Community Monitoring in a Volunteer Health Worker Setting: A Review of the Literature

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Abbreviations

ANM	Auxillary Nurse Midwife
ASHA	Accredited Social Health Activist
BP	Blood Pressure
CBM	Community Based Monitoring
CBO	Community Based Organisation
CDQ	Community Defined Quality
CHC	Comprehensive Health Centre
CM	Community Monitoring
COPE	Client Oriented, Provider Efficient
CRC	Community Report Card
CSC	Community Score Card
D&E	Deferral and Exemption Scheme
DFID	Department for International Development (UK)
DHM	District Health Management Team
FHC	Facility Health Committee
ICCM	Integrated Community Case Management
IMPACT	Improved Management Through Participatory Appraisal and Continuous Transformation
inSCALE	Innovations at Scale for Community Access and Lasting Effects
ISS	Integrated Supportive Supervision
MOU	Memorandum of Understanding
MPW	Multipurpose Health Worker
NRHM	National Rural Health Mission (India)
PATHS	Partnerships for Transforming Health Systems Programme (Nigeria)
PDQ	Partnership Defined Quality
PFQA	Patient Focused Quality Assurance
PHC	Primary Health Care
PPRHAA	Peer and Participatory Rapid Health Appraisal for Action
SMOH	State Ministry of Health
TOR	Terms of Reference
TT	Tetanus Toxoid
vCHW	Volunteer Community Health Worker
VHC	Village Health Committee
VHT	Village Health Team (Uganda)
VHW	Volunteer Health Worker

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inSCALE – Innovations at Scale for Community Access and Lasting Effects

The inSCALE programme aims to increase coverage of integrated community case management (ICCM) of children with diarrhoea, pneumonia and malaria in Uganda and Mozambique. inSCALE is funded by Bill & Melinda Gates Foundation and sets out to better understand community based agent (CBA) motivation and attrition, and to find feasible and acceptable solutions to CBA retention and performance which are vital for successful implementation of ICCM at scale.

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Executive summary

1. The *Innovations at Scale for Community Access and Lasting Effects* (inSCALE) initiative will test a range of innovations that aim to improve the coverage and quality of Integrated Community Case Management of Malaria. One of the planned innovations will test the impact of community monitoring of Volunteer Health Workers (VHWs) on worker performance and motivation.

2. This report was commissioned by the Malaria Consortium in March 2011 to review the literature on community monitoring in the context of Volunteer Health Worker programmes and to make some recommendations, based on the review findings, to inform the design of inSCALE's planned community monitoring initiative.

3. The literature review revealed a lack of consensus on the definition of community monitoring. It also found that not only has the potential role of community monitoring in improving the performance of Volunteer Health Workers not been explored in any depth in the theoretical literature, but also that there appears to be a complete absence of implementation experience. This means that inSCALE cannot draw on an anthology of ready-made good practice and lessons learned as it moves ahead with the design of its community monitoring pilot.

4. Nevertheless, there are many lessons to be learned from the use of community monitoring methodologies in other health-related contexts. To this end, this report examines eight community monitoring methodologies and approaches which have emerged primarily from the quality improvement and social accountability spheres. These are: Citizen Report Cards; Community Score Cards; Community COPE; Partnership Defined Quality; Patient Focused Quality Improvement; Peer Participatory Rapid Health Appraisal for Action; Integrated Supportive Supervision; and monitoring by health committees. Methodological strengths and weakness, implementation experiences, and results achieved, are highlighted and compared.

5. The report concludes that all of the reviewed methodologies lend themselves to adaptation, and all could be modified to incorporate a focus on Volunteer Health Workers. However, inSCALE needs to consider the strengths and weakness of each approach from a number of different perspectives, namely:

    - Whether they promote high quality community participation
    - Their acceptability to health providers
    - The extent to which they promote accountability and responsiveness on the part of health providers and decision makers at higher levels
    - Their scalability, and
    - Their potential to be institutionalised

6. A key question for inSCALE is whether it should give priority to methodologies that are already – or which could become – an integral part of the fabric of the health system (e.g. PFQA, ISS, PPRHAA, health committees, community COPE), or to methodologies that lie somewhat outside the boundaries of the health system (CRC, CSC). Both have their merits. In the latter case, the

challenges associated with getting the approaches institutionalised are likely to be higher, unless the Ministry of Health decides that it likes and supports one or other of these approaches (as happened with the National Rural Health Mission in India, which championed the Citizen Report Card approach). Involving Ministries of Health in the pilot countries in the decision-making process may, therefore, make sense.

1. Introduction

1.1 Background

The Malaria Consortium was recently awarded a grant by the Bill and Melinda Gates Foundation to find solutions to the constraints to volunteer health worker retention and performance, which can undermine successful implementation of Integrated Community Case Management of Malaria (ICCM) at scale. The *Innovations at Scale for Community Access and Lasting Effects* (inSCALE) initiative will test a range of innovations that aim to improve the coverage and quality of ICCM. Uganda and Mozambique are focal countries for the innovation pilots, but lessons learned from implementation in these countries are expected to have wider application in Africa and beyond.

One of the planned innovations will test the impact of **community monitoring of volunteer health workers** (VHWs) on worker performance and motivation. Community monitoring is seen as a potential (partial) substitute for poor quality and/or infrequent formal supervision. Interest in this approach is also based on a pragmatic concern to 'embed' ICCM efforts at community level in order to ensure a high level of local ownership of and support for malaria control efforts. In some contexts, interest in community monitoring reflects a broader concern to advance good governance in the health sector by providing a mechanism through which relationships of accountability between citizens, providers and policy makers can be strengthened, and service delivery failures addressed.

For some years debates about VHW motivation and retention have focused on the appropriate mix of financial and non-financial incentives. In the latter case, a great deal of attention has been paid to the need to strengthen supervisory systems; introduce appropriate performance management mechanisms; and improve health worker training. The importance of promoting 'community support' for volunteer health workers is also emphasized, but practical suggestions as to how this might be achieved are often lacking in the literature. Community monitoring offers a concrete and potentially institutionalizable mechanism for achieving this.

This report, commissioned by the Malaria Consortium in March 2011, reviews experience and lessons learned from community monitoring experiences in the health sector in Africa and other parts of the world. The review is intended to inform the design of a community monitoring initiative for inSCALE.

1.2 Objectives of Assignment

The terms of reference (TOR) for the assignment ask for a review of the literature on community monitoring in the context of volunteer health worker programmes, and for recommendations, based on lessons learned from these experiences, to inform inSCALE's planned community monitoring initiative. Specifically, the TOR ask for:

- An overview of the definitions of community monitoring, including its aims and objectives and how these have varied across programmes.

- A description of the approaches that have been used to implement community monitoring, including details of the components of each approach such as the tools used, the cadre of staff involved and their interactions, the nature of training required and who was involved, the frequency of community engagements, and the monitoring mechanism.

- An assessment of which approaches to community monitoring have worked and what factors or components have contributed to their success or failure. This should include examining the impact of the approaches on retention, motivation and performance of volunteer health workers, and an evaluation of the feasibility, acceptability and scalability of each approach.

- A recommendation of which of the approaches and/or components of community monitoring are most relevant for inScale.

1.3 Organisation of Report

To achieve the TOR objectives, the report is organised as follows:

Section 2 looks at where and how community monitoring features in the literature

Section 3 provides an overview of different definitions of community monitoring

Section 4 describes seven different community monitoring methodologies and approaches

Section 5 highlights how community monitoring has been used in different contexts

Section 6 summarizes key similarities and differences between the various community monitoring methodologies and approaches

Section 7 looks at the relevance of the methodologies to inSCALE

Section 8 concludes the report

The assignment terms of reference and other supporting information can be found in appendices to the main report.

2. Community monitoring in the literature

2.1 Desk Review Methodology

To complement material already held by the consultant, various online databases were searched (e.g. PubMed, ELDIS, UK DFID Governance and Social Development Resource Centre) for documentation relevant to the literature review. In addition, grey literature (internal programme reports, evaluation reports etc) generated by donors, Ministries and implementing partners was sourced using google. The search focused initially on Africa, but was later expanded to include other countries.

Several categories of literature were examined for relevance to the study topic. This included literature on:

- The functioning and impact of volunteer health worker schemes
- Volunteer health worker motivation, retention and incentives
- Salaried health worker motivation, retention and incentives
- Quality improvement initiatives in the health sector
- Conceptual approaches to social accountability, including community monitoring
- Community monitoring methodologies
- Case study material on the application of community monitoring methodologies in health and other sectors

In addition, resources on Volunteer Health Teams and ICCM in Uganda, supplied by the inSCALE team, were also examined.

2.2 Results

The results of the literature review were as follows:

- Review of documentation on the functioning and impact of volunteer health worker schemes (including well-known and large-scale schemes such as the Pakistan Lady Health Workers programme, the Nepal Female Community Health Volunteers Programme, and the Ghana Community-based Health Planning and Services Initiative), failed to identify any scheme with a community monitoring component. However, the literature review cannot claim to be exhaustive: it is possible that there are VHW schemes, missed during this review, that have community monitoring components.

- The literature on volunteer health worker motivation, retention and incentives contains frequent references to the need for 'community support' of VHWs, although proposals about how this can be achieved are usually very sketchy. The need for improved performance monitoring of volunteers is also mentioned frequently in the literature. A single reference to

community supervision/monitoring as a mechanism for tracking provider performance within the context of a VHW scheme was identified (see Box 1).

Box 1: Promoting 'Community Support' and Improved Monitoring of Volunteer Health Workers

Much of the literature on VHW motivation and incentives mentions the importance of enhancing community support of these schemes, although in most cases community monitoring is not mentioned. For example, a qualitative study of non-financial incentives for VHWs in Ethiopia (Amare 2009:23) recommends the following:

"Involve and train leaders of community anchors such as idirs [burial associations], churches, mosques, youth and women's associations as well as kebele [community associations] leaders, to support and motivate vCHWs in ways appropriate to their special attributes. They can do so by promoting vCHWs and recognising their work; providing morale [sic] support to vCHWs; promoting better health practices and providing a forum for vCHWs; facilitating and following up in the implementation of health practices promoted by vCHWs."

A review of community health worker incentives by Bhattacharyya *et al* (2001:28) was the only document identified that refers to a potential role for communities in monitoring health workers:

"Encouraging communication and interactions between CHWs and community members is critical to building an understanding of the CHW's role and support for their work. There are a number of examples of community supervision of CHWs. While community health committees cannot be expected to do clinical supervision, they can monitor CHW performance at the community level. For example, the barefoot doctors in China were accountable to the villages and were given technical supervision by the health centers."

- The importance of improving performance management, and of strengthening the relationship between health workers and communities, are both regularly mentioned in the literature on (salaried) health worker motivation and incentives. However, the interface between these two key areas is usually not explored. Two exceptions are a qualitative study into health worker motivation in Vietnam (Dieleman *et al*, 2003) (see Box 2) and a study by Bjorkman and Svensson (2007) on the impact of community monitoring on provider motivation and service delivery in Uganda (see Section 5).

Box 2: The Importance of Community Feedback to Health Worker Motivation

A study into factors affecting the motivation of health workers in Vietnam found the following:

"Feedback from the community was for both district and commune health workers the second most important motivating factor and it seems therefore required to find ways to ensure community feedback. This appears especially important in rural areas. As health workers in remote areas are less likely to receive supervision, feedback from the community could become an important tool for staff motivation……'Appreciation by the community' can be achieved by setting up a mechanism where by information from the community is collected, through for instance exit interviews and discussions in the community. Currently such a mechanism is lacking in Vietnam."

(Dieleman *et al* 2003: 9)

- The extensive literature on quality improvement (QI) in the health sector contains many references to community participation. Client- and community-focused QI initiatives usually involve some sort of service delivery monitoring function. Community involvement in this context is seen as an important means of ensuring that services are 'client-friendly'; it may also be seen as a means of gaining legitimacy with clients or, perhaps, of generating compliance from communities for increased service utilisation. The QI literature is dominated by a focus on the quality improvement methodologies, with less attention to results and impact (the paucity of case study material on Community COPE being one such example). In many cases, where QI results are reported, there is heavy reliance on anecdotal evidence.

- The largest body of literature on community monitoring has emerged from the 'social accountability' sphere. The drivers behind community monitoring initiatives rooted in this genre are a concern for citizen rights, for correcting information asymmetries between policy makers, providers and their clients, and for bringing about social change through redistribution of power and resources. There is a growing body of literature on community monitoring methodologies, and a small, and generally unpublished, literature on how various methodologies have been used in different contexts. As per the quality improvement literature, documentation of community monitoring implementation experiences tends to focus more on process and less on results and impact. Where results have been documented, there is heavy reliance on anecdotal information.

In summary, therefore, the literature review revealed the following:

- An absence of information on the application of community monitoring in the context of volunteer health worker programmes;
- Scant mention of the utility of community monitoring in conceptual discussions about salaried health worker motivation and performance;
- Generally poor documentation of results and impact, and lack of rigour in the presentation of results, in the client and community involvement components of many quality improvement initiatives;

- Limited information on community monitoring results and impact within the social accountability literature.

In short, therefore, the potential role of community monitoring in improving the performance of Volunteer Health Workers has not yet been explored in any depth in the theoretical literature, while the lack of implementation experience means that 'good practice' guidelines on community monitoring in the context of VHW programmes do not yet exist. InSCALE will therefore need to be creative as it moves ahead with the design of a community monitoring initiative to be tested in the context of ICCM.

3. Definitions of community monitoring

In its most basic sense, the term 'community monitoring' is used to describe the process of collecting data at community level. In some contexts, the term may be used to refer to any monitoring process involving members of the community. In contrast, in the participatory monitoring and evaluation literature, community monitoring, or community-based monitoring (CBM) are defined as "monitoring… of community development by an interested community, so that the community can make independent choices about its own development" (Toledano *et al* 2002:2).

Within the social accountability sphere, the term 'community monitoring' refers to a form of public oversight where communities, whether directly or indirectly, demand greater accountability from policy makers and providers in relation to the delivery of public services (see below).

> "Within the health field CBM has been used to increase the quality and accountability of health services by enabling local people to evaluate and direct the health services available to them as well as hold healthcare providers accountable to program objectives. CBM of health services aims to promote decentralised inputs for better planning of health activities, based on the locally relevant priorities and issues identified by various community representatives." (source: Wikipedia, no attribution)

This definition is grounded in a 'good governance' agenda in that the strengthening of government accountability is seen as a prerequisite to improvements in health services. It is also grounded in a rights-based approach in that citizens are assumed to have an entitlement to quality health care. Further, it is implied that community monitoring leads to a redistribution of power, information and resources between policy makers, providers and communities. In the social accountability sphere, therefore, community monitoring is perceived to be much more than a pragmatic (or technocratic) way of improving the quality and delivery of health services. Rather, it has the potential to be part of a progressive agenda for political and social change.

Box 3: Community Monitoring in the Context of the National Rural Health Mission, India

Within the context of the National Rural Health Mission in India, community monitoring is defined as such:

"Community-based monitoring involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community based organisations (CBOs), people's movements, voluntary organisations and Panchayat representatives [lowest tier of government], to directly give feedback about the functioning of public health services. The community monitoring process [involves] a three-way partnership between health care managers and providers (health system); the community, community-based organisations, NGOs and Panchayat Raj institutions. The emphasis [is] laid on the developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'." (Garg and Laskar, 2009)

In some Indian states the term 'community monitoring' has been replaced with the term 'community action'. This is because the original term was felt to be too threatening to policy makers and providers. Other states are using the term 'community monitoring and planning' since the aim of the monitoring exercise is to feed into and inform planning processes.

Within the quality improvement literature, emphasis is placed on client and community involvement or participation in the monitoring of quality rather than 'community monitoring' *per se*. Monitoring processes are commonly presented as a joint initiative, involving health providers, service users and (sometimes) the wider community. However, in practice the quality of client and community participation in these processes can vary from being informed of a change process (one of the lowest forms of participation), to being consulted, to participating in joint decision-making (a higher level of participation), depending on the value-set of the organisations and personnel implementing these approaches (see ladder of participation in Appendix 3). Quality improvement initiatives may or may not be grounded in an explicit commitment to supporting clients and communities realise their entitlement to good quality, accessible services.

In summary, the term 'community monitoring' has a variety of usages. Moreover, there are differences in the value-sets underpinning each definition. The lack of consensus over meaning and the differences in underlying principles, means that it will be important for inSCALE to agree a clear definition of community monitoring early on in the process of designing its CM pilot.

4. Community monitoring methodologies

4.1 Typology of Methodologies

Table 1 below groups a number of community monitoring methodologies or approaches according to the tradition or 'school of thought' from which they have emerged.

Table 1: Typology of Community Monitoring Methodologies/Approaches

Social Accountability	Quality Improvement	Other
Citizen Report Cards	Community COPE	Monitoring by health committees
Community Score Cards	Partnership Defined Quality	
	Patient Focused Quality Improvement	
	IMPACT (PRRHAA and ISS)	

A brief description of each methodology or approach can be found below. Further information on how these methodologies have been used and their relevance to inSCALE can be found in Sections 5 and 7 respectively.

4.2 Social Accountability Methodologies

4.2.1 Citizen Report Cards

Citizen Report Cards (CRCs) are large-scale surveys that gather feedback from users on the quality of services. They are usually used on a city-, state- or nationwide basis. The methodology was developed in India in 1994 by a Bangalore-based NGO, the Public Affairs Centre. Since then, CRCs have been widely used in India, and in other countries, including Zimbabwe and Rwanda, to gather user feedback on performance in single (e.g. health) or multiple sectors (e.g. services delivered by specific tiers of government).

CRCs are intended to be more than a data-gathering exercise. The media coverage that comprises part of the CRC process, together with advocacy undertaken by citizens, means that the tool serves as a mechanism for extracting public accountability (Wagle *et al*, 2004).

> *"…with the effective combination of citizen, political and bureaucratic action, CRCs could be the ideal catalyst for mobilising demand for accountability and reform, and for moving ordinary people, including the poor, from 'coping to voice' and from 'shouting to counting'."* (Ibid, 2004:4).

