RMCH
REDUCING MATERNAL AND CHILD MORTALITY
THROUGH STRENGTHENING PRIMARY HEALTH CARE

BLACKSASH
MAKING HUMAN RIGHTS REAL

Black Sash RMCH Baseline Report:

Strengthening Community Accountability Mechanisms to Improve Maternal, Neonatal and Child Health Services

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Glossary of Acronyms

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BS	Black Sash
CBO	Community Based Organization
CCs	Clinic Committees
CCG	Community Care Giver
CHC	Community Health Centre
CHCCs	Community Health Centre Committees
CHW	Community Health Worker
CSC	Community Score Card
DoH	Department of Health
EC	Eastern Cape
FG	Focus Group
FGD	Focus Group Discussion
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HST	Health Systems Trust
KZN	KwaZulu-Natal
MNCH	Maternal, Neonatal and Child Health Services
NDoH	National Department of Health
NGO	Non-governmental Organisation
NHA	National Health Act
NIMART	Nurse Initiated Management of Antiretroviral Treatment
PCR	Polymerase Chain Reaction testing for HIV
PNC	Postnatal Care
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PSJ	Port St. Johns
RMCH	For the purposes of this project: **R**educing **M**aternal and **C**hild Mortality through Strengthening Primary **H**ealthcare Could also mean: Reproductive, maternal and child health services
SDD	Social Development Direct
SGBs	School Governing Bodies
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

Glossary of Terms

Accountability	*Supporting communities to constructively engage with the health system to strengthen accountability for delivery of high quality MCH services thereby improving demand for these services*
Public accountability mechanisms	*Structures governed by the National Health Act, such as clinic and community health centre committees.*
Baseline study / situational analysis	*Work done to collect and interpret information on the current status of a particular situation/environment/study topic.*
Case Study Approach	*A research approach in which data is collected within its real-life context.*
Demand barriers	*The reasons why people choose not to access PHC even when it is free at point of access. Demand barriers include out of pocket costs e.g. transport, people not knowing about MCH services, attitude of staff, and perceptions of poor quality service.*
Multi-stakeholder	*Framework/structure bringing together multiple stakeholders from both civil society and the public sector.*
Qualitative research methods	*A research technique in which data is collected through interviews and focus group discussions. This is data based on key informants perceptions and interpretations.*
Supply barriers	*These are factors at the facility level affecting access to and uptake of PHC services. Supply barriers include not enough trained doctors and nurses; not enough supplies or equipment*

Introduction

The situational analysis detailed in this summative report focuses on the issue of demand and accountability for MNCH services in two focus districts of OR Tambo in the Eastern Cape and uMgungundlovu in KwaZulu-Natal. In other words it is interested in learning about 1) access to and use of public health services related to reproductive health, post natal and antenatal care and neonatal care, and 2) the functionality of accountability mechanisms that are in place to ensure that the public health system is able to respond to the needs of women and children.

It is widely appreciated that meaningful participation of service users in the decision making process is integral to ensure the health system responds to their needs, and therefore that demand is generated for these services. A number of legislative and policy frameworks exist in South Africa to support the realisation of community participation in health. The right of citizens to actively participate in decisions related to their health is guaranteed in the 'The National Patients' Rights Charter of South Africa' as well as in government's 'Batho Pele (People First)' principles, which seek to ensure voice, participation, responsiveness, access, value for money, redress, transparency and accountability to citizens. The White Paper on the Transformation of Health in South Africa, 1997 and the South African National Health Act (NHA) 61 of 2003, furthermore sought to establish community structures e.g. Clinic/ Community Health Committees (CCs/CHCs), from which participation and accountability can be realised. The NHA further emphasises that Provincial legislation or policy must provide for the establishment of CCs/CHCs and outline their functions, and which exist in both the EC and KZN.

In spite of the existence of a legal and policy framework to enshrine accountability, there is widespread and chronic lack of accountability and responsiveness to citizens. The principle of active citizenship is being undermined by the dominance of a centralized approach to service delivery which has hampered meaningful citizen engagement in planning and implementation. Furthermore research has shown that many of these community accountability mechanisms e.g. CCs/CHCCs are often dysfunctional and principally function as forums for complaints or for political debate, and are therefore falling short of their intended use and potential. Until users of MNCH services and the broader community are able to meaningfully express their needs, concerns and engage with service providers for improved delivery, high rates of maternal and child mortality are likely to continue unabated.

In order to improve MNCH services a dual strategy is needed whereby both supply and demand are addressed. Even if MNCH services are being provided by facilities (supply) demand barriers such as people not knowing about which MNCH services they should access, cultural preferences and practices, out of pocket costs to access services such as transport and perceptions of poor quality services, will continue to undermine DoH's efforts to reduce maternal and child mortality. Accountability mechanisms like CCs/CHCCs should be seen as a key vehicle from which to address these demand barriers. Accordingly, the limited effectiveness of CCs/CHCCs is a problem that needs a remedy.

In response to this problem and towards finding a solution, Black Sash (BS) was awarded a grant by the RMCH Programme in partnership with NDoH to consider and pilot test interventions which could promote increased collective action and problem solving at district level, using multi-stakeholder forums and dialogues. Although CCs/CHCCs are currently functioning poorly there are a number of alternative accountability mechanisms operating within these districts e.g. CBOs, NGOs, SGBs, War Rooms, Imbizos etc. The BS RMCH project therefore set out to investigate the extent to which a multi-stakeholder approach; whereby we link CCs/CHCCs and a range of civil society/multi-stakeholder organisations and forums, would create opportunities for collaborations and problem solving to improve MNCH services and outcomes. The intention is to build partnerships between CCs/CHCCs and these structures in the sub-district who are working in the MNCH field or who have a focus on health, who are addressing social determinants of health, or who have specific capabilities which can strengthen and build capacity of the CCs/CHCCs.

Accountability used to be thought of only in terms of citizens holding government to account. However, accountability is no longer seen as a force which runs only in a single direction from government to citizens.

New thinking on accountability is that it requires citizens to take responsibility and action to realise their rights, including taking responsibility for their own health and wellbeing. This new generation of thinking on building dynamic accountability mechanisms supports the idea of creating multi-stakeholder forums, which brings the community (service users) and government (service providers) together for collective problem solving and action to improve health service delivery.

The following principles underpin the Black Sash RMCH project:

- We will promote both rights and responsibilities for RMCH services
- We will seek to understand the perspectives of both community members and health professionals
- We will foster constructive and collective input from both community and health professionals about how to jointly improve the delivery of RMCH services through multi-stakeholder forums

The emphasis of the Black Sash RMCH project is to identify and support such mechanisms at community level, to raise the importance and challenges of 'Reducing Maternal and Child Mortality through Strengthening Primary Health Care' (RMCH) with the intention that they would champion MNCH in their forums, focusing on the rights and responsibilities of community members, monitoring of health service delivery and uptake, and on constructive engagement between health facilities and communities to improve these services. The overall goal of the project is to consider ways to promote increased collective action and problem solving at district level, using multi-stakeholder forums and dialogue.

