3-DAY WORKING MEETING ON THE USE OF COMMUNITY SCORE CARD (CSC) IN HEALTH CARE PROGRAMMES

MS TRAINING CENTRE FOR DEVELOPMENT COOPERATION
ARUSHA TANZANIA

19 – 21 JANUARY 2013

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APAC	Australian Partnership with African Communities
AVP	Alternative-to-Violence Programme
CBOs	Community-Based Organisations
CI	CARE International
CIUK	CARE International UK
CO/COs	Country Office/Offices
CSC	Community Score Card
CSOs	Civil Society Organisations
DPs	Development Partners
GPF	Governance Programming Framework
HDI	Human Development Index
HEqG	Health Equity Group
HIV	Human Immuno-deficiency Virus
M&E	Monitoring and Evaluation
MPI	Mwanza Policy Initiative
MS-TCDC	MS – Training Centre for Development Cooperation
NGOs	Non-Government Organisations
NSGRP	National Strategy for Growth and Reduction of Poverty
PPIMA	Public Policy Information Monitoring and Advocacy
SAA	Social Analysis and Action
SMIHLE	Supporting and Mitigating the Impact of HIV/AIDs for Livelihood Enhancement
SRMH	Sexual Reproductive and Maternal Health
TAPI	Transparency, Accountability, Participation, and Inclusiveness
ToT	Training of Trainers
UK	United Kingdom
USA	United States of America
VSLA	Village Savings and Loans Association
VUCs	Village Umbrella Committees
WASH	Water Sanitation and Health
WG	Women's Group
WRA	White Ribbon Alliance

INTRODUCTION

CARE USA's Sexual, Reproductive and Maternal Health (SRMH) team in close collaboration with CIUK's Governance Team, CARE Canada, and CARE Tanzania, convened twenty-three CARE Community Score Card (CSC)[1] experts from five country offices (Tanzania, Malawi, Ethiopia, Rwanda, and Egypt) and multiple sectors (health, food security, water & sanitation, and education) to consolidate and build CARE's collective CSC knowledge. The meeting was held at the MS Training Centre for Development Cooperation (MS-TCDC) in Arusha, Tanzania from Saturday, 19 January 2013 to Monday, 21 January 2013.

During the 3-day working meeting, the CSC experts tackled important CSC implementation issues, such as how to manage potential negative fall-out from the CSC process in sensitive contexts; how to scale up and ensure sustainability of the CSC; how to use CSC evidence to influence national level policy; and how to ensure the CSC process is gender sensitive. This document summarizes the content covered in the meetings, as well as the resulting outputs and recommendations. In addition to this report, a number of knowledge products, guidelines and recommendations, identified by participants as important for advancing CARE's CSC learning and practice, are being developed and will be shared broadly within CARE and with external audiences. The participants have also formed a CSC community of practice to be hosted by CIUK's Governance Team.

The meeting's content included presentations, plenary discussions, and small group work and report back, all of which were guided by the following core questions:

1. **What type of health service issues can the CSC tackle and how?**
2. **How to overcome challenges and prevent negative fall-out from the CSC process**
   - How to implement the CSC process in **challenging political climates** or during election season
   - How to **address and overcome participants' fears** in engaging in the process
3. **Power Hours: How to tackle important CSC implementation issues**
   - *Power Hour A*:
     - How to choose the **right indicators**
     - What should **CARE's role** be in the CSC process?
     - How to ensure that **marginalized groups** are represented and their issues are addressed through the CSC process (especially **youth**)
   - *Power Hour B*:
     - How to ensure CSC is **gender sensitive** and women are included
     - How to **avoid CSC participants' unrealistic expectations/demands** and foster a sustainable system for the supply side issues to be addressed. When/is it appropriate **to have outside actors (NGOs, etc.) address supply side issues** generated through the process? How to **consider and take on board providers** especially those outside the government (or even health sector)

[1] The CSC is a participatory governance tool developed by CARE Malawi that brings together community members, service providers, and local and district authorities, in a mutual process of identifying and addressing barriers to service delivery.

- Strategies to ensure **good facilitation.**

4. **Linking CSC and advocacy: what are the opportunities and challenges?**
5. **Can the CSC be taken to scale and how?**
6. **How to ensure CSC sustainability**
7. **What are the burning questions that are still unanswered** (questions generated during the meeting)?
    - Minimum conditions (Enabling factors) that needs to be in place for CSC to be effective?
    - What motivates service providers to engage in CSC? What is the incentive structure (What are the perceived benefits)?
    - To what extent is the CSC "working" and having an "impact"? What impact is the CSC achieving?
8. **How to best measure and evaluate CSC and health projects**
9. **How to move CARE's CSC and health work forward.**
    - Learning and research gaps: What do we want to learn more about? What work (lessons learned, initiatives etc.) do we want to document? What are the research gaps?
    - What will help to increase the visibility and credibility of our work around CSC? External face visibility: disseminate evidences about impact of our work, sharing experiences and lessons learned, publications, website, joining advocacy-learning initiatives etc.
    - What kind of support do you (the CO) need to take the CSC work forward? From whom (CARE Members, other COs, peers, other organization etc)? Would a community of practice be useful to support this work?

The detailed agenda of the meeting has been attached to this report (**see *Appendix 1***).

1.0 DAY ONE: SATURDAY, 19 JANUARY 2013

1.1 Opening

This was an introductory part of the meeting, which included welcome remarks, overview of the meeting agenda for the three days, and participants' self-introductions and expectations. The **purpose** of this exercise was to:

- Clarify the objectives for convening the meeting
- Outline participants' expectations
- Ensure participants understand the agenda
- Explain roles for day lead, session leads, time keepers, logistics lead, documentation of meeting proceedings, energiser leaders (2), and reflection/feedback (2)
- Enable participants to get familiar with each other
- Create an environment conducive to participation and openness.

1.1.1 Welcome Remarks and Agenda Overview

The Director of SRMH CARE USA, Christine Galavotti, opened the meeting by welcoming participants and pointed out that CARE was privileged to have delegates at the meeting from 5 countries in Africa: Egypt, Ethiopia, Malawi, Rwanda, and Tanzania, joining with CARE staff from Canada, UK and USA. She said that the participants' range and depth of experience was truly remarkable, and that she looked forward to drawing on that rich experience to enhance our understanding of how to use the CSC to address health service issues. She also expressed hope that participants would share experiences from their respective countries in order to fulfil the objectives of meeting. Last but not least, she pointed out that this was not a workshop on how to use CSC but rather a meeting of experts that would bring out questions and challenges faced in using CSC, identify gaps and make recommendations for the way forward.

The facilitator then took participants through the three-day agenda of activities and explained that the meeting had been organised around health issues. She informing them that there would be two types of sessions: plenary sessions during which presentations would be made and experiences shared, and break-away group sessions during which participants would work on and discuss specific issues and later report back results in plenary. The facilitator also briefly explained the sessions' topics and the accompanying questions for the three days.

Before going into participants' expectations and self introductions, the following ground rules during the three days were laid out: and agreed upon

- No use of cell phones during sessions
- No use of laptops
- Sharing time (being concise and to the point so as to give everyone opportunity to contribute)
- Respecting all ideas
- Active participation
- Being on time.

1.1.2 Participants' Expectations

Participants said they expected the following from the meeting:

- To learn more about CSC process and approach
- Having a common understanding in CARE and developing a common CSC manual
- Getting tips of what **not to do** in CSC
- Developing a standardised approach to CSC
- Finding out if any research on CSC has been conducted and the findings of such research
- How to increase sustainability of CSC
- Learning other tools/approaches that can be linked to CSC
- Learning from others how to measure the impact of CSC
- How to link CSC to advocacy work.

1.1.3 Participants' Introductions

In order to get to know each other and to create an environment conducive to participation and openness, participants were asked to make self-introductions by each one choosing a new friend, and each pair of friends were to garner personal information that was later shared. There were a total of 25 participants from all the 8 countries attending the meeting; they all shared information about their names, experience with CARE as well as with other organisations and their field of expertise. Participants' introductions revealed diversity in terms of duration of working with CARE, hobbies and motivations. Hobbies and recreation interests mentioned included swimming, basketball, football (one was a female goal keeper!), watching television, and dancing. In addition, some participants expressed passion to work with communities, especially on governance issues. On motivation to working with CARE, some participants said they would like to see sustainability of their initiative, and marginalised groups (especially girls) becoming empowered to negotiate and make decisions. The full list of participants is as follows:

S/N	FULL NAME	COUNTRY
01	Agnes Mukamana	CARE Rwanda
02	Amr Lashin	CARE Egypt
03	Anteneh Gelaye	CARE Ethiopia
04	Carolyn Krug	CI USA
05	Christine Galavotti	CI USA
06	Eliza Mhango	CARE Malawi
07	Fanaye Gebrehiwot	CARE Ethiopia
08	Francis Mangani	CARE Tanzania
09	Gaby Jabbour	CI Canada
10	Gaia Gozzo	CIUK
11	Jean-Claude Kayigamba	CARE Rwanda
12	Jodi Keyserling	CI USA
13	Lara Altman	Consultant
14	Lucy Uchungu	CARE Tanzania
15	Maria Cavatore	CIUK
16	Marnie Davidson	CI Canada
17	Muhamed Bizimana	CIUK/Sierra Leone
18	Mwawi Mkandawire	CARE Malawi
19	Mwemezi Ngemera	CARE Tanzania
20	Palikena Kaude	CARE Malawi
21	Raymond Nzali	CARE Tanzania

22	Sara Gullo	CARE USA
23	Simeon Phiri	CARE Malawi
24	Thumbiko Msiska	CARE Malawi
25	Tusingwire Yasin	Norwegian People's Aid (NPA), Rwanda

1.2 Session 1: What Type of Health Service Issues can CSC Tackle and How?

Facilitator(s): Christine Galavotti and Maria Cavatore

Purpose /Expected Outcomes:

- Provide participants with a common understanding of the types of health care issues that their respective countries are facing;
- Develop a common understanding of what can be addressed by CSC and how it can be addressed;
- Identify issues that CSC is uniquely positioned to address;
- Outline types of issues that CARE normally addresses through the CSC process; and
- Set the stage for the following sessions (information provided in this session would be useful for the advocacy session).

Expected Deliverable(s):
A brief:

- outlining key health care implementation issues;
- mapping what issues can be 'directly' addressed by the CSC process and those that can only be addressed at a higher level or not at all;
- outlining issues that CSC is uniquely positioned to address; and (iv) mapping issues that CARE tends to address using the CSC process and what issues CARE would like to try to address using CSC.

The facilitator started the meeting with a broad discussion of the kinds of issues CARE faces in the health sector and especially the kinds of issues it faces in trying to improve the health of mothers and infants. The discussion included a presentation on the **use of community score card in health care programmes.** The presentation focused on (i) a brief **overview** of the objectives of the CARE SRMH team; (ii) major **approaches** CARE uses to address the issues that it faces; (iii) **health issues and barriers** to service use and delivery (root causes of those issues, and which of the issues CSC is uniquely able to address, and which issues are perhaps not best addressed with the CSC process).

1.2.1 Presentation: SRMH Programme Objectives

CARE is serving 122 million people in 84 countries worldwide, and it has identified SRMH as one of its four (4) top priorities. The SRMH team currently supports SRMH programming in 29 of those countries. In June 2012 CARE identified SRHM as one of its priority issues for emergency and disaster preparedness and response.
SRMH Objectives include:

- Reduce maternal and new-born mortality and improve health outcomes by increasing **coverage, quality and equity** of health services
- Generate and build evidence, measure impact and share learning globally
- Advocate increasing global impact through scale-up and replication.

As a global organisation CARE works to achieve these objectives by not only working in each country in close collaboration with its country partners to deliver programmes, but also by working across countries and CARE International to generate and build global knowledge about evidence-based practices in maternal and reproductive health, to measure impact of its programming, to share learning and to conduct advocacy to increase its global influence and impact through scale-up and replication of its successful programming across CARE and by others in the global community.

1.2.2 Plenary Discussion: Barriers to Accessing Health Care Services

Maria Cavatore led participants in a group brainstorm to identify barriers to health care services in their respective countries and projects. This exercise would later lead them into group work. Participants identified the following:

- Decision-making authority
- Religious beliefs
- Distance to health care facilities
- Financial constraints
- Lack of information about free access
- Lack of services and poor quality of service
- Shortage of medical supplies
- Shortage of medical professional staff
- Social and cultural beliefs
- Lack of good governance: corruption and mismanagement (providers selling medicines, poor control of medical stock)
- Complexity of the health sector
- Political interest and interference
- Sector prioritisation by the government
- Delayed salary payment for health care service providers, and absence of sanction mechanisms for late payment
- Issues of timing between policy and implementation
- Top-down decision-making processes
- Bi-lateral aid/donor
- Donor influence/conditions
- Complexity of the health sector
- Attitude issues, especially nurses.
- Time to obtain services
- Professional level of provider (doctor, nurse, health assistant)
- Reliable availability of supplies
- Attitude of health care service provider

- Disrespectful care and poor treatment of clients
- Cost of services, transport, and medicines

She then categorised the barriers in two groups namely:

❖ **Barriers at family and community levels:**
- Lack of knowledge and decision-making autonomy
- Gender inequities and social norms
- Perceived quality and responsiveness of health care workers
- Culturally inappropriate or disrespectful care
- Lack of transport
- Cost

❖ **Barriers at health care system level:**
- Gender norms, social distance, and discrimination
- Lack of empowerment and motivation
- Lack of supportive and effective supervision
- Poor working conditions, lack of medical supplies and equipment
- Lack of training for health care service providers.

One group-identified barrier was then broken down to the root cause by continuously asking why is x a barrier? Why does it happen?

Identified Barrier: Supply/lack of free medical care services
- Poor Quantification – stock outs
- Mismanagement – medicines expiring, patients not being informed they are free
- Corruption - stealing of supplies by health care providers;
  Why would health care providers steal?
  - No control of stock
  - Not paid salaries on time

  Why not paid on time?
    - Mechanisms of payment are poor
    - No sanctions for late payment
    - Not prioritized by government/ministry

      Why isn't payment of HW a priority?
      - National prioritisation of social sectors is a top-down process, not taking into account people's needs
      - Lack of pressure from the civil society as well as from medical professional bodies

The plenary session then returned to the presentation being given by Christine Galavaotti where a visual example of two contrasting health care facilities was displayed for participants to choose where they would likely go for health care services: (i) **Facility A** located about one hour away, has a trained health care provider, is short of medical supplies but costs very little; (ii) **Facility B** is three hours away, is well stocked with supplies, and has very pleasant, responsive, kind and attentive health care providers, but costs three times as much. Interestingly, in a recent study in Tanzania that assessed women's preferences for where they would go for delivery, the two most important factors for women were the presence of a **smiling and friendly**

health care service provider who would listen carefully to a patient, and a **reliable supply of medicines** —and these preferences were linked to their actual behaviour. These factors had a dramatic effect on whether women delivered at a facility or not. In addition, these factors were more important, by far, than cost, distance, availability of transport, and the training level of the health care service provider (doctor versus nurse of lower level).

Therefore, achieving CARE's goals of effective service delivery may not be a simple matter of increasing the supply of more highly trained providers or increasing the number of facilities close by. It is important to understand what drives women's use of services as well as what drives service quality, availability, access and so on. Because if women and communities do not use the services, it doesn't really matter how well trained the providers are.

And it is not just barriers the community faces but barriers that the health worker faces. If we think about what some of these barriers are and why they exist, it raises additional issues that may need to be addressed: inadequate or non-existent national policies, lack of guidelines or adequate training curricula for health workers, limited bilateral aid for health, corruption and bottlenecks in paying salaries, in funding and supply chains. So it is the whole system and the context in which health services are delivered and utilized that affects outcomes.

1.2.3 Group Work: Discussion of Identified Barriers

The participants then broke out into 5 groups according to their Country Offices (Egypt, Ethiopia, Malawi, Rwanda and Tanzania), to identify and deconstruct the barriers to accessing health care services in their respective countries. The facilitator emphasised the importance of participants asking themselves the question "why" at every stage of these barriers (i.e. as it was done earlier in the plenary group brainstorm). Below outlines the report back each CO gave when the participants were reconvened.

❖ **CARE Tanzania**

CARE Tanzania looked at **inadequate utilisation of MRH services** in the country. Why aren't people using these services?

- Distance to health facility
- Inadequate supplies
- Drugs and medical equipment
- Negative staff attitude
- Inadequately trained and motivated staff
- Behaviour of service users
- Cost of health care services
- Stigma
- Lack of information
- Gender inequity
- Poor infrastructure of health facility
- Poor supervision of herald services.

The group picked one barrier, i.e. **inadequately trained and motivated staff** on which to ask the question "why": health care providers are inadequately trained and not motivated because of:

- Unwillingness of staff to serve in remote areas

- Lack/shortage of college graduates
- Poor salaries and the medical profession not being valued as it should.

Why are **health care providers unwilling** to serve in remote rural areas?

- Lack of accommodation
- Lack of reliable water supply and electricity
- Lack of incentives
- Poor quality schools for their children
- Lack of training opportunities.

Why is there **no accommodation?**

- Local government not allocating resources for building staff houses
- No economic activities in remote areas for people to invest in houses for rent
- Unwillingness of the community to contribute to building staff houses.

Why are local government authorities **not allocating resources for building staff houses** for health care providers?

- Capital investment not prioritised
- Politicisation of budget allocation and utilisation
- Low capacity of district staff on planning and budgeting
- Lack of mechanism for community participation in planning process
- Inadequate allocation from central government
- Lack of citizen pressure.

❖ **CARE Malawi**

- **Barriers to health service delivery:**
  - Lack of supplies and electricity
  - Lack of infrastructure for delivering optimum health care services
  - Distance to health care facilities (geographical barriers)
  - Shortage of staff
  - Lack of knowledge/information for health care workers as well as for communities
  - Poor governance
  - Attitude of health care workers
  - High cost of health care services due to distance to health care facilities (transportation), and payment for services
  - Religious and socio-cultural beliefs.

CARE Malawi focused on: (i) Poor health-seeking behaviours. Why? (ii) Lack of human and material resources. Why?

- **Why do people have poor health-seeking behaviour**?
  - Lack of knowledge due to poor mechanism and lack of resources for dissemination of health information to the community, and poor planning
  - Attitude of health care workers due to inadequate knowledge about communities' rights (political history), and unrealistic demands from the community
  - Religious and socio-cultural beliefs.

- **Why is there shortage of human and material resources?**
  - **Shortage of human resource:**
    - A result of low motivation for heath care workers.
      - Due to poor salaries and poor working conditions.
        - Which are in turn caused by Government giving priority to other sectors over the health sector
    - In addition, health care workers are unable to use available data because they do not have the capacity to interpret data.
      - This is due to inadequate training – the training curriculum does not address the real needs
  - **Lack of material resource** is caused by:
    - Limited funding, poor planning, over population, and corruption (nepotism)

❖ **CARE Egypt**

CARE Egypt provided an overview of the three types of health care services existing in the country, and examined the inequity of service delivery between rural and urban settings. There are three types of health services in Egypt: (i) public; (ii) community; and (iii) private.

