How Do We Know We Are Making A Difference?

Challenges Before The Practitioner Of Community Monitoring Processes In Assessing Progress And Evaluating Impacts

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- Theories of change in community monitoring
- Tracking and assessing progress and evaluating impacts
- Social accountability of private sector services
- Role and ethics of facilitating organisations: putting people centre stage

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Acknowledgement – I am very grateful to my colleagues of the Steering Committee of COPASAH for providing me the opportunity to write this paper. In this paper, I have tried to draw upon my own experience and reading of literature to share some insights and explore some dilemmas that I have as a practitioner. I have gained tremendously from discussion with various colleagues and friends and I would like to record my deepest gratitude to all.
As a development practitioner, I have engaged with various tools of development planning and review over the last twenty years or more. I learnt to apply the 'logical framework approach' way back in 1991 and became familiar with various acronyms like OOP and ZOPP and also learnt about quasi-experimental and experimental designs. However, as a practitioner I felt that these approaches missed some key aspects of community dynamics and also the complex and often iterative nature of community level processes. I must thank Sanjeev Sridharan of the Li Ka Shing Knowledge Centre at Toronto who opened my eyes to alternative ways of looking at evaluation. Much of this paper draws on insights gained through my subsequent discussions, readings and analysis of my own work.
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Summary

Community based monitoring is emerging as a promising practice for improving programme effectiveness and as a key component of rights-based implementation of health programmes. One of the challenges of this approach is to demonstrate that it is yielding results. Community based monitoring is often seen as a process intensive intervention, which may not yield results in terms of changes in health 'services' and health 'outcomes' in the short term. However, it is very important in 'empowering' communities and in building their capacities in engaging with service providers and to negotiate better services for themselves. This paper discusses the different conceptual dimensions of community monitoring and then explores the difficulties of monitoring and assessing progress and results. It also explores a set of mechanisms for documenting and assessing progress drawing upon contemporary practice of evaluation. Using practical examples drawn from the author's own practice and two examples of field level practice in India, the author proposes a practical methodology for assessing progress, drawing lessons and for establishing robust evidence based results in the field of community based monitoring.

Introduction

My personal acquaintance with community monitoring began in 1998 or 1999. I forget the year, but I remember the occasion well, even though it was a second hand experience. My colleague had just returned from attending a public hearing on panchayat-related[1] development activities in the Bhilangana block of Tehri Garhwal district[2] in the state of Uttar Pradesh (subsequently Uttarakhand) in India. She was full of stories of how during this event the people were giving testimonies of their names being misrepresented on labour muster rolls, of how people said that they had not received any money for any work while the records showed that they had. This had led to the local *gram pradhan* (elected head of the village panchayat) and *'thekedar'* (contractor) publicly apologising for these mistakes and promising to return the money. This work in Tehri Garhwal had been inspired by the process of *Jan Sunwai* (public hearing) that had been started a couple of years ago in Rajasthan by the Mazdoor Kisan Shakti Sangathan (MKSS). The process and the results that were obtained sounded very impressive.

The mechanism of the *Jan Sunwai* later emerged as a very important tool for poor and marginalised communities to confront public authorities with questions about the performance of public systems. By 2005, the concept of 'social audit' had been legally included within the review and monitoring mechanisms of the Mahatma Gandhi National Rural Guarantee Scheme[3] (MNREGS) in India. During the same year, the Right to Information Act (RTI) had had been passed by the Indian Parliament, empowering the citizens to ask questions from the public authorities. Both these pieces of very progressive legislations were to some extent influenced by the success and the potentials of the *Jan Sunwai* mechanism.

My first experience of a 'public hearing' had somewhat different results. It was in 2001 when I had resettled in Lucknow, the state capital of Uttar Pradesh. I was part of a group of health activists who were very upset that the government of Uttar Pradesh was continuing to pursue an aggressive and coercive family planning programme despite the fact that after ICPD (International Conference on Population and Development, Cairo 1994), the national government had committed to a Target Free Approach (TFA – 1996) and to voluntary and informed choice through the National Population Policy (NPP 2000)[4]. In order to build a case against the existing state government's family planning policy framework, members of the network Healthwatch - UP Bihar, identified many women who had been coerced through

[1] The panchayat is the lowest level of government in India. The *gram panchayat* or village panchayat is the elected committee at the village level entrusted with the implementation of various development activities

[2] India is administratively divided into States, Districts and Blocks. A block comprises of a cluster of villages

[3] Any family which is registered under the scheme is entitled 100 days of paid work during a calendar year. The social audit process is meant to check whether the payments are made to the correct individuals and the work performed according to the norms and specifications.

[4] UP is the most populous state in India with a present population of nearly 200 million. Population control in the name of family planning has for long been an obsession with successive governments in UP and this was also supported by international aid agencies. The USAID supported IFPS project has been underway in the state since 1992 and continued through till March 2012.

various means to get them sterilised. We were able to identify many women in whom the operation had failed and who had subsequently become pregnant. We also conducted an opinion poll of elected panchayat representatives and other local leaders across ten districts to understand their opinion on how they felt family planning services should be delivered. One day in April 2001, a couple of hundred health activists and members of the community who had suffered from the coercive population policy of the state came together at the state capital. We wanted to share our story with the government authorities and also to ask questions. We presented secondary data, we presented the results of the opinion poll, and many of the victim/ survivors gave their own testimonies. Unfortunately, no representative from the government came to attend the hearing. The media reported the event widely but as organisers we had a mixed sense of success. We were not able to provide any direct benefit to any of the women or men who had come and shared their suffering, and while there was a sense of catharsis, and of solidarity, we were not sure we had been able to engage the state.

