PRACTICAL HANDBOOK ON COMMUNITY-LED MONITORING TOOLS

Vilnius

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TABLE OF CONTENTS

PREFACE

Before you begin studying this manual, we would like to briefly tell you about what Community-led monitoring (CLM) means to us at the Eurasian Harm Reduction Association (EHRA).

We consider CLM an ideal tool for documenting and demonstrating the problems and pains that community members face in their daily lives and in the process of accessing and utilising services that are developed in response to their needs. CLM is a form of community control by State policy makers and on what taxpayers' funds are spent and the effectiveness of such funds. Through the use of monitoring data, CLM and advocacy can ensure accountability, transparency and responsibility of authorities.

CLM as a form of community monitoring is much broader than just the monitoring of health and social services. In the context of drug use, in addition to specific and non-specific services for people who use drugs, CLM can focus on monitoring human rights violations and the impact of systemic violence, criminalisation and stigma on the quality of life of people from the community.

We believe **that only the community itself can determine and decide** on what to monitor; what areas and issues are important and should be considered; what monitoring methods to use; and how to interpret the results for further targeted advocacy. The most important point is that the intellectual property, all of the data and the resources in connection with CLM should be owned by the community.

We believe **that the following clear value principles should be observed in the implementation of CLM:**

- CLM is always on the side of the client/community representative;
- CLM should always focus on identifying and solving systemic problems related to services, human rights violations and criminalisation; and,
- CLM should not be focused on identifying client or community problems.

The issue of ethics in CLM plays a key role. When funding CLM activities, it is important to avoid the influence of service providers and State institutions both on community organisations that conduct monitoring and on the results of such monitoring. We are of the opinion that community organisations or initiative groups cannot evaluate services whilst being a service provider itself. The community organisation that conducts CLM should be delegated by the community and accountable only to it and no one else, and the results of CLM should be available to everyone.

If professional researchers are involved, they should not use their advantage in knowledge and skills in conducting sociological research to pressure the community in posing advocacy questions and formulating results.

Service providers, representatives of State institutions, and other associations and organisations who have more connections and opportunities to advocate for changes at local and national levels should perceive CLM results not as a threat, but as an opportunity for joint actions to fix and improve systemic issues.

From our side, we are ready to invest our resources into the development of community capacity and capability to conduct CLM and support community organisations in their advocacy of CLM results in the CEECA region. We will work with service providers and clients to ensure that they have an unbiased attitude to CLM and an understanding of why it is essential to support CLM and to use such results for improving services and solving other systemic issues.

EHRA Secretariat Team

ACRONYMS

AEPR	Adverse Event Prevention and Response
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organisation
CLM	Community-Led Monitoring
CV	Curriculum Vitae
EHRA	Eurasian Harm Reduction Association
FGD	Focus Group Discussion
GIS	Geographic Information System
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
KII	Key Informant Interview
ODK	Open Data Kit
OST	Opioid Substitution Therapy
PC	Personal Computer
SI	Structured Interview
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SSI	Semi-Structured Interview
TB	Tuberculosis

A. INTRODUCTION

Why, and for whom, this guide is developed. Aim and key limitations

Probably most of our readers have seen other publications on Community-Led Monitoring (CLM) and legitimately would wonder why they should spend their time on yet another one. What will it give them? How does it differ from other CLM publications? Give us a second and we will give you three solid reasons.

First of all, we made this text 100% reader-friendly, meaning that you literary do not need to know anything about 'saturation' or 'validity' or any other research related terminology. We want knowledge not to be a privilege accessible and possessed by a closed professional circle, but rather to be seen as a right of each and every person. While we did not aim to provide comprehensive training and magically cook skilled social scientists, we strongly believe that fundamental concepts, methodologies, and the overall processes, could and should be available and accessible for all. The 'nothing for us without us' principle should also be applied to knowledge creation and dissemination, with community-based organisations as active co-creators of knowledge and not passive participants of research projects. By making knowledge accessible and inclusive, we also promote equity. Thus, anyone can read, understand and, most importantly, apply this guide, just give it a try.

If this argument has not changed your mind, we should also mention that this guide includes three parts: 1) a description of CLM and key concepts; 2) Key steps; and, 3) a practical ready-to-use, step-by-step recipe of key CLM tools. Imagine a cookbook with a preface on how to manage different types of products (such as diary, vegetables, meat), followed by simple recipes of tasty dishes; this book is built the same way. We aim to introduce you to CLM, fundamental concepts and key steps first, and then give you practical instructions on CLM tools which you can easily apply in practice. This guide is calibrated so that you will see both the forest and the trees, and you will not find yourself in a situation where you did not see the forest for the trees or vice versa, missing either the bigger picture or smaller, yet important, components.

Finally, we decided to present additional tools which might not be typically used, or are not yet used in CLM. Why? We think that these tools can equip you with additional and feasible methods to address additional problems. This also might inspire some communities to reconsider and expand the definition of CLM, applying new methods and providing evidence of their effectiveness. Remember that little things make big things happen! A drop in the ocean is just one tiny thing, but millions of these tiny drops form an unstoppable tsunami.

To sum up, we hope that all of the above has convinced you, and that you will give it a try. We want to make CLM inclusive, friendly, and a safe environment where you feel confident, accepted and appreciated. This guide will show you that CLM is not that complicated and exclusive and that you can own the process and manage and deliver CLM projects in your daily routine. We hope that this guide will open the curtain to the CLM world and that you will begin your journey in this magical world, which can bring so many benefits to community-based organisations, donors, State sector and society overall. But to do this, we need you to be onboard. Let this guide be the first step, which will be just the beginning.

So, enjoy reading and good luck!

B. KEY CONCEPTS

Whenever you have entered, or are about to enter, the CLM world, you will face the variety of knowledge accumulated, which might sometimes feel overwhelming. To facilitate your entry, we have summarised key evidence-based knowledge in Annexes 1-14 that includes direct links to the full documents as you might be interested in them too. Yet, at the moment, we feel it is important to note that the CLM concept might be used to name a variety of activities ranging from very simple to sophisticated research-like exercises. Furthermore, the practical implication of the "leading" role of the community might vary across different approaches and CLM frameworks. All-in-all, what you need to know is that this topic is rapidly developing as different organisations form their understanding of CLM and, thus, concepts and frameworks are developing too. Most probably at some point we will have a consensus and united vision with a definition of CLM that is comprehensive and accepted by all actors, but we are not there yet. Therefore, we feel that it is important to state some fundamental defining concepts and principles that we share.

What does the CLM concept mean?

Community-led monitoring is a systematic and ongoing practice of data collection and data assessment to examine different components, processes and challenges impacting access to, and quality of, health and social services; it is initiated and led by community members who might use these services. Community representatives decide what they need, which areas and questions are important to be addressed, which aspects have to be routinely monitored and how CLM results should be used in further targeted actions aiming to facilitate the timely delivery of high-quality services.

It might sound easy, but let us unpack what we really mean by 'led by communities'? The key defining principle for us is who initiates and delivers CLM. Thus, CLM is an activity that should be driven by the communities and their persistent needs. In this case, we talk about who holds the power to make decisions and manage the process, which involves both quality of community engagement and/or leadership and the number of representatives involved. We aim to establish a process where the community is not only involved in the process of decision-making, but rather can decide on needs to be prioritised and challenges to be addressed; and by so doing, drive this process according to their needs and, thus, the result will be owned by the community. We can think of a car and who holds the steering wheel. Even though there might be other passengers in the car, including professional drivers, who can give advice and share their expertise (usually it is good when "experts" share their views upon request), the driver makes the decisions, holding the steering wheel and the responsibility. In such a case, we talk about the bottom-up process, which typically should not be prioritised for communities by other actors, yet it does not imply that the goals of other actors and stakeholders should be neglected. In fact, goals might coincide, and the best-case scenario is to build a cooperative environment with other organisations involved. We acknowledge and highly support win-win collaboration across professionals from different sectors (such as healthcare professionals, academia, thew private sector, site representatives, etc.).

We also suggest considering some of the limitations and challenges of CLM which you might face.

Quality of evidence. Depending on the needs of the community and whom you will be targeting in the advocacy, you might require different evidence. It is good to establish the overall aim and audience of CLM and think in advance about which data you might need to advocate for the change. For example, in some cases, a simple photo might make a change, yet in other cases, you might be asked to provide evidence collected and analysed in a certain way (see Annex 13). (Will be added after the position opinion will be developed by EHRA)

C. CLM STEPS

Now that we have established what CLM is and what it is not, let us discuss key steps in how to introduce it. We suggest considering six steps, but in real life, you might not have a clear-cut border line between these steps as some of the steps might occur concurrently. Hence, this should be seen rather as a plausible plan, yet take into account that some steps cannot happen before others. Thus, the consequences of the steps should be kept in mind.

As already mentioned, CLM is not a single action and a one-time data collection. It is a systematic and ongoing process of data collection, meaning that we establish a cycle of continuous actions/steps. In this document, we describe six main steps of the CLM cycle: 1) as a first step, you identify the service-related needs and problems; 2) then you initiate a proper data collection process; 3) at this stage, you analyse and interpret the data you collected and develop possible solutions and actions to be taken; 4) afterward, you disseminate the results among key stakeholders; 5) you develop an advocacy strategy which you break down into a number of specific advocacy actions to be implemented and change or solve the challenge you are addressing; and, 6) you monitor this change to examine the trends and progress.

The endpoint of the CLM cycle should be defined by your goals, meaning that the CLM cycle lasts until the advocacy tasks are reached and changes are successfully implemented. You can check Figure 1 which illustrates the CLM cycle.

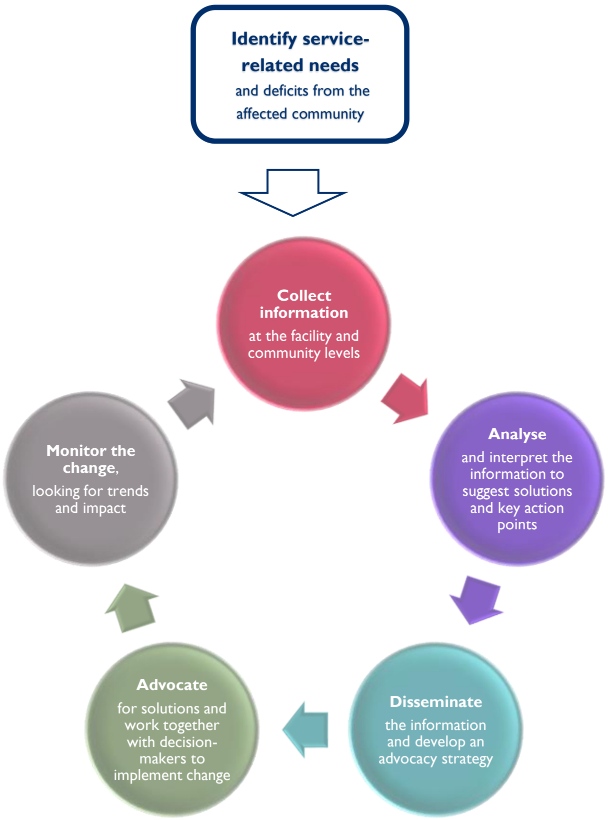

Figure 1. Six steps of the CLM cycle

Source: Adapted from O'Neill Institute, Treatment Action Campaign, Health Gap, ITPC, ICW, Sexual Minorities Uganda (SMUG), et al. Community-led monitoring of health services: building accountability for HIV service quality. White Paper. Undated. https://healthgap.org/wp-content/uploads/2020/02/Community-Led-Monitoring-of_Health-Services.pdf (accessed 19 November 2022).

STEP 1: Identify service-related needs and monitoring questions for CLM

The very first initial step is to decide on which challenges of social or healthcare service delivery you will focus on. For instance, you may consider:

Health-related services	Social support-related services
HIV/AIDS related health services TB Hepatitis B Hepatitis C SRH All health services tailored to Key Populations	Housing Humanitarian support Prenatal and postnatal services and Childcare Livelihood support Education Social/Employment support Leisure

As mentioned previously, this should be driven by persistent community needs. For example, you might have data from a needs assessment, or you constantly hear negative feedback from some community members, etc. Thus, we might want to improve the availability of uninterrupted medical or social services, improved physical access to these services, or to promote an environment where community members are treated respectfully and without discrimination while receiving services, and where services are provided within standards and regulations. All-in-all, it should be a challenge faced by the majority of the community when they access or receive social or healthcare services.

To be able to develop a good monitoring question, it is very important to understand which main concepts of service delivery you wish to consider, i.e. what is your focus. Then, think about your monitoring question(s) in order to obtain a clear answer; for example, to have a comprehensive understanding of what is, and what is not, going well with respect to a certain problem, or what barrier community members face to access this service, or why the quality of this service is poor.

To help you to navigate the domains of social and healthcare services, and the different aspects of their delivery, quality, or accessibility, we propose to check the Access Framework, which nicely and simply places it all in order. The Access Framework suggests considering the perspectives of both people using services (demand-side factors) and providers of these services (supply-side factors) as these factors are interconnected, multilayered and dynamic. Therefore, to address challenges effectively, we need to think about them all. On the supply side (i.e. providers), the Access Framework identifies five dimensions of accessibility: 1) approachability; 2) acceptability; 3) availability and accommodation; 4) affordability; and, 5) appropriateness. On the demand side (i.e. patients), the Access Framework identifies five corresponding dimensions of the ability of a population to interact with the dimensions of a providers accessibility in order to achieve access and include, 1) ability to perceive; 2) ability to seek; 3) ability to reach; 4) ability to pay; and, 5) ability to engage[1]. These ten dimensions are outlined in Figure 2, below.

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[1] Levesque, J., Harris, M.F. & Russell, G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health 12, 18 (2013). https://doi.org/10.1186/1475-9276-12-18 (accessed 19 November 2022).

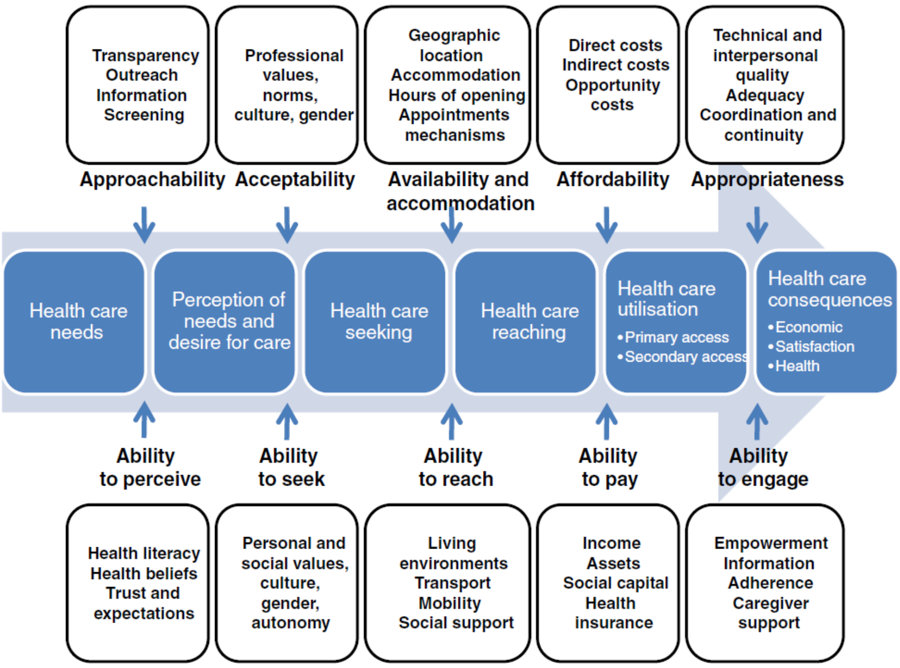

Figure 2. The Access Framework

Source: Levesque, J., Harris, M.F. & Russell, G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Health 12, 18 (2013). https://doi.org/10.1186/1475-9276-12-18 (accessed 19 November 2022).

Now you have a roadmap of different dimensions of service delivery, quality and accessibility and we can think about the monitoring questions. See Table 1, below, which provides some examples of the monitoring questions; note that these are just examples and they should be reconsidered based on the local context in which you are working.

Table 1. Examples of monitoring questions and dimensions of service delivery, quality and accessibility

Dimension	Monitoring questions
Approachability **Ability to perceive**	✓ Is there information available on who can utilise social or healthcare services and how? ✓ Is it clear and understandable? ✓ Is it free/publicly available?
Acceptability **Ability to seek**	✓ Is the service provided free of stigma and discrimination, based on human rights norms? ✓ Is it provided with anonymity/confidentiality (if applicable)?
Availability and accommodation and sustainability **Ability to reach**	✓ Does the service exist? ✓ What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered by the service, frequency of service usage, etc.)? ✓ Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?) ✓ Does accommodation, geographic location and opening hours of an organisation providing social or healthcare services meet the needs of the community? ✓ How long does it take to get the service? (travel time, waiting time) ✓ Can a client access care when s/he needs it?

Dimension	Monitoring questions
	✓ Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with the exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals/community? ✓ What are the barriers in social adaptation and integration with the local community? ✓ Are there any delays in providing the needed service? ✓ Are working hours convenient? ✓ Is the waiting time to receive service long? ✓ Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? ✓ Does the appointment mechanism meet the needs of clients? ✓ Are there any problems with supplies? Is an allocated funding sustainable? ✓ Does the transport system and mobility level of clients allow the utilisation of existing social or healthcare services?
Affordability **Ability to pay**	✓ Is the selected service free of charge or not? ✓ Are there any criteria to get the selected service for free? ✓ Does a client have to pay out-of-pocket money to receive the services? ✓ Does social/health insurance cover services? ✓ Is the service affordable long-term for the client?
Appropriateness **Ability to engage**	✓ Are services organised to address the specific needs of clients? ✓ Are service packages age and gender specific? ✓ Does the quality of care which a client receives vary depending on the personal characteristics of the client (gender, race, ethnicity), geographic location and socioeconomic status? ✓ Are services offered to a client on a voluntary basis? ✓ Is the service provided with respect the individual preferences, values and needs of the client? ✓ Is a client actively involved in the individual care management plan? ✓ Is the referral process smooth along the care cascade? ✓ Is a client referred, directed, accompanied, or linked to other health or social services to ensure the continuity of care? ✓ Is any social support provided?
Quality	✓ Is the provided service evidenced-based and does it adhere to established standards? ✓ Are all activities/steps/components followed that are included in guidelines or protocols for this service? Are they implemented in full?

Sources: PACT (2016). 5A's of Access. Brussels; PACT. https://eupatientaccess.eu/ (accessed 19 November 2022). WHO, UNODC, UNAIDS (2012). Technical guide for countries to set targets for universal access to HIV prevention, treatment, and care for injecting drug users – 2012 revision. Geneva; WHO. https://www.who.int/publications/i/item/978924150437 (accessed 19 November 2022).

You may also encounter challenges across other areas, including:

Priority area	Monitoring questions
Human rights[2]	Whether human rights violation happen? ➢ Termination of parental rights and child custody;

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[2] Eurasian Harm Reduction Association (EHRA). Guideline on Advocating for the Human Rights of Women Who Use Drugs. Vilnius; EHRA, 2017. https://old.harmreductioneurasia.org/wp-content/uploads/2018/12/EHRNWomen2017.pdf (accessed 19 November 2022).

Priority area	Monitoring questions
	➢ The lack of access to drug treatment, including opioid substitution therapy (OST), for pregnant women; ➢ The lack of access to quality reproductive health; ➢ Coercive abortion; ➢ Violations of labour rights due to drug use or drug dependence; ➢ Violation of the right to education due to drug use or drug dependence; ➢ The lack of access to shelters and protection services in cases of domestic violence; ➢ The lack of access to legal services; ➢ The lack of access to HIV prevention, testing, treatment and care services; ➢ Police violence; ➢ Sentencing for drug offences with no due regard to gender-related issues; and, ➢ The special vulnerability of women who use drugs to police prosecution. The nature of the violation (what, who caused it, who was affected, where, when, how, and why); What are the barriers to personal human rights protection? Whether it is an isolated incident or part of a larger pattern; State actions linked to the violation or having caused it.
Stigma, discrimination, criminalization	The adverse impact of criminalisation, stigma, and discrimination on access to health and social services by community members; The adverse impact of criminalisation, stigma, and discrimination on the quality of life of community members; The adverse impact of criminalisation, stigma, and discrimination on health conditions (including sexual and reproductive health) of community members; The adverse impact of criminalisation, stigma, and discrimination on the integration into society as well as partner relationships of community members; Societal losses from criminalisation, stigma, and discrimination; Is the punishment proportionate to the crime? What is the burden of criminalisation on the local budget, judicial system, law enforcement system, and the social system, etc?

Double-check if the challenge you selected has already been considered and if data to address your monitoring question already exists. Avoid duplication of efforts and in collecting unnecessary information. You may initiate another data collection of the existing data within the scope of a CLM activity if you have concerns about the already existing data and you want to check this fact. But remember that CLM activities are time-, effort- and finance-consuming and need to be implemented without duplication of effort.

STEP 2: Collect information

a) Define measurable indicators

Now our task is to decide on indicators which we can measure. Each monitoring question has to be translated into specific and relevant indicator(s). Depending on our key focus (the overall aim you choose for your CLM activity) and outlined monitoring questions, you may use quantitative, qualitative or a mixture of both type of indicators. Many existing international guidelines and toolkits may help you to define relevant indicators (Annex 2).

If you choose a quantitative indicator(s), you will need to apply quantitative method(s) and if you decide that to answer your monitoring question you need qualitative indicator(s), you use qualitative method(s).

Figure 3. Quantitative versus Qualitative indicators

For example, if you need to measure progress, trends, scale of the activity/intervention/programme, you will need to use quantitative indicators and collect quantitative data (number of people, tests, courses, facilities, etc.) using quantitative methods.

But, if you want to receive an in-depth understanding about the reasons and roots of the specific issue, explore circumstances, process, and practices in service delivery, you will need qualitative indicators and data (words, photos and videos).

Now, you know your monitoring question and which indicators you will need, so let us talk about methods. Usually, two types of data collection methods are used for CLM (see Annex 11):

- *Quantitative methods (associated with numbers)* seek answers to questions "how many", "how much", or "how long". They are used if your monitoring question focuses on numbers which may specify the volume and duration of the services / cases;
- *Qualitative methods (associated with words and text)* seek answers to questions "what", "how" and "why", of a certain event, aiming to describe a new event, understand perceptions, examine, unpack, and uncover – to generate a hypothesis.

Both can be utilised solely or as a combination (mixed methods). The combination of methods allows the collection of data which can provide a full, more comprehensive picture of what is happening with the monitoring issues.

IMPORTANT! As mentioned in Chapter B, CLM can be defined and, thus, introduced with some level of variation. So, you may use simple routine data collection or more research-like CLM methods or a combination of them. Why? You may need to have strong evidence collected and analysed and recognisable by certain stakeholders in line with an international common understanding of what is and what is not reliable or valid data of both quantitative or qualitative research methods. Yet, it very much depends on the challenge you are addressing and the CLM goal. You can read full information about how to make data reliable and valid and what these terms mean in Annex 13. Take into consideration that more advanced methods will require the involvement of experts with the relevant background and practical skills.

Remember that **CLM is a repeated process of data collection**. Therefore, while selecting a data collection method, keep this in mind when planning – you have to be ready to repeat the data collection process with the selected method several times. You should envision the frequency of data collection in order to collect enough or proper data to answer the chosen monitoring questions.

b) Define the sample size, data collection sites

After outlining the indicators, you are now well informed as to which information you need to collect, the frequency of data collection and the data collection method. Now, you are about to identify among whom (respondents) and where (data collection sites) you will collect the needed information.

- *Respondents - Who?* Think who will be the best people to ask your monitoring question. You may take into consideration age, gender or other characteristics of your respondents. They might be similar or different, but you need to have a solid reason for such a decision. Do you mix women and men? Or do you think that respondents aged 20 years old and 50+ years of age should be grouped together and asked the same questions? How will you report this data? Will you report the results per age group or not? Why so?
- *Data collection sites – Where?* Decide where you will reach out to your respondents and collect data. Data collection sites and respondents are to be thoroughly selected based on the focus, scope, and target audience of the CLM. Data collection sites could be public or private; medical facilities; official institutions; or community-based service points or organisations; national, regional, urban or rural.

IMPORTANT! If you will need more advanced methods (such as research-like methods), please consult Annex 11 and Annex 7 to learn how to properly calculate how many respondents you need to question (sample size) or how to properly sample them. Also, you might be interested in quality assurance mechanisms (Annex 13).

c) Develop data collection forms and procedures

Once the data collection methods are defined and the information you need to collect is outlined, you have to develop **data collection forms** (questionnaires), meaning tools you will be using for data collection: on paper or electronically (for instance, mobile phones, computers, tablets or special gadgets). Do not “reinvent the wheel”; check if there are already existing questionnaires or scorecards recognised as best practice to use in your CLM. Remember, you will need to use this tool several times for follow-up monitoring, comparing collected data over time and monitoring the trends (for instance, progress in prevention, testing, treatment). Therefore, you have to be careful in your choice of data collection tools and methodologies and predict whether it will be feasible and what resources you will need to repeat it.

While developing questionnaires, ensure the language is simple and clear and use the local language of community members and respondents. Do not use academic terms or abbreviations (Annex 4). Use international guidelines and toolkits for developing questionnaires[3]. For electronical gadgets, realise the data collection forms electronically.

We also recommend summarising everything in a **data collection protocol** so that you have all of your plan described step-by-step in one place and it can be seen all together. A data collection protocol is a document which clearly outlines the purpose, objective and data collection methods and lists the full process of data collection. This document should be developed in collaboration with all CLM team members, including technical advisers involved or qualitative research experts, if any. Note that in some cases, you might need to develop your data collection protocol into a Research Protocol in order to seek ethical clearance. In such a case, we recommend involving experts who will assist with the proper design of the study, the calculation of an appropriate sample size (if relevant), and effective tools and/or ethical issues. You can find a tentative example of a Research Protocol in Annex 3. To get more information about ethics, why and when they are needed, and how to seek ethical clearance, please check Annex 12.

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[3] For example, EpiC. Community-Led Monitoring Technical Guide. Durham (NC); FHI 360, 2021. https://www.fhi360.org/sites/default/files/media/documents/resource-epic-community-led-monitoring-technical-guide.pdf

Data management and storage procedures is a part of the data collection protocol and outlines the full process of data collection, management and storage; addresses **privacy**, **confidentiality** and **security** aspects; and ensures data protection[4]. Please read Annex 12 to learn more.

In the data management and storage procedures, you should clearly articulate:

- *how data will be collected* – will it be confidential or anonymous; who will collect the data; will you record personal data and, if so, which data (note that you may need to include a statement on this – check your local legislation on personal data); will you record interviews, etc. If you collect personal data, check local regulations, including if you need to apply for ethical clearance. This is usually determined by law. Typically, if you involve human beings, you need to go through a review by an Ethical Review Board, yet it may vary across countries (Annex 12);
- *how data is managed and stored* – where it will be stored; who has access to the data; will it be passed on to the third parties (for example, to run analysis, if any); how long the collected data will be stored;
- *how data is analysed and reported* – how you plan to analyse data; who will be perform data analysis (a third party or the CLM team); will the data be anonymised for analysis; and how results will be reported anonymously or confidentially. Remember that it is crucial to report results in a way whereby it is impossible to attribute some pieces of the results (some statistics or quotes) to a specific participant or his/her title or organisation, or where the participant works.

Data collection, management and storage should be undertaken on the selected sites in line with the data collection protocol and data management and storage procedures on a regular basis.

STEP 3: Data analysis and results interpretation

Data analysis methods can be simple – and advanced (by using a specific analytical approach).

When data is collected, you decide how you will analyse and interpret it. You may decide to use simple mathematical methods by compiling and grouping data and using simple formulas in Excel or apply a specific analytical approach and advanced statistical methods. In the first case, you will be able to see progress and trends on the selected indicators on certain sites over time. However, it will not allow you to apply these results to the whole community. The advanced statistical methods will give more valid and recognised results which may represent the situation in the whole community.

In order to have an ***advanced approach***, you would need to involve an expert. Proper data analysis requires specific knowledge and skills. Not every person will be able to undertake professional data analysis, especially concerning qualitative data. Therefore, it is highly recommended to build a partnership with academic institutions or professional research agencies and involve them not only at the CLM development stage but also for the data analysis. Research experts can also be helpful in developing the data analysis frameworks, to perform data analysis and conduct a data quality audit. Remember that only properly collected data can be properly analysed later, so if you need advanced methods, involve the expert at the stage of designing the project. Finally, expertise will not always cost you a fortune as in some cases universities or other institutions might be glad to establish win-win collaborations with communities, allowing them to have access to the participants and for you to acquire the needed expertise. In the next sections, we describe approaches, tools and software to be considered by the CLM team.

In any case, at the results interpretation stage, the CLM team should involve a border range of community members and key stakeholders (if relevant) to help to properly interpret the results as well as to develop

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[4] UNAIDS (2019). The Privacy, Confidentiality and Security Assessment Tool: User Manual. Geneva; UNAIDS https://www.unaids.org/sites/default/files/media_asset/confidentiality_security_tool_user_manual_en.pdf

recommendations for programme improvement and advocacy. You can also bring your results to your participants and ask them to provide feedback, and then to incorporate that feedback.

STEP 4: Results dissemination

It is very important to disseminate the results and communicate them as evidence to decision and policy makers for further programme development/improvement and advocacy needs.

You may consider different options to communicate results, including organising round tables, consultations, presenting a short presentation and full printed version of the report. It is also good to have a hard copy of a brief summary to communicate the key results.

STEP 5: Advocacy action

We will not consider here advocacy planning and action in detail; you may see other relevant publications. Yet, CLM typically includes advocacy actions. It is important to keep it in mind when developing an advocacy plan and think which change you aim to reach through the advocacy as it will involve different stakeholders across different levels (such as national, regional, local) and may require different data, for example:

- change of policies, laws, or regulations;

- change in the service provision mechanism, including composition, quality, funding or supplies;

- change of decision-making and management in a specific setting; and,

- change of skills, attitudes, behaviour, etc., of personnel involved in service provision.

Also, CLM data collection itself might serve as an advocacy tool; for example, service providers might change their behaviour or attitudes knowing that you are conducting a CLM in their facility.

STEP 6: Monitoring the change

The last, but not least, step is to monitor the change. If the challenge you addressed was overcome and no longer exists, monitor the continuity of results reached. Note that you may face situations where the policy or regulation was changed, but on-the-ground the practice remained, or change is not accepted by some personnel or at some sites. This is why we should keep an eye on the change. Moreover, it will help to guarantee that there will not be a rollback situation, where all your hard work will be a waste of time and resources.

CLM team Roles

Now you know all of the CLM steps, but who should implement them and what are the key roles that should be covered by a CLM team?

It is critical that everyone involved in the CLM activity is aware of the full CLM process and understands his/her/their role, function, responsibilities and the timeline. We suggest developing job descriptions that clearly outline the functions and responsibilities for each team member.

Table 2. Main functions of CLM team members

Functions	Description
Supervision	Oversight of CLM design development; data collection tools development; community data collection, management, analysis, and verification process; results interpretation and development of solutions and decisions; results distribution and targeted communication; definition of advocacy actions for needed change.

Functions	Description
CLM design **Data analysts (if any)**	CLM design development; data collection tools and procedures development (for quantitative and qualitative methods); testing of tools; doublechecking of data; cleaning and validation.
Data aggregation and verification	Aggregation of the data across all collection sites; data verification and cleaning the data.
Data collection	Interact directly with clients and/or service providers at health facilities to collect quantitative data; they also collect qualitative data by conducting interviews and holding focus group discussions with recipients of care, community members and other stakeholders.

The CLM team may involve external professional expertise for receiving technical support in CML design, tools development and data analysis, etc., if needed.

Each team member has to be thoroughly instructed/trained before the CLM begins. This will mitigate the risk of human errors and improve the quality of data.

D. CLM TOOLS

OFFLINE FOCUS GROUPS DISCUSSIONS (FGD) WITH COMMUNITY MEMBERS – COMMUNITY MEETINGS

Complexity	$$$
Time	$$$
Price	$$$

Definition:

Focus group discussion (FGD) is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through a group discussion[5]. It can be applied for CLM and as a more advanced methodology in qualitative research.

For CLM, we recommend considering one of the most widely used **type of FGDs – community meetings or community FGDs**[6]. This method is based on the participation of community members, their knowledge and experiences, and thus it is called by some authors 'participatory'.

When is it used?

You can apply it when you want to learn about some specific intervention or service provision, to discuss what went well and what did not, or to explore how quality is perceived amongst community members, etc. Thus, you want to see through *the eyes of the community, walk in their shoes and learn about their lived experience*. Typically, you are interested in the *discussion*, that is why we call this method a focus group discussion, but it does not employ conflict. The key aim is to obtain in-depth information about *WHAT* is happening and *WHY* it is happening in relation to the monitored issue.

Advanced FGDs can be used as a separate research method or complementary to quantitative and other qualitative methods. They also aim to learn *attitudes, experience, perceptions, views and beliefs* of different community members and other relevant groups, but should use a proper data collection strategy as well as an analytical approach.

Who is involved:

- A skilled focus group moderator; and,
- A group of people who can openly provide important information, relevant to the issues being monitored.

Key implementation steps:

1. ***Define key topics and objectives of the activity***[7]. The first initial step is to formulate the key aim of conducting FGD and to answer the questions:

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[5] Green, J., Thorogood N. (2004). Qualitative Methods for Health Research. London; Sage Publishing. ISBN 9781473997110.