The first activity of the BS RMCH project was to conduct a rapid situational analysis in OR Tambo in the EC and in uMgungundlovu in KZN. The objectives of the situational analysis included 1) assessing the functionality and effectiveness of existing CCs/CHCCs and whether they focus on MNCH services 2) identifying and mapping existing civil society/multi-stakeholder organisations and forums, and whether they focus on MNCH services 3) determining whether there is currently any engagement between CCs/CHCCs and civil society/multi-stakeholder organisations and forums and what potential exists for building institutional linkages between them to strengthen and improve the capacity of CCs/CHCCs 4) determining whether CCs/CHCCs or civil society/multi-stakeholder organisations and forums are currently using any accountability tools which could be replicated or improved upon; such as community monitoring, social audits, public hearings, budget tracking or community scorecards. This baseline report will then be used to guide the development of interventions, tools and training to strengthen CCs/CHCCs and their engagement with civil society/multi-stakeholder organisations and forums, with the intension of improving MNCH services.

Methodology

The study employed qualitative research methods and a case study approach for each health sub-district. The situational analysis covered one CC or CHCC per sub-district as well as mapping a number of civil society/multi-stakeholder organisations and forums operating within the catchment population of the chosen clinic or CHC. The following clinics were selected from each of the sub-districts within our two focus districts:

Table 1: Sample of CCs/CHCCs selected for the situational analysis

OR Tambo District, Eastern Cape	
Sub – District	**Clinic / CHC Committee**
King Sabata Dalindyebo	Stanford Terrace
Mhlontlo	Tina Falls Clinic
Qaukeni	Xurana Clinic
Nyandeni	The Port St John's Community Health Centre
uMgungundlovu District, Kwa-Zulu Natal	

Sub – District	Clinic / CHC Committee
Msunduzi	Caluza Clinic*
	Pata Clinic*
Mkhambathini	Njabulo Clinic
Richmond	Richmond Clinic
Mpofana	Bruntville CHC
Impendle	Nxamalala Clinic
Mshwati	Crammond Clinic
Mngeni	Mpophomeni Clinic

**Two case studies were covered due to the high population served and the burden of disease*

Sources of data included the following:

- 24 focus groups, 12 stakeholder workshops and 114 interviews covering the provincial, district and sub-district levels ;
- a review of existing minutes of CC/CHCC meetings;
- a literature review of evidence on the impact of CCs/CHCCs across the African continent;
- Statistics on key indicators of maternal and child health in the focus districts;
- Interpretations of challenges faced by CCs/CHCCs and possible solutions to address these, were also informed by attendance at a regional EQUINET workshop on health centre committees in Harare Zimbabwe, attended by practitioners across East and Southern Africa.

Limitations of this baseline study included:

- Insufficient, incomplete and unreliable data received on CCs/CHCCs from DoH or health facilities including: their existence, membership and minutes of meetings
- Lack of cooperation and resistance from officials including: difficulties in obtaining meetings, access to facilities or information, and people not speaking freely about existing challenges.
- Focus of our fieldwork was disproportionately focused on assessing CCs/CHCCs and lacked a deep assessment and emphasis on civil society/multi-stakeholder organisations and forums. Subsequently additional fieldwork was carried out to close information gaps.

Key Findings

Context: Maternal, Neonatal and Child Health Indicators in OR Tambo and uMgungundlovu

Table 2: Summary comparative table of MNCH indicators in OR Tambo & uMgungundlovu

MCH Indicator	OR Tambo	Comment	uMgungundlovu	Comment
Maternal mortality ratio in facility	68.5 per 100 000 live births	Significantly lower than uMgungundlovu	279.4 per 100 000 live births	uMgungundlovu has the second highest rate nationally
Stillbirth in facility rate	28.4 per 1 000 births	OR Tambo has the second highest rate nationally	27.6 per 1 000 births	uMgungundlovu second highest provincially
Inpatient early neonatal death rate	20.3 per 1 000 live births	OR Tambo has the second highest rate in the country and the highest rate among the NHI districts	9.1 per 1 000 live births	
The antenatal 1st visit before 20 weeks rate	31.5%	OR Tambo had the lowest rate in the province, below the national average of 44.0%, and the lowest among the NHI districts	46.5%	uMgungundlovu's rate is slightly above the national rate of 44.0%
HIV prevalence among antenatal clients tested	28.4%		39.8%	uMgungundlovu has the second highest rate among the NHI districts

Early infant HIV diagnosis coverage	60.3%	OR Tambo rate is well below the national coverage of 73.9%	80.9%	uMgungundlovu was above the national coverage of 73.9%
Immunisation coverage under 1 year	73.6%	OR Tambo has the fourth lowest rate of immunization in the country and the second lowest among the NHI districts	103.7%	Coverage exceeding 100% may be due to poor data quality or an underestimation of the under-1 population
Child under 5 years diarrhea case fatality rate	15.1%	OR Tambo's rate was the highest in the province and the country	2.6%	uMgungundlovu's fatality rate was the second lowest in the province
Child under 5 years pneumonia case fatality rate	8.6%	OR Tambo has the fourth highest in the country and the highest among the 11 NHI districts	3.3%	

****Based on figures from HST District Health Barometer 2013/2013***

Demand Barriers to Accessing MNCH Services

The data collected on key barriers to accessing MNCH services at the individual, household and community level (or demand side barriers), as well as the key factors affecting service delivery at the health system level (or supply side barriers) faced in communities; was found to be very similar to the challenges highlighted in previous studies and elsewhere in the country.

Table 3: Key Barriers to Accessing MNCH Services

Factors affecting service use at the individual, household & community level	Factors affecting service delivery at the health system level
Lack of knowledge or perceived need for MNCH services: ANC, PMTCT, PNC etc	Inconsistent availability of equipment & supplies
Fear or mistrust of health care workers due to past negative experiences	Lack of ambulances resulting in higher deliveries outside health facilities posing dangers for maternal & child health when complications arise during delivery
Concerns that health workers do not adhere to confidentiality regarding e.g. HIV status, teenage pregnancy or use of contraceptives	Lack of maternity wards: clinics do not have maternity wards and only some CHCs have maternity wards but often not enough space to accommodate everyone seeking care
'Forced' HIV testing when accessing ANC and refusal to render services when women decline to be tested for HIV	Opening hours of clinics & mobile clinics: not all facilities are open 24hrs and mobile clinics don't advertise their opening hours
Lack of understanding and /or respect for traditional practices related to MNCH, resulting in women avoiding health facilities	Staff shortages and therefore not able to keep up with the high volume of mothers and children at the health facility
Financial barriers: transport costs, distance from facilities etc	Poor working conditions, salary & long hours for facility staff impacting negatively on quality of care
Lack of women's decision making autonomy in regard to reproductive & child health in the household & community	Difficulty in retaining staff in rural areas

Key Findings on Clinic & Community Health Centre Committees

Comparative Analysis & Common Findings across the Focus Districts

Table 4 provides for a comparative analysis between the two focus districts of OR Tambo and uMgungundlovu on a number of criteria related to indicators of functionality of clinic and community health centre committees (CCs/CHCCs). The scores were gathered through key informant interviews and therefore reflect *perceptions* of functionality of those interviewed. In general, the CCs/CHCCs in uMgungundlovu are functioning better than those in OR Tambo although in neither district are they fully realising their potential. The reason why committees are functioning relatively better in uMgungundlovu is due to complex interacting factors. However, in summary a few important factors include: uMgungundlovu DoH has one official responsible for overseeing CCs/CHCCs, CC members receive a form of basic training and induction, DoH has arranged for refreshments at CC/CHCC meetings (although not covering all committees), and in some cases transport for representatives to attend meetings, which has reduced out of pocket costs and provided an incentive to participate in committees.