These anecdotes are intended as a preamble to the exploration of how we as practitioners can assess progress, outcome and impact of our work related to community monitoring. In the story from Tehri Garhwal there were immediate benefits to the people who had asked the questions, however in our own experience from Lucknow, we had no such luck. The instrument of the social audit, which was pioneered by MKSS in Rajasthan is now considered a very potent method for 'social accountability' even by the World Bank. Many *'jan sunwais'* have been conducted across India, and some activists have even lost their lives in the process, but the situation of the poor has remained substantially the same in many of these locations. In our case the experience gave the activists of Healthwatch UP and Bihar the strength to continue their advocacy on health rights further. It contributed to the development of a women's mass organisation Mahila Swasthya Adhikar Manch in the state. It also contributed to the development of the community based monitoring methodology that was tested as a pilot intervention across nine states across the country through the National Rural Health Mission.

The challenge for the practitioner is how to assess that the community monitoring approach in health is working and also to find ways of distilling lessons, and to adapt and apply them in different contexts. The stories illustrate that the level and scale of influence of these processes can be vastly different depending upon timescale of review and the perspective that one adopts. How do we then judge progress and results? This paper will try to explore some of the mechanisms that may be adopted to 'monitor' progress and 'evaluate' success and distil lessons. The paper is the result of the author's own exploration of applying many of these concepts and thus represents work in progress.

Where do you want to go with Community Monitoring?

My encounter with community monitoring is now about fifteen years old. I am still discovering new facets, challenges and possibilities. Broadly 'community monitoring' refers to initiatives where community members become involved in monitoring aspects of public

service delivery. This could be through participation of parents in school management and oversight committees or patients or members of the community in hospital management and oversight committees. At the very simple level, the assumption is that the involvement of the community of users will make the services geared towards the need of the community and so the usefulness or quality and utilisation of the services will improve. However, this simple assumption often does not work. There could be many reasons for this. At a personal level, I have seen doctors who do not attend their official clinic, but run a private clinic close by. Recently, I was in a village and in my conversation with two young girls learnt that their teachers were not teaching them despite being present in the school. Many parents in that village preferred to send their children to a private school that runs opposite the road from where the government school is located. The World Bank devoted the World Development Report 2004 to investigate this issue. The report started with the assertion – "Too often, services fail poor people.." and in the same paragraph suggested ways of improving the situation – ..by enabling them (poor people) to monitor and discipline service providers…" . My own experience of trying to make very large and monolithic public systems like the health system work is not easy. On the one hand these are huge and labyrinthine bureaucratic structures enjoying political patronage, while on the other hand communities often prefer a path of least resistance and seek the essential services elsewhere. Thus, to bring the two together in a relationship where the traditionally powerless community becomes enabled enough to 'monitor and discipline' the public authorities and service providers is a most challenging but not an impossible task.

Understanding the role of the 'Community Participation'

The term 'community participation' seems a reasonably straightforward concept, but on closer examination appears more complicated. A recent World Bank report (Mansuri and Rao 2013) reviewing community participation in various development interventions found that 'elite capture' was a common phenomenon. However, this was something that we had learnt years ago through our own close association with the community. We had learnt that communities are not homogenous, even if they all happen to live in remote areas and share some common hardships. Some people have more resources and more local power and participation in decision making bodies, and these 'elites', are better placed to make use of the development benefits. Thus, if one is interested in the 'poorest and most marginalised', one needs to be cautious of 'elite capture'. We had also learnt that those who face the greatest deprivation do not necessarily have the greatest desire for change, thus their interest or 'participation' in efforts which could possibly 'change' their reality could not be assumed.

The word 'participation' also has many meanings. In one of the early discussion papers on this issue, authors Gaventa and Valderramma (1999) noted four linked approaches to participation. The four linked domains that they referred to were Social Participation, Citizen Participation, Political Participation and Participatory Methods. Much earlier, a Ladder of Citizen Participation (Arnstein 1969) had been described – moving from manipulation to tokenism to citizen control. The possibility of change in the conceptualisation or purpose of participation has also been described as a move from 'users and choosers' to 'makers and shapers' (Cornwall and Gaventa, 2000). Further elaborating this shift from passive

participation to active engagement, Gaventa and Valderrama (1999) note domains of shift viz. from beneficiary to citizen; from a project perspective to a policy consciousness; from being consulted to becoming part of the decision-making process; from being included in the appraisal process to becoming organic to the implementation; and moving from micro to the macro. In short, shifts in these various domains taken together changes the context, the actions and the implications radically.

Faced with this diversity of conceptual positions on just the concept of 'community participation', it is difficult not to get lost. As a practitioner, when faced with this kind of conceptual labyrinth, I have tried to reconcile the 'theoretical' postulates with my lived 'experiences' and 'instinctive' feelings. What is it that has given me the most satisfaction in working together with people in the community? Have I seen any changes in the way they engage with 'development' processes? Has my understanding of 'participation' changed over the years?

It doesn't require long for me to understand that it has. I started my life as a rural doctor trying to 'do good'; educating people about healthy habits, providing curative health care to the poor at very low cost. Soon I realised how little I knew about their lives and its realities and how my medical education didn't equip me to communicate with my 'patients' with empathy or provide care which would sit easily within their existing life circumstances. Using participatory methods, I had started a joint enquiry with the women in the community of how women lived their reproductive lives. I learnt how they negotiated menstruation, childbirth and the post partum period. Together, we explored stigma and safety and bodily autonomy. Women in the remote rural mountains started scripting a new life for themselves challenging patriarchal norms of segregation and stigma while adopting safe health care practices. The four linked concepts of participation that Gaventa and Valderrama have written about, immediately start making sense. The movement of women's engagement in their health care efforts from a passive participant (patient) to an active agent (similar to the progress on Arnstein's ladder) is clearly evident.

From 'Participation' to 'Monitoring'

According to different authorities, community monitoring or oversight of public services by citizens are possible when certain conditions are available within the governance structure of the particular country or state (NIAR (nd), Newell and Wheeler (2006), Potts (nd) quoted by Flores (AMHI/OSF 2011)). Some of these contextual conditions are as follows:

Voice – A strong, organised, citizen group which is able to articulate its opinion and position can be called the citizen's voice. It assumes mobilisation, knowledge about rights and entitlements and a confidence among the citizens to confront public authorities with their claims and experiences of deficits in public services.

