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COMMUNITY-LED MONITORING AS ACCOUNTABILITY MECHANISM IN URBAN HEALTH INSTITUTIONS: A MIXED-METHODS CASE STUDY FROM BLANTYRE, MALAWI

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A B S T R A C T

Community-led monitoring (CLM) is promoted as an institutional accountabilit mechanism for rights-based HIV services, yet facility-level evidence from urba settings is scarce. This convergent parallel mixed-methods study at two urba facilities in Blantyre, Malawi combined a client survey (n=250), key informan interviews (n=12) and three focus group discussions (n=15). Awareness of CLM was moderate (56.0%) but participation lower (40.2%), with involvement rate 2.78/5, placing CLM at the consultative rung of Arnstein's ladder. Awarenes was the only robust predictor of participation (adjusted odds ratio 5.02, 95% C 2.38–10.6). Notably, 46% of participants monitored services withou recognising the term "CLM". CLM strengthened communication more tha institutional responsiveness; accountability mechanisms existed but functione informally, and the two facilities differed on none of nine indicators (all p>0.12, Urban CLM is a real but under-institutionalized practice: formalising existin monitoring through low-cost documentation, scheduled feedback an independent complaint channels is the decisive governance lever.

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1. INTRODUCTION

HIV/AIDS remains one of the defining public health and institutional challenges of the past four decades, with an estimated 40.8 million people living with HIV and 1.3 million new infections annually, and sub-Saharan Africa bearing approximately 65% of the global burden (UNAIDS, 2025a, 2025b). Beyond its immediate health toll, HIV/AIDS is a socio-economic development challenge: it erodes household income, strains national budgets, and reduces the productivity of working-age adults, with effects that fall hardest on the poorest households and on women. Malawi has made substantial progress against this backdrop, achieving the UNAIDS 95-95-95 targets, with adult prevalence declining to 8.9% and annual new infections falling from around 56,000 in 2010 to approximately 12,000 in 2023 (Ministry of Health, Malawi, 2022; Payne et al., 2023). Yet these national-level achievements mask persistent facility-level challenges in service quality and rights protection, challenges that are especially acute in high-volume urban facilities such as Ndirande and Limbe in Blantyre, where the Southern Region records HIV prevalence above the national average (Payne et al., 2023). Despite success in HIV management overall, gaps in service quality, equity and accountability persist, particularly for marginalized and key populations (UNAIDS, 2025b; World Health Organization, 2025). These are, in the first instance, institutional gaps: they concern how frontline service organisations are governed, how they record and respond

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to user feedback, and how accountable they are to the populations they serve.

The global HIV response has increasingly recognized that biomedical progress alone is insufficient to close these gaps. The UNAIDS Global AIDS Strategy 2021–2026 emphasizes rights-based, people-centered approaches that prioritize community leadership and accountability as necessary complements to clinical service delivery (UNAIDS, 2021a). Within this shift, community accountability mechanisms of which community-led monitoring (CLM) is a leading example have moved from the margins to the mainstream of HIV programming, on the premise that affected communities are best placed to identify service failures and press for their correction.

Against this background, the present study addresses the evidence gap on CLM's facility-level functioning in urban settings by examining its operation at two high-volume health facilities in Blantyre, Malawi. Its objectives were to: assess the extent of community involvement in CLM; evaluate rights-based dimensions of service delivery at the two facilities; examine CLM's influence on service quality, accountability and responsiveness; and identify the structural and social barriers that constrain fuller community participation.

2. LITERATURE REVIEW

The evidence based on community accountability offers grounds for both optimism and caution. Systematic reviews of social-accountability interventions community scorecards, citizen report cards, and community-based monitoring find that such mechanisms can improve service utilization, provider effort and, in some cases, health outcomes, but that effects are highly heterogeneous and contingent on context: on the responsiveness of providers, the strength of feedback channels, the capacity and independence of community actors, and the wider institutional environment (Danhoundo et al., 2018). CLM inherits both the promise and the contingency of this broader family of interventions. Its distinctive emphasis on the leadership of affected communities' positions those living with HIV as co-producers of accountability rather than passive beneficiaries, extending a principle with deep roots in the HIV movement's history of community mobilisation. Whether that principle is realized in practice, however, depends on the same enabling conditions that the general accountability literature identifies, and it is these conditions that the present study examines at the facility level in an urban Malawian setting where they are least assured.

