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BLOOMBERG SCHOOL
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Community scorecard:
Assessment, planning and action by
communities in Tanzania

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Community Scorecard and other themes of this CORE meeting

- ◆ Integration of CHWs into health systems
- ◆ Strengthening CHW links with their communities
- ◆ Social accountability
- ◆ Monitoring and Evaluation
 - BUT: M&E for group interventions remains a major challenge

Two parts to this talk

1. Considerations on M&E for group interventions
2. Experience with Community Scorecard in MCSP/ Tanzania

Part 1:
**Considerations in M&E for
group interventions**

Power

- ◆ English word ***Power*** is from Old French ***Pouvoir*** “to be able”
- ◆ The powerful are able to do what they want to do, they can enact their agenda
- ◆ The powerless cannot do what they want to do
- ◆ My typology of groups classifies them by the power of their members

Three types of groups

Type	Examples	Facilitator tasks	Outcomes of facilitation
#1: All members have high power	<ul style="list-style-type: none"> ➤ Corporate board ➤ CORE Working Groups (!) 	<ul style="list-style-type: none"> ➤ Team building ➤ Build common vision 	<ul style="list-style-type: none"> ➤ Shared vision and goals ➤ Leadership, roles
#2: Mixed – some have power, others do not	<ul style="list-style-type: none"> ➤ Community Scorecard Interface meeting ➤ Community-wide committees ➤ Health facility oversight boards 	<ul style="list-style-type: none"> ➤ Create optimal conditions for inter-personal contact 	<ul style="list-style-type: none"> ➤ Trust, respect ➤ Sharing of power and responsibility
#3: All members initially have low power	<ul style="list-style-type: none"> ➤ Care Groups & other mothers' groups ➤ Paolo Freire's literacy groups 	<ul style="list-style-type: none"> ➤ Empowerment of group members 	<ul style="list-style-type: none"> ➤ Empowerment ➤ Social capital → Ask Will Story!

Gordon Allport



https://en.wikipedia.org/wiki/Gordon_Allport

Allport's Contact Hypothesis

- ◆ Describes a way to promote harmony among groups experiencing conflict
- ◆ Attributed to psychologist Gordon Allport
- ◆ Interpersonal contact is the way to reduce conflict and prejudice between
 - majority and minority groups
 - higher and lower power groups
- ◆ It is not enough to bring groups together in a random way. The groups must be brought together under optimal conditions

Allport's optimal conditions

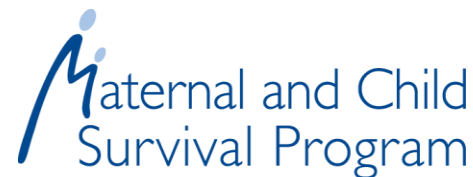
- ◆ Equal status
- ◆ Common Goals
- ◆ Intergroup Cooperation
- ◆ Support of Authority
- ◆ Neutral environment

Implication for M&E

- ◆ To measure quality of facilitation for a “mixed power” type of group, examine whether the facilitator was able to establish Allport’s **Optimal Conditions**



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Part 2

Experience with Community Scorecard in MCSP/ Tanzania

MCSP/Tanzania

- ◆ Ended Dec 2016, new project recently started
- ◆ Mara and Kagera Regions in northwest Tanzania, east and west of Lake Victoria
- ◆ Package of interventions includes:
 - CHW training and support
 - Strengthening quality of facility care
 - Respectful maternity care
 - Engaging communities to increase use of services and practice key behaviors

Community Scorecard in MCSP/Tanzania

- ◆ Initial agenda for discussion is maternal and neonatal health, and family planning
- ◆ Focus on barriers to utilization of services
- ◆ Incorporated late in the MCSP project
- ◆ Wanted to address limitations of:
 - CHW training and support
 - Facility-based interventions

Community scorecard: Goals

- ◆ Increase use of services by community
- ◆ Increase quality of care in first-level facilities with community input
- ◆ Make formal structures more flexible and responsive e.g. village health committees
- ◆ Better integration of CHWs after training
 - First-level facilities
 - Village leaders and committee

Community scorecards: Evaluation objectives

- ◆ MCSP project wanted to know:
 - Were scorecards being implemented as planned? What are barriers to implementation?
 - In the follow-on project, should more or less effort be invested in community scorecards?
 - How do community scorecards fit with other project activities?

