Research Brief

Future Health Systems
Innovations for equity

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Community scorecards: engaging community and bringing in positive changes to health service delivery at community clinics in rural Bangladesh

Community clinics, a flagship programme of the Government of Bangladesh, are health facilities set up to deliver primary health care, family planning and nutrition services to rural people at the grassroots level. Currently there are 13,500 community clinics (CC) in Bangladesh, aimed to cover every 6000 rural population. This set up is a unique example of public-private partnership as community clinics run through community participation. A community clinic is managed by a Community Group (CG), representing healthcare providers and a Community Support Group (CSG) that is representative of the community (Figure 1). Despite the widespread establishment of the community clinics, challenges such as shortage of supply, provider absenteeism, lack of properly defined roles and responsibilities of human resources, poor behaviour towards patients, weak accountability and governance, and absence of active participation from community in healthcare delivery restrict efficient use of these facilities and available resources.

To complement the monitoring mechanism of community clinics, the Future Health Systems (FHS) Bangladesh team at icddr,b aimed to implement a community scorecard (CSC) to ensure community participation and provider accountability in the local health system. A CSC is a social audit tool that brings together service users and providers of a particular service to assess, plan, monitor and evaluate services.

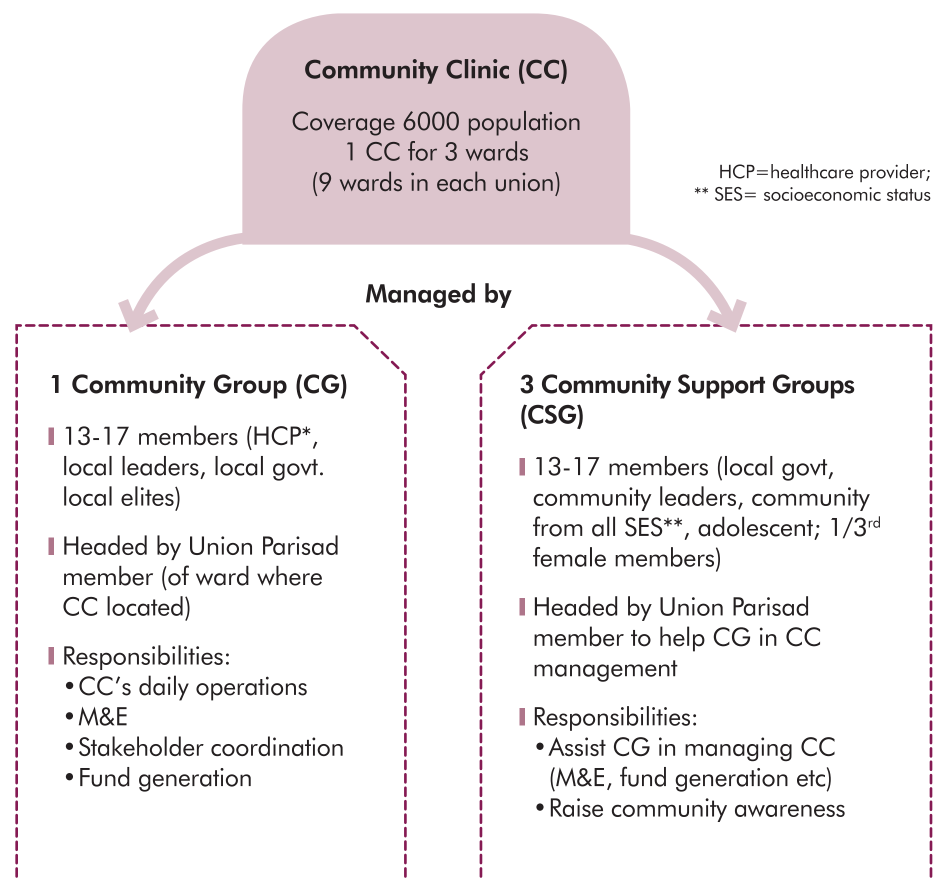

Figure 1: Management of Community Clinics

The process of CSC implementation constituted of four basic phases:

(figure 2)

Phase 1:
Planning and preparation

Rapport building activities were done with CC committees; orientation sessions were held to clarify the functions of CCs, the roles and responsibilities of CG and CSG members, and to introduce the CSC; stakeholder and accountability mapping sessions were done with community and providers.

