



Community-led monitoring and the role of Ritshidze in improving the quality of primary healthcare in South Africa

K Govender,¹ MSc (OT); N Rambau,² P Barron,³ FFCH (SA); B Setshogelo,⁴ K Vallabhjee,⁵ FFCH (SA); M Nyathi,⁴ H Schneider,¹ PhD; S Xaba,⁴ N Mpofu,⁶ A Yawa,⁷

¹ School of Public Health, University of the Western Cape, Cape Town, South Africa

² Project Co-ordinator, Ritshidze, South Africa

³ School of Public Health, University of the Witwatersrand, Johannesburg, South Africa

⁴ Project Officer, Ritshidze

⁵ Clinton Health Access Initiative, South Africa

⁶ Policy, Communications and Research Manager, Treatment Action Campaign (TAC), Johannesburg South Africa

⁷ General Secretary, Treatment Action Campaign (TAC), Johannesburg, South Africa

Corresponding author: K Govender (kgovender@uwc.ac.za)

Community-led monitoring (CLM) of health services is a mechanism of community participation and accountability that is increasingly advocated across the globe. In South Africa (SA), a large-scale community-led monitoring initiative called Ritshidze ('saving our lives') was established in 2019. Steered by a coalition of civil society organisations representing people living with HIV, Ritshidze monitors just over 400 primary healthcare (PHC) facilities in 8 provinces on a quarterly basis. In this piece we describe the purposes and design features and the five-step approach to CLM of the Ritshidze model. We also highlight some of the positive changes achieved, and reflect on possible reasons for successes. In doing so, we aim to draw attention to this significant national initiative and its potential as a mechanism of social accountability in SA.

S Afr Med J 2024;114(6):e2043. <https://doi.org/10.7196/SAMJ.2024.v114i6.2043>

There has been ongoing debate on the ideal mechanisms of community participation in healthcare, and the extent to which community participation has a meaningful impact on the quality and outcomes of health services.^[1-3] The Alma Ata Declaration on primary healthcare situates communities and health users at the centre of healthcare, but community participation has since come to mean a wide variety of things, from minimal involvement to broad-ranging rights-based social mobilisations.^[2,4]

In South Africa (SA), health committees (HCs), also known as clinic committees, are statutory structures through which communities can formally participate in decision-making on the planning, implementation and delivery of healthcare in clinics and community health centres (CHCs), the first point of entry into the public health system for the vast majority of people in SA. HCs are a common feature of health systems in low- and middle-income countries, and typically act as the primary mechanism for communities to participate in the delivery of healthcare.^[5]

In their systematic review, McCoy *et al.*^[5] concluded that HCs can potentially have a positive impact on the health system if they are 'designed and implemented with care'. However, HCs have also been criticised as being ineffective structures for genuine community participation and their ability to improve healthcare services. In SA, a shortage of resources, role confusion, a lack of skills and information asymmetry between providers and managers and patients and communities are some of the challenges HCs experience in performing their functions.^[6] As a result, involvement in decision-making processes is often limited, and furthermore, HCs are largely excluded from higher level governance and policy. This mirrors global experiences where health facility committees have been described as relatively powerless^[5] and prone to 'elite capture'.^[7] Elite capture of community participation structures results in the

exclusion of the most affected in the community,^[7] and results in fewer benefits for poor or stigmatised groups.^[8] Communities may not have the skills or may be reluctant to address their concerns with the health system owing to power imbalances and the fear of reprisal or receiving poor care after they have expressed a grievance.^[9]

Forty-five years after the Alma Ata Declaration, policy makers, civil society and academia are still grappling with the question of how best to achieve community participation. Community-led monitoring (CLM) of health services is a mechanism of community participation that is increasingly advocated across the globe as a means to realise health and human rights.^[9,10] In SA, a large-scale CLM initiative called Ritshidze was established in 2019. Translated to 'saving our lives' in Tshivenda, Ritshidze is a coalition of organisations representing people living with HIV. It grounds its work in CLM as a means to improve the quality of health services received by public healthcare users, people living with HIV and members of 'key populations'.^[11] Key populations refer to lesbian, gay, bisexual and trans people, men who have sex with men, people who use drugs and sex workers.

This piece serves as the first in a series of articles reporting on the Ritshidze model. We introduce the principles of CLM, and describe the purpose, design features and processes of the model.

An overview of community monitoring

CLM has been described as a social accountability strategy where communities are positioned as capable agents of change to realise health and human rights.^[11] This marks a shift from top-down and more bureaucratic mechanisms of representation.^[12] In the language of human rights, communities and civil society actors are 'rights-bearers' who hold 'duty bearers' to their mandate. Rights bearers can lay claim to entitlements from duty bearers, with the latter typically

a range of state actors, from frontline providers and managers to policy makers. The emergence of CLM was driven by its potential to counteract many of the challenges communities experience when reporting their grievances with the state and other mandated service providers.

