RMCH
REDUCING MATERNAL AND CHILD MORTALITY THROUGH STRENGTHENING PRIMARY HEALTH CARE

RMCH GRANTEE PROJECT COMPLETION REPORT

Black Sash

Grant dates

1st of July 2013 1st of October 2014

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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Project Information	
Name of Project:	Strengthening Public Accountability Mechanisms to improve Maternal & Child Health Services
Type of Agreement with RMCH:	CSO Grant to improve demand and accountability for MNCWH
Project Purpose:	The project purpose is to investigate if and how existing **accountability structures in public health facilities** can be strengthened. Using a **Community Scorecard approach**, the project improves the understanding of the extent to which a multi-stakeholder approach creates opportunities for collaboration and problem solving to improve the performance of heath facilities. This pilot project investigates if **Clinic Committees** can form social compacts with functioning Alternative Public Accountability Mechanisms (e.g. War Rooms, Imbizos, NGOs/CBOs), service users and the community to identify common opportunities to improve child and maternal health outcomes.
Implementing Districts:	Eastern Cape, OR Tambo and KwaZulu-Natal, uMgungundlovu
Organisation Name (CSO Grantee):	**Black Sash** **Report Author:** Written by Brittany Bunce (RMCH Project Manager), Mira Dutschke (Research Consultant) and Janine Clayton (Research and Materials Development Consultant) and reviewed by Sonya Ehrenreich (Donor Compliance) and Lynette Maart (National Director) **Contact details:** lynette@blacksash.org.za, sonya@blacksash.org.za, info@blacksash.org.za
Total Project Budget:	R4 999 463.60
Catchment Population:	uMgungundlovu and OR Tambo Districts
Project Start and End Dates:	1 July 2013 – 31 October 2014
Project Reporting Period:	1 July 2013 – 31 October 2014
Date Report Prepared:	31st October 2014

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Acronyms	
BST	Black Sash Trust
CBOs	Community-Based Organisations
CCs	Clinic Committees
CCGs	Community Care Givers
CEO	Chief Executive Officer
CHC	Community Health Centre
CHW	Community Health Worker
CSOs	Civil Society Organisations
DFID	Department for International Development UK
DoH	Department of Health
EC	Eastern Cape
EQUINET	Network for Equity in Health in East and Southern Africa
KZN	KwaZulu-Natal
MNCH	Maternal, Neonatal and Child Health
MDGs	Millenium Development Goals
NDoH	National Department of Health
NGOs	Non Profit Organisations
NHA	National Health Act
PAR	Participatory Action Research
RMCH	Reducing Maternal and Child Mortality Through Strengthening Primary Health Care
SDD	Social Development Direct
UCT	University of Cape Town

Executive Summary

The Black Sash Trust (BST)/ RMCH Project investigated if and how existing accountability structures in communities and public health facilities could be strengthened and included strategies to increase community participation to improve maternal and child health. Maternal and child health mortality rates remain unacceptably high in South Africa, and community-focused efforts are crucial in addressing this situation.

Accountability mechanisms are necessary structures to help ensure that the health system is able to respond to the needs of women and children who are seeking maternal and child health (MCH) services, thereby improving the demand for, and interaction with these services. The establishment of clinic committees (CCs) and community health centre committees (CHCCs) – *hereafter used interchangeably and referred to as CCs* - as provided for in the National Health Act 2003 (NHA), are meant to be the public accountability mechanisms to ensure the delivery of high quality and inclusive services. These structures are also critical to efforts in re-engineering of primary health care approaches in the access and provision of MNCH services.

The National Health Act 2003 identifies CCs as statutory bodies and clearly stipulates that all Provinces need to develop CC policy guidelines and need to establish and maintain CCs in all health facilities to engage with health issues and increase participation at the community level. The White Paper on the Transformation of the Health System (Department of Health, 1997) further emphasises that active participation (in health) is an essential aspect of healthy communities. It is further acknowledged that participation in health has the potential to improve supply and demand of maternal and child health outcomes. The emphasis on community participation is an especially important aspect for consideration in South Africa's commitment in attempting to achieve the Millenium Development Goals (MDG) 4: To reduce under 5 mortality rate by 2/3 and MDG 5: To reduce maternal mortality ratio by ¾.

The Project therefore identified clinic committees as the accountability mechanism on which to focus the overall RMCH intervention. Clinic Committees together with service providers such as community and facility based health care workers and outreach staff (Community Health Workers (CHWs), Community Care Givers (CCGs) and DCSTs) play an important role in addressing demand side barriers. This project showed that strengthening the accountability function of these Clinic Committees, involving service users and service providers, and other multi-stakeholders involved in MNCH, has the potential to form a social compact to jointly address supply and demand challenges.

Using a Community Scorecard approach, the project investigated if Clinic Committees can develop social compacts with functioning Alternative Public Accountability Mechanisms (Civil society organisations (CSOs), ward committees, religious/traditional/political leaders etc), service providers and users, and the community to identify opportunities to improve child and maternal health. Black Sash piloted the Community Scorecard intervention in two health sub-districts, namely, Port St John's in Nyandeni Sub-District of OR Tambo District in the Eastern Cape (EC), and in Bruntville in Mpofana Sub-District of uMgungundlovu district in KwaZulu-Natal (KZN), to test this intervention. Through testing this intervention, the project contributed to the RMCH Demand and Accountability objectives in addressing challenges at community and health facility level, which contribute to high mortality rates of mothers and their babies.

