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Enhancing social accountability for health care in Afghanistan

In the United States and parts of Africa and Asia, community scorecards (CSCs) have improved accountability and responsiveness of services. Work supported by Future Health Systems (FHS) sought to evaluate CSC feasibility in a fragile context (Afghanistan) through joint engagement of service providers and community members in the design of patient-centred services, to assess impact on service delivery and perceived quality of care (QOC).

Background

Since 2005, the Community Based Healthcare Department (CBHC) at the Afghanistan Ministry of Public Health (MOPH) has instituted several community engagement strategies to ensure access to quality primary health services, including the deployment of over 29,000 community health workers, institution of community health councils and community health supervisors. However, while the Afghanistan balanced scorecard (BSC) proved to be a successful tool for oversight of contracted services, there were minimal measures for patient perspectives on QOC.

The CSC – a hybrid of a social audit and citizen report card that aims to empower communities, enhance responsiveness in the delivery of care, and strengthen progress toward national and global health goals – has been successfully implemented in Africa and Asia. However, in 2011 the application of CSC in fragile contexts had not been documented. CSCs may work differently in fragile contexts: issues such as lack of trust between communities and the public health system, and fragmentation and conflict within communities might undermine their effectiveness. The FHS team at Johns Hopkins University therefore designed an exploratory research study to determine CSC feasibility in Afghanistan, building upon previous BSC work.

> "Evidence from FHS research led to the adoption of the community scorecard by the Ministry of Public Health."

The research

The research had two phases. First, a multi-stakeholder mixed methods study was conducted on community capacity investments and with MOPH and NGO interest in exploring CSC feasibility. Based on these findings, a follow-up exploratory study was conducted in partnership with the CBHC National Coordinator at the Afghanistan Ministry of Public Health. The critical question was: how do you keep communities involved in health system governance, accountability and transparency to ensure service quality, utilization and facility performance?

In 2011, an awareness workshop was conducted with the MOPH and its stakeholders, including NGOs, the World Bank, WHO, UNICEF, and CBHC technical advisory boards. CSC experience and evidence from other countries was shared, and NGOs delivering the basic package of services were solicited to join the CSC research. Initially two NGOs volunteered to launch and test CSC in two provinces. In 2013, a third NGO volunteered to test feasibility in a different province. They then engaged health facility staff and provincial directorate to gain interest. Despite intense initial scepticism among stakeholders about the ability of engaging communities in measuring facility performance and accountability, the CSC implementation research proceeded.

During focus group discussions with community members and leaders on strategies and services provided by the national health service, it became clear that some community expectations were too ambitious, so the FHS team and partners developed a strategy to inform communities of their entitlements based on the BPHS standards for primary care facilities.

The CSC process created community awareness and CSC metrics were determined through a collaborative process involving communities and health providers. The metrics included a health provider self-assessment scorecard, to be conducted

every three months and performance was reviewed during facilitated meetings between communities and health care providers.

Communities tended to score provider performance and QOC relatively highly. Infrastructure and supplies scored the lowest, causing stakeholders to discuss how to address these issues and build community ownership. The renewed relationship seemed to have improved utilisation of the facilities. Through three rounds of CSC – one every three months – the community and facility staff reviewed results and developed action plans for who should take responsibility for improvements. Improvements at different facilities included assuring water supply, increasing cleanliness, creating waiting rooms for women, repair and cleanliness of toilets, increased beds for maternity units, deployment of a female nurse, and solar power installation.

Participating NGOs were excited by the results, especially from some very remote areas. However, the MOPH felt that this strategy may not be as successful in remote provinces like Takhar, with ethnically diverse communities that were resistant to change and more difficult to work in. An additional CSC pilot was undertaken in Takhar, and surprisingly, even better results were observed here.

What changes took place?

The CSC process promoted social accountability through the participation of key stakeholders in identifying and addressing health system challenges. Overall it created an environment that enabled the sharing of opinions, perspectives and recommendations, and collective action plan development. This process appeared successful, despite the history of conflict, and potential distrust.

In October 2015, due to the success of the CSC process, the Minister of Health endorsed the CSC as a national strategy for community engagement.

The CSC process also had a wider impact. In 2013, three FHS Afghanistan team members travelled to Zambia to another DFID-funded project implemented by World Vision International to exchange experiences on CSCs.

How did FHS contribute to the changes?

The leadership and buy-in of the long-standing CBHC National Coordinator was essential to the success of the CSC process, as people believed and trusted him. Additionally, managers of participating NGOs were enthusiastic, instrumental and committed to change.

FHS provided important facilitation, and supported operations research on the CSC that was implemented in various health facilities in Afghanistan. Evidence from this research led to the adoption of CSC by the MOPH.

What next?

FHS findings in Afghanistan suggest that CSC, if contextualised appropriately, can be a useful strategy for the integration of community perspectives in the care process to enhance local health system performance in post-conflict settings. Other recent publications (such as Ho et al, 2015) have demonstrated similar findings in other post-conflict settings.

While the MOPH has endorsed the CSC, it is important to continue to support the MOPH CBHC and advocate for support for institutionalising the CSC. This is particularly important if NGOs are to take the CSC forward without financing.

CREDITS

This Story of Change was prepared by Anbrasi Edward, Johns Hopkins Bloomberg School of Public Health.

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