Situating CLM within the organisational and institutional literature clarifies what the mechanism is actually being asked to do. Social accountability instruments are, in organisational terms, externally sourced feedback systems grafted onto public-sector service organisations that were not originally designed to receive them. Their effectiveness therefore depends less on the volume of community voice generated than on the absorptive capacity of the receiving institution: whether the organisation has a defined point of entry for external feedback, a routine for recording it, an assigned officer accountable for acting on it, and a review cycle in which action is verified. Where these organisational routines are absent, community voices accumulate without converting into institutional change, and the mechanism is experienced by communities as consultation without consequence. This organisational reading reframes the familiar finding that social accountability "works sometimes": variation in effect is substantially variation in the institutional infrastructure that receives the feedback. It also predicts where such mechanisms will fail most reliably in organisations with high staff turnover, unfunded administrative functions, and no documentation discipline which is a fair description of high-volume urban primary care in many low-income settings. The present study therefore treats CLM not only as a community practice but as an institutional interface and asks whether the receiving organisations have the routines required to complete the accountability cycle.

Community-led monitoring positions communities as active agents in monitoring and improving service quality, systematically collecting and analyzing data on the availability, accessibility, acceptability and quality of services to advocate for improvements grounded in client experience (Baptiste et al., 2020; Sharp et al., 2024). Grounded in social accountability theory and the availability-accessibility-acceptability-quality (AAAQ) framework, and endorsed by PEPFAR, the Global Fund and the World Health Organization, CLM aims to bridge the gap between policy commitments and lived realities (UNAIDS, 2021b, 2023). In Malawi, CLM has been implemented largely by civil-society organisations, and its initiatives have reported positive outcomes such as increased multi-month ART dispensing (UNAIDS, 2023). However, most evaluations to date focus on rural settings, where traditional leadership and village structures facilitate mobilisation; evidence on CLM's facility-level functioning in urban areas, and on whether it genuinely shifts power between communities and providers, remains limited (Sharp et al., 2024).

The Malawian institutional context adds a further layer of contingency. CLM in Malawi is implemented largely through civil-society organisations operating on short, donor-financed grant cycles, rather than through a permanently funded line within district health budgets. This financing architecture has two organisational consequences that bear directly on the present study. First, it makes the continuity of monitoring dependent on the continuity of external grants, so that documentation practices, monitor stipends and meeting schedules fluctuate with the funding cycle rather than with service need. Second, it locates accountability outside the formal management line of the facility: community monitors typically have no standing position within facility governance structures and no formal entitlement to a response, which leaves the interface between community evidence and managerial action dependent on individual

goodwill rather than institutional obligation. Health Advisory Committees exist as the formal community-oversight structure at facility level, but their mandate overlaps imperfectly with CLM, and the relationship between the two is rarely specified in operational guidance. Examining how these arrangements function in practice at facility level is a prerequisite for any credible proposal to institutionalise CLM within the public health system rather than alongside it.

The rationale for focusing specifically on urban facilities is both empirical and theoretical. Urban health centres in Malawi operate under conditions that differ markedly from rural ones: they serve larger and more mobile populations, experience higher patient volumes and longer waiting times, and lack the cohesive traditional structures chiefs, village heads, village development committees that facilitate community mobilisation in rural districts. The relative anonymity of urban life may weaken the informal social ties on which community accountability elsewhere depends, while the heterogeneity of urban populations, including substantial numbers of key-population members, raises the stakes for equity and non-discrimination (UNAIDS, 2023). These features make urban facilities a demanding test of whether CLM can function where the conditions favoring community participation are least assured, and they justify treating the urban context as a distinct object of study rather than assuming that rurally derived models will transfer without adaptation.

This study's analytical approach is further shaped by framing CLM as a results-based strategy, evaluated against the principles of results-based management. Results-based management orients organisational activity toward measurable results through a continuous cycle of objective-setting, data collection, feedback, corrective action and review, and it places documentation at the heart of accountability. Evaluated through this lens, the pertinent question is not merely whether monitoring activities occur, but whether they generate documented results whether community-generated evidence reliably feeds back into corrective action. This framing directs analytical attention to the integrity of documentation and feedback loops, which, as the findings show, is precisely where CLM at the two study facilities is weakest. The study is further grounded in the rights-based approach to health (Hunt et al., 2015) and Arnstein's ladder of citizen participation (Arnstein, 1969), which together provide a normative benchmark for assessing not only whether communities participate in monitoring, but the depth and authenticity of that participation.

