Four models of community-based monitoring: a review

A report prepared for the Global Fund to Fight AIDS, Tuberculosis and Malaria

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Executive summary

This report has been commissioned by the Community, Rights and Gender Department, at the Global Fund to Fight AIDS, Tuberculosis and Malaria, to scope the current state of knowledge regarding Community Based Monitoring (CBM) mechanisms. CBM is a process by which service users or local communities gather and use information on service provision or information on local conditions impacting on effective service provision, in order to improve the quality of services and hold service providers to account. Literature searches (including peer-reviewed and grey literature) and consultation with experts provided the sources. The report (i) introduces the rationales for CBM; (ii) outlines a typology of 4 CBM models, (iii) assesses the evidence for CBM; (iv) assesses the strengths and weaknesses of the different models, and (v) introduces principles for successful implementation of CBM.

(i) Rationales for CBM

Against a background history of top-down, paper-based, and donor-led accountability mechanisms, CBM is thought to advance four major goals:

- Capitalising on service users' experience of services: Service users have up-to-date experiential knowledge, and motivation to improve their services.
- Enabling community ownership and buy-in: Communities are more likely to engage with services that are responsive to their needs and demands.
- Creating local feedback loops and a learning organisation: CBM helps ensure that data is used intelligently to improve local services, not only to report to donors.
- Improving quality of services and health outcomes: As a result of the above processes, health services and health outcomes are expected to improve.

(ii) 4 models of CBM

Model 1: Downward accountability: Services incorporate mechanisms to allow service users to provide feedback, and for feedback to be acted upon (e.g. complaint-handling systems).

Model 2: Citizens as Service Delivery Watchdogs: Citizens are mobilised to provide independent monitoring of services (e.g. reporting stock-outs of essential drugs).

Model 3: Local Health Governance Mechanisms: Monitoring roles are given to existing formal health governance structures, which include community representatives (e.g. Local Health Councils).

Model 4: Social Audit: Community members are trained and supported to assess health facilities and hold public hearings in order to hold office-bearers to account. This is a comprehensive approach, incorporating a variety of tools and processes, in some cases government-mandated.

(iii) Evidence for CBM

There is a growing body of research providing evidence of the positive impact of CBM on health service uptake and health outcomes. Our review of the evidence also suggests close interplay of CBM and social context. Contextual conditions such as political will, health system support and representation of marginalised communities facilitate effective implementation of CBM. CBM, at the same time, can also reveal the absence or presence of necessary supportive contextual conditions, such as protection of human rights or good governance, and serve as a stimulus to policymakers to bring those conditions about.

(iv) Strengths and weaknesses

Downward accountability is relatively low-cost and simple to implement, involving procedures for gathering, interpreting and acting on community-generated intelligence. However, it can be challenging when the number of complaints received are high, requiring a labour-intensive process to make decisions about which complaints should be acted upon. The model is largely information-centric, limited to generating and processing of service-related information, and communities often lack specific measures and ability to hold service providers to account in taking appropriate action.

Citizens as service delivery watchdogs can mobilise independent monitoring and gain public attention. Although the recent explosion in Information Communication Technologies (ICTs) has further propelled innovation in such citizen-based initiatives, lack of access of ICTs among marginalised communities continues to pose a challenge to mainstreaming such approaches. The ability of citizens to report issues is not always matched with a corresponding ability to demand or enforce a response. To be effective, this approach needs to incorporate routes to securing action in response to problems identified.

Local health governance mechanisms have formal status and thus have routes to concrete and impactful action. However, they can be weak on the inclusion of marginalised groups, and can be slow to initiate change.

Social audit is a comprehensive model of CBM, from gathering data to making that data heard. When it is government-backed, it has 'teeth'. However, it can be resource intensive and risks creating adversarial relationships between communities and service providers.

(v) Principles for successful implementation

Based on the available body of theory, experience and evidence regarding CBM, we derive five main principles for successful CBM:

- CBM is not treated as an isolated, add-on or one time activity, but part of regular programmatic activities
- Monitoring is backed up by mechanisms to implement required changes and political will
- Local priorities are monitored
- There is proper representation and inclusion of disadvantaged communities (women, sexual minorities)
- There is clarity and consensus on the roles, authority/mandate, and functions of the actors involved

Chapter 1: Introduction, definition and rationale

Community-based monitoring defined

Participatory and community-based health programmes have now become established areas of work in the field of Global Health. Increasingly, Community-based Monitoring (hereafter CBM), which draws on the long tradition of Participatory Rural Appraisal (PRA) and more recently Participatory Monitoring and Evaluation, has also gained currency amongst Global Health actors (Estrella & Gaventa, 1998). Despite its increasing appeal, there is no generally accepted definition of CBM. A wide range of terminologies, ranging from community-based monitoring, community-centric monitoring, community-led monitoring, community-based performance monitoring, participatory monitoring and evaluation, citizen monitoring, proliferate in the works of international agencies.

The Accountability and Monitoring in Health Initiative (AMHI) from the Open Society's Public Health Program defines community monitoring in health as follows:

"Systematic documentation and review of the availability, accessibility and quality of health services against specific government commitments or standards by actual beneficiaries of services, for the purpose of doing advocacy with providers and policy makers to improve the services" (in Accountability and Monitoring in Health Initiative, 2011, p.7)

The above definition primarily views community monitoring in terms of government accountability and its commitments towards citizens' demands for services. Garg and Laskar (2010) define CBM as follows:

"Community-based monitoring involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community-based organizations (CBOs), people's movements, voluntary organizations and Panchayat[1] representatives, to directly give feedback about the functioning of public health services. The community monitoring process will involve a three-way partnership between healthcare providers and managers (health system); the community, community-based organizations, NGOs and Panchayati Raj Institutions. The emphasis will be laid on the developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'."

The authors' definition of CBM here relates to a specific health intervention, the National Rural Health Mission, India. Although this definition is very comprehensive, it makes reference to a number of complex activities and expected outcomes, together with context-specific structures such as Panchayat institutions for CBM to attain its desired outcomes. It therefore calls for a definition that is generally applicable.