The project started out with an extensive situational analysis in September-December 2013, resulting in a Baseline Report on the functionality of existing accountability structures and challenges relating to Maternal and Child Health in OR Tambo and uMgungundlovu. It also conducted a literature review on experience in strengthening clinic committees and on possible interventions to strengthen demand and accountability for MNCH services such as community scorecards, safe motherhood groups and participatory budgeting, as

intervention methodologies. These findings were shared with stakeholders in OR Tambo and uMgungundlovu during several workshops held in February 2014 and together with stakeholder input a preferred intervention strategy was chosen. The community scorecard methodology was chosen as the most appropriate method to be tested under the RMCH project. To implement the community scorecard intiative, Black Sash developed several products including training materials and manuals, as well as information pamphlets on MNCH services.

The intervention also built the capacity of the CCs in the two pilot districts to form RMCH Action Groups to lead the implementation of the community scorecard process with the service users, service providers and other multi-stakeholders. The RMCH Action Groups received training from Black Sash on relevant content to ensure they could engage in an accountability process to strengthen demand for MNCH. The training focused on the roles and responsibilities of CCs, the health system in South Africa, MNCH service entitlements and challenges undermining the health of women and their babies, and how to implement a community scorecard process to address these challenges at community level. Following extensive planning and preparation the Black Sash worked with the RMCH Action Groups to conduct the Community Scorecard process in the implementation disctricts, and through the multi-stakeholder meetings, discussed and identified key challenges, as well as jointly developed solution-focussed action plans.

A major challenge of this project was getting clinic staff to participate and talk openly about their issues. In some instances it was also very challenging to access and include key health officials in the various stages of implementation of the project. The commitment, passion and engagement of the RMCH Action Groups in both districts was a crucial factor contributing to the success of this project. In OR Tambo 3 facility staff members (including a midwife) were also part of the RMCH Action Group. This made conducting the community scorecard with the health facility in that district a lot easier than it was in uMgungundlovu. This highlights the importance of including health facility staff in the scorecard process.

A key lesson learnt from this project is that joint monitoring and accountability through Clinic Committees is important. To facilitate partnerships especially between facility staff and the community, exploring communication and joint problem solving between different levels of health care staff and facility management is a key recommendation. Finally in using this intervention, monitoring maternal and child health outcomes (as identified in the agreed upon action plan) has to be repeated several times over a long period of time, to observe any changes and impact. The RMCH Action Groups in the districts *have* the capacity to implement the community scorecard process independently, but require adequate support and resources to do so. Existing partnerships with Civil Society Organisation (CSO), who are members of the RMCH Action Group, will assist with sustainability and potentially allow RMCH Action Groups to repeat the scorecard process and follow up on the actions developed and agreed upon. However it is recommended that emphasis should be placed on government providing adequate financial support to CCs so that they need not rely on project cycle funding from CSOs, which is not sustainable in an environment of reduced donor support to South Africa's civil society sector.

Section 1: Background/Introduction

The overall goal of the project is to consider ways to promote increased collective action and problem-solving at district level, using multi-stakeholder forums and community dialogue.

The RMCH project aims to strengthen clinic and community health centre committees and promote multi-stakeholder collaboration by improving the dialogue between service users and providers for improved maternal and child health services and thereby improving the performance of the clinics. The project focused

on four sub-districts in the OR Tambo (EC) and seven sub-districts in the uMgungundlovu (KZN) Districts. Black Sash worked with both public accountability mechanisms (i.e. Clinic and Community Health Centre Committees) and alternative accountability mechanisms operating within these sub-districts. These alternative accountability mechanisms were both formal (i.e. ward committees, School Governing Bodies, 'War Rooms,' CBOs/NGOs) and informal mechanisms (i.e. community monitoring practices, social audits, women's forums, stakeholder coalitions etc.).

The project started with a rapid situational analysis in OR Tambo in the Eastern Cape and in uMgungundlovu in KwaZulu-Natal, to analyse the functionality of Clinic Committees and alternative accountability mechanisms; and the extent to which they focus on Maternal and Child Health challenges, and have previously used accountability tools. A review and documentation of existing alternative accountability mechanisms working on social determinants of health, placing emphasis on joint ownership and mutual accountability, as well as tools being used to encourage community dialogue and action was also conducted as part of the situational analysis.

The situational analysis identified a number of barriers and enablers of functioning Clinic Committees in the two districts. Identified *challenges* included: lack of monitoring; challenges with recruitment; lack of induction and training programmes for CCs; low levels of literacy of CC members; confusion around roles and responsibilities; tension of navigating both upward and downward accountability; lack of reimbursement for CC operating costs; lack of engagement with the community and with facility staff; lack of DoH monitoring of CC functionality; tense relationship between CCs and facility staff; gatekeepers at sub-district and district levels undermining CC's accountability role; and poor understanding of reporting structure. The Black Sash also looked at the factors that *enabled* the functioning of Clinic Committees such as support from active ward councilors; active health facility managers who supports CC and reports back to the sub-district and facility staff; inclusion of Civil Society Organizations and other multi-stakeholders in CC activities; engagement and feedback to catchment population/service users; supportive sub-district managers and district managers; working relationships with outreach health workers such as CHWs and CCGs; and reimbursement of travel costs to attend meetings and refreshments provided at meetings (only found in uMgungundlovu).

The Black Sash's baseline study was used to inform an intervention that would be most suitable in addressing the MNCH issues identified in the chosen districts. The baseline study also included an extensive desktop review. The project team identified the methodology of a Community Scorecard as a context-relevant intervention to implement and test, and that also has a history of success in other, similar settings like Malawi. The methodology chosen was also seen as realistic and achievable within the tight timeframes of the project.

