

The Community Score Card in Tanzania:

Process | Successes | Challenges | Lessons Learned



INPUT TRACKING MATRIX

Input Indicators	Entitlement (Policy)	Actual (Comm Perception)	Remarks
1. Number of Staff (qualified)	1 Staff per Ward	1 Staff per District	The government should employ more staff
2. # of beneficiaries Served	District target = 63 groups with 315 individuals	27 groups of 135 individuals	Inadequate fund to serve all clients
3. Total Budget of WDF	Tzs. 15 m	Tzs. 11.5 m	Very little fund from the Comm Dev Ministry.
4. 10% Donation from the district Council budget	Tzs. 10 m	Tzs. 2.5 m	There is no clear picture of the distribution of fund.

26/09/2010



Contents

I. Introduction.....	1
II. Research Objective and Framework.....	2
III. What is the Community Score Card?.....	2
IV. How to Implement the Community Score Card?.....	3
V. Methodology to Assess CSC Implementation Process and Outcomes.....	6
Research Context.....	6
Research Methods.....	7
Step 1: Initial Consultations & Desk Reviews.....	7
Step 2: Designing Research Tools.....	8
Step 3: Training Facilitators and Data Collectors.....	8
Step 4: Data Collection.....	9
Step 5: Data Analysis.....	10
Step 6: Reporting and Lesson Learning.....	10
Limitations of the Research Design.....	10
VI. Key Findings: Impact and Successes.....	11
Improved Knowledge of Positive Health Seeking Behaviors.....	12
Improved Knowledge of Policy Structure Guiding Health Service Delivery.....	12
Improved Understanding of Rights and Responsibilities.....	13
Empowered Communities.....	13
Increased Public Participation in Public Service Provision.....	14
Strengthening Relations between Service Users and Service Providers.....	14
Strengthened Commitment of Service Providers to Fulfill Responsibilities.....	15
Improved Transparency and Accountability in Service Provision.....	15
Improved Quality of Service Provision.....	15
Understanding the Constraints Service Providers Face.....	16
VII. Challenges Encountered.....	17
Follow Through on Commitments Made During Process.....	17
Tempering Participant Expectations.....	17
Creating Manageable Solutions within a “Broken” System.....	18
Matching Perceptions to Reality.....	19
Divergent Experiences with Respect to Full Participation of All Involved.....	19
Disconnect Between Community and District Level Priorities.....	20
VIII. Lessons Learned & Recommendations.....	20

I. Introduction

In Tanzania, there are significant challenges in equitable access to quality health services and improving health outcomes. This is particularly true among poor women, children and youth, people living in rural areas and disadvantaged districts, people living in poverty, people with disabilities and other marginalized groups, as evidenced by stark differentials in access to services and health outcomes among these groups.

The Tanzanian Health Sector Reform process has been on-going since the early 1990s. Many elements of the reform framework are important to building a more equitable and effective health system, including decentralization through devolution and the formation of health facility management boards to enable citizen participation in health. The health sector reform process is complemented by the roll-out of local government reform, which is also focused on decentralization and improving governance and accountability on the local level. In recent years, health sector reforms have outlined different levels of participation for citizens through the Client Service Charter and guidelines for formulation of Comprehensive Council Health Plans by Local Government Authorities.

Despite these reforms, there is still a great lack of transparency and accountability at all levels of Government structures, while at the same time a lack of citizen and civil society participation in health. There is a need for interventions that work to expand the space for civil society engagement in the health sector. There is also a need for community leaders and groups to develop a shared idea of what they should be demanding with respect to better service provision.

Against this background, CARE Tanzania has implemented several projects focused on enhancing the participation of civil society organizations and community-based groups in decision-making processes pertaining to health policy and resources. Under the Health Equity Project (HEqP) and the Governance and Accountability Project (GAP), CARE Tanzania has used the community score card (CSC) to facilitate a process of public engagement with government and local level service providers. The aim of the CSC process is to increase public participation in planning, financing and governance. The CSC is a community based engagement and monitoring tool that is a hybrid of techniques of social audit, community monitoring and citizen report cards, which together strengthen local level policy engagement and budget and tracking processes.

In 2008, the CSC process was used under the HEqP to collect information on family planning in 4 communities in Magu and Missungwi Districts in Mwanza Region. In 2010, HEqP used the CSC process in another 4 communities in Magu and Missungwi to promote dialogue between service providers and service users. Anecdotally, the HEqP

team has learned through feedback and follow up with the community, that the CSC process was useful in increasing citizen awareness of their health rights and increasing citizen engagement in health.

Care Tanzania's Governance and Accountability Project (GAP) has also been implementing the community score card in several districts in Mwanza region and has recorded achievements in health and education as a result of the use of the score card. GAP has implemented the CSC in 8 communities since 2008. During these processes, special emphasis has been given to the informed participation of women and young people (female and male), who are the most negatively affected by current barriers to quality health care.

The purpose of this research is to systematically assess these preliminary and anecdotal findings of increased citizen engagement and awareness of their health rights and achievements in health as a result of the CSC process. These research findings will be used to inform future implementation of the CSC tool as well as create synergies between and among CARE Tanzania's different projects as they move towards a program approach.

II. Research Objective and Framework

The main objective of this study is to gauge the effectiveness of the CSC. This research report gives an overview of the CSC process, outlines the methodology used to assess the effectiveness of CARE Tanzania's CSC implementation process, and highlights the successes, challenges and lessons learned in CARE Tanzania's experience implementing the CSC.

III. What is the Community Score Card?

The CSC is a social accountability tool used to bring about improved governance through the promotion of participation, transparency, accountability and informed decision-making. The CSC enables maximum participation of the local community, by bringing together the service users ("the demand side") and service providers ("the supply side") to jointly analyze issues underlying service delivery and find a common and shared way to address problems and concerns.

