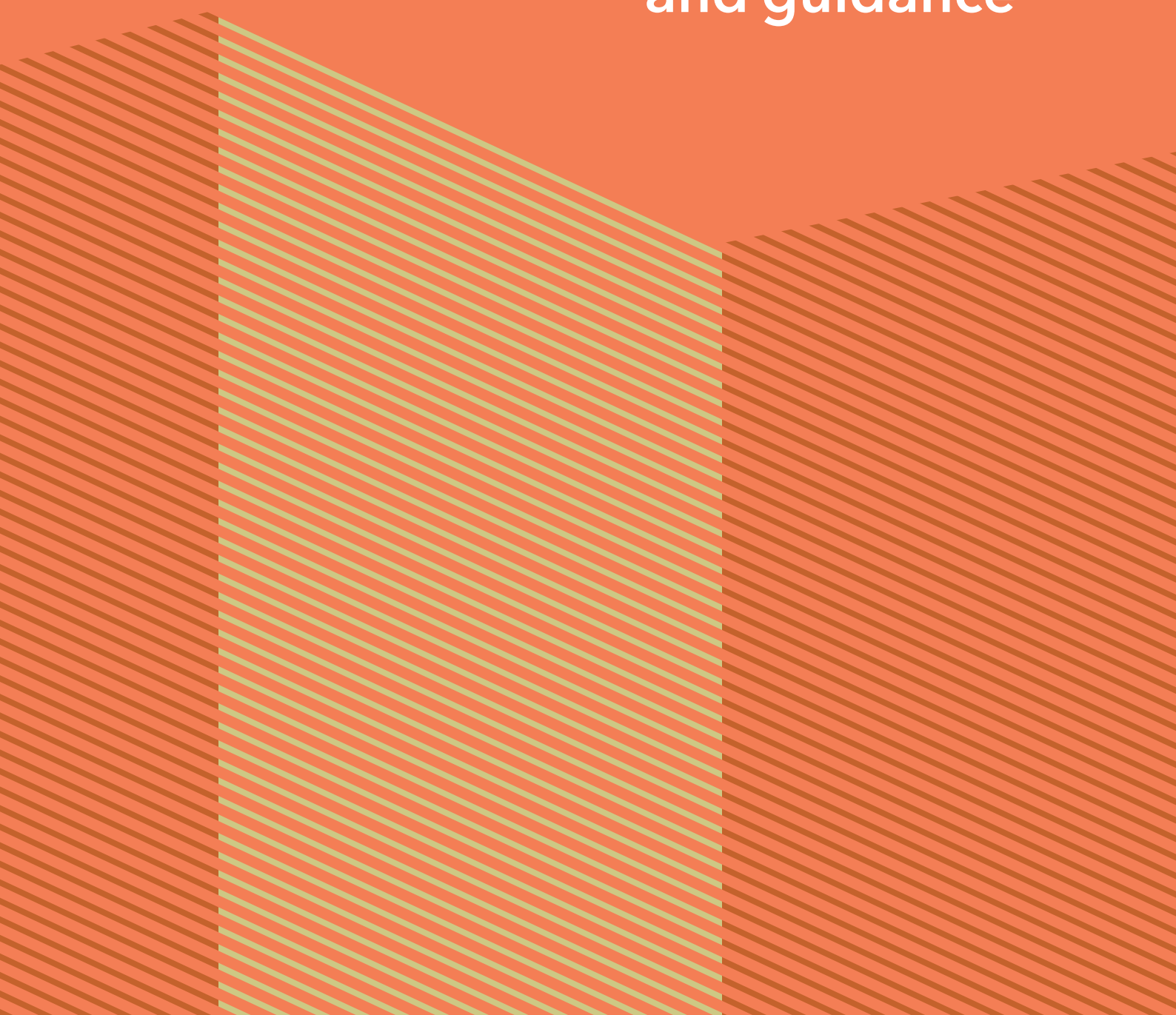


Community-led monitoring progression matrix

framework
and guidance

The lower half of the cover features a large, abstract geometric design. It consists of several overlapping rectangular blocks. The central block is filled with a pattern of thin, parallel green diagonal lines. The surrounding blocks are filled with a pattern of thin, parallel orange diagonal lines. The overall effect is a modern, layered architectural look.

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Foreword

We stand at a defining crossroads in the global HIV response. The scientific and biomedical tools required to end AIDS as a public health threat by 2030 are within our reach and yet our progress continues to be stalled by significant variation in the quality of and access to HIV services.

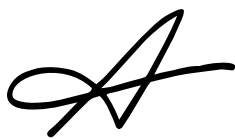
These structural barriers deny millions of people the lifesaving services they need. To break this impasse, we must look beyond clinical interventions towards the people most affected.

Using data from community-led monitoring (CLM) can improve services dramatically and represents a transformative shift in global health. As a grassroots accountability mechanism, it possesses the unique power to illuminate the critical details and gaps that traditional, top-down monitoring systems frequently overlook. By turning the lived experiences of communities into rigorous data, CLM drives accountability, challenges stigma, and promotes high-quality and consistent access to services that are essential to a successful response.

For CLM to meet the demands of the future, it must undergo its own evolution. As we transition towards national HIV responses that are truly nationally owned, sustainable and multisectoral, CLM can no longer exist as a peripheral approach. It must become a systemic, permanent feature of national systems for health. This evolution requires four fundamental shifts: from donor-funded to domestically integrated models; from siloed or disease-specific to integrated monitoring; from analogue to real-time digital monitoring ecosystems; and from anecdotal to a core feature in national monitoring and programme review processes. One thing must, however, remain the same: CLM must continue to be informed, led, implemented and used by, and for, affected communities.

