Use of Community Scorecard (CSC)  
As a Social Accountability Tool for Improving MNCH Services in Gombe State

Background

The 2016 Nigerian National Health Policy affirms the role of communities in “delivering effective, efficient, quality, accessible and affordable health services,” and identifies the primary health care (PHC) system as the platform for the “promotion of community participation in planning, management, monitoring and evaluation of the local government health system.” The aim is to enable communities play a critical role in advocating for and making the PHCs more effective and efficient.

However, the situation in many communities across Nigeria has not been a true reflection of the policy statement. Community involvement in decision making in relation to the running of public healthcare centres has been lacking or at best minimal, largely because the interaction between communities and public health institutions which the policy seeks to promote has been non-existent.

The reasons for non-involvement of communities in the management of PHCs vary from one community to another. However, in several cases, the Ward Development Committees (WDCs), which are supposed to drive the interaction between communities and the PHC, were barely functioning. Until recently, the implications had been little or no demand driven service delivery at public healthcare centres across Nigeria.

Intervention by Pact

To address the problem of lack of community participation in the running of the public health system in Gombe State, Pact introduced and promoted the use of the Community Scorecard (CSC) as part of its suite of interventions under the State Accountability for Quality Improvement Project (SAQIP).

The use of the community scorecard introduced community involvement, which in turn prompted increased government’s responsiveness and accountability in relation to the state’s public health system.

Funded by the Bill & Melinda Gates Foundation), SAQIP’s goal was to build the capacity of the Gombe State Primary Health Care Development Agency (SPHCDA) and its LGA structures to carry out their mandate to provide quality maternal, newborn and child health (MNCH) services in the state.

Highlights

In 2015, SAQIP intervened to promote community participation and government responsiveness through the use of the community scorecard.

The community scorecard involves women of childbearing age, WDC, heads of households and health workers; jointly identifying gaps and proffering solutions.

Currently, the community scorecard is funded by WDCs and being utilized to improve MNCH services in supported health facilities.

1. Nigerian National Health Policy (2016)
The Community Scorecard

The community scorecard (CSC) was deployed by SAQIP in Gombe to increase participation, accountability, and transparency between service users, providers, and decision makers in the public health system. The CSC process brought together the demand and supply side to jointly analyze issues affecting service delivery in PHCs to find a common and shared way of addressing the issues. As a proven participatory tool for assessing, planning, monitoring, and evaluating services; the use of the CSC followed a systematic process of about eight phases that are summarized in Box 1.

Box 1: Community Scorecard Process

<table>
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<th>CSC Development Phases</th>
<th>I. Planning and Preparation</th>
<th>II. Generation of CSC custom indicators</th>
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<td>stakeholders through eight phases to develop and use the CSC. The CSC process is driven by the WDC, which is a semi-formal community representative. The WDC ensures complete community ownership of the process.</td>
<td>The first phase involved identifying focal facilities and user groups per facility. CSC facilitators (moderators and note-takers) were also identified and trained. Introductory visits to key stakeholders (local leaders, service providers, etc.) took place and a list of needed materials and budget was created.</td>
<td>Focus Group Discussions (FGDs) were organized by trained facilitators to generate CSC indicators. The FGDs revealed community perspectives on critical factors affecting MNCH services at the PHC level with prevalent issues forming the adopted CSC indicators.</td>
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<th>III. Pretesting and finalizing indicators</th>
<th>IV. Conducting scorecard with community</th>
<th>V. Conducting scorecard with service providers</th>
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<td>The indicators developed through the FGDs were pre-tested, updated where necessary and finalized for use.</td>
<td>Scorecard used for two groups of household heads and childbearing aged women who scored the indicators based on their experience and perception. The results are computed and read out to generate further discussions and possible solutions to identified issues.</td>
<td>Same CSC process for the community groups was repeated for the group of service providers. However, the indicators for the care providers excluded satisfaction with antenatal (ANC), maternity services and attitudes of providers, to minimize bias.</td>
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<th>VI. Interphase meeting and action planning</th>
<th>VII. Dissemination and follow up of action plans</th>
<th>VIII. Subsequent rounds of CSC</th>
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<td>Joint meeting of representatives of all three groups – household heads, women of childbearing age, and service providers – was held during which the average scores and issues generated in each group were presented, deliberated upon and addressed. Action plans were developed to address the issues.</td>
<td>Results of scorecard activities were widely shared at LGA and ward levels with relevant stakeholders like service providers, community and religious leaders, WDC members, business community and LGA PHC Department; to garner support for improving health services.</td>
<td>CSC is repeated every six months by the same facilitators but for new sets of interviewees selected randomly during ANC. In subsequent rounds, results of previous rounds as well as previous action plans and their status are presented to the interviewees after their own scoring for deliberation on any changes between the rounds.</td>
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Key Results and Learning

- SAQIP supported Gombe State to develop a community scorecard of eight indicators that has been adopted and currently applied across the state. See Box 2 for the eight indicators.

- Between 2015 and 2019, SAQIP supported key stakeholders in the state including Gombe SPHCDA and WDCs to deploy four rounds of use of the community scorecard.

- Scores for all eight indicators have improved significantly over baseline: up to 49.5% improvement in scores between first and fourth rounds of CSC.

  Highest improvements have been recorded in client waiting time, satisfaction with ANC services, and satisfaction with maternity services (figure 1).

Box 2: CSC Indicators

1. Availability of health workers
2. Attitudes and friendliness of staff
3. Availability of drugs
4. Satisfaction with ANC services
5. Satisfaction with labour and delivery services
6. Community mobilisation by PHC
7. Client waiting time
8. Cost of MNCH services

Key Results and Learning

- The CSC process provides actionable feedback to the local health system through in-tentional and systematic dissemination meetings.

- For buy-in by facility staff, it is important for facilitators to emphasize that the goal is not fault findings but a platform to identify critical gaps and develop strategies to address them (See Box 3).

- The CSC dissemination is very critical as it provides feedback to decision makers that could trigger immediate actions. For instance, during the CSC dissemination at Deba LGA, the presence of the Executive Chairman enabled immediate address of reported cases of staff absenteeism and recruitment of security personnel to a facility.
Box 3: Case Story on Use of Community Scorecard at Kumo PHC, Akko LGA

Aisha Jibir, 46, is a civil servant and the treasurer of Kumo WDC, Gombe State. She joined the WDC in 2016 after it was revitalized. She was trained by SAQIP as a facilitator in the use of the community scorecard and has facilitated its use thrice at her community (Kumo PHC).

“When we started, we feared there would be quarrels because the facility staff thought we were coming to fight them. But when they realized it is a way to correct things and improve the services in the facility, everybody liked it, as we heard from the women, their husbands and from the facility staff. Now because we talked together, more women are coming for ANC. The prices of drugs have also reduced because the women complained,”

- Aisha.

Recommendations and Conclusion

The CSC gives the community a voice to evaluate the quality of MNH services, advocate for improvement, and contribute towards increased government responsiveness to local health issues. We recommend that the tool be sustained and scaled up across all PHCs in the state, and indeed across Nigeria, as a means of providing demand-driven MNH services.