Table 4: Comparative analysis & common findings across the focus districts

Area/Indicator of functionality	Statement	OR Tambo			uMgungundlovu		
		Yes	No	Other	Yes	No	Other
Composition, structure, recruitment	The clinic committee includes the following members: a local government councilor, members of the management of the facility, members of civil society	25%	75%		75%	25%	
	The clinic committee members were nominated and elected by the community	75%	0%	25%	75%	25%	
	The clinic committee has the following office bearers: Chairperson, Deputy Chairperson, Treasurer, Secretary	75%	25%		87.5 %	12.5%	
	The clinic committee has a Constitution	0%	75%	25%	37.5 %	62.5%	
	The clinic committee has a Code of Conduct	0%	100%		50%	50%	
	The clinic committee has sub-committees	0%	100%		13%	87%	
Meetings	The clinic committee meets on a regular basis	75%	25%		100 %	0%	
	Clinic committee members attend meetings on a regular basis	50%	50%		75%	25%	
	CC/CHCC reported that MNCH is included as an agenda item of the clinic committee meetings	50%	50%		62.5 %	37.5%	
	Minutes are taken at the clinic committee meetings	100 %	0%		87.5 %	12.5%	
	The minutes of the meetings are circulated to all the members of the clinic committee	0%	50%	50%	62.5 %	37.5%	
Roles and responsibilities	The roles and responsibilities of the clinic committee are clearly defined and understood by the clinic committee members	25%	75%		75%	25%	
	The clinic committee members have received training and induction following their appointment	0%	100%		62.5 %	37.5%	
Reporting	The clinic committee submits regular reports to the District Portfolio Councilor for Health	0%	100%		50%	50%	

Lack of District DoH Monitoring and Evaluation of Functionality of CCs/CHCCs

The monitoring and evaluation mechanisms currently in place to assess the functionality of CCs/CHCCs are limited to checking the existence of meeting minutes (content of these meetings is not emphasised) and attendance registers. More qualitative indicators such as understanding roles and responsibilities and having the relevant resources and capacity to fulfil their functions adequately, does not seem to be monitored. There is a general lack of reporting with regards to which committees exist, their composition and representation and whether they are functional or not. At the departmental level there were no available reports on the status of committees. It was stated that the CCs/CHCCs are only occasionally mentioned in the departmental quarterly reports.

Challenges with Election Process, Composition and Recruitment

Representatives of committees are often not democratically elected by the catchment population of the clinic or CHC. Instead they are chosen by the facility manager, the induna/ traditional leader or another DoH official. A common explanation for this undemocratic procedure was that community members did not turn up to elections. However, it was often found that inadequate mobilisation and awareness raising was undertaken prior to the election date. It was common to find representatives serving far beyond the three year term of office. However at the same time, high turnover of representatives was also cited as a key challenge.

CC/CHCC committees seldom abide by the NHA composition requirements (e.g. the absence of a ward councillor was found on most committees). It was also commonly reported that the committee was not representative of the entire community within the catchment area of the health facility. A lack of youth participation was reported as they are not willing to serve in structures where there is no remuneration. It was found that the same people are therefore being elected to different community structures (SGBs, ward committees etc) and sometimes the meetings and activities of these different structures coincide, resulting in

poor attendance and commitment. Tension between ward councillors and traditional leaders were also often cited as undermining the effective functioning of committees.

Low Levels of Literacy and Inadequate and Inappropriate Training

Certain challenges faced by committees in South Africa are uniquely embedded in our history of Apartheid and deeply institutionalised structural poverty and inequality. Most of the CCs/CHCCs covered in this study reported that they were unable to attract youth into their ranks due to the lack of financial incentives. The vast majority of representatives are therefore comprised of the elderly. This presents two key challenges. Firstly, the elderly may not have the required energy and mobility to mobilise the community into action for health promotion. Secondly, many of the elderly had very poor literacy and numeracy skills as a result of coming from a generation oppressed by a deeply exploitive and inadequate Apartheid education system. Literacy was therefore found to be a key barrier to the functionality of committees.

In spite of the great need for training and capacity building for committees to play the role envisioned for them in the NHA, in neither district have formal training manuals and programmes been developed. Neither the provincial policy in EC nor the Act in KZN stipulates who is responsible for training the committees and how it should be funded. The result is that in OR Tambo no training was provided to committees assessed in this study and in uMgungundlovu the basic training being provided is said to be inappropriate and insufficient. However, in uMgungundlovu new recruits to CCs/CHCCs are often not inducted and no refresher training is provided which is also problematic. Existing training is often limited to providing representatives with the complex national and provincial policies for CCs/CHCCs which are difficult to comprehend without thorough training to engage with its content.

It is clear that there is a very tangible connection between whether training has been conducted and a understanding of roles and responsibilities, as significantly more representatives in uMgungundlovu (where some training is happening) proclaimed to understand their roles in comparison to OR Tambo (where no training had been received).

Confusion around Role and Responsibilities of CCs/CHCCs

The understanding of roles and responsibilities of committees is not clearly understood either by representatives themselves, communities, facility staff, other DoH officials or the civil society/multi-stakeholder organisations. Activities involved in the day-to-day running of the health facilities are often cited as indicated in the case study below from OR Tambo. Similar confused explanations of roles and responsibilities were found in uMgungundlovu.

The clinic committee in OR Tambo indicated that their roles and responsibilities included:

- Ensuring the safety and security of nurses;
- Ensuring secure accommodation for clinic staff living outside the official residence;
- Providing a security function at the clinic;
- Fetching water for the nurses;
- Assisting CHWs in ensuring that patients are taking their medication;
- It was reported that the CC is responsible for fundraising so that they can have money to pay for their own travelling and other costs of running the committee;
- The committee reportedly undertakes any tasks requested by the nurses at the clinic.

The fundraising role of committees across districts was found to be inappropriate. What was particularly concerning were reports that committee members were selling fresh produce from household gardens, which

should support their own household livelihoods (which are often vulnerable as it is), to raise money for the health facility.

Tension of Navigating both Upward and Downward Accountability

A serious tension exists in regards to the accountability of committees in relation to both the community and the health system. According to the NHA, committees are obliged to be accountable at all times to the community, but according to policy directives they also need to be accountable to the health system because they are directly accountable to the MEC of Health and are required to submit quarterly reports to the District Portfolio Councillor for Health (EC CC/CHCC Policy, 2009).

This tension is also played out in the advocacy role of the committees. They are meant to advocate in the best interests of the communities they serve while at the same time being expected to advocate for the interests of the clinic or CHC at district, province and with the public at large. This tension is one which is extremely hard to navigate. A concern exists that accountability is imbalanced and when confusion arises regarding to whom committees are accountable to, the default seems to be towards the facility and not the community.