This publication is designed to be a companion for stakeholders as they navigate these vital transitions. It provides a framework for joint review, establishes essential minimum standards, and fosters a unified vision for the future of CLM.

I wish to express my profound gratitude to the community representatives, partners and friends whose expertise and experience shaped and helped pilot this guidance. I trust this document will serve as an indispensable tool in your work. Together, we can deliver CLM systems that are not only robust and sustainable but also capable of ensuring national HIV responses remain of high quality and—above all else—truly people-centred.



Dr Angeli Achrekar
Deputy Executive Director
 UNAIDS

Glossary

Community There is no universally agreed definition of community. The World Health Organization defines communities as “groups of people that may or may not be spatially connected, but who share common interests, concerns or identities” (1). The word “community” in the context of community-led monitoring (CLM), as used in this document, refers to people living with or affected by a disease who are the potential or actual end-users of services or programmes related to that disease in a specific geographical location. For example, if a CLM initiative intends to monitor HIV services for sex workers in a particular community, ideally the community monitors and organizations undertaking the monitoring should be led by sex workers and be from the same community.

Community-led monitoring (CLM) There is no universally agreed definition of CLM. The use of the term within this document aligns with the Joint United Nations Programme on HIV/AIDS (UNAIDS) definition as “an accountability mechanism for HIV responses at different levels, led and implemented by local community-led organizations of people living with HIV, networks of people from key populations, other affected groups or other community entities. CLM uses a structured platform and rigorously trained peer monitors to systematically and routinely collect and analyse qualitative and quantitative data on HIV service delivery—including data from people in community settings who might not be accessing health care—and to establish rapid feedback loops with programme managers and health decision-makers. CLM builds evidence on what works well, what is not working and what needs to be improved, with suggestions for targeted actions to improve outcomes” (2). CLM as part of community-led HIV responses aims to improve the quality and accessibility of services (3).

Community-led organizations These are groups and networks, formally or informally organized, for which the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies and have transparent mechanisms of accountability to their constituencies. Community-led organizations, groups and networks are self-determining and autonomous, and are not influenced by governmental, commercial or donor agendas. Not all community-based organizations are community-led (4).

Core principles of CLM There is no universally agreed set of CLM core principles, but most stakeholders agree on common elements, as described in the UNAIDS CLM guideline published in 2021 (2). These core principles include CLM being community-led, community-owned, focused on action and accountability, independent, collaborative, routine, systematic and results-oriented. The joint position statement from technical assistance providers on the occasion of the Community-led Monitoring Global Convening provides complementary guidance on this (5).

Introduction

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

The data collected through CLM builds evidence on what works well, what is not working and what needs to be improved, with suggestions for targeted action to improve outcomes. These data complement local and national monitoring and provide key information to fill critical gaps in the decision-making process that leads to evidence-informed action to improve quality of services delivery.

CLM efforts are distinct, reflecting local capacities, priorities, previous implementation experiences and leadership in communities(6). To guide a joint reflection, contribute towards minimum standards, and foster a common vision of CLM progress and needs among CLM stakeholders at the national or subnational level, UNAIDS has developed the CLM Progression Matrix (hereafter, the Matrix).¹ The Matrix echoes extensive experiences that have used maturity models to assess and guide organizational and systemic improvement in a number of areas, including health systems(7, 8).

The process of building mature and sustainable CLM systems across all its different variables is expected to take time. Multiple challenges may need to be addressed, including lack of a common vision for CLM; insecure or unstable operating environments(9); gaps in programme capacity, community leadership or ownership(10); gaps in adherence to normative guidance(11), including to the core principles of CLM; inability to measure longer-term impact(12); and a pervasive, recently intensified underfunding and lack of predictable and sustainable financing(13, 14, 15).

Progress will not always follow a linear process and may sometimes go backwards as a result of staff turnover, changes in the political landscape, insufficient or delayed funding, or other factors that impact on CLM implementation.

Within this context, it is critically important for CLM stakeholders to regularly review their progress towards a CLM practice that is consistent with core CLM principles; instils a culture of continuous improvement; delivers results; supports accountability; and increasingly becomes part of country decision-making processes at the national and subnational levels.

¹ The Matrix has been under development for the past four years. This fourth iteration incorporates UNAIDS CLM guidance, lessons learned from CLM technical assistance provision, and feedback from donors, technical assistance partners and communities.

Purpose

The Matrix is a self-assessment tool to assist all CLM stakeholders—including service end-users, CLM implementers and partners, service providers, programme managers and policy-makers—to reflect on the progress of CLM efforts at the national or subnational level in the year(s) past and set objectives for the coming year(s). The ultimate goal is to improve the quality of services being delivered through improving CLM.

As a result, communities, CLM implementers and partners can better identify, in a collaborative manner, capacity gaps. These can serve as the basis for multistakeholder discussions to adjust and improve ways of working, enhance collaboration and integration, and plan technical support and resource allocations for the next implementation period. The Matrix can also be used at an early stage, before CLM implementation, to assess the broader context, the capacity of the community to undertake CLM, and the capacity of the country to integrate CLM as part of a service delivery improvement and decision-making processes at the national and subnational levels.

The Matrix aims to support CLM stakeholders to understand the nuance associated with CLM results and progress over time. It also provides a structured framework to share and compare different stakeholder perspectives on progress, while looking at the same programme delivery and results. It is therefore also a tool to bridge gaps in understanding between stakeholders who may be measuring progress in different ways. The ambiguity that may arise in these conversations is an opportunity for stakeholders to understand each other's perspectives and, at a minimum, agree a general statement on progress, with a greater focus on the goals to be achieved in coming years.