3. METHODOLOGY

3.1 Design and setting

A convergent parallel mixed-methods design was used, guided by a pragmatist philosophy, at Ndirande and Limbe health facilities in Blantyre, Malawi. Both are high-volume urban primary-care facilities serving densely populated catchments with HIV prevalence above the national average, and both host active CLM structures.

3.2 Theoretical and analytical framework

Two frameworks structured both instrument design and interpretation. The rights-based approach to health (Hunt et al., 2015) supplied the normative content of the service-delivery measures, operationalised through the availability, accessibility, acceptability and quality (AAAQ) dimensions and their associated entitlements non-discrimination, confidentiality, participation and access to remedy. Survey items on equity, privacy, confidentiality and complaint-handling were written directly against these entitlements so that each measured a specified right rather than generalised satisfaction. Arnstein's ladder of citizen participation (Arnstein, 1969) supplied the analytical scale for the depth of participation, distinguishing non-participation from tokenism (informing, consultation, placation) and from degrees of citizen power (partnership, delegated power, citizen control). Forms of involvement recorded in the survey were mapped onto these rungs a priori: receiving information and attending meetings were classified as informing and consultation; joint review sessions with facility staff and participation in decisions about corrective action were classified as partnership or above. This mapping makes the study's central participation-depth claim auditable rather than impressionistic. Results-based management supplied the third, organisational lens, directing attention to whether the monitoring cycle closes that is, whether community-generated evidence is recorded, assigned, acted upon and verified and thereby specifying documentation as an object of measurement rather than administrative detail.

3.3 Sampling

Purposive and stratified sampling were used. Stratification was applied by facility, with the achieved sample (Ndirande 128, Limbe 122) drawn in approximate proportion to each facility's average monthly client volume; within each facility, systematic random intercept sampling was used at ART clinic exit points, with every nth attending client approached until the daily quota was reached. The minimum survey sample was estimated using Yamane's formula, applied to the combined estimated monthly client population across both facilities (N=1,800) at a 95% confidence level and a precision of e=0.06, yielding a minimum requirement of approximately 247; the achieved sample (250) exceeded this minimum, and all valid responses were retained to maximise precision. Of clients approached, 268 were invited to participate and 250 completed the survey, a response rate of 93.3%; the principal reasons for non-participation were time constraints and, in a small number of cases, discomfort with the topic.

Twelve key informant interviews (health staff, CLM focal persons, expert clients, a peer educator serving key

populations, and a district coordinator) and three focus group discussions (15 community and Health Advisory Committee members) were conducted, giving 277 participants in total. Purposive selection of key informants was guided by role-based criteria established prior to data collection: informants were required to hold direct operational responsibility for CLM implementation, client-facing HIV service delivery, or formal community oversight (Health Advisory Committee membership) at either facility. Potential informants were identified in consultation with facility in-charges and the district AIDS coordinator and approached directly by the research team. Qualitative sample size was guided by data saturation.

3.4 Data collection

Data were collected August 2026 using a KoboToolbox client survey, a key informant interview guide, and a focus group guide administered in local language. The survey captured demographic characteristics, CLM awareness and participation, and perceptions of accessibility, equity, confidentiality, responsiveness and satisfaction. All instruments were piloted with ten clients and two key informants at a facility outside the study sample, resulting in minor revisions to question wording and skip-logic for clarity. The survey and interview guides were translated from English into Chichewa (local language) and back-translated independently by a second bilingual translator to check for conceptual equivalence; discrepancies were resolved by consensus among the research team. Data collection was conducted by six trained research assistants, standardised through a one-day training on the study instruments, ethical procedures, and probing techniques for sensitive topics, supervised directly by the principal investigator.

3.5 Statistical analysis

Quantitative data were analysed in R (version 4.3.x), using the car package for multicollinearity diagnostics and base stats functions for model estimation. Associations between categorical variables were tested using the Pearson chi-square test with Cramér's V as an effect size; where expected cell counts fell below five, Fisher's exact test was substituted for the chi-square test. Predictors of CLM participation were examined using binary logistic regression, reporting adjusted odds ratios with 95% confidence intervals; the model included gender, awareness of CLM, facility, age group and education as predictors, with reference categories as follows: female (gender), aware of CLM (awareness), Ndirande (facility), 18–29 years (age group), and no formal/primary education (education). Model diagnostics included variance inflation factors (all below 2, indicating no material multicollinearity) and the Hosmer-Lemeshow goodness-of-fit test ($p=0.41$), indicating adequate model fit. The significance threshold was set at $\alpha=0.05$. A linear regression of satisfaction had been planned, but it was not pursued to inferential conclusions because the categorical predictor structure and the distribution of the satisfaction outcome did not meet the assumptions required for a stable model; satisfaction is therefore reported descriptively.

