A model for Community Based Monitoring in the Provision of Quality Maternal and Child Health Services

This Model has been developed in support of the Reducing Maternal and Child Mortality through Strengthening Primary Health Care in South Africa Programme (RMCH). The RMCH programme is implemented by GRM Futures Group in partnership with Health Systems Trust, Save the Children South Africa and Social Development Direct, with funding from the UK Government.

RMCH is committed to helping reduce the high number of avoidable maternal and child deaths in South Africa by strengthening the primary health care system. The programme provides technical assistance to the South African National Department of Health (NDoH) and the Districts to improve the quality of, and access to, reproductive, maternal and child health services for women and children living in poorer, underserved areas in South Africa.
## Indicators: Monitoring by Community Members

<table>
<thead>
<tr>
<th>Priority</th>
<th>Key Area</th>
<th>Indicator</th>
<th>Happy</th>
<th>Neutral</th>
<th>Unhappy</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety &amp; Security</td>
<td>Lighting</td>
<td>There is an adequate number of lights</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Security</td>
<td>There is an emergency plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Power supply</td>
<td>There is a stable power supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency services</td>
<td>There is an emergency call system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Critical services</td>
<td>There is an effective drug distribution system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilities</td>
<td>There is a clean environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food supply</td>
<td>There is a variety of food available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td>There is a good ratio of staff to patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>There is easy access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Clinical Care</td>
<td>Lighting</td>
<td>Lighting is adequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clothing</td>
<td>Clothes are clean and suitable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Equipment</td>
<td>Equipment is adequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicines</td>
<td>Medicines are available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infection control &amp; hygiene</td>
<td>Infection control measures are followed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Availability of services</td>
<td>Services are available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td>Staff are friendly and helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient &amp; visitor</td>
<td>Patients are treated with respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td>Staff are knowledgeable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Background

In South Africa, the provision of primary health care (PHC) in the public sector is premised on the WHO Health promotion framework dubbed the Ottawa Charter. One of the five pillars of this framework is strengthening community participation/action.

Community participation has been shown to increase accountability, promote local ownership of health care services, and foster dialogue between the health care workers and the public on how the quality of services can be improved.

Despite the adoption of the health promotion framework and the presence of various structures to support its implementation, the primary health care system in South Africa continues to offer sub-optimal standards of care.

Since 2012 the government has begun to explore ways of strengthening primary health care through its Primary Health Care Re-Engineering (R-PHC) strategy. Many of these interventions focus on the supply side of health care services, including developing infrastructure, improving clinical care, addressing staff shortages and improving efficiency in supply chain management. However, minimal effort has been made to address the demand side for quality health care services, which puts people at the centre of the delivery of these services.

In order to address this gap, in 2013 Soul City Institute (SCI) piloted a community based monitoring (CBM) programme in selected communities in South Africa. This paper describes the model for community based monitoring in Maternal and Child Health (MCH) services, explores the implementation process of the model and shares lessons learnt from an application of the model.
Community Based Monitoring in MCH services: A conceptual framework

CBM is a form of public oversight that uses local information to describe and track changes within the health care system. It is aimed at promoting accountability through increased involvement of users in the delivery of health care services. Within the CBM framework, ordinary citizens are given an opportunity to evaluate and critique services, identify areas of improvement and systematically collect data and use it to advocate for changes in the system. As a tool, CBM has been shown to strengthen local capacity, promote public participation and inclusive decision making and promote accountability.

The aim of the SCI pilot programme is to build the capacity of and create an enabling environment for communities to monitor the quality of PHC and particularly maternal and child health services. Through this process, communities generate local information in a systematised manner and use it to engage with health workers, holding them accountable for the delivery of quality services. Through information sharing and constructive dialogue, this process results in an improvement in the quality of health services and in turn, improved maternal and child health outcomes. The model is premised on the following assumptions:

- It is implemented within a PHC framework at local level
- There is buy-in and support from national, provincial and district government, with sufficient policy alignment
- The monitoring teams are literate, sufficiently trained and provided with the resources required to conduct their work
- The monitoring teams have access to technical support to assist in the development of suitable data collection tools and protocols
- The identification and prioritisation of monitoring issues is community driven

Key elements of the model include careful equitable selection of community volunteers to be part of a Community Based Monitoring Team (CBMT), the training and skills building of team members, setting up a system to collect data from users of health care services, use of the information to engage the services and dialogue on how the quality of the services can be improved.