Accountability framework – In order to ask questions from the government or state it is necessary to have a framework on which such questions can be based. These can also be

called the ‘rights’. While the constitution of a country often provides a framework, it is generally very broad. More specific frameworks can be available within programme and policy guidelines. In the field of health, even quality of care parameters and standard operating procedures adopted by the government authorities can serve as the accountability framework. Sometimes the accountability framework is drawn from international commitments that the state may have made e.g. within UN treaty body frameworks. Implied within the concept of accountability framework is the concept of ‘compact’ or the states assurance to provide the services.

Resources and Remedies - Having a strong citizen voice and the rights or the compact may be good enough to start the process of community monitoring within a particular context, but it may not be sufficient to make it effective or to sustain it. Community monitoring will sustain if the community demands and claims lead to some form of change. In rights language, it is necessary for some form of remedies - redress or restitution to be possible through this mechanism if it has to sustain itself. This requires both political and financial resources.

Purpose of Community Monitoring

Community monitoring is a desirable act from the point of view of those who hold the community interests dear. However, it is not necessarily seen in the same way by providers and bureaucrats. In order to bring both parties to the same table, it is necessary to use frameworks of common interest. Some of the issues of common interest are

- Reducing corruption
- Increasing quality and effectiveness of services
- Improving effectiveness of development related investment or aid

Others argue that these are important but not necessarily the only reasons for enabling the poor and marginalised communities to assume charge of the process of monitoring. They argue that it is essential that the poor and marginalised become empowered to participate in decisions relating to their lives and participate in the political processes that govern their lives. This means community monitoring is part of a process to

- Empower the poor
- Improve democratisation of public systems
- Increase peoples participation in policy making

Thus, community monitoring is an evolving field and the terminology is still fluid. It is also given different names by different people. Many prefer to call it ‘social accountability’ while others call it ‘demand for good governance’. Still others see it as ‘participatory governance’ and some would like to keep it bland and call it ‘community action.’ Often these different

names indicate where we come from and where we would like to go, and when we have so many different names, it is possible that there may be some differences in our origins, approaches and destinations.

However, as a practitioner one needs clarity of purpose. For me, the clarity of purpose is provided by my faith in poor and marginalised communities' ability to aspire for, and their ability to create better conditions for themselves. I get inspiration from my belief in equity, social justice and human rights, and in the shared access and control over the resources available to all of us through principles of participatory decision making. Thus, for me 'community monitoring' allows for and depends upon changes in many local power relationships and my desired outcome is a situation where

- the poorest and most marginalised, especially women, are organised and empowered and they are aware about their health related rights and entitlements
- they are able to use the public services without facing any difficulties
- they are able to share their concerns and problems with the service providers and other authorities

and

- mechanisms exist for dialogue, receiving complaints and for redress
- high quality services are provided in the prescribed and respectful manner by the service providers
- improvements and changes are made based on feedback and complaints received.

I would also like to see this process contributing to an overall empowerment process among the marginalised, especially women, where they become active participants in local political processes so that they are able to access opportunities and development benefits according to current provisions of law and policy, and within the overall framework of equality and justice promised by the Indian constitution.

How Do We Know We Are Moving Ahead? What to Monitor, How to Assess Progress?

Over the years, the nature of development, policy and interventions, have been undergoing many changes. On the one hand, the overall ideology of development has become a set manoeuvres between the practical paradigm of 'Millenium Development Goals' and the more aspirational 'human rights based approaches'. On the other hand, 'results' and 'evidence based' policy making have become the rallying cry of funders as they try to ensure greater effectiveness of their development dollars. Thankfully the twin issues of 'participation' and 'accountability' are included as contemporary concerns, which allow community monitoring to have a place in the sun so to speak, but the current emphasis on results and evidence calls for the use of appropriate methodologies to demonstrate progress, results and effectiveness.

Community Monitoring: A Complex Social Intervention

As a practitioner one needs to understand what the current situation is and then plan one's intervention. Community monitoring can be considered a complex social intervention, where we are not only expecting a set of complementary outcomes but it also assumes that the interventions introduced through the project will set in motion some social processes, which will act synergistically to achieve the desirable outcomes. If women's empowerment is a desirable outcome of a 'community monitoring' intervention, it is possible for the empowerment to manifest itself in different ways in different contexts. Some of these empowerment outcomes may be difficult to anticipate at the outset. This makes identifying all dimensions and measures of change difficult at the outset. Thus, understanding and assessing progress for community monitoring requires us to look beyond the commonly used methods for monitoring and evaluation.

The usual way of monitoring progress of a development intervention is to develop a 'logframe' or prepare a chart of inputs and anticipated outcomes and set a list of indicators. This is the usual route-map and milestones method adopted by smart development practitioners. This approach is based on social and economic 'logic', which has probably been tried and tested elsewhere and includes a set of contextual assumptions. It is supposed to provide a simple and concise summary of what the project aims to do. It is systematic and logical and provides a basis for monitoring progress and results. However, the journey that we wish to undertake as practitioners of community monitoring with poor rural women is somewhat uncertain. At the same time we would like to see whether participatory approaches are appropriate for developing citizenship aspirations within women; we would like to know whether women's action can influence the policy domain. At a more practical level, we also wish to demonstrate that these actions by women can improve their ability to receive good health care and improve their health status overall. In order that these outcomes are possible it is necessary to build confidence among women so that they can engage with their health care providers. But to do so they must be able to challenge many social boundaries at home and in their communities.

The first question is whether we have a 'tried and tested' set of interventions which can 'predict' this set of outcomes? For 'community monitoring' as far as I am aware there are no fixed formulae as yet and there are contradictory results from randomised control trials[5]. So what can one do? We can search online, talk to fellow practitioners, visit some field projects and at the end we can have the beginnings of some answers. We can start off our intervention and be vigilant about progress but the usual methods of project monitoring may not be adequate tools for charting our journey. We will have a level of uncertainty mixed with hope when we start. We are aware that there are a range of possibilities that could lead to the destination. We also have certain assumptions about social processes. Within this complexity, we also need to identify whether the movement of the intervention is in the desired direction. We need to learn about 'progress' and pitfalls on a continuous basis so that appropriate changes can be made. What then could be the appropriate monitoring and evaluation methods that can support community monitoring?

