RMCH
REDUCING MATERNAL AND CHILD MORTALITY THROUGH STRENGTHENING PRIMARY HEALTH CARE

BLACKSASH
MAKING HUMAN RIGHTS REAL

The Community Score Card Evaluation Report 2014

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RMCH Action Group facilitating a Small Group discussion during the Community Scorecard Pilot in OR Tambo.

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Main Messages

This report is about a pilot aimed at improving public health through an accountability initiative. More specifically it evaluates a Community Scorecard piloted in South Africa, which existing community structures in conjunction with government representatives and service providers can use, to monitor Maternal and Child Health in the future.

The Scorecard pilot took place in Port St John's in the Eastern Cape and in Bruntville in KwaZulu Natal. This initiative has the potential to strengthen existing accountability mechanisms in public health such as the Clinic Committees - specifically members of those structures focusing on Maternal and Child Health. The Black Sash intervention empowered the RMCH[1] Action Groups to pilot the Scorecard with the community and services providers and to map out an Action Plan, which all stakeholders agreed upon.[2]

Clinic Committees[3] together with the RMCH Action Group have great potential but they need basic resources to function. Not only do they have to address supply side challenges (for example shortage of staff or ambulances) but they also have to tackle demand side challenges, which are barriers to service uptake by the community. The pilot presents an opportunity for government and funders to positively impact on Maternal and Child Health outcomes by channeling resources towards the existing Clinic Committees and RMCH Action Groups that have the capacity, energy and the enthusiasm to carry on monitoring public health impacts and work in partnership with all stakeholders towards jointly overcoming challenges.

Service providers, especially nurses, have a tough working environment. They lack the basic resources necessary to deliver Primary Health Care to the rural communities in which they are based. Service users are obviously disgruntled by the inadequacy of the services they receive, yet they often do not understand the reality within which facility staff have to operate. Many clinic staff do not have the power to address the organizational culture that may prevent them from openly seeking that dialogue. This could affect the extent to which service providers can communicate with and respond to the needs of the community.[4] Accountability between different levels of health care staff would be a logical continuation of this pilot.

The initiative needs to continue if monitoring of changes in service delivery is to take place. The Black Sash project has succeeded in equipping the RMCH Action Groups in the two pilot sites of OR Tambo (Eastern Cape) and uMgungundlovu (KwaZulu Natal) to run this process independently. Ideally, the initiative should be rooted within the community that it works in through one of the organizations already associated with the RMCH Action Group.

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[1]RMCH stands for **R**educing, **M**aternal and **C**hild Mortality through Strengthening Primary **H**ealth Care.

[2]This report was written before the implementation of the Action Plan and is limited to a formative evaluation process leading up to that.

[3] There are both Clinic Committees and Community Health Centre Committees. In this report I refer to Clinic Committees to refer inclusively to both these structures.

[4]Cleary S et al. (2013) *Resources, Attitudes and Culture: An Understanding of the Factors that Influence the Functioning of Accountability Mechanisms in Primary Health Care Setting* in BMC Health Service. Research 320(13) page 9.

The Report

This report is an evaluation of the Black Sash RMCH[5] project, which implemented a Community Scorecard initiative in two provinces namely the Eastern Cape (OR Tambo District, Port St Johns) and in KwaZulu-Natal (uMgungundlovuDistrict, Bruntville). The RMCH project aims to improve access to and quality of care for Maternal and Child Health through the Community Scorecard process by addressing both supply and demand side barriers and strengthening existing accountability mechanisms such as the Clinic Committees.

To achieve this, Black Sash set up the RMCH Action Groups in each of the pilot sites. The RMCH Action Group is a partnership between Clinic Committees, Civil Society Organisations[6], communities, health care providers[7] and other stakeholders with an interest in Maternal and Child Health. The Community Scorecard process, implemented by the RMCH Action Group, aims to facilitate joint problem solving between the community, service users, service providers and multi-stakeholders in addressing Maternal and Child Health issues. The process is outlined in more detail below.

In summary the RMCH Action Group ran two meetings, one with the community and one with the facility staff. At these meetings each group discuss key Maternal and Child Health challenges including both supply and demand barriers framed in terms of both group's rights and responsibilities. They then develop indicators from the top rated challenges and 'score' these indicators against the current situation on a scale of 1 – 5, 1 being very bad and 5 being very good. They also give reasons for these scores and make suggestions for improvement.

Both the Scorecards from the community and the facility meetings were then taken to the multi-stakeholder meeting. At this meeting, the community, the facility staff and a range of other stakeholders presented and discussed both Scorecards. Together, they developed a joint Action Plan on how to address each of the indicators identified at the Scorecard meetings. The Action Plan spelt out what each of the stakeholders will do, the responsibilities they have and how they will measure progress towards achieving the changes identified in the earlier meetings. Notably the priorities identified at the multi-stakeholder meeting are aligned with the priorities of the Department of Health.

The evaluation is based on a set of indicators defined by the external evaluator, aimed at illustrating the extent to which Black Sash achieved its objectives for each of the Scorecard events. Key informant interviews provide the data on these indicators. Additional information from Black Sash documents complements the field notes where necessary. Below is a summary of the main findings.

[5] **R**educing, **M**aternal and **C**hild Mortality through Strengthening Primary **H**ealth Care

[6] "Civil society organisations" include but are not limited to traditional healers, Non Governmental Organisations, Community Based Organisations, ward committees, religious leaders etc.

[7] "Facility staff" includes but are not limited to Community Health Workers, Community Care Givers and other facility staff such as midwifes, nurses and other professionals working in the clinics.

Overall the training was successful in communicating Maternal and Child Health issues, rights, responsibilities and the role of the Clinic Committee. Transferring knowledge on patient rights and responsibilities set the scene for the Clinic Committee with the RMCH Action Groups to become stronger accountability structures. Clinic Committees however, need resources to effectively fulfill their roles. There is great potential in the commitment and organizational skills on the part of the RMCH Action Group and other members of the Clinic Committees, which should be capitalized on by providing them with the basic resources they need to function. The training successfully encouraged RMCH Action Group and other Clinic Committee members to engage with civil society. If the initiative continued this would enable RMCH Action Group and other Clinic Committee members to bring their work closer to the community. Reaching out to the community, especially to those people who are not coming to clinics, is crucial in addressing demand side barriers, which prevent people from using the services that are available.

Considering the demand side challenges brought to light during this project reaching out to the community has the potential to improve Maternal and Child Health challenges. The RMCH Action Group and other Clinic Committee members understand that the community members have a role to play in getting to the clinic and taking up the services. Addressing demand side barriers requires access to those people who are not yet attending the clinic and thus rely heavily on community based health care workers[8]. Community based health care workers are closest to the community as they have intimate knowledge of the health challenges and access service users directly through door-to-door visits. Reaching people who should ideally be going to the clinic and taking up services is a very important step to address demand side barriers towards improved Maternal and Child Health outcomes. [9]

It is well-documented that the rural health care system is under resourced. This leads to unacceptably high maternal and child mortality statistics.[10] The Scorecard Pilot revealed the challenging environment in which service providers and nurses work. Lacking the basic resources,[11] they need support if they are to continue to carry the weight in delivering Primary Health Care to remote, poverty stricken, rural communities. Having facility staff such as a midwife or a nurse greatly helped the Facility Scorecard process in the Eastern Cape where she illustrated the desperate conditions under which she functions. This exposure fostered greater understanding on behalf of service users and was the key to many points on the Action Plan.

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[8]Such as Community Care Givers, Community Health Care Workers and other health care outreach staff.

[9]Rosato M et al(2008) *Community Participation: Lessons for Maternal Newborn, and Child Health* in Lancet 372, 962 - 72 suggest that community health workers are most effective when they also facilitate change at the community level. They play a central role in community mobilization in recognizing maternal problems in the home and encouraging people to seek care (See page 968).

[10]Bunce B et al (2014) *Black Sash RMCH Baseline Report: Strengthening Community Accountability Mechanisms to Improve Maternal, Neonatal and Child Health Services*, Cape Town: Black Sash Trust at page 6 spell out key indicators in the two pilot sites.

[11]"Resources" in this sense refers to all the resources needed to operate. While it includes financial resources it also refers to staff, skills, medication and equipment ranging from everything to ambulances, medicines and specialized equipment needed for Maternal and Child Health Services.

Developing the indicators was problematic and this process would benefit from further refinement. It was not possible to translate all the identified challenges into indicators, as this would have made the list too long to be practical. By grouping the challenges under certain headings there is the risk that certain important details are getting lost. While Black Sash project staff with the RMCH Action Group navigated these issues well and identified indicators the collective was satisfied with, further testing of participatory methodologies in developing accountability indicators could provide useful.