**Community scorecards:
Process of implementation
in Tanzania**

Process of implementation: Community Scorecards

Step #1:

Preparation for Community Meeting

- ❖ Brief Regional and District officials
- ❖ Select villages
- ❖ Visit villages, select participants, orient participants on goals of scorecard process
- ❖ Train facilitators from Civil Society Organization (CSO) and District Council Health Management Team (CHMT)

Process of implementation: Community Scorecards

- ◆ Step #2 is a “big day”
- ◆ Shares some characteristics with other “big day” approaches to community-based interventions:
 - Community Led Total Sanitation

Process of implementation: Community Scorecards

<i>Step #1:</i> Preparation for Community Meeting	<i>Step #2:</i> Community Meeting to analyze problems & create Action Plan
<ul style="list-style-type: none">❖ Brief Regional and District officials❖ Select villages❖ Visit villages, select participants, orient participants on goals of scorecard process❖ Train facilitators from CSO and CHMT	<ul style="list-style-type: none">❖ Step 2A: Introduction of participants, description of process❖ Step 2B: Divide into 4-5 groups to analyze and prioritize problems❖ Step 2C: Interface Meeting - Each group presents their analysis, then they discuss and create joint Action Plan

Groups for the Community Meeting, Step 2B

1. Health care providers;
2. Village leaders;
3. Older women and TBAs;
4. Older men;
5. Men and women of reproductive age, parents of young children

Groups for the Community Meeting, Step 2B

- ◆ Groups meet separately in Step 2B
- ◆ Each group has a separate but related set of problems (indicators) to prioritize
- ◆ After prioritizing separately, they come together to elaborate a common set of problems to include in the Action Plan

Process of implementation: Community Scorecards

Step #3:

Follow-up on implementation of Action Plans

- ❖ Meeting at 3 months of all participants from original Community Meeting to assess state of implementation
- ❖ Follow-up by CHMT and CSOs during routine visits of implementation in health facilities and at community level

Process of implementation: Community Scorecards

<p><i>Step #1:</i> Preparation for Community Meeting</p>	<p><i>Step #2:</i> Community Meeting to analyze problems & create Action Plan</p>	<p><i>Step #3:</i> Follow-up on implementation of Action Plans</p>
<ul style="list-style-type: none"> ❖ Brief Regional and District officials ❖ Select villages ❖ Visit villages, select participants, orient participants on goals of scorecard process ❖ Train facilitators from CSO, District Council Health Management Team (CHMT) 	<ul style="list-style-type: none"> ❖ Step 2A: Introduction of participants, description of process ❖ Step 2B: Divide into 4-5 groups* to analyze and prioritize problems ❖ Step 2C: Interface Meeting - Each group presents their analysis, then they discuss and create joint Action Plan 	<ul style="list-style-type: none"> ❖ Meeting at 3 months of all participants from original Community Meeting to assess state of implementation ❖ Follow-up by CHMT and CSOs during routine visits of implementation in health facilities and at community level

Documentation exercise on community scorecards

- ◆ Mara and Kagera Regions in northwest Tanzania
- ◆ Interviews with:
 - Program staff
 - MOH counterparts
 - Health facility staff
 - Village leaders
 - Men and women of reproductive age

Community scorecards: Findings

Some findings from Tanzania

1. Quality of implementation makes a big difference: It has to be done right.
2. Quality of implementation depends on quality of facilitation → Defined a framework for quality of facilitation incorporating Allport's Optimal Conditions
3. Addresses some problems better than others
4. Sustainability depends on district support more than community engagement
5. Similarities to other participatory methodologies

Finding #1: Improving quality of implementation

<i>Step #1:</i> Preparation for Community Meeting	<i>Step #2:</i> Community Meeting to analyze problems & create Action Plan	<i>Step #3:</i> Follow-up on implementation of Action Plans
<ul style="list-style-type: none"> ❖ Train more facilitators, at least two per group ❖ Clear pre-meeting orientation of participants ❖ Address expectations participants may have 	<ul style="list-style-type: none"> ❖ Clear introduction of CSC and its aims ❖ Aim for total duration no more than 3 hours ❖ Maintain focus and stick to time ❖ Ensure that expert on Community Health Funds is present 	<ul style="list-style-type: none"> ❖ Allocate more resources for follow-up ❖ Create & distribute report on Community Meeting quickly ❖ Create 1-page checklist of Action Plan for wider distribution
<p>Cross-cutting actions to improve implementation:</p> <ul style="list-style-type: none"> ❖ Greater engagement of district officials (DC, DMO etc.) at all 3 steps of process 		

Finding #2: Facilitation

- ◆ Made a framework with three dimensions:
 1. Logistical
 2. Relational
 3. Technical
- ◆ Brought in theory to explain the **Relational** dimension:
 - Allport's Contact Hypothesis

Creating Allport's optimal conditions in Interface Meeting

- ◆ **Equal status:** No uniforms, first names
- ◆ **Common Goals:** Increased use of health facilities, adoption of preventive behaviors
- ◆ **Intergroup Cooperation:** Creation of Action Plan
- ◆ **Support of Authority:** District authorities present, informed and engaged
- ◆ **Neutral environment:** Not health facility or village government offices

