3. BEST PRACTICES DOCUMENTATION FINDINGS

3.1. Supporting social audits and community interface towards re-establishment of Health Facility Governance Committees in Kilosa and Mbozi districts of Tanzania

3.1.1 Project Start-Up

The re-establishment of health committees was done through a partnership between ActionAid Tanzania (AATZ), Tanzania Council for Social Development (TACOSODE), *Mtandao wa Vikundi vya Wakulima Tanzania* (MVIWATA) and MIICO. Translated from Swahili into English, MVIWATA means National Networks of Farmers' Groups in Tanzania.

ActionAid Tanzania is a development agency that is committed to social justice, gender equality and poverty eradication. At the core of the organisation's vision is a Tanzania without poverty and injustice in which every person enjoys his/her right to a life of dignity (ActionAid Tanzania, 2018). In contribution towards this vision, AATZ works with marginalised and impoverished people to reduce the burden of poverty and social injustice.

TACOSODE is an established umbrella network for non-profit organisations in Tanzania. The overall mandate of the organisation is to build the functional capacity of its membership training, networking, policy analysis and advocacy. TACOSODE has built a niche in strengthening responses to HIV in Tanzania for various at risk populations such as young people, women and girls and people living with HIV. In 2017 year alone, the organisation has reached 6,663 people with HIV prevention activities, including people who use drugs and young people.

MVIWATA is a network bringing together smallholder farmers in Tanzania. It seeks to empower them economically and socially through multiple strategies. The organisation improves farmers' well being and empowers them through capacity building, lobbying and advocacy, as well as facilitating cross learning. MVIWATA is motivated by the slogan "*Mtetezi wa Mkulima ni Mkulima Mwenyewe*," which translates to "the defender of a farmer is the farmer" (MVIWATA, 2019). In the project context, the organisation provided the necessary interface with smallholder farmers who fall within its areas of operation.

Based in the Mbeya region of Tanzania, MIICO is a registered non-profit organisation registered in 2005. The organisation is passionate about reducing poverty and the

improving well being of vulnerable communities. This is done through agro-based initiatives and marketing of agriculture produce. Skills building is thus one of the mainstays of the organisations, meant to uplift vulnerable community members. MIICO has been implementing a strong social accountability arm, which has helped smallholder farmers in Mbeya region to identify development challenges and present these to public officials.

The re-establishment of health committees was meant to strengthen the oversight and accountability role of smallholder farmers on the delivery of sexual and reproductive health services in Kilosa and Mbozi districts of Tanzania. The actions also involved collaboration with the local district council, health and social welfare ministry and local community governance structures i.e. Ward Development Committees.

TACOSODE supported MVIWATA and MIICO (local partners) to facilitate re-establishment of the committees. Committees were re-established in the respective villages where the health facility or dispensary is situated. Through the project actions, 12 health committees were re-established (five in Kilosa and seven in Mbozi). Noteworthy, the formation of these committees is provided for under a national modal instrument under the Ministry of Health and Social Welfare. It gives distinct guidelines on the formation of such committees as part of the participatory health governance architecture in the country. Furthermore, government recognises the establishment of community health funds to support delivery of health care in the country. The funds are a basket, were community members contribute and are managed by the aforementioned committees.

3.1.2 Key Project Activities

Data collection through the community scorecard: The community scorecard methodology was applied to collect data on the delivery of health services (HIV and SRH) in five villages of Kilosa district led by MVIWATA. These five villages are Mhenda, Ilonga, Mvumi, Ulaya and Ludewa. In Mbozi district the process was done by MIICO with technical support from TACOSODE and AATZ. The overall purpose of the community scorecard is to improve on quality of health service delivery. TACOSODE, MIICO and MVIWATA in partnership with AATZ achieved this by using participatory data gathering techniques including Focus Group Discussions (FGDs) and Key Informant Interviews). A total of 140 people (75 female, 65 male) participated in Kilosa district. In Mbozi district, 414 community members participated in discussions. Focus group discussions were conducted in each village to brainstorm and evaluate the health facility and services under consideration. Key informant interviews were conducted with service providers to gauge their views on how health services are provided, barriers to delivery of quality services, indicators of quality services provision, priority issues and suggestions for improvement.