Alternative Approaches to Evaluation and Monitoring

Huey Chen (2004) a leading evaluation expert has compared evaluation to fishing. Not only does one need a set of equipment, and the skill to use them, but one needs to know which method of fishing is appropriate under what circumstances. Wrong hook and wrong bait in the wrong place could be the difference between success and failure. Mention has been made of community monitoring as a 'complex social intervention'. The Medical Research Council of UK[6] defines these "as interventions with several interacting components" and acknowledges that "..they present a number of special problems for evaluators….. Many of the extra problems relate to the difficulty of standardising the design and delivery of the interventions, their sensitivity to features of the local context, .. and complexity of the causal chains linking intervention with outcome." Following this advice, the common practice of comparing post-intervention status to a pre intervention baseline to find the change, commonly called the summative form of evaluation or outcome focussed evaluation, is not of much use for our purposes.

For our purpose, evaluation methods that allow the process to be examined are more appropriate and this is where the concept of 'programme theory' is useful. Carol Weiss has argued in 'Nothing as Practical as Good Theory' (Weiss 1995) that 'social programs are based on explicit or implicit theories about how and why the program will work". Taking this idea forward Pawson and Tilley (2004) say that all social programmes are shaped by the 'vision of change' and are 'hypothesis of social betterment'. Realist evaluation tries to understand the core theories behind an intervention and then interrogate whether these theories work, under what circumstances and for whom. In their conceptual framework, the context and mechanisms of the interventions interact differently under different circumstances and the outcomes can be different for the same mechanism of interaction under different contexts. Realist evaluation "seeks to unpack the mechanism of how complex

[5] Bjorkman and Svensson (2009) have shown community monitoring works in Uganda while Bannerjee and colleagues (2010) have not found similar results in India.
[6] Developing and Evaluating Complex Interventions: -New Guidance, Medical Research Council, 2008 – available at http://www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC004871, accessed 19th October, 2010

programmes work (or why they fail) in particular contexts and settings"(Pawson et al 2005). The realist approach tries to understand the mechanism (M) which relates the outcome that is desired (O) to the context (C) in which the intervention is applied. It allows for an interrogation of the role of the context, is open to a range of outcomes and tries to understand the mechanism which is articulated as a series of hypothesis or theories. Clearly this method of evaluation which allows us to have an imaginative vision and which is rooted in the context is much more appropriate for our monitoring – adapting – learning – evaluation process.

Another approach to evaluation which appears appropriate for community monitoring is Development Evaluation. It has been pioneered by Patton (2008) and is an approach that allows learning and innovation to take place concurrently with the implementation process. This concurrent learning process is crucially important to the community embedded practitioners who cannot fail and walk away, or even succeed and then 'close' their practice. Learning lessons, from success and probably more from failures is necessary for the practitioner to continually improve their praxis. In many situations the practitioner cannot wait till the 'end' of the programme but needs information on a real-time basis to solve emerging problems within the overall programme.

Developmental evaluation differs from traditional forms of evaluation in several key ways:

- The primary focus is on adaptive learning rather than accountability to an external authority.
- The purpose is to provide real-time feedback and generate learnings to inform development.
- The evaluator is embedded in the initiative as a member of the team.
- The evaluator role extends well beyond data collection and analysis; the evaluator actively intervenes to shape the course of development, helping to inform decision-making and facilitate learning.
- The evaluation is designed to capture system dynamics and surface innovative strategies and ideas.
- The approach is flexible, with new measures and monitoring mechanisms evolving as understanding of the situation deepens and the initiative's goals emerge

(From : Westley, F., Zimmerman, B., & Patton, M. Q. (2006) quoted in Dozois, E., Langlois, M., & Blanchet-Cohen, N.(2010)

Developmental Evaluation is still an emerging field of practice. I do not as yet have deliberate experience of adopting this approach but at an intuitive level it seems like an appropriate methodology to use in our work around community monitoring.

Moving from Theory to Practice

I hope that by now I have been able to make a case that it is not only possible but necessary to use some method for assessing change and understanding progress in our work around community monitoring. We can do so by using approaches which allow us to learn, adapt and improve while at the same time keep us grounded to our overall purpose and principles. However, before we start the process of monitoring or evaluation or assessing progress we have to be extremely clear where we stand and where we want to go. In other words, we need to clarify the conceptual frame of our intervention and develop our programme theory. This process forces us to think through the purpose, and goal of our intervention in the broadest possible manner and also allows us to be expansive in our goal setting. However, in order to stay rooted we need to also consider our own unique contexts while we are engaged in this exercise.

Mention has been made at the outset that different people can have different expectations from community monitoring. We need to have clarity about the balance between improving effectiveness aspect and empowering citizens/ deepening democracy aspects that we seek through our work. We also need to have some idea about the levels of effect or impact we seek through our work. Is the result anticipated at the level of the community and their health, or in the levels of organisation and empowerment? Is the result expected at the level of health status, delivery of services or the attitude and behaviour of providers? Similarly, what is the balance of our interest in specific changes in one area and changes at the level of development discourse and practice? To give an example, a large-scale development project promoted by the government or by an international donor may be interested in improving effectiveness, reducing corruption and in specific results on the ground. However, a non-governmental intervention started over a small area may be more interested in strengthening voice of the local community, demonstrate some change and then advocate with the state government to introduce this component as a regular monitoring mechanism in all public service schemes. What is it that we want? It is useful to have some clarity when we start our work.

