Research Brief

Future Health Systems
Innovations for equity

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Accountability in health service delivery: a community scorecard exploration in rural Bangladesh

Community clinics were established by the Government of Bangladesh with an aim to extend primary health services to the grassroots population in rural areas. Currently there are 13,500 CCs throughout the country and each covers 6,000 population under its jurisdiction and are meant to provide maternal, child health, family planning and other primary health care services. However, challenges still remain in ensuring accountability, quality and equity in healthcare service at the local level. Voice and accountability mechanism are almost non-existent. There are gaps in logistics, quality assurance procedures and the facilities suffer from high staff absenteeism, unskilled staff and inefficient use of supplies. Stakeholders are not fully aware of clinics' purposes and there is weak communication and lack of involvement of local government institutions.

The Future Health Systems project of icddr,b, Bangladesh introduced and implemented community scorecards (CSC) as a means to sensitize the existing community clinic management groups and the community to strengthen accountability relations and improve performance of the community clinics. CSC is a citizen driven accountability process for assessment, planning, monitoring and evaluation of service delivery. This tool aims to gather feedback from service users to improve communication between service providers and the community and make a positive influence on accountability, quality, efficiency and equity in service delivery.

Prior to implementing the CSC, an accountability mapping exercise was carried out following the Brinkerhoff framework to explore the level of understanding around accountability in health systems amongst users and the healthcare providers and the accountability relations in health service provision. Nine accountability mapping sessions at the nine catchment areas under 3 community clinics were carried out between August to November 2017 in Chakaria, Cox's Bazar. Each session had 12-15 participants (with CC's Community Support Group and health care providers). This research brief highlights findings from the accountability mapping.

Accountability mapping session

Understanding around accountability: community and provider perspectives

Participants of the accountability mapping sessions were asked to share their understanding around accountability in health sector. From the discussion we found that accountability in Bengali is most of the times interpreted as answerability or "*jobabdihita*" in Bangla. We tried to find out how the local people and the healthcare providers understand the meaning of '*jobabdihita*'. A few of the responses were:

"(Accountability is being) answerable to the people living in the community for any development decision/actions/services by the government or local government bodies (*Shorkar ba Union Parishad er kono unnoyon karjokrom ba sheba karjokrom er jonno sthaniyo jonogoner kachhe jobab ditey ba tottho dite baddho thaka*)." (45 year old male community participant)

"Accountability means answerability (*jobabdihita*), answerability of concerned person for his/her action or giving an account of one's activities to his linked body or institutions (*Jobabdihita hochhe jobab dewa, kono kaajer hishab dewa, songslisto bektir o protisthaner kachhe taar kaajer hishab ba kaaj bujhiye dewa*)." (58 year old male community participant)

Health Assistant vaccinating an infant at the CC in Shaharbil, Chakaria

According to service providers:

"answerability is not only to report on what was done or what has not been done, but also to explain how it's been done and providing explanation in writing regarding the reasons for not being able to do the expected work (*Jobabdihita shudhu matro protibedon dewa noy, kaajer orjon ba howa na howar pechone karon ki taar likhito protibedon dewa*)" (25 year old female service provider).

'*Baddhobadhokota*' (being bound to) '*dayee*' (being responsible) '*kortobbo*'(duties) '*protigga ba protisruti*'(promises) were a few words used to explain accountability. According to some

"Accountability is legal/social obligation to account for fulfillment of someone's commitment or promise for services (*Jobabdihita hochhe karo shebar jonno dewa protisruti puroner jonno samajik/aingoto badhdhobadhokota.*)" (46 year old male Provider)

For some, accountability was seen as a punitive action or a punishment.

"*Jobabdihita* is a punitive action, a 'punishment' for not doing something or wrong doing (*kono kaaj na kora ba bhul kaajer jonno shasti ba shastimulok babostha*)." (35 year old male provider)

Accountability mapping

The process

The Brinkerhoff matrix maps accountability linkages and highlights stakeholder interactions where each stakeholder is placed in both rows and columns to allow exploring interactions between each pair. The matrix shows patterns of answerability and sanctions in terms of which stakeholders can demand information and impose sanctions, and which stakeholders are charged with supplying information and are subject to sanctions. In our case, the matrix was populated by the participants. With technical support from icddr,b, the community people and the providers developed a free list of stakeholders and identified people/ institutions/group in the accountability network of health service provision.

List of stakeholders identified by the community people

- CC service recipients (rich, poor, male, female, children, pregnant women, etc);
- CC management committee members (Community Groups [CG]; Community Support Groups [CSG]); Health Department (Upazila Health Complex [UHC], Upazila Health & Family Planning Officer [UH&FPO], Community Health Care Provider [CHCP], Health Assistant, etc); Family Planning department personnel (Family Welfare Assistant [FWA], Family Planning Inspector [FPI], etc.);
- Local government official (Union Parishad [UP] Chairman, UP Members, Upazila Nirbahi Officer [UNO] / Sub-district executive officer), Upazila Parishad, etc.)

List of stakeholders identified by service providers

- Service users (male, female, children, rich, poor, etc.);
- Health service providers (CHCP, HA, UHC, Civil Surgeon, Line director/ Director General Health Services [DGHS], FWA, FPI, UH&FPO, Deputy Director, Family Planning [DDFP] etc.);
- Local Government (Union Parishad, Upazila Parishad, UNO, etc.)