> "Systematic documentation and review of the availability, accessibility and quality of health services against specific government commitments or standards by actual beneficiaries of services, for the purpose of doing advocacy with providers and policy makers to improve the services"
>
> *in Accountability and Monitoring in Health Initiative, 2011, p.7*

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[1] In India, Panchayats represent constitutionally-mandated system of governance that function as basic unit of local administration. The focus of these institutions is to promote decentralised and participatory local self-government, along with accountability and efficient delivery of services at the local level.

In simple terms, CBM may be understood as a mechanism enabling service users or local people to gather and use information on service provision or local conditions in order to improve services and hold service providers to account. For a practice to be called CBM, community or service user engagement is crucial in the service of at least one of two important goals:

- **Monitoring of health services**: Community members monitor the flow of health services and resources. The objective here is to ensure regularity and availability of day-to-day service delivery i.e. coverage, availability, accessibility and quality of health services in question. Often times, the communities also exercise oversight over the use and allocation of health resources, namely operational funds, stock of inventory, performance of health staff. They engage in identifying and documenting gaps and discrepancies in service provision and through appropriate mechanisms, provide data to service providers to make informed decisions surrounding service delivery.

- **Monitoring of local conditions:** At the second level communities are engaged in monitoring of local conditions or barriers that undermine or hinder the delivery of health services. Monitoring of the overall situation of human rights, incidents of human rights abuses, gender-based violence, stigma and discrimination, criminalisation of sex work, discriminatory drug policies, poverty and homelessness facing marginalised communities, are typically the areas that communities keep close oversight over.

To be effective, the 'monitoring' part of CBM needs to be accompanied by responsive action. Some authors write about communities having 'voice' – i.e. being able to speak up and present important information, but authorities needing to have 'ears' – i.e. hearing the concerns being raised (Campbell, Cornish, Gibbs & Scott, 2010). Other authors write about monitoring needing to have 'teeth' – i.e. that information raised is acted upon, concerns are enforceable (Fox, 2015). So CBM requires these dual processes: (i) mechanisms to allow communities to exercise their 'voice' and (ii) mechanisms to ensure authorities are compelled to act on this important information.

Rationale for CBM

CBM's increasing popularity may be attributed to the growing realisation among development actors that the more traditional, so-called top-down model of monitoring provide inadequate accounts of the local realities. They tend to be 'paper-based' rather than 'experience-based', and largely owned and steered by implementing agencies/development actors, rather than user communities. They rely more on progress reporting for stakeholders up the aid chain, namely government agencies or donors, based on a pre-defined format, indicators, milestones and criteria. This, on the one hand, makes the entire system slow and unresponsive to changing local conditions; on the other hand, the potential for community ownership is jeopardised owing to limited power on the part of communities to produce, process and act upon local realities.

CBM has the potential to overcome the aforementioned limitations through its ability to:

- **Capitalise on service users' experience of services;** communities with their on-the-ground presence have intimate knowledge and experience of how health services take place. For communities, participating in monitoring of services is more than a task. As users

of services, nobody is more motivated and uniquely situated than local communities to ensure that health services are routinely available and of good quality.

- **Enable ownership & buy-in among the community:** community oversight is critical to the long-term sustainability of services. Whether CBM is fully initiated by communities ("organic CBM"), or induced by external agencies ("induced CBM"), communities are more likely to engage with services if they know they have the opportunity to identify and report on discrepancies in availability and quality of services, and recommend corrective measures (for more on organic and induced participation, see Mansuri & Rao, 2013)[2]. CBM also fosters community ownership by offering communities a means of keeping track of and deliberating upon issues that matter to them.

- **Create local feedback loops & a learning organisation:** traditional, expert-driven monitoring models typically comprise a complex and multi-layered process of data collection and decision making. Large amounts of data are collected at the local level and reported to the centre in rigid frameworks and tools designed more to ensure financial accountability than service improvement. While it can provide useful data on expenditures and control, this system is less suitable in enabling the service provider to become a learning entity with the capacity to adapt swiftly to changing local conditions and to use locally produced data for innovation and systemic improvements. CBM helps to address this limitation by offering a shorter feedback loop where locally generated information is analysed and, wherever relevant, acted upon at the local level, without every problem having to travel to distant centres (e.g. ministries, departments, I/NGO headquarters) for resolution. The data so gathered also helps reveal broader patterns that might require a structural/policy level response (for more on feedback, see Jacobs, Barnett, & Ponsford, 2010).

Chapter 2: Models of CBM

While multiplicity in approaches to CBM are noted, below we present a typology of 4 forms of CBM that represent extant practices of CBM in health sector. We provide a general overview for each of the models with their overall rationale, and highlight key methods/activities under each model, illustrated by corresponding examples.

Model 1. Downward accountability

Downward accountability, also commonly known as accountability to communities or service users may be understood as a formal mechanism through which service users or communities can exercise voice over the practices of implementing agencies or service providers, and the implementing agency is expected to justify its actions (Andrews, 2014). Save the Children's Myanmar Programme, for instance, defines accountability to communities as , "making sure that the children and families we work with, and for, really do have a say in every aspect of what we do – planning, implementing, monitoring and evaluating" (Save the children, 2013, p.2). This definition considers CBM encompassing more than a monitoring role by communities but having their voice in contributing to overall project management.

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2 Mansuri and Rao (2013) define organic participation as those spurred by civic groups acting independently of, and often in opposition to, government. Induced participation, on the other hand, are promoted by the policy actions of the state, and implemented by bureaucracies.

In general, downward accountability draws on twin principles: a) communities (as claimants) have rights to be heard about planning and delivery of service provisions; b) service providers (as duty bearers), in turn, are obliged to listen and respond to those voices, particularly those that represent communities' dissatisfaction about services. The service provider enters into an explicit or implicit understanding to collaborate with communities along three main dimensions: a) information sharing (e.g., who is the implementer, how it is being implemented, what resources are used, what are intended goals, who are being targeted etc), b) early detection of problems in service delivery (e.g., interruption of services, staff misconduct, concerns over service quality, misappropriation of resources) based on communities' feedback/complaints and, c) taking corrective actions on the activities that are seen as deviating from the original service goals.