The Facility Scorecards in both pilot sites were difficult to navigate as facility staff were at first resistant to participate and seemed defensive. Possible reasons for this are explored in more detail below but overall service providers, especially nurses, said they were used to being attacked for the health system's failure to provide the necessary services. It is very important that the facility staff be assured that the Scorecard is not meant to accuse them for the systematic failures that lie outside of their control. In KwaZulu Natal it seemed that nurses were more comfortable speaking openly once the Operational Manager left the meeting. Apart from having clinic staff on the RMCH Action Group, which worked in the Eastern Cape, it could thus also be beneficial to separate different staff categories such as managers and nurses. A Scorecard process facilitating communication between the different staff categories within a health facility could also improve accountability and oversight or what Cleary et al (2013) call bureaucratic accountability. This evaluation agrees with their finding that it is likely to affect the way facility staff can participate in external accountability initiatives (such as the Community Scorecards), which in turn can affect the way they are able to deliver client centered services.[12]

For monitoring purposes this initiative has to be repeated to see if there was improvement on the indicators. As a pilot this was a once off initiative. If repeated this project ideally should be located in the community it is working in. The RMCH Action groups in the districts are committed to take this process forward. Black Sash has empowered the RMCH Action Group members to run a Community Scorecard process. Ideally one of the NGOs or civil society partners that are already part of the RMCH Action Group in the area should be supported with the resources needed to repeat this process. Rooting the process in the communities has many advantages, most of all that the relationships, which have been built, can develop organically through the Clinic Committee and existing civil society structures thereby complementing and strengthening existing accountability initiatives. At the time of writing Black Sash was investigating ways to support the RMCH Action Group in attracting this funding so they can take the process forward independently.

Context

South Africa is committed to reducing Maternal and Child mortality and morbidity as the number of deaths in this category is still unacceptably high. One in 322 South African women

[12]Cleary S et al. (2013) *Resources, Attitudes and Culture: An Understanding of the Factors that Influence the Functioning of Accountability Mechanisms in Primary Health Care Setting* in BMC Health Service at page 9.

does not survive pregnancy or childbirth, and one in 25 babies die before his or her first birthday[13]. Many of these deaths can be prevented through evidence-based, cost effective health interventions. Black Sash through its Baseline study and other project documents has identified two major challenges to Maternal and Child health: 1) limited or delayed uptake of essential maternal and child health services, especially by population groups that are historically disadvantaged; have low literacy rates and among migrants, 2) limited capacity and motivation of health workers to adhere to national protocols and standards.[14]

The Black Sash RMCH project aims to strengthening local, public and alternative accountability mechanisms, in the conviction that this will lead to an increase in demand and set up the processes to deal with demand and supply side barriers, accountability and participation.

To achieve this, the Black Sash sets out to:

- Train RMCH Action Groups (sub-committees in existing Clinic Committees focusing on Maternal, Neonatal and Child Health Services) on the roles and responsibilities of Clinic Committees, maternal and child health and the Community Scorecard process;
- Pilot the intervention (a Community Scorecard) in two districts (uMgungundlovu in KwaZulu-Natal and OR Tambo in Eastern Cape), aimed at increasing collective, multi-stakeholder action;[15]
- Create relationships between the Clinic Committees, civil society, multi-stakeholder organisations and forums already operating in the areas;[16]
- Develop materials and tools of a high quality, reflective of the reality as found in the Baseline Study, aiming to support Clinic Committees and civil society/ multi-stakeholder partners to improve accountability and demand for RMCH services;[17]
- To evaluate the extent to which various stakeholders (Clinic Committee representatives, civil, society and multi stakeholder forums – alternative accountability structures) are prioritising RMCH issues as a result of the Black Sash intervention.

This report evaluates:

1) The extent to which the training achieved its stated aims, namely to empower participants:
   a) To be active and informed members of a Clinic Committee;
   b) Understand the need and plan to prioritize Maternal and Child Health issues;
   c) To have the capacity to engage with multi-stakeholders in achieving Maternal and Child Health outcomes.
2) The resource materials developed for the training.

[13]The Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) in South Africa, UNFPA pamphlet.

[14]BunceB et al. (2014)*Strengthening Community Accountability Mechanisms to Improve Maternal and Child Health* Black Sash Trust, Cape Town page 21.

[15]Bunce B et al (2014) *Black Sash RMCH Baseline Report: Strengthening Community Accountability Mechanisms to Improve Maternal, Neonatal and Child Health Services*, Cape Town: Black Sash Trust page 4.

[16]Baseline Report ibid at page 21.

[17]Project plan Output 3.1.activity 1 and output 3.4.

3) The extent to which stakeholders understand the need and plan to prioritise RMCH issues in their work after the intervention.
4) The process through which Black Sash supported the RMCH Action Groups to implement the entire Community Scorecard process in their districts.

This includes:

i) An evaluation of the Community Scorecard;
ii) An evaluation of the Facility Scorecard;
iii) An evaluation of the multi-stakeholder meeting;
iv) An analysis if relationships between Clinic Committees and other civil society, multi-stakeholder organisations or forums, were created or where these relationships existed before an analysis if they improved after the intervention.[18]

Literature Review

The literature indicates that Clinic Committees have an important role to play within the health system of which community-based workers[19] are an important part. They need to be central in putting issues on the agenda and pushing for solutions. Strategies to improve Maternal and Child Health should involve the community as a complement to any facility-based component. Rosato et al (2008) illustrate that Community Based workers can facilitate the scaling up of Primary Health Care initiatives. They find that the key to the success of community empowerment was the moment when the community engaged with the problem-posing, problem-solving process and recognized that they could collectively change their circumstances.[20] In addressing inequality and disempowerment community mobilization is a priority for Maternal and Child Health Programs.

This mobilization is to happen through the Clinic Committees set up by the SA National Health Act 61 of 2003. Clinic Committees are supposed to strengthen the relationship between health providers and the community and to provide the space for participation.[21] According to a Health Systems Trust study Clinic Committees have played an instrumental role in improving health outcomes, ensuring greater efficiency and effectiveness in healthcare, and in ensuring equitable outcomes and extended coverage of services.[22] The challenges identified in that study are highly relevant to the RMCH project and correspond to a large degree with the findings of this evaluation.

Joshi et al (2012) also support the notion that, for social accountability in public service delivery to take place, initiatives should be part of a long term, ongoing political engagement. Merely focusing on mechanisms through which people hold service providers

[18] Mobilisation Guidelines for RMCH Intervention (draft) page 4.
[19] Community Care Givers, Community Health Care workers and other clinic based outreach staff.
[20] Rosato M et al (2008) *Community Participation; Lessons for Maternal, Newborn, and Child Health* in The Lancet Vol. 372 962 - 971 at page 967
[21] Black Sash *RMCH Literature Review: Situational Analysis Strengthening Public Accountability Mechanisms to Improve Maternal and Child Health Services* (2014) page 4.
[22] Black Sash (2008) *RMCH Literature Review* ibid at page 4 citing Padarath et al *The status of clinic committees in primary level public health sector facilities in South Africa* Health Systems Trust: Durban.

to account, they argue, can depoliticize the process through which people make claims.[23] This supports the conclusions of this evaluation that this initiative needs to be repeated a number of times over in collaboration with all the stakeholders identified.

This project deals with what Cleary et al (2013) call external accountability mechanisms – mechanisms that seek to regulate answerability between the health system and the community. Accountability between different levels within the health system in contrast Cleary et al (2013) call bureaucratic accountability. They found that bureaucratic accountability mechanisms could affect the external accountability mechanisms. For example, meeting the expectations of relatively powerful managers further up the system may crowd out efforts to respond to citizens and patients. Organizational cultures characterized by supervision and management systems focused on compliance to centrally defined outputs and targets can constrain front line managers and providers from responding to patient and population priorities.[24] The findings of their research resonate with the findings of this evaluation.

Implications

The key audience for this evaluation report are the National Department of Health; the Provincial Departments of Health in KwaZulu-Natal and the Eastern Cape; District Departments of Health; the Futures Group and the Health Systems Trust; Save the Children UK; and Social Development Direct. Donor and funding organisations working on accountability in the public health sector or on reducing Maternal and Child mortality can also benefit from this evaluation since it provides a strong incentive and working suggestions on how to take these initiatives forward.

This evaluation report reflects on the process through which Black Sash implemented the Community Scorecard in the chosen districts. A larger audience of this report are therefore any Non Governmental Organisations, civil society and academic research organisation that seek to implement an accountability mechanism such as the Scorecard. It also has implications for the Clinic Committees in their every day functioning and in ensuring participation from the community. As such this report is also of value to service users, health care staff, and multi-stakeholders working in the field of Maternal and Child Health.