Qualitative data were transcribed, translated from Chichewa where necessary, and analysed thematically using a coding framework developed both deductively, from the study objectives, and inductively, from emerging themes. A second researcher independently coded a 20% subsample of transcripts using the same coding framework; discrepancies were discussed and resolved by consensus, achieving a Cohen's kappa of 0.79, indicating substantial agreement. The two strands were integrated at the interpretation stage through triangulation, assessing convergence, complementarity and divergence in relation to each objective.

3.6 Rigour and trustworthiness

Validity and reliability were pursued by deriving survey items directly from the study's objectives and theoretical frameworks, administering the instrument electronically to reduce errors. Trustworthiness of the qualitative data was pursued through triangulation across three data sources and multiple informant types, the retention of Chichewa quotations alongside translations, and an audit trail of coding decisions. For focus group discussions, ground rules on mutual confidentiality were established and agreed upon by participants before discussion began, and participants were encouraged to speak in general terms about experiences rather than disclosing personal HIV status where they preferred not to. Item-level missingness arising from skip logic was addressed transparently by reporting valid n per item rather than imputing values.

3.7 Reflexivity

The lead researcher has prior professional experience in monitoring and evaluation within HIV and health-systems programming in Malawi, including exposure to CLM initiatives in a non-facility-affiliated capacity. This background informed the study's design and interpretive lens but created no direct professional relationship with staff or clients at either study facility, reducing the likelihood of social-desirability bias in participant responses. To further mitigate this, data collection was conducted by independent public health research assistants rather than the principal investigator, and participants were informed that the research team was unaffiliated with the facilities' management structures.

3.8 Ethics statement

Ethical clearance for this study was obtained from the University of Malawi Research Ethics Committee (UNIMAREC), and permission to conduct the research was granted by the Blantyre District Health Office. All participants received clear information about the purpose of the study, their right to decline participation or

withdraw at any time without consequence, and the confidential handling of their responses. All participants provided written informed consent before taking part. No minors were enrolled. Data were anonymised prior to analysis and are reported in aggregate.

4. RESULTS AND DISCUSSION

4.1 Socio-demographic characteristics

Survey respondents were predominantly female (62.0%) and aged 26–35 (54.4%); half (50.4%) were people living with HIV, and facility representation was balanced (Ndirande 51.2%, Limbe 48.8%) (Table 1).

Table 1. Socio-demographic characteristics of survey respondents

Characteristic	Category	n	%
Gender	Female	155	62.0
	Male	95	38.0
Age	61+	12	4.8
	36-60	66	26.4
	26-35	136	54.4
	18-25	36	14.4
Type	PLHIV	126	50.4
	General user	94	37.6
	Other/CLM member	30	12.0

N = 250

Most had at least secondary education (53.3%). Key informants (mean community working experience 3.1 years) spanned both facilities and a range of roles and focus group participants were aged 24–58.

4.2 Community involvement in monitoring

Awareness of CLM was moderate (135/241; 56.0%) but participation was lower (78/194; 40.2%), and involvement was rated 2.78/5 (SD 1.31; n=151), locating CLM at the consultative rung of Arnstein's ladder.

Table 2: Sources through which respondents first heard of CLM

Source of first awareness	n	% of aware (135)
Community meeting	58	43.0
Non-governmental organisation	44	32.6
Health facility	24	17.8
Friend or relative	24	17.8
Radio, church or youth club	14	10.4

Awareness was propagated mainly through community meetings and non-governmental organisations rather than the facility (Table 2). Among participants, involvement was predominantly consultative; attending meetings and advocacy actions, rather than participation in decision-making review sessions (Figure 1).

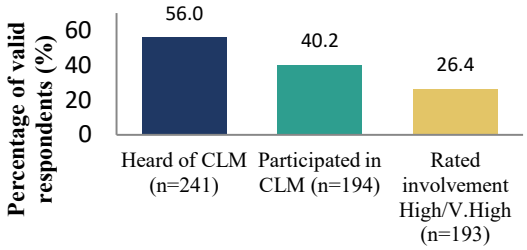

Figure 1. The awareness–action gap in community-led monitoring

Disaggregating the forms of involvement revealed the consultative character of participation. Among participants, the most common activities were attending community meetings (42.0%) and participating in advocacy actions (35.8%), followed by monitoring service quality (27.2%) and collecting feedback from users (21.0%); participation in review sessions with facility staff, the form most closely tied to decision-making, was least common (13.6%). Participants were mobilised chiefly by community leaders (32.1%), health workers (26.9%) and peer educators (23.1%).