In CLM, communities collect routine data on the quality of services provided, which are then used as a tool to negotiate for improved services. Communities are able to engage from an informed position and speak to specific health entitlements and concerns they have regarding the quality of services they receive. CLM can be especially important in settings where resources are limited and monitoring systems are weak,^[12] a common situation in the health systems of low- and middle-income countries.

CLM can take different forms, such as the routine collection of data using standardised tools with feedback to facilities, citizen report cards, community score cards and community treatment observatories.^[9] In Mozambique, the use of community scorecards in combination with health advocates led to an improvement in relationships between health providers and communities, and increased involvement of men in reproductive services.^[5] Health advocates were cited as pivotal to the success of community monitoring, providing education to communities on health policy standards and their health rights,^[13] communicating that CLM cannot take place in isolation and requires other components to be effective. Successful models of CLM share a common set of features, described by Baptiste *et al.*^[9] as: (i) community-led; (ii) continuous and systemic; (iii) collaborative; (iv) involving community education; (v) involving community advocacy; (vi) transparent; (vii) accountable; and (ix) inclusive.

Equally important is the willingness and ability of duty bearers to productively engage with communities carrying out CLM.^[11] In their review, Lodenstein *et al.*^[11] identified key factors that influence the responsiveness of healthcare providers and the health system to social accountability mechanisms. These include: (i) the legitimacy of the civil society organisation conducting the social accountability intervention; (ii) health providers identifying with the role of activist; (iii) health providers relying on the expertise and capacity of communities; and (iv) health providers believing that they can influence the health system positively.

What is Ritshidze?

Ritshidze is a coalition of civil society organisations representing people living with HIV in SA. It is part of a broader global network implementing similar social accountability interventions in 20 other countries. In 2018, the 'People's Country Operational Plan' (COP19) – an advocacy document aimed at influencing the US President's Emergency Plan for AIDS Relief (PEPFAR)'s spending priorities on HIV and TB programmes in SA – called for the funding of CLM.^[14] Ritshidze has since been funded by PEPFAR through the Joint United Nations Programme on HIV and AIDS (UNAIDS), and is supported by the SA Department of Health at the national and subnational levels. The Foundation for AIDS Research (amfAR), Health Global Access Project (GAP) and the O'Neill Institute for National and Global Health Law provide implementation and programme management support. Ritshidze was established in response to the insufficient progress SA was making with regard to treatment coverage, retention in care and

viral suppression in people living with HIV. According to Ritshidze, progress was hindered primarily by the chronic dysfunction within public health facilities, citing the poor performance of several PEPFAR-supported sites across the country.^[11] Other considerations were the necessity to optimise funding by using methods that have shown high levels of efficacy.

Through CLM, Ritshidze seeks to hold the national, provincial, and district departments of health, PEPFAR and its implementing partners, and other duty bearers to account for the quality of health services provided to people living with HIV and TB. The overall goal is to improve HIV and TB service delivery, and primary healthcare more generally.

Ritshidze's approach to community-led monitoring

Each quarter, Ritshidze carries out CLM in about 400 clinics covering 27 districts in all SA provinces except the Northern Cape (Table 1).^[11] The facilities were purposefully selected, as they have large HIV treatment cohorts and because they performed relatively poorly in treatment linkage and antiretroviral therapy continuity. More than half of the facilities (62%) are in Gauteng and KwaZulu-Natal provinces, with a further 19% in Eastern Cape and Mpumalanga, 11% in Western Cape and Free State, and lastly 8% in Limpopo and North West.

Ritshidze's five-step model involves: (i) gathering evidence; (ii) analysing the data; (iii) generating solutions; (iv) engaging duty bearers; and (v) advocating for change.^[11] The model follows a quarterly cyclical approach. The first month of the cycle is spent gathering evidence by community monitors and their teams, followed by data analysis and generating solutions in the second month. The third month is spent engaging duty bearers and advocating for change. Ritshidze's work is grounded in the following principles: (i) CLM must be led by communities directly affected by HIV, TB and key populations; (ii) must not be influenced by external agents such as donors and the state; (iii) must be owned and led by communities at every stage; (iv) must generate political will to enact change and hold duty bearers to account, (v) must adhere to ethical data collection; (vi) data must be owned by communities and be publicly available; and (vii) community monitors must be representative of service users, well trained, supported and adequately paid, while still ensuring independence from the donor.^[15]

Community monitoring teams: CLM is undertaken by a team comprising a community monitor employed by Ritshidze, together with members from the people living with HIV (PLHIV) organisations, overseen by a district organiser who oversees the team and their activities. There are 80 teams in total. The teams monitor the public health facilities where they themselves receive healthcare. Community monitors are trained on how to use the model and are provided with detailed guidelines, mentoring and support on how to implement each step. Each community monitor is allocated 5 - 8 facilities to monitor. At a national level, project officers oversee the entire data collection effort. Dedicated teams are also employed to monitor the services provided to key populations.