[6] Morra Imas, L. G., Rist, R.C. (2009). The Road to Results: Designing and Conducting Effective Development Evaluations. Washington D.C.; The World Bank. https://openknowledge.worldbank.org/bitstream/handle/10986/2699/52678.pdf (accessed 19 November 2022).

[7] You can check some of the structures for reseach question formulations, for example: SPICE, ECLIPSE, PerSPE©TiF, CHIP, PICo, SPIDER, PICOC/PICOS/PICo, BeHEMoTh. More information can be found at

- Why do you want to conduct it? Any missing information available to understand the monitored question?
- Is this FGD related to the monitored question(s)?
- Does collecting opinions, views and experiences of individuals allow the collection of valuable information to better understand the monitored question(s)?
- What are the main topics you want to address within the FGD?

At this point, think of the aim and the key objectives of the FGD; try to formulate them on paper; and list them down. Also, think of several themes that you want to discuss with the participants. The FGD aim should be tailored to the monitored question and be realistic and reachable; envision the available resources.

2. ***Determine FGD participants.*** Now that you know the aim of the FGD, you can decide with whom to talk. You can gather a mixed group of participants representing different social backgrounds, age, gender, power distribution, etc. Yet some recent guides recommend that a FGD bring together participants with similar backgrounds (such as sex workers, people who use drugs, young people)[8].

   It is important to include in a FGD those community members relevant to the monitored question, meaning that they have the experience or knowledge for which you are interested. Also, think about the participants, such as who would be comfortable raising issues and sharing possible solutions in a group setting. It is preferable that participants do not know each other.

   Consider the pros and cons of mixing participants, such as those with opposite views and/or representing different organisations. What are they? Think about the aim of the FGD and the CLM question. Overall, more homogeneous groups might allow for more in-depth discussions as participants might perceive it as a safer space to reveal their views, especially regarding sensitive topics. Yet such a group might end up with a poor discussion as they agree on everything or project socially-accepted answers. Still, it might be challenging to gain that same level of rapport with an heterogeneous group of participants, such as where there is a power imbalance (for example, funders and organisations seeking funding). However, for some purposes, such an heterogeneous group composition might be needed as they might support the establishment of an advocacy platform, fostering dialogue, and providing an opportunity to hear alternative views or to come up with one decision.

   It is recommended not to invite more than 8-10 participants. Keep in mind that all participants might want to speak up, as well as there might be discussions[9].

   Take into consideration the approachability of some participants, as they might be busy or unwilling to come.

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https://training.cochrane.org/resource/question-formulation-and-searching-qualitative-evidence (accessed 19 November 2022).

[8] Chase M. (2022). From Insights to Evidence: A guide for translating program and policy priorities into qualitative and quantitative measures for Community-Led Monitoring. Bryanston, South Africa; International Treatment Preparedness Coalition (ITPC). https://itpcglobal.org/blog/resource/from-insights-to-evidence-a-guide-for-translating-priorities-into-qualitative-quantitative-measures-for-community-led-monitoring/ (accessed 19 November 2022).

[9] Chase, M. (2022), Ibid.

3. ***Develop a FGD guide and select the moderator.*** Based on the CLM question, FGD aim and key topics, develop a structured[10] or semi-structured guide[11]. Prior to the FGD, each participant may also complete an individual questionnaire to gather socio-demographic information and perhaps to compare what has been said in public and private.

   It is recommended not to include too many topics/themes (up to 5-6 questions). Remember to include probes[12] in the FGD guide. On average, a FGD should last no more than 90-120 minutes and should include: a) introduction and informed consent and Q&A (10-15 mins.); b) main part (60-90 minutes); and, c) concluding remarks (10-15)[13]. It is important to have a trained moderator who has no conflicts of interest and can be neutral in regard to the topics discussed and/or the invited participants. The moderator has to have a strong ability to encourage a discussion on specific topics that provide in-depth information relevant to the issues being monitored. Think also about the culture, religion, gender or age of the moderator as, in some contexts, these factors might influence rapport and affect the discussion. You can find an example of a full FGD guide in Annex 9.

4. ***Choose time and location.*** When choosing a location, take into consideration how many people you invite and the size of the location; think of a quiet space and ensure that you will not be disturbed during the FGD. For example, you can put a sign on the outside door to ask people not to enter. Ideally, it should be a separate room with a bathroom. Having coffee, tea or water can facilitate introductions and serve as an ice-breaker.

   You can also consider conducting FGDs in the outreach settings. In such a case, ensure that confidentiality or anonymity will be maintained and that you will not be disturbed. Think of timing, public transport, rush hour traffic, transport cost and the possibility of compensation (if so, you should inform participants during the recruitment phase as to how they can get compensated).

5. ***Recruitment.*** We recommend developing a personal invitation and sending it to all participants – (*Important for group invites!* Do not send an invite in one email displaying the email addresses of all participants as some people might not agree to participate; yet, you have revealed their contact information to others). You can also print invitations and share hard copies with potential participants. The invitation should consist of comprehensive information and include: the aim; who is conducting FGD and how (i.e. the methodology); when; how much time it will take (for example, you can develop a project brief as an attachment); correct directions; information on how to arrive by public transport; and if and how to get compensation. Finally, you can provide the contact details of the person organising the FGD. You may use email (send only PDF files, include the topic in the email as it might

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[10] When all questions are formulated in advance and the moderator sticks to them. Pros: all questions of interest, included initially in the FGD guide, will be addressed; gives confidence to the moderator. Cons: some new topics emerging might be missed.

[11] It allows some level of freedom and anticipates some additional questions, which are not included in the guide, and the FGD guide order can be changed to fit group dynamics. This is recommended for highly qualified moderators, trusted by the whole project team. Pros: allows the capture of emerging themes which were not overseen in the guide. Cons: due to the lack of time, as new unplanned topics are discussed, not all questions of initial interest might be addressed and, thus, additional data collection might be needed; the moderator might find it difficult to formulate new questions/formulates them poorly/finds it difficult to come back to the FGD guide/lacks confidence; these factors might affect group dynamics.

[12] Probes are follow-up questions designed to validate or encourage further, in-depth, thought on a specific issue. Probes might be used when the response is vague or unclear. Note that it is impossible to know what issues respondents might raise that will need probing to dig up and learn more. However, it is helpful to be familiar with probing and some general ways to probe (see Annex 1).

[13] Techniques to be considered to moderate FGD: International HIV/AIDS Alliance. (2014). Tools Together NOW. 100 participatory tools to mobilize communities for HIV/AIDS. https://issuu.com/aids_alliance/docs/tools-together-now (accessed 19 November 2022).

prevent your invite from ending up in the spam box) or post (might take longer) to send invitations. You should try to send the invitation two-three weeks ahead of the FDG. Also, you may decide to include a deadline to respond or send a kind reminder via email or call participants. Think of planning apps, which might help to select and agree on the date, send invites, or to run online activities, such as Doodle, Google Calendar, etc. You can find an example of an invite in Annex 10.

6. ***Conduct the FGD.*** Rehearsals are mandatory preparation steps: check the location and equipment (such as a recording device, chargers/batteries); test the FGD guide with your colleagues and ensure that all supplementary materials are printed/available, including informed consent forms. Consider the mix of the participants, assess whether there are any possible risks related to it, and prepare several possible scenarios to mitigate these risks.

   Make sure you arrive early at the location space, earlier than scheduled, as some participants might show up earlier.

   It is important for recording (and in keeping with the confidentiality principle) to always use a backup recorder. For the face-to-face activities, ask participants to introduce themselves so that you can attribute the voice on the audio recording to a specific participant in the recording; use badges to facilitate discussion among participants. Names should not be transcribed, yet, if needed, results could be reported by groups of participants disaggregated by age, gender, power distribution, etc. If the FGD is conducted anonymously, participants can use any names they like.

7. ***Analyse and report***. All collected data should be recorded and transcribed. It is recommended to anonymise transcripts even if the FGD was conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.). The recording should be deleted after transcriptions are verified (by randomly comparing the transcription and the recording: select three random parts of the text and listen to one minute of the recording to see if there are inconsistencies).

   Analysis, if planned, can be undertaken manually, just by pulling the data together and identifying the key themes. For advanced methodologies, you may consider using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). In such a case, it is recommended to involve trained personnel familiar with qualitative data analysis.

   Reporting should be conducted in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or the organisation in which s/he/they work.

   It is beneficial to bring the results of the project back to the FGD participants to validate and to incorporate feedback, if any. The final report should also be sent to all participants of the FGD.

Resources:

Human resources and competencies:

The following roles might be considered, taking into account that these roles might be carried out by current team members and/or can be combined:

- Coordinator or supervisor;
- Moderator;
- Team member to transcribe recordings;
- *For advanced methods:* an expert in qualitative research to support the FGD guide, data analysis and reporting. For an advanced FGD method, you will need expertise in conducting qualitative

research and for qualitative data analysis if, for example, you plan the use of Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment and setting:

- PC, recording device; a flashcard for backup storage;
- Location to run the FGD;
- Audio and/or video recorder.

Tools to be used:

- FDG guide;
- Invitation letter;
- Informed consent form;
- FDG list of participants;
- *For advanced methods:* Software: Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

Community FGDs are inexpensive and can also help you to raise awareness and credibility. Yet it may not accurately represent community views as some community members may be more willing to talk or there might be gender-related or other barriers that result in some community members remaining silent. Remember that such a method should be well-thought through in advance, meaning that guidelines and recruitment strategy should be developed and piloted beforehand, as well as a skilled moderator of the community meeting and consideration of the following:

- Costs to cover the project team;
- *If applicable:* Costs to reimburse participants for travel costs and time (it is not recommended to pay for participation as it might skew results);
- *If applicable:* Costs to cover the rent of the location;
- *If applicable:* Costs to cover the licenses of Software and needed equipment.

Implementation duration:

Depending on how many FGDs are planned and the number of moderators involved, the project can last between one and four months. While it might be crucial to collect more data, remember that your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure direct engagement and feedback from community members;
- The tool allows for an in-depth understanding of the examined issue; and,
- Can be fast and easily adapted to different monitoring questions.

Limitations:

- The evidence collected might be questioned as it might lack consistency, accuracy, or qualitative research foundations;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,
- An advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

- Reza-Paul, S., et al. (2019). Delivering community-led integrated HIV and sexual and reproductive health services for sex workers: A mixed methods evaluation of the DIFFER study in Mysore, South India. PloseONE, 14(16). https://doi.org/10.1371/journal.pone.0218654 (accessed 19 November 2022).
- Rastokina, E. (2020). Successful Community-Led Monitoring Practices in the EECA Region. Almaty, Kazakhstan; https://www.communitiesengagementhub.org/s/CLM-in-the-EECA-region.pdf (accessed 19 November 2022).

ONLINE FOCUS GROUP DISCUSSIONS (FGD) WITH COMMUNITY MEMBERS – COMMUNITY MEETINGS

Complexity	$$$$
Time	$$$
Price	$$$

Definition:

Focus group discussion (FGD) is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through a group discussion[14]. It can be applied for CLM and, as a more advanced methodology, it can be used in qualitative research.

For CLM, we recommend considering one of the most widely used **types of FGD - community meetings or community FGD**[15]. This method is based on the participation of community members, their knowledge and experiences and, thus, it is called by some authors as 'participatory'.

When is it used?

You can apply it when you want to learn about a specific intervention or service provision, to discuss what went well and what did not, or to explore how quality is perceived amongst community members, etc. Thus, you want to see through *the eyes of the community, walk in their shoes and learn about their lived experience*. Typically, you are interested in the *discussion*, that is why we call this method a focus group discussion, but it does not employ conflict. The key aim is to obtain in-depth information about *WHAT* is happening and *WHY* it is happening in relation to the monitored issue.

Advanced FGDs can be used as a separate research method or can be complementary to quantitative and other qualitative methods. They also aim to learn *attitudes, experience, perceptions, views and beliefs* of different community members and other relevant groups but should use a proper data collection strategy as well as an analytical approach.

Who is involved:

- A skilled focus group moderator; and,
- A group of people who can openly provide important information relevant to the issues being monitored.

Key implementation steps:

1. ***Define key topics and objectives of the activity***[16]. The first, initial step is to formulate the key aim of conducting a FGD and to answer the following questions:

    - Why do you want to conduct it? Any missing information available to understand the monitored question?
    - Is this FGD related to the monitored question(s)?
    - Does collecting opinions, views and experiences of individuals allow the collection of valuable information to better understand the monitored question(s)?
    - What are the main topics that you want to address within the FGD?

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[14] Green, J., Thorogood N. (2004), Ibid.

[15] Morra Imas, L. G., Rist, R.C. (2009), Ibid.

[16] You can check some of the structures for research question formulations, for example: SPICE, ECLIPSE, PerSPE©TiF, CHIP, PICo, SPIDER, PICOC/PICOS/PICo, BeHEMoTh. More information can be found at https://training.cochrane.org/resource/question-formulation-and-searching-qualitative-evidence

At this point, think of the aim and the key objectives of the FGD, try to formulate them on paper and list them down. Also, think of several themes that you want to discuss with participants. The FGD aim should be tailored to the monitored question, be realistic and reachable; envision available resources.

2. ***Determine FGD participants.*** Now that you know the aim of a FGD, you can decide with whom to talk. Take into consideration the approachability of some participants, as they might be busy or unwilling to come. As you are conducting an online activity, you can think if all your participants will be able to join online, if they have a stable Internet connection, or need equipment, etc.

   You can gather a mixed group of participants representing different social backgrounds, age, gender and power distribution, etc. Some recent FGD guides recommend bringing together participants with similar backgrounds (such as sex workers, people who use drugs, young people)[17].

   It is important to include in a FGD those community members relevant to the monitored question, meaning that they have the experience or knowledge in which you are interested. Also, think about the participants, who would be comfortable raising issues and sharing possible solutions in online group setting. It is preferable that participants do not know each other.

   Consider the pros and cons of mixing participants; for example, those of opposite views and/or representing different organisations. What are they? Think about the aim of the FGD and the CLM question. Overall, more homogeneous groups might allow for more in-depth discussions as participants might perceive it as a safer space to reveal their views, especially regarding sensitive topics. Yet such a group might end up with poor discussion as they agree on everything or project socially accepted answers (it might still be challenging to gain that same level of rapport with a heterogeneous group of participants, for example, where we have a power imbalance (such as funders and organisations seeking funding)). For some purposes, such an heterogeneous group composition might be needed as they might support the establishment of an advocacy platform, fostering dialogue and providing an opportunity to hear alternative views or to come up with one decision.

   It is recommended to not invite more than 8-10 participants. Keep in mind that all participants might want to speak up, as well as there might be discussions[18].

3. ***Develop a FGD guide and select the moderator.*** Based on the CLM question, FGD aim and key topics, develop a structured[19] or semi-structured guide[20]. Prior to the FGD, each participant may also complete an individual questionnaire to gather socio-demographic and perhaps to compare what has been said in public and private. You can develop several slides to display and facilitate your online discussion.

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[17] Chase,M. ITPC (2022), Op.cit.

[18] Chase,M. ITPC (2022), Op.cit.

[19] When all questions are formulated in advance, and the moderator sticks to them. Pros: all questions of interest, included initially in the FGD guide, will be addressed; gives confidence to the moderator. Cons: some new topics emerging might be missed.

[20] It allows some level of freedom and anticipates some additional questions which are not included in the guide, and the FGD guide order can be changed to fit group dynamics. This is recommended for highly qualified moderators, trusted by the whole project team. Pros: allows the capture of emerging themes which were not overseen in the guide. Cons: due to lack of time, as new unplanned topics are discussed, not all questions of initial interest might be addressed and, thus, additional data collection might be needed; the moderator might find it difficult to formulate new questions/formulates them poorly/finds it difficult to come back to the FGD guide/lacks confidence; these factors might affect group dynamics.

It is recommended not to include too many topics/themes (up to 5-6 questions). Remember to include probes[21] in the FGD guide. On average, a FGD should last no more than 90-120 minutes and should include: a) an introduction and informed consent and Q&A (10-15 minutes); b) the main part (60-90 minutes); and, c) concluding remarks (10-15 minutes)[22]. It is important to have a trained moderator who has no conflicts of interest and can be neutral in regard to the topics discussed and/or participants invited. The moderator has to have a strong ability to encourage a discussion on specific topics that provide in-depth information relevant to the issues being monitored. Think also about the culture, religion, gender or age of the moderator as in some contexts these factors might influence rapport and affect the discussion. You can find an example of a full FGD guide at Annex 9.

4. ***Choose the time and online tool.*** An online FGD can be conducted using different online tools such as Zoom, MS Teams or Skype. Remember that most tools have limited free functionality. Thus, Zoom will have a limitation of how many participants you can host and how long you can run the meeting (up to 30 minutes for free); Google Meet limits your ability to record. Therefore, check the functions of the apps before deciding on what to use. All in all, ensure that you can host participants invited for 90-120 minutes and record the discussion.

   You may run a test online session to pilot the FGD guide and to get used to the online tool and its technical properties.

   The time of the FGD should also be convenient for all those invited, as we will discuss below.

5. ***Recruitment.*** We recommend developing a personal invitation and sending it to all participants (*Important for group invites!* Do not send an invite in one email displaying the email addresses of all participants as some people might not agree to participate; yet, you have revealed their contact information to others). The invitation should consist of comprehensive information and include: the aim; who is conducting the FGD and how (i.e. the methodology); when; and how much time it will take (for example, you can develop a project brief as an attachment). Finally, you can provide the contact details of the person organising the FGD. You may use email (send only PDF files and include the topic in the email as it might prevent your invite from ending up in the spam box) or post (might take longer) to send invitations. You should try to send the invitation two-three weeks ahead of the event. Also, you may decide to include a deadline to respond or send a kind reminder via email or call participants. Think of planning apps which might help to select and agree on the date, send invites, or run online activities, such as Doodle, Google Calendar, Google Meet, MS Teams, Skype and Zoom. You can find an example of an invite at Annex 10.

6. ***Conduct the FGD.*** Rehearsals are mandatory preparation steps: check online tools and equipment (such as the recording devices, chargers/batteries); test the FGD guide with your colleagues and ensure that all supplementary materials are available, including informed consent forms. Consider the mix of the participants, assess whether there are any possible risks related to it, and prepare several possible scenarios to mitigate these risks.

   Make sure you open the online meeting space earlier than scheduled as some participants might show up earlier.

   It is important for recording (in keeping with the confidentiality principle) to always use a backup recorder. Stress the importance to use correct screen names and the principle to adhere to one

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[21] Probes are follow-up questions designed to validate or encourage further in-depth thought on a specific issue. Probes might be used when the response is vague or unclear. Note that it is impossible to know what issues respondents might raise that would need probing to dig up and learn more. However, it is helpful to be familiar with probing and some general ways to probe (see Annex 1).

[22] Techniques to be considered to moderate FGD: International HIV/AIDS Alliance. (2014), Ibid.

participant talking at one time; if not, the sound might record poorly and it will be challenging to determine who said what. Names should not be transcribed; yet if needed, results could be reported by groups of participants: disaggregated by age, gender, power distribution, etc. If the FGD is conducted anonymously, participants can use any names they like.

You should also decide how you will distribute the informed consent form. For example, you can read it out loud and ask all participants to consent one by one, or send it in chat and ask them to agree by typing “yes” (in such a case, remember to save PrintScreen).

7. ***Analyse and report***. All collected data should be recorded and transcribed. It is recommended to anonymise transcripts even if the FGD was conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.). Recording should be deleted after transcriptions are verified (by randomly comparing the transcription and the recording: select three random parts of the text and listen to one minute of the recording to see if there are inconsistencies).

Analysis, if planned, can be undertaken manually, just by pulling the data together and identifying key themes. For advanced methodologies, you may consider using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). In such a case, it is recommended to involve trained personnel familiar with qualitative data analysis.

Reporting should be undertaken in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or the organisation for which s/he/they work.

It is beneficial to bring the results of the project back to the FGD participants to validate and incorporate feedback, if any. The final report should also be sent to all participants of the FGD.

Resources:

Human resources and competencies:

The following roles should be taken into account by current team members and/or can be combined:

- Coordinator or supervisor;
- Moderator;
- Team member to transcribe recordings;
- *For advanced methods:* an expert in qualitative research to support the FGD guide, data analysis and reporting. For the advanced FGD method, you will need expertise in conducting qualitative research and qualitative data analysis; for example, if you plan to use Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment:

- PC, recording device; a flashcard for backup storage; and
- Audio and/or video recorders.

Tools to be used:

- A FDG guide;
- Invitation letter;
- Informed consent form;
- A list of FGD participants;
- *For advanced methods:* Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

Community FGDs are inexpensive and can also help you to raise awareness and credibility. Yet it may not accurately represent community views as some community members may be more willing to talk, or there might be gender-related or other barriers making some community members to be silent. Remember that such a method should be well-thought through in advance, meaning that guidelines and the recruitment strategy should be developed and piloted beforehand, as well as a skilled moderator of the community meeting FGD should be involved. The following costs should be considered:

- Costs to cover the project team;
- *If applicable:* Costs to cover licenses of the Software and needed equipment.

Implementation duration:

Depending on how many FGDs are planned and the number of moderators involved, the project can last between one and four months. While it might be crucial to collect more data, remember that your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure direct engagement and feedback from community members;
- The tool allows an in-depth understanding of the examined issue;
- Can be fast and easily adapted to different monitoring questions; and,
- Can be applied for distant locations, low in travel costs.

Limitations:

- Internet connectivity and accessibility will skew the type of people you are able to reach;
- Additional skills and costs to run online events;
- The evidence collected might be questioned as it may lack consistency, accuracy or qualitative research foundations;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,
- The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

- ➢ Reza-Paul, S., et al. (2019). Delivering community-led integrated HIV and sexual and reproductive health services for sex workers: A mixed methods evaluation of the DIFFER study in Mysore, South India. PloseONE, 14(16). https://doi.org/10.1371/journal.pone.0218654 (accessed 19 November 2022).
- ➢ Rastokina, E. (2020). Successful Community-Led Monitoring Practices in the EECA Region. Almaty, Kazakhstan; https://www.communitiesengagementhub.org/s/CLM-in-the-EECA-region.pdf (accessed 19 November 2022).

FACE-TO-FACE STRUCTURED INTERVIEWS WITH COMMUNITY MEMBERS AND OTHER KEY INFORMANTS

Complexity	$$$
Time	$$$
Price	$$$

Definition:

Qualitative Interviews is a qualitative technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through individual or group conversations[23]. It can be applied for CLM and, as a more advanced methodology, it can be used in qualitative research. This particular kind of conversation is probably the most commonly and widely used method in qualitative health research.

Such a conversation involves the one who asks the questions – the **interviewer** - and the one who answers – the **interviewee or key informant.**

Structured interviews (SI) schedule the kind of data produced quite tightly, so the interviewer must follow a specified set of questions of the guide in a specified order so that there are answers for all the questions of the guide for each and every respondent which can be pulled together and checked, similar to "comparing" them (in qualitative research, we do not compare by means of statistical analysis but rather by using other analytical approaches). That is why the interviewer should strictly follow the guide, ask all of the questions and do not change them or their order.

When is it used?

You can apply this method when you want to learn about a specific intervention or service provision, to discuss what went well and what did not, or to explore how quality is perceived amongst the community members, etc. Thus, you want to see through *the eyes of the community, walk in their shoes and learn about their lived experience*. The key aim is to obtain in-depth information about *WHAT* is happening and *WHY* it is happening in relation to the monitored issue. But, in this case, you are interested to hear an *individual´s perspective*; you do not need discussions or group conversation. Why do you need this? There can be many reasons: you know that people will not tell their experience or share their thoughts in a group, or you have already conducted FGDs and would like to examine some aspects in more detail, for example.

Advanced SI can be used as a separate research method or complementary to quantitative and other qualitative methods. They also aim to learn *attitudes, experience, perceptions, views and beliefs* of different community members and other relevant groups but should use a proper data collection strategy as well as an analytical approach.

Key implementation steps:

1. ***Define key topics and objectives of the activity.*** The first initial step is to formulate the key aim of this activity and the main topics that you want to address. At this point, think of the overall aim and the key objectives of CLM and try to formulate them on paper and list them down. Also, think of several themes that you want to discuss with participants. The aim should be realistic and achievable; envision available resources.

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[23] Green, J., Thorogood N. (2004), Op.cit.

2. ***Determine participants.*** Now that you know the aim, you can decide with whom to talk. Take into consideration the approachability of some participants as they might be busy or unwilling to participate.

3. ***Develop a SI guide and select the interviewer(s).*** Based on the aim and key topics, develop a structured guide. Prior to interviewing people, pilot (run a "test-drive") of the developed guide, collect feedback and make changes if needed. Remember that questions and probes should be understandable and meaningful (no professional terms or terminology should be used, you should use plain language, etc.).

   It is recommended not to include too many topics (up to 5-6 topics) in the guide.

   On average, an interview should last between 60-120 minutes: it should not be too short as it is impossible to build rapport and follow the guide in 30 minutes; but it should not be lengthy and exhausting for both interviewee and interviewer (you can consider having a follow-up conversation if the interviewee is talkative). The Guide can include: a) an introduction, informed consent and Q&A (10-15 minutes); b) the main part (40-90 minutes); and, c) concluding remarks (10-15 minutes). You may decide to talk to participants that represent different social backgrounds or focus on the perspective of one specific group.

   It is important to have a trained interviewer who has no conflicts of interest and can be neutral with regards to the topics discussed and/or the invited participants. Think also about the culture, religion, gender or age of the moderator as in some contexts these factors might influence rapport and affect the discussion. You can find an example of a full guide at Annex 9.

4. ***Choose the time and location.*** When choosing a location, think of a quiet, separate space with a bathroom and ensure that you will not be disturbed during the conversation. For example, you can put a sign on the outside door to ask people not to enter. Having coffee, tea or water can facilitate the introduction and serve as an ice-breaker. Think of timing, public transport, rush hour traffic, transport cost and the possibility of compensation (if so, you should inform participants during the recruitment phase as to how they can get compensated).

   You can also decide to conduct interviews through outreach and in public areas, etc. If so, you should think about safety. It is not recommended to conduct interviews at the home of a participant unless your safety is 100% guaranteed and can be closely monitored by a third party. Also, the privacy of the participant might be compromised if interviews are conducted in public areas as anyone can see or hear them. Public places might be very noisy, and the quality of recording can be poor.

5. ***Recruitment.*** We recommend developing a personal invitation and sending it to all participants (Important for group interviews! Do not send an invite in one email displaying the email addresses of all participants as some people might not agree to participate; yet, you have revealed their contact information to others). You can also print invitations and share hard copies with potential participants. The invitation should consist of comprehensive information and include: the aim; who is conducting the interview and how (i.e. the methodology); when; how much time it will take (for example, you can develop a project brief as an attachment); correct directions; information on how to arrive by public transport; and if and how to get compensation. Finally, you can provide the contact details of the person organising the interviews. You may use email (send only PDF files, include the topic in the email as it might prevent your invite from ending up in the spam box) or post (might take longer) to send invitations. You should try to send the invitation two-three weeks ahead. Also, you may decide to include a deadline to respond or send a kind reminder by email or call participants. Think of planning apps which might help to select and agree on the date, send invites, or run online activities, such as Doodle, Google Calendar, etc. You can find an example of an invite at Annex 10.

6. ***Conduct interviews.*** Rehearsal is mandatory and includes these preparation steps: check the location (if applicable, for public areas run a test recording and check the quality) and equipment (such as a recording device, chargers/batteries); test the final guide with your colleagues (you should be familiar with the questions and their order); and ensure that all supplementary materials are printed/available (if any), including forms to provide informed consent.

   Make sure you arrive early at the location/meeting space, earlier than scheduled, as some participants might show up earlier.

   It is important for recording (in keeping with the confidentiality principle) to always use a backup recorder. Remember that names, if recorded, should not be transcribed, yet, if needed, you should be able to report the results by groups of participants disaggregated by age, gender or power distribution, etc. That is why you can ask participants to introduce themselves first; this part of recording is for you only and should not be transcribed. If interviews are conducted anonymously, participants can use any names they like.

7. ***Analyse and report***. All collected data should be recorded and transcribed. It is recommended to anonymise transcripts even if interviews were conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.). The recording should be deleted after transcriptions are verified (by randomly comparing the transcription and the recording: select three random parts of the text and listen to one minute of the recording and see if there are inconsistencies).

   Analysis, if planned, can be undertaken manually by pulling the data together and identifying key themes. It would be beneficial to bring the results of the project back to the participants to validate and incorporate feedback, if any. The final report should also be sent to all participants.

   For advanced methodologies, you may consider using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). In such a case, it is recommended to involve trained personnel familiar with qualitative data analysis.

   Reporting should be undertaken in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or an organisation for whom s/he/they work.

Resources:

Human resources and competencies.

The following roles might be considered, taking into account that these roles might be carried out by current team members and/or can be combined:

- Coordinator or supervisor;
- Interviewer;
- Team member to transcribe recordings; and,
- *For advanced methods:* an expert in qualitative research to support the SI guide and data analysis and reporting. For advanced SI methods, you will need expertise in conducting qualitative research and qualitative data analysis, such as if you plan the use of Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment:

- PC, recording device; a flashcard for backup storage; and,
- Audio and/or video recorders.

Tools to be used:

- SI guide;
- Invitation letter;
- Informed consent form; and,
- *For advanced methods:* Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

- Costs to cover the project team;
- Costs to reimburse travel costs and time (it is not recommended to pay for participation as it might skew the results); and,
- *If applicable:* Costs to cover the licenses of Software and needed equipment.

Implementation duration:

Depending on how many interviews are planned and the number of interviewers involved, the project can last between one to four months, or longer. While it might be crucial to collect more data, remember about the window of opportunity, and your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure direct engagement and feedback from community members;
- The tool allows an in-depth understanding of the examined issue; and,
- Can be fast and easily adapted to different monitoring questions.

Limitations:

- The evidence collected might be questioned as it may lack consistency, accuracy, or qualitative research foundations;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,
- The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

Pevzner, S.E., et al (2011). Evaluation of the Rapid Scale-up of Collaborative TB/HIV Activities in TB Facilities in Rwanda, 2005-2009. BMC Public Health 11, 550. https://doi.org/10.1186/1471-2458-11-550 (accessed 19 November 2022).

KEY INFORMANT INTERVIEWS WITH SERVICE PROVIDERS

Complexity	$$$$
Time	$$$
Price	$$

Definition:

Key informant interviews (KII's) are individual interviews with people who have firsthand knowledge about the community, including community leaders, health and social workers and service providers, etc. These community experts, with their knowledge and understanding, can provide insight on the nature of problems and give recommendations for solutions[24].

KII's can be applied to CLM and, as a more advanced methodology, can be used in qualitative research.

When is it used?

While assessing access to, and the quality of, health and social services, you may consider exploring the perspectives of both sides: clients who use services (demand-side factors) and providers of these services (supply-side factors) since they are sides of the one process and very much interconnected. Therefore, this method may help you to look at the problem from the service provider perspective, explore the process of service provision and figure out how quality is perceived amongst the service providers. The key aim is to obtain in-depth information about *WHAT* is happening and *WHY* it is happening in relation to the monitored issue from the service provider side. You can also use KIIs for examining some aspects identified during FGDs with community members in more detail.

KIIs are usually individual interviews which allow people to more easily and frankly sharing sensitive information and thoughts, talking about their experience rather than in a group conversation.

Key implementation steps:

The process of conducting KIIs is the same as in face-to-face structured interviews with community members. Therefore, for the key implementation steps, please see the chapter on face-to-face structured interviews with community members and the chapter on face-to-face semi-structured interviews with community members and other key informants.

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[24] Carroll AM, Perez M, Toy P, (2004) Performing a Community Assessment Curriculum, Los Angeles: UCLA Center for Health Policy Research, Health DATA Program Train-the-Trainer Project

FACE-TO-FACE SEMI-STRUCTURED INTERVIEWS WITH COMMUNITY MEMBERS AND OTHER KEY INFORMANTS

Complexity	$$$$
Time	$$$
Price	$$$

Definition:

Qualitative Interviews are a qualitative technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through individual or group conversations[25]. It can be applied to CLM and, as a more advanced methodology, it can be used in qualitative research. These particular types of conversation are probably the most commonly and widely used method in qualitative health research.

Such conversations involve the one who asks questions - the **interviewer** - and the one who answers – the **interviewee or key informant.**

Semi-structured interviews (SSI's) set the agenda of the interview in terms of topics to be covered, probes and order issues predefined in the guide, but the interviewee's responses may influence all of these to determine the kinds of information produced about topics and the relative importance of these topics. The interviewer should actively listen to the responses, build rapport and, depending on the information and its importance/relevance, may decide to change the order of the questions, add something, yet stick to the guide. The guide usually contains the main questions followed by different probes and is built so that it is possible to change the order of questions.

When is it used?

You can apply this method when you want to learn about some specific intervention or service provision, to discuss what went well and what did not, or to explore how the quality is perceived amongst community members, etc. Thus, you want to see through *the eyes of the community, walk in their shoes and learn about their lived experience*. The key aim is to obtain in-depth information about *WHAT* is happening and *WHY* it is happening in relation to the monitored issue. But in this case, you are interested to hear an *individual´s perspective*; you do not need discussions or group conversation. Why do you need this? There can be many reasons: you know that people will not tell their experience or share their thoughts in a group, or you have already conducted FGDs and would like to examine some aspects in more detail, for example.

Advanced SSI's can be used as a separate research method or complementary to quantitative and other qualitative methods. It also aims to learn of the *attitudes, experience, perceptions, views and beliefs* of different community members and other relevant groups but should use a proper data collection strategy as well as an analytical approach.

Key implementation steps:

The key implementation steps are the same as in face-to-face structured interviews with community members. Please see the chapter on face-to-face structured interviews with community members.

