentiality.

Preparation of the training manual

The training manual content was guided review of CLM related UNAIDS [2], PEPFAR, The International Treatment Preparedness Coalition (ITPC) [8], Community-Led Accountability Working Group (CLAW) [3] guidance and best practice documentations. The training manual used the National CLM framework as bases to develop contextualized content for the training manual. The draft outline of the training manual was reviewed and approved by the National Technical Working group and the training draft manual was validated by key stakeholders in a three-day validation workshop. The training manual was finalized accommodating inputs from the validation workshop.

Training participants and trainers

The training participants will be those CSO staff engaged in CLM including the CLM coordinators, Monitoring and evaluation staff, field supervisors and data collectors and members of the CLM coalition at federal, regional and woreda levels. The training participants shall have at least a diploma level educational background. The CLM data

collectors (peer monitors) shall be PLHIV, KP (FSWs, high risk AGYW and PWID), people affected and infected by TB and Malaria.

The trainers should be those who have attended the TOT training and have good experience of monitoring and evaluation and research methods.

How to use the training manual

The training manual is designed as a six-day training program. It has 6 units and 24 sessions/ learning activities in it. Keeping the number of participants to a small size (maximum of 24 participants) will allow quality training and achieve higher participation, involvement, intimacy, and rapport among participants. This manual is prepared to train all CLM implementers and advocates including affected communities, their organizations and networks staff and other partners implementing and supporting CLM implementation.

There should be at least two training facilitators per session and at least one facilitator per group learning session. It is very critical to adhere to the manual content and learning activities. Training and group learning are conceived here as an exchange between the facilitator and the participants. The role of the facilitator is, thus, to assist the participants in the learning process.

The training uses a modular training approach. The training module is the main training material to facilitate sessions. There will be group learning activities that engage participants with questions and answers, case studies, group work and group presentations.

To enhance the learning process for everyone, participants explore and share their experiences and knowledge, critically analyze and practice CLM concepts, methods, tools and process. The main assumption is that participants know many things. Regardless of his or her level of formal education, each participant has a valuable contribution to make, if encouraged to be an active partner in the learning process.

Generally, facilitators need to prepare enough flipcharts and markers, A4 papers and pens, notebooks, training manuals, handouts, and copies of case studies, based on the learning activities. The facilitators should make sure to have planned enough time for the sessions. It should be kept in mind that participatory tools are time-consuming, and they will face time shortages. The facilitator should be time-conscious and manage the allotted time carefully. A timekeeper should assist him/her. Ways and means should be sought to shorten the time needed for sessions, for example in some exercises reporting

back to the large group can be skipped if the participants fully understand the activities. The learning manual should be distributed in advance so that participants can focus all their attention on listening and practicing. This will save time and participants will benefit from the discussions. The facilitator must rehearse each training session and well prepared in advance. All necessary materials should be ready the day before.

Monitoring the training quality

Training quality assurance is a very important component of the training. Training quality is monitored through the following measures:

- Administration of pre and post-test: Administer a pre-test questionnaire annexed at the end of the manual at the beginning of the training. Mark out of 100 points for each participant. See areas (questions) where most participants fail to answer correctly and address the area very well during the training. Please administer the same pre-test questionnaire as the post-test at the end of the training. Mark out of 100 points for each participant and compare it with the pretest score to see the difference you make through the training.
- Participant's daily course evaluation: Participants should administer daily training evaluation. This should be reviewed during daily trainers' meetings to address the concerns of trainees in subsequent sessions.
- Conduct daily facilitators' meetings: the facilitator's meetings should be conducted daily to discuss progress, participation, and challenges and address them in the subsequent sessions. This session helps trainers improve their skills and improve quality of training.
- Participants' overall reflection: There should be a session for participants' overall reflection on the training content and methods at the end of the training. The reflection should be documented as part of the training report for consideration in future training.

The training quality assurance and training conduct should be documented in a brief training report. The report should help to improve the quality of future training and revision of this training manual.

Unit -1: Getting Started

Unit objectives: by the end of this unit participants will be able to:

- Introduce each other.
- Clarify their expectations from the training.
- Discuss the training objective and schedule.
- Agree on the training norms.

Learning activities:

- Session -1: Participant introduction, expectation, and training objectives
- Session -2: Training its timetable and setting training norms.
- Session -3: Pre-test administration

Time allotted: 2 hours and 30 minutes.

Session – 1: Introducing each other, Participant expectations, and training objectives.

Session objective: by the end of this session participants will know each other and set the training objectives along with their expectations.

Method: Self-introduction, brainstorming, group discussion, and presenting the objective.

Resources needed: Active participation, facilitator note, sticky note, flipchart, and marker.

Time allotted: 50 minutes.

Instruction-1.1: Do pair introduction. Ask participants to pair with the next person. Each person will ask about his colleague the following information and introduce him/her to the group. The other person does the same.

- Name, and nick name if you have one.
- Name of your organization
- Your area of work
- Hobbies, pets you like, jokes that makes you lough and would like to share.

Note to the facilitator.

In any participatory training it is important to have participants introduce themselves to each other to facilitate participation, experience sharing and effective communication. In addition, if participants become comfortable with one another right at the outset, they will deal with each other in a much better way.

Participatory methods and tools will be used right from the beginning. Therefore, start by introducing yourself to the participants. Do not start with announcing administrative matters such as, coffee break, lunchtime, or stating the "Dos" and "Don'ts" of the workshop.

These introductory activities can sometimes be very amusing. Right from the beginning there will be a lot of interaction between the participants, which will help them to relax and be more spontaneous. Such activities will also facilitate the building of group cohesiveness and engagement of everyone. In this way, participants learn a lot about one another.

Besides, such an introduction acts as an icebreaker; since participants come from different places and backgrounds, this will help to break down the "walls" that may exist between them. Because participants are engaged early on in activities that are marked by movement, standing up and sharing, they become acquainted with one another, so that they are more comfortable working with one another. This also helps the "trainers" to be seen right from the beginning as real facilitators and not lecturers.

Instruction – 1.2: Ask participants what they expect from the training by asking them to express their expectations from the training and fears – giving one example each.

- Provide sticky notes to participants to write at least two things they expect from the training and post the sticky note on the wall. Then review the posted sticky notes. Please merge repeated and overlapping statements. Please use flipchart to write down the list of participant expectations when sticky notes are not available.
- Keep sticky nots posted on the wall or post the flip chart if sticky note is not used and keep these lists displayed throughout the training, and refer to them as appropriate, and in particular for the evaluations at the end if these expectations are addressed.
- Clarify expectations that cannot be attained through this training while you discuss training objectives.

Instruction – 1.3: The facilitator presents the objectives of the training on a flipchart (Prepared ahead of time) and asks the participants to compare it with their expectations (show the flipchart or stick notes with the list of expectations displayed on the wall).

Note to facilitator.

A clear understanding of the objectives will facilitate participation and make the workshop flow smoothly and help facilitators and participants to assess whether the expectations will be realistically met or not by the training program.

Such an approach will allow participants to express their expectations freely. If participants expect something beyond the scope of the training, the facilitator should address this clearly at this point. Lack of clear understanding of objectives vis-à-vis expectations can lead to misunderstandings between the facilitators and participants later in the training.

Training Objectives

General objective: Build capacity of affected communities, their organizations, and networks to apply the concepts, principles, methods and tools of CLM to collect, analyses, interpret and use data to co-create solutions and advocate to improve access to and quality of health care, protect human rights of affected communities particularly PLHIV and Key populations.

Specific objectives: By the end of the training participants will be able to

- Describe the concepts, goal, guiding principles, components, thematic and population priorities and governance structure of CLM in Ethiopia
- Discuss the steps to set up CLM.
- Design and collect, analyze and present CLM data.
- Engage stakeholders to co-create solutions and advocate for access to and quality of services.
- Discuss the use of technology in CLM.
- Describe strategy and interventions of combination HIV prevention, HIV testing, treatment and care, clients' rights including stigma free care, informed consent and confidentiality.

Session – 2: Training schedule, set the norm and environment.

Session objective: by the end of this session participants will discuss and set training schedule norms and environment.

Method: Brainstorming, group discussion, summary, and presentation

Resources needed: Training Schedule flip chart and marker.

Time allotted: 40 minutes.

Instruction -1.4: Distribute a copy of the training schedule and go through the major activities of the six-day training program.

Training day	Morning	Afternoon
Day - One	**Unit-1:** Getting started. **Unit-2:** CLM Concepts, principles, and governance	**Unit -2:** CLM Concepts Cont **Unit 3:** Establishing CLM
Day- Two	**Unit 3: Establishing CLM (cont)** **Unit -4: Evidence** : design and implementation of CLM data collection and analysis methods, tools, and process .	**Unit -4:** Evidence cont.
Day- Three	**Unit -4:** Evidence cont.	**Unit -4:** Evidence cont.
Day- Four	**Unit -4:** Evidence cont.	**Unit -4:** Evidence cont.
Day- Five	**Unit -4:** Evidence cont.	**Unit-5** Engagement and Advocacy
Day Six	**Unit-6-** Education	**Unit-6:** Education (cont) End of Training- Post-test, training evaluation, closing and certification

Tell participants that to effectively cover training content over six days training period they must work together for a minimum of 8 hours per day. Methods of Training evaluation include taking Pre and Post Test exams and Closing with a Certificate.

Present the daily schedule for major activities (see the example below) as a proposal, which is left for the participants to decide and agree upon.

Instruction -1.5: Ask participants to suggest and agree on the time to start the day, have the morning tea break, the time to stop for lunch, start the afternoon session, afternoon tea break, and time for closing the day.

- Leave the schedule on the wall for the rest of the training period.
- Review the schedule daily to include the various parts of the training to be covered each day.

Time schedule for the training (an example)

Time	Activity
9:00	Start
10:30–11:00	Tea break
12:30–13.30	Lunch
13:30	Start with energizer
15.30–16.00	Tea break
17:00	Closing

Instruction -1.5:

- Ask participants to suggest a group norm that should be observed by the training participants throughout the training.
- Write down the list of norms the participant suggests on the flip chart (Make a pictorial presentation or description of a norm whenever possible)
- Please merge repeated and overlapping suggestions about the training norms.
- Post the flip chart and keep these training norms displayed throughout the training and refer to them whenever a participant fails to abide by the norms.
- Put fines for failing to respect this norm and nominate a judge to affect these fines.

Facilitators note.

Make sure the training norms list includes the following.

- Active participation
- Cooperate with the facilitator.
- Be punctual.
- Switch off mobiles or keep it in silent mode.
- Respect each other. Don't undermine others' opinions and do not interrupt others.
- No side talks and no overlapping talks.
- Get to the point.
- Listen well to what others say.
- Confidentiality. What is talked about in the group will be confidential

Instruction -1.6: Ask participants to participate actively in the life of the workshop. Ask for volunteers to perform the following roles daily:

- Timekeeper and Judge: Controls time and remind facilitators, follow, and punish those failed to observe group norms or rules.
- Energizer: Make activities or stories, fun, Jokes that energize
- Recap: Provides key points or summary of the previous day training activities
- Evaluation facilitator: Distributes and facilitate administration of daily training evaluation.

Encourage everybody to volunteer at least in one of the activities in the three days training.

Prepare the table below in a flip chart and record the participants names volunteered for activities in each of the training days.

Post the flip chart on the wall with the assignments throughout the training and involve participants in different activities as per the schedule (see the example below)

Activity	Day-1	Day-2	Day-3	Day-4	Day -5	Day 6
Timekeeper and Judge	Seble	Natty	Nebiyu	Tufa	Ahmed	Lema
Energizer:	Nigusu	Meti	Fate	Halima	Tiku	Taha
Recap:	Mekibib	Tesfaye	Solome	Sadik	Adane	Kuku
Evaluation facilitator	Alene	Bayush	Ulfata	Semere	Hayat	

Facilitators note.

To make the training sessions pleasant, a conducive atmosphere should be created by pre-arrival preparations. Employing a participatory style and methods throughout the training extends to creating a conducive atmosphere for the learning process.

Learning which takes place in a group setting is affected by the social relationship between the people involved. Moreover, the relationship between the facilitator and the participants and among the participants themselves can influence the learning situation either positively or negatively.

Participants normally respond best to an atmosphere of acceptance, respect, and encouragement. They should therefore be encouraged to ask questions and contribute to the discussion. They will not do so if the facilitator humiliates them or makes them look foolish in front of their fellow participants nor will they be at ease if the trainer shows favoritism towards some members.

Creating an atmosphere where individuals feel able to work, learn and contribute depends on the facilitator displaying an attitude of respect for the participants. Participants who are treated with respect will respect each other and will also treat others with respect when they themselves are facilitating.

The physical surroundings can also affect learning. The basic principle is that the best learning takes place best when there are no distractions. The physical environment should therefore be quiet and at a comfortable temperature. There should be sufficient light in the room. The room should be equipped with the necessary materials for the session such as flip charts, papers, markers and ideally, a flip chart stand or a substitute. Make sure that seat is arranged in "U' shape and there is enough space for circulation.

Participants and facilitators need to be relaxed, that is an environment for adult learning. Monitor the mood and use energizers as appropriate to keep the participants active.

Session – 3: Pretest administration

Session Objective: by the end of this session participants will administer pretest evaluation questions to assess the knowledge and skills of participants on CLM before and after the training.

Method: Pre-Test questions

Resources needed: Pre-Post test Questions.

Time allotted: 60 minutes.

Instruction 1.7: Administer pretest.

- Please arrange the participants' seats in a way that they cannot see each other's test questions.
- Distribute the test questions and tell participants to read each test instruction and administer every question.
- Please tell participants to write their code number on the test paper. Tell participants to remember their code number.
- Collect the test questionnaires 60 minutes from the start of the test.
- Correct the test questionnaire according to the answer key out of 100 points.
- Post all participants scores along their code number, the mean score, the lowest and highest score.
- Identify questions or areas that most participants performed poorly and address them through the training sessions.

Unit 2- Concepts, Principles and Governance of CLM

Unit objectives: By the end of this chapter participants will be able to:

- Define community-led monitoring.
- Describe the goal, and guiding principles.
- Describe components of CLM
- Describe the priority populations and themes of CLM.
- Describe CLM governance structure in Ethiopia.

Learning Activities

- **Session -1:** Concept, and guiding principles of CLM
- **Session -2:** Components of CLM
- **Session -**3: CLM Priorities and governance structure

Total Time allotted: 2 hours and 30 minute.

Session-1: Concept, and guiding principles of CLM

Session objective: by the end of this session the participants will define community led monitoring and describe the goal and guiding principles of CLM.

Method: question and answer, discussion, and facilitator presentations.

Time: 45 minutes.

Materials needed: Training manual, flip chart, marker, LCD Projector, and Laptop

Instruction -2.1: Ask the participants the following questions and give them chances to respond to each question.

- What is a community led organization?
- Describe at least one thing that defines community-led monitoring?
- Describe key principles of CLM?
- What is the goal of CLM?
- How do you describe the place of CLM in the national HIV/TB/Malaria strategic plans?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator notes

What is a community led organization?

Community-led organizations, groups, and networks—whether formally or informally organized—are entities for which most of the governance, leadership, staff, spokespeople, membership, and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies, and which have transparent mechanisms of accountability to their constituencies.

What is Community led Monitoring?

CLM is a process in which communities, particularly people who use health services, take the lead in identifying and routinely monitoring the issues that matter to them. They create indicators to track prioritized issues, undergo training to collect data and analyse results, and engage with a larger group of stakeholders to share insights from the data and co-create solutions. When problems uncovered through CLM cannot be resolved, communities conduct evidence-based advocacy and campaigns until corrective actions are implemented by those responsible. CLM also documents positive innovations and effective practices that can be implemented with greater consistency and scale.

CLM uses the power of people living with HIV and key populations to transform information on health systems into life-saving advocacy campaigns. It rapidly generates data on HIV prevention and treatment services and empowers communities to use their findings to identify and advocate for solutions that break down barriers to human rights, better health and quality of life.

CLM uses a structured platform and trained peer monitors to systematically and routinely collect and analyze qualitative and quantitative data on HIV service delivery—including data from people in community settings who might not be accessing health care—and to establish rapid feedback loops with program managers and health decision-makers (Figure 1).

CLM is a community-led and community-driven process. Communities play an essential role in CLM. Communities have access to "insider" knowledge and unique experience and perspectives that are not available to external actors. Communities have a central role in ensuring access to health services, improving their quality and holding decision makers accountable. It increases accountability for, and improves outcomes of,

national and local HIV programmes — and the health of community members.

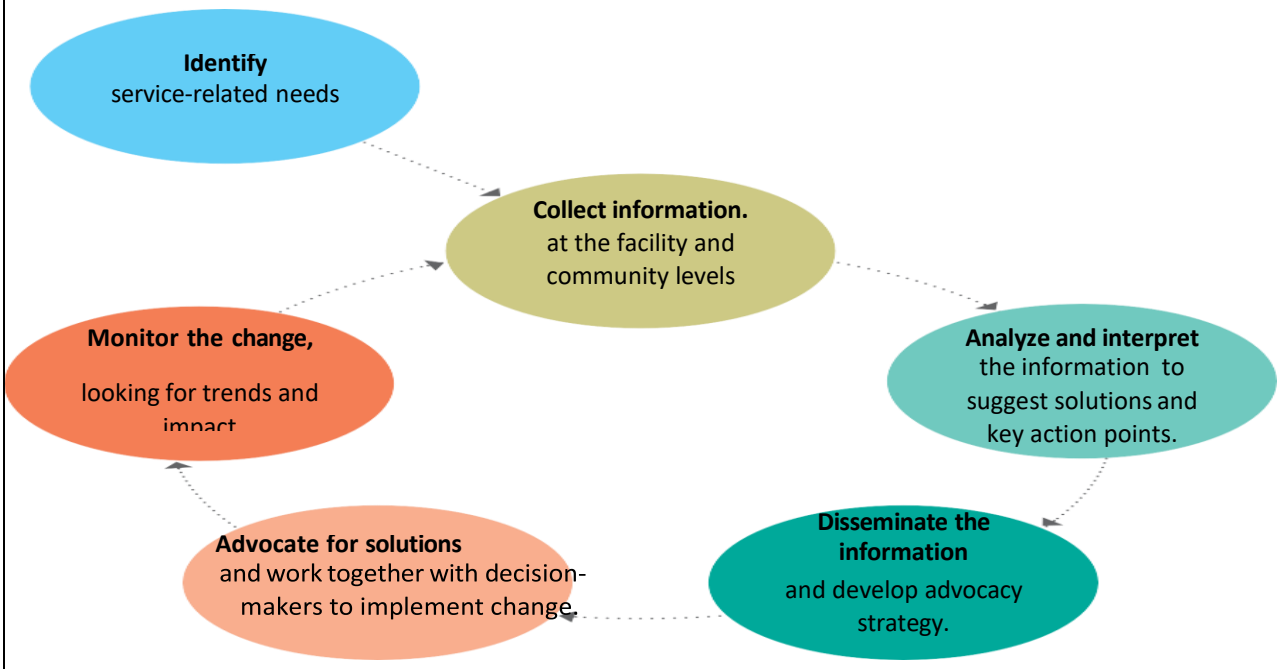


Figure-1: The CLM cycle.

CLM data builds evidence on what works well, what is not working, and what needs to be improved, with suggestions for targeted action to improve outcomes' may be used to track a range of issues. Examples are.

- whether and to what extent stigma has made it difficult for people to access HIV services,
- the proportion of people who have been denied access to HIV prevention and testing,
- the number of people who have discontinued antiretroviral therapy (ART) – and the reasons for this.

This evidence is fed back to programme managers and policy makers, which enables them to increase the "five As" (availability, accessibility, acceptability, affordability and appropriateness) and the efficiency and effectiveness of HIV services.

CLM Monitors trend and foster accountability.

CLM can be used to monitor trends of service quality within other disease areas (such as tuberculosis and sexual and reproductive health), humanitarian situations, challenging environments, and for social and structural health interventions, including combination prevention and human rights compliance, promotion, and protection.

As the purpose of CLM is to serve as a surveillance and accountability community mechanism (i.e., a watchdog function) for health services, CLM should not be confused with community-based HIV service delivery or with the routine collection and reporting of internal program data by community-led organizations.

CLM compliments health information and decision making:

The data collected complements local and national monitoring and provides key information to fill critical gaps in the decision-making process that lead to evidence-informed action to improve services.

CLM builds communities Capacity:

Through the CLM process, community-led organizations and key population groups increase their technical capacity to gather, analyse, secure, use, and own data.

CLM fosters partnership among stakeholders.

CLM provides a platform from which to strengthen relationships with other partners in the HIV and AIDS response around a shared understanding and response to service enablers and barriers.

CLM in the National HIV strategic plan 2023/24-2026/27

The NSP 2023/24-2026/27 defined community-led monitoring (CLM) as an intervention through which communities systematically and routinely collect and analyse data at policy and strategy level, programming and service delivery levels. CLM collects data at policy, strategy, and programme levels to identify key bottlenecks and barriers. The CLM data collected at the policy and programme level will help to ensure accountability and address barriers. When implemented at the health facility level, community-led monitoring and research can provide deep insights on targeted action to improve patient experience and the overall quality of care, resulting in better health outcomes for individuals and the broader community. The strength of CLM rests in that it is owned and conducted by community and civil society organizations. NSP 2023/24-2026/27 identified the following activities will be implemented to strengthen

community-led monitoring:

- Establish a CLM task force at national and regional level, chaired by national and regional PLHIV networks, that involves a range of CSOs, CBOs, KPPs groups, PLHIVs, MOH, RHBs, health-care facilities, UN agencies, donors and development partners.
- The CLM task force at local and national levels will oversee the conceptualization and design of the CLM and review and act on CLM findings.
- Develop CLM national strategy, guidelines, and data collection and compilation tools to monitor, identify and address policy, programme, and service gaps and barriers.
- Avail digital tools and equipment including appropriate technologies for data management and storage.
- Build community capacity on the use of appropriate new information communication and coordination tools and technologies, including digital tools.
- Provide human resource (staffing), technical (training), technological and financial capacity of CSOs, CBOs, KPPs, and PLHIVs associations to implement CLM.
- Adopt, implement and monitor a digital CLM platform.
- Establish a dedicated local project governance, field management, and operational and technical support to ensure the smooth functioning of the E-Monitor CLM platform.
- Co-create community response protocols and process. Implement and scale up a digital CLM platform that can be tailored to the local context.
- Provide technical assistance to CSOs leading CLM for the development of a data warehouse to bring CLM data from multiple sources such as facility surveys, scorecards, and other mobile and excel-based data sources.
- Provide a real-time CLM dashboard and response module for multiple stakeholders to take prompt action on the ground and to promote evidence-based decision-making.
- Perform an annual assessment of needs, issues, and impact of CLM activities.

NSP underlined that, CLM will be complementary to national health management information systems (HMIS). Together, the data can inform national strategic and operational planning for HIV, programmes to improve overall implementation and mitigate programmatic risks. CLM data can also be compiled and triangulated with government data over time for a more comprehensive picture of service delivery.

In Ethiopia, community-led monitoring has been piloted with support from PEPFAR and US state department small grant to improve quality and friendliness of HIV services for KPs and PLHIV. The Global Fund NFM3 and GC7 grants has funding to support implementation of CLM to improve HIV services.

Recently National CLM framework was developed to guide CLM implementation in Ethiopia. The National CLM framework defined the goal, objectives, guiding principles, methods and tools ang governance of CLM in Ethiopia.

Goal and objectives of CLM in Ethiopia

Goal:

Ensure access to and quality of HIV, TB, Malaria services including protection of human rights of people infected and affected by HIV, TB, and Malaria.

Objectives

- Enable communities, CLOs, and CSO networks to collect, analyze and use qualitative and quantitative data at health facility and community levels to co-create solutions and advocate to improve access to and quality of services, and enhance human rights including stigma-free care, informed consent, and confidentiality.
- Build communities, CLOs, and CSO networks capacity on service standards, evidence generation, engagement, and advocacy.
- Enhance collaboration and accountability among communities, CLOs, CSO networks, government, partners, and donors.

Guiding Principles

- Community-led and community-owned – Process led by affected community and CLOs.
- Independent: conducted independently and autonomously, without being directed or interfered with by other stakeholders (e.g., the government or a donor).
- Accountability: Collection and analysis of data through a lens of community need, identifying solutions, and holding decision-makers accountable for their implementation.

- Collaborative: Promoting good partnerships between all those involved in the service monitoring and improvement cycle—including the Ministry of Health, Regional health bureaus, and woreda health offices, health facilities, and service providers
- Routine and systematic: CLM should be developed and funded sustainably to allow for ongoing systematic data collection, advocacy, and action that can monitor trends over time.
- Results and solution oriented: The intended outcome of CLM is to achieve improvements collaboratively that respond to the community's priorities and improve health outcomes.
- Advocacy : The key component of CLM will be engagement and advocacy with key stakeholders such as MoH, RHBs, Zonal and woreda health offices and health facilities for co-creation of solutions
- Ethically governed: The ethical principles, autonomy, justice and beneficence, will govern the CLM design, data collection, reporting and use

Session-2: Components of CLM

Session objective: by the end of this session the participants will describe components of CLM.

Method: question and answer, discussion, and facilitator presentations.

Time: 45 minutes.

Materials needed: Training manual, flip chart, marker, LCD Projector, and Laptop

Instruction – 2.2: Ask the participants the four components of CLM and ask them to elaborate on each component they knew? Once the participants reflected on the components summarize the discussion by presenting the following note.

Facilitators note.

CLM Components

CLM covers four key areas: **education, evidence, engagement and advocacy.**

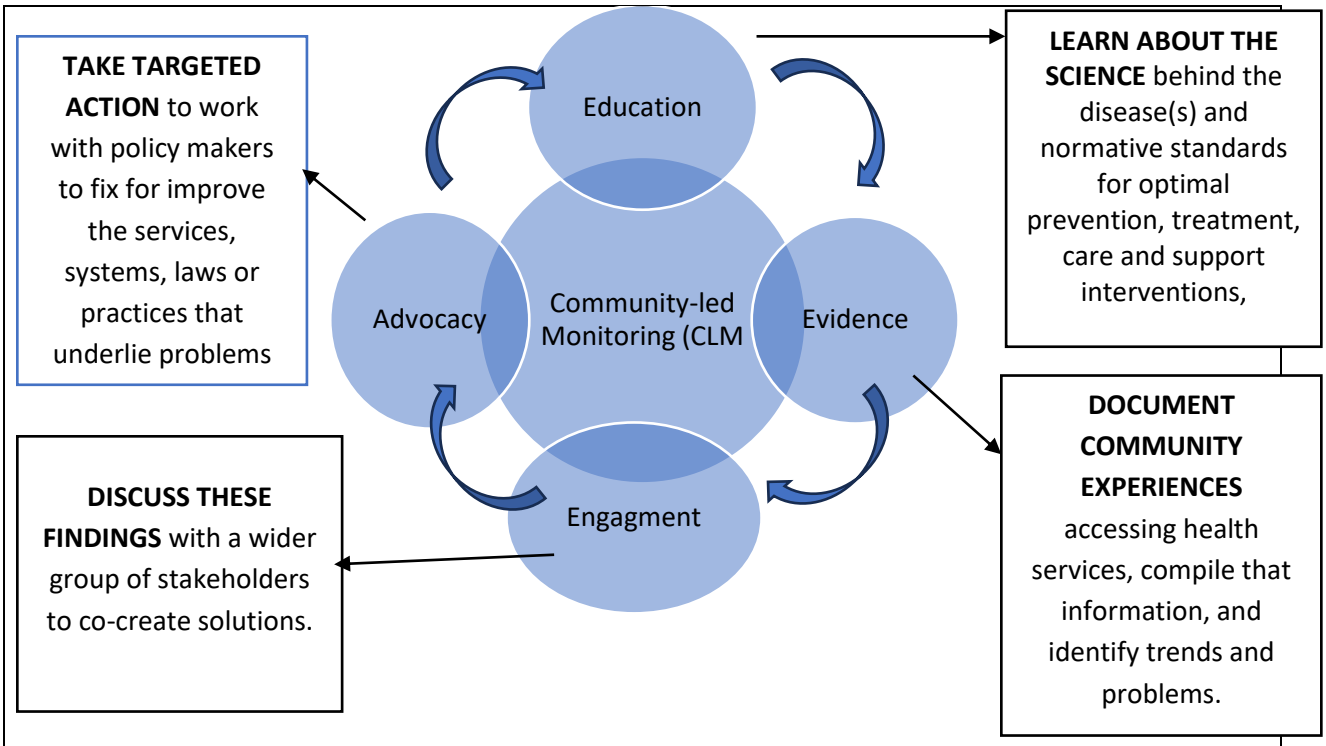


Figure 1 Components of CLM

a. Education

Community led monitoring uses the national and global human rights and service delivery guidelines and standards as a bases to monitor human rights and services delivered to people affected and infected by HIV, TB and Malaria.

Education and training of people affected and infected by HIV, TB and malaria as well as those organizations hosting or implementing CLM is fundamental for success of a CLM program. A CLM approach focused on HIV would include education and training around the targets and interventions of prevention, testing, care and treatment, and human rights issues These education and trainings ensure that community members understand the services and treatment they are entitled to and are familiar with their national treatment guidelines. Education builds a strong, sustainable foundation for organizations that host and implement CLM and related advocacy.

Therefore, CLM related education and trainings to communities affected and infected by HIV, TB, and malaria and CLM host and implementing organizations should include targets and package of services for HIV, TB, Malaria and human rights in Ethiopia.

b. . Evidence

Community data is the evidence that informs solutions and advocacy. Gathering this

evidence is often the most visible component of CLM. CLM systematically and routinely collect and analyze qualitative and quantitative data to co-create solutions and advocacy to improve access to and quality of services and human rights of communities affected and infected by HIV, TB and Malaria.

CLM evidence generation involves systematically and routinely collecting data, verifying, entering and cleaning it, data analysis (including monitoring for trends), and data quality audits.

c. Engagement

CLM is an effective way to solve problems collaboratively. CLM ensures engagement of key stakeholders to co-create solutions to improve access and quality of services and protect human rights of communities affected and infected by HIV, TB and Malaria. Engagement provides communities and health care providers with a platform for convening and sharing data to facilitate improved health outcomes for recipients of care.

Engagement develops from partnerships between a variety of stakeholders. CLM stakeholders are representatives from networks of people living with HIV, and key populations, officials from health care facilities and ministries of health, policy makers, donors, NGOs and academic partners.

Engagement facilitates collaboration in identifying, implementing, and sustaining solutions, and furthers government investment in, and accountability for, improving the reach and quality of HIV services and their delivery.

CLM establish rapid feedback loops with decision-makers at the program and health facility level. CLM implementers meet with health facilities and/or district and national decision makers, where data are reviewed, and solutions are co-created to mitigate identified gaps in treatment and service delivery.

d. Advocacy

The purpose of CLM is to improve access to and quality of HIV, TB and Malaria prevention, care and treatment services and protect human rights of affected and infected communities through evidence-based advocacy. CLM aims to identify and advocate for innovations and good practices that can be sustained, replicated, and brought to scale.

Evidence-based advocacy uses targeted actions to change norms, guidelines, standards,

and policies that directly affect the health of people living with and at risk for HIV, TB and malaria. This advocacy is aimed at improving individual and community health outcomes at local, subnational, and national levels.

When it is not possible to co-create solutions, communities, their organizations, and networks forge ahead to address their needs and hold decision makers accountable, using watchdogging and/or participatory monitoring and accountability approaches.

Session-3 CLM Priorities and governance structure

Session Objective: by the end of this session the participants will identify stigmatizing attitudes and discriminatory practices in the health care settings.

Method: Question and answer, discussion and facilitators presentations.

Time: 60 minutes

Materials needed: Case study, Flip chart, marker, LCD projector and Laptop.

Instruction -2.3: Ask the participants the following questions and give them chances to respond to each question.

- What are the population groups that should be prioritized for CLM?
- What are the thematic issues that should be prioritized for CLM?
- What should be scale of CLM implementation in Ethiopia now and the next 5 years.

Once the participants reflected on the questions summarize the discussion by presenting the following note. .