Awareness of CLM was the strongest predictor of participation at the bivariate level (χ^2=20.44, p<0.001, Cramér's V=0.333); gender showed only a weak borderline significant association (χ^2=4.20, p=0.040, V=0.148) and facility none (p=0.975).

Table 3. Binary logistic regression predicting CLM participation

Predictor	Adjusted OR	95% CI	p
Heard of CLM (ref: No)	5.02	2.38–10.6	<0.001
Female	1.65	0.82–3.32	0.16
Ndirande	0.81	0.40–1.62	0.55
Age 26–35	1.14	0.40–3.26	0.81
Age 36–60	1.29	0.57–2.91	0.55
Age 61+	0.78	0.12–5.00	0.80
Education: Secondary	0.83	0.39–1.76	0.63
Education: Tertiary	0.63	0.20–2.00	0.43

n=169; McFadden pseudo-R^2=0.10.

In logistic regression (n=169), awareness remained strongly predictive (adjusted odds ratio [OR]=5.02, 95% confidence interval [CI] 2.38–10.6, p<0.001), while

gender did not survive adjustment (OR 1.65, 95% CI 0.82–3.32, p=0.16), indicating that the apparent gender effect largely reflects differences in awareness (Table 3). A novel finding was that 46% (32/69) of participants engaged in monitoring despite not recognising the term "CLM," indicating that community monitoring practice runs ahead of formal CLM literacy.

4.3 Rights-based service delivery

Access was rated easy or very easy by 60.6% (of 241), with the main barriers being lack of privacy, transport costs, unfriendly staff, long waiting times and stigma. Equity was the weakest dimension: only 38.4% felt clients are always treated equally, and 31.2% had witnessed discrimination, most commonly on grounds of disability, age, gender and HIV status, and disproportionately affecting key populations (Figure 2). Among those answering confidentiality items (n=126), 37.3% felt information was always confidential, but 22.2% had avoided services for fear of breaches. Overall rights-based satisfaction was moderate (mean 3.42/5, SD 1.22). The right to remedy was compromised by fear of reprisal, indicating that low complaint rates reflect under-reporting of grievances.

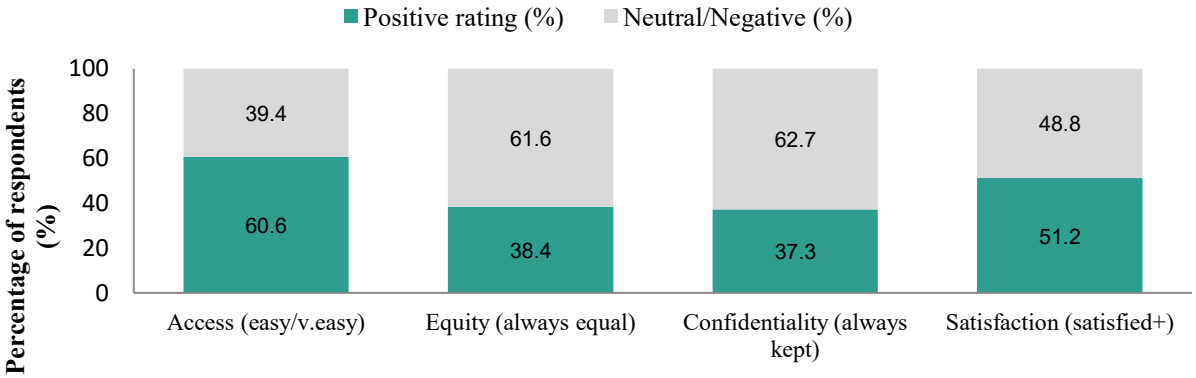

Figure 2. Rights-based service delivery across four dimensions

4.4 Influence of CLM on service delivery

Perceived improvements included reduced waiting times, coded registration replacing open registration, renovated youth-friendly spaces, and Saturday adolescent clinics were reported consistently across independent key informants but were concentrated among those directly involved in CLM. Among respondents answering the relevant items, 68.5% (of 54) felt CLM improved communication, while only 36.2% (of 116) felt it improved responsiveness, and satisfaction with facility response was moderate (mean 2.95/5). Accountability mechanisms existed (47.8% had seen them) but functioned informally: suggestion boxes were often unopened, meetings irregular, and written records inconsistently maintained across sites a documentation weakness rather than a total absence. Where feedback was documented and acted upon, the results were tangible; where it was not, issues recurred.