- **Public** health care services, which is sub-divided into 4 levels, namely (i) national; (ii) sub-national; (iii) district/city; and (iv) village.
- **Community** health care service, which is provided by NGOs at national, sub-national, district, city and village levels. Services at community health care facilities cost $2
- **Private** health care services are provided at national, sub-national, and city levels, and cost $20.

- **Why is there limited access to public health care services?**
  - Low availability of female doctors
  - Women patients lack knowledge of SRMH services
  - Low decision making to seek SRMH services
  - Centralisation of funds allocation (supply driven/lack of equity)
  - Low salary – inexperienced staff allocated to villages.
  - Differences in salaries between urban and rural-based health care facilities
  - More importance is accorded to second and third-level health care over primary care health care
  - Young doctors from public/state university, mainly with Grade “C or D” passes are sent to village health care facilities
  - Specialist care versus general – specialist care isn’t available at local public health institutions
  - Public health care services are accessed mainly by the so-called second class citizens, who do not have a voice to complain nor challenge poor health care services
  - Lack of incentive structure to draw talented doctors
  - The doctor/population ratio is based on inaccurate demographic data.

❖ **CARE Ethiopia**

CARE Ethiopia discussed the WASH Programme and focused on the mismatch between issues on the ground (the evidence) and the policies and solutions identified (by the government) to be implemented.

- **Barriers/issues:**
  - Cultural attitudes
  - Lack of information on SVC therefore there is need for doing research on SVC
  - Low capacity of community to contribute money (40%)
  - Lack of community management
  - Non-participation of women in selecting water sites, far away sites present problems for women (time, security)
  - Natural barrier (topography) makes it difficult to construct water points
  - Natural disasters
  - Illegal removal of equipment

- **Desired outcomes:**
  - Sustainable water for people to use
  - Sanitation services and quality water for the community
  - Economically empowered women through VSLAs and water committees.

- **Why is there a mismatch between the barriers (evidence) and the solutions/implementation**:
  - Solutions are top down: work is donor driven, and Government gives directives and sets regulations for NGO work thus there is no space or mechanism for the community
  - Communities have low expectations of authorities to solve the problem and fear to give feedback to authorities due to past experience and cultural norms. They do not expect results and they do not want to upset authorities
  - Evidence used to generate solutions does not match attainment of MDGs: political pressure impact on funding; there is misinformation and lack of coordination among actors; image building; and Government does not trust on information from others.

❖ **CARE Rwanda**

CARE Rwanda's discussion focused on **poor quality of health care services delivery. Why?:**

- **Poor customer care. Why?**
  - Lack of skills/competencies
  - Insufficient knowledge in human rights policies and procedures
  - Accountability issue (service providers to patients)
  - Discrimination – HMP
  - Social gender norms
  - Few sanction mechanism on lack of supervision support
  - Lack of mobile technology for information sharing

- **Lack of professionally qualified medical human resource. Why?**
  - Lack of incentive and motivation
  - Genocide/war (staff killed and others left

- Not enough schools
- Low quality education/training

- **Lack of modern medical equipment/supplies**
  - Expensive
  - Donor pull out
  - Lack of expertise in using modern medical equipment
  - Lack of prioritising procurement of equipment (no budget

In closing the group-report back the facilitator asked participants to identify the issues that can be best addressed by CSC and those that cannot be addressed by CSC. Below is the result of this exercise:

❖ **Barriers that can best be addressed by CSC are:**
- Customer care
- Poor behaviour/attitude (of health care service providers and of service recipients)
- Participation in decision-making processes
- Monitoring of health care service delivery
- Lack of knowledge of SRMH services
- Corruption at local level.

❖ **Barriers that cannot be addressed by CSC are:**
- Provision of modern medical equipment
- Distance to health care facilities
- Availability of female health care service providers
- Low salaries.

This was followed by a brief discussion about ways that CSC can be used indirectly with other approaches. It was explained that CSC could be used to make a change at local level even if it cannot make changes at national level. The facilitator pointed out that the division between what CSC can and cannot do is not as clear-cut as it seems but acknowledged that CSC has a wealth of information collected at local level and that might be used to prompt changes at the national level.

1.2.4 Presentation: CARE's Approach to Addressing the Barriers: Cross-cutting Strategies

[Part of the presentation delivered by C. Galavotti] Health care workers and communities face tremendous challenges to achieving optimal health outcomes. The SRMH team uses a number of cross-cutting strategies to help create an environment in which optimal health can be achieved and improve SRMH outcomes. Some of these strategies include:

- Working with communities to overcome barriers to the timely use of health services and improve healthy behaviour. For example, CARE particularly focuses on increasing *gender equality*, transforming social norms and *empowering women* to seek and obtain quality services—when women know what services are available, when they understand that they have a right to obtain those services and that they have a right to respectful care, a well-equipped facility and a well-trained provider, and when the community supports

women in getting those services, effectiveness improves. CARE has developed a number of tools to work with women and marginalised groups, with couples, other community stakeholders, and health care service providers, to examine and challenge gender and social norms that prevent women from achieving these goals.

- Working with the health system, particularly focused on using innovative approaches to *empower health workers* and increasing their *capabilities, motivation and responsiveness.* Health care service providers, especially community health workers and other lower-level providers, often face tremendous challenges to providing quality services—inconsistent remuneration, lack of supportive supervision, lack of equipment and supplies, and little ability to influence their work environment and secure their own rights to training, equipment and support. CARE is developing and testing a number of approaches to increasing health workers ability to be effective and to improve their ability to use data to make decisions about care through team-based incentives and support, mobile skill labs, and mobile phone technology.
- Making sure health workers are aware of their rights and have mechanisms for securing their rights is another important part of our work—an empowered health work force will be better positioned to demand adequate training, supervision, remuneration and supplies.
- Through supporting *participatory governance* and *mutual quality improvement* approaches--Strategies such as the Community Score Card brings community members and health care providers/officials together in a mutual process of identifying needs, concerns, and barriers to service utilisation and delivery, generate solutions to overcoming those barriers, and actively monitor improvements in coverage, quality and equity. And, through the scorecard process, new alliances and coalitions can be formed and evidence generated that can be used to advocate for improvements in policies, budget transparency, accountability and responsiveness to constituents and stakeholders.

❖ **Reducing Maternal Mortality, Ayacucho, Peru**

The facilitator concluded by sharing an example of how all these strategies have been brought together in one of CARE's maternal health programmes in the highlands of Peru. This is just one of the many examples of successful maternal health programming CARE has shared globally. In the Peru maternal health programme CARE worked closely with partners, including the government, to upgrade facilities and support health worker training, and to do birth preparedness planning and education with the community, including facilitating community support for emergency transport.

The most remarkable and important aspect to this effort was the work done to increase acceptability of services to women in the region because, despite the facility upgrades and the health worker training, women were not going to the facility to deliver their babies. Spanish-speaking health care providers did not communicate effectively nor provide services in ways that were culturally acceptable to Quechua women. So CARE, working with the community members, identified this lack of cultural acceptability as an important barrier to their use of reproductive and maternal health services, and then worked with community members and health care providers to identify solutions. As a result, signs were posted in the local language—

Quechua—informing women of their rights, translators were made available, and culturally appropriate maternal health practices were adopted.

These changes contributed to increased rates and timeliness of maternal health care seeking, and within four years, (i) maternal deaths had decreased by 49 per cent from baseline; (ii) increased need for emergency obstetric care was met (84% from 30%); and (iii) facility-based case fatality rate was reduced from 1.7% to 0.1%. Through advocacy and technical assistance from CARE, citizen monitoring activities like this are now part of Peru's National Policy Guidelines and a joint effort is underway between the Ministry of Health, the regional and local governments and civil society networks to support implementation of these mechanisms of citizen participation across the country, and to monitor implementation to ensure government accountability.

❖ **Conclusion**

The results and experiences from across CARE around the world demonstrate the power of using cross-cutting strategies to address underlying causes of poor SRMH outcomes and to create an environment in which women, communities and health workers are empowered to ensure that all people secure their rights to the highest standard of health. CARE has unique strength in working across these domains and has developed a variety of model approaches, tools and measures to support this work.

1.3 Session 2: How to Overcome Challenges and Prevent Negative Fall-out from the CSC Process

Facilitator(s): Sara Gullo and Muhamed Bizimana

Purpose/ Expected Outcomes:

- Outline the minimum conditions for a successful CSC in a politically controlled, sensitive and volatile contexts
- Identify principles/values to help reduce negative effects of CSC in relation to building citizen voice and meaningful participation in service delivery in politically controlled, sensitive and volatile contexts.

Expected Deliverables:

- An outline of characteristics of a controlled, sensitive and volatile contexts in relation to service delivery
- Minimum conditions for applying a CSC in a politically sensitive or controlled context as a result of target COs experience
- A map of CSC challenges and limitations in relation to identified characteristics of controlled, sensitive and volatile political contexts. Including fears of local and national authorities, service providers, and community in participating in the CSC process. Including issue of fear to speak out, untying free speech of citizens.

The session began with a brief oral presentation from CARE Ethiopia on its experiences usingthe CSC. This entailed the following:

CARE Ethiopia had two projects funded by CARE UK & CARE Canada. Project to internalise TAPI. Findings of these projects established that citizens' report card could not be used so switched to using CSC. The Government of Ethiopia made an NGO Policy that prohibited international NGOs to work on any matters that concern advocacy and governance. In order to overcome this challenge, CARE CO Ethiopia came up with a strategic plan: they changed the term "governance" to "quality service provision". As a result the Government of Ethiopia allowed the use of CSC and even agreed to train people, with CARE as co-facilitators, on how to use CSC.

Why did the Ethiopian Government restrict NGOs' operations? This was because NGOs, especially Action Aid, had been very active during the 2005 general elections in Ethiopia. So the policy stated very clearly that it is only the Government that has the right to work on all "rights" (i.e. rights of children, rights of women etc.). The policy also stipulates that the Government determines the level of funding and budget for activities – i.e. only thirty per cent (30%) should be spent on administrative costs, and the rest (70%) should go directly to actual implementation of activities.

The session was then opened to questions from the group:

Q1: Has the use of CSC been legally institutionalised?
A1: No, but the Government would reject outright any project proposal that talks of rights issues.

Q2: Do the people have fear of reporting back to government authorities?
A2: Yes, there is still fear by health care providers as well as by recipients: service providers fear about how to deliver services, and service recipients also fear to speak out negatively about NGO in case of reprisals (i.e. not getting health care services).

Q3: What is the benefit of using CSC? How has the Government integrated CSC into its activities?
A3: Integration of CSC is done at zone level during the WASH Forum

Q4: Is the law on funding and implementing "governance" and "rights" projects strict across regions or does it vary?
A4: There is some sort of a guideline that interprets the use of CSC but interpretations also depend on the relationship between NGO and Government. There are also various interpretations in different regions , this has allowed CARE to work around the law.

1.3.1 Group Work: Factors that Lead to Negative Consequences of CSC

Participants were organised in small groups (according to their countries) and were asked to share their experiences in using CSC. Each country was given cards on which to record experiences in the following manner:

- Challenges faced and negative consequences/Fall out as result of political environment
- Strategies to address challenges

Participants were organised into 2 large groups as follows:

- **Group 1**: CARE Malawi and CARE Egypt
- **Group 2**: CARE Ethiopia and CARE Rwanda.

Participants from CARE Tanzania were asked to join both groups – i.e. participants split into the two groups.

❖ **Group 1: Malawi, Egypt, and Tanzania Report Back**

CHALLENGES + FALL OUT	STRATEGIES
1. Government's acceptance of social accountability	Follow upon promises made by politicians; this is an opportunity to track progress and hold Government accountable
2. Politicians using CSC evidence for personal gain (fraudulent campaigning purposes)	Use CSC as tool to inform communities the challenges government/you are facing and what you can and cannot do for them
3. Politicians can convert meetings into a platform to advance political agenda	Don't have meetings. Balance deficiency messaging with strength-based messaging
4. Input tracking depends on information – if government doesn't wish to make data available the CSC process may be prevented from taking its course	Collaborate with other NGOs who collect information
5. Politicians may use evidence to show failure of incumbent	Clarify purpose of evidence – don't push information up during politically sensitive times Provide opportunity for all sides to participate in community meetings
6. Difficult to continue to advance CSC agenda when politics/campaign reaches local level	Use evidence to advance our agenda, and to follow up on promises
7. Government may not want negative information to be highlighted	Make information more local – from health officials and health care providers not from politicians
8. Some NGOs don't want to mediate between communities and government because they are afraid communities will blame them	Take CSC evidence directly to partner networks so CARE not blamed for criticising government
9. "Rights" language is not acceptable	Change language

❖ **Group 2: Ethiopia, Rwanda and Tanzania Report Back**

- **Challenges/Fall-out**
  - There is a mismatch between community needs and what can be address
  - Lack of/low financial and technical capacity to respond; there are a lot of needs but no capacity to meeting these needs
  - Authority to respond – LGAs' hands are tied because they have no mandate to respond
  - Issues raised do not match local planning: CSC planning time is January-December while Government planning in Rwanda is July-June so the two plans are not aligned. There is need to reconcile the two timings.

- **Strategies to address challenges**
  - Aligning CSC with government planning process

- Including stakeholders (Government and NGOs) in CSC Action Plan etc.
- Advocating for institutionalisation of CSC in local Government management and planning process
- Capacity issues: to include all stakeholders (Governments, DPs, NGOs) to address technical and financial capacity issues. It is the responsibility of implementers of CSC to ensure capacity building
- Planning well ahead to match CSC implementation with Government policy process for influencing policy.

Facilitator's comment on the group work:

All groups have brought out into the picture the challenges that implementers of CSC face out there. Looking at these negative consequences and challenges, what would be the minimum conditions to implementing CSC without fear of it being hijacked/taken over to fulfil a political agenda?

1.4 Power Hour A: How to Tackle Important CSC Implementation Issues

Facilitators: Gaia Gozzo and Muhamed Bizimana

Purpose/Expected Outcomes: By the end of the session, participants would have had the opportunity to:

- Identify and discuss common implementation issues that they face with CSC processes
- Be exposed to and discuss COs' different experience and successful strategies in tackling these issues.

Expected deliverable:
Short document capturing the experience of different COs in tackling implementation issues, including a summary of the main lessons learned and guidance/recommendations on best practices/strategies to tackle them.

The session began with a brief presentation about the power hour, providing guidelines about the important CSC issues to be tackled during the session. These were:

- **How to choose the right indicators for CSC:** There are various schools of thoughts and approaches on how to choose CSC indicators:
  - Whether and when should we use national standards as indicators, or community-defined indicators, or use the national standards as a base to define the community indicators?
  - When should we use similar or different indicators for service users and providers?
  - What are the challenges in defining and choosing the "right" indicators in term of most relevant for the community members, for the service providers, and for the issues to be addressed at local and national level?

- **What is (and should be) the role of CARE in each step of the CSC process?**

- What is (and should be) the role of CARE in dealing with community organizations and members, with partners, with service providers and the government in each step of the CSC process (capacity building, convenor, facilitator etc.)?
- What is our legitimacy and what is our added value?
- How is the role of CARE evolving in engaging in CSC processes?

- **How to ensure that marginalised groups (especially the youth) are represented and** their issues are addressed through the CSCS process:
  - How can we ensure that **marginalized groups are represented** and their issues are addressed through the CSCS process?
  - How can we make sure that the CSC are inclusive processes that take on board the concerns and demands of poor and marginalised people (especially women and youth) who are less able to articulate and advocate for their needs and rights?
  - What are the pre-requisites (skills, knowledge, level of agency and empowerment etc.) for their effective participation in and influence of decision-making process?

CARE Malawi, CARE Tanzania, and CARE Egypt were then invited to present their countries' experiences in choosing indicators, inclusion of marginalized groups and CARE's role respectively. These were short presentations (5-10 minutes) that discussed the approaches used, the key challenges encountered (what did not work and why) and what were the successes (what did work and why), what lessons were learned, and lastly, recommendations.

1.4.1 Malawi's Maternal Health Alliance Project (MHAP): Developing Indicators

❖ **Project Objective**

The overall objective of MHAP project is to "identify and implement strategies, tools, approaches, and methodologies that demonstrably improve implementation and integration of evidence-based maternal and new-born health, family planning and HIV prevention interventions for optimal impact using the scorecard tool. The project is being implemented in Ntcheu District in 20 facilities, 10 being treatment sites and the other 10 control sites. The project has followed all processes of CSC: preparation, issue generation, indicator generation, scoring and consolidation, and interface meetings in 5 initial sites.

❖ **Tips for generating indicators**

- Review the programme design or the objectives of the project, identify major issues and group them according to area of interest; issues that are similar should have at least one indicator
- The indicators have to be **SMART,** i.e.:
  - **S**pecific to issues
  - **M**easurable – they should be in a form/scale that you can tell the change from time to time
  - **A**chievable – they should be in a form that you can have an idea of what interventions can be drawn to make change
  - **R**ealistic not exaggerated
  - **T**imely – the ones for which you can set time to implement

There is need to have indicators that can help solve issues. You can develop many indicators, but as facilitators you need to prioritise the indicators according to the needs of the community. You can have indicators in which you can have long-term and short-term interventions, since we are also interested in evidence-based information. There is need to agree on the type of scale that can be used, i.e. figures in terms of percentage or numbers, and ensure people will understand the formula. If you planned well and generated issues that are relevant to project objectives, indicator generation can become easier so it means the FGD guide need to have questions in all focus areas.

❖ **Experience of MHAP team during indicator development**

During developing the focus group discussion (FGD) guide for generating issues, the project team and all facilitators looked into the objectives of SRHM, i.e. improving coverage, equity and quality of maternal and neo-natal health services. The FGD guide contained questions in all areas of focus (coverage, equity, and quality). After the issue-generation process, the project team and facilitators met to develop indicators. Issues were grouped according to area of focus. The facilitators worked in groups to come up with indicators in relation to the issues identified and to project objectives. The groups came up with similar indicators and agreed to use the 100% mark for scoring. Same indicators were developed for both service users and service providers since issues were similar in both parties, except for one indicator that was applicable to service providers.

1.4.2 Tanzania's Experience: Governance and Accountability Project (GAP)

The **goal** of the **GAP** Initiative is **improved** impact of CSOs on the government policy processes in Tanzania. The **purpose** of the project is to ensure CSOs are effectively monitoring and influencing the National Strategy for Growth and Reduction of Poverty (NSGRP) processes with a focus on service delivery to poor and marginalised women and girls.