Conundrum of Stipends and Incentives to Participate

Across the board there is a huge demand for stipends from members of CCs/CHCCs. CCs/CHCCs are currently operating as an unfunded entity and representatives (often from poor households) have to pay for transport and other running costs. Poor attendance at committee meetings is often due to members being unable to pay for transport to attend, especially where they live far away from the facility.

Many CC/CHCC members join with the expectation of the appointment leading to a paid job or eventually to a stipend and then leave when they find this does not materialise. The outcry around the lack of stipends is aggravated when CC/CHCC members compare their situation to that of ward committees, CHWs and other community structures who receive stipends.

In uMgungundlovu some of the committees have started receiving refreshments/lunch during their meetings as well as transport, which is greatly appreciated and motivating. However, many are still not receiving consistent support which is creating disillusionment. Some facility managers end up taking this upon themselves in the absence of receiving support from the DoH.

Lack of Engagement between CCs/CHCCs and the Community

Committees should be consulting regularly with the catchment population of the clinic or CHC in order to ensure they remain aware of key health challenges and can therefore adequately represent the needs of the community. However community representatives often indicated that they do not know who the members of their CC/CHCC are and that they were not even aware of the existence of a committee. They therefore have no knowledge of what the roles and responsibilities of the committees are. Nor do they know how to approach the CC/CHCC if they want to raise an issue or suggestion.

Most committee engagement with the community in both districts was limited to the suggestion box placed at the clinic. The suggestion box has proved to be an inadequate and token mechanism for community engagement as communities receive no feedback on whether their challenges are being addressed or play no part in problem solving to address health challenges. A few of the committees across the districts indicated that they are consulting with the community through meetings called by the tribal authority and this is reportedly working well. However, the challenge is whether community members will be able to speak freely in the presence of traditional leaders, especially women. During some FGDs with committees it was noted that the CC as a collective, does not engage with the community but that individual members of the CC seem to be engaging with the community.

Lack of Engagement between CC/CHCC and Facility Staff

In the majority of cases there is no engagement between the CC/CHCC and the facility staff beyond the clinic/CHC manager. Facility managers were often not providing any feedback to their staff regarding what is discussed at CC/CHCC meetings. The relationship between the committee and facility staff was often tense,

which undermines the potential for collective problem solving. The monitoring and oversight role of the committees was interpreted by facility staff as a 'watchdog' role.

Poor Understanding of the Reporting Structure & Health Governance System

It was also found that the committees across the two focus districts have a lack of understanding of reporting channels resulting in interactions between the CC/CHCC and health system often being limited to facility managers and clinic supervisors (in OR Tambo). There are very few cases of interactions with Sub-District managers, District Managers, District Portfolio Councillors of Health or MECs of Health. Key informants identified certain officials as acting as gatekeepers. Since CCs/CHCCs do not understand the reporting system, they are unable to navigate themselves past gatekeepers to ensure challenges are resolved at higher levels of the district health system if need be.

Importance of Building Strong Relationships between CCs/CHCCs and Key Stakeholders

The importance of building strong relationships (social and political capital) between the CCs/CHCCs and other key stakeholders was found to be a key determinant of the success of committees, as demonstrated in the case study box below. The following support and linkages were seen as critical and any intervention to strengthen the role of these committees needs to emphasise the role of the following stakeholders:

Sub-District and District Managers: were found to be critical actors in championing the demands of health committees; usually facilitated with the support of the facility manager (as a member of the committee).

Facility/Operational Managers: The relationship between Facility/Operational Managers and committees was found to be a key determinant of the success and functionality of the committee.

Ward Councillors: were found to be mostly absent but where they were present it was clear they played an important role in bringing the voice of the community to the district and even provincial levels.

District Portfolio Councillor for Health: In spite of the fact that CCs/CHCCs are meant to submit regular reports to this stakeholder, none of the committees in OR Tambo were aware of this obligation and only half of the committees in uMgungundlovu were interacting with this actor and submitting reports.

Civil Society/Multi-Stakeholder Organisations and Forums: are mostly unaware of the existence of CCs/CHCCs. However, most civil society/multi-stakeholder organisations and forums expressed interest in collaborating with committees to solve MNCH challenges. In the rare cases where CCs/CHCCs had collaborated with War Rooms in uMgungundlovu, much was achieved.

Case Study of a Successful CHCC in uMgungundlovu

Factors contributing to the success of this health committee:

- ✓ Significant support from two active councillors
- ✓ Active CEO who ensures meetings occur as scheduled, minutes are taken and feedback is provided to the sub-district office regularly
- ✓ Committee members include members from civil society organizations representing a broad spectrum from all sectors and incorporating many strong leaders
- ✓ Strong relationship between CEO and the PHC/sub-district manager
- ✓ Community representatives ensure consultation with the community.

Successes attained by a particular health committee:

- ✓ The relationship between the health facility and the community was very tense. The committee has been instrumental in ensuring a more constructive relationship. A number of prominent leaders are represented on the committee (i.e. traditional leaders/healers, church leaders, and councillors) and they have played a role as facilitators in ensuring both the facility and service users/community understand each others' constraints (e.g. nurses working under long hours with several patients to see each day)
- ✓ As a result of the good relationship between the CEO and the PHC/sub-district manager, the CEO was successful in obtaining a mobile clinic at the request of the committee.
- ✓ If the Sub-District Manager is not able to address concerns brought to her, she will take these to the District office.The following requests of the CHCC were also processed through the office of the District Manager or MEC of Health
    - Nurse Initiated Management of Antiretroviral Treatment (NIMART) Training for Nurses
    - Training for HCT counsellors
    - CD4 Testing Machine
    - Two ambulances for the CHC

