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EVIDENCE FOR ACTION

# Scorecards and social accountability for improved maternal and newborn health services: A pilot in the Ashanti and Volta regions of Ghana

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ABSTRACT

*Background:* With the limited availability of quality emergency obstetric and newborn care (EmONC) in Ghana, and a lack of dialogue on the issue at district level, the Evidence for Action (E4A) program (2011–2015) initiated a pilot intervention using a social accountability approach in two regions of Ghana. *Objective:* Using scorecards to assess and improve maternal and newborn health services, the intervention study evaluated the effectiveness of engaging multiple, health and non-health sector stakeholders at district level to improve the enabling environment for quality EmONC. *Methods:* The quantitative study component comprised two rounds of assessments in 37 health facilities. The qualitative component is based on an independent prospective policy study. *Results:* Results show a marked growth in a culture of accountability, with heightened levels of community participation, transparency, and improved clarity of lines of accountability among decision-makers. The breadth and type of quality of care improvements were dependent on the strength of community and government engagement in the process, especially in regard to more complex systemic changes. *Conclusion:* Engaging a broad network of stakeholders to support MNH services has great potential if implemented in ways that are context-appropriate and that build around full collaboration with government and civil society stakeholders.



## 1. Introduction

Although maternal and newborn mortality has decreased in Ghana in the last 20 years, generally progress has been slow [1]. Limited availability of quality emergency obstetric and newborn care (EmONC) is a major contributing factor. A 2011 EmONC national survey highlighted major gaps in the delivery of maternal and newborn health (MNH) care. Only 89 (8%) out of 1159 health facilities with a maternity ward had the capacity to provide the full complement of basic or comprehensive EmONC [2,3]. Three subsequent studies in Ghana also showed low quality of maternal and newborn care [4–6].

Based on an analysis of the challenges and opportunities in the MNH sector, the Evidence for Action (E4A) program in Ghana initiated a pilot intervention to improve the quality of maternal and newborn health care in its project districts. In Ashanti and Volta regions of Ghana, 17% and 15% of the facilities respectively fully met the EmONC status requirements in 2011 [3]—status was based on the performance of signal functions in the last 12 months. E4A Ghana (2012–2015) was a UK Department for International Development-funded program using evidence and advocacy to strengthen accountability for MNH. The intervention is based on a social accountability premise (see Martin Hilber et al. [7]) in line with approaches promoted by the government of Ghana.

The question underlying the E4A intervention was whether engaging stakeholders from different sectors, including community representatives, to assess and support local health facilities could create shared ownership and, through that shared ownership, improved accountability for MNH services that might, in turn, lead to improvements in quality of care. Potentially, involvement of community representatives can stimulate improvements in quality of services, but the effectiveness of community participation has varied greatly from one context to another and requires further study [8–10]. In general, there is a gap in published empirical data concerning community accountability

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initiatives in the health sector in general [10] and in MNH in particular (see Martin Hilber et al. [7]).

In Ghana, the 1992 Constitution of Ghana and other national legislation including the 2003 Local Government Service Act 656, the 1996 Ghana Health Service And Teaching Hospitals Act 525; and the 1994 National Development Planning (System) Act 480, provide the foundations for multistakeholder engagement and community participation within government processes.

However, translation of this inclusive strategy into Ghana's decentralized health system and MNH sector showed significant gaps. Quality assurance processes of facilities and MNH services are overseen by the Ghana Health Service (GHS) [11]. Hospitals have their own quality assurance teams, and health centers and Community Health and Planning Service (CHPS) compounds are also overseen by District Health Directorates through routine quarterly monitoring and supervisions. Clients and/or community members and other stakeholders such as municipal or district assemblies and community-based organizations (CBOs) have limited roles in monitoring and improving quality of care in health facilities [12], although the GHS Act 525 provides for their representation on District Health Management Teams (DHMT) (GHS Act 525 1996).

### 1.1. Research aim

The present paper examines qualitative and quantitative evidence from the social accountability intervention used by E4A to assess the effectiveness of engaging multiple health and non-health sector stakeholders to improve MNH services at facility level. It also identifies some limitations to this strategy and makes recommendations for future interventions of a similar nature.