Practical examples and resources:

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[25] Green, J., Thorogood N. (2004), Op.cit.

Veinot, T.C., et al. (2006). "Supposed to make you better but it doesn't really": HIV-positive youths' perceptions of HIV treatment. Journal of Adolescent Health 38(3):261-7. doi: 10.1016/j.jadohealth.2005.03.008 (accessed 19 November 2022).

VIDEO AND PHOTO OBSERVATIONS

Complexity	$$
Time	$$
Price	$$

Definition: Observations are a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. Thus, it aims to understand a phenomenon by observing it directly rather than learning of it through the accounts of people.

When is it used?

You can apply this method when you want to learn about an issue as it allows you to examine what people do as well as what they say they do.

You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sorts of available data, including documents, photos and videos, notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a concrete CLM tool – video and photo observations.

More advanced methods of observation are often referred as the *"gold standard"* of qualitative methods as it allows us to examine what people do as well as what they say they do[26]. Observation can involve participants or not, or be online or face-to-face. We will not discuss specific approaches, like anthropology, ethnography, oral history or phenomenology, as it requires more time and effort. Rather, we aim to present here some basic, yet fundamental, concepts which might facilitate an overall understanding of this approach. To learn more about specific methodologies, including anthropology, ethnography, oral history or phenomenology, one can examine references at the end of this chapter.

Photo and video-based observation is a tool which can record both qualitative (for example, doctor-patient interactions) and quantitative data (duration of a consultation by some health professionals). Also, you can apply this tool for non-participant observations, such as in exploring healthcare infrastructure, or some signboards with needed information like opening hours, information posters, etc.

Photo and video recording accurately records events or phenomena of interest, allows researchers to verify their observations and to return to it afterwards; these tools also give researchers insight into the consistency between self-assessment and observable behaviour, events, or phenomenon of interest. Some participants might be affected by a camera and their behaviour might change dramatically, so consider the context and how and whether the presence of a camera will skew your results. Ethical concerns might also decrease the number of people willing to be filmed or photographed; for example, you may decide not to film faces to diminish this barrier. Finally, you will require technical skills to produce photos and videos of good quality as well as to have all the needed equipment.

Key implementation steps:

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[26] Green, J., Thorogood N. (2004), Op.cit.

1. ***Define key topics and objectives of the activity***[27]. The first initial step is to formulate the key aim of the CLM activity and what you want to learn. At this point, think of the overall project aim and the key objectives, try to formulate them on paper and list them down. Then, think if you have chosen the right method to reach your objectives. Try to answer these questions: Do you need to observe a phenomenon? Why? Is this method appropriate? Choose this approach if you cannot answer your overall CLM question with other tools. Remember that observations might be costly and time-consuming as well as having to face some challenges to obtain ethical clearance. All-in-all, the project aim should be realistic and reachable; envision the available resources.

2. ***Determine participants.*** Now that you know the aim, you can decide whom or what you want to observe. For example, you might not have access to some processes or facilities, etc.; think about ethics and informed consent (if applicable). Take into consideration the approachability of some participants as well as the time available.

3. ***Select an observer.*** Observers should have the needed skills, not only to observe but to record observations (such as the use of equipment) and to manage what can quickly become a large mass of data. The particular setting will determine how and when observations are recorded (such as photos and videos). Note that the observer is also recommended to take notes while observing.

   It is important to have a trained observer who has no conflicts of interest. Think also about the culture, religion, gender or age of the observer(s) as in some contexts these factors might have an influence on those being observed.

   For advanced methods: If you plan to use advanced methods of observation, you have to ensure that the observer covers the following two "roles":

   a) A representative of participants/local community who will be able to provide reflexive "insider accounts" (i.e. referred to as ***emic*** in ethnography). It allows an empathetic understanding of the phenomenon of natives, seeing it "through the eyes" of the local community and understanding meaning, motivation, logic and context of their perspective.

   b) An "outsider" (i.e. referred to as ***etic*** in ethnography), a "stranger from Mars" or "professional stranger", a trained researcher, who will bring "a fresh eye perspective, able to ask naïve questions as well as relate an insider's view to the outsider world by bringing proper analytical approach and social theory components. This decision on whom to choose as an observer should be reflected in the research project design.

   Note that a researcher might hold both roles or these might be managed differently, yet it is crucial to keep both roles as the tensions between an emic and an etic perspective is what drives the research. For example, a trained researcher might not need extra time to learn methodological tricks: how to document, collect and analyse data (such as taking notes, photos, etc.), yet in order to understand social structures and local culture some ethnographies might take many months in a small-scale community. A representative of the local community already knows how things are working inside and does not need to expend such time.

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[27] You can check some of the structures for research question formulations, such as SPICE, ECLIPSE, PerSPE©TiF, CHIP, PICo, SPIDER, PICOC/PICOS/PICo, BeHEMoTh. More information can be found at https://training.cochrane.org/resource/question-formulation-and-searching-qualitative-evidence

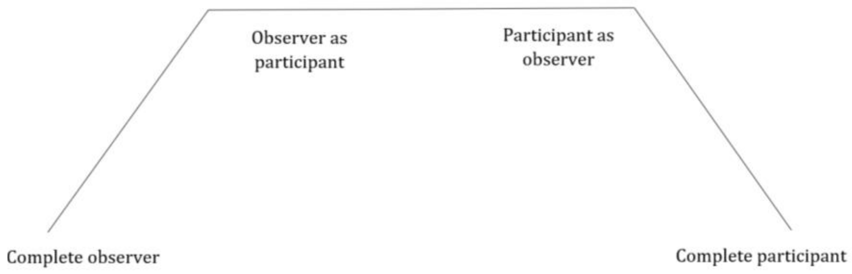

Figure X. Gold´s ideal types of research roles[28]

Remember that in order to assess the quality of services provided, how services adopt new policies, or to follow the standard of care, you will need experts who have the needed knowledge and skills.

4. ***Establish a recording method and develop questions and techniques.*** If you use video or photo recording, remember that your aim is to make effective observations, so it is important that you minimise or eliminate any disruptive or unfamiliar devices in the environment that you wish to observe. For example, it is often least effective to video record observations in situations where the people being observed know that they are being filmed. Note that it is also usually unethical to film without telling them.

   It is possible that your goal will be to monitor facilities and processes, not people. For example, you can check the accessibility of the facility and take photos of ramps or elevators. Or you might be interested in the opening hours that are correctly displayed on the publicly available posters, etc. Even if you take photos of some schedules, posters and/or utilities, etc., minimal notetaking is needed. Notetaking is used in order to place your photos and video in a context and to record when, and by whom and where the observation was made. You may record your feelings about the person you filmed or any communication/accidents, including technical problems or any discussions with personnel which happened outside of the recording.

   Tips:

   - If you use video- or photo- recording, consider the quality of the recorded data;
   - Run a test recording session;
   - Ensure that you are familiar with the device; and,
   - Always have a spare device or battery.

   For advanced methods: For more advanced observations, you should determine whether you are conducting an ***informal observation*** (when you have little or no concept as to what to expect and you simply observe the behaviour of people to learn from it and later to follow it up with more structured research methods; for example, an informal observation can be applied when we examine a new behaviour) or a ***formal observation*** (which are structured, repeated observations aiming to find specific cues to codify and report; in this case, researchers have to think in advance about which data they aim to collect and which data sources or settings to examine and code, etc.). Then, knowing your objective, determine if there are specific questions you have, or if you are going in completely open-minded. Based on the project aim, and before launching the actual observation, you should define which data will be collected, how it will be collected and how it will be analysed. Although it depends on the project aim, we recommend considering a formal observation first as it might be more feasible

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[28] Gold, R. (1958). "Roles in sociological field observation." Social Forces, 36, 217-213.

to run. Thus, you should do some homework before observing, including the development of checklists of data to be collected. Although you might collect additional data, you should guarantee the collection of minimal needed data. To do that, you should have an overall understanding of the processes beforehand, such as how testing is provided, what is the overall algorithm, which steps it includes, etc., unless you know what testing services are included, or which language is accepted, you will not be able to capture the challenges.

Tips:

- First observations might be awkward, both for you and your participant; give them time to adjust and to forget about you;
- Do not make judgmental comments or change your facial expression when you do not agree with or support some actions taken by the participant. Stay neutral but make notes. Remember that you should know what to do if you are in a situation where you observe sexual harassment or human rights violations;
- Always take notes during all the observation periods with the same regularity. Remember that participants are watching you. You should not only make notes when you observe something interesting or you like/do not like – it should not be an obvious indication as participants will adjust their behaviour. Participants should not understand what is considered “good practice” and what is not. Participants should have the feeling that you always take notes even when nothing is happening; in this way they will stop paying attention and will behave naturally; and,
- Do not share your notes with participants.

5. *Observe and collect data*

a) First of all, decide where and how long you will observe

It is important to be familiar with your study location and community. Think of involving a “guide” (i.e. gatekeepers) who can facilitate your work as well as help with the next steps, such as the analysis. Visit the location, facility and community from whom you are hoping to get information. You may decide to reimburse this person for time and travel costs, yet it should be a modest reimbursement administrated, not as a salary type of payment as it may affect the social dynamics of the relationships built.

Also, check if you have accreditation to access sites, specialists, to film or to take photos, etc. You should decide when, and for how long, you will observe and how many times you plan to repeat it, if any. For example, think about the busiest hours at a health facility - would it make sense to observe during the rush hour? Or do you aim to observe a specific specialist(s) during their working hours?

b) Decide how you will video or record photo data

Choose equipment, run a test, ensure you are aware of how to use such equipment. Always make notes to put your videos and photos in context. Ensure that the time to take notes is built into time in the field. For example, you do not do it in a two-week period when it is hardly possible to recall all the details; after the observation, it might be possible to remember most of the silent exchanges and decipher hurriedly scrawled notes; by the following day, these may be illegible and their salience is forgotten.

Remember that it is crucial to be as unobtrusive as possible; take notes, photographs and film only where it is allowed, where you have permission and it makes sense for the research without disrupting the environment.

For advanced observations: If you are doing formal observations, you will need to code certain behaviours, actions, words, visuals, and other observed data (involve a social scientist with proper experience to develop codes accurately). Also, remember to keep eye contact with the person you observe, not intensely, yet consider how it may look if you keep writing most of the time that you observe someone's behaviour. A laptop computer may also be seen as an additional barrier as well as the sound of you typing (if you take notes using a laptop).

Ensure you arrive on time or even earlier; do not make people wait for you. Think ahead as to how you will l administer informed consent (i.e. verbal versus printed version) and take with you all needed materials and equipment.

c) Data storage and management

It is also important to store collected data properly: remember about confidentiality or the anonymity of your participants. Regularly save photos and videos on the hard drive, flashcard, or laptop (once a week) and try to always use a backup system. Develop an algorithm for how and where you store the data, including file naming: 1) each photo or video name should include the place of observation and/or participant number and date of observation; and, 2) keep the same logic for note tracking.

Keep separate field observation notes and your own initial interpretations, analytic comments and views. You can use different notebooks, different colours, or document files on your laptop, etc.

Remember about ethics when storing data. Use a corporate laptop with a password to store recorded data. When storing recordings, always have backup storage. Ensure that only CLM team members have access to these devices. You can also consider having team members signing a non-disclosure agreement (Annex 14). Typically, video recordings and photos, if stored, should be anonymised unless a different approach is approved by an Ethics Committee. Remember, if you plan to use some parts of videos, or photos, for the report, presentation or publication (i.e. making them publicly available), you should not put at risk your participants. Also, this approach should be communicated not only in the Research Protocol submitted to an Ethics Committee, but also to the participants as they should provide you with informed consent, meaning they understand what they have agreed to.

6. ***Analyse and report***. It is recommended to anonymise notes, photos and videos, even if observations were conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.). *The video and photo* data usually requires additional consent and, thus, can be used.

   You can pull together all the photos, videos and notes to decide on key topics and to summarise the key findings. It would be beneficial to bring the results back to the participants to validate and incorporate their feedback, if any.

   For advanced methodology: Analysis, if planned, can be undertaken manually using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). It is recommended to involve trained personnel familiar with qualitative data analysis. Overall, a qualified researcher will choose an analytical approach and aim to separate the difference between what s/he/they observed (which are factual behaviours) and why it happened. Typically, to make some sense of the observed data, a researcher will need to interview people in the environment s/he/they were observing, either during the observation itself, or afterwards. By so doing, connections can be made between interactions, responses, behaviours and other phenomena.

> Reporting should be undertaken in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or an organisation in which s/he/they work.

The final report should also be sent to all participants.

Resources:

Human resources and competencies.

The following roles might be considered, taking into account that these roles might be carried out by current team members and/or can be combined:

- Coordinator or supervisor;
- Observer; and,
- *For advanced methods:* an expert in qualitative research to support the SI guide, data analysis and reporting. For advanced SI methods, you will need expertise in conducting qualitative research and qualitative data analysis, such as if you plan to use Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment:

- PC, recording device; a flashcard for backup storage; and,
- Audio and/or video recorders.

Tools to be used:

- *If applicable:* Informed consent form; and,
- *For advanced methods:* Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

- Costs to cover the project team;
- *If applicable:* Costs to reimburse gatekeepers for travel costs and time; and,
- *If applicable:* Costs to cover the licenses of Software and needed equipment.

Implementation duration:

This CLM method can run for weeks if a simplified methodology is applied.

For advanced methods: Depending on how many observations are planned and the number of observers involved, the project can last for months.

While it might be crucial to collect more data, remember the window of opportunity, and your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure the direct engagement and feedback from community members;
- Can be fast and easily adapted to different monitoring questions; and,
- Allows the collection of photo and video data which can be perceived as objective.

Limitations:

- Skills and equipment to record data; additional cost;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,

- The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

Rindstedt, C. (2013). Children's strategies to handle cancer: a video ethnography of imaginal coping. Child: care, health and development, 40(4). https://doi.org/10.1111/cch.12064 (accessed 19 November 2022).

TRANSECT WALKS

Complexity	$$$$
Time	$$$$
Price	$$$

Definition: Observations is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. It aims to understand phenomenon by observing it directly rather than learning through the accounts of other people.

When is it used?

You can apply this method when you want to learn about something that allows you to examine what people do as well as what they say they do.

You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sort of available data, including documents, photos and videos, notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a specific CLM tool – transect walks.

More advanced methods of observation are often referred to as a "gold standard" as it allows the examination of what people do as well as what they say they do[29]. Observation can involve participants or not, or be online or face-to-face. We will not discuss some specific approaches, like anthropology, ethnography, oral history or phenomenology, as it requires more time and effort. Rather, we aim to present here some basic, yet fundamental, concepts which might facilitate an overall understanding of this approach. To learn more about specific methodologies, including anthropology, ethnography, oral history or phenomenology, one can examine references at the end of this chapter.

Transect walks is a type of participant observation when data is collected during the walk over a certain community area. This community area should be predetermined in advance (such as consideration of community mapping) and the team plans the *transect walk* by drawing a ***"transect line"*** through a map of this determined area. The line should go through, or transect, all zones of the community in order to provide a representative view of that community. An observer is then accompanied by several community members, walks along the area represented by the transect line on the map, and collects the data by means of direct observations, or by interviewing community representatives. This tool may help to identify spatial organisation; architectural styles; use of space; presence or absence of facilities or services; overuse or underuse of facilities, services, and activities; and housing conditions or conditions of facilities, their type, etc. *Transect walks* provide an evaluator with a "big picture" view of the community. They help identify issues that need further investigation[30].

Key implementation steps:

1. ***Define key topics and objectives of the activity***[31]. The first initial step is to formulate the key aim of this CLM activity and what you want to learn. At this point, think of the overall project aim and the key objectives, try to formulate them on paper, and list them down. Then, think if you have chosen the right method to reach your objectives. Try to answer these questions: Do you need to observe a

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[29] Green, J., Thorogood N. (2004), Op.cit.

[30] Morra Imas, L. G., Rist, R.C. (2009), Op.cit.

[31] You can check some of the structures for research question formulations, such as SPICE, ECLIPSE, PerSPE©TiF, CHIP, PICo, SPIDER, PICOC/PICOS/PICo, BeHEMoTh. More information can be found at https://training.cochrane.org/resource/question-formulation-and-searching-qualitative-evidence

phenomenon? Why? Is this method appropriate? Choose this approach if you cannot answer your overall CLM question with other tools. Remember that observations might be costly and time-consuming as well as facing some challenges to obtaining ethical clearance. All-in-all, the CLM aim should be realistic and reachable; envision available resources.

2. ***Determine participants.*** Now that you know the aim, you can decide whom or what you want to examine. Determine where you will use a transect walk. Is it feasible? You should first determine the area where you aim to observe a phenomenon. Then to decide where the transect walk will be, you have to draw a ***"transect line"*** through a map of this designated area. The line should go through, or transect, all zones of the community in order to provide a representative view of the community.

   Take into consideration the approachability of some participants as well as the available time. For example, you might not have access to some processes or procedures and think about ethics and informed consent. You may need to reach out to key stakeholders who might serve as "gatekeepers" and facilitate access for you and other observers. Think how many observations (walks) you will need.

3. ***Select an observer.***

   You may involve experts or community members only in this CLM activity. Yet, remember that to answer some CLM questions and collect proper information, an observer needs some expertise, so think about it beforehand.

   Also, ensure that you have a person on the team who will check the quality of the data collected and to regularly collect and save it and, if needed, inform the team lead about challenges.

   For advanced methods: If you plan the use of an advanced observation methodology, you have to ensure that the observer covers the following two "roles":

   a) A representative of the participants/local community who will be able to provide reflexive "insider accounts" (i.e. referred to as ***emic*** in ethnography). It allows an empathetic understanding of the phenomenon of natives, seeing it "through the eyes" of the local community and an understanding of the meaning, motivation, logic and context of their perspective.

   b) An "outsider" (i.e. referred to as ***etic*** in ethnography), a "stranger from Mars" or "professional stranger", a trained researcher who will bring "a fresh eye perspective, able to ask naïve questions as well as relate an insider's view to the outsider world by bringing a proper analytical approach and social theory components. This decision as to whom to choose as an observer should be reflected in the research project design.

   Note that a researcher might hold both roles or these might be managed differently, yet it is crucial to keep both roles as the tensions between an emic and an etic perspective is what drives the research.

   For example, a trained researcher might not need extra time to learn methodological tricks: how to document, collect and analyse data (such as taking notes, photos, etc.), yet in order to understand social structures and local culture, some ethnographies might take many months of living in a small-scale community. A representative of the local community already knows how things are working inside and does not need to incur such time.

   It is important to have a trained researcher who has no conflicts of interest. Think also about the culture, religion, gender or age of the observer(s) as in some contexts these factors might influence the results.

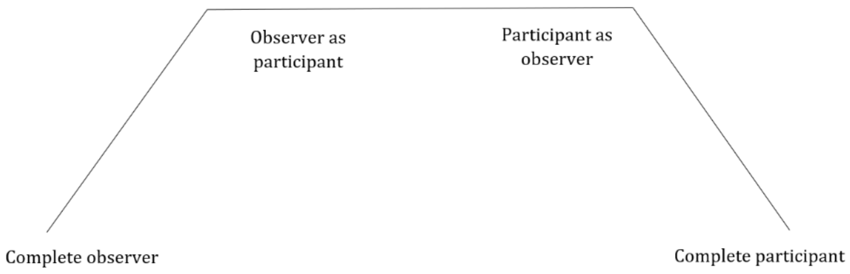

Figure X. Gold´s ideal types of research roles

4. ***Establish a recording method and develop questions and techniques.***

You can use different forms to record data through the transect walks. For example, you can develop a standardised questionnaire with closed questions to assess elements or map services in the designated area, etc. Alternatively, you can ask an observer to fill in the diary to see the narrative and have a more in-depth understanding of their experiences, feelings and emotions. Yet this should be an easy, comprehensive and understandable data collection instrument. It should not take too much time to fill in as a long-complicated format might increase the dropout rate. All observers should be clearly instructed on how to record, manage and store data.

Tips to select a data collection instrument:

- Decide if you will collect qualitative or quantitative data, or both;
- Handwriting might be difficult to manage; think of having a digital diary using a smartphone or another device;
- If you decide on using a handwriting format, print forms and ask participants to fill them in right after the observation; and,
- Check forms regularly and provide feedback; remember that if the client faced a problem, which you read on the form, you should be able to provide some solutions.

For advanced methods: For more advanced observations, you should determine whether you are conducting an ***informal observation*** (when you have little or no concept as to what to expect and you simply observe the behaviour of people to learn from it and later to follow it up with more structured research methods; for example, an informal observation can be applied when we examine a new behaviour) or a ***formal observation*** (structured, repeated observations aiming to find specific cues to codify and report; in this case, researchers have to think in advance about which data they aim to collect (which data sources or settings to examine and develop codes, etc.). Then, knowing your objective, determine if there are specific questions you have or if you are going in completely open-minded. Based on the project aim, and before launching the actual observation, you should define which data will be collected, how it will be collected and how it will be analysed. Although it depends on the project aim, we recommend to consider a formal observation first as it might be more feasible to run. Thus, you should do some homework before observing, including developing the checklists of data to be collected. Although you might collect additional data, you should guarantee that minimal needed data is there. To do that, you should have an overall understanding of the processes beforehand, such as how testing is provided, what is the overall algorithm and which steps it includes; unless you know what testing services are included, or which language is accepted, you will not be able to capture the challenges.

5. ***Observe and collect data.***

First of all, decide where and how long you will observe. It is important to be familiar with your location and services that will be assessed through the transect walks. You begin this activity by determining the area where transect walks will happen. Then, you draw a ***"transect line"*** through a map of this designated area and begin data collection. Remember that the line should go through, or transect, all zones of the community in order to provide a representative view of the community. Think of involving a "guide" (i.e. gatekeepers) who can facilitate your access as well as help with the next steps, such as the analysis.

You should decide when, and for how long, you will observe, how many observers will be involved, and how many times you plan to repeat observations, if any.

Record data – at this stage, it is crucial to schedule regular checks if data is recorded properly; collect it and store it on one laptop with a backup.

Keep separate the field observation notes and your own initial interpretations, analytic comments and views. You can use different notebooks, different colours, or document files on your laptop, etc.

For advanced observations: If you are doing formal observations, will you need to code certain behaviours, actions, words, visuals and other observed data (involve a social scientist with proper experience to develop codes accurately). Also, remember to keep eye contact with the person you observe, not intensely, yet consider how it makes you look if you keep writing most of the time that you observe someone's behaviour. A laptop may also be seen as an additional barrier as well as the sound of you typing.

Data storage and management: It is also important to store collected data properly: remember about confidentiality or anonymity of your participants. Remember about ethics when storing data. Use a corporate laptop with a password to store recorded data. When storing recordings, always have backup storage. Ensure that only CLM team members have access to these devices. You can also consider having team members sign a non-disclosure agreement (Annex 14).

6. ***Analyse and report***. It is recommended to anonymise collected data even if observations were conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.).

   The analysis strategy can depend on what type of data you collected: qualitative or quantitative. For qualitative data, pull together all data and determine the key topics and themes which emerge in the narratives. For quantitative data, you can calculate mean, median or mode (i.e. measurements of central tendency).

   For an advanced methodology: Analysis of qualitative data, if planned, can be undertaken manually using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). It is recommended to involve trained personnel familiar with qualitative data analysis. Overall, a qualified researcher will choose an analytical approach and aim to separate the difference between what s/he/they observed (which are factual behaviours) and why that happened. Typically, to make some sense of the observed data, a researcher will need to interview people in the environment s/he/they were observing, either during the observation itself, or afterwards. By so doing, connections can be made between interactions, responses, behaviours and other phenomena.

   Reporting should be undertaken in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or an organisation for whom s/he/they work.

   The final report should also be sent to all participants.

Resources:

The following roles might be considered, taking into account that these roles might be carried out by current team members and/or can be combined:

- Coordinator or supervisor;
- Observer; and,
- *For advanced methods:* an expert in qualitative research to support the SI guide, data analysis and reporting. For advanced SI methods you will need expertise in conducting qualitative research, and qualitative data analysis, such as if you plan the use of Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment:

- PC, recording device; and,
- Flashcard for backup storage.

Tools to be used:

- Standardised data collection form/diary;
- *If applicable:* Informed consent form; and,
- *For advanced methods:* Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

- Costs to cover the project team.
- *If applicable:* Costs to reimburse gatekeepers for travel costs and time; and,
- *If applicable:* Costs to cover the licenses of Software and needed equipment.

Implementation duration:

This CLM method can be fast if a simplified methodology is applied. It can last a month or so depending on your CLM question.

For advanced methods: Depending on how many observations are planned and the number of observers involved, the project can last months.

While it might be crucial to collect more data, remember the window of opportunity, and your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure direct engagement and feedback from community members;
- The tool may allow having an in-depth understanding of the examined issue if narratives are collected; and,
- Can be fast and easily adapted to different monitoring questions.

Limitations:

- The evidence collected might be questioned as it might lack consistency, accuracy, or qualitative research foundations;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,
- The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

Morra Imas, L. G., Rist, R.C. (2009). The Road to Results: Designing and Conducting Effective Development Evaluations. Washington D.C.; The World Bank. https://openknowledge.worldbank.org/bitstream/handle/10986/2699/52678.pdf (accessed 19 November 2022)

CLIENT'S DIARY

Complexity	$$
Time	$$$
Price	$$

Definition: Observations is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. It aims to understand phenomenon by observing it directly rather than learning of it through the accounts of people.

When is it used?

You can apply this method when you want to learn about what people do as well as what they say they do.

You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sorts of available data, including documents, photos and videos, and notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a specific CLM tool – a client's/patient diary.

More advanced methods of observation are often referred to as a *"gold standard"* of qualitative methods as it allows the examination of what people do as well as what they say they do[32]. Observation can involve participants or not, or be online or face-to-face. We will not discuss specific approaches, like anthropology, ethnography, oral history or phenomenology, as it requires more time and effort. We rather aim to present here some basic, yet fundamental, concepts which might facilitate an overall understanding of this approach. To learn more about concrete methodologies, including anthropology, ethnography, oral history or phenomenology, one can examine references at the end of this chapter.

Diaries / patient diaries are a method to allow you to collect self-reported information about a person's behaviour, experience, and/or any activity of interest over a defined period of time. For example, you can examine the patient pathway or perceived quality of services, etc.

For some people, it is easier to express their views privately, so private reflections might be more candid, and participants might be more able to express themselves in a diary than in an interview. Still, this method very much depends on the participant's willingness to follow through. Please note that diaries may contain not only qualitative information (i.e. feedback, impressions and perceptions, description of an activity, experience, or behaviour) but include quantitative data too (i.e. numerical results of tests, timing, number of hours spent in line at a healthcare facility, costs, etc.).

For advanced methods: It is important to establish a procedure to validate at least some data. For example, in some cases, people might not have sufficient knowledge on how to read diagnostic tests, or a doctors' perception of waiting time might be different compared to the actual time spent by patients.

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[32] Green, J., Thorogood N. (2004), Op.cit.

Always try to use several methods of data collection and examine the perspectives of multiple actors involved; thus, you will have a more comprehensive picture of the world.

Key implementation steps:

1. ***Define key topics and objectives of the activity***[33]. The first initial step is to formulate the key aim of this CLM activity and what you want to learn. At this point, think of the overall project aim and the key objectives, try to formulate them on paper and list them down. Then, think if you have chosen the right method to reach your objectives.

   At this stage, try to answer these question - Will it be possible to answer it through patient´s diary?

   All-in-all, the project aim should be realistic and reachable; envision available resources.

2. ***Determine participants.*** Now that you know the aim, you can decide whom or what you want to observe through diaries. Think of who will fill in the diary. For example, the people you choose might not have access to some documents or medical records which you need in order to answer your CLM question(s). It is important to choose the right people who have knowledge or experience in the issue that you are monitoring. Also, take into consideration the approachability of some participants as well as the time available. Note that not all people will be interested in having the extra job of keeping the diary up-to-date. You may decide to provide some reimbursement for their time and effort. You also need to decide how many participants you will involve.

3. ***Select an observer***. Choose who will serve as an observer. It might be that the one who will be filling the diary will also serve as an observer, but if you plan to include several participants, you might think of a person who will serve as an observer reading and pulling together all of the diaries and managing the whole process. If you decide to choose one observer ruling the whole CLM tool, make a calendar to schedule regular meetings of the observer and participants. If you choose to have many observers who will also fill their diaries, think how to check regularly if they fill in the diaries.

   For advanced methods: If you plan to use *advanced methods* of observation, you have to ensure that the observer covers the following two "roles":

   a) A representative of the participants/local community who will be able to provide reflexive "insider accounts" (i.e. referred to as ***emic*** in ethnography). It allows an empathetic understanding of the phenomenon of natives, seeing it "through the eyes" of the local community and to understand the meaning, motivation, logic and context of their perspective.

   b) An "outsider" (i.e. referred to as ***etic*** in ethnography), a "stranger from Mars" or "professional stranger", a trained researcher who will bring "a fresh eye perspective, able to ask naïve questions as well as relate an insider's view to the outsider world by bringing a proper analytical approach and social theory components. This decision as to whom to choose as an observer should be reflected in the research project design.

   Note that a researcher might hold both roles, or these might be managed differently, yet it is crucial to keep both roles as the tensions between an emic and an etic perspective is what drives the research.

   For example, a trained researcher might not need extra time to learn methodological tricks: how to document, collect and analyse data (such as taking notes, photos, etc.); yet in order to understand the social structures and local culture, some ethnographies might take many months of living in a small-

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[33] You can check some of the structures for research question formulations, such as SPICE, ECLIPSE, PerSPE©TiF, CHIP, PICo, SPIDER, PICOC/PICOS/PICo, BeHEMoTh. More information can be found at https://training.cochrane.org/resource/question-formulation-and-searching-qualitative-evidence

scale community. Representatives of the local community already know how things are working and do not need to incur such time on.

It is important to have a trained researcher who has no conflicts of interest. Think also about the culture, religion, gender or age of the observer(s) as in some contexts these factors might influence the results.

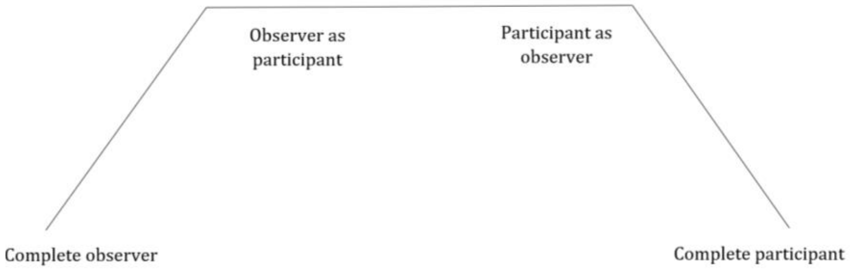

Figure X. Gold´s ideal types of research roles

Remember that in order to assess the quality of services provided, how services adopt new policies, or follow the standard of care, you will need experts who have the required knowledge and skills.

4. ***Establish a diary format.*** If you consider **client´s diaries** (for example, patient diaries) as a CLM tool, we suggest using a standardised format for the diaries as it will facilitate not only data analysis but also will help different patients to record "what should be recorded" (Annex 15). It is also important to leave space for some comments and feedback as it might help you to catch something you did not think about beforehand.

   You should decide what type of information, and in which format, you are aiming to collect. Diaries might be structured in a predefined format (such as printed sections) or be of a free format; you can use a hardcopy (think about design: size, colour, font, etc.; a diary should be comfortable and trigger positive emotions) or an online version (think about confidentiality, accessibility, internet connection, etc.). Note that to develop a comprehensive format of a diary that will allow the examination of the issue selected, you will need to have expertise: for example, in order to assess the continuum of care, you need to know all the key elements; if you are focusing on quality, you need to know local and international standards and policies, etc. If you do not have the needed expertise, "your net will be too wide to catch the fish"; you will collect data which will not allow you to answer the CLM question(s).

   Always run a pilot before choosing a specific format and structure. There are also applications to include people with visual and hearing impairments. Diaries may only contain qualitative data or also some quantitative data.

   Check diaries regularly (such as once per week) and collect feedback: try to understand what went well and what did not with diaries and, if needed, edit and adapt the format accordingly. Remember that a poor format may lead to empty diaries.

   Tips:

   - Handwriting might be difficult to manage; think of having a digital diary using a smartphone or another device;
   - If you decide on using a handwriting format, print diaries and ask participants to fill them in; and,

- Check diaries regularly and provide feedback; remember that if the client faces a problem which you read in the diary, you should be able to provide some solutions.

For advanced methods: For more advanced observation, you should determine whether you are conducting an ***informal observation*** (when you have little or no concept of what to expect and you simply observe the behaviour of people to learn from it and later to follow it up with more structured research methods; for example, informal observations can be applied when we examine a new behaviour) or a ***formal observation*** (structured, repeated observations aiming to find specific cues to codify and report; in this case, researchers have to think in advance about which data they aim to collect (which data sources or setting to examine, the development of codes, etc.). Then, knowing your objective, determine if there are specific questions you have or if you are going in completely open-minded. Based on the project aim and before launching the actual observation, you should define which data will be collected, how it will be collected and how it will be analysed. Although it depends on the project aim, we recommend considering formal observation first as it might be more feasible to run. Thus, you should do some homework before observing, including developing the checklists of data to be collected. Although you might collect additional data, you should guarantee that minimal needed data is there. To do that, you should have an overall understanding of the processes beforehand, for example how testing is provided, what is the overall algorithm, and which steps it includes. Unless you know what testing services are included, or which language is accepted, you will not be able to capture the challenges.

