Background and Rational

In Bungoma County, the percentage of women that deliver their babies in health facilities is lower than the national average. Some of the reasons for this are long waiting times at health facilities, disrespect and abuse from health providers, shortage of staff, inadequate facilities (lack of electricity and privacy), or facilities charging users for services which should be free.

In order to address the points mentioned above, MANI implemented the Community Score Card (CSC) approach in six sub-counties. CARE’s CSC approach was to improve relations between members of the community (the service users) and the health facility staff (the service providers). The approach would reinforce and complement other components of the MANI project, such as quality improvement initiatives, and Rights-Based Approach to maternity care, by providing a forum for service users and providers to talk about their experiences with health services.

CSC is a social accountability approach designed by CARE to monitor the availability, access and quality of public services. The CSC process provides a framework for discussion and negotiation between community members, service providers, and local officials, who then develop specific actions to address identified concerns or issues. The CSC consists of five phases: planning and preparation, conducting the scorecard with the community, conducting the scorecard with service providers, interface meeting and action planning, and action plan implementation and monitoring. (See Figure 1: CARE’s CSC Methodology).

Figure 1: Care’s CSC Methodology

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1 Kenya Demographic and Health Survey (KDHS) 2014 Kenya National Bureau of Statistics
The following is the timeframe for implementation of the different phases of the CSC approach:

- One day for sensitization of stakeholders, health managers and/or community members
- One day of indicator-development, dialogue and scoring for community group, development of community score card and validation
- One day of indicator-development, dialogue and scoring for service provider group
- One day for interface meeting
- One day follow-up meeting to follow on action plan
- One day review meeting after six months of implementation

Implementation of CSC

Training of CSC facilitators

MANI started the implementation of the CSC approach with the training of 24 CSC facilitators. A senior CSC trainer trained 24 community County Health Extension Workers (CHEWs) to be CSC facilitators for MANI. The training took place in March 2016. CHEWs were drawn from across all the 6 sub-counties where MANI works.

Roll out of CSC at MANI Priority Facilities

MANI implemented the CSC approach in the 35 priority health facilities from March 2016 to December 2016. MANI first implemented the approach in 20 facilities. Gradually more facilities were added to reach a total of 35. The repeat cycles took place from October 2016 to December 2017. The third cycle of 37 health facilities was conducted from March 2018 to June 2018. The selected high-volume facilities to run CSC have been involved in various MANI interventions, including Quality Improvement Committees, and performance-based financing incentives as well as linked to functional community units. The high-volume facilities included the county referral hospital, all the sub-county referral hospitals and selected health centres and dispensaries that reported more than 100 deliveries per month.

Facilitators compiling generated issues

Community Health Volunteers (CHVs) helped to mobilize community members to attend the community indicator development days to generate issues, score services, validate the scores and develop the indicators that will be measured at the beginning and at the follow-up meetings. CSC facilitators also held indicator development days with health facility staff. After service users and service providers had each generated their scorecards, there was an interface meeting. This was a carefully facilitated discussion between service users and service providers about the issues identified by both groups. During the meeting, participants from both sides came up with some concrete actions they would take to resolve the key issues.

In the case of MANI, sub-county Public Health Officers and Ward Administrators were also present at interface meetings to witness the agreed follow-up actions and help identify ways of providing support. The aim of this method is to improve both service delivery and community engagement. The attendance during the interface meeting of government duty bearers helps clear bottlenecks, which are often beyond the immediate capabilities of health providers to resolve.

CSC Quarterly Review Meetings

These meetings were conducted three months after the scorecard process to discuss and review the action plan, go through achievements, changes, health facility Maternal and Newborn Health indicators and assess changes made from the action plan in the period since the action plan was developed. The review meetings helped to establish the gaps and implement the remaining action points. These meetings brought together 20 community members, four members from the facility including Facility Management Committee/Hospital Management board, two facilitators and three representatives from MANI project.

Group validating and scoring indicators

Key Results/Achievements

An initial score was taken at the beginning of CSC implementation in all 35 facilities and one and half years later and a new assessment was made across facilities. The following progress was reported by both the community and health facilities.

The analyses involved merging the common issues into sub themes and themes and averaging the scores of sub themes to generate a single score for the main theme. The sub-themes fed into the themes and an average score was generated for each theme.
The themes and sub-themes of common issues are listed below:

- Relationship between service providers and service users, including issues of attitude, privacy and confidentiality, harassment, communication and language
- Commitment and time management of service providers i.e. opening and closing of facilities and laxity of service providers
- Availability and accessibility of health information including availability of service charters, counselling services, IEC materials and health education sessions.
- Availability of resources, especially availability of drugs, equipment and supplies, adequate staff and provision of quality services
- Availability of transport to health facilities, like effective ambulance services and affordable ambulance charges
- Management and governance issues related to facility charges, communication barriers and provision of general health services

**Key Achievements**

Below is the graphical presentation of the scores (Graphs 1 and 2) of all 37 health facilities. They measure performance in the six key themes/indicators listed above. The scores are out of 100.
The most improved theme reported by the service users was the availability and accessibility of health information while the most improved theme reported by the service providers was the management and governance of facilities. The service user provider ethics registered a significant improvement both at the community and facility level, while the availability of resources was acknowledged by both community and facilities as a great improvement area.

**Lessons learned**

The following are lessons learned from the community scorecard exercise. None impacted negatively on the roll out of the CSC but they provide useful insights for the future and for other CSC, or similar, initiatives:

- Integrating CSC with the other quality improvement approaches that MANI developed, allowed us to minimize duplication in terms of engaging with the same health providers for MANI meetings; to use resources effectively and to ensure that the different aspects of the project complemented and strengthened each other. The role of the Quality Improvement Committees (QIC) in following up with the action points from the CSC action plans complemented both the CSC and QIC work.

- It is important to help the service users develop an understanding of the context of their level of health service delivery and the challenges faced by service providers as they discharge their duties so as to avoid creating unrealistic expectations.

- Service providers do not always have the capacity and resources to make decisions and implement change at their level. That is why it is important to involve the sub-county health managers, chairpersons of health facility management committees and ward administrators in the interface meeting.

**Box 1: Quotes demonstrating different stakeholders’ perceptions of the benefits of the CSC process**

“Last year there were two male workers here and the mothers didn’t feel their privacy was protected. These two men were from the same communities as our patients and they were talking about patients outside the facility. The CSC process has helped a lot – we didn’t know that women didn’t want to come and be attended by these two men. The CSC process raised a lot of issues, now we give the women hot water and sanitary pads after labour. We fixed the toilet inside the facility so that women don’t have to go outside. Male involvement used not to be possible, but now because we have screens around the labour bed, now they accompany their wives. This process has helped us to find out what mothers think.”

Risper Wanyonyi, Nurse, Tongaren Model Health Centre

“CSC is an eye-opener to the service providers and managers, it’s a good assessment tool that helps in understanding how the community perceives the health services offered at our facilities. If this process is implemented in all our health facilities, then Bungoma County would be ahead in health services provision.”

Kiboi Nickson, Ward Administrator, Lwandanyi Ward, Sirisia Sub-county

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