Phase 2:
Community and provider generated scorecard

Separate sessions were held with community and providers where problems in the CCs and their related indicators were identified, listed, scored (on a scale of 1 to 5, 5 being the highest score) and prioritized.

Phase 3:
Interface meeting and action plan setting

Consensus was built between community and providers around common sets of priority indicators and targets; and action plans were developed with responsible persons, timeline, and required resources to achieve those set targets.

Phase 4:
Action plan implementation and monitoring and evaluation

Responsible persons took steps to carry out set tasks and monitor progress of CSC implementation.

The intervention was implemented in three community clinics in Manikpur, Baraitali, and Shaharbil Union of Chakaria Upazila (sub-district) which is located in the Cox's Bazar district in the southeast coastal area of Bangladesh.

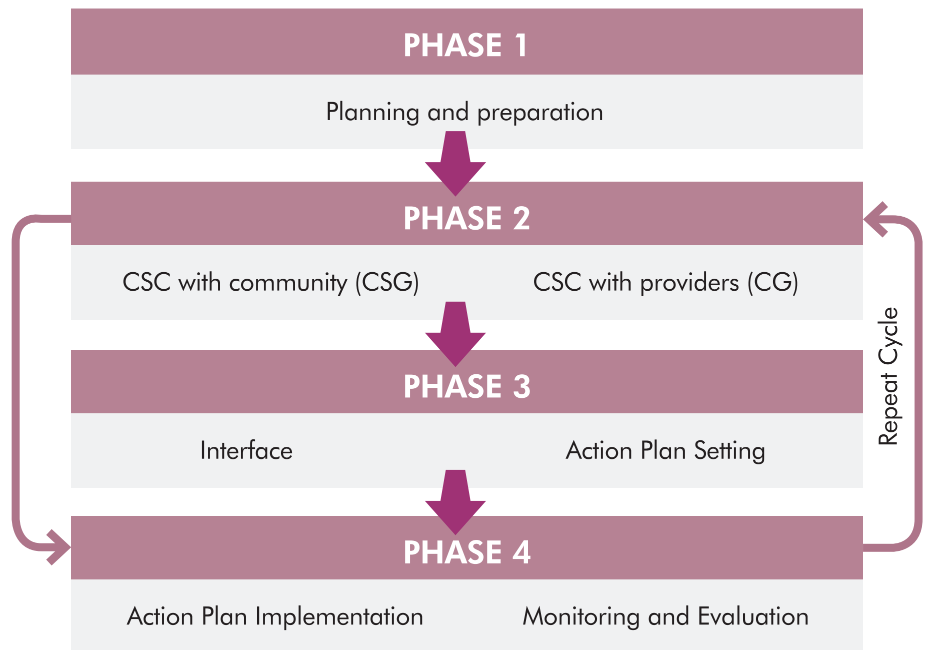

Figure 2: Community Scorecard Implementation Process Diagram

One implementation cycle constituted of activities from phase two to four which were then repeated for the next cycle. The time gap between each cycle of CSC was two months. Between January to October of 2018, three cycles of CSC have been completed.

This research brief presents the learnings from the three cycles of community scorecard implementation in the intervention community clinics.

