The Impact of Community Score Card Strategy in Improving Quality Health Services. The Case Study of Shamva District

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Abstract: - **Zimbabwe health sector focusses more on treating diseases rather than preventing disease out breaks. There have been several diseases out breaks such as cholera, typhoid and other diarrheal related diseases. Zimbabweans face challenges to combat communicable diseases such as tuberculosis, diarrheal diseases, and HIV/AIDS. The country's health sector decentralisation implementation is moving at a snail's speed, triggering complaints of unsatisfactory service delivery at rural health centres. The study examined the impact of community score card in improving quality health services in Shamva District. The study sought to understand how community scorecard strategy was implemented in Shamva District, to empower the communities with health rights for them to be able to demand suitable health services. The study was guided by interpretive and critical post-modernist paradigms. Qualitative methodology utilised open-ended questionnaires, focus group discussions, key informant interviews and participant observation data generation tools. The data generated were analysed using grounded theory. The key findings are that community scorecard improved health rights knowledge of communities in Shamva District, this led them to demand quality services from nurses. The study concluded that lack of continuous funding and sustainable plans had led to the reversal of positive results that the community score card programme had made. The major recommendation is that government provides adequate human, financial and physical resources for successful implementation of SAcc in Shamva District Health Sector.**

Key words: **Community score card, health services, accountability, community representatives, empowerment.**

I. INTRODUCTION

The study was conducted in Shamva District in a bid to understand whether community scorecard strategy is improving quality health services. The paper covers the back ground to the problem, statement of the problem, the purpose of the study, objectives of the study and research questions. The paper further covers the methodology, data analysis, discussion and presentation. The major findings, conclusions and recommendations are also given. The background to the problem is given below.

1.1   Background to the problem

Centralisation involves top-down approaches that make the head-office overburdened with instructions (Marume & Jubenkanda, 2016). Centralisation does not give authority to the local offices to make independent decisions and communities are not consulted on projects they want in their areas, hence, a mismatch between government and community priorities.The nature of decentralisation in Zimbabwe kept on changing from administrative to elected local authorities and there have been policy gaps between rhetoric and reality (Wekwete, 1990; Makumbe, 1998; Government of Zimbabwe, 2013; Chakaipa, 2001). There has been lack of decentralisation of power because of various reasons that include unwillingness of national institutions to relinquish power (Conyers, 2003).

There has been lack of inclusion of citizens as rights holders who have the mandate to demand accountability from duty bearers. The health sector in Zimbabwe is not spared from the centralisation and decentralisation administrative challenges. The communities are rarely involved in the development of their rural health centres' plans, there is lack of financial support to improve the health centres and the district staff lack full autonomy to make decisions that might help the rural health centres. Save the Children Report (2016) highlights barriers that communities are facing in accessing provisions of quality Maternal Neonatal and Child Health Services (MNCH). These barriers included, charging of user fees at rural health centres managed by council and at referral hospitals under the management of Ministry of Health and Child Care (MoHCC). This excluded the poor people who cannot afford to pay the user fees. There are high levels of commercialisation and unregulated service provision that leads to high out of pocket payments by clients to enable access to health services (Health Finance Policy, 2017).

Furthermore, lack of infrastructure that comprise of inadequate water supplies at some Rural Health Centres, poor telephone network and bad roads are barriers that citizens are facing to access health service (Save the Children Report, 2016). In addition, high transport costs to a rural health centre and transferring patients from rural centres to district, provincial or national level discourages citizens from accessing health services. Communities also indicate bad staff attitudes as an element that led many patients to shun medical treatment. Inadequate clinic infrastructure that encourages lack of patient's privacy has also been a deterrent factor for communities to seek health services (Training and Research Support Centre, 2016).

The above-mentioned challenges led to poor quality service delivery and this became a concern to the government and interested partners in health. The Ministry of Health and Child Care therefore signed a Memorandum of Understanding with donors and Civil Society Organisations (CSOs) to help address some of the challenges through implementing different Social Accountability (SAcc) programmes. This prompted the current researcher to examine the impact of community score card as a SAcc tool in improving quality health services.

1.2   Statement of the problem

HIV and Sexually Transmitted Infections (STIs) levels in Shamva District were high due to illegal mining activities in the district, resulting in high mobile population or immigrants. The Ministry of Health and Child Care (MoHCC) through the National Health Surveys acknowledges poor health services delivery in rural communities. This is partly caused by lack of full implementation of decentralisation on health services and lack of health discussion platforms between rural communities and state on the quality health service delivery. The Ministry of Health and Child Care signed memorandum of understanding with development partners and civil society organisations to help it to offer quality health services and to improve its accountability mandate.

