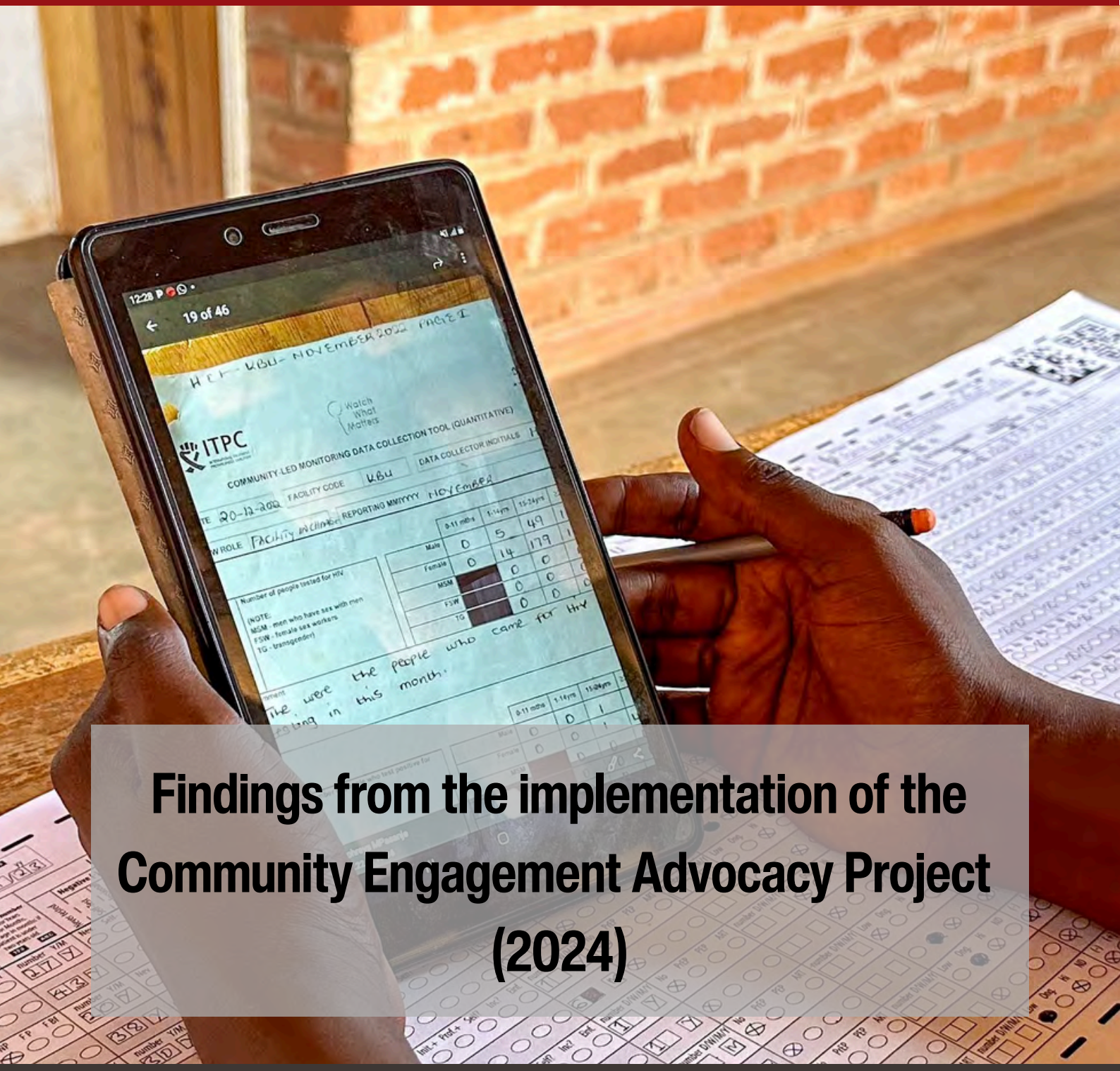
HOW DATA DRIVES ADVOCACY: SUSTAINING COMMUNITY ENGAGEMENT AND RESPONSE IN DSD PROGRAMS



Findings from the implementation of the Community Engagement Advocacy Project (2024)

February 2025

ITPC

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ACRONYMS

CAN – Community advocacy network
CE – Community Engagement
CIV-Cote d'Ivoire
CQUIN - HIV Coverage, Quality, and Impact Network
CSO – Civil society organisation
DRC – Democratic Republic of Congo
DSD – Differentiated Service Delivery
GIPA- Greater Involvement of People Living with HIV
GIZ – German Agency for International Cooperation
HF – Health Facilities
IAS – International Aids Society
ICAP - International Center for AIDS Care and Treatment Program
ITPC - International Treatment Preparedness Coalition
LENEPWHA - Lesotho Network of People Living with HIV/AIDS
LibNep+ - Liberia Network of People Living with HIV and AIDS
M&E – Monitoring & Evaluation
MANET+ - Malawi Network of People Living with HIV
NACOPHA - National Council of People Living with HIV in Tanzania
NAFOPHANU - National Forum of People Living with HIV/AIDS Networks in Uganda
NAP+ - Ghana Network of Persons Living with HIV/AIDS
NEP+ - Network of HIV positives in Ethiopia
NEPHAK - National Network of Persons Living with HIV/AIDS in Kenya
NEPWHAN - Network of People Living with HIV in Nigeria
NEPWU - National Empowerment of Positive Women United
NETHIPS - Network of HIV Positives in Sierra Leone
NZP+ - Network of Zambian People Living with HIV and AIDS
PLASOC - Civil Society Platform for Health in Mozambique
PLHIV – People living with HIV
RBP+ - *Réseau Burundais des Personnes Vivant avec le VIH/SIDA*
ReCAP+ - *Réseau Camerounais des association des personnes Vivant avec le VIH/SIDA*
RIP+ - *Réseau Ivoirien des organisations de Personnes vivant avec le VIH*
RNP+ - *Réseau National des Associations de PVVIH*
RoC – Recipients of Care
RRP + - Rwanda Network of People Living with HIV / AIDS
TAC - Treatment Action Campaign
TWG – Treatment Working Group
UCOP+ - *Union Congolaise des Organisations des PVVIH*
ZNNP+ - Zimbabwe National Network of People Living with HIV

BACKGROUND

Engagement of people living with HIV is central to differentiated service delivery, and the importance of meaningful engagement of recipients of care (RoC) since inception, are highlighted in many program requirements. However, as of today, efforts towards meaningful community engagement (CE) are still suboptimal.