Facilitator Note

Populations Priorities

The population priorities for community led monitoring in Ethiopia include:

- People living with HIV (PLHIV)
- People infected and affected by TB and malaria.
- Female sex workers (FSWs)

- People who inject drugs (PWIDs)
- Prisoners
- High-risk adolescent girls and young women
- People in humanitarian settings

CLM Priority Thematic Areas

The priority thematic areas for CLM in Ethiopia includes the following:

- HIV, TB and Malaria service quality (Providers' attitude, waiting time, reception, facility)
- HIV, TB, and Malaria services accessibility (distance, opening hours, availability of services, use fees etc)
- People living with HIV, infected by TB and malaria, and key and priority population friendliness of health facilities, drop-in centers, key population clinics and other service delivery outlets.
- Availability and accessibility of HIV prevention interventions (SBCC, Condoms, PrEP, PEP, STIs treatment, VMMC…)
- Implementation and acceptability of differentiated service delivery models (DSDM) for HIV, TB and Malaria
- Availability of HIV/TB/Malaria prevention, diagnosis, treatment and monitoring products (including condoms, test Kits, ARV and OI drugs, CD4 and Viral load test Stock outs)
- Sexual relations and SRH services and counseling
- Stigma and discrimination, unconsented care, unconsented disclosure, delayed and inadvertent disclosure.
- Psychosocial support – Peer support
- Supportive policy, legal and strategy frameworks, guidelines, and tools
- Availability and utilization of funds
- Support for economics strengthening/ Income generation activity/livelihoods.

Scale of CLM

Community-led monitoring has been piloted for the last few years in selected facilities with PEPFAR support. The scale of implementation will reach an intermediate scale (up to 50 health facilities) across different regions in the next two years (2025). The implementation will be scaled to national scale covering the 300

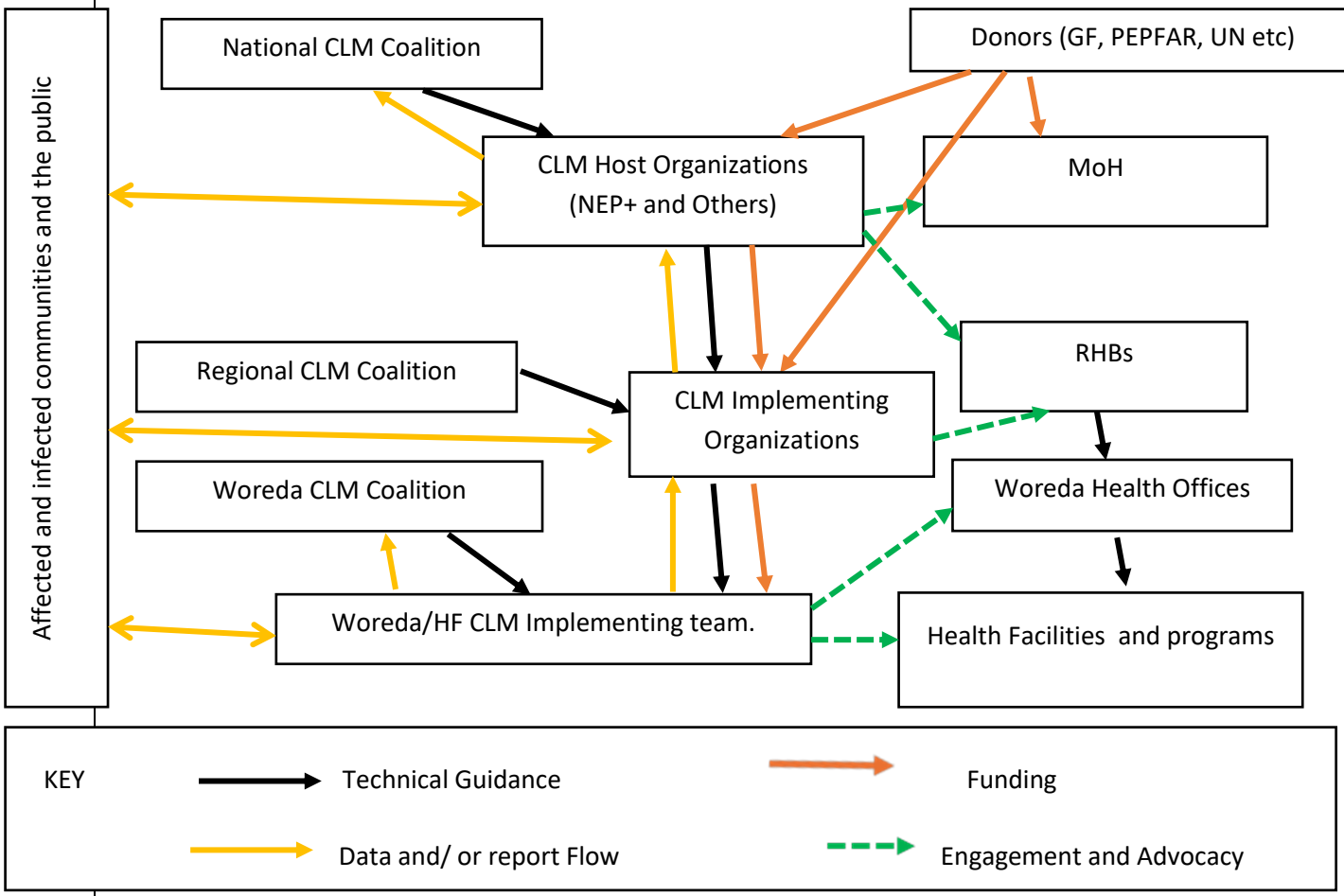
priority woredas in the next 5 years.

CLM will be implemented in public hospitals and health centers, CSO/NGO health facilities, drop-in centers and Key and priority population friendly clinics and other community programs.

Instruction -2.4: Ask the participants to mention at least one key stakeholder in CLM implementation and define their role. Once the participants reflected on the question, summarizes CLM governance structure and stakeholders' roles in CLM implementation in Ethiopia using the facilitator's note below.

Facilitators Note

The following structures are required to implement CLM in Ethiopia:



National, Regional and Woreda CLM Coalition

The CLM Coalition provides technical guidance in the design, implementation, and

monitoring of CLM. The Coalition provides technical and advocacy support to the host and implementing organizations. CLM coalition will support host and implementing partners in the following tasks depending on its level:

- The development of CLM national framework
- Develop CLM data collection methods and tools
- Conduct data quality audit including reviewing and endorsing data.
- Analyze data, identify gaps and co-create solutions.
- Identifying advocacy agendas, developing an evidence-based advocacy plan, and implementing advocacy plan.
- Accessing national policy and political forums with the host organization to present and integrate data into health information policies and systems.
- Supporting the implementing partner to mobilize resources for sustaining CLM and related advocacy beyond the current grant funding.
- Monitoring CLM performance – Changes over time (impact)

National CLM Coalition will be composed of NEP+ (Secretary), UNAIDS (chair), MoH (Co-chair), EPHI, The Global Fund secretariat, WHO, PEPFAR, USAID, CDC, CSOs (ASK US, NNAPWE, ESHDO, OSHAD, FGAE, CCRDA etc), AHF, ICAP, PSI, Project Hope EPHA and Addis Ababa University public health faculty, PLHIV, key and priority population representatives (FSWs, high risk AGYW and PWID). The National CLM Coalition will be meeting monthly for the first 6 months and quarterly thereafter. The CLM Chair will lead the CLM meetings. The CLM co-chair will call CLM meetings on behalf of the CLM coalition. CLM secretary will host CLM meetings and act as secretary of CLM coalition.

Regional CLM Coalition will be composed of the Regional PLHIV association network (Secretary), RHB (Chair), RHAPCO, UN, PEPFAR partners, CLM implementer CSOs, and university, PLHIV, key and priority population representatives (FSWs, high risk AGYW and PWID). The regional CLM Coalition will be meeting monthly for the first 6 months and quarterly thereafter. The CLM Chair will call CLM meetings on behalf of the CLM coalition. CLM secretary will host CLM coalition meetings and act as secretary of CLM coalition.

Woreda CLM Coalition will be composed of CLM implementing organization/team at the Woreda level (Secretary), Woreda health office (chair), CSOs, Health facilities heads, and HIV service leads, PLHIV, key and priority population representatives (FSWs, high risk AGYW and PWID). The Woreda CLM Coalition will be meeting monthly for the first 6 months and quarterly thereafter. The CLM Chair will call CLM meetings on behalf of the CLM coalition. CLM secretary will host CLM coalition meetings and act as secretary of CLM coalition. The

Woreda CLM Coalition plays a critical role in facilitating data collection, analysis, and using data to improve the quality of services at health facilities in Woreda.

CLM Host Organizations

The host organizations will be fewer affected community organizations and CSOs (NEP+ and others) at Operating at National and Regional level (Regional Network and CSOs) who have the capacity to lead the design and implementation of CLM. Building capacity and ensuring quality of CLM will be effective and efficient when there are fewer host organizations and many implementing partners under the host organizations at grass roots level implementing CLM on a day-to-day bases. The host organization will serve as secretary of the national CLM coalition. The Host organization will sign MoU with MoH to access data at health facilities and program levels. The Host organizations will have staffing for CLM that includes:

- CLM coordinator. This person has oversight of CLM implementation including coalition meetings, dialogues with sites, work with health officials to ensure that formal agreements for data collection are in place, ensure project visibility, and ensure national ownership of the project, and that insights from data are used for targeted advocacy.
- M&E officer. The M&E officer has oversight of community data collection, management, analysis and verification processes. The M&E officer is responsible for overseeing capacity-building, providing technical support on data collection and management processes for data supervisors and data collectors, developing and reviewing reports generated from community data before they are disseminated to the CLM coalition/CCG and external stakeholders, distilling data insights from country-level reports to macrolevel, and general data management oversight.

CLM implementers

There will be many implementing organizations close to sites to be monitored based on scope of CLM and available funding. The closer the CLM implementer to the sites monitored is the better. The CLM implementer will have the following staff depending on number of woredas covered.

- **M&E officer/Supervisor.** The M&E officer has supervision of community data collection, and management, verification processes, conduct data analysis and reporting . The M&E officer is responsible for overseeing capacity-building, providing technical support on data collection and management processes for data supervisors and data collectors, and developing and reviewing reports generated from community data before they are disseminated to the CLM coalition. Facilitates engagement with the Woreda CLM

coalition, woreda health office, and health facilities in the co-creation of solutions and improving quality of care.

- **Data collectors.** Each data collector is responsible for collecting data from specific sites. Data collectors interact directly with health facilities or service delivery points to collect quantitative and qualitative data.

MoH, RHBs and Woreda Health Offices

MoH, RHBs and woreda health offices will be Co-chair or chair of the CLM coalitions at national, regional and woreda level. MoH, RHBs and woreda health offices will be responsible the CLM meetings on regular schedules and emergency meetings requested by the CLM secretary or members. MoH, RHBs and woreda health offices will provide technical and political support to CLM host and implementers. MoH, RHBs and woreda health offices will facilitate access to data at health facilities and program levels. MoH, RHBs and woreda health offices will work with CLM host and implementers to co-create solutions to improve quality and access to services and protect human rights. MoH and RHBs will facilitate platforms to disseminate and advocate CLM findings including the Annual and semi-annual review meetings.

Health facilities and data collection sites.

Data will be collected at public health facilities and community services (DICs). The CLM sites will be selected based on criteria such as woreda incidence (priority woreda), Client load, and facility performance gaps. Once sites are selected, a formalized partnership will be established between the host/implementing organization and the site via a memorandum of understanding (MoU). The health facility head and HIV services focal points will be members of Woreda CLM and provide technical support in data collection, analysis, reporting, and co-creation of solutions to improve services. Health Facilities will provide CLM implementers /data collectors access to health facilities and facilitate quantitative and qualitative data collection. The Health Facilities heads and HIV focal will work with the CLM implementing team to discuss the CLM findings and co-create the solution to the identified service gaps. The health facility will implement solutions and monitor changes over time.

Donors and Partners

Donors and partners including academic institutions will provide technical and financial support to CLM host and implementers. The support of donors and development parents need to focus on realization of co-created solution at health center level. Donors will align their support to avoid duplication of efforts and create synergy – the division of support by geographic, population, or cost areas.

Affected community members.

Affected community members will provide data and implement CLM with the host and implementing organizations. They will use the CLM findings to act and advocate for their rights.

Unit -3: Establishing Community Led Monitoring

Unit Objectives: By the end of this session, the participants will be able to describe the five-step process to establish and run community led monitoring.

Learning Activities

- Session -1: The five-step process to establish CLM.

Total Time allotted: 3 hours.

Session 1: The five stages of establishing CLM.

Session objective: By the end of this session, all participants will be able to describe the five stages of establishing CLM.

Method: question and answer, discussion, and facilitators presentations.

Resources needed: Training Manual, Flip chart, marker, LCD projector and laptop

Time allotted: 30 minutes.

Instruction -3.1: Ask the participants things they do to establish CLM? Once participants responded for the question summarize the discussion using the facilitator's note below.

Facilitator's note:

The flow chart (Figure-2) lays out the five stages for establishing CLM. This represents a comprehensive conceptual framework for the establishment CLM.

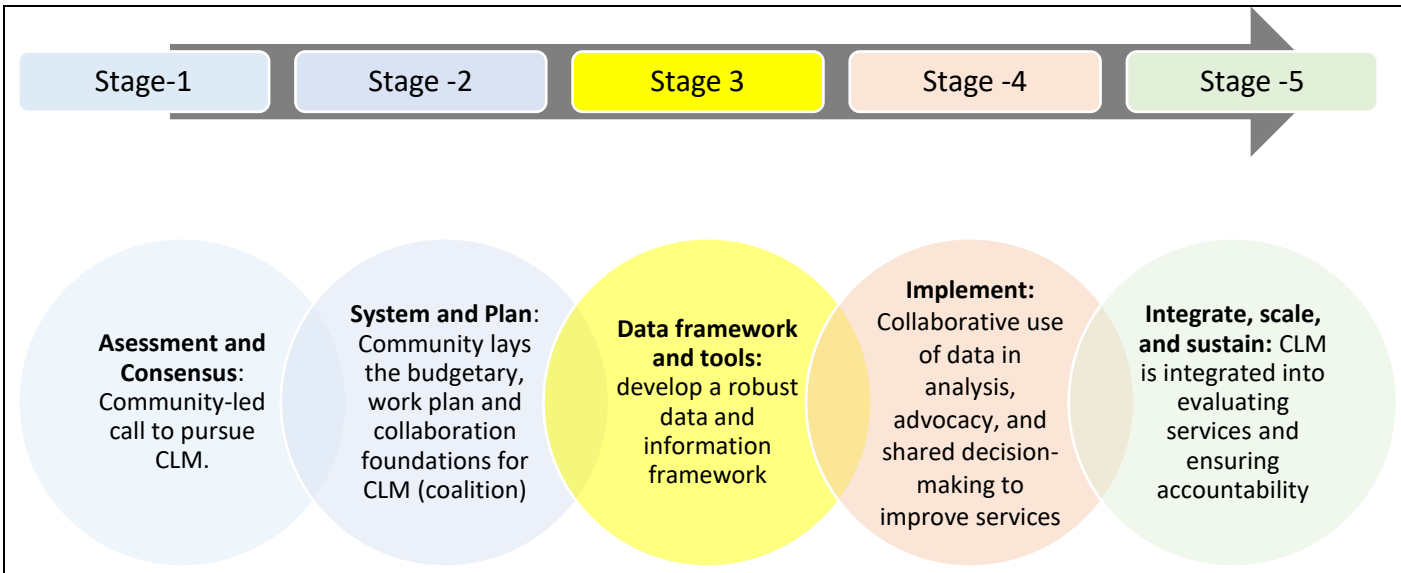


Figure 2 The Five stages of CLM implementation

Stage 1 Assessment and consensus: Community assessment of resources, context and implementation of CLM

- Presentation of CLM concept, aims and objectives to the full range of affected community members.
- Deliberative process that may include a formal or informal situational analysis of strengths, weaknesses, opportunities and threats for establishing CLM
- Identify and describe CLM-related funds and other resources available or likely to become available. Finalize and confirm funding and other available resources.
- Engage with the department of health at the highest possible level for consensus.

Outcome: Consensus and Community-led call to pursue CLM

Stage 2 System and Plan : Establish the budgetary, work plan, and collaboration foundations (arrangement) for CLM

- Establish the local and/ or national coalition of CLOs/CSOs, government, partners, academia, and donors - leadership by an existing CLO/CSO network.
- Agree on a host organization (for example CLO existing network) with leadership and collaborating roles and defined responsibilities.
- The coalition works with the host organization to develop a work plan, including terms of

reference for different posts for CLM implementation.

- Coalition/host develops a clear budget and seeks consensus from community-led groups and funders.
- Host secure political commitment – sign a memorandum of understanding with MoH

Outcome: Agreed organizational arrangement, budgets, and work plans and signed memorandum of understanding between the CLM host and the government

Stage 3 Data framework and tools: Develop a robust data framework, tools and train monitors.

- Members of the coalition outreach to community members to provide information on standards in health services, and the structural enablers and barriers to accessing them.
- Consultation and community-led identification of priority concerns for monitoring
- Design and test data collection tools in response to priorities identified, adapting those already validated, where possible.
- Establish standard procedures fir data security and confidentiality at all stages of collection, storage, analysis, and reporting.
- Prepare a robust monitoring and evaluation system for CLM activities (supervision, review, tracking)
- Establish consent and entry to health facility: Discuss with facility managers about how data are collected and used in co-creation of solutions to improve service access and quality.
- Recruit and train peer monitors conducting CLM data collection and introduce them to communities and facilities.

Outcome: A trained peer monitors (PLHIV and KPs), data framework and tools, and secure data management systems that are ready to pilot CLM.

Stage 4 Pilot /Implement CLM: Community members collect, analyze, and use data for advocacy, and shared decision-making to improve services.

- Finalize work plan for the data collection, analysis, and advocacy including monitoring and evaluation of CLM and other internal quality controls.
- Pilot the data collection, analysis, and advocacy workflow, and adapt as necessary.
- Move to routine data collection.
- Engage community and stakeholders: Share findings and develop advocacy messages.
- Solve problems and advocate for action: Present data in the service review and improvement process, propose and advocate for solutions, and agree on changes.

Outcome: CLM piloted and moved to routine data collection, analysis, and engagement for the co-creation of solutions and advocacy. Evidence-informed CLM advocacy is used for shared decision-making to improve services.

Stage 5 Integrate, scale and sustain: CLM transparently integrated with the health service evaluation and decision-making process, scaled and sustained.

- Monitor the commitments to change and any resulting innovation, looking for trends and impact.
- Integrate: Provide regular feedback to the community and the health facility/program
- Scale: Scale up the data collection strategy and themes, number of health facilities and sample size or population groups covered if necessary
- Sustain: Consolidate capacity, strengthen available expertise and funding to sustain CLM

Outcome: Community members receive improved services. CLM integrated health facility feedback loop, engagement is maintained, CLM scaled and sustained to improve health.

Depending on the readiness of communities to start CLM, not all these stages may be needed. For example, if consensus is already created among stakeholders and you might start to set systems and plan.

The order and content of each stage are not rigid or prescriptive and the actual steps taken to establish CLM need to be tailored to fit the specific context of resources and capacity already available.

As CLM develops, the stages will overlap. For example, new tools can be developed and piloted at the same time as a memorandum of understanding is being updated.

In every case, community and their organizations and networks make decisions and guides the process.

Instruction- 3.2: Divide participants into five groups. Each group reviewed and prepare a presentation on the details of the stages of establishing CLM using the facilitator note below.

Group 1: Stage -1: Assess and create stakeholder consensus on CLM and Ethiopia SWOT analysis.

Group 2: Stage -2: Establish the budgetary, work plan and collaboration foundations.
Group 3: Stage 3. Develop a robust data and information framework and train monitors and note on the Ethiopia CLM Framework
Group 4: Stage 4. Pilot and implement CLM data collection and use data to create solution and advocacy and note on the Ethiopia CLM Framework
Group 5: Stage 5. Integrate, scale, and sustain CLM, key considerations of sustainability and lessons learned.

Give participants 45 minutes for group work and prepare a power point presentation and 20 minutes for presentation and discussion. Please underline key points after each presenter.

Facilitator Note

Stage 1. Creating Consensus among Key Stakeholders - Community assessment of resources, context and implementation of CLM

The call to establish CLM should come from the affected community, even when it is the availability of funding that makes the initiation of CLM possible. Despite an imbalance of financial and political power with funders and other stakeholders, CLM will only function properly and to the benefit of affected communities when they are the ones leading the decision to proceed. Building trust between different community groups, funders and stakeholders is vital.

1. *Presentation of CLM aims and objectives by and to community members.*
   - ✓ leaders present the concept and practice of CLM for members of the community in an impartial and objective manner.
   - ✓ Ensure that this information is disseminated widely and collaboratively by and across all key and other affected populations and groups.
2. *Conduct a formal or informal situational analysis of strengths, weaknesses, opportunities and threats of CLM program implementation (see SWOT analysis finding of CLM in Ethiopia).*
   - ✓ Consideration of CLM could benefit from affected communities conducting a situational analysis to describe strengths, weaknesses, opportunities and threats (also known as a "SWOT" analysis)
   - ✓ If a situational analysis has already been undertaken, then it can serve as a checklist to tailor CLM along the way.

3. *Assess and document existing and potential CLM-related funds and other resources available or likely to become available from PEPFAR, Global Fund and Others*
4. *Confirm funding and other available resources. Engage with donors and MoH at the highest level to confirm available funds or mobilize new funding and resources*.

CLM in Ethiopia SLOT analyses

The SLOT analysis was conducted by expert opinion and consultation of stakeholders in a two-day workshop .

Strengths

- The government committed to evidence-informed HIV program planning.
- There is a national strategic plan that provides guidance and strongly supports CLM implementation.
- National and Local authorities are already engaging with communities on service provision such as PLHIV, FSWs, PWID
- PLHIV Communities are organized in networks and associations and present at grass-roots levels with a common purpose and are working with government and donors.
- KPs have been working with health facilities and partners as peer service providers (peer navigators)
- CLM has been piloted and there is some experience and monitoring tools are ready to be adapted from existing CLM programs.
- Growing global momentum for a people-centered and community-led HIV response.
- Availability of key and priority population clinics at government healthcare delivery points
- KP implementation guidelines, SOPs, and the others
- Existence of informally organized KP groups to meet their public health rights service

Limitations

- There is no national CLM framework and guidelines that define CLM governance, methods, and tools.
- There is no CLM coalition independent of government. CLM coalition was not established that is led by CSO networks that involve a range of stakeholders.

- Key populations cannot be legally acknowledged. Key populations were not organized in associations or formal groups.
- Limited capacity to implement CLM – staffing, knowledge, skill and experience on CLM among CLOs and CSOs

Opportunities

- Funding is available (GF, PEPFAR, UN etc)
- There are donors and partners ready to broker arrangements between government and CSOs/CLOs (UN, PEPFAR and other partners)
- Availability of technical support for capacity-building
- Affected communities (PLHIV) are knowledgeable about health service standards and structural enablers and barriers.
- Supportive policy and strategic frameworks

Threats

- Undue influence and interference of government and donors in the process of defining themes, selection of sites, methods and tools and analysis and reporting.
- Conflicts of interest among CLOs/CSOs and networks – hosts and implementers
- Lack of alignment between different supports (GF, PEPFAR and UN etc)
- Inadequate engagement and commitment of health facilities and programs for co-creation of solutions
- Refusal of data collection at health facilities
- Diverse languages and cultures – need to adapt tools to different local languages.
- Poor quality data that hinder advocacy and momentum
- Misuse of systems and data collected at facility levels.

Stage 2. Establish the budgetary, work plan and collaboration foundations for CLM.

1. *Create the CLM coalition to lay the foundations for CLM.*
   - ✓ Map community-led organizations, local community groups and civil society organizations and networks by the following: (a) populations represented; (b)

technical capacity and any ongoing CLM; and (c) geographical location.

- ✓ Establish CLM coalition: Through discussion and negotiation between these organizations, build a coalition of interested community-led bodies .
    - Ensure that groups or members of the key and marginalized populations are strongly represented in the coalition.
    - Install a transparent and collaborative process for free and fair decision-making.
    - Establish a process for conflict resolution that prioritizes open communication and early resolution of issues.
- ✓ Build consensus to identify one organization to be the lead (Host) for managing the coalition

2. *Develop a workplan and draw up terms of reference for different posts.*
    - ✓ Develop a workplan that fit to the CLM cycle liaising with a local health facility manager where data are to be collected.
    - ✓ Identify the different skills required to deliver the workplan and define a clear and fair hiring process that promotes the employment of people from the affected communities.
    - ✓ Identify early the gaps in the workplan that cannot be filled by community-led groups and seek the necessary technical assistance. For example, this might include the development of monitoring tools, preparation of analyses or ensuring end-to-end data security.
    - ✓ Contact and contact the groups that can support or provide this technical support.
3. *Develop a clear budget in consultation with key stakeholders.*
    - ✓ In line with any funding agreement, the bureau should describe the flow of funds and finance responsibilities, including clear reporting requirements on the use of funds.
    - ✓ Where possible, community-led groups should be prioritized as the recipients of funds, and in all cases, there should be agreement on funding flows that provide the maximum amount of external funds to the community.
    - ✓ Identify all paid posts, including data collectors, and other resource needs. This includes data platforms and Internet or other communications access.
    - ✓ Draw up terms of employment, including salaries, that are in line with country norms.
    - ✓ Consider involving a neutral broker (e.g., UN organizations and registered

auditors) to establish funding flows, reporting schedules and payment methods in a legally sound, fair, transparent and accountable way.

- ✓ To maintain objectivity, community implementers of service delivery should not conduct CLM on their own performance.

4. *Secure political engagement in a memorandum of understanding.*
   - ✓ The host or lead CLM implementer should secure political commitment to CLM at the local, district and national levels, and establish a collaborative approach to service improvement. In case of difficulties, strategic support from a neutral broker with no engagement or interest in the services may be valuable.
   - ✓ Explain to decision-makers and authorities the selection of issues to be monitored and how the use of data will be guided by the affected communities.
   - ✓ Be as inclusive as possible in these discussions. Depending on the level of data collection and advocacy envisaged, those involved could include facility managers, programme managers, and monitoring and evaluation teams.
   - ✓ Obtain written assurance that community monitors can have access to facilities to collect the CLM data, conduct their work safely and free from interference.
   - ✓ Share the data security protocol, budget and workplan with government authorities and
   - ✓ Sign memorandums of understanding with the government authority.

Stage 3. Develop a robust data and information framework and train monitors.

1. ***Identify issues of concern from affected communities.***

- Inform the community about standards for HIV services, and structural enablers and barriers.
- Identify priority concerns for monitoring through focus group discussions, one-on-one interviews and questionnaires.
- Special effort is required to ensure representation of the key population and the most marginalized groups in these discussions.
- Provide feedback to the community about the priority themes that will be monitored. The focus of CLM is mainly on collecting data that are not collected elsewhere (refer back list of CLM priority themes in Unit 2), including data with

improved age and gender disaggregation.

2. Design and test the data collection method and tools.

- Clearly define the information required and identify the appropriate method to collect it.
- If possible, use digital data collection tools that increase data quality and reduce data collation and analysis time. However, make sure that there are always updated and accessible non-digital tools when the situation is not conducive for using digital ones.
- Consult available standardized tools and take technical advice as necessary to adapt them. High-quality monitoring tools will increase credibility, improve user-friendliness of data collection tools, and ease integration into an analysis and evaluation feedback cycle.
- Ensure that the language or languages used in the data collection tools are appropriate.
- Become completely familiar with any applications being used and integrate the necessary improvements.
- Establish data security at all stages of collection, use and storage. Be especially mindful of data anonymization and secure storage and transfer.

3. *Recruit and train those conducting CLM (CLM peer monitors).*

- Keep recruitment standardized and transparent. Tailor recruitment profiles and criteria to local needs and contexts.
- Produce standardized curriculum and training manuals in an appropriate language.
- Include skills validation, with ongoing evaluation, mentoring and feedback mechanisms.
- Use trusted community leaders to present the CLM team and their work in the community and at the facilities.

4. Be informed about how data are collected and used in service evaluation.

- Create a working relationship with the facility and other decision-making staff, emphasizing mutual problem-solving for the improvement of services and the benefit of the affected community.
- Consider how data will feed into the formal facility or other monitoring and evaluation systems.

- Small amounts of well-focused local data with short feedback loops are a useful entry point.
- Work towards involving and empowering care providers in creating alliances and work procedures.

CLM Framework for data collection, analysis, and reporting in Ethiopia.

Data Collection Methods

The following quantitative and qualitative methods can be used

- Surveys - health facility client exit interviews, community door-to-door survey interviews, institution-based, telephone, online or android-based, etc
- Health facility record reviews
- Observations of services at health facility and community levels
- Focus Group discussion
- Key informant interview with service providers, facility heads, and other stakeholders
- Continues user feedback – I monitor and use client feedback mechanisms at health facilities (suggestion boxes and registers)

Data Collection Tools

- Tools adapted from pilot projects and other countries will be adapted and field-tested.
  - ✓ Structured survey questionnaires
  - ✓ Health facility record reviews and observations with checklists.
  - ✓ Key informant and Focus group discussion guides
  - ✓ I –Monitor client feedback electronic forms
- Tools shall be reviewed and approved by the CLM coalition.
- Tools shall be translated into local languages.
- Use of digital /electronic data collection tools is strongly encouraged.

Data Collection, Ethics, and data quality assurance

- Routine and systematic data collection – applies scientific participant selection and is routine to monitor trends over time and continuously improve the service.
- Data collection protocol shall be developed for data collectors – frequency of data collection, participant selection, recruitment, consent, confidentiality, and security.

- Data will be collected by trained peer monitors (PLHIV and KPs) who speak the local language.
- Data collectors shall be full /part-time staff with longer-term contracts.
    - ✓ invest in peer monitor capacity and retain with an adequate incentive package
- Use of Android-based data collection forms encouraged.
- Data shall be collected with standard informed consent.
- Ensure data confidentiality and data security at all stages of the CLM data collection, analysis, and reporting.
- Data quality shall be audited – supervision, spot checks, re-interviews, etc

Data Entry, analysis, and reporting

- Data entry and analysis (database and analysis software) should be decided and prepared early by the implementers /host and approved by the coalition
- Proper descriptive and analytical statistics used to calculate and compare indicators
- Data entry and analysis shall be done at the facility level for rapid feedback and co-creation of solutions at each of the health facilities
- Data aggregation, analysis, and reporting will be done at regional and national levels by implementers and CLM hosts supported by coalition
- Data shall be analyzed, and findings presented to the CLM coalition at the woreda/health facility, Regional, and National level within 1 month from completion of data collection
- Data shall be presented and cleared by the CLM coalition before public dissemination

Stage 4. Pilot and implement CLM data collection and use data to create solutions and advocacy

1. ***Finalize the data collection and analysis plan.***
    - Establish an analysis and advocacy group from members of the coalition.
    - Plan to analyze the cause of the problem and the environment that enables it, rather than apportioning blame.
    - Understand the practical and data needs of service providers and decision-makers.
    - Practice analysis and presentation that is clear and best demonstrates a

problem and/or solution.
- Check that the data collected will enable analysis and identify advocacy messages and points for intervention and change. Involve technical expertise, if necessary.

2. ***Pilot routine monitoring with standardized questions at the facility and community levels.***
   - Put the safety and security of data collectors first.
   - Prepare to phase in CLM, adapting tools as necessary.
   - In parallel with piloting the routine data collection, establish a mechanism for urgent feedback and response, where necessary.
   - Evaluate and report to the coalition to prepare monitors and resources for routine CLM.
   - Identify and respond to any weaknesses in the presentation of data or linkage to analysis and advocacy messages. Revise accordingly.

3. ***Move to routine data collection. Analyze data and develop advocacy messages.***
   - Group and interpret the information to bring out key findings.
   - Identify uncertainties and avoid looking only for information that supports pre-held opinions.
   - Disseminate the information first to the community and then to decision-makers (e.g., facility managers and government officials).
   - Identify possible solutions and action points with the community.
   - Collaborate with those who have experience in feasible solutions and implementation requirements.

4. ***Work with partners to establish a dedicated seat at the relevant forums where related health sector data are presented and discussed.***
   - Find such forums at the local, regional, and national levels.
   - Find allies within and outside of government to advocate for the importance of CLM data.
   - Check that methods of data presentation are useful and appropriate for different forums.