However, there is lack of evidence on the impact of social accountability strategies in improving quality health services in Zimbabwe. It is not clear whether social accountability has improved communities' knowledge on their health rights and entitlements. It is also not clear whether the communities are ready to demand accountability from the state. Furthermore, it is not clear whether the state is ready and has the capacity to respond to demands tabled by the citizens. Therefore, this study sought to bridge the knowledge gap by examining the impact of community score card strategy on public health service delivery in Shamva District.

1.2.1   Purpose of the Study

The purpose of this study was to examine the impact of community score card (CSC) strategy in improving quality health services in Shamva District.

1.2.2   Objectives of the Study

The objectives of the study were to:

1. Determine the extent to which community score card strategy builds the capacity for citizens to demand their health rights and entitlements and for the state to know its obligations.
2. Explore the community score card implementation strategy.
3. Analyse the impact of community score card strategy in Shamva District.

1.2.3   Research Questions of the Study

The study's research questions were:

1. To what extent does community score card strategy used by State and CSOs builds capacity of communities on health issues and rights?
2. How is the CSC being implemented in Shamva District Rural Health Sector?
3. How does CSC impact on Shamva District rural health services?

II. REVIEW OF RELATED STUDIES

Community Scorecard was used in Benin, Guinea, Democratic Republic of Congo (DRC), Malawi, Zambia and Lesotho. In all these countries the health systems face persistent service delivery failures and the expectations of social accountability to offer solutions are very high (Molynuex, Mulupi, Mbabu& Marsh, 2012). Health centre committees (HCC) referred with different names in all the countries were the most popular groups used to encourage community participation in health service delivery. In all the case studies both the communities and service providers had interface meetings where the community and staff members presented their score sheets results (Arckerman, 2005).

All the programmes yielded several results that include improvement in respect for patients where the health officials listen to patients' problems, the health staff are honest, transparent and non-discriminatory in providing supplementary nutrition, there are no favouritism and staff gives priority to serious cases (Shah, 2003);(Schaaf, Dumont, Arbesman & May-Benson, 2007).The issues that were highlighted that were resolved by CSC approaches are health facility staff punctuality and availability of medicines (Winterford, 2009);(DPE Report, 2013).

III. METHODOLOGY

In conducting this study, the researcher used qualitative methodology. The data generating tools used were questionnaires, participant observation, focus group discussion and key informant interviews. The data were generated, interpreted, analysed and discussed using qualitative data analysis called grounded. Ethical considerations were observed during the data generation. These include getting consent from participants and respondents of the study, being clear on the intention of the study, verifying the conclusions of the study with key informants from Shamva District, asking for permission to record sessions and take photographs and getting permission from Ministry of Health Child Care to undertake the research.

3.1   Research Methodology

The study used interpretive and some elements of critical postmodernist paradigms because of its assumptions and beliefs that are based on qualitative research methodology. The current study's ontological beliefs were supported by Guba's (1990) views that, "truths exist in the form of multiple mental thoughts and beliefs that are built by local social and trial-based opinions that a person hold". The current study's

epistemology involved the researcher interacting, observing, interpreting meanings from the populations being studied under the case study (Maykat & Morehouse, 1994).

The study used purposive sampling for focus group participants, key informants and questionnaires' respondents. Shamva District had a population of about 130 000 and these are serviced by 16 health centres (DMO, 2018). The study generated data from five health centres that were referred to as A, B, C, D and E. Six health centres in the district had Non-Governmental Organisations (NGOs) that implemented social accountability approaches and this study sampled four of them as case studies. While one health centre B did not implement CSC strategy.

3.2 Respondents biograph

The data were generated from open ended questionnaires that were administered to 204 community members who visited the five health centres during the data generating process. The pseudo names used for community members who visited the five health centres were QR-A, QR-B, QR-C, QR-D, and QR-E. In addition, the focus group discussions were conducted to 127 participants who were grouped as people with same interests such as Health centre committee members these were referred as HCC-A, HCC-B, HCC-C,HCC-D and HCC-E., village health workers were referred to as VHW-A, VHW-B,VHW-C,VHW-D and VHW-E. pregnant mothers referred to PM-A, parents with children under five years referred to as PW-A and women getting contraceptives referred to WC-B. The researcher observed a district steering committee meeting in session that involved all line ministries and other stakeholders in the district and observed the patients who were in queues waiting to be attended at the district hospital.

