Agenda

- **CQUIN Framing Remarks:** CQUIN National M&E Vulnerability Assessment Tool and Pilot
  - Bill Reidy, ICAP/CQUIN
- **Addressing National M&E Vulnerabilities in a Time of Change**
  - Francis Kalonga, Ministry of Health, Malawi
  - Marijanatu Abdulai, Ministry of Health, Ghana
  - Nkechi Okoro, Network of People Living with HIV and AIDS in Nigeria (NEPWHAN)

Panel Discussions and Q&A:
  - **Co-moderators:** Marline Jumbe & Hermann Brou, ICAP/CQUIN
    - Bill Reidy, ICAP/CQUIN
    - Francis Kalonga, MOH Malawi
    - Marijanatu Abdulai, MOH Ghana
    - Nkechi Okoro, NEPHWAN, Nigeria

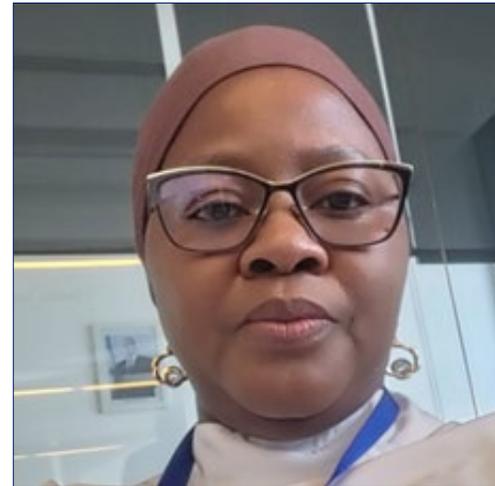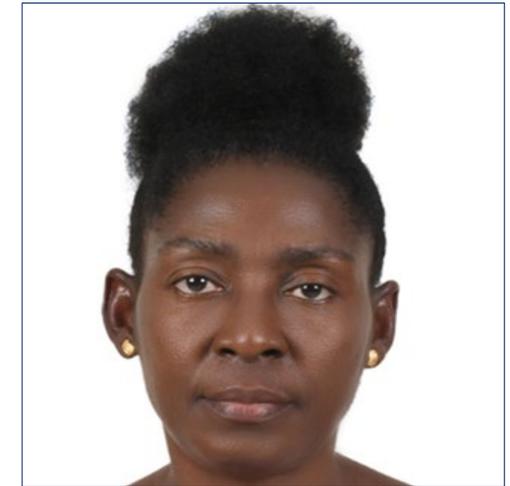- **Closing Remarks:** Bill Reidy, ICAP/CQUIN

Presenters

Bill Reidy
Deputy Director, Strategic Information & CQUIN SI Lead, ICAP at Columbia University

Francis Kalonga
Principal Monitoring and Evaluation Officer, Ministry of Health, Malawi

Marijanatu Abdulai
Monitoring & Evaluation Officer, National AIDS/STI Control Program, Ghana

Nkechi A. Okoro
Monitoring and Evaluation Manager, NEPWHAN, Nigeria

Outline

- Objectives of the CQUIN *National M&E Vulnerability Assessment* tool and pilot

- Overview of assessment tool and scoring

- Implementation of assessment to date

- Summary and future steps

Objectives of the CQUIN national M&E vulnerability assessment

Main objective:

To help countries document the scope, and degree of vulnerabilities in national HIV M&E systems presented by potential cuts in support by external funders such as PEPFAR and Global Fund

Secondary objective:

To identify gaps in country HIV M&E, which may be unrelated to current or future cuts in external support

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Structure of the assessment: 7 domains

Health management information systems (HMIS)

> 1. Paper-based system*

> 2. Electronic medical record (EMR)-based system

Optimizing HMIS implementation

> 3. Data quality

> 4. Data dissemination and use

Cross-cutting domains

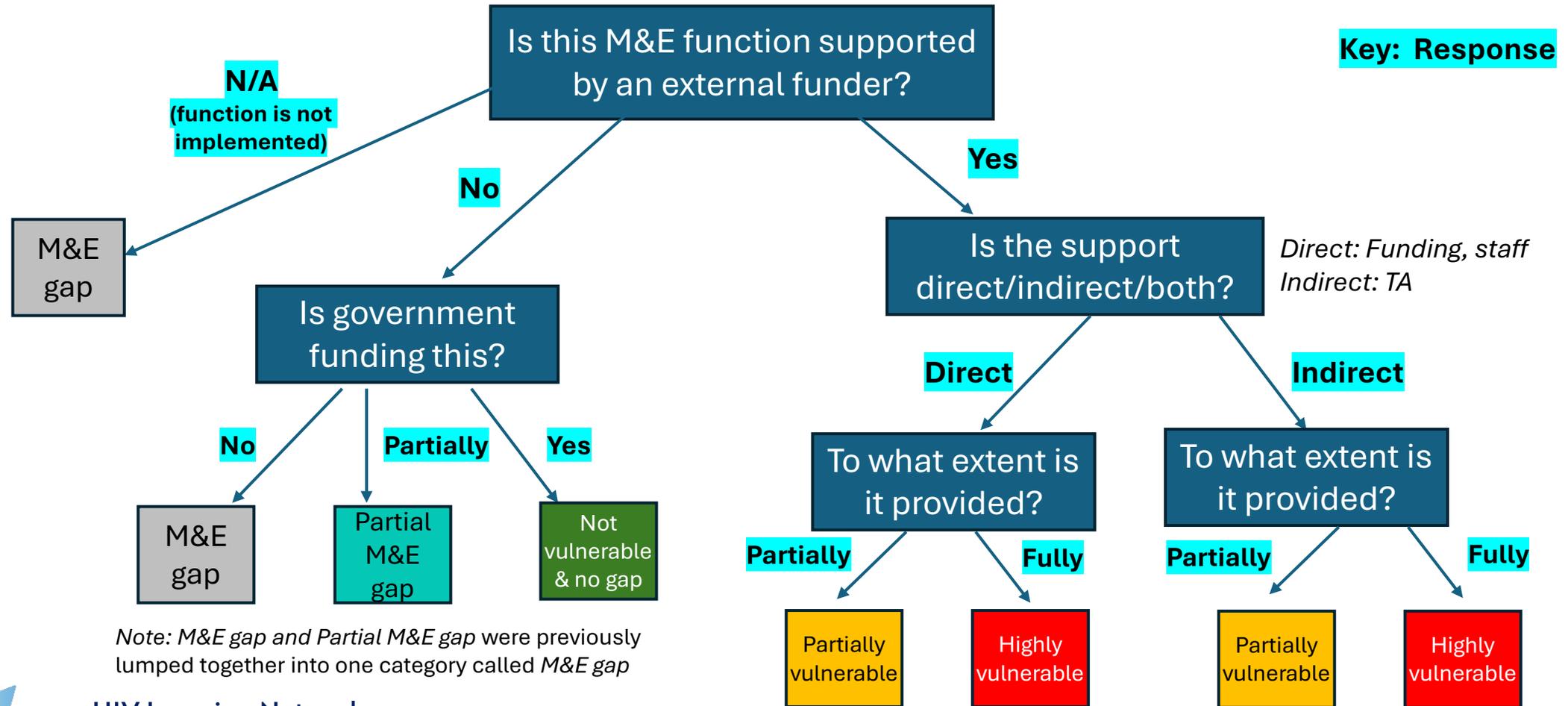> 5. M&E human resources for health (HRH) capacity

> 6. M&E of community-based HIV services

> 7. Community-led monitoring (CLM) and community engagement in M&E

*Includes paper tools and aggregate databases, e.g., DHIS2

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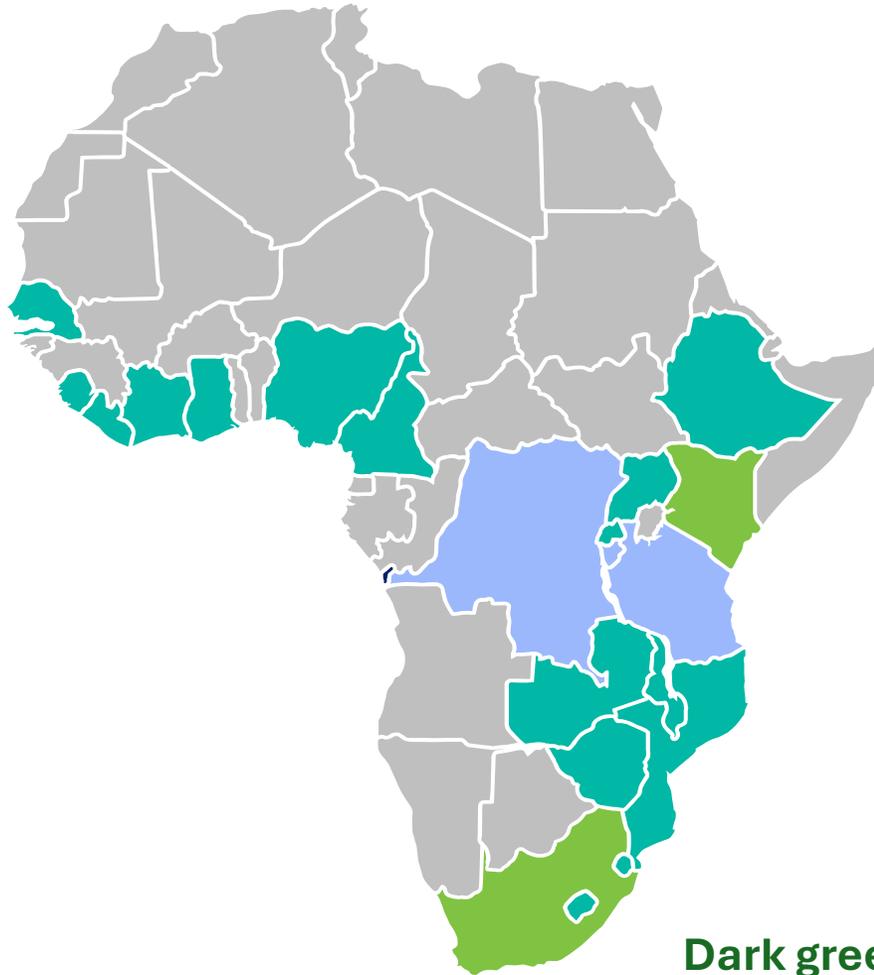# Level of assessment: M&E function scoring (max n=199)

Example M&E function: *Developing and customizing national HMIS dashboards and analytic reports that display aggregate data on key program indicators for monitoring performance*

Is this M&E function supported by an external funder?