Used at the community level, the CSC aims to empower communities to raise their issues and perceptions of public service provision, evaluate the services provided by service providers, and seek social accountability and improved responsiveness to customer-needs from service providers. In return, it offers the opportunity for government and service providers to explain decisions, constraints and challenges faced in service provision. By

facilitating this two-way, participatory dialogue, accountability to citizens and service provision can be strengthened.

The CSC has three different functions: 1) Community Empowerment -- Promoting discussion and dialogue between service user and service provider to build community empowerment; 2) Joint Decision Making -- Creating opportunities for information sharing, mutual objective and critical assessment of service quality, effectiveness and efficiency; 3) Monitoring and evaluation -- Scoring and monitoring aspects of service and encouraging service providers to measure and improve their performance.

Specifically, the CSC allows for:

- Tracking of inputs or expenditures (e.g. availability of drugs),
- Monitoring of the quality of services,
- Generating benchmark performance criteria that can be used in resource, allocation and budget decisions,
- Comparing performance across facilities/districts,
- Generating a direct feedback mechanism between providers and users,
- Building local capacity, and
- Strengthening citizen voice and community empowerment.

It is important to bear in mind that the CSC is not about finger-pointing or blaming and it is not designed to settle personal scores or create conflict within communities. Rather, the CSC helps service users give systematic and constructive feedback to service providers about their performance, while the CSC helps governments and service providers learn directly from communities about what aspects of their services and programs are working well and what is not. The information the process generates enables decision-makers to make informed decisions and policy choices and to implement service improvements that respond to citizens' rights, needs, and preferences. The score card is designed to be flexible with potential applications within any sector, including health, education or agriculture.

IV. How to Implement the Community Score Card?

The implementation of the CSC consists of the following five phases with nine steps:

Phase 1: Planning and Preparation

This stage is the foundation of the CSC process, including operational planning components such as identifying the sector, service type, and geographical target area; identifying the facilitators; getting buy in from service providers, local leaders, and CBOs; and building understanding, commitment and trust of all parties. It has the following steps;

- Step 1: Building capacity of implementers in CSC
- Step 2: Holding a district level scoping workshop
- Step 3: Community level groundwork
- Step 4: Building Capacity of Community Committee on CSC

Phase 2: Implementing the CSC with the community

The community trained facilitators organized several workshops to introduce the CSC to the community. These workshops included men, boys, women, girls, village health workers, village leaders, and health facility care providers, and were share the purpose, rationale, benefits, process, requirements, expectations, and outputs of the CSC. Through this process the following indicators were developed and agreed upon:

1. Language used by service providers to their clients
2. Availability of service providers at health center
3. Accessibility of family planning services to all groups.
4. Counseling on family planning is transparent and enough.
5. Status of the health service committee.

Later, communities scored the performance of service providers against each indicator. This stage includes steps 5 and 6 of development of Input Tracking and Performance Score Card respectively.

Phase 3: Implementing the CSC with the service providers

The service provider group followed the same process to score their own service provision as described under step 7.

Phase 4: Interface Meeting (dialogue)

The previous stages were all building towards the interface meeting. Efforts were made to involve district level government officials to build awareness, credibility, and commitment.

At the interface meeting (Step 8), service users and service providers were encouraged to share and discuss their scores and then decide on a shared score and develop the joint action plan. Scores were shared, with justifications for scoring given by each group, and then a final score was agreed upon and used as the basis for the action plan. Finally, suggestions for improved service and priority issues for action were agreed upon.

Phase 5: Follow-up

Follow up on the action plans and commitments made during the process (step 9)

How it was implemented by GAP and HEqP in phase 2

The implementation of the CSC consists of the nine steps in which the first four steps builds the foundation for CSC implementation.

Step 1: Building capacity of implementers in CSC:

Training of Trainers' workshop to empower selected implementers to make them understand the process of conducting Scorecard, this should be done at the beginning of the implementation so that implementers become familiar with the tool.

Step 2: Holding a district level scoping workshop:

Hold a district level scoping workshop involving local government officials, councilors, CSOs, and representatives of communities participating in tracking. The workshop helps to create good relationship between service providers and service users to share their experiences on targeted public policies and/or service to be monitored. Also it is a point of forming an agreement with local government officials to provide the required information that can be useful in scorecard implementation.

Step 3: Community level groundwork:

The first community meeting is very instrumental to solicit community ownership of the project by nominating community volunteers and getting a common understanding of the process and different roles and responsibilities.

Step 4: Building Capacity of Community Committee on CSC:

Conduct orientation of the selected community committee members on the CSC process to permeate knowledge to them for the sustainability of the CSC and the project in general.

Step 5: Develop Input Tracking Scorecard:

In collaboration with community committee members do the collective analysis of policies relevant to the service being monitored, collect supply side information, and hold a meeting with community/providers to give information on entitlements or budgets. Joint physical inspection of the targeted service and scores against developed indicators and finally develop Input Tracking matrix which shows the input indicators developed, entitlements as specified by service mandate, actual (community perception) and remarks and suggestions on improving the situation.

Step 6: Performance Scoring:

Performance criteria developed by the community and ranked by marks as per assessed service delivery. The process measure the actual quality of service the community receives from service providers at that particular time.

Step 7: Self – Evaluation Scorecard:

Service providers evaluate themselves on how better they provide services to the community. Inward looking for service providers and ranking quality of services they deliver vs. policy and entitled budget.

Step 8: Interface Meeting:

- Organize a joint meeting for the service users and service providers.
- Show both results from the community and service providers.
- Facilitate productive dialogue and come up with some concrete reforms
- Develop a joint action plan with commitment for follow up

Step 9: Follow-up & Institutionalization:

Monitoring the implementation of the joint action plan developed during the interface meeting. This stage alarming the accountability of all project participants at all levels. It should be done periodically e.g. after each three or six months to monitor the actual implementation of the agreed joint action plan and assess performance or the improvement of service provision at that particular area.