Domains

The Matrix proposes self-assessment of CLM progress across five domains (Figure 1). These are not the only domains that influence CLM progress, but they have been selected on the basis of three criteria:

- aligned with the core principles of CLM;
- common to all country contexts;
- addressing all stages of the CLM cycle—identify service-related quality improvement needs, collect information, analyse and interpret, disseminate information, advocate for solutions, and monitor changes(2).

Figure 1. Overview of domains of a CLM system included in the Matrix



Maturity goals and minimum standards are proposed against the five Matrix domains, providing a minimum threshold and a longer-term vision for each. Many practical examples exist to illustrate how these minimum standards can be incorporated into CLM design and implementation, regardless of the maturity level of the particular CLM system:

Domain 1 Community leadership

Maturity goal: CLM is informed, led, implemented and used by and for affected communities.

Minimum standard: networks or groups reflecting, representing and accountable to the potential or actual end-users of services or programmes being monitored (community-led organizations) should be the principal decision-makers on CLM in their locality. The targeted communities should be hired and paid to plan CLM activities, collect and analyse data, disseminate findings, and engage with broader community consultative groups. Where communities are in vulnerable situations due to unfavourable policies or discrimination, it may be necessary to identify civil society organizations trusted by the community to receive and manage CLM funding. Such outsourcing is not ideal; it should always be associated with capacity-building in the affected population and contain actions to mitigate and challenge the unfavourable

policy environment.² In all cases, stakeholders should avoid potential or perceived conflict of interests (16)—for example, community-led organizations cannot monitor services they provide.

Example 1: In Uganda, a consortium of three organizations representing women living with HIV (International Community of Women living with HIV Eastern Africa), representing people from key populations (Sexual Minorities Uganda), and working to improve health and socioeconomic rights of people from vulnerable populations (Coalition for Health Promotion and Social Development) has been funded since 2020 to conduct CLM of HIV and tuberculosis (TB) services. An advisory committee of 11 constituent members representing women, men and young people living with HIV, people with disabilities, religious leaders and people from key populations oversees and provides oversight to the CLM programme. Members of the community who are directly impacted (community monitors) engage other service recipients in every aspect of CLM data collection, analysis, dissemination and advocacy (17), ultimately compiling critical information to improve services.

Example 2: In Haiti, local organizations of people living with HIV, people from key populations, and adolescent girls and young women formed a consortium in 2020 to lead CLM work. They launched the Observatoire Communautaire des Services VIH [Community HIV Services Observatory] (OCSEVIH), which monitors barriers to HIV treatment access and retention in 65 health facilities across 16 districts. The indicators and survey design were created by people living with HIV, people from key populations, and other community members who use services, with technical support from an academic research team. Data collection was performed by a team of 11 trained community monitors who were all living with HIV or from key populations. OCSEVIH uses these data to engage decision-makers and drive improvements in HIV services (18).

Example 3: In Zimbabwe, the Zimbabwe National Network of People Living with HIV community treatment observatory model recruits and trains community cadres of people who are openly living with HIV to collect data from their peers, coordinate community dialogues, and engage with community leaders and health facilities. The cadres include mentor mothers, HIV treatment counsellors, peer navigators, key population outreach workers and peer educators who are sex workers or gay men and other men who have sex with men (19).

² The Matrix should be used to set community leadership goals that are appropriate to different country contexts and sensitive to criminalizing or stigmatizing settings. Interim measures could include a longer timeline for transitioning CLM leadership to community-led organizations or appropriate governance and project structures managed by, for example, community-based organizations or other partners that demonstrate and enable leadership of people living with HIV and people from key and vulnerable populations in CLM activities.

Domain 2 Evidence generation

Maturity goal: CLM design, collection and analysis of data seek to monitor trends over time and adopt a community lens focused on removing barriers to good health and ensuring high-quality services. Data collection for this purpose must adhere to ethical and secure data management practices.

Minimum standard: a CLM data collection system (physical, virtual or mixed) is established, with trained community monitors and analysis of data undertaken at regular intervals. If not present from day one, ownership of community-generated data and decision-making around community-generated data should be transferred to the communities leading the monitoring as soon as possible. CLM programmes must adhere to strict ethical practices, including obtaining free, prior and informed consent from participants in all circumstances, and ensuring data collection minimizes harm and protects confidentiality. In contexts where data collection could place people at risk, this consent must be in place from day one. Clear policies and processes for managing data securely throughout the lifecycle (collection, storage, analysis, sharing, disposal) must be developed as carefully and quickly as possible.

Example 1: In South Africa, Ritshidze is a large-scale CLM initiative bringing together organizations of people living with HIV. Ritshidze has conducted quarterly surveys of user experiences at more than 400 primary health-care facilities and community sites across eight provinces since 2019. Among the principles underpinning the work of Ritshidze are the importance of CLM adhering to ethical data collection, ensuring data are owned by communities, and making data publicly available. Ritshidze uses structured approaches for data collection and has created publicly accessible dashboards to provide continuous performance monitoring of services and areas for prioritized actions to improve services and end-user experiences [\(20\)](#).

Example 2: In Ukraine, in a context of conflict and fragility, Free Zone, an organization advocating for people in prison, sought to find effective modalities for reaching people in or previously in prison with information on rights, justice, stigma and discrimination. With the development of the digital tool Free Life, users were able to file complaints and seek legal support if they were restricted from accessing services [\(21\)](#). The data obtained through Free Life allow Free Zone to monitor and respond to gaps in quality of services for the treatment of HIV, TB, viral hepatitis and drug use in prisons and probation institutions. This digital CLM model was developed and implemented in partnership with the Government Center for Public Health in Ukraine. Free Life fosters communication between community and public-sector partners, and this model has been included as an instrument of the national monitoring

and evaluation system to monitor barriers in access to care and other mistreatment (22).