Tips:

- First observations might be awkward both for you and your participant; give them time to adjust and to forget about you;
- Do not make judgmental comments or change your facial expression when you do not agree with, or support, some actions taken by the participant; remain neutral, but make notes. Remember that you should know what to do if you are in a situation where you observe sexual harassment or human rights violations;
- Always take notes during all the observation periods with the same regularity. Remember that participants are watching you. You should not only make notes when you observed something interesting, you like/don't like – it should not be an obvious indication as participants will adjust their behaviour. Participants should not understand what is considered "good practice" and what is not. Participants should have the feeling that you always take notes, even when nothing is happening; in this way they will behave in a natural manner; and,
- Do not share your notes with participants.

5. ***Observe and collect data.*** You should decide how your participants will fill in the diary, whether they will need to have access to some additional information or not, do they need to spend some time at the facility, etc. Ensure that participants are well instructed and understand their role. It would be good if participants also record their emotions and feelings.

   You may also need to reconsider the number of participants involved as some may drop off or not provide good quality diaries, or there might be a necessity to expand the number of patient diaries and observation time to answer selected CLM questions.

   Most importantly, run regular checks with all the participants and collect parts of the diaries that they have completed; also, use this opportunity to provide feedback.

   It is also important to store collected data properly: remember about the confidentiality or anonymity of your participants. Remember about ethics when storing data. Use a corporate laptop with a password to store recorded data. When storing diaries, always have backup storage. Ensure that only CLM team members have access to these devices. You can also consider having team members sign a non-disclosure agreement (Annex 14). If stored, diaries should be anonymised unless a different approach is approved by the Ethics Committee. Remember, if you plan to use some parts of diaries for the report, presentation or publication (i.e. making them publicly available), you should not put your participants at risk. Also, this approach should be communicated not only in the Research Protocol submitted to the Ethics Committee, but also to the participants as they should provide you with informed consent, meaning they understand and agreed.

6. ***Analyse and report***. It is recommended to anonymise diaries even if observations were conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.).

   You can pull together all the diaries and notes of an observer (if any) to decide on key topics and summarise the key findings. It would be beneficial to bring the results back to the participants to validate and incorporate feedback, if any.

   For an advanced methodology: Analysis, if planned, can be undertaken manually using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). It is recommended to involve trained personnel familiar with qualitative data analysis. Overall, a qualified researcher will choose an analytical approach and aim to separate the difference between what s/he/they observed (which are factual behaviours) and why it happened. Typically, to make some sense of the observed data, a researcher will need to interview people in the environment s/he/they were observing, either during the observation itself, or afterwards. By so doing, connections can be made between interactions, responses, behaviours and other phenomena.

   Reporting should be undertaken in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or an organisation for which s/he/they work.

   The final report should also be sent to all participants.

Resources:

The following roles might be considered, taking into account that these roles might be carried out by current team members and/or can be combined:

- Coordinator or supervisor;
- Observer; and,
- *For advanced methods:* an expert in qualitative research to support the SI guide, data analysis and reporting. For advanced SI methods, you will need expertise in conducting qualitative research, and qualitative data analysis, such as when you plan to use Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment:

- PC, recording device; and,
- A flashcard for backup storage.

Tools to be used:

- *If applicable:* Standardised diary form;
- *If applicable:* Informed consent form; and,
- *For advanced methods:* Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

- Costs to cover the project team;
- *If applicable:* Costs to reimburse gatekeepers for travel costs and time; and,
- *If applicable:* Costs to cover the licenses of Software and needed equipment.

Implementation duration:

This CLM method can be fast if a simplified methodology is applied. For example, you can ask participants to fill in diaries for several weeks or months.

For advanced methods: Depending on how many observations are planned and the number of observers involved, the project can last months.

While it might be crucial to collect more data, remember about the window of opportunities, and your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure direct engagement and feedback from community members;
- The tool allows for an in-depth understanding of the examined issue; and,
- Can be fast and easily adapted to different monitoring questions.

Limitations:

- The evidence collected might be questioned as it might lack consistency, accuracy, or qualitative research foundations;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,
- The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

Bolger, N., Davis, A., Rafaeli, E. (2003). Diary methods: Capturing life as it is lived. Annual Review of Psychology, 54(1), 579-616. doi: 10.1146/annurev.psych.54.101601.145030 (accessed 19 November 2022).

SECRET CLIENT

Complexity	$$$$
Time	$$$
Price	$$$

Definition: Observations is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. It aims to understand phenomenon by observing it directly rather than learning of it through the accounts of other people.

When is it used?

You can apply this method when you want to learn about what people do as well as what they say they do.

You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sort of available data, including documents, photos and videos, and notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a specific CLM tool – the secret client.

More advanced methods of observation are often referred as a "gold standard" as it allows the examination of what people do as well as what they say they do[34]. Observation can involve participants or not, or be online or face-to-face. We will not discuss specific approaches, like anthropology, ethnography, oral history or phenomenology, as it requires more time and effort. Rather, we aim to present here some basic, yet fundamental, concepts which might facilitate an overall understanding of this approach. To learn more about concrete methodologies, including anthropology, ethnography, oral history or phenomenology, one can examine references at the end of this chapter.

"Secret client" / "mystery shopping" / pseudo-patient studies / simulated client studies is a method of observation which involves the testing of the services by a researcher pretending to be a "real" consumer in order to find out how consumers are treated in everyday life, rather than in a research type of situation. For example, researchers might pretend to be a patient of the hospital in order to find out how services are "really" provided. This method can involve the collection of qualitative data (such as examining issues of communication, language use, stigmatising or labelling words) and quantitative data (including waiting time, number of personnel, etc.).

For advanced methods: **Important!** Overall, pseudo-patient studies are a practical, feasible and economic method for researching service provision, including health services in developing countries. This method allows the measurement of actual practice, provides better data than interviewing as there are no problems with recall (i.e. remembering incorrectly) or social desirability (i.e. providing socially accepted "not true" answers) bias, and better information than patient records which may be incomplete or inadequate. Still, this covert method is now not much used in sociological studies, largely because of the ethical problems involved. The need for informed consent from research participants in most settings means that many ethics committees would be unlikely to approve such studies. Alternatives to secure consent include asking for consent retrospectively and asking professional organisations to consent on behalf of their members. All-in-all, the research should be bound by the ethical norms of their own communities as well as those they study.

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[34] Green, J., Thorogood N. (2004), Op.cit.

Key implementation steps:

1. ***Define key topics and objectives of the activity***[35]. The first initial step is to formulate the key aim of this CLM activity and what you want to learn. At this point, think of the overall project aim and the key objectives, try to formulate them on paper, and list them down. Then, think if you have chosen the right method to reach your objectives. Try to answer these questions: Do you need to observe a phenomenon? Why? Is this method appropriate? Choose this approach if you cannot answer your overall CLM question with other tools. Remember that observations might be costly and time-consuming as well as you can face some challenges to obtain ethical clearance. All-in-all, the CLM aim should be realistic and reachable; envision available resources.

2. ***Determine participants.*** Now that you know the aim, you can decide whom or what you want to examine. Determine where you will use a secret client method. Is it feasible? Take into consideration the approachability of some participants as well as the time available. For example, you might not have access to some processes or procedures and think about ethics and informed consent. You may need to reach out to key stakeholders who might serve as "gatekeepers" and facilitate access for you and other "secret clients". Think about how many observations you will need using the secret client method.

3. ***Select an observer.*** You may only involve experts or community members in this CLM activity. Yet, remember that to assess certain issues, like the quality of care or how the local and international standards of care are introduced, you will need to know all these standards and be able to see what is in line with the policy and what is not. There are many other cases where you need expertise, so think about this beforehand.

   Also, ensure that you have a person on the team who will check the quality of data collected, regularly collect and save it and, if needed, inform the team lead about challenges (drop-off of secret clients, poor data, etc.). If you decide to choose one observer overseeing the whole CLM tool, make a calendar to schedule regular meetings of the observer and all secret clients.

   For advanced methods: If you plan to use an advanced methodology of observation, you have to ensure that the observer covers the following two "roles":

   a) A representative of the participants/local community who will be able to provide reflexive "insider accounts" (i.e. referred to as ***emic*** in ethnography). It allows an empathetic understanding of the phenomenon of natives, seeing it "through the eyes" of the local community and an understanding of the meaning, motivation, logic and context of their perspective; and,

   b) An "outsider" (i.e. referred to as ***etic*** in ethnography), a "stranger from Mars" or "professional stranger", a trained researcher who will bring "a fresh eye perspective, able to ask naïve questions as well as relate an insider's view to the outsider world by bringing a proper analytical approach and social theory components. This decision as to whom to choose as an observer should be reflected in the research project design.

   Note that a researcher might hold both roles, or these might be managed differently, yet it is crucial to keep both roles as the tensions between an emic and an etic perspective is what drives the research.

   For example, a trained researcher might not need extra time to learn methodological tricks: how to document, collect and analyse data (such as taking notes, photos, etc.), yet in order to understand

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[35] You can check some of the structures for research question formulations, such as SPICE, ECLIPSE, PerSPE©TiF, CHIP, PICo, SPIDER, PICOC/PICOS/PICo, BeHEMoTh. More information can be found at https://training.cochrane.org/resource/question-formulation-and-searching-qualitative-evidence

social structures and local culture some ethnographies might take many months of living in a small-scale community. A representative of the local community already knows how things are working and does not need to incur such time.

It is important to have a trained researcher who has no conflicts of interest. Think also about the culture, religion, gender or age of the observer(s) as in some contexts these factors might influence the results.

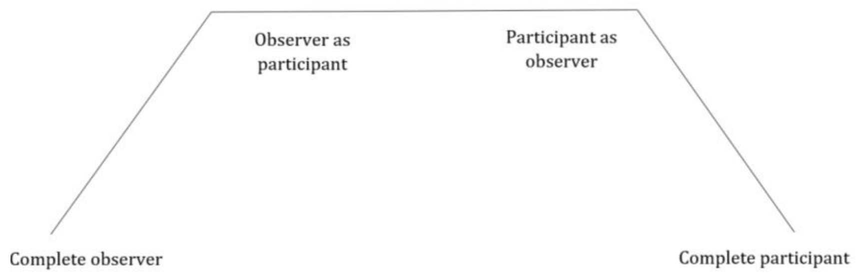

Figure X. Gold´s ideal types of research roles

Remember that in order to assess the quality of services provided, how services adopt new policies, or follow the standard of care, you will need experts who have the required knowledge and skills.

4. ***Establish a recording method and develop questions and techniques.*** You can use different forms to record data via the secret client method. For example, you can develop a standardised questionnaire with closed questions to assess elements or the quality of services, etc. Alternatively, you can ask secret clients to fill in a diary to see the narrative and have a more in-depth understanding of their experiences, feelings and emotions. Yet this should be an easy, comprehensive and understandable data collection instrument. It should not take too much time to fill in as a long-complicated format might increase the drop-out rate. All secret clients should be clearly instructed on how to record, manage and store data.

Tips to select data collection instrument:

- Decide if you will collect qualitative or quantitative data, or both;
- Handwriting might be difficult to manage; think of having a digital diary using a smartphone or another device;
- If you decide on using a handwriting format, print forms and ask participants to fill them in right after the observation; and,
- Check forms regularly and provide feedback; remember that if the client faced a problem, which you read in the form, you should be able to provide some solutions.

For advanced methods: For more advanced observation, you should determine whether you are conducting an ***informal observation*** (when you have little or no concept of what to expect and you simply observe behaviour of people to learn from it and later to follow it up with more structured research methods; for example, an informal observation can be applied when we examine a new behaviour) or a ***formal observation*** (structured, repeated observations aiming to find specific cues to codify and report; in this case, researchers have to think in advance about which data they aim to collect (which data sources or setting to examine, the development of codes, etc.). Then, knowing your objective, determine if there are specific questions you have, or if you are going in completely open-minded. Based on the project aim, and before launching the actual observation, you should define which data will be collected, how it will be collected and how it will be analysed. Although it depends on the project aim, we recommend considering formal observation first as it might be more feasible to run. Thus, you should do some homework before observing, including developing the checklists of data to be collected. Although you might collect additional data, you should guarantee that minimal needed data is collected. To do so, you should have an overall understanding of the processes beforehand, for example how testing is provided, what is the overall algorithm and which steps it includes. Unless you know what testing services include, or which language is accepted, you will not be able to capture the challenges.

5. ***Observe and collect data.*** *First of all, decide where and how long you will observe.* It is important to be familiar with your location and services that will be assessed via the secret client method. Think of involving a “guide” (i.e. gatekeepers) who can facilitate your work as well as help with the next steps, such as the analysis. As mentioned previously, you may consider involving stakeholders to facilitate your access. Visit the location and facility from which you are hoping to collect information.

   You should decide when, and for how long, you will observe, how many secret clients will be involved, and how many times you plan to repeat such a survey, if any. For example, think about the most busy hours at a health facility - would it make sense to observe during the rush hour or not? Or do you aim to observe a specific specialist during their working hours? Plan all of these in advance.

   Record data – at this stage, it is crucial to schedule regular checks if data is recorded properly; collect it; and store it on one laptop with a backup.

   Keep separate field observational notes and your own initial interpretations, analytic comments and views. You can use different notebooks, different colours, or document files on your laptop, etc.

   For advanced observations: If you are doing formal observations, will you need to code certain behaviours, actions, words, visuals and other observed data (involve a social scientist with proper experience to develop codes accurately)? Also, remember to keep eye contact with the person you observe, not intensely, yet consider how it may look if you will keep writing most of the time you observe someone’s behaviour. A laptop may also be seen as an additional barrier as well as the sound of you typing.

   Data storage and management: It is also important to store collected data properly: remember about confidentiality or anonymity of your participants. Also remember ethics when storing data. Use a corporate laptop with a password to store recorded data. When storing recordings, always have backup storage. Ensure that only CLM team members have access to these devices. You can also consider having team members sign a non-disclosure agreement (Annex 14).

6. ***Analyse and report***. It is recommended to anonymise collected data even if observations were conducted confidentially, meaning that all personal information should be deleted (such as names, titles, positions, etc.).

   The analysis strategy can depend on what type of data you collected: qualitative or quantitative. For qualitative data, pull all data together and determine key topics and themes that emerge in the narratives. For quantitative data, you can calculate mean, median or mode (for example, measurements of central tendency).

   For an advanced methodology: Analysis of qualitative data, if planned, can be undertaken manually using colour coding or Qualitative Software packages (such as Nvivo, Atlas.ti). It is recommended to involve trained personnel familiar with qualitative data analysis. Overall, a qualified researcher will choose an analytical approach and aim to separate the difference between what s/he/they observed (which are factual behaviours) and why it happened. Typically, to make some sense of the observed data, a researcher will need to interview people in the environment s/he/they were observing, either during the observation itself, or afterwards; and by so doing, to make connections between interactions, responses, behaviours and other phenomena.

Reporting should be undertaken in such a manner that it is impossible to attribute any comments or experiences shared directly to a specific participant, her/his/their role, or an organisation s/he/they works.

The final report should also be sent to all participants.

Resources:

The following roles might be considered, taking into account that these roles might be carried out by current team members and/or can be combined:

- Coordinator or supervisor;
- Observer and/or secret clients; and,
- *For advanced methods:* an expert in qualitative research to support the SI guide, data analysis and reporting. For advanced SI methods, you will need expertise in conducting qualitative research and qualitative data analysis; for example, if you plan the use of Qualitative Software packages (such as Nvivo, Atlas.ti).

Equipment:

- PC, recording device; and,
- A flashcard for backup storage.

Tools to be used:

- Standardised data collection form /diary;
- *If applicable:* Informed consent form; and,
- *For advanced methods:* Data analysis - Qualitative Software packages (such as Nvivo, Atlas.ti).

Financial:

- Costs to cover the project team;
- *If applicable:* Costs to reimburse secret clients, gatekeepers for travel costs and time; and,
- *If applicable:* Costs to cover the licenses of Software and needed equipment.

Implementation duration:

This CLM method can be fast if a simplified methodology is applied. It can last weeks or months depending on your CLM question.

For advanced methods: Depending on how many observations are planned and the number of observers involved, the project can last months.

While it might be crucial to collect more data, remember the window of opportunities and that your target audience might appreciate the timely communication of findings.

Advantages:

- Ensure direct engagement and feedback from community members;
- The tool may allow an in-depth understanding of the examined issue if narratives are collected; and,

- Can be fast and easily adapted to different monitoring questions.

Limitations:

- The evidence collected might be questioned as it might lack consistency, accuracy or qualitative research foundations;
- If ethical clearance is not obtained, ethnical concerns can be raised; and,
- The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.

Practical examples and resources:

Евразийская коалиция по мужскому здоровью (ЕКОМ), Постнов, А.В. (2018). Руководство по методологии «тайный клиент» для оценки качества сервиса в сфере профилактики и лечения ВИЧ среди МСМ и транс людей, Таллинн. Guidance on the "mystery client" methodology for assessing the quality of service in the field of HIV prevention and treatment among MSM and trans people. In Russian. https://ecom.ngo/library/secret_client

Kassie Netere, A., et al (2018). Assessment of community pharmacy professionals' knowledge and counseling skills achievement towards headache management: a cross-sectional and simulated-client based mixed study. The Journal of Headache and Pain, 19(96). https://doi.org/10.1186/s10194-018-0930-7

COMMUNITY SCORECARDS[36]

Complexity	$$$$$
Time	$$$$$
Price	$$$

Definition:

The *Community Scorecard* is a participatory tool which is used routinely by both sides - community members and service providers - for assessing, planning, monitoring and evaluating HIV and other health and social services aimed at improving service delivery.

The scorecard collects information that can be used by service providers to improve health care and social services in an informed manner. It allows a community to systematically share collective feedback directly to their catchment health and social service providers in a transparent and structured manner; it can establish a participatory dialogue between two sides and can facilitate collective agreement and action with a focus on service delivery improvement. Community members and service providers collaboratively develop criteria, or indicators, for evaluating the services which are captured in a scorecard. The collected data is reviewed along with any other data on facility or site service quality in an action plan meeting where community members, health facility and site staff, and local health administrators come together to discuss actionable steps toward service quality improvements. Improvement actions are identified together and both groups take responsibility for implementing and monitoring them. By working together, the scorecard seeks to create a collaborative and constructive dynamic between all stakeholders that results in action, accountability and positive change[37].

Purpose:

- to monitor and assess service quality and performance at the local or site level;
- to obtain a collective community feedback and deeper understanding of any issues reported through the individual client feedback system; and,
- to create a platform to negotiate the findings with service providers and the development of joint community/service provider action plans to address any identified issues.

Who is involved:

- Community members;
- Service provider representatives;
- Community leaders;
- Health/social facility manager;
- Group discussion facilitators;
- Data manager; and,
- Data analyst.

Key implementation steps:

1. Before initiating a scorecard process, first **outline its scope**:

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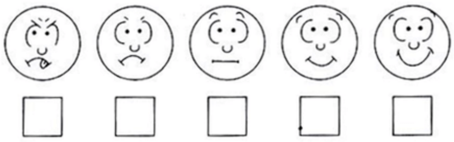
[36] Advancing Partners & Communities. 2018. Community Scorecard Toolkit: Empowering Communities and Healthcare Providers to Partner in Leading Change. Arlington, VA.; Advancing Partners & Communities. https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/tagged_apc_lci_community_scorecard_toolkit.pdf (accessed 19 November 2022).

[37] EpiC. (2021), Ibid.

1.1. *Define community priorities and monitoring questions:*
   a. Conduct a community meeting; discuss and define its needs and priorities: an overall goal of using the scorecard (such as access to Hepatitis C treatment) as well as areas that the scorecard will focus upon (such as access to the service, stigma and discrimination, medication availability); and,
   b. Define specific monitoring questions for each identified area.

1.2. *Select relevant indicators that will be routinely measured and decide on the scorecard scale:*
   a. For doing this, conduct a separate meeting with community members and representatives of service providers to discuss and jointly select indicators and a rating scale to monitor performance. Such cooperation will ensure that the indicators and the scale metrics are clearly understood by all involved in the process and will be used confidently and consistently by all sides;
   b. Indicators must be relevant and measurable. You can consult international guidelines and tools on how to develop indicators or simply select an appropriate one from the list of the suggested indicators (Annex 2); and,
   c. There are many types of scale metrics and design:

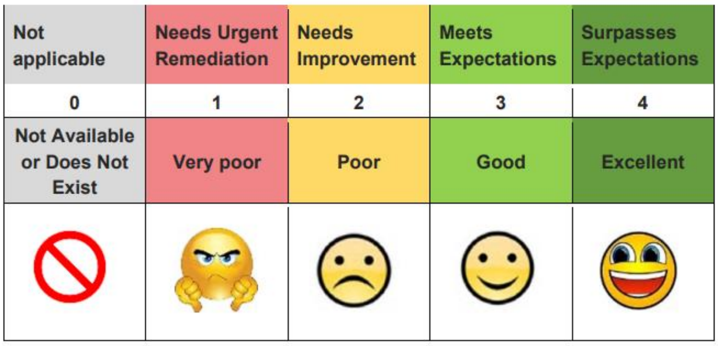
Faces



Numbers[38]

Needs urgent remediation			Needs improvements		Meets expectations			Surpasses expectations		
0	1	2	3	4	5	6	7	8	9	10
Not available	Very poor	Poor	Significantly below average	Below average	Average	Above average	Significantly above average	Good	Very good	Excellent

Or a combination of them:



Not applicable	**Needs Urgent Remediation**	**Needs Improvement**	**Meets Expectations**	**Surpasses Expectations**
0	**1**	**2**	**3**	**4**
Not Available or Does Not Exist	**Very poor**	**Poor**	**Good**	**Excellent**
🚫	😠	☹	🙂	😃

Source: EpiC. (2021) Community-Led Monitoring Technical Guide. FHI 360; Durham (NC).

Select the scale most commonly used and understood within the culture and context of the community. Keep in mind the level of literacy of the participants and select the most

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[38] Advancing Partners & Communities. 2018, Ibid.

suitable option for the scale. For instance, if a community is less literate, it is more likely that 'faces' as a scorecard scale would be clearer for participants;

1.3. Decide on service provider sites that will use the scorecard;
1.4. Decide on sub-populations within the community that need to be represented as a part of the community scorecard group (such as young people who use drugs); and,
1.5. Decide on relevant service providers (their specialisation and role) to be interviewed.

2. Design the scorecard, tools and data collection and management procedures

2.1. Design a community group discussion guide (Annex 9) (For example, please see here for the process and Chapter Offline FGD with community members);
2.2. Define an approach to data collection – paper-based or online by using tablets.
Online data collection form!
   a. If you use tablets or laptops, ensure that the participants have the necessary skills to use them;
   b. For online data collection, you will need to have a stable internet connection;
   c. Develop the data entry form on an online survey platform, such as Google Forms or Open Data Kit, so data can be entered via a web link or on an Android-based tablet;
   d. Test the online data entry form for accuracy; and,
   e. You can also think of linking data entry forms to a data visualisation platform, such as Power BI, to make data display automatically.
2.3. Design a questionnaire for key informant interviews with service providers (Chapter Key informant interviews with service providers) (For example, please see here for the process and see Chapter Key informant interviews with service providers);
2.4. Define a scorecard review period.
This is the time period between the scorecard review and the next scoring. Often scorecards are reviewed quarterly or every six months;
2.5. Identify Scorecard Facilitators who will be trained in, and authorised to administer, the scorecard. The facilitators of the community members group discussion (FGDs) should ideally be members of the respective communities (for instance, a female sex worker representative – a facilitator of female sex worker FGDs);
2.6. Define respondents – community representatives and service providers and approaches for their recruitment;
2.7. Define the minimum number of community representatives who need to be present at each *Scorecard Review Meeting (FGDs)* and service providers to be interviewed (data collection process) and *Scorecard Interface Meeting* (results interpretation and discussion meeting).
The tentative number of participants could be:
   - 10-12 community members per facility/site;
   - 1-2 service providers per facility/site; and,
   - 1 service provider administrator/official per facility/site;
2.8. Develop a data management plan - a formal document that states how data will be collected, managed and stored; by whom and where; who has access to the data, and how data security is ensured;
2.9. Develop an informed consent form (See Annex 5); and,
2.10. Obtain approval from all sides involved in the scorecard process.
Since the scorecard tool is supposed to be deployed in health and social facilities with direct engagement of service providers, it needs to have the full support of all sides.

3. Plan, schedule and conduct training for staff and facilitators

4. **Implement the scorecard and collect data**
    - 4.1. Contact and recruit participants:
        - a. Contact community groups and request voluntary participation in a Scorecard Review Meeting with community members (FGDs) from people who have received services from the health facility or site;
        - b. Contact service providers, facility or site managers, and local health administrators from respective health facilities or identified sites to request voluntary participation in key informant interview (KIIs); and,
        - c. Collect information on their availability to take part in the meetings.
    - 4.2. Schedule and organise a Scorecard Review Meeting for community members (FGD):
        - – Day;
        - – Time;
        - – Venue;
        - – Print necessary materials;
        - – Ensure internet access; and,
        - – If using tablets or laptops, confirm that they are fully charged.
    - 4.3. Conduct a Scorecard Review Meeting with community members (FGD)[39] (For the process, please see Chapter Offline FGD with community members):
        - a. If a client is also a service provider, clarify at the start of the FGD that everyone should reflect on their experience as a client rather than as a provider;
        - b. Ask participants to elaborate reasons for the score for any rating of ‘Very Poor’ or lower;
        - c. During FGDs, facilitate the election of one to two representatives who will represent the community at the interface meeting with health service providers and local government health officials;
        - d. Clearly communicate to participants the next steps in this process (purpose of the interface meeting, responsibilities of the representatives, expected outcomes of the interface meeting, etc.);
        - e. Try to ensure that the same representatives participate in subsequent focus groups and interface meetings.
    - 4.4. Schedule and organise each KII with service providers. It could be a web, telephone or in-person interview. Each participant may prefer a different type of interview;
    - 4.5. Conduct (KII) with service providers (For the process, please see Chapter Key informant interviews with service providers).

      If a service provider who is also a client, clarify at the start of the group interview to reflect on their experience as a service provider.

5. **Analyse data, develop a dashboard for result visualisation**

   Many tools can be used for data analysis and for developing a dashboard: Excel (simple analysis and visualisation), Access, Tableau, PowerBI (Advanced level).

   For advanced qualitative data analysis, you may also use specific software (such as Nvivo, Atlas.ti).

6. **Conduct the Scorecard Interface Meeting and develop an action plan**

   Based on the scorecard results at every Scorecard Interface Meeting together with service providers, identify practical actions that both sides can implement to address detected issues with

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[39] EpiC. (2021), Op.cit.

the quality of service delivery. Collectively develop an action plan which comprises identified action with a responsible person to complete it, a timeframe for its completion, and resources needed and authorities that might be involved.

The action plan enables communities and service providers to better cooperate to improve service delivery.

7. **Implement the action plan and monitor actions (repeat the process)**

Resources:

Competencies needed:

- Scorecard design;
- Facilitating group discussion meetings;
- Conducting interviews;
- Data analysis (qualitative); and,
- The ability to work with Qualitative Data analysis Software packages (Advanced level).

Technical:

- PC;
- Tablets or laptops, if relevant;
- Internet connection;
- Audio and video recorders;
- Location to hold a meeting;
- Google Forms;
- Microsoft Office: Word, Excel, Access;
- Tableau, PowerBI (Advanced level); and,
- Software: Qualitative Data analysis Software packages (such as Nvivo, Atlas.ti) (Advanced level).

Tools to be used:

- Community scorecard group discussion guide (See here);
- Key informant interview questionnaire (See here);
- Data collection and management procedures;
- Participant Register (See here);
- Informed consent form (Annex 5); and,
- Action plan form (See here).

Financial:

- Costs to cover the project team (data manager, facility manager);
- Costs to cover group discussion facilitator, if needed;
- Costs to cover data analyst work, if needed;
- Costs to cover the licenses of Software, if needed;
- Costs to cover the rent of a location, if needed; and,
- Costs to cover the rent of equipment, if needed.

Implementation duration:

2 – 5 months.

Advantages:

- Ensures direct engagement and feedback from community members;
- By working together, the scorecard creates a collaborative and constructive dialogue between clients and providers that results in action, accountability and positive change; and,
- The tool can be easily adapted to different monitoring questions.

Limitations:

- The process of facilitating the data collection, dialogue and the action planning process can be lengthy and complex, requiring specific skills to facilitate the dialogue and to analyse the collected data; and,
- Data collected from the community is sensitive in nature and might cause difficulties in sharing and discussing it with the others without customising the report by considering the sensitivity of the scorecard data.

Practical use:

1. Advancing Partners & Communities. 2018. Community Scorecard Toolkit: Empowering Communities and Healthcare Providers to Partner in Leading Change. Arlington, VA.; Advancing Partners & Communities. https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/tagged_apc_lci_community_scorecard_toolkit.pdf
2. EpiC. (2021) Community-Led Monitoring Technical Guide. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-epic-community-led-monitoring-technical-guide.pdf
3. Kiracho EE, et al. (2020). Influence of community scorecards on maternal and newborn health service delivery and utilization. Int J Equity Health. 2020 Nov 2;19(1):145. doi: 10.1186/s12939-020-01184-6
4. Gullo S., et al (2017). Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster-randomized controlled evaluation. PLoS One. 2017 Feb 10;12(2):e0171316. doi: 10.1371/journal.pone.0171316.
5. Baptiste S, et al. (2020). Community-Led Monitoring: When Community Data Drives Implementation Strategies. Curr HIV/AIDS Rep. 2020 Oct;17(5):415-421. doi: 10.1007/s11904-020-00521-2.

CLIENT FEEDBACK REPORT[40]

	Paper-based in-person exit poll	Tablet-based in-person exit poll	Specific application based	Telephone based	Web-based	Email based
Complexity	$$$	$$	$$$$$	$$	$$	$
Time	$$$$$	$$	$$$	$$$$$	$	$$
Price	$$	$$$	$$$$$	$$	$	$

Definition:

A client feedback report is a systematic and regular data collection and analysis of client feedback on health and social services that they received. It provides actual information about end-user experiences with service providers and their satisfaction with the quality of the received services. Clients are offered to provide their feedback through the survey each time they receive services.

One of the modifications of a client feedback report is the **Citizen report card** which is used to systematically collect client feedback on public services from actual users of a service and to assess the performance of individual service providers by comparing feedback to a national or international standard or across different providers[41] (see Chapter Citizen report card).

Purpose:

- to monitor access to, and the quality of, health and social at site level;
- to identify barriers to care;
- to identify service gaps; and,
- to initiate feedback loops between clients and providers.

Modalities:

The survey can be completed through different modalities. After receiving a service, a client can complete a survey by using a mobile phone and installed specific application (for instance, LINK or OneImpact). Client feedback can be also collected on-site right after the service (for instance, in a clinic) by field- or facility-based gadgets operated by health staff or community outreach workers. Moreover, clients may also be followed up remotely after service access by a case manager who takes them through the survey by phone or sends it directly to the client's phone by SMS or email with a link to the web-based survey[42].

Who is involved:

- Clients - Community members who received services;
- Community leaders;
- Health/social facility manager (if applicable);
- Case manager (if applicable);
- Community outreach workers (if applicable);
- Data manager; and,
- Data analyst.

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[40] EpiC.(2021), Op.cit.

[41] Morra Imas, L. G., et al (2009), Op.cit.

[42] EpiC. (2021), Op.cit.

Key implementation steps:

1. **Define community needs and priorities for monitoring client satisfaction:**
    a. Conduct a community meeting; discuss and define its needs and priorities (such as HIV testing, TB diagnostics, mental health, etc.) as well as areas that the scorecard will focus on (such as access to the service, stigma and discrimination, medication availability) and service-related characteristics for which you would like to receive feedback (such as operating hours, cleanliness, privacy, waiting time, etc.); and,
    b. Decide on the service provider sites that will be assessed (such as a government health facility, a private health facility, lab services, community clinic, drop-in centre, etc.).

2. **Design a questionnaire, tools and data collection and management procedures:**

    a. Write survey questions and design the layout of the questionnaire.

    The client feedback questionnaire must be brief and clear to understand by the client.

    For the survey, you may use a structured and semi-structured questionnaire.

    A **structured questionnaire** includes a number of possible answers from the client which can be selected (one or more). Usually, structured surveys use closed-ended questions, but they allow open-ended responses to all, or most, questions[43]. For instance,

    What is your age?
    - 18-24 years
    - 25-40 years
    - 40-50 years
    - 50+ years

    What services does your partner CBO deliver to key populations?
    - HIV testing;
    - Case management;
    - HIV prevention counselling;
    - Other (please specify)___________

    A **semi structured questionnaire** asks predominantly open-ended questions. It is especially useful when you want to obtain a deeper understanding of reactions to experiences, or to understand the reasons why respondents have particular attitudes[44].

    For example:

    How do you ensure the confidentiality, and protection, of personal data of a client?
    In your opinion, what resources, arrangements, facilities do you need to make the intervention more successful?
    You can find a summary of the advantages and disadvantages of closed- and open-ended questions in Annex 6.

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[43] Morra Imas, L. G., et al. (2009), Op.cit.

[44] Morra Imas, L. G., et al. (2009), Op.cit.

Structured surveys	Semi structured surveys
Harder to develop: survey needs to cover all possible pieces of information	Easier to develop: survey can include broad open-ended questions that capture anything missed in the structured sections, reducing the danger of leaving something out
Easier to complete: checking a box takes less time than writing a narrative response	More difficult to complete: burdensome for people to complete self-administered questionnaires
Easier to analyse	Harder to analyse but provide a richer source of data; interpretation of open-ended responses is subject to bias
More efficient when working with large numbers of people	

Source: Morra Imas, L. G., et al. (2009), Op.cit.