The model fits the definition of 'induced accountability', as it is largely initiated and administered by the service provider or implementing agency. Major decisions surrounding what forms of information or feedback/complaints will be sought and entertained, how and when are they processed or acted upon, chiefly rest in the hands of the service provider.

This model typically covers practices/methods such as community hotlines, community information boards, grievance redressal systems, and complaint handling systems. In some cases, the model may also combine more than voice-based activities and include spot-checks and local advocacy, as evident in World Vision's example below.

Key implementation methods/activities:

- Community display boards
- Community hotlines
- Complaints and response mechanisms via email, website, in-person, or complaint/suggestion boxes
- Grievance redressal system, often involving user management committees, or health management committees
- Community meetings
- Spot-checks and monitoring visits by community members
- Beneficiary feedback systems or Community Perception Surveys

"making sure that the children and families we work with, and for, really do have a say in every aspect of what we do — planning, implementing, monitoring and evaluating"

Save the children, 2013, p.2

Downward accountability illustrated

Complaint Handling System (or Grievance Redressal System)
Who implements it? International development agencies, including Save the Children, Care International, Oxfam, World Vision, Action Aid. Specific terminology for the system varies from one INGO to another. Public sector organisations in many countries have also introduced different forms of complaint lodging and monitoring systems.

How does it work?

- A display board or flyer is mounted at or near a service delivery point with information about the service provider, and the process by which complaints or feedback, if any, may be lodged. In some instances, display board contains up-to-date information on performance indicators and community score cards.

- Local communities have an option to lodge their complaints or feedback either through phone, email or in-person meeting with the staff of implementing organisation.

- Concerned service provider collects and assesses complaints based on certain pre-defined criteria.

- Nature of complaints is classified as serious/sensitive complaints and regular/insensitive complaints.

- Service providers are expected to act upon sensitive complaints (e.g. staff misconduct, sexual harassment, misuse of resources) instantly, while those classified as non-sensitive/regular complaints may either be referred to other agencies, or if deemed invalid, excluded from further processing. .

Citizen Voice and Action
Who implements it? World Vision
How does it work?

- The approach is explicitly defined as one that is expected to serve as a replicable and sustainable approach to downward accountability

- Combines three activities of community-based data collection, awareness raising (e.g. right to health) and community-led advocacy.

- Communities carry out spot-visits, to measure whether their clinic complies with these government's service standards (e.g. availability of midwife at local clinic).

- Communities convene a collaborative, town-hall style meeting where citizens have the opportunity to engage their governments, identify problems, and design a plan of action to improve their health services.

Model 2. Citizens as service delivery watchdogs

This model comprises citizen groups who are primarily engaged in monitoring and addressing systemic problems affecting public service delivery/institutions (e.g. corruption, lack of transparency and accountability, disregard of citizens' voices and entitlements, policy and programmatic gaps). The origin of this model of CBM may be traced to various forms of spontaneous citizen movements, coalition groups, and rights-based movements. In due course, such movements may assume a formal character by integrating themselves into government or donor initiatives, or mobilising resources from external sources. In that sense, the model combines features of both organic and induced accountability.

The citizen group that make up this model may not necessarily comprise the actual service user / beneficiary / key population. Wider networks, volunteer groups, NGOs, rights-based coalitions who share a common vision (e.g. rights to health), may take on the task of representing the issues of the key affected populations, particularly those representing historically disadvantaged or excluded communities. The model seeks to capitalise on both needs- and rights-based approaches to health. User communities or their representative organisations use different channels to express their evolving service needs and preferences. They also exercise their rights as citizens or service users to demand improved services and systemic reforms, and hold the service providers accountable to previously held service standards.

Activities range from reporting on healthcare provisions through web-based/sms-driven technology and peer outreach to monitor service delivery context (e.g. incidence of stigma and discrimination, police violence), to building larger coalitions/networks aimed at advocating for policy reforms (e.g. ARV accessibility). Often times such initiatives are long-standing, not "stand alone" interventions, and almost always have a strong community education and mobilisation component (e.g. awareness raising, health literacy, advocacy and sensitisation programmes).

Key methods/activities

- Web-based or sms-based reporting on service provisions (e.g. concerns over availability and stocks of medicines, staff misconduct/absenteeism, misuse of resources etc.)
- Peer outreach by affected communities to monitor and report on context (e.g. sex workers monitoring and reporting on physical/sexual abuse by police or brokers, stigma and discrimination facing marginalised communities, citizens monitoring implementation of national health strategy etc.)
- Activism and advocacy, either by affected communities or their representative groups, both real activism/movements (advocacy and sensitisation) and virtual activism (web-based, online); targeted at both national and global level.
- Community driven operational research, health education/literacy and sensitisation programmes.

Citizens as service delivery watchdogs illustrated

Community Treatment Observatories
Who implements it? International Treatment Preparedness Coalition (ITPC)
Active in: East Africa, West Africa, Central Africa, Latin America
How does it work?

- Keep a check on ARV supply drugs

- Alert mismanagement of drug supplies and stock-out

- Support or lead operational research e.g. community-led research in Jamaica has documented out-of-pocket expenses incurred by People Living with HIV in their effort to access and adhere to treatment (ITPC, 2014).

- Represent/participate in policy reform processes.

Citizens Health Watch Zimbabwe (CHW), Zimbabwe
How does it work?

- Functions as a citizen-centred platform for debate, information sharing and monitoring of Zimbabwe's health delivery system.

- Operates under six broad clusters of activities: Health Delivering Monitoring Matrix, Health Information for All, Medicines Use Awareness Programmes, Health Innovation Forums, Media Monitoring on Health Information Coverage, Advocacy Campaigns.