Finding #3: Addresses some problems better than others

Can be addressed directly	Challenging to address
<ul style="list-style-type: none"> ❖ Promote facility deliveries and earlier ANC-1 attendance ❖ Establish emergency transport system ❖ Promote role of men to accompany women to facility ❖ Change attitudes of health care providers ❖ Improve relationship between community & health facilities 	<ul style="list-style-type: none"> ❖ Staffing in health facilities ❖ Improvements to health facility: staff housing, water, electricity
<ul style="list-style-type: none"> ❖ Collect funds from community: <ul style="list-style-type: none"> ○ Emergency transport system ○ Guard for health facility ○ Community Health Fund 	<ul style="list-style-type: none"> ❖ Management of funds ❖ Procure essential drugs with funds collected from community ❖ Provide feedback on how funds were used

Steps taken to increase ANC, PNC & facility delivery

Level	Steps
Community & household	<ul style="list-style-type: none"> ❖ Men accompany women to health facility ❖ Households contribute to emergency transport fund
Village leadership	<ul style="list-style-type: none"> ❖ Bylaws mandating facility delivery ❖ Improve health facility structures ❖ Follow-up on plan for 100% facility delivery ❖ Pay for security guard at health facility ❖ Demand posting of additional health workers
Health facility	<ul style="list-style-type: none"> ❖ Improve communication, less harsh words ❖ Respond to community concerns ❖ Submit requests to replenish drugs ❖ Report on trends in facility delivery
District	<ul style="list-style-type: none"> ❖ Ensure staffing, drugs, electricity, supplies at facilities ❖ Follow-up on actions taken by health facilities and village leadership to implement plans ❖ Facilitate linkages with authorities

Finding #4: Sustainability depends on district support more than community engagement

Factor	Steps to promote sustainability
Political commitment	❖ Obtain commitment of Regional and District officials to implementation and follow-up
Cost	<ul style="list-style-type: none"> ❖ Relatively low-cost compared to other community activities: Community Meeting is one day only, no allowances provided ❖ Costs needs to be in district or CSO budget
Facilitation of Community Meeting	<ul style="list-style-type: none"> ❖ Need well-trained and confident facilitators ❖ Ideally need two facilitators per group ❖ Facilitators need transport to the site
Follow-up	❖ Need plan for durable system of effective follow-up of Action Plans by RHMT, CHMT and CSOs
Coordination	❖ Work with District Council to coordinate with other community-level activities

**Community scorecards:
Similarities with other
methodologies**

Similarities to other participatory methodologies

- ◆ Community Led Total Sanitation
- ◆ Opportunities & Obstacles for Development
- ◆ Community Conversations
- ◆ Site Walkthrough

Comparison of 3 participatory assessment & planning methods

	Community Scorecard	Community-Led Total Sanitation	Opportunities and Obstacles for Development
Acronym	CSC	CLTS	O&OD
Development of Action Plan	3-5 hour Community Meeting	1 day Community Meeting: 1/2 day assessment, 1/2 day planning	7 day process: Day 1 choose committees, Days 2-6 committees work, Day 7: plans presented
Focus	Health / RMNCH	Sanitation / open defecation	All sectors: Health, education, water etc.
Number of participants	45-60	Entire village	Entire village
Who implements Action Plan?	<ul style="list-style-type: none"> ❖ CHMT, district ❖ Health providers ❖ Village leaders ❖ Community members 	<ul style="list-style-type: none"> ❖ Community members 	<ul style="list-style-type: none"> ❖ Integrated into district development plan and implemented by district

Comparison of 3 participatory assessment & planning methods

	Community Scorecard	Community Conversations	Site Walk-Through
Organization	MCSP/MoHSW	UNDP	EngenderHealth
Development of Action Plan	3-5 hour Community Meeting –1 session	6 2-hour meetings over 6 weeks	4 hour Community Meeting – 1 session
Focus	Health / RMNCH	HIV	Reproductive Health/ Family Planning
Number of participants	30-45	Entire village	40: Women, men, influential people, religious & village leaders, youth
Who implements Action Plan?	<ul style="list-style-type: none"> ❖ CHMT, district ❖ Health providers ❖ Village leaders ❖ Community members 	<ul style="list-style-type: none"> ❖ District AIDS Control Coordinator ❖ Council HIV/AIDS coordinator ❖ Village leaders 	<ul style="list-style-type: none"> ❖ RCHCO ❖ District Reproductive and Child Health Coordinator ❖ Health providers ❖ Village leaders ❖ Community members

Strengths and weaknesses of Community scorecards

Strengths	Weaknesses
<ul style="list-style-type: none">❖ Relatively inexpensive to implement❖ High level of participation❖ Accountability for service providers, leaders and community members❖ Involves key stakeholders e.g. VEO, and some problems can be solved immediately❖ Feedback given on the spot for problems like service provider attitudes	<ul style="list-style-type: none">❖ Time-consuming if not managed well❖ Discussion between groups can become confrontational if not well facilitated❖ Can raise unrealistic expectations re funds, incentives and feasibility of addressing problems❖ Limited community capacity to address certain problems, and to communicate plans clearly