V. Methodology to Assess CSC Implementation Process and Outcomes

In keeping with the spirit and intent of the CSC tool, this evaluation seeks to assess how effective this process was in bringing about rapid improvements in the relationship and communication between service users and service providers, as well as the effectiveness of the tool in improving transparency, accountability and participation.

The main objective of this study is to gauge the effectiveness of the CSC with respect to the following dimensions:

- ***Impact:*** how useful this tool was and why, the intended and unintended changes that occurred through the CSC process;
- ***Sustainability:*** potential viability of those changes over time;
- ***Relevance:*** if changes were perceived by project beneficiaries as important for improving their living conditions and by local authorities as aligned with their development priorities, what aspects of the tool could be modified to encourage broader participation.

Research Context

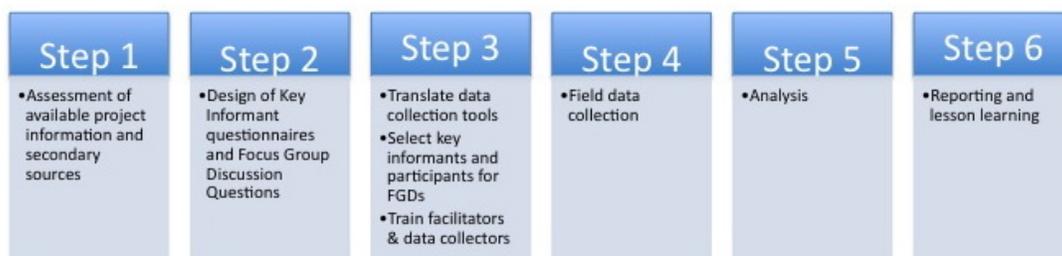
The research study was carried out in the HEqP and GAP sites across 6 districts and 16 communities as indicated in the below table.

Districts	Communities
Magu	Langi
	Matela
	Ng'aya
	Muda
Missungwi	Mwagala
	Nyamatala
	Mwajombo
	N'gombe
Nyamagana	Pamba
	Buhongwa
Ilemela	Pasiansi
	Bugogwa
Ukerewe	Bwasa
	Kagera
Sengerema	Busisi
	Mwabaluhi

Research Methods

This research was designed to collect primary source data from different stakeholders involved in the CSC process, including community members (men, women, girls, and boys), community health committees, Health Facility staff, local leaders and district leaders.

The evaluation was designed in six sequential steps:



Step 1: Initial Consultations & Desk Reviews

The terms of reference for this research study were reviewed to understand what research questions needed to be answered through this study and to establish the research agenda to answer those questions. Available project information was gathered for review, including activity reports, annual reports, and original project proposals, to understand the background relevant to this research study.

The objectives of the study were clearly articulated and defined in accord with the desires of CARE staff. The roles and responsibilities of the team were discussed and confirmed,

including the lead research, CARE Country Office staff CARE staff in Lake Zone Region (Mwanza), translators, and community partners.

Step 2: Designing Research Tools

It was decided that the research study would use a mix methods to assess CSC impact, including Focus Groups Discussions (FGDs) and Key Informant (KI) interviews. The FGD guide and the KI questionnaires were designed by the lead researcher, then inputs were solicited from lead CARE Country Office staff, and revisions were made according to their inputs and suggestions.

FGs involved community beneficiaries including, men, women, boys, girls, and community committee members. FGDs were intended to have no more than five participants to achieve a comfortable environment in which all participants would have the opportunity to share their perspectives and opinions on the process. KI interviews involved Health Facility staff, local leaders and district leaders.

Given the limited time and resources available for this evaluation, criteria were established for selection of participants in the FGDs and KI Interviews. Only participants that were involved in the CSC process were allowed to participate in both the FGDs and KI interviews. Participants were selected on the basis of their knowledge of the process and their representation of project stakeholders.

All data collection materials were originally designed in English and later translated into Swahili.

Step 3: Training Facilitators and Data Collectors

All data collection materials were translated into Swahili. Key informants and communities for participation in the FGDs were selected according to the criteria described above. A detailed work plan was developed for the field work, including when to visit each village, times for the interviews, places for the interviews, and who would interview whom. CARE staff with experience in community based development projects were selected as facilitators and data collectors. Data collection tools were printed in sufficient quantities.

Prior to data collection in the field, a training session with the facilitators and data collectors was held to explain the evaluation design, review in detail the KI questionnaires and the FGD guide. Specifically, the English and Swahili versions of the tools were compared side by side and discussed to ensure that the translations adhered to the original intent and spirit of the tools.

In this training session, the lead researcher facilitated a discussion on what is a FGD, clarifying what it is and what it isn't, and providing suggestions on procedures and best practices in facilitating a successful FGD.

Step 4: Data Collection

A brief check-in meeting was scheduled following the first day of field-based data collection to solicit feedback and initial impressions from the data collection team, review the data collection tools, and make corrections as necessary. Once agreement among the team members was reached that the tools could be used in a satisfactory manner and that no changes would be necessary, the data collection and evaluation proceeded according to the following detailed work plan developed for data collection.

Project	District	Community	Focus Group Discussion (FGD) Participants	Key Informant (KI) Interview Participants
Health Equity Project (HEqP) Sites	Magu	Langi	5 separate FGDs with: Women, men, girls, boys and community committees	Interviews with Health facility staff (4), Village leaders (4), District leaders
		Matela		
		Ng'aya		
		Muda		
	Missungwi	Mwagala	5 separate FGDs with: Women, men, girls, boys and community committees	Interviews with Health facility staff (4), Village leaders (4), District leaders
		Nyamatala		
Mwajombo				
N'gombe				
Governance and Accountability Project (GAP) Site	Nyamagana	Pamba	FGDs with; Women, men, girls, boys and community committees	Interviews with Health facility staff (2), Village leaders (2), District leaders from Magu and Missungwi
		Buhongwa		
	Ilemela	Pasiansi		
		Bugogwa		
	Ukerewe	Bwasa		
		Kagera		
Sengerema	Busisi			
	Mwabaluhi			
Total			46	18

All data collection efforts were conducted in Swahili. Each FDG was facilitated by a CARE staff member. Each facilitator was accompanied by a dedicated note-taker and transcriber. Each transcriber was responsible translating the Swahili content into English.