Approach

This was a process and formative the evaluation process. The aim of the evaluation was to improve the materials and intervention design by identifying what has and has not worked in achieving the project aims in the pilot sites. The evaluation was based on data collected through a qualitative, participatory research approach through interviews with key stakeholders identified by Black Sash and any additional stakeholders identified throughout the evaluation process.[25] The analysis of the materials developed was based in addition to

[23]Joshi A et al (2012) *Widgets or Watchogs? Conceptual explorations in social accountability* in Public Management Review 14(2) 145 - 169 at page 145.
[24]Cleary S et al. (2013) *Resources, Attitudes and Culture: An Understanding of the Factors that Influence the Functioning of Accountability Mechanisms in Primary Health Care Setting* in BMC Health Service at page 9.
[25]Terms of Reference for External Consultant.

data from interviews, on documentation provided by Black Sash. When necessary Black Sash field staff provided translations for data gathered in different languages.

Key Informants

The key informants were the members of the RMCH Action Groups, as identified by the Terms of Reference for the evaluation consultancy. They consisted of:

1. **Members of the RMCH Action Group:**
    a. *In the Eastern Cape OR Thambo*:
        i. Mr JamJam Mzwandile: Clinic Committee; civil society representative.
        ii. Ms Nontsikelelo Ndabeni: NGO representative.
        iii. Ms Stella Ndzumo: Clinic Committee, ward councillor secretary
        iv. Mrs Mwirira Harriet: Midwife DENOSA Representative.
    b. InKwaZulu Natal, Bruntville:
        i. Ms Simangele Mchunu: Chairperson, Community Care Giver
        ii. Ms Phumelele Mabida: Dept. chairperson, traditional healer
        iii. Ms Nomusa Duma Civil Society
        iv. Ms Hlengiiwe Khanyile Community Care Giver

2. **Civil society, service users and multi-stakeholder partners**
    a. In Eastern Cape OR Tambo
        i. Ms Nobuntu Ndima: Service user
        ii. Ms Nomakaya Ndwandwa: Department of Health Programs Coordinator
    b. In KwaZulu Natal Bruntville
        i. Ms Sebenzile Mlambo: Clinic Operational Manager
        ii. Junior Nurse (anonymous)
        iii. Ms Nosihle Sosibo: Service User
        iv. Mrs ME Majola: Nurse Manager

3. **Members of the Clinic Committees**
    a. In Eastern Cape OR Thambo
        i. Mr JamJam Mzwandile (Chair Person)
        ii. Ms Stella Ndzumo (member)
    b. *InKwaZulu Natal, Bruntville*
        i. Ms Simangele Mchunu: Chairperson
        ii. Ms Phumelele Mabida: Dept. chairperson
        iii. Mrs ME Majola: Nurse Manager

The direct beneficiaries of the project are identified as:

1. Clinic Committee representatives [including those not on the RMCH Action Group e.g. Facility Manager]
2. Community Health Care Workers [in addition to those part of the RMCH Action Group for example in uMgungundlovu]
3. Civil Society multi-stakeholder organisations and forums

4. Community Members/ Service users
5. Health Facility Staff

Other relevant Stakeholders are

1. The District Department of Health officials (District Manager, Sub-district manager, Clinic supervisors, District Portfolio Councillors)
2. Traditional Healers
3. Black Sash Project Staff

Key Events

Evaluation data was collected during 3 key events. Where data could not be collected in the field the notes from the internal Black Sash evaluation were used.

1. *Training workshop*: The purpose was to train the RMCH Action Group and relevant Department of Health officials on the Community Scorecard Mechanism
    a. One was in the Eastern Cape, OR Tambo from the 10th to the 13th of June.
    b. One was in KwaZulu-Natal, uMgungundlovu from the 3rd to the 5th of June and from the 9th to the 11th of June 2014.

    During this training the RMCH Action Groups finalized their project plans for implementing the Community Scorecard process. The external evaluator did not attend these events.
2. *The Community Scorecard Meetings*
    a. Community scoring meeting: OR Tambo: 24th June 14; Bruntville: 3rd July 14
    b. Facility scoring meeting in each district: OR Tambo: 25th June 14; Bruntville: 4th July 14.

    At these meetings community and facility scoring processes are implemented. The external evaluator attended the Community Scorecard meetings in both provinces.
3. *Multi-stakeholder meeting*: at these meetings action plans were developed; responsibilities were assigned for the different, identified tasks including monitoring of progress. The external evaluator was able to attend only one of the multi-stakeholder meetings in the Eastern Cape: 24th of July, as the Bruntville multi-stakeholder meeting happened simultaneously.

Method

The evaluation was organised around the different events. The aims of the key events are spelled out in more detail below. The author-identified indicators based around these aims and used these to develop interview questions to be asked the key informants. The responses to the questions were recorded, transcribed and used for the analysis to determine if and to what extent the project aims spelt out in this evaluation were met. The full list of indicators can be found in Annexure 1. The full interview transcripts are available upon request.

Training and Materials

Two training events took place in two provinces in the local language. Data on the training was collected from the RMCH Action Group members who attended. Black Sash's internal evaluation of the training was also used. The Black Sash Baseline Report succinctly spells out the challenges that Clinic Committees currently experience. The training was meant to

directly address these challenges and enable those Action Group members who are also members of the Clinic Committees, to champion overcoming the obstacles. This is to be achieved in collaboration with all stakeholders (after the writing of this report).

Clinic Committees are the conduit through which accountability between service users and service providers is supposed to happen in the public health care sector. The training was meant to equip participants to be active and informed members of a Clinic Committee dealing with Maternal and Child Health issues. The indicators assessed if participants understood the urgency in championing Maternal and Child Health issues. They also sought to find out if they understood the roles, functions and reporting structures of the Clinic Committee. They ascertained if participants personally felt empowered to facilitate the Community Scorecard in their provinces. They also asked if participants felt competent to build relationships to improve joint decision-making and action in connection with Non Governmental Organisations and other multi-stakeholders.

The evaluator asked participants if the materials were suitable for them. The questions will identify if participants understood the materials, and if they could engage with and understand the content.

Community Scorecard Pilots

The RMCH Action Group members subsequently ran pilots of the Scorecard in their own districts with the community and with the health facility representatives. Each group developed a list of "things they want to see changed" in their health care facility based on the main challenges each side experiences. The Scorecard aimed to promote joint dialogue and action on the part of community members and health workers to address maternal and child health challenges experienced in their local communities.

For this part of the evaluation RMCH Action Group members, some of whom are also on the Clinic Committee, narrated their experiences and expectations about the Scorecard. Community representatives/service users and facility staff were interviewed as well. The open-ended questions gave insight into what worked and didn't work during the pilot Scorecard process, and the extent to which they felt they had ownership and felt it was likely to succeed. A comparison of both the facility and the community pilots also provided insight into the contextual factors that may have influenced the outcomes.

The multi stakeholder meeting

At the multi-stakeholder meeting the RMCH Action Group got together with all the stakeholders to complete the first round of the Scorecard process. The stakeholders included facility staff, civil society organisations, service users, government representatives, traditional healers and community based health care workers[26]. Here the participants developed action plans based on the things that they had identified and assigned responsibility for different tasks including monitoring of progress.

[26]This includes Community Care Givers, Community Health Care Workers and other outreach health care providers.

The same RMCH Action Group members who were interviewed for the Scorecard Pilot were interviewed after the multi-stakeholder meeting as well. Since they facilitated this process, the interview aimed to ascertain whether they were able to build relationships, which can ultimately improve Maternal and Child Health outcomes in their provinces. This also provided opportunity for them to reflect on the Scorecard process and on the extent to which they felt capable to use it as an effective tool to monitor health services. They also reflected on the commitment to using the tool in future.

The external evaluator attended only one of the multi-stakeholder meetings, in the Eastern Cape. Here a regional manager of the Department of Health was also interviewed around the Scorecard.

Analysis

Training

Training helped participants understand the need to champion Maternal and Child Health
Most of the interviewees noted that the training was very effective in communicating rights and responsibilities of both service users and service providers. Generally speaking the training also helped people understand the urgency in addressing Maternal and Child Health issues.

Health Care Workers other than clinic staff reported to have gotten a deeper understanding of the issues around Maternal and Child Health. The Committee Chair in the KwaZulu Natal, Simangele, reflected that the training helped her understand the main challenges faced by the community in respect to Child and Maternal Health. She also said that the training equipped her to be a better Community Care Giver as well. Hlengiwe Khanyile, a Community Care Giver in Bruntville also said the training helped her learn more about the clinic, rights and responsibilities, Antenatal Care, patient's rights, and respect.

