RMCH
REDUCING MATERNAL AND CHILD MORTALITY THROUGH STRENGTHENING PRIMARY HEALTH CARE

COMMUNITY BASED MONITORING:
A dozen things to know

Q1 What is community based monitoring (CBM)?

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.

Q2 Why is CBM important in maternal and child health (MCH) services?

CBM is important in maternal and child health services as it promotes public participation in monitoring and holding health care facilities to account, thus empowering women and children to be able to bring about better health care services for themselves. Although most MCH services are free at the point of care, key barriers to accessing services are waiting times and the negative attitudes of the health care workers. In using CBM data, communities are able to hold health care services to account, thus advocating for better quality services and participating in seeking solutions at the local level. This in turn improves access to and utilisation of services. In addition, CBM helps the public understanding of how the health services work, enabling the public to understand factors that may hinder the delivery of quality services. This fosters dialogue and improves rapport between health workers and the public.

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.

Q3 How was the Soul City Institute (SCI) CBM programme implemented?

(Refer to "A MODEL FOR COMMUNITY BASED MONITORING IN THE PROVISION OF QUALITY MATERNAL AND CHILD HEALTH SERVICES" for more details)

The SCI community based monitoring programme was piloted in 12 communities in Fezile Dabi, Frances Baard, Amathole and Ugu districts (3 communities per district). Following a consultation process at national, provincial, district and local level, community based monitoring teams (CBMT) were selected from the community and trained to monitor services at their local clinic. The CBM teams engaged with the public and set up a monitoring system primarily based on tracking the five Department of Health priority quality improvement indicators (cleanliness, staff attitudes, drug stock outs, infection control and waiting times). The teams collected data on these indicators from patients using the clinic. The data was collated and the findings were presented in a dialogue with the facility manager, other health workers and the clinic committee on a monthly basis. The data was used to make decisions on how health care services could be improved. In addition, public dialogues were held to discuss complaints from patients, giving an opportunity to the facility and district management to respond to issues raised by the public. The dialogue promoted joint decision-making and action plans for improvement were drawn up.

Q4 What structures are important in implementing the CBM model?

Various structures are important in the setting up and maintenance of the CBM teams and processes. The presence of a ***district level coordinating structure*** facilitates the implementation of the programme and enables interaction with different stakeholders in the district. In some communities, ***local community based organisations (CBOs), faith based organisations (FBOs) and non-governmental organisations (NGOs)*** could facilitate the selection of the CBM teams and are important for their sustainability. In some instances, CBOs could be involved in mobilizing the community to facilitate the selection of CBM team members. In addition, some team members could be drawn from local NGOs and CBOs.

Community level decision-making structures are also very important. These are often more common in rural settings, where structures such as the ***chief's council*** could facilitate community entry and encourage support for the programme. The ***local government ward council structures*** are also very important and the presence of the ward councilor in the public dialogues provides an opportunity for a multi-sectoral approach to solving some of the challenges identified by the public.

Q5 What lessons can be learnt about good practice in the selection and constitution of various teams and committees?

The selection of CBM team members should be guided by principles of volunteerism, fairness and representivity. Specified minimum criteria may be included to ensure that members have adequate literacy levels. During a public information meeting, community members can volunteer and if more than the specified numbers are interested, an election process can be undertaken. If they volunteer, it is still important to ensure broad geographic representivity as this gives the team better legitimacy. Another selection process involves the use of local CBOs to recruit CBM team members. Whichever approach is used, it is important to take the names back to the community for ratification.

The constitution of the teams is equally important and diversity with respect to gender, age, interests is encouraged.

Q6 What are the capacity needs of the general public and various committees to effectively monitor health services?

The CBM team members need to be supported to enable them to perform their functions, through capacity building and on-going support, particularly in the early phases of the programme. Areas for capacity building will differ depending on the community and gaps identified, as such the curriculum has to be tailored.

A good starting point may be helping the team members 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 with an emphasis on confidentiality. Closely aligned with this is the issue of patients' rights and responsibilities as they interact with these services. The CBM process is based on sensitising patients on what they are entitled to, and helping them enforce these entitlements. Reference to the patients' charter is useful, as it is a statutory guiding document on patients' rights and responsibilities.

Other areas of capacity strengthening include mapping of community resources, promoting active citizenry, constructive dialogue, managing conflict and organising and running meetings.

In addition to training the CBM teams, it is important to ensure a functioning clinic committee, which may require relevant training of members of the clinic committee.

Q7 What is the BEST VEHICLE to deliver and strengthen these capacity needs?

Capacity strengthening for CBM teams can be achieved through training and on-going technical support. The training is conducted at the beginning of the process and should include a defined curriculum (see question 6). This training is delivered over two and a half days and is a combination of didactic and interactive learning. The training also includes role playing and team problem solving.

In addition to this, CBM teams should be supported on an on-going basis and as the need arises through technical assistance. This could include helping them develop data collection tools, enhancing their data analysis skills and helping them navigate difficult relationships at facility level. This technical support could be supplied through the local councils and local NGOs.