4.5 Barriers and facility comparison

Barriers, synthesised from the qualitative sources, were inadequate and delayed funding, transport costs for monitors, staff attitudes and turnover, fear of stigma and reprisal, cultural and gender norms, and a shortage of documentation materials. These barriers were mutually reinforcing, forming a cycle in which resource scarcity weakened documentation, weak documentation undermined accountability, and invisible accountability eroded community trust. The two facilities did not differ significantly on any of nine indicators (all p>0.12), indicating systemic rather than site-specific constraints (Figure 3).

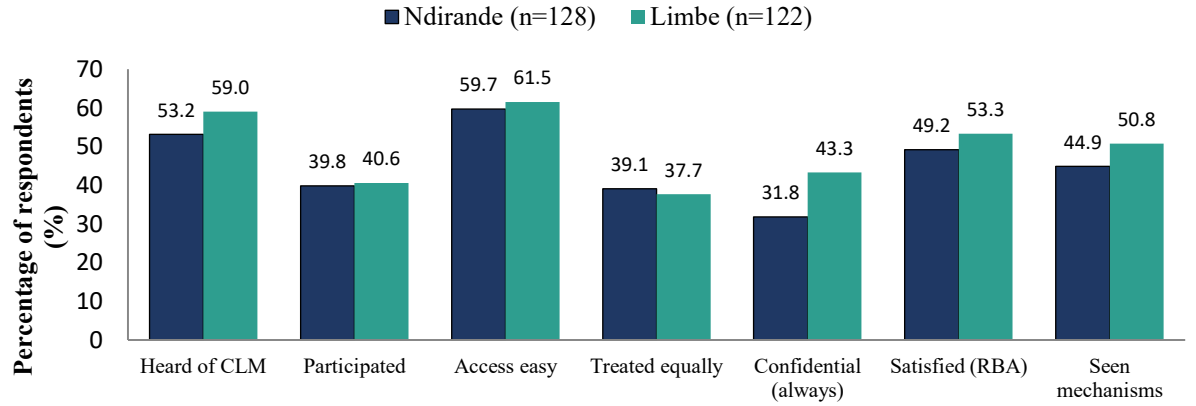

Figure 3. Facility comparison across indicators

A note on missingness. Item-level n varied across measures (from 241 down to 54 for some sub-items), reflecting the survey's skip-logic design: participation-related items were only presented to respondents who first confirmed awareness of CLM, and several rights-based and CLM-influence items were answered only by relevant sub-groups (e.g., those who had accessed specific services). Valid n is reported alongside each result rather than imputed.

5. DISCUSSION

This study provides one of the first independent, facility-level assessments of CLM in urban Malawi. Its central contribution is to reframe the participation deficit. With awareness the decisive predictor of participation, and 46% of participants unaware of the CLM label, the binding constraint is less community apathy than the gap between widespread but unrecognised monitoring activity and the awareness, resourcing and documentation needed to formalise it. The highest-yield intervention is therefore to name, label and institutionalise the community activity that already exists rather than to build participation from nothing. This reframing has, to our knowledge, not been documented in the Malawian literature, and it carries direct implications for programme design, since studies that measure participation only among those recruited into formal CLM structures will systematically underestimate community monitoring and miss the population for whom formalisation, rather than mobilisation, is the appropriate response.

Consistent with evidence from South Africa and Uganda (UNAIDS, 2023), CLM was associated with tangible improvements in waiting times, commodity availability and staff attitudes. The consistency of these accounts across independent informants at both facilities strengthens their credibility. However, CLM's stronger effect on communication than on responsiveness indicates that it opens channels of voice faster than it closes feedback loops into documented action. Interpreted through results-based management, the cycle breaks at the point of documentation: CLM strengthens data collection and feedback but not the recording, action-tracking and review that convert voice into durable results. This diagnosis is more precise than a binary claim that documentation is absent, and it points to a correspondingly precise, low-cost remedy.