Key: Response

N/A (function is not implemented)

M&E gap

No

Yes

Is government funding this?

Is the support direct/indirect/both?

Direct: Funding, staff
Indirect: TA

No

Partially

Yes

M&E gap

Partial M&E gap

Not vulnerable & no gap

Note: M&E gap and Partial M&E gap were previously lumped together into one category called M&E gap

Direct

Indirect

To what extent is it provided?

To what extent is it provided?

Partially

Fully

Partially

Fully

Partially vulnerable

Highly vulnerable

Partially vulnerable

Highly vulnerable

Note: If either Direct or Indirect are provided partially (rather than fully), the item is classified as partially vulnerable

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Implementation of assessment to date

- 16 countries have completed the pilot assessment
  - 4 in Oct-Nov 2025
  - 12 in Jan-Feb 2026
- An additional two countries are midway through completing the tool
- Countries are also providing feedback to inform updates to tool
- ICAP-CQUIN team will continue to support countries to complete assessment and interpret results

Dark green: Completed assessment
Light green: Partway through completing
Light blue: Have not begun assessment
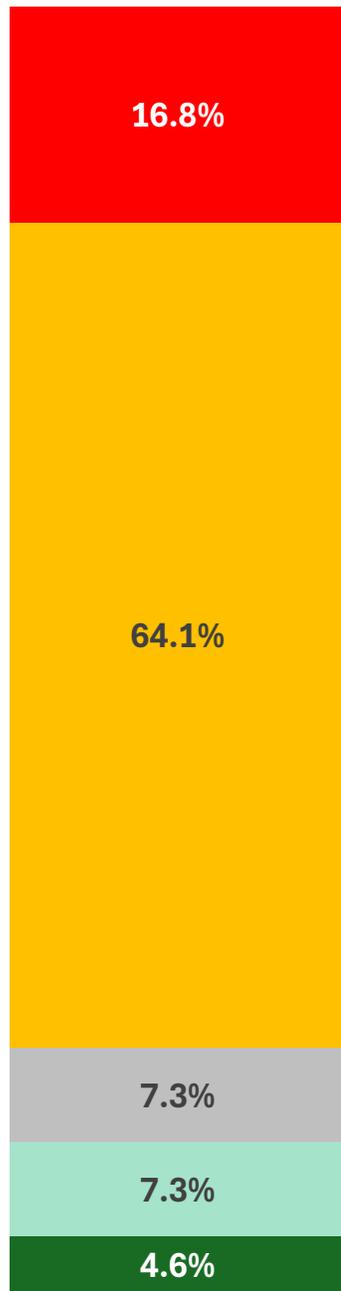
M&E systems vulnerabilities and gaps
Combined scores across all 7 domains
## 7 CQUIN countries (n=1,361 M&E functions scored)

- Preliminary analysis of data from 7 countries shows that 81% of M&E functions were supported by external donors

- 15% of M&E functions were not externally supported and were either *not* funded or were *partially* funded by the government

- Only 5% of M&E functions were reported as fully funded by government, and without external support

Category	Description
Highly vulnerable	Full external support
Partially vulnerable	Some external support, some government support
M&E gap	Not funded or supported by government or external partner
Partial M&E gap	Partially funded by government, no external support
Not vulnerable	Fully funded by government, no external support

Type of external support provided
Combined scores across all 7 domains
7 CQUIN countries (n=1,361 M&E functions scored)

Type of external support provided

Among 1,105 (81%) M&E functions scored as highly or partially vulnerable
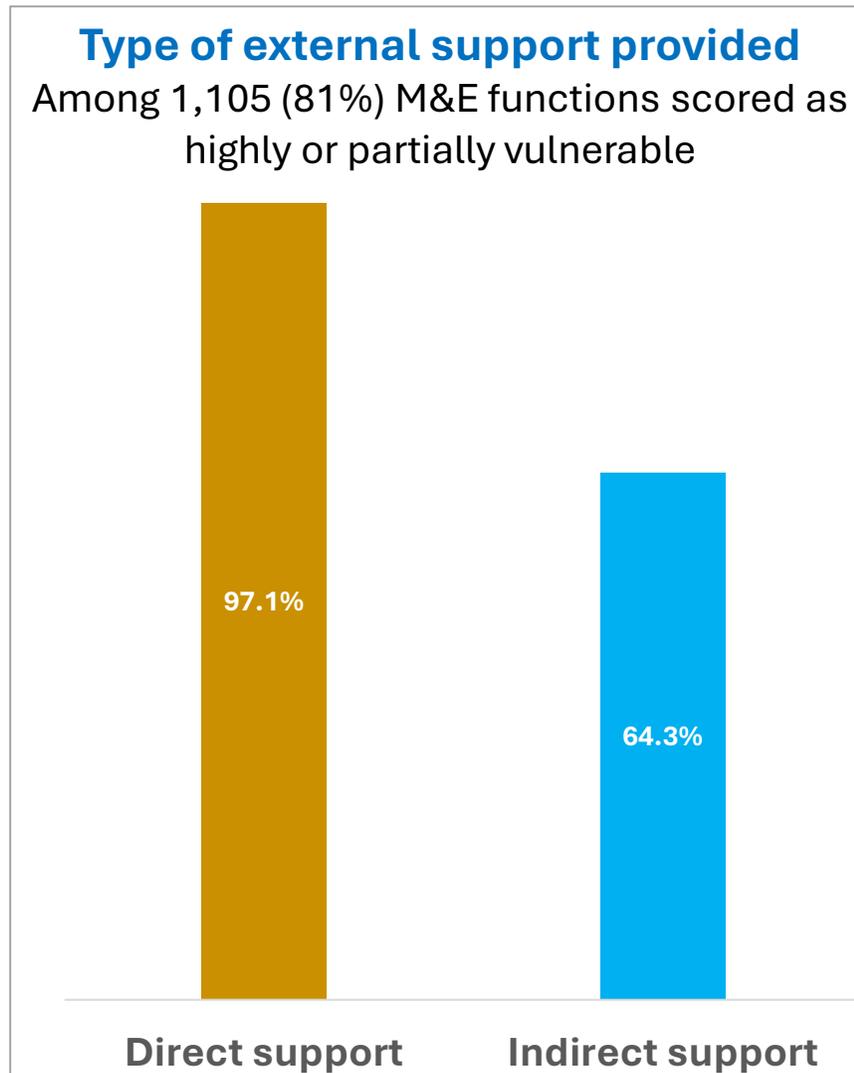
- **Nearly all (97%)** of the highly and partially vulnerable M&E functions were receiving **direct support** via an external donor or partner
- The **majority (64%)** of vulnerable M&E functions were also receiving **indirect support** through an external donor or partner
- **61%** of M&E functions receive **both** direct and indirect support

From the assessment tool:

Direct support *refers to financial or human resource contributions / personnel provided to carry out the M&E function (e.g., funding salaries or positions, covering operational costs, procurement etc.)*
Indirect support *refers to technical assistance or implementation support that helps to strengthen or sustain the M&E function without directly financing it (e.g., technical guidance or mentorship, joint supervision, training or review activities, and other above-site activities such as participation in technical working groups)*

Summary

- The CQUIN *M&E System Vulnerability Assessment* is intended to help countries identify, and address gaps and potential threats to the viability of M&E system elements

- Preliminary results suggest MOH engage external funders to play a broad complementary role in HIV M&E, via direct and indirect support

- We must better understand implications of 'vulnerabilities' and 'gaps' across the domains assessed
  - Can inform MOH plans and engagement with donors
  - What approaches can countries use to improve sustainability of M&E?

- A variety of stakeholders are needed in this process
  - MOH, community, PLHIV, key populations representatives