Example 3: In Papua New Guinea, the Komuniti Wok Senis Kamap initiative, launched in 2021 by the Key Population Advocacy Consortium (KPAC), leverages five interlinked data-collection models³ across three CLM platforms:

- CLM in virtual spaces, which allows for continuous monitoring of HIV service quality through the KPAC National Response Centre and social media;
- CLM in communities, which allows for routine monitoring (one to three times a year) of HIV service quality through facility exit interviews and key population community forums;
- CLM in facilities, which allows for routine monitoring (one to three times a year) of HIV service quality through facility observations by key population “mystery clients”.

The KPAC CLM “recipes” include steps for managing data securely, ensuring reliability of data, and obtaining consent from authorities and individuals to conduct CLM activities (23).

Domain 3 Action and accountability

Maturity goal: CLM identifies collaborative solutions and holds decision-makers accountable for their implementation to achieve improvements that respond to the community’s priorities, improve the quality of services, and impact health outcomes positively.

Minimum standard: service providers agree to the CLM system being set up, accept community leadership, and accept that data will be reported back at regular intervals through a formal mechanism (e.g. at quarterly or six-monthly meetings).

Example 1: In Malawi, the Citizen Science Project⁴ monitors 14 sites in the districts of Dedza and Kasungu. The data generated drive services improvement and co-creation of solutions with partners through multiple approaches, including:

- organizing meetings with officials from the Department of Reproductive Health, the Department of HIV/AIDS, the national AIDS council, members of civil society, and representatives of the Diversity Forum (the umbrella body for key population networks) to advocate for safe spaces for people

3 These five models of data collection represent five CLM “recipes”: CLM 1 by national response centres, CLM 2 by social media, CLM 3 by facility exit interviews, CLM 4 by community forums and CLM 5 by facility observation through mystery clients.

4 Implemented by the International Treatment Preparedness Coalition in partnership with the Malawi Network of Religious Leaders Living with or Personally Affected by HIV and AIDS and the Network of Journalists Living with HIV.

from key populations at facilities and key population-friendly services—the project reported an overall increase in the percentage of people testing positive for HIV in target sites from 2.4% in 2022 to 3.1% in 2023, driven primarily by increased identification of young sex workers living with HIV;

- sharing CLM data with the Malawi Condom Committee and the district condom coordinating committees in Dedza and Kasungu to call attention to access to condoms—the project recorded a 23.4% increase in total condom distribution in the two districts in 2023;
- convening a meeting about domestic funding for voluntary medical male circumcision with the district AIDS coordinating committee, the principal nutrition and HIV/AIDS officer, the district council, and HIV implementing partners in the district of Dedza—the project reported successfully lobbying for two additional static circumcision sites, with the proportion of circumcisions among men aged 15 years and over increasing from 77% in 2022 to 82% in the two CLM districts in 2023 (24).

Example 2: In the Philippines, the Philippine Community-led Monitoring System⁵ adopts a collaborative approach between communities, service providers in health-care facilities and higher authorities such as city health offices at the local government unit level, and the Department of Health at the national level. In July 2023, the Network Plus Philippines Inc.⁶ leveraged CLM evidence of antiretroviral medicine stockouts and presented at the National Treatment Hub Conference. These data were influential in the decision by the Department of Health to allocate an additional 146 000 units of antiretroviral medicines to directly address the shortage of HIV treatment for facilities nationwide (25).

Example 3: In the Republic of Moldova, a CLM initiative led by PULS Communitar was set up to address persistent complaints about the opioid agonist maintenance therapy programme. The initiative aimed to validate these complaints at nine opioid agonist maintenance therapy sites across eight locations, and advocate for more person-centred solutions. The findings were presented to the Ministry of Health at the Global Fund to Fight AIDS, Tuberculosis and Malaria Country Coordinating Mechanism meeting and through the parliamentary platform on health in the state response to the needs of people who use drugs. Based on feedback from the CLM initiative, experiences of opioid agonist maintenance therapy programmes were studied, a draft order was prepared, and the use of buprenorphine at two sites was started. Lack of official recognition by the Government for CLM remains a challenge, but the groundwork laid by the project is a step towards institutionalization of CLM in the Republic of Moldova (26).

⁵ Implemented by TLF SHARE and its community-led organization partner HIV and AIDS Support House.

⁶ The national network of organizations of people living with HIV.

Domain 4 Partnership and collaboration

Maturity goal: CLM promotes and benefits from partnerships based on mutual respect and the integrity of all actors involved in the service monitoring and improvement cycle. These partnerships recognize the unique role of each partner in improving health outcomes.

Minimum standard: there is evidence of some partnership and collaboration intent (agreements in place or buy-in by government), but stakeholders (including service providers, communities and others) are still working to some degree in silos and/or are not completely aligned to CLM objectives.

Example 1: In Sierra Leone, the Network of HIV Positives in Sierra Leone (NETHIPS) and partners established a community treatment observatory in 2017 to generate evidence and engage service providers in improving service delivery. The community treatment observatory model included a community consultative group. This multistakeholder technical advisory board comprised selected stakeholders in the national HIV response, including representatives of people living with HIV, people from key and priority populations, the national AIDS secretariat, the national AIDS control programme, and technical and financial partners. Participation in community consultative group forums was based on technical expertise in health and community systems strengthening, ability to influence policy, and willingness to participate. The group met quarterly to analyse community treatment observatory reports and to discuss and prioritize issues and strategies. The group's work was guided by terms of reference developed by NETHIPS and validated by the members(27).

Similar models for institutionalizing partnership and collaboration were adopted in another 10 countries as part of the Regional Community Treatment Observatory in West Africa, established by the International Treatment Preparedness Coalition. The community consultative groups were typically chaired by high-level national decision-makers—in Benin, for example, the Chair of the group sat within the Office of the President(28).