Figure 4: Community scorecard data gathering in Kilosa District

Farmers in a community scorecard FGD at Mvumi, Kilosa district

Farmers in a community scorecard FGD at Ulaya, Kilosa district

Farmers in a community scorecard FGD, Kilosa district

FGD participants at Ilonga, Kilosa district

Images: SAfAIDS (2018)

Furthermore, the partnership facilitated meetings to validate findings of the scorecard reports with service providers. The meetings discussed scorecard findings. Commitments were made by each concerned department to address identified gaps in health (HIV and SRH) service delivery.

The community scorecard findings showed a number of health service delivery challenges in the two districts. Identified challenges include shortage of staff at health facilities, inconsistent supply of medicines that could not match demand. There was also inadequate infrastructure to deliver SRH services i.e. having no set rooms for HIV testing services (HTS) thereby undermining issues of confidentiality. It was noted that there is no water and electricity in some health centres and dispensaries

Community feedback / interface meetings: Interface meetings were conducted between service users and providers. The meetings discussed scorecard findings and generated mutually agreed action plans to address priority service gaps. Interface meetings were attended by nurses, farmers, extension officers, village chairmen, ward executive officers, MVIWATA and MIICO staff and AATZ technical officer. A key deliverable from the meetings was mutually agreed action plans focused on re-dress of the priority health challenges in Kilosa and Mbozi districts. Noteworthy, the plans were endorsed by local government representatives, politicians, service providers and the community.

Challenges in delivery of health services were identified as emanating from weak governance and accountability systems. While there was provision for establishment of health committees, the challenges pointed to inactivity, inefficiencies in execution of the committee roles. Also some of the health committees were not properly constituted in line with the Modal Instrument. MVIWATA and MIICO, with input from the technical partners TACOSODE and AATZ, then focused attention on the role and functions of these committees.

Health facility mapping: TACOSODE oriented MIICO and MVIWATA Project Coordinators on the modal instrument that put in place members of health facility management committees. Thereafter, the partnership visited the District Executive Director (DED) and The District Medical Officers (DMO) for Kilosa and Mbozi to discuss and see whether the re-establishment of the facility health management committee members was done. The DMO wrote letters to Ward Executive Officers (WEOs) notifying them to arrange for the exercise in their respective wards and villages. After having all the blessings from the district level, TACOSODE, MVIWATA, MIICO and representatives from the DMOs office conducted a mapping exercise of health committee in each village.

Figure 5: Health committee mapping and orientation on the modal instrument

MIICO staff pose with the TACOSODE Coordinator (second from left) during orientation on the Modal instrument for establishment of health facility governance committees

Mapping out the existence of health facility committees and orientation on the modal instrument to village leaders and facility staff in Mbozi district

Images: SAfAIDS (2018)

In Mbozi, at all health facilities visited, health committees were not yet re-established nor was it announced to the public that applications have to be sent to the WEOs office for them to be nominated. In Kilosa, the team found that re-establishment was done but to some extent didn't follow the modal instrument requirements. It was also discovered that some of members of the committees were political leaders who were not eligible. Gender representation was also not considered in the committees, which is against the modal instrument guidelines.

After the mapping process, the partnership held feedback meetings with the District Councils to present findings of the mapping exercise. Commitment was also secured from the Councils to initiate and support the process of re-establishing the health committees.

Facilitation of Health Committee re-establishment: TACOSODE in collaboration with MVIWATA, MIICO and the respective of the District Council managed to facilitate re-establishment of 12 health committees (five in Kilosa and seven in Mbozi). The process started with Ward Executive Officers (WEOs) posting announcements in the respective villages where the targeted health facility is situated. The announcement was an invitation for prospective members of the committees to submit their expression of interest.

Figure 6: Public meetings to approve health committee members

Community members from Ludewa Village attend public meeting to approve health committee members

Community members from Ulaya Village attend public meeting to approve health committee members

Images: SAfAIDS (2018)

Citizens who were interested in being committee members and met the criteria submitted their applications to the WEOs. Short listing of members was done through the Ward Development Committees (WDC). Thereafter, public meetings were organised by village leaders in collaboration with Health Facility in Charges. During these public meetings, all candidates for committee membership introduced themselves by mentioning their names, villages they came from and how committed are they towards representing the entire community and ensuring quality services are provided. Following the presentations, citizens asked the candidates questions and voted for their approval. Other members were rejected during the public meetings. As an example, at Ulaya village in Kilosa DC, citizens rejected one member and nominated another one to replace. The community members were of the view that the member selected by the WDC could not fully commit to the committee activities. In Mbozi the public meetings started from 6th-8th August, 2018, and in Kilosa from 13th-15th August, 2018.