Because of the scale on which they are used, CRCs are usually implemented on an annual basis. CRCs usually depend on some form of external funding.

Report cards collect data relating to a number of indicators of user satisfaction. These usually relate to aspects of the quality, accessibility, affordability, and reliability of key services. Indicators are usually agreed in advance of the CRC process, with no community input. The unit of analysis is either the individual or the household and scores are aggregated to provide measures of satisfaction at

village, sub-district, district level and upwards. Data may be gathered from underserved or otherwise marginalized groups so that perspectives on health service performance can be measured from an equity perspective.

CRC implementation involves seven key steps:

- Defining the scope of the survey, the purpose and the actors
- Designing the questionnaire
- Deciding the sample size
- Executing the survey
- Analysing the data
- Disseminating the results
- Institutionalising the CRC process

The process of disseminating results involves holding initial feedback sessions with providers, devising a publicity strategy in order to disseminate the survey results over a wide area, and organising 'interface meetings' where service users and providers can engage in (hopefully) constructive dialogue about performance successes and gaps. Interface meetings are intended to lead to the compilation of an agreed plan of action to address service delivery failures. These meetings may be held at national, state or district level and usually involve many participants.

The seven steps comprise the 'science' of the CRC approach. The 'art' of the approach relates to activities such as successfully managing media campaigns, finding ways to keep the issues raised during the CRC process on the radar of key policy makers, managing processes of negotiation, and running successful interface meetings (Wagle *et al*, 2004).

It is possible to track the performance of government agencies over time using CRCs, and compare the performance of single agencies with that of other agencies (thereby substituting for the lack of competition within the public sector).

4.2.2 Community Score Cards

Like Citizen Report Cards, the aim of Community Score Cards (CSCs) is to gather feedback from a community about a service and to use this information to improve the functioning of that service. CSCs are usually implemented on a smaller scale than CRCs (perhaps in a number of communities served by a health facility) and therefore require fewer resources and less time for implementation. Unlike CRCs where the unit of analysis is the individual or household, in the CSC process the unit of analysis is the community. Key steps in CSC are outlined in Table 2 below:

Table 2: Steps in the Community Scorecard Process[1]

Step	Description/Explanation
Gathering of supply-side data	• Supply-side data gathered (policy commitments; information on service standards; inventories; financial records; budgets) • Rationale is to clarify community entitlements to specific services • Data usually gathered by external facilitator of CSC process
Compilation of input tracking scorecard and community performance scorecard	• Information on CSC process disseminated and community mobilised to attend community meeting • Stratification of community based on differences in usage of the service that is being monitored • Focus group discussions organised • Supply-side data discussed, communities briefed about their entitlements, and small number of input indicators agreed • Community-observed differences between 'entitlements' and actual inputs[2] recorded in input tracking scorecard • Community perceptions triangulated through observation and verification using other data sources • Small number of performance indicators agreed by the community based on focus group discussions and in reference to input indicators • Service quality scored (score may be reached through consensus or through individual scoring followed by a group discussion) • Community suggestions about how to address gaps in service delivery recorded
Compilation of performance self-assessment scorecard by providers	• Brainstorming with providers to agree performance indicators • Scoring against indicators • Providers' suggestions about how to address gaps in service delivery recorded
Interface meeting	• Results of input tracking scorecard, and community and health provider scorecards shared • Action plan to tackle service delivery gaps agreed • Emphasis on consensus building around required action as opposed to finger pointing/fault finding • Careful facilitation by the external facilitator needed • Senior government officials and/or elected representatives invited to attend meeting (challenges that cannot be addressed by health providers alone will require the support of officials higher up the system)
Institutionalising the	• Important to get the commitment of local policy makers to move

[1] Adapted from Singh and Shah (2004).

[2] For example, the HR standard for a health centre might be three mid-level staff. If the facility only has one mid-level member of staff the difference between the entitlement and the actual would be two members of staff.

CSC process	from a once-off score card process to an ongoing process of generating user feedback on services • Regional/national governments can use the results of CSC processes to influence resource allocation decisions to districts – thereby ensuring the process of institutionalisation • Ensure that CSC results are disseminated using local media • CSC facilitation transferred from an outside agency to local CSOs through training

Unlike CRCs, the Community Scorecard process includes a step that involves raising community awareness of their health entitlements. This is key to effective scoring. A further difference is that the performance indicators are defined by the community as opposed to external facilitators.

4.2.3 Comparison of Citizen Report Cards and Community Score Cards

The table below highlights the main differences between Citizen Report Cards and Community Score Cards.

Table 3: Comparison of Citizen Report Cards and Community Score Cards[3]

Citizen Report Card	Community Score Card
• Unit of analysis is household/individual	• Unit of analysis is the community
• Information obtained from community via a survey questionnaire	• Information colleted from community via focus group interactions
• Relies on formal stratified random sampling to ensure that data is representative of the underlying population	• Involves no explicit sampling. Instead, the aim is to ensure maximum participation of the local community in interactions
• Performance indicators defined in advance	• Performance indicators defined by community
• The major output is the actual perceptions assessment of services in the form of the report card	• Emphasis is less on actual score card and more on achieving immediate response and joint decision-making
• Doesn't involve a provider self-assessment	• Does involve a provider self-assessment
• The media plays the major role in generating awareness and disseminating information	• Relies more heavily on grass-roots mobilization to create awareness and invoke participation
• Conducted at a more macro level (city, state or national)	• Conducted at a micro/local level (village cluster, and set of facilities)
• More useful in urban settings	• More useful in rural settings
• Time horizon for implementation is long (3-6 months)	• Time horizon for implementation is short (about 3-6 weeks)

[3] Adapted from Singh and Shah (2004).

• Designed and carried out by external agency	• Designed and used by service providers and communities. External facilitation provided initially but local capacity for facilitation built as soon as possible
• Feedback to providers and the government is at a later stage after media advocacy	• Feedback to providers is almost immediate and changes are arrived at through mutual dialogue during an interface meeting
• On-going monitoring by communities of provider performance takes place in each CRC	• Greater potential for on-going monitoring (i.e. between CSC sessions) of provider performance since monitors and monitored are in same locality

4.3 Quality Improvement Methodologies

4.3.1 Community COPE

The Client Oriented Provider Efficient (COPE) methodology was developed by AVSC International[4] in 1988. COPE can be used to evaluate the quality of care at health facilities and is also a tool for helping health personnel make improvements in the quality of care (Lynam *et al* 1992). The methodology was originally developed for use in family planning clinics, but has since been adapted for application in other health care settings. The COPE methodology, which is conducted quarterly, involves three main components (see Table 4):

Table 4: Core Components of COPE[5]

Component	Description
Provider Self Assessment	• Providers use a checklist to carry out a self-assessment of different aspects of the health service e.g. quality of nursing services; human resources; administration; management; infrastructure and supplies etc • Ten client interviews conducted
Client Flow Analysis (optional)	• Clients' movements within the health facility are tracked from when they arrive until when they leave in order to assess waiting times and identify bottlenecks in the delivery of services
Action Plan Preparation	• Providers prepare an action plan. This summarises the results of the COPE exercise, and lists the action that will be taken to rectify problems, by whom and when

[4] Now EngenderHealth.
[5] From EngenderHealth, 2003).

An outside facilitator is required to support the first couple of COPE exercises. Subsequently, responsibility for co-ordinating and supporting COPE is transferred to a member of facility staff, thereby ensuring that use of COPE can be sustained without outside support, and at low cost.

COPE's emphasis on self-assessment is based on the rationale that health providers who are involved in identifying and analysing service delivery problems will be more able, and better motivated, to do something about these. COPE also assumes that many of the problems besetting health facilities can be resolved by the facility itself without resort to higher levels of authority.

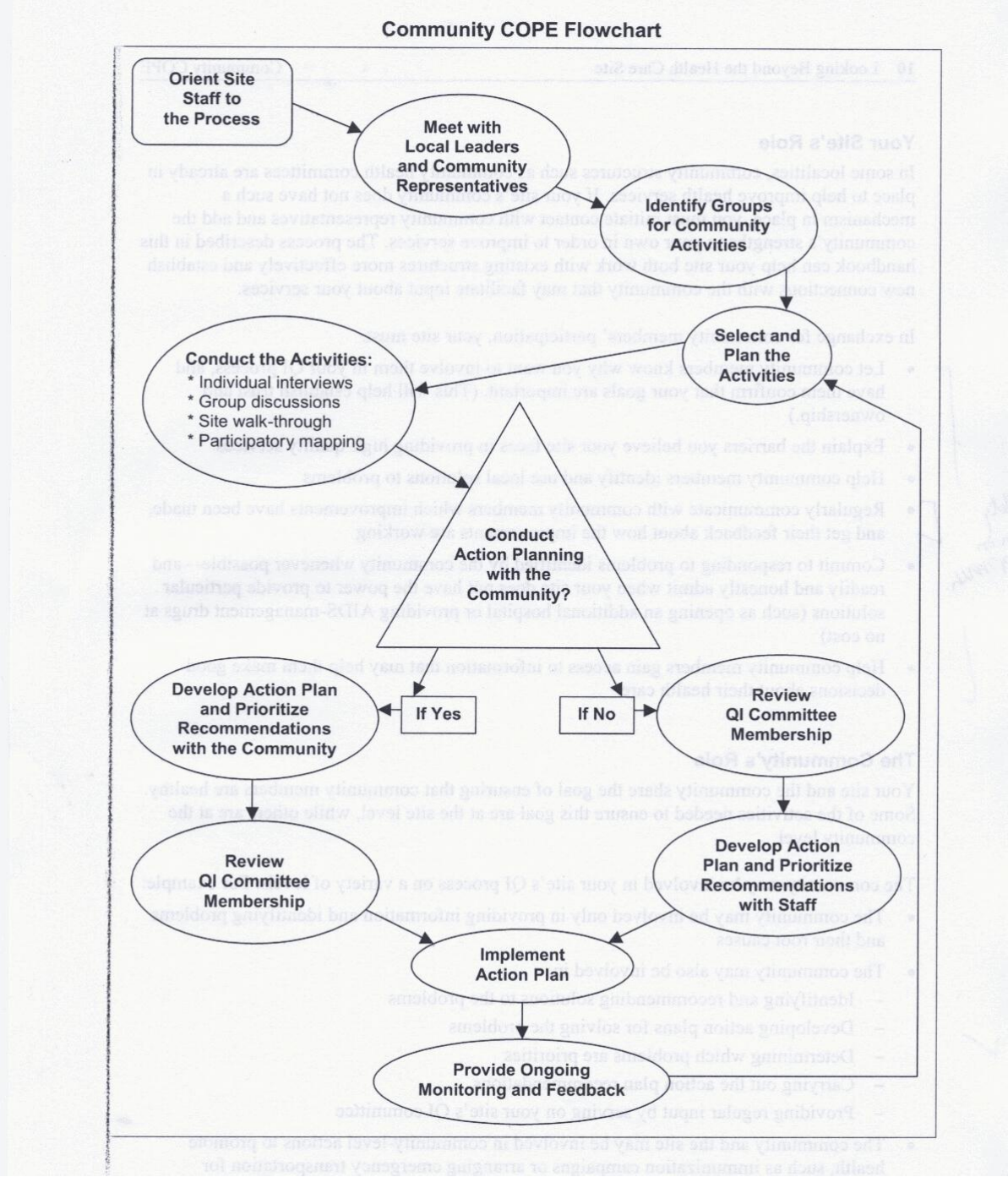
Although a small number of clients are consulted about the quality of care as part of the COPE process, clients are not involved in the process of analysing data or preparing a facility action plan. The COPE methodological guidelines (see EngenderHealth, 2003) do, however, specify that health providers should find ways to feed back to clients about the improvements that have been or will be made at the facility (via inter-personal communication; posters; bulletin boards; or community meetings). Feedback is considered important in that it demonstrates to clients that their voices are being listened to and action is being taken. Overall, however, COPE involves a relatively low level of participation by clients, with the primary emphasis on consulting and informing (see ladder of participation in Appendix 3).

As COPE evolved, it was recognised that the process omitted to establish the reasons for non-use of the health facility. The methodology was later adapted to include a community component (Community COPE). Community COPE is intended to be undertaken by health facilities that are already involved in the regular COPE exercise. The process, which is carried out by members of the health facility, involves visiting communities and gathering information on community perceptions about the health facility and about services using semi-structured interviews, focus group discussions, or participatory mapping methodologies (see EngenderHealth 2003 for interview and mapping tools).

The process begins with a sensitisation visit involving community leaders at which the objectives of Community COPE are explained and support solicited for mobilising specific groups within the community to attend a community COPE meeting. Target groups will include individuals who use the health facility irregularly or not at all. This could be men, for instance, or perhaps individuals residing in a particularly deprived part of the community. The process of jointly preparing an action plan with members of the community is optional within Community COPE – individual facilities can decide the extent to which they wish to involve the community. The decision about whether or not to invite community representatives onto the facility Quality Improvement or COPE Committee is also left to individual facilities.

The process of carrying out community COPE is illustrated in Figure 1 below.

Figure 1: The Community COPE Process



Conceptually Community COPE places stronger emphasis than COPE on the quality of community involvement in the QI process; ensuring that appropriate feedback mechanisms are in place so that communities can maintain their dialogue with providers on an ongoing basis; and on client rights and entitlements. However, the fact that community participation in two key aspects of the approach – action planning and QI Committees – is optional weakens these commitments. The danger with an approach that gathers information from clients and communities, but does not

provide a mechanism for communities to follow up on progress, is that providers may lack incentives to respond to community needs.

4.3.2 Partnership Defined Quality

Developed by Save the Children US in 1996, Partnership Defined Quality (PDQ) is another approach that provides a platform for communities and health providers to work together to improve the quality of health services. Originally called Community Defined Quality (CDQ), the name was later changed to reflect the fact that health providers and communities need to work in partnership in order to improve quality. PDQ is intended to be implemented alongside other QI tools that focus on the technical aspects of service delivery.

PDQ involves five key steps (see Table 5 and Figure 2 below).

Table 5: Steps in PDQ[6]

Step	Description/Explanation
Planning and Design	• Define the goal of the exercise • Decide who will facilitate the process • Carry out rapid mapping of health services and community • Identify other QI initiatives and partners and integrate/link up with these • Select participating health facilities and communities • Plan for how to ensure good representation by community members
Building Support	• Brief leaders and decision makers within health system and at community level about PDQ and ask for their support
Exploring Quality	• Define quality with health providers • Examine provider perspectives on barriers to good quality services • Define quality with community • Examine community perspectives on barriers to good quality services
Bridging the Gap	• Present provider and community perspectives on quality; demonstrate where views differ and where they collide • Conduct tour of community and health facility for team building purposes • Develop shared vision of quality • Present provider & community perspectives on gaps in quality • Prioritise problems needing attention • Decide who will be on the QI team

[6] Based on Lovich *et al* 2003.

Working in Partnership	• Build capacity of QI teams to implement continuous process of QI • Establish process for ongoing review of progress

The first four steps lay the foundation for providers and communities to work together on an ongoing basis to improve quality. These steps may not be repeated – once these steps have been taken, the focus of the approach shifts to supporting the work of quality improvement teams.

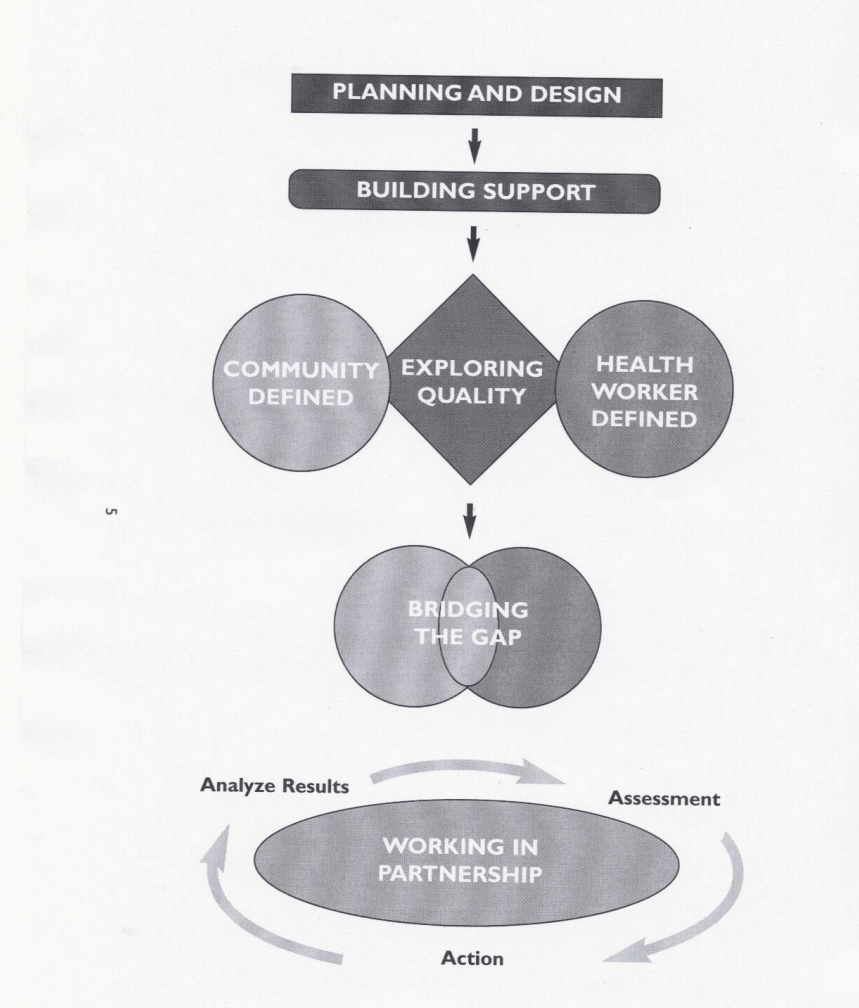
In some respects PDQ is similar to Community COPE, although there are some key differences:

- PDQ places more emphasis on ensuring a high level of community participation throughout the process.
- PDQ involves an interface meeting where different perspectives of quality are shared.
- There is stronger emphasis in PDQ on supporting communities and providers to understand health entitlements.