❖ **Definition of Marginalisation**

- Marginalisation is the social process of becoming or being made marginal (especially as a group within the larger society); "the marginalisation of the underclass"; **or** to relegated or confined to a lower or outer limit or edge, as of social standing
- Marginalisation is when a person is pushed to the edge of society. This is a potential effect of discrimination because a person is made to stand out and made to be different from everyone else, and they can therefore feel like they are all alone and marginalised from the rest of society or, in the case of a health and social care sector, other service users.

Marginalised groups under GAP include vulnerable poor women and girls, adult women with disabilities, children with disabilities, girl children living in fishing areas, and out-of-school girls.

❖ **Strategies used in CSC process**

To ensure that marginalised groups are represented and their issues are addressed through CSC process, deliberate measures were taken from the beginning of the process (see the table below):

CSC Steps	Strategies to engage marginalised women and girls
District scoping workshops	• Informing village leaders to ensure marginalised groups are involved during the CSC process
Community-level ground work	• Three (3) women out of 5 community committee members were selected to facilitate CSC process at grass-root level (community level)
Building capacity of Community Committee on CSC	• Highlight importance of gender during training of the community committee members
Developing the Input Tracking Score Card	• Ensure indicators consider gender issues • Selected community volunteers (3 women) participate in developing indicators
Community Performance Score Card	• Community volunteers mobilised marginalised groups to attend meetings • Use of focus group discussions (FGDs) during community performance scoring • FGDs took into account gender and age
Interface Meeting	• Community volunteers mobilised marginalised groups to attend meetings • Convenient time for women and other vulnerable groups • Meetings held within communities (no transport cost) • Facilitators encouraged marginalised groups to participate • Considered priorities of marginalised in developing action plan
Follow up	• Monitor the addressed marginalised priorities if implemented

1.4.3 Egypt's Experience: Social Accountability (SA)

❖ **Overview of SA at CARE**

Social Accountability in Egypt is carried out at **more than one level**: it is done at local, national, and regional levels [www.ansa-aw.net]. **CARE** has **more than one role**:

- They are implementers (50 schools; 86 health units; and a number of youth centres)
- They are trainers for partners, officials, and CSOs
- Advocates.

❖ **Challenges**

- Introduction of SA concept to government "why is it good for me"
- Sensitisation and introduction to demand side
- Implementation (buy-in, demand-side acceptance and understanding of their role(s), demand-side capacity to develop plans, more than one upgrading/development project, managing expectations
- Interface meeting.

❖ **CARE CO's Reaction**

- At project level:
  - Facilitating Interface meetings
  - Sensitisation

- New contractual arrangements
- New roles (implementers, trainers, observers, evaluators)

- Other activities at programme level:
  - Conducting a training of trainers (ToT) session on social accountability for ANSA-AW members
  - Conducting up to 75 training/awareness-raising sessions on SA
  - Developing the first social accountability modules in Arabic
  - Developing CARE Egypt CSC training manual
  - Promotion/introduction of CSC to private sector
  - Promotion of CSC as a comprehensive planning tool.

1.4.4 Group Work: World Café

After sharing these experiences in plenary, facilitators divided participants in three groups/tables and assigned each table to discuss a different issue. Each group/table was given a table host as a facilitator (Gaia, Muhamed and Maria). Participants discussed the assigned issue for 20 minutes and then rotated to the next table. Then each table host was given 20 minutes to report back to the larger group.

❖ **Questions for world café:**
- What are the key challenges (what did not work and why)?
- What are the successes (what did work and why)?
- What are the lessons learned and recommendations?

1.4.4.1 How to Choose the Right Indicators

Choosing indicators is a big challenge. In most case national standards are used for Input Tracking Matrix but the challenge is to translate these high-end indicators into community-defined one. As a process, CARE discusses with community members so as to make them understand the issues in service delivery and main barriers to providing service. On their part, the community define the change they want to see, and with the support of the facilitators, CARE starts the process of defining the indicators with the community.

The issue with national standards is that they are rarely achieved because service providers do not know how to implement them. Also do not always align with what the local community sees as a priority for measurement.

The interface meeting is useful for revising the scoring and for addressing potentially unrealistic expectations or misconceptions about the quality of service. The interesting point on community-defined indicators is that they can provide key information about perception and knowledge of both community members and service providers and allow us to understand which knowledge gaps should be addressed. It could also be possible to include a mixture of national standards and community-defined indicators within the same score card. This does not normally happen but it is a possibility one could explore.

How these indicators can be used for advocacy depends on the project goals: are the advocacy goals at national level or are we are looking at locally based solutions? If we are aiming for national advocacy then the use of national standards is useful; if we are looking at locally based solutions, then indicators defined by the community will be enough. However, this is debatable.

Additionally, the justifications column in the CSC is just as important as the scoring against indicators. The justifications allow the understanding of nuances and why/how some indictors may not be met. The column also provides information on the type of activities that will be further included in the action plan.

❖ **Best Practice**

The role of facilitator is key in order to support communities and service providers in defining their indicators and ensuring that the community members and service providers agree on the indicators to be used. The scoring should be discussed during the interface meeting, and it is also vital for facilitators to be able to collect the information about the national standards and have a sound understanding of them.

❖ **Challenges**

- Breaking down the national standards into community defined indicators which are relevant to these standards
- The national standards are sometimes too complicated and not always applicable to community needs and demands.

Discussion

- During scoring of indicators it is important to add a justification column
- It is essential to link and correlate community-defined indicator with national indicators/standards as community score might be unrealistically low or high because their perception or experience might be different from national standards
- How can we align community indicators and national indicators: does one hold Government accountable for indicators set by communities or by national standard indicators?
- Despite the many challenges there are success stories as we have always managed to identify indicators; an indicator is the best tool for collecting evidence.

1.4.4.2 Inclusion and Participation of Marginalised Groups

SUCCESSES	CHALLENGES	RECOMMENDATIONS	QUESTIONS
Deliberate action by CSC to ensure member of marginalised groups are identified as community facilitators. Case of Rwanda where community facilitators are 50% women and 50% men.	Attitude of local leaders in relation to marginalised groups. Tendency to push marginalised groups aside, discriminate them.	Need of a strategy to prevent loss of marginalised group voice (expressed needs, concerns and priorities) during community interface meeting for deliberation and decision on priorities and actions	Who are the marginalised?
CSC organise focus group discussion for special groups (marginalised and vulnerable groups)	Targeting and working with marginalised ethnic groups in a controlled environment or an environment not	How to combine or support CSC with empowerment activities to increase the agency of marginalised	How to identify facilitators within marginalised groups?

	recognizing the issue of ethnicity	groups	
Use of (community/village) local leaders in the identification of marginalised groups	No organisational guidelines on how to include marginalised groups in various processes	How to attach a sensitisation campaign to CSC to maintain awareness and support participation of marginalised groups	How to deal with unexpected power shift or change of power
Ensure ethnic diversity when mobilising/organising communities for CSC. Example of Ethiopia	Self-exclusion of marginalised groups	How to link with peers or other non-government institutions in the identification of marginalised groups	Are representative of marginalised groups change over time in order to ensure their don't become only convey the message that suit them?
In context where discussion on ethnicity isn't allowed, work with and through organisation representing marginalised groups. case of Rwanda	How to target marginalised groups in area where CARE (or peer agencies) doesn't have operations/intervention	How to balance the scale for representation in the CSC and the actual scale of representation in the communities we work in to be able to draw compelling evidence for governments that are interested in numbers	
CSC is being used as a platform to enable marginalised groups to express their concerns, needs and priorities	Management of power dynamics to ensure the voice of the most powerless doesn't get lost		
CSC deliberately create space where marginalised groups can express their needs, concerns and priorities that cannot be expressed in public (large groups) throughout	Including and involving youth – generate interest and willingness to participate		
	Ensure the needs and concerns of marginalised groups are reflected in community priorities at the end of the CSC cycle		
	Negative wording/terminology that reinforces marginalisation		
	Finding the right balance to negotiate flexible implementation schedule to match youth school schedules		
	Legitimacy of organisation speaking on behalf of marginalised groups		

Discussion

- It is important to define who are marginalised groups
- Strategies for inclusion might differ depending on environmental context and nature of marginalisation (e.g. it might be challenging to ensure sex workers or MSM participate).

Therefore, there is need to train facilitators on how to ensure ideas and inputs of such groups are included

- Use FGDs to get inclusion ideas and inputs from marginalised groups.

1.4.4.3 CARE's Role

CARE's role is diverse: capacity building; policy analysis; documentation and knowledge; selection and partnering with CSOs; implementation; advocacy; lobbying; etc. The best approach for CARE is not to work directly as advocate but work through partners in inclusion of marginalised groups.

- **Trainer:** Facilitators, Government officials, Partners
- **Facilitator:** Facilitator of the whole process: accompaniment and monitoring of every step to check that the process is on track and the quality of the results
- **Implementer:** CARE implement directly when entering new areas (CARE CO Malawi or CARE CO Tanzania with the Health Equity as using the VSL platform so made more sense)
- **Coordination Role: (CARE CO Rwanda – PPIMA):**
  - Training, technical backstop to partners, strategic oversight of projects, planning and monitoring on weekly basis, coordinator of the advocacy coalition
- **Resource centre and innovator**
  - CARE as expert that can provide assistance and training to other actors
  - Innovate the methodology by modifying the process and adapting it to local context
- **Generation of evidences for advocacy**
  - Generation of evidences for policy paper and policy positions
  - Generation of evidences to advocate for the institutionalization of CSC and scale up and across
  - Dissemination of findings of CSC directly or through partners
  - Organise round table and invite district level authorities
  - Coordinate dialogue spaces at national level (national dialogue in Rwanda)
- **Knowledge sharing**
  - Share experiences and best practice
  - Training other COs (CARE CO-Zambia or CARE Morocco)
- **Convenor and broker of relations:** Bring in other actors
- **Use of CSC as a monitoring tool** to assess the quality of services provided by CARE– CO Ethiopia
- **Providing funding**

2.0 Day Two: Sunday, 20 January 2013

Recap of Day 1 was done by Mwemezi and Muhamed: they quickly went over what had been discussed the previous day and then emphasised on the following:

- CARE should apply CSC on itself (i.e. inward-looking assessment process).
- It is important to add a column in the CSC scoring process, for justifications.
- It is important to think about national standards that, where applicable, correlate to the community defined indicators and to consider linking/aligning when possible so as to better contribute to/influence at the national level. In some cases, the community score card indicators might be unrealistically low or high because their perception or experience might be different from national standards.
- Before implementing CSC it is very important to identify marginalised groups in order to ensure their inclusion.

2.1 Session 1: Linking CSC and Advocacy: Opportunities and Challenges

Facilitators: Jodi Keyserling and Gaia Gozzo

Purpose/Expected Outcomes:

- Provide participants with a common understanding of the context for advocacy and governance work at CARE.
- Build on first session of Day 1, reiterate barriers related to policies, programmes or budget allocations at national level and consider how CSCs can be used to address them.
- Identify organisational and environmental challenges for linking CSC processes to national-level advocacy work.
- Explore how COs are using CSC to influence policy makers and share CO best practices
- Identify what COs would like to do more of, what is needed to do more and what tools are available to facilitate this.
- Have COs commit to taking action.

Expected Deliverables:

- A lessons-learned document (that could serve as the basis of short case studies) summarising experiences from COs that have used CSC evidence to influence policy action. This would include a section on challenges and potential strategies for overcoming these challenges
- A list of questions and/or tools that COs can use at various points of implementing CSCs to facilitate use of evidence to inform advocacy
- Learning from the session will also be informing on-going revisions to the Advocacy Manual and will be shared during a meeting in early February.

Jodi made a brief presentation to introduce the session's topic that focused on the history of governance and advocacy at CARE from evidence-based advocacy to rights-based approach. It set the governance and advocacy context at CARE, defined governance and advocacy, and explained the governance programming framework (GPF), linkages between the CSC process and advocacy and collective accountability of citizens and governments. [This is highlighted in more detail in the following bullets.] The facilitator emphasised that advocacy is part of governance, i.e. an approach to ensuring good governance so the CSC process happens within a

country's community structures. This introductory presentation was followed by country office experiences from CARE Tanzania, Malawi and Rwanda.

❖ **Context for governance and advocacy at CARE**

- Rights-based approach
- Programme approach: A successful project should be a means to bigger IMPACT, NOT an end in itself
- Governance approach
- Evidence-based advocacy
- Vision 2020: strong capacity for advocacy and "local-to-global" advocacy
- Global advocacy priorities – SRMH.

❖ **Defining governance and advocacy**

CARE does its advocacy work through the Governance Programming Framework (GPF) that is composed of four domains, namely:

- Sustainable development with equity
- Expanded, inclusive, and effective spaces for negotiation
- Accountable and effective public authorities and other power holders
- Empowered citizens.

❖ **Advocacy/Policy Influencing:**

- Address policy causes of poverty and discrimination
- Influence the decisions and actions of policy makers
- Aimed at creating policies, reforming policies, and ensuring that policies are implemented.

❖ **Linkages between CSC process and advocacy**

- CSC in the context of service delivery, which is defined by specific policies, helps support policy implementation
- CSC process provides insight an into how current policies and/or budgets are being effectively implemented ("pulse" on what is actually happening at the sub-national level)
- CSC process often identifies issues around policy implementation or gaps in policy that cannot be solved at community or district level and require policy action:
  - Evidence generation
  - Inform CARE or partner advocacy strategy (e.g. policy objectives, messaging) and content.

2.1.1 CO Experience CARE Tanzania: Using CSC Process and Information to Inform District and National-level Advocacy Efforts

❖ **Utilisation of CSC evidence in advocacy**

The CARE Tanzania experience covered 3 projects. CSC facilitators and community volunteers advocated to village and ward councils for inclusion of identified priorities in the village and ward plans. CARE and partner CSOs conducted round-table meetings with district officials to present issues identified through the CSC process for further action, and then lobbied for inclusion of the identified issues into the district plans and budgets.

CARE's role: preparation of policy brief (technical support to member organisations) ensuring the brief was presented to MPs and well understood, to advocate for increasing resources for maternal health. CARE also monitored how the brief was used during Parliamentary session. This evidence was used to develop mass communication advocacy strategy through radio and television spots, billboards and newspapers. The evidence was also used to do advocacy work at national campaigns (e.g. White Ribbon Day and National Gender Festival).

❖ **Opportunities and enabling factors for successes:**

- Tanzania's political stability supports citizens' engagement in policy-making and planning process through an approach known as opportunities and obstacles to development (O&OD)
- Government circular from the Prime Minister's Office to district councils allows the application of social accountability monitoring tools such as CSC and PETS to monitor public services delivery
- Use of networks (e.g. HEqG, WRA, MPI, TGNP) to advocate CSC evidence-based issues and concerns, where CARE was not able or allowed to do public campaign on the use of CSC
- Use of local partner CSOs to do advocacy
- CO commitment, funding and staff capacity.

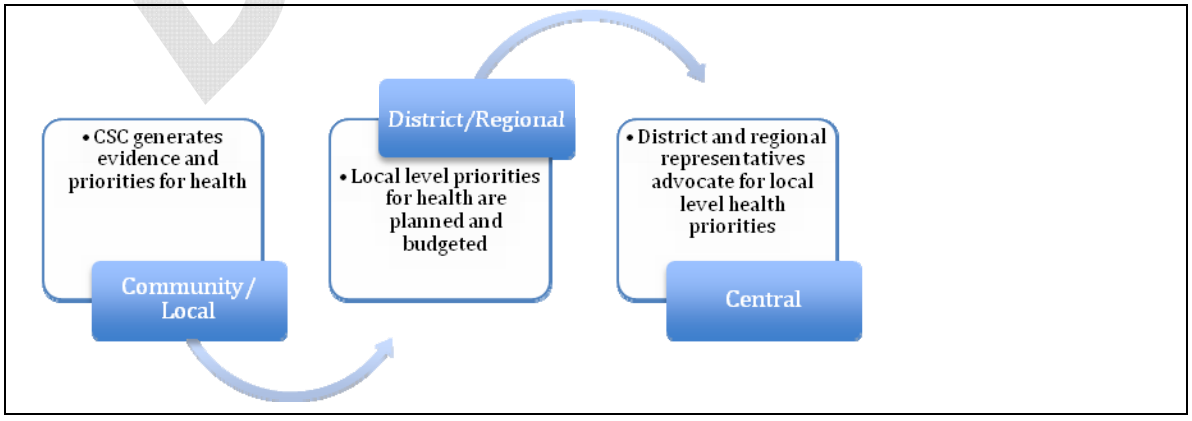
❖ **Challenges:**

- Political pressure to abandon some of the mass media campaign during the general and presidential elections in 2010
- The sustainability of advocacy at various levels after GAP winded up (no financial support to community volunteers and CSOs)
- Fear and resistance from service providers on the outcomes of the CSC process
- Measuring the impact of advocacy work, given the number of other interventions that could be responsible for the positive changes observed.

❖ **CSC Advocacy Model**

- Community/local levels: CSC generates evidence and priorities for health care outcomes
- District/regional levels: Local-level priorities for health care are planned and budgeted
- Central level: District and regional representatives advocate for local-level health care priorities.

The advocacy model is shown below:



❖ **Future Applications of CSC: Lessons Learned**

- Inclusive nature of the process lead to better results
- Timing matters
- Evidence of results feed a positive view of this process
- Perceptions do not always match reality
- Process and outcomes can potentially be sustained through the village health committee.

2.1.2 CO Experience CARE Malawi: Sharing Information with Partners to Inform Advocacy Efforts

Since 2003 Malawi CARE CO has been implementing CSC for several projects at various levels and has identified the following **achievements**:

- Development of rights-based assessment methodologies; and
- Establishment of an organisation of informed rural consumers of health care services.

The role of CO CARE was to **train and to mobilise** communities, which resulted in communities being able to get the Director of Planning and Development (DPD) attend district interface meetings with the community and listen to their concerns and issues on health care service delivery. Thereafter, DPD registered these concerns/issues to Central Government for action. So this approach was used as a tool to ensuring local and central governments' accountability to the people. The same approach was used by the community to bring DPD to an interface meeting with communities regarding shortage of medicines: DPD took up the matter with Central Medical Stores, after which the shortage of medicines was greatly reduced.

❖ **Challenges**

- Limited space for interaction between health care service providers and users.

❖ **Opportunities/Enabling Factors:**

- Presence of stakeholders on health care;
- Availability of information;
- Staff capacity to facilitate dialogue, existing relationships with government; and
- Informal links/relationships between civil society and government.

Q&A

Q: Can you explain a bit more about the challenge you faced?

A: There was mismanagement in providing medications (government was not distributing drugs to the districts) as well as selling of medications by the HWs so CARE held dialogues with Central Government Stores as well as with civil society to ensure issues brought up by communities had a space to be aired and adequately addressed.