- Organises both face-to-face discussion forums between community monitors and policy makers, and technology enabled citizen-government engagements (through telephones, websites, social, electronic and print media)

Model 3: local health governance mechanisms

These represent formal community structures, linked to one or more health facilities or service delivery points at the local level. Their origins and evolution may be traced to a previous history of community organising, community-development, or participatory planning. These mechanisms perform critical oversight over the operations of the concerned facility or facilities. Beyond community monitoring, they may be engaged in decision making processes over mobilisation and disbursement of funds, hiring and appointment of local health staff, procurement and distribution of medicines, among others. This model seeks to address insufficiencies in other forms of CBM that primarily rely on voice-based solutions to community problems, without communities having proper means and guarantee of enforcing CBM outcomes (e.g. imposing sanctions upon local health workers for continual neglect of community grievances).

Local health governance mechanisms are expected to serve as a representative body to the larger community in which they are embedded. Participation of disfranchised communities in these committees/structures is therefore critical to its overall goal. Many of these structures also demand representation of service providers in order to make service providers and communities mutually accountable to each other. Several countries now have these kinds of local mechanisms mandated/endorsed by the government as part of the strategy of health sector decentralisation. In others, they operate within the frameworks of community mobilisation or community empowerment initiatives, supported by donor agency. Having roots in community-driven, participatory movements but with

support from bureaucracies, the model fits the definition of both induced and organic accountability. Activities of these mechanisms range from regular meetings to discuss community level health issues, to providing operational support in organising other CBM activities (e.g. public hearings, social audits, and community charters), and being represented in national or regional policy deliberations.

Key methods/activities

- Organise meetings to discuss community level issues, problems of health use and disbursement of funds, procurement of medicines, and appointment of health staff.
- Advisory and operational support in organising social audit activities, public hearings
- Serve as representatives in national policy making discussions (advisory role)

Local Health Governance Mechanisms Illustrated

Community Health Committees/Rural Health Committees/ Dispensary Management Committees
Where active: Kenya, promoted/endorsed by Ministry of Health, Kenya
How do they work?

- Oversee the general operations and management of the health facility

- Advise the community on matters related to the promotion of health services

- Represent and articulate community interests on matters pertaining to health in local development forums

- Facilitate a feedback process to the community pertaining to the operations and management of the health facility

- Facilitate mobilisation of external and community resources towards the development of health services within the area

- Lead in advocacy, communication and social mobilisation

- Monitor, evaluate and report on the community work plan.

Pehchan Crisis Response Teams
Where active: Several states of India
Who implements it? Community-based Organisations led by men who have sex with men and other sexual minorities (with support from International HIV/AIDS Alliance)
How do they work?

- Monitors, verifies and documents individual cases of human rights violations e.g. violence by police and clients to female sex workers and other key populations

- Files police reports and takes legal actions

- Organises media sensitisation and other awareness programmes

Model 4: Social audit

Social audit or social auditing is another major form of CBM that is gaining in popularity. It may be understood as multi-pronged, combination model of CBM that leverages many of the features of the aforementioned models. Social audit represents a longer-term effort of improving local governance of health programmes, enhancing citizen involvement in planning and delivery of health services and promoting performance-based planning of health facilities. India, for instance, was one of the first countries to adopt a large scale, government-endorsed social audit as part of its rural health decentralisation strategy. It embodies a mandate of bringing public health system closer to user communities. Similar models are also adopted in other countries such as Nepal and Bangladesh. Many of these models, like the ones in India and Nepal, are also informed by the principle of state-non-state partnership, where independent non-state actors (representatives from local NGOs, CBOs) are 'outsourced' to facilitate certain steps in health-facility auditing (e.g. conducting exit interviews with patients, facilitation of public hearings). Given the pivotal role of the government in promoting and implementing activities under this model, it fits the definition of induced accountability.

As a multi-pronged approach, social audit spans a wide range of activities from communities or their representative organisations (e.g. local CBOs). It ranges from assessing performance of health facilities (community report cards), to providing space for communities to channel grievances/complaints (public hearings), and enabling the 'co-planning' of health facilities with the involvement of both local health authorities and community representatives (action planning by Health/Facility Management Committees).

Key methods/activities
- Setting up of oversight committee and hiring of independent social auditors (from local NGOs or CBOs).
- Observation visits by social auditors to assess performance of health facility, including regularity of services, availability of medicinal stocks, hygiene status, presence of health workers at health facilities
- Preparation of citizen report card on each health facility performance; it is expected to serve as a "diagnostic tool" for service providers and concerned others to identify problems or areas in need of improvement
- Public hearings: meetings of a wide range of community stakeholders to discuss the performance of one or more health facilities/projects. It is a forum where communities are able to done in the presence of local administrators (say, Local Development Officer, District Health Officer, Village Development Officials). Communities provide 'testimonies' of their experiences with the particular health facility. Service providers and other local authorities are expected to justify and answer questions raised by the communities
- Action planning for service improvements, either at the larger public hearings, or through subsequent organisation of a smaller 'interface meetings' between community representatives and service providers.

Social Audit Illustrated

Social Audit under India's National Rural Health Mission
What does it involve?
- Recruitment of local social auditors who typically are local NGO/CBO activists, or local civil society actors

- Assessment of health facilities. This ranges from taking stock of medicinal inventory, checking health system register and attendance sheets, conduct of focus groups and exit interviews with patients/service users.

- Preparation of facility reports in the form of community score card or community report card

- Public hearings where communities have opportunity to question service delivery provisions, lodge complaints and service providers are expected to justify their current and future actions

- Action planning to address ongoing service delivery problems

- Transfer of report to higher level authority (e.g. Ministry of Health) for planning

Care's Community Score Card
Where is it implemented? First launched/piloted by Care Malawi, now implemented in different countries.
What does it involve?
- Promoted and carried out with a principle of 'joint problem solving'

- Initial meeting and sensitisation about why it is done, what it involves

- Development and conduct of score card (i.e. assessment of health facilities, health personnel)

- 'Interface meetings' to report back (involving both service providers and community representatives)

- Joint action planning with the involvement of community representatives and implementing agency staff

Chapter 3: Summary of evidence on CBM

A growing body of evidence shows positive health and social outcomes associated with CBM in particular and social accountability in health in general. A study of public hearings in India found it to have provided women health service users with a critical space to demand improved maternal health services from health personnel (Papp, Gogoi, & Campbell, 2013). The study also draws attention to the deeply entrenched power and gender inequalities characterising marginalised communities, which may undermine the long-term implementation of CBM. It calls for sustained investments in CBM related activities. Another study of community score card intervention in the Ugandan health system was associated with improved child health outcomes and performance of health facilities (Bjorkmann and Svensson, 2009). Beyond the scoring component, this experiment also made efforts to engage local actors (CBOs, local health professionals) in the monitoring process, which arguably contributed to the improved service delivery outcomes. A systematic review of local health governance mechanisms found that health facilities/wards with health committees (HCs) had a significantly higher likelihood of health service use compared with those without HCs, as well as fewer cases of diarrhoea and greater use of outreach services (Lodenstein, Dieleman, Gerretsen, & Broerse, 2013). The study notes that such efforts are likely to yield positive health outcomes when implemented within pre-existing resources and community structures (e.g. self-help organisations).