5. ***Present data in the service review and support the improvement process.***
   - Present arguments step-by-step, along with context and insight.

- Be prepared to explain sources of data and methods of collection to establish credibility.
- Propose solutions and seek support from service providers and others involved in strategy.
- Work together to implement change at the appropriate level.
- Agree and standardize the analysis of the impact of any future interventions.

Scales of CLM

It is critical to determine the scale and category of CLM based on the budget ceiling, the host organization's capacity and the timeline for implementation, among other factors. Planners should strive to obtain a representative sample size. This depends on the total population size (or the total number of people living with HIV) using the facility (for pilots), in the district (for subnational-level CLM) or in the country (for national-level CLM). There are three categories of implementation that the host organization can assess to determine "right fit". These are:

- **Pilot/urban-level CLM.** This is small scale and usually implemented in one or two health facilities in an urban area or capital city. For a population of <10,000 people living with HIV. In some situations, the small size may give the host organization a chance to pilot CLM and build capacity for implementing larger-scale work. Once the pilot is completed, CLM can be scaled up based on such aspects as skills, budget and timeline. However, this category may be the most appropriate for very local-level advocacy and may not require scale up.
- **Intermediate (Subnational)-level CLM.** This level of implementation goes across two or three subnational areas (for example, districts, provinces and regions), collecting data from a population of 10,000-100,000 people living with HIV. Data can be collected from up to 50 health facilities, based on aspects such as skills, budget and timeline.
- **Full scale (National-level CLM).** Data can be collected from 51+ health facilities, based on aspects such as skills, budget and timeline. A national CLM and related advocacy model works for a population of >100,000 people living with HIV.

CLM Framework for data use and advocacy in Ethiopia.

- Findings from analysis of data for each health facility should be discussed with the respective health facility head and HIV focal at the woreda CLM coalition

meeting and solutions should be co-created to improve access to and quality of services. The health facility head, HIV focal and CLM team should follow up implementation of the solutions. The gaps which have no solution at facility that needs advocacy and action at the national and regional levels should be identified and communicated to CLM host and implementers to conduct advocacy at MoH and RHBs with the support of national and regional CLM coalitions.

- Data aggregated and analyzed at the national and regional levels should be presented to respective CLM coalitions before dissemination. The findings should be discussed to identify key gaps and co-create solutions with MoH and RHBs. The Host and implementing organizations should follow up with MoH and RHBs for implementation of solutions co-created.
- The CLM coalitions, host and implementing organizations will use a range of strategies for advocacy on persistent service and policy gaps including high level meetings, policy briefs, media campaigns, social media campaigns, presentations in the National and Regional review platforms etc.

Stage 5. Integrate, scale, and sustain CLM.

1. ***Monitor the commitments to change, looking for links between intervention and impact.***

- Focus on capturing trends, linking interventions to outcomes over time.
- Outcomes can be health outcomes, service access, service quality or policy change.

2. ***Provide regular feedback to the clinic and the community.***

- Implementation of decisions and their effects are transparently reported back to service providers, decision-makers and communities to maintain accountability.

3. ***Scale up implementation site, theme or data collection strategy***

- Enlarge the data collection strategy as required to include a wider range of community members or to capture information at different levels of decision-making.
- Scale up the thematic areas monitored and population groups targeted.
- Scale up sites of CLM (see CLM categories from previous session)

*4. **Consolidate capacity and strengthen available expertise.***

- Self-evaluation to identify needs for capacity-building or refinement of the management structure.
- Standardized assessment of impact as established in the analysis and monitoring plan.
- Ensure continuity while seeking ways to expand the use of CLM.

Key considerations to sustain the CLM approach

- Funding of and investment in CLM. There is a need to ensure adequate availability of funds to implement CLM and related advocacy interventions.
- The scale of the CLM approach should match the available budget (the number of sites and indicators selected has an impact on the budget).
- Integration of the CLM approach into national strategic plans or other national policy frameworks or country investment plans.
    - ✓ There is a need for CLM to be adopted as a key community intervention that contributes to the national response.
- Capacity building of CLM implementing partners.
    - ✓ Investment in training and institutional systems strengthening of civil society organizations (CSOs) to ensure the capacity to implement CLM.
- Ownership of CLM by communities and CSOs. It is essential to ensure that CLM is truly community-led and supported by national structures.
- Ensure CLM Coalition and/or district or national structures function well and mobilize resources.
- It is necessary to create mechanisms for feedback and dissemination of data to realize advocacy outcomes.
    - ✓ It is critical to have national or district platforms where solutions can be created to alleviate treatment and service gaps and improve quality.
- Ethical clearance and/or authorization for data collection. CLM implementers need ready access to data at health facilities and should be able to conduct focus group discussions.
- Data quality assurance. The CLM approach will be compromised if the wrong data are used. Mechanisms must be put in place to ensure data accuracy and integrity.

Lessons learned.

Lessons learned from these early CLM experiences include the following:

- Building trust between all those involved, including government, service providers, community groups, and sponsors, is a critical factor in the success of CLM. This requires transparent, consistent, and broad-based communication, policy development, and practice.
- Early engagement with departments of health is essential. The top policymakers should be convinced that CLM is a useful tool for reaching HIV-related goals and targets. Local health service managers need to see CLM as a partner in delivering on their responsibilities.
- Although CLM is often responding to service deficits, the approach should not be to apportion blame for those shortcomings. Rather, the goal should be to have a full analysis of contributing factors and to share in identifying solutions that satisfy user needs.
- Formal collaboration between different networks of people living with HIV and community-led organizations from affected communities is the most suitable and efficient CLM model to ensure systematic processes and appropriate data collection.
- Early agreement between members of the CLM coalition on the topics of data collection will provide the foundation and framework for developing future activities.
- Tailored and ongoing training for data collectors is important for ensuring their confidence and competence in the use of all data collection tools.
- Data collectors and other community members involved in conducting CLM should be remunerated in line with national practices and standards.
- The burden of establishing CLM can be eased by sharing validated and appropriate standardized tools. There are established tools that could be adapted to local contexts and UNAIDS is working to initiate a central resource repository of resources.
- CLM can deliver useful data and beneficial action even without being formally incorporated into the national monitoring platform. However, CLM data should eventually develop to become part of the broader information structure without compromising community leadership.
- Communities must be the leaders of CLM and be equal partners when decisions are made about service quality. Non-community members with technical expertise

can support and advise, as requested.

- Acceptance and integration of CLM in decision-making processes and negotiations with local authorities, funders, and other external supporters depends on collaborative efforts towards problem-solving and credibility. Credibility comes from valid and useful data, combined with demonstrated community leadership and civic participation.
- A structured long-term plan for capacity-building, supervision, and performance feedback for data collectors, analysts, and advocates will optimize the results and impact of CLM.
- A structured, long-term advocacy plan that builds buy-in and ownership among stakeholders such as healthcare workers will facilitate consistent and iterative progress in service improvement.
- CLM is not a stand-alone activity. Rather, it is an essential component of a larger framework of community-led responses to health and well-being. CLM is most effective when it is included in national policy and has other concrete signs of long-term and sustainable support.

Unit-4: Evidence

Unit Objectives: By the end of this unit, all participants will be able to:

- Describe the data collection methods used for CLM.
- Develop data collection tools.
- Discuss sample size and sampling techniques.
- Discuss quantitative and qualitative data collection techniques.
- Describe ethical consideration, and data security.
- Describe the data quality audit.
- Discuss data analysis methods and tools.
- Describe methods of data presentation and reporting

Learning Activities

Session 1: Quantitative and qualitative data collection methods
Session 2: Development of data collection tools
Session 3: Determining sample size and sampling technique.
Session 4: Quantitative and qualitative data collection techniques
Session 5: Ethical consideration and data security
Session 6: Data quality audit.
Session 7: Data analysis.
Session 8: Data presentation and reporting

Total time allotted: 23 hours

Session 1: Quantitative and qualitative data collection methods

Session objectives: By the end of this session participants will describe quantitative and qualitative methods used in the community-led monitoring.

Method: Question and answer, brainstorming ideas, discussion, and presentations.

Time allotted: 4 hours.

Resources needed: Training manual, flip chart, marker, LCD projector and laptop.

Instruction -4.1: Ask the participants the following questions and give them chances to respond to each question.

- What data collection methods do you know?
- Describe what is quantitative and qualitative data collection methods and give one example?
- Explain the difference between quantitative and qualitative methods?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

Data collection methods

CLM mostly uses a combination of quantitative and qualitative data collection methods. Understanding why and when to use quantitative and qualitative data collection methods is critical in the design of CLM.

Quantitative research is the process of collecting and analyzing numerical data. It can be used to quantify phenomenon (proportion, prevalence, incidence, percentages, ratios etc)find patterns and averages, make predictions, test causal relationships, and generalize results to wider populations.

Qualitative methods are a type of research method that explores and provides deeper insights into real-world problems. Qualitative research gathers participants' experiences, perceptions, and behavior. It answers the how's and whys instead of how many or how much. Qualitative research at its core, ask open-ended questions whose answers are not easily put into numbers such as 'how' and 'why'. One of the strengths of qualitative research is its ability to explain processes and patterns of human behavior that can be difficult to quantify.

When qualitative methods used along with quantitative methods it helps us to interpret and better understand the implications of quantitative data. It provides data critical in the design of comprehensive solutions to public health problems in developing countries.

Comparison of quantitative and qualitative research approaches

Parameter	Quantitative methods	Qualitative methods
General framework	• Seek to quantify. • Close-ended questions • Use highly structured methods: surveys, case-control studies, quasi-experimental and experimental studies	• Seek to explore phenomena – explain, a deeper understanding of the context or reasons behind a phenomenon. • open-ended questions • Use un or semi-structured methods (In-depth interview, focus group discussion, observations)
Analytical objectives	• To quantify a phenomenon (prevalence, proportion, mean etc) • To quantify variation • To predict causal relationships	• To describe and explain relationships, individual experiences and group norms. • Explain how and why a phenomenon happens, how it manifests, what are psychosocial consequences etc
Study design	• Predetermined sample size and selection procedures • Emphasized is randomness and statistical validity	• Flexible sample and selection procedure • Focus on contextual and in-depth understanding
Data format	• Numerical (obtained by assigning numerical values to responses)	• Textual - transcripts (obtained from audiotapes, videotapes, and field notes)
Flexibility of study design	• Fixed from start to end. • Questions asked the same way for all participants	• Flexible- questions or participants can be added. • Oder and content of questions asked might vary
Skill requirement for data collection	• Trained research assistants can collect the data	• It demands specialized skill and understanding of the issue under discussion –

		The researcher collect the data

Quantitative methods of data collection

- ***Surveys***
  - Method of gathering information from a group of individuals by asking them structured questions.
  - Information is collected primarily by asking questions (individual interviews) using structured questionnaires with close ended questions.
  - Surveys can be conducted through various mediums such as paper and pencil, online forms, telephone, or face-to-face interviews.
  - data collected from a sample of respondents selected systematically to be representative of a whole group or population.
  - Can be cross-sectional (at one specific point in time) or longitudinal (over a period of time to document trend – likely to be the case in CLM)
  - It can be house to house (door-to door) surveys in the community, exit interviews in the health facility, telephone surveys or online surveys etc

- ***Record Reviews***
  - Review of health facility registers or sample of client clinical records or laboratory reports etc
  - Clinical record review or chart review is a previously recorded data on registers (ART register, PMTCT, HCT registers) or Client follow up charts etc to answer clinical queries.
  - Such a study can be used to answer specific clinical questions in a relatively easy and less resource intensive manner.
  - But these studies may be constrained by the limited information retrievable and inadequacy of records.
- ***Observations***
  - Observation is a way of gathering data by watching behavior, events, or noting physical characteristics in their natural setting.
  - Observation of availability of equipments, drugs and infrastructure in health facilities or observation of counseling practices as Mistry clients
  - Observations can be overt (everyone knows they are being observed) or covert (no one knows they are being observed and the observer is concealed – Mistry clients).

Qualitative methods of data collection

- ***In-depth interviews or key informant interviews***
  - Interviews with individuals using open-ended discussion questions.
  - collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored.
  - Good when questions are sensitive to ask in group settings such as sexual experiences or questions on politically sensitive issues.
  - Interviews are audio recorded.
  - Most commonly used method in public health

- ***Focus group Discussion.***
  - Discussion with a group of 6-8 people using open-ended discussion questions.
  - Elicit data on the group experiences, common problems, cultural norms, values, and opinions of a group.
  - Uses discussion guide which has open-ended questions.
  - Interviews are audio-recorded.
  - Most used method in public health

- ***Participant and non-participant observations***
  - Participant observation is when the observer becomes a part of the group that is being studied. This type of observation allows the observer to get a closer look at the group and their behavior, interactions, and practices.
  - Non-participant observation is when the observer remains outside the group and simply watches their behavior.
  - Uses records or diaries of experiences and observations.
  - Mostly used in social and ethnographic studies not common in public health

Methods that used both qualitative and quantitative methods in CLM

Community score cards (CSC)

- is a two-way and ongoing participatory tool for assessment, planning, monitoring, and evaluation of services.
- Uses a focus group to score different dimensions of the service in a rank from very poor to very good and explore in a group discussion the reason behind

the low score and identify remedial actions or solutions.
  - The score across groups and the suggested root cause and remedial actions aggregated to come up with a consolidated report.
  - It is easy to use and can be adapted to any sector where there is a service delivery scenario.
  - It brings together the demand side ("service user") and the supply side ("service provider") of a particular service or program to jointly analyze issues underlying service delivery problems and find a common and shared way of addressing those issues. It is an exciting way to increase participation, accountability, and transparency between service users, providers and decision-makers.
- ***A community treatment observatory (CTO)***
  - is a mechanism that systematically and routinely collects and analyzes qualitative and quantitative data. This can include, for example, indicators on the number of HIV tests conducted in a specified area, or the frequency and duration of ARV stock-outs experienced in a certain time period. Community monitoring is an ongoing process, with multiple entry points.
  - Data is collected at set intervals (e.g. monthly) and entered into a centralized database. Because data is routinely collected, CTOs can monitor trends and variations within the health system over time. This allows activists to document the availability, continuity and quality of all aspects of HIV service delivery, alert procurement systems when commodities (i.e. drugs and diagnostics) reach critically low levels and develop and issue recommendations for improvements.
  - CTO uses quantitative methods (surveys, record reviews, observations etc using structured questionnaires and checklists) and qualitative methods (in-depth interviews and focus group discussions)
  - Quantitative data indicators measure and track numbers (e.g. number of HIV tests performed). They are collected at the health facility level and are used to provide the current picture of what services look like. While some of the quantitative data collected by a CTO can be similar to that collected by national health management information systems (HMIS), in many cases, CTOs collect data that national systems do not track (e.g. stock-out monitoring, turnaround time before test results are shared with recipients of care, disaggregation by key populations etc.).
  - Qualitative data indicators describe and characterize the nature of a situation.

They help reveal the lived realities and points of view among recipients of care and their communities. Qualitative data is collected through open-ended survey questions, interviews, and focus group discussions.

Instruction-4.2: the participants into two groups and share the two groups' articles on community treatment observatories (CTS) and Community score card (CSC) to review the articles for 45 minutes and make a 20-minute PowerPoint presentation for each group.

- Group -1: Community scorecard.
- Group -2: Community Treatment observatories.

Summarize key points after each group presentation.

Instruction-4.3: Divide participants into four groups. Each group decide on study objectives, decide on data collection method, and tools to be developed.

Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Give participants 60 minutes for group work and 10 minutes for presentation. Then summarize the session using the facilitator's note below.

Session 2: Development of data collection tools

Session objectives: By the end of this session participants will be able to develop data collection tools for quantitative and qualitative data collection methods.

Method: Group work, question, and answer, brainstorming ideas, discussion, and presentations.

Time allotted: 3 hours and 30 minutes.

Resources needed: Training Manual, Flip chart, and marker.

Instruction -4.4: Ask the participants the following questions and give them chances to respond to each question.

- What are the steps you follow in the development of a quantitative and qualitative data collection tools (questionnaire, record review or observation checklist or an in-depth interview or FGD guide)
- What do they understand by validity and reliability of a measurement? Explain the difference between validity and reliability of a measurement?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

Quantitative Methods Measurement instrument development

Concept to measurement

- Starts clearly defining the issues or concept or theme to be measured – quality of care, access to care, stigma and discrimination experience in health care, stock out of ARV drugs, treatment adherence etc
- Define the indicators or themes that can be measured example if the quality of care – availability of drugs and supplies, infrastructure, client provider interaction etc, or for stigma and discrimination in healthcare settings – the experience of any discrimination at healthcare settings by staff, the forms of stigma, any consequences of discrimination on the client etc
- Decide on how the indicator can be measured – qualitative or quantitative method? Which quantitative or qualitative or a mixed method fits to measures the indicators or themes to be monitored
- Do not try to cover too many themes or indicators in one study When you try to cover too many issues in one study it will be too long for participants, or you can't comprehensively measure. Break it in to different studies.
- Do comprehensive literature review on the theme or issue to be studied before you start developing the questionnaire.
- Adapt an existing questionnaire or tool whenever it is available. Mostly there is one even if not standardized (do search than do it from scratch). Make sure you are properly adapting tools used elsewhere to local context. Do not copy

and paste. It should be adapted, translated to local language, checked for validity and reliability and field tested before it is locally applied.

- Develop the measurement tool (questionnaire, checklist, or discussion guide)

Basic Rules in development of quantitative questions or measurement items

- Develop a set of clear question or questions that directly measure the indicator/concept/ issue/variable under the study. Example
  Question: Did you miss taking your ART pills in the past one month?
  Response: a) Yes b) No c) I do not remember
- Make sure the question are compressible to respondents. The questions are clear and are understandable to the prospective respondents
- No doble statement questions. Avoid asking to things in one question.
  Example. How is the illumination and ventilation of the counseling room?
  Response options: a) Very good b) good C) fair d) bad e) very bad
- Make sure questions comprehensively measure all the dimensions of an indicator or a theme base on review of literature and experience on the issue

  Example A the study that assess client providers interaction asked the following five questions with a) Yes b) No and C) Not sure were the response options.

  1) Did the health care staff greet you at first encounter during childbirth?
  2) Did the health care staff introduce themselves to you at first encounter during childbirth?
  3) Did the health care providers communicated you about the care in a way you understand?
  4) Were you encouraged and given the opportunity to ask questions?
  5) Did you receive enough explanation about the care you received and progress of childbirth?
  6) Did the health care providers sought your consent before doing any procedure?

  Example B the study that assess client providers interaction asked the following question

  Q, How was your interaction with the ART provider in your last ART follow up visit?

  a) Good b) Fair C) Bad

  In the above example, study A comprehensively measured different aspects of

the client provider interaction using five different questions than the second question which does not specify which aspect of the client -provider was good or bad. Such questions are difficult to answer and mostly do not identify the specific problems in the service quality for intervention.

- Include key participant sociodemographic characteristic questions that you want the measurement to be disaggregated example sex, age, population type (sex worker, PWID, Prisoner, PLHIV etc), education etc
- Limit the number of open-ended questions in a quantitative study or do not add qualitative questions in a qualitative data collection tool.
- Clearly define response option. Operationalize the response options. Example
  Q. How do you rate illumination of the counseling room?
    a) Very good (can read 12 font text),
    b) good (can read 14 font text)
    c) fair (can read 16 font text
    d) bad (can only read 18 font text)
    e) very bad (can read 20 font text or bigger fonts)
- Make sure the response options are exhaustive (based on experience, literature review or a preceding qualitative study). When you cannot exhaust the response options put an open-ended response option called others specify. Ensure that the common responses are within the response option list. Example Q. Have you experienced any of the following discriminatory practices at the health care setting by service providers in the past 12 months? (Response options taken from a review of the second stigma index survey
    a) Counseled not to have sex because I am HIV positive.
    b) Counseled not to have children because I am HIV positive.
    c) I was forced to start specific contraceptive methods because I am HIV positive.
    d) The provider was using a double glove for examination.
    e) I was insulted.
    f) They delayed the service
    g) They denied me service because I am HIV positive
    h) Others specify _____
- Use the right scale of response options when you are using a scale –3 scale questions good, fair, bad or 5 scale very good, good, fair, bad, very bad. Example. How is the illumination and ventilation of the counseling room? Response options: a) Very good b) good C) fair d) bad e) very bad

- Once the measurement tool is drafted check the validity and reliability of the instrument
- Translate the instruments to local languages and validate the translation (translate to local language and other person back translate to the original language and compare consistency and accuracy of translation using the two versions)
- Then field test the instrument in a similar population

Check validity and reliability of the instrument.

Validity of measurement

- Validity is about the ability of methods and instruments used in research to produce results that are close to the truth.
- Validity is about how well a measurement, scientific test or instrument reflects the reality it claims to represent.
- Measurement validity is a test of how well an instrument measures the concept it is intended to measure. In other words, validity is concerned with whether we measure the right concept or not.
- Several types of validity tests are used to test the goodness of measures, including face validity, content validity, criterion-related validity, and construct validity.
- The first criterion used in the three-survey questionnaire was a face validity test, a repeated check by the researcher whether the questions in the survey questionnaire and response options were appropriate to measure the concept which the study intended to measure.
- Content validity: ensures that the measure includes an adequate and representative set of items that tap the concept. The more the question items represent the domain or universe of the concept being measured, the greater the content validity. It is a function of how well the dimensions and elements of a concept have been delineated. The development of content validity of an instrument is typically achieved by a rational analysis of the instrument by raters (ideally 3 to 5 people) familiar with the construct (issue) of interest. Specifically, raters will review all the items for readability, clarity and comprehensiveness and come to some level of agreement as to which items should be included in the final instrument. In short, a panel of judges can attest to the content validity of the instrument.
- Construct validity: testifies to how well the results obtained from the use of the

measure fit the theories around which the test is designed.

Reliability of Measurements

- Reliability has to do with the quality of measurement. In its everyday sense, reliability is the "consistency" or "repeatability" of your measures.
- A measure is considered reliable if it would give us the same result over and over again (assuming that what we are measuring isn't changing!).
- If a measurement device or procedure consistently assigns the same score to individuals or objects with equal values, the instrument is considered reliable.
- It is an indication of the stability (or repeatability) and consistency (or homogeneity) with which the instrument measures the concept and helps to assess the "goodness" of a measure.

Field testing of the study instruments

Once the survey questionnaire or record review and observation checklists are developed it needs to be field tested in a setting and data sources to the actual study. It is recommended the field test include reasonable number of respondents for field testing depending on the study respondent. The field testing should consciously look at and make notes on the following.

- Do participants easily understand the question and response options?
- Are response options appropriate to the question?
- Are response options complete?
- Are there doble stated questions which are difficult to answer to participants.
- How long does it take to complete the interview?
- Do the participants comfortably complete the interview, or do they get bored do they interrupt questions because of time or are you rushed to complete the questionnaire?
- Are there questions very sensitive to the participates or cause adverse events – sadness, depression, or make participants cry, etc (for example questions on rape experience, intimate partner violence, discrimination experience, etc)

Training of data collectors

Data collectors need to be formally trained in theory and practice the participant selection procedure, interview skills, and data collection instruments. Data collectors should review and practice the data collection instrument questions and response

options item by item. Data collectors should practice interview skills and questions and response options and skills should be reinforced before actual data collection. Including data collectors in the field testing of the data collection tools provides practice and skill reinforcement opportunity.

Qualitative Methods discussion guide development

Concept to measurement

- Starts clearly defining the issues or concept or theme to be explored– quality of care, access to care, stigma and discrimination experience in health care, reasons for stock out of ARV drugs, explore reasons for loss to follow-up etc
- Define the major themes, sub-themes, and prob questions.
- Make sure all questions are open-ended elicit discussion and explore the views, attitudes, beliefs, and experiences of participants.
- Limit the number of discussion themes to appropriate to time (1.5-2 hours for FGD and 30 minutes to 45 minutes for IDI)
- Qualitative tools are flexible, you can add discussion questions or ask questions flexibly as the discussion flows.
- What matters is the fact that the moderator explores the issue in depth

Instruction 4.5: Divide participants into the same four groups created in the previous session. Give participants 90 minutes for group work. Each group used the same topics from the previous session to develop a questionnaire/checklist with 5 relevant socio-demographic and a minimum of 10 topic-related questions and an FGD or IDI guide with 5 qualitative questions and probes. Use laptops to write your assignment.

Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Once the groups finalized drafting the questionnaire/checklist and qualitative guide exchange the draft. Give 30 minutes for each group to validate the questionnaire/checklist from another group based on guidance provided for the development of measurement instruments.

Give 15 minutes for each group to present the questionnaire they reviewed, and the gaps identified in a plenary. Then summarize the session reminding key issues from the previous session.

Session 3: Sample size and selection of participants

Session objectives: By the end of this session participants will be able to discuss sample size and sample selection techniques for quantitative and qualitative methods.

Method: Group work, question and answer, discussion, and presentations.

Time allotted: 2 hours and 30 minutes.

Resources needed: Training manual, flip chart, marker, LCD projector and laptop.

Instruction -4.6: Ask the participants the following questions and give them chances to respond to each question.

- What do you understand by the general and study population? What is the difference between the two?
- How do you determine the number of study units to be included in the quantitative study?
- How do you determine the number of study units to be included in the qualitative study?
- How do you select the study participants to be included in the quantitative study?
- How do you select study participants to be included in the qualitative study.

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

1. Population

1.1. Population

The population of a study is defined as the units (individuals, organizations, events,

objects, or items) in which the researcher is interested and from which samples are drawn to answer the research questions. The unit of analysis may be a person, group, organization, country, object, or any other entity about which researchers wish to draw scientific inferences (Casteel & Bridier 2021:331-345; Thacker 2020:3). There are three types of populations in research, namely the general, target, and accessible populations.

1.2. General population

A general population comprises a certain group of people who share the same characteristics or elements that are the focus of a research project (Casteel & Bridier 2021:331-345; Thacker 2020:3). For example, PLHIV, pregnant women, key populations, ART services, DICs etc.

1.3. Target or study population

A target population is the population in which a researcher takes an interest. This target population possesses all predetermined eligibility criteria, and the researcher can generalize the research findings from them. PLHIV on ART, KPs who visit DICs, DICs providing ART services, etc.

1.4. Eligibility criteria

Eligibility criteria are formulated to decide who can or cannot participate in the study. The eligibility criteria represent a guideline to decide who will be included or excluded from the study. The eligibility criteria describe characteristics that must be shared by all participants of a study (Majid 2018)

2. Determining Sample size

2.1. Determining Sample size for quantitative methods.

The number of study subjects (sample size) of a study is determined based on a set of factors that include.

- Resources (funding and staff, etc.) and time available to collect, analyze and report the data.
- The size of the study population when less than 10,000 it is finite population and there is sample adjustment for finite population. When greater than 10,is 000 considered infinite population and no adjustment for finite population.

- The degree of precision, power, and confidence we need in the study.
- Study questions – is it mainly a descriptive survey (determine prevalence proportion, mean, etc), or case-control, comparative correctional and longitudinal (compare the group to statistical differences or analyze cause and effect)
- Sampling methods used – a multistage sampling method requires an adjustment (multiply the sample by 1.5-2 times) for each stage of a multi-stage sampling.
- Adjustments for non-response 10-15% of the sample size when high risk of non-response is anticipated.
- The rule of thumb the smallest sample size for a quantitative study is 30 study units (you cannot use parametric statistical methods for sample size less than 30 rather a non-parametric methods)
- The easiest way is to use epi info stat calc to determine the sample size based on study design and sampling parameters (p= probability of an event in the study population, d = degree of precision desired (0.05 or 5%, degree of confidence 90-95% or α 0.05 = 1.96 and desired power (β) of study mostly 80-90%.
- You can also calculate the sample size manually using the sample size formula provided below

The sample size for a descriptive study

$$n = \frac{(Z_{\alpha/2})^2 pq}{d^2}$$

nf= n/(1+n/N) Correction for finite population (<10,000 study population)

+ 10-15% (n) addition for nonresponse when high risk of nonresponse

Sampling parameters

- P= proportion of an event in the study population or similar population (previous studies).
- Degree of precision or margins of error (d) = 5% = 0.05
- 95% Confidence interval ($Z_{\alpha/2}$ = 1.96)
- Power 80% ($Z\beta$ = 0.84)

The sample size for the comparative (analytic) methods

$$n_1 = n_2 = \frac{\left(z_{\alpha/2}\sqrt{2\bar{p}\bar{q}} + z_{\beta}\sqrt{p_1q_1 + p_2q_2}\right)^2}{\Delta^2} \quad \text{Calculate } \bar{p} = \frac{p_1 + p_2}{2}$$

$\Delta = p_1 - p_2$

n final = $n_1 + n_2$

Sampling parameters

- P= proportion of an event in the study population or similar population (previous studies).
- P1= proportion of event in comparison group 1
- P2= proportion of event in comparison group 2
- 95% Confidence interval ($Z_{\propto/2} = 1.96$)
- Power 80% ($Z\beta = 0.84$)

Other ways of sample size determination

Not always are the sampling assumptions and sample size determination formula applied. Based on budget and time you might decide the sample size on consensus of the CLM team, but the rule of thumb is no less than 30 study units.

The International Treatment Preparedness Coalition (ITPC) is a global network of PLHIV recommended the following sample size for CLM to decide on number of units to collect data (sample size):

- Pilot/urban-level CLM for a population of <10,000 people living with HIV, sample at least 20-25% of them.
- Subnational-level CLM goes across two or three subnational areas (for example, districts, provinces, and regions), collecting data from a population of 10,000-100,000 people living with HIV and sampling at least 10-15% of them. Data can be collected from up to 50 health facilities, based on aspects such as skills, budget and timeline.
- National-level CLM data can be collected from 51+ health facilities, based on aspects such as skills, budget and timeline. A national CLM for a population of >100,000 people living with HIV, sampling at least 3-5% of them.

2.2. *Determining Sample size for qualitative methods.*

The study's research objectives and the characteristics of the study population (such as size and diversity) determine which and how many people to select.

Sample size may or may not be fixed before data collection, depending on the resources and time available, as well as the study's objectives. You might stop the interview if information becomes redundant, or you might need to go further if new themes/interesting info emerges.

In a qualitative study, the sample size is considered enough when there is a saturation of information while undertaking the qualitative data collection. When no new information and the information is being collected is repetitive that is considered saturated.

In qualitative study, representation is not the main interest but rather the depth and breadth of data collected. Even if it were possible, it is not necessary to collect data from everyone in a community to get valid findings.

3. Sampling methods (sampling techniques)

3.1. Sample selection for quantitative methods

There are two border sample selection strategies -a probability and non-probability sample selection strategies.

The probability sampling strategy is the standard for a quantitative study. It ensures all members of the study population have an equal chance of being selected for the study. The aim is to ensure the representativeness and generalization of findings to the study population. The probability sampling techniques include simple random sampling (a lottery method), systematic random sampling, cluster sampling, and multi-stage sampling.

However, it is not always possible to do a random sampling and a CLM or study might use non-probability sampling due to budget, time, or inaccessibility of the study population to construct a sampling frame or apply probability sampling techniques. These nonprobability sampling techniques include snowball (chain referral), convenience, quota sampling, and self-selection, for example, a study on PWID or FSWs at the community level is likely to use a snowball (chain referral) sampling technique. See details of non-probability techniques under the qualitative

sampling below. In action research where the aim is not generalization nonprobability sampling is commonly applied.

Simple random sampling (a lottery method)

Simple random sampling is a type of probability sampling in which the researcher randomly selects a subset of participants from a population. Each member of the population has an equal chance of being selected. Simple random sampling needs a sampling frame. Sampling frame is a complete list of study population from which a sample is selected. Sampling frames are not always available or very time and resource demanding to construct. Lottery methods or random number table can be used to select sample.

Systematic sampling

Systematic sampling is a probability sampling method in which a random sample, with a fixed periodic interval, is selected from a larger population. The fixed periodic interval called the sampling interval, is calculated by dividing the population size by the desired sample size. It might not need the full list of the study population. For example, for the study population of 1000 households the sample size is 200 then the sampling fraction is 1000 divided by 200 which is 5. You decide the first household to be selected using lottery method between 1 and 5. For example ask a friend to call a number between 1 and 5. Then you start with that number randomly selected for example 3 then start with the 3rd household and select every 5th household after. You might give house numbers or use existing house numbers to order the households.