2.1.3 CO Experience CARE Rwanda: Using Information to Inform National-level Dialogues

A national public dialogue is an opportunity/space that is organised every year by the civil society platform that includes all PPIMA partners at local and national levels and Government institutions. For example, in 2011 there was public policy dialogue on Community-based Health Insurance (CBHI). Citizens' issues from CSC included:

- Why CBHI fees have been increased while citizens at community level do not have the financial capacity to cover the cost of new insurance premiums
- Problems related to service delivery at health centres and hospitals
- The process of categorising CBHI fees for clients (who pays what) was not clear.

❖ **Challenges**

- Some issues raised about policies cannot change immediately (for example, CBHI fees)
- Some Government officials were defensive and not accepting evidence provided by CSC.

❖ **Success**

- Problems related to service delivery at health centres have been addressed by the Ministry of Health
- A free telephone line has been establish to enable citizens to register to the Ministry of Health issues and concerns related to health care service delivery
- Categorisation of CBHI in the country has been revised, thus enhancing citizens' confidence.

❖ **Enabling Factors**

- There was political will to improve service delivery
- CARE had the staff capacity

2.2 Group Work on the Use of CSC Evidence in Advocacy

Based on the presentation and country office experiences shared during the plenary, participants were divided into 3 work groups and asked to discuss the following questions:

- What are the **CHALLENGES** (organisational and environmental) of using CSC evidence to inform advocacy?
- What are the **SUCCESSES**? What **ENABLING FACTORS** made the experiences successful (i.e. what needs to be in place to make this linkage)?
- What do Cos need to incorporate national-level advocacy into their thinking? What tools/support are needed?

2.2.1 Report back from Group Work

❖ **Challenges:**

- Could be seen as political interference;
- CARE could risk its reputation as a neutral NGO;
- Lack of funding or funding is short term for advocacy efforts;
- Donor restrictions on program objectives, donor sensitivity to advocacy; Advocacy agendas change with the projects, and end when projects end;

- CARE's role: Historically, CARE has not been known as an advocacy group, rather seen as a partner with governments. So CARE has remained behind the scences and worked through other partners. CARE faces a dilemma – between maintaining an amicable relationship with governments and on the other hand advocating for good governance; Partisan issues – challenges with working with local populations if an issue is partisan or seen as supported by the government ;
- Other organizations pushing competing agendas;
- Government prohibits advocacy (Ethiopia case);
- Risk in creating conflict/violence – do no harm;
- Low civil society capacity;
- Often civil society lacks a clear agenda/focus for advocacy and does not have the evidence to present to the government;
- No CARE lead for advocacy in CO;
- Limited involvement in advocacy at local government level (district authorities reluctant of taking community issues to higher-level government authorities), fear of holding power holders to account.

❖ **Enabling Factors:**

- Linking advocacy to other approaches (e.g. budget research; partners and networks);
- Fund-raising activities (e.g. Tanzania CO CARE made a lot of effort to raise funds);
- Commitment of COs and capacity;
- Political stability;
- Personal networks between CARE staff and government officials or civil society groups;
- Clear understanding of advocacy, i.e. that it is **not confrontational;**
- Work with partners, networks – can increase impact and allows for more information sharing; Political will of governments, support for citizen engagement and accountability;
- Engaging governments from the start of the CSC process;
- CARE's thinking around advocacy is evolving, there is the opportunity to move from one-off project to longer-term program approach;
- Providing technical support to NGOs;
- Use of various platforms; and
- Decentralisation of central government authority to lower-level government structures.

❖ **Tools/support needed:**

- Financial resources;
- Capacity building of local partners (CARE staff would need specialised training in order to build capacity of its partners);
- Advocacy strategies for implementation;
- Mapping of key players/stakeholders;
- Documentation – policy briefs, evidence/CSC validiaty for advocacy, also lessons learned from other CO experiences;
- Support CSC evidence with research, additional surveys;
- How to link the local level evidence to the global level policy initiatives;
- Designate CO staff that will be responsible for advocacy efforts; and
-
- How CSC can best be used to gain government support.

2.2.2 Commitment to Action

Before concluding the session, participants were asked to answer the following questions and make a commitment to action. The commitments are listed below.

- What are the current opportunities to influence SRHM advocacy in your settings using CSC information? What are potential roles for CARE?
- What is one action you can take WITH CURRENT RESOURCES to move forward national-level advocacy?

❖ **CI Canada**
- Leverage Canadian network for MNCH funding and in support of Muskoka Initiative Coalition; and
- Dedicate staff time to participating in pan-Canadian MNCH technical working groups/coalitions.

❖ **CARE CO Egypt**
- Continue with the decentralisation advocacy effort:
- Map current governance stakeholders;
- Conduct focus group to determine policy recommendations (for government);
- Hold national-level meetings to bring awareness to CSC evidence.

❖ **CARE CO Ethiopia**
- Share information generated through CSC process with Government officials; and
- Use consortiums to share the changes needed with government officials.

❖ **CARE CO Malawi**
- Conduct strategic forums at district and national levels to share issues generated and action plans.

❖ **CARE CO Rwanda**
- Generate evidence for advocacy; and
- Develop advocacy strategy for SRHM.

❖ **CARE CO Tanzania**
- Source funds for national-level advocacy.

2.3 Session 2: Can CSC be taken to Scale, and How?

Facilitators: Christine Galavotti and Maria Cavatore

Purpose/Expected Outcomes:
- Participants' understanding of the diffusion of innovation (DOI) model
- Participants clarify reasons for taking CSC to scale
- Participants' identification of barriers to taking CSC to scale

- Participants generate recommendations for best practices for taking the CSC to scale, and strategies for overcoming challenges, using the principles from the DOI and own experiences.

Expected Deliverable:
A document outlining:

- When and why does it makes sense to take CSC to scale—what are the conditions needed, what can scale accomplish;
- What are the key challenges CO's face in taking CSC to scale;
- What are some strategies for overcoming challenges and taking CSC to scale; and
- Recommendations for others on best practices for going to scale.

2.3.1 Presentation: Taking CSC to Scale

Theories of Change
Theory of the programme —how does the programme work to influence outcomes?
Theory of scale up—how do we achieve widespread adoption and effective implementation of the programme?

CARE talks a lot about theories of change; one important kind of these theories is the theory of how we think our programme works – having a programme theory helps us focus our programme efforts on key levers or critical factors that we believe drive change in outcomes. We therefore have a theory about how the CSC works—for example, one key factor in the CSC being effective is having all the key stakeholders bought into the process—so, because we know this is important to the programme working, we make sure we direct enough energy and time into orienting all the stakeholders and making sure they support the process.

Theory can also help us think more clearly about what factors influence scale up, and how we might direct our efforts most effectively to target those factors, or ways we might need to adapt our programme strategy for a new context or situation, to facilitate widespread adoption and effective implementation of the programme.

Diffusion of Innovation
One theory that has been around for quite some time but, I think, remains very useful, is a theory called Diffusion of Innovations (DOI). This model was developed in the late 60's by Everett Rogers, a graduate student studying the process of adoption of an innovation in agriculture. The theory had to do with the introduction of new seed corn and how it achieved widespread use in the community over time. DOI describes the way in which new ideas, opinions, attitudes, and practices spread throughout a community. Innovation refers to a new idea, product or practice, a new practice or way of doing things. Communication channels refer to the means through which a message is transmitted from one individual, group or community to another. Innovations spread throughout the community by means of communication—this can be from one individual to another or in a variety of other ways.

This theory also suggests that there are five basic stages to the innovation decision process that are necessary for potential adopters of the innovation:

- Awareness – they need to be aware of it

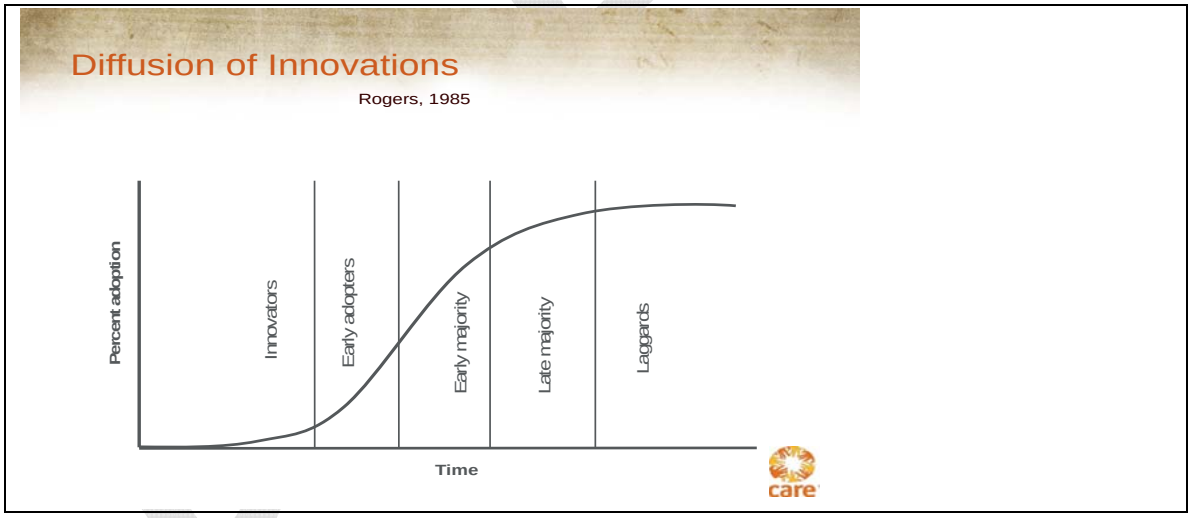
- Knowledge – they will have to have some level of understanding and be knowledgeable about the innovation
- Persuasion – they will need to be persuaded that it is something they should adopt
- Adoption/motivation – they make a decision to adopt the innovation and are motivated to adopt it
- Implementation – they implement the innovation.

Homophily

Since innovations spread through communication channels, the concept of homophile is also important to the theory. Homophile is the degree of similarity between people communicating with each other. When there is greater similarity between these people it accelerates the diffusion process.

Adopter categories

According to diffusion theory, not everyone adopts an innovation as soon as it becomes available. Instead, some groups seek out and adopt innovations early, others adopt innovations when they become popular, and others continue to resist the innovation. Rogers classified adopters into five categories: [a] Innovators (the first 5%): the first to adopt new ideas and are often perceived as deviants from the system's norms; [b] Early adopters (the next 15%); [c] Early majority (the next 30%); [d] Late majority (the next 30%); [e] Laggards (the remaining 20%). When depicted as a cumulative response, the adopter categories produce an S-shape curve as seen below.



CARE's adoption of CSC 10-12 years after it was first used in Malawi in an agriculture programme is a really interesting example, especially having 5 CARE country programmes in the CSC meeting who are using it, and many more across the CARE world who are currently using, have in the past or, even more exciting, are planning to use it in the future. The facilitator said CARE is perhaps moving from the early adopter state into the early majority, and expressed hope that, with meetings like this one, it will continue to accelerate that curve.

Programme Characteristics that Facilitate Diffusion

Both the theory and research identify some key characteristics of an innovation that makes it more likely to be taken up by others.

- Low complexity: simple to use – the simpler it is to use the more likely it is to be adopted

- Observability of effects: people who you might want to take it up can see the positive benefits that occur as a result of the innovation. You aren't asking them to trust you – that there are positive benefits – you can show them; and this is part of the persuasion process
- Trialability: ability to try out a programme on a small scale first. An opportunity to try it out makes it more likely to be adopted. This is really important – before someone invests a huge amount of time, effort or resources into something, it is good if they can get a smaller taste of it, of how it works and confirm that it will work for them in their context. Again, this helps persuading adopters
- Compatibility (how a programme can fit into a people's organisational culture) of the programme with the existing programme and values is really important: how does this fit with our culture, our way of communicating with each other, and what we care about?
- Relative advantage over existing or alternative programmes (the advantage of the new over the current practice): how is this better than what we are currently doing? For the time and effort I will invest, will it significantly improve outcomes I care about?

Referring to the possibility that all of the meeting participants had been thinking about scale up or, in some case, had already attempted to scale up a smaller CSC process, the facilitator asked them to state the reasons for scaling up (i.e. why scale up?); challenges to scaling up; fear of or resistance to scaling up; time and resources/funding needed to scale up; timing of funds; political context; economic context, etc. in response, participants mentioned several reasons for and challenges to scaling up:

Reasons for scaling up

- Further experimentations
- Ensuring sustainability of CSC
- To replicate the learning achieved
- Creating greater impact
- Fulfilling request from governments
- To improve CARE's reputation as a leader in governance and health
- Leverage support and funding for CARE's work
- Expanding what we believe adds value, share a tool that works
- To achieve CARE's goal of eradicating poverty.

Challenges to scaling up

- CARE as a laboratory/innovator but it needs others to scale up
- Lack of funding and technical capacity needed for scaling up
- Not enough visibility so CARE needs to link up with others to enhance its visibility
- Government tensions/restrictions
- How to link a CSC tool/approach with the "bigger picture" - change you want to see at local level with policy that you what you want to see at national/global level
    - Exp: want to create VSLA groups at local levels to increase HH income, but at national/global level want to see stronger economy, global player in economy – policies to promote business at home and industry development which in
- When you have partners that are committed, what happens when they change their priorities

- Define scale – use in every context forever or certain contexts for defined periods of time?
    - Depends on why the CO is looking to scale up, what is the need? Which communities and contexts. Two types of scaling up:
        - Geographical scale up: local to national
        - Scaling across sectors: Health to Education, Econ Dev., etc.

It is important to ask why government is asking to scale up CSC, just as it is important to know that CARE needs others in order to scale up CSC.

The facilitator then explained that another way is to think about some of those challenges as BARRIERS to behaviour change because a lot of scaling up the CSC is about changing behaviour. To successfully and effectively implement CSC on a broad scale the behaviour of a number of different actors has to change: community members have to come to meetings and participate in the process; women and community members have to speak up in meetings; programme managers have to go to meetings and listen and share information; district officials and local leaders need to endorse the process and so on. In other words, lots of different behaviours of lots of different people need to change and, as they change, more change will occur — they will interact in different ways, they will learn things they didn't know before, they will change their attitudes and behaviours, they will take risks, they will form new relationships and bonds, they will change their expectations, and so on.

One of the most effective communication strategies used to achieve behaviour change is entertainment education. The basic idea is not new, as it has been in practice for centuries: societies have informally used stories via poetry, plays, puppet shows and drama to inform and enlighten. Now, however, instead of the tribal elders passing down the stories, or the travelling storyteller spreading the news across the countryside, increasingly mass media – both print and broadcast media – carry these messages to the community.

Long-running serial drama is one of the most effective entertainment-education strategies. It consists of long-running stories, or soap operas, which have been used in Latin America and India, on radio and television, and in several countries in Africa (including a popular drama in Tanzania called in Kiswahili "*Twende na Wakati"*) to promote social goals. This kind of drama draws from social science theory the idea that much of what people know has been learnt through observing others (i.e. vicariously through MODELS). For example, when a person sees someone else touching fire and getting their hand burnt they learn not to touch fire, they don't need to have the DIRECT experience of burning their hand to learn. Serial dramas can be designed to show key characters making their way through life, slowly changing specific attitudes and behaviours. There are 'good guys' and 'bad guys', and then there are characters right in the middle, just like the audience who, over time, evolve and change their attitudes and behaviours. Characters and story lines illustrate people with whom the audience can identify, moving through life, facing and overcoming obstacles and situations similar to those found in the lives of the target audience. They face both positive and negative influences, they experience setbacks, they seek support, and, eventually, they achieve specific behavioural goals. Long-running dramas (2-3 years) allow stories to unfold at a realistic pace, showing people changing as well as showing the consequences, good and bad, of specific behavioural choices.

Role models are at the heart of many communication activities, and for good reason: role models in the media can do many things, such as:

- Educate: provide information on how to change and model the steps
- Persuade: alter perceptions of costs and benefits by showing the consequences of different courses of action, models can alter one's perceptions of the cost and benefits of a behaviour
- Motivate: show success of similar others obtaining desired rewards. When you see someone like you doing something that has a positive outcome that can be motivating. For example, if you see someone standing up for themselves and then getting what they want, that might motivate you to assert yourself in a similar situation. Increase belief that "maybe I can do that too" (self-efficacy).

Role models are particularly effective when they are similar to the intended audience and confronting similar situations. If, for example, a person observes a young athlete running a marathon that doesn't tell them anything about themselves and their ability to run a marathon, that person need to see a model with whom they can identify, someone similar to themselves, doing something that they didn't think they could do to increase their confidence and their belief that perhaps they could do that too. Models can in fact model thinking, feeling and doing; they can think out loud, for example, and illustrate ways of coping with setbacks and preparing oneself to try again.

The facilitator gave an example of how some of the principles she had been talking about could be integrated into a communication strategy in order to raise awareness, increase knowledge, persuade, and inspire people to adopt new behaviours and implement new practices. She shared her previous experience (before joining CARE) of 22 years at CDC in a global reproductive health and HIV initiative to develop long-running radio dramas to equip people with the information and resources they needed to change their behaviour:

- The **Makgabaneng Programme in Botswana** is a long-running radio serial drama that succeeded in changing behaviour of pregnant women in seeking PMTCT services. The programme received support from CDC to develop characters and story lines that would adhere to the behaviour change principles of role modelling. The programme was written, produced and acted in Setswana by local talents in collaboration with the Botswana Ministry of Information and Broadcasting. The programme has been airing twice weekly nationwide since August of 2001; in addition, thousands gather regularly to participate in community events and listening discussion groups.

About 18 months into the program, two key characters had experienced pregnancy, fear of testing, and decisions about whether to enroll in the PMTCT program. An early success of this programme was evident in a dramatic increase in calls to an HIV hotline number following the airing of an epilogue urging women to call for more information about PMTCT – calls hovered around 200 per day throughout the month and then jumped to almost 500 after the epilogue aired on 23 April 2003 and on 24 April 2003. When it aired again on 26 April 2003 there was an **eightfold increase** in call volume – over 1600 calls came in on only one day.

A number of other evaluation activities later showed that the programme was having an impact – through a national survey almost half (49%) of the population reported NEVER missing an episode of the programme. Furthermore, listeners were more than 4 times more likely to report being tested for HIV during pregnancy.

Although this programme focused on individual behaviour change, it was important in that it could make participants see how a strategy like this could be used in many different ways, to tell many different stories. For example, stories of communities coming together to take action to improve the health of their community, and facing all kinds of difficulties and obstacles but eventually succeeding. Or a story of a new young health care worker who becomes disillusioned when she sees the older nurses around her mistreating patients, and is ridiculed by others when she is kind to a young woman in labour – what's her story, how will she find her way? Maybe the CSC comes to town and she has a chance to express her concerns and, over time, she gets more support and feels more able to provide quality care. A district health official who is totally against the process and feels very threatened…what happens to change his mind? The religious leader who challenges social and gender norms and publically endorses provision of family planning services to young unmarried women, or the young father who accompanies his wife to a health care facility. But it is critically important that these are real stories (based on what you know and learn about your communities), not idealised and not simplified but complex, dramatic, and entertaining. The stories have to have 'bad guys' in there who do everything wrong, and the role model characters cannot be perfect—they have to make mistakes—like real people – and they have to struggle before they change. Strategies like this are one way to use the "Observability of effects" lever mentioned in the DOI theory, you can use dramas to show people how change might happen and persuade them that it is possible and could achieve good outcomes.