Section 2: Contribution to the Strategic Objectives of the RMCH Project, NDoH Policies and MDGs

The Black Sash project fulfilled and contributed to a number of RMCH Demand and Accountability Objectives and observed the following:

- ☐ Clinic Committees together with Community Health Care Workers[1] are critical entities to increase the demand for, use of and access to maternal and child health services. As a channel for joint problem solving and communication between the Health

[1] This includes all kinds of outreach workers that go from door to door delivering Primary Health Care advice in the Community.

Facility and the community, CCs have the potential to build knowledge of good health practices, sexual and reproductive health rights and available MNCH services, especially within the community. In conjunction with the work of Community Health Care Workers, the Clinic Committee also has the ability to reach out to those members of the community who are not accessing services and not attending the clinics, thereby encouraging them and assisting them to attend. This is crucial step for removing demand side barriers as well as promoting better health seeking behaviour.

- ☐ Through the community scorecard, service users and health workers were able to share their experiences and understanding of the barriers that women and girls in these remote, rural and peri-urban communities face, in accessing MNCH services. Bringing all the stakeholders together in a multi-stakeholder forum is one of the steps the project took to jointly start to minimise and overcome these specific barriers.
- ☐ The purpose of the community scorecard is to enable citizens to monitor and influence the health system so it is responsive to their needs and to hold it accountable. This project provided the platform for the RMCH Action Group to develop an action plan of which the points of action require on-going monitoring to problem-solve and reach resolve. The process of monitoring, of course, requires on-going resources to support the efforts of the CC.
- ☐ Clinic Committees are legally mandated health governance structures and accountability mechanisms. Through the community scorecard process this project aimed to strengthen these accountability mechanisms so that interested citizens can become active and involved, make their voices heard and participate effectively in monitoring and accountability processes.
- ☐ As a pilot intervention, this project tested the feasibility of using the community scorecard to strengthen the accountability function of Clinic Committees. The project findings will be communicated to government through technical advice, knowledge and capacity development. It is hoped that these findings allow for relevant departments to replicate the intervention and continue with the community scorecard methodology for improved stakeholder and community engagement, in attempts to reduce the mortality rate of mothers and babies, especially.
- ☐ All the materials and products developed throughout this project are designed to provide relevant resources to test similar interventions. It is also hoped that the findings enable government departments, especially the Department of Health (DoH) and CSOs to remain invested in the intiative and sustain efforts through harnessing the potential of CCs to contribute to the reducing maternal and child mortality rates.

How the project contributed to NDoH MNCWH policies

Overall the project works towards reducing under 5 Mortality (MDG 4); reducing Maternal Mortality (MDG 5); and increased participation, active citizenship and accountability. These are all recognized as important aspects for improving primary health care services. The project contributed to MNCWH policies in the following ways:

- ☐ This project and the methodology it relies on, namely the community scorecard process (which requires the involvement of community structures) focuses on increased community participation and therefore contributes towards the achievement of these important MDGs 4 and 5 to which government has committed.

- ☐ The underlying ethos of the training provided, as well as the methodology of the scorecard, emphasises the need for the acknowledgement of the rights *and* the responsibilities carried by both the service user, namely community members/catchment population of a particular health facility, and the service provider, namely the health care worker.

- ☐ Through the training workshop the dire situation of MNCH in the implementation sites was emphasised, and through the transfer of MNCH specific information and services, CHC members' knowledge about the MNCH issues and related services increased. The training, as well as later implementation, of the community scorecard further highlighted the real opportunities in which communities could decrease the maternal and child mortality rates by making use of health care services and taking responsibility for preventing ailments that could otherwise be life-threatening. As a result, they reported that they were motivated to address the identified issues in their respective communities.

- ☐ On the supply side, service providers had the opportunity to dialogue with, and attempt to understand, the challenges faced by communities in managing issues relating to MNCH. Joint solutions, which service users could effect, were highlighted in the development of the Action Plan to address some of the challenges experienced on both demand and supply side.

- ☐ The need for accountability in both providing and using MNCH services was highlighted through vigorous discussion and later in developing the action plans.

- ☐ As users of the MNCH services, community members represented by CC members, could be informed of the challenges faced by service providers and the impact of these challenges on the relevant services delivered. Dialogue processes emphasised a solution-focussed approach with the ultimate aim of contributing to the MNCH, encouraging increased participation of communities in their own health seeking behaviour, as well as understanding the limitations and challenges that health care workers also experience.

- ☐ The methodology of the community scorecard has also provided a tool and process for effective multi-stakeholder engagement and for increased participation, in working towards active problem-solving jointly at the community and facility level.

- ☐ The intervention also prioritised and ensured the inclusion and participation of vulnerable groups such as young mothers, as well as openly disclosed HIV infected community members, in the training for CCs and alternative accountability mechanisms (RMCH Action Groups). Ensuring the representation of vulnerable groups at both community meetings (in which the community scorecard toook place) as well

as being present and involved in multi-stakeholder meetings in which key MNCH issues were identified, was crucial in ensuring involvement from those often most marginalised groups.

- ☐ Conscious efforts were also made to include and involve men of all ages, as well as women of child-bearing age and older women, to champion the community scorecard process and to understand and raise the issues regarding the status of MNCH issues in their respective communities.