Step 5: Data Analysis

The translation process proved exceptionally time consuming, which created a delay for the lead researcher in receiving data from the field and commencing data analysis.

The qualitative data generated from all FGDs was reviewed by the lead researcher, compiled into one working document and then systematically analyzed according to perspectives shared from men, women, boys, girls, and community committee members. Each perspective was categorized to assess the effectiveness of the CSC tool according to its impact, its sustainability, its relevance, as well as improved relationships between service users and service providers and the overall effectiveness of the tool in improving transparency, accountability, and participation.

The data generated from the FGDs was then compared and validated against the data generated from the KI interviews.

Step 6: Reporting and Lesson Learning

Following the data collection and analysis, the final step in this research process was reporting the findings of the analysis and integrating the research results. Given that this process did not have any overarching indicators, besides those developed by the CSC participants themselves, this research process relied on the basic principle of participatory evaluation: investigating impact through stakeholders' perception of change. The research results were triangulated against an assessment of project history and information taken from the monitoring reports produced over the lifetime of the project.

A report outline was developed and agreed upon. A draft report was submitted for review and the final report was submitted based on feedback received on the draft report.

Limitations of the Research Design

Given resource limitations, CARE staff themselves served as the facilitators for FGDs, interviewers for KI interviews, and transcribers and translators. It is recognized that this could have influenced participant responses and held an unintended consequence of limiting participants' willingness to speak honestly about their perceptions of the impact of this process.

The distances required to travel to each district and village cut short the time allocated to training the FGD facilitators and data collectors, and as a result insufficient time was dedicated to reviewing the data collection tools, especially FGD guide questions and prompts, to ensure a robust understanding of the spirit and intent of the questions on the part of the data collection team and the FGD facilitators.

A transcriber was assigned to each FGD to take notes and later translate the notes from Swahili to English. The skills of each transcriber and translator were of varying quality, and in many cases a great deal of richness of information was lost in the transcription and translation process.

In some cases, the criteria for participation in FGDs and KI Interviews were not respected by data collectors. The reasons for this are not clear. However, in some cases, FGD transcripts/translations were returned in which not a single participant had been involved in the CSC process. In these cases, the data was not considered, as participants were only able to provide vague perceptions on the process from an outsider's perspective, which did not adhere to the purpose of the research study.

The data generated from this research study was difficult to validate and triangulate, as there was no baseline study conducted to understand the "before" situation. The study did not include a quantitative analysis of statistics specific to health outcomes in the project impact area as it is not clear what these would be compared against to measure the outcomes and impacts of implementing the CSC tool. Using Demographic Health Survey statistics is not a good proxy measure because the statistics and information contained therein does not reflect the goals and objectives of the CSC process in terms of community participation in health planning and engagement in health issues. The lack of a log frame and systematic collection of information in the project interim stages also weakened the ability to validate and triangulate stakeholders' perceptions on the CSC process.

VI. Key Findings: Impact and Successes

The findings reveal that participants overwhelmingly held a positive view of this process. On the whole, participants understood their respective role within this process and understood the potential outcomes and value of the CSC process. Participants found the process to be useful, applicable, and practical, in other words, participants appreciated the process for presenting tangible and needed solutions to community health service provision problems they face.

Participants perceived the process to be very inclusive and representative of all stakeholders, which further substantiated positive feelings not only about the process itself, but also about the outcomes of the process. In fact, one notable outcome and benefit of this process was a heightened awareness of the value and need for women to be involved in community decision-making combined with demonstrated increased in the capacity and willingness of women to speak in front of leaders and participate freely and openly in such a public process.

One advantage of the CSC process is that it cuts through the “bureaucracy” of traditional government systems and provides almost immediate and real time feedback loops between service users and public service providers. The process elucidated the inherent challenge of making decisions about public service provision against a backdrop of limited resources and resource constraints. Through this process, participants realized the value of analysis and evidence in setting priorities for decision-making. Resulting action plans were rooted in systematic analyses of which services require immediate attention and align with community needs and preferences.

While difficult to measure, the data indicates that there were improvements in transparency, accountability, quality of service provision and community empowerment and engagement in health issues. The process acted as a catalyst in ensuring accountability on the part of health service providers.

The following direct impacts have been observed in communities from the implementation of the CSC process.

Improved Knowledge of Positive Health Seeking Behaviors

Across all communities, the process appeared to hold an indirect educative benefit. Through the implementation of this process, knowledge of positive health seeking behavior was reinforced. In helping community members understand their right to certain types of health services, participants were reminded of the importance of facility-based births, child immunizations, attending pre- and post-natal clinic, family planning methods, and male involvement in FP/RH. In most cases, participants in the CSC process took seriously their role in sharing these positive health seeking messages to other members of the community not involved in the process.

As a result, communities were mobilized in adopting positive health seeking behaviors. For example, through this health “education” acquired during this process, several community leaders and health service providers reported increased attendance of antenatal clinics and increased male use of contraceptives.

Improved Knowledge of Policy Structure Guiding Health Service Delivery

Not only did this process spread important messages about positive health seeking behaviors, but the process provided a forum for communities to learn more about the overall system in which health services are delivered. This positive outcome of the CSC process was cited by a wide range of stakeholders in this process.

Through this process, community level village leaders were able to learn more about the district level planning and budgeting processes and how that process feeds into the

central level. Prior to the CSC process, the role of village health volunteers was not recognized in the budgeting process, but following this process these volunteers have gained the opportunity to engage in local level budgeting within some communities. Increased knowledge on policy and budgeting processes helped service users better understand how the overall health system works and recognize the types of services they should expect and can demand according to government budgets for health facilities and supplies in health centers. This is especially true with respect to budgets for drugs and commodity supplies. Health service providers dually benefited from this process in terms of increased knowledge on how to more effectively influence local government planning and budgeting processes. The results of the CSC were used as evidence to advocate for increased resources during on-going district level planning and budgeting cycles.