2.3.2 Group Work

Participants were asked to break into smaller groups according to their respective countries to discuss how and why to scale up, and the strategies they would each use for scaling up. The facilitators urged them to share best practices and make recommendations for scaling up, and to discuss how to address challenges. Each CO's report back on ideas and recommendations are outlined below.

❖ **CARE Tanzania**

Why scale up?

- Citizens engagement would enable meeting programme objectives as well as CARE objectives
- The objective is to increase Government accountability in addressing citizens' needs.

How to scale up

Scaling up will be done by the 4 main social sectors (i.e. Economic Development; Education; Health; Natural Resources; and Women). This would lead to geographical scaling up as well.

Strategies for scaling up

- Internal re-structuring by moving the Advocacy Coordinator from SRHM Technical Unit to CO level
- Capacity building for CARE staff in other technical units through knowledge sharing, and for CARE partners
- Mapping out partners
- Meeting with Government officials to gain a buy-in.

❖ **CARE Ethiopia**

Why scale up

- The Government is convinced that CSC is a tool that enhances accountability
- Objectives: increased citizen participation in policy processes, increased transparency and accountability in service delivery, reduced cost, increased demand from stakeholders, and increased impact

How to scale up

- Scale across issue areas: women, economic development and water
- Geographical and population scale up would happen as scaling across issues happens.

Strategies for scaling up

- Involving the Government in the process of scaling up from the beginning so as to facilitate institutionalisation of CSC [this is a very important strategy]
- Including accountability of tool at project planning level
- Demonstrating the tool through role-playing at group meetings
- Engaging partners/strategic partners in the process of scaling up
- Evidence generation and sharing
- Using the media for sensitisation and advocacy
- Resource mobilisation

❖ **CARE Malawi**

Why scale up?

Scaling up will achieve the following objectives:

- Sustainability of the CSC process
- Increasing the impact of CSC
- Piloting
- Improving performance (i.e. service delivery).

How to scale up

- Scaling up into other CARE projects such as nutrition, health, education etc.
- Adopting scaling into several other sectors
- Geographically, other projects such as SDDI and MAZIKO have already adopted CSC.

Strategies for scaling up

- Knowing stakeholders in the area
- Negotiating with Government to integrate CARE plans into their plans (DIP)

❖ **CARE Rwanda**

Why scale up?

- Government is convinced that CSC is a tool that enhances accountability
- Increased demand from stakeholders
- Increased impact

How to scale up

Scaling up will be done geographically and across social sectors to achieve the following objectives:

- Increasing citizens' participation in policy-making processes
- Increasing transparency and accountability in service delivery
- Reducing cost.

Strategies for scaling up

- Using partners (CSOs)
- Strategic partners
- Evidence generation and sharing
- Media for sensitisation and advocacy
- Resource mobilisation
- Institutionalisation of CSC

❖ **CARE Egypt**

Why scale up?

- To have other CARE-trained centres replicating knowledge
- Request from districts and needs

This move will produce more evidence for advocacy and test peer-to-peer learning.

How to scale up

- Establishing 4 new centres in 4 new districts in order to replicate knowledge through training
- Supporting the decentralisation process
- Showing the benefit of the process

Strategies for scaling up

- Making use of peer educators as ambassadors
- Encouraging champions to come out
- Providing social accountability analysis (SAA) and CSC materials
- Documenting good and bad practices
- Using informal spaces such as public meetings, FGDs and exposure visits
- Following up and monitoring progress of scaling up process (revision of tool and of the process).

In closing the session, the group discussed and identified main strategies for scaling up, they include the following:

- Enhance staff capacity and reduce turnover – or share internally so don't lose experience when there is turnover
- Scaling up to totality is important but so is sustainability of the scaled-up totality.
- Peer to peer – people will use the CSC if they have heard about the benefits from their peers
- Use of technology and media to diffuse use – depends on CO context and what is allowed or available
- Role of informal spaces to discuss CSC – personal network and connections
- Put in place a stronger mechanism for internal accountability

- Work with government to integrate CSC plans with theirs
- Identify other key stakeholders and partners for aiding in scaling up
- Identify champions of CSC (for advocacy to government and stakeholders)
- Leverage existing partnerships
- Generate evidence of CSC success, document and share
- Use media at national level for advocacy (of CSC and CSC identified issues); use media at local level to augment knowledge of CSC (and CSC identified issues)

2.4 Power Hour B: How to Tackle Important CSC Implementation Issues

Purpose/Expected Outcomes: Tackle important CSC implementation issues and provide clear guidance for programme managers on the 3 topics.

Expected Deliverables:

- **Recommendations** about additional modifications **to make CSC more gender sensitive**
- **Mapping of unrealistic expectations/demands** and guidance on how to overcome these obstacles and foster a sustainable supply-side system
- **Guidance on who can facilitate the CSC process**, how to train facilitators, and facilitation tips for each phase of the CSC process (preparation and planning, community score card, service provider score card, interface meeting, action planning, action plan implementation and follow up).

❖ **Questions for Group Work:**

- How can we ensure CSC is **gender sensitive** and that women are included? (Recommendations about additional modifications to make the tool more gender sensitive)
- How can we **avoid CSC participants' unrealistic expectations/demands** and foster a sustainable system for the supply-side issues to being addressed? (Mapping of unrealistic expectations/demands and guidance on how to overcome these obstacles and foster a sustainable supply side system). When is it appropriate to have outside actors (NGOs etc.) address supply-side issues generated through the process? How do we consider and take on board providers, especially those outside the Government (or even outside the health sector)?
- What strategies can be applied to ensuring **good facilitation? (**Guidance on who can facilitate the CSC process, how to train facilitators, and facilitation tips for each phase of the CSC process, i.e. preparation & planning, community scorecard, service provider scorecard, interface, action planning, action plan implementation and follow-up).

2.4.1 Group 1 Report Back: Ensure Gender Sensitive

The first group discussed how to ensure the CSC process is more gender sensitive: their discussions focused on identifying and addressing gender, cross-cutting gender issues, use of community score cards and service providers score cards to ensure gender balance and inclusion, interface meeting, action plan and M&E.

❖ **Gender issues identified/addressed through the CSC Process**

- Demand for FP services: women accessing/utilising FP services
- Including women as a specific group in the health insurance scheme
- Women access to agricultural input and land
- Women's and girls access to quality health care services.

❖ **Cross-cutting issues regarding gender**

Asking challenging questions in focus group discussions about the 'whys', for example:

- Why don't young women come to health care facilities for FP services?
- Why don't men come with their partners during delivery of the baby?
- Why don't health workers talk to unmarried women about FP services and their rights to obtain those services?

RECCOMMENDATIONS FOR MAKING THE CSC PROCESS GENDER SENSITIVE

❖ **Preparation Work**

- Inclusion of women and women groups in all aspects of the preparation work
- Separate meetings for women only to determine issues and needs specific to them (except for gender-neutral issues)
- Gender equality training for CARE staff and all others involved in the process (trainers and facilitators)
- Gender analysis at community level: to identify one to two key gender inequalities or issues related specifically to the contents of the score card. Findings can then frame the gender issues that are ranked in later steps
- Gender balance in the staff doing the preparation work.

❖ **Community Score Cards**

- Women facilitators need to be included in the design of the indicators: discussion of the issues, the clustering leading to the indicators, and the actual scoring. At least one indicator has to do with gender inequalities or dynamics
- Focus groups discussion for only women facilitated by women, and then bring everyone back to mixed-group discussion of same issues using safe space facilitation techniques
- Mobilise/enable women to attend community score card meetings
- Enable women to attend community score card meetings (venue, time and format that enable women and girls to participate in meetings).

❖ **Service Provider Score Cards**

- Gender balance in service providers' (SPs) meeting: make sure women SPs are involved and actively participating
- Provide gender analysis for SPs, and also encourage providers to identify one gender issue/GE indicator based on the analysis or their own work priorities.

❖ **Interface meeting**

- Meeting held at a venue, as well as in form and time that are conducive to women participation
- Inclusion of women in the interface meeting – mobilise women to attend interface meeting
- Provide an environment that is conducive to women participation – understand power dynamics and make sure women have equal voice.

❖ **Action Plan and M&E**

- Gender sensitive: sex-desegregated data and indicators address gender-specific needs, and women need to be enabled to provide specific indicators. So whatever information/data is provided has to be sex and gender desegregated.
- Implementation plans include at least two gender goals.
- Women participation in follow-up action planning – give meaningful roles to women in the action plan.

2.4.2 Group 2 Report Back: Avoid Unrealistic Expectations/Demands

The group discussed how to **avoid CSC participants' unrealistic expectations/demands** and foster a sustainable system for the supply-side issues to being addressed, mapped unrealistic expectations/demands, and then provided guidance on how to overcome these obstacles and foster a sustainable supply side system. Below is a table showing the result of this exercise:

UNREALISTIC EXPECTATIONS/DEMANDS	APPROACHES/STRATEGIES
• There is a mismatch between the focus of CSC and some issues that are raised	• During the interface meeting: need to be clear about what can be addressed and what cannot • CARE must clearly define its role in this process to government officials • Provide special training (facilitation skills) to community facilitators • CARE must have a thorough understanding of the specific issues in community so that CSC can address the most important of these issues
• Outcomes of action plan must match what they have in mind	• Explain clearly which actions (in the action plan) will be implemented, and what they will look like • The resource included in the action plan must match available resources
• All items from the action plan will be implemented	• Make sure that decision makers are present and actively involved in designing the action plan • Facilitator has a key role in prioritisation of activities included in the action plan
• Timing to solving issues: community members expect some issues to be addressed immediately	• Make sure the responsibility of implementing the action plan is balanced between community members, MP and local government • Facilitator has a key role in prioritisation of activities included in the action plan • Look for different sources of funding, including the district • Be realistic about timing for the implementation of the action plan • Align the elaboration of the action plan with the Local Government's budget cycle
• Service providers and local leaders demand stipend/per diem in order to participate in the CSC process	• Keep talking! • Visit Local Government representative at home • Understand the reward system and explain it to Local Government actors
• Service providers or Government want 'material' contribution from CARE to address some issues	• Remind communities of their rights and entitlements (be realistic about them)

	• Be transparent about CARE's role and funding
• Communities are 'too empowered' so their demands become unrealistic	• Make sure that decision makers are present and actively involved in designing the action plan • Remind communities of their rights and entitlement (be realistic about them)
• Communities have multiple problems, and they want all issues to be addressed	• Coordinate with other organisations working in the area • Be transparent about CARE's role and funding
• Partners can have unrealistic expectations from their advocacy initiatives (unrealistic expectations for changes as a result of advocacy work)	

Discussion

- Column of resources does not reflect resources from districts
- Issues to be solved by service providers, other to be solved by users, others by Government.

2.4.3 Group 3 Report Back: Ensure Good Facilitation

The third group tackled the question of choosing facilitators: identification process; training of facilitators (methods; materials); preparation/planning of CSC process; preparation and planning.

❖ **Identification process of CSC facilitators:**

The following criteria should be used in making a choice of facilitators:

- Familiarity with the community and ability to mobilise the community
- Good information on how to talk to the community (honest dialogue)
- Knowledge of the local language and culture, as well as knowledge of local CSOs and NGOs context
- Knowledge of facilitation methodology and strong facilitation skills
- Contextual understanding of target population (both men and women, as well as the elderly)
- Respected (not feared) in the community but not a government leader
- Neutrality – i.e. not a person from the sector
- Easy accessibility to the person
- Higher education is not needed but literacy is.

The group wondered whether CARE could be a co-facilitator at the beginning as a transition to local facilitators in order to ensure continuity of the process. They also noted that including people with authority/power (e.g. politicians, religious leaders, traditional leaders, and local government authorities) would not be a good idea due to concerns of fear and neutrality. The group thought inclusion of NGOs would present potential competition.
Participants in this group raised the issue of whether facilitators should be paid salaries.

❖ **Training facilitators:**

- *Facilitation skills/tips include*
  - Listening: communication and maintaining neutrality
  - Negotiation: conflict management
  - Inter-personal relationships: mediation

  - Problem solving: process management; addressing sensitive issues through SAA; cultural competence/gender sensitivity
  - CSC methodology: ID; ToT; on-the-ground training; refresher training; and training on why social accountability is important, and on building a common understanding of rights.

- *Methods*: Experiential; ToT; role playing; exploring bias; and co-facilitation

- *Materials:*
  - World Bank
  - CARE Australia
  - Malawi: CSC toolkit, facilitation guides, and video
  - Egypt: ToT from the World Bank (being added to)
  - Ethiopia: process/training documentation; other organisations
  - Tanzania: CSC toolkit steps; process documentation; and video
  - Rwanda: Alternative to Violence Programme (AVP) – communities and gender sensitive.

❖ **Preparation/planning**

- Do not make CSC so new (scary)
- Emphasise that CSC is not a policing tool
- Interface meeting and action planning:
  - Sensitisation process
  - Input tracking must be on-going and must verify data from a variety of sources
  - Remind solution oriented and that everyone has a role to play
  - Remember to SMILE
  - In listing agreements start with areas of agreement
  - The facilitator must have adequate knowledge on the scope of mandates, entitlements, and available services
  - Share the stage – no group should dominate the floor; every group should create room for other groups' voice to be heard
  - Use local language to define the process
  - Do not mix languages
  - Manage expectations: lay out realistic expectations within roles of each group
  - Hold meeting at a neutral venue.

- Service providers/communities:
  - Hold pre-interface meeting to diffuse tensions
  - Ensure representation
  - Role play
  - Manual in local language

- Preparation of higher authorities is also important – validation meeting.

2.5 Session 3: How to Ensure CSC Sustainability

Facilitators: Lara Altman and Sara Gullo

Purpose/Expected Outcomes:

- Familiarity with concrete sustainability example from Malawi
- Defining the aim of CARE's CSC sustainability
- Identification of factors and strategies that lead to CSC sustainability
- Identification of factors that inhibit sustainability and ways to overcoming them.

Expected Deliverable:

A **brief** outlining **CSC sustainability aim**, i.e.:

- CSC Sustainability aim
- Compilation of factors to support CSC sustainability (both those that have been used in CARE's projects and new ideas)
- Compilation of factors that inhibit CSC sustainability and how they can be overcome.

2.5.1 CARE Malawi Experience: Use of CSC in SMIHLE Project

Presented by Simeon Phiri, Project Coordinator SMIHLE, CARE Tanzania

The Supporting and Mitigating the Impact of HIV/AIDs for Livelihood Enhancement (SMIHLE) project was implemented from July 2004 to November 2010, with funding from AusAID through Care Australia. It was part of APAC (Australian Partnership with African Communities) programme. The **purpose of the project** was to develop and promote operational models and practices that strengthen the delivery of services that mainstream HIV/AIDs and gender. The operational models that were promoted included community institutions, seed banking, village savings and loans, and marketing.

The SMIHLE (APAC) Programme **focused** on three main areas:

- Improving knowledge and understanding of the relationship between HIV/AIDs and food security among the rural communities
- Strengthening CBOs to manage food security activities that mitigate the impact of HIV/AIDS
- Strengthening linkages between CSOs, CBOs, Government and the private sector to facilitate responsive service delivery.

SMIHLE implemented the community scorecard approach from 2006 in order to share the responsibility of monitoring project interventions with communities and increase participation of project beneficiaries, and accountability, transparency and inclusion by duty bearers. The project facilitated trainings for project staff, Area Executive Committee members and District Executive Committee members.

Some of the areas of CSC assessment

- Performance of CARE project staff, community volunteers, local leaders, government extension officers etc.
- Quantities of Agricultural inputs issued by the project.
- The timing of the trainings the project provided to the communities.

Positive outcomes of the CSC process

- Communal orchard and fish farming established with funding from DC
- Rural road rehabilitation through the Cash-for-Work Programme
- Support to people living with HIV and AIDs through local NGOs and support groups

- Timely response to some development requests from DC

DZOOLE CSC Committee

The Project facilitated CSC trainings of 10 community members from each T/A and gave the CSC Committee the responsibility of implementing the tool as the project was phasing out. The CSC Committee assessed the following issues:

- Performance of the school committee
- Implementation of the Farm Input Subsidy Programme by the local leaders
- Usage of the Constituency Development Fund by the elected member of parliament of the area
- Performance of community volunteers
- Performance of the CSC committee.

Outcomes of DZOOLE CSC Sessions

- The School Management Committee was dissolved, and women were included in the new committee
- Local leaders recognized local structures like VUCs and VDCs in beneficiary selection
- A bridge was constructed with Constituency Development Fund
- Community volunteer performance improved.

Challenges in CSC Implementation by DZOOLE Committee

- Interface meetings sometimes cause tension between the CSC Committee and duty bearers due to poor understanding of the purpose of the score card
- The process takes a lot of time to be completed
- Some well-trained members of the CSC Committee leave the area before they deliver
- It is difficult to assess some culture-influenced areas like selection of a chief.

Recommendations from the community on the CSC process

- The CSC training must start with local leaders followed by the committee
- The tool must be introduced at the beginning of the project.

2.5.2 Sustainability of Community Score Cards in GVH Mwaphira, Malawi

Presented by Lara Altman, Consultant to SRMH Team, CARE USA

The **objective** of this study was to develop an understanding of GVH Mwaphira's continued use of the community score card and its impacts:

- Why does the community still use CSC?
- What does the process look like now?
- What are the ways in which it has been used?
- What are its challenges and limitations?
- What are its impacts on service delivery and human development indicators?
- What are its impacts on governance indicators and equity?

The **methods** applied to the study data collection and data/information analysis:

- Data collection
  - Background information from SMIHLE documents and team members
  - Town hall meeting: open forum with 70 attendees (50 of them women)

  - Four focus group discussions: women, Scorecard Committee, local leaders, and School Committee. Instruments were developed using CIUK's governance indicators, with input from SRMH and CIUK
  - One qualitative interview with Interim Director of Planning and Development (district-level government)
- Analysis of data/information.

Results: Purpose:

Results of the study based on the **purpose** of the score card were divided into **three main themes**:

- Monitor performance
- Identify problems and solutions
- Improve governance

"The purpose of the Scorecard is to do things openly, where everyone participates…the main purpose is to do things openly without bias." (WG)

Results: CSCS Process:

- Scorecard Committee as facilitators
- Evidence of all 5 stages of Scorecard process
- Changes to process: "But if we see that some other problems are not being addressed, we can modify the process to suit those problems." (TH)

Issue generation occurs in three ways:

- Scoring process different – sometimes score only performance indicators, not multiple indicators
- Splitting up into groups to do scoring is not consistent – less emphasis on scoring with service providers
- Interface meeting not always used to compare scores

NOTE: unclear that each step happens every time Scorecard is used.