> *"In PDQ, the community is not asked just for their views or opinions, they are asked to participate and share responsibility and efforts for quality improvement. This requires implementation team members who have experience with community mobilisation and who know how to reach the broad membership of the community, including the marginalized members."* (Lovich *et al*, 2003)

The process of bringing communities together with health providers in an interface meeting, and the creation of a space where communities can highlight where services fall short of expectations and negotiate for change, means that PDQ holds potential as a mechanism for strengthening accountability between communities and health providers. However, the extent to which PDQ serves this purpose is dependent on how well the process is facilitated in a context where significant differences in power define community-provider relationships.

Figure 2: Partnership Defined Quality Process



Although the PDQ methodological guidelines provide detailed guidance on the various steps in the process, in practice there is plenty of scope for innovation in how each step is implemented. For instance, in some contexts video has been used to great effect to present different perspectives on quality in bridging the gap meetings.

PDQ is dependent on outside facilitation (i.e. by personnel located outside the participating health facilities). Facilitators can be drawn from NGOs, donor programmes or could be senior government personnel. The community component requires a facilitator from outside the participating health facilities and who does not have a political role in the community. This could be an individual from a local NGO or CBO.

4.3.3 Patient Focused Quality Assurance

Patient Focused Quality Assurance (PFQA) is an adaptation of COPE. PFQA allows health facilities to assess, monitor and improve the quality of service provision on an ongoing basis. One component of

PFQA focuses on gathering client perspectives of services through client exit interviews. Depending on the size of a health facility, and the adequacy of human resources, a pre-agreed number of interviews are conducted periodically. This could be anything from 50 to 100 interviews every three or six months. The aim is to find out what in-patients and out-patients think about the quality of services, including waiting times, the attitudes of health providers, the adequacy of information given on diagnosis and treatment, the availability and price of drugs, the cleanliness of the facility environment and so on (see interview schedules in Appendix 4).

Facility PFQA teams collate the data from the interviews, identify priority issues that require attention, and draw up action plans to address these. To ensure transparency and accountability, the results of PFQA interviews and facility action plans are displayed in consultation rooms or in other areas where they can be seen by clients.

Subsequent rounds of client exit interviews are used to check whether previously identified problems have been dealt with adequately. If not, these issues become priorities to be addressed in the next facility action plan. The idea is that regular consultation with clients will lead to greater responsiveness on the part of health providers to clients' needs and views. However, the extent to which providers respond to problems identified by clients depends on the providers' attitudes, the leadership of facility managers, and on external pressure exerted through mechanisms such as integrated supportive supervisory systems.

In terms of the nature and extent of community participation in the PFQA process:

- Clients are not involved in data analysis
- Clients' ability to interpret graphical displays of exit interview results may vary depending on how literate they are and how complex the displays are
- PFQA on its own does not provide a mechanism via which clients and communities can discuss the interview results, or input to facility plans for tackling identified problems. Other feedback mechanisms, such as facility open days, can, however, be introduced alongside PDQA and used to promote dialogue between providers and communities

Health staff that have already been exposed to, or who have participated in health systems strengthening activities, and who appreciate the importance of improving provider-client relationships, can be trained relatively quickly in PFQA. External facilitation of the first round of PFQA interviews is usually necessary, but providers can be left to administer subsequent rounds. Very few resources are required to implement PFQA, namely copies of questionnaires; and flipchart paper and pens to display results. However, it should be noted that in resource constrained environments access to paper and to photocopiers (or to the funds needed to purchase these supplies or services) can prove challenging,

4.3.4 IMPACT

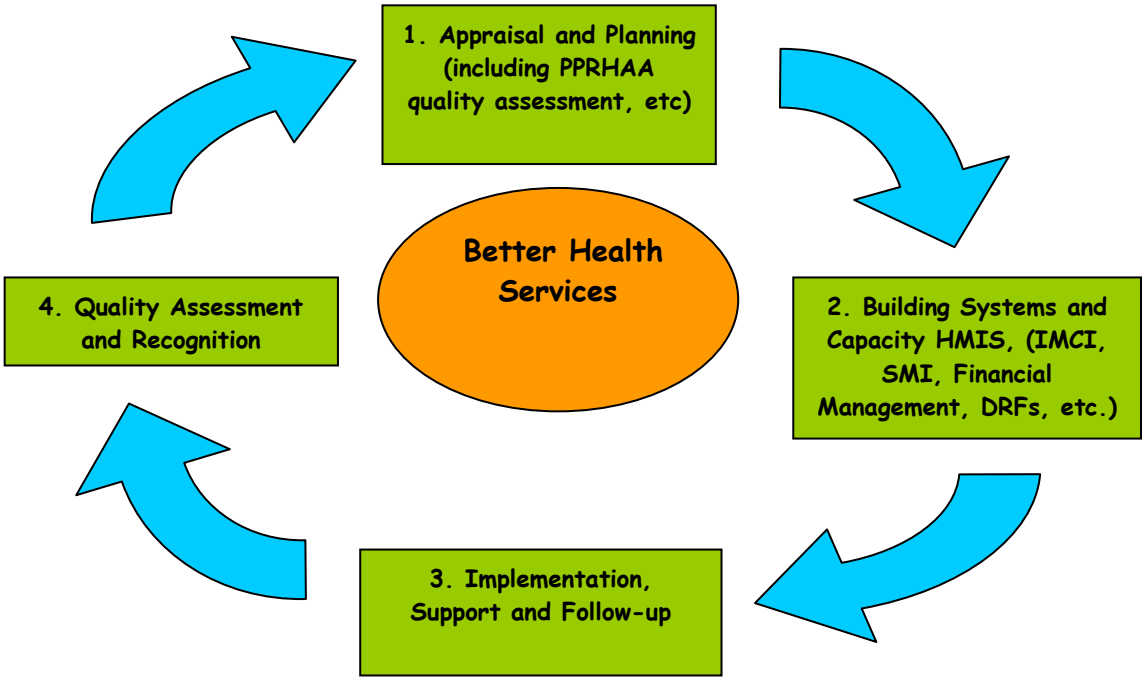
Improved Management Through Participatory Appraisal and Continuous Transformation (IMPACT) is a health systems change management process that was developed for and implemented in selected

states of Nigeria under the UK Department for International Development-funded Partnerships for Transforming Health Systems Programme (2002-2008) – PATHS 1. The process has four main components:

- Annual assessment and planning using the Peer and Participatory Rapid Health Appraisal for Action (PPRHAA) approach
- Support for development of health sub-systems (e.g. drug systems, financial management systems, general management and administrative systems, quality assurance) and improvement of clinical services
- Support, supervision and follow-up through Integrated Supportive Supervision
- Quality Assessment and Recognition

See Figure 2 below.

Figure 2: Key Components of IMPACT[7]



The two components of IMPACT that involve some sort of community monitoring activity are Peer and Participatory Rapid Health Appraisal for Action and Integrated Supportive Supervision. These are discussed below.[8]

[7] Diagram from PATHS 1 internal documentation.
[8] The fourth component, Quality Assessment and Recognition, was introduced late in the timeline of PATHS 1 and was never actually implemented (although extensive design work was completed).

PPRHAA

PPRHAA is an annual process of appraisal that involves rapid diagnosis of strengths and problem areas across key areas of health management and service delivery. PPRHAA can be used to assess the performance of health facilities or health departments. Providers and their managers, service users and the wider community all participate in the process. Peers from within the health sector facilitate the process, and health providers and managers are actively involved in the diagnosis of strengths and problems within their own workplace. Emphasis is placed on the process being a supportive, learning exercise.

A rapid diagnostic phase involves the administration of various checklists that focus on particular aspects of the health service or system, for example: patient care management; internal management and external linkages; financial management; equipment and infrastructure; client and community views. Information on output and coverage indicators is also collected (see PATHS, 2005). The diagnostic phase leads to the prioritisation of key problem areas. The results of individual facility or departmental assessment exercises are shared in local government or state summits. This leads to a planning phase where actions that need to be taken to address priority problems are agreed. The summits also provide an opportunity to identify where support from higher levels of government is required in order to tackle challenges that lie outside the capacity of the individual facilities or health departments to address.

Clients and communities participate in PPRHAA through the client and community views (CCV) component. This aims to:

- Provide an opportunity for citizens to share their views on the accessibility, affordability and acceptability of services;
- To raise awareness among providers and managers of the need to hear and listen to the views of clients and the community;
- To support facility staff to develop action plans that respond to the concerns of clients and the community.

As a rapid appraisal methodology, PPRHAA is designed to provide a 'snap-shot' of citizen's views of health services. For each facility being appraised, the methodology requires PPRHAA teams to carry out a small number of client interviews, two focus group discussions (one with men and one with women) within a community in the catchment area of the health facility, and a small number of interviews with key community informants (see Box 4). Views on the quality of services – their ease of access, their affordability and overall acceptability – are sought. Clients and communities are encouraged to suggest solutions to the problems they identify. This information is incorporated into individual facility or departmental appraisal reports.

Box 4: Use of Participatory Ranking Exercise in PPRHAA

A participatory ranking exercise is used in PPRHAA focus group discussions. Each discussion group comprises ten men and ten women. The tool aims to increase the quality of participation of group members. The exercise requires focus group participants to vote on the quality of services provided by a range of different providers in the locality. The quality of services is measured using six key indicators (see example below). Votes are cast using beans, stones or other locally available resources. Each discussion group participant is given five beans, which they use to rate each facility against each indicator. For example, one participant might choose to give the General Hospital one bean, the government health centre four beans, and the private health centre no beans when rating cost and affordability. The highest scoring facility is perceived to provide the best quality care.

Tools such as these are relatively easy to use, and provide a visual comparison of the performance of different providers based on community perceptions. Health facilities may choose to display the results in the facility. Gender differences in perceptions of quality can be quite stark. For example, in one facility in Northern Nigeria men rated the quality of community participation in health very highly, while women gave this indicator a very low score. This prompted the health facility to introduce measures to reach out to local women. This included inviting female representatives to sit on the facility health committee.

If a facility scores poorly against other health facilities in the locality this can introduce an element of healthy competition between facilities, with lower scoring facilities striving to 'up their game' relative to better performing facilities. In the example below, the Government Health Centre scored the highest in relation to overall quality.

Indicator	General Hospital	Government Health Centre	Private Health Centre
Cost and affordability	15	35	0
Satisfaction with care	15	20	15
Drug availability	40	5	5
Staff attitudes and behaviour	12	28	10
Hygiene/upkeep of environment	0	25	25
Community participation	0	50	0
Totals	**82**	**163**	**55**

Community informants interviewed during the appraisal exercise are invited to participate in 'PPRHAA summits'. These may be held at local government and higher levels (e.g. district and state). The meetings provide an opportunity for community representatives to reinforce some of the concerns raised by their communities during the appraisal stage and to ensure that these issues are addressed in the PPRHAA action plans. In theory, these events provide a mechanism via which the voices of the community can be heard by decision-makers 'higher up the system'. However, whether or not this actually happens depends on how well these events are facilitated.

Integrated Supportive Supervision

Another key component of IMPACT is Integrated Supportive Supervision (ISS). This involves quarterly on-site supervisory visits undertaken by Integrated Supportive Supervision Teams. Community representatives participate as core members of the ISS teams alongside health and other specialists from within the district (i.e. health providers or managers with expertise in general management; drug supply; patient care management etc).

The ISS teams use a simple checklist to monitor performance in key areas of service delivery and facility management, and review facility progress in delivering the commitments contained in the PPRHAA action plans. Clients and other key informants, such as community members of facility health committees, are interviewed as part of the ISS process in order to monitor quality from the community perspective (see Box 5). On-site supervisory support is provided to help staff address problem areas. Feedback from each round of ISS visits is provided to the local health department and senior staff of the SMOH, and policy-makers are advised of any issues that require their attention.

'Community monitoring' therefore takes place at two levels within ISS: (i) clients and members of the community are interviewed to get their feedback on the quality of services and (ii) community representatives are involved in the actual supervisory process. When ISS results are reported to higher levels, these meetings provide a space for community demands to be put before policy makers.

Box 5: Supervisory Checkist Relating to Client and Community Views

Primary Health Care Level

1. Do clients have knowledge of drugs and other treatment costs?
2. Are communities/clients aware of facility opening hours and services provided?
3. Are clients/communities satisfied with facility performance e.g. staff attitudes, waiting times?
4. Are there other factors denying clients access to services?
5. Are clients/communities aware of their health rights?
6. Is there evidence of any mechanisms is use to improve community access to information about services e.g. facility open days, use of town criers etc?
7. Are there formal mechanisms for client/communities to channel complaints and seek redress?
8. Are communities/clients aware of existence of suggestion box and are they used?
9. Are facility management committees active?
10. Do CBOs and health education staff undertake health education activities?
11. Is the link between clients, communities and health facilities strong?

Members of the ISS teams require training on their overall role, how to use the ISS monitoring checklist, how to incentivise providers through the provision of supervisory support, how to write reports on facility performance, and on effective ways to feed back findings to the local health department.

4.4 Other Approaches

4.4.1 Involvement of Health Committees in Monitoring of Services

Although not a methodology *per se* there are many examples in Africa and elsewhere of community health committees that have undertaken a monitoring role in relation to health services and/or health providers. In some cases, the monitoring process may be rather *ad hoc*, with health committee members paying intermittent visits to the health facility to check on issues such as the level of absenteeism of health staff; or the cleanliness or tidiness of the facility environment. In other cases, the process may be more formalized, with a pre-agreed monitoring schedule in place and a variety of assessment checklists in use. Monitoring may cover all aspects of service delivery, and some of the underpinning sub-systems on which delivery depends (e.g. administrative or transport systems), or may focus on particular aspects of the service (e.g. monitoring of drugs or outreach services – see Box 6).

Box 6: Health Committees Can Monitor Outreach Services

Health calendars specify when specific services will be provided and by whom, and are drawn up by communities in consultation with health providers. The calendars could, for example, specify the timeframe for Immunisation Plus Days, outreach services provided by the local health facility or by higher-level health facilities, or the availability of specific specialist services in the local clinic. They could also specify what services will be provided by Volunteer Health Workers and when. The information in the calendar clarifies and makes explicit some of the health entitlements of the community. Health Committees can monitor whether the services specified in the calendar are delivered and can use the calendar to negotiate for improvements should shortcomings in service delivery be identified.

Health Committee involvement in the monitoring of providers and service delivery works best in contexts where facilities are engaged in quality improvement activities or a wider process of health systems strengthening, and where providers have been sensitised to the importance and benefits of fostering strong community-facility linkages. It also works best where health committees have been exposed to information on community health entitlements and trained to carry out – and recognise the boundaries of - their monitoring role.

A comparison of key aspects of methodology design (e.g. who leads the monitoring process; how frequently the methodology is implemented etc), and of various other characteristics (e.g. the complexity of each methodology; quality of community participation; potential to be institutionalised) can be found in Section 6. However, Section 5 first looks at how some of the methodologies have been implemented in practice and what lessons have been learned from these experiences.

5. Community monitoring case studies

This section looks at how some of the community monitoring methodologies described in Section 4 have been used in practice. As mentioned previously, the amount of accessible case study material on each of the methodologies varies tremendously. While use of the two social accountability methodologies (Citizen Report Cards and Community Score Cards) has been well documented, very limited detailed case study material on some of the other methodologies (e.g. Community COPE and Partnership Defined Quality) was identified during the timeframe available for the literature review. It may be possible to fill in some of the gaps in information with a further investment of time.

5.1 Social Accountability Case Studies

5.1.1 Citizen Report Cards in Uganda

A hybrid of the Citizen Report Card methodology[9] was used in 50 rural intervention sites in nine districts of Uganda in a randomised field experiment, which set out to test whether community monitoring would lead to improvements in provider performance and in the quality of service delivery. The assumption was that monitoring of provider performance by the community would result in increased effort on the part of the health providers to deliver a high quality service (Bjorkman and Svensson, 2007).

The intervention began in 2004. Communities within a five-kilometre radius of a participating health dispensary were involved. Half of the health facilities were assigned to a treatment group and half to a control group. Key steps in the process are outlined in Table 6 below.

[9] The approach used in Uganda contained elements of both the Citizen Report Card and Community Score Card approaches.

Table 6: Steps in the Uganda Citizen Report Card Process

Step	Description/Explanation
Design and implementation of pre-intervention surveys	• Quantitative service delivery survey implemented. This drew on facility records. • Household survey collected data on health outcomes and health facility performance (from the perspective of usage, availability, access, reliability, quality and satisfaction)
Preparation of report cards	• Bespoke report cards drawn up (in local language) for each facility/community. These focused on key areas requiring improvement
Village meeting	• Attended by approximately 150 participants • Information in report cards presented using variety of methods (maps, diagrams, role-play, focus group discussions) • Facilitated discussion on patients rights and entitlements • Communities encouraged to specify required improvements in services. These formed basis of an action plan
Health facility staff meeting	• Results from the two surveys disseminated • Providers supported to review and analyze their performance
Interface meeting	• Joint meeting between health providers and community • Held at the health facility • Both parties discussed their suggestions for improvements • Joint action plan produced ('community contract'). This specified the timeframe for performance improvements and how the community would monitor these improvements
Ongoing performance monitoring	• Local Community Based Organisations worked with communities to devise a monitoring plan. Various meetings were held with health providers to follow up commitments in the community contract
Mid-term review	• CRC process was repeated on a smaller scale after six months • Progress with delivering commitments in community contract assessed • Discussions between health providers and community representatives focused on why, in some cases, improvements had not been made and what could be done about this, and how to sustain improvements that had been made • Community contract updated

Key differences between the Uganda CRC process and other CRC processes were as follows:

- Communities were not required to score service performance in Uganda: an analysis of the health situation was followed by a discussion of community entitlements, which led to the development of an action plan

- The interface meetings in Uganda happened early on in the process and took place at the health facility (rather than district level or higher)
- The process was repeated after six months (as opposed to annually)

The results of the intervention were as follows:[10]

- The community monitoring initiative increased the quality and quantity of service provision in the treatment health facilities as compared to the control facilities
- Child deaths fell by 33 percent
- An increase in the weight of infants was recorded
- Utilisation of outpatient services was on average 16 percent higher in the treatment facilities
- Deliveries, ANC uptake and utilisation of family planning services were higher in the treatment facilities
- Improvements in treatment practices (waiting times, absenteeism, examination procedures) were recorded in the treatment facilities
- Communities in the treatment sites were more active than those in the control sites in monitoring health services
- No increase in government funding or support to the treatment facilities (including supervisory support) were recorded, hence the improvements were largely down to changes in the behaviour of health providers

The study concluded that the community monitoring process had improved accountability between health providers and communities, with beneficial impacts on service delivery, utilisation and health outcomes.