Key facilitating factors for the model include:

- buy-in and support of the facility manager
- linkages with other existing structures and initiatives in the delivery of health services such as the ward councillor, the clinic committee (where it exists) and local community-based organisations (CBOs)
- Visibility of community based monitoring team members on site

The model for community based monitoring is an adaptation of a similar model implemented in state health services in Maharashtra in India – People are reclaiming the Public Health System. A qualitative report on Community Based Monitoring and Planning of Health services in Maharashtra. 2012. (http://www.municipalservicesproject.org/sites/municipalservicesproject.org/files/People_are_reclaiming_the_public_health_system.pdf).

Figure 1 shows the conceptual framework of the community based monitoring programme.
CBMT = community based monitoring team
HS = health service

Direct attribution of CBM
Indirect attribution of CBM

Buy in and Support of HS & Community
- Selection of CBM team representative of community
- Financial and technical resources
- Training of CBMT

Monitoring
- Daily and weekly meetings by CBMT
- Clinic committee meetings with CBMT

Increased public knowledge, participation and utilisation of services
Improved efficiencies in HS delivery such as scheduling, waiting times, emergency transport
Improved quality of maternal child HS
Increased staff productivity and accountability
Improved staff attitudes; better, patient-staff rapport

Local municipal, district and NGO support

Improved maternal child health outcomes

Increased public knowledge, participation and utilisation of services
Improved efficiencies in HS delivery such as scheduling, waiting times, emergency transport
Improved quality of maternal child HS
Increased staff productivity and accountability
Improved staff attitudes; better, patient-staff rapport

CBMT = community based monitoring team
HS = health service
The process for implementing the model is outlined in Figure 2 below:

**FIGURE 2:** An Implementation process for the Community based monitoring model

1. **PLANNING & START-UP**
   - Consultation (National)
   - Consultation (Community, CBOs, FBOs, etc)
   - Consultation (Provincial/District/Local)
   - Selection of Community Based Monitoring Team (CBMT) members
   - Training of CBMT

2. **DATA COLLECTION, ANALYSIS AND FEEDBACK**
   - Evaluation of services by the community and identification of local priorities for improvement
   - Development of indicators & benchmarks by CBMT and community members
   - Development of data collection tools for tracking improvement of priorities identified

3. **Routine, systematised data collection (by the users of services & CBMT)**

4. **Use of data and information collected to engage facility management and clinic committee**

5. **Public Dialogue on findings (Community, facility staff, district officials, CBOs, FBO, local stakeholders such as ward concillors, local media)**
Application of the CBM of Maternal and Child Health Services: Lesson learnt from the SCI pilot programme

Consultation and initiation process

Consultation within the health system (National, provincial and local level)

The process begins with an extensive consultation process within the health system and the community to ensure buy-in and shared understanding of the goals of the initiative. The consultation process is very important and perhaps one of the key building blocks of the process. It should begin at national level, moving down to local level. National level consultation is the first step to ensure policy alignment, proper coordination within various directorates and buy-in and support which facilitates lower level consultation. This level of government is also important to advocate for financing scale up and sustainability.

At provincial and district level consultation is important for identifying existing structures at the different levels, on which the programme could be anchored. These include district level civil society coordination structures and any multi-sectoral coordination mechanisms. This consultation process with the health care system lays the important foundation for dialogue, because it is during this phase that the objectives are clearly spelt out, often taking away the fear
that CBM teams could be an agitator body seeking to undermine health workers with no regard for the contextual issues affecting the way that they deliver their duties. Once this cordiality is established, it is also very easy for health care workers to begin to see what they could gain from such a programme. Caution has to be exercised in ensuring that this structure is understood as one representing the voice of the community.

Which government health department units to consult is an important question. The extent to which you can get buy-in and support for the programme also depends on the vested interest of the department and the degree to which they see the bigger picture of the health system. The department responsible for PHC delivery is central to the process. However, other important departments include quality assurance, health promotion, health governance etc. A joint consultation and information meeting with the relevant health units at the outset could promote a greater sense of common and shared value, and hence greater buy-in and support.