Capacity building of the Health Committees: TACOSODE, MVIWATA, MIICO and the DMO's office for Kilosa and Mbozi districts conducted capacity building workshops for the re-established committees. The trainings were done in each village, whereby all selected committee members and the village/ward leaders attended the training. The purpose of the training was to build the capacity of the committees on how to effectively execute their expected roles. Key topics covered during the capacity building workshops are: i) The PSA project overview and its linkages to accountability strengthening in Mbozi and Kilosa districts; ii) Social accountability within the five processes of public resource management; and iii) committee roles, responsibilities and structure in line with the modal instrument guidance.

A total of 96 people were trained and are actively practicing their oversight roles in 12 health facilities and dispensaries in Kilosa and Mbozi district councils.

Figure 7: Capacity building trainings of health committees in Kilosa

DHS from Kilosa Mr. Beda (standing) trains health committee on their roles and responsibilities at Manyovu

Koga Mihama a Facilitator from TACOSODE trains health committee on linking their role with social accountability monitoring at Manyovu hall-Kilosa

Images: SAfAIDS (2018)

3.1.3 Elements of Best Practice

Effectiveness of the Action

There is evidence that AATZ, TACOSODE, MIICO and MVIWATA, through the PSA project, have been able to meet the overall project objectives. Output 2.1 of the project seeks to realise 'Strengthened capacity of issue-based CSOs, smallholder farmers' organisations and media, in rights and evidence-based SAM and advocacy." Through re-establishment of health committees, the project has managed to build the capacity of smallholder farmers in Kilosa and Mbozi to engage in rights and evidence-based social accountability monitoring of health (SRH) services and advocacy. This has been achieved through the establishment of the Committees, which are an efficient structure for social mobilisation of communities. Furthermore, the building of knowledge and skills on social accountability and functioning of the committees has contributed to capacity realisation and utilisation.

"I've learnt that accountability is a two way aspect whereby both service providers and recipients have got their roles towards realization of required rights. Service deliverers (duty bearers) are responsible for delivering quality services while citizens (right holders) are responsible for active participation and monitoring service delivered. Now, I'm capable for monitoring development plans in my community..." Community participant after going through SAM training at Ichenjezya, Vwawa Township, Mbozi

Increased involvement of community in managing public resources and exacting accountability

Re-establishment of the committees has provided a platform for the community to be involved in managing public resources and exacting accountability. The process of identification of potential members and approving them was done by the community, with facilitation by the PSA project. Public meetings were thus successfully done in all the villages and the committee members were approved at the meeting through community voting system. In Kilosa, 41 members of health committee from five villages have been recognised and approved. In the same district, five health committees were approved by the public meeting of Mhenda, Ulaya, Ludewa and Mvumi. In Mbozi district seven health committees were approved by the public meeting of Itaka, Iyula, Idiwili, Msia, Igamba, Mlowo, and Hasamba.

Using the scorecard methodology also gave the farmers an opportunity to objectively assess health service delivery and interact with service providers towards resolving priority gaps in the community. This space was missing prior to project intervention. It was effective in identification of gaps that led to re-establishment of the health committees.

Figure 8: Scorecard FGDs in Mbozi district

FGDs with farmers' groups in Itewe village, Mbozi district.

FGDs with health service providers in Itaka village, Mbozi district

Images: SAfAIDS (2018)

Establishment of spaces for community to participate in rights and evidence-based social accountability monitoring of health (SRH) services

The health committees, whilst provided for under the modal instrument, did not provide a space were communities could participate in rights and evidence-based social accountability monitoring of health (SRH) services. Health facility assessments showed that health committees existing before the project didn't follow the modal instrument requirements. Findings showed that the community was not represented in the committee and politicians had taken over control. Furthermore, gender representation was not considered, which resulted in the committees mainly comprising of men. Stemming from this scenario, the communities did not have the opportunity to raise issues and seek accountability in delivery of health services.

The project was effective in meeting its target of establishing 12 health committees. Feedback from the FGDs shows that the communities are now engaged in monitoring of health services as they are now confident to raise issues through committee. The results from the actions also show how the committees have been useful in getting service delivery issues addressed by the health and social welfare ministry as a result of the elevated 'community voice'.