Cluster sampling

In cluster sampling, researchers divide a population into smaller groups known as clusters. They then randomly select among these clusters to form a sample. Cluster sampling is a method of probability sampling that is often used to study large populations, particularly those that are widely geographically dispersed. Clusters might be health facilities, classrooms, schools, villages, kebeles or woredas. The assumption is the clusters are similar (homogeneous for the character under the study)

Stratified sampling

Stratified sampling is a type of sampling method in which the total population is divided into smaller groups or strata to complete the sampling process. The strata is

formed based on some common characteristics in the population data. The strata might be sex, Age groups, urban rural residence, type of facility (health center and hospital), type of provider (nurse, doctor etc), viral suppression etc

Multi-stage sampling

In multistage sampling, you select study participants through two or more stages of sampling. First you divide the population into clusters (smaller units) and select some clusters at the first stage. At each subsequent stage, you further divide up those selected clusters into smaller clusters and repeat the process until you get to the last step. For example, for a national study at first stage use woredas as clusters and randomly select some woredas from list of woredas in the country. In the second stage select kebeles from all the kebeles in the selected woredas at first stage. The select households from the selected kebeles using systematic sampling.

3.2. Sample selection in qualitative methods

Randomness is not the rule, unlike the case in quantitative study. Most common recruitment/ sampling methods used are:

- Purposive sampling
- Quota sampling
- Snowball sampling
- Convenience
- Self-selection

What is purposive sampling?

Purposive sampling, one of the most common sampling strategies, groups participants according to preselected criteria relevant to a particular research question (for example, HIV-positive women in Capital City). Sample sizes, which may or may not be fixed prior to data collection, depend on the resources and time available, as well as the study's objectives. Purposive sample sizes are often determined on the basis of theoretical saturation (the point in data collection when new data no longer bring additional insights to the research questions). Purposive sampling is therefore most successful when data review and analysis are done in conjunction with data collection.

What is quota sampling?

Quota sampling, sometimes considered a type of purposive sampling, is also common. In quota sampling, we decide while designing the study how many people with which characteristics to include as participants. Characteristics might include age, place of residence, gender, class, profession, marital status, use of a particular contraceptive method, HIV status, etc. The criteria we choose allow us to focus on people we think would be most likely to experience, know about, or have insights into the research topic. Then we go into the community and – using recruitment strategies appropriate to the location, culture, and study population – find people who fit these criteria, until we meet the prescribed quotas.

How does purposive and quota sampling differ?

Purposive and quota sampling are similar in that they both seek to identify participants based on selected criteria. However, quota sampling is more specific concerning sizes and proportions of subsamples, with subgroups chosen to reflect corresponding proportions in the population. If, for example, gender is a variable of interest in how people experience HIV infection, a quota sample would seek an equal balance of HIV-positive men and HIV-positive women in a given city, assuming a 1:1 gender ratio in the population. Studies employ purposive rather than quota sampling when the number of participants is more of a target than a steadfast requirement – that is, an approximate rather than a strict quota.

What is snowball sampling?

A third type of sampling, snowballing – also known as chain referral sampling – is considered a type of purposive sampling. In this method, participants or informants with whom contact has already been made use their social networks to refer the researcher to other people who could potentially participate in or contribute to the study. Snowball sampling is often used to find and recruit "hidden populations," that is, groups not easily accessible to researchers through other sampling strategies.

Convenience sampling

Convenience sampling involves using respondents who are "convenient" to the researcher. There is no pattern whatsoever in acquiring these respondents—they may be recruited merely asking people who are present in the street, in a public building,

or in a workplace or at a health facility.

Self-selected sample (or volunteer sample)

Self-selected sample (or volunteer sample) involves recruiting people who volunteer to participate in a study, often for payment. Typically, posters will be placed on a university campus or in a public location, or classified ads will be placed online or in a newspaper. Advantages: An easy way to obtain participants.

Instruction - 4.7: Divide participants into the same four groups created in the previous session. Give participants 50 minutes for group work. Each group used the same topics from the previous session to define the general, and study/target population, and determine the sample size and sample selection strategy for the quantitative and qualitative methods they selected in previous sessions.

Group 1: Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Give 10 minutes for each group to present the questionnaire they reviewed, and the gaps identified in a plenary. Then summarize the session, reminding key issues from the previous session.

Session 4: Quantitative and qualitative data collection techniques

Session objectives: By the end of this session participants will be able to discuss quantitative and qualitative data collection techniques.

Method: Group work, question and answer, case study, role play, discussion, and presentations.

Time allotted: 3 hours and 30 minutes.

Resources needed: Training manual, flip chart, marker, LCD projector and laptop.

Instruction -4.8: Ask the participants the following questions and give them chances to respond to each question.

- What are the skills of an effective interviewer?
- What is a common pitfall of poor interviewers to be avoided?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

Quantitative Methods Data collection: Interview skills

A productive interview is one in which participants understand questions well and respond freely to questions. A good interviewer knows the interview questions and topic and is prepared for the interview, has rapport-building skills, the one who listens and effectively asks questions.

How do I collect interview data?

- Identify and select the participant as per the selection procedure.
- Communicate with the participant about the study and select the place comfortable for the interview.
- Make sure the participant has time for the interview.
- Be prepared for the interview.
- Take informed consent.
- Conduct the interview using the questionnaire.

Be prepared for the interview.

- Be familiar with research documents - Know the research material well and practice the informed consent form and survey questionnaire. It gives you time and comfort to focus on the questions than the questionnaire.
- Read… Read …and read to understand and all questions, response options, instructions and skip patterns of the questionnaire. Be well versed of the research questions and the questionnaire.

  - Be clear of each question and response options.
  - Be well versed of skip patterns.
  - Be well versed and make sure you read and understand the instructions for each set of questions.
- Review the questionnaire before the survey starts and each morning before you start the interview.
- Be mentally and psychologically prepared to conduct the interview.

How should I present myself to interview participants?

- Relationship begins at first contact, with the participant's first impression of the interviewer based on a variety of factors such as the greeting, manner of speaking, clothing, and body language.
- Make sure all are done according to what is appropriate for the specific culture and setting.
- Cell phones should be turned off or in silent mode.

Interview participants thoroughly.

- Obtain informed consent from each participant before the interview.
- Address all questions listed in the interview questionnaire.
- Make sure you ask every question clearly and participant understands the question and records response options correctly.
- Look if the respondent had any confusion or misunderstanding about the question asked and \rephrase the questions.
- keep track of the questions response options instructions and skip patterns.
- Be neutral -don't lead responses let the participant respond (don't bias respondents to responses you want)
- Be a good Listener- encourage participants to elaborate on their answers without expressing approval, disapproval, judgment, or bias.

Common pitfalls of a poor interview

- Poor preparation and rapport-building
- Poor understanding of the study topic – cannot link participants' responses to response categories.
- Missing skip patterns.
- Missing instructions such as thick all that apply (multiple responses)

- Do not ask questions as it is stated in the questionnaire (misleading, biasing)
- Incomplete interview /questionnaire

Instruction -4.8: Ask the participants the following questions and give them chances to respond to each question.

- What are the skills needed to moderate FGD or IDI sessions?
- What is a common pitfall in moderating and not taking FGD/IDI sessions to be avoided?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

Qualitative data collection: Moderating FGD/IDI and taking notes.

How do I organize and conduct Focus group discussions (FGD) or In-depth interviews (IDI)?

- Be prepared for the FGD or IDI.
  - Set time and Arrange venue and logistics
  - Recruit and appoint only 6-8 participants per FGD session.
- Take informed consent.
- Take socio-demographic data of participants.
- Explain group discussion norms and rules.
- Give participants ID and Develop a seating chart.
- Moderate the discussion as per the guide and probe appropriately.
- Take note and record the discussion.
- Thank participants, provide refreshments, and address concerns.
- Label and pack field notes, records, and other data.
- Do note expansion and debriefing as soon as possible.
- Do transcription and data storage/backup properly.

Where should I conduct FGD or IDIs?

The FGD and IDI Venue should be convenient for participants:

- No sound pollution and

- Privacy to get unbiased opinion.
- Seat arrangement and participant ID for anonymity
- Circle and Seats/Participants given ID (001-008)
- Table convenient for note taking and placing recording equipment.
- If there is no table, the note-taker should use a clipboard.

Who conducts the FGD and IDIs?

- Each FGD and IDI session will be facilitated by two researchers -a moderator and a note-taker.
- In each FGD and IDI session the moderator (main facilitator) will introduce and guide the discussion using the FGD guide
- The note taker (co-facilitator) manages recording equipment and takes detailed notes.
- Both the moderator and note-taker should be prepared to perform either role, in case it becomes necessary to switch roles during the FGD/IDI

What does the FGD/ IDI moderator do?

- Recruiting participants
- Set appointments with participants -the FGD/IDI time and place.
- Arranging the venue and setting of the FGD/IDI
- Arranging logistics for FGD/IDI (FGD/IDI guide, informed consent form, digital recorders, spare batteries, refreshments, etc.)
- Answering any advance questions
- Being prepared to handle emotional adverse events and other needs such as referral.
- Effectively moderate the FGD/IDI session
  - Inform and take written consent as per the informed consent form.
  - leading the discussion,
  - posing all questions specified in the focus group question guide,
  - keeping the discussion on track
  - Encouraging all participants to contribute
  - Ensure participants speak loudly, clearly, and one at a time for clear recording.
  - Manage the discussion effectively i.e. heightened emotions, arguments, negative emotions, one person monopolizes discussion.
  - Ensure adverse events are correctly managed.

- Expanding field notes and conducting debriefing sessions.
- Transcription of audio records

What does the note-taker do?

- Take detailed notes of the discussion and document his/her observations on the discussion.
- Operating and managing tape recorder
- Labeling, packaging, and storage of field notes, tape records, and other data
- Facilitate the logistics of participant arrivals and departures,
- Manage participant's early withdrawal and manage intruders.
- Assist with managing adverse events.
- Provide Participants with refreshments and other logistics.

Effective moderator

- Understand the objectives of the FGDs in the study (important for building probes)
- Knows the focus group guide very well.
- Value participants' contributions to the study and see (moderator's) own role as a learner rather than a teacher.
- Create a discussion in which he or she participates very little. Do not lead or prompt comments.
- Bring unnecessary or off-topic inputs to a close politely, but as soon as possible (ie. avoid gathering extraneous data)
- Direct the discussion at a pace that allows all questions in the guide to be addressed thoroughly.
- Able to monitor and gauge the tone of the discussion, and
- Able to make quick judgments about when and how to interject.
- Is Flexible

Be prepared for the FGD/IDI.

- Be familiar with and practice the FGD/IDI guidelines, probes, and informed consent.
    - Being familiar with the guide enables you to use it flexibly, taking advantage of natural shifts in the discussion.
    - Be prepared to address any questions participants may raise about any issues in the research topic/content.

  - Review the focus group guide before every session.
- Prepare the logistics and label all materials– including notebooks and the focus group discussion guide.
- Review debriefing forms from previous FGD/IDI sessions to identify issues for further exploration.

Encourage positive group dynamics during FGD.

- A crucial skill for moderating a productive focus group is the ability to build rapport with and among participants from the start of the discussion.
  - quickly establishing a positive, relaxed, and mutually respectful group dynamic.
  - Politely discourage participants from dominating the discussion and encourage those who are silent to contribute.
- Techniques for building rapport and fostering a relaxed, positive atmosphere
  - Be friendly.
  - Smile
  - Make eye contact with all participants.
  - Speak in a pleasant tone.
  - Use relaxed body language.
  - Incorporate humor where appropriate.
  - Be patient and do not rush participants to respond.
- Establishing mutual respect
  - Set ground rules at the beginning.
  - Have a humble attitude.
  - Do not patronize.
  - Maintain a non-judgmental attitude.
  - Do not scold or berate participants' responses.
  - Do not allow any participant to berate others.
  - Do not coerce or cajole participants into responding in a certain way

Effective questioning skills and moderating FGD and IDIs

- Ask one question at a time, clarify, and remain neutral.
  - Open the discussion with a general comment and wait for a response.
  - asking one question at a time,
  - Invite a wide range of commentary by asking participants for experiences, thoughts, and definitions.
  - If everyone appears to agree about a particular issue, verify this by

inquiring, "Are there any other points of view?" or "Does anyone see it differently?"
  - Use silence to your advantage -Limit your participation.
  - Encouraging maximum participation
  - verifying unclear responses and using follow-ups and probes.
  - remain neutral by asking open-ended questions and avoiding leading questions.
  - If participants do not understand the question or seem to have misinterpreted it, rephrase it.
  - If the question still does not stimulate a productive discussion, let it go and move on to the next question.
  - Cover the issues in the guide on time.
- Ask open-ended questions.
  - A better technique for getting in-depth answers is to phrase questions as open-ended – that is, requiring more than a "yes" or "no" response.
  - Open-ended questions set no limits on the range or length of responses, instead allowing participants to explain their position, feelings, or experiences.
  - Avoid Leading questions are questions worded in such a way as to influence participants' responses along a particular line of thinking.

- What are probes and how do I use them?
  - Probes are neutral questions, phrases, sounds, and even gestures to encourage participants to elaborate their opinion.
  - Probing requires the moderator to listen carefully to participants and to engage actively with what they say.
- Use probes.
  - when a participant's response or contribution is brief or unclear,
  - when a participant or the group seems to be waiting for a reaction from you before continuing to speak, or
  - when a person appears to have more information on the subject

- ***Keep track of time in FGD and IDI***
  - The FGDs will take 60 to 90 minutes.
  - Keep track and set realistic goals for covering all of the questions within the time.

- Keep track of questions that have been addressed, and be ready to redirect the conversation, if necessary, to cover all questions.
- record the start and end times of each focus group.

How to be an Effective Note-taker

- Key skills for qualitative researchers include the ability to take notes quickly and with discretion, and then to expand those notes into rich descriptions.
- Effective Note takers skills include.
  - Mastery of an efficient system for taking copious notes and
  - The ability to quickly identify and take down individual quotes that capture the spirit of a given point.
  - Careful observation of verbal and nonverbal behaviors
  - Be discreet about notetaking as they operate the recording equipment.

Tips for taking FGD/IDI notes.

- Create a form on which to write your notes.
- Take notes strategically.
  - Direct quotes might be difficult but focus on phrases, and key points.
  - Use shorthand.
- Record participant identifiers (seating map)
- Record both the question and the response.
- Cover a range of observations.
- Distinguish clearly between participant comments and your observations.

Conduct Debriefing After the FGD and IDIs

- Debriefing is a very important part of focus group research and must be done with a certain degree of rigor to maximize its usefulness.
- The note-taker typically conducts a debriefing session with the moderator immediately after the FGD/IDI (1 hour after the FDG)

Why do we conduct debriefing?

- To log any additional information about the FGD while it is still fresh in the memory.
- To discuss issues or comments that need clarification.
- To discuss questions that did not work well and why.
- To note any information that contradicts or confirms data collected in previous sessions.

- To discuss new topics that arose during the focus group or identify missing information.

Expanding field notes: How do I expand my field notes?

- Moderators should expand their notes as soon as possible after each FGD session.
- It involves transforming shorthand into prose or a narrative and elaborating on your initial observations.
- Expanded notes are also called "field notes," and they are written directly into your field notebook or a computer file.
- Begin each notebook entry with the date, time, place, and type of data collection event.
- Eventually, all expanded notes should be typed into computer files.

Expanding notes involves the following:

- Scheduling time to expand your notes, preferably within 24 hours from the focus group session.
- Expanding your shorthand into sentences
- Compose a descriptive narrative from your shorthand and keywords.
- Identifying questions for follow-up.
- Reviewing your expanded notes and adding any final comments

What should I do with my FGD/IDI recordings and field notes?

- label all materials codes.
- Placing them together in one large envelope,
- Expand field notes and enter them into computer files.
- Transcribing the tapes, and entering the transcripts into computer files
- Pack the data in a heavy-duty envelope.
- Store and transfer data safely.

What form do FGD & IDI data take?

- digital recordings,
- transcripts of those recordings,
- Note-takers field notes.
- notes from the debriefing session held after the FGD &IDI.

Field notes what purpose does it serve?

- help to facilitate discussion between moderator and note taker and PIs immediately after the session.
- by moderators during the discussions, to remind themselves of questions they need to go back to
- helpful to quickly draft the transcript.
- Filed notes are the pins to give a human face to transcripts.
- Provides data on nonverbal expressions to verbal records captured in the tape
- Captures the seating chart and helps to identify the speaker (participant 1, participant 2, etc.)

What do we do with audio recordings?

- In-depth interviews and focus groups are tape-recorded.
- Before transcription, backup copies of the tapes should be made.
- The backup copies should be securely stored on a computer.
- Preparing recorded data for analysis requires transcribing all tapes and typing the transcriptions into computer files.

Instruction- 4.9: Read the following case studies and ask the participants how they handle the situation. Summarizes each case discussion using the following note.

Case -1: In a Focus Group Discussion, you noticed that a participant has dominated the discussion. Some of the ideas she is forwarding are important. But she wants to leave no room for others to speak. What will you do?

Case -2: In a Focus Group Discussion, you noticed that one of the participants is hesitant to participate but listens attentively. What will you do?

Case -3: In a Focus Group Discussion, you noticed that one of the participants was sobbing. What will you do?

Case -4: In a Focus Group Discussion, you noticed that one of the participants frequently jumps in and interrupts other participants. What will you do?

Case -5: In a Focus Group Discussion, you noticed that one of the participants is aggressive and reacts hotly to the opinion of the participant shared earlier. What will you do?

Case -6: In the middle of a Focus Group Discussion, you noticed that one of the participants wanted to leave early. What will you do?

Case -7: In the middle of a Focus Group Discussion, someone uninvited intruded into the discussion. What will you do?

Case -8: In the middle of a Focus Group Discussion, the recording equipment failed. What will you do?

Facilitator Note

Case -1: In a Focus Group Discussion, you noticed that a participant has dominated the discussion. Some of the ideas she is forwarding are important. But she wants to leave no room for others to speak. What will you do?

- Thanking the person for his or her contribution and inviting others to comment on what the person said.
- Encouraging a talkative person to make only one point at a time.
- Use body language to discourage someone from talking for an excessive amount of time,
  - Such as decreasing your eye contact with the talkative participant and increasing eye contact with others.

Case -2: In a Focus Group Discussion, you noticed that one of the participants is hesitant to participate but listens attentively. What will you do?

- Some participants will be hesitant to join an ongoing debate or discussion.
  - Offer them a safer opportunity to speak by pausing the discussion and asking whether anyone else has something to contribute.
  - Also pose questions directly to especially quiet individuals,
  - thank them for sharing their experience and encouraging them with body language.

Case -3: In a Focus Group Discussion, you noticed that one of the participants was sobbing. What will you do?

- If a participant is … Crying
  - If a participant begins to cry, it is up to the moderator to gauge whether

it is better to address the issue directly or not call attention to the person.
  - If you decide to discuss it, you might ask the person to identify the source of his or her distress and address it.
  - In some situations, the note-taker might take the crying participant aside to resolve the situation.
- If more than one participant appears tired it is time for a break.
  - Encourage people to get up and move around/Refresh.

Case -4: In a Focus Group Discussion, you noticed that one of the participants frequently jumps in and interrupts other participants. What will you do?

  - Remind the group that one of the ground rules of the FGD is to refrain from interrupting others.
  - Then thank the individual and suggest returning to his or her point after the first speaker's contribution has been completed.

Case -5: In a Focus Group Discussion, you noticed that one of the participants is aggressive and reacts hotly to the opinion of the participant shared earlier. What will you do?

  - Remind the ground rule that no one is permitted to insult or personally attack anyone else.
  - Try to decrease the level of aggression by calmly asking the individual in question to explain the reasoning behind the stated negative opinion and then involving the rest of the group in the discussion.
- If a participant is … Angry.
  - If a participant becomes angry, try to soften the level of emotion by acknowledging that the issues at hand are indeed sensitive or controversial.
  - If you consider it preferable to address the person's anger, steer the conversation toward the idea that it is the **issue** that is upsetting rather than another participant.

Case -6: In the middle of a Focus Group Discussion, you noticed that one of the participants wanted to leave early. What will you do?

- Participation is always voluntary: from recruitment till the end of the

interview.

- Participants who do not want to remain for the duration of the discussion, for any reason, should be reminded of the voluntary and confidentiality agreements and thanked for their participation.
- If the participant has adverse emotional events during the FGD the note-taker should approach and manage or refer the participant for support

Case -7: In the middle of a Focus Group Discussion, someone uninvited intruded on the discussion. What will you do?

- No other persons except the session moderator/ note-taker and study participants should be present during the FGD.
- Restrict entry to discussion room (sign on door etc.)
- If interrupted by an intruder take any steps necessary to protect the confidentiality of participants.
  - Stop the discussion temporarily and
  - explain the private nature of the discussion to the person(s) responsible for the interruption.
  - The note-taker can take the interrupter outside or aside to explain the need for privacy.
- Then resume the discussion.

Case -8: In the middle of a Focus Group Discussion, the recording equipment failed. What will you do?

- Facilitators should check and practice recording equipment before conducting any FGD.
- Always keep spare batteries on hand and ensure there is sufficient memory on the device for the session.
- Notes MUST be taken during the interview even if the session is being recorded.
  - If the equipment fails, the note-taker's detailed notes, supplemented by the moderator's brief notes, will serve as backup documentation.
  - It helps in identifying who says what by the ID of the speaker.
- Check for equipment failure immediately after the FGD and expand notes as soon as possible if a failure has occurred

Instruction - 4.10: Divide participants into the same four groups created in the previous session. Give participants 30 minutes to conduct a role-play using an FGD using the FGD/IDI guide developed earlier. Two of the group members act as a moderator and note-takers. Other group members act as participants.

Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Give 10 minutes for each group to reflect on their experience as note-takers and moderators of the focus group discussion – how does the FGD session go? Does the moderator follow the correct steps to create rapport? what were the challenges, and skill gaps of the moderator and how can it be improved . Then summarize the session.

Session 5: Ethical consideration and data security

Session objectives: By the end of this session participants will discuss the ethical consideration, confidentiality, and data security in CLM.

Method: Question and answer, discussion, and presentations.

Time allotted: 1 hour.

Resources needed: Training manual, flip chart, and marker.

Instruction -4.11: Ask the participants the following questions and give them chances to respond to each question.

- What are the three key principles of research ethics? Discuss each one and give an example.
- What is informed consent? What are the key considerations in informed consent? What is the difference between informed consent and assent?
- When do you take verbal and written consent?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

CLM often involves collecting highly sensitive, personal information about people's health and their experiences. People's privacy and their consent are extremely important to data collection for CLM. Experience with implementing CLM has shown that loss of privacy, confidentiality, and security are common reasons for people to avoid using healthcare services. The public health goal of CLM must be carefully balanced with the individual right to privacy and confidentiality.

Research Ethics

Research ethics deals primarily with the interaction between researchers and the people they study.

The three principles for research on human participants (Belmont Report):

- Respect for Persons
- Beneficence:
- Justice:

Respect for Persons: Individuals should be treated as autonomous (independent) agents ensure.

- Voluntary participation /consent
- Informed of risks and benefits of participation
- Participants consented to participation verbally or in writing.
- Minors and Persons with diminished autonomy are entitled to additional protection – seek the guardian's consent.

Beneficence: Do no harm and maximize possible benefits and minimize possible harms

- Investigators should design research studies to maximize benefits and minimize risks to individuals.

Justice: The burdens and benefits of research should be distributed fairly among individuals, groups, societies, etc.

Informed Consent

Informed consent is the process in which a researcher or a data collector informs participants about the study objectives, voluntary nature of participation, risks, and benefits of participation in the study and seek the participant's written or verbal consent depending on the nature of the study. The participants must be competent to make a voluntary decision about whether to participate or not. A participant should

be 18 years and older and mentally competent to provide consent.

Elements of informed consent include the provision of information on who conducts the study and contact addresses if any complaints, the nature, and objectives of the study, the voluntary nature of participation in the study, the risks, and benefits of participating in the study, and supporting the participant to make an informed voluntary decision or consent to the accept or reject participation in the study.

The barrier to informed consent	How CLM and related advocacy can overcome the barrier
Language	Use the person's mother tongue on the consent form and when speaking to them.
Literacy	Offer written and oral communication options.
Comprehension	Use simple words to explain CLM and how participants are being asked to engage in it. Avoid acronyms, abbreviations and jargon. Speak slowly and clearly
Age	If a person is under 18 years of age, they cannot consent to participate in CLM without their parents or caregiver (a legal guardian) being present. For this reason, it is generally advisable to sample adults over the age of 18 years. If CLM is specifically aiming to sample adolescents and young people, you must obtain consent from the participants, as well as their parents or caregivers.
Timing of discussion	Asking participants to answer questions before they have accessed health services may lead them to see CLM participation as a requirement for access to those services. It is advisable to ask for participants' engagement after they have received the services they came to the facility for. Reinforce that their participation is voluntary.
Amount of time allotted	Ensure adequate time for the discussion so the participant (and the data collector) do not feel rushed
Social desirability bias	This refers to the tendency among research participants to choose responses they believe are more socially desirable or acceptable, rather than choosing responses that are reflective

	of their true thoughts or feelings. This means that a person may say they agree to participate in CLM when they really do not want to do so. Make sure that you clearly offer the acceptable option of not participating in CLM. It might be a good idea to repeat this option for several times.

Data confidentiality and security

Once data is collected, three interrelated concepts affect the protection of that data:

- **Confidentiality** relates to measures to ensure participants the right to protect their data during storage, transfer, and use to prevent unauthorized disclosure of that information. Confidentiality is about anonymous reporting, unlinking participant personal identifiers from the data, and the use of pseudonyms. It is about policies and procedures on appropriate use and dissemination of data, and findings.

- **Security** is a collection of technical approaches to address issues covering physical, electronic, and procedural protection of the information that has been collected. Security is protecting data from inadvertent or malicious and inappropriate access to data by any person who is not a member of the study team.

Checklist for protecting the privacy, confidentiality, and security of participants in CLM.

- Ensure that you have participants' informed consent before asking any questions.
- Ask questions in a safe and quiet place, where you cannot be seen or heard by other people.
- Never record participants' names on data collection tools or in electronic databases.
- Have a written data security policy that defines how data are collected, stored, and shared.
- Limit the number of people who have access to data.

- Data should be stored securely (for example, in a password-protected computer).
- Ensure secure data transfer using secure internet (for example, https://).
- Manage permissions and access privileges to the data portal and transfer mechanisms.
- Put passwords on computers and documents where data are stored digitally.
- For paper-based data, make sure that questionnaires are kept in a locked cabinet.
- Once the data is transferred to the portal, delete raw materials that were used to collect it.

Instruction 4.12: Ask participants to read an informed consent form annexed to the training manual for 15 minutes and ask them to reflect for 15 minutes to reflect on the consent form if it has all the key components.

Session 6: Data quality audit.

Session objective: By the end of this session all participants will be able to describe data quality and strategies to improve data quality and process of data quality audit.

Method: Question and answer, discussion, and presentations.

Time allotted: 1 hour.

Resources needed: Training manual, flip chart, and marker.

Instruction -4.13: Ask the participants the following questions and give them chances to respond to each question.

- What is data quality? What are the attributes of quality data?
- What are the strategies to ensure data quality at design, data collection, analysis, and reporting?
- What is a data quality audit? What are the key components of a data quality audit?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

1. What is data quality?

Simply put, data quality in field research is a measure of whether your collected data meets your research requirements and answers the research question accurately and comprehensively. Quality field data should not have any errors, it should represent respondents accurately and should be free of any bias. The following characteristics are generally accepted to represent good data quality:

- Accuracy: There should be no errors in the data.
- Relevance: Your data should only include fields that you need and information that you intend to collect.
- Completeness: No questions should be left partially unanswered or skipped.
- Timeliness: The timeliness of the data should fit the purpose of your study, which is most often real-time.
- Consistency: There should be consistency across the questions being asked and these questions should be carefully planned according to the goals of your study.

2. Strategies to ensure data quality:

Data quality is critical to informed decisions in the design and implementation of impactful interventions and getting the intended results. Such decisions need to be accurate; data must also be accurate. Therefore, it is of utmost importance to ensure that the data being collected to support decision-making is of high quality. There are different strategies in which to ensure the quality of data which includes the following.

a) Use correct data collection methods and tools:

Collecting good data begins by using the appropriate data collection methods and tools. If your study is more qualitative, using close-ended questionnaires means that you won't be able to capture long explanations required for qualitative research. For each data collection project, it is important to select the right tools and the right methods for collecting data.

b) Recruit the right data collection personnel.

Different data collection projects require different sets of skills. Although some projects can be done by just about anyone who can be able to ask questions and record responses, some projects require that people with specialized knowledge be used. For example, I you need to collect public health data and must use specialized machines, you may need to recruit personnel who have at least some trainings in health. Some projects may also require that the recruited individuals be experienced in asking certain kinds of questions. For example, when a questionnaire involves asking for very sensitive information, beginner researchers may find it difficult to collect the right answers.

c) Train data collection team adequately

After having the right people for the data collection project, it is also important to train them adequately. There are usually 2 parts to training data collection teams. First, they must be trained in the general aspects of administering a questionnaire such as sampling procedures, personal presentation, tone, probing, and so on. Secondly, you need to orient the team on how they will ask and record responses on the data collection tools at hand. It is important to not assume that the team you have, even if it is filled with experienced people, will be able to collect the right data without having them undergo some orientation.

d) Develop and document instructions.

Even after having the data collection team undergo training, the data collection tools being used must contain clear instructions on how to administer them. Questions must be framed exactly the way they will be asked. Instructions must be included on what the enumerator is encouraged, allowed, or not allowed to do on the question, for example when probing is encouraged, and when reading out of available response options is allowed or not allowed. Questions that require calculations must include a hint on how the calculations will be carried out. Questions whose response will be a number must include the unit of measurement to be used. In certain cases, the enumerator may have to convert a number provided into a different measurement unit – this information must be documented, and the enumerator is trained on how to do this.

e) Pretest

Pretesting data collection tools before administering them to your targeted subjects is important for several reasons. First, you will be able to find out if the tool you are

using adequately covers your research objectives. Once the pretest data has been collected, you will be able to establish whether data analysis will yield the kind of results you intend to get from the data. With this information, you will be able to revise your tools accordingly.

Secondly, this is a hands-on orientation for your data collection team. It is also a way to get feedback from the data collection team in terms of whether the data collection instrument is adequately optimized for data collection. For example, some response options may need to be expanded, and some questions may be repetitive and hence would have to be removed.

You will also gauge whether the tool is too long or just the right length. The issue to do with respondent fatigue may be uncovered from the pretest, and hence the tool may have to be revised accordingly.

f) Supervisors/ Data quality control officers/team to do routine data collection checks.

While in the field, data checks can be done after each day of data collection to ensure that the data being collected is of the intended quality.

This may involve assigning a supervisor or data quality control officer. It is important to train these individuals from the beginning and lay out data quality guidelines to be followed and tracked by the data quality control officers. Having the data checked frequently will ensure that you are not caught unawares on the final hour realizing that all the data collected is not of the optimal quality as you expected. Supervisors should observe interviews and check completed questionnaires completeness, accuracy, and consistency and provide feedback to reinforce data collectors' skills during the data collection period.

g) Ensuring the Length of data collection tools is just optimum.

Data collection tools must be of optimal length to avoid respondent fatigue. To capture accurate responses, respondents must be in their right mind. When a data collection tool is too long, respondent devise a way to ensure that you do not waste any more of their time. This in most cases will result in poor quality data.

3. Data Quality Audit/Assessment

A data quality audit is the process where an organization examines its data for

accuracy, completeness, and consistency. A data quality audit aims to improve the quality of the data by spotting and filling gaps, identifying and fixing mistakes and weeding out duplicate records.

What is data quality assessment?

Data quality assessment (DQA) is the process of evaluating the characteristics and properties of data sets, such as accuracy, completeness, consistency, timeliness, and relevance. DQA aims to identify and quantify the errors, gaps, and anomalies in the data, as well as to measure the impact of data quality issues on the analytical objectives and outcomes. DQA can also help to establish data quality indicators, benchmarks, and targets, and to provide recommendations for data quality improvement.

Why is data quality assessment important?