Section 3: Project Achievements against Set Targets (Work plan)

Project Outputs	Activities	Status: Achieved or Not Achieved	Summary of Achievements	Number of Stakeholders Reached
OUTPUT 3.1 and 3.2 (Undertake a rapid situational analysis of functionality of public accountability mechanisms (health facility committees) and Alternative Accountability mechanisms within selected communities in all sub-districts of OR Tambo and uMgungundlovu	**Activity 1**: Development of TOR and tools for use in situational analysis	Achieved	Consultant (Southern Hemisphere) engaged to develop TOR and tools for use in situational analysis together with Black Sash Project Manager and Researcher.	NA
OUTPUT 3.1 and 3.2	**Activity 2:** Engage consultant researchers to manage rapid situational analysis, identify key informants, oversee interviews and focus group discussion	Achieved	Black Sash decided to manage the situational analysis internally to maximise institutional learning. The Project Manager and Researcher were in charge of overseeing the interviews and focus groups and writing up the baseline report. Black Sash Eastern Cape and KwaZulu-Natal fieldworkers as well as 2 additional fieldworkers in OR Tambo and 4 additional fieldworkers in uMgungundlovu (from Black Sash partner CBOs) were trained to conduct focus groups and interviews using the data collection tools. Two regional training workshops were held in EC and KZN to train field staff on the tools.	❖ 13 Stakeholders (BS and partner CSO staff) trained on tools to conduct situational analysis in uMgungundlovu ❖ 8 stakeholders (BS and partner CSO staff) trained on tools to conduct situational analysis in OR Tambo
OUTPUT 3.1 and 3.2	**Activity 3:** Conduct interviews & focus group discussions in	Achieved	The objectives of the situational analysis included 1) assessing the	Total number of key informants reached: 248

	OR Tambo & uMgungundlovu		functionality and effectiveness of existing CCs and whether they focus on MNCH services; 2) identifying and mapping existing civil society/multi-stakeholder organisations and forums, and whether they focus on MNCH services; 3) determining whether there is currently any engagement between CCs and civil society/multi-stakeholder organisations and forums and what potential exists for building institutional linkages between them to strengthen and improve the capacity of CCs; 4) determining whether CCs or civil society/multi-stakeholder organisations and forums are currently using any accountability tools which could be replicated or improved upon; such as community monitoring, social audits, public hearings, budget tracking or community scorecards.	people Key informants included: service users, service providers, CCs, DoH officials (Province, District and sub-district levels) and a number of representatives from alternative accountability structures. The study was extensive and included: ❖ 24 focus groups, ❖ 12 stakeholder workshops and ❖ 114 interviews covering the provincial, district and sub-district levels. ❖ The situational analysis covered one CC per sub-district (4 in OR Tambo and 8 in uMgungundlovu) as well as mapping a number of civil society/multi-stakeholder organisations and forums operating within the catchment population of the chosen clinic or CHC.
Output 3.1 and 3.2	**Activity 4:** Analysis of interviews and focus group discussions and development of baseline report	Achieved	A Baseline Report was finalised and submitted to RMCH. ❖ *See Baseline report submitted as appendix to this report*	NA
Output 3.1 and 3.2	**Activity 5:** Share results of rapid situational assessment with key stakeholders & develop recommendations for improvement at workshops in OR Tambo and uMgungundlovu	Achieved	District dissemination workshops were held in Mthatha (EC) and PMB (KZN) respectively. The purpose of these district workshops was to share the findings of the baseline report with key stakeholders (DoH, Civil Society and CCs) and the proposed interventions, and to gather feedback from the stakeholders and beneficiaries who were involved in the	❖ Mthatha Workshop: 50 stakeholders attended ❖ Pietermaritzburg Workshop: 39 stakeholders attended

			baseline study.	
OUTPUT 3.3: Develop, implement and refine intervention strategies to improve the functionality of public & alternative accountability mechanisms and strengthen the engagement between them, within selected communities in OR Tambo and uMgungundlovu	**Activity 1:** Develop intervention strategies (tools, models, programmes, training)	Achieved	Black Sash successfully designed and developed the Community Scorecard intervention strategy based on extensive literature reviews, engagement with partner organisations and networks and the baseline assessment that was conducted in the two focus districts. Several products were developed to strengthen the intervention with CCs and included, training manuals (Facilitator's Manual and Participant Workbook) and MNCH information pamphlets focussing on national priority interventions for MNCH.	NA
OUTPUT 3.3:	**Activity 2:** Implement / test these interventions within selected communities in OR Tambo and uMgungundlovu	Achieved	A series of training and capacity – building workshops were held in both pilot sites in which CC members, members of alternative accountability mechanisms, DoH officials and health facility staff were trained in the community scorecard methodology and other relevant content such as: the health system; MNCH rights and responsibilities; and roles, responsibilities and reporting structures for CCs. A core group called the RMCH Action Group, consisting of CC members and representatives from alternative accountability mechanisms, was established and mentored to champion the intervention in the pilot sites. A community scorecard process was successfully completed in each site which involved 1) mobilising stakeholders to attend scorecard meetings 2) conducting a community scorecard with service users 3) conducting a service provider scorecard with facility staff and outreach staff 3) Hosting a multi-stakeholder meeting with service users and provider where the scorecards were discussed and a joint MNCH Action Plan developed 4) Implementation of the action plan and continuous monitoring of the intervention. Unfortunately there was not enough	**<u>Piloting of RMCH Training Programme:</u>** **1)** 2 day Training of Trainers for national and regional Black Sash management staff and field workers : **22 people trained** **2)** 2 day Follow up Training of Trainers for implementation staff: **9 people trained** **3)** Clinic committee members and representatives from civil society organisations, health workers, DOH and other multi-stakeholders trained: a) 6 day training in Bruntville, uMgungundlovu, Mpofana Sub-District: **25 people (19 women 6 men)** of which 16 were RMCH Action Group members b) 4 day training in Port St Johns, OR Tambo, Nyandeni Sub-District**: 27 people trained (20 women, 7 men)** of which 19 were RMCH Action Group members **<u>Community Scorecard Pilot</u>**