Increased capacity (knowledge and skills) of the community to exact accountability from the state in delivery of health (SRH) services

The action was effective in increasing knowledge and skills of the re-established committees to exact accountability from the state in delivery of health (SRH) services. This was done through the targeted capacity building workshops that were conducted in each district. Key topics covered during the training were roles and responsibilities of the committees, management of the community health fund, social accountability concepts and practice including the five processes of public resource management. Though such trainings, there has been increased involvement of committees in managing public resources and exacting accountability towards delivery of quality SRH services.

Ethical Soundness

Ethical soundness was assessed from the perspective of whether the project actions constituted social and professional conduct that did no harm to the targeted smallholder farmers in Kilosa and Mbozi districts. The project design was based on the key principle of community participation; hence the health committees reflected the interest and voice of community members. Furthermore, there was consultation and engagement between AATZ, TACOSODE, MIICO and MVIWATA with the District Councils (Health Management Teams) of Kilosa and Mbozi. This ensures that all actions were guided with acceptable standards of practice as derived by the government and communities served.

The project design did not disrupt local socio-cultural traditions within the 12 villages were the committees were set up. A facilitation approach guaranteed this. Finally, the project contributed towards realisation of access to sexual and reproductive health services as a right for all citizens.

Relevance

Policy relevance – Health committees were re-established as part of the broader health sector reform by the health and social welfare ministry. The formation of such structures is spelt out in the Primary Health Services Development Programme (2007-2017). A follow up guideline for establishing and implementing council health service boards, health centres and dispensaries health committees in Tanzania (2013) was published to guide functions of the committees. The committees present room for community participation in health services delivery.

The action was relevant as it meant to address gaps in implementation of provisions of the modal instrument. Scorecard data shows that the composition and functions of the health committees prior to the project intervention were not consistent with the provisions of the government guidelines.

Health committees also contribute to the purpose of the Community Health Fund Act being to provide for the mechanism of establishment of Community Health Fund and to provide for the constitution of the management organs, and the administration of the fund and other related matters[1]. Thus during the FGDs, it was highlighted by participants that the committees have helped to strengthen administration and planning on use of the CHF to improve delivery of health services.

> **"When we did the scorecard process, we discovered that the committees were not comprised of elected individuals as per the provisions of the guidelines. Rather, it was mainly comprised of politicians who were imposed and did not understand the role and functions of the Committee..." —*Koga Mihama, Coordinator, TACOSODE***

Relevance to the community need – Feedback from the FGDs shows that the communities within the target villages were facing challenges in accessing quality SRH services at dispensary and facility level, prior to the action. This was attributed to non-responsive health committees that did not have the capacity and legitimacy to undertake the expected functions. This manifested in SRH service access challenges such as absence of HTS dedicated room at Ulaya health centre.

The project has been relevant in addressing the oversight and accountability capacity gap, through supporting re-establishment of health committees. This was achieved by raising awareness on the government guidelines, supporting the local processes of re-establishing the committees and building their capacity on rights based approach to social accountability.

A key role of committees is to mobilise communities to contribute to the CHF to co-finance health services delivery at the facility. Prior to the action, one of the challenges with the fund was low contributions from the community to the fund. According to a key informant interviewee, the low contributions resulted from the lack of confidence by communities in the previous committees, which were not properly constituted.

1 Republic of Tanzania, The Community Health Fund Act, 2001

In addition, it was stated that the communities were also not motivated to contribute as they did not see a value for money through their contributions.

The Project Officers and committee members all testified that there had been a significant increase in the levels of CHF contributions from the communities since re-establishment of the committees. This was attributed to increased confidence by the community in the revived structures. However, quantifiable data on the increase could not be availed during data collection.

> **"There has been an increase in contributions to the community health fund. People are now more confident with the new committees. Before this, there was little contribution..."**
> ***—FGD participant***

Relevance to project purpose – Overall, the PSA project seeks to improve public service delivery in agriculture (food security), and health (HIV/AIDS, sexual and reproductive health and rights) by strengthening the oversight and social accountability roles. The design and methods of the project action have been relevant in strengthening the oversight and accountability roles of community based target groups in the delivery of health services. Through process facilitation, evidence generation and capacity building on social accountability; oversight and social accountability roles of the health committees and the local council have been strengthened.

Cost Effectiveness

The project approach adopted by the partnership ensures cost effectiveness, while still realising expected results. The project actions were done within the local community facilities and spaces i.e. capacity building of health committees was done at local council halls and meetings to select committee members were done at the health facilities with minimal cost. Cost effectiveness thus stems from situating all actions within the community.