### 1.2. Social accountability initiative overview

The initiative was designed to strengthen partnerships between clients, providers, and the community at large for improved MNH care through a social accountability process using scorecards. Before carrying out scorecard assessments, health providers and community-based NGOs were trained on MNH rights and client care to ensure a common understanding of entitlements in MNH service delivery. Although this intervention did not focus on clinical skills building for quality EmONC, the aim was to improve the enabling environment for EmONC and engage the community at large in this endeavor.

Between July 2014 and July 2015, the scorecard process was undertaken twice in 37 health facilities located in eight districts of the Ashanti and Volta Regions. The scorecard process involved assessing the enabling environment for health facilities to provide EmONC services, including clients' perspectives and satisfaction with MNH services received on the day of assessment. The results were later used to facilitate stakeholder meetings at the district/municipal, health facility, and community level (catchment area of facilities). The aim of these meetings was to promote and support a culture of partnership but also of accountability—both from the demand side (community participation) and from the supply side (increased engagement of decision makers, improved lines of accountability).

A nine member assessment team was formed in each of the participating districts/municipalities, including four members of the municipal/district health management team (M/DHMTs—an administrative body); a planning officer of the municipal/district assembly (M/DA—a political body), staff from a community-based organization (CBO) active in the E4A program; and three MNH council leaders. The rationale behind creating multistakeholder assessment teams was to provide opportunities for duty bearers (from both administrative and political bodies) and rights holders to work collectively to identify and address gaps across sectors.

Meetings organized at the district/municipal level brought together heads of all assessed health facilities, municipal district/assembly representatives, District Health Directorates, Regional Health Directorates, Ghana Health Service (national level), the National Health Insurance Authority (in some cases), community leaders, media, and CBOs. At the facility and community level, additional and follow-up interface meetings were organized that involved health facility staff and community members. Results from scorecards were used during the meetings to identify gaps and propose solutions for each facility, but also to promote understanding between clients, providers, and communities, for example around the skills and resource constraints under which facility staff worked. Scoring was shown by facility and by benchmarking facilities within districts to support transparency and promote some competition. At each round, facilities drew action plans with clear allocation of responsibilities and timelines for each solution proposed. Scores, gaps, and action plans were made public, including via the media, to foster transparency and accountability for improved MNH quality of care.

## 2. Materials and methods

### 2.1. Study settings

The intervention was piloted in 37 health facilities of eight districts of the Ashanti and Volta regions. The districts covered a range of different settings such as Asante Akim in the Ashanti region, which has a large population at around 140 000 in 2010 with 57% living in urban areas, to South Dayi in the Volta region with 47 000 people, only 39% of whom are considered urban [13].

Ten of the 37 facilities are hospitals designated to provide comprehensive EmONC services (CEmONC; including the ability to provide cesarean delivery and blood transfusion). The remaining 27 basic EmONC (BEmONC) facilities were comprised of 18 health centers, seven clinics, one polyclinic, and one CHPS compound.

### 2.2. Study design

The study had two components. The quantitative component comprised two rounds of facility assessments. The qualitative component prospectively assessed the impact of changes in policy, attitudes, and/or practices.

### 2.3. Facility assessments

The E4A team in collaboration with GHS developed the facility assessment questionnaires based on key domains of quality of MNH care (Box 1). The full overview of scorecard questions under each

**Box 1**
Themes covered in the assessment tools.

*Assessment Tool 1: Facility Infrastructure and Equipment – MNH services*

Domain 1: Accessibility and access to information
Domain 2: Staffing
Domain 3: Infrastructure (including electricity)
Domain 4: Water, sanitation, and hygiene
Domain 5: Essential equipment
Domain 6: Essential drugs

*Assessment Tool 2 – Client Perspectives – MNH services*

Domain 1: Accessibility of facility
Domain 2: Access to information
Domain 3a: Provider–client interaction - prenatal care
Domain 3b: Provider–client interaction - delivery
Domain 3c: Provider–client interaction - postnatal care