Results: Areas of application:

- Used in five sectors
- Used on multiple levels
- Cultural practices: grave diggers
- Individual/household: problem-solving, communication – "The household can assess itself in terms of how it is harvesting its crops…they can make improvements for the following season...The quarrelling is not there because they can sit down and discuss issues affecting their households." (SC)
- Diffusion: sector, level, geography.

Results: Governance:

- **Domain 1**: marginalised citizens are empowered
  - "NGOs come with assistance (like seed) – when they give small amounts, we're able to say no, this is not enough, we need more. We are empowered because of the Scorecard." (WG)
  - "In the first place, when a service provider came to the village, we could not hold the provider accountable. The service provider would say, '*You were not at the*

training, only I know the procedure. You cannot say anything or tell me what to do.' We were living in fear. After we were trained in the Scorecard, we gained power. We are able to take those people, sit down, and tell them what is wrong using the Scorecard method, and those people can accept." (WG)

- **Domain 2**: public authorities/power holders effective and accountable
  - "Before Scorecard, the relationship between the people and those who hold positions in the village was not good at all. People were living in fear….There was also bias and demarcation…Now, things are okay; people are free to ask the village head if something is wrong, and… he accepts advice from the people in his village and other villages. He has come to realize that people are in a democratic world." (WG)
- **Domain t3:** spaces for negotiations are expanded, inclusive, and effective
  - "In our culture, the chief is not supposed to be questioned. This time, after Scorecard… we can question the chief now. People are freer to ask the high positions in the community." (SC)
  - "When the Scorecard started, things have changed. The whole village participates, and they take into account the opinions of the people in the village." (WG)

Results: Other outcomes:

- Women empowerment:
  - "Before, a woman could also live in fear, could not ask her husband things. Now, we can communicate easily, we can even score ourselves…We can sit down with our husbands and say, 'You are not performing well, you can go!'" (WG)
  - Women initiate problems/issues and know steps of process
  - Half of the members of the Scorecard Committee are women
- Service-related outcomes:
  - Agriculture Extension Workers and HSAs visit area more frequently
  - Teachers teaching longer days
  - Some 380,000 kwacha allocated by the district government to repair school was recovered.

Results: Sustainability:

- Reasons for sustainability:
  - Training
  - Responsibility/citizenship: "We are the citizens of here, we want to implement the knowledge we have and make things go well….we feel responsible for the area." (SC)
- Benefits of Scorecard:
  - "We could not stop using the Scorecard even after SMIHLE ended because we see the good of it. In the past, people could do anything they wanted without fearing anything. Now they know that the Scorecard Committee can score them, so they have to do things the right away." (SC)
- Challenges to sustainability:
  - "The Scorecard process is a very good tool, but the area is so vast, and those who were trained to facilitate the process are very few…." (WG).

Results: Challenges/Limitations:

- Mobility

- Tension/facilitation
- Resources (materials for documentation)
- Time
- Useful for all topics, except for conflicts to do with position of chief.

Conclusion:

- The study produced evidence of:
  - Adaptability of Scorecard process
  - Usage across multiple levels
  - Impact on governance indicators: empowerment, accountability, transparency, space for negotiation
  - Impact on service delivery: more consistent, responsive to community's needs
- The scorecard process changing problem solving and communication generally
- Sustainability is attributed to good training, sense of responsibility/citizenship, and benefits of the Scorecard.

Q&A

Q1: Has the study been published?
A:1 Analysis of data is currently underway, and study findings/report are expected to be published soon.

Q2: Is there any documentation of the changes that have been made to this process?
A2: Yes, there is documentation (including the one just presented here) of the changes to the process.

Q3: How are members of CSC Committees replaced?
A3: I am not sure of the process but I believe the CSC Committee members choose their successors; communities are not happy with this process.

2.6 Group Work: How to Ensure CSC Sustainability

Participants broke into groups to answer the following questions:

- When we say CSC sustainability **what do we mean**? What do we want to achieve when we talk about CSC sustainability?
- Based on your experience and what you have heard about the Dowa case, what specific actions or strategies can be taken in the planning and rollout of the CSC process to ensure sustainability?
- Besides the Dowa example, have you ever been part of a project that has achieved CSC sustainability? If so, can you briefly share this example with the group?

2.6.1 The Meaning of 'Sustainability'

Participants gave the following responses:

- Sustaining buy-in by local partners, Government etc. (institutionalisation of the CSC process)
- Process continues even if CARE is not present any more

- Sustained accountability of service providers (respect)
- Sustained change in local citizens' participation process
- Changes in the communities (speaking out and engaging in current spaces)
- Sustaining CSC process through self-organised action
- Groups (communities, CSOs, councils) can use CSC independently
- Organisational (NGOs) and Government
- Sustainability of outcomes (project-specific)
- Continuity of intervention and of key elements (dialogues, meetings, and action plans)
- Implementation of CSC steps – how many?
- Is it sustainability of health care outcomes?

2.6.2 Strategies for Ensuring Sustainability

Participants gave the following responses:

- Have in place trained CSC committees before exiting, and ensure adequate time for handing over/transition
- Strong focus on community buy-in from the beginning of the process
- Good documentation of process and outcomes/action plans
- Being gender sensitive
- Political will
- Self-supporting/funding (duration of funding not really important to sustainability)
- Lack of funding may limit somewhat, while increased funding may support sustainability
- Duration of facilitation might or might not support sustainability, but it does not really matter much whichever way if the community 'gets it' and adopts
- Adoption of CSC committees before the project ends: (i) be strategic about selection of committee members; (ii) setting selection criteria; (iii) involve the Government in the selection process; (iv) use same staff for subsequent interventions; (v) provide exposure visits
- Stepping back and pushing communities to continue the process
- Linking community volunteers with other local CSOs that are applying CSC or other approaches
- Engaging community members in the CSC process right from the start
- Identifying other CSOs that the process will be transitioning to and which are to take over the process
- Involving government actors/public officials at the beginning of the process
- Align the process with existing local mechanisms and processes
- Taking advantage of experience…
- Pride of the CSC committee, ranking committees and comparing
- How CSC can benefit NGOs
- Adaptability of CSC (time etc.) supports community ownership and sustainability.

The facilitator observed that some of these strategies would help in future project start-ups. And that it is very exciting for an organisation to begin something and then see it continuing even when the organisation is long gone.

2.6.3 Examples of Sustainable Projects

- **Ethiopia: anti-corruption**
  The communities adopted the tool and are using it on themselves and for all activities

- **Rwanda VSLA:**
  - VSLA were trained and then they continued on their own
  - Used by local authority for performance reporting and for advocating for additional support to address issues.

- **Tanzania:**
  - Coalition of NGOs was established to ensure there is funding for sustainability of CSC
  - Mwanza Policy Initiative (MPI): all NGOs meet and advocate, thus creating better funding chances.

The facilitator commended participants for coming up with very comprehensive definitions of what 'sustainability' means. She urged them to continue discussion of what can be adopted in view of charting the way forward on the last day of the meeting.

3.0 DAY THREE: MONDAY, 21 JANUARY 2013

3.1 Session 1: How to Best Measure and Evaluate CSC and Health Projects

Facilitators: Maria Cavatore and Sara Gullo

Purpose/Expected Outcomes:
Participants would have:
- An understanding of CIUK's governance guidelines
- An understanding on what the indicators relevant to different project's stakeholders are
- An understanding of how to combine measuring process (governance) with service improvements and health outcomes, and the links (attribution) between the two.

Expected Deliverable:
Health and governance M&E cheat sheet – key recommendations and links to resources, documentation of best practice M&E – case study examples.

The session began with an outcome mapping exercise where participants were asked to think of a project for which they would like to see changes and/or improvements, and then write down on cards. These cards were then posted and shared with the group.

3.1.1 Outcome Mapping Exercise: What Changes do we want to see from the CSC Process?

1. Women empowered to speak up, claim their rights, women's voiced enhanced
2. Communities empowered to demand their rights (e.g. health services form the government).
3. Improved spaces for girls and women to negotiate with service providers on health issues
4. Creation of space/opportunities for effective negotiation, dialogue, communication
5. Improve 'trust' relationship between citizen and government
6. Joint planning between local officials and the community
7. Increased community participation in governance activities, civil society
8. District health authorities to incorporate SRMH in their budget
9. Better information flow from the local to the policy makers
10. Acceptance of changes outlined in action plans by government
11. Changes in SRMH policies and in the policy implementation
12. Increased citizen participation in planning and monitoring SRMH services
13. Improved quality of SRMH health services at the local level
14. Increased access to and quality of health services at the local level
15. Equal and free access to SRMH services
16. Access to family planning services
17. Increased in male involvement in SRMH and FP
18. Health care providers have adequate equipment and supplies
19. Health care providers more responsive to the needs of women and adolescent girls in the project sites
20. Attitude change by service providers
21. Increased accountability of Service Providers
22. Increase in the level of satisfaction of citizens in services received
23. Improved accountability across the board (health care providers, gov. officials) - Everybody being accountable and responsible for their actions

3.1.2 M&E Governance and Health Outcomes: Guidelines

The facilitator then made a brief presentation that provided participants with a pack of tools as a guidance for monitoring and evaluation (M&E). The **objective** of this session was to present CIUK Governance M&E tools, and to discuss the best ways to measure different levels of outcomes within the CSC process.

❖ **Overview of GPF pack, including M&E Guidelines**

The Governance Performance Framework (GPF) is made up of (i) M&E guidance note;
(ii) Context Analysis Guidance note; and (iii) GPF design. The **context** of governance consists of three interactive (non-static) domains, with interlinking levels of governance and heterogeneous social groups: (i) Sustainable development and equity; (ii) Empowered citizens; and (ii) Accountable and effective public authorities and other power holders. Each of the domains has been sub-divided into dimensions of change (see table below).

Domain 1	Domain 2	Domain 3
Marginalised citizens are empowered	**Public authorities and other power-holders are effective and accountable to marginalised citizens**	**Spaces for negotiation between power-holders and marginalised citizens are expanded, inclusive and effective**
Dimensions of Change 1. Citizens are aware of their rights and duties, and exercise agency 2. Citizens participate in and organise collective actions 3. Citizens hold public authorities and other power-holders to account 4. Citizens influence policy effectively 5. CSOs are representative of and accountable to marginalised citizens	***Dimensions of Change*** 1. Public authorities and power-holders have the capacity to uphold rights and deliver public goods 2. Public authorities and power-holders are responsive to impact groups, designing and implementing pro-poor and inclusive policies, programmes and budgets. 3. Public authorities and power-holders are transparent, providing accessible and relevant information 4. Public authorities and power-holders are accountable to impact groups 5. The rule of law is effective and justice is administered equitably and impartially	***Dimensions of Change*** 1. Institutionalised spaces are expanded, inclusive and effective 2. Informal spaces are claimed and created 3. Inclusive political settlements are achieved at multiple levels 4. Alliances and coalitions for progressive social change are formed

The three domains are CARE's theory of change so the CSC process is a good example of this theory. The facilitator pointed out that the M&E guidance table is generic and could be used to develop indicators. She also explained to participants how they can use the table, emphasising that there is neither right nor wrong way of developing indicators using this framework. One participant wanted to know how this table could be used to develop indicators for talking to donors. Gaia explained that it is not possible to develop global indicators so each individual organisation should adapt the table to its own specific situation/context. In CARE, what is important is service delivery so governance is a function of ensuring that services are delivered appropriately.

❖ **Overview of CIUK Governance M&E Guidance**
- Part of the tools aligned to the GPF
- Builds on the domains and dimensions of changes from GPF
- Indicators provide guidance to measure "levels of changes"
- The guidance provides guidance and generic indicators, should be contextualised (impact groups, changes, governance outcomes or impact)
- To create a learning culture to understand if our work is having the intended impacts.

❖ **How to use the M&E Guidelines document to develop M&E framework for CSC**
- Understand which **domain of change** the specific project outcome/result is corresponding to
- Identify the different **dimensions** within the domain of change

- Look in more details at the **characteristics of the change**
- Choose which **indicators** seem most appropriate to measure the changes aimed at in the project and adapt them to the context of the project

[Note: The M&E Guidelines document has been attached to this report as ***Appendix 2***]

❖ **Challenges and various debates**

Governance and accountability are more complex than some of the other sectors. There are two (2) ways of looking at governance:

1) **Governance as a means to an end**: improving education/health through social audit, participatory budgeting, community score-card (measuring processes: knowledge, skills, empowerment, engagement, spaces, and responsiveness of power holders)
2) **Governance as an end it itself** (democracy, transparency, rights, and corruption)

In the case of CSC: what do we need to measure? What are the types of outcomes we want to see? What about Impact?

❖ **Potential attribution chain for a CSC health care project**

- Assumption that impact is expressed in terms of developmental changes in people's lives (reduction of maternal mortality and mortality of children under the age of 5 years) relegates behavioural changes related to voice and accountability to output level.

Maria said she had developed the **potential attribution chain for CSC health project**, and requested participants to give their feedback on what they think about it. The chain consists of the following steps:

- **Process**: capacity building
- **Output**: skills and knowledge of service providers and citizens
- **Outcomes**: behaviour changes; responsive and accountable SP; citizen engagement; expanded, inclusive and effective spaces
- **Outcomes**: improved access, utilisation and quality service delivery
- **Impact**: improved HDI.

Q&A/Comments

- One participant asked: "How does one distinguish between the first group of outcomes with the second one?" Responding, Maria clarified that the first group of outcomes should be **short-term** and the other long-term.
- Another participant noted that behaviour change is core, everything else follows suit that is why behaviour change is on top of the list
- Christine G: These are the basic elements so by having good measurement of these elements one can learn the process.

❖ **CSC M&E: what do we want to measure?**

It is important to know what should be measured, how and when it should be measured. In this case we want to measure **Governance and health care outputs and outcomes based on the Governance Programming Framework (GPF):**

- **Domain 1:** Citizens aware of their rights and duties, citizen participation and influence, citizens hold public authorities/service providers to account, alliances and networks built, CSO are inclusive and representatives,

- **Domain 2:** public authorities/service providers have the capacity to deliver public goods, PA/SP are responsive, accountability mechanisms are created and/or strengthened, policies are implemented
- **Domain 3:** institutionalised spaces are expanded, inclusive and effective, informal spaces are claimed and created.

Measuring health services outcomes focuses on improvement of access to health care services, utilisation and quality of services. It is also important to define what we mean by quality. **Impact** is measured by reduction of maternal mortality and of under-5 child mortality.

❖ **M&E standard steps:**

The following are the standard steps for carrying out monitoring and evaluation:

- **Theory of Change:** desired changes to achieve impact; the Theory of Change of a CSC project should include both governance and health components
- **Log frame**: aim and objectives, outputs, outcomes and impact of the project
- **A sound baseline**: decentralisation (who is responsible for what, and at which level? Governance and health context analysis). It is very important to establish who is doing what, when conducting a baseline study. In the context of governance it is very important to do a sound stakeholders analysis/incentives, and an understanding of service delivery bottlenecks.

❖ **M&E plan**

The M&E plan consists of what to measure, when, and how to measure it (time and attribution to measure HDI indicators). **Evaluation** focuses on outcomes/impact, verifies the Theory of Change, understands attribution, and **looks at unexpected changes.**

❖ **Measuring success: Reflections from Tanzania and Ethiopia**

Success of CSC can come **at different levels**:

- Long-term outcomes (i.e. **impact**): changes in people's health due to improved health care services, changes in the services themselves, changes in skills and knowledge and behaviour of local people (agency), and behaviour of service providers/local governments. It is important to develop a clear **Theory of Change and result chain and attribution**
- What about **unexpected changes**? CSC take-up in other sectors (increased participation and influence).

❖ **Conclusion**

In order to understand the effectiveness of the CSC process, it is equally important to measure:

- **Citizens empowerment**: Citizens capacity (knowledge – governance and health), collective action to engage and demand accountability, CSO are representative, inclusive and accountable
- **Service providers and Public authorities accountability**: capacity (knowledge – governance and health), collective actions, accountability (responsiveness- relevant quality services, information provision, resource allocation, policy implementation)
- **Spaces for negotiations**: formal and informal (inclusive, representative, effective, accountable)

Access, utilisation and quality of services

Improvement in Human Development Indicators: Health

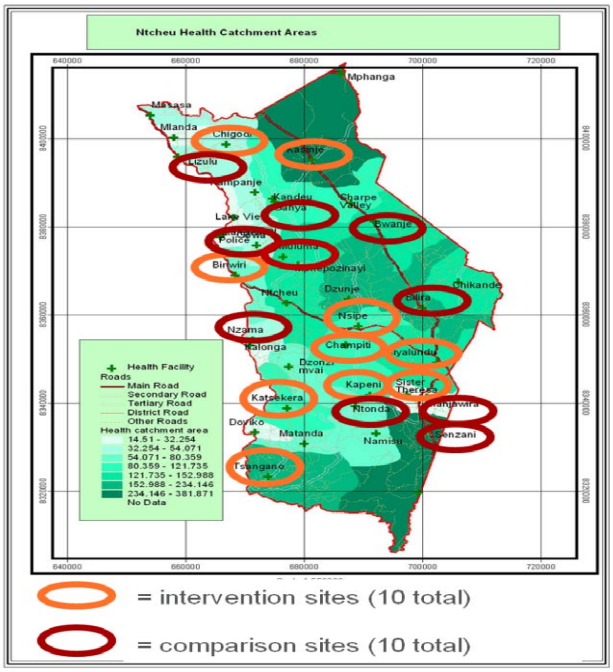
3.1.2 Example of Malawi: Using CIUK Governance M&E Guidance to Create Governance Measures

What is the evaluation plan? The evaluation plan for this project includes the study design; components of evaluation; women's surveys (Domains 1, 2, and 3): health care workers' surveys (Domains 1, 2, and 3).

❖ **The Study design**

The study is conducted in Ntcheu District, which has a population of 471,589 and expected 23,579 births annually. It intends to use cluster-randomised control evaluation.

- **Ten (10) intervention clusters** have been created, and 20 intervention GVHs selected using probability proportional to size (PPS). These will participate in the **intervention and baseline** (population = 58,164), twenty (20) spill over GVHs selected using (PPS) will participate **only in the baseline** (population = 69,450)
- **Ten (10) control clusters** have been created, within which 20 control GVHs selected using (PPS) will only participate in the baseline (population = 68,241).



We believe it is critically important to rigorously evaluate the impact of the Alliance and, in particular, the contribution of CARE's CSC approach. Only solid compelling evidence will garner the support of the global community and give us the opportunity to translate our experience with the CSC in Malawi into action to dramatically reduce maternal and neo-natal deaths in the other high burden countries.