Future Steps

- Additional countries will be completing assessments
- Feedback from countries will guide updating of pilot tool
- April CQUIN meeting
  - Version 2 of tool to be introduced at M&E pre-meeting
  - Comprehensive results of pilot assessments will be presented
  - Further engagement of recipient of care representatives
- Post-April meeting: countries complete scoring using updated version 2 tool
  - Account for changing circumstances in country
- CQUIN M&E community of practice to guide further work
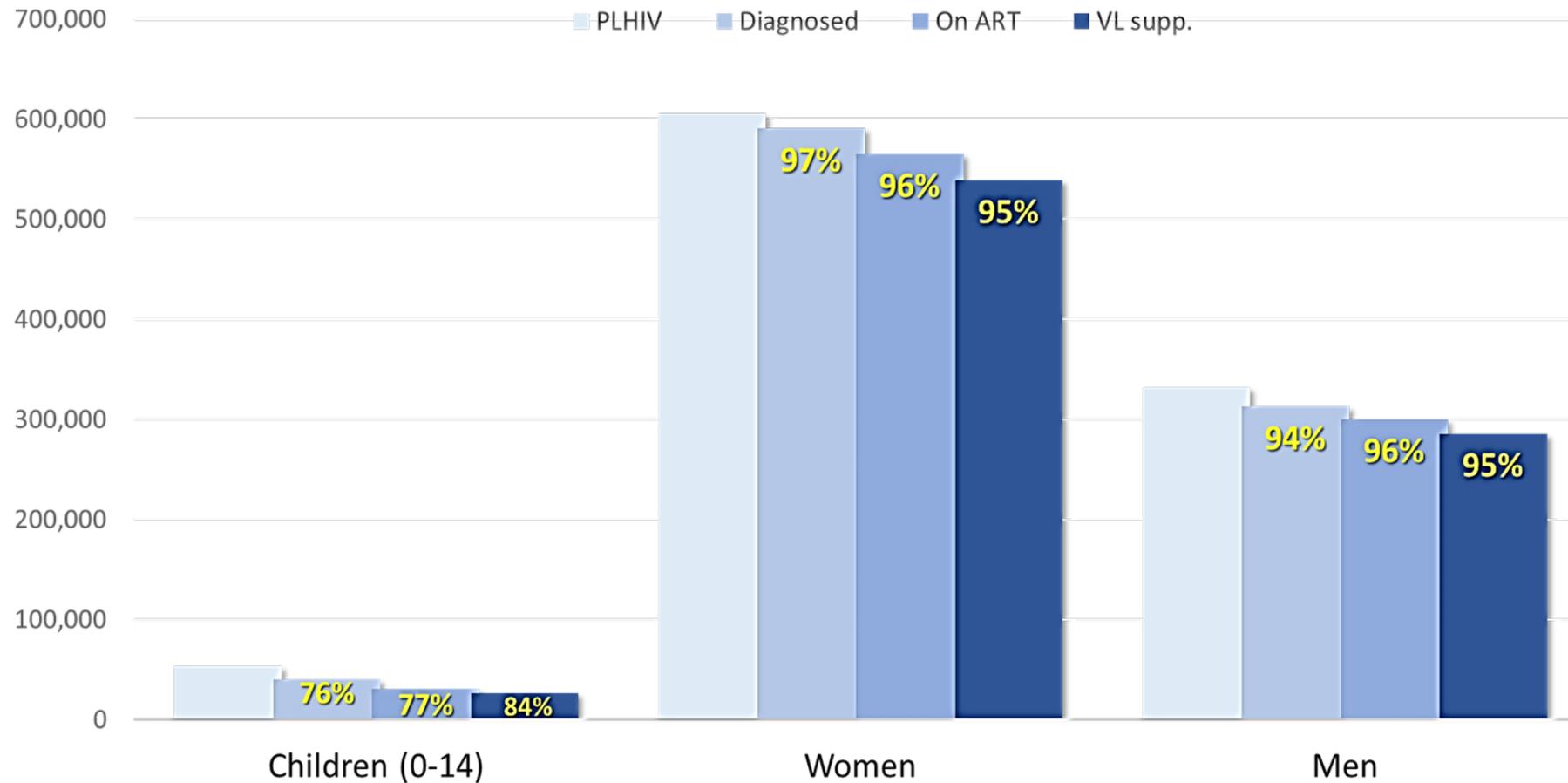
Thank you

Outline

- Malawi HIV Epidemic Overview
- National HIV M&E Architecture
- Assessment Methodology
- Key Findings
- Lessons Learned and Best Practices
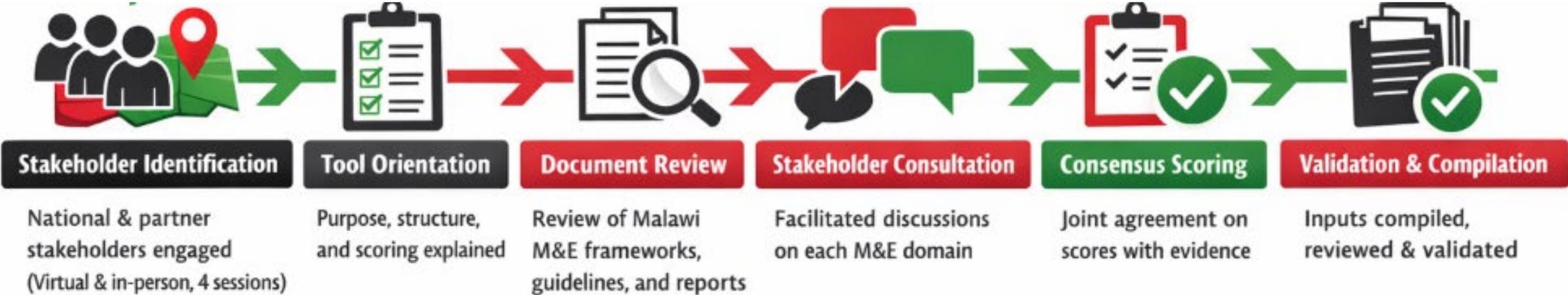- Next Steps

Malawi HIV Epidemic Overview

Spectrum Treatment Cascade (Dec 2024)

National HIV M&E Architecture

Platform / Tool	Level of Data	Key Function in HIV M&E	Support for Funding & Implementation
MaHIS (Malawi Healthcare Information System)	Patient-level & Aggregate	National unified digital health platform integrating EMRs, DHIS2, and the ScanForm. **Vision:** Hybrid digital systems in all facilities by 2030	MoH, GF and PEPFAR
DHIS2 / DHAMIS	Aggregate	National HIV reporting platform used for program monitoring and reporting	MOH, GF and PEPFAR
EMR / e-Mastercard	Patient-level	Clinical management of ART patients and generation of facility aggregate reports	MOH and PEPFAR
LIMS	Patient-level	Viral load and laboratory results management and reporting	LMOH, GF and PEPFAR
ScanForm	Patient-level (non-identifiable)	AI-enabled scanning of paper registers via Android phones; auto-generates reports and supports data quality	MOH, GF and PEPFAR. *Ultimately, this should be GoM-Led/owned*
Registers & Monthly Summary Forms	Patient-level & Aggregate (paper)	Facility/Community: Primary data capture where digital systems are unavailable; later summarized into EMR or DHIS2	MOH and PEPFAR

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Malawi M&E System Assessment Methodology

Stakeholder Identification
National & partner stakeholders engaged (Virtual & in-person, 4 sessions)

Tool Orientation
Purpose, structure, and scoring explained

Document Review
Review of Malawi M&E frameworks, guidelines, and reports

Stakeholder Consultation
Facilitated discussions on each M&E domain

Consensus Scoring
Joint agreement on scores with evidence

Validation & Compilation
Inputs compiled, reviewed & validated

Malawi M&E Vulnerability Assessment Results: M&E Functions (1)

- Core M&E domains remain partially or highly vulnerable, indicating continued reliance on external technical and financial support

- Malawi's national HIV data ecosystem is heavily partner-supported. Key systems—including the EMR, DHAMIS, DHIS2, and ScanForm—are largely maintained and supported by external donors

- Only 3 of the 199 M&E functions assessed showed full government funding and no external support

Assessment domains:

1. **HMIS – Paper/Aggregate:** A majority of functions showed **partial M&E gaps and vulnerabilities**, though **fewer are highly vulnerable**.

2. **HMIS – Electronic:** Largest concentration of **highly vulnerable functions**, suggesting sustainability risks for digital systems.

3. **Data Quality:** All M&E functions showed **gaps or vulnerabilities**, reflecting partial support by government but no elements of data quality fully owned and led by MOH.

4. **Data Use:** Almost half (41%) of M&E functions were scored as **highly vulnerable**, therein entirely relying on external support.

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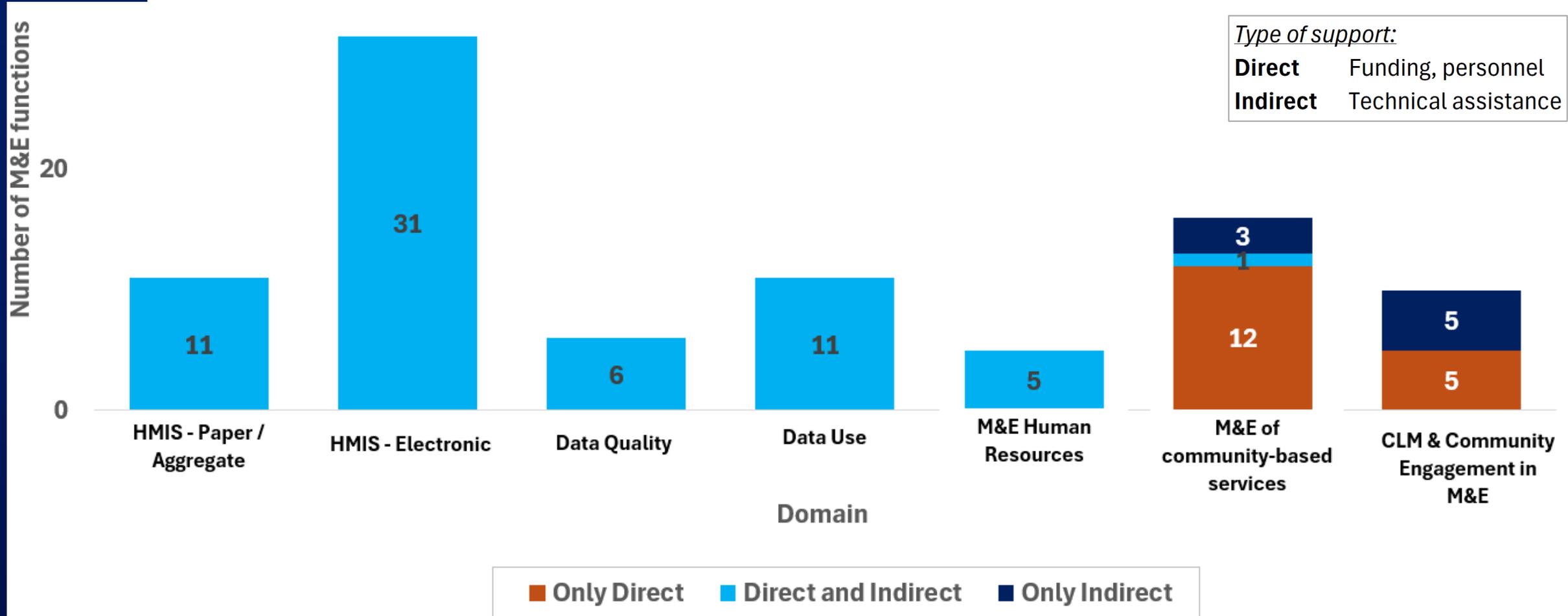# Malawi M&E Vulnerability Assessment Results: M&E functions (2)

5. M&E Human Resources: Partial M&E gaps and partial vulnerabilities remain in staffing and technical capacity; many positions are donor-supported and high turnover affects continuity and analytical capacity.