Developing an Appropriate Programme Theory

Having developed clarity of purpose of our intervention we need to develop the 'programme theory' of how the desired change will be achieved. For example, if our desired status is one of an empowered and mobilised community, we need to understand their current levels of mobilisation and propose a mechanism for improving the same. Similarly, if we want that communities are able to speak freely with their health providers about the problems they face, we will need to explore the current status of their relationship and propose a method through which it may be improved. As we seek answers to these questions we will also need to find methods that we can adopt in our practice to complete our programme theory.

One of the first considerations in developing the appropriate programme theory is to explore the context in which the intervention is to be applied. According to discussions at a recently held meeting of practitioners of community monitoring, which has been summarised by Kaim (AMHI/OSF 2013), the context can include both the larger environmental context as well as the institutional context of the organisation that is engaging in promoting the exercise. The environmental context is further divided into the political context, which is important for determining the extent to which this kind of citizenship promoting exercise will be 'allowed', the health system context with which the engagement is expected to take place and the cultural context of the community which is expected to play a key role in this monitoring exercise. The institutional context includes the institutions vision, its relations with the community as well as its strategic advocacy focus and last but not the least, the skill sets it possesses. The institutional context clearly determines the approach that it will adopt to promote the engagement of the community with public authorities.

Sridharan and Nakaima (2011) have provided some practical steps for applying the realist evaluation methods and I have found their approach very useful[7]. The first four steps of their proposed ten step approach have been very important for us in developing programme theory related to our interventions. They ask:

- What are the different components of the programme? Are these components stable?
- What is the programme theory?
- Does the evidence base support the programme theory linkages?
- What is the anticipated performance trajectory?

While the journey of community monitoring can be aspirational and the path still not well known, these four questions allow us to set up our compass and give us an idea of what we are looking for so that we know we are going in the right direction. In order to develop an appropriate intervention for community monitoring based on sound programme theory, I have found the following analytic approach useful.

Key Considerations	***Assessment of Current Status***	***Possible Programme Components***
Voice – Current status of mobilisation among the marginalised	We will need to understand - What is the current state of mobilisation of the community? What are the levels of hierarchies within the community? Who are the most marginalised? Are they aware of their entitlements? What are the	Mobilisation Awareness raising, Conscientisation. Community action

[7] The ten steps proposed by Sridharan and Nakaima are divided into four sections. The first four steps mentioned here form the section Programme Planning. The three other sections are Learning Frameworks and Pathways of Influence, Evaluation Design and Learning from Methods and Spread and Sustainability.

	levels of leadership and autonomy? Are there groups and cliques?	
Accountability Framework – Are there laws, policies and programmes and budgets that provide the necessary services as entitlements. Has the country made any international committments. Are there standard operating procedures, quality standards for service delivery?	What are the current levels of service delivery? What are the key gaps? Is there data available about these gaps? Do the community or primary users see these as gaps? What are the data disclosure procedures? Are there laws around information disclosure? Are the service providers aware of the state laws and policies and their responsibilities? Are they provided adequate resources? What are the current monitoring mechanisms? Are these provisions for community to participate in these mechanisms?	Policy Analysis Secondary data analysis Research Social Audit Participatory Research (PRA/ PAR) Enquiry/Investigation/Fact Finding Score cards/ Report cards Expenditure tracking Complaints/ Grievance collection
Resources and remedies for change – Is there interest in change? Are there adequate human, financial and material resources for change? Are there provisions and mechanisms for changes and remedial action?	What are the areas of concern for local authorities and service providers? Can they be allies? What are the larger political/ programmatic concerns and compulsions?	Advocacy with authorities Public Dialogue Public Hearing Committee Hearing Legal Action

Sreedharan and Nakaima suggest that the list of programme components that we finally select as part of our intervention package must have some evidence that they have worked somewhere so that we have some idea about its stability. We can develop our programme theory by linking the three columns of the table above to create an appropriate hypothesis about the change we expect that the programme component will bring about. The linkages we choose will depend upon our context as well as our interest. As we develop the linkages and finalise our programme components and a sequence of action, we develop a possible

performance trajectory. The methods that we identify also provide clues about the interim processes through which we anticipate that these changes will take place.

Setting the programme theory and anticipating the trajectory of change is essential to the monitoring and evaluation process. The practitioner now has to be vigilant to understand the processes as they unfold and to take stock from time to time. As a practitioner, I have found the concurrent documentation and analysis of stories of 'change and resistance' from the field to be very valuable to track progress and understand change and assess trajectory. Other processes of monitoring and review like stakeholder meetings, third party assessments can all be useful for understanding whether the programme theory holds and whether the components are working as assumed. They help us to make necessary changes and also to draw lessons about possibilities and limitations. Both qualitative and quantitative methods can be used to understand how close far we are to our expected goal, but we need to be constantly aware of unanticipated processes that can be both beneficial and problematic.

The approach that Sridharan and Nakaima propose not only allows us very practical tips for starting our work, but also provides ways in which we can try to cull lessons to improve our programme. They acknowledge that most evaluators are concerned with 'effectiveness' while the practitioner may require methods which 'follow a continuous improvement model'. They contend most evaluation assumes that interventions and contexts as static and stable whereas in real life this is often not the case and it is necessary to be adaptive. They also raise questions about the role of evaluation in the context of spread, scalability and generalisability.

Drawing Lessons from Existing Practice

In this section I will try to apply some of these premises to existing practice of community monitoring. I will limit this application to two examples from India, with which I am more familiar. Case studies based on these two practices have also being prepared separately by COPASAH and are readily available to the interested reader. One of the cases is that of the Community based monitoring (CBM) of National Rural Health Mission in the state of Maharashtra and the other is that of the Mahila Swasthya Adhikar Manch (MSAM or Women's Health Rights Forum) in the state of Uttar Pradesh. While I am offering these as examples I am aware of major limitations of this exercise. While I have discussed the use of these cases in this paper with the key functionaries of the two organisations, my dataset of information is extremely limited.