Albeit limited in number, a few scholars have also raised caution against the use of CBM tools that do not adequately consider the local context of implementation. A study of a visual diary, a form of community-based monitoring tool, administered by female HIV outreach workers in Andhra Pradesh, was found to have fuelled division among sex worker communities. The study attributes this conflict to the rigid requirements of data collection and reporting processes, coupled with lack of consideration of the fluid nature of local sex work conditions Biradavolu, Blankenship, George, & Dhungana, 2015). Emerging evidence from social audit implementation in India points to the fact that even with nationally-mandated and standardised procedures, outcomes from such processes are far from being consistent across various contexts. Low representation of marginalised groups in the assessment of health facilities, as well as role conflicts among various actors in the processes have been observed (Kumar et al., 2013). This is suggestive of the pitfalls of the so-called top-down, externally-induced and standardised approaches to CBM, despite them having a higher potential in making an impact at scale.

The table below presents a summary of findings from a representative, not exhaustive, sample of research on CBM that form part of this review. The findings are representative of various models and activities of CBM, demonstrating key points, with discussions on corresponding outcomes and discussions on context of intervention.

Table 1: Summary of evidence on CBM and related field

Study	Location/ sector	Key findings/impacts	Challenges/contextual considerations
Bjorkman and Svensson, the Quarterly Journal of Economics, 2009; conducted a randomized field experiment (pre and post-intervention surveys) in 50 communities from nine districts in Uganda, with the primary objective of introducing community-based monitoring, including the use of citizen report cards, with facilitation from local NGOs.	Uganda	• At follow up, the communities exposed to CBM intervention ('intervention group') show a significant difference in the weight of infants—0.14 z-score increase—and 33 percent reduction in under-5 mortality. • Utilization of general outpatient services was 20 percent higher in the CBM intervention cluster, compared to the control facilities. • Treatment practices (e.g. immunization of children, waiting time, examination procedures, and absenteeism) improved significantly in the treatment communities.	• Beyond the introduction of citizen score card as monitoring tool, there was a wider process of engaging trained local actors (CBO representatives) who worked closely with the health staff in implementing this experiment. The Health Unit Management Committee (HUMC) role in serving as "link" between the community and the health facility was also critical. This implies introducing a tool of CBM, such as citizen score card, may not in itself guarantee improved services but it requires investment in community-based structures such as health management structure, community groups, and close working relationship and dialogue between community representatives and local health personnel.

Study	Location/ sector	Key findings/impacts	Challenges/contextual considerations
Papp et al., Global Public Health, 2013; qualitative study that seeks to identify the processes and psycho-social pathways through which social accountability is mediated, and to contribute to understandings of its potential in improving policy implementation and quality of care.	Orissa, India/ Maternal Health	• Public hearings (PH), as specific form of social accountability/CBM tool, served as critical space for women to be a) aware of their entitlements, b) confront local health authorities through direct complaints, and c) help public officials to change mind-set. • PH influential in leveraging intermediaries (e.g. journalists, celebrities), who in turn help maternal health issue to make it to policy agenda.	• Social exclusion, gender inequality, and deprivation require community-led accountability efforts to be not an isolated , one time event, but part of regular programmatic activities. • Potential reprisals from service providers to be considered in design/implementation of accountability tools that particularly involve marginalised communities.
Goncalves, World Development, 2013; analysed municipality panel data-set covering the whole of Brazil for the period 1990 to 2004 to analyse link between adoption of participatory budgeting, public expenditures and health outcomes.	Brazil/Infant Health	• Participatory budgeting linked to better allocation of resources on health-promoting priorities such as basic sanitation, anti-slippage measures, and waste removal. • Found a significant reduction in the infant mortality rates among municipalities that adopted participatory budgeting.	• Political commitment from local governments necessary for scaling up and larger impact.
Kumar et al., Indian Journal of Community Health, 2013; community based prospective study was conducted to assess the composition and training of Community Monitoring Groups (CMGs) and their capacity to prepare report cards for local health facilities.	Nainital, India	• Report cards and Facility score cards were prepared by CMGs once a year. • Public hearings (Jan-Sunwais) was also conducted once in a year at all sub-centres and PHCs.	• Irregularity in preparation of report cards, organisation of public hearings ('Jansunwais') and inconsistency in the way reports are completed. • Despite strong policy recommendations from NRHM, low representation of marginalised groups in CMGs • Inconsistencies in following national standards (e.g. lack of rotational representation)