The consultative depth of participation locates CLM within the tokenism band of Arnstein's ladder, consistent with the social-accountability literature's caution that participatory mechanisms often leave the underlying distribution of power untouched (Danhoundo et al., 2018). Yet the coexistence of consultative participation with real service improvements suggests that even tokenistic participation can yield gains where facilities are receptive, supporting a developmental rather than a dismissive view of CLM. The equity findings persistent discrimination and fear-driven under-use indicate that the technical successes of the HIV response have outpaced progress on the interpersonal and rights dimensions of care, underscoring the continued relevance of the rights-based approach. The finding that fear of reprisal suppresses complaints reveals that the right to remedy fails not for want of complaint channels but for want of trusted, independent ones.

The statistical equivalence of the two facilities across all nine indicators is analytically pivotal: it indicates that the constraints on CLM are systemic to the urban primary-care context rather than the product of local management, and it therefore directs interventions to the district and national levels. This equivalence also enhances the transferability of the findings to other urban facilities facing the same systemic conditions, while cautioning against constructing a "better facility" narrative unsupported by the data.

Read as an organisational problem rather than a community one, the documentation deficit is tractable in a way that "weak participation" is not. The activities that break down at both facilities opening a suggestion box on a fixed schedule, minuting a meeting, assigning a named officer to an issue, recording whether the issue was closed are low-cost administrative routines, not capital investments or skills that require lengthy training. Their absence is best explained not by unwillingness but by the fact that no one holds them as a defined responsibility with time allocated to it: they sit outside every job description at facility level and outside the reporting requirements that district management actually monitors. This is a familiar organisational failure mode in which a function that is everyone's concern becomes no one's task. It has an equally familiar remedy assigning the function explicitly, specifying the minimum record, and including that record in existing supervisory checks and the remedy is available without new funding, which matters in a system where the binding constraint on any proposal is fiscal. The practical implication is that the highest-return intervention identified by this study is administrative rather than mobilisational: the community input already exists, and what is missing is the organisational routine that would convert it into a documented institutional response.

The confidentiality findings merit particular emphasis because of their behavioural consequences. That 22.2% of respondents had avoided seeking services at some point for fear of confidentiality breaches represents a direct threat to the HIV response: avoidance undermines treatment continuity, retention in care and, ultimately, viral suppression. The qualitative evidence that CLM had driven a shift from open to coded registration and the creation of private consultation spaces demonstrates that community monitoring can address such concerns concretely, yet the persistence of recalled breaches shows that the underlying risk has been reduced rather than eliminated.

The barriers identified funding, transport, staff attitudes and turnover, fear of reprisal, and cultural and gender norms correspond closely to those documented across the sub-Saharan literature on community health worker and

social-accountability programmes (Danhoundo et al., 2018; Sharp et al., 2024), suggesting that they are structural features of community monitoring in low-resource settings rather than local peculiarities. This study's contribution is to show how these barriers interlock into a self-reinforcing cycle centred on the documentation deficit: without funding and materials, documentation weakens; without documentation, accountability remains informal and person-dependent; and without visible accountability, the community trust on which participation depends erodes.

The divergence between the survey and qualitative findings on the depth of monitoring activity is analytically productive rather than contradictory. The survey, which measures recognition of the formal CLM label, portrays a shallow reach, while the qualitative data, which captures lived practice, portrays a richer set of monitoring activities already under way. Reconciled, the two strands yield the study's central insight: communities are conducting more monitoring than they recognise as "CLM," and the task of policy is to name, formalise, resource and document that activity rather than to create participation from nothing.

The scope conditions under which these findings should be expected to transfer can be stated explicitly. The argument advanced here depends on three features of the study sites rather than on anything specific to Blantyre: a high-volume primary-care facility in which clinical workload dominates administrative capacity; a community monitoring function financed from outside the facility's own budget and therefore outside its management line; and a population sufficiently heterogeneous that participation cannot be organised through pre-existing traditional structures. Where those three conditions hold which is to say, across much of urban primary care in low-income settings the mechanism identified here should be expected to operate: monitoring activity will run ahead of formal programme literacy, voice will outpace documented response, and the accountability cycle will break at the recording step rather than at the participation step. Where any of the three does not hold, the diagnosis should be re-tested rather than assumed. Stating the conditions in this form is more useful to policy than a claim of statistical generalisability that a two-facility design cannot support, because it tells implementers in other districts what to check before adopting the recommendations rather than inviting them to adopt the findings wholesale.