The Uganda CRC process was reliant on external facilitation by Ugandan development practitioners and community based organisations. Whether this model can be sustained in future remains to be seen.

Issues not addressed in Bjorkman and Svensson's 2007 research report include the following:

- The costs of implementation.
- Whether the changes in provider behaviour were sustained over time.[11]
- Whether the complete CRC process needs to be repeated at intervals, or whether regular monitoring meetings are adequate to sustain improvements in accountability.
- Whether any steps were taken to garner government support for the process. Repetition of CRC and scaling up implementation both depend on securing an adequate and reliable source of funding. This could be from external donors initially, but, ultimately, provision for CRC needs to be made in government health budgets.
- An assessment of the methodology itself – its strengths and weaknesses and what adaptations could be made to improve the process and results.

[10] From Bjorkman and Svensson (2007).
[11] No further information on the research project – which continued beyond 2007 when the research report was written - was identified during the literature review.

5.1.2 Citizen Report Cards in India

The most extensive community monitoring initiative currently underway is taking place within the framework of India's National Rural Health Mission (NRHM). Launched in 2005, and due to end in 2012, NRHM aims to improve the quality of health care in 18 states with the poorest health indicators through implementation of a health systems strengthening approach.

India has a long history of civil society activism on health issues. As a result of intense lobbying by health activists, an Advisory Group for Community Action (AGCA) was established early on as part of the national level institutional machinery for NRHM. Tasked with the responsibility for advising on how community monitoring could be operationalised within the context of NRHM, the Advisory Group recommended that community monitoring take the form of a Citizen Report Card approach and that the approach be piloted in nine states before being rolled out at national level. The pilot phase began in 2007 and ended in 2009. By 2010 nearly all NRHM states had incorporated community mobilisation into their Programme Implementation Plans. Institutionalisation therefore happened very quickly.

Community monitoring, internal monitoring and periodic surveys together comprise the overall accountability framework of NRHM. However, community monitoring is conceptualised as being more than a data gathering exercise; it is also a key strategy for ensuring that health services reach the people who need them (through community inputs to local level planning), and for extracting public accountability for service delivery failures (see Box 7).

Box 7: Objectives of Community Monitoring Within NRHM

The *Manual on Community Based Monitoring of Health Services Under National Rural Health Mission*, prepared by the Advisory Group for Community Action (MoHFW, n.d:9-10) envisages that community monitoring will do the following:

- "It will provide regular and systematic information about community needs, which will be used to guide the planning process appropriately;
- It will provide feedback according to the locally developed yardsticks, as well as on some key indicators;
- It will provide feedback on the status of fulfilment of entitlements, functioning of various levels of the public health system and service providers, identifying gaps, deficiencies in services and levels of community satisfaction, which can facilitate corrective action in a framework of accountability;
- It will enable the community and community-based organisations to become equal partners in the planning process. It would increase the community sense of involvement and participation to improve responsive functioning of the public health system. The community should emerge as active subjects rather than passive objects in the context of the public health system;
- It can also be used for validating the data collected by the ANM [Auxillary Nurse Midwife], Anganwadi worker [volunteer child health and nutrition worker] and other functionaries of the public health system."

The institutional machinery for community monitoring comprises Planning and Monitoring Committees at the PHC, block, district and state levels, and a Health and Sanitation Committee at village level.

NGOs and CBOs play a major role in supporting implementation of community monitoring within NRHM. At state level a 'nodal NGO for community monitoring' co-ordinates and provides technical support to the implementation process. Below state level NGOs and CBOs are contracted to build the capacity of the institutions established to oversee the community monitoring process and to support implementation. The rationale for involving civil society organisations in NRHM is three-fold:

- To protect the independence of the community monitoring process: it is argued that because the performance of health workers and managers is under review it does not make sense for functionaries of the Health Department to lead the process;

- To stimulate "change in the balance of power within the health sector in favour of people" (MoHFW, n.d. 15);

- To ensure that NRHM can access organisations with experience and capacity in participatory monitoring, health rights and social accountability.

Preparation for the community monitoring process involved training of all key stakeholders (i.e. the members of Planning and Monitoring Committees at different levels, staff of NGOs and CBOs contracted to support implementation at village level etc). In the pilot phase, this role was undertaken by the state nodal NGO for community mobilisation. A further step was to sensitize the community to their health entitlements in preparation for the report card process.

Preparation of a report card by Village Health and Sanitation Committees (whose membership comprises community representatives, community health workers, representatives of local CBOs and NGOs, and members of the Gram Panchayat) is the next step in the community monitoring process. The report card is compiled using local level health-related data (e.g. from the records of community based health workers), discussions with health workers, group discussions with various segments of the community (e.g. women, marginalized communities, mixed group of men and women), and individual interviews with women who have recently delivered. The next step is to prepare a facility scorecard. Examples of some of the questions that comprise the basis of the community report card can be found in Appendix 5. Table 7 below outlines AGCA recommendations regarding sources of data.

Table 7: Sources of Data for Community Report Card and Facility Score Card[12]

Beneficiary	Community	Provider	Facility
Five interviews with women who have delivered in the last three months	One group discussion with community members	One interview with PHC Medical Officer	Observation of health sub-centre using checklist
	One group discussion with women	One interview with Comprehensive Health Centre Medical Officer	Observation of PHC facility using checklist
	One group discussion with marginalized communities	Five exit interviews with PHC patients	Observation of Comprehensive Health Centre using checklist
	One interview with community volunteer health worker	Five exit interviews with Comprehensive Health Centre patients	

The report and score cards are usually prepared over a two-day period.

Some of the states participating in the community monitoring pilot have adapted the original methodology in response to experience on the ground. For example, in Maharashtra questions in the community report card have been developed into pictures to improve understanding by both respondents and interviewers. In addition, the scoring system used in the report cards has been adapted to include terminology that is familiar locally (e.g. 'full roti'[13] equates to 'very good'; 'half roti' equates to 'partially satisfactory', and 'no roti' equates to 'very poor') (Singh and Moran, 2010).

The information in the community report cards and facility scorecards is collated by the PHC Monitoring and Planning Committee and then sent to the next level where it is collated again. The process of referring information upwards continues until a state level report card can be produced.

The results of the CRC process are presented at public hearings (Jan Samwad or Jan Sunwai) at different levels. These take place either annually or every six months at PHC, block and district levels. In some states, a state level public hearing also takes place annually. Other states have dropped this meeting, preferring to hold public hearings at lower levels. Members of the general public, health providers, government officials, and representatives of civil society organisations and the media attend these events.

Although the emphasis within NRHM is on creating an environment where public grievances can be aired in a non-hostile environment where there is an emphasis on problem-solving and lesson-learning, some of the early public hearings were understandably antagonistic. Nevertheless, the public hearings are widely seen as the most important component of the community monitoring

[12] From MoHFW (n.d.:38).
[13] A type of Indian bread.

process. There are many examples in the NRHM literature of how health providers and government have responded quickly to grievances voiced at these meetings (see Box 8).

Box 8: Examples of Provider and Policy Maker Responsiveness to Community Demands

"People are now aware of their health rights due to constant interaction as a result of community monitoring. They started realizing the significance of health services and started questioning the service providers and discussed issues related to health indicators like hygiene, sanitation, immunisation etc. Questions were raised on issues like availability of medicines in the health centres, working of MPWs, ASHAs,[14] and medical officers."

(Experience in Maharashtra, cited in Singh and Morang 2010:49)

"In the first Jan Sunwai, eight women came forward to reveal how they were charged a certain amount during their deliveries and did not receive the JSY [conditional cash transfer] for institutional delivery. The Village Health and Sanitation Committee took up this issue and confronted the doctor who was very annoyed at this and threatened to resign. But the people were determined and after 15 days 36 JYS cheques were cleared…. and private medical practice was banned."

"[The PHC] was not functioning properly…the issue was raised in the Jan Sunwai by the people. The district officials who had earlier committed their presence for the meeting did not turn up and subsequently the community locked the PHC and the [Medical Officer] was forced to address the people. This resulted in the smooth functioning of the PHC and CHC thereafter."

(Experiences in Rajasthan, cited in Singh and Morang, 2010:50)

The general consensus is that the original methodology was unduly tedious and complex. Much effort has gone into simplifying the process for the next phase of implementation.[15] The pilot phase of community monitoring within NRHM resulted in many innovations, where individual states have adapted elements of the methodology to suit their specific circumstances.

The fact that community monitoring has now been included in the health plans of most of the states involved in the NRHM has secured the financial future of CRC – at least until 2012. The speed at which the process has been institutionalised is very unusual:

> *"Most efforts at involving civil society to strengthen government accountability tend to be ad hoc initiatives initiated by civil society activists and embraced by well-meaning public servants who believe in the value and the power of democratic participation. Rarely do such strategies find themselves institutionalised into the law or otherwise permanently embedded in the structure of the state. As Walter Eberlei[16] has written, a certain "event culture" tends to prevail*

[14] Multi-purpose health workers and Accredited Social Health Activists.
[15] The simplified materials are not yet available on the net.
[16] Eberlei, W., 2001, 'Institutionalised Participation in Processes Beyond the PRSP', Institute for Development and Peace (INEF).

when the concepts of societal participation and civic engagement are brought to the table (Eberlei, 2001:9). Many public officials seem to believe that all that these concepts imply is the holding of a series of hearings, workshops and consultations, not the long-term participatory dialogue with civil society….. participatory mechanisms are usually vastly under-institutionalised, depending too much on the ingenuity and good will of individual bureaucrats."

Ackerman (2005:17)

5.1.3 Community Score Cards in Malawi[17]

A Community Score Card process was implemented in Malawi under the CARE International Local Initiatives for Health (LIFH) project. LIFH aimed to develop a model for introducing a rights-based approach to health service delivery for the sub-district level. A CSC pilot involving two clusters of villages in the catchment area of Chileka Health Centre in Lilongwe District (one near and one far from the facility) was designed and implemented in 2002-2003.

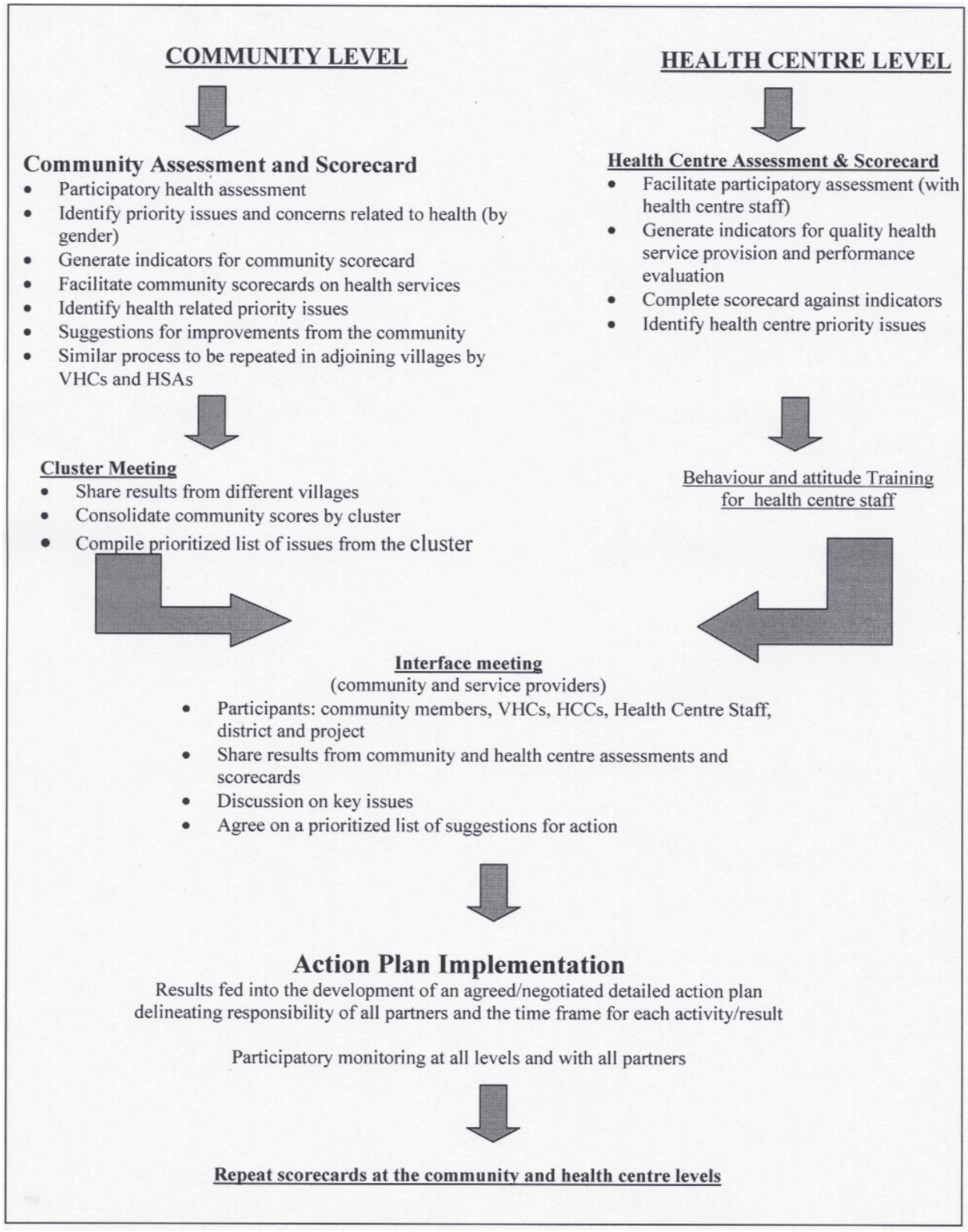
An early assumption was that if the CSC process was to be scaled up over time it would be essential to train health centre staff and community members to facilitate the process. Health Surveillance Assistants based at the health centre and members of Village Health Committees were trained to take on this role. Community facilitators were expected to support the scorecard process in villages other than their own.

A 'learning by doing' training approach was adopted: project staff facilitated the CSC process in the first set of villages, and then handed over to the local facilitators in subsequent villages.

Figure 3 below summarises key steps in the LIFH scorecard process.

[17] Based on Shah (2003).

Figure 3: Steps in the LIFH Community Scorecard Process



A participatory health assessment was carried out in the participating communities over a two-day period. Discussions involving separate groups of men and women of different ages were facilitated and participants were encouraged to share their thoughts on the health problems they faced, use of services, and their perspectives on the quality of service provision. The results of the discussions were analysed and a list of 22 performance indicators compiled. These were grouped into four categories: positive attitude of staff; management of the health centre; quality of services provided; equal access to the health services for all members of the community.

The next step was for separate groups of male and female community members in each participating village to score each indicator out of 100 points.[18]

> *"No-one has ever asked us to give marks for the health services. This should not end here… we have to make sure that they [service providers] get to hear what we have to say about the services we receive. Will higher authorities get to hear this?"*
>
> Men's discussion group, Ndevu Village

Next, the scorecard results from each cluster of villages were discussed in meetings involving the CSC facilitators and selected village representatives. The scores were aggregated to produce two cluster level scorecards. Recommendations about how services could be improved were discussed and a list of priority recommendations for presentation at an interface meeting with health centre staff was compiled. Actions that could be taken by the community were highlighted.

Health centre staff prepared their own scorecard based on a self-assessment of service quality. A brainstorm produced a list of 25 performance indicators. These were grouped into six categories, most of which overlapped with the community indicators: positive attitude of staff; management of health centre; quality of services offered; relationship with users; infrastructure and equipment; and staff incentives. The indicators were scored out of 100. Surprisingly, the scores given by the health providers closely matched those given by the community.

An interface meeting, attended by health staff, community members, VHC representatives, CSC facilitators, and representatives of the District Health Office was then held at the health facility. The two cluster scorecards and the provider scorecard were presented: the first by the community facilitators and the second by health centre staff. Suggestions about how services could be improved were shared. The results were debated, clarifications sought, and agreement reached on some of the suggested recommendations for improvement. However, some of the District Health Office representatives disagreed with some of the proposals that had been put forward and this led to a delay in compiling an action plan.

Two further interface meetings were held before an action plan was agreed; district officials continued to disagree with some of the proposals. A separate meeting was subsequently held with the district representatives to explain the CSC process and their role in it. Ideally, this should have taken place right at the start of the process.

[18] Scores out of 100 were used because this makes it easier to measure the extent of change over time.

Progress made with delivery of the commitments in the action plan was reviewed at monthly Health Centre Committee meetings and at community level in Village Health Committee meetings. A repeat scorecard process was carried out after eight months using the same indicators as previously. Progress with delivery with action plan commitments was reviewed at the same time.

Community perceptions of facility performance improved, on the whole, between the two scorecard processes. Table 8 below highlights the increase in scores awarded by the two clusters of villages between August 2002 and March 2003. The results show that in some cases there were differences of opinion between the two clusters of villages. For instance, in Chakuzamutu cluster an increase in 70 points was recorded against the indicator 'respect for patients'. In Ndevu cluster, in contrast, an increase of only 10 points was recorded. In this cluster it was felt that the facility cleaner had been disrespectful to villagers.