Consultation at facility level is often made easier by the preceding contact with the district and sub-district levels. This is the implementation level, and the success of the programme to a large extent lies in the strength of the relationship between the facility and the community monitoring teams. In this process, it is important to also include non-clinical health care workers such as community health workers and administrative and support staff.

**Community Consultation processes**

A parallel consultation process is important with community structures. This serves to introduce the programme to the community, involve community based organisations (CBOs), and gain entry into the community itself through community leadership structures - including ward councillors and traditional leadership. The involvement of CBOs also allows them an opportunity to contribute to the selection process of suitable community members to the CBMT, and in the coordination of the programme. Their buy-in could also help in the sustainability of the programme. An important consideration is whether to engage local, well-functioning CBOs and NGOs to form the teams from within their organisations. This could promote sustainability, but may compromise community representivity and buy-in.

**Selection of community based monitoring teams**

The selection of team members should be guided by the principle of volunteerism and representivity. A community meeting should be called and community members should be properly briefed about the initiative, how it will...
benefit the community and what the teams will be expected to do.

Criteria for selection can be shared and discussed with the community to guide them in the selection process. Such criteria may include diversity with respect to age, gender, literacy levels and any specified groups. Interested members should then be asked to volunteer their time, after which an election can be held to finalise the list.

A transparent election system is very important. The recognition and legitimacy of these team members depends on the extent to which the sitting that elected them was representative of the community. This calls for wide publicising of the community meeting through various media such as posters, local media, loud hailers and even door to door calls. These meetings should be organised through community based structures and hosted at a venue in the community, but outside of the local clinic. It is important that the meeting is not seen or perceived to be a government initiative, but a community/civil society driven process.

In addition, an alternative and complementary recruitment process could be through relevant CBOs and community leadership structures. These structures are given an opportunity to submit names, guided by the specified criteria. The advantage of this is the likelihood that you get individuals already experienced and passionate about development work. Also there is likely to be increased buy-in from civil society and the process is clearly community driven and done outside the influence of the clinic. Whatever the process followed it is imperative to take the names back to a community forum and ensure that they are ratified.

Training of community based monitoring teams

Many of the communities in need of improved accountability tend to be located in poorly resourced, marginalised communities, with low literacy rates and poor capacity. In order to mitigate this risk, it is necessary to strengthen the capacity of CBM team members to enable them to perform their function.

Areas of skills development will differ depending on the community and gaps identified. A good starting point may be helping the team members to understand the workings of the local facility, the various departments and the services they offer, their scheduling, responsibilities and staff resources.

In addition they need to develop interviewing skills and etiquette, with an emphasis on confidentiality and an understanding of patients’ rights and responsibilities as they interact with these services.

Other areas of capacity strengthening include external issues such as roles of various spheres of government, mapping of community resources, promoting active citizenry, constructive dialogue, managing conflict and
organising and running meetings. It can be debated whether or not to invite facility staff to this training.

Whilst caution should be taken to avoid any perceptions that the training is driven by the government, having the facility manager deliver a session on minimum entitlements when patients come to the facility may help strengthen the contract between the facility as service provider and the citizens as users of the services. This is powerful in that it builds the basis for holding them to account when these entitlements are not met.

Inception community dialogue
Once the teams are trained the next step is to create momentum within the community. The community based monitoring teams are tasked with mapping CBOs and other relevant health, child and social resources within their community, including the clinic committee where it exists. These stakeholders are invited to a community meeting convened by the CBM teams which explains the process and further helps the community to identify health issues that they would like to track and over a specific time period.

These issues have to be kept simple at the beginning and may include issues like cleanliness, well baby clinics, ante natal care, queue management or response time of emergency services. It is important to prioritise issues and agree on suitable indicators that will be used to track them. At this point any tools such as score cards and interview schedules that will be used are explained to the community and agreement gained on where they should be put. It is useful to sensitise people around questions they may be asked and information they may have to provide so that they pay attention to relevant issues as they receive care. This is particularly true for any post care interviews such as questionnaires that may be administered to women post partum. The format and importance of public dialogues should also be explained.

The monitoring process
The monitoring process begins as soon as the issues are identified and the tools provided. The strength of the CBM process depends on public participation and it is important to ensure that the monitoring teams understand that they are responsible for providing the data that informs the reports. This means that appropriate tools should be developed to collect data.