Improved Understanding of Rights and Responsibilities

This process proved quite enlightening for all participants, including community members themselves, to understand their respective roles and responsibilities with respect to improving public service provision. Through this process, participants gained an understanding of basic rights of the community in health issues and knowledge of the types of services they can expect to receive in health facilities.

I learned how to be confident and express myself to the health service provider because I have my basic rights
-- Community member participant

Beyond that, communities reported increased understanding of their own responsibilities in seeking, demanding, and advocating for health service provision as indicated by national health policy frameworks. For example, some community members were not even aware of some of their basic health rights including national level policies for free health service provision to pregnant women and children under 5 years of age. Community members were encouraged to learn of not only their right, but responsibility, to be involved in decision making processes and advocating for national level policy implementation on the community level.

The process influenced the improvement of health services in our communities because community members now know the health centers are their property and it is their responsibility to monitor their performance
--government representative

Empowered Communities

This process built a high level of confidence and courage among community members in terms of expressing their rights to health service providers and making targeted demands to public representatives for improved provision of public services within their communities. Community members widely understood their role within this process to be

advocating for and demanding their rights, and the process itself provided a safe environment in which they could do so.

Pima Kadi (CSC) helped me know that I have a right to follow up on issues affecting me. It even gave me the courage to seek a village leadership position. Now I am a Ward Councilor.

--Village Health Council woman

In most cases, the process brought about a positive outcome in terms of empowering women to advocate for themselves, which reflects a positive change from the fears they held at the beginning of the process of talking in front of people, especially in the presence of men.

Increased Public Participation in Public Service Provision

This process was successful in fulfilling its objective of increasing public participation in public service provision. One of the most consistently cited lessons learned on the part of community members through this process is that with increased participation in public planning processes there is a correlated increase in finding solutions that meet their needs and preferences. Participants were given the firsthand opportunity to see how important their opinions and preferences can be in terms of finding solutions to improved service delivery.

This lesson was further reinforced through the introduction of suggestion boxes within some health centers that provide service users with a continued opportunity to express their concerns about service provision.

Strengthening Relations between Service Users and Service Providers

This process was consistently deemed by participants for being useful in improving and strengthening the relationship between health service providers and health service users by creating an opening for patients and providers to discuss health issues and concerns openly and directly. Through this process, health service providers improved their rapport with patients, and great reductions were witnessed in the frequency of abusive and harsh language on the part of health service providers, which used to instill fear in patients in their interactions with health service providers. Patients who were discriminated against in the past are now receiving services without bias. And patients no longer feel fear in dealing with health service providers.

We used to think that we were not supposed to sit near the doctor and ask questions of him directly, but this process has made it easier for us to engage directly with the doctor and health service providers. Our situation has improved.

--health facility user

Moreover, this process built and strengthened relationships between public leaders, service providers and community members. Through this process, relationships between village leaders and district leaders improved.

Strengthened Commitment of Service Providers to Fulfill Responsibilities

Through this process service providers demonstrated an improved awareness of and commitment to fulfilling their responsibilities. Participants in this process widely cited that this process was useful for changing attitudes towards work on the part of health service providers, which resulted in an increased level of responsibility and responsiveness and improved work performance on the part of nurses and doctors. Recognition of the constraints that health care service providers operate under combined with open and honest feedback from service users, served to increase the motivation of service providers in fulfilling their mandated roles.

This process was most useful for improving our performance. This process enabled us to remember how best to respond to community needs and wants. This process sensitized us in areas that were hard for us to fix, and our superiors were given the responsibility to support us in that respect.

--Health care service provider

Improved Transparency and Accountability in Service Provision

Prior to the implementation of the CSC, service users were often told to pay for services, including birthing and delivery, drugs and other commodities. This process was able to empower community members to advocate for and demand services that should be provided freely according to Tanzanian health policy. In most cases, participants reported that services are now provided according to the law, and patients are receiving treatments and services without demands for informal payments or bribes. Improved transparency and accountability in service provision was a very positive outcome of this process, which has also increased the level of trust in the relationship between service providers and service users.

Improved Quality of Service Provision

The process influenced the improvement of health services and facilities. As a result of this process, participants cited better and more regular provision of quality care on the part of health service providers, in addition to improved relations between service users and service providers.

Specific improvements include: a higher level of responsiveness to patient needs, increased availability of workers within health centers, improved “customer” care values and listening skills, especially during consultations and when making a diagnosis, increased availability of drug supplies within the health centers, referrals to other sites in

the case of drug or commodity stock outs, provision of advice during antenatal clinic visits and health education to the community during clinic sessions, and warm reception by health center and dispensary staff.

One of the most tangible outcomes of this process that was more or less consistently cited across communities is a notable reduction in the use of abusive language and behavior of health service providers, especially by mothers giving birth.

The involvement of community leaders and elected representatives within this process helped make these changes possible as they were in a position to follow up on issues as required and put pressure on health service providers if necessary.

It is important to mention that these improvements were not uniformly cited across all communities and health facility sites, and even when improvements were noted there is a need for continued improvement on aspects of improved quality service provision.

Understanding the Constraints Service Providers Face

Perhaps the greatest outcome of this process is increased empathy on the part of service users of the constraints service providers face in performing their jobs. This process created wide recognition of the different challenges which impede the provision of quality services such as: weak supply chain systems affecting drug and commodity availability, lack of funds to purchase new equipment, shortage of staff and massive human resources for health constraints, far distances nurses must travel to arrive to work, lack of blood transfusion and emergency transport services, and poor compensation and benefits packages for health facility staff.

Participants in this process readily agreed that these overarching, systemic constraints make it difficult for health service providers to perform their jobs well and that despite these difficulties and challenges, for the most part, service providers are putting forward their best effort to fulfill their responsibilities to provide quality services and meet customer needs.