Study	Location/ sector	Key findings/impacts	Challenges/contextual considerations
Kakade et al., BMC proceedings (2012); uses data from three rounds of community-based facility reporting to examine how CBM has contributed to improvement of local health services.	Maharashtra, India	• From 48% of health services rated as 'good' in Round 1, they increased to 61% and 66% in Rounds 2 and 3. • Immunisation improved from 69% rating as 'good' in Round 1, to 90% rating as 'good' in round three. • Health services by primary health centre (for example, 24-hour delivery services, in-patient services, laboratory and ambulance services etc.) improved.	• Wider community representation to address systemic and structural challenges to health. • Necessary to set acceptable accountability standards at all the levels of health system.
Lodenstein et al. Systematic Reviews 2013; conducted realist synthesis to assess the available evidence of the effect of social accountability interventions on providers' and policymakers' responsiveness in health service delivery and policymaking.	Low- or middle-income countries/ General Health	Studies included in the review highlighted improved health services/ outcomes via social accountability interventions including: a) Facilities/wards with health committees (HCs) had a significantly higher likelihood of health service use compared with those without HCs. b) Wards with HCs also had fewer cases of diarrhoea and greater use of outreach services, more staff; weekend outreach services for the most distant villages; medicines became more readily available.	• Clarity and consensus on the role(s), authority/mandate, and function(s) of community-based monitoring structures (e.g. Health Management Committees) important.
Molyneux et al., Health Policy and Planning, 2012; reviewed the available empirical literature on accountability mechanisms linked to peripheral health facilities.		Review highlights several health and community outcomes, including: a) Self-help groups involved in health monitoring led to fulfilment of unmet health needs, and better allocation of resources (Peru). b) Users complaints increased due to enhanced awareness of rights/entitlements (Zambia)	• Committee members closely related to one another, leading to poor handling of charges related to funds misappropriation. • Working through pre-existing community structures are found to be more sustainable, replicable and participation-inducing (Cambodia).

Chapter 4: Assessing suitability and applicability of CBM

In this section, the focus is to help readers make an informed decision about the applicability or suitability of each of the CBM models. The first table shows an assessment of the four models in terms of their intended service delivery impacts. CBM may contribute to improving the availability, accessibility, acceptability or appropriateness of health services. Table 2 assesses the degree to which each model may contribute to each of those goals. Table 3 summarises the key characteristics of each model. Table 4 assesses the strengths and weaknesses of each model.

Definitions of impact areas assessed in Table 2

1. **Availability** – tools, equipment, materials that are necessary to prevent individuals from being exposed to immediate health problems, which include sufficient supply and regularity in stock of medicines, sufficient health workers, with the competencies and skill-mix to match the health needs of the population (Blankenship, Bray, & Merson, 2000; "WHO | What do we mean by availability, accessibility, acceptability and quality (AAAQ) of the health workforce?," n.d.)

2. **Accessibility** – the equitable distribution of the health facilities (health personnel, commodities), taking into account the demographic composition, rural-urban mix and under-served areas or populations; also the social and institutional conditions, community structures, historical legacies, that facilitate or encourage the individuals to avail health services—these can range from social/structural issues such as gender norms, level of stigma and discrimination, human rights situation to health system specific issues such as travel time to health facilities, hours of operation, availability of referral services (Blankenship, Bray, & Merson, 2000; "WHO | What do we mean by availability, accessibility, acceptability and quality (AAAQ) of the health workforce?," n.d.).

3. **Acceptability** – health workforce characteristics and ability (e.g. sex, language, culture, age, etc.) to treat all patients with dignity, create trust and promote demand for services (WHO | What do we mean by availability, accessibility, acceptability and quality (AAAQ) of the health workforce?," n.d).

4. **Appropriateness**; fit between services and clients need, its timeliness, the amount of care spent in diagnosing health problems and determining interventions (Levesque, Harris, & Russell, 2013).

Table 2: CBM models by the intended impact areas

Models	Intended Impact Areas				Key Approaches	Examples
	Availability	**Accessibility**	**Acceptability**	**Appropriateness**		
Model 1: Downward accountability	High	Low to Medium	Medium to High	High	• Community hotlines • Complaint handling systems • Community feedback meetings	• Save the children's 'Complaint and Feedback Mechanism' • World Vision's 'Citizen Voice and Action' (See page 6)
Model 2: Citizens as service delivery watchdogs	Medium	High	Medium	Medium	• Web-based online monitoring/ reporting • Community-driven operational research (needs assessments etc) • Citizen charters • Advocacy and campaigns	• International Treatment Preparedness Coalition (ITPC), Community Treatment Observatories • Citizen Health Watch, Zimbabwe Stop stock-outs campaign
Model 3: Local Health Governance Mechanisms	Low to medium	High	High	Medium	• Participatory Budgeting and Procurement Tracking via Local Health Committees • Community Oversight Committees	• Community User Groups within Bamako Initiative (esp. in Benin, Guinea and Mali) • Local Health Councils, Brazil • Crisis Intervention Teams, Avahan the India AIDS Initiative
Model 4: Social audit	Medium	Medium	High	High	• Community Score Card • Public hearings	• Care's Community Score Cards • National Rural Health Mission, India

Table 2: Explanation

Downward accountability tends to perform better in ensuring supply of services is consistent with the pre-established service standards such as geographic outreach, target populations, mix and quality of services. By offering formal space for communities to channel voices, they also increase the likelihood of enhancing communities' trust and acceptability in overall services. Given their main focus on immediate service delivery, their potential in engaging with socio-institutional structures that facilitate or undermine health interventions, remain low to moderate.

Informed by the principles of community empowerment and rights-based approach to health services, citizen as service delivery watchdogs are more oriented to making services widely accessible and acceptable to communities. Experience in some settings has shown that simply creating platforms for citizens to raise issues and make them public may not be enough to lead to action, unless there are specific mechanisms in place to insist that action is taken. At community levels, citizen watchdog initiatives which ensure that some community members are trained and supported to act on information and demand action, have produced very positive results.

Local health governance mechanisms are expected to represent the interests of not just individual health users but the wider community. With the formal mandate of not just monitoring of and voicing concerns about health services but influencing decisions related to overall intervention context, they have a higher potential of improving accessibility and acceptability of services. However, they suffer from the same limitation as citizen as service delivery watchdogs. As a representative body involving different stakeholders, they may be slow in responding to the routine service delivery problems, and therefore perform low to moderate in the criterion of availability.

Social audits are typically aimed at improving local health governance, and introducing performance-based planning of health facilities. The outcomes of community-based rating of health facilities are expected to serve in revisions of service provisions that reflect the evolving community needs. It is also informed by collaborative approach to problem solving, encouraging involvement of both community representatives and frontline health workers. They have higher potential at building trust, acceptability and demand for local health services. Social audit often entails periodic, standardised, and time-consuming activities. Therefore, its impact in tackling routine service-related problems at the local level, and more critically ensuring regular supply of health services may be moderate to low. They also rank moderate in the criterion of accessibility because the agendas of performance-based management of pre-existing health facilities, may supersede the needs for addressing social-institutional barriers that undermine the performance of such facilities in the first place.

