Research brief: Community Empowerment and Accountability: A Simplified Community Scorecard Approach in the Democratic Republic of Congo

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Background

Community engagement has long been proposed as a mechanism by which the quality of health services could be improved. IMAWorld Health (dba IMA), through its Accès aux Soins de Santé Primaires (ASSP) project has introduced a component for community participatory evaluation of the quality and scope of health services, specifically, a simplified community scorecard, as part of its approach to improving quality and utilization of health services. The simplified community scorecard approach provides a mechanism by which communities regularly rate the health services on indicators that are important to the community. The scorecard methodology is designed to emphasize cooperation between local stakeholders and action based on dialogue and consensus. Community analysis focuses on joint identification of problems and constructive solutions, consciously avoiding personal blame and sanctions. The entire process strongly emphasizes shared community and health worker interests in improving health services.

The study has three objectives. The first objective is to monitor the implementation of the simplified community scorecard intervention and offer recommendations for strengthening the intervention's approach. The second study objective is to track changes over time in the participating communities' perceptions of quality of health services, communities' utilization of health services, and real changes in the supplies, equipment, and services available at their health facilities, as well as to describe the characteristics of a successful or unsuccessful site. The final objective of the study is to assess unintended impacts of the intervention.

Study Methods and Design

The evaluation uses a mixed-methods approach. Quantitative data comes from the ASSP project's baseline and endline surveys, which were administered to health facilities, health workers, and households in 2014 and 2017, as well as routine program monitoring. Using descriptive statistics and a difference-in-difference approach, changes in indicators of scopes of service, utilization, quality, community empowerment, and health worker satisfaction are tracked over time, and the impact of the scorecard approach is estimated.

Qualitative data collected in communities that participated in the scorecard approach is also used. In-depth interviews or focus groups were held with community members, health workers, CODESA members, animateur communautaires, the chief physician of the health zone, and implementing

partners. These conversations were designed to understand how the approach was implemented, how it was received, whether impacts have been observed, and to elicit suggestions for improving the approach.

Study Findings

The community scorecard approach appears to have been well-received by facilitators, community members, and most health workers. Descriptions of the initial rounds of scorecard meetings closely matched ASSP's design. Quantitative analysis did not detect an impact of the scorecard approach on facility-level indicators of scopes of service, service delivery, or quality, either from the perspective of health workers, community members, or objective assessments via health facility surveys. Participants saw improvements in health services and those impacts were concentrated at the levels at which the community or health workers had direct control (e.g. painting, cleaning, hours of operation, health worker attitudes). Requests that required action at higher levels of the health system (e.g. medicines, supplies, staffing, health worker remuneration) had mixed results. The majority of health workers reported appreciating the scorecard approach. Community members corroborated this and observed that health workers seemed to appreciate the joint problem-solving and advocacy. The main barrier to full participation by health workers was a lack of remuneration.

Limitations

Although trends and associations are part of the analyses and the difference-in-difference approach controls for baseline differences between groups, the methods employed in this research are unable to establish whether the intervention caused a change in the outcome. This is primarily due to the fact that the intervention was not randomly assigned. The ASSP project operated in both scorecard and non-scorecard areas, which leads to two additional limitations. First, the presence of ASSP in scorecard areas means that any positive impacts of the scorecard approach could be diluted if other components of the ASSP projects also impacted a particular outcome. Secondly, the presence of ASSP throughout the study areas means that the full impact of the scorecard alone cannot be estimated.

Final Conclusions and Recommendations

The limiting factors identified in the evaluation, many of which were financial (the cost of facilitating meetings, opportunity cost of attendance for very poor community members, and health worker resentment due to unpaid salaries) should be addressed if possible. Project leadership should determine whether it is a priority that all sections of society are actively participating in the scorecard activity. If it is, this expectation should first be communicated to facilitators. The design of the scorecard approach should then be altered to overcome barriers that certain populations face.

Respondents overwhelmingly reported that meetings should be held more than once per year. The project could encourage communities to set their own meeting schedules. While most respondents were satisfied with the eleven indicators listed on the scorecard, a few had suggestions for new indicators; this option could be reinforced and formalized within the approach. The project could also go further by

providing groups with objective standards for service delivery (for example, national guidelines) and facility-specific data, as well as comparison with their peer facilities.

In general, there was disagreement among stakeholders as to whether the joint action plan should primarily consist of actions the community and facility could take together, or if it should also be used for advocacy to higher levels. In practice, communities attempted to appeal to higher levels of the health system. Project leadership should provide clarity on the level(s) at which the action plan should focus.

There were mixed perspectives among stakeholders about whether the scorecard approach would continue without project support. Sustainability may be improved if a formalized process is developed to give communities acknowledgment and regular feedback on the status of their requests. Further, educating participants and facilitators on the decision-making process and the levels at which specific types of decisions are made may decrease frustration when results are not quickly realized.

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