Participants felt positively about the role of this process in creating an opportunity to discuss these challenges and create a plan of action to tackle these constraints faced by health service providers and create a conducive environment that motivates service providers to provide quality services that meet customer needs. Participants recognized that changes in improved quality of health service provision may be slow to come, not on account of lack of will or effort on the part of service providers, but rather because of the systemic constraints they face in performing their job.

VII. Challenges Encountered

Follow Through on Commitments Made During Process

One leading challenge in this process is fulfillment of and commitment to implementing the commitments made during this process. Some of the commitments made during this process were realized and others not.

Participants were keen to cite examples of the many “failed” commitments that emerged from this process, including the commitment to have the health committee at the health center which has not been realized, increased numbers of health care workers, availability of ambulatory and emergency transport services, building renovations, uninterrupted supply of drugs and commodities, and improved sanitation and waste management systems.

Failure to capitalize on commitments made during this process did not seem to lessen participants’ positive perceptions of the process. The majority of participants felt and continued to feel hopeful that positive outcomes emerged from this process. But implementation aspects of this process were noted as a big challenge, and in some cases this was attributed to the failure of the process to garner interest and support from stakeholders and public representatives that could have monitored and enforced these commitments and corral the resources necessary to implement these commitments in cases where resources were lacking or insufficient. Corruption was also frequently cited as a reason for the failure to realize these commitments.

Tempering Participant Expectations

Many important health issues were addressed during this process, however some communities and community members were quick to point out things that were “missing” in this process and issues of importance to them that were not taken up under this process. These include: 24 hour water and electricity availability at the health center, a kitchen within health centers, untimely mosquito nets distribution in villages, free health services to elders, reconstructing toilets at the dispensary, and increasing hospital facilities like beds, mattresses and mosquito nets.

Beyond that, some communities were keen to point out continued problems post intervention, including continued poor quality of health services, extraction of bribes and informal payments, abusive language and behaviors of health care workers in their interactions with patients, unskilled health care workers, long patient queues and wait times, and inadequate supply of drugs and commodities.

While this is discouraging and requires further assessment to understand and address underlying reasons for these issues, it is important to bear in mind that this process is not designed to serve as a onetime, panacea to cure all health and social problems within a community. In order for this process to be successful, on-going commitment on the part of the community and engaged leadership from health staff and community representatives in following up on issues discussed during this process is required to realize incremental changes over time that work within the constraints the system presents.

It is likely that tempering community expectations of the process will continue to be a challenge that facilitators face in its implementation. Participants in this process require open, honest communication and clear set of expectations about what this process can realistically and feasibly deliver.

Creating Manageable Solutions within a “Broken” System

The learning curve community members encountered in this process were steep, especially as relates to understanding the broader, systemic context in which health services are delivered. It was noted by community representatives and leaders that at times community members had a difficult time identifying and utilizing problem solving skills to identify potential, practical solutions to problems in the delivery of health services.

While this is a valid concern, the ultimate challenge faced by all participants within this process is that the CSC process alone would never be capable of solving some of the systemic problems plaguing the Tanzanian health system. For example, the Tanzanian health system faces persistent shortages of human resources for health, weak supply chain management systems that affect availability of drugs and commodities, and insufficient resources to meet the needs of the system.

No matter how involved communities are on a local level in demanding their rights, the CSC process alone will not fix the overall system in which these health facilities deliver services. This reality is a big challenge to facilitators of this process, in terms of both moderating participants’ expectations of what the CSC process can deliver as well as ensuring that the commitments and solutions emerging from this process are feasible, cost effective, realistic, measurable, and time bound. As demonstrated through this CSC process in Mwanza region, small, incremental changes are possible, however facilitators of this process are challenged to ensure solutions proposed within this context are manageable and realistic within a broader system.

Matching Perceptions to Reality

Communities reported many tangible improvements in health outcomes as a result of this process. Dispensary staff, community leaders and representatives, and community members alike reported the following positive health outcomes as a result of this process:

- reduction in maternal mortality
- increase in family planning uptake
- reduced fertility rates
- increases in early attendance of clinic by pregnant women
- increases in facility based births
- increases in male condom use
- increased male involvement in RH issues
- reduction in early (teenage) and unwanted pregnancies
- increased testing for malaria and HIV
- girls are finishing school

Taken at face value, these developments are extraordinarily positive and appear to be a testament to the power of this process. However, the causal relationship between this process and these perceived health outcomes is not clear, especially since there are no systematic methods put in place to assess, validate and back these claims. A huge challenge in the design of this process is that the assessment process is driven by people's perceptions which do not always correspond to reality.

A compelling example of this challenge is that many of the men's FGs reported pregnantwomen are now receiving quality services during delivery and improved RH services from the health system. However, this assessment is perception based and not rooted in a thorough assessment of Standards of Care in service delivery and SRH/MH facility assessments that demonstrate improved quality of care. Moreover, this project did not have a mandate for clinical service provision training or improvement, so perceptions of improved outcomes related to technical quality of care or technical knowledge of service providers cannot be attributed to this process alone.

Divergent Experiences with Respect to Full Participation of All Involved

Across the FGDs, there were mixed reviews on ability of everyone to participate and contribute to this process equally. Some claimed that few in the process were able to speak openly as most community members held deep fears about speaking in public, this was especially true at the beginning and initiation of the process given customs and traditions that a women cannot speak in front of men. Some communities reported a low turn-up and level of participation of men and adolescent girls throughout this process. On the other hand, many FGs reported that all participants were able to speak openly and

honestly throughout the process about opinions with regard to health service provision, including women.

Across all communities, the division of participants into smaller focus groups according to age and sex provided participants with the needed space to speak openly and honestly.

