From Evidence to Action: A Case Study on Community-Led Monitoring from Mozambique

Background

Advanced HIV Disease (AHD) is defined as a CD4 count below 200 cells/mm³ or WHO clinical stage 3 or 4 which remains a primary driver of HIV-related mortality in sub-Saharan Africa. In Mozambique, structural gaps in health facilities result in many patients never receiving the full AHD care package, while communities surrounding those facilities have historically lacked a formal mechanism to identify or escalate these failures. MATRAM, a Mozambican community-based organisation operating within the IMPAACT4HIV project, implemented a structured Community-Led Monitoring (CLM) exercise at the Matola Provincial Hospital and the Manhiça Health Centre between January and April 2026, to generate community-owned evidence on the quality of AHD services and translate it into targeted advocacy action.

Methodology

Four validated CLM instruments were deployed by trained community health workers: (1) a *User Survey* administered to 60 patients living with HIV across both facilities, covering quality of care, waiting times, medicines availability, and opportunistic infection screening; (2) a *Provider/Ombudsman Survey* assessing human resources, supply availability, infrastructure, and accountability mechanisms; (3) a *Structured Observation Matrix* in which community activists directly observed facility conditions including patient flow, privacy, and hygiene; and (4) a *Community Listening Tool*, facilitated through consultation meetings with 24 community members, to surface systemic barriers and co-develop action plans with health committee members.

Key Findings

ARV supply was consistently reported: all 60 patients received prescribed antiretrovirals in the correct quantity. However, critical gaps in the AHD service package were identified. Only 4 of 60 patients (7%) had been screened for Kaposi's sarcoma or serious fungal/bacterial infections which are conditions that are directly life-threatening in AHD. Nutritional assessment had not been conducted for 22 of 60 patients. While 46 patients reported having received a CrAg test and 50 had been offered fluconazole, 6 had not and 4 were uncertain, pointing to inconsistent implementation of cryptococcal infection prevention protocols.

The Health Providers at both facilities reported shortages of needles, syringes, disinfectants, Isoniazid, Pyridoxine, and Fluconazole during the monitoring period. Matola Provincial Hospital lacked functional viral load testing equipment. Privacy deficiencies were documented in the ART, PrEP, PEP, STI, and pharmacy sectors at Matola — a structural driver of treatment disengagement. Thirty patients reported no access to potable water, and 30 reported unclean bathroom facilities. Six patients reported that complaints books were absent or not displayed in visible spaces, representing a breach of national patient rights standards.

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CLM findings were not submitted as a report and set aside. Community activists, health committee members, and facility supervisors convened jointly to develop site-level action plans addressing identified barriers. Five formal complaints were documented across the two facilities. Two were resolved within the monitoring period including one at each site demonstrating that structured community accountability mechanisms can produce immediate, on-the-ground results. Three remain under active follow-up through health and co-management committees, with documented timelines and responsible parties.

Conclusions and Implications

This case study demonstrates that community-generated evidence, when collected through validated instruments and channeled through structured accountability processes, can surface life-threatening service gaps that routine programme data does not capture and can produce measurable corrective action within the same reporting period. The near-total absence of Kaposi's sarcoma and opportunistic infection screening among surveyed patients would not appear in standard facility dashboards; only a patient-facing community instrument could surface it.

MATRAM together IMPAACT4HIV project partners call on the Ministry of Health, CNCS, and implementing partners to: mandate opportunistic infection screening as a non-negotiable AHD service component at all ART sites; address critical supply disruptions for Fluconazole, Isoniazid, and consumables; enforce privacy standards in AHD service areas; ensure functional viral load testing or documented referral pathways at all sites; and incorporate AHD-specific indicators into the national CLM framework to enable systematic quality-of-care tracking at scale.

"When we go into the community with our tools and our notebooks, we are not there to judge the facility. We are there to be the voice of the person who is too sick, too tired, or too afraid to speak for themselves."
— Community Activist, MATRAM, Matola District, 2026