			time for Black Sash to continue mentoring and supporting the RMCH Action Groups through implementation of the action plan as the project cycle came to an end. However a number of actions were followed up on including assisting the Port St John's Action Group in hosting a MNCH awareness day involving multiple stakeholders and over 180 beneficiaries. The Bruntville RMCH Action Group was supported to present the Action plan in the local multi-stakeholder forums 'War Rooms'. The RMCH Action Groups are continuing to take the process forward independently. Ideally, they need to receive additional funding directly to be able to drive the process forward independently of Black Sash.	**<u>Implementation:</u>** 1) Number of service users who attended the community scorecard meeting: a) OR Tambo: **79 (61 women, 18 men)** b) uMgungundlovu: **69 (63 women 6 men)** 2) Number of facility staff who attended the service provider scorecard meeting: a) OR Tambo: **27 (19 women, 8 men)** b)uMgungundlovu: **26 (24 women, 2 men)** 3) Number of stakeholders who attended the Multi-stakeholders meeting: a) OR Tambo: **69 (49 women, 20 men)** b)uMgungundlovu: **54 (38 women, 16 men)** **<u>Implementation of RMCH Action Plan:</u>** 1) Launch of RMCH Action Group's MNCH Awareness Campaign in Port St Johns, OR Tambo District: **180 participants (52 men, 128 women)**
OUTPUT 3.3:	**Activity 3:** Assess interventions in collaboration with stakeholders and document learning (case studies, tools, guidelines)	Achieved	A consultant was contracted to undertake an external evaluation of the project. The evaluation report has been submitted as an appendix to this report. The findings in the external evaluation have contributed to the reflections included in this report and to the various products developed including the case studies, model and policy brief. In addition an evaluative documentary detailing the community scorecard process was developed as a dissemination resource. ❖ *See external evaluation report*	***20 key informant interviews*** *and observation of community scorecard process in both pilot sites as above*

OUTPUT 3.3:	**Activity 4:** Share learning from interventions at district workshops with key stakeholders in Pixley ke Seme, Ngaka Modiri Molema, Ekurhuleni and eThekwini and prepare a report of workshop findings	In Progress (Due for completion December 2014)	The workplan target set for dissemination had to be revised as it was found to be unfeasible within the limited time-frames. Initially the project was meant to share learning from interventions at district workshops with key stakeholders in Pixley ke Seme, Ngaka Modiri, Ekurhuleni and eThekwini. Difficulty in ensuring attendance at workshops in these districts, in part due to a lack of support from RMCH Facilitator's to assist with access to the new district DoH, as well as extremely tight timeframes required these targets to be changed. Black Sash's attempts to get buy-in from the districts to these workshops were not successful. RMCH technical advisers suggested that we hold two workshops and fly dissemination districts into PMB and Mthatha however there was no appetite from the dissemination districts to do so. It was then suggested that one dissemination event be held in Pretoria since DoH in the relevant dissemination districts was likely feeling overwhelmed by a number of competing and uncoordinated requests from grantees. However subsequently NDoH also raised concern that districts were being asked to leave their areas too much which could compromise service delivery and so this even was also cancelled. It is felt that a lot of time was wasted to no avail as a result of the indecision from the RMCH Programme Management on a suitable dissemination strategy coupled with difficulty in accessing these new districts. Black Sash has printed a number of resources (Facilitator's Manuals, MNCH Pamphlets and DVDs) in anticipation of the central Pretoria dissemination. These materials will now be posted to RMCH/ Futures Group who will distribute them on our behalf at workshops to be held in November and December since project close out (31 October) does not allow our participation in these events. Materials will also be distributed to our focus districts (OR	• National Colloquium on Health, UCT: **80 Participants** • Global Health Symposium, Cape Town: **1900 participants** • EQUINET PAR Workshop: **32 participants** • UCT Public School of Health/ Learning Network: **9 people**

			Tambo and uMgungundlovu) where Black Sash is still working through other project funding. Additional value-add dissemination events were held including at Provincial and National DOH meetings, academic meetings and conferences, for example: an academic poster and presentation at the Global Health Symposium which attracted a national and international audience; the National Colloquium on Clinic Committees hosted by UCT; a 4 day long workshop hosted by EQUINET on Participatory Action Research; and a presentation at UCT Public School of Health/ Learning Network. Presentations were made at all these events by the RMCH Project Manager. A national exchange programme of CCs took place in Cape Town from 29 September- 3 October which was attended by 4 members of the Bruntville RMCH Action Group and 4 members of the Port St John's Action Group; this was considered a key dissemination opportunity as well. This was arranged by UCT and the Cape Metro Health Forum and our participation in it was a consequence of the project team's involvement in national networks that had been developed during the course of the project.	
OUTPUT 3.4:	**Activity 1:** Black Sash teams operating in different districts and from different regional offices to participate in workshops for training and to share insights, experiences and knowledge gained	Achieved	Three quarterly workshops were held to share learning from the RMCH project with all regional offices of the Black Sash. Workshops were held in November 2013 to share the results of the baseline study and get input on possible interventions; the second workshop was held in May 2014 to prepare Black Sash staff for the intervention strategy; the last workshop was held in September 2014 to share learning from the intervention strategy.	❖ November 2013 1st Quarterly workshop: **57 people in attendance** ❖ May 2014 2nd Quarterly Workshop: **21 people in attendance** ❖ September 2014 3rd Quarterly Workshop: **18 people in attendance**
OUTPUT 3.4:	**Activity 2:** Black Sash to participate in quarterly workshops hosted by RMCH with other grantees to share insights,	Achieved	RMCH Hosted two National Workshops which included RMCH Programme staff from Futures Group and SDD as well as Output 3.3 grantees and officials from National Department of Health. Black Sash	*Unknown*