Disconnect Between Community and District Level Priorities

In some communities, there was a missed opportunity during this process to attract the attention of “higher level” stakeholders and garner their support for this process. One village representative commented on how district officials often disregard plans and decisions made by village government authorities and the community at large. Instead, they come up with their own plans and budgets, which are fed to central level and do not take into account community’s needs and concerns or provide solutions to their problems and challenges. Further, district officials tend to ignore meeting invitations from villagers, or worse yet, they send subordinate officers who are not in a position to provide any answers to community questions or make any statements on behalf of the district level government.

This troubling reality compromises perceptions of legitimacy of the process in the eyes of community members and weakens the ability of participants in this process to enforce and stand strong on commitments made during the process.

VIII. Lessons Learned & Recommendations

Lesson Learned: Inclusive nature of the process lead to better results

On the whole, the implementation of the CSC process was deemed by communities to be very inclusive with representation by a wide range of stakeholder types, including village leaders, villagers, health workers, district council members, and CARE staff members. However in a few cases, some notable exceptions included the following “missing” stakeholders: Members of Parliament, District level officials, including the District Executive Director (DED), Councillors, teachers, religious leaders, and handicapped persons as well as pregnant women (as a stand alone group) and witch doctors.

The absence of participants of these types was perceived as a weakness by the community members and public sector representatives alike, as the perspectives these “missing” stakeholders would have brought to the process could have greatly advantaged the outcomes of the process, especially in terms of action orientation and positive follow up on commitments made during the process.

One compelling example of the importance of the presence of “higher level” stakeholders in this process is that in one community, the council allocated 18,000,000Tsh to renovate a health clinic and build a house for a health care worker. The positive outcome highlights the importance of the presence of elected officials, as they can garner the political will and resources needed to act upon commitments made during this process. This also serves an indirect benefit of ensuring public representatives are in touch with community perceptions and opinions of problems in the community.

Furthermore, religious leaders could reinforce the values of transparency, empathy, accountability, responsibility and ensuring respect for basic rights, while teachers could reinforce the educative benefits of this process, including promoting positive health seeking behaviors, such as using condoms and preventing early pregnancies.

Recommendation: A thorough and formalized stakeholder analysis should be conducted before project implementation to understand whose presence the community believes would bolster and strengthen the process itself as well as reinforce and ensure the realization of commitments made during the process. Feedback mechanisms need to be formalized to ensure that messages and outcomes of this process are carried out to stakeholders on all levels who are not in attendance, ranging from community members to service providers to elected officials to partner organizations and NGOs.

Lesson Learned: Timing Matters

Information gathered during this process holds the potential of influencing planning and budgeting processes within LGAs. Local Government Authority plans and budgets in theory are planned to respond to community needs and focus on providing solutions to community’s problems. If timed right, the CSC results can be fed into these higher level planning and budgeting processes, and evidence generated from this process can be used to advocate for the resources necessary to address mutually identified problems.

Recommendation: Implementation of the process should be timed to align with district level planning and budgeting processes to ensure inclusion of “evidence” generated by this process into annual budget requests and allocations.

Lesson learned: Evidence of results feed a positive view of this process

People’s positive impressions of this process were grounded in witnessing and experiencing tangible changes within their community as a result of this process. Also, participants within this process need to believe their opinions and perspectives are being considered and taken seriously. One very minor, yet powerful and tangible, example of this that emerged within this process is demonstrated improvements in the issue of health center cleanliness.

Recommendation: Facilitators of the CSC process need to ensure that solutions and action plans emerging from this process are responsive to service users' needs while also realistic, feasible and manageable within the overall constraints of the system. In scaling up this approach or introducing this tool into a new community, it would be recommendable to start with so called “quick wins” or rather problems that are easier to tackle and solve where success might be easier to demonstrate, for example, cleanliness of health center facilities. This process can then be used in a gradual, on-going manner to collectively engage service users and service providers in solving more difficult issues such as commodities management, referral systems, HRH, supply chain management issues, etc. If the CSC process is proven successful in increasing transparency, community involvement and engagement, and accountability, then this participatory process may be more successful in advocating for solutions to more difficult challenges faced in health service provision. It is recommendable that several rounds of scoring and interface meetings take place in the implementation of this process.

Lesson Learned: Perceptions do not always match reality

As we learned, participants in this process were quick to attach significant improvements in health outcomes and health indicators to the implementation of this process. However, there was no baseline study conducted within the project impact area to establish a clear understanding of the “before” situation in terms of health outcomes and indicators. And moreover, there are currently no rigorous M&E systems in place to track, measure, assess and validate any improvements in health outcomes and indicators as a result of this process.

Recommendation: To systematically assess the actual quality of care being provided within health facilities, a facility assessment should be conducted in coordination with the MOH to identify actual weaknesses and gaps in quality service provision. The results of this facility assessment should be shared with service providers and service users prior to the implementation of the CSC so as to focus indicator development, results and proposed solutions on *actual* rather than *perceived* problems.

In addition, the CSC tool requires a rigorous M&E model to measure, assess and validate health outcomes. More conceptual thinking needs to go into the design of M&E tools in future iterations of the CSC tool. One monitoring tool that could potentially be easy and cost effective to implement would be exit interviews with service users and service providers on a pre- and post- CSC implementation basis, which could add a quantitative tracking and monitoring element to the quality of services by ranking different services on a numerical scale and including qualitative comments as necessary.