Nontsikelelo, a civil society representative in the Eastern Cape, explained how the community was not aware but bringing that information to them helped her recruit for the Score Card:

> "[I]t was difficult [recruiting] because there was a problem as to why is this program only focusing on deaths of women and children. We explained to them why they focused because of the figures they have 40 % of the death rate is women and children and they explained to them most of these deaths are cause by the faults that the community may make at some point."

In contrast at the managerial level the Operational Manager in KwaZulu-Natal, who was not part of the training, reflected on why more Maternal and Child Health specific staff shortage are difficult to address and prioritize:

> "There is no dedicated maternity staff, because where would they go when there are no patients? We cannot have people dedicated to maternity since we have a problem with space and if there are no patients they would just be sitting around"

Participants noted the pamphlets were very helpful. The pamphlets were in the vernacular languages of the districts. There was a problem with the quality of the translations in that there were some Xhosa words mixed in with the Zulu translations. On the training materials it was noted that it would be easier for participants to understand them in a vernacular language.

The language of the pamphlets is a difficult issue as feedback was not uniform. It is not possible to resolve this issue here. The language issue did however speak to the need for this kind of project to be based in the community in which it is taking place, as the local language as well as local understanding of the terms is likely to be easier from within rather than from outside the community.

Training helped participants understand the roles and responsibilities of the Clinic Committee

The Black Sash training improved the understanding that members of the Clinic Committee have of their roles, responsibilities and powers.[27]The Clinic Committee Chair in the Eastern Cape reflected that the training helped him understand his role as the Chair. The Committee Chair in Bruntville, Simangele, notably pointed out that she will now be more involved in budget matters for example:

> "The Black Sash training helped me too much because some of the roles of the chairperson or the Clinic Committee I didn't know. I didn't know that I have impact or something to say to the meetings all the time I was just going there to listen. The next meeting that will be I will be the real [chairperson] now I know my roles I know how to deal with the community; I know how to deal with the meetings that we usually have with the clinic staff or the CEO and the managers. The other thing I didn't know that I learnt from Black Sash is that I must know the budget of the clinic. Now I will be more open eyes I will be more wanting to know about the budget about all the things that are going to happen to the clinic as well as our community."

A service provider, Harriette a midwife in the Eastern Cape, who doesn't sit on the Clinic Committee said she felt the Black Sash training improved the relation between clinic staff and the Clinic Committee.

> "I feel we as service providers we can engage with the Clinic Committee because at first it was as if we don't want to engage with [it] because it was as if it was a watch dog. But now we know it is a link between the service users and the service providers so we can engage with them for the best of the community."

Even community members who did not sit on the Clinic Committee before said that the training increased their understanding of the roles and functions of the Clinic Committees. Nontsikelelo a civil society representative said the training helped her understand the roles of the Clinic Committee in the community:

> "[I]t is sort of a bridge between the community and the clinic. It […] makes ways for the people to know what is going on in the clinic and the other way around." (translated)

[27] See also interviews from Stella (Clinic Committee member in Eastern Cape); Nonsikelelo a civil society representative in the Eastern Cape; Hlegniwe also a Community Care Giver in the KwaZulu Natal

There are other examples of Clinic Committees working well and understanding their roles and responsibilities. Nobuntu, a service user in the Eastern Cape, gave an example of a Clinic Committee (the name of which she didn't want to mention) that had been very successful in her community as a conversation conduit and addressing challenges like staff placement in another clinic.

While the training was useful in empowering stakeholders to understand the roles and functions of the Clinic Committees they all reported to be struggling without any resources to fulfill those roles. This discussed in more detail below, where participants were asked if the training helped them be clearer about their roles and responsibilities.

Understand the roles and the tasks of the Clinic Committee can improve service delivery

Everyone from service users to providers as well as the civil society representatives understood that the Clinic Committee is supposed to be a way for the community and the clinic staff to communicate Child and Maternal Health issues especially, and general clinic matters with each other. Most of them felt that this was likely to improve Maternal and Child Health issues, since everyone felt that both demand and supply side barriers had to be addressed.

The Black Sash intervention was cited as instrumental in starting that conversation in the Eastern Cape. The Eastern Cape based midwife said:

> "[The Clinic Committee is] starting to facilitate communication after we were introduced to the reduction of Maternal and Child Mortality through the Black Sash project. The communication has improved with the Clinic Committee because as members they do know their duties towards the service provider to the community and the multi-stakeholders. The Clinic Committee is our link to the community. Once they understand the problems we are facing as the service provider they can take it to the community to understand our problems then they can also bring our problems the community is finding with us as service providers. They also have the space to interact with the multi-stakeholders to improve the services we are giving and to improve the health status of our community in respect to maternal and child mortality"

Even though everyone seemed to be clear about the roles and responsibilities of the Clinic Committee it was pointed out several times that these are hard to realize without resources. Stella, a ward committee secretary and Clinic Committee member said:

> "Well when we are talking about the tools we are talking about the resources that we don't have unfortunately. For example when the Clinic Committee has to sit in their meetings they are from different villages and areas. Now imagine if they have to go to this large community of Port St John's really it's a bad situation because they have nothing to work on. To improve the job of the Clinic Committee they need a vehicle it needs an office where they can work on the telephone the machines like the computers the pens and books to work with there is nothing as we speak there is absolutely nothing. People of course have to tell the department what is going on in the communities and the department has to tell the people what is going on in the department. The Clinic Committee is the only mechanism that can make sure that that happens that is why they need to be empowered they need to be given resources and they need to work hard towards making that achievement."

Nurse Majola sits on the Clinic Committee and attempts to share issues with the community. She facilitates feedback through meetings with the staff, the mobile clinic and local clinic and the community care givers to align them to help with respect to Maternal and Child Health issues such as tracing follow up of clients, improving the statistics on mortality and referrals through home visits etc. Like Stella she said that the work of the Committee would be greatly improved if it were able to connect between the wards. They would need a car, materials, and stipends to encourage the people, most of whom are currently donating their time to attend meetings and do the work.

Reporting requirements and hierarchies of the Clinic Committee

The accountability of the Clinic Committee is difficult to navigate since it is accountable to both, the community as well as the clinic and the Department of Health. The Clinic Committee Chair in the OR Tambo district, JamJam explained the Clinic Committees accountability to the community and the Department of Health respectively.

> "I have to account to the community I have to account to the dept. what this facility goes like. I have to resolve things and then go back to the community and give a report. If the senior manager comes down to ask what is going wrong here I have to tell him everything that is going on here. That's what accountability means to me."

Phumele, a Clinic Committee member and traditional healer and Stella a Clinic Committee member and Civil Society representative said that the training helped them understand the hierarchy and reporting structure.

> "She learnt a lot and she learnt that mothers and children will get helped but the most important thing for her was the reporting structures. How she cannot go straight to the top but she has to start at the bottom and then move up."

The Operational Manager in KwaZulu Natal was not part of the training. She explained how the clinic was reclassified from a Primary Health Care facility to a Community Health Centre, which means that it is expected to perform a wider range of services than before. The clinic was unable to do so because they lacked the space and the infrastructure. She did not know who was responsible for the reclassification, or who makes these decisions and was therefore unable to challenge the space limitations or the equipment shortages related to the wider range of services they were expected to deliver.

Making connections/ building relationships with Non-Governmental Organisations and other stakeholders.

The majority of participants understood the need to engage with all the stakeholders around public health accountability. In the Eastern Cape one Clinic Committee member, Stella, linked this to the training:

> "I don't feel there has been an established relationship between the Clinic Committee and the NGO's and NPO's but after this training that needs to be worked on. It is very important for the Clinic Committee to work with these organizations because that's where the Clinic Committee will get the info they need to work on because it's there for the people."

In KwaZulu Natal the relationships were reportedly better. Hlengiwe the Community Care Giver in that province said she has in the past already called help from civil society. The

traditional healer Phumele said that they work well together because they go directly to the service users houses:

> "There are other structures within the community they can work with pregnant mothers and women. The NGOs (Non-governmental Organizations) and the CCGs (Community Care Givers) work together because they do door-to-door so they work very well together."

Sebenzile the Operational Manager also reflected that communication within the clinic facility and the department was important. She cited an example when this helped her sort out a particular problem at her clinic:

> "It would be good to have clear communication between the facility, the departments and 'higher authorities'. For example there was a supply chain issue which the OM could sort out."

