Governance and Accountability Programme: Tanzania

ONTEXT: Tanzania suffers significant challenges in providing equitable access to quality health services. While t
nzanian Health Sector Reform process has been ongoing since the early 1990s, particular societal groups continue
ffer as a result of poor healthcare access; these groups include poor women, children and youth; people living in rur
eas; people living in impoverished rural areas; and people with disabilities. Reforms have failed to either uniform
prove accountability in terms of health service provision, or to promote citizen and civil society participation in t
alth sector. The Governance and Accountability Programme is one of a number of CARE programme that worked
omote citizen engagement with the provision of health services, focusing on the Mwanza Region in the northwest
nzania.

OBJECTIVE: to strengthen the capacities of CSOs in Mwanza, Tanzania, in order for them to participate in and influence
overnment policy processes more effectively; to improve service provision for poor and marginalised community group
and for women and girls in particular

PPROACH: GAP took a **rights-based** approach to improving
rvice delivery for the poor and marginalised in Mwanza, in
at it employed the use of social accountability mechanisms in
der to a) improving community members' awareness of their
ghts and responsibilities in relation to service providers, and
building confidence for community members to approach
rvice providers on non-delivery of entitlements, and c)
eating mechanisms to allow for service improvement
rough dialogue with providers.

AP focused particularly on **strengthening women's voice**,
orking in **partnership** with local CSOs to empower women
d girls to assess service provision and to work with service
oviders to ensure their entitlements are met.

TERVENTION:

he CSC process was implemented in 8 communities in Mwanza, following the following seven steps:

Building the capacity of CSC implementing partners: A series of training sessions were held for project staff a
partners, which detailed the CSC conceptual framework and methodology and more general coverage of policy analysis.

Community and District level ground work: A workshop was held at the district level to introduce GAP and the CS
process to service providers and government officials. Potential stakeholders who participated included representatives fro
community health centres, schools and microfinance institutions. Similar meetings were held at the community level, where
participants were asked to select five volunteers from each ward to be trained on CSCs and to act as facilitators.

Community-level capacity building: project staff provided training to community-based trainers who would lat
facilitate the CSC process.

Developing the Input Tracking Score Card: To ensure community participation in the input tracking process, bo
implementing partners and community volunteers collected data from service providers; this data was then reviewed a
analysed by community members in meetings and focus groups, and served the basis for developing scores and input tracki
indicators.

Developing the Performance and Self-Evaluation Score Cards: Service providers underwent a similar process of se
evaluation, ranking the perceived quality of services provided based on existing policy and budget allocation, a
brainstorming how service provision might be improved.

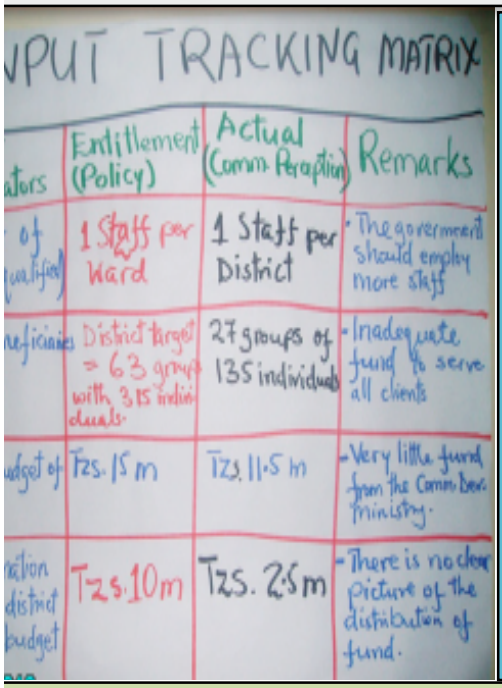
Interface meeting: Service users and providers were brought together to discuss their respective results and to wo
together to develop future action plans. Key decision-makers from local government participated in these meetings;
participants were primed in advance to ensure discussions remained constructive.

Follow-up, implementation and institutionalisation: Action plans were implemented and monitored by CARE, partne
community committees and community members. GAP continued to advocate for the wider adoption of the CSC process

Motivation of service providers: GAP often found that service providers gained confidence and a sense of pride on scoring highly on particular indicators, and were thus motivated to improve services in order to achieve future high scores. In the wards where GAP was implemented, leaders continued to interact regularly with community members through increased public notices and consultations

Decentralisation and health reforms: Health Sector Reforms have provided an important framework for promoting equitable and effective health service provision. While reforms have fallen short of expectations, the process of decentralisation through devolution, and the formation of such governance structures as local health facility management boards, provided foundations for local health management on which GAP could build.

- **Resistance from service providers**: in the project early stages, service providers appeared unwilling engage in the CSC process. This was ascribed to a lack appropriate orientation, which was subsequent addressed through more comprehensive and explanato CSC meetings.
- **Lack of community understanding:** The relati novelty of social accountability mechanisms such as t CSC at community level resulted in some cases in a lack community understanding and subsequently delaye implementation. This can be combated in three way ensuring quality facilitation through appropriate ar ongoing training; ensuring policies are careful explained using the local language; and providing we planned, comprehensive orientation on the CSC proce for both service providers and users to create a secu and comfortable environment for participation.



SUCCESSES:

- **Knowledge of health/policy structures:** Engaging with CSCs and buildi an awareness of health policy structures reinforced positive health-seeki behaviour, as participants were reminded of the importance of servic such as facility-based births and immunizations, to which they are entitled
- **Community empowerment:** Participants noted that CSCs improved the confidence to approach and engage in discussion with service provide Women in particular gained confidence in front of male participants.
- **Improved service delivery:** Service providers showed increase commitment to fulfilling their responsibilities based on a greater awarene of user needs. Accountability improved, with providers no long demanding unnecessary payments for treatment. Services are reported more responsive and less discriminatory towards marginalised groups.
- **Stronger user-provider relationship:** CSCs created a space for patien provider discussions on health issues. Providers' rapport with patien improved, who now feel more comfortable in the presence of medical sta and are more aware of providers' constraints. Groups that previous experienced discrimination now appear to receive treatment without bias.

EY LESSONS

Inclusive process = better results: While CSC implementation was generally deemed as very inclusive, in some cas key stakeholders – such as District officials, teachers, religious leaders and the handicapped – were missing from t process. Both service users and providers noted this as a weakness in terms of the accuracy of action plans. Preparato stakeholder analysis and formalised feedback mechanisms would guard against such omissions in the future.

Timing matters: CSC outcomes have the potential to inform planning and budgeting with LGAs. Implementati should therefore be timed to align with district level planning.

Evidence of results builds support: positive impressions of the CSC were grounded in subsequent improvements service delivery. Facilitators should thus ensure that action plans are realistic and feasible. In the case of new projec starting with 'quick wins' – easily tackled problems – would serve to win initial support.

Need to understand improvements: while the CSC assesses service delivery and improvements based on us perceptions, it is important for project staff to understand what the process improves in practice. This could achieved through conducting a thorough baseline survey before initiating scoring and introducing M&E mechanisms measure, assess and validate both tangible and intangible (e.g. behavioural change) outcomes.

Strong facilitation is crucial to meaningful participation: The CSC process can entail discussion around high sensitive and often taboo topics, particularly if used to improve service delivery around an issue such as HIV/AIDS. T scoring process and interface meeting can also descend into finger pointing and blaming, which is both unproducti and a disincentive for service provider participation. In-depth and ongoing training for facilitators should therefore provided, and should emphasise the importance of impartiality and confidentiality; the use of visual tools such flipcharts during meetings; and of the ability to 'translate' policy in a way that is understood by participants.