Indicators: Ritshidze collects data on nearly 500 indicators across all its surveys. The data cover staffing and waiting times, clinic conditions, HIV and TB services, services for key populations, access to medicines

Ritshidze is a coalition comprising civil society actors who have played a prominent role in supporting and advocating for people living with HIV in SA. These include the Treatment Action Campaign (TAC), the National Association of People Living with HIV (NAPWA), Positive Action Campaign, Positive Women's Network (PWN), and the SA Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+).

and accountability. The indicators communicate the extent to which the facility provides care that is supportive of public healthcare users, PLHIV and members of key populations. Community monitors seek both qualitative and quantitative data. For example, the length of waiting time is complemented with data on the possible reasons, together with personal testimonies, individual interviews, videos and case studies from health users and community members.

Gathering evidence: Community monitors and teams collect evidence from the healthcare facility and the community, ensuring the experiences of both current public healthcare users and those not accessing health services are captured. Data are collected using observations, patient surveys and a health facility manager survey. The community monitor identifies community members willing to provide individual testimonies at the facility as well as through door-to-door and other engagement in the community. A dedicated team follows up these community members through individual interviews to capture written, in-person and video-recorded qualitative data. Data are recorded on paper forms and through CommCare, an online app that allows community monitors to complete the surveys on their tablets.

Data analysis and solution generation: Once the data have been uploaded to CommCare, they are automatically analysed and uploaded to the Ritshidze dashboard, where they are represented using a combination of graphs, tables and reports. Reports are generated at a facility, district, provincial and national level, as well as per PEPFAR agency (USAID and Centers for Disease Control and Prevention), per implementing partner, or per 100 facilities which the National Department of Health has identified as being focus areas, allowing users to compare findings across all levels and over time. These reports are accessible by all through the Ritshidze data dashboard, allowing easy access for communities, civil society, journalists, academia and the public. Solutions are also generated on a quarterly basis by the monitoring teams to address the challenges highlighted through the data analysis process. These are also submitted to CommCare to be taken together with the reports to feedback meetings.

Engaging duty bearers and advocating for change: Ritshidze teams provide feedback to facilities, districts, provinces and national duty bearers on a quarterly basis. CLM teams first engage the health facility on the issues identified, to generate solutions. At the end of the meeting, the facility is requested to commit to actioning solutions. For issues that cannot be resolved at a facility level, and where no change has been made at this level, Ritshidze escalates the issues to the district, provincial and national health structures.

At district, provincial and national levels, annual State of Health reports are developed and presented in community accountability meetings that bring together duty bearers and community members to talk about their personal experiences trying to access public healthcare. Annually, a People's COP is developed using Ritshidze data that are also presented to PEPFAR teams. Civil society organisations use the People's COP to address ongoing issues with PEPFAR and the National Department of Health.

Ritshidze's impact

Ritshidze recently released a report highlighting its findings for the years 2021 and 2022. Positive changes in key performance indicators were documented (Table 2),^[11] including reduced waiting times, improved access to medicines and better facility staffing.

Ritshidze's achievements can be attributed to several factors, also identified by Baptiste *et al.*,^[9] as key features of successful community monitoring. Firstly, it is led by organisations that represent people living with HIV; the validity of Ritshidze's work

Table 1. Facilities monitored per province in the first quarter of 2024

Province	Facilities, <i>n</i>
Gauteng	137
KwaZulu-Natal	128
Eastern Cape	41
Mpumalanga	43
Western Cape	24
Free State	25
Limpopo	18
North West	18
Total	434

Table 2. An overview of key performance indicators in 2021 and 2022

Indicator	2021	2022
Waiting times	↓ 33	↓ 17
PLHIV getting refills for ≥3 months, %	↑ 18 to 33	↑ 33 to 44
PLHIV not receiving medicines, %	↓ 8	↓ 3
PLHIV indicating that the facility was well staffed, %	↑ 26 to 35	↑ 35 to 40

PLHIV = people living with HIV.

is supported by employing community monitors and working with members who live in the same communities they serve. Community monitors are grounded in their communities and are thus uniquely positioned to provide local insights. Secondly, regular and routine CLM allows for timely comparison of findings, and monitoring addresses both facility and systems-based issues. Thirdly, community monitors are transparent and accountable in presenting their results to health facilities, including clinic committees and communities, publishing data online in real time and live streaming community accountability meetings. Finally, community education is considered key, and community monitors educate public healthcare users, clinic committees and community members about health and advocacy.^[8]

Conclusion

Ritshidze is a unique phenomenon in SA. It is an excellent example of the use of data, empowering communities and social accountability in practice. It has a wide coverage of more than 400 clinics and CHCs, and, as such, is a major social accountability intervention. It illustrates that strengthening and sustaining meaningful community involvement requires consistent commitment, and investment of time and resources. While Ritshidze and others recognise that CLM is not a solution to all healthcare problems, it does however provide communities the tools to engage meaningfully with the health system in a way that informs change at a facility level and at higher levels of the health system.