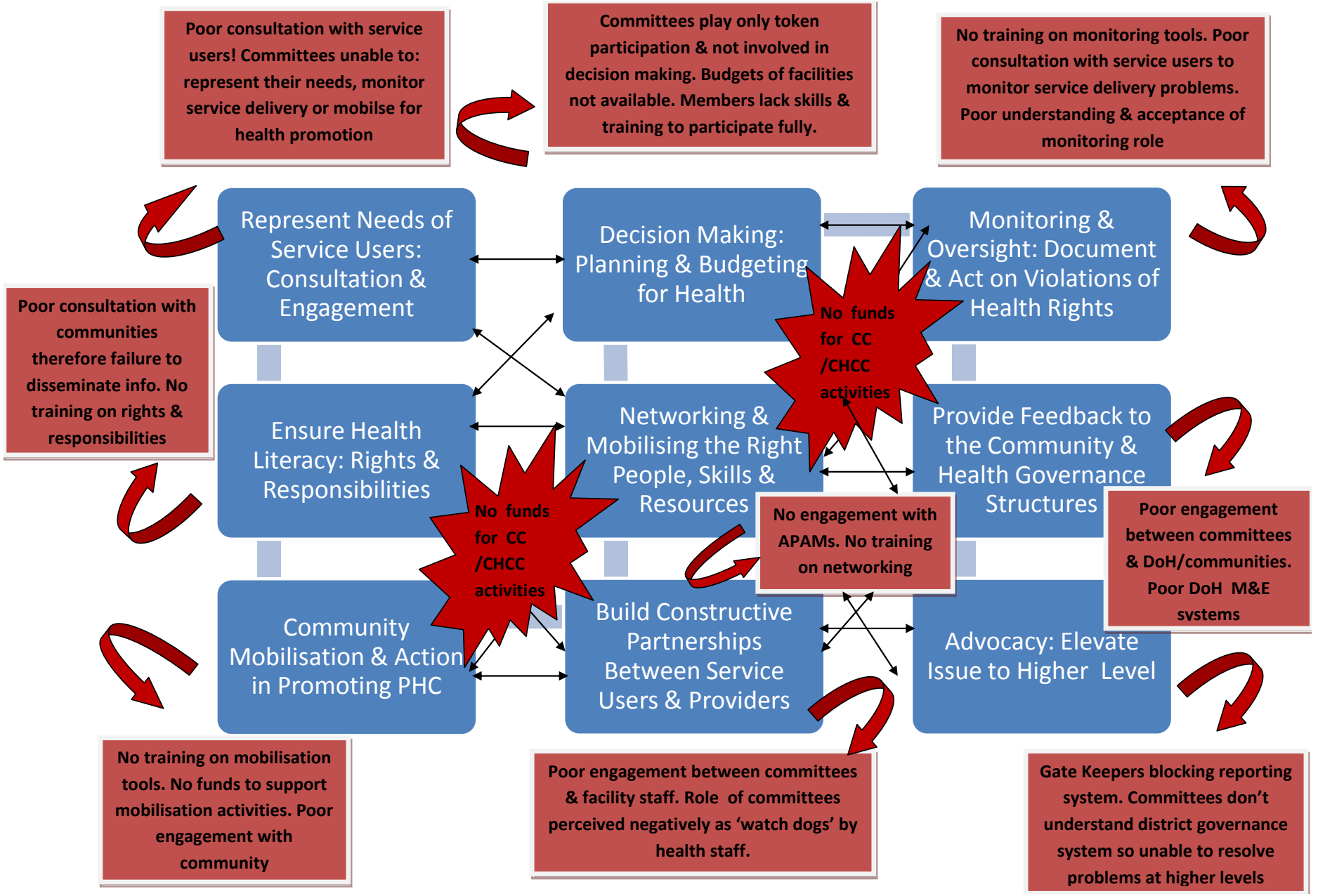
Table 5: Enablers & Barriers to the Functioning of CCs/CHCCs

Enablers	District where enabler found in certain case studies	Barriers	District where barrier found in certain case studies
Transport and refreshments provided for committee meetings	uMgungundlovu	Lack of reimbursement for out of pocket costs	Both
Constructive and supportive relationship between facility manager & CC/CHCC	Both	Lack of understanding of reporting structures	Both
Good consultation between committee and the community	Both	DoH officials or facility staff acting as gatekeepers	Both
Facility manager who champions issued discussed in committee meetings at the sub-district level	uMgungundlovu	Lack of community consultation	Both
Sub-district manager takes forward requests of the committee to district manager and MEC level for resolution	uMgungundlovu	Inability to access people living in remote areas in order to educate, consult, and motivate them	Both
Receptive and supportive District Manager	Both	Lack of understanding of roles and responsibilities	Both
Collaboration between CC/CHCC and civil society/multi-stakeholder organizations & forums	uMgungundlovu	Lack of training and induction	Both
Effective and strong community leadership on the committee	Both	CC/CHCC does not include people with all requisite skills to fulfill function of committee adequately	Both
Health committees' enthusiasm and commitment to making a difference to community health	Both	Lack of access to information on key health issues including MNCH	Both
CHWs and CCGs take up the issues discussed at the committee meetings	Both	Lack of participation, support and cooperation from ward councilor	Both
Required representation as stipulated in the NHA (i.e. local government councilor, management of facility, representatives from the community)	Both	No access to a venue for committee meetings	Both
		Lack of members' regular attendance at committee meetings	Both
		Lack of youth participation and representation in terms of gender	Both
		Lack of control over and no knowledge of the clinic budget as it is controlled by the mothering hospital	Both
		Lack of response from the Sub-District or District Office to CC/CHCC concerns	Both

Understanding the Key Challenges Undermining CCs/CHCCs Holistically

The diagram below illustrates how each role a CC/CHCC is expected to play is connected and mutually reinforcing on its other respective roles. Therefore, if a committee is failing, for example, to consult adequately with the community, then we cannot expect it to be able to play its monitoring role sufficiently because it will be unaware of service delivery challenges as experienced by the community. The key roles and responsibilities of CCs/CHCCs are found in the blue boxes and a summary of key issues which were found to be acting as barriers to each of the specific roles are illustrated in the red boxes, in the diagram below. Adopting a holistic understanding of CCs/CHCCs roles and responsibilities is important in order to ensure we support a number of capacities which are mutually reinforcing, and therefore have important implications for how we design interventions and training to strengthen committees. It is not enough to focus on interventions which support just one aspect of the roles and responsibilities of CCs/CHCCs (e.g. sole focus on monitoring). Instead, a holistic understanding of the roles and responsibilities of CCs/CHCCs needs to be adopted, which supports a range of skills and capabilities.

Figure 1: A Holistic Approach to Understanding Mutually Reinforcing Roles & Responsibilities of CCs/CHCCs



Key Findings on Civil Society/Multi-Stakeholder Organisations and Forums

In several of the sub-districts there are well functioning civil society/multi-stakeholder organisations and forums who Black Sash could engage with during the implementation phase of this project. The rationale for choosing these civil society/multi-stakeholder organisations and forums was based on whether they are functioning effectively, their focus on health and MNCH issues and whether they have experience with accountability tools e.g. community monitoring, social audits, public hearings, budget monitoring or community score cards etc.

The BS RMCH Project strategy is to build institutional links between civil society/multi-stakeholder organisations and forums who have specific capacities which can strengthen the CCs/CHCCs. The relevant capacities will depend on the challenges underlying maternal and child mortality and morbidity in the specific sub-district e.g. if access to water is a key determinant undermining health of mothers and children then it would make sense to link with a 'village water committee', for example. These linkages and partnerships will be created through the community score card intervention whereby CCs/CHCCs, civil society/multi-stakeholder organisations and forums, and health facility staff come together to jointly analyse issues underlying service delivery problems and find a common and shared way of addressing those issues.

The results of the mapping exercise carried out to identify these civil society/multi-stakeholder organisations and forums in the communities of the selected sub-districts are presented in tables 6 and 7. These identified structures were grouped according to the district in which they reside. The table also presents details about how these structures are engaging with MNCH issues in the community and the accountability tools they are using.