Competent to collaborate with the community and civil society organisations

Since the RMCH Action Group as made up of active community, Clinic Committee or Civil Society members, they were likely to feel comfortable making connections with community and civil society. Hariette the midwife and JamJam Clinic Committee Chair in OR Tambo felt competent to collaborate and engage with Civil Society Organisations through the Clinic Committee. While Hariette elaborated that all stakeholders include government itself, Jamjam felt optimistic about civil society participation:

> "There are people in civil society like traditional leaders and other people and those people make decisions and they are interested to help us they are supporting us as a Clinic Committee. They support us in calling people together and they also come to us when we have the meetings and give support."

This was similar in KwaZulu Natal. Phumela the Clinic Committee member and traditional healer said

> "I am positive that being on the Clinic Committee helped me with knowledge and info so when I take a person to the clinic I have additional knowledge. For me I think it is much easier as I can see in the patient there is something that is not right. So it makes it easier for me to be on the Clinic Committee as well as being a traditional healer."

The Community Scorecard Pilot

Participants understood the Scorecard process and were able to pilot with communities and facilities

Generally participants understood the Scorecard process as one that identifies issues that can be addressed by service users (through the Community Scorecard) and by service providers (through the Facility Scorecard). They also understood that this is a tool for monitoring the implementation of the things that participants agreed to collaborate with stakeholders towards changing. Overall the RMCH Action Group members were successful in facilitating the pilot. There were some difficulties in narrowing down a long list of indicators, which is discussed in more detail below, in the section on indicators.

The Black Sash intervention also seemed successful in empowering the RMCH Action Group to facilitate the Scorecard process. Nonsikelelo a civil society representative in the OR Tambo region said:

> "I want to thank Black Sash for opening my eyes and give me the knowledge and also the skill I got. Yes I did have the skill for facilitation but I didn't have the confidence. But now I can stand in front to the people facilitating and also thank the staff of BS for being patient. They have passion about people they know the rights of the people they are clear. I enjoyed a lot."

The Community Scorecard pilot seemed easier to manage than the Facility Scorecard in both provinces. Hariette, the Eastern Cape based midwife was very outspoken and a member of the RMCH Action Group – which seemed to make matters easier in this province. In the KwaZulu Natal Facility Scorecard the mood was much tenser and Black Sash project management needed to step in to alleviate fears of repercussions amongst junior clinic staff in particular. It also seemed as if they did not feel like they were able to speak freely with clinic managers present at the meeting.[28] This is discussed in more detail below.

Participants were also clear that the Scorecard is a monitoring tool, to collaboratively improve service delivery rather than to punish or accuse individuals or groups for failures that are beyond their power to control. JamJam the Chair of the Clinic Committee in the Eastern Cape said:

> "The Community Scorecard as Black Sash taught me is the tool to monitor things. It helps the community to understand their rights and to understand their responsibility. Not to accuse not to point finger to somebody but to know what must be done."

Nontsikelelo the civil society representative in the Eastern Cape reflects on this as well:

> "The Scorecard is a bridge way because in most cases the community would blame the clinic if things go wrong and the other way around the clinic would blame the community. So having this Scorecard involved it sort of makes an understanding of how things go wrong and how can they can be solved."

Stella, the ward secretary in the Eastern Cape emphasized that government representatives were part of the process:

> "Once the community has issued their concerns there is going to be a Facility Score Card afterwards there is the multi stakeholder meeting where all the stakeholders including the municipality should be here as well as the MC from the OR Tambo region where they will sit and they will be told what the community of Port St John's said about the health center and be told what the staff have said about the health center as well. That's where these stakeholders will work towards achieving this goal of improving the services by involving the higher power of the government that is what we are working on."

RMCH Action Group members were able to secure participation in the scorecard process

The project benefitted tremendously from having Community Based Health Care Workers and Ward Committee representatives on board.[29] Being close to the community was seen as

[28]Cleary S et al. (2013) *Resources, Attitudes and Culture: An Understanding of the Factors that Influence the Functioning of Accountability Mechanisms in Primary Health Care Setting* in BMC Health Service Research 320(13) page 9.

[29]Some community based workers such as Community Care Givers also receive a stipend which makes them more mobile in terms of reaching out the community.

crucial for getting people to come to the Scorecard meetings in both provinces.[30] Involving multi-stakeholders such as traditional healers was very important in mobilizing people to come to the meetings. Since both pilots took place in rural areas encompassing wards that are very far apart it is important to provide resources that allow people to travel to the meetings, such as stipends.

Stella the ward committee secretary said:

> "[…] As a ward secretary I work with other members of the ward committee so I called them using the resources that Black Sash has given me. Once we were in a meeting with our ward councilor I did the presentation on the RMCH Action Group what we do and what we want to see for the future. Everyone was very interested. Then I got the ward committee members to select the names from their villages to select the people for example in my cluster that I was working on there were five villages. So I need to get 15 people so each ward committee gave me 3 people so I phoned them telling that they must attend this training […] and everyone was positive with the info and everyone was there yesterday. People were excited to be part of Community Scorecard."

Jamjam Clinic Committee Chair in the Eastern Cape:

> "To mobilize people we talked to ward council and traditional leaders and we go to them and explain what the Scorecard is. Though if we didn't explain to them it would be very difficult but because we first explained the importance for them to come to that meeting. Once they understood it [they] became interested. Those leaders they chose people to come down. We transported them with the help from Black Sash."

Hlengiwe Community Care Giver in KwaZulu Natal:

> "I am one in charge of the mobilization. In my own side it was easy because the people like me. I am working in your house I am talking to the people and give the education to the people. So they people also talk to me about your status. I have the confidence about that. The community doesn't trust anyone if they don't know. I know me every day I work in your house I am a member of the people so we work with the community every day. "

The Score Card facilitated joint understanding and decision-making

The Clinic Committee Chair, JamJam and Harriette the Eastern Cape based midwife felt strongly about joint problem solving amongst all the stakeholders. Hariette said:

> "I think if the service users and the service providers understand both of them understand the problems they are facing and come together I think problems will be dealt with as a collective in a collective way because some of problems are the same. So we find a common ground to solve the problems so I think it is good for the service users and the service providers to come together to fight that problem together"

Stella the ward secretary in the Eastern Cape hoped that the Scorecard created space for people to get involved in making changes, which will improve collaboration. At the moment she felt the community does not engage with the facility:

[30]This reflects what Rosato M et al (2008) argue in *Community Participation: Lessons for Maternal Newborn, and Child Health* in Lancet 372, 962 - 72. They state that "community health workers are most successful when they have the respect and support of governments, public service workers, and the communities they serve" at page 967.

> "The facility and the community if they put the effort on working together this will work. They are not working together at the moment. The community has the tendency of distancing themselves when something is not going right. For e.g. we've had incidences where there has been negativity at the clinic and the community, they just stay away and they don't get involved. After this training there should be a possibility that that can be worked on that the community and the facility staff will hope fully work together."

Realistic indicators were developed in the pilot

The process of developing the indicators or "things we want to see" was not easy. Firstly it was hard translating the identified challenges into positive indicators. Secondly there was a risk that too many indicators were identified that could not be monitored hence defeating the purpose of the Scorecard. Black Sash and the RMCH Action Group provided expert assistance with the translation of challenges into indicators and grouping them together to limit the number of issues, but it is not clear that this process would be as successful without that guidance. Stella the ward secretary in the Eastern Cape explained:

> "The indicators were developed when the community gave their concerns and [turned that into] what we want to see in the future. How can we take this negativity and put it into positivity - that's how we did the indicators. The indicators that we identified [have to be] prioritized. There were other concerns […] but we had to put concerns together. […] The community had to vote and that's where the prioritization came from. The process was done by asking the community how can we change these concerns into [what we want to see]. So the indicators actually came from the community."

More testing and analysis to determine the best practice for developing Scorecard indicators from the identified challenges would be beneficial.

Despite these challenges, participants felt that by the end of the day the indicators they developed were realistic and achievable. Hariette the midwife in Port St John's said:

> "During the process of the Scorecard we did list certain indicators and those indicators were realistic because according to what the community was facing it was a real situation, which was happening. So the indicators were a reality. If I think we emphasize it and put our heads together with the community and the government we can achieve the solutions to those indicators. I think they are achievable. We can solve it."

Stella reflected that the indicators were realistic and achievable as long as all the multi-stakeholders came to the table:

> "At this moment I won't say the indicators are realistic because this is still a pilot but we hope that at the end of the day good results will come from this pilot because that is where the municipality will come it the MEC will come in and the portfolio heads will come in so I personally hope that those indicators are realistic."