	experiences and knowledge gained		attended and presented at, one workshop in February 2014 and one in August 2014.	
OUTPUT 3.4:	**Activity 3:** Black Sash collaborate with stakeholders/ beneficiaries to assess the outcome/ impact of the intervention against the baseline and get peer input on assessing the credibility and transferability of the intervention	Achieved	The training programme, community scorecard model and overall intervention were assessed through a continuous internal research and evaluation process which involved input from beneficiaries of the project as well as collaboration with peers who reviewed our work from our networks including UCT and EQUINET. Feedback was also received from the technical advisers of the RMCH Project which fed into revisions of products. The external evaluator also assessed the intervention and the evaluation report is the product of this, along with all of the internal reports produced as discussed below.	NA
OUTPUT 3.4:	**Activity 4 & 5:** Develop an evidence based summary report with respect to the work to strengthen public & alternative accountability mechanisms that reflects end of project assessment of outcomes and that includes refined tools and materials	Achieved	As part of the final portfolio of products which accompanies this end of project report, the following were developed: 1) CSC Model to strengthen demand and accountability for MNCH; 2) Two case studies: one on the BS training model and one on the experience of implementing the community scorecard in the two pilot sites; 3) A policy brief; 4) A documentary highlighting the key learnings of the intervention to strengthen CCs ; 4) A refined toolkit (Facilitator's Manual, Participants Workbook and MNCH pamphlets); 5) Baseline Report; 6) External Evaluation Report and 7) Academic Poster ❖ These documents are attached as appendixes to this report	NA

❖ **Note: Means of verification (registers) have been submitted to support these figures**

Section 4: Lessons Learned & Best Practices

The pilot project generated a number of useful lessons and best practices that have the potential to be replicated elsewhere. These key learnings are relevant to Black Sash, DFID, national, provincial and district health, other departments focussing on other social determinants of health, as well as other CSOs working in the same field.

- ☐ *Entrench accountability initiative in the local community and within the local political processes*. Key to the success of this project was the transfer of knowledge and therefore power to the local RMCH Action Groups in each district. Rather than the Black Sash facilitating the Community Scorecard themselves, the

RMCH Action Group ran the majority of the process, with Black Sash supporting and mentoring. It was evident that these community members have an indepth understanding of their communities' health care challenges as well as the political processes that govern issues around service delivery and accountability in their districts. Other community members also know the RMCH Action Group members, as they were often active members of a multitude of other community activities and forums. This was a crucial factor in achieving participation during the Scorecard meetings.

- ☐ *Include health care staff in the RMCH Action Group.* Getting facility staff to participate was a challenge in both disctricts. In Port St Johns, in OR Tambo (Eastern Cape) this challenge was overcome more easily because the RMCH Action Group included an active and outspoken midwife who was well-known in the community and employed at the Community Health Centre. She was able to relay the harsh and unfavourable conditions under which she (and the rest of the health facility staff) worked which fostered greater awareness and an understanding of the current service provider limitations, between the parties. It also encouraged other health care workers especially during the Facility Scorecard to share their experiences and challenges with the community. This created a more conducive problem-solving environment, in which accountability of multi-stakeholders was highly featured.

- ☐ *Separate different levels of facilty staff.* The Facility Scorecard was extremely hard to manage since facilty staff often did not feel comfortable to share and participate while management staff was present in the same discussions. Facility staff need to feel safe and secure to speak about their challenges without fear of negative repurcussions from their management staff.

- ☐ *Complement external accountability structure (like the Clinic Committee) with an internal/ bureaucratic accountability structure.* Many of the issues identified in the Facility Scorecard related to management of the clinic. While communication between the Facility Staff and the community is critical, this project showed that some sort of communication/ accountability structures that functions within the health facility system could improve facility staff's interaction in external accountability mechanisms and ultimately improve client centered service delivery.

- ☐ *Monitoring and Evaluation is an ongoing process.* As a pilot this project was a once off initiative. To effectively monitor maternal and child health care service provision and uptake changes over time, this initiative will have to be repeated periodically. A once off initiative is not able to indicate if services or the use thereof by community members, have actually improved as a result of the Scorecard intervention. The RMCH Action group are able and motivated to take the intiative forward but need support and resources to do so. Moving forward the initiative should be located ideally within one of the partner Civil Society Organisations who already have funding but DoH needs to also commit to financing CCs to undertake ongoing monitoring and community engagement for a more sustainable approach. It would be very valuable if a repeat scorecard could be held in 6 months time and a study undertaken to ascertain whether any changes have occurred in terms of improvements in the quality of and uptake of MNCH services. At present the project can only comment on process indicators and not impact indicators.

Section 5: Products Developed and Dissemination

- ❖ Note: All products have been submitted as appendices to this report.

The following products were developed in the thematic area of community mobilization to address demand and

accountability for MNCH:

- ☐ **Two Case Studies**:

1. **"**Using the Community Scorecard to address maternal and child health challenge in uMgungundlovu and OR Tambo Districts"
- Outlining the community scorecard process in the two implementation districts

2. **"**A training model to build the capacity of clinic health committees to support community engagement in promoting maternal and child health" – provides an overview of the training of the CHCs embarked on before the community scorecard process was tested.

- ➢ These Case studies will be submitted to DoH through the RMCH Programme. Black Sash will also share these case studies with partner CSOs and networks who might be interested in replicating the training model and community scorecard intervention.

- ☐ **Development of A Model**: "The Community Scorecard Model: Strengthening Accountability in Health Service Delivery and Uptake"

The model attempts to capture and share best practice in strengthening accountability mechanisms and demand for Maternal, Neonatal and Child Health (MCH) services

- ➢ This model will be submitted to DoH through the RMCH Programme. Black Sash will also share it with partner CSOs and networks who might be interested in replicating the model.