Furthermore, 27 key informant interviews were conducted. The experts were from five local rural health centres, district hospital, Non-Governmental Organisations that are active in community health and from the national office of MoHCC. Pseudo names were used to keep the confidentiality of the participants and respondents. Table 1.1 show the pseudonyms used under key informants.

Table 1.1: Key informants' demography and pseudonyms

Facility	Profession	Pseudonyms
Health Centre A	Nurse in Charge	NIC-A
	Community Monitor	CM –A1, CM-A2
	Community Literacy Facilitator	CLF-A
Health Centre B	Nurse in Charge	NIC-B
Health Centre C	Nurse in Charge	NIC-C
	Community Literacy Facilitators	CLF-C
Health Centre D	Nurse in Charge	NIC-D
	Community Literacy Facilitator	CLF-D
	Councillor	CL

Health Centre E	Nurse in Charge	NIC-E
	Community Monitor	CM-E
	Community Literacy Facilitator	CLF-E
District Hospital	District Medical Officer	DHE-1
	District Nursing Officer	DHE-2
	Community Sister	DHE-3, DHE-4
Organisation 1	Executive Director	IP-1
Organisation 2	Provincial Coordinators	IP-2, IP-3
	Country Director	1P-4
Organisation 3	Health Economist	NO-1
Organisation 4	Social Accountability Officer	IP-5
Organisation 5	Community researcher	NO-2
MoHCC	Director of policy and planning	HQ-1
MoHCC	Director of Community health	HQ-2
Total		**27**

IV. FINDINGS

The findings of the study are presented in the following sub themes:

1. Overview of community score card strategy
2. Community health representatives involved in Community score card strategy who are: Community monitors, community health facilitators and health centre committees
3. Results and challenges realised during implementation of community score card strategy.

4.1 Overview of Community scorecard strategy

The study discovered that CSC was the social accountability strategy that was implemented in Shamva District. This was implemented under a programme called strengthening community participation in health (SCPH). The programme was implemented by Save the Children International from 2013 to July 2017. The strategy promoted the interaction between health officials and community representatives to improve quality health services. The representatives were the health centre committees (HCCs), community monitors and community health literacy facilitators.

The aim of the programme was to empower the citizens on their health rights, entitlements and responsibilities using the patients' charter. IP-1 indicated that the underlying concept behind the programme was greater collaboration between the community, government and health service providers. IP-5 highlighted that the programme served to improve feedback mechanisms in the health system, reflecting users' views on the quality of services they received, thereby, creating a health system that responded more effectively to the needs of its users. The community representatives implemented the programme, the descriptions of their roles are given in the

next sub headings.

4.2 Community literacy facilitators under community score card programme

The community literacy facilitators (CLF) were selected by headmen upon the request of the implementing organisation. CLF-A indicated that community literacy facilitators trained citizens during home visits, at health centres during health talks that were conducted by nurses and at community meetings organised by councillors, head men and chiefs. CLFs taught patients about their rights and responsibilities using the patients' charter and distributed Shona patient charters to communities. The community literacy facilitators from health centre A and C were no longer continuing with programme since it ended in June 2017. The HLF-A and HLF-C indicated that they were no longer carrying out their roles because they were no more patients' charters to distribute.

At health centre D and E, the cadres were continuing with the programme despite the end of the programme funding. HLF-D said, "*I am still teaching the communities about their health rights because I enjoy my role and I am seeing the fruits of my work*". Communities at health centre D indicated that they are treated well by the nurses because they are aware of their rights. NIC-E highlighted that their work had been made easier by the programme because the patients and communities understood their responsibilities. The complementarities of nurses and patients' roles were resulting in quality health service delivery at the two health centres. About 85% of respondents of the open-ended questionnaires at health centres D and E indicated that they were happy with the way they were treated by their nurses. They were treated with respect and confidentiality.