Table 8: Increase in CSC scores over eight months[19]

	Indicator	**Increase in scores in March 03 as compared to August 02**	
		Chakuzamutu cluster	***Ndevu cluster***
1	**Positive attitude of staff**		
1.1	Punctuality of staff	10	25
1.2	Polite behaviour	10	35
1.3	Listening to patients' problems	35	50
1.4	Respect for patients	70	10
1.5	Respect for patients' privacy	5	20
1.6	Honest and transparent staff	43	20
2	***Management of the health centre***		
2.1	Cleanliness	15	20
2.2	Observing working hours	20	10
2.3	Giving priority to serious cases	40	20
2.4	Short waiting time for consultation	0	15
3	***Quality of services provided***		
3.1	Adequate supply of drugs	15	20
3.2	Adequate equipment	10	10
3.3	Adequate and qualified staff	25	5
3.4	Emergency services available 24 hours	5	25
3.5	Providing multiple services every day	10	15
3.6	Emergency transport services	0	0
3.7	Communication facilities (phone, radio etc)	0	10
4	***Equal access to health services***		
4.1	No discrimination in providing drugs to the	5	20

[19] Note that the figures in the table relate to the increase in scores over the eight-month period. Actual scores for one of the clusters can be found in Appendix 6.

	patients		
4.2	No discrimination in provision of suppl. nutrition	20	30
4.3	No preferential treatment	10	40
4.4	Maintaining a first come-first serve policy	50	0
4.5	Two-way communication/dialogue between communities and health centre	Not scored Aug 02	Not scored Aug 02

The scorecards for August 2002 and March 2003 for one of the village clusters and the provider scorecard can be found in Appendix 6.

Differences in the content of the action plans between the two rounds of CSC were apparent. The first action plan focused a great deal on provider attitudes and behaviour while the second focused more on how to improve specific aspects of service delivery.

Lessons learned from the Malawi CSC process include the following:

- Thorough preparation prior to the start of the process was essential (e.g. MOUs signed with all key stakeholder groups and participatory health assessment).

- The decision to train community members and health providers to facilitate the CSC process allowed a large number of villages to be involved. Lack of reliance on external facilitation means that the approach had good potential to be sustained over time.

- The simplicity of the approach meant that all villagers could take part.

- Supporting the communities to develop their own performance indicators helped to ensure that they owned the process.

- It was important to keep a strong focus on action and results – ensuring that communities and providers looked beyond the actual scoring process.

- The performance self-assessment by health providers allowed sensitive issues relating to their performance to be discussed in an open forum.

- Careful facilitation was needed in the beginning of the process. However, as providers and communities became more familiar with the process the need for external facilitation reduced.

Shah's 2003 report of the Malawi CSC process does not address the issue of how problems that are too extensive for providers and communities to deal with are referred upwards, and what incentives exist for district officials to respond to these problems. Although district level officials were invited to participate in the interface meetings in Malawi, the extent to which they felt themselves to be accountable to communities or health providers was outside the control of both groups. The lack of accountability at this level can act as a serious bottleneck to performance improvement. This is

reflected in the provider self-assessment where some of the indicators – such as those relating to staffing shortages and transport provision - showed no real change over time (see Appendix 6).

By 2003 there were plans to scale up CSC implementation to twenty health centres in each of three districts in Malawi. Unfortunately literature describing the results of and lessons from the scale-up process was not located during the literature review.

5.2 Quality Improvement Case Studies[20]

5.2.1 Community COPE in Senegal

Very little detailed case study material describing how Community COPE has been applied in specific contexts was identified during the literature review. In contrast, case study material on COPE was more readily available (see for example Bradley *et al*, 2002; Bradley *et al*, 1995; and Lyman *et al*, 1992). One exception was a brief report on how Community COPE had been used in two districts of Senegal (Thiadiaye and Foundiougne) to improve the quality of reproductive health services (EngenderHealth, 2002). The report describes how health providers in the six participating sites carried out individual interviews, focus group discussions and a participatory mapping exercise with community members in the facility catchment areas in line with the Community COPE methodology. Community participants were encouraged to share their views of reproductive health services and recommend how they could be improved. Recommendations were organised into a prioritised list, and members of the community were invited to participate in a QI action planning process. 'Follow-up Committees' involving health providers and community representatives were established to monitor delivery of the action plan and to keep the broader community informed of progress.

Many of the actions in the plan were carried out. The Follow Up Committees were responsible for liaising with the local government to garner support for addressing some of the larger or more challenging gaps in service delivery.

Results at the six project sites were described as follows:

- Improved communication between health service providers and local communities
- Improvements in staff attentiveness and friendliness
- Active involvement of members of the community in the QI process
- Improvements in the clinic environment (e.g. chairs were purchased and curtains installed to improve privacy and confidentiality)

Unfortunately, the report does not refer to any challenges associated with using the Community COPE methodology (e.g. providers' perspectives on the level of effort and resources required to carry the process out; the quality of community participation in the process etc). Neither does the report explain whether local governments were responsive to requests for support, or whether quality improvements were sustained over time.

[20] The Nigerian case studies draw heavily from Green, C (2008).

It may be possible to obtain more detailed information on the Senegal experience – and on the application of Community COPE in other countries – from EngenderHealth Field Offices.

5.2.2 PDQ in Kenya and Pakistan

As per Community COPE, very little information on the implementation of PDQ in specific contexts was identified during the literature review. Much of the available literature was rather sketchy on detail. Case study material relating to PDQ implementation experiences in Kenya and Pakistan is presented below. This information was pieced together from a number of different documents and cannot, therefore, claim to be comprehensive. Further research will be needed to fill in gaps.

Kenya

In Kenya, PDQ was implemented as part of the AMREF Busia Child Health Project over the period 2005-2010. Implemented in Butula and Funyula sub-divisions in Busia District, Western Province, the project aimed to increase demand for and uptake of maternal and newborn health services in the catchment area of 13 MOH facilities. Pre- and post-intervention studies were planned and these were expected to determine whether the maternal and newborn care services offered by the health facilities improved as a result of PDQ implementation. The plan was to measure quality improvements by monitoring whether facility-based health workers and Community Own Resource Persons (CORPs – health volunteers) adhered to technical standards, and by monitoring health service utilisation and health outcomes.

Health providers and community representatives were trained to facilitate the PDQ process. By 2008 13 facilities had completed the 'building support' stage of PDQ, and only one health facility had reached stage five – 'working in partnership'. Results, challenges and lessons learned presented at a workshop in 2009 (Save the Children, US, 2009) can be found in Box 9 below). The results of the pre- and post-intervention studies were not located during the literature review, and no information was found on the impact of PDQ on the functioning of volunteer health workers.

Box 9: PDQ in the Busia Child Survival Project, Kenya[21]

Results

- Communities embraced the PDQ approach
- One community started to pay fees when they realized that funds were needed to improve services
- Some health facilities benefited from improved access to water
- Improvements in the maintenance of the yard around one health facility were evident
- Khaniwal district recorded an increase in outpatients in PDQ compared to non PDQ communities
- Khaniwal district also recorded an increase in the number of ANC clients
- The number of immunized children and women accessing TT vaccinations increased
- Exit interviews showed higher client satisfaction in PDQ versus non PDQ communities

Challenges

- Members of the community were sometimes unwilling to attend PDQ sessions without an allowance (for transport and lunch)
- Mobilising resources to execute action plan commitments involving large costs (e.g. provision of ambulance) proved difficult
- There was a high turnover of QIT facilitators (health personnel) and this compromised the sustainability of Quality Improvement Teams (QIT)
- Poor attendance at QIT planning, monitoring and review meetings
- A new district was created and the DHMT did not understand the need for PDQ
- Established health facility committees saw QIT as a threat
- PDQ was time-consuming and resource intensive: health providers found it difficult to run the 'exploring quality' sessions when health facilities were severely understaffed

Lessons Learned

- Projects need to plan and budget adequately for PDQ
- Joint planning, implementation, monitoring and review helps to overcome communication barriers between providers and clients
- Skilled facilitation of the 'bridging the gap' meetings is needed if failures on the part of health providers and communities are to be discussed and addressed sensitively
- It would have been preferable to involve existing health facility development committees and the MOH from the beginning of the process. Their leadership and support would have helped AMREF manage community expectations regarding financial incentives
- Involving MOH in provision of support to QITs would improve prospects for sustainability
- PDQ needs to be institutionalised within government structures from the beginning
- Taking short-cuts in implementation of the PDQ process can negatively affect community empowerment

[21] From Save the Children US (2009) and Save the Children US (2008).

Pakistan

PDQ was piloted by Save the Children, Pakistan as part of the USAID-funded Pakistan Initiative for Mother and Newborn (PAIMAN) Project. Six health facilities in six districts in Punjab and North West Frontier Province were involved in the initiative, which began in late 2006. PDQ was expected to contribute to the overall PAIMAN goal of reducing maternal, newborn and child mortality in Pakistan.

The PDQ process was facilitated by PAIMAN district-based teams.[22] 'Exploring Quality' workshops were held with all staff of the participating health facilities, and with members of the community. 'Bridging the Gap' workshops were later held at the various health facilities. Quality Improvement Teams were formed, comprising health providers and community representatives, including individuals who represented the least advantaged. The QITs produced action plans for quality improvement, mobilised the community for involvement in QI initiatives, and ensured that dialogue between providers and communities was sustained. Results, challenges and lessons learned from the initiative are outlined in Box 10 below.

Box 10: PDQ in the Context of the PAIMAN Project, Pakistan[23]

Results

- Community capacity to respond to maternal and newborn health challenges, and to participate in QI activities, was enhanced
- Improvements in provider communication and counselling skills were identified
- Communities provided essential equipment to Lady Health Workers (volunteers) so that they could conduct ante-natal check-ups
- In one area an ambulance was procured by the Citizen Community Board of local government in response to community and provider concerns about the lack of emergency transport
- QITs addressed the problem of water shortages by providing new pipes and digging wells
- In one facility staff shortages were addressed by a QIT via an advocacy effort targeted to district and provincial administrators
- Communities in the project districts were mobilised to save for emergency transport
- One QIT provided curtains for the health facility with the aim of improving privacy

Challenges

- Involving the least advantaged in the PDQ process was challenging
- Communities took some time to get used to the high level of participation demanded of them. They had no experience of actively participating in QI activities

Lessons Learned

- The importance of gaining the support of the local Health Department and of community influentials early on was under-estimated

[22] The available documentation does not specify whether these were project staff or government personnel.
[23] From Save the Children US (2009) and Save the Children US (no date).

In the absence of a comprehensive evaluation of PDQ implementation experiences in Kenya and Pakistan, it is difficult to determine whether the approach is appropriate for replication in other contexts, is scalable, or sustainable. However, the results and lessons learned from the Kenyan and Pakistan experiences outlined above suggest the following:

- Community involvement in PDQ led to improvements in the quality of care provided by health staff and in the functioning of health facilities. As such, the approach may be a promising means of strengthening provider accountability;

- There appears to be a tension between the time required to empower communities to participate effectively PDQ and the time constraints under which health providers operate. Finding ways to resolve this tension is likely to be key to effective implementation;

- Many of the reported results related to relatively small-scale problems that could be addressed by health staff or communities. What the case studies do not highlight is how effective PDQ is as a process for engaging with and extracting accountability from decision-makers at higher levels.

- Scalability and sustainability are both dependent on being able to institutionalise the approach within government. How to institutionalise the approach needs to be a concern right from the start of implementation.

It may be possible to obtain more detailed case study material on the Pakistan and Kenya experiences, and on implementation experiences in other countries, from Save the Children US.[24]

5.2.3 PPRHAA in Nigeria

A large number of health facilities (public, private and mission) and local government health departments were involved in PPRHAA in the Nigerian states supported by the DFID funded PATHS 1 programme over the period 2003-2008. The rapid appraisal component of PPRHAA provided the data required for effective, evidence-based planning at facility level and upwards. Action plans produced through the process were monitored via the integrated supervisory system. By enabling the health sector in participating states to fulfil core functions of appraisal, planning, quality improvement and monitoring, the prospect that PPRHAA would be institutionalised was high.

In the Nigerian context PPRHAA proved to be a replicable process, acceptable to both providers and community members. The fact that the process required the participation of the entire health team within each participating health facility, and was facilitated by peers within the health sector (e.g. providers and managers from elsewhere in the state) contributed to its acceptability. The process helped put clients and communities 'on the radar' of health providers and policy makers by institutionalising a mechanism for client and community feedback. The process of joint action planning involving health providers and members of the community was new in all the PATHS states.

[24] The lead technical person for PDQ within Save the Children US was contacted during the course of this assignment. However, no material was obtained prior to the completion date of the assignment.

PPRHAA successfully developed providers' and managers' capacity to analyse the root causes of problems. It is also credited with having instilled a problem-solving culture, which resulted in the removal of many bottle-necks affecting service delivery. These new skills, combined with the provision of on-going monitoring and supervisory support by state PPRHAA teams, and, later, Integrated Supervisory Teams, were very significant incentives to 'change the way business was done'. There were also a few examples of where sanctions were used to enforce change, for example, via the transfer of under-performing staff. However, the ultimate sanctions – being sacked or prosecuted for malpractice – were rarely used by health managers, primarily because the fragmented nature of the health sector in Nigeria meant that managers lacked full authority to take action.

PPRHAA emphasised the importance of involving citizens in defining and assessing quality of care, and in so doing laid the foundations for introducing other initiatives to strengthen client and community involvement in the health sector.

Box 11: Community Views Make a Difference

"We go to the community and find out their views. They say their mind; they say what they need. It is important to hear the opinion of the community. Through hearing community views you will be able to come out with a reliable solution. If you don't hear the community, you may come out with the wrong solution. If you really want to help them, you need to deliver services as per their needs. This positive view of CCV is shared across the state."
PPRHAA State Focal Person, Jigawa

"Before PPRHAA there was no sense of ownership of the facility by the community. It was all the property of the government. It was provider-centred, but now it is client and provider-centred."
Zonal PPRHAA Team Leader, Enugu

A qualitative review undertaken in late 2007/early 2008 documented many positive examples of how client and community voices had been heard and responded to by providers and their managers (see Boxes above and below).

Box 12: Facilities and Health Managers Respond to Client and Community Demands

"In a PPRHAA focus group discussion session in Oyofe-Oghe in Eziegu North Local Health Authority the communities complained that they did not use the facilities because the health workers were not available at all times, especially at nights. The health staff explained that because the area is unsecured they were not confident to stay within the facility premises at night. The communities agreed to extend their local vigilante services to the facility premises. As a result of this staff were available to provide night services."
PPRHAA Focal Person, Enugu

"In Iro community, Gbonya LGA in Ekiti, in one of the PPRHAA quarterly review sessions the community complained about the ambulance not being fuelled, not enough skilled health staff and staff not available to provide night services. The PHC Coordinator redistributed the staff, and the facility management started releasing money for fuelling the ambulance."
PPRHAA Focal Person, Ekiti

"At Nachi PHC in Udi Local Health Authority, the community complained during the PPRHAA process that the facility was located in an isolated area, and as a result their women were not delivering at the health facility. To address the problem, the community made available a residential apartment not too far from the health facility and agreed that the health workers could use the premises as a maternity home."
PPRHAA Focal Person, Enugu

Challenges

In practice, with only a half-day allocated to the appraisal process per health facility, compromises in data collection had to be made. A further challenge was that PPRHAA teams had little control over who was selected for participation in the appraisal process. Community leaders were requested to invite a cross-section of the community, but this did not guarantee that individuals and groups who were less articulate, very poor, or otherwise socially excluded, would be involved. However, because the PPRHAA teams were briefed to ask about the views of less vocal or visible groups in their interactions with the community, it was hoped that over time this would help stimulate a more representative response. At the facility level, the random selection of clients for interview helped prevent any biases in feedback.

The quality of community participation in the PPRHAA summits also varied. Since the community members involved in these activities (usually a community leader and a women's representative) were not given any training on how to maximise the benefits from their participation, the outcomes depended very much on what pre-existing skills, confidence and experience the community representatives could draw on. This was a risky strategy in a context where there were often very significant power differentials between providers, civil servants and members of the community. Involving members of the community who have benefited from participation in other systems strengthening initiatives (e.g. strengthening of facility health committees) would make sense in future. A further limitation was that no provision was made for building the skills and confidence of female community representatives, despite the fact that their voices were mediated by gender power relations.

Facilitation of the client and community views component was particularly challenging in the early days of PPRHAA since knowledge of social development issues and the skills to engage effectively with communities were not always available within state and local government PPRHAA teams. The quality of data gathered, the way in which it was reported, and the tendency for client and community concerns to evaporate during the facility action planning process were all concerns initially. Targeted capacity building, in the form of formal training and on-going supervisory support, was provided by PATHS in order to increase competencies in these area. As a result, skills to

facilitate the CCV component of PPRHAA, among external consultants[25] and state PPRHAA teams improved significantly over PATHS lifetime. Likewise, the quality of client and community participation in PPRHAA improved over time.

Some of the major constraints to effective service delivery, such as shortages of staff, were not always addressed promptly, since these issues required action and solutions that lay outside the immediate control of health providers. Some problems identified through the CCV process - and which required a response from local government - were not addressed, leading to disappointment among community members. Finding out the cause of such inactivity was part of the role of integrated supervisory teams. However, in many cases, the inactivity at LGA level occurred because the incentives to respond were not strong enough.

5.2.4 Integrated Supportive Supervision in Nigeria

Integrated Supportive Supervision teams comprising health personnel and community representatives were established in six Nigerian states supported by the UK DFID funded PATHS programme. Although ISS was introduced quite late in the programme's lifetime, by the end of the programme in 2008 there were signs that the initiative had helped to bring about improvements in the delivery of health services and in provider motivation. An important factor that contributed to the successful implementation of ISS was that it was embedded within a broader process of health systems strengthening.

Community representatives were nominated for inclusion on the ISS teams because they had shown a particular interest in and commitment to improving the health of their communities. These were individuals who had been particularly active and effective on facility health committees, or who had played an important role on behalf of the community in the PPRHAA process. The inclusion of members of the community on the ISS teams put them right at the heart of a process that aimed to increase health systems performance. The fact that community representatives played an active role in checking and assessing facility performance meant that ISS helped stimulate greater accountability to the community by health providers.