- ☐ **A Toolkit including**:

1. **Facilitator's Manual** – developed to focus on the MNCH situation in South Africa as well as the roles and functions of CCs, and includes the community scorecard process as a tool to facilitate dialogues between multi-stakeholders
2. **Participant Workbook –** accompanying the Facilitator Manual as a resource for trainees. The content and methodology of the manual and workbook were informed by the baseline assessment initially performed in two districts and were later also tested during the pilot intervention and subsequently adapted and refined based on trainee feedback and observation. These resources were also translated into two local languages, namely Xhosa and Zulu.
3. **Pamphlets**: Three separate information pamphlets were developed for multiple use; to be used as accompanying training materials to the Facilitator Manual and Participant Workbook, as well as for dissemination among community members and health facility staff. They focus on:

- Patient Health Rights and Responsibilities
- Maternal Health Rights and Responsibilities
- Newborn and Child Health Rights and Responsibilities

These pamphlets outline the patient rights and priority interventions and MNCH services provided at health facilities and also highlights the need for communities to be active in the health seeking behaviour, and being able to avert preventable deaths. They were also translated into two local languages namely, Xhosa and Zulu. Further dissemination to take place includes

- ➢ These training materials were tested as detailed in the table below:

Demographics		Training Audience	No. trained	Outcome of training
National level	Black Sash National and Regional Offices	Training of Trainers for national and regional management staff and field workers (Cape Town, Port Elizabeth, Durban and Johannesburg)	22	Key senior staff and Regional Managers trained to manage and oversee fieldworkers' training with clinic committee members and other multi-stakeholders Fieldworkers trained to facilitate training with clinic committee members and other multi-stakeholders
Provincial level	Black Sash Port Elizabeth and Durban offices	Follow up Training of Trainers for implementation offices (Port Elizabeth and Durban)	9	Regional Managers trained to manage and oversee fieldworkers' training Fieldworkers trained to facilitate training with clinic committee members and other multi-stakeholders
District level	Eastern Cape: OR Tambo: Port St Johns	RMCH Action Group: Clinic committee members and representatives from civil society organisations, health workers, DOH and other multi-stakeholders	27	Clinic committees and other multi-stakeholders trained RMCH Action Group [2] established and trained. RMCH Action Group able to facilitate community scorecard process (with support from Black Sash)
	KwaZulu-Natal: uMgungundlovu: Bruntville	RMCH Action Group: Clinic committee members and representatives from civil society organisations, health workers, DOH and other multi-stakeholders	24	Clinic committees and other multi-stakeholders trained RMCH Action Group established and trained. RMCH Action Group able to facilitate community scorecard process (with support from Black Sash)

- Furthermore the application of the community scorecard module detailed in the manual and workbook during the implementation of a scorecard process in Bruntville and Port St John's involved the following number of stakeholders:

Province	District	Health Facility	RMCH Action Group	Number of service users who attended the community scorecard meeting	Number of facility staff who attended the service provider scorecard meeting	Number of stakeholders who attended the Multi-stakeholders meeting
KwaZulu-Natal	**uMgungundlovu (Mpofana Sub-District)**	**Bruntville Community Health Centre**	**16**	**69**	**26**	**54**

Eastern Cape	**OR Tambo (Nyandeni Sub-District)**	**Port St Johns**	**19**	**79**	**27**	**69**

- ☐ **A Documentary: "**The Community Scorecard: Addressing Maternal and Child Mortality in South Africa"

This resource was developed as a short film examining the community scorecard process as it took place in the two pilot sites in which it was tested. It includes intervies with various multi-stakeholders including CC members, service users and service providers of MNCH services and highlights the views of both regarding the scorecard process and MNCH issues.

- ➢ This Documentary will be submitted to DoH through the RMCH Programme. Black Sash will also share it with partner CSOs and networks who might be interested in replicating the model. The DVD is also uploaded on the internet on 'youtube' for dissemination to a global audience so that other organisations may replicate the process.

- ☐ **A Policy Brief:** Maximising the potential of clinic committees as community governance structures to promote Maternal Neonatal and Child Health

The policy brief advocates for the on-going strengthening and support of these statutory bodies by the different levels of government.

- ➢ This policy brief will be submitted to DoH through the RMCH Programme. Black Sash will also share it with partner CSOs and networks.

- ☐ **An Academic Poster: "**Strengthening Community Accountability Mechanisms to Improve Maternal and Child Health: The Promise of a Community Scorecard"

- ➢ This poster was presented at the Global Health Symposium held in Cape Town in October 2014, to an audience consisting of health workers and officials, academics, donors, national and international civil society organizations, global institutions (e.g. WHO, World Bank, United Nations etc) and therefore a global component of multi-stakeholders working towards people centered health systems.

Section 6: Key Factors Affecting Progress

Black Sash achieved all the outputs of the project although dissemination (Output 3.3, activity 4) will not be achieved within the original timeframes set since the RMCH Programme has opted to move this event to November 2014. A challenge with any intervention that seeks to improve accountability around service delivery is the relatively short funding cycle within which this is required to happen, and the measurement thereof. This project did not aim to improve the health service delivery, but to attempt to strengthen existing governance structures like CCs to provide the conduit for this change to happen over time. A once-off monitoring initative however, does not allow for long-term impact or changes to be measured, and is therefore more an inquiry as to whether it is possible and feasible to improve accountability through such initiatives.

Valuable data on successes, failures and the need for improvement could be gathered if the project cycle was to be repeated to see if actual changes in demand and supply side uptake of child and maternal health services materialised. To improve the programme it is thus recommended to invest resources over a longer period of time

that would support CCs in the roles and functions.