Furthermore, the 12 re-established committees are fully functional with minimal budget reliance from the project. The committees only meet quarterly; and all members reside within the village and hence walk to the facility to attend meetings. There is thus no additional cost associated with accommodation and transport for the project. Rewards in the form of allowances for the committee members are not borne by the project. The allowances are drawn from the CHF.

Innovativeness

The project has been unique in terms of the facilitation model utilised. The model promoted quick buy in and support from the Health Management Team at the local council. Furthermore, the use of scorecards provided a basis for communities to "own" the process and commit to the project actions.

Sustainability

Institutional sustainability

The Ministry of Health and Social Welfare guidelines provide clear steps on how health committees are sustained over time. The guidelines stipulate that five members of the Committee will be elected from within the community every three years, and the remaining three will be appointed from other institutions i.e. Facility in Charge, and Village Development Committee. The guidelines thus provide a yardstick on which the committee self sustains.

Committees do not operate in isolation, but are part of the bigger devolution arrangement supported by the government of the republic of Tanzania. Thus, the committees report to functional Ward Development Committees. Furthermore, the committee receives support from the District Council. In addition, each committee is centred on a functional health facility or dispensary.

The committee are also sustained by the community presence, with the bulk of members being drawn from the community.

Impact sustainability

Accountability in delivery of quality health services is guaranteed through the continued oversight role of the committees, which function over three-year tenures. Furthermore, the accountability and oversight role is provided for in the Ministry of Health and Social Welfare modal instrument. The 2013 guidelines stipulate that the committees will undertake the following oversight and accountability roles:

1. Coordinating and managing the community based initiatives and plans within their locality.
2. Scrutinise and approve the plans and the budget of the facility.
3. Mobilise resources, including CHF for financing facility activities.
4. Approval of CHF expenditures for procurement and other expenses of the facility.
5. To control funds disbursed for project implementation with highest transparency and accountability to the community.
6. To discuss the quarterly, bi-annual and annual financial progress report from Health facility management team (HFMT).
7. To ensure availability and functional transport, communication facilities and staff houses.
8. Responsible for advising and suggesting to the Council Health Service Board (CHSB) on health services, employment, distribution, incentives and training needs.
9. Link with Dispensary/Health centre Management Teams and other actors to guarantee the delivery of quality health services to the community.
10. To conduct quarterly HFGCs meetings.
11. To share the facility health information with the community.

Continuous improvement in delivery of quality health services is thus guaranteed when the committees complete their expected terms of reference.

However, key threats to impact sustainability remain as follows: lack of civic mobilisation to support the role of the committees and to engage them; and capacity gaps that may arise as new members join the committees and are not clear of some oversight functions or roles.

Financial sustainability

The approach by TACOSODE and implementing partners ensured that the actions guarantee financial sustainability as there was limited reliance on project funding. Committee models are naturally designed to self-finance. Incentives for participation in the health committees are drawn in the form of allowances on a quarterly basis. The allowances are drawn from the CHF, which is continually replenished from community contributions.

Reliance on 'local resources' reduces the financial outlay of bringing in external experts to provide oversight and technical role. All committee members reside within the community they serve. Support is provided by the District Council staff, who are funded by the state.

Through strengthening the oversight and accountability roles of the health committees improvement in health service quality guarantees improved sexual and reproductive health outcomes. This remains the overall value proposition of the action. However, the intervention does not guarantee the promotion of health seeking behaviours among the communities served by the health centres and dispensaries.

Sustainability of community cultures and values

The project adopted a facilitation and capacity building model that does not deliberately transform community cultures and values. Hence, there is no harm or forced transformation. As a result, the project ensures communities thrive within their respective culture and value systems.

However, albeit observed in one village, the community culture recognises more men in positions of decision making than women. This was evidenced by more men being members of the health committee than women. Thus, gender representation or equity in raising accountability issues will be influenced by community values on gender norms (relationship between men and women).

Replicability

Replicability in this report refers to the ability of the project approach to be implemented in other sites or regions. Key respondents identified that the project can be undertaken in other regions or countries within developing settings. A look at the approach taken by the PSA project shows common denominators that ensure success of implementing such an intervention in a different context.