If possible, use an existing questionnaire as a guide. Modify as needed to fit your situation. It is easier to modify than it is to create one from scratch.

Effective survey questions are usually clear, simple and easy to understand for the client. Avoid confusing and bad questions (Annex 4).

Make your survey straightforward, very easy to follow and to complete. A professional and good-looking layout with high-quality graphics and spaces between questions improves accuracy and completeness and helps the questionnaire to flow. It is especially critical for self-administrated, mail and online questionnaires[45]. While providing boxes to check, do not forget to specify what the respondents are to do: to check only one answer or all appropriate answers.

If you use a scale for measuring a client's satisfaction, you have to clearly elaborate the meaning of minimum and maximum score (see Chapter Community scorecard).

b. *Select appropriate tools for data collection*

There are a lot of different tools which can help you to collect data. You can use mobile phones, tablets and PCs to collect data electronically. You can also pick any of the multiple software applications which can help you to conduct your survey quickly and easily (Link, OneImpact). An electronic application allows you to develop your survey layout with questions; to collect and aggregate data from respondents; and prepare data for analysis. Some of them include Google Forms, SurveyMonkey, QuestionPro, PollFish, Birdeye or Open Data Kit.

	Paper-based in-person exit poll	Tablet-based at service point	Gadget-based during community outreach	Specific application based	Telephone based	Web-based	Email based
Process	Clients offered to provide their feedback by filling out a	Clients offered to provide their feedback on	Community outreach workers offer clients the	A client uses a specific application installed onto	A client's case manager calls them after service access	Clients are sent an email or SMS with a link to the	Clients are sent an email with a client

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[45] W. Lawrence Neuman (2014). Basics of Social Research: Qualitative & Quantitative Approaches. Pearson, Third Edition. ISBN-13: 978-0205762613.

	Paper-based in-person exit poll	Tablet-based at service point	Gadget-based during community outreach	Specific application based	Telephone based	Web-based	Email based
	paper-based questionnaire	a facility-based tablet or other device at the end of their service access.	option to provide feedback based on recent service access during their routine outreach activities.	his/her/their smartphone for giving feedback after receiving a service.	to offer the feedback survey and may help them take the survey over the phone.	online client feedback survey to open and complete on their own device after their service access.	feedback form to be completed on their own device after their service access and sent back.
Pros	Easy to realise, doesn't require any gadgets and PC skills; inexpensive.	High response rate; facilitates more equitable access to feedback. Can be automated with analysis and data visualisation.	No provider bias; facilitates more equitable access to feedback. Can be done with a community outreach worker smartphone. Can be automated with analysis and data visualisation.	Can be done virtually; no provider bias; doesn't require extra cost for electronic gadgets; doesn't require staff time. Can be automated with analysis and data visualisation	Can be done virtually; no provider bias; facilitates more equitable access to feedback. Doesn't require extra cost to purchase electronic gadgets.	No provider bias; does not take any staff time; can be done virtually; can be automated with analysis and data visualisation. Doesn't require extra cost to purchase electronic gadgets.	No provider bias; can be done remotely. Doesn't require extra cost to purchase electronic gadgets.
Cons	Time and effort consuming in data transfer, clearance and analysis. Not an environmentally friendly approach.	Takes provider time; potential provider bias; potential cost to procure tablets (may use existing facility tablets, if available).	Inaccuracy of feedback due to time lag after service access; requires physical contact with clients; takes staff time; might require extra cost to purchase electronic gadgets.	Has low response rate; only works for clients with a smartphone or PC. Requires skills to work with gadgets. Needs a stable internet connection.	Takes staff time; extra mobile / telephone connection costs; clients must have a phone number. Requires more effort to collect and aggregate data.	Has a lower response rate; only works for clients with a smartphone or PC. Requires skills to work with gadgets. Needs a stable internet connection.	Has a lower response rate; only works for clients with a smartphone or PC. Requires skills to work with gadgets. Needs a stable internet connection. Requires more effort to aggregate data.

Source: EpiC. (2021a) LINK technical guide: An electronic client feedback system for HIV programs. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-link-technical-guide-jan-21.pdf (accessed 19 November 2022).

c. *Pilot, pretest and adjust the survey instrument* based on feedback from clients and interviewers;

d. Plan and design data collection, management and storage process.

At this stage, you need to clearly understand the full cycle of the data collection, management and storage process – what data collection form is used for what purpose; by whom, when and where; how it is completed, recorded and transferred for aggregation; where and by whom it is stored; and how the data is protected. Who is responsible for data collection, verification, aggregation, cleaning, storage and protection? All of these questions should be addressed in a separate procedure for data management, storage and protection.

3. **Plan, schedule and conduct training for staff involved in data collection** (facility managers, case managers, community managers);

4. **Start routine data collection**

   - If you have on-site data collection, hand over devices to data collectors (smartphones or tablets) and ensure they have Wi-Fi or mobile data connectivity; instruct data collectors when or how to start data collection;
   - If you use follow-up remote client feedback collection, instruct data collectors when and how to send clients a SMS or email with a link to the online survey after receiving a service, or make a follow-up telephone call;
   - If you use an automated electronic system (such as Link), it automatically reminds a client about giving feedback after access to the service and a client can use the application to provide feedback;
   - HIV programme staff are on call to address any issues or questions from data collectors or health facility management during the data collection process.

5. **Analyse data, develop a dashboard for result visualisation on a regular basis (weekly, monthly or quarterly)**

   If you use an electronic web-based or application-based tool for data collection, the collected data will be aggregated automatically. You will only need to undertake data validation and check for mistakes.

   Paper-based and telephone-based tools require more effort and resources to transfer, clean and aggregate data for further analysis.

   Many tools can be used for data analysis and to develop a dashboard: Excel (simple analysis and visualisation), Access, Tableau, and PowerBI (Advanced level).

6. **Disseminate the results at the Interface Meeting and develop a quality improvement plan**

   Based on feedback results at every Interface Meeting with service providers, identify practical actions that should be implemented to address the detected issues with quality service delivery. Develop a quality improvement plan that comprises the identified action with a responsible person to complete it, a timeframe for its completion, resources needed and the authorities that might be involved.

7. **Implement the quality improvement plan and monitor actions (repeat the process)**

Resources:

Competencies needed:

- ✓ Questionnaire design;

- ✓ Ability to work with Google Forms, SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK) or customised electronic applications;
- ✓ Conduct interviews; and,
- ✓ Data analysis and visualisation (quantitative).

Technical:

- ✓ PC;
- ✓ Tablets or laptops, if relevant;
- ✓ Internet connection;
- ✓ Data collection-online tools: Google Forms, customised electronic applications (Link, OneImpact), SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK);
- ✓ Communication with a client using Zoom, MS Teams, Skype, telephone (if appropriate);
- ✓ Data analysis software - Quantitative Software packages (such as R, SPSS, STATA, SAS, MATLAB, ACCESS, Excel, JMP, Python); and,
- ✓ Data visualisation: Tableau, PowerBI (Advanced level).

Tools to be used:

- ✓ Client feedback form (See here);
- ✓ Data collection and management procedures;
- ✓ Informed consent form (Annex 5); and,
- ✓ Action plan form (See here).

Financial:

- Costs to cover the project team (data manager, facility managers, case managers, community outreach workers);
- Costs to cover data analyst work, if needed;
- Costs to cover the licenses of Software, if needed; and,
- Costs to cover rent or the procurement of equipment, if needed.

Implementation duration:

1 – 3 months.

Limitations:

Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues.

Practical use:

1. EpiC. (2021a) LINK technical guide: An electronic client feedback system for HIV programs. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-link-technical-guide-jan-21.pdf
2. EpiC. (2021) Community-Led Monitoring Technical Guide. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-epic-community-led-monitoring-technical-guide.pdf
3. Baptiste S, et al. (2020). Community-Led Monitoring: When Community Data Drives Implementation Strategies. Curr HIV/AIDS Rep. 2020 Oct;17(5):415-421. doi: 10.1007/s11904-020-00521-2

4. Dure Technologies and Stop TB Partnership. User Manual. OneImpact Application. Thane, India/Geneva; Dure Technologies and Stop TB Partnership, undated. https://www.stoptbpartnershiponeimpact.org/resources/Training%20Tools/OneImpact%20CLM%20App%20User%20Manual.pdf
5. Як оцінити лікувальний заклад або лікаря. How to Evaluate a Medical Institution or Doctor. In Ukrainian. https://help24.org.ua/uk/how-to-rate

CITIZEN REPORT CARDS

	Paper-based in-person exit poll	Tablet-based in-person exit poll	Specific application based	Telephone based	Web-based	Email based
Complexity	$$$	$$	$$$$$	$$	$$	$
Time	$$$$$	$$	$$$	$$$$$	$	$$
Price	$$	$$$	$$$$$	$$	$	$

Definition:

A citizen report card is a modification of a client feedback report and is used to systematically collect client feedback on public services from actual users of a service and to assess the performance of individual service providers by comparing them to a national or international standard or across different providers[46].

Therefore, before launching data collection, you need to learn national or international standards of providing priority services and define key milestones and service-related characteristics that you would like to explore.

The rest of the implementation steps are similar to the steps for the Client feedback report (see Chapter Client feedback report).

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[46] Morra Imas, L. G., et al. (2009), Op.cit.

CLIENT CHECK LIST

	Paper-based	Web-based	Specific application based
Complexity	$$$	$	$$$
Time	$$$$$	$	$$
Price	$$	$	$$$$

Definition:

A self-reported checklist is an approach to collect data on the experience of clients receiving health and social services. Checklists are frequently used for hospital or service provider inspection by comparing the real process of service provision to the standard operating procedures (SOPs) or international standards.

A check list usually includes a list of main aspects, activities and requirements which a service provider, according to SOPs and international standards of the particular service, has to fulfill to ensure a full and quality service. Clients are asked to go through and check their status (yes, no, in progress) based on their personal experience of receiving the service.

Purpose:

- to monitor the quality of health and social services at site level;
- to identify the main deviation from the standards;
- to identify service gaps; and,
- to initiate feedback loops between clients and providers.

Modalities:

The survey can be completed through different modalities. After receiving a service, a client can complete a check list by using a mobile phone and a specific installed application (for instance, LINK or OneImpact), entering answers in a web-based form, or simply complete a paper-based check list and hand it to a designated data collection person (for instance, a case manager or facility manager).

Who is involved:

- Clients - Community members who received services;
- Health/social facility manager (if applicable);
- Case manager (if applicable);
- Data manager; and,
- Data analyst.

Key implementation steps:

1. Define community needs and priorities for monitoring;
2. Conduct a community meeting; discuss and define its needs and priorities (such as HIV testing, TB diagnostics, mental health, etc.) as well as areas that the scorecard will focus upon (such as access to the service, stigma and discrimination, medication availability, etc.);
3. Learn national (SOPs) or international standards of providing particular services and define key milestones and service-related characteristics that you would like to explore;
4. Decide on service provider sites that will be assessed (such as a government health facility, a private health facility, lab services, a community clinic, a drop-in centre, etc.);

5. Based on the SOPs, national and international standards and procedures, write a brief and clear check list comprising the main requirements and activities which must be fulfilled by a service provider for quality service.

   A check list usually uses simple, closed-ended questions with answers (yes, no, in progress). Sometimes you can also use a score scale with a clear description of the score value (see Chapter Community Scorecard).

   Examples of check lists can be seen here: Example1, Example2, Example3, Example4.

6. Select the appropriate tools for data collection.

   There are a lot of different tools which can help you to collect data. You can use mobile phones to collect data electronically. You can also pick from any of a multitude of software applications which can help you to conduct your survey quickly and easily (Link, OneImpact). An electronic application allows you to develop your survey layout with questions, collect and aggregate data from respondents and prepare data for analysis. Some of them include Google Forms, SurveyMonkey, QuestionPro, PollFish, Birdeye and Open Data Kit.

7. Plan and design the data collection, management and storage process.

   At this stage, you need to clearly understand the full cycle of the data collection, management and storage process – what data collection form is used for what purpose, by whom, when and where; how it is completed, recorded and transferred for aggregation; where and by whom it is stored; and how the data is protected. Who is responsible for data collection, verification, aggregation, cleaning, storage and protection? All these questions should be addressed in a separate procedure for data management, storage, and protection.

8. Recruit clients from community representatives to complete the check list.

9. Plan, schedule and conduct training for staff involved in data collection (facility managers, case managers, community managers, clients).

10. Start routine data collection

    Ensure that the client receives a paper-based or web-based form in a timely manner and completes it after accessing the service and transfers it to a designated person for data collection at the site.

11. Analyse the data and develop a dashboard for result visualisation on a regular basis (quarterly, semi-annually, or on an annual basis).

    If you use an electronic web-based or application-based tool for data collection, the collected data will be aggregated automatically. You will only need to undertake data validation and check for mistakes.

    Paper-based and telephone-based tools require more effort and resources to transfer, clean and aggregate data for further analysis.

Many tools can be used for data analysis and developing a dashboard: Excel (simple analysis and visualisation), Access, Tableau, and PowerBI (Advanced level).

Compare the received results against national or international standards or SOPs.

12. Disseminate the results at the Interface Meeting and develop a quality improvement plan.

    Based on the results at every Interface Meeting together with service providers, identify practical actions that should be implemented to address detected issues with quality service delivery. Develop a quality improvement plan which comprises the identified action with a responsible person to complete it, a timeframe for its completion, resources needed and authorities that might be involved.

13. Implement a quality improvement plan and monitor actions (repeat the process).

Resources:

Competencies needed:

- Questionnaire design;
- Ability to work with Google Forms, SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK) or customised electronic applications; and,
- Data analysis and visualisation.

Technical:

- PC;
- Internet connection;
- Data collection-online tools: Google Forms, customised electronic applications (Link, OneImpact), SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK);
- Data analysis software - Quantitative Software packages (such as R, SPSS, STATA, SAS, MATLAB, ACCESS, EXCEL, JMP, Python); and,
- Data visualisation: Tableau, PowerBI (Advanced level).

Tools to be used:

- National SOPs and international standards;
- Check-list form (Example1, Example2, Example3, Example4);
- Data collection and management procedures; and,
- Action plan form.

Financial:

- Costs to cover the project team (data manager, facility managers, case managers, community outreach workers);
- Costs to cover data analyst work, if needed; and,
- Costs to cover the licenses of Software, if needed.

Implementation duration:

1 – 2 months.

Limitations:

Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues.

Practical use:

1. de Albuquerque, C. (2014). Realising the human rights to water and sanitation: A Handbook by the UN Special Rapporteur Catarina de Albuquerque. Checklists. Lisbon; Office of the High Commissioner of Human Rights (OHCHR). https://www.ohchr.org/sites/default/files/Documents/Issues/Water/Handbook/Book8_Checklists.pdf
2. Ninan A., et al (2014). Psychotropic medication monitoring checklists: use and utility for children in residential care. J Can Acad Child Adolesc Psychiatry. 2014 Feb;23(1):38-47. https://pubmed.ncbi.nlm.nih.gov/24516476/
3. Andrade, M.R. Monitoring Student Performance with Self-Evaluation Checklists: An Ongoing Case Study. https://www.jrc.sophia.ac.jp/pdf/research/bulletin/kiyou2701.pdf
4. Australian National University and Canberra City Health Network (2020). Checklist for allied health service staff and practitioners while delivering face-to-face services during the COVID-19 pandemic - in practice. Canberra; Australian National University. https://ahpa.com.au/wp-content/uploads/2020/10/Updated-ANU-Allied-health-checklist_in-practice.pdf
5. Pan American Health Organization (PAHO) (2020). Checklist for the Management of Health Workers in Response to COVID-19. 3rd Edition. Washington, D.C.; PAHO. https://iris.paho.org/bitstream/handle/10665.2/53261/PAHOIMSHSSCOVID-19210002_eng.pdf

CLIENT COMPLAINT AND ADVERSE EVENT REPORT[47]

	Specific application based	Telephone (Helpline)	Web-based	Detected by a service provider
Complexity	$$$	$	$	$$$
Time	$$$	$$	$	$$$
Price	$$$	$	$	$

Definition:

A *Client Complaint and Adverse Event Report* is a systematic and regular collection of complaints by clients and incidents that result in harm to the client, resulting in rapid investigation and response (Annex 16).

Purpose:

To monitor, investigate and respond to compliance and adverse events affecting clients, including those caused by revising programme policies or the re-training of staff[48].

Modalities:

The information on adverse events can be collected through different modes. Complaints can be a part of a client feedback report – a survey which a client can complete after receiving a health or social service by using a mobile phone and a specific installed application (for instance, LINK), or through a web-based complaints form, which a client can access through a web link. An adverse event or violent incidents can also be reported by telephone or detected by a service provider.

Human Rights

This tool can also be used to document human rights violation and then the results can be used in advocacy campaigns against human rights information. It is crucial to know international regulations and recommendations and be able to compare them with local policies to identify problematic areas and then to be able to document and advocate for the needed change.

Who is involved:

- Clients - Community members who received services;
- Health/social facility manager (if applicable);
- Service providers;
- Complaint coordinator/case manager; and,
- Data manager.

Key implementation steps:

1. Define community key aspects which have to be focused upon within the Client Complaint and Adverse Event monitoring system;
2. Decide which questions should be added into the client's feedback questionnaire (see Chapter Client feedback report) to collect complaints and adverse event incidents (See example here);
3. Carefully think about the whole process of the complaints monitoring system and **develop standard operating procedures** for adverse event detection, investigation and response.

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[47] EpiC. (2021), Op.cit.

[48] EpiC. (2021), Op.cit.

Describe how data will be collected, through which channels (client feedback electronic system, web-based form (that could be placed on your website), by a service provider and/or through telephone calls from clients (helpline), by whom; how it will be analysed, how frequently; how an investigation will be conducted, by whom; and how the case will be addressed. Usually, there is a specially designated person, a Compliance Coordinator, who collects, investigates and responds to the clients who report adverse cases.

Examples of SOPs include the following:

a) EpiC (2021b) Standard Operating Procedure for Adverse Event Monitoring, Investigating, and Response in the Context of Index Testing. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-epic-sop-for-adverse-event-monitoring-investigation-response-context-index-testing-english.pdf
b) EpiC (2021c) Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-epic-sop-for-identify-and-respond-to-intimate-partner-violence-context-index-testing-english.pdf

These SOPs can be adapted to include other health and social services.

4. Plan, schedule and conduct a number of trainings:

   a. A training for the staff involved in data collection;
   b. A training for community members to educate clients on adverse events and their rights, including their rights as patients; and,
   c. A training for service providers to educate them to identify, register and address adverse events and cases of violence experienced by clients. Moreover, they will have to be able to develop effective referral systems that connect clients to further appropriate services when adverse events are reported (such as medical, legal, social, psychosocial, and shelters, etc.).

5. Encourage clients to report any experiences of harm.

   Widely inform the community about the Complaint and Adverse Event Monitoring System and how to act when information related to harm is communicated through different channels (community outreach workers, case managers, health workers, social medica and chats, partner websites, leaflets and posters, etc.)

6. Investigate, monitor and improve[49]

   a. All complaints and reported adverse events throughout all possible channels have to be entered into an Adverse Event Report Form or Complaints Register. This can be undertaken by a Data Manager or Complaints Coordinator. Ensure that other team members also have access to the Register (you can use Microsoft OneDrive for this);

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[49] EpiC. (2021a) LINK technical guide: An electronic client feedback system for HIV programs. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-link-technical-guide-jan-21.pdf (accessed 19 November 2022).

b. The complaints and adverse events have to be addressed in a timely manner. Do it on a daily bases or you can set automated email alerts when new client complaints are submitted (for instance via Link, Survey Monkey or other online survey platforms);
c. If clients provide contact information, contact the clients and inform them you have received their complaint and ask questions about their negative experience to help complete the story about what happened;
d. If a complaint mentions violence or the risk of violence (emotional, physical, sexual or economic), the staff member contacting the client must be able and skilled to provide first-line support and refer the client to post-violence services or other appropriate services (such as medical, legal, social, psychosocial, or shelters);
e. The Complaint Coordinator should immediately report the complaint to the relevant service provider manager (facility or site manager) and provide documentation of the adverse event (without the client's personal information);
f. Together with service provider management, investigate the complaint or adverse event, identify what caused it (complete an Adverse Event Investigation Form) and develop a set of clear corrective actions (Corrective Actions Plan) to prevent similar adverse events in the future. The facility or site manager is then responsible for ensuring the corrective actions are taken at the facility or site; and,
g. Follow-up with clients and inform them of how their complaint was addressed (if appropriate).

Resources:

Competencies needed:

- Questionnaire design; and,
- An ability to work with Google Forms, SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK) or customised electronic applications.

Technical:

- PC;
- Internet connection;
- Data collection-online tools: Google Forms, customised electronic applications (Link, OneImpact), SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK); and,
- Communication with a client through Zoom, MS Teams, Skype, telephone (if appropriate).

Tools to be used:

- Client Complaint form (See here);
- Standard operating procedures (See here);
- Adverse Event Report Form (Example 1, Example 2);
- Adverse Event Investigation Form (See here); and,
- Corrective Actions Plan.

Financial:

- Costs to cover the project team; and,
- Costs to cover the licenses of Software, if needed.

Implementation duration:

Daily.

Limitations:

Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues.

Practical use:

1. EpiC. (2021a) LINK technical guide: An electronic client feedback system for HIV programs. Durham (NC); FHI 360.
2. EpiC. (2021) Community-Led Monitoring Technical Guide. Durham (NC); FHI 360.
3. EpiC. (2021b) Standard Operating Procedure for Adverse Event Monitoring, Investigating, and Response in the Context of Index Testing. Durham (NC); FHI 360.
4. EpiC. (2021c) Standard Operating Procedure for Identifying and Responding to Intimate Partner Violence in the Context of Index Testing. Durham (NC); FHI 360.
5. EpiC. (2021d) Identifying, preventing and responding to violence in HIV programs serving key populations: Building health care workers' capacity to offer safe and ethical index testing. Durham (NC); FHI 360.
6. World Health Organization (WHO) (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva; World Health Organization.
7.

PEPFAR SOLUTIONS PLATFORM (2020) Community Led Monitoring, Community–Led Monitoring Tools

Human rights:

1. EHRN (2017) Guideline on Advocating for the Human Rights of Women Who Use Drugs
2. UNDP (2014) Know Your Rights, Use Your Laws, Handbook for legal empowerment of people who live with or are at risk of HIV, their close ones, and service providers
3. EHRA education (2022) LESSON SERIES, GATHERING DATA ON HUMAN RIGHTS VIOLATIONS AND REACTION MECHANISM

ONLINE SURVEY WITH CLIENTS

Complexity	$
Time	$
Price	$

Definition:

A survey is a widely used technique of data collection. It provides actual information about the beliefs, opinions, characteristics and past or present behaviour of clients; their experiences with service providers and their satisfaction with the quality of the received services. They are very helpful if you need to measure many variables (indicators) and test several hypotheses; you can do so in a single survey.

Online survey – when the clients provide information through a web-based electronic form by using a link which they receive from a Data Manager, Case Manager or Community Outreach Workers.

Purpose:

- ➢ to test hypotheses;
- ➢ to measure the beliefs and opinions of clients;
- ➢ to measure a client's knowledge;
- ➢ to collect new information about the community;
- ➢ to monitor the access to, and the quality of, health and social services at site level;
- ➢ to identify barriers to care; and,
- ➢ to identify service gaps.

Who is involved:

- ✓ Clients - Community members who have received services;
- ✓ Case Manager;
- ✓ Community Outreach Workers;
- ✓ Data Manager; and,
- ✓ Data Analyst.

Key implementation steps:

1. **Define community needs and monitoring questions that you would like to explore;**

2. **Design a questionnaire, tools and data collection and management procedures.**

   a. *Write survey questions and design the layout of the questionnaire.*

      A client survey questionnaire must be brief and clear to understand by the client. For the survey, you may use a structured and semi-structured questionnaire.

      A **structured questionnaire** includes a number of possible answers by clients which can be selected (one or more). Usually, structured surveys use closed-ended questions, but they allow opened-ended responses to all or most questions[50]. For instance,

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[50] Morra Imas, L.G., et al. (2009), Op.cit.

What is your age?
- 18-24 years
- 25-40 years
- 40-50 years
- 50+ years

What services does your partner CBO deliver to key populations?
- HIV testing;
- Case management;
- HIV prevention counselling;
- Other (please specify):___________

A **semi structured questionnaire** asks predominantly open-ended questions. It is especially useful when you want to obtain a deeper understanding of reactions to experiences or to understand the reasons why respondents have particular attitudes[51]. For example:

How do you ensure the confidentiality and protection of personal data of a client?
In your opinion, what resources, arrangements and facilities do you need to make the intervention more successful?

You can find a summary of advantages and disadvantages of closed- and open-ended questions at Annex 9.

Structured surveys	Semi structured surveys
Harder to develop: survey needs to cover all possible pieces of information	Easier to develop: survey can include broad open-ended questions that capture anything missed in the structured sections, reducing the danger of leaving something out
Easier to complete: checking a box takes less time than writing a narrative response	More difficult to complete: burdensome for people to complete self-administered questionnaires
Easier to analyse	Harder to analyse but provides a richer source of data; interpretation of open-ended responses subject to bias
More efficient when working with large numbers of people	

Source: Morra Imas, L.G., et al. (2009), Op.cit.

If possible, use an existing questionnaire as a guide. Modify as needed to fit your situation. It is easier to modify than it is to create one from scratch.

Effective survey questions are usually clear, simple and easy to understand by the client. Avoid confusing and bad questions (Annex 4).

Make your survey straightforward, very easy to follow and complete. A professional and good-looking layout with high-quality graphics and spaces between questions improves accuracy and completeness and helps the questionnaire to flow. It is especially critical for online questionnaires[52]. While providing boxes to check, do not forget to specify what the respondents are to do: to check only one answer or all appropriate answers?

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[51] Morra Imas, L.G., et al. (2009), Op.cit.

[52] W. Lawrence Neuman (2014), Ibid.

If you use a scale for measuring client satisfaction, you have to clearly elaborate the meaning of minimum and maximum score (see Chapter Community scorecard).

b. *Select appropriate tools for data collection.*

For the online survey, you can pick any from a multitude of software applications which can help you to conduct your survey quickly and easily. The electronic application allows you to develop your survey layout with questions, collect and aggregate data from respondents, prepare data for analysis, and connect data with data visualisation applications. Some of them include Google Forms, SurveyMonkey, QuestionPro, PollFish, and Birdeye.

c. *Pilot, pretest and adjust the survey instrument* based on client feedback.

d. Plan and design the data collection, management and storage process.

At this stage, you need to clearly understand the full cycle of the data collection, management and storage process – what data collection form is used for what purpose, by whom, when and where; how it is completed, recorded and transferred for aggregation; where and by whom it is stored; and how the data is protected. Who is responsible for data collection, verification, aggregation, cleaning, storage and protection? All of these questions should be addressed in a separate procedure for data management, storage and protection.

e. *Develop informed consent* (Annex 5).

An informed consent form should be signed by every client prior to participating in the survey. It can be also be integrated into the survey form.

f. *Decide on the number of clients you would like to participate in the online survey.*

The easiest way is to go for a non-representative sample - whereby the clients are selected regardless of their age, social status or location, etc. The results of such a survey will not represent the whole community of the study.

For a more advanced approach which ensures that results are reliable and represent the whole of the community, the sample size should be properly calculated. There are many different electronic calculators available in the Internet resources (Creative Research Systems, Calculator.net, Survey Monkey, Raosoft) (Annex 13).

3. **Plan, schedule and conduct training for staff involved in data collection.**

4. **Select and recruit respondents.**

Respondents can be selected randomly (as in a lottery) or non-randomly (based on specific criteria) (See Annex 7). It is important to include in the survey those community members relevant to the monitored question, meaning that they have the experience or knowledge for which you are interested.

Community Outreach Workers and Case Managers can be very helpful at this stage. They can inform clients about the survey initiative; ask clients to participate in the survey; receive preliminary agreement from clients to participate in the survey; and collect their contact information. This contact information will be used by the Data Manager to distribute the electronic survey form to be completed by the clients.

We recommend developing a personal invitation and sending it to all respondents by email or other communication channels (messengers, social media). *Important!* Do not send an invite in one email displaying the email addresses of all respondents, as some people might not agree to participate; yet, you have revealed their contact information to others. The invitation should consist of comprehensive information and include: the aim; who is conducting the survey and how; the deadline; and a web link to the survey. Finally, you can provide the contact details of a Data Manager who is organising the survey.

5. **Conduct data collection.**

   Determine a specific timeline for data collection. Think about the feasibility of reaching the sample size while determining the period for data collection.

   You should think in advance about activities which can increase the respondent response rate. For instance, follow-up calls or emails may improve the situation. Moreover, Case Managers and Community Outreach Workers can do it themselves by simply sending a link for the web-based form to a client while meeting that client in person. Incentives (gift cards or mobile phone deposit cards) to clients can also help (see Annex 8).

6. **Analyse data, develop a dashboard for result visualisation.**

   For an electronic web-based data collection tool, the collected data will be aggregated automatically. You will only need to undertake data validation and check for mistakes. Many tools can be used for data analysis and in developing a dashboard: Excel (simple analysis and visualisation), Access, Tableau, and PowerBI (Advanced level).

7. **Disseminate the results and develop an action plan.**

   Discuss the results with community and relevant stakeholders and identify practical actions that should be implemented to address the detected issues. Develop an action plan which comprises the identified actions with a responsible person to complete it, timeframe for its completion, resources needed and the authorities that might be involved.

8. **Implement the action plan and monitor actions (repeat the process).**

Resources:

Competencies needed:

- Questionnaire design;
- Ability to work with Google Forms, SurveyMonkey, QuestionPro, PollFish, and Birdeye, etc.; and,
- Data analysis and visualisation (quantitative).

Technical:

- PC;
- Internet connection;
- Data collection-online tools: Google Forms, SurveyMonkey, QuestionPro, PollFish, and Birdeye;

- Data analysis software - Quantitative Software packages (such as R, SPSS, STATA, SAS, MATLAB, ACCESS, EXCEL, JMP, Python); and,
- Data visualisation: Tableau, PowerBI (Advanced level).

Tools to be used:

- Client questionnaire form (Example 1, Example 2);
- Data collection and management procedures;
- Informed consent form (Annex 5); and,
- Action Plan form (See here).

Financial:

- Costs to cover the project team (data manager, case managers, community outreach workers);
- Costs to cover data analyst work, if needed; and,
- Costs to cover the licenses of Software, if needed.

Implementation duration:

1 – 2 months.

Limitations:

- Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues**;**
- Clients need the ability to work with a PC and use web-based forms; and,
- Clients have to have a smartphone, laptop, PC or other gadget.

Practical use:

1. EpiC. (2021a) LINK technical guide: An electronic client feedback system for HIV programs. Durham (NC); FHI 360. https://www.fhi360.org/sites/default/files/media/documents/resource-link-technical-guide-jan-21.pdf
2. Rastokina, E. (2020). Successful Community-Led Monitoring Practices in the EECA Region. Almaty, Kazakhstan; UNAIDS Sub-Regional Office for Central Asia. https://www.communitiesengagementhub.org/s/CLM-in-the-EECA-region.pdf
3. The Global Fund (2020). Community-based monitoring: An Overview. Geneva; The Global Fund. https://www.theglobalfund.org/media/9622/core_css_overview_en.pdf

ONLINE SURVEY WITH SERVICE PROVIDERS

Complexity	$
Time	$
Price	$

Definition:

A survey is a widely used technique of data collection. It provides actual information about a service providers' beliefs, opinions, characteristics and past or present behaviour and their experience with patients or clients. They are very helpful if you need to measure many variables (indicators) and to test several hypotheses. You can achieve this with a single survey.

Online survey – when the health or social workers provide information through a web-based electronic form by using a link which they receive from the Data Manager, Facility Manager, Case Manager or Community Outreach Workers.

Purpose:

While assessing access to, and the quality of, health and social services, you may consider exploring the perspectives of both sides: clients who use services (demand-side factors) and providers of these services (supply-side factors) since they are sides of the one process and very much interconnected. Therefore, this method may help you to look at the problem from the service provider perspective, to explore the process of service provision and to figure out how quality is perceived amongst service providers. The key aim is to obtain information about *WHAT* is happening and *HOW* it is happening in relation to the monitored issue from the service provider side. An online survey allows people to more easily and frankly share sensitive information and thoughts, talking about their experience rather than in-person or in a group conversation.

Who is involved:

- Service providers;
- Case Manager;
- Community Outreach Workers;
- Facility Manager;
- Data Manager; and,
- Data Analyst.

Key implementation steps:

The process of conducting online survey with service providers is the same as an online survey with clients. Therefore, for key implementation steps, please see the Chapter online survey with clients.

STOCK-OUT TRACKING ALERT SYSTEM

	Specific application based	Telephone (Helpline)	Web-based
Complexity	$$	$	$
Time	$$	$$	$
Price	$$$	$	$

Definition:

A stock-out tracking alert system is a systematic and regular collection of information by the community on the lack, and interruption, of essential drugs and commodities for the treatment of infectious diseases, including HIV, hepatitis C, tuberculosis, and other diseases.

A stock-out tracking alert system can be a part of a client's complaints and feedback report.

Purpose:

To monitor the availability of, and a client's access to, essential drugs and commodities to ensure continuous and uninterrupted treatment.

Modalities:

The information on the lack, and interruption, of essential drugs can be collected through different modes. A stock-out tracking alert system can be a part of a client's complaint and feedback report – a survey which a client can complete after receiving a health or social service by using a mobile phone and specific installed application (for instance, LINK) or through a web-based complaints form which a client can access through a web link. It can also be reported by telephone (to a helpline).