Box 13: Participation of Community Representatives on ISS Teams

"The community representatives on the ISS teams visit facilities in their area, but not their local facility. They learn about the challenges and strengths of other facilities. This really helps them understand better what constraints the facilities operate under, to learn about good and poor practice, so that they know what to expect from their own facility. The idea behind having community representatives on the ISS team is to let them know that they are the owners of the facilities – whatever is being done, they should see what is going on and get involved."
Director, Planning, Research and Statistics, SMOH, Kaduna

[25] The intention was to gradually phase out the use of external consultants as state PPRHAA teams developed their facilitation skills and gained in confidence.

In a context where few health managers visited health facilities or communities regularly, there were large gaps in their understanding of community needs and concerns. Feedback sessions involving ISS teams and local government health departments gave the community members of these teams a direct line to local government, and a rare opportunity to claim improvements in services. Although by early 2008 when the programme closed it was too early to say what demands were being made on local government on behalf of the community, and whether the demands were being responded to, the mechanism itself had proved promising from a voice and accountability perspective.

Box 14: Stimulating a Response from Providers and Government

"We went to one facility to provide supervision. The in-charge had gone off to collect his salary. We called him and he promised to be at the health facility within an hour. Now he'll know to stay in his place of work."
Community member of ISS team, Tudun Wada, Zaria, Kaduna

"We appreciate ISS. The ISS teams write a report and discuss this with the authorities. Information on the problems is reaching those who need to know, and there are signs that government is beginning to respond."
Chairman FHC, Makera PHC, Kaduna

One of the strengths of ISS is that the activity is embedded into the fabric of the health system. Unlike some other types of community monitoring, therefore, prospects for institutionalisation are good.

Challenges

For ISS teams to function effectively, they require refresher training and on-going support. During the lifetime of PATHS a single training was provided. It is particularly important to ensure that targeted capacity building support is provided to the community representatives on these teams. Since most of these individuals come from outside the health sector, they tend to have less technical knowledge than the other team members, and may also lack experience of effective ways to influence decision-makers. In areas where facility health committees are being supported by government, it makes sense to ensure that active members of these committees are invited to participate on ISS teams. This will help maximise the gains from any training (e.g. lobbying and advocacy skills) provided through health committee strengthening initiatives.

ISS teams are required to assess all aspects of service delivery. This should include the work of community-based health workers, including VHWs. In the Nigerian context, however, ISS teams did not monitor the work of community health volunteers.

5.2.5 Patient Focused Quality Assurance in Nigeria

Patient Focused Quality Assurance was implemented in Jigawa State, Northern Nigeria with the support of the DFID PATHS 1 programme between 2004 and 2008. Information on implementation processes, and on outcomes and impact, was gathered via programme monitoring systems, and by a rapid review carried out in 2008. PFQA improved health providers' responsiveness to client needs, and strengthened linkages between facilities and local communities. Although many deficiencies in the quality of health services were identified by clients in PFQA client exit interviews, facilities involved in the process took steps to respond appropriately, where it was within their capacity to do so.

Box 15: Implementing PFQA: Health Providers' Views

"Data from the questionnaires is interpreted and plotted on a graph so that we know our deficiencies. We initiate ways to improve our service and decide quality indicators for that month. If there is no improvement over time, we revise our strategies. We display the results in the consulting room so that patients can see."
Garki PHC, Jigawa

"We brief the Hakimi [District Head] and other dignatories about the PFQA results and also try to get the message out to the community about what we are doing to respond to the problems raised by the survey respondents."
Dutse General Hospital, Jigawa

"We will do our best to comply with clients' views, even if it goes against our views. We will compare and contrast different views and adjust to a compromise. If we do something against the wishes of the community, we know that they won't use the facility."
Garki PHC, Jigawa

Utilisation increased in some facilities as services became more client-friendly. As relationships between providers and local communities improved, some PFQA facilities looked for other ways to deepen their engagement with local communities, for example by holding annual open days. From providers' perspectives it was important to ensure that clients and the wider community were not only aware of the changes that were taking place at the health facility, but also understood the constraints under which staff operated and the various ways in which client actions and behaviour could negatively affect services. For instance, providers complained that because members of the community did not keep to official visiting hours, ward rounds were frequently disrupted. It was hoped that open days would provide an opportunity to explain not only the entitlements of clients and their carers, but also their responsibilities.

Box 16: PFQA Facilities Respond to Problems Identified by Clients

Client exit interviews undertaken as part of the PFQA process revealed several problems that were affecting clients' views of services at Garki PHC. Fortunately, the facility was able to tackle these:

- Clients pointed out that the card issuer left his post at lunchtime, leaving the records office locked. Clients had to wait for him to come back. The facility tackled the problem by posting another member of staff to take over when he was on break.
- Clients were also confused about when they should come back to the health facility for review following an initial consultation. This has now changed. All health providers are being very careful to state when clients need to return to the health facility.
- The pharmacy department was too busy to explain how people needed to take drugs. This was problematic because some clients were given up to four different types of drugs, all with different dosages and application regimes. Many clients were leaving the health facility with no idea of what to take and when. This had to change. The pharmacist is now very careful to explain to clients what they should do.

At Gumel General Hospital the PFQA client exit interviews identified that many clients were concerned about their inability to access drugs at the health facility at certain times of the day. The facility responded by moving two Clinical Assistants to the pharmacy. They now run three shifts and can provide drugs 24 hours a day.

Periodic supervisory visits undertaken by the state PFQA team provided an incentive to maintain client-friendly standards of care. In addition, an annual quality of care conference held at state level provided an opportunity for health facilities to report on their PFQA-related activity, to highlight what changes were being made in response to client needs, and to discuss challenges that were not easy to resolve. Other systems strengthening and improvement initiatives that were taking place at the same time, such as the annual PPRHAA process, improvements in drugs supplies, and training of health providers in clinical and inter-personal communications skills, all contributed to the momentum for change.

By introducing a formal mechanism through which providers could consult with clients, PFQA enabled clients' voices on the quality of health services to be heard. Since clients were picked randomly for the exit interviews, this helped to ensure that a variety of voices were heard. The fact that 'client-friendliness' had become a key performance indicator for health facilities in Jigawa introduced a new measure of accountability between health providers and the clients and communities they were expected to serve.

The PFQA process itself – carrying out a client exit interview, collating and analysing results, prioritising key problems, and devising action plans to address these – was not complex, and a variety of facility staff (e.g. laboratory staff, pharmacy staff, clinicians) quickly got up to speed with what was required. The approach could easily be replicated in other contexts.

PFQA in the Nigerian context focused on assessing the quality of services provided in static health facilities. However, the approach could be adapted to include a focus on other types of service provided in the facility catchment area, including services provided by VHWs.

Challenges

Many of the health facilities in Jigawa were affected by severe staffing shortages, and the PFQA facilities were no exception. This meant that some facilities found it difficult to administer a large number of client questionnaires on a monthly basis (this was originally set at 100 questionnaires per month per health facility).

Box 17: Staffing Shortages Affect PFQA

"We suspended PFQA in January 2007 because the facility PFQA focal person was away on training. We have just resumed. Staff at the facility sometimes do 18 hour shifts. We are very under-staffed."
Garki PHC, Jigawa

Although the number of client exit interviews was later reduced to 50 per quarter for primary health care facilities and 100 per quarter for secondary health care facilities, the scale of the human resource problem in Jigawa meant that staffing constraints were likely to remain a problem in the short- to medium-term. Ironically, as PFQA health facilities became busier as a result of their growing responsiveness to client needs, their capacity to effectively carry out PFQA diminished.

A further limitation of PFQA is that by focusing on clients at the health facility, the approach does not provide a mechanism by which non-users of health services can be reached. This means that wider community concerns about particular aspects of service delivery, or about access and affordability, may be left unexplored. This depends, however, on the receptivity of health providers to introducing other mechanisms alongside PFQA (such as facility open days) to address this gap. These additional measures provide an opportunity to extend the voice potential of PFQA – from consulting with clients about the quality of services to engaging them in a broader dialogue about quality improvement.

5.3 Case Studies of Other Approaches

5.3.1 Health Committees in Nigeria

Facility Health Committees (FHCs), comprising members of the community and representatives of the health facility, were supported in a number of Nigerian states by the DFID-funded PATHS programme. In some states, support to these government-sanctioned committees focused on building capacity to oversee implementation of sustainable drug supply systems or deferral and exemption (D&E) schemes.[26] In other states the support was more comprehensive and broad-ranging (see Box 18).

[26] These allow access by the very poor to health care.

The idea was that FHCs would be an effective means of increasing community participation in health, would create space for community voices to be heard by health providers, and help to address key accountability failures at facility level.

Box 18: Facility Health Committees in Kaduna

Facility Health Committees in Kaduna support the work of the health facility, act as the link between the facility and the nearby communities, and help build community participation in health. Specifically, the role of the FHC is to:

- *Support* the health facility to deliver against its remit
- *Increase access*, particularly of the very poor and underserved, to health services
- *Monitor* the work of the health facility
- *Advocate* for increased government support for the facility
- *Help build* a good relationship between the facility and its catchment communities
- *Be the first point of contact for* all service delivery and quality improvement activities that require community input
- *Help supervise and support* Community Health Volunteers

The intention is that stronger Facility Health Committees will lead to the following:

- Communities play a more active role in ensuring 'better health for all the community'
- Communities feel that they have a stronger voice on how health services are managed and delivered
- Communities feel that health providers are more accountable to them
- Health services are more responsive to patient needs
- Health services reach the very poor and the underserved
- Women's views and perspectives on health issues are better represented

In Kaduna the training of FHCs focused on building skills and competencies and raising awareness of FHC roles and procedures. The training focused on:

- How to work in a team
- Effective ways to consult with the community
- How to represent the views of the community
- How to identify and reach the poorest
- Understanding the barriers of access to health services
- How to plan for better health with the community
- How to monitor client satisfaction with services
- How to advocate and lobby for improvements in health services

Participatory training techniques were used so that participants could practice what they had learnt during the training. For example, training participants carried out a role-play on what it meant to consult with the community, and practiced their lobbying skills on someone pretending to be a local politician. The SMOH provided follow-up mentoring support to the committees through the core group of state FHC trainers who were drawn from the SMOH, the Ministry of Women's Affairs, the Local Government Service Commission and local NGOs.

Results

By 2008 when the PATHS programme came to an end, there were many interesting examples of how facility health committees had attempted to address accountability failures at their local health facility. These failures ranged from a lack of information available to clients and communities; poor provider performance; the potential for provider corruption; lack of drugs; or inequitable access to health services (see Table 9 below).

In Kaduna and Ekiti, where the support provided to FHCs was more broad-ranging than in the other PATHS states, part of the FHC role was to provide checks and balances against poorly performing health providers (e.g. poor provider attendance or providers being rude to clients), and against provider corruption. In these states, being answerable to a FHC for poor performance, particularly in contexts where the overall supervision of health facilities had improved, meant that it was no longer possible for providers to assume that business could continue as usual.

On the whole, relationships between active FHCs and health providers in Ekiti and Kaduna appeared to be supportive rather than confrontational. Providers recognised that FHCs could make a very significant difference to their capacity to deliver effectively, and many spoke about the effectiveness of FHCs in helping to leverage support for the health facility from traditional authorities, from local communities and to a lesser extent from local government and politicians.[27]

[27] Whether power differentials between provider and community members of the FHCs resulted in the latter being co-opted is not known, although the practice of ensuring that 'community influentials' sat on these committees may have helped guard against this. However, there was also a potential that providers and influential community members of FHCs could combine forces for the purposes of rent-seeking. However, again, there is no evidence to suggest that this happened.

Table 9: Role of FHCs in Addressing Accountability Failures

Type of Accountability Failure				
Lack of Information	**Poor Provider Performance**	**Lack of Drugs, Poor Infrastructure**	**Corruption**	**Inequitable Health Services**
"There are many benefits to having community members involved in the DRF committee. They can explain to the community about the DRF and help manage any problems that arise, including any community misconceptions about the scheme." *Members of DRF Committee, Kudai Village, Dutse, Jigawa* There is confusion about the free drugs situation. Many adults think that they should be getting free drugs, which is not the case. The FHC members are doing a lot of work to advise the community to be patient about the situation and to support the free MCH	"We have to make sure that the workers are here all the time. We take it upon ourselves to come to the health facility to find out what the workers are doing." *Member of FHC, Oyotu Odya Health Clinic, Enugu* "We do mobilisation every two months. We ask for feedback on how clients have been received at the health facility… if there is any way that providers have to adjust we come and tell them." *Member of FHC, Makera PHC, Kaduna* Our main job is to see that the facility is progressing by ensuring that the workers are there all the time." *FHC member, Iyin*	"Our job is to shout if the free drugs don't come." FHC Member, *Barnawa PHC, Kaduna* "We have carefully documented what they need in terms of drugs and what they're getting, and the gaps." *Member FHC, Babban Dodo PHC, Kaduna* "There is a need for extensive renovation. The Local Government have promised to act and we have confidence that they will do so. They have incorporated our request into their 2008 budget." *Member FHC, Makera FHC, Kaduna* "We dug a well for the	"There is less mischief if the community is involved on this [DRF] committee… Because receipts are given and there are good records, it is easy to find out if things are being cooked." *Members of DRF Committee, Kudai Village, Dutse, Jigawa* "I was called in to receive delivery of the free MCH drugs. I also inspect the ledgers and other records relating to the drugs and check that everything is in order." *Chair, FHC, Barnawa PHC, Kaduna* "When we need DRF drugs we draw up the list and they [FHC] go through the list. They also go through the records monthly. The	"If they lack money, we bring the poor person to the health facility and ask the in-charge to organise their treatment." *Member FHC, Television PHC, Kaduna* "The FHC has introduced an ID referral card for the less privileged. Since we're in the community, we can judge who needs to come… those who cannot afford, we can tell who they are." *Member FHC, Babban Dodo PHC, Kaduna*

policy while it takes root." *FHC Member, Barnawa PHC, Kaduna*	*Health Centre, Ekiti* "I come into the health facility for supervision. I like to see the flow of clients and to see how the providers relate to the community members." *Chair, FHC, Barnawa PHC, Kaduna* FHC members have a good perspective of what is going on here since some members are on-site a great deal. We don't think of them as a threat. Them being here makes us more committed to do the right thing and to get things right." *Officer in Charge, Barnawa PHC, Kaduna*	facility and put up a sign board which explains what services are available and when. We also made a suggestion box." *Member FHC, Barnawa PHC, Kaduna* "The FHC helped us design and construct a signboard. They bought curtains for the facility and bed slats for the ward. We also had a problem with the electricity supply and they helped with that and we are now getting electricity 12 hours a day." *Health provider, Television PHC, Kaduna*	Chair goes through the fund valuation forms and signs." *Officer in Charge, Aiyejede Health Centre, Ekiti* Every day a member of the FHC comes to see what is happening with the free MCH drugs. They see how we give the patients the drugs. It is helpful that they watch the dispensing. We are only getting about 50% of the drugs we need. We therefore need to ask clients to buy outside, and this leads to suspicion of us providers. The FHC is very helpful in explaining the role of free MCH to communities since there is a great deal of confusion among clients." *Health provider, Ung Mu'Azu PHC, Kaduna*	

Unfortunately, the review of the work of Facility Health Committees in PATHS did not look in any depth at how the committees supported and monitored the work of community health volunteers. The fact that local government personnel were responsible for supervising and mentoring the volunteers meant that the extent of the FHC monitoring role in relation to this cadre of staff was never made explicit. As a result, many of the committees interpreted their role as a support role, where the emphasis was on helping the volunteers to trouble-shoot bottlenecks to service delivery or on lobbying local government for assistance on behalf of the volunteers. In practice, however, if FHCs can monitor the work of (salaried) health providers, there is no reason why they cannot extend this role to include volunteer health workers.

Challenges

Local government was commonly only approached by the health committees as a last resort, when a problem was perceived to be too large or significant for the FHC to act on. Although this demonstrates a willingness on the part of the FHC to take the initiative, the tendency to avoid challenging local government for accountability failures, except where absolutely necessary, indicates either a lack of confidence within the FHCs to present a strong and effective case, or a cynicism about the potential to get a response from local government. Both explanations are probably valid to some extent.

Although there were some positive examples of how the health committees had successfully drawn down support from state or local governments, many other examples were cited of local government failure to respond to FHC demands.

The absence of local government incentives to respond to community demands, and the absence of sanctions if they chose not to respond, meant that there were systemic constraints to FHCs' capacity to leverage support from this tier of government. Without very significant improvements in public accountability, finding effective ways to challenge local government inertia was likely to remain hit and miss.

In states where support to FHCs focused primarily on their role in jointly managing (with health providers) deferral and exemption schemes or drug revolving schemes there was less evidence that FHCs played a key role in ensuring community voices reached health providers and managers, or that they were effectively challenging accountability failures. In these states, the role of community members on the committees was in practice defined very narrowly as being a conduit for information about the availability of drugs or safety nets for the very poor, and a means by which communities could be mobilised in support of these initiatives. In most cases capacity building support to these committees had focused on increasing awareness of committee procedures and roles, rather than building members' skills and competencies to carry out these roles. These training gaps were not filled via the provision of on-going mentoring and supervisory support. This was a missed opportunity to move beyond token community participation on these committees.

Although in all states FHC membership criteria were drawn up in such a way as to ensure the participation of a cross-section of the community based on gender, age, clan affiliation, and

interest groups, including the disabled, in practice nominations were made by community leaders within the traditional authorities, and did not always result in selection of the most effective or committed individuals. Introducing some basic performance assessment indicators to measure the performance of individual committee members could in future help shift the balance of membership to high performers.

Also common were differences in skills and confidence between the female and male members of the committees, especially in the northern states of Nigeria where women were constrained by purdah from participating in community development processes that took place in the public sphere. In some of the PATHS states the failure to address these gender differences in experience and confidence at the outset was a gap in implementation.