Lesson Learned: Process and Outcomes can potentially be sustained through the village health committee

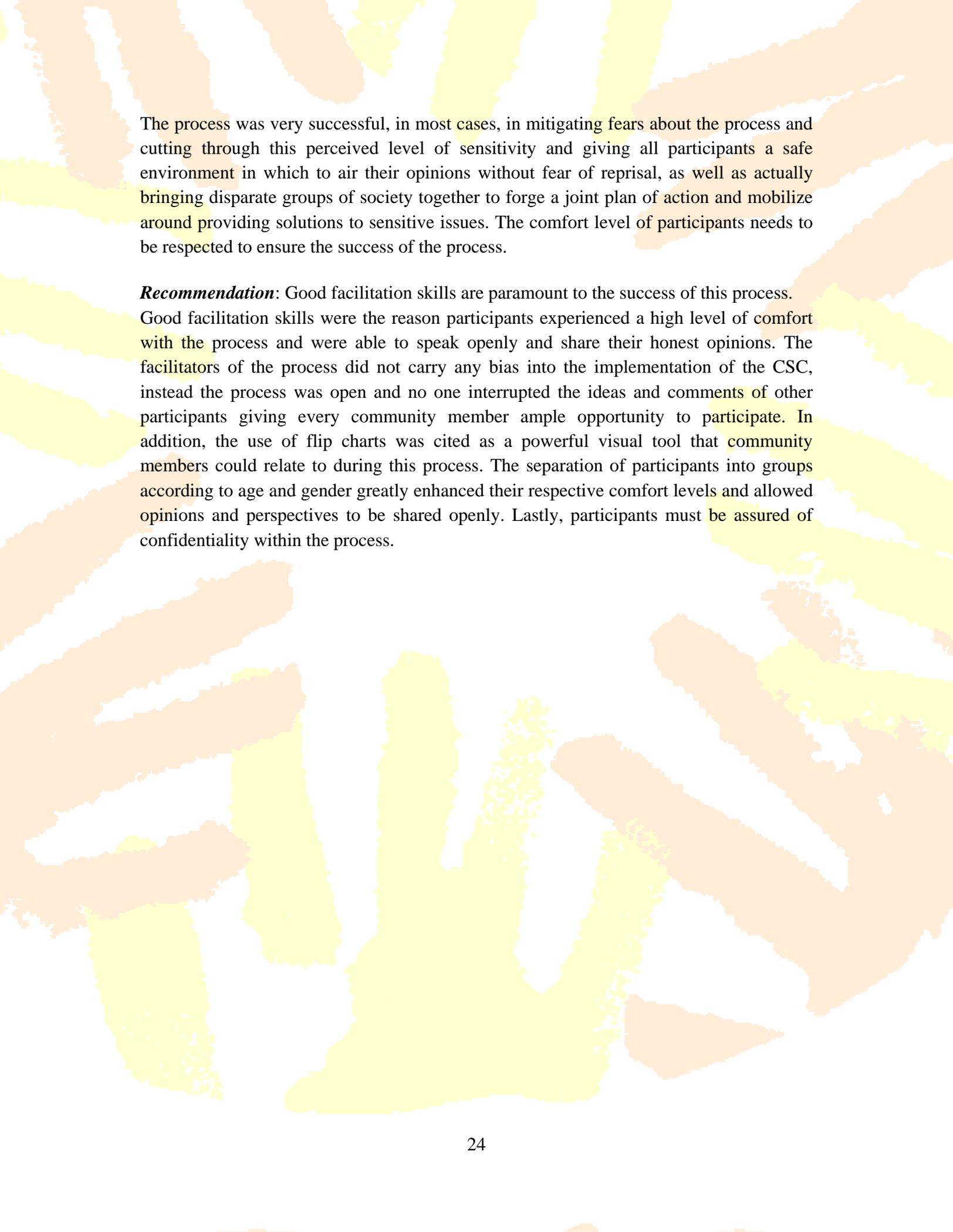
The village health committee is responsible for the governance and accountability of the health affairs in the village. Through this process, village health committees were reactivated and sensitized on their roles and responsibilities including: mobilizing the community to participate in village meetings and community development, facilitating and coordinating meetings, following up on development issues and updates to inform the community and hold leaders accountable, following up on procurement of drugs and supplies, discussing challenges and gaps in the health sector with service providers and developing solutions to improve the situation.

Recommendation: The sustainability of this process requires steps aimed at institutionalizing the practice for iterative civic use. Further analysis is required to understand barriers in the effective formation of the village health committees and realization of their responsibilities in the governance and accountability of health affairs in villages. Many stakeholders cited this model as a potentially powerful model to achieve sustainable outcomes of the CSC process over time. This model should be further assessed before scaling up the CSC tool or introducing the CSC process to other communities to exploit the strengths and weaknesses of this model and better help to ensure sustainable outcomes of the CSC process over time. At its optimal functioning, the village health committee model would be wholly integrated in the village council and would use regular and on-going village council meetings to create focused attention and catalyze action around following up on the results and commitments made during the CSC process.

Lesson Learned: Safe environment for participants is best assured through strong facilitation skills

The implementation of the CSC process inherently involves highly sensitive and perhaps controversial issues, and holds the potential to confront community norms and taboos, including male involvement in RH, SRH, prevention of sexually transmitted diseases, etc. For example, community members indicated that they were fearful of talking about condoms lest they be perceived as a prostitute by other community members.

Moreover, if not managed correctly, the process can lead to finger pointing and blaming, which adds a heightened level of fear for service providers' participation in such a process. One service provider remarked, "at the beginning of the process, I was not comfortable at all. I was afraid I would be held accountable on whatever issues were raised through the process." But going through the process proved comfortable and even "enriching."



The process was very successful, in most cases, in mitigating fears about the process and cutting through this perceived level of sensitivity and giving all participants a safe environment in which to air their opinions without fear of reprisal, as well as actually bringing disparate groups of society together to forge a joint plan of action and mobilize around providing solutions to sensitive issues. The comfort level of participants needs to be respected to ensure the success of the process.

Recommendation: Good facilitation skills are paramount to the success of this process. Good facilitation skills were the reason participants experienced a high level of comfort with the process and were able to speak openly and share their honest opinions. The facilitators of the process did not carry any bias into the implementation of the CSC, instead the process was open and no one interrupted the ideas and comments of other participants giving every community member ample opportunity to participate. In addition, the use of flip charts was cited as a powerful visual tool that community members could relate to during this process. The separation of participants into groups according to age and gender greatly enhanced their respective comfort levels and allowed opinions and perspectives to be shared openly. Lastly, participants must be assured of confidentiality within the process.