In subsequent articles we will present a more detailed review of data collected, and reflect on the success factors and challenges with the model.

Declaration. None.

Acknowledgements. None.

Author contributions. KG – writing. PB, KV, HS, NR, BS, MN, SX, NM, AY: review and edits.

Funding. None.

Conflicts of interest. None.

1. Lodenstein E, Dieleman M, Gerretsen B, Broerse JEW. Health provider responsiveness to social accountability initiatives in low- and middle-income countries: A realist review. *Health Pol Planning* 2017;32(1):125-140. <https://doi.org/10.1093/heapol/czw089>
2. Abimbola S, Drabarek D, Molemodile SK. Self-reliance or social accountability? The raison d'être of community health committees in Nigeria. *Int J Health Planning Manage* 2022;37(3):1722-1735. <https://doi.org/10.1002/hpm.3438>
3. Haldane V, Chuah FLH, Srivastava A, et al. Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PLoS ONE* 2019;14(5):1-25. <https://doi.org/10.1371/journal.pone.0216112>
4. Brunton G, Thomas J, O'Mara-Eves A, Jamal F, Oliver S, Kavanagh J. Narratives of community engagement: A systematic review-derived conceptual framework for public health interventions. *BMC Public Health* 2017;17(944):1-15. <https://doi.org/10.1186/s12889-017-4958-4>
5. McCoy DC, Hall JA, Ridge M. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Pol Planning* 2012;27(6):449-466. <https://doi.org/10.1093/heapol/czr077>
6. Haricharan HJ, Stuttaford M, London L. The role of community participation in primary health care: Practices of South African health committees. *Prim Health Care Res Dev* 2021;22(31):1-10. <https://doi.org/10.1017/s146342362100027x>
7. Dasgupta A, Beard VA. Community driven development, collective action and elite capture in Indonesia. *Develop Change* 2007;38(2):229-249. <https://doi.org/10.1111/j.1467-7660.2007.00410.x>
8. Bisnauth MA, Davies N, Monareng S, et al. Why do patients interrupt and return to antiretroviral therapy? Retention in HIV care from the patients perspective in Johannesburg, South Africa. *PLoS ONE* 2021;16(9):0256540. <https://doi.org/10.1371/journal.pone.0256540>
9. Baptiste S, Manouan A, Garcia P, Etya'ale H, Swan T, Jallow W. Community-led monitoring: When community data drives implementation strategies. *Curr HIV/AIDS Rep* 2020;17:415-421. <https://doi.org/10.1007/s11904-020-00521-2>
10. Joint United Nations Programme on HIV and AIDS. Establishing community-led monitoring of HIV services – principles and process. Geneva: UNAIDS, 2021. https://www.unaids.org/sites/default/files/media_asset/establishing-community-led-monitoring-hiv-services_en.pdf (accessed 10 January 2024).
11. Ritshidze. Ritshidze Annual Report 2021 and 2022 edition. <https://ritshidze.org.za/wp-content/uploads/2023/06/Ritshidze-Annual-Report-2021-and-2022.pdf> (accessed 10 January 2024).
12. Bauhoff S, Rabinovich L, Mayer LA. Developing citizen report cards for primary health care in low and middle-income countries: Results from cognitive interviews in rural Tajikistan. *PLoS ONE* 2017;12(10):1-14. <https://doi.org/10.1371/journal.pone.0186745>
13. Feinglass E, Gomes N, Maru V. Transforming policy into justice: The role of health advocates in Mozambique. *Health Hum Rights J* 2016. <https://www.hhrjournal.org/2016/09/transforming-policy-into-justice-the-role-of-health-advocates-in-mozambique/> (accessed 12 January 2024).
14. People's COP19 South Africa. Community Priorities. People's COP19, 2020. <https://ritshidze.org.za/wp-content/uploads/2020/11/Peoples-COP19-South-Africa.pdf> (accessed 4 January 2024).
15. Frost SDW, Martinez-Picado J, Ruiz L, Clotet B, Leigh Brown AJ. Viral dynamics during structured treatment interruptions of chronic human immunodeficiency virus type 1 infection. *J Virol* 2002;76(3):968-979. <https://doi.org/10.1128/jvi.76.3.968-979.2002>

Accepted 8 April 2024.