4.2.1 Community Monitors under Community Scorecar Programme

Community monitors were selected to conduct community score card to patients at health centres. Their selection was the same as the community literacy facilitators. Community score card was a tool that was used for respondents to rate the quality of services they receive at their health centres. CMA-2 highlighted that they worked in groups of threes, conducting community score card. CMA-1 indicated that one person was responsible for asking selected patients eight questions on the score card, while the other one was ticking the responses of the respondents on whether they were happy or not happy with the services they received at their health centres. The third person was responsible for taking notes of any other issues raised by respondents. The community score cards were administered to patients at the health centre that were grouped in a focus group ranging from six (6) to fifteen (15) people. Picture 4.1 shows the community score card that was used by community monitors. It was taken during data generating process.

Picture 4.1: Community score card used by the monitors

CM-E highlighted that the questions they asked included whether the patients were satisfied with services they were getting at the health centre. The time they spend at the facility and whether they were treated with qualified health personnel. The community monitors produced monthly reports that were given to Health Centre Committee members (HCC). The HCC members consolidated the issues brought by all the community monitors and present them during the quarterly meetings they held with the nurse in charge. The meetings were meant to discuss the concerns raised by citizens from the community score card and find solutions to them. The issues that could not be resolved at the health centre level such as the number of staff members were referred to the district level.

The community scorecard programme enabled the citizens to consolidate their voices and to build confidence that led them to bring out challenges faced at their health centre without fear. QR-E highlighted that, *the focus group discussions for community score cards gave us the chance to air out our views on grey areas at the health centre, knowing that we were in a safe space*. DHE- 3 indicated that the community score card highlighted to them areas that needed more supervision and attention. Furthermore, NIC-E pointed that CSC dialogues removed suspicions between them and communities and both sides were aware of areas that needed improvement or attention.

The community monitors at health centre A did not continue working after the end of funding of the programme. CMA-1 highlighted lack of stationery to use for community score cards report. At health centres C, D and E where the community monitors continued, there were some compromises in terms of availability of stationery.

4.3 Health centre committee under community scorecard programme

IP-2 indicated that Health Centre Committee (HCC) members were initiated by the MoHCC in the 1980s to mobilise communities to identify their health problems and prioritise them, plan how to raise their own resources, and to organise and manage community contributions to health services. The HCC membership included all socio-economic groups in the area that included the village health worker (VHW), village head (Sabhuku), church representative, youth representatives, women representatives, traditional healer, faith healer, traditional birth attendant, representative of disabled people and Nurse-In-Charge. The Nurse-In-Charge was the secretary of the committee. HCC members were a mechanism at which communities could participate at primary care level to support a people-centred health system, working with other community personnel and structures.

Health centre committee members' roles included mobilising resources from communities and other stakeholders. HCC-A indicated that, *we managed to mobilise communities at our health centre to pay wages for our security guards that protect our health centre premises during the night*. The communities reached the agreement after realising that there was constant drug theft that was affecting them therefore paying the security guard was the only solution of ensuring that patients get the drugs when they are sick.

In addition, at health centres A, C, D and E communities played pivotal roles of contributing some resources to develop the health facilities because of improved ownership sense that was brought by the programme. HCC-C indicated that communities moulded bricks for the mother waiting shelter and mobilised the youths to put a perimeter fence for the health centre. At health centre D the communities contributed money to buy roofing materials for the patients waiting shed, bought a generator and chairs used at the health centre. Last, but not least, at health centre E, communities' moulded bricks that were going to be used to build the mothers' waiting shelter and toilets for nurses.

Furthermore, the HCCs functions were also affected by the end of financial support. The HCCs no longer had the transport allowances to go to the district steering committee meetings to submit their reports on issues that come from community score cards. The district health institution did not have a budget to cater for these costs, although the DHE-1 indicated that the attendance of the HCCs in the meetings was helping the DHE to understand community's views and to improve on irregularities found in the district.

V. RESULTS

The CSC implementation had positive impact on the quality of health services in Shamva District. The description of the results that emerged are given in the next sub sections.

5.1 Increased health rights knowledge

The CSC strategy increased health rights knowledge to patients especially at treat health centres A, C, D and E where the programme was implemented. About 75% respondents of open-ended questionnaires highlighted that they were aware of their rights. QR-A pointed out that they acquired knowledge on right to privacy, confidentiality, choice of medication and consent. The NIC-D said, "*the communities knew the channels of complaining, they come to us if they were not treated well because they were taught about their rights*". WJ-B indicated that they had the right to choose the family planning contraceptives of their choice and understood their reproductive rights.