Sustaining robust community responses within health systems is imperative for achieving enduring progress. One exemplary model of successful community engagement is demonstrated by the Community Advocacy Network (CAN) of the ICAP CQUIN Project on Differentiated Service Delivery (DSD). The CAN works to ensure that the voices of people living with HIV and RoC are central to the CQUIN Learning network and to DSD more broadly. Operating across 22 countries in the African continent in 2022 and 2023, the CAN's application of community-led monitoring (CLM) to CE resulted in the development of an innovative 19- indicator tracking tool for decision-making and programming related to at the country level.

Preliminary findings and related follow-up actions serve as a crucial baseline for enhancing CE levels, identifying gaps, and establishing new relationships with governments and partners. They underscore the untapped and huge potential of meaningful CE and CLM in offering pathways for refining strategies to ensure robust community responses remain central to differentiated HIV service delivery and to health. As importantly, the CE tool fills important knowledge gaps on CE – whether for RoC themselves to better understand their role in DSD (and more broadly the country's HIV response), and for local authorities to better understand the added value of CE in DSD.

However, even if communities collect and analyse high-quality data, often there is insufficient use of this community-generated data at national, regional and international levels. Many funding models do not financially support broader coordination and advocacy and assume that advocacy skills are present within the community when there is a need to build capacity in this area. The validity of CLM data is still questioned among duty bearers, and the significant investments in CLM by multilateral and bilateral funders in the 2024-2026 period run the risk of being less impactful or unsustainable without deliberate efforts to develop constructive government partnerships and buy-in.

Since 2019, ITPC has received funding from ICAP via a CQUIN subaward to support the CAN in its work to support RoC's engagement throughout the CQUIN network. ITPC supports CAN members to work together - both in-person and virtually - to identify and address common barriers and challenges, to develop and roll out a community engagement tracking tool, and to co-create solutions for meaningful engagement of people living with HIV in DSD policy development, program design, planning, implementation, monitoring, and evaluation.

Although funding in 2024 was insufficient to cover all the needs and potential, supplemental funding from the Bill and Melinda Gates Foundation enabled ITPC to provide small grants to countries to strengthen CE by using data to inform advocacy through:

- Convening, facilitating and strengthening capacities of CAN members

- Developing, promoting and supporting the use of the CE Tracking Tool among CAN members
- Supporting CAN members to use data strategically to inform program changes

The anticipated areas of focus for the advocacy were:

- Inclusion of communities in decision-making tables and processes and CE/CLM structure/committee
- Higher involvement of DSD program implementation
- Implementation of RoC feedback system in DSD services (e.g. scorecards)
- Increased funding at national level for DSD programs
- Strengthen the community response
- Understanding the gaps with monitoring of community engagement
- Buy-In from duty bearers

METHODOLOGY

Twenty countries participated in the CE Advocacy Project, namely Burundi, Cameroon, Cote d'Ivoire (CIV), Democratic Republic of Congo (DRC), Eswatini, Ethiopia, Ghana, Kenya, Lesotho, Liberia, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Sierra Leone, South Sudan, Uganda, Zambia and Zimbabwe, as illustrated in Figure 1. The networks of People Living with HIV (PLHIV), all CAN members tracking CE in DSD since 2022 carried out the advocacy activities. Additionally five organisations from the CAN Advisory Group (CAN AG) focusing on key populations were included in the project. The CAN AG consists of men who have sex with men (MSM), Transgender people (TG), Youth, Women in General, People Who Use drugs (PUDs), and Sex Workers (SW). Since the CAN AG were not involved in the roll-out of the CE monitoring tool across 2022 and 2023, the CAN AG held focus group discussions with other KP populations which informed the advocacy priority areas.

Figure 1: Countries implementing advocacy projects in 2024

In April 2024, the CE Advocacy Project was launched, and the CAN members were invited to submit advocacy priority areas (see annex I) which were informed by the results from the roll out of the CE framework in 2022 and 2023. These results are available in ITPC's report 'Building Bridges: Amplifying Community Engagement in DSD Decision-Making and Programming'.

The advocacy priority areas outlined the planned advocacy activities, the advocacy targets and the rationale for choosing these priorities, as well as the budget required. The advocacy plans were reviewed by ITPC, and activities were implemented between June – September 2024 ITPC supported the process through in-person meeting with the CAN in April and July and virtual meetings over August and September 2024.

ITPC developed an advocacy reporting framework (see annex II) which was populated by each organization to document the outputs, outcomes and follow-up steps for each advocacy priority implemented. The framework asked additional questions to further document various aspects of the project, such as unexpected outcomes, opportunities for additional resourcing and long-term advocacy priorities. These advocacy frameworks were compiled and analysed to produce this report.

FINDINGS: GENERAL OVERVIEW

Thirty-six percent of advocacy priorities identified by the 25 CAN members were related to advocating for higher inclusion of communities in DSD program implementation and 34% to improving engagement in decision-making instances and processes, as illustrated in Figure 2. Most of the advocacy efforts were therefore focused on increasing community engagement at the program level (40%) and implementation area (46%) of DSD. The orientation of the activities under the CE Advocacy project are in line with the 2023 CE Tracking Tool results. The 2023 results highlighted that CE was lowest at the program level, with a scoring of 66% and progress in strengthening CE was slowest in the implementation stage of DSD, with an 11% increase between 2022 and 2023, compared to a 14% and 44% increase respectively in the design and M&E stages.