Data quality assessment is important for several reasons. First, it can help to ensure that the data is fit for the intended purpose and meets the requirements and expectations of the data users and stakeholders. Second, it can help to avoid or minimize the risks and costs associated with poor data quality, such as inaccurate or misleading analysis, incorrect or incomplete decisions, and loss of trust or reputation. Third, it can help to enhance the value and usability of the data, as well as to foster a data quality culture and awareness within the organization.

How to design a data quality assessment framework?

A data quality assessment framework is a set of guidelines and principles that define the scope and objectives of a data quality audit. It should be aligned with the analytical goals, questions, sources, and types, as well as be flexible and adaptable to different contexts. This framework typically consists of four main components: data quality dimensions, indicators, benchmarks, and assessment methods.

- Data quality dimensions are aspects or attributes of data quality relevant to an analytical project, such as accuracy, completeness, consistency, timeliness, and relevance.
- Data quality indicators quantify the level of data quality for each dimension and can be expressed as numbers, percentages, ratios, scores, ratings, or rankings.
- Data quality benchmarks are reference values or thresholds that indicate the

desired level of data quality for each indicator.

- Finally, data quality assessment methods are techniques used to collect and analyze the data quality indicators and benchmarks; these can include data profiling, cleansing, validation, verification, testing, auditing, or reporting.

How to conduct a data quality audit?

Conducting a data quality audit is the implementation of a data quality assessment framework to evaluate the data quality of a specific data set or source. This audit can be carried out at different stages of the data lifecycle and varying levels of detail. The steps for a data quality audit typically involve:

- Defining the scope and objectives which includes identifying the data set or source to be audited, the analytical goals and questions to be answered, the data users and stakeholders to be involved, and the resources and constraints to be considered.
- Selecting the data quality dimensions and indicators involves choosing relevant aspects of data quality for the project and metrics to quantify them.
- Setting benchmarks which includes setting reference values or thresholds that indicate an acceptable level of data quality for each indicator.
- Applying assessment methods which involves using techniques or tools to evaluate each dimension, and identify errors, gaps, or anomalies in the data.
- Interpreting and communicating the results which involves summarizing and visualizing indicators and benchmarks, highlighting strengths and weaknesses in data quality, assessing impact on analytical objectives and outcomes, and making recommendations for improvement.

How to improve data quality?

Data quality improvement is the process of implementing the recommendations from the data quality audit to enhance the characteristics and properties of the data sets. Data quality improvement can involve different actions or interventions, such as correcting or removing the errors, gaps, and anomalies in the data, standardizing or harmonizing the data formats and values, enriching, or augmenting the data with additional information or sources, updating or refreshing the data with more recent or relevant data, or documenting or metadataing the data with more details or descriptions. Data quality improvement can also involve different strategies or approaches, such as preventive or proactive, reactive or corrective, continuous or

periodic, depending on the nature and severity of the data quality issues, as well as on the resources and constraints of the organization.

Session 7: Data analysis

Session objective: By the end of this session participants will be able to apply data analysis methods and tools.

Method: Demonstration, group work, question and answer, discussion, and presentations.

Time allotted: 5 hours

Resources needed: Training manual, flip chart, and marker.

Instruction -4.14: Ask the participants the following questions and give them chances to respond to each question.

- What steps do you follow in quantitative data analysis?
- What are common challenges they face in quantitative data analysis?
- What are the quantitative data analysis software you have ever used and reflected on your experience?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

Data analysis

Data analysis is how researchers go from a mass of data to meaningful insights. There are many different data analysis methods, depending on the type of research. Here are a few methods you can use to analyze quantitative and qualitative data. It's difficult to analyze bad data. Make sure you're collecting high-quality data.

The first stage of analyzing data is data preparation, where the aim is to convert raw data into something meaningful and readable. It includes four steps:

Step 1: Data analysis plan

Develop an analysis plan that operationally defines how the study indicators and objectives are answered through the data collected. How data is computed to calculate the percentages, rations, mean, and medians. Decide on the right way of getting answers to the study question using the data collected.

Step 2: Data Validation

The purpose of data validation is to find out, as far as possible, whether the data collection was done as per the pre-set standards and without any bias. It is a four-step process, which includes…

- Fraud, to infer whether each respondent was interviewed or not.
- Screening, to make sure that respondents were chosen as per the research criteria.
- Procedure, to check whether the data collection procedure was duly followed.
- Completeness, to ensure that the interviewer asked the respondent all the questions, rather than just a few required ones.

To do this, researchers would need to pick a random sample of completed surveys and validate the collected data. (Note that this can be time-consuming for surveys with lots of responses.) For example, imagine a survey with 200 respondents split into 2 cities. The researcher can pick a sample of 20 random respondents from each city. After this, the researcher can reach out to them through email or phone and check their responses to a certain set of questions.

Step 3: Data Editing

Typically, large data sets include errors. For example, respondents may fill fields incorrectly or skip them accidentally. To make sure that there are no such errors, the researcher should conduct basic data checks, check for outliers, and edit the raw research data to identify and clear out any data points that may hamper the accuracy of the results. The use of questionnaire codes during data entry helps during data editing. If you give questionnaire code 1 to XX and the questionnaire code becomes part of the data entered, then you can easily trace the questionnaire where you get an error in the electronic data set.

For example, an error could be fields that were left empty by respondents. While editing the data, it is important to make sure to remove or fill all the empty fields.

(Here are 4 methods to deal with missing data.)

Step 4: Data Coding

This is one of the most important steps in data preparation. It refers to grouping and assigning values to responses from the survey.

For example, if a researcher has interviewed 1,000 people and now wants to find the average age of the respondents, the researcher will create age buckets and categorize the age of each of the respondents as per these codes. (For example, respondents between 13-15 years old would have their age coded as 0, 16-18 as 1, 18-20 as 2, etc.)

Then during analysis, the researcher can deal with simplified age brackets, rather than a massive range of individual ages.

Quantitative Data Analysis Methods

After these steps, the data is ready for analysis. The two most used quantitative data analysis methods are descriptive statistics and inferential statistics.

Descriptive Statistics

Typically, descriptive statistics (also known as descriptive analysis) is the first level of analysis. It helps researchers summarize the data and find patterns. A few commonly used descriptive statistics are:

- Mean: numerical average of a set of values.
- Median: midpoint of a set of numerical values.
- Mode: most common value among a set of values.
- Percentage: used to express how a value or group of respondents within the data relates to a larger group of respondents.
- Frequency: the number of times a value is found.
- Range: the highest and lowest value in a set of values.

Descriptive statistics provide absolute numbers. However, they do not explain the rationale or reasoning behind those numbers. Before applying descriptive statistics, it's important to think about which one is best suited for your research question and what you want to show. For example, a percentage is a good way to show the gender distribution of respondents.

Descriptive statistics are most helpful when the research is limited to the sample and

does not need to be generalized to a larger population. For example, if you are comparing the percentage of children vaccinated in two different villages, then descriptive statistics are enough.

Since descriptive analysis is mostly used for analyzing single variables, it is often called univariate analysis.

Instruction -4:15: The Facilitator demonstrates the steps to create a data entry template, do data recording, and do descriptive and analytic statistics (60 minutes).

Then divide participants into the same four groups created in the previous session. Give participants 120 minutes for group work. Each group used the questionnaire developed in previous sections to create a database in SPSS and create a hypothetical data set for 30 participants in the SPSS. Analyze to answer the study objectives and indicators created earlier. The facilitator will rotate around to assist the groups.

Group 1: Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Finally, each group reflects on their experience for 15 minutes and the facilitator summarizes the session.

Instruction -4.16: Ask the participants the following questions and give them chances to respond to each question.

- What steps do you follow in qualitative data analysis?
- What are common challenges in qualitative data analysis?
- What is a transcript and what are the different transcription forms? What are the challenges of transcribing Audio-records?
- What are the qualitative data analysis software you have ever used and reflected on your experience?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

Preparing qualitative data for analysis: Transcription

Analyzing Qualitative Data

Qualitative data analysis works a little differently from quantitative data, primarily because qualitative data is made up of words, observations, images, and even symbols. Deriving absolute meaning from such data is nearly impossible; hence, it is mostly used for exploratory research. While in quantitative research there is a clear distinction between the data preparation and data analysis stage, analysis for qualitative research often begins as soon as the data is available.

Analysis and preparation happen in parallel and include the following steps:

- **Transcription of audio records**:
- **Getting familiar with the data**: Since most qualitative data is just words, the researcher should start by reading the data several times to get familiar with it and start looking for basic observations or patterns.
- **Revisiting research objectives**: Here, the researcher revisits the research objective and identifies the questions that can be answered through the collected data.
- **Developing a coding framework**: Also known as coding or indexing, here the researcher identifies broad ideas, concepts, behaviors, or phrases and assigns codes to them. For example, coding age, gender, socio-economic status, and even concepts such as the positive or negative response to a question. Coding helps structure and label the data.
- **Identifying patterns and connections:** Once the data is coded, the research can start identifying themes, looking for the most common responses to questions, identifying data or patterns that can answer research questions, and finding areas that can be explored further.

Transcription

The first task of the qualitative data analysis is to do data organization and transcription of audio records. The digital audio records should be copied to the computer every day and files should be stored in a folder for qualitative data. The file name of the audio record from each participant should be labeled using participant general identifiers. The hard copy of the researcher's field notes also should have a

heading labeled with the date of the interview, the name of the sub-city, the name of the health center and participant category, and the demographic background of the participants (age, sex, responsibility, and work experience).

The next step is the transcription of audio records. Transcription is the action of providing a written account of spoken words. In qualitative research, transcription is individual, or group interviews written verbatim. Transcription entails a translation or transformation of sound/image from recordings to text. The process ranges from word by word to a selective one whereby certain phenomenon or features of talk and interaction are transcribed. A more useful transcript is a reasonably selective one as extraneous information makes a transcript difficult to read and might obscure the research purpose.

Transcription seems straightforward, yet there are a range of approaches to transcription presented in a continuum of two extremes called naturalized and denaturalized transcription.

- Naturalized transcription occurs when written features of discourse have primacy over the oral, so written down talk exhibits many features of written language that do not actually occur in spoken talk. For example, commas, full stops (periods), and paragraphing are incorporated.
- Denaturalized transcription preserves the features of oral language such as "ums" and "ers". Naturalism and denaturalism are said to correspond to certain views about the representation of language. In a naturalized approach to transcription, language represents the real world. In a denaturalized approach, the view is that within speech are meanings and perceptions that construct our reality.

Several analytic methods are discussed in these two kinds of transcription practices. For example, it is suggested that denaturalized transcripts are suited to methodologies such as grounded theory and critical discourse analysis. Content analysis is viewed as a naturalized approach (Davidson 2009:36-52).

Public health mostly uses Naturalized transcription and content analysis methodology.

The transcription is mostly done in a three-layer process and pseudonyms are used to protect the real identity of the participants or any names and places mentioned in the

interviews (Moore & Llompart 2017:403-413).

- The first step was to listen to tape recordings of the full interview,
- Then write a rough draft of the transcript, and
- Finally enriching the transcript with the researcher's field notes and re-listening to the interview tape recording.

The transcript has three parts: a header, body, and tail. The header has the key socio-demographic information of participants and the duration of the interview. The body has a verbatim transcript of the interview where the interviewer's speech is denoted by 'I" and the participant is denoted by 'P". The tail part of the transcript contains the researcher's observations.

Qualitative data analysis: what is different.

- A bit complex and it is a tedious job and takes time.
- A variety of approaches used by different researchers.
- Data is text not numeric.
- Analysis looks for meaning and relation rather than quantification.
- Reading and re-reading through the document has no replacement.
- Analysis can't wait till all data collection is completed. While on the field review field notes and tape records every day to identify dominant ideas /concepts, new / surprise themes emerging.
- Computers aid the analysis (In vivo and atlas ti), particularly data coding and linking – but never replace reading and re-reading.
- Need for corroboration – validation of findings.

Qualitative Data Analysis Methods

Several methods are available to analyze qualitative data. The most used data analysis methods are:

- **Content analysis**: This is one of the most common methods to analyze qualitative data. It is used to analyze documented information in the form of texts, media, or even physical items. When to use this method depends on the research questions. Content analysis is usually used to analyze responses from interviewees. A common method of analysis used in public health.
- **Narrative analysis:** This method is used to analyze content from various sources, such as interviews of respondents, observations from the field, or surveys. It

focuses on using the stories and experiences shared by people to answer the research questions.

- **Discourse analysis:** Like narrative analysis, discourse analysis is used to analyze interactions with people. However, it focuses on analyzing the social context in which the communication between the researcher and the respondent occurred. Discourse analysis also looks at the respondent's day-to-day environment and uses that information during analysis.
- **Grounded theory:** This refers to using qualitative data to explain why a certain phenomenon happened. It does this by studying a variety of similar cases in different settings and using the data to derive causal explanations. Researchers may alter the explanations or create new ones as they study more cases until they arrive at an explanation that fits all cases.

Data analysis is perhaps the most important component of research. Weak analysis produces inaccurate results that not only hamper the authenticity of the study but also make the findings unusable. It's imperative to choose your data analysis methods carefully to ensure that your findings are insightful and actionable.

Colaizzi process for phenomenological data analysis

Projects use the seven steps of the Colaizzi process for phenomenological data analysis. Descriptive phenomenology is concerned with revealing the "essence" or "essential structure" of any phenomenon under investigation.

Colaizzi's distinctive seven-step process provides a rigorous analysis, with each step staying close to the data. The result is a concise yet all-encompassing description of the phenomenon under study, validated by the participants who created it.

Steps	**Tasks**
Familiarization	reading and rereading all the transcripts to become familiar with the data and get a general sense of the entire content or data
Identifying significant statements	Identify all statements in the accounts that are of direct relevance to the phenomenon under study
Formulating meanings	identify meanings relevant to the phenomenon that arise from the significant statements
Clustering themes (coding)	The researcher clusters the identified meanings into themes that are common across all accounts

Developing an exhaustive description	The researcher writes a full description of the phenomenon, incorporating all the themes produced
Producing the fundamental structure	The researcher condenses the exhaustive description down to a short, dense statement that captures just those aspects deemed to be essential
Verifying /validation	Validate findings with participants – visit or call participants to validate findings.

Session 8: Data presentation and reporting

Session objective: By the end of this session participants will be able to describe data presentation and reporting.

Method: Group work, question and answer, discussion, and presentations.

Time allotted: 2 hours and 30 minutes.

Resources needed: Training manual, flip chart, and marker.

Instruction -4.17: Ask the participants the following questions and give them chances to respond to each question.

- What are the data presentation options in a study?
- What are the different graphs do you know? and when do you use these graphs?
- What is a transcript and what are the different transcription forms? What are the challenges of transcribing Audio-records?
- What are the key contents/ outline of a study/CLM report?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

Data presentation

Data analyzed should be communicated to the target audience through text, tables and graphs. The study should answer CLM questions and objectives. Read the

objectives and plan how to use the data to answer each of the CLM objective.

Text should be written clear and concise. Make statements short. Tables should be no more than a page and should have the table heading that describe content of the table. Graphs should be appropriate for the data type and should follow standards for graphs. Graphs should have a graph heading that clearly describe what it is.

Statistical Graphs

A statistical graph or chart is defined as the pictorial representation of statistical data in graphical form. The statistical graphs are used to represent a set of data to make it easier to understand and interpret statistical information. The four basic graphs used in statistics include bar, line, histogram and pie charts.

Bar Graph

Bar graphs are the pictorial representation of grouped data in vertical or horizontal rectangular bars, where the length of bars is proportional to the measure of data. The chart's horizontal axis represents categorical data, whereas the chart's vertical axis defines discrete data. The data might or might not add up to 100%.

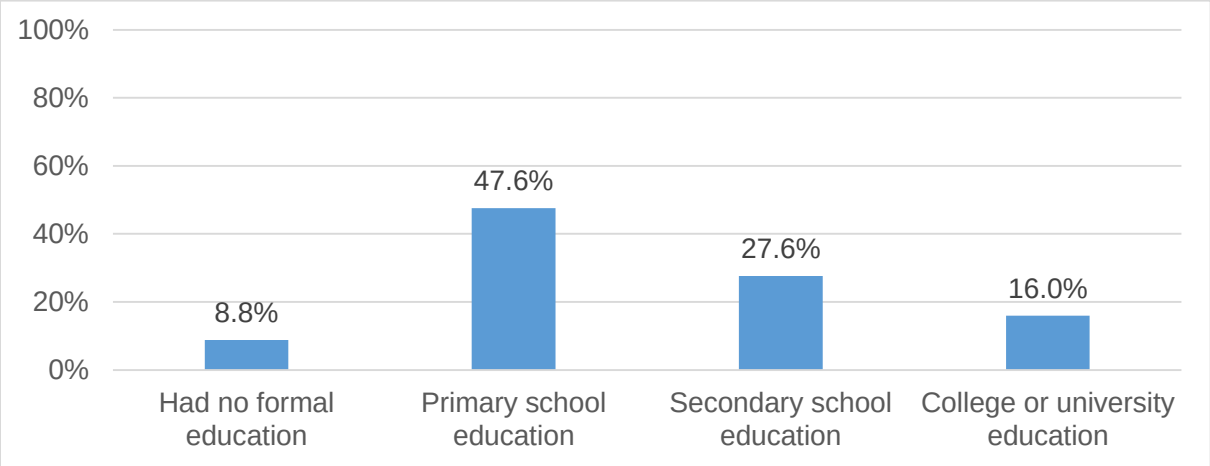


Figure 1: Percentage distribution of women in the postpartum period by educational status (N=500)

Line Graph

A graph that utilizes points and lines to represent change over time (trend) is defined as a line graph. In other words, it is a chart that shows a line joining several points or a line that shows the relation between the points. The diagram depicts quantitative

data between two changing variables with a straight line or curve that joins a series of successive data points. Linear charts compare these two variables on a vertical and horizontal axis.

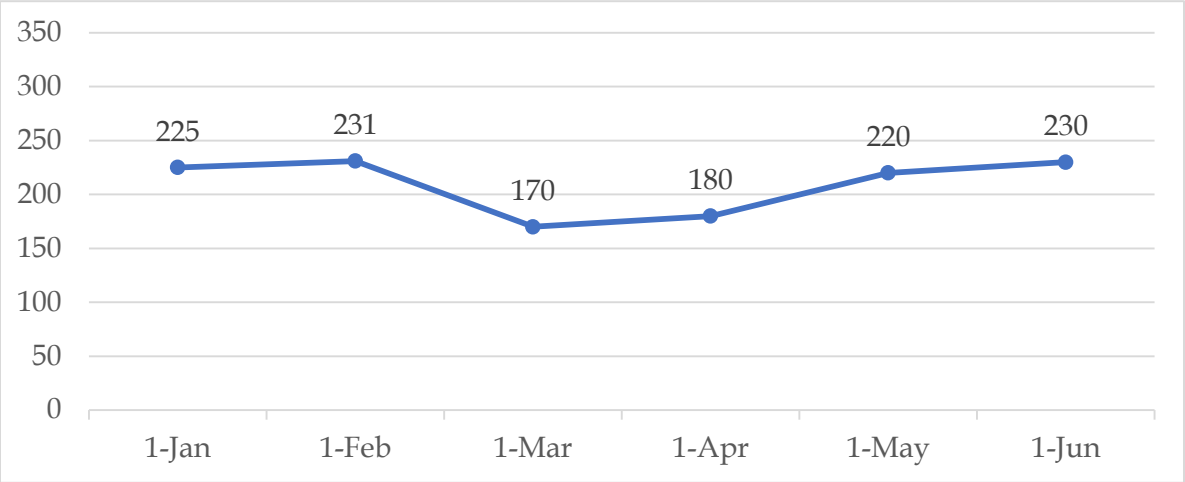
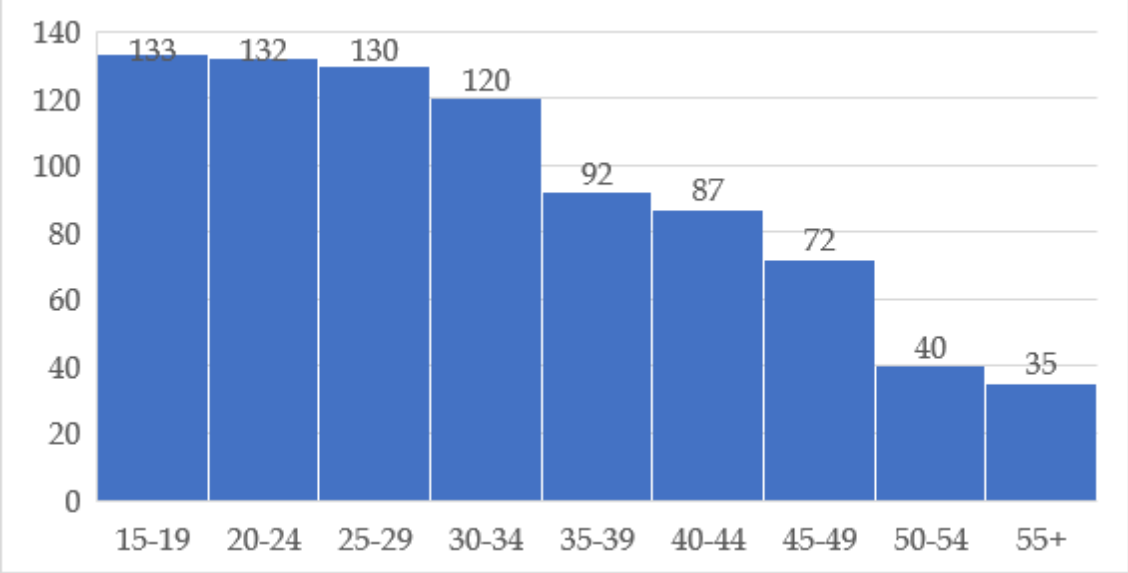


Figure: Number of HIV tests performed at keyit health center January to June 2023

Histogram

A histogram chart displays the frequency of discrete and continuous data in a dataset using connected rectangular bars. Here, the number of observations that fall into a predefined class interval represented by a rectangular bar.



Graph – Number of new HIV infection in XX region 2023

Pie Chart

A pie chart used to represent the numerical proportions of a dataset. This graph involves dividing a circle into various sectors, where each sector represents the proportion of a particular element as a whole. This is also called a circle chart or circle graph. The components should add up to 100%. Each component should be exclusive.

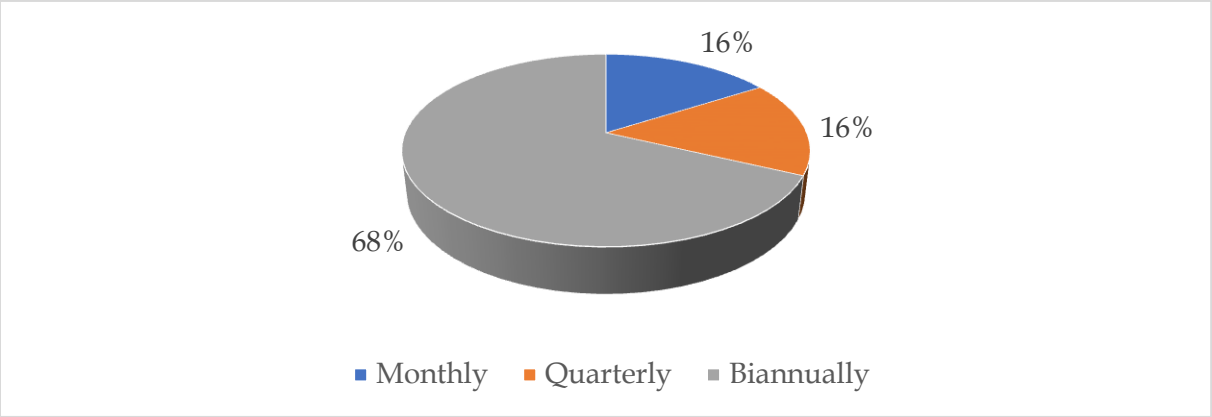


Figure: Percentage distribution of health centres by frequency of supportivsupervision (N=50)

CLM Report

Common components of a report for a study or a CLM project might include the following components.

- Cover page : Contains title, time of the study (data collection and report), the organization/s /People in charge of the report
- Table of contents
- Acknowledgments
- List of acronyms
- List of tables and figures
- Executive Summary: 1-2 page summary of objectives, methods of study, key findings and recommendations
- Introduction: Provides the rationale for the study
- Objectives : Define the general and specific objectives for the CLM data

collection and the questions or indicators to be measured

- Method and materials: Define the study place and time, study population, the data collection methods and tools used, how data collected, how data analyzed and presented, informed consent, data confidentiality and security measures, the limitations.
- Findings: Presents key findings of the study in text, table and graph in a way that answers the study/CLM objectives
- Recommendation and Action plan: Describe key interventions to address key gaps identified and develop action plan
- References
- Data collection tools

Instruction-4:18: Divide participants into the same four groups created in the previous session. Give participants 60 minutes to prepare a report using text, table, and graph using the data analyzed in previous sessions on the topics listed below.

Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Give 15 minutes for each group to present their report. Then summarize the session.

Unit 5: Engagement and Advocacy

Unit Objectives: By the end of this session, the participants will be able to:

- Describe the process of engaging stakeholders and co-creation of solutions.
- Describe advocacy strategies.
- Discuss the use of technology in CLM.

Learning Activities

Session 1: Engagement

Session 2: Advocacy

Session 3: Technology in CLM

Total time allocated: 3 hours and 30 minutes.

Session 1: Engagement

Session objectives: By the end of this session, participants will be able to describe the process of engaging key stakeholders and co-creation of solutions.

Method: questions and answer, group work, and facilitator presentation.

Time: 30 minutes.

Materials: Copies of the Manual, flipchart, and Marker.

Instruction -5.1: Ask the participants the following questions and give them chances to respond to each question.

- How do you engage stakeholders in the health facilities and communities to co-create solutions to address the identified gap?
- What will be the challenges, treats and opportunities for engagement co-creation of solutions and improving services at health facilities?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitators Note

Engagement

The goal of community-led monitoring is to enable communities and the CLM stakeholders to monitor, identify and solve problems related to access, quality, availability, appropriateness and affordability of services.

CLM is an effective way to solve problems collaboratively. CLM stakeholders - representatives from networks of people living with HIV, including key populations, officials from health care facilities and ministries of health, policy makers and academic partners collaborate to co-create solutions that enable achieving the best possible outcomes from national AIDS programmes.

Engagement provides communities and health care providers with a platform for convening and sharing data to facilitate improved health outcomes for recipients of

care. These platforms include CLM coalition meetings, joint planning and review meetings with health facilities and health offices etc

Engagement facilitates collaboration in identifying, implementing, and sustaining solutions, and furthers government investment in, and accountability for, improving the reach and quality of HIV services and their delivery. For example, CLM implementers can organize meetings with health facilities and/or district and national decision-makers, where data are reviewed, and solutions are co-created to mitigate identified gaps in treatment and service delivery.

CLM and related advocacy engagement is facilitated through a CLM coalition, which is a multistakeholder technical advisory board that provides essential support. The CLM coalition also creates an evidence-based advocacy agenda. It meets monthly to review data that has been cleaned, validated, and analyzed and to prioritize advocacy issues. During CLM coalition meetings, communities and decision-makers strategize on ways to address issues and solve problems.

Providing feedback and co-creation of solutions with health facilities

The CLM team at the woreda level shall meet the health facilities to provide feedback and co-create solutions based on the gap identified through CLM. The aim of CLM is not to apportion blame. The aim is the co-creation of solutions. Therefore, the CLM team should have communication skills, especially the skills to provide feedback and facilitate the co-creation of solutions.

Create a friendly atmosphere when meeting the health facility staff for feedback and co-creation of solutions. Great, smile and show a relaxed atmosphere. Provide details of the procedure and how data was collected and interpreted to build staff confidence in the findings. Be clear on what you communicate. Use short and clear statements. Avoid long statements, confusing expressions, and phrases.

Use the sandwich approach when providing feedback. First, provide feedback on the positive findings of the health facility or the service monitored. Then present the gaps and underlying causes. Finally, affirm the positive findings and the way gaps can be addressed with the co-creation of solutions.

Session 2: Advocacy

Session objective: By the end of this session participants will be able to discuss the advocacy strategies.

Method: Question and answer, discussion, and facilitator summarize the discussion

Resources needed: Training manual, flip chart, and marker.

Time allotted: 2 hour

Instruction -5.2: Ask the participants the following questions and give them chances to respond to each question.

- What are the steps to follow in advocacy?
- What are the advocacy strategies they knew or used?
- What are the common challenges of advocacy and the solutions?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

Data use for advocacy:

Visualization, advocacy, strategic communications, and local feedback
The end goal of CLM is not the data collection; it is using the resulting evidence to improve policy and practice. For CLM to be effective, data must be analyzed and used as evidence to influence change. Remember, the end goal of CLM is not the data collection; it is using the resulting evidence to improve policy and practice.

Making the numbers speak: How to analyze, visualize and operationalize data for a difference
Before designing your advocacy plan, it is a good idea to analyze and visualize the data for CLM. This will help you to see gaps, issues and opportunities. The way you analyze this data can make a big difference.

- Know the importance of trend analysis it speaks a lot. Instead of asking yourself, "Are these results good?", ask yourself, "Are these results better than before?"
- Know the importance of age and sex disaggregation: Instead of asking

yourself, "Are these results good?", ask yourself, "Are these results good for everyone?" Often, data on key populations are not disaggregated, obscuring the effectiveness and quality of services for sex workers, and people who use drugs.

- Know the importance of benchmarking: Instead of asking yourself, "Are these results good?", ask yourself, "Are these results above or below average?"

Data-driven advocacy planning for CLM: A 10-step method

1. Pick your advocacy priorities.

Looking at your data, identify the top advocacy priorities you want to push forward. There are two angles you can take when picking advocacy priorities, both of which may be useful and strategic depending on your context:

- OPTION A: Focus on the biggest gaps. For this option, you can ask yourself questions like, "Where are the biggest gaps between the way the world is and the way the world should be?" In other words, look at your data and identify the areas where things are most severely off track, where targets are most likely to be missed, or where populations are left furthest behind. These issues may be strategically selected as your top advocacy priorities.
- OPTION B: Lean against an open door. Another option is to ask yourself, "Where am I most likely to be successful and make a significant difference?" This might include looking at your data and picking issues where you can see there is a positive trend and progress is being made. By selecting this issue, your advocacy may be the catalyst to get an issue over the finish line, especially if there is already some forward momentum. This might include a policy issue that has been gaining traction in recent months. It also might include a target that is nearly – but not quite – achieved.

EXAMPLE: Advocacy priorities for a CLM approach:

- Expand the availability of non-facility-based HIV testing options, including community-led and community-based HIV testing services.
- Enhance linkage to – and retention in – care and treatment, especially for members of key and vulnerable populations.
- Strengthen community systems and responses to support the roll out of differentiated service delivery (DSD).
- Ensure effective treatment monitoring through acceptable turnaround times

for viral load test results.

We recommend selecting no more than five issues to ensure that your efforts remain focused. This will help you avoid the "shopping list" critique, where activists are sometimes dismissed for having too many priorities that do not appear well thought through.

2. ***Rank your priorities in order of importance.***

This will help you plan your time and resources for your advocacy work. It will also help you be more credible at the negotiating table. To pick the top priorities, you might yourself, "Which issues should be attended to first?" or "Which ones are the most urgent?"

3. ***Provide a rationale for your priorities.***

Clearly explain why you have selected the advocacy priority. It is important to use evidence from CLM data to defend the advocacy priority. Always use examples from your data to substantiate your claims. Convince your audience of the rigor with which you collected and analyzed your data. This may include underscoring your sample size or noting collaborations with academic institutions.

For example:

ADVOCACY PRIORITY: Ensure that treatment monitoring is effective by providing viral load test results promptly.

RATIONALE: Among 10,000 viral load tests performed at facilities undergoing CLM between January and June 2018, just 2,500 (25%) were returned to the recipient of care within two weeks. Our CLM data show that there is a connection between faster turnaround times and better treatment outcomes: in facilities where a larger proportion of viral load tests are returned within two weeks, viral suppression among people living with HIV on ART is higher ($p < 0.05$).