Domain 5 Resilience and sustainability

Maturity goal: CLM sustainability is ensured through the development of strong technical and operational community-led organization capacity, integration into national and subnational decision-making processes and programme reviews, viable financing models, resilient teams, and effective mechanisms for adaptation to changing circumstances.

Minimum standard: a plan for capacity-building is in place to establish resilience and link CLM evidence to improving service delivery and decision-making, and the government or another entity has made a multiyear commitment to CLM.

Example 1: In Papua New Guinea, the national HIV monitoring and evaluation system housing the national HIV data hub now incorporates CLM as a potential additional data source. This is a result of full recognition of the national and provincial governments on the role of KPAC in terms of contributing to the database about issues affecting people from key populations, as captured through CLM(29). In addition, CLM is given prominence in the Papua New Guinea National Sexually Transmitted Infections and HIV Strategy 2024–2028(30).

Example 2: In the Lao People’s Democratic Republic, CLM is part of the National HIV Strategy and Action Plan 2024–2026. This new policy mandate is helping to generate buy-in and support for CLM from the Government(31) and will improve the quality of service delivery.

Example 3: In Nepal, the National Consolidated Guidelines on Strategic Information of HIV Response 2022–2026 specifies roles within the Department of Health Services “to manage health service information from the community to [the Department] through predefined process and procedure”. The Guidelines recognize communities as key monitoring and evaluation partners and prioritize annual CLM training for people from key populations and communities in 14 districts(32).

Example 4: The Eurasian Harm Reduction Association⁷ has been supporting efforts to institutionalize CLM across five countries, with the goal of integrating CLM into health-care systems to enhance the quality of services for people who use drugs. The Association has supported the refining of CLM models and built capacity for people who use drugs to use CLM data for improving services. It has also awarded subgrants to support country-level CLM initiatives, and sustained peer learning and support and ongoing supervision, fostering a supportive learning environment. As CLM becomes increasingly embedded in health-care systems across central and eastern Europe and central Asia, sustained efforts from networks such as the Eurasian Harm Reduction Association can foster collaborative efforts, sustained services, resources and experience-sharing to refine approaches and amplify impact(26).

⁷ The Eurasian Harm Reduction Association is a non-profit-making membership-based public organization that unites and supports more than 300 central and eastern European and central Asian harm reduction activists and organizations.

Maturity levels

The Matrix plots the five CLM domains against three simplified stages of development of a CLM system—initial or challenging, establishing and maturing (Figure 2):

- **Initial or challenging:** this initial stage describes CLM efforts in their early days, in terms of either duration or progress achieved. CLM models are under development and CLM principles are barely applied.
- **Establishing:** in this intermediate stage, CLM efforts are characterized by a more structured, systematic and collaborative process and broad—but sometimes inconsistent—application of CLM principles. The foundations are in place, and CLM is becoming a recognized mechanism for data collection, service quality improvement and dialogue.
- **Maturing:** in this advanced stage, CLM efforts are characterized by their ability to drive systemic, sustainable change, and to fully apply and improve CLM principles. CLM is robust, respected and sustainable, and has a proven track record of generating impactful results and ensuring accountability.

Figure 2. Simplified stages on the continuum of development of a CLM system



These stages are part of a much more complex continuum of progress in CLM system maturity. Within each stage, there can be degrees of CLM development that are not possible to accurately capture in a simplified model.

Different stakeholders may have different perspectives on what stage the CLM system is at in the country. It may not always be easy to determine the correct maturity level when a domain is at a transition point—for example, moving from the initial or challenging stage to the establishing stage. The user decides where to land in the transition point, but the decision should be applied consistently across the different domains of the Matrix.

The limited number of stages in the Matrix and the use of a colour-coding system aid understanding, user-friendliness, discussion and communication. The level of granularity used to analyse progress within the three broad maturity levels is at the discretion of the user.

Thematic and geographical application

The Matrix is intentionally not overly prescriptive. This ensures applicability in a wide variety of contexts and allows users to reflect on their CLM systems and programmes and incorporate local realities and context for each domain. Although the Matrix is focused on CLM as an approach that can improve service delivery and health outcomes, it recognizes the multisectoral applicability of CLM(33). The maturity goals and minimum standards across the five domains outlined in the Matrix can be adapted to reflect on the progress of CLM approaches across sectors.

Regardless of whether a programme is newly established or transitioning from a methodology such as scorecards or community-based monitoring, the Matrix encourages practical action to support continuous improvement across all five variables, with progress measured by movement towards the maturing stage for every variable of the Matrix.

Depending on the context, the Matrix and its results may be used at the national level (if CLM efforts are coordinated at the national level by a group representing communities, such as a consortium, or are nationally representative) or the subnational level (if CLM efforts are confined to the parameters of an existing project with limited geographical and representational scope).