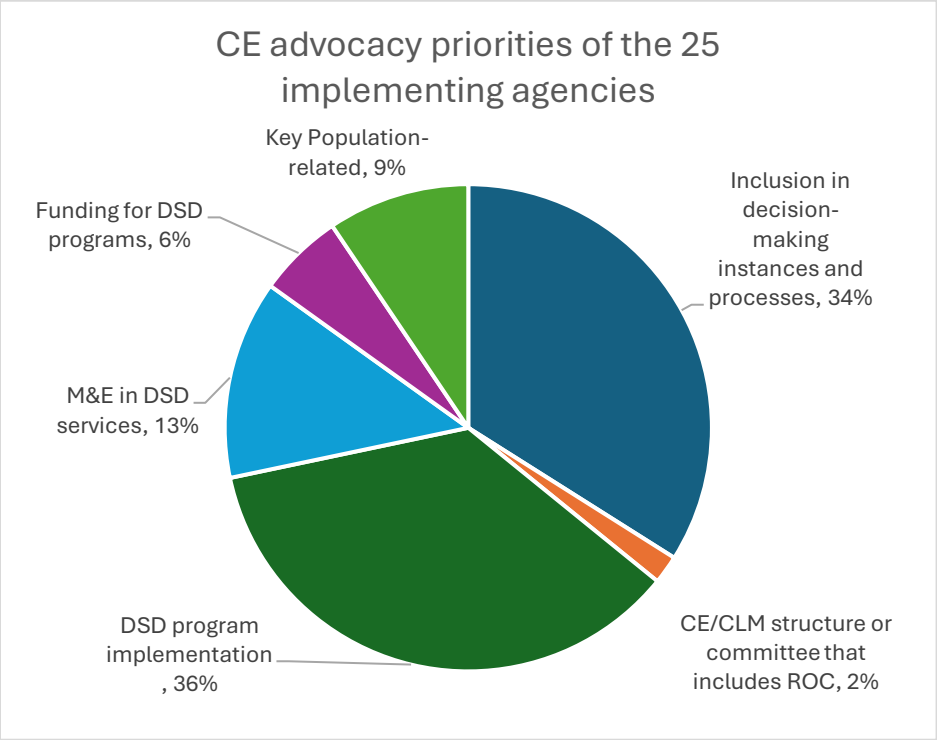

Figure 2: CE advocacy priorities

Activities carried out under the CE Advocacy project varied from country to country, but the most common ones included engagement and meetings or workshops with duty bearers, technical partners and funders at national and sub-national levels, community

sensitization and training on DSD and CE, capacity building of CAN members and partners, as well as mapping of key stakeholder and institutions involved in DSD. All 25 projects were conducted in collaboration with other stakeholders from the public and community sectors, as well as technical and financial partners such as national aids control programs; ministries of health; national, provincial and district health offices, technical working groups; funders and technical agencies; as well as CSOs and community networks and representatives.

Countries reported that **64% of advocacy outcomes were fully reached** and 47% were partially achieved, indicating a satisfactory achievement rate. Two thirds of the advocacy outcomes were reported as being realistic and feasible to achieve, whereas one third of the targeted change was, in hindsight, not feasible over a period of 4 months due to various challenges. The most reported challenge was the availability of the authorities and other advocacy targets and the issue of scheduling meetings or workshops with them over a very short time frame. Other challenges included technical issues with virtual activities, logistical issues such as transport to remote areas and the time and financial constraints of the project. Only three implementing organizations from Rwanda, Uganda and Kenya reported issues related to reluctancy from authorities to be involved in discussions around community engagement.

Advocacy efforts allowed countries to better understand the challenges in the field and propose adequate solutions. For example, in Nigeria the inexistence of links between community pharmacies and RoC was identified as the main gap to be addressed in their strategy, and they have planned for periodic monitoring visits by RoC networks to community pharmacies. Even in countries where the challenges in implementing the advocacy activities were important, the project brought insights on how to better plan future actions and what factors to consider in the designing of advocacy strategies.

In addition, beyond the targeted results, which are detailed per region in the next section, unexpected outcomes from the advocacy actions were documented. The following examples showcase the potential rapid impact of well-resourced evidence-based advocacy activities.

Figure 3 The newly created DSD task force in Mansa district, Zambia.

In Lesotho, the project supported three community advocates to **participate in different thematic groups, community health responses and operational plans**, as well as **education sessions for RoC on CE and DSD**. By carrying out these activities, new alliances were formed with organizations that showed new interest in CE, emerging

community leaders were identified and a growing interest to replicate CE model by other stakeholders was noted.

In Uganda, advocacy at district health level on the importance of CE at facility level led to the immediate **assignment of a DSD focal person in the district of Mityana** where there was previously none.

In Burundi, advocacy focused on CE in policy validation processes. In addition to the commitment from stakeholders to support CE, **RoC were immediately involved in the finalisation of national guidance on the role of communities in the health system**. RoC contributed to ensuring that the guidance included the official recognition of peer educators and CE indicators. This process will result in RoC having a more meaningful role in carrying out the activities of the country's Global Fund grant.

In Sierra Leone, advocacy aimed at **increasing the number of health facilities offering DSD service** where ROCs work as service providers. The direct outcome of the advocacy activities was that it contributed to the **approval of 150 expert clients and 180 peer educators** to work in health facilities in 7 districts. Additionally, the advocacy also contributed to the introduction of antiretroviral therapy (ART) dispensation at key population-friendly Drop-in Centres.

FINDINGS: OVERVIEW OF RESULTS PER REGION

The following section presents a summary of the outcomes per region and country. In addition, key population implementing organisations have been presented separately. This rapid analysis aims at providing a snapshot of what was achieved over 4 months of intense efforts by the CAN members.

East Africa

In East Africa, six advocacy priorities were related to higher community engagement in decision-making instances (DSD online and government-led TWG, DSD policy validation workshops and capacity building of RoC to engage with duty bearers on DSD), four priorities aimed at increasing CE in DSD implementation at policy and program levels and three at client satisfaction/community scorecards or more generally CE in Monitoring & Evaluation (M&E) of DSD.

ADVOCACY PRIORITY	MAIN ACTIVITIES AND OUTCOME
ETHIOPIA (NEP+)	
Ensure participation of RoC/community members in technical DSD meetings.	Meetings with the Ministry of Health (MoH) and partners increased **CE in technical DSD meetings** resulting in more focus on CE in DSD, including at health facility level.
Engage RoC/community members in DSD supportive supervision visits.	Participation of RoC in **joint supportive supervision visits** paved the way to the MoH agreeing to making