4. ***Set short-, medium- and long-term objectives.***

Advocacy priorities should be high-level problems that you want to fix. To make them more manageable, it is a good idea to break them down into short-term objectives (something you want to achieve in the next few months), medium-term

objectives (something you want to achieve within the next year), and long-term objectives (something you want to achieve in the next few years). Try to make your advocacy objectives SMART (Specific, Measurable, Attainable, Relevant and Time-bound).

5. ***Establish your target audience(s).***

Map your target audiences for sharing and discussing CLM advocacy data. Your audience should be the people you want to hear your message and act on it. They should be people who are in a position of power to enact the change you want to see. We recommend considering a diverse range of sectors for your potential target audience, including government, civil society, the media, the private sector, donors, technical partners and academia. You can consider identifying a primary target audience, as well as a secondary target audience. For example, your primary target audience might be laboratories that you want to have batch and streamline samples so that facilities get their results more quickly. Your secondary target audience might be health care providers who should notify the client of their test result as soon as it is received from the laboratory.

6. ***Identify friends and foes.***

For your message to be heard and acted upon, it is important to know who might be able to help you along the way, as well as who might potentially oppose you. Identifying your allies and your friends is very important. Friends can help amplify your voice, might support your advocacy with funding, or might already have the ear of your target audience. It is equally important to identify your foes: the people who might oppose you by standing in your way or discouraging you. Identifying these actors will help you avoid them or develop specific strategies to engage them effectively.

7. ***Map entry points.***

Consider when and where you will be able to advance your advocacy agenda. Entry points might include a location, a date or both. For example, there might be a key meeting or conference coming up where you can present your data and push your advocacy priority. An upcoming launch of a report, where people will be focused on your issue, could create an opportunity for you to add your voice to the conversation. Entry points may be infrequent events (for example, global conferences) or more regular occurrences (for example, national technical working group meetings).

8. Plan activities and expected results.

This will include the practical aspects of what you will actually do to push your advocacy agenda. It might include developing advocacy briefs, preparing PowerPoint slides, submitting abstracts to conferences, making phone calls, requesting meetings with decision makers, and securing TV or radio spots. For each activity, try to consider the intended results. You can ask yourself, "What do I want to achieve from this action?"

9. Consider available resources for implementing your advocacy plan.

This step includes thinking about the human, financial and time-based resources you might tap into to implement your advocacy plan. You might think about opportunities for funding from existing or potential donors and consider which CLM team members have the skillsets and time available to implement the advocacy activities.

10. Determine measurements of success.

How will you know if your advocacy is successful? Setting measurement criteria for success is critical. You may be able to assess the effectiveness of your advocacy through ongoing CLM data collection. Or you might need to do a separate assessment or evaluation.

Advocacy strategies

- **Advocacy meetings:** Conduct one-to-one, small, and large group advocacy meetings. Advocacy can be conducted in one-to-one or small group advocacy meetings with high-level decision-makers at MoH, RHBs, Zonal, and Woreda health offices. Multi-stakeholder advocacy meetings can be conducted involving a range of stakeholders to present CLM findings, the gaps, recommended solutions, and stakeholders' roles to address the identified gaps. This meeting can be used to ensure stakeholders understand the problem, the solution, and their role in the implementation of the recommended solution and make a commitment to its implementation.
- **Media campaigns:** Conduct a mainstream (radio and television) and social media campaign on the key findings, gaps, and solutions from the CLM data. Make panel discussions, shows, interviews, and briefings in mainstream media or social media (YouTube, TikTok, Facebook, tweeter, telegram, etc.)
- **Policy brief, posters, and flyers:** Prepare a short policy brief, flyers and posters

on key findings, gaps and solutions. Use the policy brief, the flyer, and posters to communicate discission makers and community.

Common challenges of advocacy

- ***Meetings with the non-relevant stakeholders:*** Programs reported that despite successfully securing meetings with local and national government stakeholders, in some cases the appropriate decision-maker delegated a more junior or alternate team member to participate in discussions . As a result, if the proposed solutions require a higher level of authority or engagement, the advocacy messages could not be implemented.
- ***Challenges in developing and using advocacy strategy and methods:*** Lack of skills to develop advocacy strategy and use different advocacy methods.
- ***Insufficient funding and prioritization for advocacy:*** Programs highlighted challenges around budgets not including enough resources to conduct the advocacy activities they wanted to do. overall, other aspects of CLM (such as data collection) being prioritized. Programs that faced delays in receiving funding noted that advocacy activities were often delayed or had to be removed from the work plan. Due to the significant effort dedicated to gathering and analyzing data, some programs noted the lack of capacity, time, and resources left for advocacy .

Recommendations to address common advocacy challenges.

- ***Engage duty-bearers and decision-makers throughout the project:*** Interview respondents spoke about how this increased engagement facilitates building mutual ownership and trust, and ultimately results in duty-bearers and decision-makers being more receptive to suggestions and co-creating solutions .
- ***Ensure that data are relevant, and community owned:*** Advocacy messages should be based on data that monitors the community's priorities and should be developed in partnership with clients of the healthcare system . When messages are derived from local communities, advocates are better able to build trust and justify to duty-bearers and decision-makers why issues should be addressed .
- ***Fully fund advocacy activities:*** Programs and donors must ensure that

advocacy activities are adequately resourced, including by budgeting to pay for advocates and technical assistance . Programs should be offered guidance and support in developing realistic and costed advocacy budgets to ensure that advocacy plans are adequately resourced .

- ***Increased technical assistance for advocacy:*** According to surveyed participants, 54% of programs identified technical assistance for advocacy as a key need for making projects more impactful . Programs suggested capacity building and mentorship around designing advocacy action plans, in addition to delivering training. Particularly as advocacy activities shift from the local level to the national level, projects report the need to build the technical capacity of advocacy staff to develop high-quality materials and policy briefs.
- ***Solution-driven, evidence-based advocacy:*** The strongest advocacy messages, and those most likely to be adopted and implemented, were those that are solution-driven and which propose concrete actions to address gaps and challenges . Programs noted the importance of highlighting CLM data during advocacy, to clearly present recommendations and findings that are rooted in and supported by data . Other strategies include developing messages that dovetail with government priorities, such as by providing innovative ideas to address persistent gaps and strengthen national efforts .
- **Develop work plans for advocacy:** Clearly defining the plan for advocacy helps the program to set objectives, organize the CLM staff and advocate, and map timelines . Workplans should be developed in consultation with key stakeholders, community members, and members of key and affected populations. Sufficient leeway should be granted in work planning to allow for the incorporation of innovative ideas or course corrections .
- ***Disseminate advocacy messages broadly:*** A variety of dissemination strategies can be impactful, ranging from participating in less formalized advocacy activities (such as engaging in ongoing conversations with stakeholders) to more formal activities (like public report launches or feedback meetings with governments and donors). Advocacy activities should include engaging a variety of media outlets, as a mechanism for reaching a wider audience and promoting community-led, grassroots advocacy.
- ***Strengthen community partnerships:*** Advocacy messages and activities should build on collaborations with other community-based organizations, civil society organizations, and non-governmental organizations. By building partnerships with other accountability groups and engaging in existing

community dialogues, CLM data and messages can be amplified by presenting a unified voice.

- ***Hire dedicated staff for advocacy:*** Programs described the importance of hiring team members to lead specifically on advocacy efforts, rather than hiring general staff to conduct advocacy and other activities. Advocacy team members should be hired for their previous experience and engagement in advocacy work.

Instruction 5.3: Divide participants into the same four groups created in the previous session. Give participants 50 minutes to define how to engage different stakeholders to co-create solutions for gaps identified, identify issues for advocacy (the ones that cannot be addressed at woreda and facility level) , and develop an advocacy strategy based on findings from previous sessions on the topics listed below.

Group 1: Adherence to treatment and viral suppression
Group 2: Quality of HIV chronic care services
Group 3: Stigma and discrimination in health care settings
Group 4: KP friendliness of HIV services

Give 10 minutes for each group to present their report. Then summarize the session.

Session 3: Technology in CLM

Session objective: By the end of this session participants will be able to discuss the use of technology in CLM.

Method: Question and answer, discussion, and facilitator summarize the discussion

Resources needed: Training manual, flip chart, and marker.

Time allotted: 60 minutes.

Instruction-5.4: Divide participants into three groups to identify technologies (computer, smart phones, tablets, internet, Cloud platform, data base, software, media, etc.) that can be used in the CLM tasks listed below.

Group 1: CLM methods and tools design and Data collection
Group 2: Data verification, data entry and analysis

Group 3: Report writing, dissemination, and advocacy.

Give participants 30 minutes for group work and 10 minutes for presentation. Then summarize the session using the facilitator's note below.

Facilitator's Note

The role of technology in the data journey is very huge and spans all CLM steps. The kind of technology you need at different steps in the data journey spans six main phases:

Concept and configuration. Plan indicators and questions expected responses and potential insights and/or trends. This planning exercise will ensure that the team knows what information it is collecting and how they will be expected to use it. Technology infrastructure setup and training also occur at this point. Computers and smartphones are used to develop tools, databases, etc. Tasks that might integrate technology include.

- Design indicators for observation
- Confirm data format for analysis
- Consider data format for capture
- Consider data transformations needed
- Consider data journey, transfer and storage
- IRB clearance
- Team training

The technology options might include.

- Database
- Survey tool digital or paper based.
- Data entry and analysis software

Data collection. Data collectors embark on their mission, armed with their recording tools (paper worksheets for written data and responses, mobile devices for photos, and audio recordings.). All assets collected will be appropriately prepared (including scanned, exported, transcribed, and summarized) for the next phase. Mobile phones are preferable to tablets in the field because they are smaller and more discrete, reducing the risks of data collectors becoming targets of security enforcers or other

bad actors who may want to confiscate their devices; Better equipped with noise-cancelling technology for audio recordings of interviews; More appropriate for use since data collectors will not be showing the content to interviewees (in which case a larger screen would be helpful for shared review; More familiar to data collectors, so they will require less training to use than tablets or other devices and Equipped with high-quality cameras for contextual photos (not of individuals) and document scanning (as part of the data collection process). The tasks that involve technology might include.

- Record quantitative data on worksheets.
- Record qualitative data (key insights, quotes) on worksheets.
- Record qualitative interviews on audio recordings.
- Capture photos of facilities, completed worksheets, physical context of location (but not people)

The technology options might include.

- Paper
- Tablet
- Mobile
- Mobile data
- Data entry and analysis software's

Review and verification. CLM data supervisors will receive and collate data and verify that the collected data meet quality checks and are labelled properly before final packaging and secure submission to a secured data portal (via computer). The portal will be the primary datastore/ source for all CLM and related advocacy records. The tasks that involve technology might include.

- Translate and transfer data from worksheets into digital tools.
- Complete required data fields on digital form
- Capture question responses, key insights, and quotes on digital tool(with timecode references)
- Upload/ update audio transcription.
- Supervisor verification of data entry accuracy
- Collation of submissions for the reporting period
- Update and notification of submissions.

The technology options might include.

- Computer
- Cloud platform
- Wi-Fi
- Data entry and analysis software's

Analysis and evaluation. Once available in the portal, the analysis team will be able to access and evaluate the data that have been collected. Team members will be allowed to extract a copy of the available data and will be expected to submit and link/upload any processed outcomes back onto the portal (attributing the relevant source to the derivative product or report). The tasks that involve technology might include.

- Data notification to analysis team
- Data clean-up and standardization
- Data review and follow up with CLM
- Analysis and insight development
- Review
- Key analysis and notes submission
- Key quotes and timecode recording
- Indexing and tagging
- Cross time period analysis
- Projections and comparisons
- Cross country or other classification analysis and patterns
- Key insights or hypothesis recording

The technology options might include

- Computer
- Cloud platform
- Wi-Fi
- Data analysis software's

Reporting and distribution. The analysis team will communicate with the CLM team about any adjustments or preliminary findings on an ongoing basis. Additionally, any completed reports will be available on the portal for the CLM team, so that they remain aware of emerging findings. The tasks that involve technology might include

- Interim feedback to CLM
- Adjustment directions to CLM if necessary
- Creation of interim updates
- Creation of final report
- Creation and distribution of shareable assets
- Presentation to community consultative group

The technology options might include

- Computer
- Cloud platform
- Wi-Fi

Advocacy and implementation. The outcomes from the analysis and reporting can be crafted into appropriate messages, evidence and visualizations that can be used to support advocacy and implementation efforts from civil society and partners. The tasks that involve technology might include

- Advocacy supported by shareable assets (tracked on digital tool where known)
- Review of CLM functionality for next phase of data capture

The technology options might include

- Computer
- Data visualization software
- Digital design

Digital CLM (i-monitor /I-CLM)

I-Monitor is android based digital CLM platform. The i-Monitor is designed tailored to communities' needs. I Monitor has a range of features including a downloadable mobile application for PLHIV and KPPs that has information about the location of services and to report challenges for a rapid response and resolution.

The platform has a response dashboard that allows CLM implementors who respond to the challenges reported by the community users to track, coordinate, and mobilize a response to the challenges reported; and an accountability dashboard that synthesizes and reports on core CLM indicators for disease prevention and treatment

services, including service availability, accessibility, acceptability, and quality.

I-monitor dashboard offers interactive maps, charts, and infographics that can be easily understood and communicated by CLM implementers, facilitating evidence-based advocacy and action. The dashboard messages can be shared directly with health facility managers and health providers to catalyse changes in service delivery, as well as the national HIV program to inform larger policy and programming decisions for the overall HIV response.

Unit-6: Education

Unit Activity: At the end of this unit all participants will describe the goal, standards, and strategies of combination HIV prevention, HIV testing, treatment and care, and clients' rights including stigma-free care, informed consent, and confidentiality.

- Describe the goal of the National Strategic Plan 2023/24-2026/27,
- Describe key and priority populations,
- Describe Combination HIV prevention interventions.
- Discuss the HIV testing strategies.
- Discuss Triple elimination of mother-to-child transmutation of HIV syphilis and viral hepatitis.
- Discuss standards and interventions for HIV care and treatment.
- Discuss standards and interventions of stigma-free care, informed consent, and confidentiality.

Methods: Question and answer, group work, discussion, and facilitator presentations.

Time allowed: 5 hours

Resources needed: Manual, Flip chart, and marker.

Learning activities:

Session - 1: Goal of the National HIV Strategic Plan 2023/24-2026/27

Session - 2: Combination HIV prevention

Session - 3: HIV testing services

Session – 4: EMTCT of HIV, syphilis and Viral Hepatitis

Session - 5: Care and treatment

Session - 6: Human rights: stigma-free care, informed consent, and confidentiality

Session-7: Post test, certification and closing remark.

Session 1: Goal of the National HIV Strategic Plan 2023/24-2026/27

Session objectives: By the end of this session participants will describe Goal of the National HIV Strategic Plan 2023/24-2026/27

Method: Question and answer, discussion, and presentations.

Time allotted: 15 minutes.

Resources needed: Training manual, flip chart, marker, LCD Projector, and laptop.

Instruction -6.1: Ask the participants the following questions and give them chances to respond to each question.

- What are the overall goal of the National HIV Strategic plan 2023/24-2026/27?
- What are the targets for combination HIV prevention, EMTCT, HIV testing, care and treatment and stigma and discrimination?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

Vision, Mission, and Goal of the NSP

Vision: An AIDS-free Ethiopia

Mission: To institute effective HIV/AIDS prevention and control programs; to coordinate the national HIV/AIDS response; and to strengthen health systems, programmatic and social enablers to ensure sustained epidemic control in the foreseeable future.

Goal: To attain and sustain HIV epidemic control by 2027, by reducing new HIV infections and AIDS mortality to less than 1 per 10,000 population nationally, and among subnational and subpopulation groups.

Session 2: Combination HIV prevention

Session objectives: By the end of this session participants will discuss population and geographic priorities and combination HIV prevention interventions.

Method: Question and answer, discussion, and presentations.

Time allotted: 60 minutes.

Resources needed: Training manual, flip chart, marker, LCD Projector, and laptop.

Instruction -6.2: Ask the participants the following questions and give them chances to respond to each question.

- What are the goal of the HIV prevention program in Ethiopia??
- What are the key or priority populations in Ethiopia?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

The objective of combination HIV prevention program is to reach 95 per cent of key and priority populations with targeted combination HIV prevention interventions by 2027.

Geographic priorities

The country has about 1,076 woredas. Based on HIV incidence estimates from the Naomi model in 2020 and recent programme data from regions (Annex 4), woredas are categorized into three geographic priority areas:

- High (265): Woredas with HIV incidence of ≥0.03 per cent among people aged 15-49.
- Medium (326): Woredas with HIV incidence of 0.01- 0.029 per cent among people aged 15-49.
- Low (485): Woredas with HIV incidence of < 0.01 per cent among people aged 15-49.

In addition, 35 woredas affected by conflict, which were not included under high-incidence woredas, was selected from Afar, Amhara, Oromia, and Tigray regions and considered as high- priority woredas to be supported by donor programmes, including the Global Fund. Thus, a total of 300 woredas will be considered as high

priority woredas. These woredas will be reached through comprehensive HIV prevention interventions targeting KPPs.

Population priorities

The following population groups are defined as Key and Priority Populations taking into consideration local epidemiology, HIV prevalence, high-risk behaviors, increased morbidity and mortality or higher vulnerabilities.

KEY POPULATIONS

- Female sex workers (FSW)
- Prisoners
- People who inject drugs (PWID)

PRIORITY POPULATIONS:

- Widowed and divorced men and women
- Long-distance drivers
- Workers in hotspot areas
- High-risk adolescent girls and young women
- Seronegative partners of PLHIV
- People in humanitarian settings
- High-risk uniformed men and women

Key Populations

Female sex workers are defined as women who regularly or occasionally exchange sex for money in drinking establishments, night clubs, local drink houses, khat and shisha houses, on the streets, around military and refugee camps, construction sites, trade routes, red-light districts, and at their homes. A sex worker can be self-identified or identified by others as a sex worker.

They can be further categorized by where they work as:

- Venue-based: female sex workers stationed in hotels and bars.
- Street-based: female sex workers who are mobile or street based.
- Home based: female sex workers stationed at home, or at areque, tella, khat' and shisha houses.
- Phone/SMS/social media based: female sex workers who can be contacted and accept sexual appointment through telephone calls and social media.

The non-paying clients of FSWs will be addressed as part of the HIV programme that targets FSW.
Prisoners are all people detained in a criminal justice and prison facility, including adult and juvenile males and females, during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing.

People who inject drugs (PWID) are men and women who, because they use injectable drugs, are at high risk of acquiring HIV infection. They require special arrangements to access HIV and harm reduction services.

Priority Populations

Long-distance drivers are obliged to regularly travel on the road that involves overnight stay out of their home. This group includes heavy/medium truck drivers, bus drivers, and tour car drivers.

Widowed and divorced men and women are those whose spouses have died and who have not remarried. Divorced men and women are those who have legally dissolved or terminated a marriage under the rule of law of the country and have not remarried. High-risk widows are sexually active, have multiple sexual partners, are involved in petty trade and selling local drinks.

Workers in hotspot area are those employed in workplaces with a workforce larger than 500 people, in areas that have a high HIV burden (if data is available >3%) and a high number of FSWs nearby, where workers have poor access to HIV and other health services, and many are far from home. This includes large construction projects, industrial parks, factories/industries, commercial farms and sugar plantations, dry ports, mega-projects (e.g., electric dams), mining, and other investment and infrastructure development projects. People working in these sites are likely to be migrant laborers away from their homes and have some disposable income. These sites will therefore attract female sex workers. These conditions result in the potential for risk behaviors associated with the acquisition and spread of HIV. Surveys will be conducted to inform HIV programming in these workplaces.

HIV seronegative partners of PLHIV: PLHIV are people who have been tested for HIV and are found HIV-positive. PLHIV partners are people who have sexual relationships with PLHIV, including spousal and non-spousal partners. Discordant couples are those in which one spousal partner is HIV-positive.

High-risk adolescent girls and young women (HRAGYW) are defined as females aged 10-24 years who are sexually active (defined as having sex at least once in the past 12 months) and who met one or more of the following characteristics in the past 12 months:

- Have multiple sexual partners or sex with non-regular partner.
- Are involved in transactional sex or are victims of sexual exploitation (irregular exchange of sex for money or materials).
- Are involved in substance abuse (heavy use of alcohol, or other illicit drugs).
- Have a history of sexually transmitted disease, unintended pregnancy, or abortion.

This group of adolescents and young women are found in higher learning institutions, high school, and night schools. They work as waitresses or domestic workers, or are out of school, including those unemployed, those who are working (coffee sellers, petty traders) or being homeless.

People in humanitarian settings: humanitarian settings include drought-affected areas, conflict and post-conflict areas, and areas affected by both natural and human-made disasters.

High-risk uniformed men and women are those on active/frontline duty and new military and police recruits. A 2018 Department of Defense (DOD) study showed an HIV prevalence of 1.2 per cent [20]. In addition, the case-based surveillance results show 13.73 per cent of the newly identified HIV-positive men and women with uniform had recent infections. In recent years, conflicts in Ethiopia have led to a huge influx of youth into the uniformed services, which often lack adequate HIV prevention services.

Instruction -6.3: Ask the participants the following questions and give them chances to respond to each question.

- What are combination HIV prevention interventions targeting in Ethiopia/ explain in detail?
- What are the service delivery models/outlets /strategies of combination HIV prevention in Ethiopia?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

Combination HIV prevention interventions

a) Social behavioral change communication and demand creation

Intensive behavioral change communication interventions (SBCC) will be implemented targeting key, priority populations in the 300 priority woredas. The SBCC will be mostly peer-based, facilitated small group learning. Demand creation interventions will include mass media (radio and television), mini-media, print media (leaflets, posters, magazines and newspapers), social media and interactive digital applications. Creative social media and interactive applications will be optimized to reach large groups of KPPs and the general population (mainly youth) to create demand and raise awareness about HIV/SRH prevention, HIV testing, care and treatment, consolidated through the integration and strengthening of community level implementers. Integration of HIV prevention into the school curriculum will be implemented nationwide targeting adolescents and youth in school.

Condom promotion and distribution

- Expected Result 1: Percentage of adults aged 15–49 who used condoms during their last high risk sex act in the past 12 months increased from 20 per cent for females and 51 per cent for males to 50 per cent for females and 70 per cent for males by 2027.
- Expected Result 2: Condom use among key and priority populations engaged in risky sexual behavior reaches 90 per cent by 2027

The condom programme will be implemented through a total market approach. Free condoms will be distributed to KPPs. Social marketing and the private sector will reach the general population and KPPs in all woredas across the country. Condom-compatible lubricants will be distributed to FSWs through social marketing and private sectors.

Condom demand creation will be the central theme of all SBCC interventions targeting key and priority populations as well as the general population.

Free condom distribution to key and priority populations will be conducted through DICs, peer service providers, door-to-door distributions at hotspot areas, health workers outreach programmes, distribution at hotels and bars as well as hotspot workplaces, and truck stops. CSOs will be engaged in the distribution of condoms through non-traditional outlets.

b) Pre-exposure prophylaxis (PrEP)

- Expected Result: 15 per cent of FSWs, PWID, high-risk PBFW, and 75 per cent of sero-discordant couples (not attaining viral suppression) will receive oral PrEP at least once during the last 12 months by 2027

Pre-exposure prophylaxis (PrEP) of HIV is the use of ARV drugs by individuals who are not infected with HIV but at a substantial risk to block the acquisition of HIV. The nationally recommended PrEP drug is a fixed dose combination that contains Tenofovir 300mg and Lamivudine 300mg once daily for the identified target groups with substantial risk for HIV infection. In the context of COVID 19 pandemic, a three Multi Month Dispensing (3MMD) PrEP drugs for all clients is recommended. While taking PrEP, clients should have followed up facility visit for prescription refills, counseling on risk reduction, counseling on correct and consistent use of condoms; routine screening of STIs, family planning service HIV testing, and assessments of adherence and retention as part of combination HIV prevention package.

PrEP will be provided to people at substantial risk of acquiring HIV. In the Ethiopian context, these are female sex workers, HIV-negative partners of PLHIV who are not virally suppressed, PWID and high-risk PBFW. Among the subgroup of FSWs who are considered at greater risk of acquiring HIV infection, either because of non-consistent condom use or as victims of repeated gender-based violence, activities to increase PrEP will be undertaken through peer supporters and CSOs. Demand creation and service delivery will ensure that the HIV- negative partners of non-virally suppressed PLHIVs on AR, who are at substantial risk of infection, have the option to take PrEP.

PrEP will be integrated in ART, MNCH/PMTCT, family planning, DICs, medical assisted treatment and KPP- friendly clinics. In addition, community-based PrEP initiation and refill will be introduced as per the WHO simplified guidelines for PrEP.

WHO also recommended that the Dapivirine vaginal ring (DPV-VR) for women every 28 days and injectable PrEP every two months for all eligible clients at substantial risk

of HIV infection, as part of combination prevention approaches. Expanded PrEP options will be made available in addition to oral PrEP, such as long-acting PrEP as these new options become more readily available and registered in the country.

c) Post-exposure prophylaxis (PEP)

PEP the use of ARV drugs for people with medical and non-medical accidental exposure to risk of HIV infection and for victims of rape. Non-medical exposures include condom breakage, sex without a condom, exposure to body fluids with a person of known HIV-positive or unknown HIV status. To be effective, PEP should be initiated as soon as possible (within 1-2 hours). The maximum delay for initiation of treatment which would prevent infection is not known in humans. Do not consider PEP beyond 72 hours post exposure. Prophylaxis is to be given for 28 days. Recommended regimen for PEP is Dolutegravir (DTG) 50 mg daily in combination with tenofovir disoproxil Lamivudine (3TC) 300 mg daily as the preferred regimen in healthy adults and adolescents for 28 days. Alternatively, AZT or TDF+3TC+EFV for 28 days or Boosted Lopinavir OR boosted Atazanavir can substitute EFV.

d) Harm reduction services

- Expected Result 1: Percentage of PWID benefiting from two or more harm reduction prevention interventions increased from 0 per cent to 60 per cent by 2027.
- Expected Result 2: Percentage of eligible PWID receiving opioid substitution therapy increased from 0 per cent to 30 per cent by 2027

This will lay the groundwork for a step-by-step introduction of harm reduction programmes, including opioid substitution therapy (OST). Combination HIV prevention/harm reduction services will be provided to PWID through community (DICs and peer service providers) in both public and private facility-based services. Initially, a pilot intervention in Addis Ababa will provide harm reduction service through CSOs community-based services. CSOs will train peers and providers on harm reduction (SBCC) and peer supporters will provide HIV prevention demand creation and linkage to HIV/OST services.

The service package for PWID, delivered by CSOs through Drop-in Centers (DICs), will include condoms, HIV testing and treatment, STIs and viral hepatitis screening, diagnosis and treatment, PrEP, and PEP. In addition, hepatitis B vaccination should be offered to HIV-negative PWIDs. Those who are interested in rehabilitation will be referred to addiction centers for OST and detoxification. CSOs, through their PSPs and

PWID champions, will use virtual safe spaces for demand creation. Public health facility KPP-friendly clinics will target PWIDs in places where DICs are not available. The opioid substitution therapy will be integrated in these selected mental health services and DICs through integrated efforts from governmental, non-governmental and civil society organizations. Selected government-owned mental health centres will be capacitated to pilot and scale-up OST. OST will be provided by trained providers with appropriate monitoring to avoid misuse.

e) Voluntary medical male circumcision (VMMC)

Expected Result: % of males aged 15-49 circumcised at Gambella and selected woredas of SNNP region increased from 72 per cent to 90 per cent by 2027

Voluntary medical male circumcision (VMCC) will be implemented and integrated in primary health-care facilities as part of minor procedures within the surgical services. VMCC will target male infants and men aged 10-49 years in settings of high HIV prevalence and low circumcision prevalence (Gambella region and selected woredas in the South Region). Primary health-care facility staff will be trained to perform routine male circumcision services at health facilities. The health facilities will be equipped with the required equipment and supplies.

A SBCC strategy will be designed to address male circumcision. The strategy will use community dialogue sessions, the engagement of influencers and tribal leaders, and promotion through clients' testimony.

VMMC will be reinitiated in military setups (uniformed men), especially among new recruits (in selected enrolment sites). The VMMC backlog will be cleared through a campaign-based modality.

f) Screening and treatment of sexually transmitted infections

Active screening and treatment of STIs using a syndromic approach will be provided to KPP, particularly FSWs, high-risk adolescent girls and young women and their partners, integrated through community and health facility level service delivery outlets. To build the capacity of HCWs on syndromic management, guidelines and manuals will be distributed to health facilities for all population groups.

Etiologic diagnosis and management of STIs will be introduced and scaled up through phased and mixed approaches via public-private facilities that have the diagnostic capacity. The national STI treatment guideline will be revised based on global

recommendations and any emerging information from national surveys and surveillance, including drug resistance data.

STI diagnosis will also be scaled up through community (DICs) and facility (KP-friendly clinics) platforms. STI screening, diagnosis and treatment will be strengthened at youth development centers and prison settings.

g) Economic empowerment of vulnerable women

Economic empowerment interventions (job creation, vocational skills training and income generating schemes) will target disadvantaged women, especially adolescent girls and young women in the 300 priority woredas, as a structural HIV prevention intervention integrated with economic empowerment initiatives of other key sectors.

Combination HIV Prevention Service Delivery Model

A mix of client-centred service delivery models will be used to reach key and priority populations, include the following:

a) Key and priority population-friendly clinics

These are HIV/SRH clinics within public health facilities that provide one-stop shopping HIV/SRH services for key and priority populations. There will be at least one KPP-friendly clinic in each of the 300 woredas, with minimum standards and defined service packages (for specific KPPs) to ensure the quality and friendliness of services.

The KPP-friendly clinics will provide comprehensive services (SBCC, counselling, condom, HIV testing, PrEP, STIs screening and treatment, family planning and referral linkages for treatment and PMTCT). The KPP-friendly clinic will integrate and serve FSWs, high-risk AGYW, PWID as well as other KPPs, based on their preference. KPP clinics serving PWIDs will have additional mental health professional support and should be closely linked with the nearby addiction rehabilitation treatment centers.

The KPP-friendly clinic will be open during off working hours and weekends and will be linked with peer service providers and community mobilizers to create demand and mobilize KPP to use the services.

b) HIV services at health facilities

The HIV service delivery outlets of health facilities will be made friendly for KPPs through training of service providers to respond to the needs of KPP who prefer to use

these general HIV services outlets. Health facilities will use risk screening tools at all outpatient and inpatient outlets to identify KPPs and provide or link them to combination HIV prevention services.

c) Drop-in-Centers (DICs)

DICs established at hot spot places in the community to provide combination HIV prevention, care and treatment and SRH services to key and priority populations, especially FSWs, high-risk AGYW and PWID.

DICs will provide comprehensive HIV/SRH services (SBCC, counselling, condom, HIV testing, PrEP, STIs screening and treatment, PEP, family planning and provision of or referral linkage for treatment and PMTCT) and have a set of minimum standards for integrated services. In addition, DICs will link to social services available in the community or through development partners.

d) Targeted outreach programmes

DICs and KPP-friendly clinics will have regular outreach programmes to reach KPPs at nearby hotspots, schools, prisons, workplaces, and humanitarian settings. Targeted outreach HIV services will be led by health workers, peer service providers and community mobilizers. Civil society organizations and development partners will lead outreach services. Outreach programmes targeted to KPPs will be implemented in all the 300 priority woredas.

e) Peer service providers (PSP) programme

CSOs will recruit, train, assign and manage PSPs linked with DICs and KPP-friendly clinics. To standardize and enhance the community-based response, there will be at least 15 trained peer service providers per woreda working full time with a monthly standard incentive package in all the 300 priority woredas.