It is also worth noting that great effort is required to build relationships and good partnerships with key health officials and management, as well as with relevant civil society organisations. In cases in which good relationships existed with the project team and these officials, more progress was evident in meeting the project objectives. Without the access, support and effective communication with the various levels of DoH, project objectives are almost impossible to achieve.

If the current status quo of CCs remain, CCs will continue to be largely dysfunctional, under-utilized though legislated statutory bodies, compromising opportunities for real community participation and involvement. It is essential that DoH commit to adequately financing, training and mentorship of these CCs if their potential is to be met.

Section 7: Sustainability

The Black Sash RMCH project has taken care to ensure sustainability of the project. The RMCH Action Groups have the knowledge and the skills to run with this project even after Black Sash has exited from the RMCH project.

The Action Plans that were developed included specific action that, if followed, can contribute to the long-term objectives of reducing maternal and child mortality.

The Black Sash worked very hard to obtain the co-operation of the district health officials and to incorporate the Action Plans into the local political process. The intervention was met with far greater buy-in in OR Tambo largely due to the new appointment of a District Manager who has committed to working with civil society to address health challenges in the district. The RMCH Action Group was introduced to the District Manager at a DMT meeting held in August to present the scorecard and action plan and request assistance with follow up on supply side challenges. Black Sash also linked the group with the Sub-District Manager to get her buy-in to the action plan. The RMCH Action Group in the Port St John's is very committed to taking the process forward and has several prominent CSOs who are resourced to take the action plan forward. The group is currently looking into attracting resources to conduct another community scorecard intervention in 6 months time. Black Sash has also incorporated several members from the Port St John's RMCH Action Group into their new Making All Voices Count (MAVC) Project where service delivery will be monitored at the Port St John's Community Health Centre; although a different methodology is being used for this monitoring involving technology, in partnership with DPME. It is hoped that although the methodology is different the data captured can be used to monitor some of the indicators that were included in the Action Plan developed through the RMCH community scorecard.

In Bruntville, uMgungundlovu District, unfortunately in spite of several attempts to meet with the District Manager we were unable to get her buy-in and this compromised the Action Plan and sustainability of the RMCH Action Group in this pilot site. We have however linked the group with the Sub-District Manager who has attended several events and it is hoped will continue to support the group. The official responsible for CC functionality was also invited to the training workshops and community scorecard intervention so as to ensure the department can replicate the intervention moving forward. Black Sash intends to remain linked to the RMCH Action Group through their BROTT project by continuing to mentor members of the project to continue monitoring service delivery.

Representatives from both the Bruntville and Port St John's RMCH Action Groups attended the National Colloquium on CCs hosted by UCT where CCs from all over the country attended. The result was the formulation of a national CC network which will meet bi-annually and so the groups have now been linked to this structure which they can continue to draw on for support and mentorship.

However, to achieve a sustained outcome continued focus, communication and follow up is required. It is not clear how without the necessary resources to do so, the RMCH Action Group, who are themselves impoverished community members, can carry on implementing this process. Costing of interventions are therefore critical to:
- Show where additional resources are required
- Enable adequate planning and budgeting at district and provincial level

Cross-sectoral engagement between CCs and Departments that also focus on the social determinants that impact maternal and child health, such as the Department of Social Development, Department of Human Settlements and Department of Water and Environmental Affairs, would also ensure more integration and collaboration.

Section 8: Recommendations for Scale up

- ☐ The Community Scorecard should ideally be scaled up and repeated again after sufficient time has passed for all the actions identified in the Action Plan to have been addressed. In the Project, the actions identified in the Action Plan were the solutions that were commonly identified by health care workers and the community members, and have the potential to result in important improvements of child and maternal health services delivery and uptake. In this way, other CCs could also be capacitated to implement community scorecards in their catchment populations.
- ☐ As stated above, for the initiative to be solidly entrenched and sustained in the community, it needs to be repeated so that the key points on the Action Plans can be adjusted post the first round of actions to reflect and update on the actions that need further follow up. This methodological approach should ideally be built into programmes and resources supporting CC led Action Plans so that action points can be followed up and also results measured.
- ☐ With the necessary resources, support and monitoring CCs are undoubtedly ideally situated as community governance structures to contribute significantly to reducing maternal and child mortality.
- ☐ In Provinces where CCs are not functioning well, attention should be given to reviewing and operationalising the policies that could ensure implementation thereof, strengthening CCs and thereby emphasising the agency inherent in these statutory bodies. MNCH involvement could be a priority focus for CCs.
- ☐ To draw on and maximise the potential contribution of CCs to reduce Maternal and Child Health challenges, the National Department of Health would need to monitor and ensure that Provinces operationalise their policies and provide sufficient resources to include the activities of CCs. This would need to filter down to and be effected at Province, District and Sub-District level to actualise the potential of CHCs as statutory bodies. As they are critical communication vehicles for communities as service users, many gains could be made in reaching improved maternal and child health for service providers as well.
- ☐ It would also be beneficial for facility staff and especially management staff to be trained and acquire knowledge of CCs roles and functioning, as that could possibly contribute to building better relationships, and thus improved chances of better communication and partnerships between the community and the health facility. This could have a direct impact on improved both the service provision and could potentially improve the uptake of MNCH services.
- ☐ A functional and operational Clinic Committee could be be one of the indicators measured in the recommended 'Ideal Clinic' intervention recently initiated by National Department of Health, and in this way, more integrated in the overall management of health facilities.
- ☐ Efforts to improve the delivery of health services through the process of Re-Engineering of Primary Health Care should not neglect the inclusion of clinic committees, and thereby ensuring mechanisms for dialogue and address of key MNCH issues.