ADVOCACY PRIORITY	MAIN ACTIVITIES AND OUTCOME
	CE a recurring item on its agenda, including during health facility meetings.
SOUTH SUDAN (NEPWU)	
Increase the % of govt-developed DSD policy communication materials that acknowledged input from national networks of PLHIV.	Meetings on community input on IEC material with government and civil society organisations (CSOs), including young and key populations, improved involvement of RoC in the **development of upcoming IEC materials.**
Increase the % of health facilities offering DSD services where community score cards and/or RoC satisfaction surveys are implemented.	Awareness raising at health facility and community levels, including the production of a documentary on RoC experiences, improved awareness of duty bearers and CSOs and community networks on the relevance of introducing **community scorecards.**
KENYA (NEPHAK)	
Increase CE in M&E of DSD activities.	Dialogue sessions with community partners enabled them to **identify and address challenges in the use of data in decision making instances** such as the DSD Technical Working Group (TWG) and DSD sub-committees.
CE in the CQUIN Capability Maturity Model self-assessment exercises.	Capacity building of communities and meetings with policy makers and the media clarified how to **ensure media coverage on PLHIV is non-stigmatising** and **empowered community champions on their role in the HIV response.**
RWANDA (RRP+)	
Improve CE in DSD supportive supervision visits and the number of DSD health facilities where community scorecards and/or RoC satisfaction surveys are implemented.	Liaison with the MoH, the biomedical centre and the HIV/TB TWG raised awareness on the need to increase CE in **supportive supervision activities** and in health facilities with **community score cards and/or RoC satisfaction surveys.** This contributed to the engagement of **peer educators in the Quality Improvement initiative** covering 109 health facilities.
UGANDA (NAFOPHANU)	
Increase CE in DSD demand creation activities.	Discussions between health care providers and RoC on DSD approaches, involvement of RoC in decision making, roles of peers in DSD and recommendations to address service delivery gaps

ADVOCACY PRIORITY	MAIN ACTIVITIES AND OUTCOME
	were organised. Following this, local authorities committed to supporting the **integration of expert clients into the group of health extension workers to support DSD**.
Engage RoC in M&E activities and other operational plans at district level.	Engagement with health facility duty bearers led to the allocation of a dedicated vehicle and fuel for monitoring purposes, as well as tasking the DSD Focal Person for regular **supportive supervision visits.**
BURUNDI (CCDP+)	
Ensure CE in policy validation exercises	An advocacy workshop with duty bearers and communities supported stronger CE in the development of **guidance on the role of the community in the health sector** and of a **CLM strategy and action plan.**
Create an online DSD TWG/platform with RoC involvement.	A workshop with a variety of DSD stakeholders led to the validation of an action plan for the creation of an **online DSD TWG/platform**
Training of RoC to work as a service provider in DSD models	The above action plan also included the **identification of peer educators (HIV, TB including KPs) for training on DSD**, in addition to agreed widespread training of the 1,500 peer educators under the Global Fund grant.
Ensure DSD health facilities implement community scorecards and/or RoC satisfaction surveys	Advocacy for resource mobilisation led to ICAP **agreeing to fund RoC satisfaction surveys** and the national HIV program to prioritise this activity.

Southern Africa

In Southern Africa, seven advocacy priorities were related to increasing CE in DSD implementation at program and community levels, three at higher community engagement in decision-making instances (DSD government-led TWGs, DSD meetings at district/provincial level and forums for DSD policy development), and two at client satisfaction/community scorecards or more generally CE in DSD M&E.

ADVOCACY PRIORITY	MAIN OUTCOME
ZAMBIA (NZP+)	

ADVOCACY PRIORITY	MAIN OUTCOME
Increase CE of RoC at provincial, district and community level.	Dialogue meetings with duty bearers and civil society **enhanced involvement of RoC** in DSD program design at provincial and district levels.
Strengthen DSD task force to prioritize CE at provincial and district level.	A mapping of key stakeholders to sit on the DSD task force **improved coordination** of DSD & CE at district levels.
LESOTHO (LENEPWHA)	
Meaningful CE in different thematic groups working on the community operational plans.	Support to three community advocates increased CE on district level meetings, resulting in the **improvement in demand creation for HIV services. Consensus was also obtained from MoH** to use the CE framework in DSD.
Empower RoC/community members to drive DSD agendas.	Capacity building of RoC and liaison with the DSD coordinator resulted in stronger RoC engagement in the development of DSD models and **better comprehension and consideration of RoC views.**
ESWATINI (DREAM ALIVE)	
Improve the percentage of health facilities offering DSD services where community score cards and/or RoC satisfaction survey are implemented	Meetings with the MoH and the DSD coordinator led to RoC being engaged in the **introduction of a client satisfaction survey** in 6 health facilities.
Improve CE in DSD sensitization/demand creation activities.	Capacity building of RoC led them to advocate for improved DSD models, including the **reintroduction of outreach models.**
MOZAMBIQUE (PLASOC-M)	
Ensure CE in discussions on targets, objectives, goals, and indicators related to DSD, as well as other issues concerning PLHIV, including data on coverage, quality, the impact of DSD, and other services related to PLHIV in Mozambique.	Meetings with the MoH and the DSD coordinator increased participation of RoC in **M&E meetings** and led to the development of a **supervision plan for DSD** activities with MoH staff involvement.
	The advocacy also strengthened RoC involvement in a dissemination workshop on DSD implementation and a training of trainers on **DSD demand creation and partnerships with health facilities.**
MALAWI (MANET+)	

ADVOCACY PRIORITY	MAIN OUTCOME
Increase CE in DSD implementation at district health facility level.	A mapping of community cadres and subsequent dialogue sessions enhanced CE at facility level leading to **improved coordination of volunteer work and referral from communities to health facilities.**
Boost demand for integrated services including family planning (FP) and hypertension (HTN) integration in ART clinics.	Advocacy on integrating Non-Communicable Diseases (NCD) in DSD services led to **increased uptake of NCD by RoC.**
ZIMBABWE (ZNNP+)	
Sustain CE at sub-national level to ensure that RoC are continuously engaged in the development and monitoring of DSD models.	A mapping of national and sub-national platforms requiring RoC engagement and feedback meetings with the MoH resulted in **RoC being part of the district and provincial DSD planning and monitoring structure**.
Improve the percentage of RoC/community members who attend health education learning sessions.	7,710 RoC were reached with **demand creation sensitization** and client satisfaction surveys were conducted in 7 provinces, producing **data on DSD model uptake and gaps in service delivery**.

West & Central Africa

In West and Central Africa, eight advocacy priorities were related to community engagement in decision-making instances (DSD online and government-led TWG, DSD planning meetings prioritizing DSD models, platforms for DSD policy and guidelines development, and DSD meetings at district/provincial level), seven to increasing CE in DSD implementation mainly at program and community levels, and two at client satisfaction/community scorecards or more generally CE in DSD M&E.

ADVOCACY PRIORITY	MAIN OUTCOME
GHANA (NAP+)	
Improve the percentage of DSD meetings where RoC/community members provide recommendations on prioritization of DSD models.	Advocacy targeting with duty bearers increased recognition of the **validity of the CE framework results** and led to the creation of an **established communication platform** between the National Aids Secretariat and data collectors.