The role of the FHC as a channel for community voices on health issues is interesting. In the states where limited capacity building support was provided to the FHCs, there was no evidence to substantiate the claims of the committee members that they were representing the views of the wider community in their committee activities. The tendency was to assume a homogenous community view, and to know what this was without any attempt at consultation. In Kaduna, in contrast, the training of FHCs put significant emphasis on consulting, representing and feeding back to the community. By the end of the PATHS programme in 2008, however, it was too soon to assess whether the training had made a difference.

6. Comparison of community monitoring methodologies

Table 10 compares the community monitoring methodologies and approaches discussed in Sections 4 and 5 from several different angles. The table compares various design features (such as the methods used to obtain information from the community or who defined the performance indicators). It also compares other factors, such as the resources required for implementation and the potential for institutionalisation.

Table 10: Comparison of Community Monitoring Methodologies

Point of Comparison	Citizen Report Cards	Community Score Cards	COPE/ Community COPE	Partnership Defined Quality	Patient Focused Quality Assessment	Peer and Participatory Rapid Health Appraisal for Action	Integrated Supportive Supervision	Health Committees
Leadership of monitoring process	CSOs	CSOs	Health providers	Health providers/ external facilitators	Health providers	Health providers	Health providers	Community
Scale of implementation	Macro (national/ district)	Micro (local level)	Micro	Has been implemented in whole districts	Piloted in small number of facilities	Has been implemented state-wide	Has been implemented state-wide	Micro or macro
Unit of analysis	Individual/ Household	Community	Community	Community	Clients	Clients/ Community	Clients/ Community	Health facility
Methods used to obtain information from clients and community	Survey (individual interview)	Focus group discussions	Focus group discussions/ Participatory mapping	Group discussions	Individual interviews	Individual interviews/ Focus group discussions	Individual interviews/focus group discussions	N/A
Performance indicators defined by	CSO	Communities	Communities/ Health providers	Communities/ Health providers	Health providers	Health managers	Health managers	Committee members
Includes provider self-assessment	No	Yes	Yes	Yes	No	Yes	No	N/A
Frequency of implementation	Once-off or annual	Once-off, annual or twice a year	Quarterly	Once-off, but QI Team's work ongoing	Quarterly or twice a year	Annual	Quarterly	Ongoing

Point of Comparison	Citizen Report Cards	Community Score Cards	COPE/ Community COPE	Partnership Defined Quality	Patient Focused Quality Assessment	Peer and Participatory Rapid Health Appraisal for Action	Integrated Supportive Supervision	Monitoring of Service Delivery by Health Committees
Reliance on external facilitation	Yes	Depends	Yes (community component)	Yes	No	No (peers from within health sector)	No	No
Complexity of approach	High	Low-Medium	Medium	High	Low	Medium	Low	Low
Level/degree of community participation	Low-medium	Medium to high	Low-medium	Medium	Low-medium	Low-medium	Medium-high	High
Mechanism for ongoing interaction between community & providers	No	Can be put in place	Yes (if community reps participate in QI Committee)	Yes (QI teams)	No (but can be put in place)	No	No	Yes
Potential as a voice mechanism	Yes (depends on effective facilitation of interface meetings)	Yes	Yes (if communities participate in action planning & QI committees)	Yes	Maybe (other mechanisms need to be introduced alongside PFQA)	Yes (depends on effective facilitation of PPRHAA summits)	Yes	Yes
Resources required	High	Medium	Low	Medium	Low	Medium	Low	Low
Potential for institutionalisation	Low – resource intensive; relies on external facilitation; not familiar activity for health sector	Low-Medium – not familiar activity for health sector; can rely on external facilitation; but simple process	High – not resource intensive; but provider time constraints may undermine community COPE	Medium – complex process; relies on external facilitation; potentially costly	High – few resources required; simple process	Medium – resource intensive; monitoring and planning core activities of the health sector	High – core activity of the health sector	High – few resources required; many governments have policy commitment to health committees

7. Discussion and implications for inscale

7.1 Adaptability of Community Monitoring Methodologies

Sections 4 and 5 highlighted how some of the community monitoring methodologies examined in this report were adapted from the original prototype to allow particular research questions to be addressed, or in order to suit specific implementation contexts. For instance, the Uganda Citizen Report Card methodology included elements of the Community Scorecard approach (e.g. via its focus on community health entitlements; emphasis on facility-based interface meetings; and lack of emphasis on using the media as a tool to extract accountability). The Malawi Community Scorecard pilot skipped the 'input tracking' component and based performance indicators on the outcome of a participatory health assessment. Since all the methodologies reviewed in this report lend themselves to adaptation, it makes sense for inSCALE to design a hybrid approach that draws on the best components and features of all.

None of the case studies presented in Section 5 showed how community monitoring can be used to track the performance of Volunteer Health Workers (although the case study on PDQ in Kenya hinted that the approach was expected to have some sort of motivational effect on volunteer CORPs). In practice, all the methodologies could be adapted to incorporate a focus on Volunteer Health Workers: ISS teams could extend their focus beyond static facilities and monitor VHW performance; health committees could be given an explicit monitoring role in relation to VHWs; and Community Scorecards could include a focus on community perceptions of the performance of VHWs.

7.2 Strengths and Weaknesses of Different Methodologies

Table 10 in Section 6 looked at the strengths and weaknesses of the various community monitoring methodologies. For instance, while PFQA scores highly for methodological simplicity, it scores less well from the perspective of promoting a high degree of community participation. PFQA also relies on the motivation of health providers to 'push along' the quality improvement process – mechanisms that create a 'push from below' for performance improvement are lacking in this approach. Nevertheless, other accountability mechanisms can be introduced alongside or as part of PFQA with the express aim of providing opportunities for ongoing dialogue between health providers, health managers and communities (e.g. holding facility open days, or establishing Quality Improvement Teams involving community representatives). PPRHAA, too, unless well facilitated by personnel with strong skills in participatory approaches and a concern for community empowerment (the former at least may be lacking among health providers) can also produce a relatively low level of community participation.

Citizen Report Cards were designed for implementation on a large-scale and, at first sight, this methodology does not look appropriate to the needs of inSCALE. However, the way in which this approach was adapted for use on a smaller scale in Uganda suggests that the methodology should not be discarded out of hand. Nevertheless, CRC's reliance on external facilitators means

that this approach could be costly and difficult to implement. It is also unlikely to be sustainable (unless championed by the MOH at national level). In contrast, the fact that health providers and community representatives (perhaps members of local health committees) can be trained to implement the Community Scorecard approach means that it scores well from sustainability and scalability perspectives. Where community monitoring approaches rely on external funding for implementation, the issue of how to get funding for future implementation incorporated into government budgets needs to be addressed early on in the implementation process.
A key question for inSCALE is whether it should give priority to methodologies that are already – or which could become – an integral part of the fabric of the health system (e.g. PFQA, ISS, PPRHAA, health committees, community COPE), or to methodologies that lie somewhat outside the boundaries of the health system (CRC, CSC). Both have their merits. In the latter case, the challenges associated with getting the approaches institutionalised are likely to be higher, unless the Ministry of Health decides that it likes and supports one or other of these approaches (as happened with NRHM in India). Involving the MOH in the pilot countries in the decision-making process may, therefore, make sense.

A further consideration is that the good practice that is beginning to emerge from within the social accountability sphere cannot be ignored. Active engagement by clients and communities in assessing and monitoring quality and provider performance is vital if pressure for change is to be sustained. Active engagement is not promoted by those methodologies that rely on informing and consulting alone (PFQA, PPRHAA and some adaptations of community COPE). Moreover, those approaches that create space for citizens to call decision-makers at higher levels to account for service delivery failures (such as a failure to provide adequate drugs for ICCM volunteers) are more likely to stimulate improvements in services than those that do not. The methodologies that promote the concept of interface meetings (involving communities, health providers and higher level officials such as members of the DHMT) – need to be looked at very carefully.

A further consideration is the need to incorporate a focus on equity into the community monitoring approach. The CRC approach adopted by NRHM in India ensured that the experiences and perspectives of disadvantaged groups within the community were captured and compared to the experiences and perspectives of more advantaged groups. The results were used to compile an 'equity index' which showed whether or not service delivery was progressive or regressive from an equity perspective. In parts of India, however, it is relatively straightforward to segment communities from an equity perspective since caste is a major marker of advantage/disadvantage. In Africa, in comparison, distinguishing between advantaged and less advantaged groups in generally poor communities may be less straightforward (see Box 19 however).

Box 19: Markers of Inequity in Northern Nigeria

A recent (2010) study in Northern Nigeria undertaken by the UK Department for International Development (DFID) and Government of Norway-funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) found that 80% of child deaths were clustered among 20% of households. The heavy skew of child mortality was not related to child spacing, distance from health facility, religion, tribe, education, culture, polygyny, marital status, seclusion, or employment. Rather, a lack of respect and social support shown to a woman at family level were found to be important contributing factors. Studies in other parts of Africa and elsewhere have also identified the existence of clustering. Therefore, number of child deaths in a household could provide a way of distinguishing disadvantaged households from others. However, finding ways to do this sensitively – and without further stigmatising these households - will be challenging.

7.3 Good Practices in Community Monitoring

Based on the community monitoring experiences and lessons learned that have been presented in this report, a number of good practices relating to community monitoring are outlined in Table 11 below.

Table 11: Good Practices in Community Monitoring

Ensure High Quality Community Participation and Ownership	• Build ownership of the community monitoring approach via careful preparation of communities • Use facilitators with prior experience of participatory approaches, health rights and social accountability • Involve communities in defining performance monitoring indicators • Build in a focus on equity right from the start • Keep the monitoring tools simple – use pictorials/adopt local terminology to describe different measures of performance
Promote Accountability and Responsiveness	• Build in mechanism(s) that promote ongoing dialogue about quality and performance between clients, communities and providers • Incorporate mechanism(s) that provide opportunities for regular interaction between community representatives and local government • Consider how higher level officials can be incentivised to respond to community demands
Build Provider Support for Performance Monitoring	• Monitor the work of health volunteers from a systems perspective – focus on VHW performance in the context of health systems functioning in general • Create a problem-solving culture and address performance gaps from

	the perspective of lesson learning and how to move forward
Keep an Eye on Scalability and Sustainability	• Keep the monitoring approach simple • Work out cost implications right from the start • Use health providers/community representatives as facilitators • If using external facilitators have a clear exit strategy • Consider the time implications associated with involving busy providers • Involve existing organisations (e.g. health committees) rather than create new ones • Build in a focus on institutionalisation right from the start – seek champions for the approach, encourage local funding, and influence policy

8. Conclusion

The lack of experience – or at least documented experience – of using community monitoring in the context of Volunteer Health Worker programmes means that inSCALE is unable to draw on an anthology of ready-made good practices and lessons learned. Nevertheless, there are lessons to be learned from the use of community monitoring methodologies in other health-related contexts. This report looked at eight methodologies that could potentially be adapted and used to monitor the work of volunteer health workers in an ICCM setting. The exploration and presentation of some of the strengths and weaknesses of these approaches throughout this document will hopefully begin to clarify for the inSCALE team which direction it wishes to travel in.

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Appendix 1: Ladder of participation[28]

The 'Ladder of Participation' demonstrates different degrees of participation. The ladder is organised as follows:

- **Decoration**: This is when community members are invited to a consultation process, but no effort is made to involve them, and they end up being mere 'decoration' at the meeting. This is the lowest form of participation.

- **Informing**: Community members are told by an opinion leader what is going to happen. The communication is one-way and community members have no say in the decision.

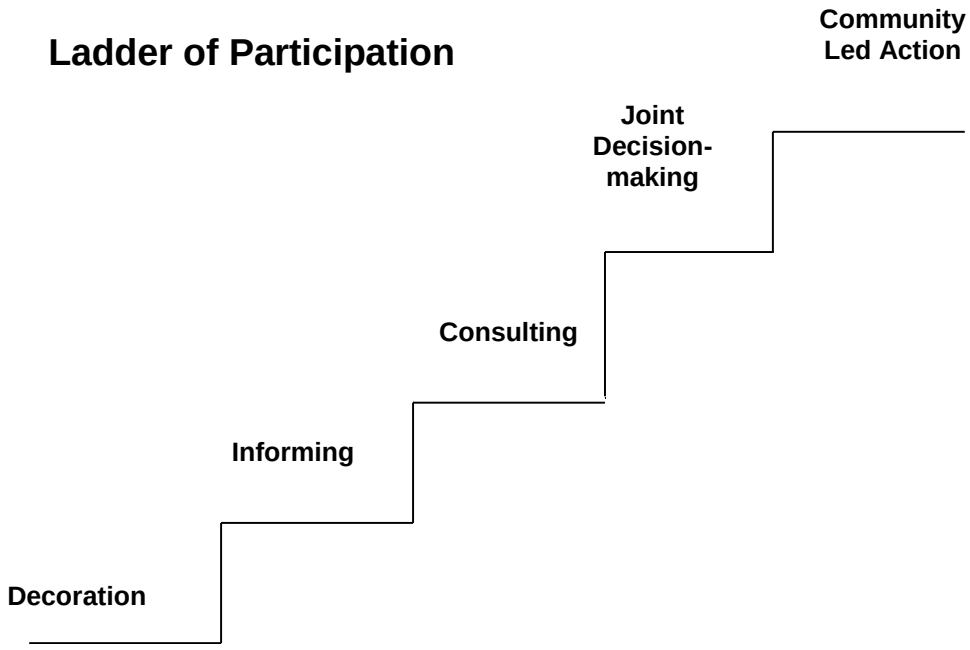
- **Consulting**: This is where an opinion leader asks for community input to a decision. This is an example of two-way communication. However, the final decision is made by the opinion leader.

- **Joint Decision-making:** This is where the community and the opinion leader jointly make a decision, based on consensus.

- **Community-led Action:** This is where community members make their own decision. The community is fully in the 'driving seat.'

A diagram of the Ladder of Participation can be found below.

[28] Adapted from Arnstein, Sherry R. 1969, "A Ladder of Citizen Participation," JAIP, Vol. 35, No. 4, July 1969, pp. 216-224.


Ladder of Participation
Community Led Action
Joint Decision-making
Consulting
Informing
Decoration

Appendix 2: PFQA guidelines and questionnaires[29]

Instructions for Conducting the Out-Patient Baseline Survey using the Client Questionnaire

INTERVIEWERS: Two interviewers are required – 1 male and 1 female
Ask for a maximum of 10 in-patients to be selected who are about to be discharged, males and 5 females if possible.

Who should be interviewed?
Interview those who have come for curative care and not for any other reasons such as immunisation, antenatal care, TB, dressings etc.
If the patient is a child then interview the adult who has brought the child.
Include patients who have difficulty in speaking because they are deaf and dumb or have a speech disorder by interviewing their relative or guardian.
Omit patients who have difficulty in understanding because of mental problems.

How many clients do I interview?
Interview at least 30 patients per week - 15 males and 15 female patients. This can be done by interviewing at least three males and three females per day, Monday to Friday, who come for curative care. Therefore in one month at least 100 patients will have been interviewed.

Where do I interview them?
After the patients have collected their drugs or received their injections. Find a place that is quiet and away from the other patients and staff but near the pharmacy. Offer the patient somewhere to sit so that they feel comfortable during the interview.

Interview technique
- Ask the client if you may interview them.
- Explain briefly why you are interviewing them (read to them the introductory paragraph at the top of each questionnaire)

How do I ask the questions?
- Ask the questions exactly as they are written and only give further explanations if you feel they do not understand the question.
- Use the language that the patient understands best.
- Ask the questions very clearly and let the client decide their response from the response categories. (Remember that it is the client's perception of the service that we are measuring and **not** what you think their perception is! Do **not** try to influence the client's answer.)

[29] Developed by the UK DFID Funded Partnerships for Transforming Health Systems Programme, Nigeria. Material from report prepared by Haran., D, 2004, 'Client Centred Quality Assurance in Health Facilities in Jigawa State, Nigeria', January.

CLIENT QUESTIONNAIRE - OPD

Final Version

Health facility:		**Date:** dd/mm/yyyy	**Sex: M adult / F adult M child / F child**	**No:**	

Hello, we are conducting a survey with users of this health facility to find out what you really think about this health facility. We want your honest answers to help us improve our services to you and future clients. Your answers are strictly confidential and we thank you for your participation and honesty.

1	Did you have to wait too long at any service point in this hospital?	YES [ ] NO [ ] NA [ ]
2	*If YES, at what point?*	*Card Room [ ] Nurse table [ ]* *Consulting room [ ] Injection Room [ ]* *Dispensary [ ] X-Ray [ ]* *Other place [ ] NA [ ]*
3	*How long did you wait before you saw a doctor?*	*< 30 mins [ ] 30 mins [ ]* *>30mins – <1hr [ ] 1 hr [ ]* *> 1 hr [ ] NA [ ]*
4	Did the doctor listen to you well when you described your concerns?	YES [ ] NO [ ] NA [ ]
5	Did the doctor examine you?	YES [ ] NO [ ] NA [ ]
6	If YES, how satisfied were you with the examination?	Very satisfied [ ] Satisfied [ ] Not satisfied [ ] NA [ ]
7	Did the doctor tell you what is wrong with you?	YES [ ] NO [ ] NA [ ]
8	Has the doctor told you whether or not you need to return?	YES [ ] NO [ ] NA [ ]

9	How was the attitude of the doctor towards you?	Very Good [ ] OK [ ] Poor [ ] NA [ ]
10	Did you have privacy during your consultation?	YES [ ] NO [ ] NA [ ]
11	Were you prescribed any drugs?	YES [ ] NO [ ] NA [ ]
12	Did you receive all the drugs that were prescribed?	YES [ ] NO [ ] NA [ ]
13	Could you afford to pay for all the fees levied?	YES [ ] NO [ ] NA [ ]
14	How did you find the cost of the drugs ?	Not expensive [ ] Expensive [ ] NA [ ]
15	Did you get a receipt after each payment you made?	YES [ ] NO [ ] NA [ ]
16	How was the attitude of the person in pharmacy?	*Very Good [ ] OK [ ] Poor [ ]* NA [ ]
17	Did the person in the pharmacy tell you how to take the drugs?	YES [ ] NO [ ] NA [ ]
18	*How was the attitude of the card issuer?*	*Very Good [ ] OK [ ] Poor [ ]* *NA [ ]*
19	How was the attitude of the other health facility staff?	*Very Good [ ] OK [ ] Poor [ ]* NA [ ]
20	*What do you think of the cleanliness of the health centre and the surroundings?*	*Very Good [ ] OK [ ] Dirty [ ]* *NA [ ]*

21	Overall how do you rate the service you received today?	Excellent [ ] Good [ ] Fair [ ] Poor [ ] NA [ ]
22	*Do you have any other comments you would like to make on how services could be improved?*	

Thank you very much for giving us your time !