6. M&E for Community-Based Services: A large share of functions show donor-supported, **partially vulnerable** M&E functions; also many M&E functions are completely not supported **(M&E gaps)**, reflecting limited government ownership and lack of external support.

7. Community-led Monitoring & Community Engagement: Continued reliance on external support for several functions. Some M&E functions show **high or partial vulnerability**, others show **M&E gaps**; for example, community-generated data is not yet systematically integrated into national M&E systems.

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Distribution of M&E functions by Type of Support - Malawi
Among M&E functions scored as highly or partially vulnerable

Type of support:
Direct   Funding, personnel
Indirect   Technical assistance

Number of M&E functions

20

0

| HMIS - Paper / Aggregate | HMIS - Electronic | Data Quality | Data Use | M&E Human Resources | M&E of community-based services | CLM & Community Engagement in M&E |

11 — 31 — 6 — 11 — 5 — 3 / 1 / 12 — 5 / 5

Domain

■ Only Direct   ■ Direct and Indirect   ■ Only Indirect

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Malawi Assessment Scores: Key Populations M&E Functions

Domain	M&E function	Description	Score
HMIS: Paper-based/DHIS2	1.8.a.	Developing standardized key population data collection tools	
	1.8.b.	Ensuring confidentiality and secure data storage for KP data	
	1.8.c	Ensuring sufficient disaggregation of KP data in reporting tools	
	1.8.d	Ensuring that KP data are reflected in national aggregate databases	
	1.8.e	Engaging KP-led organizations in data collection and validation	
HMIS: EMR	2.10.a	Recording key populations data in EMR while maintaining confidentiality	
	2.10.b	Implementation of policies, procedures, and training on KP EMR elements	
	2.10.c	Integrating EMR KP data with routine health service data	
Data Use	4.6.a.	Fund, coordinate, and implement national or key population surveys	
CLM/CE in M&E	7.6.a	CLM data collected on KP service delivery/programming	
	7.6.b	CLM data informs KP service delivery/KP programming	

Category		Description
	Highly vulnerable	Full external support
	Partially vulnerable	Some external support, some government support
	M&E gap	Not funded or supported by government or external partner
	Partial M&E gap	Partially funded by government, no external support
	Not vulnerable	Fully funded by government, no external support

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Key Vulnerabilities in Malawi's HIV M&E System

Vulnerability	Key Issues	Implication for HIV Programs
Fragmented Data Systems	Multiple parallel systems (paper HMIS, ScanForm, EMR, e-Master Card, DHIS2, DHAMIS) with limited interoperability across clinical, laboratory, and commodity systems	Data duplication, inconsistencies, and fragmented reporting
Reliance on Manual Processes	Community-level paper tools and manual transfer of EMR/e-Master Card data into DHAMIS. Limited HMIS–EMR integration for community-based service data	Delays, transcription errors, and gaps in reporting continuity
Dependence on External Partner Support	Facility-level HMIS operations and data transmission largely dependent on implementing partners (IPs) and externally funded staff	Disruptions to reporting and system functionality when partner support is reduced
Capacity and Organizational Gaps	Lack of a comprehensive national M&E capacity-building plan. Limited diversity of expertise within M&E teams (e.g., epidemiologists, IT specialists, data analysts)	Constrains advanced analysis, system management, and evidence-based decision-making
Data Governance & System Resilience	Gaps in Key Population data documentation, confidentiality safeguards, and system resilience during disruptions	Risks to sensitive data management and timely access to program information

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How will the Assessment Findings be used in Malawi?

Alignment With USG–Malawi MoU Implementation Plans	▪ Identify priority integration areas aligned with MoU commitments ▪ Guide evidence-based selection of scalable, high-impact integration models ▪ Inform annual joint planning, resource alignment, and partner coordination ▪ Provide baseline data to track MoU implementation progress
Inputs to GC8 Grant Writing and Program Design	▪ Highlight service delivery gaps that integrated approaches can address ▪ Provide evidence to strengthen GC8 narratives and investment cases ▪ Inform module design, intervention selection, and budget prioritization ▪ Identify system bottlenecks where GC8 resources can catalyze improvements
Strengthening Malawi's National Integration Agenda	▪ Generate evidence for policy updates, guidelines, and integration frameworks ▪ Support harmonization of HIV/TB, RMNCAH, AHD, KP, and PrEP programming ▪ Improve coordination of partner investments to reduce fragmentation ▪ Provide practical recommendations for facility and district-level integration
Enhancing Monitoring, Learning and Accountability	▪ Inform development of integrated SI tools and dashboards ▪ Enable routine monitoring of integrated service delivery performance ▪ Support cross-program learning and adaptive management

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Building a Resilient HIV M&E System: Lessons and Best Practices

🔗 Integration of Health Information Systems (MaHIS) and Strengthening System Interoperability

📄 Scale-up of Government-Funded scannable data capture tools

📘 Simplified and Integrated HIV Service Guidelines

👥 Strengthening Government M&E Capacity

🏛 Integration of IP Staff into Government Structures

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Next Steps

- Finalize and disseminate the national HIV M&E assessment report to government and partner stakeholders

- Prioritize implementation of key system-strengthening actions across HR, data quality, community M&E and digital systems

- Strengthen coordination and accountability through regular stakeholder review meetings and feedback loops

- Institutionalize ongoing capacity-building to sustain technical leadership at national and subnational levels

Outline

- Ghana HIV Epidemic Overview

- National HIV M&E Architecture

- M&E Vulnerability Assessment methodology

- Key findings
  - Highlight of the key populations M&E functions vulnerabilities

- Lessons learned and best practices

- Recommendations

- Conclusion and next steps

Ghana HIV Epidemic Overview

People living with HIV **334,721**	**Sex** Males – 105,460 (31.5%) Females – 229,261 (68.5%)	**Age Group** Children (0-14) – 18,229 (5.4%) Adults (15+) – 316,492 (94.6%)
New HIV Infections **15,290**	**Sex** Males – 4,987 (32.6%) Females – 10,303 (67.4%)	**Age Group** Children (0-14) – 1,243 (8.1%) Adults (15+) – 14,047 (91.9%)
AIDS-related Deaths **12,614**	**Sex** Males – 5,455 (43.2%) Females – 7,159 (56.8%)	**Age Group** Children (0-14) – 1,325 (10.5%) Adults (15+) – 11,289 (89.5%)

1st 95%	68%	2nd 95%	69%	3rd 95%	90%

Adult (15-49) HIV Prevalence **1.49%**	Adult (15+) ART Coverage **47.5%**	PMTCT Coverage **99.3%**

- Key populations contribute disproportionately to new infections

- Focus populations: FSW, MSM, PWID and their partners (KP populations and their partners contribute to over one-quarter of new infections annually

Data source-Ghana HIV Estimates 2024

National HIV M&E Architecture - Ghana

- HIV M&E system is anchored within the national health information system and coordinated by MoH Ghana Health Service

- Key features include:
  - Integrated national HMIS reporting system
  - Routine facility and community reporting
  - Individual-level data capture using the HIV e-Tracker

- Ghana uses a hybrid reporting system combining paper-based registers and aggregate electronic reporting platforms

  - District Health Information Management System 2 (DHIMS2) remains the national

    electronic reporting platform used for aggregation and analysis of health data with paper

    registers remaining as the primary source documents at facility-level

M&E Systems Vulnerability Assessment Pilot: Methodology

- **Stakeholder Identification :** National and partner stakeholders involved in HIV M&E were identified and engaged virtually and in person (4 sessions)

- **Tool Orientation:** Participants were briefed on the purpose, structure, and scoring approach of the assessment tool.

- **Document Review**: Relevant M&E frameworks, guidelines, and programme reports were reviewed to inform responses.

- **Stakeholder Consultation:** Facilitated discussions were held to assess each domain of the tool.

- **Consensus Scoring** : Stakeholders jointly agreed on scores and provided supporting evidence.