ADVOCACY PRIORITY	MAIN OUTCOME
Ensure CE of RoCs in all health facilities to feedback on the implementation of DSD models.	By training more data collectors and producing 12 **regional CE dashboards**, challenges at implementation level in facilities were identified and communicated to the NACP.
LIBERIA (LIBNEP+)	
Improve CE in DSD impact assessments/evaluations.	Training sessions increased capacity of organizations of PLHIV and key populations in conducting **health impact assessments/evaluations.**
Improve CE in providing recommendations on prioritization of DSD models.	A national consultative meeting with duty bearers led to their commitment to include **RoC in the prioritization of DSD models** in DSD planning meetings.
Improve CE in online DSD TWG platforms.	Training of community members on online engagement and setting up of adequate material has **strengthened capacity to conduct online meetings**.
SIERRA LEONE (NETHIPS)	
Improve the % of health facilities offering DSD services where RoCs work as service providers.	Stakeholder meetings and community dialogues increased coverage of **health facilities offering DSD services where RoC work as service providers** to seven districts.
Improve the % of DSD health facilities where RoC satisfaction surveys are conducted.	The meetings and dialogues also supported the approval of 280 community monitors to conduct **satisfaction surveys** in the seven districts.
DRC (UCOP+)	
Ensure CE of national networks of PLHIV in policy design and the development of DSD models and IEC material.	Meetings with duty bearers and communities supported the integration of task shifting of **HIV testing by communities, DSD and advanced HIV disease** in the national HIV normative guidance.
Ensure RoC are trained on treatment literacy and adherence.	The sensitization of 51 community members and 10 healthcare providers led to increased capacity in being able to conduct **treatment literacy and adherence.**
NIGERIA (NEPWHAN)	
Increase CE in DSD supportive supervision visits.	The development of a checklist to create a database of community pharmacies and learning

ADVOCACY PRIORITY	MAIN OUTCOME
	visits for 15 RoCs in 5 States increased the **use of community pharmacies by RoC.**
Increase % of DSD health facilities where RoC work as service providers.	The 15 trained community leaders raised awareness of RoC on DSD to improve **demand creation of DSD services.**
COTE D'IVOIRE (RIP+)	
Increase CE in DSD policy design.	Engagement with the NACP and the national TWG increased community participation in **DSD policy design meetings.**
Increase capacity of members organisations of the national PLHIV network on DSD.	With the development of a WhatsApp group and webinars, members of the national PLHIV network were fully informed on different **DSD models and their pertinence.**
SENEGAL (RNP+)	
Increase CE in DSD policy development and implementation.	Dialogue sessions with duty bearers and communities at subnational level **increased CE in DSD at implementation level.**
CAMEROON (RECAP+)	
Increase level of ownership of DSD operational manual among community leaders.	A dissemination session was organised on the country's DSD manual with community and financial partners in view of **increasing community engagement in DSD implementation**.
Increase knowledge on DSD models within the community to improve their engagement.	**A training of 30 community leaders on their rights and DSD** was held, measured through an improvement in participant knowledge on DSD of 33 points pre/post training.

Key population specific advocacy

The following five organisations addressed KP-specific community engagement in DSD models. The objective of all the advocacy activities were to ensure that KP representatives are also included in the design, implementation and monitoring of DSD models

ADVOCACY PRIORITY	MAIN OUTCOME
KENYA (ISHTAR)	
Ensure CE of the LGBTQI community in the design of DSD policies and models.	Consultation around the **DSD guidelines to discuss KP-specific gaps**, including training needs to improve DSD services for key population and **definition of a feedback mechanism for members of key populations**
KENYA (ASWA)	
Build capacity of sex workers (SW) on their right to healthcare and develop partnerships to improve intake of SW in health facilities.	Meetings with partners and duty bearers and capacity building of sex workers on DSD enabled them to **identify gaps in existing DSD services.**
KENYA (JINSIANGU)	
Ensure CE of the LGBTQI community in the design of DSD policies and models.	A consultative review meeting of the DSD operational manual with duty bearers and KP organisations led to the **identification of opportunities to improve KP specificities in DSD** and a **commitment to include preferred DSD models in the Key and Vulnerable Populations Guidelines.**
	Joint DSD meetings with the transgender (TG) community and healthcare providers led to the **creation of a mechanism to address sensitive issues around services to TG RoC.**
UGANDA (HER-initiative)	
CE of Young and Adolescent Girls and Young Women (AGYW) in the DSD TWG.	Policy dialogue meetings resulted in a commitment from AIDS Commission to **include HER-initiative in the National HIV Prevention TWG** to represent AGYW-RoC.
Ensure DSD programs are tailored to the needs of AGYW.	HER-initiative was invited to join a **think tank for KP programming to put forward DSD recommendations** and commitments from duty bearers to address service delivery gaps for AGYW-RoC.
UGANDA (ICWEA)	
Increase inclusion of key and vulnerable populations, including	Meeting with Ministry of Health and members of the TWG provided **guidance** to ICWEA on who to engage with to achieve their objective.

ADVOCACY PRIORITY	MAIN OUTCOME
women living with HIV in DSD models	Dialogue sessions with implementing partners, health care workers and RoC led to an **increase in knowledge of RoC on the pharmacy model for DSD.**
BURUNDI (BAPUD)	
Improve CE of people who use drugs (PWUD) in DSD policy design.	Meetings to improve feedback of community representatives of the TWG to the PWUD community **increased involvement of key populations** in the design, implementation and monitoring of DSD programs

Long term advocacy plans

Countries identified their long-term advocacy priorities (see annex III) based on the insights from the CE Advocacy project. In addition to all countries planning country-specific strategies to continue strengthening community engagement in DSD, other themes have emerged such as establishing more structured community feedback mechanisms to strengthen feedback on DSD services, capacity building of community members to empower them in claiming their rights to appropriate health services, and focus on key an vulnerable populations (including adolescent girls and young women, children, elderly RoC), as well as scaling up of DSD services and expansion of these to address specific needs such as mental health.

Many country-plans also include health system strengthening strategies such as sufficient trained human resources for health, sustainable funding, digitalisation of health data and formalised collaborative frameworks (guidelines and policies, meetings, TWGs, focal points), indicating that they have successfully identified systemic issues that need addressing.