A Junior Nurse (anonymous) expressed frustration at the question. The problem for her seemed to be that they are in a rural area where concerns are not addressed as a priority:

> "The indicators were realistic. I don't understand what is preventing us to get the things that we are wanting to see. Like why can we not get a doctor or more nurses in here? I think they are realistic and achievable. In my previous job people would come to help us sort out problems, but here in the rural areas no one comes when you have problems."

This statement reflects the importance of communication not just between service users and service providers, but also amongst different levels of facility staff such as managers and nurses. The Operational Manager at the same clinic explained to the external evaluator (but apparently not to her staff) why staff shortages were unlikely to be addressed since they are having space limitations. The Operational Manager Sebenzile warned in the same vein:

> "When developing indicators, when you set out to measure the rights realised, it must be sure that the things are really rights and not just something else. "

The Scorecard prioritises Child and Maternal Health issues at facility (supply) and community level (demand)

One of the biggest achievements of the pilot is that it provides a platform for nursing staff to express their challenges and concerns. Junior Nurse (anonymous) from KwaZulu Natal said that this was the only forum where she could raise these issues:

> "This Community Scorecard is the first time both parties are brought to the dialogue. Other than the unions, there is nowhere the nurses can go. This was the first time anyone ever asked me what my issues are."

The KwaZulu Natal Nurse Manager Majola expressed the frustration she experiences by not having the tools they need to do their job:

> "The closest referral hospital is in Northdale also 70 km away from here. People struggle to get there. Ambulances are an issue it is really frustrating – you wait for +- 3 hours. You have the doctor on the phone telling you what to do, but you are not able to do it. It is frustrating and demotivating because you are not able to help. Nurses can only do so much and then you need someone or something to back them up."

The Operational Manager in KwaZulu Natal Sebenzile also expressed frustration at demand side barriers:

> "Mothers don't book early enough for their appointments. "Mothers that are non-clinical cases have never seen the inside of a clinic. It is upsetting because they know we are here but they don't want to come. They know that we test for HIV and they don't want it. But we must test for HIV to protect the baby."

This is likely to affect the way that service providers interact with their clients, and may in turn impact on service user's decisions to go to the clinics regularly.[31] Nontsikelelo a civil society member reflected on how the Scorecard can address demand side barriers:

> "The most exciting thing about this pilot is the chance to know why the community is not using the facilities that are available to them. The Community Scorecard addresses the challenges of the community like the responsibilities of the community and also the rights of the community vs. the challenges of the staff members and also the rights of the staff members.

[31]Cleary S et al. (2013) *Resources, Attitudes and Culture: An Understanding of the Factors that Influence the Functioning of Accountability Mechanisms in Primary Health Care Setting* in BMC Health Service Research 320(13) page 9.

Nomusa a civil society representative in KwaZulu Natal expressed how services should be taken up and the kind of responsibilities service users have with regards to their health rights:

> "I think people should not just go to the health center when they need medicines or when they are sick. I think they can go there and have a word with the staff and see what's the problem maybe when the waiting period time is long they can go and ask if there is something wrong or is there a shortage of staff or whatever. The community must wake up and have an input in making the facility work."

It is remarkable however that despite the demand side barriers identified the Nurse Manager in KwaZulu Natal seemed to feel that existing monitoring and accountability mechanisms were working. This is in stark contrast with what the Junior nurse from the same facility said in her interview and indicates that attention to bureaucratic accountability within the health care system would complement an initiative within the Clinic Committee.

The accountability she referred to was the Suggestions Box, where service users can express their unhappiness about services at the clinic. This monitoring looks at the client on an individual basis and does not account for community voices and also does not seem to allow for nurses to give their point of view. Mostly the junior nurse in KwaZulu Natal said, that they just get sent in to apologize for something that happened. It is important that alternative accountability mechanisms are seen as complimentary to existing initiatives.

Understand the rights and responsibilities

Part and parcel of addressing both demand and supply side issues require the understanding that with rights come responsibilities. Jamjam the Clinic Committee Chair and Stella the ward councillor's secretary said the interventions helped people in the community understand this. Nobuntu, a service user in the Eastern Cape, put it eloquently:

> "The health of my child is my responsibility because a child can't say it's painful here I'm hungry now a child can't say that but if you are responsible for your child it is easy to see what is needed."

The Scorecard will increase accountability between facility staff and the community

As a first step open communication is necessary for accountability. Hariette, the Eastern Cape based midwife, is hopeful that the Scorecard can achieve this:

> "As time goes on with the help of the Clinic Committee which is supposed to be the link btw the service providers and the service users things will get better because the Clinic Committee will be taking our challenges to the community but also bringing the challenges of the community to us as the service providers so with time I am hopeful that things will be fine."

Hlengiwe the Community Care Giver also reflected on the need for communication:

> "For some of the things we need the community to talk. Maybe the government didn't know that in Bruntville we don't have an ambulance so now if you take the Scorecard to the clinic and the clinic takes the Scorecard to the other stakeholders so then things happen."

They feel that participation of service users is important

Participants from both the facility and the community understood that service user's involvement in the planning and delivery of Maternal and Child Health services was important. Even service providers and the Department of Health acknowledged service user involvement is important.

Nomakaya Department of Health:

> "[Service users] have to contribute to service delivery because they don't want things that are being imposed on them they want to be involved in the services that are rendered in our communities."

In KwaZulu Natal a Junior Nurse (anonymous) said that while it is important to involve service users, it is equally important to give service providers a voice. She reflected on the war rooms saying:

> "It is all about what the nurses are doing wrong. I am asked everywhere that I must apologize: in the suggestions box, in front of the minister, in the war rooms, everywhere. [The community] don't understand our reality. Service users are already involved through the war rooms. It is very important because that is supposed to reduce conflict. It is failing in my mind, but that is what it was supposed to do. It is failing because the dialogue is one sided. "

The Scorecard was non-confrontational, aimed at problem solving, not finger pointing

At the facility Scorecard clinic staff was initially quite reserved in their participation. It appeared that even though nurses and clinic staff work under extremely harsh conditions, they often find themselves between a rock and hard place: on the one hand service users are unhappy with the lack and quality of services but on the other hand nurses even when they do their best are not able to provide those services because they lack the resources to do so. Not only do they get negative feedback from the community but they also get negative feedback from the Department when the Maternal and Child Health statistics are bad.

In the Eastern Cape it was extremely helpful to have a nurse on the RMCH Action group part of the process. Harriette, the midwife in the Eastern Cape explains:

> "We started with the Community Scorecard. At first it was sort of pointing fingers here and there because we didn't know the meaning of the Scorecard. But after telling and knowing the meaning which was to come a dialogue all of us to find a common ground we started knowing what it is about then it went smoothly whereby people where cooperating, not being aggressive to one another, pin pointing fingers it is you that is supposed to be doing this it is you who is not doing this."

Nontsikelelo a civil society representative in the Eastern Cape understood the challenges faced by clinic staff and how this affected the process:

> "It was difficult today (at the facility Scorecard) because the staff does not want to admit their faults but also they can justify why because the conditions are not suitable for them. There is not enough staff and those that are present are not skilled enough for the job."

Multi stakeholder meeting

Understand the purpose of the multi stakeholder meeting

Participants had very clear understanding that the multi-stakeholder meeting aimed to bring all the stakeholders who have a role to play in Maternal and Child Health together to come to common solutions to the challenges.[32]

Even the Department of Health representative recognized that everyone had a role to play. Nomakaya said:

> "I think the stakeholders' meeting today was interesting as each one of the stakeholders has a role to play in service delivery especially in reduction of Maternal and Child deaths. Each one of the stakeholders has a role to play in reducing Maternal and Child deaths in our communities."

Agreed on an Action Plans that prioritize Child and Maternal Health issues.

A collectively agreed upon action plan was developed at the multi-stakeholder meeting. Harriette the midwife in Eastern Cape reflected:

> "In that meeting we were able to agree on the action plan, which was also collective it was not individualistic. It was a collective action plan which was agreed on which was also given a time frame according to my understanding and I hope we can achieve it because it was a collective decision that was made. "

Jamjam, the Clinic Committee Chair in the Eastern Cape, reiterated this:

> "In the multi-stakeholder meeting we've agreed on the action plan and it is very good. Even the service users and the service providers all agree on the action plan. Now we need to sit down and work now and everyone will focus on the matter on the program."

Nomakaya from the Department of Health agreed with the action plan and its priorities:

> "I think the action plan is in accordance with the priorities with the DoH (Department of Health) because most of the indicators that are being addressed in the action plan are the indicators towards the reduction of maternal deaths and children's deaths. The DoH (Department of Health) is prioritizing maternal and child health because we are being troubled by a lot of maternal and children's deaths in our communities."