Context

Common Environmental Context **–** The Government of India launched the National Rural Health Mission (NRHM) in 2005 as a new and integrated approach for providing health care services to the rural poor in India. The design of NRHM was made with the participation of a range of civil society public health experts and health activists within the overall mandate of the Common Minimum Programme, a common agenda of governance adopted by the UPA (United Progressive Alliance) Government. Community participation and strengthening of

monitoring and accountability mechanisms were included as key strategies within this overall approach. An advisory committee on community participation called the Advisory Group on Community Action (AGCA) was also included within the overall planning and review processes of the NRHM. This committee comprises solely of civil society members, and it was instrumental in designing and rolling out the pilot phase of Community Monitoring. This pilot phase was rolled out across 9 states between 2007 and 2009. Subsequently, some state governments continued with community monitoring while others initiated the process.

The process of community monitoring depends upon the constitution of a set of planning and monitoring committees from the village upwards to the state. They start at the level of the village as the Village Health, Sanitation and Nutrition Committees and these committees are expected to conduct an enquiry into the status of health services received by the community, especially women and children and draw up a report card. Similarly, they are also expected to review the services available at the health centres and draw up another facility report card. These two report cards form the basis for a periodic dialogue with health care functionaries and authorities at different levels to identify improvements and remedial action.

CBM-Maharashtra: The community based monitoring process in Maharashtra was part of the larger nine state pilot project that was implemented nationally with the support of the Ministry of Health, but this exercise in Maharashtra had some unique aspects. The implementation of CBM in Maharasthra was supported by the voluntary organisation SATHI, which was involved in developing the methodology at the national level as member of the AGCA. It was also a key constituent of Jan Swasthya Abhiyan (JSA), which had organised the Right to Health Campaign in 2003-04. SATHI had prior experience of using the method of public hearing or *jan sunwai* through a series of such events that had been organised as part of the Right to Health Campaign. Some of these public hearings had been conducted in collaboration with the National Human Rights Commission (NHRC), and this allowed people who had been denied health services to make a direct call to state authorities for better health care services. SATHI is implementing the initiative with a large number of partners who facilitate the different processes at the district and sub-district levels.

MSAM – Uttar Pradesh: Mahila Swasthya Adhikar Manch (MSAM) is a state-wide women's group with over 11,000 members, structured into village level groups and block and district level federations in the state of Uttar Pradesh (UP). It is facilitated by some voluntary organisations and coordinated by SAHAYOG. SAHAYOG has been working on women's health rights and accountability since 2001. SAHAYOG and its partners are part of Healthwatch Forum UP, a health advocacy platform that had engaged in many health rights campaigns, including the Right to Health Campaign with JSA. MSAM was initiated in 2006 as a follow up to a state wide campaign called Puri Nagrik, Pura Haq (Complete Citizens Full Rights) which had engaged thousands of women across the state. After NRHM was announced, SAHAYOG and its partners found that there were spaces for communities to engage with the health system. However, Uttar Pradesh was not included among the states

included in the pilot CBM under NRHM and MSAM led advocacy for better health services has not happened within any prescribed NRHM platform for engagement.

Processes and Mechanisms

CBM-Maharashtra: The CBM process followed in the state of Maharashtra follows the basic approach prescribed under the national guidelines. The process includes preparatory activities like creating an environment and getting a mandate from all stakeholders, formation and capacity building of the different committees, a process of community enquiry to obtain community feedback of services that are summarised through a report card, and finally a public hearing or *Jan Sunwai*. The *Jan Sunwai* is used as the key tool for ensuring public accountability. The *Jan Sunwai*'s allow people to interact with government health officials in the presence of local legislators, members of the panchayat, as well as an independent panel of judges. It has also emerged as a media event. The *Jan Sunwai* is seen as the key mechanism for deepening democracy in the CBMP in Maharashtra. It has been used since it 'generates egalitarian aspiration among the marginalised', enhances 'confidence of the oppressed', and reduces hierarchies by challenging the "remoteness of the bureaucracy". Over 200 *Jan Sunwais* have been held in various districts between 2008 and 2012.

MSAM – Uttar Pradesh: The community monitoring process is not limited to health services and involves other social sector services for the poor including the pre-school services, the subsidised ration shop services, pension scheme for the old and the rural livelihood programme. The focus of the intervention is to build capacity among women leaders of MSAM groups to become aware of their own entitlements and the responsibility of the public system. They are also trained to identify gaps in service delivery and to address public authorities with their grievances and issues. The women leaders have conducted community level enquiry process of a different scheme every year and the methodology used was based on participatory tools that can be used by the non-literate. The results are shared with district level authorities. There is also a regular series of village, block and district level meetings where women discuss issues related to their ongoing experience of service delivery. SAHAYOG has been organising annual state level dialogues as well as occasional interface and public hearings with senior public functionaries.

Outcomes

The following section very briefly tries to capture the changes at different levels, with some emphasis on the difference between the two efforts. Additional details about both these efforts are available as companion case studies.

Changes in Community Empowerment

CBM-Maharashtra: The key community level players were expected to be the members of the VHSNC members. Their involvement has been uneven across the different districts. In many cases members of community groups organised by the NGO facilitators are more active in this process than the VHSNC members themselves. Leaders of the local government institutions have started taking an interest in this process and now they play a significant role in ensuring action by the health system in some areas. There has also been an increase in the communities' interest and awareness about health, and an increased solidarity among the community.

MSAM – Uttar Pradesh: The most important gain through this process has been the empowerment of the women leaders of MSAM who are almost exclusively from the most marginalised groups in the community. Many of the empowered women leaders have also started participating in the local government elections and processes.

Changes in Community – Provider Relationships

CBM-Maharashtra: The providers and the community are mandated to face each other through the process of public dialogue at different levels and so it has improved accountability of the community–provider relationship at different levels. Enhanced accountability has been linked with improvements in delivery, quality and outreach of services in several areas, which is reflected in numerous 'stories of change'. However, the effect of the interactions reduces as we look at higher levels of governance. Positive changes in community-provider relations are seen mostly at village, PHC and block levels. State level interfaces have been more difficult to organise, although higher level officials have been relatively supportive of accountability processes at lower levels.