CG members generating scorecard in Manikpur, Chakaria • September 2018

Mother and child waiting for service at the community clinic in Shaharbil, Chakaria

Key changes brought about by implementation of CSC

CSC implementation process identified several indicators for change. Key changes brought about by the process in the three community clinics are shown in Figures 3-5. The community and the provider committees identified indicators in four broad categories:

COMMUNITY OWNERSHIP

Even though the CC manual mandated CG members and CSG members to manage day to day activities and assist in ensuring smooth functioning of CCs, in reality, there was lack of awareness about the roles and responsibilities of the members, leading to limited contribution by committee members for the betterment of the facilities. The CSC process built stronger community ownership. Following CSC implementation, CGs and CSGs are now more active in their mandated activities and are taking lead in decision making, identifying problems and rectifying the ones they can with the resources they have at hand. In Manikpur CC, there has been a steady increase in the score (from 2.7 in Cycle 1 to 5 in Cycle 3) for committee members knowing about their roles and responsibilities and attending meetings. Similarly in the CC in Shaharbil, the CSG made necessary reforms to committee formation and became more active over the period of the 3 CSC cycles which can be seen in the increasing scores (2.9 in Cycle 1 to 4.1 in Cycle 3).

FACILITY IMPROVEMENT AND INFRASTRUCTURE MANAGEMENT

Pre CSC implementation, some of the CC facilities were in a rundown condition. Due to lack of regular maintenance, inadequate infrastructure and logistics, repairs were needed. After the problem of inadequate seating was identified in Manikpur CC in the first CSC cycle, the CG took the initiative to arrange for extra chairs with local donation, which is reflected in the improvement in scores (2 in Cycle 1, 4 in Cycle 3). In Baraitali CC, lack of electricity was identified as a major problem and was scored only 1.9 in the first CSC cycle. By Cycle 2, arrangements were made to ensure power supply, thereby achieving a score of 5. In Shaharbil CC, the CSC identified lack of water supply and inadequate furniture as problems where improvements have been made over the three CSC cycles (2.8 in Cycle 1, 4 in Cycle 3). These improvements made the CCs more user-friendly and responsive towards community needs.

ENSURING ACCOUNTABILITY IN SERVICE DELIVERY

A major barrier in the community clinics was lack of local level accountability among providers which severely hampered service delivery. Operation times of the CCs were not maintained