RMCH Action Members knew what to do in terms of the Action Plan

RMCH Action Group members felt clear about what they needed to do to follow the steps of the action plan. Hariette the midwife in the Eastern Cape said:

> "I feel I know what I am supposed to do in terms of the action plan […]. There are some proceeds that we are supposed to follow in terms of the action plan to achieve what we want to achieve which is the reduction of maternity and child mortality in this area."

Both the service users and providers suggestions contributed to the Action Plan

Participants felt that the two groups carried equal weight at the multi-stakeholder meeting. Hariette the Eastern Cape based midwife expressed her hope about the Action Plan:

> "I hope that whatever solutions we came to they will be achieved. Because it was decisions and solutions that were made as a group not as an individual, not just the service users alone

[32]See specifically Harriette, the Eastern Cape based midwife and Nontsikelelo the Eastern Cape based Civil Society Representative.

the service providers on their own or the NGO (Non Governmental Organizations) alone. It was a collective solution or collective problem which was understandable."

Jamjam the Clinic Committee Chair in Eastern Cape recalled how the service users were initially a bit reluctant but that this balanced out in the end:

"In the multi-stakeholder meeting the service users and the service providers sometimes the service providers where speaking loudly and the service users were a little fear but at the end of the day the service users came up and said things that they don't agree with. At the end they come up with one point and they agreed on one point. "

Nontsikelelo the civil society representative also said the multi-stakeholder meeting was balanced and potential conflicts were avoided:

"They were equal because the community members they share the info they shared before and also the staff members shared the info they shared before. No one group was louder than the other. It's important because the community sometimes points fingers and the facility staff and visa versa. So now we combined them we have to resolve the issues."

RMCH Action Group was able to navigate conflict successfully

Facility staff and community members said that there was the potential for conflict but that it was avoided. Jamjam the Eastern Cape based Clinic Committee Chair said:

"Here were conflicts before. Such that service users they are blaming service providers that the service providers have not got attitude. There's a huge attitude. Now there are always dark faces. But at the end of the meeting everyone was smiling. Even the service providers admitted that there are things such attitudes but now we understand that we need to service our people, we need to give quality services to our people. The service users admitted that even us we did not understand but now we all understand and know our rights and responsibilities. "

Stakeholders felt they are able to effectively monitor progress

Participants felt that this process would help them to monitor progress if it was continued. Hariette the midwife from Eastern Cape said:

"This process is going to help us to monitor and also to report back the difficulties we are finding and we find the solutions. Because it is not a one sided process. Because the service providers will also be more monitored and the communities same will be monitored. Because the service provider has the responsibility same with the community also has the responsibility to take. It will be really interesting because each one has a task to play and with that we will achieve what is needed. "

Jamjam, the Clinic Committee Chair reflected this position:

"The service providers at the beginning they were like they want to close the information they didn't want to share. But as the Clinic Committee and RAG (RMCH Action Group) members supposed by because they ended up sharing the info and now the service users were very happy to hear the info of the experience of the service providers that there are things that did not go well. In the monitoring of this program the process of the Community Scorecard will help us very much because we know what to do we know where to start in the monitoring because sometimes you'll find that even the Clinic Committee were not well equipped. But now we are well equipped we have the info what to do when we want to monitor this maternal problem. "

Stakeholders believed this will contribute to improved Child and Maternal Health Services

Nomakaya from the Department of Health felt that because the Scorecard called on the community and their responsibilities as well, it had the potential to improve Maternal and Child Health services:

> "The Scorecard has a potential to improve Maternal and Child Health because those things that are listed in the Scorecard those are the community's responsibilities. If they feel committed to do those things that are listed in that Scorecard we can reduce maternal and child deaths in the communities."

The Junior Nurse (anonymous) from KwaZulu Natal did not feel so hopeful and expressed despair:

> "I doubt it will change. I don't know why. I have been exposed to this environment where you are overworked, have no equipment and get insulted. I have lost hope"

This again emphasized the importance of a forum where facility staff can speak about their issues and the importance of this initiative to continue.

Civil society representatives in both provinces said they felt this intervention could improve Maternal and Child Health services. Nontsikelelo, civil society representative in the Eastern Cape said:

> "They are going to improve maternal health care and also to limit the number of deaths of children before the age of 1. We learnt a lot in terms of the roles of the Clinic Committee and the challenges that were faced by the clinic staff."

Participants want to continue monitoring

In both provinces participants very strongly felt that monitoring progressive improvements requires their continued participation. Participants expressed their commitment to the processes and wanted to continue the monitoring. JamJam understood the monitoring is an ongoing process and would like help from the Department of Health or an organization like Black Sash:

> "The things we need to do we'll need to make this Scorecard again, maybe in 6 months time. And we go to make outreach programs and teach our people and bring back the relationship between community and Health Care Workers."

Nonsikelelo, a civil society representative also in the Eastern Cape concurs and wanted assistance to take the Scorecard to other facilities:

> "As RMCH Action Group at the moment we don't have plans but we would like Black Sash to assist us so that we can raise funds for the project so that we can take the program to the other facilities."

This was also expressed by the service user Nobuntu in Eastern Cape:

> "I want to do the Community Scorecard again in some months so I can see if there was any change. And I feel this Community Scorecard not to be done here in town only. Even in the clinics outside the town I think it's where the problem lies."

In KwaZulu Natal Simangele the Clinic Committee Chair expressed the same desire:

> "They should represent the Scorecard to every clinic in South Africa so there will be less women who are scared to go ANC (Antinatal Care) at their clinics. For the community or their mothers to know there will be no one who will judge me when it comes to my status or STIs (Sexually Transmitted Infections) they should be more welcomed to the clinic. "

After the multi-stakeholder meeting participants were asked this question again where participants reiterated their commitment to stay involved. Jamjam had developed plans to carry on the initiative after Black Sash was gone:

> "We intend to stay in maternal health service because this was a pilot but now we need to continue monitoring this maternal health system because we saw this program is very good."
> "We will monitor even if Black Sash is gone. We'll do it because we are very equipped now. We have all the tools to monitor this. In order to continue with the program […] we'll sit down and we need to register an NPO (Not for Profit Organization) at this group. We'll need assistance we will need to go to Pretoria to register this NPO. We need an office of this group and we will monitor to get files, we need stationary and we will need outreach program. We'll need to travel and we need to organize people Black Sash taught us how to organize people."

Finally the Junior Nurse (anonymous) who was not so hopeful about the project said:

> "All I want is for them (Black Sash) to continue to give health workers a platform. That would be the best."

They feel constructive relationships were build

After the multi-stakeholder meeting the majority of participants reflected that the project had build relationships between service providers and service users. Harriette, the Eastern Cape based midwife said:

> "The relationship between the service providers and the service users in the community at first was not a good one […] But the problem is that the community didn't know that there were challenges to the service providers so there was a bit of crashing between the service providers and the community. At first there was tension because the community didn't understand the challenges, which are being faced by the service providers."

Nontsikelelo the civil society representative in the Eastern Cape reiterated this further:

> "We managed to build the relations between the community and the staff members. Before we didn't bring them together so that the community can raise the issues also at the presence of the staff members."

Results

Training

The interview responses collected indicate that the training was effective in disseminating Child and Maternal Health information especially to non-clinic based Health Care Workers, the community and civil society organizations. Community based workers were reportedly successful in spreading the reality around Child and Maternal Health within the communities they work in. One civil society representative explained that using Child and Maternal death statistics helped her recruit community members for the Scorecard as they were not aware of the urgency and the need to prioritize the issue. An Operational Manager who was not part of the training said that they would not be able to employ Child and Maternal Health

specific staff as they were experiencing a shortage of space and "if there were no patients they will be just sitting around".

The training also successfully framed the Clinic Committee as a channel of communication between service users and service providers and multi-stakeholders, which includes everyone from the civil society to different levels of the government sectors. The training also helped participants understand the roles and responsibilities of the Clinic Committee. Especially the Committee Chairs in both provinces said they had a clearer understanding of their roles and responsibilities and looked forward to taking these up in future meetings. Notable was the comment from KwaZulu Natal Chair who said she was not aware that she had the power to inquire about the budget allocations and spending of her clinic. This has definitely planted the seed through which this Clinic Committee can grow into a fully-fledged and comprehensive accountability structure.

Participants said that the training helped them to understand the reporting structure and hierarchy within the Department of Health. Clinic staff at KwaZulu Natal that was not part of the training was not sure about the reporting structure.