Table 6: Civil Society/ Multi-Stakeholder Organisations and Forums Identified in OR Tambo, Eastern Cape

Non-Governmental Organisations and Community Based Organisations

Name of Organisation/Forum	Focus Area(s)	Has the Organisation/Forum Engaged with the Clinic Committee?	Has the Organisation/Forum Engaged in any of the Following: community monitoring, citizen report card, community scorecard, public hearing, social audit, public expenditure tracking?
Catholic Development Centre	Early Childhood Development, Safety & protection issues for, school going children, Teenage pregnancy, STIs & HIV, Impact of alcohol and drugs during pregnancy	No	Yes – community monitoring
TB/HIV Association	Support MCH services. HIV Wellness of infants	Yes	Yes – monitoring of service quality
SOS Village, Mthatha	Support & care for orphans Basic healthcare – vaccines & provide childbirth facilities Health education – nutrition, first aid & hygiene	No	Yes – home visits
Treatment Action Campaign (TAC)	Advocates for increased access to HCT and conducts HIV awareness campaigns.	No	Yes – community monitoring, social audit, budget tracking, public hearings
P.S.J. Creative Young Women's Group	Peer education on HIV/AIDS and ARVs Education to pregnant women on PMTCT & on their rights to treatment	Yes	Yes - Community monitoring, public hearings
PHMSA (Peoples Health Movement SA)	PMTCT, PCR for children, and monitors adherence, monitors patient treatment at clinics & their access to treatment	Yes	Yes - Community monitoring
Marie Stopes	Sexual and reproductive healthcare, family planning, VCT, HIV /STIs, termination of pregnancy and post-abortion care	No	No
Restless Development	Youth workshops on Sexual Reproductive Health, HIV, GBV & Prevention of Unplanned Pregnancies. Classroom lessons delivered on gender, sexuality, STIs, HIV/AIDS, safe sex, contraception, sexual and reproductive health rights and pregnancy and birth.	No	Yes – Community meetings
HST(Health Systems Trust)	District health systems, PHC re-engineering, NHI, health system research, health information systems	Yes	Yes - monitoring of health services
Sinawe Referral Centre for Abused Children	Provide post exposure prophylaxis, carry out compulsory HIV testing on sexual offenders	No	No
Masibumbane	Reaching newly diagnosed people living with HIV (PLHIV) who are	Yes	Yes – Community meetings

Development Organisation, Lusikisiki	not yet eligible for antiretroviral (ARV) treatment.		

Community Forums

School Governing Body (SGB)	Any issues affecting the learners i.e. teenage pregnancies, drugs etc.	Engagement on the individual level	Yes - Public meetings
Council of Churches	Focused on youth - drugs and teenage pregnancies.	Yes	No
Quality Learning and Teaching Committee (QLTC) Tina Falls	Health (teenage pregnancy, alcohol, dangers of STD & high blood pressure), teaching (safety of learners and educators and educating teachers on how to deal with pregnant learners), crime (awareness of negative effects of criminal activities on learners' future)	Engagement on the individual level	Yes - Community meetings and public hearings

Multi-Stakeholder Forums

Ward Committees	Door-to-door visits to engage households on livelihoods, health and other related issues. Ensure service delivery in all spheres: health, water, roads, sanitation. Monitor services at the clinics i.e. no shortage of medication, availability of staff & a 24 hour service at public health clinics.	Yes	Yes- Public meetings/ hearings, Community monitoring
Imbizo	Community gathering called by Traditional leader, also includes stakeholder from different sectors, community challenges are then addressed	Engagement on the individual level	Yes – the forum is a public meeting/hearing
Masibumbane Development Organisation, Lusikisiki	Reaching newly diagnosed people living with HIV (PLHIV) who are not yet eligible for antiretroviral (ARV) treatment.	Yes	Yes – Community meetings

Table 7: Civil Society/ Multi-Stakeholder Organisations and Forums Identified in uMgungundlovu, KwaZulu-Natal

Non-Governmental Organisations and Community Based Organisations

Name of Organisation/Forum	**Focus Area(s)**	**Has the Organisation/Forum Engaged with the Clinic Committee?**	**Has the Organisation/Forum Engaged in any of the Following: community monitoring, citizen report card, community scorecard, public hearing, social audit, public expenditure tracking?**
CADRI Development	HIV/AIDS support groups.	Yes	Yes - Public hearings, Community Monitoring

Centre for Criminal Justice	Domestic violence, counseling	Yes	Yes – community meetings/information sessions
Siyaphambili (Disabled People's Group)	Medical assistance such as wheel chairs & grants for disabled people	No	Yes - public hearings
Red Cross	They engage in health and education and they run programmes which include HIV/AIDs education, peer education programmes, and campaigns against gender based violence, water and sanitation	No	Yes - community meetings, door-to-door monitoring
Drop in Centre, Impendle	They focus on health and deal with counseling, HIV / AIDS, education and	Yes	No
Vumani ECD Centre	Prepares children for grade R, combating child abuse, hygiene	No	Yes – meetings with parents
Thandanani Children's Foundation	Family strengthening, economic wellbeing, and health and education.	No	No
Umelaphi Bendabuko	They focus on the health sector.	Yes	No
Izimbali zesizwe Youth	Youth workshops on self-awareness, teenage pregnancies, domestic violence and sex education.	No	Yes - Community meetings
Lifeline	Their focus areas include: education, health, social work and case work	No	Yes - Community monitoring
Community Care Project Trust (CCP)	The core purpose of CCP is the training of community members through churches and schools to assist infected families and communities to tackle the HIV and Aids challenge.	No	Yes – Community mobilization
Whizz kids	HIV/AIDS, promoting testing and distribution of condoms, adherence to ART, life skills training	No	Yes – Community meetings, community monitoring
Love Life	Teenage pregnancies, HIV/AIDS, focus on various social problems	Yes	Yes – Community meetings
The Valley Trust (TVT)	Child Health and Development, Youth leadership, health communication, OVCs, Health referral system strengthening, integrated & sustainable livelihoods	Yes	Yes - Promoting active citizenships, community monitoring, community mobilization, lobbying and advocacy

Multi-Stakeholder Forums

War room	Promoting human values, fighting poverty, crime, diseases, deprivation and social ills, ensuring moral regeneration, by working together through effective partnerships.	Yes	Yes - Public hearings
uMgungundlovu District Aids Council	HIV/AIDS	Yes	Yes - Public hearings
Ward Committee	Shortage of water and nurses, maternal issues (working with CCGs).	Yes	Yes - Community meetings, public hearings
Ward AIDS committee	TB and HIV/AIDS, encouraging expectant mothers to attend ANC	Yes	Yes - Multi-stakeholder meetings.

Other

Traditional Healers Association	Traditional healing, PMTCT, referral for expectant mothers	No	Yes - community meetings

Narrative of Key Findings on Civil society/Multi-Stakeholder Organisations and Forums and Implications for RMCH Project

It was found that there is currently limited to no engagement between the CCs/CHCCs and the civil society/multi-stakeholder organisations and forums. Based on the findings of the baseline it was found that this is due to their lack of knowledge regarding the existence of these committees as well as what their roles and functions are. In many cases where limited interaction was found between CCs/CHCCs and civil society/multi-stakeholder organisations and forums, it was mostly on an individual bases between an individual committee member and one of these civil society/multi-stakeholder organisations, or where members of the committee happen to also be members of one of these structures. Current linkages are therefore based on an individual and are not institutionalised, and these linkages need to become more institutionalised as they would potentially be lost if the individual is no longer serving on the CCs/CHCCs. Key informants representing these civil society/multi-stakeholder organisations were supportive of the idea of engaging with the CCs/CHCCs as they felt that creating a dialogue between the committee and the civil society/multi-stakeholder organisations could improve the functioning of accountability mechanisms and address demand barriers to MCH services.