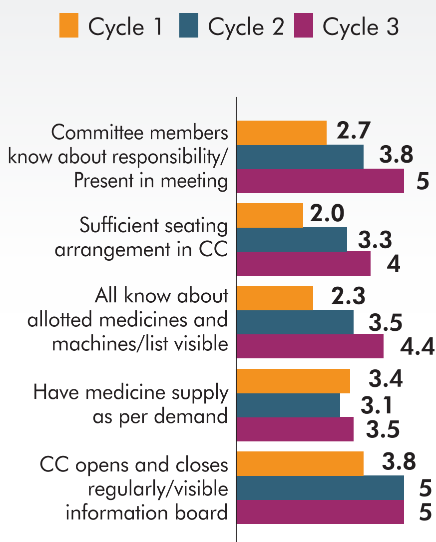

Figure 3: CSC indicators and change in scores, Manikpur CC

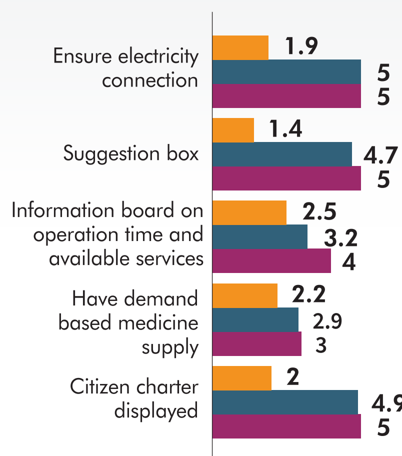

Figure 4: CSC indicators and change in scores, Baraitali CC

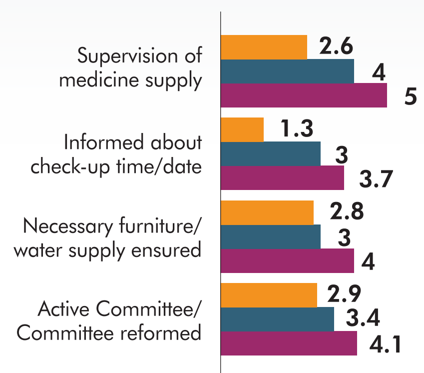

Figure 5: CSC indicators and change in scores, Shaharbil CC

properly, providers were often absent/late, there was lack of clarity among users about what services are offered at the CC. The CSC process helped to improve this situation. The Manikpur CC now has a list of medicines available and information board displayed, and the CSC scores show that people's knowledge about allotted medicines and machines in the CC have improved over the 3 cycles (2.3 in Cycle 1, 4.4 in Cycle 3). Improvements have also been achieved in terms of maintaining regular CC opening and closing times (3.8 in Cycle 1, 5 in Cycle 2). In Baraitali CC, based on the indicators identified, the CC committees installed a suggestion/complaint box (1.4 in Cycle 1, 5 in Cycle 3), hung up an information board with operation times and available services (2.5 in Cycle 1, 4 in Cycle 3) and displayed the Citizen Charter at the facility premise (2 in Cycle 1, 5 in Cycle 3). Supervision of medicine supply in Shaharbil CC has drastically improved (score of 5 in Cycle 3) since it was indicated as a problem in the first CSC cycle and given a score of only 2.6.

COMMUNITY AWARENESS ABOUT HEALTH SERVICES

Before the CSC process, many community members viewed community clinics as mere drug dispensaries. They were not fully aware of the health services that are offered at the clinics. The implementation of the CSC saw improvements in this area as well. Users of the community clinic in Shaharbil were more informed about antenatal/prenatal check-ups times and dates after CSC implementation than they were before (1.3 in Cycle 1, 3.7 in Cycle 3).

Benefits & Challenges

The experience from a short term implementation of CSC at CCs of rural Bangladesh has highlighted some potential benefits as well as some challenges of using CSC to improve service delivery, accountability and governance.

Benefits:

- Improving dialogue and relationship between provider and user.
- Facilitating common understanding of issues and solutions to problems.
- Empowering community to identify challenges by themselves and propose solutions.
- Ensuring community monitoring.
- Improving community ownership and participation in CC service provision.
- Clarifying roles and responsibilities of users in service delivery.
- Improving accountability and governance in health service provision at CCs.
- Creating opportunities for providers to monitor service quality together with the user.

Challenges:

- Additional time and resource are required for implementation of CSC in the facilities.
- Possible conflict of interest between provider and user (good facilitation skill is required to avoid this).
- Building consensus among participants regarding ranking and prioritizing issues can be challenging. A proper facilitation skill can help overcome this issue.
- Unrealistic expectations from users about services offered at CCs.
- Lack of awareness and orientation on roles and responsibilities of CG/CSG members hampered creating an enabling environment for implementation of CC activities.
- Service providers were not aware of community perspective about service provision which limited opportunities for joint action towards the initial stage of implementation.
- Furthermore, there were some challenges which were beyond the control of the local authority and higher level lobbying is required to overcome these barriers.

The security of Uttar Baraitali Community Clinic was always a concern. Post CSC implementation, through collective action of the CSG, CG and local government, a boundary wall was built around the premises.

Salient Learnings

- The CSC is a simple tool that can be used by community based management committees like CSG and CGs to enhance community participation in health and monitor service delivery with an aim to improve quality of services, accountability and governance.
- Identifying indicators in the CSC process is crucial. Community members are able to identify problems by themselves. However, converting the issues to measurable and achievable indicators require proper facilitation and training.
- Sustainability of CSC is dependent on building proper facilitation skills for CSC sessions. Budget for arranging meetings and identifying key facilitators is needed to ensure sustainability.
- CSC has its limitations in terms of the type of issues it can assist to resolve. For issues beyond local level control, other complementary mechanisms need to be identified.
- At the policy level, the process of implementing CSC can be adopted to complement the monitoring mechanism of community clinics mandated by the Government of Bangladesh.
- Finally, in the context of Bangladesh, where the community is largely unaware of their health rights and entitlements, and the providers don't always see accountability process as constructive, the initial mobilization and awareness building sessions are critical in successful implementation of CSC.

CREDITS

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