In addition, the CL also highlighted that the rights knowledge led to the reduction of child abuse cases and early marriages although more actions still needed to be done. QR-D said, "*we people living with HIV and AIDS and Sexual Transmitted Infections (STIs) we are no longer discriminated against because we now know our rights and we are living positively*". QR-E indicated that the knowledge opened their mind and they were respecting the rights of nurses also. HCC-E supported this point, she said, "*before acquiring the knowledge, communities expected nurses to work without taking breaks*". Therefore, the CSC improved the rights

knowledge for communities and health officials thereby improved quality of health services delivered to communities.

5.2 Improved relations between health staff and communities

Before the CSC implementation, both the HCCs and nurses at Health centres A, C, D and E acknowledged that there were conflicts and suspicion between them which were hindering quality health service delivery. The nurses were treated as bosses of health centres, who intimidated patients while patients were viewed as un-informed people. In addition, DHE-4 indicated that "*when the community scorecard programme started it caused mayhem in the district, the nurses felt challenged by the programme, but, latter became comfortable with the programme*". The programme enabled the two parties to reconcile.

The NIC-E indicated that they had good relations with their HCC members and the discussions they had on issues raised by communities through community scorecard helped them to iron out some outstanding challenges. She went on to say "*the HCC stand for us when there were challenges with politicians, they came into our shoes and protected us. We were fully represented by them to communities and they also fully represented the communities to us*". The engagement of communities and nurses at health centre level yielded good results which contributed to quality health service provision.

VI. CHALLENGES

There were challenges that were identified during the implementation of CSC in Shamva District. These are given in next sub section.

6.1 Lack of feedback documentation by HCCs

The study gathered that there were minutes for the meetings that were conducted between the HCCs and health officials at local and district level that were used at provincial, national level and to donors for administration purposes. However, there was lack of evidence that showed HCCs were giving feedback to communities on the progress made on their demands. The feedback might be happening in an unco-ordinated way. However, HCCs failed to prove their feedback mechanisms. Lack of documentation hampers informed decision making.

6.2 Poor sustainable plans

Failure by the programme to incorporate the programme in day to day routines of communities led the programme to stop after the end of external funding. Non-involvement of local leaders such as traditional leaders and councillors on training of health rights and other health-related issues also contributed to failure of the programmes after the end of external funding.

6.3 Lack of policy influence

The community score card programme did not manage to influence policy change in the district health sector. All the

health centre where the programme was being implemented had positive results of the programme, but this did not cascade to other health centres in the same district as health centre B where the programme was not being implemented.

6.4 Lack of decentralisation

The decentralised health structures were in place, but they lacked full autonomy and budget to implement their programmes. DHE-1 indicated that they relied on the centre for financial resources and authority to make some decisions. DHE-1 went on to say, "*it is very difficult to operate at district level while waiting for decisions to be made at national level*".

VII. DISCUSSION

Community score card programme was a game changer in Shamva District health sector. The programme managed empowered communities at health centres A, C, D and E with health rights and they demanded quality health services from the nurses. The district health executive acknowledges the improvements in the deliberative dialogue between communities and health workers. Lack of guaranteed funding and failure to indigenise the programme hampered the sustainability of the programme at some health centres.

VIII. CONCLUSIONS

The findings of the study covered above informed the conclusions of this study. The researcher concluded that social accountability strategies in Shamva District were tactical in nature they did not link up to strategic levels. There was no evidence of community score card activities influencing policy change.

The researcher also concluded that there was cosmetic participation between communities and HCCs. This was evidenced by lack of documentation for meetings the HCCs had with communities.

The researcher further concluded that without financial resources and sustainable plans CSC strategy did not yield purported results. Instead the programmes somehow created more donor dependency.

IX. RECOMMENDATIONS

The researcher proposes recommendations to health sector stakeholders in Shamva District. These are given below.

9.1 Linking social accountability to strategic policy issues

It is recommended that government officials and implementing organisations should link up tactical and strategic social accountability to influence the Shamva District communities to advocate and lobby for pro-poor policies that are relevant to them. Currently, Shamva District inputs are rarely linked to national decisions.

9.2 Capitalizing on the use of both organic and induced programming

It is recommended that Shamva District Health Sectors use mixed approach in CSC implementation. Mixed approach can sustain programmes beyond donor funding withdrawal. It is recommended that burial societies and community clubs' systems be used for sustainability.

9.3 Importance of documentation of evidence

It is recommended that communities and their representatives be trained on gathering evidence for their proposed programmes to get support from potential funders evidence is required to make funding decisions.

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