We designed a cluster-randomised control evaluation to test this hypothesis. The intervention and evaluation is being carried out in Ntcheu District of Malawi. We chose the health centre and its catchment population as our cluster unit for randomisation because the allocation and loci of delivery of the intervention is at that cluster rather than at individual level. The 20 health

centre/catchment areas that were eligible for inclusion in the study were matched into 10 pairs (matching characteristics included: services provided, health centre administration, proximity to the Mozambique border, and catchment population size). After pairing, we randomly allocated one cluster in each pair to either intervention or comparison as outlined on the map above. Intervention and evaluation activities will be distributed across the treatment and comparison sites. Across the **10** ***intervention*** health facility/catchment population sites, 20 group villages (GVHs) in total were selected using probability proportional to size (PPS) methodology. Communities in these 20selected intervention GVHs, will participate in the CSC process with their respective health facilities. In the ***comparison*** health facility/catchment population area, 20 GVHs in total were selected using PPS for evaluation. Furthermore, in order to examine spill over effects of the CSC intervention on those communities within the intervention catchment area but not participating in the CSC, an additional 20 GVHs were selected for evaluation.

The baseline survey and follow-up in these 60 GVHs (treatment, comparison, and spill over) will include women aged 15-49 who have given birth within the last 12 months. All health care workers associated with both the treatment and comparison health care facilities will also participate in baseline and follow-up surveys. The evaluation will be done through two cross-sectional surveys and a medical chart review at baseline and at end line.
Our challenge is translating Governance domains and dimensions into measures to be used in surveys.

❖ **Evaluation components**

COMPONENT	TARGET	SAMPLE	OUTCOMES OF INTEREST
Women's Survey	Women aged 15-49 who have given birth within the last 12 months and whose child is still living	1,950	- Governance (empowered communities, accountable & effective service providers, spaces for negotiation) - Women's empowerment (gender attitudes, self-efficacy) - Maternal health (ANC, L&D, BF), PMTCT, and family planning coverage, quality, equity
Health Worker Survey	All health workers in catchment areas	~400	- Record review of women who have delivered in a facility in the last month - Governance - Maternal health, PMTCT, and family planning coverage, quality, equity
Labour and Delivery Medical Record Review		(~195)	- Skilled, quality care during labor and delivery

Women's Survey – Domain 1

Domain 1: Marginalised Citizens are Empowered	
Dimension 1.1: Citizens aware of rights/duties and exercise agency	Awareness of rights and duties among marginalised populations
	Self-Efficacy
	Women's Attitudes and Beliefs about Gender (Gender Relations)
	Participation in household decision-making
Dimension 1.2: Citizens participate in and organise collective actions	Social Capital
	Social Cohesion
	Community Support in Times of Crisis
	Collective Efficacy (modified measures & new measures)
	Participation in social groups
Dimensions 1.3 Citizens hold public authorities and other power holders to account Dimension 1.4 Civil society is representative of and fully accountable to marginalized citizens	Taking part in collective action/ Social Participation

Measurement development - Awareness of rights and duties among marginalised populations

Resource used to develop measures

Malawi Charter on Patients' and Health Service Providers' Rights and Responsibilities:

1. Right of access to appropriate health care
2. Right to choice and second opinion
3. Right to adequate information and health education
4. Right to informed consent or refusal of treatment
5. Right to participation or representation in decision making regarding his or her care
6. Right to respect and dignity
7. Right to a guardian
8. Right to privacy and confidentiality
9. Right to a safe environment
10. Right to complain about health services

Measures in WM's survey

A healthcare provider can refuse to provide me health care because of my age or marital status.

The government of Malawi ensures that maternal and child health services are provided free of charge.

The healthcare provider is required to keep my healthcare information private and confidential.
I have a right to complain if a health care worker yells at me or is disrespectful.

Healthcare providers are required to answer all my health related questions.
Every individual has the right to prompt emergency treatment from the nearest public or private health facility.

I cannot refuse a health service or treatment if a healthcare provider recommends it.

I do not have the right to complain about the quality of health services in this community.

Community health workers (HSAs) should visit pregnant women and new mothers/babies at home.

Response Scale: *Strongly Agree, Agree, Neither agree/disagree, strongly disagree.*

Social Cohesion

Resource used to develop measures	Measures in WM's survey
Social Cohesion I can rely on people in my community: - if I need to borrow money. - if I need to talk about my problems. - to help deal with a violent or difficult family member. - to help me if I have difficulty breastfeeding my baby. - to help me if I can't provide my child with enough healthy food. - to help take care of my children/ household if I need to go to the doctor or hospital. -to help take care of my children/ household if I need to go outside the home to work. Adapted from Lippman (2009) & Avahan (date?) to measure - perceptions of mutual aid, trust, connectedness and support.	**Social Cohesion** I can rely on people in my community if I need to borrow money. There is no one in my community that I can rely on if I need to talk about my problems. I can rely on people in my community to help deal with a violent or difficult family member. I can rely on people in my community to help me if I have difficulty breastfeeding my baby. I can rely on people in my community to help take care of my children/household if I need to go to the doctor or hospital. There is always conflict among the people in my community. *Response Scale: strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.*

Women's Survey - Domain 2:

Domain 2: Public authorities and other power holders are effective and accountable to marginalised citizens	
Dimension 2.1: Public authorities and power-holders have the capacity to uphold rights and deliver public goods:	N/A
Dimension 2.2: Public authorities and power-holders are responsive to impact groups, designing and implementing pro-poor and inclusive policies, programmes and budget. Dimension 2.4: Public authorities and power-holders are accountable to impact groups:	Perceptions of Health Service/Quality

Measurement development - Perceptions of Health Service/Quality

Resource used to develop measures

Quality (IOM definition)

1. Effective
2. Patient Cantered care
3. Efficient
4. Safe
5. Equitable- care
6. Timely

Family Planning measures were informed by Judith Bruce's

Fundamental Elements of Quality of Care: A Simple Framework

Technical Competence

1. Choice of contraceptive methods
2. Information given to patients
3. Interpersonal relationships
4. Continuity and follow-up
5. The appropriate constellation of services

Measures in WM's survey

Core measures:

The staff at [health facility] provides high quality health services.
The staff at [health facility] is friendly and treats me well.
The staff at [health facility] ensures privacy and confidentiality when providing services.
The staff at [health facility] gives me all the information I need to take care of my health.
I often have to wait too long of a time to receive care at the health facility.
Whenever I go to the health facility, there is a provider available to serve me.
The health facility is clean.
Whenever I go to the health facility, it rarely has the supplies and medicine I need.
Men are welcome to accompany their wives during pregnancy and delivery care.
A family member or friend is welcome to accompany a woman during delivery.
Unmarried women can access family planning and reproductive health service at the health facility.

After each health service section:

-Satisfaction with service & likelihood to recommend

Maternal health & Family planning sections: additional measures

Women's Survey – Domain 3

Domain 3: Spaces for negotiation between public authorities/other power holders and marginalised citizens are expanded, inclusive and effective	
Dimension 3.1: Institutionalised spaces are expanded, inclusive and effective: Institutionalised spaces are conducive to inclusive and effective negotiations for increased access with equity to rights and opportunities. Dimension 3.2: Informal spaces are claimed and created: A diverse and broad range of informal/ non-institutionalised spaces exists	Taking part in collective action/Social Participation Section

Measurement development -Taking part in collective action/ Social Participation Section

Resource used to develop measures

Adapted from SASCAT (Halpern/Da Silva)

In past 12 months….
1…..have you joined together with other people in your neighbourhood or community to address a problem or common issue?
2…has your neighbourhood carried out organized activities with people from another neighbourhood?
3…have you spoken out in public about a problem that affects someone else?
4…have you talked with local authorities or governmental organizations about problems in the community?
5…have you attended a rally or demonstration about a problem in your community?

Score: yes or no

Measures in WM's survey

Have you heard about the Community Scorecard process?
(IF YES TO Q11003) In the last 6 months, have you participated in a Community Scorecard meeting?
In the past 6 months, have you joined together with other people in your community to improve health services for women or children?
In the past 6 months, have there been meetings between the community, health providers, and government representatives?
Were any of these meetings part of the Community Scorecard Process?
Was your Village Health Committee part of any of these meetings?
Did any other formal groups or committees participate in these meetings?

Now, I would like to ask more about these meetings.
In the past 6 months, have there been meetings between the community, health providers, and district government authorities during which…
A.Information about health services was shared?
B.Problems or other issues with health services were discussed?
C.Community members voiced their concerns about health services?
D.Health issues of concern to the most vulnerable and marginalized groups were discussed?
E.Plans for improving health services were made?

(IF YES TO ANY IN Q11010) Did at least half of the community attend these meetings?
(IF YES TO ANY IN Q11010) Were at least half of those from the community who attended these meetings women and girls?

Cont. Measurement development -Taking part in collective action/ Social Participation Section

And more…

Measures in WM's survey cont.

As a result of working together in the past 6 months, have community members and health care providers achieved the following?
Mobilized resources, including in kind and financial, to improve health services?
Improved the quality of maternal and newborn health services?
Increased the availability of maternal and newborn health services provided in this community?
Improved the level of trust between community members and health workers?

In the past 6 months have meetings between health workers, district government authorities and the community…
(READ ALL RESPONSES AND PAUSE AFTER EACH RESPONSE)
Been well run?
Been inclusive of broad participation from the community?
Been focused on important issues?

Response: Yes/No/Don't Know

We also did the same process to develop governance measures for the health worker survey.

Health Care Worker Survey – Domain 1

Domain 1 Marginalised Citizens are Empowered	
Dimension 1.1: Citizens aware of rights/duties and exercise agency	N/A
Dimension 1.2: Citizens participate in and organize collective actions	N/A
Dimensions 1.3 Citizens hold public authorities and other power holders to account Dimension 1.4 Civil society is representative of and fully accountable to marginalized citizens	N/A

Health Care Worker Survey – Domain 2

Domain 2: Public authorities and other power holders are effective and accountable to marginalised citizens	
Dimension 2.1: Public authorities and power-holders have the capacity to uphold rights and deliver public goods:	Performance Monitoring & Supervision
	Perceived efficacy of Health Interventions
	Rights and Entitlements
	Self-efficacy
	Social Cohesion/Social Capital
	Work attachment
	Current work conditions/environment
Dimension 2.2: Public authorities and power-holders are responsive to impact groups, designing and implementing pro-poor and inclusive policies, programmes and budget Dimension 2.4: Public authorities and power-holders are accountable to impact groups:	Attitudes and Perceptions Towards Clients
	Collective Efficacy (Also applicable to 2.1)
	Participation in Social Groups
	Social Participation – Collective Action (Also applicable to Domain 3)
	Perceptions of Health Services

Health worker survey – Domain 3

Domain 3: Spaces for negotiation between public authorities/other power holders and marginalised citizens are expanded, inclusive and effective	
Dimension 3.1: Institutionalised spaces are expanded, inclusive and effective: Institutionalised spaces are conducive to inclusive and effective negotiations for increased access with equity to rights and opportunities Dimension 3.2: Informal spaces are claimed and created: A diverse and broad range of informal/ non-institutionalised spaces exists	Taking part in collective action/Social Participation Section

The facilitator explained that most the important thing is to break down the domain to suit one's project.

Q&A

Q1: How often does one have to apply this tool?
A1: Twice: at the beginning and at the end of the project
Q2: Is the Malawi CSC project a stand-alone tool or is it part of projects (i.e. is it implemented on its own or is part of a major maternal health project?
A2: It is part of the health system – it is embedded in the district structure.

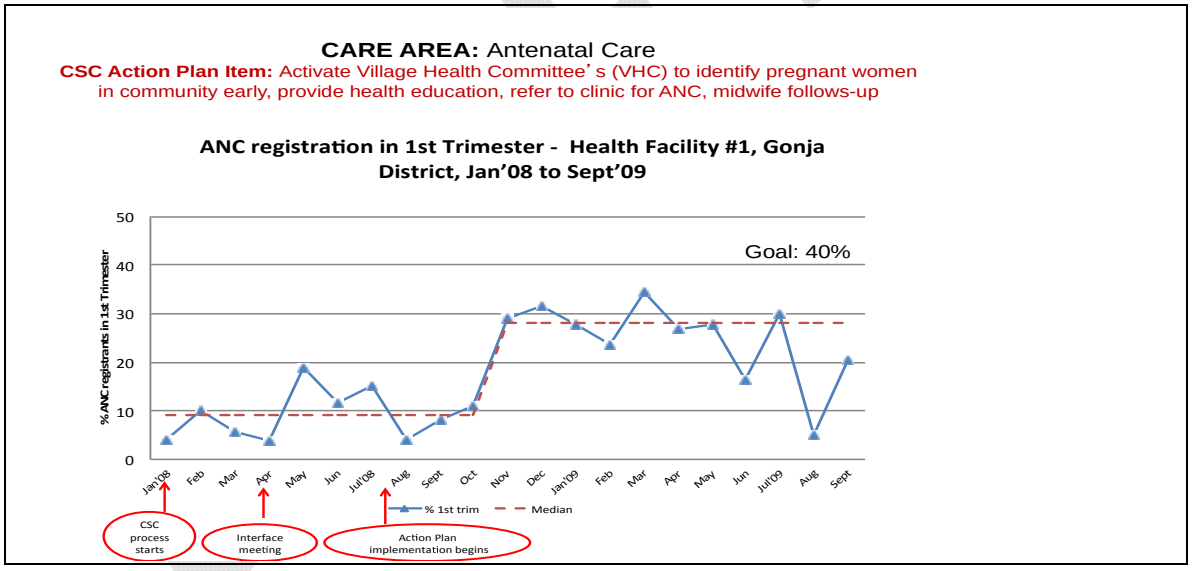
3.1.3 M&E Group Exercise

This exercise was done by participants in plenary and was facilitated by Sara Gullo and Maria Cavatore. The **purpose** of the exercise was to**:**

- Discuss and get participants' ideas on the importance of M&E and evidence generation
- Brainstorm on the types of evidence that may be useful for different groups and for different purposes.

Facilitators distributed two sheets of papers to participants:

- One sheet of paper contained a **scenario** of a health facility in Gonja District showing a graph of ANC registration in the first trimester. The registration period was from January 2008 to September 2009.



- The second sheet contained a number of **questions** directed at various types of actors: donor, project manager, community leader, service provider, and government official to which participants were asked to respond. Below are the questions and accompanying responses:

1 - Donor

You are interested in funding CARE because governance has been identified as a key approach to strengthen health systems, however you do not have any concrete information that the CSC process is effective. You are considering funding service provision instead because it seems more concrete.

→Would the evidence you have in front of you convince you fund CARE? What more is needed?

a) Health date over more time
b) What else is going on? Where other measures implemented at the same time as CARE's intervention
c) I would need more data to demonstrate effectiveness of CSC
d) Data on other health impacts, not just ANC registration
e) Doesn't say anything about the quality - more data is needed to demonstrate the effectiveness of the CSC

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2 - Government official

You recently were posted as a government official in a new district. You are designing your district implementation plan for the next 3 years. CARE has been financially supporting the facilitation of the CSC in your district to improve health implementation and outcomes for the past 2 years, but is closing out. CARE has met with you to discuss the possibility of the district government continuing the CSC process and allocating funding for these purposes. You are considering putting government staff time and resources to continuing implementing the process. However, first you need to ensure it is a good use of scarce resources.

→Would the evidence you have in front of you convince you to fund and continue the CSC? What more is needed?

a) Data on health impacts and impacts in other areas (economic)
b) Financial information – how much does it cost to implement? What are the cost savings (health care, time lost by workers, etc.)
c) Provide the government with all tools and resources needed to implement
d) Demonstrate how the CSC helps them to implement the policies they are responsible for

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3 – Project manager

Your programme has been doing a lot of CSC activities. You are starting to wonder if they are really make a difference or if you are wasting your efforts and should focus on your other activities.

→Does this information help you have a decision? What more is needed?

This question was not used in the group exercise.

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4 – Community leader

You have heard that neighbouring communities are working to improve community well-being and health services using the CSC. You have also heard that this is taking community members away from productive activities.

→Would this information convince you to adopt CSC? What more is needed?

a) Show benefits of more women going to the clinic – what are they for the community – economic, health?
b) Demonstrate that interface meeting is non-confrontational
c) Allow community leader to talk to another community to hear about benefits

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5 – Service provider

You have been asked to participate in the CSC process. You fear you will be blamed for issues that are beyond your control (consistent drug supply, number of providers, etc.). For you to participate in CSC the benefits coming from the CSC process must outweigh the risks?

→Would this information convince you to participate in CSC? What more is needed?

a) Need to hear from peers/testimonial of benefits
b) Know what your obligations would be in process
c) Case studies of other service centres
d) Who else are involved – other communities, health centres?
e) Understand the action plan, what are the benefits and implications for me?

Key Take-Away from the Group Discussion:
More data contributes to:

a) Reporting to donor
b) Fundraising
c) Internal learning
d) Scaling up
e) Sustainability

The facilitator concluded the session by saying that the exercise had emphasised the importance and need for conducting M&E. "Being able to collect and bring all implementation evidence to donors for funding/funding justification is the rationale for doing M&E"
A participant commented that doing M&E is part of learning for him as a project manager.

3.2 Discussion of Emerged Burning Issues

This session addressed **burning issues** that had come up during the two days of discussion. The participants were divided into 3 groups to discuss the questions and then share the results in plenary. Below are the three questions:

- **What are the minimum conditions (enabling factors)** that need to be in place for CSC to be effective? What are the factors that are preventing CSC for achieving results? (When and where should CSC be used or not be used?)
- What **motivates service providers to engage in CSC**? What is the incentive structure (what are the perceived benefits)?
- To what extent is **CSC "working" and having an "impact"**? What impact is CSC achieving?

3.2.1 Group 1: Minimum conditions/Enabling factors that need to be in place for CSC to be effective

❖ **Existing environment – generally what is required**

- Decentralized environment helps channel information from CSC process to national level
- Presence of civil society that participates at different levels (local, national)
- Policy and legal framework: laws on accountability are in place; vertical accountability system
- Decentralized system with clear roles and responsibilities regarding finances, power
- Political stability (maybe not?)

- **Civil society (CS) capacity**
  - National level enabling factor: civil society fora for coming together with government
  - District level: capacity to network at district and national levels; legitimacy of civil society; same level of empowerment
  - Local level: active civil society.

- **Service providers (SPs) capacity**
  - National level: at senior level SPs will work to improve performance and enhance accountability to service user (recipient)
  - District level: (i) Good decentralisation system with good coordination at various levels will ensure internal coherence (this is an enabling factor); (ii) Familiarity with accountability and CSC, and willingness to engage and benefit
  - Local level: Culture of responsiveness and openness to CSC.

- **Authorities**
  - National level: (i) Capacity building around accountability, social contract etc.; (ii) Openness to support and participate in outcomes CSC
  - District level: (i) Authorities collaborating with citizens and service providers
  - Local level: Support from traditional leaders.