Power relations and sanctions

Figure 1 shows findings from the accountability matrix. Once identified, the stakeholders were grouped into broader categories and placed in the matrix. Participants then assigned different arrows (thin arrow to indicate weak capacity, medium to indicate medium capacity and thick arrow to indicate strong capacity) to indicate the variance in capacity of each pair of actors to demand or supply information or to impose or respond to sanction from each other. Based on the ''technical / material capacity'' the participants used a scale of 0 to 3 to identify power of each pair of stakeholders. (0=no capacity for response / sanctions and no knowledge of demand supply issues; 1= Limited or unclear knowledge and limited capacity; 2= Clear but incomplete knoweledge and some capacity; and 3= Strong knowledge and fully defined responsibilities and established capacities). This scale was pre-defined by the research team and explained beforhand to participants.

Figure 1: Health Sector Accountability Matrix
Supply/Response Capacity, Chakaria, September 2017

Health Sector Actors		Demand Information, Impose Sanctions							
		S. Providers	S. Receiver	Local Govt.	CG/CSG	UHC	FP Office	CS Office	DGHS
Supply Information, Respond to Sanctions	Service Providers		↓↑ (1)	↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)
	Service Receiver	↓↑ (2)		↓↑ (2)	↓↑ (3)	↓↑ (3)	↓↑ (2)	↓↑ (2)	↓↑ (3)
	Local Govt.	↓↑ (3)	↓↑ (2)		↓↑ (3)	↓↑ (2)	↓↑ (3)	↓↑ (3)	↓↑ (3)
	CG/CSG	↓↑ (3)	↓↑ (3)	↓↑ (3)		↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)
	UHC	↓↑ (3)	↓↑ (1)	↓↑ (3)	↓↑ (3)		↓↑ (3)	↓↑ (3)	↓↑ (3)
	FP Office	↓↑ (2)	↓↑ (0)	↓↑ (3)	↓↑ (3)	↓↑ (3)		↓↑ (3)	↓↑ (3)
	CS Office	↓↑ (2)	↓↑ (1)	↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)		↓↑ (3)
	DGHS	↓↑ (2)	↓↑ (0)	↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)	↓↑ (3)	

↓=Demand, ↑=Supply | ↓↑=Strong, ↓↑=Medium, ↓↑=Weak

Learnings from accountability mapping

1. The arrows originating from top authority were mostly thick, reflecting the fact that accountability relations are top-down. Only the local level actors are accountable to higher authorities and not vice-versa.
2. There is an imbalance of power relation between top level and local stakeholders, thus making the bottom to top link weak (specifically from beneficiary to provider) which acts as a bottleneck to a responsive health system.
3. Two directorates in health sector (DGHS and DGFP) are involved in service delivery and management of CCs but there is weak or no connection between the two wings, giving rise to inefficiency in the system.

Challenges to ensure accountability in health systems

The participants also identified some key challenges in the accountability relations:

1. There is weak monitoring of CC management committee activities from the central level. Although the number of management committee meetings is reported in the national information system (DHIS2), the details of these meetings and the meeting minutes are not available.
2. Not all community clinic staff are permanent government appointees which creates a lack of ownership.
3. Political influence on CG/CSG formation interrupts effective monitoring and operation of community clinics.
4. Community Support Groups (CSG) are not always active and members are, in general, not aware of their roles and responsibilities which hinders establishing an effective accountability mechanism.
5. Community people did not have clear understanding of how they can contribute in improving service delivery and accountability at community clinics. Community participation in health, although was inherent in the design of CCs, was almost nonexistent. Apart from infrequent financial contributions, no other effective opportunities exist for community engagement in health.
6. Healthcare providers, in general, do not see monitoring mechanisms as constructive. In the case of CSC, initially it was not liked by the providers as they thought it would point fingers at them for unsatisfactory service provision.
7. Local stakeholders' voices are not heard strongly. There is no process within the health system where demands can be placed from community to the top management.
8. Lack of power or right of grassroots level workers to place demand strongly to their higher authority.

Complaint box at Chakaria Upazila Health Complex

Potential effect of CSC on ensuring health system accountability

Although only a few rounds of CSC were implemented, we experienced some potentially positive effects of CSC on accountability. The CSC process:

- Created opportunities for effective dialogue between community and service providers.
- Increased voice of community members in health service delivery (e.g. ask questions about services, express any dissatisfaction).
- Increased participation of community in raising funds for community clinic development.
- Community playing active role in monitoring community clinic activities and assisting efficient functioning of community clinic (displaying operation time, service availability chart, etc).
- Engaged local government representatives and they are now taking interest in CC operation and CG,CSG meeting agenda.
- Encouraged community to take lead in communicating with local government authorities and to negotiate with representatives in solving issues around CC service delivery and fund raising. The group through CSC started to negotiate with local government representative to allocate funds for CC operation and management.

Recommendations to strengthen accountability

- A bottom up approach needs to be developed to ensure a responsive health system that is accountable to its users.
- A stronger and effective central level monitoring mechanism should be in place to establish accountability in health.
- An effective communication strategy needs to be developed to allow healthcare providers at the grassroots level to communicate with higher level authorities.
- Health system management should be transparent and it should take initiative to engage community in decision making, mobilization and allocation of resources through a participatory mechanism like CSC.
- Awareness should be built about roles and responsibilities of community members as well as providers in health service provision.
- Organizational structure should be supportive of engaging community in health service management and delivery. Providers should be adequately trained to engage with community members.

Community clinic at Manikpur, Chakaria

CREDITS

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