Q8 What processes and tools are necessary to increase public participation and involvement in the successful implementation of the model?

One of the key intermediary outcomes of the model is increased public participation. Four processes are key in promoting public participation:

The inception community dialogue: The inception community dialogue generates public interest, although at this stage some people may be skeptical about the success of the programme; often citing that government and NGOs come and promise them better services, but often do not make good on their promise. At this dialogue, the public engages actively about what they perceive to be challenges in accessing health services and what changes they would like to see. Although only 15 people get elected to be part of the CBM teams, many others may express interest and want to be part of bringing the change that they hope to see in their community.

Displayed reports card: Large A3 report cards are mounted in the clinic hallway and generate a lot of public interest when they come to the clinic. Often people will stand by the cards, sometimes taking time to evaluate the services by putting a score; other times engaging and debating amongst each other about the scores and whether they were satisfied with the services. This forces people to engage more with the clinic staff, clinic committee and CBM teams as they share their own experiences.

Visibility of CBMT: Having the CBMT on-site reminds people of their function and the CBM programme and prompts them to relate their own experiences and share what they think could be solutions. During the pilot phase, in one facility, the CBM team were referred to as the 'Blue team' and were inundated with people sharing their opinions on what they thought should be done.

"I would request that the blue team fights for the clinic to be open during the weekends…. Imagine you have to go into labour but it is the weekend…. The blue team has to assist there…".

(Community member)

Public dialogue: The public dialogue is the best example of how the programme promotes public participation. During the pilot, most of the public dialogues were well attended and became a platform for people to have their complaints and compliments heard and addressed by the facility manager and the district management team. This boosted their confidence in the system and also encouraged them to see the bigger picture and understand some of the constraints in the system. People expressed that for the first time they felt they were being listened to.

"The community is owning the facility, they are speaking up, they are talking about the challenges, which shows that they own it. They are curious and ask 'why is this happening, what can we do'? If something isn't going well, the community members question it, which shows they own the facility; that they care. They have always been involved, but now they are showing more interest…."

(Clinic committee chairperson)

Q9 How can efficiency be improved and the model optimized?

- The ability to select from or link elected members to local CBOs may help with sustainability of the teams. Those selected through CBOs can then have their names ratified at a community meeting.

- Formal orientation of the teams to the facility is important. The model could be optimized by including an orientation and tour of the local clinic at the end of the training. This will help them become familiar with the various departments and staff and remove the mistrust observed in some of the sites.
- A structured process to report back to the public on improvements or challenges in the monitoring process is important. This can be done at the public hearing, so it is important to have formal public meetings to provide feedback.
- The media could be used to popularize the programme, share information on the gains made, which will increase public confidence in the programme, and report on some of the challenges, thus putting pressure on public officials to act.

Q10 How has the intervention facilitated enhanced communication between the community members and the health services?

The programme has facilitated communication between community members and health workers with both sides expressing better understanding of each other and more respectful interactions.

"Today when you get into the consultation rooms the sisters no longer talk to you the way that they used to. They are now a bit respectful and they respect people's opinions…."

(Community member).

"They [The CBMT] have improved our relationship with the community. When they were outside, they would perceive us like any other patient. Since they were inside, they understood the services better, they were advocating for us more than the community ".

(Facility manager).

Q11 What structures are important in facilitating such interactions?

- The community based monitoring teams have been very important in the change in attitudes of both the health workers and the community members, thus facilitating better interactions.
- In cases where the clinic committee was functional, this was also an important structure in gaining the confidence of both sides. The presence of CBM team complimented and reinforced the work of the clinic committee and *vis versa*.
- The involvement of the ward councilor, district health team and traditional leadership also has a role in facilitating the process. The ward councilor has political clout and is an elected representative of the public, making them a strategic champion for the programme. District health teams help resolve any complaints raised which cannot be addressed at the level of the facility manager. The traditional leadership yields a lot of respect and influence in the community.

Q12 Has the model been effective in increasing demand, access to and utilisation of quality maternal and child health services?

Qualitative data strongly suggests that the model has been effective in increasing utilisation of quality MCH services. A shift in staff attitudes towards patients is an important component of quality care. Although evidence for increased service utilisation has not been assessed, the improvements in queue management (including improved efficiency, shorter waiting times and greater throughput of patients) have most likely led to a higher proportion of those who attend services receiving medical care.

"Services were slow and you would come to the clinic twice before you received assistance. They [HCWs] did not understand the community. Now the community knows their rights and the services are satisfactory since the establishment of the [CBM] team"

(Community member).

In addition, many community members shared how they felt things had changed for the better, expressing confidence in the clinic staff. These positive remarks suggest better confidence in the system and likelihood that they positively impact service utilisation.

"We had a lot of problems at the clinic, like the bad staff attitude and nurses not talking to patients properly and the clinic was dirty. But now there's a lot of improvement and change as the clinic is cleaner and the services are much better. Because of the CBM all these things have happened and there are also more things that I can't explain but they're visible. We are grateful and proud of CBM and their presence in the clinic."

(Community members).

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