CONCLUSIONS

The CE Advocacy project provided an opportunity for communities to translate the 2022-2023 CE framework data into actionable priorities, enabling measurable outputs to be attained in a very short timeframe. Whereas documented outcomes are likely also a result of pre-program advocacy efforts, the program has created a platform for more structured use of CE data and extending tailored CE advocacy grants over the medium to long-term would enable a more tangible impact on DSD services and health outcomes.

The initiatives demonstrated how communities, when equipped with the right tools and resources, can actively contribute to DSD policy development, program implementation, and monitoring.

This project not only amplified the voices of recipients of care, including marginalized groups, but also ensured that health services are more tailored to the diverse needs of populations, such as in Rwanda where more DSD health facilities include RoC in their trainings and implement client satisfaction surveys, as illustrated in figure 4.

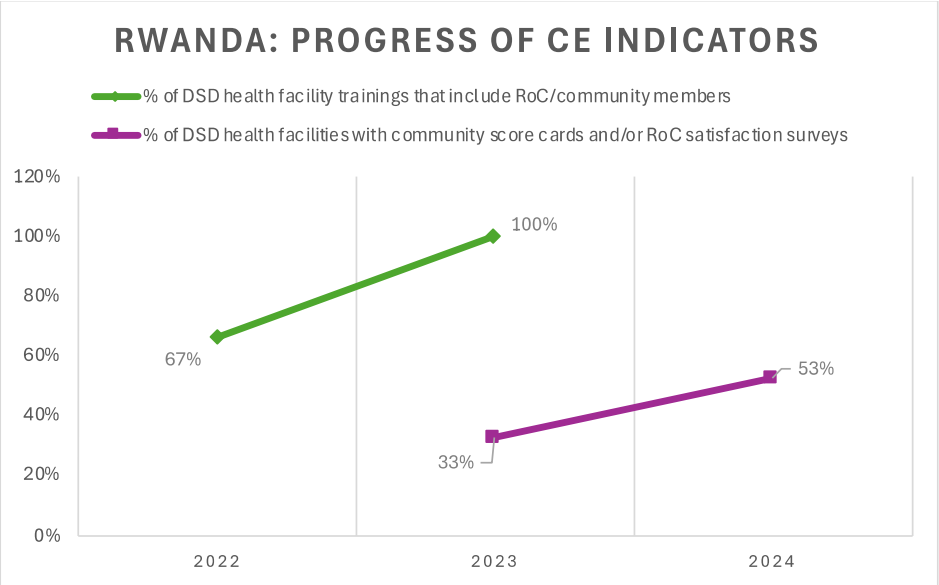

Figure 4: Progress of selected CE indicators 2022-2024

All countries have identified how to sustain the positive outcomes from the CE advocacy project, which are mainly around continued engagement, feedback and advocacy with all stakeholders, capacity building of communities and the institutionalisation of CE-related frameworks within the respective public health systems.

Countries are advised to review their long-term advocacy priorities, to identify the 3 high-impact areas of focus which are feasible within the next 12 months. It is also recommended that countries further detail their long-term advocacy priorities into costed action plans to enable resource mobilization and scaling up of activities to expand the scope of their advocacy.

Countries have also identified potential leverage points for financially sustaining CE advocacy efforts (see annex III), which is crucial to building on the progress made since 2022 in strengthening community engagement in DSD programs. For example, Liberia plans to advocate for funding from the corporate social responsibility of companies focused on health, education and sustainability initiatives in the communities where they operate, Zambia is planning to present a case study on CE of RoC in the IAS Person-Centered Care Advocacy Academy and most countries plan on engaging with existing international donors to mobilize resources for CE-related advocacy.

However, the reliance on short-term funding cycles poses a significant challenge to the scalability and sustainability of CE advocacy efforts. Ensuring that advocacy efforts are adequately resourced—both financially and technically—remains essential for their long-term impact.

The CE Advocacy Project has underscored the transformative potential of community-driven approaches in shaping health policies and programs. Beyond the specific advocacy targets and outcomes, the project shows how to create a paradigm shift in how

communities are valued as critical stakeholders in health systems. By prioritizing the inclusion of recipients of care in DSD and fostering partnerships across sectors, the project has laid the groundwork for more inclusive and responsive health service delivery models.

ANNEX I: Snapshot of the advocacy plan template

ADVOCACY PLAN							
Advocacy Implementation Plan	**Advocacy Priority Area**	**Level of CE (policy, program, community)**	**Area of CE (design, implementation, M&E)**	**Activities implemented (what and who will be involved in planning and carrying out the activity; what will be conducted)**	**Advocacy target (individuals, organizations, working groups, health entities, etc. that activity is aimed at and at what level)**	**Colour Scoring in 2023 Dashboard**	**Reason for Choosing Advocacy Priority Area**
Advocacy Priority Area 1 EXAMPLE	Improve the percentage of DSD meetings where RoC/community members provide recommendations on prioritization of DSD models	Program Level	Design	1. Liaise with MOH to establish how many meetings are scheduled for the period May - October 2024. 2. Liaise with country DSD coordinator to discuss the rationale/importance of including RoC during these meeting. 3. Share invites and agendas with RoC as well as delegate specific community members who will be attending. 4. Track source documents (registers and minutes)	MoH, RoC, Community Based Organizations	Gray	Low levels of engagement during the 2023 reporting period. We have identified this as a gap where RoC do not actively participate in these meetings and is an area of engagement that needs to be strengthened.

ANNEX II: Snapshot of the advocacy report template

Advocacy priority (from the initial advocacy plan submitted):						
Level of CE	Area of CE	Activities implemented	Advocacy target(s)	Outputs/ deliverables	Outcomes/ results	Next steps/follow up
QUESTIONS: • Was the advocacy priority **realistic and feasible** to achieve change in four months? • How were you able to **confirm that change was achieved**? • Do you think you could have been **more ambitious** in your advocacy? • What didn't go as planned and why? What were any **challenges** you faced in planning and carrying out the advocacy activities? • Did you **partner** with any other organization, community, or individual to support your advocacy? • Were there any **unexpected outcomes/results** from your advocacy? • How can positive advocacy outcomes/results be **sustained**? • What potential leverage opportunities for **additional resourcing** of community engagement and advocacy efforts did you iden tify? • When you were collecting the data, did you keep a **record** of the facilities which had low scores? • What **other advocacy priorities** do you want to take on in the next 6 months to one year?						