PSPs will deliver a standard package of services (SBBC, especially peer education, condom, HIV self-testing, information and referral for PrEP and referral linkage for other HIV prevention and treatment services). The PSPs will support health facilities, KPP-friendly clinics and DICs with adherence support and tracing patients lost to follow-up.

f) Mentor-based programmes for high-risk AGYW and high-risk divorced and widowed women

Mentor-based HIV prevention programmes will target high-risk AGYW and high-risk widowed and divorced women in the 300 priority woredas and in 50 higher learning institutions. Mentors will deliver one-to-one and small group education, counselling, life skills, and services including condoms, PEP, HIVST, STIs, FP/SRH and referral linkage. CSOs will recruit, deploy, and monitor performance of mentors and mentor-based services for high-risk AGYW and widowed and divorced women.

f) Social marketing and private sector services delivery

Condoms will be distributed through social marketing and private sector outlets (pharmacies, shops, hotels, bars, and peer service providers) targeting the general population in all woredas. Lubricants for FSWs will be distributed through pharmacies, DICs and private facilities. Private pharmacists in PWID hotspot areas will be trained and engaged in counselling and linkage of PWID to harm reduction services at MAT clinics, DICs, KPP clinics, and private and public facility HIV services.

g) Integrated HIV services for prisoners

Health facilities in prisons and juvenile correctional centers will have integrated HIV prevention services. Prison HIV and health services will be strengthened to deliver HIV and health services, including general medical examination, HIV counselling and testing, TB screening, STI screening, and treatment, viral hepatitis screening, diagnosis and treatment and hepatitis B vaccination for HIV-positive prisoners, and screening of other communicable and non-communicable diseases. There will be provision for treatment referral as indicated. In addition, condoms shall be provided upon release from prisons.

h) Integrated HIV services at hotspot workplaces

A national assessment will map hotspot workplaces across the country. All hotspot workplaces with 500 or more staff shall have at least one clinic run by the employer that provides integrated health and HIV services. The package of services includes SBCC (peer-based and mini-media in multiple languages), condoms, GBV prevention, HIV counselling and testing, STI screening and treatment, screening for TB, hepatitis screening, diagnosis, and referral/treatment and SRH services. This is an opportunity to build upon the experiences of the malaria programme to expand prevention and screening services for both TB and HIV in seasonal hotspots that attract significant numbers of migrant workers.

h) Integrated HIV services for uniformed people

Uniformed people under the Ethiopian Defense Forces and Federal and Regional Police will be provided with HIV services integrated with their health-care facilities. The MOH will provide technical support, HIV/AIDS logistics, commodities and supplies to health-care services of the National Defense Forces and the Federal Police. The Uniformed Services HIV programme will focus on high-risk groups that include new recruits and those deployed away from home. Combination HIV prevention includes SBCC, condoms, HIV and hepatitis counselling and testing, VMMC, STI screening diagnosis and treatment, PEP, HIV, and hepatitis treatment services. HIV/AIDS, gender, human rights and health education will be part of the training curriculum for uniformed people.

i) Integrated HIV services in humanitarian settings

The capacity of health facilities in or near humanitarian settings, including camps for internally displaced people (IDPs), will be supported with human resources, training, equipment, supplies, and drugs to provide comprehensive HIV/SRH/GBV services. Community outreach and peer service providers programmes will be strengthened and the emergency response platforms will be used to deliver HIV/SRH/SGBV services.

j) Integrated HIV services in higher learning institutions (HLI)

HIV services at private and public higher learning institutions will be strengthened to provide combination HIV prevention services to young people, particularly high-risk AGYW.

Summary of integrated service packages by population group, venue and geographical prioritization

Population group	Integrated service package (WHAT)	Venue/ service delivery platform (HOW)	WHERE
Female sex workers (FSW)	• SBCC including peer-based and small group learning • Condom promotion and distribution, including lubricants for FSWs • Pre-exposure prophylaxis (PrEP) • Post-exposure prophylaxis (PEP) • Screening and treatment of STIs • SRH services • HIV testing (PITC, ICT, SNS, HIVST)	• Drop-in Centres (DICs) • KP-friendly clinics • Targeted outreach to streets, bars, hotels, brothel houses and FSWs group homes, etc. including moonlight outreach. • Peer service providers (trained FSWs)	300 high-incidence woredas

	• Screening/management for hepatitis B and C • GBV services • ART • U=U messaging • VL testing • Economic empowerment	• FP/SRH clinics for SRH, STIs, PrEP and PEP services • ART clinics • PMTCT clinics • Virtual safe spaces		
People who inject drugs (PWID)	• Medically assisted therapy (MAT) including opioid substitution therapy (OST) • Drug overdose treatment • Clean needle and syringe through private pharmacies and social marketing • SBCC including peer-based and small group learning. • Condom promotion and distribution. • Pre-exposure prophylaxis (PrEP) • Post-exposure prophylaxis (PEP) • Screening and treatment of STIs • HIV testing (PITC, ICT, HIVST) • Screening/management for hepatitis B and C • Hepatitis B vaccination for negative PWID • SRH services • GBV services • ART • U=U messaging • VL testing	• Drop-in Centres (DICs) • Public and private health facility, mental health units, addiction rehabilitation services • Peer service providers (trained PWIDs) • KP-friendly clinics • FP/SRH clinics for SRH, STIs, PrEP and PEP services • ART clinics • PMTCT clinics • Virtual safe spaces	Addis Ababa and 4 hotspot towns	
Prisoners	• SBCC, including peer-based and small group learning. • HIV testing • Screening and treatment of STIs • Screening/management for hepatitis B and C • TB screening • Screening and treatment of mental illness • Referral for ART • Condoms on release from prison	• Prison clinics HIV referrals to health facility HIV services • Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services • Peer service providers (trained prisoners)	Correctional facilities across the country	
High-Risk AGYW	• SBCC peer based, small group learning • Condom promotion and distribution • Screening and treatment of STIs • Psychosocial peer support • SRH services	• Adolescent friendly-clinics/spaces in public health facilities • Drop-in Centres (DICs) • KP-friendly clinics • Targeted outreach to streets, hotels, cafes,	300 high-incidence woredas	

	• HIV testing (ICT, SNS, HIVST) • Screening/management for hepatitis B and C • GBV services • Post exposure prophylaxis (PEP) • ART (either on site or through referral) • U=U messaging • VL testing • Economic empowerment	broker houses, night schools, etc. • Peer service providers (trained HRAGYW) • FP/SRH clinics for SRH, STIs, PrEP and PEP services • Universities clinics HIV services • ART clinics • PMTCT clinics		
Serodiscordant partners	• SBCC including one to one counselling and group education. • Condoms • Pre-exposure prophylaxis (PrEP) • Post-exposure prophylaxis (PEP)	• Public health Facility – SRH, STIs, HIV testing, PMTCT, and ART services • PLHIV association peer services	Across the country	
Widowed and separated men and women	• SBCC (peer based, small group learning) • Condom promotion and distribution, including lubricants. • Post-exposure prophylaxis (PEP) • Screening and treatment of STIs • SRH services • HIV testing (PITC, ICT, HIVST) • Screening/management for hepatitis B and C • ART (either on site or through referral) • U=U messaging • VL testing • Economic empowerment	• Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services • Community outreach by community health workers • Peer service providers • Saving associations and groups	300 high-incidence woredas	
Long-distance drivers	• SBCC (peer based, small group learning) • Condom promotion and distribution • Post-exposure prophylaxis (PEP) • Screening and treatment of STIs • HIV testing (PITC, ICT, HIVST) • Screening/management for hepatitis B and C • ART (either on site or through referral) • U=U messaging	• Public health facilities – SRH, STIs, HIV testing, and ART services • Outreach/mobile clinics at Truck stops run by CSOs.	The Ethio-Djibuti, Metema-Sudan, Addis-Mombassa and other long road corridors	
Workers in Hotspot areas	• SBCC including peer based small group learning • Condom promotion and distribution • Screening and treatment of STIs • HIV testing (PITC, ICT, HIVST) • Post-exposure prophylaxis (PEP)	• Public health facilities – SRH, STIs, HIV testing, and ART services • Workplace clinics HIV services • Outreach HIV services at	Hotspot workplaces	

	• ART • PMTCT • GBV services • Screening/management for hepatitis B and C	hotspot workplaces • Peer service providers (trained workers to serve as peer providers)		
People in humanitarian settings	• SBCC • Condom promotion and distribution • HIV testing (PITC, ICT, HIVST) • Post-exposure prophylaxis (PEP) • Screening and treatment of STIs • GBV services • Mental health screening • Screening/management for hepatitis B and C • ART • PMTCT	• Refugee and IDP camp clinics HIV services • Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services • Targeted outreach to humanitarian settings • Mobile clinics at humanitarian settings	35 woredas affected by conflict	
High-risk uniformed persons	• SBCC including peer-based small group learning. • Condom promotion and distribution • VMMC • Screening and treatment of STIs • HIV testing (PITC, ICT, HIVST) • Post-exposure prophylaxis (PEP) • Screening/management for hepatitis B and C • GBV services • ART	• Ethiopian Defense Force Services Federal/Regional police camps clinics/hospitals HIV services • Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services • Peer providers in training camps and on mission (trained uniformed people to serve as PSPs)	Uniformed people training centers and camps	

Session 3: HIV testing services

Session objectives: By the end of this session participants will discuss the interventions and strategies of HIV testing services.

Method: Question and answer, discussion, and presentations.

Time allotted: 30 minutes.

Resources needed: Training manual, flip chart, marker, LCD Projector, and laptop.

Instruction -6.4: Ask the participants the following questions and give them chances to respond to each question.

- What is the target for HIV testing in the NSP 2023/24-2026/27?
- What is the main aim of HIV testing in Ethiopia?
- What are HIV testing strategies in Ethiopia?
- What are the challenges of each of the HIV testing strategies?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

HIV Testing (Case finding)

NSP Objective:

NSP 2023/24-2026/27 set a target to enhance HIV case finding to attain 95 per cent of PLHIV knowing their HIV status and linked to care by 2027.

HIV testing definition

HIV testing services refer to the full range of services that should be provided with HIV testing, including counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment, care and other clinical services and the delivery of accurate results.

Targeted HIV testing

The goals of HIV testing services is identify people living with HIV by providing high-quality testing services for individuals, couples and families, effectively link individuals and their families to HIV treatment, care and support and to HIV prevention services, based on their status and support the scale-up of high-impact interventions to reduce HIV transmission and HIV related morbidity and mortality.

Targeted HTS is a process whereby individuals who are at risk of acquiring of HIV infection are tested for HIV if found eligible based on HIV risk screening tool. The focus of targeted testing is towards identifying of new HIV positive cases and proper utilization of HIV risk screening tool (HRST) is important to implement targeted testing and achieve the first 95 of the UNAIDS goals.

HIV testing services (HTS) should be provided to eligible clients who are at high risk of HIV infection. HTS need to focus on high-risk individuals who remain undiagnosed need to be tested and linking them to treatment and care services as

early as possible. People who are HIV-negative but with an ongoing risk also need to be re-tested and provided appropriate prevention package of services example are female sex workers, PWID and discordant couples with unsuppressed viral load.

As we move closer to epidemic control, case finding will become more and more difficult hence HIV testing services should utilize HIV risk screening tools for both adults and children, enhanced index case testing response for recent infections, etc.

Guiding Principles for HIV counseling and testing

HTS should always be voluntary. Protecting and maintaining client confidentiality is important, especially when offering ICT. An enabling environment that removes barriers such as stigma, discrimination, IPV is important for increasing access to and uptake of HTS. Therefore, the following WHO guiding principles (also called 5Cs) should be applied in all HTS sites.

1. **Consent:** People receiving HIV counseling and testing must give informed verbal consent to be tested and counseled. Written consent is not required. They should be informed of the process for HIV counseling and testing and their right to decline testing. In Ethiopia, for pediatric age group (less than 15 years of age), the parents or guardian need to consent verbally. Mature minors (13-15 years old who are married, pregnant, commercial sex workers, street children, heads of families, or who are sexually active) can give verbal consent by themselves. Unconscious or patient who is not in status of providing self-consent, should not be tested for HIV unless the clinician determines it is necessary to establish diagnosis and make treatment decisions. Consent of kin should be obtained during counseling.
2. **Confidentiality:** HTS are confidential, meaning that what the HIV counseling and testing provider and the person discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Counselors should raise, among other issues, whom else the person may wish to inform and how they would like this to be done. Shared confidentiality with partner or family members and trusted others and with health care providers is often highly beneficial.
3. **Counseling:** HIV counseling and testing services must be accompanied by appropriate and standardized pre-test information and post-test counseling.
4. **Correct:** HIV counseling and testing providers should strive to provide standardized testing services to reach to correct diagnosis.
5. **Connection:** Connections to prevention, care and treatment services should include the provision of effective referral to appropriate follow-up services as

indicated, including long-term prevention care and treatment services.

HIV Testing: Case finding strategic strategies.

HIV testing and case finding will use the following interventions:

Index case testing (ICT):

HIV testing will be offered to all index cases to elicit and test sexual partners and biological children of PLHIV. This will be supported with ongoing chart reviews to update the family tree and offer ICT services to new family members. ICT minimum requirements will be fulfilled by all ICT services at health facilities nationwide. ICT services offer an opportunity to engage and re-engage known HIV-positive contacts of index cases who have not started or might have discontinued ART.

Urban health facilities will utilize targeted community outreach by integrating with urban health extension workers to find and link elicited contacts of index cases. Moreover, inter-facility and facility-community collaboration with community implementing partners will enhance case finding through provision of ICT services at community level.

Social Network Strategy (SNS)

SNS is a recruitment strategy that uses social network connections to locate individuals at the highest risk for HIV who are unaware of their HIV status and provides HIV counselling, testing, and referral services. SNS can be particularly useful in finding key and priority populations that have limited access to HIV testing. These target populations will include FSWs, PWIDs, and high-risk AGYW. SNS will be scaled up in the KP-friendly clinics and community DICs in the 300 woredas using a peer-led approach near KPP hotspots.

Provider initiated testing and counselling (PITC)

PICT is offered in all health facilities at various service entry points (e.g., inpatient, outpatient, TB and STI clinics, malnutrition and postnatal clinics), based on the results of the application of the risk screening tool.

Voluntary counselling and testing (VCT)

VCT services, including premarital testing will be available on a fee basis to the

general population at public and private health facilities. T

HIV self-testing (HIVST)

HIVST will be available through free, social and private market approaches to expand access. HIVST will be distributed without charge for KPPs at health facilities and in community settings. Self-testing will be scaled up at community level through outreach to hotspot areas and workplaces, DICs and humanitarian settings. In addition, community-based distribution of HIVST will be implemented to reach PBFW who are not attending or delay attending ANC and PNC services at health facilities. HIVST will be distributed at health facilities to sexual contacts of PLHIV and KPPs. Moreover, caregiver assisted HIVST will be scaled up to reach untested children aged 2 to 15 years of index cases. Tailored demand creation strategies will be implemented to enhance the uptake of HIVST.

HIV testing integrated with MNCH.

HIV testing is offered to all pregnant and breastfeeding women with unknown HIV status who attend antenatal, labour, delivery and postnatal care. In line with Ethiopia's strategy towards the triple elimination of HIV, syphilis, and hepatitis B, universal testing will be offered to pregnant women. Pregnant women will be tested at least once, with subsequent tests at labor, delivery and during the breastfeeding period, based on risk.

Early Infant Diagnosis (EID)

EID for HIV-exposed infants will be expanded using both conventional and point of care platforms. HIV testing conducted at ANC clinics (testing for prevention) will be monitored separately from testing for case finding.

Session - 4: EMTCT of HIV syphilis and viral hepatitis

Session objective: By the end of this chapter, participants will be able to discuss interventions for virtual elimination of mother-to-child transmission of HIV syphilis and viral Hepatitis.

Method: questions and answers, group discussion, and presentations.

Time allotted: 30 minutes

Resources needed: Training manual, flip chart, marker, LCD Projector, and laptop.

Instruction -6.5: Ask the participants the following questions and give them chances to respond to each question.

- What is the target for PMTCT in the NSP 2023/24-2026/27?
- What are the strategic interventions to eliminate mother-to-child transmission of HIV syphilis and viral Hepatitis?
- What are the challenges of the PMTCT Program in Ethiopia ?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

NSP objectives are

- Expected Result 1: Mother-to-child transmission of HIV during pregnancy, childbirth, and breastfeeding reduced to less than 5 percent by 2027.
- Expected Result 2: The percentage of PBFWs living with HIV who are on ART increased from 85 percent to 95 percent by 2027.
- Expected Result 3: At least 98 percent of PBFWs living with HIV will be virally suppressed at labor and delivery by 2027.
- Expected Result 4: The percentage of infants born to women living with HIV who receive a virological test for HIV within 2 months (and 12 months) of birth increased from 62 percent to 95 percent by 2027.

Triple elimination of MTCT of HIV, syphilis, and hepatitis B requires early screening and the initiation of treatment among both pregnant women and their partners. The successful prevention of MTCT of HIV depends not only on primary prevention of

HIV infection among girls and women of childbearing age, but on early detection of maternal infection, preferably before pregnancy, and initiating and sustaining lifelong ART treatment with viral load suppression, while also providing prevention and care programmes for male partners. Routine antenatal screening for syphilis and hepatitis B similarly provides opportunities for treatment of both conditions.

Strengthening the health system to address vertical transmission of HIV, syphilis and HBV also improves a broad range of MCH services and outcomes. All infants and young children exposed to HIV, syphilis and/or HBV should receive prevention and care services, including early screening, appropriate prophylaxis, routine immunization, follow-up and treatment where indicated.

In line with global guidance service standards, the PMTCT programme should include human rights in relation to equitable access to SRH services and ANC; pregnant women's autonomy in decision-making; informed consent for HIV, syphilis and HBV testing and treatment; respect for privacy and confidentiality; adequately addressing violence, abuse and coercive practices; and ensuring meaningful participation of recipients of care in the design and delivery of programmes.

The following strategies will be employed in PMTCT services and offered in more than 2,865 health facilities at MNCH clinics nationwide:

- Scale up primary prevention for PBFW through improved health literacy.
- Utilize HIV self-testing to reach PBFW at community level through the HEP and MSGs.
- Encourage the early initiation of ANC through demand creation through the HEP.
- Use a validated risk screening tool to identify high-risk HIV-negative PBFW and provide condoms, link to PrEP, and repeat HIV testing.
- Enhance PrEP provision for sero-discordant partners at MNCH.
- Strengthen family planning services among HIV-positive women of reproductive age.
- Strengthen the roll-out of dual HIV and syphilis testing.
- Universal screening of pregnant women for HIV, syphilis, and HBV.
- Strengthen couples' counseling and disclosure.
- Strengthen index case testing in the PMTCT setting through self-testing for partner and biological children older than 2 years of age.
- Strengthen provision of optimized ART regimen for PBFW and linkage to initiation of syphilis and hepatitis B prophylaxis/treatments

- Linkage and retention support for HIV-positive pregnant and breastfeeding women (from PMTCT-only sites, ART sites, and communities)
- Strengthen and sustain Mothers Support Groups to enhance adherence and retention in care at least in the high-burden geographic areas.
- Strengthen and scale up point of care (POC) viral load testing for pregnant and lactating mothers.
- Strengthen and scale up POC testing for early infant diagnosis (EID) for HEI and improve sample referral transport and the timely return of results.
- Scale-up HBV birth dose vaccination for all infants as part of the national immunization programme.
- Strengthen the referral network between PMTCT and ART sites (linking HIV-positive mothers to nearby ART clinics after completion of lactation and infants for ART initiation)
- Provision of enhanced dual (AZT+NVP) and cotrimoxazole prophylaxis for all HEI for improved outcomes.
- Strengthen follow-up of PMTCT maternal and HEI cohort to monitor retention and outcomes.
- Reinforce nutritional support for eligible HIV + pregnant, lactating women and HEI.

Session -5: HIV care and treatment

Session objectives: By the end of this session, participants will be able to describe stigma and human rights violation grievance redress and monitoring mechanisms for health care facilities.

Method: questions and answers, group discussion, and presentations.

Time allotted: 60 minutes.

Resources needed: Training manual, flip chart, marker, LCD Projector, and laptop.

Instruction -6.5: Ask the participants the following questions and give them chances to respond to each question.

- What is the target for HIV care and treatment in the NSP 2023/24-2026/27?
- What are the strategic interventions to meet the treatment targets?
- What are the challenges of the treatment Program in Ethiopia ?

- What are the differentiated service delivery models being implemented in Ethiopia? What are the challenges?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator's Note

NSP Objective: Attain 98 percent treatment coverage among PLHIV who know their status and 98 percent of PLHIV on ART to achieve viral suppression across all population groups and geographic areas.

HIV chronic care

It is critical for people living with HIV to initiate ART as early as possible. This enables to shorten the time between HIV diagnosis and ART initiation hence significantly reducing HIV related morbidities and mortality, and transmission of HIV.

As all PLHIV are eligible for ART, enrolment in care provides an opportunity for close clinical and laboratory monitoring, early assessment and timely prevention and management of opportunistic infections and other comorbidities.

Key elements of chronic HIV care include:

- Retesting for verification
- Complete clinical assessment (history taking, complete physical examination and relevant lab tests)
- WHO clinical staging
- Prevention, screening and management of opportunistic infections and co-morbidities
- Rapid ART initiation
- Patient monitoring and follow up
- Support for disclosure and assisted partner notification
- Risk reduction counseling and combination HIV prevention approaches
- Screening for and managing mental health problems and substance use
- Adherence and psychosocial counseling and support
- Nutritional assessment and counseling
- Screening for other STIs
- Prevention screening and treatment of cervical cancer.

- Management of pain and symptoms.
- Pregnancy status, family planning and contraception.
- Document all relevant client information

The following critical interventions need to be addressed at initial encounter with the client:

- Confirm HIV status by retesting and enrolling into HIV care (including recording into HIV positive tracking and pre-ART registers).
- Ensure any OI and other clinical problems that may delay ART initiation are ruled out or addressed.
- Ensure initiation of ART within two weeks after TB treatment is started except when signs and symptoms of meningitis (both TB and/or cryptococcal meningitis
- Ensure that barriers to adherence and treatment continuity are assessed and addressed accordingly.
- Ensure client is fully aware and makes informed decision for early initiation and continuation of treatment.

When to Start ART

All HIV positive individuals are eligible for ART. The ideal time for ART initiation is at time of HIV diagnosis. Understanding of clients about HIV and the importance of life long treatment adherence need to be emphasized. All adherence barriers should be exhaustively assessed and addressed while ART is initiated.

Rapid ART initiation is defined as initiation of ART within seven days of HIV diagnosis, if there are no contraindications. Rapid ART initiation should be offered to all PLHIV following a confirmed HIV diagnosis, clinical assessment, and assessment of client readiness except in the case of TB meningitis and cryptococcal meningitis. ART initiation should be offered on the same day (initiating ART on the date of HIV diagnosis), for people who are ready to start. Rapid ART initiation, including same-day increases the number of people starting ART, reduces mortality, and may further reduce both mother-to-child transmission and transmission to HIV-negative partners. This recommendation applies to all PLHIV at all age groups and is particularly important in people with very low CD4 cell counts who have an increased risk of death.

What ART regimen to start with (first-line ART)

Using simplified, less toxic, more effective, and convenient regimens as fixed-dose combination is recommended for first-line ART.

Population	Preferred first-line regimens	Alternative first-line regimens	Special circumstances
Adolescents(10 to 19 years OR weight ≥30 kg), adults, pregnant, childbearing and breast-feeding women including those with TB/HIV-co infection	TDF+3TC+DTGb (FDC)	TDF + 3TC + EFV AZT + 3TC + DTG AZT + 3TC + EFV	AZT+ 3TC + ATV/r TDF+ 3TC+ ATV/r ABCc+3TC+DTG
Children > 4weeks and ≥3kg but less than 10 years	ABC + 3TC + DTGb*	ABC+ 3TC+LPV/r AZT+3TC+DTG	ABC+3TC+EFV d AZT+3TC+EFV AZT+3TC+LPV/ra

Advanced HIV Disease

Definition of advanced HIV disease: For adults and adolescents, and children older than five years, advanced HIV disease is defined as CD4 cell count <200cells/mm3 or WHO stage 3 or 4 event. All children younger than five years old with HIV are considered as having advanced HIV disease.

Diagnosis of advanced HIV disease: is done through CD4 testing of clients at base line for those initiating treatment,(re-engaging with care after a period of interruption for >28 days) and targeting those who have interrupted ART treatment and with persistently unsuppressed VL (>1000 copies per ml). In addition to CD4 testing and when CD4 testing is unavailable, a clinical diagnosis of WHO stage 3 or 4 can also be used to diagnose advanced HIV disease.

Management of advanced HIV disease: A package of interventions including screening, treatment and/or prophylaxis for major opportunistic infections, rapid

ART initiation and intensified adherence support interventions should be offered to everyone presenting with advanced HIV disease including those who are re-engaging with care after a period of interruption for >28 days. Baseline CD4 cell count testing for all PLHIV remains clinically important in order to identify those who have advanced HIV disease and who should be offered the package of care that include ART initiation, adherence support, diagnostic screening for TB and cryptococcal meningitis and Prophylaxis and preventive treatment that includes Co-trimoxazole prophylaxis, TB preventive treatment a Fluconazole pre-emptive therapy for cryptococcal antigen– positive people without evidence of meningitis.

Differentiated HIV service delivery Model (DSDM)

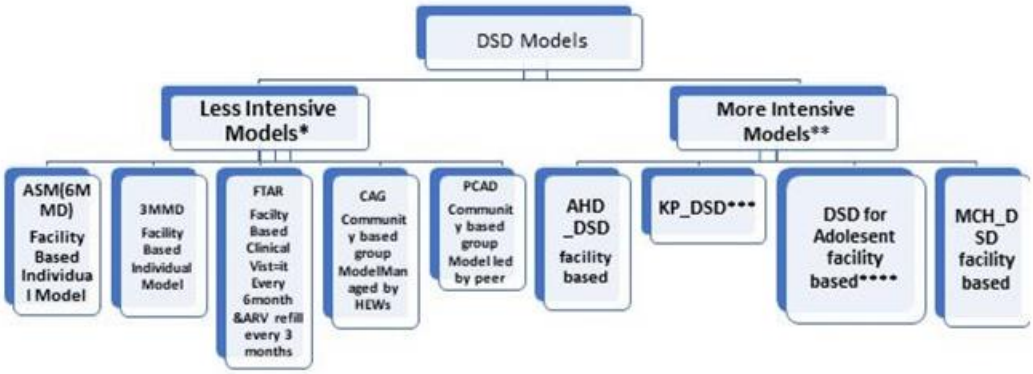
Differentiated care is a client-centered approach that simplifies and adapts HIV services across the cascade to reflect the preference and expectations of various groups of PLHIV while reducing unnecessary burdens on the health system.

Ethiopia adopted Appointment Spacing Model/3MMD and 6MMD, Fast Track ART Refill, , Health Extension Professional Managed Community ART groups (CAGs), Peer Led Community ART Group/ Distribution (PCAG/D), Adolescent ART group, Advanced HIV Disease (AHD), MCH and Key Population service delivery models. All these approaches have reduced the burden for patients (reduced time and cost of travel to clinic and less income loss) and the health system (reduced clinic attendance), while maintaining high retention in care (more than 90% retained in care across multiple time points).

Differentiated service delivery models.

Less Intensive Model: This individual and group model is intended for clients who are established on ART. It includes both facility and community-based approaches. It requires less frequent clinic visits and focuses on education and empowerment of clients.

More Intensive Model: This Model is intended for clients who need close follow up and frequent clinic visits. It includes clients with OI, unsuppressed viral load adolescents, pregnant women and those with psychosocial barriers to adhere and retention.



1. **Less intensive DSD models**

The following are the eligibility criteria for less intensive DSD models:

- Patients who are on ART at least six months
- No current illness, which does not include well-controlled chronic health conditions.
- Good understanding of lifelong adherence; adequate adherence counseling provided (a patient with adherence of 95% for the last 6 months)
- A Patient who doesn't have current Opportunistic Infections
- A Patient with no adverse drug reactions and doesn't need careful clinical monitoring.
- A Patient who is willing or provide consent to get the ART service based on his/her preferred DSD models.
- Children with age greater than five years since all children<5 years are considered to have AHD, age ≥5years is considered for age limit.

The following are the less intensive DSDM

a. Appointment Spacing Model (ASM/6MMD)

In the appointment spacing care model, stable clients will be appointed every six months for clinical visit and medication refill. Clients in this model should get additional supports like arrangement of treatment supporter at home level among their family members and arrangement of adherence reminders like alarm and education on how to maintain the drug quality at home level.

For children taking 3MMD, the caregiver should be allowed to pick up the child's medication without bringing the child unless the child is due for a clinical visit. For clients requiring Co-trimoxazole, a 3-6-month supply should be provided at the same time as ART pickup. TPT should also be given in multi-month intervals at the same time as ART pickup.

b. Three Months ARV Dispensing (3MMD)

In the three months ARV dispensing model, clients who are eligible but not willing to be enrolled in 6 MMD (ASM) will be appointed every three months for both clinical visit and medication refill.

The MOH interim guidance recommended provision of 3 months ARV dose (3MMD) for PMTCT clients, children, newly identified clients including Key Populations (KPs), clients on second- or third-line ART and any other clients who do not need admission (Advanced HIV Disease, High Viral Load (HVL), etc).

c. Fast Track ARV Drugs Refill Model

Fast Track ARV drugs Refill (FTAR) is one of the facilities based DSDM of HIV care where patients categorized as stable make clinical visit once every six months but collect their medication every three months from pharmacy. The clinical visit at 6 months' interval is meant to ensure the standard package of care is delivered to the clients and to review if the patient still meets the stable criteria. The facility-based fast track system for ART refills can provide an opportunity for those ASM clients who, for various reasons, faced difficulty in taking all of the prescribed six-months of ARV drugs to their home at once from the ART pharmacy as in the ASM framework.

d. Health Extension Professional Managed Community ART refill group (HEP_CAG)

Community ART refill groups (CAGs) are groups comprising of stable clients on ART living in the same community/locality that have a shared understanding. This model is managed by health extension professionals (HEPs) who already have roles in HIV testing and other HIV service provision as one of their packages. The ART refill is for three months and each CAG will have one community refill in between the heath facility visits that will happen every six months. Clients can return or referred to the facility at any point in the cycle for any issues that may arise between scheduled health facility visits.

e. ***Peer lead community based ART distribution/Group (PCAD/G)***

The peer led Community based ART distribution (PCAD) groups are groups of PLHIV comprising of stable clients living in the same community/ locality. In PCAD, group members will take turns to pick up ARVs at the health facility and distribute among the other group members in the community. Each client will get clinical evaluation and lab monitoring service as per the standard of care package. They will manage their own health and take action with the support of community and facility-based healthcare workers and this will help to align with the clinical consultation visits at health facilities as the recommended, in our set up is every six months.

4. More intensive DSD models

a. Health care worker managed DSD Model for adolescent living with HIV (DSD for ALHIV)

DSD for adolescents has three core elements which include ART refill, clinical consultation and psychosocial support. This model is coordinated by trained health care workers (HCWs), and regularly meet on weekends and share psychosocial supports. Young adults who already passed through psychosocial support program and transitioned out from Pediatric ART also facilitate the program voluntarily. During this peer session, adolescents interact, learn and share experience among their peers and from facilitators. Understanding the treatment, adherence to treatment and viral suppression are main parts of their discussion. Making the clinical, ARV refill and viral load monitoring service available over the weekends together with the psychosocial support program will make comprehensive HIV service a one stop shopping model for adolescents living with HIV.

Eligibility criteria for Adolescent clients on DSD model:

- Adolescent clients who disclosed their HIV status and willing or provide consent to get the ART service based on his or her preferred DSD models.
- Health care facility where there is functional pediatric psychosocial support program,
- Adolescents, 10- 19 years, fully disclosed, enrolled in the pediatric psychosocial support program,
- No restriction on stability- including both with suppressed and unsuppressed viral load test result

b. DSD for key population (for FSWs)

In Ethiopia there are efforts to make public and private facilities KP friendly by building the capacity of providers and arranging service delivery approach to match their needs. Confidentiality clinics and drop in centers (DICs) were established around hot spot areas in major towns in the country that provide comprehensive HIV services to female sex workers. The KP friendly services delivered at drop in centers have significantly improved HIV prevention, care and treatment service access to FSWs. Therefore, enhancing the coverage and quality of HIV prevention, care and treatment services for KP (FSWs) through initiating DSD for key population is deemed necessary.

c. DSD for Advanced HIV Disease and PLHIV at high-risk Disease Progression

For adults and adolescents, and children older than five years, advanced HIV disease is defined as CD4 cell count <200cells/mm3 or 'WHO stage 3 or 4' event. All children under 5 who are not on effective ART are considered to have advanced disease because of high viremia and rapid disease progression with high mortality. For patients with advanced HIV disease, the frequency of clinical visit is recommended every month.