- **Validation and Compilation** : Inputs were compiled, reviewed by the team, and validated before submission.
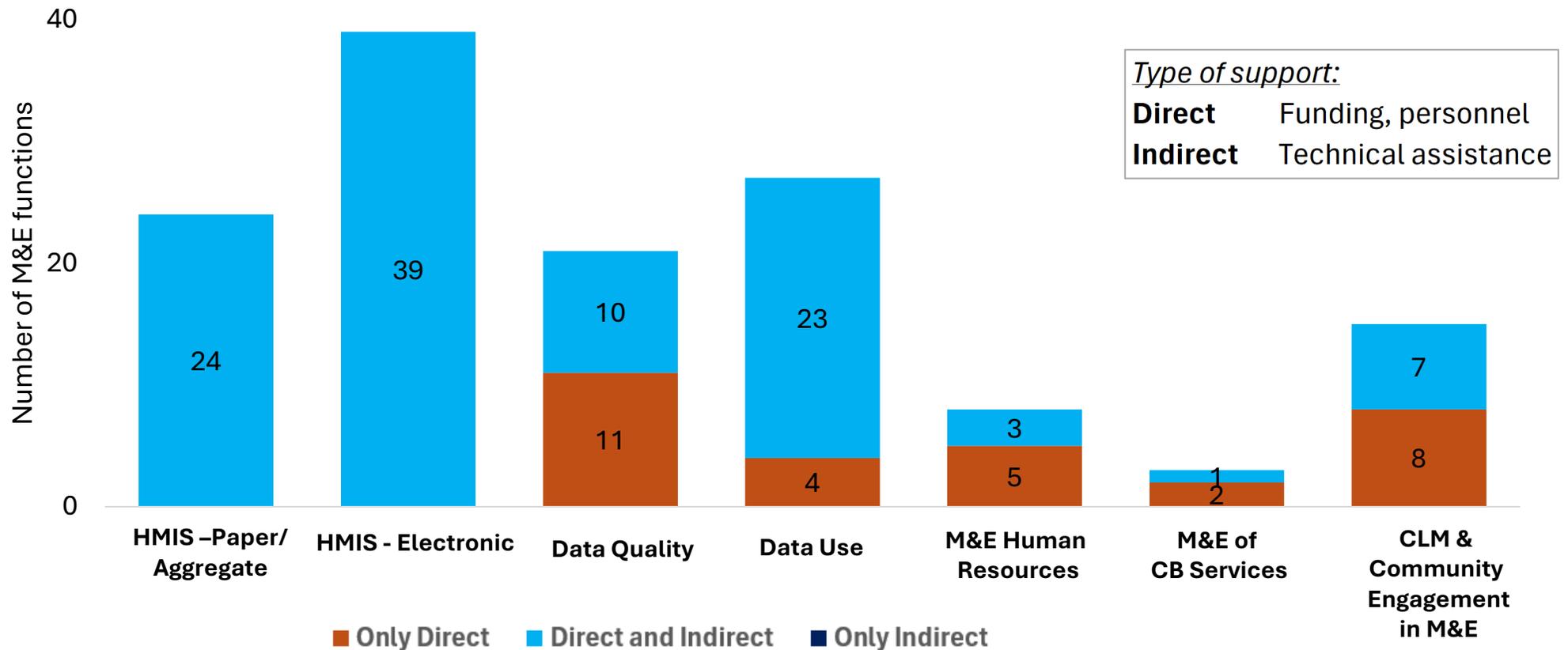
Distribution of M&E Functions by Vulnerability - Ghana

- Widespread partial vulnerabilities across most domains – shows the broad role of external support
- High vulnerabilities are especially evident in Data Quality domain
- Major gaps in M&E of Community-based services

Distribution of M&E Functions by Type of External Support - Ghana
Among M&E functions scored as highly or partially vulnerable

Type of support:
Direct Funding, personnel
Indirect Technical assistance

Number of M&E functions

| | 40 | | | | | | |

Legend: ■ Only Direct ■ Direct and Indirect ■ Only Indirect

Categories: HMIS –Paper/ Aggregate, HMIS - Electronic, Data Quality, Data Use, M&E Human Resources, M&E of CB Services, CLM & Community Engagement in M&E

Values: HMIS –Paper/Aggregate: 24; HMIS - Electronic: 39; Data Quality: 10, 11; Data Use: 23, 4; M&E Human Resources: 3, 5; M&E of CB Services: 1, 2; CLM & Community Engagement in M&E: 7, 8

- Support is predominantly *both* direct and indirect, across most domains
  - Thus, funding and/or staff, along with technical assistance is provided
- Indirect support is less common in *Data Quality, M&E HR, and CLM & Community Engagement in M&E* domains
- M&E of community-based HIV services receives the least overall external support

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Key populations M&E functions – Assessment results

	M&E function	Description	Score
HMIS: Paper-based/DHIS2	1.8.a.	Developing standardized key population data collection tools	🟧
	1.8.b.	Ensuring confidentiality and secure data storage for KP data	🟧
	1.8.c	Ensuring sufficient disaggregation of KP data in reporting tools	🟧
	1.8.d	Ensuring that KP data are reflected in national aggregate databases	🟧
	1.8.e	Engaging KP-led organizations in data collection and validation	🟧
HMIS: EMR	2.10.a	Recording key populations data in EMR while maintaining confidentiality	🟧
	2.10.b	Implementation of policies, procedures, and training on KP EMR elements	🟧
	2.10.c	Integrating EMR KP data with routine health service data	🟧
Data use	4.6.a.	Fund, coordinate, and implement national or key population surveys	🟥
CLM	7.6.a	CLM data collected on KP service delivery/programming	🟧
	7.6.b	CLM data informs KP service delivery/KP programming	🟧

Key:
- 🟩 No vulnerability
- 🟧 Partial vulnerability
- 🟥 High vulnerability
- ⬜ M&E gap
- 🟩 Partial M&E gap

- 10/11 KP functions have partial vulnerabilities
- National key population surveys are highly vulnerable
- Limited integration of KP data into routine national systems

Summary of Findings (1)

1. Paper-based and aggregate HMIS / DHIS2
- Partial vulnerabilities dominate, indicating wide role of external support in paper-based reporting processes.
- For example, the printing of these paper-based registers is mainly supported by donors and with the dwindling funds a recent scoping review has shown some lack of paper registers at the facility level resulting in most of them using improvised registers to capture data

2. HIMS Electronic
- Partial vulnerabilities dominate, for the electronic reporting system which is heavily donor funded. A system that has been put in place to solve the challenges of the paper-based system . However, not all facilities have tools such as tablets, orientation etc to work .

3. Data quality

High vulnerabilities exist for this domain as;
- Routine data verification and data quality assessments are not consistently conducted across all levels of the health system due to funding gap.
- In some cases, data submitted by facilities are not regularly compared with source documents such as registers and patient records.
- This leads to potential discrepancies between reported data and actual service records, increasing the risk of inaccurate programme reporting.

Summary of Findings (2)

4. Data Use

- While routine data are collected, there is limited ownership of the data at the sub national levels . Funding gap for data review meetings, analysis, and feedback mechanisms restricts the consistent use of programme data for decision-making.

5. M&E Human Resources

- Significant vulnerabilities exist in the **M&E workforce capacity**
- Insufficient number of dedicated M&E officers at district and facility levels
- Limited opportunities for advanced M&E training and capacity building.

6. M&E of community-based services

- Limited integration of community data into DHIMS2
- Weak and inconsistent documentation of community services

7. CLM and community engagement in M&E

- Limited funding for CLM

Lessons Learned/Best Practices

Lessons Learned

- Existing M&E systems in Ghana provide a strong foundation for routine data collection and reporting

- The review process helped clarify key operational challenges affecting M&E implementation

- Funding gaps pose a significant risk to the sustainability of critical M&E functions

- Findings will support targeted resource mobilization and sustainability planning

- The country demonstrated commitment to address identified gaps and strengthen priority M&E functions

Best Practices

- Established national HMIS platform: Ghana's use of DHIMS2 as a centralized national reporting system strengthens data management and reporting across programmes.

- Integration of M&E into programme implementation: M&E activities are embedded within programme implementation structures, helping ensure routine data collection and reporting across HIV service delivery points.

Key Recommendations

- **Secure sustainable financing for core M&E functions**
  - Prioritize M&E investments within the Global Fund GC8 application

- **Strengthen data quality systems**
  - Institutionalize routine Data Quality Assessments
  - Increase supervision and verification activities

- **Strengthen the M&E workforce**
  - Recruit additional M&E officers
  - Expand training and capacity-building programs

- **Improve data use for decision-making**
  - Invest in platforms that support data visualization and analysis

- **Strengthen community-level monitoring**
  - Integrate community reporting into national systems
  - Expand support for CLM

Conclusion/Next Steps

- Overall, the assessment demonstrates that Ghana has a well-established M&E system with strong national coordination and electronic reporting platforms

- However, targeted investments are needed to strengthen data quality, data use, and community-level monitoring to further enhance HIV programme performance

- The assessment clearly identifies specific vulnerabilities across key M&E domains, particularly in data quality, data use, and community-level monitoring

- These findings provide evidence-based justification for requesting GC8 funding to strengthen these components