DISCHARGED IN-PATIENTS QUESTIONNAIRE

Final version

Health facility:		**Date:** dd/mm/yyyy	**Sex: M adult / F adult M child / F child**	**No:**	

Hello, we are conducting a survey with patients of this health facility to find out what you really think about this health facility. We want your honest answers to help us improve our services to you and future clients. Your answers are strictly confidential and we thank you for your participation and honesty.

How long were you on admission? _____days

1	What do you think about the state of:	
1a)	Cleanliness of the wards:	Very clean [ ] Clean [ ] Dirty [ ] NA [ ]
1b)	Bed sheets:	Very clean [ ] Clean [ ] Dirty [ ] NA [ ]
1c)	Bathrooms:	Very clean [ ] Clean [ ] Dirty [ ] NA [ ]
1d)	Toilets:	Very clean [ ] Clean [ ] Dirty [ ] NA [ ]
2	Did you receive all the drugs prescribed for you in the hospital pharmacy while you were on admission?	Yes [ ] No [ ] NA [ ]
3	Were you satisfied with the way the drugs were administered to you?	Very satisfied [ ] Satisfied [ ] Not satisfied[ ] NA [ ]
4	Who administered your drugs?	Nurse [ ] Relatives [ ] Someone else [ ] NA [ ]
5	How did you find the cost of drugs?	Not too expensive [ ] Too expensive [ ] NA [ ]
6	What is your view of the cost of medical treatment in this hospital?	Not too expensive [ ] Too expensive [ ] NA [ ]
7	Did you have adequate privacy for toileting whilst on the ward?	Yes [ ] No [ ] NA [ ]
8	Was a screen used when doctors or nurses were doing clinical procedures?	Yes [ ] No [ ] NA [ ]
9	How satisfied were you with the tests you had while on admission?	Very satisfied [ ] Satisfied [ ] Not satisfied[ ] NA [ ]

10	Were you thoroughly examined by the doctor while on admission?	Yes [ ] No [ ] NA [ ]
11	Did the doctor tell you what is wrong with you?	Yes [ ] No [ ] NA [ ]
12	Did the doctor see you every day while you were on admission?	Yes [ ] No [ ] NA [ ]
13	What do you think about the attitude/behaviour of the doctor?	Very good [ ] Good [ ] Poor [ ] NA [ ]
14	Were you satisfied by the information given to you by the doctors?	Very satisfied [ ] Satisfied [ ] Not satisfied[ ] NA [ ]
15	How did you feel about the meals you received while on admission?	Very good [ ] Good [ ] Not good [ ] NA [ ]
16	Did you get enough to eat?	Yes [ ] No [ ] NA [ ]
17	How was the noise level on the ward?	Quiet [ ] Reasonable [ ] Too loud [ ] NA [ ]
18	While on admission, was there a time when the nurses had to call for a doctor for you in an emergency?	Yes [ ] No [ ] NA [ ]
19	If YES, were you promptly seen by the doctor?	Yes [ ] No [ ] NA [ ]
20	Did nurses attend to you promptly when you called for services?	Yes [ ] No [ ] NA [ ]
21	What do you think of the attitude/ behaviour of the nurses?	Very good [ ] Good [ ] Poor [ ] NA [ ]
22	What do you think of the attitude/ behaviour of the other hospital staff?	Very good [ ] Good [ ] Poor [ ] NA [ ]
23	Did you suffer from bedsores while in hospital?	Yes [ ] No [ ] NA [ ]
24	Did you observe preferential treatment to others while on admission?	Yes [ ] No [ ] NA [ ]
25	Were you told whether or not to return to the	Yes [ ] No [ ] NA [ ]

	hospital?	
26	Were you given any medicine to take home?	Yes [ ] No [ ] NA [ ]
27	If YES, do you understand how to take the medicine?	Yes [ ] No [ ] NA [ ]
28	Did your relatives have adequate sleeping facilities while you were on admission?	Yes [ ] No [ ] NA [ ]
29	If you were ill again would you like to be admitted in this hospital?	Yes [ ] No [ ] NA [ ]
30	Overall, how do you feel about services in this hospital?	Very satisfied [ ] Satisfied [ ] Not satisfied[ ] NA [ ]
31	*Do you have any other comments you would like to make on how services could be improved?*	

Thank you very much for giving us your time!

Appendix 3: NRHM community report and facility score cards

The NRHM community report card and facility score cards monitor performance in 17 key areas. These are outlined in the table below.

	Themes	Source of Information
1.	Disease surveillance	Group discussions with community members
2.	Curative services	Group discussions with community members
3.	Untied funds[30]	Group discussions with community members
4.	Child health	Discussion with women
5.	Quality of care	Discussion with women
6.	Community perceptions of VHW (ASHA)	Discussion with women
7.	Adverse outcomes or experiences report[31]	Interview with women and group discussions
8.	Maternal health guarantees	Interview with JSY (cash transfer) beneficiary
9.	Janani Suraksha Yojna (JSY)[32]	Interview with JSY (cash transfer) beneficiary
10.	Functioning of VHW (ASHA)	Interview with ASHA
11.	Equity Index	Discussion with marginalized women
12.	Infrastructure and personnel	Facility Check List
13.	Equipment and supplies	Facility Check List
14.	Service availability	Facility Check List
15.	Unofficial charges	Exit interview with clients
16.	Quality of care	Facility Check List
17.	Functioning of Rogi Kalyan Samiti[33]	Interview with Medical Officer

Examples of some of the questions used in the community report card can be found below. The first example relates to the services provided by outreach personnel and are questions asked in a group discussion. The second example relates to the functioning of a community volunteer health worker (ASHA). These questions are also directed to group discussion participants. The third example relates to 'maternal health guarantees'. These questions are targeted to women who have recently delivered.

[30] Every sub-health centre gets a grant of 10,000 rupees for 'local health action'. The funds are kept in an account managed by the Auxillary Nurse Midwife and the head of the Gram Panchayat.
[31] Women experiencing maternal danger signs, or infant/child/maternal mortality or similar.
[32] Conditional cash transfer scheme that aims to increase institutional deliveries.
[33] Hospital Patient Welfare Committee/Hospital Management Society.

Example 1: Curative Services Provided by Outreach Personnel

No.	Questions	Responsibilities of Functionaries	Response	Score
1.	Did you receive tablets for fever, cough, diarrhoea, from the ANM or ASHA?		Everyone: 2 Some people: 1 None: 0	
2.	Do TB patients in your village receive regular medication from ANM or ASHA?		Everyone: 2 Some people: 1 None: 0	
3.	Does ANM or ASHA organise a health day in your village regularly?	Organising a health day at Anganwadi centres[34]	Everyone: 2 Some people: 1 None: 0	
4.	In the event of accident do you regularly get first aid treatment in your village	Providing first aid for accidents and emergencies	Everyone: 2 Some people: 1 None: 0	
5.	Do you regularly get anti-malarial tablet from ANM or MPW?		Everyone: 2 Some people: 1 None: 0	
6.	Did ANM pr ASHA refer someone to PHC or CHC for serious illness?		Everyone: 2 Some people: 1 None: 0	
Total Score (Maximum = 12)				

[34] Childcare centres.

Example 2: Community Perspectives on Functioning of VHW (ASHA)

No.	Questions	Responsibilities of Functionaries	Response	Score
1.	Does ASHA provide counselling on care during pregnancy, newborn care etc?	ASHA should advise community members regarding care during pregnancy, newborn care etc	Yes: 2 Irregular: 1 No: 0	
2.	Does the ASHA accompany women to the hospital?	ASHA should accompany women for institutional delivery	Yes: 2 Irregular: 1 No: 0	
3.	Does the ASHA visit households of women who delivered within six hours?		Yes: 2 Irregular: 1 No: 0	
4.	Does the ASHA organise monthly health day for immunisation and other health services		Yes: 2 Irregular: 1 No: 0	
5.	Does the ASHA provide medicines for simple illnesses like fever, diarrhea, cough etc?	ASHA should provide first contact care for simple illnesses at the hamlet level	Yes: 2 Irregular: 1 No: 0	
Total Score (Maximum = 10)				

Example 3: Maternal Health Guarantees

No.	Questions	Response	Score
1.	Did ANM register your name after pregnancy was confirmed?	Yes: 1 No: 0	
2.	Did ANM examine your BP and abdomen at least four times prior to your delivery?	Yes: 1 No: 0	
3.	Did ANM give you red tablets?	Yes: 1 No: 0	
4.	Apart from the red tablets, was any other tablet given to you?	Yes: 1 No: 0	
5.	Did ANM give you a TT injection?	Yes: 1 No: 0	
6.	Did ANM examine your blood and urine?	Yes: 1 No: 0	
7.	Has ANM referred you to PHC or CHC for delivery?	Yes: 1 No: 0	
8.	Has TBA or ASHA attended you for a home delivery?	Yes: 1 No: 0	
9.	Ha ANM visited you at least once after your delivery?	Yes: 1 No: 0	
10.	Did you receive regular dietary advice from ANM?	Yes: 1 No: 0	
Total Score (Maximum = 10)			

A comprehensive set of report card questions, and samples of facility checklists can be found in the document *Implementers Handbook for Community Monitoring to Improve Health Services*, Ministry of Health and Social Welfare, Government of India (no date).

Appendix 4: Results from Malawi LIFH community Scorecard Process

A. Results from Chakuzamutu Cluster of Villages

1. Positive Attitude of Staff

No.	Indicators	Scores (out of 100)		Comments and Reasons
		August 2002	March 2003	
1.1	Punctuality of staff	50	60	• They start late, but work during the lunch time and after hours • There is some improvement in time keeping
1.2	Polite behaviour	40	50	• There is one health worker who shouts at us when children urinate or we sit at the wrong place • There is some improvement in staff attitude
1.3	Listening to patients' problems	50	85	• They give us a chance to explain our problems • People are now free to express themselves to the health workers
1.4	Respect for patients	25	95	• There is more respect these days than was the case previously • Everybody is given due respect
1.5	Respect for patients' privacy	70	75	• We have never heard health workers reveal patients' 'sensitive' health conditions to others • They keep secrets about our health conditions
1.6	Honest and transparent staff (in terms of dealing with drugs, food, etc)	2	45	• At least they give a picture of the situation in general although no exact figures are disclosed • At least these days we are informed that nutritional supplements like soya have been delivered at the health centre • They have started writing on the notice board to inform us about drug and other supplies availability, however others are not able to read

	Overall score	**45**	**50**	• **Generally, the attitude of staff has changed except for two health workers who are still rude to patients**

2. Management of the Health Centre

No.	Indicators	Scores (out of 100)		Comments and Reasons
		August 2002	**March 2003**	
2.1	Cleanliness	70	85	• The health centre is always clean • Things have changed at the health centre; the surroundings are well maintained and the rooms are mopped
2.2	Observing working hours	40	60	• They open on time but come late after lunch
2.3	Giving priority to serious cases	30	70	• Those who are seriously sick are given priority attention with other patients' consent
2.4	Short waiting time for consultation	45	45	• The waiting time is always long because the same person is responsible for diagnosing and dispensing drugs • Sometimes they allow those who have come later to be attended to first thereby delaying those who came earlier
	Overall Score	**50**	**75**	• **The health centre is clean** • **Patients are treated on first-come first-serve basis**

3. Quality of Services

No.	Indicators	Scores (out of 100)		Comments and Reasons
		August 2002	March 2003	
3.1	Adequate supply of drugs	25	40	• Drugs are not always available but better than before • The drugs are not always available due to increased service utilization
3.2	Adequate equipment	20	30	• Although the health centre has been upgraded, there are no admission wards and other rooms are not yet functional • Some services are not available e.g. dental, surgery and blood transfusion • The health centre still lacks some equipment
3.3	Adequate and qualified staff	15	40	• The health workers are qualified but inadequate • The health workers are not adequate but they are dedicated
3.4	Emergency services available 24 hours	10	15	• Serious cases do not get the treatment they deserve • There are no admission wards for serious cases
3.5	Providing multiple services every day	75	85	• Antenatal and under five clinics are also available apart from outpatient services
3.6	Emergency transport services	2	2	• We do not benefit from the ambulance service • The ambulance is not based at the health centre and it is responsible for several health centres • It is as good as having no ambulance at all
3.7	Communication facilities (telephone, wireless radio message)	75	75	• At least a telephone is available
	Overall score	**35**	**50**	• **Services have changed because most health workers have a positive attitude towards patients** • **Women are also treated nicely at family planning and antenatal clinics**

Equal Access to Health Services

No.	Indicators	**Scores (out of 100)**		**Comments and reasons**
		August 2002	**March 2003**	
4.1	No discrimination in providing drugs to patients	30	45	They try to treat patients equally although some health workers still favour friends and relatives
4.2	No discrimination in providing supplementary nutrition	35	55	There is equal distribution of the food There is no favouritism
4.3	No preferential treatment	35	45	Some health workers still give priority to friends and relatives
4.4	Maintaining a first come –first serve policy	25	70	Things are now better because patients are given numbers for their position on the queue
4.5	Two way communication and dialogue between communities and the health centre		30	At least we are in touch with health workers (HSAs) since they visit us frequently They also communicate through the health centre and village health committees
	Overall score	**25**	**50**	**Patients are treated equally, even malnourished children receive equal shares of supplementary food**

B. Results of Provider Scorecard

1. Positive Attitude of Staff

No.	Indicator	Scores		Comments and Reasons
		August 2002	**March 2003**	
1.1	Observing official working hours	20	40	Field workers are usually punctual but nurses and clinicians are not always so There is a slight change but some nurses stay off campus and therefore not always punctual If work is extends into lunch hour, you can not expect health workers to come back from lunch on time
1.2	Polite behaviour		60	Some health workers are polite
1.3	Interaction among health centre staff		80	Frequent meetings are conducted Even those who stay far away are in touch, and informed
1.4	Open and approachable staff	20	40	Communities still complain about a few health workers
	Overall score		**60**	There are a few members of staff who are rude to patients

2. Management of Health Centre

No.	Indicator	Scores		Comments and Reasons
		August 2002	**March 2003**	
2.1	Health centre cleanliness	50	60	Community services people usually clean the surroundings
2.2	Availability of rules to guide staff cooperation	45	60	Some rules, guidelines and procedures are in place
	Overall score		**60**	The grounds are not well maintained (grass not cut)

3. Quality of Services

	Indicator	Scores		Comments and Reasons
		August 2002	**March 2003**	
3.1	Adequate drugs available	50	60	Sometimes stock outs are experienced
3.2	Adequate drugs given to patients		60	Drugs are provided according to the condition when they are available
3.3	Adequate number of staff	50	50	There has been no change
3.4	Qualified staff	75	75	There has been no change in the skills of staff
3.5	Proper treatment of patients	50	70	Patients are assisted according to their needs
3.6	Proportion/number of		60	Not all patients visit the hospital

	Indicator	Scores		Comments and Reasons
		August 2002	**March 2003**	
	catchment population using the facility			
3.7	Availability of adequate food for patients	45	30	There are frequent stock outs, which can take up to three months to replenish
	Overall score		**70**	Patients are provided adequate attention and assistance

4. Relationship with Users

No.	Indicator	Scores out of 100		**Comments and Reasons**
		August 2002	**March 2003**	
4.1	Reception of patients	40	60	There is some improvement in the reception although a few staff are not very friendly
4.2	Frequent meetings among health centre staff, VHC and HCC		40	Meetings are conducted regularly, except in situations when programmes clash
4.3	Positive relationship between staff and users		30	Communities do not seem to appreciate the aim of some of the services provided (e.g. nutritional supplements) as such they tend to demand too much from health workers Some patients have their own expectations about the type of treatment and feel dissatisfied when these are not met
	Overall score		**40**	Patients have a good relationship with the health workers. Patients that come during the night are also attended to.

5. Infrastructure and Equipment

No.	Indicator	Scores		Comments and reasons(s)
		August 2002	**March 2003**	
5.1	Availability of good and safe water		100	There is a bore hole as well as tap water
5.2	Availability of transport	20	20	There is no improvement at all since there is only one ambulance serving seven health centres
5.3	Adequate number of staff houses	50	60	A few more houses have been constructed but not yet adequate
5.4	Adequate toilets, kitchen and guardian shelter		40	These are available but most of them not yet in use since they have not been handed over
5.5	Availability of beds and beddings		0	These have not yet been supplied since the maternity unit is not yet operational There are no in patient wards at the health centre which could require the beddings
5.6	Adequate space	50	50	Some services still have no adequate space (e.g. immunization)
5.7	Availability of communication facilities		80	A telephone is available but can not be fully utilized for referral purposes, especially calling for an ambulance Radio communication with other health centers and the ambulance can only be done through the District Health Office
	Overall score		**50**	Generally facilities have been rehabilitated and new ones provided, but most of them are not in use yet Inadequate staff housing

6. Staff Incentives

	Indicator	Scores		Comments and Reasons
		August 2002	**March 2003**	
6.1	Promotion opportunities for staff	5	5	There have been no promotions in the last six months
6.2	Provision of allowances for overtime	50	50	The same rate/amount is given
	Overall score		**30**	Most staff members do not have uniforms (e.g. HSAs) Community health workers lack transport Health workers lack most supplies to effectively perform their duties

Note: Overall scores for the six categories of indicators were not given in August 2002.