Who is involved:

- ✓ Clients - Community members who have received services;
- ✓ Health/social facility manager (if applicable);
- ✓ Complaint Coordinator/Case Manager; and,
- ✓ Data Manager.

Key implementation steps:

1. Learn local and national policies, standards and regulations with regard to specific disease treatment and its components (including treatment regimens and drugs and commodities which have to be delivered by a service provider);
2. Decide which questions should be added into the client's feedback questionnaire (See Chapter Client feedback report) to collect complaints related to a shortage of drugs and commodities (See example here);
3. Teach the community about their right to access medicine and encourage patients to report shortages and stock-outs;
4. Widely inform the community through different communication channels (community outreach workers, case managers, health workers, social media and chats, partner websites, leaflets and posters, etc.) about the stock-out tracking alert mechanism and teach them how to report drug shortage; and,
5. The rest of the implementation steps are the same as the steps for the client feedback report (See Chapter Client feedback report).

Resources:

Competencies needed:

- Questionnaire design; and,
- An ability to work with Google Forms, SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK) or customised electronic applications.

Technical:

- PC;
- Internet connection;
- Data collection-online tools: Google Forms, customised electronic applications (Link, OneImpact), SurveyMonkey, QuestionPro, PollFish, Birdeye, Open Data Kit (ODK); and,
- Communication with a client through Zoom, MS Teams, Skype, telephone (if appropriate).

Tools to be used:

- Client Complaint form (See example here);
- Client complaints registry;
- Data collection and management procedures; and,
- Action Plan form (See here).

Financial:

- Costs to cover the project team; and,
- Costs to cover the licenses of Software, if needed.

Implementation duration:

Daily.

Limitations:

Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues.

Practical use:

1. Rastokina, E. (2020). Successful Community-Led Monitoring Practices in the EECA Region. Almaty, Kazakhstan; UNAIDS Sub-Regional Office for Central Asia. https://www.communitiesengagementhub.org/s/CLM-in-the-EECA-region.pdf
2. Juntos pelo Acesso aos Medicamentos (TOGETHER FOR ACCESS TO MEDICINES) (2018). EMPOWERING PATIENTS, COMMUNITIES AND HEALTH FACILITIES TO IMPROVE ACCESS TO MEDICINES

SERVICE MAPPING

Complexity	$$
Time	$$
Price	$

Definition:

Mapping health and social services identifies information about available services that community members can benefit from and be referred to.

Source: Bayes Ahmed, Peter Sammonds, Naomi M.Saville (2019) Indigenous mountain people's risk perception to environmental hazards in border conflict areas, Elsevier, International Journal of Disaster Risk Reduction, Volume 35

When is it used?[53]

Mapping can be useful for:

- Generating discussions about available services, service gaps and potential barriers to the services;
- Planning of new services or to evaluate existing services;
- Capturing changes, or perceived changes, over time (before and after an intervention, for example); and,
- A useful data collection tool for use with groups where literacy is an issue.

Who is involved:

- Facilitators/Interviewers;
- Community members (individuals or groups);
- Data Manager; and,
- Data Analyst.

Key implementation steps:[54]

1. Define which services you want to map (health, social, legal, etc.) and which neighbourhoods are of interest;

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[53] Morra Imas, L.G., et al. (2009), Op.cit.

[54] Morra Imas, L.G., et al. (2009), Op.cit.

2. Recruit community representatives from the selected neighbourhoods;
3. Conduct a group discussion meeting and invite recruited community representatives;
4. First, community members have to develop a simple drawing of their neighbourhood on paper by using a pencil and putting pharmacies, hospitals, needle and syringe exchange sites, substitution therapy sites, etc., that they visit;
5. As a next step, community members list the services that they receive at the outlined facilities;
6. After this, community members may assess the level of service received by using different coloured stickers or any other tools;
7. Moreover, the participants may draw different coloured dots to indicate the distribution of special groups, such as poor community members, drug users, or leaders;
8. You can also ask community members specific questions about barriers to accessing services (see the Chapter Offline focus groups discussions with community members);
9. After this, visit the identified service locations and doublecheck the availability of the listed services;
10. You can also think about conducting individual interviews with the service providers at the selected sites (see the Chapter Key informant interviews with service providers);
11. Analyse the collected data and discuss the results with the community members and relevant stakeholders;
12. Develop an action and advocacy plan;
13. Implement the action and advocacy plan; and,
14. Monitor the action plan implementation.

Resources:

Competencies:

- ✓ Questionnaire design;
- ✓ Ability to work with GIS and Google Maps and Google Earth applications;
- ✓ Ability to facilitate group discussions;
- ✓ Conducting interviews; and,
- ✓ Data analysis and visualisation (quantitative).

Technical:

- PC;
- Photo and video gadgets;
- Sticky notes;
- Coloured markers; and,
- An internet connection.

Tools to be used:

- Maps prepared by professional cartographers;
- Maps prepared by field workers who walk through a community;
- Paper flipcharts and coloured markers;
- GIS and Google Maps and Google Earth applications;
- Service mapping matrix (See here);
- Community questionnaire on barriers to accessing services (See here);
- Access barrier matrix (See here); and,
- Service provider questionnaire on the existing services.

Advantages:[55]

- A fast technique of summarising and presenting large amounts of information;
- Useful for participatory evaluations involving stakeholders because it provides a way for them to work together;
- Increases everyone's understanding of the community and its needs;
- Can be applied with an illiterate community; and,
- Information obtained via mapping can be used in planning multicommodity activities.

Practical examples and resources:

1. World Vision. Guidance for integrated programming. Community Engagement Tools. Social mapping. Undated. https://www.wvi.org/sites/default/files/SocialMapping_0.pdf
2. Uddin MJ, et al. (2014). Vulnerability of Bangladeshi street-children to HIV/AIDS: a qualitative study. BMC Public Health. 2014 Nov 6;14:1151. doi: 10.1186/1471-2458-14-1151.
3. Kathirvel, S., Jeyashree, K., Patro, B.K. (2012) Social mapping: A potential teaching tool in public health. Medical Teacher, 34:7, e529-e531, DOI: 10.3109/0142159X.2012.670321
4. Oxfam. Guidance on community-led service mapping. Undated. https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621215/gd-community-led-service-mapping-170921-en.pdf

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[55] Morra Imas, L.G., et al. (2009), Op.cit.

SOCIAL MEDIA CONTENT ANALYSIS

Complexity	$$$$$
Time	$$$$$
Price	$$

Definition:

Content analysis is a technique to determine the presence of certain words, themes, or concepts and relations between them in written or symbolic material (such as pictures, movies, song lyrics, books, book chapters, social media, interviews, discussions, essays, newspaper headlines and articles, historical documents, speeches, conversations, advertising, theatre, informal conversation, etc.)[56]. For instance, it can be used to evaluate the level of social media use for health promotion or HIV prevention or the "mood" of society in relation to an "abortion ban".

There are two types of content analysis - conceptual analysis and relational analysis. Conceptual analysis determines the existence and frequency of concepts in a text. Relational analysis examines the relationships among identified concepts in a text[57].

For instance, with conceptual analysis you can determine how many times words such as hunger, hungry, famished, or starving appear in news. With relational analysis, you could identify what other words or phrases appear next to "hunger" or "starving" and then determine what different meanings emerge as a result of these groupings[58].

We often measure information in the content as numbers and present it as tables or graphs.

When is it used?[59]

- To identify the intentions, focus or communication trends of an individual, group or institution;
- To describe attitudinal and behavioural responses to communications;
- To reveal patterns in communication content (such as propaganda, homophobia);
- To reveal international differences in communication content;
- To determine the psychological or emotional state of persons or groups;
- Useful for documenting trends over time; and,
- A more useful tool when combined with other research methods such as interviews, observation, and use of archival records.

Who is involved:

- Data Analyst; and,
- Media/Communication Manager (optional).

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[56] W. Lawrence Neuman (2014), Op.cit.

[57] Carol, B., et al. (2005). Content Analysis. Writing@CSU. Colorado State University. https://www.publichealth.columbia.edu/research/population-health-methods/content-analysis.

[58] Writing Guides. Colorado State University. https://writing.colostate.edu/guides/

[59] Carol, B., et al. (2005), Ibid.

Key implementation steps:[60, 61]

1. Identify a research question;
2. Decide the level of analysis: word, word sense, phrase, sentence, themes;
3. Choose social media channels and text for analysis;
4. Decide whether you will analyse only that social media channel and their texts which was initially defined, or will you be able to include new material which can be important in relation to the research question;
5. Copy the text which you are going to include in the analysis to a Word document (if possible);
6. Decide whether to code for existence (whether it is available in the test) or frequency (how many times it appears) of a concept;
7. Develop rules for coding your texts.

   Developing a set of rules helps to ensure that the researcher is coding words or phrases consistently throughout the text in the same way every time. Decide whether the words or phrases should be coded exactly as they appear in the text or coded as the same concept when they appear in different forms? For example, “harm” versus “harmful”, “the thing that causes damage”, “the person who insults”.

   The rules could make all these word segments fall into the same category, or perhaps the rules can be formulated so that the researcher can distinguish these word segments into separate codes.

   Decide what to do with irrelevant information: should this be ignored (such as common English words like “the” and “and”)?

8. Code the text:

   - This can be undertaken manually or by using software. The software allows researchers inputting categories and having information coded automatically, fast, and efficiently. However, afterwards it needs effort for cleaning the database. When coding is done by hand, a researcher can recognise errors far more easily (such as typos, misspelling);
   - Code the relationship (if needed).

9. Analyse your results:

   - Interpret results carefully as conceptual content analysis can only quantify the information. Typically, general trends and patterns can be identified;
   - Explore the relationship between concepts (if needed); and,
   - Draw conclusions and generalisations where possible.

Resources:

Human resources and competencies:

- Expertise in qualitative and quantitative data analysis; and,
- An ability to work with Qualitative and Quantitative Data analysis Software packages.

Technical:

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[60] Carol, B., et al. (2005), Op cit.

[61] Population Health Methods. Content Analysis (last updated June 7, 2022). Columbia University, available at: https://www.publichealth.columbia.edu/research/population-health-methods/content-analysis

PC.

Tools to be used:

- QSR NVivo: http://www.qsrinternational.com/products.aspx
- Atlas.ti: http://www.atlasti.com/webinars.html
- R- RQDA package: http://rqda.r-forge.r-project.org/

Financial:

- Inexpensive research method;
- Costs to cover data analyst work; and,
- Costs to cover the licenses of Software and needed equipment.

Implementation duration:

Time and effort-consuming.

Advantages:[62, 63]

- Examines communication using text;
- Applicable for both qualitative and quantitative analysis;
- Allows a close look at information;
- Coded form of the text can be statistically analysed;
- Provides insight into complex models of human thought and language use; and,
- A modest way of analysing relations.

Challenges:[64, 65]

- Can be quite time consuming;
- Can be difficult to automate or computerise;
- Might bring additional errors, particularly when relational analysis is used to attain a higher level of interpretation; and,
- Often disregards the context that produced the text, as well as the state of things after the text is produced.

Practical examples and resources:

1. Ramanadhan, et al (2013). Social media use by community-based organizations conducting health promotion: a content analysis | BMC Public Health | Full Text (biomedcentral.com).
2. Abroms LC, Padmanabhan N, Thaweethai L, & Phillips T. (2011). iPhone Apps for Smoking Cessation: A content analysis. American Journal of Preventive Medicine. 40(3):279-285. https://doi.org/10.1016/j.amepre.2010.10.032
3. Owen P. (2012). Portrayals of Schizophrenia by Entertainment Media: A Content Analysis of Contemporary Movies. Psychiatric Services. 63:655-659. https://doi.org/10.1176/appi.ps.201100371

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[62] Carol, B., et al. (2005), Op.cit.

[63] Population Health Methods, Ibid.

[64] Carol, B., et al. (2005), Op.cit.

[65] Population Health Methods, Op.cit.

4. Eberhardt, EA. (1991). *The rhetorical analysis of three journal articles: The study of form, content, and ideology.* Ft. Collins, CO: Colorado State University.
5. Gottschalk, L.A., Stein, M.K., Shapiro, D.H. (1997). The application of computerized content analysis in a psychiatric outpatient clinic. *Journal of Clinical Psychology, 53*(5)*,* 427-442. https://doi.org/10.1002/(sici)1097-4679(199708)53:5%3C427::aid-jclp3%3E3.0.co;2-k
6. Craig, R.S. (1992). The effect of day part on gender portrayals in television commercials: a content analysis. *Sex Roles: A Journal of Research, 26* (5-6), 197-213. https://doi.org/10.1007/BF00289707

ANNEXES

Annex 1. Main Global Strategic Frameworks for HIV, TB and other health-specific outcomes

UNAIDS	UNAIDS 2021. End Inequalities. End AIDS. Global AIDS Strategy 2021- 2026. www.unaids.org/sites/default/files/media_asset/global-AIDS-strategy-2021-2026_en.pdf
PEPFAR	PEPFAR Strategy: Vision 2025 https://www.state.gov/wp-content/uploads/2021/09/DRAFT-Overview-PEPFAR-Strategy-Vision-2025_Version-2.0-2.pdf
The Global Fund	Global Fund Strategy (2023-2028) https://www.theglobalfund.org/media/11612/strategy_globalfund2023-2028_narrative_en.pdf
United Nations	United Nations 2015. Transforming our World: The 2030 Agenda for Sustainable Development https://sdgs.un.org/publications/transforming-our-world-2030-agenda-sustainable-development-17981

Annex 2. M&E Indicator and Key Guidelines

	HIV, Viral Hepatitis and STI	TB	Health Strengthening	Health service quality
UNAIDS (2022). HIV Indicator Registry. https://indicatorregistry.unaids.org/	▨			
UNAIDS (2022). Global AIDS Monitoring 2022 https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf	▨			
World Health Organization (2020). Consolidation HIV Strategic Information Guidelines. https://www.who.int/publications-detail-redirect/9789240000735	▨			
World Health Organization (2021) Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. https://www.who.int/publications/i/item/9789240031593	▨			▨
WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision. https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/Target_setting_guide2012_eng.pdf	▨			▨
UNAIDS HIV and universal health coverage, a guide for civil society. https://www.unaids.org/sites/default/files/media_asset/hiv-uhc-guide-civil-society_en.pdf	▨			▨
WHO 2022 Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. https://www.who.int/publications/i/item/9789240052390	▨			▨
Global Fund for HIV, TB and Malaria (2020). HIV Indicator Guidance Sheet. https://www.theglobalfund.org/media/5189/me_indicatorguidancesheetsannexa-hiv_sheet_en.xls	▨			
Global Fund for HIV, TB and Malaria (2020). Tuberculosis Indicator Guidance Sheet. https://www.theglobalfund.org/media/5192/me_indicatorguidancesheetsannexa-tb_sheet_en.xlsx	▨	▨		
Public Health England (2022). TB Strategy Monitoring Indicators. https://fingertips.phe.org.uk/profile/tb-monitoring/data#page/1		▨		
UNODC (2020) HIV prevention, testing, treatment, care and support in prisons and other closed settings: a comprehensive package of interventions. Technical Brief 2020 Update https://www.unodc.org/documents/hiv-aids/publications/Prisons_and_other_closed_settings/20-06330_HIV_update_eBook.pdf	▨	▨		

	HIV, Viral Hepatitis and STI	**TB**	**Health Strengthening**	**Health service quality**
One Impact (2021). Monitoring and Evaluation Plan. https://stoptbpartnershiponeimpact.org/resources/M&E/M&E/STP%20CLM%20OneImpact%20M&E%20Plan.pdf		▨		
UNODC (2019). HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs. Technical Guide. https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/19-04568_HIV_Prevention_Guide_ebook.pdf	▨	▨		
TB Data Impact Assessment and Communications Hub (2021). Navigating Tuberculosis Indicators. https://www.tbdiah.org/wp-content/uploads/2021/10/Navigating-TBIndicators-A-Guide-for-TB-Programs-MS-21-197-TB_508_Final.pdf		▨		
PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide. MER 2.0 (Version 2.6) September 2021. https://www.state.gov/wp-content/uploads/2021/09/FY22-MER-2.6-Indicator-Reference-Guide.pdf	▨	▨	▨	
Global Fund for HIV, TB and Malaria (2020). Resilient and Sustainable Systems for Health Indicator Guidance Sheet. https://www.theglobalfund.org/media/10077/me_indicatorguidancesheets-annexa-rssh_sheet_en.xlsx			▨	
WHO, Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. https://apps.who.int/iris/bitstream/handle/10665/352205/9789240044210-eng.pdf?sequence=1&isAllowed=y			▨	▨
WHO, OECD, The World Bank. Delivering quality health services: a global imperative for universal health coverage. 2018. https://apps.who.int/iris/rest/bitstreams/1136599/retrieve				▨

Annex 3. Tentative blocks of a Research Protocol[66]

Aims	The "what" of the study, including the broad aim (what are you going to do) broken down into measurable objectives.
Background	The "why": why it is an interesting question, important question or a policy-relevant question.
Methods	The "how": a detailed description of the data you will collect and how, including sample size, if appropriate, issues of access, data collection, management and storage, analysis, etc.
Ethical issues	Particular ethical issues of your study, including whether you need and have ethical approval, and how you will address them.
Resources	Costing for staff, travel, resources and materials.
Timescale	This should include important milestones, such as commencement and completion of fieldwork, draft report completion, etc.
Dissemination and outputs	How will you inform others, including participants, of the findings? What other outputs are you expecting?

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[66] Green, J., Thorogood N. (2004), Op.cit.

Annex 4. Main mistakes in writing survey questions

	Things to Avoid	Bad Questions	A Possible Improvement
1	Jargon, slang, abbreviations	Did you drown in brew until you were totally blasted last night?	Last night, about how much beer did you drink?
2	Vagueness	Do you eat out often?	In a typical week, about how many meals do you eat away from home, at a restaurant, cafeteria, or other eating establishment?
3	Emotional language	“The respected Grace Commission documents that a staggering $350 BILLION of our tax dollars are being completely wasted through poor procurement practices, bad management, sloppy bookkeeping, ‘defective’ contract management, personnel abuses and other wasteful practices. Is cutting pork barrel spending and eliminating government waste a top priority for you?”	How important is it to you that Congress adopt measures to reduce government waste? Very Important, Somewhat Important, Neither Important nor Unimportant, Somewhat Unimportant, Not Important At All.
4	Prestige bias		
5	Double-barreled questions	Do you support or oppose raising social security benefits and increased spending for the military?	Do you support or oppose raising social security benefits? Do you support or oppose increasing spending on the military?
6	Beliefs as real	Do you think more educated people smoke less?	What is your education level? Do you smoke cigarettes?
7	Leading questions	Did you do your patriotic duty and vote in the last election for mayor?	Did you vote in last month’s mayoral election?
8	Issues beyond respondent capabilities	Two years ago, how many hours did you watch TV every month?	In the past two weeks, about how many hours do you think you watched TV on a typical day?
9	False premises	When did you stop beating your girl/ boyfriend?	Have you ever slapped, punched, or hit your girl/boyfriend?
10	Distant future intentions	After you graduate from college, get a job, and are settled, will you invest a lot of money in the stock market?	Do you have definite plans to put some money into the stock market within the coming two months?
11	Double negatives	Do you disagree with those who do not want to build a new city swimming pool?	There is a proposal to build a new city swimming pool. Do you agree or disagree with the proposal?
12	Unbalanced responses	Did you find the service at our hotel to be Outstanding, Excellent, Superior, or Good?	Please rate the service at our hotel: Outstanding, Very Good, Adequate, or Poor.

Source: W. Lawrence Neuman (2014). Basics of Social Research: Qualitative & Quantitative Approaches. Pearson, Third Edition. ISBN-13: 978-0205762613.

Annex 5. Example of informed consent

You will not receive any direct benefit from taking part in this study; however, we hope that the information you share with us will help to ________

- An important note on confidentiality - although we plan to use your feedback and shared experiences to TBD, we will not attribute any comments or experiences that you share with us directly to you or your organisation. We'll be taking notes, but they will be transcribed anonymously and will be used to shape the development of our recommendations.
- We'd also like to record this meeting, just to help us internally with our notes; the recording will not be shared with anyone outside of the ___ team and it will be deleted once we complete our analyses. Additionally, again, our report will not contain any information that links your name or organisation to specific statements. Does anyone have any objections to us recording this meeting? If not, I will begin recording now.

Does anyone have any questions so far?

I will now take a minute to go around the room and ask each of you to confirm that you understand this information and agree to participate in the focus group fully under the conditions that I described. When I say your name, please unmute yourself and say "I consent" if you agree.

Annex 6. Closed versus Open Questions

Advantages	**Disadvantages**
CLOSED	
– It is easier and quicker for respondents to answer. – The answers of different respondents are easier to compare. – Answers are easier to code and statistically analyse. – The response choices can clarify question meaning for respondents. – Respondents are more likely to answer about sensitive topics. – There are fewer irrelevant or confused answers to questions. – Less articulate or less literate respondents are not at a disadvantage. – Replication is easier.	– They can suggest ideas that the respondent would not otherwise consider. – Respondents with no opinion or no knowledge can answer anyway. – Respondents can be frustrated because their desired answer is not a choice. – It is confusing if many (e.g. 20) response choices are offered. – Misinterpretation of a question can go unnoticed. – Distinctions between respondent answers may be blurred. – Clerical mistakes or marking the wrong response is possible. – They force respondents to give simplistic responses to complex issues. – They force people to make choices that they would not otherwise make in the real world.
OPEN	
– They permit an unlimited number of possible answers. – Respondents can answer in detail and can qualify and clarify responses. – Unanticipated findings can be discovered. – They permit adequate answers to complex issues. – They permit creativity, self-expression and richness of detail. – They reveal a respondent’s logic, thinking process and frame of reference.	– Different respondents give different degrees of detail in answers. – Responses may be irrelevant or buried in useless detail. – Comparisons and statistical analysis become very difficult. – Coding responses is difficult. – Articulate and highly literate respondents have an advantage. – Questions may be too general for respondents who lose direction. – Responses are written verbatim, which is difficult for interviewers. – A greater amount of respondent time, thought and effort is necessary. – Respondents can be intimidated by questions. – Answers take up a lot of space in the questionnaire.

Source: W. Lawrence Neuman (2014). Basics of Social Research: Qualitative & Quantitative Approaches. Pearson, Third Edition. ISBN-13: 978-0205762613.

Annex 7. Types of Samples

RANDOM SAMPLE	
Type of Sample	**Technique**
Simple Random	Select cases out of the sample frame by using a purely random process (such as a random-number table or computer programme)
Systematic	Starting point of selection cases is random within a sample frame, but then every Nth case is selected
Stratified	Sample in which the sampling frame is divided into two or more strata (sub-populations) from which participants are randomly selected
Cluster	Create a sampling frame for larger cluster units, draw a random sample of the cluster units, create a sampling frame for cases within each selected cluster unit, then draw a random sample of cases, and so forth.
NON-RANDOM SAMPLE	
Type of Sample	**Technique**
Convenience	Get any cases in any manner that is convenient
Quota	Get a preset number of cases in each of several predetermined categories that will reflect the diversity of the population using haphazard methods
Purposive	Get all possible cases that fit a particular criteria using various methods
Snowball	Get cases using referrals from one or a few cases, and then referrals from those cases, and so forth
Deviant Case	Get cases that substantially differ from the dominant pattern (a special type of purposive sample)
Sequential	Get cases until there is no additional information or new characteristics (often used with other sampling methods)

Source: W. Lawrence Neuman (2014). Basics of Social Research: Qualitative & Quantitative Approaches. Pearson, Third Edition. ISBN-13: 978-0205762613.

Annex 8. Tips to Increase Mail Questionnaire Response

1. Address the questionnaire to a specific person, not “Respondent____,” and send it first class.
2. Include a carefully written, dated cover letter on letterhead stationery. In it, request respondent cooperation, guarantee confidentiality, explain the purpose of the survey, and give the researcher’s name and phone number.
3. Always include a postage-paid, addressed return envelope.
4. The questionnaire should have a neat, attractive layout and reasonable page length.
5. The questionnaire should be professionally printed and easy to read, with clear instructions.
6. Send two follow-up reminder letters to those not responding. The first should arrive about one week after sending the questionnaire, the second a week later. Gently ask for cooperation again and offer to send another questionnaire.
7. Do not send questionnaires during major holiday periods.
8. Do not put questions on the back page. Instead, leave a blank space and ask the respondent for general comments.
9. Sponsors that are local and are seen as legitimate (such as government agencies, universities, large firms, etc.) get a better response.
10. Include a small monetary inducement ($1) if possible (mobile telephone top-up incentive as an option).

Source: W. Lawrence Neuman (2014). Basics of Social Research: Qualitative & Quantitative Approaches. Pearson, Third Edition. ISBN-13: 978-0205762613.

Annex 9. Example of the Focus Group Discussion/Interview Guideline

A. OPENING SCRIPT

(Timing – TBD)

Welcome and Intros:

<Instruction to the facilitator: Thank the participant for their time and introduce yourself>

Hello! Thank you very much for joining us today.

My name is ___ and I am a part of the ___ team at the ___. I would like to thank you for your time to take part in this focus group discussion/interview.

< If aplicable: Display slide summarising the agenda>

Note: Send slides in advance of the meetings!

AGENDA

0:00-0:10 – Welcome, Quick Introductions and Opening Script.

0:10-1:10 – Focus group discussion: Facilitated Discussion on_____.

1:10-1:20 – Closing Script.

Purpose and methodology:

<Explain to participants that>:

- *<For online FGD/interview>* Before we begin, I would like to ask you to turn on your cameras and ensure your name is correctly displayed on the screen. Let's take a few seconds to do that…
- I will now explain the methodology of the focus group discussion/interview. You are being invited to take part in a project which has the objective of TBD. The purpose of this meeting is to hear from (each of) you on how to TBD.
- This focus group discussion/interview will last for about TBD.
- I will ask general questions about your experience to facilitate the conversation. The questions are very general and require no specific knowledge, only your experience and thoughts. It is important for us to hear about the different experiences, concerns and suggestions of different people and to learn of your opinion with regards to TBD. Your views may well differ from others in the group *<for group interview and FGDs>.* Remember, there are no right or wrong answers.
- *<for group interview and FGDs>* Each of you is free to express your own opinion. You do not have to speak in any particular order, but only one person should speak at a time.
- If there are any questions or discussions that you do not feel comfortable answering or participating in, you should not feel obliged to do so. However, please try to be as involved as possible and answer as accurately and honestly as possible.
- While we aim to help TBD, we cannot guarantee that we will be able to address all of the needs of participants that may be identified during this study.
- Please keep in mind that the person who will be moderating your discussion/conducting the interview is here as a neutral facilitator/interviewer. As time is limited, your

facilitator/interviewer may sometimes encourage you to move to a new question to keep the discussion on schedule.

Informed consent:

- You will not receive any direct benefit from taking part in this study; however, we hope that the information you share with us will help to TBD.
- An important note on confidentiality - although we plan to use your feedback and shared experiences to TBD, we will not attribute any comments or experiences that you share with us directly to you or your organisation. We'll be taking notes, but they will be transcribed anonymously and will be used to shape the development of our recommendations.
- We'd also like to record this meeting, just to help us internally with our notes; the recording will not be shared with anyone outside of the ___ team and it will be deleted once we complete our analyses. Additionally, again, our report will not contain any information that links your name or organisation to specific statements. Does anyone have any objections to us recording this meeting? If not, I will begin recording now.

Does anyone have any questions so far?

I will now take a minute to go around the room and ask each of you to confirm that you understand this information and agree to participate in the focus group/interview fully under the conditions I have described. When I say your name, please (unmute yourself and) say "I consent" if you agree.

B. QUESTIONS

Ice-breaker: Now I would like everyone to introduce themselves. Please give your name, location and your role at your organisation. Let's start with ___.

(Timing – TBD)

<For online FGD and interviews, you can display a slide with questions>

Questions: Now that we have each introduced ourselves, I'll ask a few questions that I hope each of you will be able to answer and share your thoughts or opinions on…

Q1. What is the one thing that went well?

Probes: Why do you think so? Why so? Can you give an example? Can you explain to me what you mean when you say ….? Could you please tell me more about… I'm not quite sure I understood… Could you tell me more about your thinking on that? You mentioned…. Could you tell me more about that? Can you give me more details? Am I getting you right when you say… you mean…? Can you tell me more…Can you elaborate on… What makes you feel that way? What are some of your reasons for liking it? You just told me about…. I'd also like to know about… What else? Something else?

Q2. Name one area for improvement?

Probes: Why do you think so? Why so? Can you give an example? Can you explain to me what do you mean when you say ….? Could you please tell me more about… I'm not quite sure I understood … Could you tell me more about your thinking on that? You mentioned…. Could you tell me more about that? Can you give me more details? Am I getting you right when you say… you mean…? Can you tell me more… Can you elaborate on … What makes you feel that way? What are some of your reasons for liking it? You just told me about…. I'd also like to know about… What else? Something else?

Q3. What would be your one key message to the team?

Probes: Why do you think so? Why so? Can you give an example? Can you explain to me what do you mean when you say ….? Could you please tell me more about… I'm not quite sure I understood … Could you tell me more about your thinking on that? You mentioned…. Could you tell me more about that? Can you give me more details? Am I getting you right when you say… you mean…? Can you tell me more… Can you elaborate on … What makes you feel that way? What are some of your reasons for liking it? You just told me about…. I'd also like to know about… What else? Something else?

C. CLOSING SCRIPT

Thank You: Unfortunately, that's all the time we have for today! Thank you for your participation in this study and your feedback! It's very valuable to us.

Confidentiality: Again, as a reminder, we will use your feedback and comments anonymously to strengthen our report, but we will not be attributing any of your comments directly to you or your organisation.

Next Steps: If you have any additional questions or comments that we didn't have time to discuss today, please email me! We can communicate over email or set up another time for us to continue a discussion. We will also share the final report with you and the wider partner/counterpart community in TBD.

Bye: Have a great day! Thank you again!

Annex 10. Example of an Invitation

Dear ____________________

You are being invited to take part in _________.

This **research project includes** _________. It is important for us to hear about the different experiences in the provision of __________services, as well as to collect concerns and suggestions on how to improve such approaches.

Please refer to the enclosed information page for more details about the project.

With this email, you are invited to participate in the _________. This will take about _________ **minutes**. All information will be kept **confidential** within this study. You will not receive any direct benefit from taking part in this study. However, we hope that the information that you share with us will provide valuable information to different organisations and networks on how to introduce _________.

Please, take into account that this _________will be conducted _________ (location, time, map/link).

Please feel free to contact us if you wish to receive more information about this _________.

Thank you for your time!

With best regards,

____
Email address:

Annex 11 Quantitative versus Qualitative methods

Usually, two types of data collection methods are used for CLM and research:

- Quantitative (QN)
- Qualitative (QL)

Both can be utilised solely or as a combination (mixed methods). The combination of methods allows the collection of data which can provide a full, more comprehensive picture of what is happening with the monitoring issues[67].

Quantitative methods (associated with numbers) seek answers to the questions "how many", "how much", or "how long". They are used if your monitoring question focuses on numbers which may specify the volume and duration of the services/cases:

- How many people received services (HIV test, ARV, etc.)?
- What % of clients do not feel safe?
- What % of clients are not satisfied with the number of syringes they receive?
- How many facilities provide the service?
- How long is the gap between HIV diagnostics and HIV treatment?
- How long does the service last?
- How long does it take for the clients to reach the facility?
- For how long did clients not have access to the services?[68]

In general, quantitative methods use limited quantitative indicators and relevant numerical data which is collected in a specific way (such as through surveys or experiments) to generate reliable[69] results which can be applied for an entire community[70].

Qualitative methods (associated with words and text) seek answers to the questions "what", "how" and "why", of a certain event, aiming to describe a new event, understand perceptions, examine, unpack, uncover – and generate an hypothesis. Qualitative research tends to use non-numerical, language data (written or oral); data is collected through observations or interviews to describe, understand and examine a phenomenon[71]. Your monitoring questions could be formulated as follows:

- What was the experience of the community members?
- Which factors affect the monitored question and causes challenges?
- Why do we experience the identified challenges?
- What is the impact of this issue on community members?

For example, quantitative research can estimate how many patients received reactive test results during a certain period in a certain city among a certain population, and later we may decide to conduct interviews and examine the experience of patients in accessing testing, or how they perceived the quality of the provided services. Please see the practical example below.

At the same time, if we deal with a new emerging issue interconnected with the monitored issue, we might apply qualitative methods first to understand the nature of the new phenomenon before collecting quantitative information about it. For example, if a new drug has appeared, before running the survey we might need to conduct qualitative interviews and understand how this new drug is used, prepared and distributed as this information will allow us to understand the risks faced by people who use this new drug and ask the "right", meaningful, questions that allow us to capture and, then, evaluate these risks through quantitative research.

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[67] Chase M. (2022), Op.cit.

[68] Chase M. (2022), Op.cit.

[69] Reliable result – when the same result can be consistently achieved by using the same methods under the same circumstances, the measurement.

[70] Seale C. (ed.) (2001). Researching Society and Culture. SAGE Publications Ltd., ISBN 07619 52764.

[71] Green, J., Thorogood N. (2004), Op.cit.

Overall, when talking about QL versus QN methods, think of an iceberg example: quantitative methods allow you to have the BREADTH of the iceberg (such as how many icebergs there are in a certain area during a certain period) while qualitative can show you the part of the same iceberg covered under the DEEP waters (such as how big is the underwater part of the iceberg).

Example of the difference between Quantitative and Qualitative methods

Our monitoring question: On access by people who use drugs to HIV testing and the existing barriers faced by the community to this service.

Quantitative methods:

Measured indicator: Number and % of people who use drugs being tested for HIV and received the result for the last 6 months.