Thank you
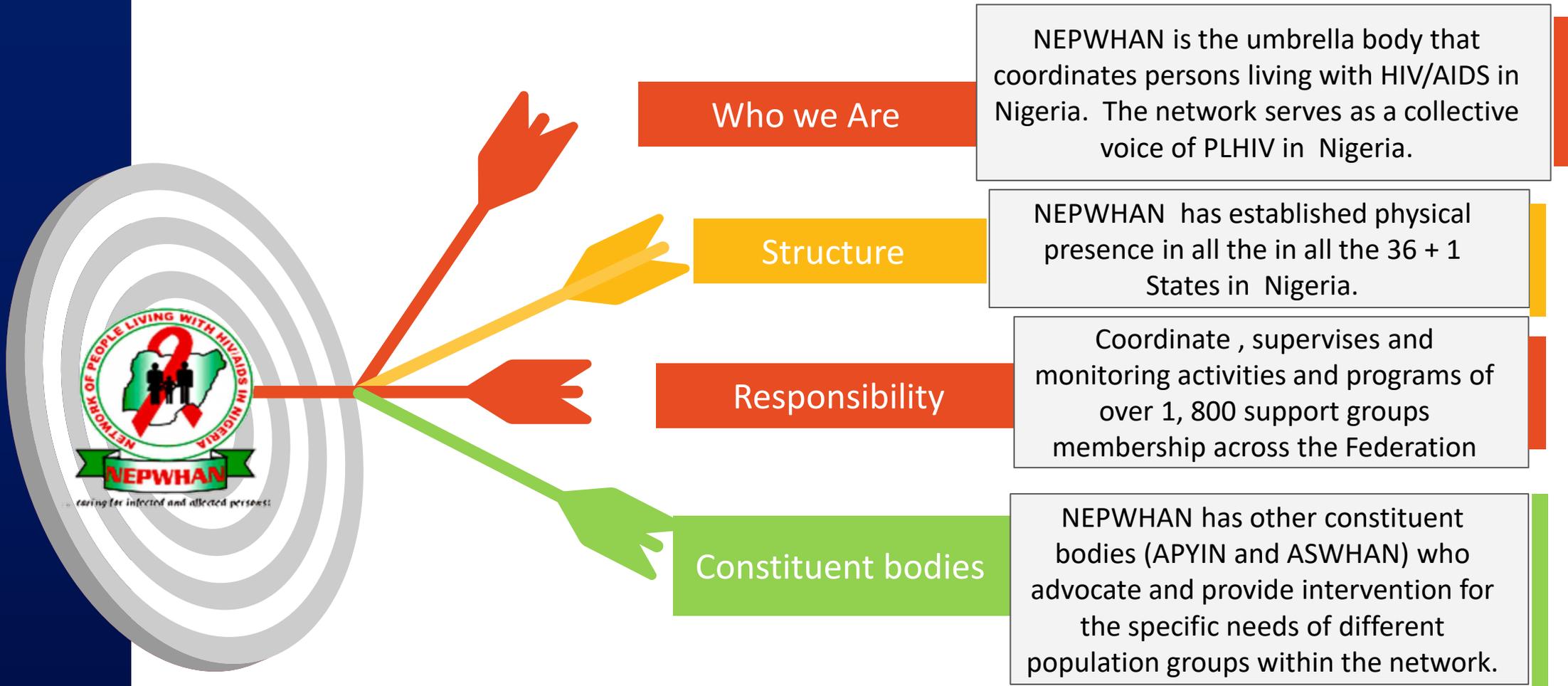
Outline

- Background on Community-Led Monitoring (CLM) in Nigeria

- The conceptual approach to community data systems

- Community data collection tools

- Use of community-generated data

- Findings from the M&E System Vulnerability Assessment (Domain 7)

- Emerging threats to community data systems
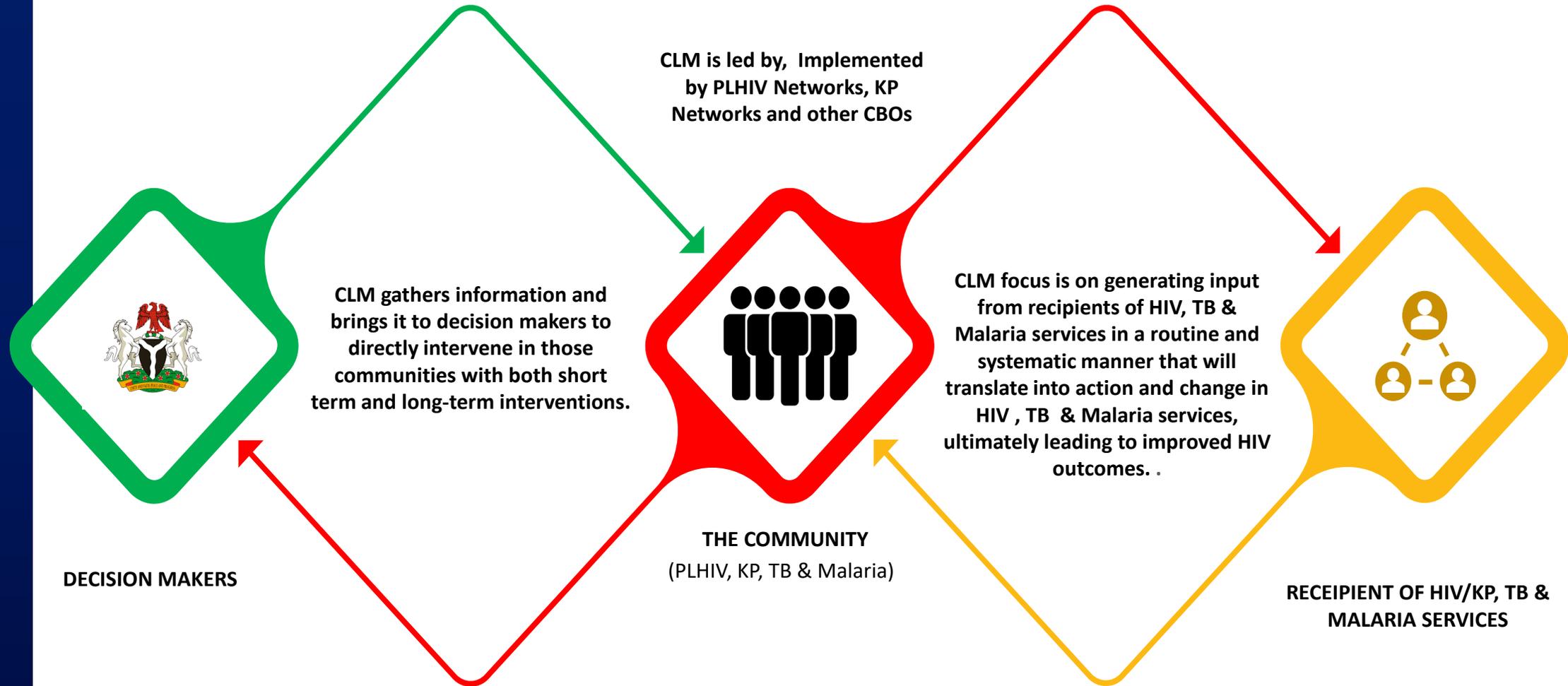
- Conclusion/Next Steps

About NEPWHAN

Who we Are

NEPWHAN is the umbrella body that coordinates persons living with HIV/AIDS in Nigeria. The network serves as a collective voice of PLHIV in Nigeria.

Structure

NEPWHAN has established physical presence in all the in all the 36 + 1 States in Nigeria.

Responsibility

Coordinate , supervises and monitoring activities and programs of over 1, 800 support groups membership across the Federation

Constituent bodies

NEPWHAN has other constituent bodies (APYIN and ASWHAN) who advocate and provide intervention for the specific needs of different population groups within the network.

Background: Community-Led Monitoring in Nigeria

❖ CLM uses a **data-driven** approach to identify and address challenges faced by recipients of HIV, TB, and malaria services through an integrated monitoring framework.

❖ Coordinated by **civil society networks**: NEPWHAN (HIV/AIDS), TB Network Nigeria (TB), and ACOMIN (Malaria).

❖ Supports monitoring of health programs and advocacy for policy reforms and accountability at national and subnational levels.

❖ **4 Key Components of CLM;** Community education; Evidence generation; Community engagement and Advocacy

❖ **Key Service Dimensions** Monitored are ; Awareness; Availability; Accessibility; Acceptability; Quality of services-including human rights violations and discrimination

❖ **Key Lesson:** Community advocacy is stronger as we have our **credible, community-generated evidence**

# The Conceptual Approach: Community at the Center Driving the Needed Change

CLM is led by, Implemented by PLHIV Networks, KP Networks and other CBOs

CLM gathers information and brings it to decision makers to directly intervene in those communities with both short term and long-term interventions.

CLM focus is on generating input from recipients of HIV, TB & Malaria services in a routine and systematic manner that will translate into action and change in HIV , TB & Malaria services, ultimately leading to improved HIV outcomes. .

DECISION MAKERS

THE COMMUNITY
(PLHIV, KP, TB & Malaria)

RECEIPIENT OF HIV/KP, TB & MALARIA SERVICES

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What we monitor on integrated CLM (through CEI, FGD, KII)

HIV	TB	Malaria	Gender-based Violence/Gender & Human Rights
• ARV stockouts • Viral load testing • Stigma/discrimination PrEP & PEP access.	• Early diagnosis • Availability of GeneXpert testing • TB drug adherence • HIV & TB Co-Infection Services – Ensuring integrated screening and treatment.	• Consistent supply of rapid test kits (RDTs) • Availability of Artemisinin-based Combination Therapy (ACTs)	• Stigma & Discrimination – Tracking cases of mistreatment against PLHIV(in their diversities), and marginalized groups. • Gender-Based Violence (GBV) Response – Ensuring survivors have access to medical, psychosocial, and legal support. • Patient Confidentiality & Informed Consent – Advocating for ethical, respectful healthcare services