CLM progression matrix framework

Domain	Initial or challenging
Community leadership Maturity goal: CLM is informed, led, implemented and used by and for affected communities CLM principle: "Ownership of the CLM process, including decisions about dissemination and use of the data generated, remains with the community from which they were drawn. Special effort should be made to ensure representation of organizations and groups affected by HIV in any coordinating body" (2)	The organizations leading or implementing CLM do not represent or have not been endorsed by the affected communities
	The organizations leading or implementing CLM are nongovernmental or civil society organizations with little or no representation of the affected communities
	The organizations leading or implementing CLM do not have the power to make decisions about the scope of CLM (i.e. what to monitor) or about data
	The community does not own the CLM data it generates (i.e. does not have a say in how the data are stored or used)

Establishing	Maturing
The organizations leading or implementing CLM represent or have been endorsed by key, vulnerable and affected communities, with clear accountability mechanisms to these communities	CLM coordination and implementation partners represent all commonly recognized and targeted key, vulnerable and affected populations in the country
The organizations leading or implementing CLM are representative of the affected communities and are increasingly recognized and appreciated as partners to government and other stakeholders supporting data generation and co-creation of solutions to improve quality of services and access of clients to services in the country	The organizations leading and implementing CLM are community-led organizations, and they are coordinating or capacity-building other community-led implementers CLM work is coordinated by a community-led and community-agreed forum (in cases of multistakeholder leadership and power within communities)
The organizations representing affected communities that are leading or implementing CLM have some degree of power to make decisions about the scope of CLM, but final decisions may be under the influence of other CLM stakeholders	Community representatives are part of the discussion and are autonomous and independent to make decisions on collection, handling, analysis and storage of data, and on CLM data dissemination and advocacy strategies
The community may own the CLM data it generates (i.e. has a say in how the data are stored and used), but data ownership, handling and sharing arrangements have not been fully defined, or final decisions may be influenced by other stakeholders	The community owns the CLM data it generates and has fully defined data ownership, handling and sharing arrangements

CLM progression matrix framework

Domain	Initial or challenging
Evidence generation Maturity goal: CLM design, collection and analysis of data seek to monitor trends over time and adopt a community lens focused on improving service quality and removing barriers to good health. Data collection adheres to ethical and secure data management practices CLM principle: “CLM [requires] regular and methodical data collection ... CLM is conducted independently and autonomously, without being directed or interfered with by other stakeholders (e.g. the government or a donor) ... As its capacity and contribution grow, CLM can broaden the range of topics covered and enable the comparison of standardized data from different groups” (2)	CLM tools, data collection or analysis: - are not defined, owned or implemented by the affected communities, or those representing them, in an independent or autonomous manner - focus on a few barriers to services, as prioritized by a community within a disease area - are not guided by clear CLM principles and protocols to prevent, identify or manage conflicts of interest, or to guarantee data safety, confidentiality and quality - have limited capacity, timelines, completeness and credibility - are applied intermittently or in an ad hoc manner, and trends are generally not derived - are not regularly optimized based on learning and feedback loops - lack clear prioritization criteria and transparency for selection of CLM sites based on local situation and needs (i.e. caseload and recipient of service profile) - do not complement or are not triangulated with national health information systems

Establishing	Maturing
CLM tools, data collection or analysis:	CLM tools, data collection and analysis:
may involve the affected communities in their definition, ownership or implementation, but not in an independent, autonomous or consistent manner	are consistently, independently and autonomously defined, owned and implemented by the affected communities
focus on a breadth of barriers to good health and related services within a disease area, although some gaps remain	focus on all key barriers to good health and related services and adopt a multidisease (integrated) and person-centred approach, as prioritized by the affected communities
are partially guided by some protocols to prevent, identify and manage conflicts of interest, or to guarantee data safety, confidentiality and quality	are fully guided by clear protocols to prevent, identify and manage conflicts of interest, and to guarantee data safety, confidentiality and quality
are generally timely, complete and credible	are timely, complete and credible
are applied in a routine (at least quarterly) and systematic manner, and some trend analysis is undertaken	are applied in a routine and systematic manner, and trend analysis is standard
are sometimes optimized based on learning and feedback loops	are optimized as needed based on learning and feedback loops, including from the affected communities
demonstrate clear prioritization criteria, and transparency for selection of CLM sites exists, but gaps remain	demonstrate clear prioritization of criteria and transparency for selection of CLM sites, knowledge generation and management
complement or are triangulated to some extent with national health information systems, but this is not done regularly, and there may be overlaps or duplications	complement or are triangulated with national health information systems regularly without jeopardizing their nature, purpose and integrity

CLM progression matrix framework

Domain	Initial or challenging
Action and accountability Maturity goal: CLM seeks to identify collaborative solutions and hold decision-makers accountable for their implementation to achieve improvements in services that respond to the community's priorities and impact health outcomes positively CLM principle: "Collection and analysis of data are through a lens of community need, focused on removing barriers to good health, identifying solutions and holding decision-makers accountable for their implementation"(2)	CLM data are shared with only some stakeholders involved in the service monitoring and improvement cycle on an ad hoc basis
	CLM data are not generally translated into clear or actionable advocacy messages through a co-creation process involving the affected communities, or those representing them, and all other stakeholders involved in the service monitoring and improvement cycle
	Subsequent advocacy may lead to limited action to improve health outcomes
	Advocacy results generally are not tracked or documented by the CLM implementer

Establishing	Maturing
CLM data are shared with all stakeholders involved in the service monitoring and improvement cycle at the local level, but a formal structure or process for doing this may not be in place	CLM data are shared routinely and in a timely manner with all stakeholders involved in the service monitoring and improvement cycle through a formally established structure or process
CLM data are translated into clear and actionable advocacy messages for local, regional or national dissemination, but not always on a regular basis in the service monitoring and improvement cycle	CLM data are regularly translated into clear and actionable advocacy messages in the service monitoring and improvement cycle
Subsequent feedback at the local level and advocacy at the regional and national levels has led to multiple actions to improve health outcomes, sometimes through a co-creation process involving the affected communities, or those representing them, and all other stakeholders involved	Subsequent advocacy has resulted in multiple actions to improve health outcomes, always through a co-creation process involving the affected communities, or those representing them, and all other stakeholders involved
Some monitoring and advocacy results have been tracked and documented by the CLM implementer	Advocacy results are well tracked, documented and disseminated by the CLM implementer