The national interim guidance for continuation of HIV services in the face of COVID 19 pandemic recommends 3 months dispensation of ART (3-MMD) for patients with advanced HIV disease. However, patients should be advised to look for concerning symptoms that warrant in person evaluation. In addition to ART, it is critical to ensure the availability and provision of other medications that have been shown to reduce mortality in Advanced HIV Disease, including cotrimoxazole and TB preventive therapy (TPT) once active TB has been ruled out.

d. MCH _DSD

Mothers living with HIV and their infants are important target population for differentiated service model (DSD). There are various models of care used to support MCH/HIV services. Some of the DSD models in Ethiopia includes family planning service integration to HIV care, point of care (POC) EID testing for HEIs and provision of 3 month ARV dispensing for HIV positive pregnant and breast feeding women during COVID 19 pandemic.

The role of PLHIV and PLHIV associations in DSD

PLHIV and CSOs are meaningfully engaged in implementation, evaluation and oversight of DSD. Representatives from PLHIV are actively engaged as member of DSD technical working groups. Networks of PLHIV offer a key mechanism for enhancing support to those who are affected, and improving negative experiences of living with HIV. As programs encourage greater involvement of PLHIV, there is increasing engagement of affected communities in national responses to HIV, and PLHIV networks have the potential to maximize stakeholder contributions. In addition, approaches that increase engagement and empowerment can potentially shift the focus of PLHIV's roles from representation to the building of individual and community capacity to promote health.

Adherence to ART

WHO defines treatment adherence as "the extent to which a person's behavior – taking medications, following a diet and/or executing lifestyle changes – corresponds with agreed recommendations from a health care provider". For ART, a high level of sustained adherence is necessary to suppress viral replication and improve immunological and clinical outcomes; decrease the risk of developing ARV drug resistance; and reduce the risk of transmitting HIV.

Barriers to adherence

Multiple factors related to the health care delivery systems, the medication and the individual taking ARV drugs may affect adherence to ART.

Individual factors: may include forgetting doses; being away from home; changes in daily routines; depression or other illness; a lack of interest or desire to take the medicines; and substance or alcohol use.

Medication-related factors: may include adverse events; the complexity of dosing regimens; the pill burden; and dietary restrictions.

Health system factors: may include requiring people with HIV to visit health services frequently to receive care and obtain refills; travelling long distances to reach health services; and bearing the direct and indirect costs of care. Lack of clear information or instruction on medication, limited knowledge on the course of HIV infection and treatment and adverse effects can all be barriers to adherence to ART.

Specific population groups face additional challenges to adherence, and these should

be considered when implementing the recommended interventions.

Pregnant and postpartum women: The pregnancy and postpartum period presents significant biological, social and economic challenges that may affect treatment adherence. Pregnancy-related conditions such as nausea and vomiting may negatively affect treatment adherence. Other individual factors include suboptimal understanding of HIV, ART and PMTCT, lack of partner disclosure and support, and fear of stigma and discrimination. Service delivery barriers include poor-quality clinical practices, gaps in provider knowledge and training, poor access to services and health worker attitudes.

Adolescents: Adolescents face specific challenges, including psychosocial issues such as peer pressure, the perceived need to conform and inconsistent daily routine. Adolescents are often left out of decisions and have limited opportunities to discuss their concerns, and there is limited availability of adolescent-specific treatment literacy and adherence counselling tools. For adolescents who are transitioning from pediatric to adolescent care, additional challenges may include assuming increased responsibility for their own care, issues relating to disclosure to peers or partners, difficulties in navigating the health-care system, lack of links between adult and pediatric services and inadequately skilled health workers.

Infants and young children: Successfully treating a child requires the commitment and involvement of a responsible caregiver. Parents and other family members of CLHIV may themselves be living with HIV, and suboptimal HIV care and treatment for family members could result in suboptimal care for the child. Other challenges include lack of nutrition support, limited choice of pediatric formulations, poor palatability of liquid formulations, high pill or liquid volume burden, large pill size, frequent dosing requirements and difficulties in swallowing tablets.

People with mental health conditions and substance use: People with HIV with uncontrolled depressive symptoms are more likely to have poor adherence to ART. Adherence is complicated by mental health comorbidity that results in forgetfulness, poor organization and poor comprehension of treatment plans. Similarly, use of alcohol and other substances may also contribute to poor adherence to ART. Alcohol and substance use can lead to forgetfulness, poor organization and diversion of monetary resources.

Adherence -supportive interventions

Several interventions may also be of value in addressing specific challenges that impact on adherence and/or viral suppression. Interventions to optimize adherence to ART includes using fixed-dose combination regimens for ART and strengthening drug supply management systems to reliably forecast, procure, and deliver ARV drugs and prevent stock-outs. Efforts to support program-level interventions for improving adherence to ART include: avoiding imposing and maximize adherence should begin before ART is initiated. Developing an adherence plan and education are important first steps. Initial patient education should cover basic information about HIV, the ARV drugs themselves, expected adverse effects, preparing for treatment, and adherence to ART.

Patient education, counseling and peer support: Patient education and counseling are essential both when ART is initiated and throughout the course of treatment. Informing and encouraging people receiving ART and their families and peers are essential components of chronic HIV care.

Substance use and mental health interventions: Studies indicate that improving well-being by treating depression and managing substance use disorders improves HIV treatment outcomes.

Nutritional support: Nutrition assessment, counseling and support are essential components of HIV care. HIV programs should ensure that existing national policies on nutritional support are observed when it is necessary and feasible to maximize adherence to ART and achieve optimal health outcomes in food-insecure settings.

Reminder and engagement tools: Mobile phone calls can be considered as a reminder tool for promoting adherence to ART as part of a package of adherence interventions. Other patient reminder tools include alarms, phone calls, diaries and calendars can be used to as a reminders about the timing of ARV drugs, drug dosage and appointments.

Monitoring adherence to ART in routine program and care settings

Objective monitoring of adherence to ARV drugs is necessary for effective and efficient treatment planning and ongoing support. Each facility visit brings opportunity for assessing and supporting treatment adherence. Effective monitoring of adherence requires a combination of approaches based on human and financial resource capacity, acceptability to PLHIV and to health workers and the local context.

Viral load monitoring: Viral load monitoring is considered as a gold standard and recommended to diagnose and confirm treatment response and failure. Although treatment failure is often caused by lapses in adherence to ART, it may also result from other factors such as drug resistance, drug stock-outs, drug interactions or malabsorption. Viral load monitoring must therefore be combined with other approaches to monitoring adherence. These approaches should also be considered as a way to provide additional information about possible causes of virological failure or to support adherence monitoring in settings where viral load testing is not available. Following an initial viral load result (>50-1000 >1000 copies/ml), enhanced adherence intervention should be carried out prior to conducting a second viral load test. Viral load monitoring also has a high potential to motivate adherence.

Pharmacy refill records: Pharmacy refill records provide information on when PLHIV pick up their ARV drugs. When people obtain pharmacy refills at irregular intervals, this may indicate non-adherence to ART; however, in many routine care settings, people may pick up their medications when receiving care irrespective of their adherence level. This behavior could lead health care providers to overestimate adherence by solely using pharmacy refill records. In many settings, pharmacy refill records are already a part of national monitoring and evaluation frameworks and can also provide additional information on adherence to ART when used in combination with other tools.

Self-report: Asking people living with HIV or their caregivers how many doses of medication they have missed since the last visit (or within a specified number of days in the past) can help to estimate non-adherence. However, although this method is commonly used, people may not remember missed doses accurately or may not report missed doses as they may want to be perceived as being adherent and to avoid criticism. Counselling on the importance of remembering and/ or documenting ARV drug doses and an environment that promotes and enables honest reporting of non-adherence are critical components of monitoring adherence to ART in routine care settings.

Pill counts: Counting the remaining pills in bottles may help to assess adherence. Pill counts usually take place at routine health care visits. However, some people may throw away tablets prior to health care visits, leading to overestimated adherence. Although unannounced visits at people's homes could lead to more accurate estimates, this approach poses financial, logistical and ethical challenges. Counting pills also requires health care personnel to invest significant time and may not be

feasible in routine care settings. Pill count can perform better when combined with self-reported adherence.

Session 6: Human rights: stigma-free care, informed consent and confidentiality in the health care settings

Session objectives: By the end of this session participants will discuss interventions to enhance stigma free care, informed consent, and confidentiality in the health care settings.

Method: Question and answer, discussion, and presentations.

Time allotted: 45 minutes.

Resources needed: Training manual, flip chart, marker, LCD projector and laptop.

Instruction -6.6: Ask the participants the following questions and give them chances to respond to each question.

- How is the magnitude of stigma, unconsented HIV testing, and unconsented HIV status disclosure in healthcare settings?
- What are the strategic interventions to enhance stigma-free care, informed consent, and confidentiality and protect clients' rights at health facilities?

Once the participants reflected on the questions summarize the discussion by presenting the following note.

Facilitator Note

NSP Objective: Stigma, and discrimination, in healthcare settings will be reduced from 30 percent to less than 10 percent by 2027.

Policy Framework and Guidance on Stigma-free care, Informed Consent, and Confidentiality in healthcare settings in Ethiopia

Client's rights

Clients have the following rights.

- Access to quality and acceptable information and services according to the country's policies and resources
- Nondiscrimination: No discrimination of client's disease status, ethnic or racial, social, and economic status. All clients have the right to access stigma-free care.
- Privacy: Clients have the right to privacy during care
- Informed consent: verbal or written consent of clients to the provision of services. Clients have the right to decline care or medical interventions.
- Confidentiality of information and data. The client has the right to protection and confidentiality of their medical information.
- Be free from any form of violence.
- Access to effective complaint redress

Duty of providers.

All healthcare staff have the following duties.

- Respect and protect the rights of clients, ensuring all clients have access to non-discriminatory, available, accessible, acceptable, and quality health care, that is confidential, provided based on informed consent, and ensures privacy.
- Act in the best interest of clients.
- Act on the principle of not harming clients.
- Act within the provider's abilities without taking on anything that lies outside of the provider's competence.
- Use up-to-date scientific evidence or adhere to national guidelines in the care of clients.
- Effective use of information, data, and resources in the care of clients
- Provide adequate and accurate information to the clients.
- Appropriate recording and documentation of clients' information
- Adhere to the principles stated in the staff codes of conduct signed.

Health facility policy commitment statements

The health facility is committed to the following.

- Ensure clients including PLHIV and key populations basic human rights are respected and protected in health care settings.
- Provide stigma-free care for all including PLHIV and key populations.
- Ensure prevention and mitigation of violence towards clients or providers in

health care settings.

- Ensure standard verbal or written informed consent in the provision of care to all clients.
- Ensure the privacy of all clients during the provision of care.
- Ensure confidentiality of information and data in the care of all types of clients
- Ensure the safety of providers including the availability of personal protective equipment (PPE) and Post-exposure prophylaxis (PEP).
- Establish and run effective client redress mechanisms including the assignment of a focal person, a discipline committee, suggestion boxes or registers, and the standard procedures to receive, review, investigate, and act on client complaints.
- Ensure all health workers and support staff are oriented or trained in the health facility policy framework and guidelines.
- Ensure that all clients' data is properly recorded and archived at the service delivery points.
- Ensure all staff understand and sign a code of conduct that helps to ensure the provider's adherence to their duty of care.

Stigma free care

All health facilities and their staff in the country are required to provide stigma-free care to all clients. Stigma and discrimination are prominent barriers to services among PLHIV and key and priority populations. All healthcare staff including support staff shall learn, identify, and prevent stigmatizing attitudes and practices at health facilities with a special focus on people living with HIV, female sex workers (FSWs), and people who inject drugs.

Stigma and discrimination in health care settings are often expressed in various ways such as counseling that discourages sex and fertility, avoiding contacts including double gloving and extra precautions, verbal abuses, name-calling, postponing appointments, unnecessary referrals to other health facilities, gossiping, delay or denial of services.

Staff at all services including guards, card room, other support staff, and health workers shall avoid stigma and discriminatory practices towards clients especially PLHIV and key populations. In addition, staff should create an environment that is free of stigma and discrimination and should report any discriminatory practice to health facility management, discipline committee, or designated unit. To this end, staff should avoid the following discriminatory practices based on disease status,

race, religion, gender, age, disability social and economic status:-

- Counseling that discourages sex and fertility for PLHIV and key populations. PLHIV and KPs have equal rights for safe sex and fertility. Providers should support PLHIV and KPs to make responsible decisions about their fertility and sexual relations.
- Selective application of precaution or avoiding physical contact with PLHIV and KPs including unnecessary use of gloves or doble gloving. The staff shall be supported and trained to apply standard precautions irrespective of the client's disease and socioeconomic status.
- Verbal or physical abuses such as name-calling, gossiping, insulting, shouting, dehumanizing expressions, etc.
- Negative, degrading, or dehumanizing nonverbal expressions towards clients because of the disease, and socio-economic status such as PLHIV and key populations.
- Delay or denial of services because of disease, and socio-economic status such as PLHIV and key populations.
- Positive discrimination which includes providing special attention, care, and treatment to PLHIV and KPs

Health facilities and staff should identify such discriminatory practices in health care settings and address them through orientation, training, standard precaution, client education and complaint redress, and accountability measures.

The orientation and training for staff shall include manifestations of stigma and discrimination in healthcare settings, features of stigma-free care, and standard precautions. The health facility shall also educate clients using posters, education sessions, audiovisuals, brails, sign language, and other platforms about manifestations of stigma and discrimination, their rights for stigma-free care, and mechanisms to file complaints in case of violation of their rights.

Informed consent

Informed consent is an obligation of health care staff that originates from the client's right to autonomy – an informed decision on what happens to their body. Clients have the right to decline care and interventions.

Informed consent is an essential principle in healthcare that upholds the client's right to autonomy and informed decision-making regarding their own body. Clients have

the right to accept or decline care and interventions based on their understanding of the information provided to them.

Providers shall ensure a comprehensive informed consent process for all clients for all services and interventions. Elements of informed consent:

- Provision of information on the nature, risks, and benefits of the procedure or intervention
- Provision of information on the nature, risks, and benefits of reasonable alternatives, ,
- Assessment of the client's understanding of the information provided.
- Supporting the client to make an informed voluntary decision or consent to accept or reject the intervention.
- Engaging the client in the decision-making process to avoid making the client feel forced to agree with the provider.
- Informing the client of their right to refuse or decline consent to the service or intervention.
- Documenting the informed consent process on the client's records.

Informed consent can be obtained either verbally or in writing based on the nature of the procedure or intervention and existing policy. In Ethiopia, some medical interventions such as HIV testing, and disclosure of HIV status are done based on verbal informed consent. Others such as surgical procedures are done based on written informed consent.

People receiving HIV counseling and testing must give informed verbal consent to be tested and counseled. Written consent is not required. They should be informed of the process for HIV counseling and testing and the right to decline testing [8].

People 15 years and older who are mentally competent can provide informed consent for health care. Mature minors (13-15 years old) who are married, pregnant, female sex workers, street children, heads of families, or who are sexually active can give consent by themselves [8].

In cases where the client is unconscious or not in the status of providing self-consent, should not be tested for HIV unless the clinician determines it is necessary to establish a diagnosis and make treatment decisions where consent is taken from families (kin). Similarly, emergency procedures can be performed with the consent of families or with the decision of a service provider in the absence of families.

Confidentiality and disclosure

Confidentiality

Confidentiality is a human right - an essential part of the right to privacy. This right is protected by the Health Act and the national policies and guidelines. Every person has the right to confidentiality – the right to decide what aspects of his or her life are private and what can be released into the public domain. This includes the right to confidentiality regarding a person's HIV status.

Confidentiality is an agreement or set of rules that limits access or places restrictions on certain types of information. In a healthcare setting, confidentiality relates to information about clients, including their HIV status. Confidentiality in health care settings is about client information that is disclosed by the providers with the expressed consent of clients. The client decides whom he/she is willing to share this information with, expecting that access to this information is restricted (respected) according to his/her wishes. Clients' HIV status is confidential means the client has control over who knows his/her HIV status.

Shared Confidentiality

Shared confidentiality is when information is shared among staff within an institution or outside involved in the care of the client for the benefit of the client when required by the law. Sharing client information with those providers outside of health facilities should have the expressed consent of clients. Staff working at the community level tracing contacts of HIV-positive individuals should ensure the confidentiality of the client's information.

Disclosure

Disclosure is sharing client information with others with the expressed consent of the client. Staff in HIV testing and treatment services often counsel and assist clients in disclosing their HIV status to their sexual partners to enable sexual partners to access HIV testing and prevention services. However, this assisted partner notification should always be based on the client's expressed consent. The provider should assess the risk of intimate partner violence and address the client's concerns before any assistance for partner notification. Please refer to the training manual for HIV testing for details [10]

The health worker should protect the information provided by a client and should not

disclose any information related to HIV status, treatment, or behaviors to any third party without the expressed consent of the client. Client information shared between healthcare workers must always be provided to enhance the health of the client and all effort must be made to get the informed consent of the client.

Unconsented disclosure is the disclosure of HIV status to others not involved in care without the expressed consent of the client. Unconsented disclosure has serious psychosocial consequences for clients. Staff who disclose client information such as HIV status without the client's expressed consent shall be subject to disciplinary measures. Staff should timely document the client's consent to disclose HIV status to others in client records.

HIV services including HIV testing and treatment are confidential, meaning that what the provider and the person discuss or know will not be disclosed to anyone else without the expressed consent of the client.

Health facilities shall orient/train staff on informed consent, confidentiality, and disclosure. The health facility shall educate clients through posters, education sessions, and other platforms about their rights for informed consent, confidentiality, and disclosure, and mechanisms to file complaints in case of violation of their rights.

Interventions to enhance stigma free care and protect human rights.

In most instances health care staff lack the knowledge and skills, are judgmental and lack the tools and system to deliver stigma free care and protect clients' rights. Health facilities need the following to enhance stigma free care and protect human rights:

- Trained staff on stigma and discrimination, human rights, and duty of care. All health care staff including heath workers, support staff and management needs to be trained on these three days stigma free care training as on site or off-site course.
- Policy and guidelines to support stigma free care and protect human rights. The AIDS policy, the National Strategic Plans and Service delivery guidelines should support the delivery of stigma free care and enhance human rights in health care settings. In addition, all health facilities should adopt the policy statement issued by MOH and it should be posted in local languages in places within the health facility where clients and staff can see them.
- Staff understand and sign the code of conduct that enhance stigma free care and protect human rights. There should be a code of conduct approved and

signed by all health care staff.

- There is an effective grievance redress mechanism for stigma and human rights violations in health care settings. The health facility needs to adopt the MoH guidline for grievance readiness in health care facilities. The health facility needs to have a grievance redress committee that involves clients as member and meets at least twice a month to review, investigate and act on grievances. There should be a designated office or person within the health facility that receives grievances of clients. In addition, there should be a suggestion box and/or register for clients to file their complaints, suggestions, and grievances on daily bases. Verbal and written grievances including the suggestion boxes and registers shall be reviewed and investigated within two weeks. Action shall be taken on grievances, documented, and communicated to clients and staff.
- There should be a mechanism to monitor stigma and human rights violations in the health care settings. The health facility needs to have regular supervision, client surveys, and review meetings with clients including PLHIV and key populations where stigma and human rights violations in the health care settings is a standing agenda for this supervisions, surveys, and review meetings.
- Client education: All health facilities should educate clients on their rights including access to stigma-free care. The health facilities should use group education, posters, billboards, flyers etc. to educate clients about their rights.

Session -7: Post Test, certification, and closing

Session objectives: By the end of this session, participants will administer post-tests, receive certificates, and provide closing remark

Method: Administration of post-test questions, certificate award, and closing

Time allotted: 1 hour.

Resources needed: Post-test, and certificates.

Instruction 6.7: Administer post-test

- Please arrange the participants' seats in a way that they cannot see each other's test questions.
- Distribute the test questions and tell participants to read each test instruction and administer every question.
- Please tell participants to write their name and code number on the test paper. Tell participants to remember their code number.
- Collect the test questionnaires 35 minutes from the start of the test.
- Correct the test questionnaire according to the answer key out of 100 points.
- Post participants' scores along with their code number, the mean score, and the lowest and highest score to participants.
- Identify questions or areas that most participants performed poorly and address them through the training sessions.

Instruction 6.8: Award certificates to participants who score ≥ 75% on the post-test. The MoH or RHB representative conducts the closing remark.

END of TRAINING

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[12] UNAIDS, "GLOBAL AIDS STRATEGY 2021–2026. END INEQUALITIES. END AIDS.," UNAIDS, Geneva, 2021.

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Annex

Annex-I Informed Consent Form

A. WOMEN INFORMATION SHEET

Title of Research Study: "A Strategy to Improve Quality of Obstetric and Newborn Care in Ethiopian Health Centres."

Dear Prospective Participant

Greetings. My name is _____. A research study is being conducted to assess quality of obstetric and newborn care and to develop a means to improve it. You are being invited to participate in a research study entitled 'A Strategy to Improve Quality of Obstetric and Newborn Care in Ethiopian Health Centres".

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to develop A Strategy to Improve Quality of Obstetric and Newborn Care in Ethiopian Health Centres."

WHY AM I BEING INVITED TO PARTICIPATE?

You are invited to the study because you had childbirth in this health facility recently and we would like to have your opinion about quality of obstetric and newborn care and share us your experience of labour and delivery care provided in the health facility.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

Your participation in this study is voluntary. You will be asked questions about your childbirth experience and if you agree we will review your labour and delivery chart. Please note that if you are a minor, a consent will also be sought from your parents/legal guardian for your participation. If your parents/legal guardian agree to your participation, in addition to completing a questionnaire your delivery records will be reviewed.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

You have the right to withdraw from the interview any time if you feel to do so. Your agreement to participate in the interview does not mean you are obliged to answer all the questions.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Taking part in this study may not have direct benefit to you, but the community at large may benefit from this study outcome through provision of information that may help to improve quality of obstetric and newborn care.

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There is no foreseeable risk for being part of the study; the only risk might be the bad feelings you might have from a bad experience at labour and delivery. Counselling services could be offered in this regard. Furthermore, the participant's time will be required to give the necessary information. It is for that reason that time and place convenient for the participant as well as the researcher will be arranged.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Your responses will be confidential and its confidentiality will be maintained by entering data in a password-protected computer. Only the authorized personnel from the study team will have access to this information. No personal identifier such as name will be recorded on the questionnaires.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Interview questionnaires and forms will be kept under lock and data will be accessible to the researchers. Once questionnaire data transferred to computed electronic data will be password protected.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

Please note that there will be no monetary compensation nor reward for participation of the neonatal mortality cases in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study will seek a written approval from the Health Studies Research Ethics Review Committee of XXXX. A copy of the approval letter can be obtained from the researcher if you so wish once available.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact me, Dr. Lily Abebe at 0911xxx4. My email address is XXX@gmail.com The findings will be accessible on XXX website once published.

Should you have concerns about the way in which the research has been conducted, you may contact Prof XXX at lly@gmail.com

Further, if you have any questions or concerns about your rights as a research participant, please contact the University of South Africa Ethical Committee as follows:

Prof XXXE

Chair of the Research Ethics Committee

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

SIGNATURE:

B. <u>WOMEN INFORMED CONSENT:</u>

I, _____ (woman in the health centre), hereby confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I have received a signed copy of the informed consent agreement.

Name_____Signature_____Date_____

Researcher's Name & Surname ……

Researcher's signature …… Date……..

Annex -II: Pre and posttest Questionnaire.

Please do not print the pre-posttest Questionnaire with the training manual. The questionnaire should be printed separately and provided to participants just before the pre and posttest administration at the beginning and end of the training.

Please delete the answer key before you print questionnaire for pre and post test sessions.

Participant Name _____ Code Number_____

PART ONE: Choose the best answer and circle the letter for the response options chosen

1. _____ is a process in which communities, particularly people who use health services, take the lead in identifying and routinely monitoring the issues that matter to them.
   A. Community Advocacy and Action
   B. Community Led Monitoring.
   C. Community System Strengthening.
   D. Community Based Monitoring
   E. None

2. _____ are entities for which most of the governance, leadership, staff, spokespeople, membership, and volunteers reflect and represent the experiences, perspectives, and voices of their constituencies, and which have transparent mechanisms of accountability to their constituencies.
   A. Civil Society Organization.
   B. Non-Governmental Organization
   C. Community Led Organization.
   D. Community-funded organizations.
   E. None

3. Which one of the following is/are not the objective of CLM?
   A. Apportion blame to stakeholder not performing well to ensure accountability.
   B. Enable communities to collect, analyze, and use qualitative and quantitative data at health facility and community levels to co-create solutions and advocate to improve access to and quality of services.
   C. Build communities, CLOs, and CSO networks capacity service standards, evidence generation, engagement, and advocacy.
   D. Enhance collaboration among communities, CLOs, CSO networks, government, partners, and donors.
   E. None

4. CLM data is used in the following except one.

A. Complement data routinely collected through the health system.
B. Provide evidence for advocacy for those issues not changing over time.
C. Create a short feedback loop with health facilities and Co-create solutions.
D. Monitor Trend over time.
E. None

5. Which of the following doesn't match with Guiding Principles of CLM?
   A. Routine and systematic: maintain sustainability to allow for ongoing and systematic data collection, advocacy, and action that can monitor trends over time.
   B. Collaborative: Promoting good partnerships between all those involved in the service monitoring and improvement cycle.
   C. Dependent on donors: directed by donors or government stakeholders.
   D. Focus on action and accountability: Collection and analysis of data through a lens of community need, identifying solutions, and holding decision-makers accountable.
   E. None

6. Which one of the following is not a key component of CLM?
   A. Education.
   B. Evidence,
   C. Engagement.
   D. Advocacy
   E. None

7. Which of the following is not the key priority population for this CLM program in Ethiopia?
   A. PLHIV
   B. FSWs
   C. PWIDs
   D. All people who seek the health services.
   E. None

8. Which one of the following is not the priority thematic area of CLM?
   A. HIV service quality (Providers' attitude, waiting time, reception, facility)
   B. Stigma and discrimination
   C. HIV prevention interventions (Condoms, PrEP, PEP, STIs treatment, VMMC…)
   D. Availability of ART and OI drugs,
   E. None

9. Which one of the following isn't part of research ethics?
   A. Informed consent.
   B. Confidentiality,
   C. Validity

D. Justice
E. None

10. Which of the following is the correct order for the process of analyzing quantitative data?
    A. Data analysis plan --- Data validation ---- Data coding ---- Data editing --- Analysis.
    B. Data analysis plan --- Data validation ---- Data editing ---- Data coding --- Analysis
    C. Data analysis plan --- Data editing ---- Data validation ---- Data coding --- Analysis.
    D. Data analysis plan --- Data coding ---- Data editing ---- Data validation --- Analysis.
    E. None

11. Which one of the following is a probability sampling technique?
    A. Purposive sampling
    B. Quota sampling
    C. Snowball sampling
    D Cluster sampling
    E None

12. Which one of the following is a nonreality sampling mostly used to study key populations
    A. Cluster sampling.
    B. Snowball sampling
    C. Simple Random sampling (a lottery method),
    D. Systematic sampling
    E. All

13. Which one of the following is a qualitative data collection method?
    A. In-depth interview.
    B. Focus group discussion.
    C. Participants observation
    D. Non-participants observation
    E. All

14. All of them are correct about qualitative methods except:
    A. Seek to explore phenomena – explain a deeper understanding of the context or reasons behind a phenomenon.
    B. The aim is to quantify the events happening in the community.
    C. Uses open-ended questions and uses un or semi-structured tools.
    D. It demands specialized skill and understanding of the issue under discussion.
    E. None

15. Which one of the following is not a component of the Guiding Principles for HIV counseling and testing?
    A. Consent.
    B. Confidential.
    C. Counseling.
    D. Disclosure to sexual partners irrespective of client consent
    E. None
16. One of the following is a testing method that effectively enables sexual partners and families of PLHIV to access HIV testing services?
    A. Voluntary counseling and testing.
    B. Index case testing.
    C. Social network strategy.
    D. Providers initiative testing without consent.
    E. HIV self-testing.

17. Which one of the following is not a quality of a good FGD moderator?
    A. Give the freedom for participants to discuss whatever they want even if it is off-topic.
    B. Be prepared for the discussion and understand the objectives of the FGDs in the study.
    C. See (moderator's) own role as a learner rather than a teacher and create a discussion in which he or she participates very little.
    D. Use good questioning skills and stay neutral.
    E. None

18. Which of the statements doesn't correctly correlate with Quantitative methods?
    A. Seek to quantify.
    B. Use open-ended questions and flexible methods.
    C. Used to predict causal relationships.
    D. Emphasis is randomness and statistical validity.
    E. None

19. Which of the following is the correct order of the Colaizzi process for qualitative data analysis?
    A. Validation - Coding- Identifying significant statements -Familiarization- Formulating meanings - Developing an exhaustive description -Producing the fundamental structure.
    B. Familiarization- Coding- Identifying significant statements -Formulating meanings - Developing an exhaustive description -Producing the fundamental structure – Validation

C. Familiarization- Identifying significant statements -Formulating meanings -Coding- Developing an exhaustive description -Producing the fundamental structure – Validation
D. Validation - Identifying significant statements -Familiarization- Formulating meanings -Coding- Developing an exhaustive description -Producing the fundamental structure
E. None

20. Which of the following graphs is only used when the components add up to 100%?
A. Bar Graph
B. Line graph
C. Histogram
D. Pie chart
E. All

Part II: Match column A with B and write the selected letter on the space provided on column

Column A	Column B
1. _____ is about building capacity on standards of services and intervention that lay the foundation for CLM. 2. _____is measures to protect data from inadvertent or malicious and inappropriate access to data by any person who is not a member of the study team. 3. _____ is participants or informants with whom contact has already been made use their social networks to refer the researcher to other people who could potentially participate in or contribute to the study. 4. _____ is about the quality or repeatability of measures. 5. _____is targeted actions to change norms, guidelines, standards, and policies that directly affect the health of people living with and at risk for HIV. 6. _____ is about anonymous	A. Data Quality Audit B. Evidence C. Validity D. Data security E. Data verification. F. Systematic sampling G. Informed consent H. Simple random sampling I. Advocacy. J. Engagement. K. Snowball sampling L. Data review and analysis. M. Cluster sampling. N. Confidentiality O. Education P. Reliability Q. Trustworthiness R. Contact sampling.

reporting, unlinking participant personal identifiers from the data, and use of pseudonyms. 7. _____ is about bringing together a range of stakeholders to co-create solutions to improve health services. 8. _____ is a sampling method in which a random sample, with a fixed periodic interval, is selected from a larger population. 9. _____ is the process that will be done after data entered the database, the CLM focal point lead performs a first-level analysis to verify its timeliness, completion, clarity, and coherence. 10. _____ is about how well a measurement, scientific test, or instrument reflects the reality it claims to represent	

ANSWER KEY

Please don't print the answer key with the pre-posttest question. Delete the answer key before you print the pre- and posttest questionnaire for the participants.

Answer Key MCQ		Answer Key Matching
1. B	**11. D**	**1. O**
2. C	**12. B**	**2. D**
3. A	**13. E**	**3. K**
4. E	**14. B**	**4. P**
5. C	**15. D**	**5. I**
6. E	**16. B**	**6. N**
7. D	**17. A**	**7. J**
8. E	**18. B**	**8. F**
9. C	**19. C**	**9. A**
10. B	**20. D**	**10. C**

Annex -III: Daily Training Evaluation

Note: Please rate the training day on the following parameters from very poor to very good.
Thick √ for one of the scores provided for each criterion

No.	Evaluation criteria	Score				
		Very poor	Poor	Fair	Good	Very good
1	Trainers facilitation skill (use of participatory methods)					
2	Trainers knowledge on the subject matter					
3	Ability of trainers to make the training friendly to participants					
4	Relevance of the training content					
5	Time allocated for the training					
6	Training material and exercises (manual, exercises and materials)					
7	Training environment (refreshment, room and seat arrangement)					
8	Participation of trainees in the discussion and group works					
9	Coverage of the topics allocated for the day in the schedule					
10	Overall organization of the training course					

How do you rate the day? a) Very sad b) sad c) just ok d) happy e) very happy

What was very good about the day please write few important things that make you happy today

_____
_____
_____

What was very bad about the day please write few important things that make you sad today

_____
_____
_____