Sources of data: the data can be received through official statistics, impersonal e-health registers, surveys.

Information collected through quantitative methods allows an estimate of how many community members were tested for HIV and received their test results for the last 6 months in city X. This gives an understanding about the BREADTH of the issue.

Qualitative methods:

Purpose: to examine the experience of patients in accessing testing and to identify patient perceptions towards the main barriers to this service for people who use drugs.

Questions to be addressed:

- What was the experience of people who use drugs with conducting HIV tests?
- What are main existing barriers for people who use drugs to access a HIV test?
- What went well? Why so? Can you give me an example?
- What did not go well? Why? Can you give me an example?
- Why do you experience the identified challenges?

Sources of data: interviews, focus groups.

This gives you an understanding about the DEPTH of the issue.

Quantitative: Breadth

Qualitative: Depth

Characteristics of QN and QL methods

	QN	QL
Concept	Fixed and measurable reality "Objective in its subjectivity"	Dynamic and negotiable reality "Subjective in its objectivity"
Objective	Measure, assess, compare – test hypotheses ***(breadth)***	Understand a new phenomenon, uncover, unpack – generate hypotheses ***(depth)***
Typical RQ	HOW MANY?	WHY? & HOW?
Typical Sample	Large: Random versus non-random	Small: Purposeful
Data collection	Surveys, experiments, clinical data examination	Focus groups, interviews, observations

	QN	QL
Questions used	Indicators, closed questions[72], scales	Open-ended questions, non-leading[73]
Data analysis	Statistical analysis, modelling	Iterative interpretation[74] (colour coding, deductive versus inductive coding, etc.)
Results	Generalisable and/or statistically significant[75]	Context and time specific (saturation of data[76])

Sample size

Quantitative methods

To ensure reliability of the CLM and research results, some quantitative data collection methods require a properly calculated sample size which is statistically significant and represents the population/community/target audience of the CLM and research. There are many different electronic calculators available in the internet resources (Creative Research Systems, Calculator.net, Survey Monkey, Raosoft). However, we strongly recommend involving professionals (research technical advisers) to calculate and properly distribute the sample size. Data collection sites and respondents are to be thoroughly selected based on the focus, scope and target audience of the CLM. Data collection sites could be public or private; medical facilities, official institutions or community-based service points or organisations; national, regional, urban or rural.

Qualitative methods

In qualitative research, you do not need to collect data from everyone in a community in order to get true and meaningful findings. So, a sample (that is, a subset) of a population is selected for any given research. It is determined on the basis of the research objectives and the characteristics of the study population (such as size and diversity). There are different sampling methods that can be used, for example, purposive sampling, quota sampling, snowball sampling, etc. (you can read more about sample methodologies here[77]). In qualitative research, sampling is done until saturation is reached in order to assure the high quality of results. Thus, saturation is reached when no new data can be collected, meaning that with each new interview or focus group discussion conducted, you do not receive any new information and only hear responses that you have heard before. You can only estimate the number of people needed to be interviewed, yet the collected data will determine the final sample size of the study. Note that in some cases, you might not reach saturation as it is a resource- and time-intense process.

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[72] Closed questions – require answers like YES/NO/DO NOT KNOW or/and give to a respondent a limited amount of response options to choose from.

[73] Open-ended are ones that require more than one-word answers (i.e. YES/NO) or choosing among a few options. Non-leading questions that do not contain or imply certain answers. Usually, they contain evaluation, or judgment brought by the interviewer and may reflect his/her/their perceptions and has nothing to do with the respondent´s perceptions. Open-ended, non-leading question: Why do you think so? Open-ended, leading question: Do you think it is correct/effective?

[74] The iterative process of data analysis is when we constantly go back and forth. As we progress with analysis, we revisit previously analysed and coded data and recode them with the new emerging codes. The process should be repetitive, systematic and recursive.

[75] Generalizable QN results mean that they can be applied (generalised) to the whole population and not only to a number of selected participants. Statistical significance gives us an understanding of whether our results are due to chance or to some factor of interest.

[76] In qualitative research, sampling is done until saturation is reached in order to assure high quality of results. Thus, saturation is reached when no new data can be collected, meaning with each new interview or FGD conducted we do not receive any new information and only hear responses we heard before. We can only estimate N of people needed to be interviewed, yet the collected data will determine the final sample of the study. Note that in some cases, we might not reach saturation as it is a resource- and time-intensive process.

[77] W. Lawrence Neuman (2014), Op.cit.

Annex 12 Ethics

Ethical practice is different in different contexts and across different disciplines. It is, then, important to know the local rules and act accordingly. Note that some Ethics Committees may request CVs of all team members as an attachment to the research protocol. Consult the Ethics Committee before development of the research protocol so that you do not waste your time on a document which does not meet the required format or does not contain all of the required information. Also, consider the timing: typically, ethical clearance is a lengthy process and you may be asked to give additional information and/or clarify something and/or change the design to meet ethical standards and some Ethics Committees have predetermined meeting dates (such as four times per year). Ensure that you are familiar with all of the rules and the calendar of your Ethics Committee. In most cases, you will be asked to pay a fee (i.e. you should receive a formal invoice; it should not be paid to a person as an out-of-pocket payment).

Although it is impossible, and maybe undesirable, to suggest a concrete structure for the research protocol, we list down a number of issues to be considered by any research protocol. Also, you can find tentative blocks for a Research Protocol at Annex 3.

Informed consent (Annex 5) is the principal that participants should not be coerced, or persuaded, or included into any research project against their own will, but that their participation is voluntary and is based on a full understanding of the implications of their participation, including: data collection, data management and storage, data analysis and reporting of the results.

Also, note that in many contexts, informed consent cannot be obtained from minors; check your local legislation. If you run a self-administrated survey, ensure you administer informed consent through an interviewer or trained personnel. As mentioned previously, participation in a study should be **Voluntary.** Take care that informed consent is printed and signed by a participant or recorded during the interview. These documents, or parts of the recording, should be stored for a while, even after you publish the report, as there might be questions raised regarding the voluntary nature of participation.

Principals of **confidentiality or anonymity** are fundamental for any research project[78]. It implies that all the collected data is treated so that it is impossible to connect it with any participant, her/his/their position/role or organisation for whom s/he/they works (confidentiality) or no personal data is collected (anonymity), including names, family names, address, phone number, position, the organisation where a participant works, etc. For example, if a research project upholds to the principals of anonymity, participants may provide any names they like while being interviewed.

There should be a **possibility to withdraw consent and/or not to answer some questions without giving any reason.** Remember that involvement in the research can have emotional consequences, particularly when we ask a participant to report on sensitive topics (such as ill health, emotional trauma, sexual behaviour, or other issues normally considered private). This may trigger unpleasant memories and lead to unwanted stressful conditions. Ensure that the research design allows a reflection of concerns of the participants rather than pursuing the researcher´s perspective as well as to provide an opportunity to stop the survey or interview. Trained interviewers who are familiar with how to create an empathic, safe and caring atmosphere can assist with the overall research design planning (such as location, questionnaire/guide, research agenda, etc.). If you run a self-administrated survey, ensure that participants are aware of the research project rules, including the withdrawal of consent. A social power imbalance between an interviewer and interviewee should also be addressed by the research design; a trained researcher might come up with practical tips on how to diminish the role of a social power imbalance.

We also should take into consideration if the research project involves interventions that appear to impact directly upon the lives of the participants. If so, the research proposal should clearly weigh the potential risks and list the benefits. Remember the fundamental principal of **Do No Harm.**

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[78] The Helsinki Declaration notes that, “Every precaution should be taken to respect the privacy of the subject and the confidentiality of the patient´s information.” (WMA General Assembly (2000) World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects)

Finally, modest **reimbursement** might be provided to compensate participants' time and transport costs. We do not recommend paying participants in cash for their participation as there is evidence showing how such an approach might skew sampling and research results, as well make it difficult to run research projects in future without such payments or with lesser amounts paid.

Annex 13 Quality Assurance

If you have decided on your CLM and research questions, you should think about how to incorporate quality assurance into your study design. We suggest considering key core components: feasibility and appropriateness of the study, issues of validity and reliability, tools and data validation, and the qualifications of the personnel.

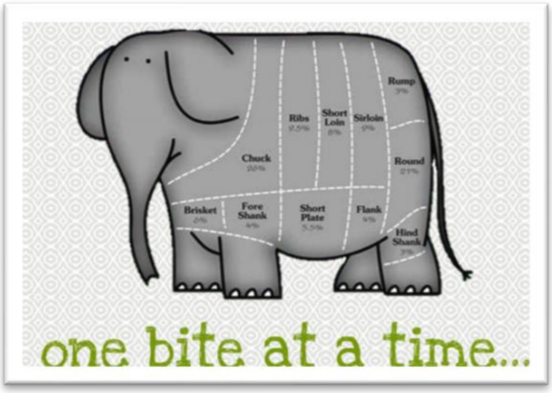
Note that quality control and quality checks should be part of the research protocol with deadlines and responsible people to perform these tasks.

Appropriateness and Feasibility

Probably one of the first things to consider when you are designing your research project is how appropriate (relevance) and feasible it is.

You have to distance yourself, be dispatched from your project, and take an outsider's standpoint, who sees it for the first time ever. Think of this project as appropriate now; if it is relevant; will the results be able to change something, uncover something new; and what will be the impact? Is it answering something that is currently a "burning question"? Is there a window of opportunity to use collected evidence and advocate for modification of the current law? Is it a pending challenge for some populations? While fundamental research might consider a broad number of human problems, in our case we are interested in more practical issues. Note that sometimes more funding might be available for research topics requiring quick action.

Then, consider the feasibility of the study you envision: the resources that you have; think about the time needed to run the project; accessibility of funding; accessibility of research participants, etc. Can your research question be answered with the available resources/in the time allocated? Do you have the needed skills and capacities? Are technical resources there? Be pragmatic; if you have a BIG research aim, put it in pieces. Think about your BIG aim (big research question) as if it is a BIG elephant that you need to eat. Do not try to eat the whole elephant in one take; plan how you can eat it in small pieces. This way you will enjoy your meal and have a sufficient amount of food per dinner for a full year. All-in-all, research projects that are too ambitious might end up with poor results, burnout of the team, and disappointed funders who were promised something that was not achieved.



Validity and reliability

It is also important to guarantee that the research is valid and reliable.

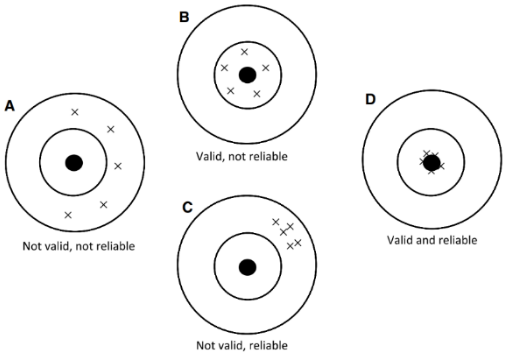
The validity of a research study refers to it being correct or true or how well the research findings and methods capture the truth among the study participants and represent the true findings among similar individuals outside of the study. In other words, this concept of validity can be defined as how well an instrument/methodology/research project measures what it is intended to measure.

The second measure of quality is reliability, or the extent to which a research instrument consistently has the same results if it is used in the same situation on repeated occasions. It refers to the consistency and accuracy ("consistent accuracy") of the instrument/methodology/research project.

For example, think of using a thermometer to weigh bananas: you can apply and reapply it, but it will only be able to measure the temperature and not the weight; so you will receive a reliable, but not a valid, measurement for the weight of bananas. You will not be able to capture the needed measure with the wrong instrument. Or imagine that a weight-measuring scale is wrong by 4kg's (it deducts 4kg's of the actual weight). So, we can say that it is reliable because the scale displays the same weight every time that we measure the bananas. Yet, the scale is not valid because it does not display the actual weight of the item.

We also might consider using a proper instrument - a thermometer with a correct temperature measurement scale to measure the current air temperature in the room (valid), yet you have applied it five times and each time you got a different result (unreliable).

Figure 5.1. Validity versus reliability[79]



Quality control checks and validations

The research project should have a timeline which includes quality controls and validation checkpoints. You might consider the following milestones:

- ***Test your tools:*** after your tool is developed, test it with a couple of respondents from the study population that you aim to focus on. We recommend to do this before applying for ethical clearance as you may need to completely change the questions, meaning that you will end up with a new tool which you will need to send again to the Ethics Committee. It is not only important to ask proper questions using proper language which is spoken by the population that you focus on, but it is also crucial to ask meaningful questions (such as applying an appropriate measurement to measure a phenomenon). Thus, your participants can serve not only as a source of data, but also as co-researchers who can assist with question formulation and the research agenda. Moreover, if you create the feeling of ownership, where your participants do not feel themselves as "studied passive objects" but rather as active members of the research team whose voice is heard and incorporated into the research agenda, it will be later translated into the research results, helping to disseminate and introduce them. As has been demonstrated, people tend to apply the knowledge if they own it. All-in-all, your tool should be understandable (i.e. avoid terms, use plain language) and valid (it should measure what you want to measure).

- ***Control data collection:*** ensure that you have midpoint data collection checks, meaning that you check not only N of participants surveyed or interviewed, but also the quality of the collected data. For example, you might be interested in how many respondents were reached and how many agreed/rejected to participate (response rate); on how many missed questions you have in the questionnaires (missed data); or how many questions participants rejected in a semi-structured interview, etc. It is better to detect and deal with these

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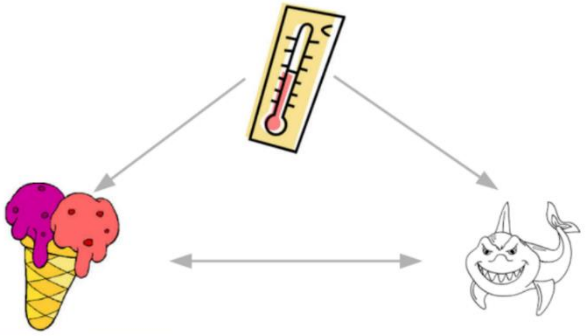
[79] Erkenntnis, I. (2021). Developing Dark Pessimism Towards the Justificatory Role of Introspective Reports. Springer, 86, p:1319–1344. https://doi.org/10.1007/s10670-019-00156-9.

challenges during the data collection period as there are very few things that we can do after the field phase of the research project is completed.

- ***Data management and analysis validation:*** you need to validate how well collected qualitative or quantitative data is managed and prepared for analysis. For example, you can randomly compare parts of audio recordings and transcripts to check if they are fully and accurately being transcribed. Also, you can compare several paper-based survey questionnaires and the dataset being created. We also recommend checking how data is stored and managed in terms of confidentiality and anonymity. To validate analysis, you may consider having several researchers involved who can check and review each other's results or work closely to guarantee the high quality of the results. If not, you can end-up as an infamous study that found a strong correlation between ice cream sales and the number of shark attacks for a number of beaches that were sampled, concluding that increasing ice cream sales causes more shark attacks (sharks like to eat people that are full of ice cream). In fact, it was due to the fact that people come to beaches only in summer when it is hot and when they eat ice cream; to control for this, there will be no correlation (increasing sale of ice cream is correlated with the summer period as well as the summer period being correlated with the increased number of people visiting beaches, and increased visits to beaches is correlated with an increase in the number of people swimming and being attacked).

Figure X. Simpson´s paradox[80]



- ***Bring results back to your participants:*** It is important to bring study results to research participants before publishing the report. Check with them if your results sound meaningful, collect feedback and incorporate it in the report. You can conduct a FGD to do that.

  Finally, a blind peer review process is another way to validate your analysis and research results; thus, you might consider publishing your results in a scientific journal.

Qualified personnel

Having qualified personnel is important not only for running surveys or FGDs effectively, but also to develop a good quality research project. We recommend involving needed researchers and/or other personnel at the stage of research concept development and articulating it as the Research Protocol.

Moreover, we suggest considering introducing responsibilities attached to the required quality control checks and validations (i.e. tools testing, data collection validation, transcript validation, etc.).

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[80] Vialaneix, N., Laguerre, S. (2022). Introductory statistics. https://www.nathalievialaneix.eu/teaching/biostat1/index.html (accessed 19 November 2022).

Annex 14 Non-disclosure agreement

City, country: ____

Organisation: ____

First name, family name of the team member: _________________________

Team role/position: _______________________________________

The information you will access in this project should be treated as confidential (anonymous) and should not be disclosed or passed to third parties.

Please read your responsibilities in this project, make sure you understand each of them, ask questions and, if you agree, sign the form. By signing this form, you agree to keep all information accessed by this project confidential (anonymous).

№	Responsibilities	Comment
1	I will not try to establish the identity of CLM participants	
2	I understand all aspects of data security and privacy and will comply with them during the implementation of the project	
3	I will not share data with any third parties other than those working on the same project who have signed a copy of this form	
4	I understand that I am required to ensure the safe storage of all data (paper forms or electronic databases) accessible to me	

Signature: ____

DD/MM/YY: ____

Failure to comply with these rules can result in the denial of access to project data, the change or termination of your work relations within the Project, and the imposition of any appropriate sanctions, including those determined by local law.

Annex 15 Diary template: example

Date:_____

Name of Healthcare institution visited:___________

№	**Questions**	**Response**
Qualitative data (examples)		
1	Was it easy to access this service?	
2	What service have you received?	
3	What went well during the visit (what you liked)?	
4	What did not go well during the visit? (what you did not like)? How can it be improved?	
5	How much time did it take? Was there any waiting time, queues?	
6	How were you treated by the healthcare provider?	
7	Were you asked to pay for anything during the visit? If yes, indicate what?	
8	Did you receive full and comprehensive information, service, including medication?	
9	Please describe your feelings and emotions when receiving services.	
Comments, observations:		
Quantitative data (examples)		
№	**Questions**	**Response**
1	Medical record data e.g. blood pressure, blood test analysis, etc.	
2	Costs: travel cost, service cost, out-of-pocket payment, medication cost	
3	Waiting time (minutes)	
4	Likert scale For example: Please select one response which best describes your experience: Service quality was good: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree. I received responses to all my questions: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree.	

Annex 16 Adverse event definitions

Adverse event: Any incident that results in harm to the client or others because of their participation in HIV services.

Harm: Any intended or unintended cause of physical, economic, emotional, or psychosocial injury or hurt from one person to another, a person to themselves, or an institution to a person, occurring before, during, or after HIV services.

Adverse event related to index testing: Any incident that results in harm to the client or others as a result of their participation in index testing services.

Illustrative severe adverse events include:

1. Threats of physical, sexual, or emotional harm to the index client, their partner(s), or family members, or to the index testing provider;
2. Occurrences of physical, sexual, or emotional harm to the index client, their sexual or drug-injecting partner(s), or family members, or the index testing provider;
3. Threats or occurrences of economic harm (such as loss of employment or income) to the index client, their partner(s), or family members;
4. Withholding HIV treatment or other services from the person offered index testing, their partners, or family members;
5. Forced or unauthorised disclosure of client's or contact's name or personal information;
6. Abandonment or forced removal of children less than 19 years old from the home.

Illustrative serious adverse events include:

1. Contacting partners without obtaining consent for participation in index testing and/or for notifying partners;
2. Stigma perpetrated by health site staff (such as intentionally prolonging clients' wait times, discriminatory behaviour) or criminalisation (such as sharing personal information with the criminal justice system about a member of a key population and/or person living with HIV who is seeking care).

   While intimate partner violence (IPV) and other forms of violence may have adverse events (i.e. they can occur because of one's participation in HIV services), they may also occur for other reasons. Having a robust adverse event prevention and response (AEPR) system in place allows facilities or sites to respond to IPV and other forms of violence, regardless of their cause, appropriately. No one who experiences violence should be denied services because the violence was not caused by participation in an HIV programme.

Source: U.S. President's Plan for AIDS Relief. (2020) Guidance for implementing safe and ethical index testing services. Washington (DC); PEPFAR. https://www.pepfarsolutions.org/resourcesandtools-2/2020/7/10/pepfar-guidance-on-implementing-safe-andethical-index-testing-services?rq=index%20testing (accessed 19 November 2022).

Annex 17 CLM tools

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
1.	Community scorecards	Approachability of the service	• Is there information available on who can utilise social or healthcare services, and how? • Is it clear and understandable? • Is it free/publicly available?	Community scorecard is a participatory tool which is used routinely by both sides - community members and service providers - for assessing, planning, monitoring and evaluating HIV and other health and social services aimed at improving service delivery. The scorecard collects information that can be used by service providers to improve healthcare and social services in an informed manner. It allows a community to systematically share collective feedback directly to their catchment health and social service providers in a transparent and structured manner; establish a participatory dialogue between two sides and facilitate collective agreement and action with a focus on service delivery improvement. Community members and service providers collaboratively develop criteria, or indicators, for evaluating the services which are captured in a scorecard. The collected data is reviewed along with any other data on the facility or site service quality in an action plan meeting where community members, health facility and site staff and local health administrators come together to discuss actionable steps toward service quality improvements. Improvement actions are identified together and both groups take responsibility for implementing and monitoring them. By working together, the scorecard seeks to create a collaborative and constructive dynamic between all stakeholders that results in action, accountability and positive change. **Purpose:** • to monitor and assess service quality and performance at the local or site level; • to obtain collective community feedback and deeper understanding of any issues reported by the individual client feedback system; and, • to create a platform for negotiation of the findings with service providers and	Paper-based survey (community members); face-to-face individual interviews (service providers).	• The process of facilitating data collection, dialogue and action planning process can be lengthy and complex, requires specific skills to facilitate the dialogue and analyse the collected data; • Data collected from the community is sensitive in nature and might cause difficulties in sharing and discussing it with others without customising the report by considering the sensitivity of the scorecard data; Requires additional time and resources for data aggregation, verification and clearance.	$$$$$	$$$$$	$$	See details
		Acceptability of the service	• Is service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity / confidentiality (if applicable)?							
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc.). • Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?). • Does accommodation, geographic location and opening hours of an organisation providing social or healthcare services meet needs of the community? • How long does it take to get the service? (travel time, waiting time). • Can a client access care when s/he/they need it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with exception of diagnosis motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services							

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[81] The scale is based on the principle of the Likert scale across three selected parameters of the CLM methods: complexity ($ - low to $$$$$-high), price ($ - low to $$$$$-high), and time ($ - short time period $$$$$-long time period). This rating is done to place all selected CLM methods on one scale in relation one to other.

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			among professionals / the community? • What are the barriers in social adaptation and integration with the local community? • Are there any delays in providing the needed service? • Are working hours convenient? • Is the waiting time long to receive the service? • Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? • Does the appointment mechanism meet clients' needs? • Are there any problems with supplies? • Is allocated funding sustainable? • Does the transport system and mobility level of clients allow them to utilise the existing social or healthcare services?	development of joint community/ service provider action plans to address any issues identified.						
		Affordability of the service	• Is selected service free of charge or not? • Are there any criteria to get selected for the service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?							
		Appropriateness of the service	• Are services organised to address specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on client's personal characteristics (gender, race, ethnicity), geographical		Online survey (community members); face-to-face individual interviews (service providers).	• The process of facilitating data collection, dialogue, and action planning can be lengthy and complex, requires specific skills to facilitate the dialogue and analyse the collected data;	$$$$$	$$$$	$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in the individual care management plan? • Is the referral process smooth along the care cascade? • Is a clent referred, directed, accompanied, or linked to other health or social services, ensuring continuity of care? • Is any social support provided?			• Data collected from the community is sensitive in nature and might cause difficulties in sharing and discussing it with others without customising the report by considering the sensitivity of the scorecard data; Community members have to have internet access, gadgets and be able to work with applications and Google Forms.				
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in guidelines or protocol for this service? Are they complete?							
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • The lack of access to HIV prevention, testing, treatment and care services; • The nature of the violation (what, who caused, who was affected, where, when, how, why); • What are the barriers to personal human rights protection? • Is it an isolated incident or part of a larger pattern?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Stigma, discrimination and criminalisation	• Adverse impact of criminalisation, stigma and discrimination on access by community members to health and social services; • Adverse impact of criminalisation, stigma and discrimination on the health conditions of community members (including sexual and reproductive health).							
2.	Client Feedback report	Approachability of the service	• Is there information available on who can utilise social or healthcare services, and how? • Is it clear and understandable? • Is it free/publicly available?	Client feedback report is a systematic and regular data collection and analysis of client feedback on health and social services they received. It provides actual information about end user experiences with service providers and their satisfaction with the quality of the received services. Clients are offered to provide their feedback through the survey each time they receive services. One of the modifications of a client feedback report is a Citizen Report Card which is used to systematically collect client feedback on public services from actual users of a service and assesses the performance of individual service providers by comparing it to a national or international standard or across different providers (see Chapter Citizen report card). **Purpose:** • to monitor access to, and quality of, health and social services at site level; • to identify barriers to care; • to identify service gaps; • to initiate feedback loops between clients and providers.	Paper-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Time and effort consuming in data transfer, cleaning and analysis.	$$$	$$$$$	$$	See details
		Acceptability of the service	• Is the service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity / confidentiality (if applicable)?		Tablet-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Takes provider time; potential provider bias; potential cost to procure tablets.	$$	$$	$$$	See details
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc.). • Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?). • Does accommodation, geographic location and opening hours of an organisation providing social or		Specific application based online survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Has low response rate; only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection.	$$$$$	$$	$$$$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			healthcare services meet the needs of the community? • How long does it take to get the service? (travel time, waiting time). • Can a client access care when s/he/they need it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with the exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality or religious barriers to access social or healthcare services among professionals / the community? • What are the barriers in social adaptation and integration with the local community? • Are there any delays in providing needed services? • Are working hours convenient? • Is the waiting time long to receive the service? • Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? • Does the appointment mechanism meet clients' needs? • Are there any problems with supplies? • Is allocated funding sustainable? • Does the transport system and mobility level of clients allow them to utilise existing social or healthcare services?							
		Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get selected for free service?		Telephone based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root	$$	$$$$$	$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?			causes of service quality issues; Takes staff time; extra mobile/telephone connection costs; clients must have a phone number; Requires more effort to collect and aggregate data				
		Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in the individual care management plan? • Is the referral process smooth along the care cascade? • Is a client referred, directed, accompanied, or linked to other health or social services, ensuring continuity of care? • Is there any social support provided?		Web-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; has a lower response rate; only works for clients with a smartphone or PC; requires skills to work with gadgets; needs a stable internet connection.	$$	$	$	See details
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?		Email based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues;	$	$$	$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to shelters and protection services in cases of domestic violence; • The lack of access to legal services; • The lack of access to HIV prevention, testing, treatment and care services; • Police violence; • Sentencing for drug offences with no due regard to gender-related issues; • Special vulnerability of women who use drugs to police prosecution; • The nature of the violation (what, who caused, who was affected, where, when, how, why); • What are the barriers to personal human rights protection? • Is it an isolated incident or part of a larger pattern?			Has lower response rate; only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection; requires more effort to aggregate data.				
		Stigma, discrimination and criminalisation	• Adverse impact of criminalisation, stigma and discrimination on access by community members to health and social services; • Adverse impact of criminalisation, stigma and discrimination on community members' quality of life;							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Adverse impact of criminalisation, stigma and discrimination on community members' health conditions (including sexual and reproductive health); • Adverse impact of criminalisation, stigma and discrimination on community members' integration into society as well as partner relationships; • Societal losses from criminalisation, stigma and discrimination; • Is the punishment proportionate to the crime?							
3.	Citizen report card	Approachability of the service	• Is there information available on who can utilise social or healthcare services, and how? • Is it clear and understandable? • Is it free/publicly available?	The Citizen report card is a modification of a Client feedback report and is used to systematically collect client feedback on public services from actual users of a service and assesses the performance of individual service providers by comparing with national or international standards or across different providers. Therefore, before launching data collection, you need to learn the national or international standards of providing priority services and define key milestones and service-related characteristics that you would like to explore. **Purpose:** • to monitor access to, and quality of, health and social services at site level; • to assess the performance of individual service providers in terms of their compliance with national or international standards; • to identify barriers to care; • to identify service gaps; and, • to initiate feedback loops between clients and providers.	Paper-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Time and effort consuming in data transfer, cleaning and analysis.	$$$	$$$$$	$$	See details
		Acceptability of the service	• Is the service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity/confidentiality (if applicable)?		Tablet-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Takes provider time; potential provider bias; potential cost to procure tablets.	$$	$$	$$$	See details
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by the clients? (Number of services provided, number of clients covered by the service, frequency of service usage, etc.); • Is this service ready to be provided when it is needed? (Are the required medicines,		Specific application based online survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Has low response rate; only works for clients with a smartphone or PC;	$$$$$	$$	$$$$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			equipment, personnel, commodities in place?); • Does accommodation, geographic location and opening hours of an organisation providing social or healthcare services meet the needs of the community? • How long does it take to get the service? (travel time, waiting time); • Can a client access care when s/he/they need it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with the exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality or religious barriers to accessing social or healthcare services among professionals / the community? • What are the barriers to social adaptation and integration with the local community? • Are there any delays in providing the needed service? • Are working hours convenient? • Is the waiting time long to receive the service? • Is there a client flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? • Does the appointment mechanism meet clients' needs? • Are there any problems with supplies? • Is allocated funding sustainable? • Does the transport system and mobility level of clients allow			Requires skills to work with gadgets; Needs a stable internet connection.				

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			them to utilise existing social or healthcare services?							
		Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?		Telephone based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Takes staff time; extra mobile/telephone connection costs; clients must have a phone number; Requires more effort to collect and aggregate data.	$$	$$$$$	$$	See details
		Appropriateness of the service	• Are services organised to address specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a client referred, directed, accompanied, or linked to other health or social services ensuring continuity of care? • Is any social support provided?		Web-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Has lower response rate; only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection.	$$	$	$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?		Email based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Has lower response rate; only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection; Requires more effort to aggregate data.	$	$$	$	See details
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to shelters and protection services in cases of domestic violence; • The lack of access to legal services; • The lack of access to HIV prevention, testing, treatment and care services; • Police violence; • Sentencing for drug offences with no due regard to gender-related issues; • Special vulnerability of women who use drugs to police prosecution; • The nature of the violation (what, who caused, who was affected, where, when, how, why); • What are the barriers to personal human rights protection? • Is it an isolated incident or part of a larger pattern? • State actions linked to the violation or having caused it?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Stigma, discrimination and criminalisation	• Adverse impact of criminalisation, stigma and discrimination on access by community members to health and social services; • Adverse impact of criminalisation, stigma and discrimination on community members' quality of life; • Adverse impact of criminalisation, stigma and discrimination on community members' health conditions (including sexual and reproductive health); • Adverse impact of criminalisation, stigma and discrimination on community members' integration into society as well as partner relationships; • Societal losses from criminalisation, stigma and discrimination; • Is the punishment proportionate to the crime? • What is the burden of criminalisation to the local budget, judicial system, law enforcement system, social system, etc.?							
4.	Client checklist	Approachability of the service	• Is there information available on who can utilise social or healthcare services, and how? • Is it clear and understandable? • Is it free/publicly available?	A self-reported checklist is an approach to collect data on a client's experience in receiving health and social services. Checklists are frequently used for hospital or service provider inspection by comparing the real process of service provision to the standard operating procedures (SOPs) or international standards. Checklists usually include a list of main aspects, activities and requirements which a service provider, according to SOPs and international standards of the particular service, has to fulfill to ensure a full and quality service. Clients are asked to go through and check their status (yes, no, in progress) based on their personal experience of receiving the service.	Paper-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Time and effort consuming in data transfer, cleaning and analysis.	$$$	$$$$$	$$	See details
		Acceptability of the service	• Is the service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity/confidentiality (if applicable)?		Specific application-based online survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues;	$$$	$$	$$$	See details

Community-led monitoring tools

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
				Purpose: • to monitor the quality of health and social services at site level; • to identify main deviations from the standards; • to identify service gaps; and, • to initiate feedback loops between clients and providers.		Has low response rate; only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection.				
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc.); • Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?); • Does accommodation, geographic location and opening hours of an organisation providing social or healthcare services meet the needs of the community? • How long does it take to get the service? (travel time, waiting time); • Can a client access care when s/he/they need it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with the exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality or religious barriers to access social or healthcare services among professionals/the community? • What are the barriers in social adaptation and integration with the local community? • Are there any delays in providing the needed service? • Are working hours convenient?		Web-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Has lower response rate; only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection.	$	$	$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Is the waiting time long to receive the service? • Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? • Does the appointment mechanism meet clients' needs? • Are there any problems with supplies? • Is allocated funding sustainable? • Does the transport system and mobility level of clients allow them to utilise existing social or healthcare services?							
		Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?							
		Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on the client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a client referred, directed, accompanied or linked to other health or social services, ensuring continuity of care? • Is there any social support provided?							
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?							
5.	Client Complaint and Adverse Event Report	Approachability of the service	• Is there information available on who can utilise social or healthcare services, and how? • Is it clear and understandable? • Is it free/publicly available?	A Client Complaint and Adverse Event Report is a systematic and regular collection of client complaints and incidents that result in harm to the client, rapid investigation and response. **Purpose:** To monitor, investigate, and respond to client compliance and adverse events, including by revising programme policies or re-training staff[82]. This tool can also be used to document human rights violations and then the results can be used in advocacy campaigns against human rights information. It is crucial to know international regulations so that recommendations can be able compared them local policies to identify problematic areas and then to be able to document and advocate for the needed change.	Specific application-based online survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection.	$$$	$$$	$$$	See details
		Acceptability of the service	• Is service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity/confidentiality (if applicable)?							
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered by the service, frequency of service usage, etc.). • Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?). • Does accommodation, geographic location and		Telephone (Helpline)	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Needs specially designated people and a telephone number for collecting complaints.	$	$$	$	See details

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[82] EpiC. (2021), Op.cit.