Table 3: CBM models by characteristics

Models	Voice/teeth	Top- down /bottom-up	Service Provisions/ Learning	Issues to consider
Model 1; Downward Accountability	Voice high Teeth low to medium	Top-down high Bottom-up low to medium	Service provisions high Learning low to medium	• Important to engage communities in deciding criteria as to what constitutes urgent/sensitive complaints. • Ability to feed community grievances into broader intervention to promote system-wide learning/improvement.
Model 2: Citizens as Service Delivery Watchdogs	Voice high Teeth low to medium	Top-down low to Medium Bottom-up high	Service provisions medium to high Learning low to medium	• Establish wider linkage and coalitions building across other rights groups, public reform commissions, human rights commissions, anti-corruption bodies. • ICTs' (mobile technologies, internet) availability among hard-to-reach communities to be considered.
Model 3: Local Health Governance Mechanisms	Voice medium to high Teeth medium to high	Top-down low to medium Bottom-up medium to high	Service provisions low to medium Learning medium to high	• Ensure representation and inclusion of the wider communities (women, sexual minorities, etc). • Give adequate consideration to the possibility of 'elite capture' of local decision making processes. • Make sure that communities are not pitted against each other in unhealthy competition for resources (e.g. participatory budgeting has this potential).
Model 4: Social Audit	Voice medium to high Teeth high	Top-down low to medium Bottom-up medium	Service Provisions low to medium Learning medium to high	• Multi-pronged social audit is resource intensive (planning, identification of social auditors, scoring health facilities/personnel's performance, public hearings, and action planning). Plus, standardised guidelines and protocols necessary for consistency, comparison and learning. • Adversarial relationship between communities and service providers may develop if seen as confrontational—focus on dialogue not confrontation. • Avoid a culture of negative sanctions/ punishment for underperformance.

Definition of characteristics:

- Voice/teeth: voice represents both the aggregation and representation (dialogue and negotiation) of the views of the communities, particularly underserved communities; teeth represents institutional capacity to respond to citizens' voice, or provide positive incentives and negative sanctions to reform service delivery (Fox, 2015);

- Top-down/bottom-up: top-down here means the extent to which criteria for and process of communities' involvement in monitoring of health interventions are pre-determined by the service providers/government/donors; bottom up, in contrast, is defined in terms of the extent of communities' direct involvement in setting up of criteria, processes and priorities of monitoring and reporting of health interventions;

- Service provisions/learning: service provisions is defined as effective coverage of target populations that the intervention originally to out to serve. It also includes room for quick correction in service delivery based on pre-defined service delivery criteria (i.e. coverage, quality, timeliness). Learning involves process by which information generated through CBM (e.g. complaints/grievances, community needs/preferences) are intended for use in long-term planning of informing reforms in policy, systems etc.

Table 4: Models' advantages and disadvantages

Model	Advantages	Disadvantages
Downward Accountability	• Easily implemented and standardised (esp., community hotlines, community boards) • Suitable for quick, corrective reforms to staff performance, service provisions • Privacy and confidentiality of the complainants can be ensured (e.g. hotlines, complaint boxes); risk of reprisal/backlash from service providers can be minimised • Potential for holding service providers to account based on pre-determined service standards (via community display board where project info, funds, critical milestones are made public before the start of the service) • 'Triangulation' of community-level data/feedback possible using other approaches (i.e. community meetings, public hearings, community report cards).	• Largely induced and administered by service providers • Excessive focus on voice or information-based approach to problem solving; communities have limited power to sanction negative performance, which may lead to lower level of community ownership • Verification and processing of complaints is time consuming and resource intensive

Model	Advantages	Disadvantages
Citizen as service delivery watchdogs	• Coverage potential high, especially via web/sms-driven efforts • Strong advocacy potential, bolstered by local and global coalitions of affected communities in areas of reducing cost of treatment/ARV provisions, making treatment and care widely accessible. • Good at combining community activism with community-driven research and education i.e. peer outreach with sms-reporting) • Promotes health literacy i.e. raise community awareness on changing health-care needs to help maintain and promote good health	• ICT accessibility among (hard-to-reach) communities is questionable, challenging wider coverage • Verification of reports time consuming and resource intensive • Social media, web-based or sms-driven reporting/discussion may lead to excessive "individualisation" of strategies through,. This may lead to erosion of traditional community-level initiatives such as community health management committees, Drop-in-centers.
Local Health Governance Mechanisms	• Beyond monitoring, community has a role in health governance (e.g. planning and review, oversight, budgeting, staffing) • With formal mandate, communities have enforceability power, that is, they are able to offer rewards for good performance, and exercise sanctions for underperformance. • Inclusion of different members of the community can help shift power over decision making and agenda setting	• Disadvantaged groups often excluded • May be slow to respond to immediate or day-to-day service delivery challenges • Without formal mandate, communities have no power to sanction, resulting in lower community ownership • Health workers may see community monitoring and supervision as interference to their work, resulting in low performance motivation • Tendency to generate conflict of interests, and undue competition among committee representatives, esp. over control of funds
Socal Audit	• High scale up potential, with buy-in/endorsement from Government (e.g. India's NRHM) • Potential to ensure multi-stakeholder accountability • Potential for evidence-based and results-based planning of health facilities/health staff • Empowerment of community members via training and authority	• Resource intensive: highly trained social auditors and tools (e.g. score cards) necessary • Performance-driven approach may encourage adversarial accountability relationship and backlash from service providers • Demands standardised and robust guidelines for cross-facility comparison and decision making

Chapter 5: key considerations and discussion points

From expert-driven approaches to monitoring and evaluation, the growing interest in CBM represents a welcome shift. The models discussed above are by no means exhaustive nor is this a comprehensive summary of the evidence that presently exists. The typology is suggestive of the range of models and their variations in terms of intended outcomes, complexity of implementation, need for resources (time, financial, expertise), level of community engagement, and support from formal authority, among others. At the same time, the models are not mutually exclusive. In practice, overlaps between models are common, with one model leveraging strengths of others. There is no evidence for a 'best practice' model of CBM that has higher likelihood of success across different contexts. Rather, even the implementation of the same or similar model in two different contexts has been found to yield uneven or different outcomes (e.g. Social Audit in India, Local Health Councils in Brazil).