Traditional Authorities: In a few of the sub-districts in both OR Tambo and uMgungundlovu traditional authorities were found to be important structures. They were also found at times to act as gatekeepers in terms of accessing the 'community at large'. Therefore any intervention in these sub-districts needs to be cognitive of this dynamic. Working with traditional authorities remains a difficult terrain to negotiate. There are some communities which see the institution of traditional authorities as legitimate. However there are also communities in these districts which have a tumultuous relationship with them and see them as an unauthentic, imposed institution with a historic link to the Apartheid Bantustan system. This is a nuanced context which the Black Sash will need to very carefully navigate when working in these districts. It should also be noted that there is presently a contentious relationship between the traditional authorities and the ward councillors in many of the sub-districts which needs to also be taken into account.

In KZN, the War Rooms were found to be a very prominent civil society structure operating in uMgungundlovu. However, most of the CCs/CHCCs do not attend the War Room meetings, and it was also reported that they are not currently functioning well in some of the sub-districts, and these War Room structures were often found to be very political. The War Rooms did however express interest in the idea of working with the CCs/CHCCs. The following case study below presents a good example of how interaction with a multi-stakeholder forum (i.e. War Room) has enriched the work of the committee.

Case Study: Transportation obtained to committee meetings

- ✓ The health committee managed to obtain transport for its members to meetings by raising the issue in a War Room meeting.
- ✓ The Town Planning Department of the Municipality subsequently promised that they would avail a vehicle for this purpose.
- ✓ This intervention has increased participation at committee meetings.

The strategy of the Black Sash RMCH project is to bring the CCs/CHCCs and civil society/multi-stakeholder organisations and forums together to create links and partnerships that will strengthen and build the capacity of the committee. Through the use of community score carding, CCs/CHCCs and civil society/multi-stakeholder organisations and forums will then work with the community and health facility staff to collectively solve MNCH problems based on mutual understanding and joint dialogue.

Recommendations

Recommendations from the Situational Analysis for District DoH

1. **CCs/CHCCs need to be funded:** The issue of stipends should be urgently addressed as it is undermining the efficacy of these committees. The Black Sash believes that an approach of reaffirming the principle of community service and social activism needs to be emphasised as the key incentive for participation in such committees. However, reimbursement for out of pocket costs (i.e. transport, airtime, access to office supplies) needs to be provided by the DoH, and this financial commitment should be secured in a legislative act as policies have proved to be insufficient to ensure follow through. A key concern for our project's sustainability is that our current funding ends in November 2014 after which the activities to strengthen CCs/CHCCs in these districts will need to be handed over to DoH. It is not sustainable to rely on the project cycle funding of NGOs or donors and we therefore feel there needs to be an explicit commitment from DoH to fund the operating costs of these committees.
2. **Address the tension of upward and downward accountability**: This tension needs to be explicitly resolved in both policy (Draft Policy on Health Governance Structures and provincial policies/acts) and in discussion with CC/CHCC representatives during induction and training. CCs/CHCCs are accountable to both the community as well as to the health system which presents a challenge which is difficult for CC/CHCC representatives to navigate. The obligation to report back to the health system (District Portfolio Councillor for Health and MEC for Health) on key community health challenges and on their activities as a committee should nevertheless not be at the expense of their accountability to communities.
3. **Appropriate training taking into account the literacy challenge:** There is a great need for appropriately designed training which is cognitive of the literacy challenge, especially apparent in deeply rural sub-districts. Creative methods of training such as participatory learning and action methods can be employed to ensure maximum participation of CC/CHCC representatives irrespective of their level of literacy. Civil society organisations that are familiar with participatory methods can be engaged to undertake this training. There also needs to be a clear designation of responsibility within the DoH for overseeing or providing the training to CCs/CHCCs and adequate funding provided for this. It would also be advisable to conduct training with all the members of the committee and not just with the chairpersons, as it was found that most chairpersons do not have the capacity to train the rest of the committee. Due to the high turnover of committee members it is advisable for refresher training to be conducted at regular intervals as opposed to once off training. There are existing training manuals which have been developed by NGOs and universities e.g. Nelson Mandela

University and the University of Cape Town (and the manual which will be developed by the Black Sash), which can be used.

4. **Adopt a holistic approach to supporting CCs/CHCCs:** We need to support a more holistic approach to the roles of CCs/CHCCs and an understanding that different roles are related and mutually reinforcing. It is not enough to focus on interventions which support just one aspect of their roles e.g. monitoring, without first ensuring that they are equipped with all the requisite skills to fulfil their mandate e.g. social mobilisation, holding community consultations, gathering data on service delivery challenges and needs analysis, partnership creation, resource mobilisation, understanding health budgets etc.
5. **Emphasis to be placed on community consultation and mobilisation:** The use of the clinic suggestion box was found to be insufficient for effective community consultation and mobilisation. Appropriate methods for mobilisation and consultation should form part of the training CCs/CHCCs receive e.g. holding regular community meetings. It is also recommended that the community be made aware of when committee meetings will be held. One of the indicators of a successful committee which could be monitored by the DoH; could focus on the extent to which the community is mobilised and engaged by the CCs/CHCCs.
6. **Facility Managers need to provide feedback to facility staff and CHWs on CC/CHCC meetings and activities:** so that they are aware of the roles, responsibilities and activities undertaken by the committees. This will avoid the perception of CCs/CHCCs being seen as 'watchdogs' and will promote an approach of collective problem solving.
7. **Focus on building constructive relationships (social and political capital):** A move away from contentious relationships towards nurturing constructive relationships needs to be emphasised by the DoH and other stakeholders (civil society) who work with committees. Building relationship between committees and the following actors needs to be especially emphasised: Sub-District and District Managers, District Portfolio Councillor of Health, Facility Managers, facility staff, local government councillors, CHWs and civil society/multi-stakeholder organisations and forums. Special emphasis needs to be placed on incentivising the ward councillors to champion these committees. Facility Managers should be encouraged to take the demands of the committee to Sub-District Managers for resolution where challenges cannot be resolved at a facility level. Relationships between CCs/CHCCs and civil society/multi-stakeholder organisations and forums need to be actively promoted to improve the functionality and collective problem solving of accountability mechanisms.
8. **Focus on incentivising the youth to participate in CCs/CHCCs:** It was found that most committee members are elderly people who are not able to effectively engage in community mobilisation for health or represent the interests of the youth, who are faced with very specific MNCH and general health challenges. A mix of representatives is therefore required including both the youth and elderly.
9. **Place stronger focus on demand barriers to MNCH:** sensitivity training needs to be provided to health staff in order for them to understand the demand barriers to accessing PHC (and MNCH in particular) and how this is negatively impacting on maternal and child mortality. CCs/CHCCs should be seen as key vehicles for addressing demand barriers due to their close proximity to the community. The DoH should encouraged CCs/CHCCs to include MNCH as a specific agenda item,

which can be suggested during training. DoH could also look into the potential of forming RMCH sub-committees within the CC/CHCC structure, as provided for in the EC policy on CC/CHCCs.