- **Citizens**
  - National level: Citizens' trust in institutions and value in participation
  - District level: Citizens believe in the right to participation
  - Local level: Citizens accept that with citizenship come rights but also responsibilities.

- **CARE**
  - National level: Capacities, skills and technical support
  - Organisational buy-in (CARE level)
  - Management support (financial and human resources).

- **Donor**
  - Willingness to take some risk (risk assessment)
  - Flexibility in supporting unpredictable changes and risks
  - Understanding that CSC is a long-term process.

Note:

- A **cross-cutting** issue in all the columns is the presence of **champions of change** at every level
- **Key stakeholders** include authorities, citizens, CARE, and donor.

Q&A

Q1: Can we really implement CSC during elections in areas of instability, such as in DRC?

A1: One participant responded by saying that election is itself an aspect of accountability therefore it can and should be implemented. Another participant added that the fear is for government to take over the CSC agenda during elections. A third participant pointed out that services continue to run even in conflict conditions, although delivery won't be at optimum level, so the CSC process should also be implemented.

3.2.2 Group 2: What motivates service providers to engage in the CSC?

The group addressed three issues:

- Barriers that health care workers face in providing responsive quality services
- Barriers for health workers to participate in the scorecard process
- Possible benefits for health care workers to participate in the CSC process?

❖ **What barrier do health care workers face in providing responsive quality services**?

- Lack of recognition
- Low motivation because of low salary
- Inadequate training and big workload
- Bad infrastructure
- Knowledge and belief in service (for example, attitudes about family planning or abortion)
- Low pay/late pay
- Hostile communities (service users/recipients)
- No equipment and supplies
- Lack of emotional support from the community, supervisors, co-workers, and family
- Ineffective management
- Lack of support
- Lack of consequences – sanctions

❖ **What bars health care workers from participating in the score-card process?**

- Misconception that CSC benefits only the community
- Fear of perception
- Low expectations – lack of belief things will change (fatalistic not worth the effort)
- Fear of being exposed for bad practice and corruption
- Gender discrimination participating in public spaces
- Power dynamics inhibit participation
- Fear of social sanction from co-workers or supervisors
- I'm not responsible
- Fear of taking risk, change, uncertainty
- Current workload
- Afraid process will create more work
- Feeling of being outnumbered – intimidating process
- Gender-related – female health workers may not feel empowered to participate; gender roles take them away from home duties
- Lack of information about process
- Protect image, loss of status or reputation
- Fear of exposure to risk, conflict (ethnic conflicts).

❖ **What are the possible benefits for health care workers participating in the CSC process?**

- Improved relationships with communities and service users (both ways need a smiling provider and a smiling community member)
- Improved relationship with supervisor and health officials

- CARE's commitment to take additional actions to improve quality (assurances for more material and human resources, such as health care service providers, pay, etc.)
- Opportunity for health worker to clarify their expectations to community – 'come on time' where to access appropriate services
- Improved positive reputation of services
- Recognition for quality improvement
- Popular figure could come and endorse services, recognise health workers' efforts, and encourage communities to respect health care workers
- Health care worker can communicate their rights to the community – increase in community recognition of health worker rights
- Increased community fulfilling their obligations as well (i.e. health insurance)
- Health worker can share information – CSC will increase communities' knowledge about health and health care services so they may use services more appropriately
- Get feedback, especially positive ones
- Improved understanding between health worker and community about appropriate health-seeking behaviours
- Process can support getting additional resources and support – health care workers' voices need heard
- CSC can help improve performance (which may be useful if there are performance-based incentives as is the case in Rwanda). Align with current incentive systems
- Improved working conditions – medical supply, salaries paid on time, increasing number of health care workers
- Positive self regard (happy and fulfilled)
- Belief that they can change things for the better.

One participant commented that this exercise (i.e. addressing barriers) might be an indirect way of encouraging citizens to participate in the CSC process.

3.2.3 Group 3: What is working well or not?

❖ **Challenges**

- Change: why and how to achieve change – we capture change but not the journey to change
- Documenting the journey to change must be part of the design
- Capacity building should be conducted for all project staff
- Learning sessions to share experiences with facilitators and implementers
- There is need for tools/guidelines on governance: measuring, documentation and presentation.

3.4 How to Move CARE's CSC and Health Work Forward

Facilitators: Christine Galavotti and Gaia Gozzo

Purpose/Expected Outcomes:

This was the last session of the meeting, which dedicated to determining the future of CARE work around CSC. The session's objective was to discuss and reach consensus around what is needed to move CARE's CSC and health work forward (programmatic tools/resources, capacity building, research, knowledge sharing etc.).

Expected Deliverable:
An agreement/document on how CARE's CSC and health work should move forward.

The discussion was guided by three questions:

- **Learning and research gaps**: What do we want to **learn** more about? What work (lessons learned, initiatives etc.) do we want to **document**? What are the research gaps?
- What will help to increase the **visibility and credibility of our work around CSC**? External face visibility: disseminate evidences about impact of our work, sharing experiences and lessons learned, publications, website, joining advocacy-learning initiatives etc.
- What **kind of support do you need** to take the CSC work forward? From whom (CARE Members, other COs, peers, other organization etc.)? Would a community of practice be useful to support this work?

The discussion was conducted in plenary, and responses were pasted on flip charts:

3.3.1 Learning and Research Gaps

- We need to learn more from each other about different contexts, and how to adapt learnings for different contexts
- Monitoring of impact (document and share Malawi DOWA experience)
- Document case studies and impact evaluations
- Regional study – assess why, and under what conditions SRHM is more effective
- Added value/impact of SAA and CSC
- Systematic evaluation of initiatives and how to address them
- How to integrate CSC into other projects – adaption needed
- Economic analysis of CSC
- How the CSC can be used for advocacy
- CSC at scale: how to do the scaling, challenges to scaling up, and lessons learned in scaling up
- What contributes to sustainability?
- Collaboration of CI and COs around CSC: learning from experience, making the collaboration visible within CARE, and staying connected
- Internal CARE learning: sharing across sectors.

3.3.2 Visibility and Credibility of CARE Work around CSC

- Branding and copyrighting CSC case studies, methodology, guidelines and tools. Does not mean that COs won't also have their own adaptations
- Launch event to show case the new toolkit, work, and partner testimony in order to brand CARE's work (Malawi video; Ethiopia and Tanzania experiences)
- Better understanding and engagement with global space/platforms working on CSC

- Goal – Google CSC and find CARE website
- Publishing results in peer reviewed journals
- Create one video from the Malawi, Ethiopia and TZ videos .

3.3.3 Kind of Support Needed

- Community of practice comprising of email group of CSC experts, additional meetings and learning events (Africa and Asia). CARE will establish this under CIUK's Governance Community of Practice.
- Guidelines on CSC methodology and guidelines regarding evaluation with links to resources within CARE and in other organisations
- "Tips of the trade"
- WIKI - CARE UK
- Peer learning through exchange visits
- Donor education/advocacy
- Fact sheets on PowerPoint presentation
- Help COs document their experiences and evidence.

It was recommended (and unanimously agreed) that, in order to establish an electronic group-sharing mechanism for participants of this meeting, a community of learning can be created under the community of practice domain, through which participants can collaborate by interacting electronically, seeking support and sharing information, learning materials/resources etc. **Muhamed** from **CARE UK** will take up this task by first creating an email list of all participants and then proceeding with establishing the community of learning.

3.5 Closing

3.5.1 Energiser

Before closing the meeting, **Amr Lashin (from CARE CO Egypt**) presented a very interesting energiser: a short video depicting the background to the revolution in his country that brought down President Hosni Mubarak's regime. The video was titled "*The Power of Picture; The Power of Words*". He explained how the citizens had reacted to a simple picture of a 22-year-old young man who was arrested by the police and then killed for no reason at all. A picture of him in the newspaper was what sparked the citizen action that led to the fall of Hosni Mubarak.

3.5.2 Closing Remarks

Christine Galavotti said that the meeting had met its objectives, and had given participants the opportunity to build relationships and partnerships. She thanked all participants for very active participation and for all the contributions they made to improve the CSC process.

Gaia Guzzo thanked Christine (and CARE US) for initiating the meeting; she also expressed deep appreciation to Sara, Carolyn, Lara, Maria, Marnie, Gaby, and Muhamed for facilitating the meeting, and to all CARE COs staff who shared their respective countries' experiences on CSC.

APPENDIX 1: MEETING AGENDA

DAY 1: SATURDAY, 19 JANUARY 2013				
SESSION TOPIC	**EXPECTED OUTCOME**	**DELIVERABLE**	**SESSION LEAD(S)**	**TIME**
Welcome and Agenda Overview	• Convening objectives for the workshop are clarified • Participants' expectations are outlined • Participants understand agenda • Understanding roles– Day Lead, Session Leads, Time keepers, Logistics Lead, Note takers, Energizer leaders (2), Reflection/feedback (2)	N/A	Christine Galavotti & Gaia Gozzo	**9:00 – 9:30** (30 min)
Participants' Introductions	• Participants are familiar with each other • An environment conducive to participation and openness is created	N/A	CIUK & SRMH	**10:00 – 12:00** (1 hour 45 min session with 15 minutes of tea break)
What type of health service issues can the CSC tackle and how?	• Provide the participants with a common understanding of the types of health issues countries are facing • Develop a common understanding for what can be addressed by the CSC and how • Identify issues that the CSC is uniquely positioned to address • Outline types of issues CARE normally addresses through	A brief outlining the following: - The key health service implementation issues -Mapping of what issues can be 'directly' addressed by the CSC process and those that can only be addressed at a higher level or not at all - Issues that the CSC is uniquely positioned to address -Mapping of what issues CARE tends to address using the CSC process and what issues CARE would like to try to address using CSC	Christine Galavotti and Maria Cavatore	

	CSC process • Set the stage for following sessions (info provided in this session will be useful for advocacy session)			
LUNCH				**12:00 – 1:00**
How to overcome challenges and prevent negative fall-out from the CSC process? • How to implement the CSC process in **challenging political climates** or during election season? • How to address and overcome **address and overcome participants' fears** in engaging the process?	• Minimum conditions for a successful CSC in a politically controlled, sensitive and volatile contexts outlined • -Principles/values to help reduce negative effects of CSC in relation to building citizen voice and meaningful participation in service delivery in politically controlled, sensitive and volatile contexts identified	• Characteristics of a controlled, sensitive and volatile contexts in relation to service delivery outlined • Minimum conditions for applying a CSC in a politically sensitive or controlled context as a result of target COs experience • Map of CSC challenges and limitations in relation to identified characteristics of controlled, sensitive and volatile political contexts. Including fears of local and national authorities, service providers, and community in participating in the CSC process. Including issue of fear to speak out, untying free speech of citizens • A document outlining strategies to overcome fears and to mobilise local and national authorities, service providers, and community buy-in as well as involvement in supported CSC processes.	Muhamed Bizimana and Sara Gullo	**1:00 – 3:00** (2 hours)
Power Hour A - How to tackle important CSC implementation issues? -How to choose the **right indicators**? - What should **CARE's role** be in the CSC process?	• Participants will have the opportunity to identify and discuss common implementation issues that they face with CSC processes • Participants will have the opportunity to be exposed and discuss COs' different	A short document capturing the experience of different COs in tackling implementation issues, including a summary of the main lessons learned and guidance/recommendations on best practices/strategies to tackle them.	Gaia Gozzo and Muhamed Bizimana	**3:00 – 5:00** (2 hours with tea break)

-How to ensure that **marginalised groups** are represented and their issues are addressed through the CSC process? (especially **youth**)	experience and successful strategies in tackling these issues			
Reflective session	• Feedback on day 1 from 2 participants (they will also do recap on day 2) • Day 1 reflection • Planning for day 2	N/A	CIUK, SRMH team, Feedback from 2 participants	**5:00 – 6:00** (1 hour)
DAY 2: SUNDAY, 20 JANUARY 2013				
SESSION TOPIC	**EXPECTED OUTCOME**	**DELIVERABLE**	**SESSION LEAD(S)**	**TIME**
Recap of Day 1 & Day 2 Agenda Overview	-Participants reflect on previous day -Understanding of day's agenda and participant expectations -Understanding and decisions on roles– Day Lead , Session Leads, Time keepers, Logistics Lead, Note takers, Energizer leaders (2), Reflection/feedback (2)	N/A	Recap done by participants	**8:00 – 8:30**
Linking CSC and advocacy: what are the opportunities and challenges?	Provide participants with a common understanding of the context for advocacy and governance work at CARE -Building on first session on Day 1, reiterating barriers related to policies, programmes or budget allocations at national level, and considering how CSCs can be used to address them -Identify organisational and environmental challenges for	-Lessons-learned document (that could serve as the basis of short case studies) summarizing experience from COs that have used CSC evidence to influence policy action. This would include a section on challenges and potential strategies for overcoming them. -A list of questions and/or tools COs can use at various points of implementing CSCs to facilitate use of evidence to inform advocacy. -Learning from the session will also be informing on-going revisions to the Advocacy Manual and will be shared during a meeting in early February.	Gaia Gozzo & Jodi K	**8:30 – 10:30**

	linking CSC processes to national-level advocacy work. -Explore how COs are using CSC to influence policy-makers and share CO best practices -Identify what COs would like to do more of, what is needed to do more and what tools are available to facilitate this			
Can the CSC be taken to scale and how?	-Participants' understand the Diffusion of Innovation DOI model -Participant's identify barriers of taking CSC to scale -Participant's identify barriers of taking CSC to scale using the DOI model	-Document outlining strategies and approaches to support scaling of CSC	Chris G. & Maria C.	**10:30 – 12:30**
LUNCH				**12:30 – 1:30**
Power Hour B - How to tackle important CSC implementation issues? -How to ensure CSC is **gender sensitive** and women are included? -How to **avoid CSC participants' unrealistic expectations/demands** and foster a sustainable system for the supply side issues to be addressed? When/is it appropriate **to have outside actors (NGOs, etc.) address**	Tackle implementation issues and provide clear guidance for program managers on the 3 topics.	-Recommendations about additional modifications to make the CSC more gender-sensitive -Mapping of unrealistic expectations/demands and guidance on how to overcome these obstacles and foster a sustainable supply side system -Guidance on who can facilitate the CSC process, how to train facilitators, and facilitation tips for each phase of the CSC process (Preparation & Planning, Community Scorecard, Service Provider Scorecard, Interface, Action Planning, Action Plan Implementation and Follow-up)	Gaby Jabbour Marnie D Chris Galavotti Sara Gullo Jodi K.	**1:30 – 3:30**

supply side issues generated through the process? How to **consider and take on board providers** especially those outside the gov't (or even health sector)? -Strategies to ensure **good facilitation?**				
How to ensure CSC sustainability	-Familiarity with concrete sustainability example from Malawi - Defining what is CARE's CSC sustainability aim -Identification of factors and strategies that lead to CSC sustainability -Identification of factors that inhibit sustainability and ways to overcome them	Brief outlining the following: -CSC sustainability aim • Compilation of factors to support CSC sustainability (both those that have been used in CARE's projects& new ideas) • Compilation of factors that inhibit CSC sustainability and how they can be overcome	Lara A. Sara Gullo	3:30 – 5:00 (with tea break)
Reflective session	-Feedback on day 2 from 2 participants (they will do recap on day 2) -Day 2 reflection -Planning for day 3/planning for ''How to move CARE's CSC and health work forward?' session	N/A	CIUK, SRMH team, Feedback from 2 participants	**5:00 – 6:00**
DAY 3: MONDAY, 21 JANUARY 2013				
SESSION TOPIC	**EXPECTED OUTCOME**	**DELIVERABLE**	**SESSION LEAD(S)**	**TIME**
Recap of Day 2 & Day 3	-Participants reflect on previous	N/A	Recap done by	**8:00 – 8:30**

Agenda Overview	day -Understanding of day's agenda and participant expectations -Understanding and decisions on roles– day lead, session leads, time keepers, Logistics Lead, note takers, energiser leaders (2), Reflection/feedback (2)		participants	
How to best measure and evaluate CSC and health projects?	- Participants will have an understanding of CI UK's governance guidelines - Understanding on what the indicators relevant to different project's stakeholders are. - Understanding of how to combine 1) measuring process (governance), 2) service improvements & health outcomes and 3) the links (attribution) between both	Health and governance M&E cheat sheet – key recommendations and links to resources and, Possibly, products that the participants recommend would be useful	Chris G., Maria C., Sara G.	
What are the burning questions that are still unanswered?	To be done by participants	To be done by participants	CI UK	**10:30 – 12:30**
LUNCH				**12:30 – 1:30**
How to move CARE's CSC and health work forward?	-Discussion and consensus around what is needed to move CARE's CSC and health work forward (programmatic tools/resources, capacity building, research, knowledge sharing etc.?): 1) What will help us improve CSC and health program	-Way forward document for CARE's CSC and health work	Gaia Gozzo and Chris Galavotti	**1:30 – 3:30**

	quality and effectiveness? 2) What will help us increase visibility and credibility? 3) What will allow us to more efficiently collaborate with internal and external partners? 4) What should we be documenting around our CSC experience?			

APPENDIX 2: M&E GUIDELINES DOCUMENT

Domain of change/dimensions of change	Desired change	Example of indicator-generic	Progress assessment: where to assess change + method/approach	Contextualised indicators
Domain 1: Empowered citizens				
Citizens are aware of their duties/rights and exercise agency	Citizens are informed about their rights and duties and gain a sense of agency (responsibility and hold government to account)	Marginalised citizens understand their rights and responsibilities	Date for assessment – Methods: perception survey, FGD, random interview, KAP survey	
Citizens participate in and organise collection actions	Marginalised citizens have individual and collective capacity to articulate their needs, aspirations and demands	- Marginalised citizens have the capacities to put forward their demands - Ability to negotiate - Number of citizens group formed, organised and active - Number of collective actions organised (campaigns, march, interface meetings)	Document reviews (meeting reports, newspaper articles) Perception surveys	
Domain 2: Public authorities and power-holders are effective and accountable to marginalised citizens				
Public authorities and power-holders have the capacity to	Depersonalised and effective implementation of progressive and transparent legislation,	- Organisation capacity to delivery services - Existence of	Monitoring observable events, media monitoring, impact assessment at local level of specific public policies, official statistics, budget analysis	

uphold rights and deliver public goods	policy and budget processes	legislation to protect the rights and provide accessible quality services for marginalised pop - Resources allocation for service provision		
- Public authorities and power holders are responsive to impact groups - PA/SP are transparent, providing accessible and relevant information	Marginalised citizens access and use improved services PA/SP provide information that is accessible	- PA are delivering public services - Quality of services delivered - Availability of service provision information (entitlement, opening hours)	Key Informant perceptions, use of CSC to record changes in satisfaction with quality services Key Informant perceptions/knowledge survey, review of information provided	