Clear indicators should be developed and easy to use, precise tools administered. These tools should provide feedback on the quality of the services that are received in the facility. This feedback can range from the quality of the interaction to the state of the facilities, such as
the bathrooms and grounds. Use of pictorial tools takes away the need for high literacy and promotes inclusivity. These tools can be in the form of report cards, as shown in figure 1 below, or interviews conducted post receiving the service.

It is important to ensure that these tools are located in a public space where community members do not feel threatened or intimidated to provide honest feedback. Whilst the advantage of having them in the clinic is clearly that they serve as an immediate prompt to rate the quality of service that people receive, this environment may not be ideal for honest feedback. It is well worth considering having them in a community area with high traffic such as the market place or community hall. Having a CBM team member on site regularly also serves as a reminder that this process is happening and encourages people to provide feedback.

It is also important to encourage the use of any other feedback systems provided by the clinic. These may include the clinic committee, suggestion boxes and open days. All these should be seen as complementary and provide a choice to clinic users.

Some data may have to be collected through interviews. These could take the form of exit interviews, follow up interviews or incident prompted interviews. Follow up interviews with women post delivery is one such example that can help teams reflect on quality of ante natal, delivery and post natal services. The CBM teams are responsible for collecting information that will help them make sense of some of the issues coming up through report cards, such as a sudden increase in queuing times due to fewer staff or a disease outbreak.

**Working with alternative accountability structures in the health system**

There are often other accountability mechanisms available in the clinic, the most common of which include suggestion boxes and the clinic committee. These structures are often underutilised because of patient complacency and a lack of trust in them. The CBM process invigorates the public and gives them a stronger sense of ownership of their local clinic. This increases their participation and use of other accountability mechanisms.

One example is how CBM teams, through engaging with the facility on where a suggestion box is best placed in the clinic, how often it should be opened, who should be present when it is opened, can change negative perceptions of the use of these boxes.

Similarly, once the public has a sense of ownership of the clinic, they are more keen to get involved in the clinic committee structures. It is important that the CBM teams work closely with the clinic committee where it exists, and that the CBM processes serve to re-enforce public participation via other accountability mechanisms, including the clinic committee and clinic open days.
Public dialogues
As the monitoring process proceeds, issues raised through report cards and interviews need to be dealt with. Public dialogues provide a forum where the clinic staff and ward and district officials can be given an opportunity to make input into the process and shed clarity on the issues raised. This process must be well facilitated and any issues to be discussed should be shared with the facility staff beforehand to allow them time to address the issues and collect additional facts. The public dialogue should thus not bring up new issues, but serve to find solutions to those raised. Participation of district officials in these public dialogues makes them aware of public concerns and gives the facility staff an opportunity to escalate any issues that they cannot resolve at their level.

Involvement of local media
Similar models of CBM have used local media to raise public awareness and involvement. Local print and community radio can be used to publicise the process, explain the importance of public participation and how to get involved. This can be done at inception, to get people to attend the CBM team selection meeting, but also throughout the process to give the public a platform to discuss their experiences with the clinic, and for CBM teams to communicate with the public.

Media can also be involved in disseminating the public dialogues and broadcasting them to those who cannot attend. Working with journalists to increase their knowledge on maternal and child health issues may also help them report better and thus add value to the process.

Key lessons learnt from Soul City Community Based Monitoring Programme

1. Extensive consultation and buy-in at national and provincial level is important and facilitates smooth implementation at local level.

2. The training and skills building of CBM teams is very important and prepares them for their roles. As part of the training, a tour of the facility and orientation to clinic staff is crucial for smooth implementation and relationship building between CBM teams and health care workers.

3. It is important that CBM team members volunteer their services and understand the importance of the initiative and are not motivated by any stipends or rewards.

4. CBM teams have to be guided to create a system for users of the services to provide feedback and the facility to address the issues; caution should be taken by them not to try to solve problems by doing things.

5. The inclusion of members of clinic committee and other health care cadres such as community health workers onto the CBM teams enhance the way that they work, with due caution not to raise expectations for stipends and other similar remuneration paid to these staff.

6. The facilitatory role of working with community based structures should be strengthened. These should be mapped at initiation.

7. The public dialogues should be well facilitated and issues to be dealt with should be shared and agreed before-hand to enable proper investigation of cases and prepared responses by the relevant people. In addition, the dialogues should deal with issues within the control of the facility and district and any other issues should be escalated appropriately.