10. **Emphasise both rights and responsibilities:** It was found that many service users are not clear on what MNCH services they have the right to access and what quality of services they are expected to receive. Service users are also often unaware of what their responsibilities are in relation to ensuring their own health. The Districts should disseminate information on rights and responsibilities to communities, and CCs/CHCCs can also be requested to disseminate this information. Black Sash will be developing appropriate MNCH rights and responsibilities pamphlets which could be used for this purpose. This could contribute to increased demand for MNCH services.
11. **Improve DoH systems for monitoring and evaluating functionality of CCs/CHCCs:** District DoH should establish M&E systems to track the existence and functionality of CCs/CHCCs and updated details of representatives, which can inform the need for training and financial support for CCs/CHCCs. Indicators of functionality should not be limited to existence of meeting minutes and should incorporate a number of qualitative and quantitative indicators such as: training provided to all committee members, CC/CHCC undertakes frequent community consultation etc. This information should be reported on in quarterly reports and made easily available to civil society members working with CCs/CHCCs.
12. **Ensure all stakeholders are clear on reporting structure for CCs/CHCCs:** It was found that interactions between the CC/CHCC and the health system are mostly limited to facility managers. We found only very few cases of interactions between CCs/CHCCs and sub-district managers, district managers, district portfolio councillors of health or MECs for health. It was also reported that certain officials are acting as gatekeepers. It is therefore recommended that CC/CHCC members be provided with training on the reporting structure. Health officials also need to be sensitised to the right of committees to access higher levels of the district health system if challenges cannot be resolved at the facility level. The health system also needs to monitor issues which CCs/CHCCs were not able to resolve and support committees to take these issues up at higher levels.

Recommendations to Guide the Black Sash RMCH Project Moving Forward

The roles and responsibilities of CCs/CHCCs need to be understood as an integrated and interconnected system as all their relevant roles are mutually reinforcing. An intervention to strengthen committees therefore needs to focus on building a number of skills and capacities and must be a holistic approach. The Black Sash intervention will build the capacity of CCs/CHCCs through providing training and building relationships with civil society/multi-stakeholder organisations and forums operating in the relevant districts.

The Black Sash does not want to create additional structures but rather strengthen the existing CC/CHCC and therefore it is proposed that a sub-committee be created within each CC/CHCC which will focus on MNCH and which will include representatives from civil society/multi-stakeholder organisations and forums. The sub-committee will be called the 'RMCH Action Group'. CCs/CHCCs will be involved in choosing who they want to create a partnership with in forming these RMCH Action Groups. Once the pilot CCs/CHCC in each district has been chosen, Black Sash will present a list of

those civil society/multi-stakeholder organisations and forums we have identified, and will give the CCs/CHCCs an opportunity to identify any other civil society/multi-stakeholder organisations and forums they would like to partner with.

The Black Sash intervention will involve 1) Providing training to the RMCH Action Groups 2) Supporting the RMCH Action Groups to implement a community scorecard process to address MNCH challenges in their community. The training will ensure that the RMCH Action Groups are equipped with necessary basic capacities to fulfil the multiple and integrated roles communities are meant to play in health promotion. The focus of this training would respond to the key challenges identified in the situational analysis. The training will also enable them to undertake community monitoring (using the community scorecard tool) in their respective communities. DoH representatives who are responsible for providing or overseeing the training of CCs/CHCCs will be invited to attend the training for sustainability purposes. The second stage of the Black Sash intervention would then focus on implementing a community scorecard process in pilot sites in order to support the monitoring and oversight role of committees, which was found to be particularly poor.

Key Focus Areas of the Training:

1) The Health System in South Africa: Overview of the district health system and re-engineering of PHC approach. The role of community participation in health
2) Roles and responsibilities of CCs/CHCCs as stated in national and provincial legislation and policy and as understood to be appropriate by communities and public health professionals
3) How to work with communities
4) How to work with health workers
5) Health rights and responsibilities, with a focus on RMCH
6) The crisis of RMCH in South Africa at large and in our local communities: focus on demand barriers to the uptake of RMCH services
7) District health governance system & associated reporting structures: channels for reporting and redress
8) Motivation for CCs/CHCCs and civil society/multi-stakeholder organisations and forums to create a partnership and dialogue: tools on partnership development and resource mobilisation
9) Community monitoring: how to facilitate a community score card process

The **Community Score Card (CSC)** model is a hybrid tool which combines the different accountability approaches of social audit, community monitoring and citizen report card. CSCs have proven very successful particularly in rural settings and in the context of monitoring PHC at the facility and district level. The CSC is a very simple tool which enables broad community participation and will be easy to handover to CCs/CHCCs and their civil society/multi-stakeholder partners (RMCH Action Groups) to sustain beyond the lifespan of the Black Sash RMCH Project. We envision that the RMCH

Action Groups would act as the facilitators of the CSC process and Black Sash's role will be to support and oversee the implementation in pilot sites.

In summary the community scorecard process involves holding separate meetings with the community (service users in the catchment population of the facility) and facility staff where key MNCH challenges would be discussed, indicators decided upon and then given scores. A multi-stakeholder dialogue will then be held where a number of stakeholders will be invited to participate, including facility staff, the community (service users), district DoH, provincial DoH, other relevant government departments, traditional and other community leaders and civil society/multi-stakeholder organisations and forums. Both the service user and provider scorecards will be presented and suggestions for addressing the identified challenges will be discussed, after which a joint action plan will be developed which both the community and service providers will take responsibility for.

It proposed that the most appropriate roles for War Rooms and Imbizos in the context of this intervention include 1) initial mobilisation of the community and awareness raising around the intervention 2) to mobilise people to attend the scorecard process 3) bringing the key issues that are found through the score card process and the action plan to get buy-in from different stakeholders to take the action plan forward.

The Black Sash is also interested in how we could combine certain elements of the **Partnership Defined Quality (PDQ)** approach with the CSC approach to develop an innovative 'hybrid' tool to strengthen accountability mechanisms and demand for MNCH services. The PDQ process facilitates a joint understanding and vision of 'quality of care' between community and health care workers. Together, the community and health workers identify and prioritise problems and constraints that make it difficult to achieve quality health services and develop solutions to improve these. Black Sash feels some aspects of this approach which focus on building trust and consensus between community and health care workers could be particularly beneficial.

Black Sash will be implementing the training programme and CSC process in one pilot site in OR Tambo and one pilot site in uMgungundlovu. We will then disseminate the training tools to the remaining sub-districts of OR Tambo and uMgungundlovu through district workshops. The intension is that DoH use the tools to strengthen accountability mechanisms more widely across the district once the tools have been refined and edited, taking into account learning from the pilots sites. Key learning from the intervention and training tools and manuals will also be disseminated through workshops to be held in the following districts: eThekwinii, Ngaka Modiri Molema, Pixley ke Seme and Ekurhuleni.