Community Data Systems: HOW is data managed?
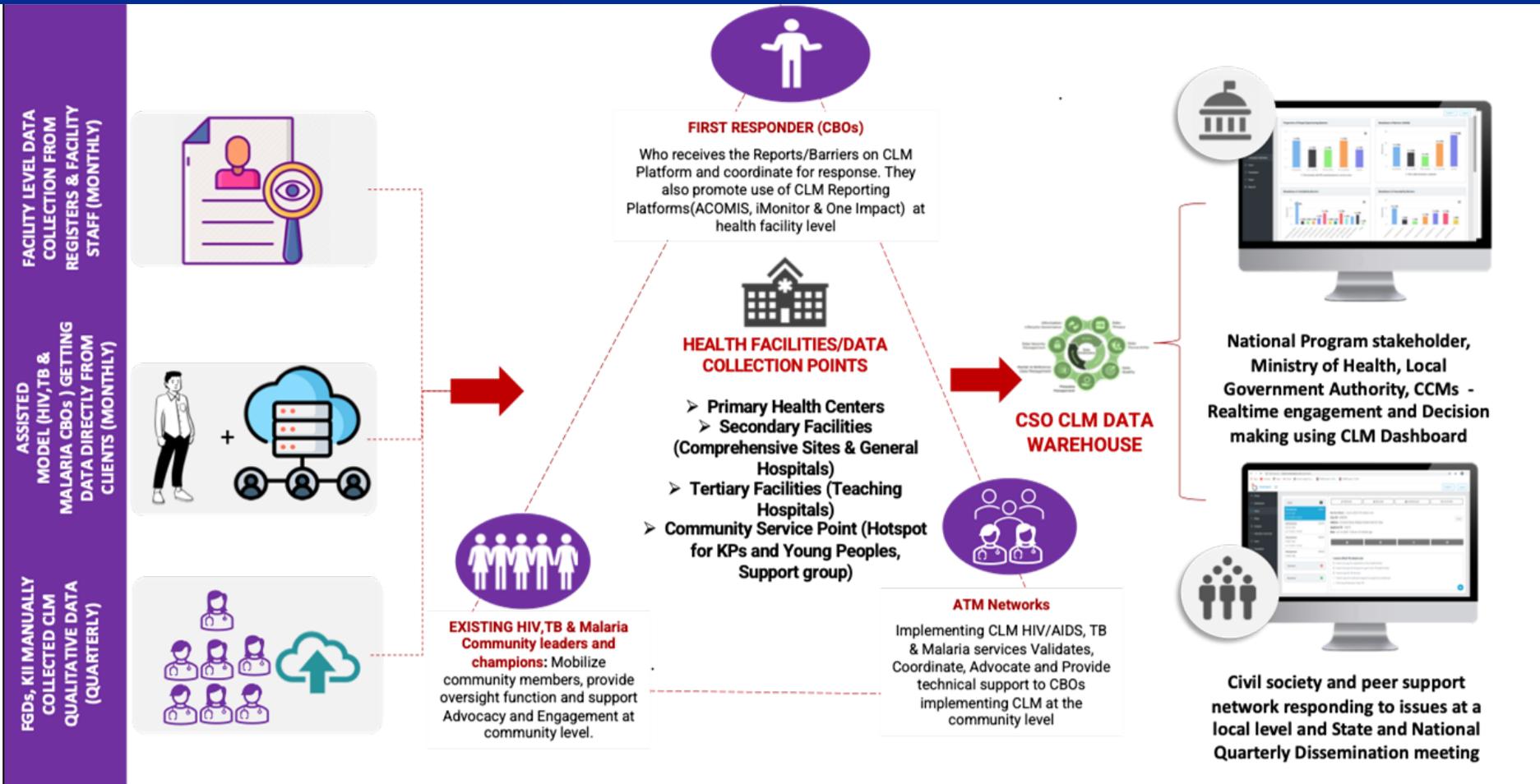
- ❖ Data collection happens electronically and using paper-based tools
- ❖ Each Network has their own data-base management platform; for HIV, we use *Community iMonitor*
- ❖ To enable visibility data is coordinated or unified by a common dashboard and you can see what is happening in the other networks
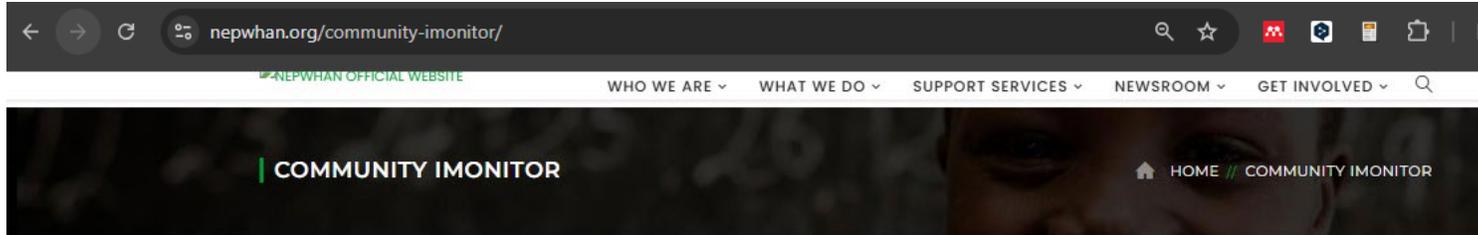
❖ **Community iMonitor** is NEPWHAN's digital platform that enables people living with HIV, key populations, and community members to share real-time feedback on the quality, accessibility, and dignity of health services.

❖ Through the **iMonitor** mobile application, users can report service barriers, rights violations, and gaps in care—helping NEPWHAN and partners respond quickly and improve HIV, TB, and integrated health services across Nigeria.

No. of Health Facilities Providing CLM for HIV in Nigeria- 2025

Bar chart showing number of health facilities:
- Primary Health Care: 174
- Secondary Facilities: 94
- Tertiary Facilities: 182
- Private Facilities: 73
- Community Service Delivery Points: 62
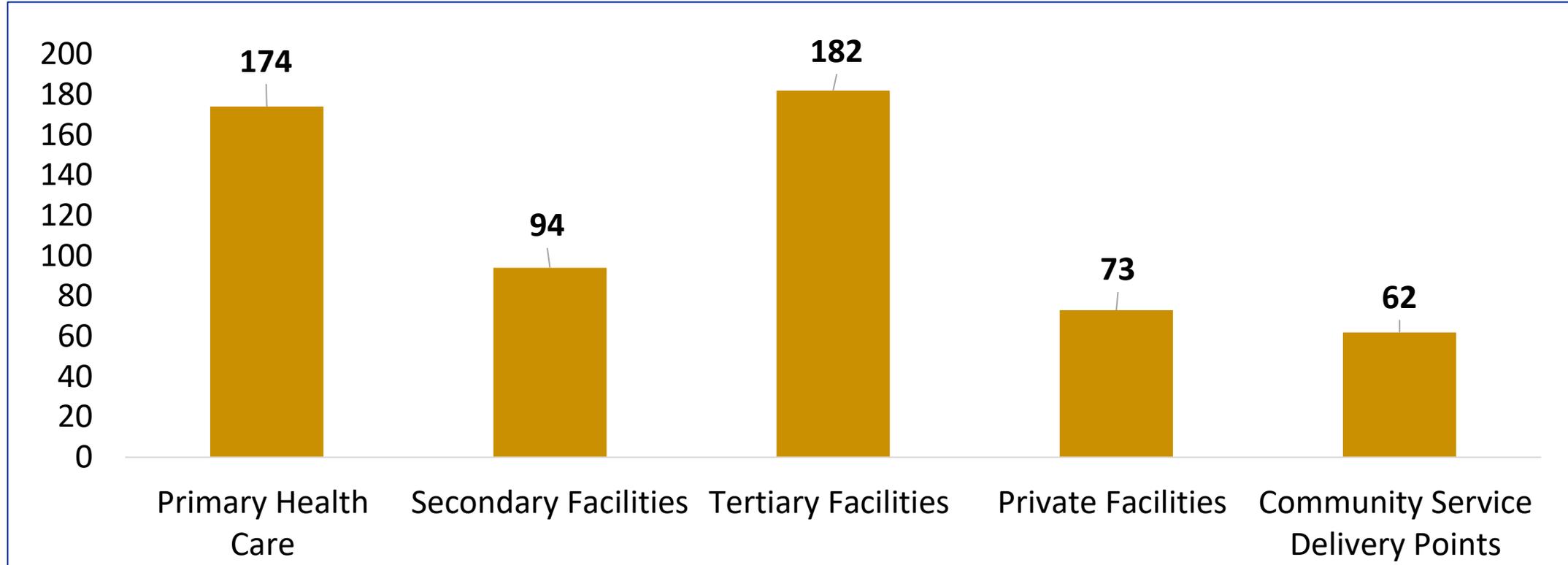
❖Overall, 585 HF were supported with CLM specifically for HIV services in 2025

❖In addition, CLM for broader health needs was provided in 174 primary health care facilities

❖CLM has helped ensure that **community voices inform health system improvements**

M&E System Vulnerability Assessment

The highlights are related to: **Domain 7: Community-led monitoring and Community Engagement in M&E**

The domain assessed 6 subdomains:

- ❖ Policy and Governance for CE/CLM
- ❖ CE involvement in design of paper based and electronic M&E tools at HF, subnational and national level
- ❖ Routine collection of CLM data on critical indicators (prevention, HTS, retention?)
- ❖ CLM data use (subnational, national)
- ❖ CE involvement in data reviews and data quality checks (HF, subnational, national)
- ❖ CLM data for **KP** services

Distribution of M&E Functions by Vulnerability
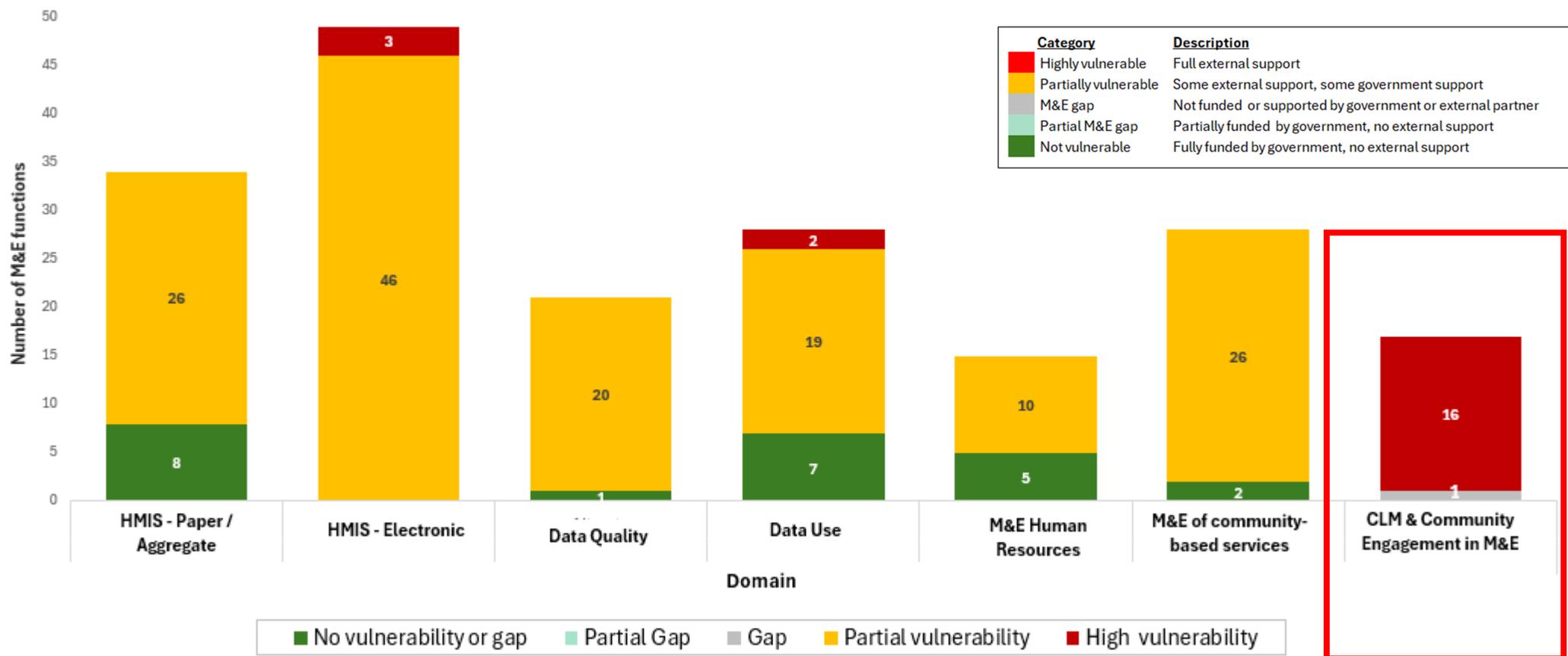
- Widespread high vulnerabilities across most sub-domains in **CLM & Community Engagement in M&E domain**
- One of the function which is inclusion of community data elements in national HMIS (e.g., DHIS2 community modules) having a gap