MSAM – Uttar Pradesh: The community– provider relationship is often adversarial at the local level. There is no formal forum for interaction and most interactions with providers take place by the mediation of the facilitating NGOs. The interaction of women leaders with public functionaries at the state level is more 'ceremonial' than substantive. However the women leaders have gained greater credibility within their villages and also with health providers. The facilitating organisations have also become more credible and have been invited to formal platforms at the district and state levels.

Changes in the Health Care Services

CBM-Maharashtra: The *jan sunwai* process in Maharashtra has led to many improvements in service delivery. These improvements are mostly in response to gaps identified at the local level and have ranged from increase in outreach services, to

completion of unfinished construction work, to better maintenance of hospitals, to starting of mandated surgery services.

MSAM – Uttar Pradesh: There have been some changes in service availability at the peripheral level. Women leaders have often used their collective identity to demand for better services. However, there is no evidence pointing to systemic changes in the way services are being delivered as a result of MSAM feedback.

Other Gains

CBM-Maharashtra: This process continues to be an example and inspiration for community based monitoring processes in the health sector within the country. This example has been demonstrated to the Planning Commission of the country as a successful example and has been proposed as standard practice within the 12th Five Year Plan framework. It is being documented and discussed within the COPASAH for learning purposes.

MSAM – Uttar Pradesh: This process has been documented and disseminated by various means and provided inputs to the development of the policy framework for community involvement within the recently released report on Universal Access to Health Care prepared by the High Level Expert Group constituted by the Planning Commission of India. Like the CBM – Maharashtra process, it is also being documented and discussed within the COPASAH for learning purposes.

Challenges/ Disappointments

CBM-Maharashtra: Though it is an officially mandated programme, the higher levels of bureaucracy do not pay adequate heed to the suggestions and recommendations that emanate from below. The process has not been able to address any of the structural gaps that affect service delivery e.g. staffing/ posting, equipment/ supplies etc., which require system wide changes. This has led the organisers to identify categories of 'CBM sensitive' as well as 'CBM resistant' problems. Secondly, while the process has been able to identify area-specific problems and suggest solutions, these insights and recommendations have not found much reflection in the planning process, which is supposed to be through a bottom-up district centred approach. Thus, the CBMP feedback has been able to influence the Rogi Kalyan Samiti (Patient Welfare Committees) in their facility level planning in some areas, while there has been hardly any dent in District PIP formulation.

MSAM – Uttar Pradesh: The systemic changes in health service delivery have been far less than the community level impact of this endeavour. The community empowerment process has led to many women leaders joining the formal electoral process. Some of these leaders are continuing to work together with the women's

groups. But this is not uniform and in some cases these leaders have become co-opted by the existing vested interest groups.

Ongoing Documentation and Learning Mechanisms

Both these experiences have had a very strong ongoing documentation process. In both cases, there has been an active process of collecting 'stories' of change. In the case of the CBM-Maharashtra, these stories have been regularly compiled and published in a quarterly state level newsletter *'Davandi'.* In the case of MSAM- Uttar Pradesh, compilations of stories have been published and systematically used as learning material *Our Story in Our Words (Humari Kahani Humari Zubaani).* Both efforts have produced video films documenting their experiences and learning. There are platforms where the various partners come together periodically to review progress and incorporate changes. A number of formal evaluation studies have also been commissioned in both cases and lessons emerging from these incorporated into practice. In both cases the senior most level of leadership within the coordinating organisation has been playing an active documentation and learning role within the programme leaving the task of coordination and implementation to others. This has allowed for a robust and active learning process to emerge concurrently with the implementation process. These senior functionaries have also been very active in advocating for this approach within different policy spaces, multiplying the influence of the intervention manifold.

Summary - The two interventions described above have used a similar bottom-up accountability approach to improve health services delivery. Even though some of the contextual factors are similar, there are differences in the institutional and environmental context in both cases. The overall programme theories too have both similarities and differences. The key intervention is different in the two cases – in one case it is the *jan sunwai* and in the other it is capacity building among women leaders. Both efforts have been using a vigorous documentation process through which they are able to chart progress and incorporate ongoing learning within the programme implementation process. The results too have similarities and differences, which are not difficult to understand once one has gone through the entire sequence. One could even say that the expectations from these two processes should not be similar.

Best Practice and Scalable Intervention

Today, we are faced with the paradigm of 'evidence based' practice and policy making. A development agency that has the mandate and purpose of stimulating and supporting socio-economic change over large geographies and multiple countries is anxious to learn of 'best practices' and 'scalable solutions'. Even though we may not be part of these larger bodies we may need to respond to their interests. On first sight, this approach seems to make sense for large scale development practice. They want to repeat past successes and this approach appears to provide some assurances of success, especially if a rigorous experimental study has been seen as successful. But on closer examination, this assertion does not seem a rigorous one to me.

I am not among the large scale implementers of development projects. I started my life as a small-scale innovator and then became interested in the larger development interventions because from where I was located they did not appear to deliver what they promised. Furthermore, this gap between promise and actual practice had disastrous consequences for the lives of the poor. I have seen this time and time again in many health interventions – some of which have also received international plaudits including the Global Polio Eradication Initiative and the Janani Suraksha Yojana (Mother's Safety Scheme – or the maternal health initiative of the Government of India). What I learnt from my close observation of these gaps was that the original project did not have a clear articulation of 'why' it should succeed in the different contexts that it was being implemented in. Thus, it could have benefited from a well articulated 'programme theory'. But what was more serious was that there was no ongoing collection of information on what happened within the community once the programme was implemented.

As we are moving into an increasing quantitative understanding of results and evidence, programme managers fret about numbers, often promoting misreporting, and no one even raises questions about the possibility of things going anywhere else but what has been 'predicted'. Most large scale projects seem to be based on the naïve assumption that when interventions will be introduced people will start using them out of self interest. Moreover, if self interest needs to be generated, some cash incentive will do the trick, or else some arm twisting may be necessary. Most of the information collected in the case of the large scale projects I mentioned above was of the delivery of inputs with little or no attention on how the inputs affected different communities, including the relationship between different social groups and between providers and the community. What was perhaps worse was the lack of openness to hearing any other possibility than what had been written in the 'books'. To me this appears not only as a lack of openness to learning but as a form of 'fundamentalism'.