For organisations seeking to initiate CBM, an important principle is to design a CBM model suited to the particular community context, which integrates a range of appropriate mechanisms. Lessons from Fox's (2015) recent review of evidence on social accountability interventions in international development are relevant here. He attributes interventions achieving negative to mixed outcomes to their use of tactical, minimalist approaches to accountability, which largely rely on information seeking and information sharing functionalities. He calls for hybrid or strategic approaches to accountability that "combine information access with enabling environments for collective action that can scale up and coordinate with reforms of the state that encourage actual public service responsiveness to voice" (Fox, 2015, p.350).

In instances where communities have initiated successful monitoring and accountability procedures themselves, they have also combined the features of enabling citizens to report issues and problems with mechanisms to ensure that those issues are effectively dealt with (e.g. training sex workers in the law so they can effectively engage with the police; building supportive networks with health services so that their feedback is listened to; where appropriate, mobilising protests to force authorities to address their issues, Cornish et al, 2010). Such local initiatives produce important information on the conduct of authorities, and could be a source of important information and collaboration for external agencies seeking to understand citizen perspectives and action.

The question about who constitutes "community" continues to reverberate in the policy and programmatic debates around community-based development and health programmes. The field of CBM is not immune to these debates. More specifically, whether or how community-based or community-centric monitoring is similar or different from community-led or community-driven monitoring is unclear, particularly because the literature tends to use the terms interchangeably. A normative rhetoric may favour community-led monitoring, which means affected populations or user communities should essentially drive or lead the process of CBM. However, this does not always happen in practice. Wider socio-institutional structures such as criminalisation of sex work, stigma and discrimination, fear of violence and reprisals from powerholders prevent user communities from actively participating in and leading the process of CBM. Actively challenging or confronting powerholders may put individuals and communities at further risks of intimidation and violence. Larger citizen groups, rights-based organisations, media and even donor communities therefore have important role to play in advancing the rights and interests of marginalised

communities. However, this also raises important questions concerning communities' representation and inclusion in the process and more importantly their ownership of local monitoring efforts and outcomes. The Global Fund's ongoing efforts in areas of CBM envision communities and community networks playing a watchdog role, working with policymakers and implementers to redress specific problems experienced by communities (The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2014). Against that background, as Estrella and Gaventa (1998) aptly put it, questions of 'whose reality counts?', and 'who defines success or failure?', should guide the Global Fund's decisions concerning how community is conceptualised, promoted and operationalised within ongoing programme monitoring efforts.

User communities are both entitled to and interested in availing of quality health services. By implication, they are inherently incentivised to participate in and support CBM. However, their continuing interest to participate in community-level activities may be contingent upon how effectively CBM outcomes are implemented or enforced. When communities feel their role in delivery of local programmes is tokenistic or simply instrumental, serving the aims of service providers not communities, or they are in doubt about whether or how the feedback or data are being acted upon, it can lead to indifference and eventual withdrawal from the process. Community ownership of CBM therefore depends upon the community's confidence that data or feedback are linked to concrete changes in service provision or service environment. This calls for widespread and sustained investments on the part of the Global Fund to engage and empower communities not just in the process of data collection, but also through the process of data analysis and action, and dissemination of CBM outcomes. and eventual withdrawal from the process. Communities' ownership of CBM therefore rests in its ability to guarantee that data or feedback so generated are linked to concrete changes in service provisions or service environment. This calls for widespread and sustained investments on the part of GFATM to engage and empower communities not just in the process of data collection, but also through the process of data analysis and action, and dissemination of CBM outcomes.

Chapter 6: conclusions and key principles for implementation

In sum, our review suggests that CBM's advantages span several areas, from improvement in service delivery and health outcomes, to ensuring proper allocation and distribution of resources, and tackling socio-institutional barriers to service delivery. It also serves long-term goals of decentralisation of health services, production of evidence-based decisions, and enabling citizen participation in health projects.

Despite ongoing efforts to promote community-based health programmes, national and international organisations are confronted with the challenges of increased uncertainty, complexities and rapid socio-political changes at the local level. The need for routine investigation of critical local-level facilitators and barriers that affect service provisions has therefore become even more acute. CBM serves as an effective vehicle to:

a) develop more nuanced understandings of the dynamic local processes that have bearings on health services.

b) enable localised production, processing and analysis of programmatic data.

c) enhance community-level knowledge and foster a culture of joint problem solving and learning.

d) equip user communities to engage in evidence-based policy dialogue and cultivate media and wider public support for locally relevant issues.

e) inform necessary flexibility and adaptability to the overall service delivery system.

Lastly, CBM is of paramount importance to ensure community participation, accountability and transparency in the delivery of health services. Whether communities have 'limited power' to lodge programme-specific feedback (e.g. complaint handling system), or have 'extended power' to exercise sanctions (e.g. budget endorsements by local health management committees), they jointly contribute in making sure service providers are held accountable for their actions. By making themselves open and visible to public scrutiny, service providers can in turn remain vigilant to changing community preferences and demands, and become a learning organisation that can change and adapt in response to CBM.

> "combine information access with enabling environments for collective action that can scale up and coordinate with reforms of the state that encourage actual public service responsiveness to voice"
>
> *Fox, 2015, p.350.*

Principles for successful implementation:

- CBM is not treated as an isolated , add-on or one time activity, but part of regular programmatic activities
- Monitoring is backed up by mechanisms to implement required changes and political will
- Local priorities are monitored
- Proper representation and inclusion of disadvantaged communities (women, sexual minorities)
- Clarity and consensus on the role(s), authority/mandate, and function(s) of actors involved

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