Distribution of M&E Functions by Type of Support
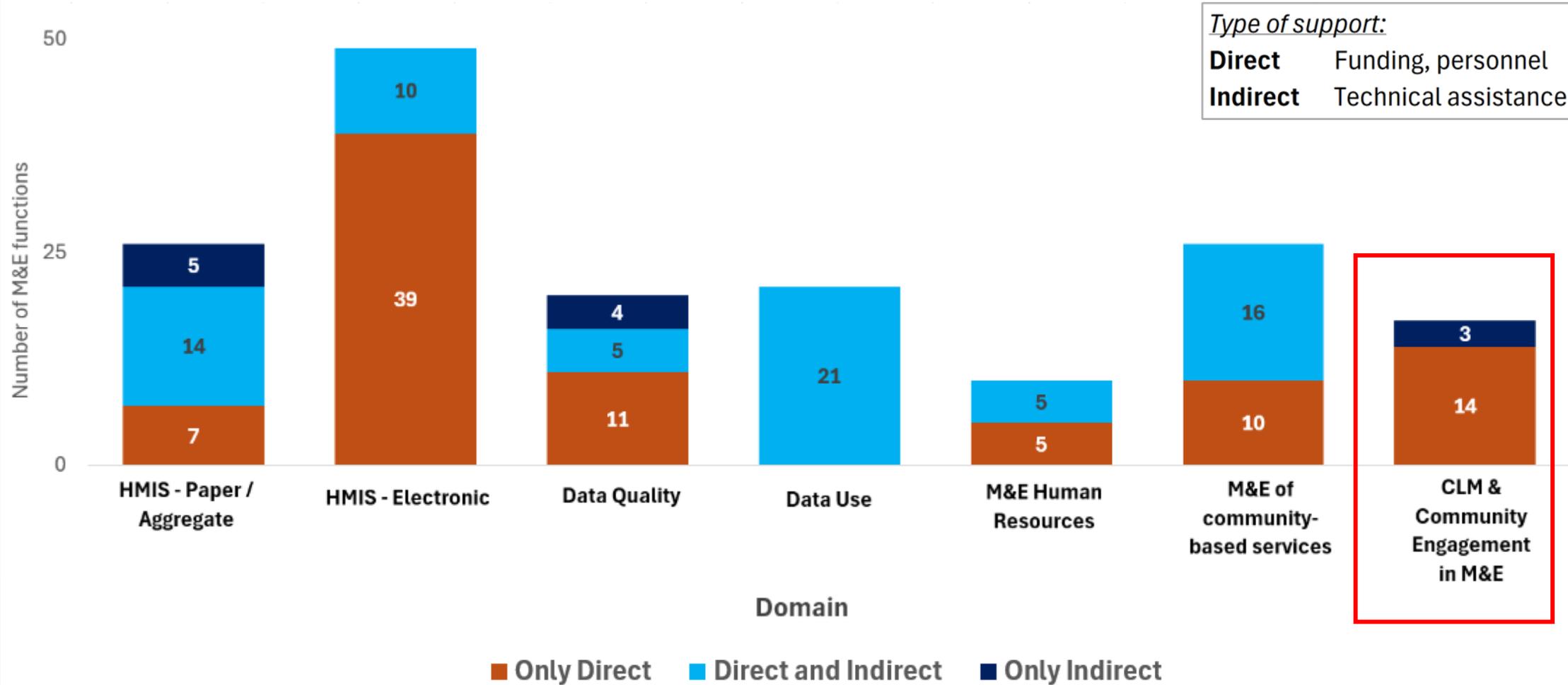
❖ High reliance on external donor support through direct funding
❖ This funding structure creates sustainability risks as external funding declines

Results by Sub domain for the CLM in CE of M&E 1/2

7. Community-led monitoring and Community Engagement in M&E				
	7.1. Policy and Governance for CE/CLM			
		7.1.a	Development of national policies supporting CLM/engagement	🟥
		7.1.b	Guidelines on community data and national reporting	🟥
		7.1.c	Presence of formal coordination structures including community reps	🟥
		7.1.d	Mechanisms for regular dialogue between government/community	🟥
		7.1.e	SOPs for community-level data collection, verification/reporting	🟥
	7.2 CE involvement in design of paper based and electronic M&E tools at HF, subnational and national levels			
		7.2.a	Community members to be a part of the M&E tool design process	🟥
	7.3 Routine collection of CLM data on critical indicators (prevention, HTS, retention?)			
		7.3.a	Standardized data collection templates for community	🟥
		7.3.b	Community data to feed into subnational and national M&E systems	🟥
		7.3.c	Inclusion of community data elements in national HMIS	⬜

Key:
🟩 No vulnerability
🟧 Partial vulnerability
🟥 High vulnerability
⬜ M&E gap
🟦 Partial M&E gap

All vulnerable, except one item with an M&E gap:
- ❖ **Global Fund GC7 RSSH grant** supported the development of **integrated Community Systems Strengthening (CSS) and CLM frameworks** for HIV, TB, and Malaria.
- ❖ **NEPWHAN representation in the GF CCM** ensures **community voices inform national decision-making**.
- ❖ **Coordination and accountability mechanisms** established through **ATM partner review meetings** under the GC7 RSSH grant.
- ❖ The **national CLM framework and SOPs** define **64 CLM indicators** and **structured community data reporting pathways** from service delivery points to the **national data system**.
- ❖ **CSO/ATM networks developed paper-based tools and an electronic CLM platform**, currently **being piloted by Dure Technologies**.

Results by Sub domain for the CLM in CE of M&E -2/2

7. Community-led monitoring and Community Engagement in M&E				
	7.4 CLM data use (subnational, national)			
		7.4.a	Use of CLM data in standard reporting at all levels	🟥
		7.4.b	Systems to triangulate community-generated data	🟥
		7.4.c	Feedback loops to ensure communities receive data summaries	🟥
		7.4.d	Dashboards or bulletins that share community data and results	🟥
	7.5. CE involvement in data reviews and data quality checks (HF, subnational, national)			
		7.5.a	Participation of community representatives in data review meetings.	🟥
		7.5.b	Civil representatives engaged in national program performance reviews	🟥
	7.6. CLM data for KP services			
		7.6.a	CLM data collected on KP service delivery/programming	🟥
		7.6.b	CLM data informs KP service delivery/KP programming	🟥

Key:
- 🟩 No vulnerability
- 🟧 Partial vulnerability
- 🟥 High vulnerability
- ⬜ M&E gap
- 🟩 Partial M&E gap

All highly vulnerable:
- ❖ **C19RM/RSSH** grant supports the use of community data for advocacy and accountability, enabling CSOs to follow up with duty bearers on service delivery issues.
- ❖ Community data is **triangulated with HF registers**, reviewed monthly at sub-national level and quarterly at national level
- ❖ Structured review mechanisms include bi-monthly project review meetings at sub-national level and bi-annual at national
- ❖ **A GF supported CLM dashboard** is currently being piloted, expected to strengthen data visualization and program monitoring.
- ❖ Community participation in national program performance reviews is supported by NACA, while KP-led CBOs (39) are funded under the GC7 grant and implemented by NEPWHAN
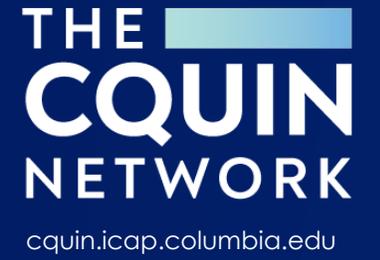
icap Global Health NETWORK

Emerging Threats to Community Data & CLM in Nigeria

❖ High **dependence on donor funding:** Many CLM activities rely heavily on external funding sources which puts the community at a considerable risk of losing the gains as donor funds shrinks

❖ **Limited Geographic Coverage issues**: CLM in Nigeria is currently happening in 36+1(the Federal Capital Territory (FCT)) States in Nigeria, *but in selected LGA and Health facilities.*

❖ **Activity prioritization:** Some of the activities that enable global dissemination of the impact of CLM interventions were deprioritized.

❖ **Weak institutional integration** into national M&E systems- Community monitoring systems are not fully embedded within national M&E systems

Conclusion/Next Steps

What can be done in this stage of funding crises?

❖More efforts should be channeled to domestic resource mobilization for alternative source of funding.

❖Intensify effort on service integration (combining HIV, TB, malaria, GBV, and NCDs) to reduce duplication and maximize efficiency.

❖Strengthen community systems for pandemic response.

❖Integrate CLM data into **national HMIS/DHIS2 systems**

Thank You!