ANNEX III: List of potential leverage for funding & long-term advocacy priorities

COUNTRY	LEVERAGE POINTS FOR FUNDING	LONG-TERM ADVOCACY PRIORITIES
GHANA	The NACP, the Global Fund, PEPFAR and NAP+ West Africa	1. Development of the policy brief to present to the GF Country Team, the incoming CCM, CSO Caucus on CCM. 2. Training Sessions for DSD Community leaders including KPs to reinforce the importance and share strategies for Community Engagement. 3. Develop Guidelines: Create a best practice guide on community engagement tailored to Country contexts to ensure consistency in approach. 4. Feedback Mechanism: Establish a feedback mechanism to assess the effectiveness of community engagement activities and make necessary adjustments. 5. Collaboration and Monitoring Framework: Develop a formal framework for collaboration that outlines roles and responsibilities for service providers and RoCs. 6. Regular Meetings: Schedule regular meetings between service providers and RoCs to discuss challenges, share best practices, and plan joint initiatives. 7. Joint Training Sessions: Organize training workshops that bring together service providers and RoCs to enhance understanding and coordination of services. 8. Mentorship Program: Establish a mentorship program where experienced peer educators can train and support new recruits in service delivery and advocacy. 9. Incentive Scheme: Consider developing an incentive scheme to encourage the participation of peer educators from the KP in service delivery roles. 10. Policy Dissemination Strategy: Develop a comprehensive strategy to disseminate existing policies and programs effectively to healthcare facilities and communities. 11. Monitoring Dissemination: Implement a monitoring system to track the dissemination process and gather feedback on the reach and understanding of the policies. Create user-friendly M&E tools and dashboards that can easily be used by service providers to track implementation progress and outcomes.

ETHIOPIA	Integrate CE advocacy issues with CLM advocacy.	1. % of health facilities offering DSD services where community score cards and/or RoC satisfaction surveys are implemented 2. % of DSD health facility trainings that include RoC/community members as planners, facilitators and participants
ZAMBIA	Present a case study on CE of RoC in the IAS Person-Centered Care Advocacy Academy.	1. Advocate for improved coordination of DSD at district and provincial level. There should be regular DSD task force meetings with the involvement of RoC and all partners implementing DSD. 2. Advocate for the allocation of adequate resources towards DSD at provincial and district level.
LIBERIA	• Partnership with NGOs and CBOs that share common goals • Corporate Social Responsibility of companies focused on health, education and sustainability initiatives in the communities where they operate. • Media partnership to amplify advocacy efforts. • International Aid and foundations that fund community engagement and advocacy.	1. Youth and future Generations- empowerment through education, skill building and civic opportunities engagement which will ensure that future generations are ready to take on leadership roles and advocate for their community's need. 2. Health and wellness program- advocate for long term improvement in health services, focusing on both access and quality. 3. Community feedback Mechanisms- establishing structures where community members can continuously share their input, needs and concern. 4. Strengthening Civic Participation- advocate for increased civic engagement and community involvement in local decision-making process. 5. Education and awareness Campaigns- Education around key issues such as health, civic rights or environmental sustainability can change long term attitudes and behaviours. These efforts will show that community members are informed and able to advocate for themselves.
SOUTH SUDAN	Working in collaboration with CLM Implementers and other key stakeholder	1. Advocating for Policy reforms or RoC involvement in development of policies that protects the rights of PLHIV 2. Training of RoC as service providers in the community by PEPFAR Implementing partners 3. Advocating for scale up of HIV Services at state level

LESOTHO	Government and donor partnerships.	**Institutionalize Community Involvement in Healthcare Decision-Making** • Advocate for the formal inclusion of Representatives of the Community (RoC), especially people living with HIV (PLHIV), in national and regional health committees and decision-making bodies. This could include securing seats on health committees or establishing regular feedback mechanisms from PLHIV representatives. • Push for policies that require healthcare systems to consult with PLHIV and other vulnerable groups when designing and implementing healthcare programs, ensuring that these programs are responsive to the needs and challenges of these populations. **Expand Access to Comprehensive Person-Centered Care for PLHIV** • Advocate for person-centered care models to become a standard part of HIV/AIDS services. This includes expanding Differentiated Service Delivery (DSD) models to address specific needs, such as mental health support, integrated treatment for co-occurring conditions (e.g., tuberculosis), and accessible services in rural areas. • Work with healthcare providers to develop training programs on person-centered approaches, building a healthcare workforce that understands the unique needs of PLHIV. **Promote Stigma Reduction and Rights-Based Approaches in Healthcare Settings** • Advocate for policies that protect the rights of PLHIV, ensuring that they can access healthcare free from discrimination and receive confidential, respectful treatment. **Increase Financial Investment in Community-Led HIV Initiatives** • Push for sustainable funding streams to support long-term community advocacy, capacity-building, and mobilization efforts that help improve health outcomes for PLHIV.
KENYA	Existing TWG, support groups and DSD health facilities.	1. Train communities on data for decision making. 2. Engagement with the MOH to and other partners to develop a community centered approach to community engagement advocacy. 3. Establishing of community engagement and response platform through consultation with the community. 4. Engagement forum with community actors to have a dialogue on DSD model and human

		rights. 5. Capacity building of the community champions on collection and reporting of feedback from the community. 6. Developing county specific advocacy strategies.
KENYA (ISHTAR)	PEPFAR and GF	1. Engage in community health meetings to push for DSD models for KPs at national and county TWGs 2. Develop feedback mechanisms to highlight gaps in Community engagement and participation in program design and development 3. Advocate for funding for community engagement and capacity enhancement
KENYA (ASWA)	NGOs implementing KP-programs and government health services.	-
KENYA (JINSIANGU)	Government and state-funded advocacy initiatives	1. Advocate for the development and inclusion of KP DSD models into the KVP guidelines 2. Engage development partners to support the improvement of DSD approaches for the KP community 3. Leverage the improved feedback mechanism with Link facilities and progress with CLM to drive more community engagement in improving service programmes 4. Utilize the recommendations from the development of preferred KP DSD models to advocate for the broader awareness of TG specific preferred models within CQUIN and other platforms. 5. Advocate for harmonized engagement of DSD with Govt, private and non-state actors to improve RoC service delivery
RWANDA	ICAP	1. Advocate for CE in AGYW interventions for better linkage, follow up and retention to care for those who sero-convert to HIV; 2. Continue to advocacy for CLM implementation in all the health facilities;
ESWATINI	MoH, partners and stakeholders.	1. To advocate on DSD models that are truly centered with ROC must not only focus on processes, procedures and protocols.