While community monitoring is not in the same category of interventions like the polio eradication or maternal health service delivery, the close observation of these large scale programmes has provided some lessons for me. Community monitoring is perhaps an even more complex social intervention because in this case there is no technical product that is expected to deliver results. Thus, it is extremely important to develop an appropriate

'programme theory'. To do so, one needs to define the context and I have already tried to show how one can develop it based on what Sridharan and Nakaima have proposed as stable 'components'. Once the homework is done we need a mechanism that will allow us to test the hypothesis in an ongoing manner. These interventions are not only complex because they have interacting components in their conceptual design, but also because they will 'upset' the power equilibrium existing in society, between members of the community and between the community and the health providers. We cannot exactly anticipate how an individual will react to a challenge to their social position. We need to observe, and we may need to adapt. This requires what may be called an active 'intelligence' gathering and processing mechanism. This is where I feel stories and their ongoing analysis is important.

Through my own work as a practitioner on areas of emerging development practice, I feel that we do prepare a mental map, and we do collect and analyse stories. But we do so 'mentally' and intuitively. We need to be much more deliberate and this will sharpen our own practice into realm of 'evidence based'. It will also allow us to be more deliberate in drawing lessons, relating to the context and to the specific components of our interventions. In this way, we can avoid the pitfall of proposing 'best practice' type of universal solutions. So my recommendation is that we should be very deliberate in writing our assumptions and hypothesis about our interventions. We should write up what it is that we aim to change and how we think this is going to happen. We should be explicit about the different components of our programme – why we think they will work. We should be clear from where have we derived this anticipation of success, and this may be from our own earlier practice. If possible we can draw a diagrammatic vision of the proposed societal interactions and routes of change. The more explicit we are in charting the possibilities of our intervention, the more accurate we can be later in understanding whether these were correct. These specific anticipations also work as our milestones during the process of review.

The second area which I feel we may need to strengthen is our process of understanding what is happening in the community once the interventions have begun. We need to understand the dynamics of social interactions that have started as a result of our interventions. We not only need to understand what is happening as 'events' but in terms of 'sequence' and 'consequence'. I have found stories to be very useful for this purpose. However we need to train our field workers to collect sufficient details and this can also build their skills as community-based ethnographers. It is best if these stories are dated and analysed at different points of time and also in a sequential manner. They can provide interesting insights about the time trajectory of social change that Sridharan and Nakaima have alluded to.

Community monitoring is a dynamic learning process. As facilitators of this process we are not the only party which is learning and changing. The community mobilisation and empowerment process is expected to increase the community's autonomy and make them the key players in the intervention, marginalising the role of the facilitator. Similarly, the public authorities are not passive entities either. They will continually try to identify their interests and act accordingly. Thus, in a process of documentation or evaluation of such a dynamic inter-dependant learning process, it is necessary that the key stakeholders also become part of the evaluation process, not only as respondents but as active participants.

To summarise it would be helpful for any practitioner to prepare

- a written summary of their assessment of the environmental context, including a policy / programmatic analysis to identify accountability frameworks and possibilities for changes;
- an assessment of their own instititutional context and a plan to draw on existing resources where there are capacity gaps;
- a programme theory which includes a series of hypothesis of why they think their programmatic approach or different programme components will work;
- a diagrammatic representation of what are the direct and anticipated interactions that will take place between different actors/stakeholders and factors (community, cultural, programmatic, service conditions). This can be both beneficial interactions and resistances;
- a list of possibilities for intermediate situations through the programme theory articulation and diagrammatic representation;
- a documentation and assessment plan for how and when the documentation process will take place once the intervention begins and to regularly review these to identify lessons and modify interventions;
- a document with these review processes and the decisions.

One can locate specific studies and even quantitative assessments within this framework, however it is useful to remember that changes in power relationships can take considerable time to take place and initial changes can be difficult to sustain. So an interpretation of quantitative results needs to be nuanced with an understanding of the change processes within the community and between the different stakeholders.

Project managers are often too anxious in trying to see whether the various project inputs are being delivered in time and managing different practical discrepancies. In order to strengthen the learning component of our intervention, it is important to have an ‘embedded evaluator’ in the manner proposed by the Patton and colleagues of the Development Evaluation discipline. This person has to be sufficiently close to conceptual dimensions of the process to be keenly interested and reasonably distant so as not to be caught up in the day to day implementation, and sufficiently respected for their analyses to be taken seriously by the day to day managers and implementers. We also need periodic opportunities where the documentation of progress may be reviewed and lessons drawn for incorporation into the ongoing implementation process. Our implementation process should be flexible enough not only to make changes to adjust, but to adapt, learn and grow. Many of us may not be in a position to hire a professional Development Evaluator, but we can certainly find colleagues who could provide this function. We may need to involve such colleagues right from the conceptual stage, or as early as possible.

I hope I have been able to highlight the importance of thinking – reflecting - writing throughout this process - from the context to the planning process; from the regular ongoing documentation and stories of change and resistance to the report of review process; from the positive outcomes to the lessons learnt and challenges faced. This body of documentation

becomes the source of a case-study and the body of new evidence that is sought by the large scale development project implementer and policy maker. It is comparable, if not superior to the experimental study even though it does not vouch for generalisability of the solution nor provide sophisticated statistical analyses. Instead, it provides an idea of not only what works and doesn't, substantiated by evidence and logic. It also provides insight about how the processes take place within a community and how the context may interact in particular ways with our interventions. It could also provide us more than one way to approach the situation and different ways of interpreting success and possibilities. It is a tragedy that we seek uniform solutions in the vastly diverse world of ours, and this approach to monitoring and evaluation can promote this spirit of diversity.

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