CLM progression matrix framework

Domain	Initial or challenging
Partnership and collaboration Maturity goal: CLM promotes and benefits from partnerships based on mutual respect and the integrity of all actors involved in the service monitoring and improvement cycle. These partnerships recognize the unique role of each partner in improving health outcomes CLM principle: “Promot[e] good partnerships between all those involved in the service monitoring and improvement cycle ... All collaboration should be based on mutual respect for the integrity of other actors, with recognition of the unique role of each contributor in improving health ... Most of the iterative and continuous approach to quality improvement and building partnerships will be at the local level” (2)	CLM partnerships are potentially isolated (project-based) and fail to constitute broad stakeholder platforms (having community groups, service providers, government officials, technical assistance providers, donors and development partners on board) to effectively coordinate implementation and share information and lessons learned
	CLM partnerships have not achieved common agreement with the government, resulting in insufficient official buy-in and official implementation bottlenecks
	CLM partnerships fail to harmonize and bring together community groups working on CLM, which suffer from competition and insufficient coordination
	There is no board or other oversight mechanism to address implementation bottlenecks identified by CLM data

Establishing	Maturing
CLM partnerships manage to establish limited stakeholder platforms (having community groups, service providers, government officials, technical assistance providers, donors and development partners on board) for coordination of implementation and information-sharing, but these are driven primarily by development partners	CLM partnerships are built on the basis of formal stakeholder coordination and information-sharing platforms (having community groups, service providers, government officials, technical assistance providers and donor and development partners on board) recognized by national and local partners
CLM partnerships are engaged with the government, with agreement that implementation is consistent with CLM principles, but bottlenecks remain	Government buy-in is demonstrable in its actions to enable CLM implementation
CLM partnerships secure limited coordination and harmonization of CLM efforts by community groups, but significant gaps remain	CLM partnerships secure robust coordination and harmonization of CLM efforts by community groups, which reach consensus and coordinate on, for example, fund allocation and technical assistance provision
A board or other oversight mechanism to address implementation bottlenecks identified by CLM data exists, but may include only a limited number of stakeholders or may not fully function yet	A board or other oversight mechanism exists to address implementation bottlenecks identified by CLM data, incorporating all relevant stakeholders, and functions effectively

CLM progression matrix framework

Domain	Initial or challenging
Resilience and sustainability Maturity goal: CLM sustainability is ensured through the development of strong technical and operational community-led organization capacity, integration into national and subnational decision-making processes and programme reviews, viable financing models, resilient teams and effective mechanisms for adaptation to changing circumstances CLM principle: “CLM should be developed and funded in a sustainable manner to allow for ongoing data collection that can monitor trends over time ... Bring in the necessary technical expertise while building community capacity” (2). CLM is not a standalone activity but an essential component of a larger framework of community-led responses to health and well-being. CLM is most effective when it is included in national policy and has other concrete signs of long-term and sustainable support	CLM is not considered by major stakeholders as an integral part of national or local accountability mechanisms
	National (country or local) CLM ownership is limited
	There is no national CLM strategy, and CLM is not considered or mentioned in the national health strategic plan or framework
	There is little or no local capacity for CLM in the implementing organization(s)

Establishing	Maturing
CLM is perceived by most major stakeholders as an integral part of national or local accountability mechanisms	CLM is perceived by all major stakeholders as an integral part of national or local accountability mechanisms
National and local ownership is growing	National and local ownership are strong
A national CLM strategy is under development or has been completed but may lack support or contain important gaps that affect implementation; CLM may be mentioned in the national health strategic plan or framework but lacks details to enable effective operationalization	There is a standalone CLM national strategy, or it is part of a national health strategic plan or framework with broad support and sufficient detail to enable effective operationalization
CLM partners have recognized, well-documented technical capacity to undertake all, and lead most elements of, CLM implementation, organization and oversight, but are limited to only one capable staff member	Technical capacity of CLM partners is widely recognizable across the community (beyond a small number of coordinating and key implementing organizations), with capability and redundancy capacity to lead all elements of CLM implementation, organization and oversight; the organizations leading and implementing CLM may share their CLM technical expertise with other stakeholders designing or implementing CLM initiatives

CLM progression matrix framework

Domain	Initial or challenging
Resilience and sustainability continued	CLM initiatives are donor-driven and lack a national CLM strategy, framework or vision to guide them, and do not have government buy-in
	National technical resources and financing for CLM are very limited or nonexistent; funding cycles are short, inhibiting multiyear planning
	CLM as a standalone effort does not contribute to improve health system function and performance
	CLM does not have in place review processes enabling it to adapt to changing circumstances or priorities

Note: although the terms “community-led monitoring” and “community-based monitoring” may both refer to monitoring of the services conducted in community settings, the two are distinguished by who is doing the monitoring. For CLM, clients of services such as people living with HIV or people from key and vulnerable populations make decisions regarding what is monitored, take ownership of the data from monitoring, and lead the development of advocacy messages. For community-based monitoring, the decision-makers are not necessarily primarily (or at all) people living with HIV or people from key populations. The two are closely related but different models, as reflected in some of the descriptions in the Matrix. Users should be aware of the distinction between the two, particularly in cases where there may be hybrid approaches (e.g. involvement of people living with HIV but few (if any) people from key populations in leadership). The essence of the Matrix is not where an organization is now but how it will progress towards CLM maturity.