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			opening hours of an organisation providing social or healthcare services meet the needs of the community? • How long does it take to get the service? (travel time, waiting time). • Can a client access care when s/he/they need it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with the exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality or religious barriers to access social or healthcare services among professionals / the community? • What are the barriers in social adaptation and integration with the local community? • Are there any delays in providing the needed service? • Are working hours convenient? • Is the waiting time long to receive the service? • Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? • Does the appointment mechanism meet clients‘ needs? • Are there any problems with supplies? • Is allocated funding sustainable? • Does the transport system and mobility level of clients allow them to utilise existing social or healthcare services?							
		Affordability of the service	• Is the selected service free of charge or not?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?							
		Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Is the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a client referred, directed, accompanied or linked to other health or social services, ensuring continuity of care? • Are any social support services provided?		Web-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Only works for clients with a smartphone or PC; Requires skills to work with gadgets; Needs a stable internet connection.	$	$	$	See details
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?							
		Human rights violations	• Termination of parental rights and child custody;							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to shelters and protection services in cases of domestic violence; • The lack of access to legal services; • The lack of access to HIV prevention, testing, treatment and care services; • Police violence; • Sentencing for drug offences with no due regard to gender-related issues; • Special vulnerability of women who use drugs to police prosecution; • The nature of the violation (what, who caused, who was affected, where, when, how, why); • What are the barriers to personal human rights protection? • State actions linked to the violation or having caused it?							
		Stigma, discrimination and criminalisation	• Adverse impact of criminalisation, stigma and discrimination on access by community members to health and social services; • Adverse impact of criminalisation, stigma and discrimination on community members' quality of life; • Adverse impact of criminalisation, stigma and discrimination on community		Detected by a service provider	Resource and effort consuming; requires special training for service providers and skills to detect post-violence trauma.	$$$	$$$	$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			members’ health conditions (including sexual and reproductive health); • Adverse impact of criminalisation, stigma and discrimination on community members’ integration into society as well as partner relationships; • Societal losses from criminalisation, stigma and discrimination; • Is the punishment proportionate to the crime?							
6.	Online survey with clients	Approachability of the service	• Is there information available on who can utilise social or healthcare services, and how? • Is it clear and understandable? • Is it free/publicly available?	A Survey is a widely used technique of data collection. It provides actual information about the beliefs, opinions, characteristics and past or present behaviour of a client and their experiences with service providers and their satisfaction with the quality of the received services. They are very helpful if you need to measure many variables (indicators) and to test several hypotheses; you can do so in a single survey. Online survey – when the clients provide information through a web-based electronic form by using a link which they receive from a Data Manager, Case Manager or Community Outreach Workers. **Purpose:** • to test hypotheses; • to measure the beliefs and opinions of a client; • to measure a client’s knowledge; • to collect new information about the community; • to monitor access to, and quality of, health and social services at site level; • to identify barriers to care; and, • to identify service gaps.	Web-based survey	• For valid and representative results, advanced approaches for sample size (calculation and selection) needs to be applied; • Needs a clients’ ability to work with a PC and use web-based forms; and, • Clients have to have a smartphone, laptop, PC or other gadgets.	$	$	$	See details
		Acceptability of the service	• Is the service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity / confidentiality (if applicable)?							
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered by the service, frequency of service usage, etc.); • Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?); • Does accommodation, geographic location and opening hours of an organisation providing social or healthcare services meet the needs of the community? • How long does it take to get the service? (travel time, waiting time); • Can a client access care when s/he/they need it?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with the exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals / the community? • What are the barriers to social adaptation and integration with the local community? • Are there any delays in providing the needed service? • Are working hours convenient? • Is the waiting time long to receive the service? • Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times? • Does the appointment mechanism meet clients' needs? • Are there any problems with supplies? • Is allocated funding sustainable? • Does the transport system and mobility level of clients allow them to utilise existing social or healthcare services?							
		Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a client referred, directed, accompanied or linked to other health or social services ensuring continuity of care? • Are any social support services provided?							
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?							
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence;							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Violation of the right to education due to drug use or drug dependence; • The lack of access to shelters and protection services in cases of domestic violence; • The lack of access to legal services; • The lack of access to HIV prevention, testing, treatment and care services; • Police violence; • Sentencing for drug offences with no due regard to gender-related issues; • Special vulnerability of women who use drugs to police prosecution; • The nature of the violation (what, who caused, who was affected, where, when, how, why); • What are the barriers into personal human rights protection? • Is it an isolated incident or part of a larger pattern?							
		Stigma, discrimination and criminalisation	• Adverse impact of criminalisation, stigma and discrimination on access by community members to health and social services; • Adverse impact of criminalisation, stigma and discrimination on community members' quality of life; • Adverse impact of criminalisation, stigma and discrimination on community members' health conditions (including sexual and reproductive health); • Adverse impact of criminalisation, stigma and discrimination on community members' integration into society as well as partner relationships;							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Societal losses from criminalisation, stigma and discrimination; • Is the punishment proportionate to the crime?							
7.	Online survey with service providers	Acceptability of the service	• Is the service provided free of stigma and discrimination, based on human rights norms? • Is it provided with anonymity/confidentiality (if applicable)?	A Survey is a widely used technique of data collection. It provides actual information about service providers' beliefs, opinions, characteristics, past or present behaviour and their experience with patients or clients. They are very helpful if you need to measure many variables (indicators) and to test several hypotheses; you can so in a single survey. Online survey – when the health or social workers provide information through a web-based electronic form by using a link which they receive from a Data Manager, Facility Manager, Case Manager or Community Outreach Workers. **Purpose:** While assessing access to, and the quality of, health and social services, you may consider exploring the perspectives of both sides: clients who use services (demand-side factors) and providers of these services (supply-side factors) since they are sides of the one process and very much interconnected. Therefore, this method may help you to look at the problem from the service provider perspective, explore the process of service provision and figure out how quality is perceived amongst service providers. The key aim is to obtain information about WHAT is happening and HOW it is happening in relation to the monitored issue from the service provider side. An online survey allows people to more easily and frankly sharing sensitive information and thoughts, talking about their experience rather than in person or in a group conversation.	Web-based survey	For valid and representative results, advanced approaches for sample size (calculation and selection) need to be applied; This only works for service providers with a smartphone or PC; Requires skills to work with gadgets; and, Needs a stable internet connection.	$	$	$	See details
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilisation of the service by clients? (Number of services provided, number of clients covered by the service, frequency of service usage, etc.); • Is this service ready to be provided when it is needed? (Are the required medicines, equipment, personnel, commodities in place?); • Can a client access care when s/he/they need it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with exception of diagnosis-motivated reasons)? Are there any cultural, gender, age, residence, nationality or religious barriers to access social or healthcare services among professionals / the community? • Are there any delays in providing the needed service? • Are working hours convenient? • Is the waiting time long to receive the service? • Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?							
		Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care that a client receives vary depending on the client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a client referred, directed, accompanied or linked to other health or social services, ensuring continuity of care? • Are there any social support services provided?							
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to HIV prevention, testing, treatment and care services.							
		Stigma, discrimination	• Adverse impact of stigma and discrimination on access by community members to health and social services; • Adverse impact of stigma and discrimination on community members' health conditions (including sexual and reproductive health).							
8.	Stock-out tracking alert system	Availability of medicines	• Are the required medicines in place? • Can a client receive medicines when s/he/they need them? • Are there any delays in receiving needed medicines? • Are there any problems with supplies? • Is allocated funding sustainable?	A stock-out tracking alert system is a systematic and regular collection of information on the lack, and interruption, of essential drugs and commodities for the treatment of infectious diseases, including HIV, hepatitis C, tuberculosis and other diseases in the community. A stock-out tracking alert system can be a part of a client's complaints and feedback report. **Purpose:** To monitor the availability of, and a client's access to, essential drugs and commodities to ensure continuous and uninterrupted treatment.	Specific application-based online survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Only works for clients with a smartphone or PC; Requires skills to work with gadgets; and, Needs a stable internet connection.	$$	$$	$$$	See details
		Affordability of the medicines	• Can the needed medicines be received free of charge or not? • Are there any criteria to get the needed medications for free? • Does a client have to pay out-of-pocket money to receive the needed medications?		Telephone (Helpline)	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Needs specially designated people and a	$	$$	$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Does social/health insurance cover the medicines? • Are the medications affordable long-term for the client?			telephone number for collecting complains.				
					Web-based survey	Individual client feedback is focused on individual experience and may have limited depth or explanation of root causes of service quality issues; Only works for clients with a smartphone or PC; Requires skills to work with gadgets; and, Needs a stable internet connection.	$	$	$	See details
9.	Service mapping	Availability and accommodation sustainability of the service	• Does the service exist? • Does accommodation, geographic location and opening hours of an organisation providing social or healthcare services meet the needs of the community? • How long does it take to get the service? (travel time, waiting time)	Mapping health and social services identifies and records (draw a map) information about available services that community members can benefit from and be referred to. **Purpose:** Mapping can be useful for: • Generating discussions about available services, service gaps and potential barriers to services; • Planning of new services or to evaluate existing ones; • Capturing changes or perceived changes over time (before and after an intervention, for example); • Useful data collection tool for use with groups where literacy is an issue.	Offline group meeting	• Service mapping does not give information about reasons, "why" it happens and what leads to the problem. • It only gives a picture of existing services and does not provide details about their appropriateness and quality.	$$	$$	$	See details
10.	Social media content analysis	Stigma, discrimination	• Adverse impact of criminalisation, stigma and discrimination on access by community members to health and social services; • Adverse impact of criminalisation, stigma and discrimination on community members' quality of life; • Adverse impact of criminalisation, stigma and discrimination on community members' health conditions	Content analysis is a technique to determine the presence of certain words, themes, or concepts and relations between them in written or symbolic material (such as pictures, movies, song lyrics, books, book chapters, social media, interviews, discussions, essays, newspaper headlines and articles, historic documents, speeches, conversations, advertising, theatre, informal conversation, etc.)[83]. For instance, it can be used to evaluate the level of use of social media for health promotion or HIV prevention or the "mood" of society in relation to an "abortion ban".	Social media content	• Can be quite time consuming; • Can be difficult to automate or computerise; • Might bring additional errors, particularly when relational analysis is used to attain a higher level of interpretation; and, • Often disregards the context that produced the text, as well as the	$$$$$	$$$$$	$$	See details

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[83] W. Lawrence Neuman (2014), Op.cit.

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			(including sexual and reproductive health); and, • Adverse impact of criminalisation, stigma and discrimination on community members' integration into society as well as partner relationships.	**Purpose:** [84] ● Identify the intentions, focus or communication trends of an individual, group or institution; ● Describe attitudinal and behavioural responses to communications; ● Reveal patterns in communication content (such as propaganda, homophobia); ● Reveal international differences in communication content; ● Determine the psychological or emotional state of persons or groups; ● Useful for documenting trends over time; and, ● A more useful tool when combined with other research methods such as interviews, observation and use of archival records.		state of things after the text is produced.				
11	Offline Focus groups discussions (FGD) with community members – community meetings	Approachability	• Is there information available on who and how can utilize social or healthcare services? • Is it clear and understandable? Is it free/publicly available	Focus group discussion (FGD) is a technique aiming to examine individual perceptions, views, attitudes, experiences, and beliefs via a group discussion. **Purpose:** ● You can apply it when you want to learn about some specific intervention or service provision, discuss what went well and what did not, or explore how quality is perceived amongst the community members, etc. So, you want to see via the eyes of the community, walk in their shoes and learn about their lived experience. Typically, you are interested in the discussion, that´s why we call this method focus group discussion, but it does not employ conflict. ● The key aim is to obtain in-depth information about WHAT is happening and WHY it is happening in relation to the monitored issue.	Offline group meeting	• The evidence collected might be questioned as they might lack consistency, accuracy, or qualitative research foundations. • If ethical clearance is not obtained, ethnical concerns can be raised. • The advanced methodology requires qualitative research expertise and thus, can be costly and time-consuming.	$$$	$$$	$$$	See details

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[84] Carol, B., et al. (2005), Op.cit.

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
				• Advanced FGDs can be used as a separate research method or complementary to quantitative and other qualitative methods. They also aim to learn attitudes, experience, perceptions, views, and beliefs of different community members and other relevant groups, but should use proper data collection strategy as well as analytical approach.						
		Acceptability of the service	• Is service provided free of stigma and discrimination, based on human rights norms? Is it provided with anonymity/confidentiality (if applicable)?			•				
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilization of the service by the clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc) • Is this service ready to be provided when it is needed? (Does the required medicines, equipment, personnel, commodities in place? • Does a client can access care when s/he needs it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with exception of diagnosis motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals/community? • Are any delays in providing needed service? • Are working hours convenient? • Is the waiting time to receive service long?			•				

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times?							
		Affordability of the service	• Is selected service free of charge or not? • Are there any criteria to get selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? Is the service affordable long-term for the client?			•				
		Appropriateness of the service	• Are services organized to address specific needs of clients? • Are service packages age and gender specific? • Is a quality of care which a client receives vary depending on client's personal characteristics (gender, race, ethnicity), geographical location and socioeconomic status • Are services offered to a client on a voluntary basis? • Is the service provided with the respect to a client's individual preferences, values and needs? • Is a client actively involved into individual care management plan? • Is a referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care?) Are there any social support provided?			•				
		Quality of the service	• Is the provided service evidenced-based and does it adhere to established standards?			•				

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			Are all activities/steps/components included into guidelines or protocol for this service done? Are they done in full?							
		Human rights violations	• Termination of parental rights and child custody • The lack of access to drug treatment, including OST, for pregnant women • The lack of access to quality reproductive health • Coercive abortion • Violations of labor rights due to the fact of drug use or drug dependence • Violation of the right to education due to drug use or drug dependence The lack of access to HIV prevention, testing, treatment and care services			•				
12	Online Focus groups discussions (FGD) with community members – community meetings	Approachability	• Is there information available on who and how can utilize social or healthcare services? • Is it clear and understandable? Is it free/publicly available	Focus group discussion (FGD) is a technique aiming to examine individual perceptions, views, attitudes, experiences, and beliefs via a group discussion. **Purpose:** ● You can apply it when you want to learn about some specific intervention or service provision, discuss what went well and what did not, or explore how quality is perceived amongst the community members, etc. So, you want to see via the eyes of the community, walk in their shoes and learn about their lived experience. Typically, you are interested in the discussion, that´s why we call this method focus group discussion, but it does not employ conflict. ● The key aim is to obtain in-depth information about WHAT is happening and WHY it is	Online group meeting	• Internet connectivity and accessibility will skew type of people you able to reach out • Additional skills and costs to run online events • The evidence collected might be questioned as they might lack consistency, accuracy, or qualitative research foundations • If ethical clearance is not obtained, ethnical concerns can be raised • The advanced methodology requires qualitative research expertise and thus, can be	$$$$	$$$	$$$	See details
		Acceptability of the service	• Is service provided free of stigma and discrimination, based on human rights norms? Is it provided with anonymity/confidentiality (if applicable)?							
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilization of the service by the clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc) • Is this service ready to be provided when it is needed? (Does the required medicines, equipment, personnel, commodities in place? • Does a client can access care when s/he needs it?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with exception of diagnosis motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals/community? • Are any delays in providing needed service? • Are working hours convenient? • Is the waiting time to receive service long? Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times?	happening in relation to the monitored issue. • Advanced FGDs can be used as a separate research method or complementary to quantitative and other qualitative methods. They also aim to learn attitudes, experience, perceptions, views, and beliefs of different community members and other relevant groups, but should use proper data collection strategy as well as analytical approach.		costly and time-consuming				
		Affordability of the service	• Is selected service free of charge or not? • Are there any criteria to get selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? Is the service affordable long-term for the client?							
		Appropriateness of the service	• Are services organized to address specific needs of clients? • Are service packages age and gender specific? • Is a quality of care which a client receives vary depending on client's personal characteristics (gender, race, ethnicity), geographical location and socioeconomic status • Are services offered to a client on a voluntary basis?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Is the service provided with the respect to a client's individual preferences, values and needs? • Is a client actively involved into individual care management plan? • Is a referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care?) Are there any social support provided?							
		Quality of the service	• Is the provided service evidenced-based and does it adhere to established standards? Are all activities/steps/components included into guidelines or protocol for this service done? Are they done in full?							
		Human rights violations	• Termination of parental rights and child custody • The lack of access to drug treatment, including OST, for pregnant women • The lack of access to quality reproductive health • Coercive abortion • Violations of labor rights due to the fact of drug use or drug dependence • Violation of the right to education due to drug use or drug dependence The lack of access to HIV prevention, testing, treatment and care services							
13	Face-to-face structured Interviews with community members and other key informants	Approachability	• Is there information available on who and how can utilize social or healthcare services? • Is it clear and understandable? Is it free/publicly available	Qualitative Interviews is a qualitative technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs via individual or group conversations. Such conversation involves the one who asks questions - interviewer and the one who answers interviewee or key informant.	Offline individual meeting	• The evidence collected might be questioned as they might lack consistency, accuracy, or qualitative research foundations	$$$	$$$	$$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Acceptability of the service	- Is service provided free of stigma and discrimination, based on human rights norms? Is it provided with anonymity/confidentiality (if applicable)?	Structured interviews (SI) schedule the kind of data produced quite tightly, so the interviewer must follow a specified set of questions of the guide, in a specified order, so that we would have answers for all the questions of the guide for each and every respondent and could pull them together and check kind of "compare" them (i.e., in qualitative research we do not compare by means of statistical analysis rather using other analytical approaches). That´s why the interviewer should strictly follow the guide, ask all of the questions do not change them or their order. **Purpose:** ● You can apply this method when you want to learn about some specific intervention or service provision, discuss what went well and what did not, or explore how quality is perceived amongst the community members, etc. So, you want to see via the eyes of the community, walk in their shoes and learn about their lived experience. ● The key aim is to obtain in-depth information about WHAT is happening and WHY it is happening in relation to the monitored issue. But in this case, you are interested to hear individual´s perspective, you do not need discussions or group conversation. Why do you need this? There can be many reasons for that: you know that people will not tell their experience or share the thoughts in a group, or you have already conducted FGDs and would like to examine some aspects in more details, etc.		- If ethical clearance is not obtained, ethnical concerns can be raised - The advanced methodology requires qualitative research expertise and thus, can be costly and time-consuming				
		Availability and accommodation sustainability of the service	- Does the service exist? - What is the level of utilization of the service by the clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc) - Is this service ready to be provided when it is needed? (Does the required medicines, equipment, personnel, commodities in place? - Does a client can access care when s/he needs it? - Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with exception of diagnosis motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals/community? - Are any delays in providing needed service? - Are working hours convenient? - Is the waiting time to receive service long? Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Affordability of the service	• Is selected service free of charge or not? • Are there any criteria to get selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? Is the service affordable long-term for the client?	• Advanced SI can be used as a separate research method or complementary to quantitative and other qualitative methods. They also aim to learn attitudes, experience, perceptions, views, and beliefs of different community members and other relevant groups but should use proper data collection strategy as well as analytical approach.						
		Appropriateness of the service	• Are services organized to address specific needs of clients? • Are service packages age and gender specific? • Is a quality of care which a client receives vary depending on client's personal characteristics (gender, race, ethnicity), geographical location and socioeconomic status • Are services offered to a client on a voluntary basis? • Is the service provided with the respect to a client's individual preferences, values and needs? • Is a client actively involved into individual care management plan? • Is a referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care?) Are there any social support provided?							
		Quality of the service	• Is the provided service evidenced-based and does it adhere to established standards? Are all activities/steps/components included into guidelines or protocol for this service done? Are they done in full?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Human rights violations	• Termination of parental rights and child custody • The lack of access to drug treatment, including OST, for pregnant women • The lack of access to quality reproductive health • Coercive abortion • Violations of labor rights due to the fact of drug use or drug dependence • Violation of the right to education due to drug use or drug dependence The lack of access to HIV prevention, testing, treatment and care services							
14	Key Informant Interviews with service providers	Approachability	• Is there information available on who and how can utilize social or healthcare services? • Is it clear and understandable? Is it free/publicly available	Key informant interviews (KIIs) are individual interviews with people who have firsthand knowledge about the community including community leaders, health and social workers, service providers etc. These community experts, with their knowledge and understanding, can provide insight on the nature of problems and give recommendations for solutions. It can be applied for CLM and as a more advanced methodology can be used in qualitative research. **Purpose:** • While assessing an access to and quality of health and social services you may consider exploring perspectives of both sides: clients who use services (demand-side factors) and providers of these services (supply-side factors) since they are sides of the one process and very much interconnected. Therefore, this method may help you to look at the problem from the service provider perspective, explore the process of service provision and figure out how	Offline individual meeting	•The evidence collected might be questioned as they might lack consistency, accuracy, or qualitative research foundations •If ethical clearance is not obtained, ethnical concerns can be raised •The advanced methodology requires qualitative research expertise and thus, can be costly and time-consuming	$$$$	$$$	$$	See details
		Acceptability of the service	• Is service provided free of stigma and discrimination, based on human rights norms? Is it provided with anonymity/confidentiality (if applicable)?							
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilization of the service by the clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc) • Is this service ready to be provided when it is needed? (Does the required medicines, equipment, personnel, commodities in place? • Does a client can access care when s/he needs it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			with exception of diagnosis motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals/community? • Are any delays in providing needed service? • Are working hours convenient? • Is the waiting time to receive service long? Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times?	quality is perceived amongst the service providers. ● The key aim is to obtain in-depth information about WHAT is happening and WHY it is happening in relation to the monitored issue from the service provider side. You can also use KIIs for examining some aspects, identified during FGDs with community members, in more details. ● KIIs are usually individual interviews which allow people more easily and frankly sharing sensitive information and thoughts, talking about their experience rather than in a group conversation.						
		Affordability of the service	• Is selected service free of charge or not? • Are there any criteria to get selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? Is the service affordable long-term for the client?							
		Appropriateness of the service	• Are services organized to address specific needs of clients? • Are service packages age and gender specific? • Is a quality of care which a client receives vary depending on client's personal characteristics (gender, race, ethnicity), geographical location and socioeconomic status • Are services offered to a client on a voluntary basis? • Is the service provided with the respect to a client's individual preferences, values and needs? • Is a client actively involved into individual care management plan?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• Is a referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care?) Are there any social support provided?							
		Quality of the service	• Is the provided service evidenced-based and does it adhere to established standards? Are all activities/steps/components included into guidelines or protocol for this service done? Are they done in full?							
		Human rights violations	• Termination of parental rights and child custody • The lack of access to drug treatment, including OST, for pregnant women • The lack of access to quality reproductive health • Coercive abortion • Violations of labor rights due to the fact of drug use or drug dependence • Violation of the right to education due to drug use or drug dependence The lack of access to HIV prevention, testing, treatment and care services							
15	Face-to-face semi-structured Interviews with community members and other key informants	Approachability	• Is there information available on who and how can utilize social or healthcare services? • Is it clear and understandable? Is it free/publicly available	Qualitative Interviews is a qualitative technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs via individual or group conversations.[85] It can be applied for CLM and as a more advanced methodology can be used in qualitative research. This particular kind of conversations are probably the most	Offline individual meeting	•The evidence collected might be questioned as they might lack consistency, accuracy, or qualitative research foundations •If ethical clearance is not obtained, ethnical concerns can be raised	$$$$	$$$	$$$	See details

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[85] Green, J., and Thorogood N. (2004). Qualitative Methods for Health Research. Sage Publishing: London, UK. ISBN 07619 47701

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Acceptability of the service	• Is service provided free of stigma and discrimination, based on human rights norms? Is it provided with anonymity/confidentiality (if applicable)?	commonly and widely used method in qualitative health research. Such conversation involves the one who asks questions - interviewer and the one who answers interviewee or key informant. Semi-structured interviews (SSI) set the agenda of the interview in terms of topics to be covered, probes, and order predefined in the guide, but the interviewee's responses may influence these all as the responses we receive to determine the kinds of information produced about topics and the relative importance of these topics. The interviewer should actively listen to the responses, built rapport, and depending on the information and its importance/relevance may decide to change the order of the questions, add something, yet stick to the guide. The guide usually contains main questions followed by different probes and is built so, that it is possible to change the order of questions. **Purpose:** • You can apply this method when you want to learn about some specific intervention or service provision, discuss what went well and what did not, or explore how quality is perceived amongst the community members, etc. So, you want to see via the eyes of the community, walk in their shoes and learn about their lived experience. • The key aim is to obtain in-depth information about WHAT is happening and WHY it is happening in relation to the monitored issue. But in this case, you are interested to hear individual´s perspective, you do not need discussions or group conversation. Why do you need		•The advanced methodology requires qualitative research expertise and thus, can be costly and time-consuming				
		Availability and accommodation sustainability of the service	• Does the service exist? • What is the level of utilization of the service by the clients? (Number of services provided, number of clients covered with the service, frequency of service usage, etc) • Is this service ready to be provided when it is needed? (Does the required medicines, equipment, personnel, commodities in place? • Does a client can access care when s/he needs it? • Are there any exclusion or inclusion criteria for clients to receive social or healthcare services (for medical services with exception of diagnosis motivated reasons)? Are there any cultural, gender, age, residence, nationality, or religious barriers to access social or healthcare services among professionals/community? • Are any delays in providing needed service? • Are working hours convenient? • Is the waiting time to receive service long? Is there a patient flow system in place which is operated for scheduling or modifying visits and for notifying clients of projected waiting times?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Affordability of the service	• Is selected service free of charge or not? • Are there any criteria to get selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? Is the service affordable long-term for the client?	this? There can be many reasons for that: you know that people will not tell their experience or share the thoughts in a group, or you have already conducted FGDs and would like to examine some aspects in more details, etc. • Advanced SI can be used as a separate research method or complementary to quantitative and other qualitative methods. They also aim to learn attitudes, experience, perceptions, views, and beliefs of different community members and other relevant groups but should use proper data collection strategy as well as analytical approach.						
		Appropriateness of the service	• Are services organized to address specific needs of clients? • Are service packages age and gender specific? • Is a quality of care which a client receives vary depending on client's personal characteristics (gender, race, ethnicity), geographical location and socioeconomic status • Are services offered to a client on a voluntary basis? • Is the service provided with the respect to a client's individual preferences, values and needs? • Is a client actively involved into individual care management plan? • Is a referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care?) Are there any social support provided?							
		Quality of the service	• Is the provided service evidenced-based and does it adhere to established standards? Are all activities/steps/components included into guidelines or protocol for this service done? Are they done in full?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Human rights violations	• Termination of parental rights and child custody • The lack of access to drug treatment, including OST, for pregnant women • The lack of access to quality reproductive health • Coercive abortion • Violations of labor rights due to the fact of drug use or drug dependence • Violation of the right to education due to drug use or drug dependence The lack of access to HIV prevention, testing, treatment and care services							
16.	Video and Photo Observations	Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services, ensuring continuity of care? • Are there any social support services provided?	Observations is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. So, it aims to understand phenomenon by observing it directly rather than learn from other people´s accounts of it. **Purpose:** ● You can apply this method when you want to learn about it as it allows you to examine what people do as well as what they say they do; ● You should also remember that observation typically combines different methodologies aiming to collect and analyse all sorts of available data, including documents, photos and videos, and notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a concrete CLM tool – video and photo observations;	Individual direct observations	• Skills and equipment to record data are an additional cost; • If ethical clearance is not obtained, ethnical concerns can be raised; and, • The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.	$$	$$	$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?	• As a more advanced method of observation, it is often referred to as a "gold standard" of qualitative methods as it allows us to examine what people do as well as what they say they do[86]. Observation can involve participants or not, or be online of face-to-face.						
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to HIV prevention, testing, treatment and care services.							
17.	Transect walks	Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?	Observation is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. So, it aims to understand phenomenon by observing it directly rather than learning from people´s accounts of it. Transect walks is a type of participant observation when data is collected during a walk through a certain community area. This community area should be predetermined in advance (consider community mapping) and the team plans the transect walk by drawing a "transect line" through a map of the	Individual direct observations	• The evidence collected might be questioned as it might lack consistency, accuracy, or qualitative research foundations; • If ethical clearance is not obtained, ethnical concerns can be raised; • The advanced methodology requires qualitative research expertise and, thus,	$$$$	$$$	$$$	See details

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[86] Green, J., Thorogood N. (2004), Op.cit.

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care? • Are there any social support services provided?	determined area. The line should go through, or transect, all zones of the community in order to provide a representative view of the community. Then, an observer, accompanied by several community members, walks through the area represented by the transect line on the map and collects data by means of direct observations, or by interviewing community representatives. This tool may help to identify spatial organisation, architectural styles, use of space, presence or absence of facilities or services, overuse or underuse of facilities, services, and activities, housing conditions or conditions of facilities, their types, etc. Transect walks provide an evaluator with a "big picture" view of the community. They help to identify issues that need further investigation. **Purpose:** ● You can apply this method when you want to learn about it as it allows you to examine what people do as well as what they say they do; ● You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sorts of available data, including documents, photos and videos, and notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a concrete CLM tool – transect walks; and, ● As a more advanced method of observation, it is often referred to as the "gold standard" of qualitative methods as it allows you to examine what people do as well as what they say they do.		can be costly and time-consuming.				
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?							
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women;							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
			• The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to HIV prevention, testing, treatment and care services.							
18.	Client's diary	Appropriateness of the service	• Are services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services ensuring continuity of care? • Are there any social support services provided?	Observations is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observations. So, it aims to understand phenomenon by observing it directly rather than learning from people´s accounts of it. Diaries/client diaries are a method allowing you to collect self-reported information about a person's behaviour, experience, and/or any activity of interest over a defined period of time. For example, you can examine the patient pathway or perceived quality of services, etc. For some people, it is easier to express their views privately, so private reflections might be more candid and participants might be more able to express themselves in a diary than in an interview. Still, this method very much depends on the participant's willingness to follow through. Please note that diaries may contain not only qualitative information (i.e. feedback, impressions and perceptions, the description of an activity, experience, or behaviour) but includes quantitative data too (such as numerical results of tests, timing, number of hours spent in line in a healthcare facility, costs, etc.).	Individual direct observations self-reported information	• The evidence collected might be questioned as it might lack consistency, accuracy, or qualitative research foundations; • If ethical clearance is not obtained, ethnical concerns can be raised; and, • The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.	$$	$$$	$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?	**Purpose:** ● You can apply this method when you want to learn about it as it allows you to examine what people do as well as what they say they do; ● You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sorts of available data, including documents, photos and videos, and notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a concrete CLM tool – a client's / patient diary; ● As a more advanced method of observation, it is often referred to as the "gold standard" of qualitative methods as it allows us to examine what people do as well as what they say they do.						
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to HIV prevention, testing, treatment and care services.							
19.	Secret client	Affordability of the service	• Is the selected service free of charge or not? • Are there any criteria to get the selected service for free? • Does a client have to pay out-of-pocket money to receive the services? • Does social/health insurance cover services? • Is the service affordable long-term for the client?	● Observation is a technique aiming to examine individual perceptions, views, attitudes, experiences and beliefs through observation. So, it aims to understand phenomenon by observing it directly rather than learning from people´s accounts of it; ● "Secret client" / "mystery shopping" / pseudo-patient studies / simulated client studies is a method of observation which	Individual direct observations, self-reported information	• The evidence collected might be questioned as it might lack consistency, accuracy, or qualitative research foundations; • If ethical clearance is not obtained, ethnical concerns can be raised; and,	$$$$	$$$	$$$	See details

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Appropriateness of the service	• Are the services organised to address the specific needs of clients? • Are service packages age and gender specific? • Does the quality of care which a client receives vary depending on a client's personal characteristics (gender, race, ethnicity), geographic location and socioeconomic status? • Are services offered to a client on a voluntary basis? • Is the service provided with respect to a client's individual preferences, values and needs? • Is a client actively involved in their individual care management plan? • Is the referral process smooth along the care cascade? • Is a patient referred, directed, accompanied, or linked to other health or social services, ensuring continuity of care? • Are there any social support services provided?	involves the testing of the services by researchers pretending to be "real" consumers in order to find out how consumers are treated in everyday life, rather than in a research type of situation. For example, researchers might pretend to be a patient of Hospital A in order to find out how services are "really" provided. This method can involve the collection of qualitative data (such as examining issues of communication, language use, stigmatising or labelling words) and quantitative data (such as waiting time, number of personnel, etc.). **Purpose:** ● You should also remember that observation typically combines different methodologies, aiming to collect and analyse all sorts of available data, including documents, photos and videos, and notes collected during direct observations of the event of interest, etc. You may also see that researchers decide to conduct interviews or even a survey to understand the studied question comprehensively. Here we talk only about a concrete CLM tool – secret client; and, ● As a more advanced method of observation, it is often referred to as the "gold standard" of qualitative methods as it allows us to examine what people do as well as what they say they do.		• The advanced methodology requires qualitative research expertise and, thus, can be costly and time-consuming.				
		Quality of the service	• Is the provided service evidence-based and does it adhere to established standards? • Are all activities / steps / components included in the guidelines or protocol for this service? Are they complete?							

#	CLM tool (filter)	Problem area (filter)	Monitoring question (filter)	Brief description	Data collection mode (filter)	Limitations	Complexity[81] (filter)	Time (filter)	Price (filter)	Implementation steps
		Human rights violations	• Termination of parental rights and child custody; • The lack of access to drug treatment, including OST, for pregnant women; • The lack of access to quality reproductive health; • Coercive abortion; • Violations of labour rights due to drug use or drug dependence; • Violation of the right to education due to drug use or drug dependence; • The lack of access to HIV prevention, testing, treatment and care services.							