		2. Dialogues with ROC and invests in feedback mechanisms from Facility to community. 3. Introduction of Long lasting injectables, this will reduce defaulter rate.
SIERRA LEONE	Global Fund, CDC and UNAIDS existing programs.	1. % of DSD supportive supervision visits that include RoC/community members 2. % of DSD impact assessment/evaluations where RoC/community members participated 3. Recruit/Appoint DSD technical lead at NACP
UGANDA	Routine inter-dialogue/engagements with the health workers and District local Government	1. Empowerment of community resource person to further advocacy efforts/engagements. 2. Routine check-in with the District Local Government as well as Health Facilities and pharmacies/drug stores 3. DSD literacy sessions acceleration in the facilities and communities including development of DSD literacy materials. 4. Information sharing platforms, referrals and linkages in the communities and facility.
UGANDA (HER-Initiative)	National Budget review meetings UNAIDS, PEPFAR, Uganda AIDS Commission	1. Push for inclusion of more AGWY in different HIV Care and Treatment working groups 2. Advocate for wider AGYW -ROC community level information dissemination of the DSD policy and guidelines including treatment literacy at health facility and community level. 3. Partner engagement to follow up on the recommendations from the HIV policy dialogue
UGANDA (ICWEA)	Global Fund, PEPFAR and government	1. Increase PLHIV and women living with HIV participation in their diversities the DSMD technical working group including vulnerable groups of women e.g. Women with disability. 2. Advocacy for increasing community knowledge and understanding of the DSMD guidelines and the new strategies available eg the Pharmacy models. 3. Advocacy for meaningful involvement of community structure right from DSD baseline assessments, program design, implementation, monitoring and evaluation of the Programme. 4. Advocacy for community-led integrated client-centred service delivery intervention with other clinical and non-medical related services in the DSD so that ROC receive a full package from a “one - stop centre.” These should include nut not limited to;- Linkage to social - economic services; Screening of clients for any other illnesses and make appropriate referrals and Psycho-social care and support and services that may gender inequality evils.
DRC	Global Fund, PEPFAR and government	5. Advocate for the participation of RoCs in monitoring and evaluation meetings related to DSD. 6. Advocate for the participation of RoCs in the development of DSD monitoring and evaluation tools.

		7. Advocate for RoC to work as service providers in health facilities offering DSD. 8. Advocate for the implementation of community scorecards and/or client satisfaction surveys in health facilities providing DSD services.
NIGERIA	-	1. Periodic media roundtable meetings of NEPWHAN and stakeholders. 2. Periodic monitoring visit by the RoC networks to the health facilities and community pharmacies. 3. Continuous/periodic advocacy to relevant stakeholders to communicate the need (especially quality assurance needs) of the community. 4. Follow up advocacy visits to stakeholders to redeem commitment made for improved quality of care. 5. Periodic awareness creation meeting with the RoC networks for any new development in care. 6. Periodic update and sensitization of RoC on new development in care through the support group system. 7. Scale up CE Advocacy Project to more states or to more senatorial, districts in the state.
BURUNDI	ICAP and national HIV programs (CNLS and PNLS)	1. One of the persistent challenges for RoC remains access to a comprehensive package of services for elderly patients, including proper management of comorbidities such as hypertension, hepatitis, cervical cancer, and diabetes. 2. Another major challenge is access to services for women, children, and adolescents, who remain target groups that are not making progress toward achieving the 95-95-95 targets.
BURUNDI (BAPUD)	MOH, CAN, UNAIDS, and WHO	**1. Advocate and implement the 90-90-90** **2. Advocate and mobilize resources for peer navigation** **3. Advocate and mobilize resources for nutritional support for KPs and PLHIV** Each priority 1-3 will require: 1 Focus group 1 National Advocacy Media Collaboration Duration: 2 months 4. **Development of advocacy plan** Meeting to collect data Development of the first draft of the advocacy plan Reading, amending, and approving the advocacy plan Resources mobilization for the advocacy plan

		Duration: 4 months
MOZAMBIQUE	Clinical partners	1. Continue advocating for the participation of RoC in integrated supervision activities related to DSD at the level of health facilities; 2. Influence the program to implement widespread dissemination actions for DSD in HIV prevention, care, and treatment at the national level and within health facilities.
CIV	Domestic resources	Merge advocacy actions with the Community Consultative Groups to harmonise the interventions.
SENEGAL	Financial and technical partners and respond to call for proposals	1. Conduct regular follow-ups on the commitments made by administrative and medical authorities (quarterly); 2. Organize quarterly meetings at the decentralized level with RNP+ focal points, inviting administrative and medical authorities; 3. Further involve RNP+ in the governance of digital data in the health sector; 4. Strengthen communication on differentiated service delivery (DSD); 5. Build the capacity of regional focal points through training on transformational leadership to enhance their leadership abilities.
MALAWI	PEPFAR, Global Fund and other donors.	Our next advocacy plan will be on influencing implementers to include People living with HIV and Key population is implementation and participation in projects that affect them.
ZIMBABWE	Community, government, local business community and international donors.	1. Advocacy for the removal of barriers affecting the uptake of DSDs including issues of HRH shortages. 2. Research and disseminate DSD awareness and preferences study findings and recommendations.
CAMEROUN	UNAIDS	1. Train community organizations on tools for collecting data on community activities and integrating them into the national health information system. 2. Expand the training of stakeholders and community organizations in DSD across the entire Cameroonian territory.

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DAE
DREAM ALIVE ESWATINI


NETWORK OF PERSONS LIVING WITH HIV/AIDS
GHANA


LibNeP+


LENEPWHA
LESOTHO NETWORK OF PEOPLE LIVING WITH HIV/AIDS


MANET+


NAFOPHANU


NEP+


National Empowerment Positive Women United
NEPWU


NEPHAK say yes to life


NETWORK OF PEOPLE LIVING WITH HIV/AIDS IN NIGERIA
NEPWHAN


NETHIPS
Network of HIV Positives
in Sierra Leone


PLASOC-M
Plataforma da Sociedade Civil
para Saúde do Moçambique


RBP +


RéCAP+
Réseau Camerounais des
Associations de Personnes
vivant avec le VIH/SIDA


RIP+
RESEAU IVOIRIEN DES ORGANISMES
DE PERSONNES VIVANT AVEC LE VIH - SIDA


RNP+
Réseau National des associations
de Personnes vivant avec le VIH / SIDA


RESEAU RWANDAIS DES PERSONNES VIVANT AVEC LE VIH / SIDA
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