Establishing	Maturing
CLM initiatives may be donor-influenced but are coordinated by a national or local CLM forum, which is led by community-led or civil society organizations and guided by a national CLM strategy, framework or vision and partial government endorsement	CLM initiatives combine donor and domestic resources; are coordinated by national and local CLM forums; are guided by a national CLM strategy, framework or vision; and have full government endorsement
Financing for CLM is sufficient; funding cycles are multiyear and enable medium-term planning	Multifunder financing for CLM is stable or growing; funding cycles are multiyear and enable medium-term planning
CLM is gradually considered as complementary to health information systems and has started to contribute to addressing communicable diseases such as TB	CLM is considered as a good complement to health information systems and contributes to addressing other health issues beyond HIV, with CLM recommendations included in areas of improving, for example, supply management and health service provider orientations
CLM has limited review processes, enabling it to adapt to some extent to changing circumstances or priorities	CLM has a robust review process in place, enabling it to adapt swiftly to changing circumstances or priorities

Using the Matrix

The Matrix is an action-oriented forward-looking tool to facilitate positive development and maturity of CLM in a country. The use of the Matrix should follow a multistep, collaborative reflection process that is cyclical in nature. The key steps are outlined below and in [Figure 3](#).

Step 1: map CLM stakeholders

The use of the Matrix should align with the CLM principles of community leadership and collaboration. CLM stakeholders at the national, subnational and local levels, as appropriate to the intended CLM implementation scope, should be invited to participate in the Matrix-guided reflective discussion on CLM implementation. This could include community-led organizations and end-users of the services being monitored, service delivery partners, the government, technical assistance providers and funders. Countries may benefit from regularly updated CLM stakeholders mapping.

Step 2: convene a reflective workshop

A multistakeholder reflective workshop should be planned and budgeted for on an annual (or potentially biennial for mature programmes) basis. Collaboration and exchange may be best fostered through external facilitation. This ensures all stakeholders are able to engage and contribute equally. Consideration should be given to meeting modalities that optimize resource use, including through leveraging existing national review and planning processes.

Step 3: gather insights on progress and gaps

Review and reflect on the CLM progress using the descriptors under each Matrix domain. Domain maturity descriptors are broadly phrased—they should be used not as a checklist but as a series of comments and questions to assist in the reflection process.

Workshop participants may prepare data, case studies and other evidence of where they believe CLM efforts in the country fit against the Matrix for each of the five domains at that point in time. It is possible that after going through a reflective process, implementers will determine they are at different stages of CLM development for each of the five domains being assessed. The purpose of this reflection is not to look at a single domain or score in isolation but to get an overall understanding of progress and maturity for the CLM efforts as a whole. Where progress is slow or poor, stakeholders should seek to understand the reason for this to enable remedial action.

The Matrix encourages prospective thinking. If there is a lack of agreement on progress in certain domains or if progress is deemed to be slow, the focus should be on where the programme may evolve in the following phase of development (typically within one or two years).

Step 4: draft an action plan

Seek consensus across stakeholder groups on the key actions required on the basis of the CLM progress analysis undertaken. Set realistic and achievable goals within a limited period (typically one year) and allocate responsibilities across CLM stakeholders. When the agreed actions have cost implications, try to get clarity on these and on possible funding sources to cover them.

If consensus is not achieved over the maturity level in one or more dimensions, it may be better to focus on the progress that can be achieved in the next period of implementation—and the process or outcome indicators that would confirm this progress to all partners—rather than dwelling on disagreements over existing achievements.

Step 5: implement agreed actions

Share the outcomes of the CLM reflective workshop transparently. Encourage integration of the agreed CLM actions into the responsible CLM stakeholder action plans and follow up implementation until the next CLM maturity review (typically after one year). CLM is a continuous process, and efforts are needed between reviews to continue implementing the recommendations as defined in the CLM self-assessment and improving the CLM activities.

The Matrix may be used in conjunction with, or may inform, other processes such as an HIV sustainability roadmap⁽³⁴⁾. The Matrix may also benefit from using CLM costing guidance as part of efforts to cost community-led responses.

Figure 3. Overview of the Matrix annual implementation cycle



Interpretation of results

Limitations often arise when trying to capture real-world complexity in a simple model. This is the case for the proposed Matrix. The colour-coding system, which aids understanding, user-friendliness and communication, should not be interpreted as rating CLM efforts as simply “good” or “bad”. The Matrix seeks to promote honest reflection among CLM implementers and stakeholders. It reinforces areas of strength and areas for continued work and provides simple and broad parameters to improve adherence to the principles and overall effectiveness of CLM.

Persistent absence (two or more years) of progress in any one domain is a red flag, indicating that the CLM programme is failing to live up to the CLM core principles⁽²⁾ and meet the minimum standards proposed by UNAIDS in this guidance document. It is possible that the context, such as unfavourable policies towards a particular population or a particularly difficult operating environment (e.g. a humanitarian crisis situation), may prevent progress in any or all of the five domains. In these circumstances, an honest discussion should be initiated among all stakeholders about why progress has not been achieved, and whether alternative or complementary approaches could be trialled to meet core CLM principles.

The specific indicators of progress will vary between contexts, according to the priorities set at the beginning of the CLM work. A number of resources that support CLM good practice are available from the Community-led Accountability Working Group⁽³⁵⁾, the International AIDS Society⁽³⁶⁾, the International Treatment Preparedness Coalition⁽³⁷⁾, UNAIDS and others. The development of a targeted technical support plan could be considered in some cases.

The aim of assessing CLM progress is to contribute to improving quality of services, end-user experiences and health outcomes over time, as reported by service users in the data collected by the CLM programme. Given the major impacts of the funding landscape on CLM from early 2025, stakeholders may adapt and use the Matrix according to their situation and needs, such as raising resources for improving specific elements of CLM identified and prioritized in the Matrix self-assessment.

CLM remains a powerful tool that contributes to the common goal endorsed by Member States of ending AIDS as a public health threat by 2030, ensuring empowerment of people living with HIV, and citizen involvement and voice in the broader health sector and beyond.

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