Existing legal and policy frameworks: The existence of the Ministry of Health and Social Welfare Guidelines, accompanying Community Health Fund Act (2001) and modal instrument provided a legitimate platform for re-establishment of the committees. This ensured quick buy in and support from the ward and local district level and institutions. These minimum conditions are necessary to get buy in and support for setting up of such structures at the community level.

Recognition and commitment to participatory community health governance: The adoption of both the CHF Act and guidelines formed part of a broader participatory governance agenda by the government of Tanzania. This created an avenue for the communities in Kilosa and Mbozi district to participate in committees that exact accountability from the state. Replication of the project actions is quite feasible where the state is committed to and takes action to promote participatory community health governance.

Presence of civic minded communities who are committed and willing to exact accountability from the state in delivery of quality SRH services: Through the conducting of capacity building on rights based approach to social accountability, the project was able to build a cadre of men and women who took action to exact accountability from the state.

3.1.4 Key Project Successes

Improving collection of Community Health Fund – Re-establishment of the health committees in Kilosa by AATZ, TACOSODE, MVIWATA and MIICO has led to an improvement in contributions to the CHF. A key role of committees is to mobilise communities to contribute to the CHF for co-financing health services delivery at the facility. Prior to the action there were low contributions from the community to the fund. According to a key informant interviewee, the low contributions resulted from the lack of confidence by communities in the previous committees, which were not properly constituted. In addition, it was stated that the communities were also not motivated to contribute as they did not see a value for money through their contributions. The communities now have greater confidence in the re-established committees and are more committed to contributing towards this fund.

3.1.5 Challenges

Despite the remarkable success of the project, there are notable challenges that were faced during implementation:

Disparities in gender representation during the public meetings: In Kilosa it was observed that most of the participants in community meetings were women and the elderly across all five villages. Men did not actively participate in community gatherings and meetings. Participatory governance approaches requires the concerted efforts and participation of both men and women.

Low citizenry engagement: In comparison to the village populations, participation in the re-establishment process was low in some circumstances. As shared by a key informant, participation was said to be low in public meetings because of promises that were never met by community leadership from previous meetings. In addition, engagement between the committees and the community can be strengthened. Noteworthy, not all community members are fully aware and understand the role and value of the committees. This leaves some health delivery challenges not being reported to the committees for action.

Training resources challenges: It was observed when conducting the committee training that government reports and plans are written in English, which made it difficult for trainers to translate content analysis into Swahili language. Furthermore, some district level documents required for the training were not available.

Resistance from political leaders: There was resistance from political leaders who were also part of the previous committees. They tried to influence the selection processes and made demands for their inclusion in the re-established committees. The partnership managed to address this through engaging the local District Council who shared the committee eligibility requirements with the communities.

Capacity of committee members to analyse financial reports: Committee members are at different levels of literacy and this has an implication on their ability to read and interpret financial documents. This limits involvement of the committee members in analysis and making decisions about the community health fund. Financial literacy was thus identified as a priority area for capacity building.

3.1.6 Lessons Learnt

- Engagement of the community in participatory health systems governance is an effective tool for closing the gap between national health priorities and facility level gaps in health service delivery. The evidence from the project shows clearly that the role of the community has helped close some gaps that would otherwise not have been noticed without raising community voices.
- Engagement of the local government and community structures is a key pillar for participatory project designs. Engaging the local council and ward level structures helped to redress resistance from political leaders and ensured quick buy in from the community. This greatly contributed to realisation of the project results.

3.1.7 Conclusion and Way Forward

The re-establishment of HFGCs in Kilosa and Mbozi districts is a best practice that needs minor improvements in certain areas highlighted above. This is based on a score of 75% against the BP criterion. The initiative by AATZ, TACOSODE, MIICO and MVIWATA is quite commendable and has truly transformed the lives of smallholder farmers in Mbozi and Kilosa districts through the re-establishment of the health committees. The participatory approach helped to ensure quick buy in and support from the communities.

To further strengthen results and address challenges, the following actions are recommended for the partnership:

i. There is need to conduct sensitisation of the mass community on the importance of civic engagement in social accountability monitoring on health service delivery, participatory public resources management, how they can interact with the committee and how it is meant to address their health needs, and the community health fund.

ii. Main streaming of gender norms transformation with the project messages and methodology to address the disparities observed during community gatherings. It is imperative that both men and women take an active role monitoring delivery of health services.

iii. Conduct capacity building sessions on analysing of financial documents and interpretation so as to address literacy gaps among the committee members.

Image: SAfAIDS (2018)