6. MAJOR FINDINGS AND OUTCOMES

The study produced five principal findings. First, awareness of CLM was moderate (56.0%) while participation was lower (40.2%), and awareness was the only robust predictor of participation after adjustment (adjusted OR 5.02, 95% CI 2.38–10.6, $p<0.001$). Second, 46% of those who participated in monitoring did not recognise the term "CLM", indicating that community monitoring practice runs ahead of formal programme literacy. Third, participation was concentrated at the consultative rungs of Arnstein's ladder: attending meetings (42.0%) and advocacy (35.8%) were common, while joint review sessions with facility staff, the form most closely tied to decision-making, were least common (13.6%).

Fourth, CLM was associated with documented service improvements reduced waiting times, coded registration, renovated youth-friendly spaces and Saturday adolescent clinics yet its effect on institutional responsiveness (36.2%) was markedly weaker than on communication (68.5%), locating the break in the accountability cycle at the point of documentation rather than at the point of participation. Fifth, the two facilities did not differ significantly on any indicator examined (all $p>0.12$), indicating that the constraints on CLM are systemic to the urban primary-care context rather than attributable to local management.

7. CONCLUSION

CLM at Ndirande and Limbe represents a real but incomplete shift toward community accountability in HIV service delivery. It has strengthened communication and contributed to measurable service improvements, but consultative participation, informal and inconsistent documentation, and fear of reprisal constrain its transformative potential, holding it at the consultative rung of Arnstein's ladder. Realising its potential requires formalising the community monitoring that already exists through awareness-raising, reliable low-cost documentation, independent complaint mechanisms, and sustained funding to advance CLM from consultation toward genuine citizen power. These findings offer a credible, evidence-based agenda for strengthening community-led accountability in urban HIV services in Malawi and comparable settings.

8. RECOMMENDATIONS FOR FUTURE WORK

Implications. Four priorities follow: (1) close the awareness–action gap through deliberate, facility-based CLM communication and by connecting with the informal networks through which communities already encounter CLM; (2) institute simple, low-cost documentation complaint registers, meeting minutes, action trackers to close the results-based cycle; (3) establish independent, confidential complaint mechanisms, and actively promote awareness of them, to counter fear of reprisal; and (4) secure sustainable funding by embedding CLM in district and facility budgets and providing for monitors' transport and materials.

Limitations. The study was confined to two urban facilities, which was a deliberate design choice given the urban evidence gap identified in the Introduction; this limits statistical generalisability, particularly to rural

settings, which operate under different social and institutional conditions. The cross-sectional design precludes causal inference; purposive sampling and self-report introduce potential bias; and documentary evidence was incomplete, so accountability findings rely on triangulated participant accounts. Because the survey measured recognition of the CLM label while interviews captured lived practice, part of the practice–literacy gap could reflect an instrument effect, though convergent evidence supports the substantive interpretation. Findings are therefore offered as analytically transferable propositions for national piloting.

Three lines of further research follow directly from these limitations. First, a longitudinal or stepped-wedge design would permit causal inference about CLM's effect on service quality, which the present cross-sectional design cannot support. Second, a multi-district study spanning both urban and rural facilities would test whether the practice–literacy gap identified here is specific to urban settings or general to the Malawian CLM system. Third, an implementation trial of the low-cost documentation package proposed above a complaint register, meeting minutes, an action tracker and a named responsible officer would test directly whether closing the recording step converts community voice into documented institutional response, which is the central proposition this study advances but cannot itself verify.

9. DECLARATIONS

a. Artificial intelligence utilisation

Copilot was used to assist with language editing of the manuscript draft. All AI-generated suggestions were reviewed, verified, and revised by the authors, who take full responsibility for the accuracy, originality, and integrity of the content. AI was not used to analyse or interpret study data, nor to generate results, hypotheses, or conclusions.

b. Competing interests

The authors report no conflicts of interest.

c. Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The study was conducted as part of the corresponding author's Master of Business Administration (Project Management) research activities at the University of Malawi.

d. Authors' contributions

Misheck Dickson Banda conceived and designed the study, led data collection and analysis, data interpretation and drafted the manuscript. Maalila Malambo contributed to supervision and critical revision of the manuscript for important intellectual content. Both authors approved the final version and agreed to be accountable for all aspects of the work.

e. Data availability

The datasets generated and analysed during this study are available from the corresponding author, subject to ethical approval conditions protecting participant confidentiality. Anonymised data are available at https://doi.org/10.5281/zenodo.21562463

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