Many RMCH Action Group members are active civil society members and so have an innate understanding of the importance of collaborating with multi stakeholders. The training did however help build those relationships. Civil society representatives including traditional healers were seen as especially important partners due to their proximity to the community while government partners were seen as important to provide and tailor services to the needs of the community. The importance of Community Based Health care workers in addressing demand side challenges cannot be overstated.[33]

All the Clinic Committee members reported struggling without the resources required. For the Clinic Committee to be a successful communication/ accountability channel between the service users and the clinic it needs certain, basic resources to function. Communities in rural areas are far away from each other and people have very limited personal resources to fall back on. Travel stipends or vehicles, communication allowances, and basic stationary are necessary to deliver on the task of connecting with the remote and isolated communities. Clinic Committee members should also receive a stipend for attending the meeting, since it is unrealistic to expect poverty stricken community members to work for free. No matter how big the commitment if Clinic Committee members do not get any compensation for sitting on the Committee they will be forced to leave to take up paid employment when the opportunity presents itself.

Scorecard Pilot

The participants felt empowered and successfully ran the Scorecard pilot processes in their provinces. There was a difference in the facilitation of the Community Scorecard and the Facility Scorecard in both provinces. While the Eastern Cape facility meeting benefitted from having a very active and outspoken clinic staff member part of the group, the KwaZulu Natal

[33]Rosato M et al (2008) *Community Participation: Lessons for Maternal Newborn, and Child Health* in Lancet 372, 962 - 72 also found this.

facility meeting was very tense to start off with and needed considerable more assistance from project management to get the process running smoothly. A big part of this was to continuously ensure to clinic staff especially more junior nursing staff, that they were not being accused through the process.[34]

Having facility staff as part of the RMCH Action Group, helped. Also perhaps having the facility Scorecard before the community Scorecard could help make facility staff feel more like partners and less like the accused, which is a role they seem to be placed in quite frequently and which seems to contribute to the reported bad attitudes of clinic staff.

Developing the indicators was problematic but in the end of the Scorecard process they did turn out to be realistic. The challenge in developing the indicators was that the initial list of challenges developed by both groups was too long to be translated into indicators. Indicators were grouped together into different themes but this risked loosing some important details. Ultimately it was possible to come to a participatory conclusion to the challenge but it is important that facilitators are prepared and have enough time to deal with this. It is also crucial for different levels of facility staff to be on the same page. Communication between managerial facility staff and more junior/ nursing staff needs to be facilitated as well if the indicators are to be truly achievable.

One of the most important successes of the Scorecard Pilot was that it allowed nursing staff, who are having a really hard time working under such badly resources conditions, to express their concerns. Demand side barriers were cited as huge problems by both facility staff and community representatives and there appears to be great value in creating the space for nurses and clinic staff to express their concerns as well as for service users to explain what prevents them from taking up the services. The facility Scorecard especially in KwaZulu Natal was particularly tricky. Nurses often find themselves in a challenging position: on the one hand service users are unhappy with the lack and quality of services but on the other hand nurses even when they do their best are not able to provide those services because they lack the resources to do so. Not only do they get negative feedback from the community but they also get negative feedback from the Department when the Maternal and Child Health statistics are really bad. Junior Nurse (anonymous) reflected on the tension:

> "There was a lot of tension because the experience we have made during the war rooms. We were expecting the same 'the service users attacking us – as always'. This changed because of the explanation. The clarification that was provided by Black Sash was working well and made it clearer."

Service users and providers were clear about the notion that all rights have corresponding responsibilities. Parents in addition to have the responsibility for ensuring their own health, bear the extra responsibility for their children.

[34]Cleary S et al. (2013) *Resources, Attitudes and Culture: An Understanding of the Factors that Influence the Functioning of Accountability Mechanisms in Primary Health Care Setting* in BMC Health Service Research 320(13) reiterate the need to ensure power balance between the participants. This applies also to the institutional power balance that may exist in a particular setting.

Most participants hoped that this intervention would increase accountability, although they only spoke about communication leading to accountability, rather than accountability itself. Participants understood that involving service users in the planning was important because they understood their own needs best. Participants noted that for monitoring progressive improvement of service delivery the initiative would have to be repeated and should be rolled out to the other provinces. Participants felt strongly about wanting to continue with the Scorecard process after the pilot and are planning various strategies to get the funding to do so.

Multi- stakeholder meeting

The aims set for the multi-stakeholder meeting were also achieved. RMCH Action Group members successfully facilitated the meeting with great energy and enthusiasm. The Action Plan that was developed came with equal participation from both service users and providers. Even the Department of Health Representative was impressed that the Action Plan reflected the Child and Maternal Health priorities set by the Department. This sort of buy in is crucial for sustainability of the project and is thus commendable.

The RMCH Action group is committed to take this process forward. Since Black Sash has managed to empower the RMCH Action Group members to run a Scorecard Process, it is recommended that one of the Non Governmental Organizations or civil society partners in the area would find the resources to repeat this process. Rooting the process in the communities where it takes place has many advantages; most of all that the relationships which are build develop organically through the Clinic Committee and the civil society structures already existing.

Ethical Considerations

Research on this evaluation was coupled with the filming of a documentary. Some key informants were not comfortable to be interviewed on camera, especially the clinic staff, who operate under a policy not to be on film in their uniforms. The notable exception was the midwife in the Eastern Cape. These key informants were interviewed without the camera or being recorded to get their insights as well. Those people who were not comfortable with having their name appear on the report are not mentioned by name. Everyone who was mentioned by name provided permission and signed consent to go on record.

Further Research

This report reflects on the tension experienced at the facility Scorecard meetings in both provinces but more notably in KwaZulu Natal. Further research on how facility management structures (what S. Cleary, et al (2013) call bureaucratic accountability) impact on external accountability structures such as the Clinic Committees would be highly relevant. This has the potential to give further insight into what prevents or enables facility staff to engage meaningfully in external accountability mechanisms such as the Scorecard. It also could provide further information on how the clinic management structures facilitate or impede the development of patient centred services in resources poor settings.

The role of the Clinic Committees in addressing Maternal and Child Health issues could warrant further investigation. This report as well as the Health Systems Trust research reflected on, indicate that they have an important role to play. It appears though that the functioning of Clinic Committees is in no way uniform. While important factors have already been identified further research on this issue is important especially once the identified challenges have been addressed.

From a programmatic point of view the development of indicators, or “things we want to see changed”, could be refined further. This report has spelt out what the challenges in this current pilot were. Research on how other community accountability structures have dealt with this challenge would complement the research from this Black Sash initiative.

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Annexure 1 – Indicators

Training of the RMCH Action Groups
The Black Sash Baseline Report succinctly spelt out the challenges that Clinic Committees currently experience. The training was meant to directly address these challenges and enable those Action Group members who were also members of the Clinic Committees, to champion overcoming the obstacles. This was to be achieved in collaboration with all stakeholders

The training overall aimed to strengthen the capacity and functioning of Community Committees and equip them to pilot a Community Score Card in their district. The indicators were as follows:

- Participants understand the need to champion Primary Health Care and Maternal and Child Health issues
- Understand the roles and tasks of the Clinic Committee
- Understand the reporting hierarchy of the Clinic Committee
- Understand the need to make connections with all stakeholders/ understand the importance of building relationships
- Feel competent to collaborate with the community and civil society
- Materials were adequate.

The Scorecard Pilot
These indicators showed if the expectations of RMCH Action Group members from the training were realistic in terms of facilitating the pilot and promoting joint dialogue and action in addressing Maternal and Child Health issues.

- RMCH Action Group were able to pilot the Scorecard with the community and the facility staff
- Were able to get people to participate
- Feel that the Scorecard will facilitate joint understanding and decision-making.
- Felt that the indicators that were developed were realistic
- The Scorecard developed prioritized Maternal and Child Health issues from a supply and demand side/ understands the notion of rights and Responsibilities
- Feel the Scorecard will increase accountability
- Want to continue to monitor service delivery
- Feel that participation of service users is important
- The process was non-confrontational

Multi-stakeholder meeting
This section looked at the implementation process of the Scorecard. In particular it looks at the extent to which the whole Scorecard process facilitated joint dialogue between the RMCH Action Group and all the stakeholders (in particular NGOs, civil society, service users and facility staff). It also assessed the extent to which participants felt that the Scorecard would monitor and ultimately improve health service delivery.

The indicators were as follows.

- RMCH Action Group understands the purpose of the multi-stakeholder meeting
- Agreed on an Action Plan that prioritizes Maternal and Child Health issues.
- They know what they need to do to move forward
- They were able to navigate conflict
- They feel this will enable them to monitor progress

- They believe that this will contribute to reduced Child and Maternal Health deaths
- They want to continue monitoring
- They felt constructive relationships were build.