

A community health watch to establish accountability and improve performance of the health system

This research brief focuses on a pilot community empowerment tool that was developed and implemented in a union in Chakaria, a remote coastal area near the southeastern tip of Bangladesh. The tool was intended to enable the community to monitor health services and their utilization by mobilizing and empowering people through increasing their awareness of health, health rights and existing health services. The tool also focused on involvement of community leaders and elected representatives in the process to ensure the goals were reached.

A study was carried out in Purboborobheola union of Chakaria, a remote rural area under Cox's Bazar district of Chittagong division in Bangladesh, a low performing area in terms of health and development indicators during 2006 and 2007. Nine neighbouring communities (i.e. nine wards in one union) participated in the study.

The government health facilities available in and around the study area consisted of the family welfare center (FWC) in Purboborobheola, one of which is typically located in each union of an upazila,

and the nearby Upazila Health Complex (UHC). The FWC in each union provides very basic primary care. It is staffed by a Sub-Assistant Community Medical Officer with the qualifications of a paramedic, a Family Welfare Visitor trained in family planning and maternal health, and an assistant. The Upazila Health Complex, which is situated at an average distance of 3.4 km from all the villages in the study, is staffed by 9 doctors, a dental surgeon, has X-ray, pathology, family planning departments and an operating theater.



Dissemination of community monitoring results and dialogue between local leaders and the community



Men's discussion session

The core of the study was the development of a community empowerment tool that was designed to mobilize the community in three stages. Stage one involved building a rapport with the community, assessing community needs and identifying solutions to existing health problems and needs. Stage two involved developing a monitoring plan and its implementation by the community. Stage three involved data analysis and interpretation by the community of the data collected by community monitoring teams, and disseminating those results to community members and the local leadership. The dissemination sessions were designed to not only distribute information but also receive feedback from the community and discuss solutions. Stages two and three form the crux of the health watch activities and were repeated in 4 month cycles.

People of all age groups above fifteen years participated in this study. The study developed a community mobilization and empowerment tool that enabled community members to interact with the health facilities they have access to in an organized way, in a capacity different from their usual interaction with the health system.

Building an empowerment tool: Stage one

Community discussions

The first stage of the study was that of building a dialogue with the community. Initial meetings with community leaders, discussions with community members were ways of judging the palatability of the topic and the feasibility of success of the study goal. Union Parishad members, the local elected leadership of the people were found to be enthusiastic about the study goals and were themselves concerned about the quality of health services being offered to the people.

Following the meetings with community leaders, discussion meetings with the community were arranged. Men and women, young and old, rich and poor, and the vulnerable were invited to come and participate in these discussions.

The topics in these meetings were intended to generate and increase knowledge of community

members about their health status, health needs and rights, the health system and to build bridges and better communication between the different stakeholders in the community (rich and poor, citizens and government officials, patients and health providers). To this end, common health problems faced by the community, existing health resources, and problems in the health facilities were discussed.

The sessions were also used to search for solutions to existing health issues and to think about an action plan to improve the health situation. The concept and utility of a process of monitoring for ensuring better health services and access to health services were also discussed in these sessions. Participants responded well to the concept of monitoring, particularly as the idea resonated with their use of it in their daily lives in tending crops, preparing and cooking food, or in ensuring children are getting the best out of their education. Participants discussed different indicators that could be monitored to look at the use of health facilities and the quality of services offered there. The crucial external assistance required identified by the community was technical assistance which was then promised by the ICDDR,B study team.

Building an empowerment tool: Stage two

Formation of community monitoring teams

Each community identified volunteers for a monitoring team and its leadership. Both women and men, young and old were conscripted in each of these teams of six to eight with three to four community leaders forming a progress review committee. The community monitoring team members volunteered their time to do the bulk of the work in gathering data, analyzing and interpreting it. Progress review committee (PRC) members were responsible for guiding the local community teams in the monitoring process.

Training community monitoring teams and PRCs

Training sessions were organized that provided training to the community monitoring team member



Community team conducting interview

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Data collected by community monitoring teams



Messages from community monitoring

and Progress Review Committee members on different aspects of the monitoring process, particularly on the purpose of the monitoring, how to conduct interviews, and how to conduct community surveys using a simplified Lot Quality Assurance Sampling technique among other topics. The components of a health system were also discussed.

Community monitoring of health and health facilities

The community monitoring team members in each community conducted exit interviews at the Union Health and Family Welfare Centre (UH&FWC) as well as in the Thana Health Complex to collect data on who are visiting the health facilities and the barriers to healthcare they face. The various teams followed a schedule for monitoring set up by the PRC.

The monitoring teams also conducted community surveys using the LQAS sampling technique to collect data on health or the coverage of health services on relevant topic of their choice. Three LQAS community surveys were conducted on immunization status, sanitary facilities available and use of iodized salt.

Building an empowerment tool: Stage three

Community data analysis and findings

After each round of data collection, the community monitoring teams and PRC members in each ward met in a workshop where they were trained in data compilation and data analysis methods. The teams would then produce a table of the compiled data

collected in the current round of health facilities exit interviews and LQAS community health assessment. The teams were also trained in how to analyze and interpret the data they had compiled. They took part in exercises to produce key messages interpreting the data for dissemination to local leaders and all community members.

Findings from the community data analysis showed the number of patients attending the Family Welfare Center and the Upazila Health Complex broken down by sex, age, literacy and distance of dwelling from facility. The community found that about 4.5 times more women than men come to the FWC for healthcare whereas in the UHC the numbers are about the same. Most patients who visit the FWC live nearby and come walking, while patients from near and far are equally likely to visit the UHC and employ different kinds of transport to do so. Equal numbers of male and female child patients were brought to the FWC while more male children compared to female children were taken to the UHC for care. More women than men faced barriers to healthcare in both the FWC and the UHC.

Some of the barriers to good healthcare identified were:

- Have to stand in line for a long time.
- Have to get blood tests done at own cost although laboratory exists in health facility.
- As the doctor leaves early (before scheduled time), he/she cannot see the reports.
- Doctor does not want to hear description of the illness from the patient.
- Correct medicine not given.
- Doctor does not use correct instruments to diagnose illness.

- While keeping patients waiting in line, the doctor stays busy with representatives from medicine companies.
- When patients take a slip to visit a specific doctor, the doctor cannot be found.

The LQAS community surveys found that six out of nine communities did not have adequate sanitary latrine facilities, while all nine communities had adequate vaccination coverage.

Disseminating findings and dialogue with community

Each monitoring team and PRC disseminated its findings to their community regularly at the end of each cycle of data collection, compilation and analysis. A larger dissemination at the union level took place at the end of a year of activities where the data collected and analyzed were presented in various forms. Tables of compiled data with findings, key messages in words and pictures that reflected the findings of the data gathered through monitoring

Complex. The same findings were also presented orally by a representative from the monitoring teams to community members and leaders present. These presentations formed the basis of a public dialogue between the community and various elected leaders and government officials.

Findings

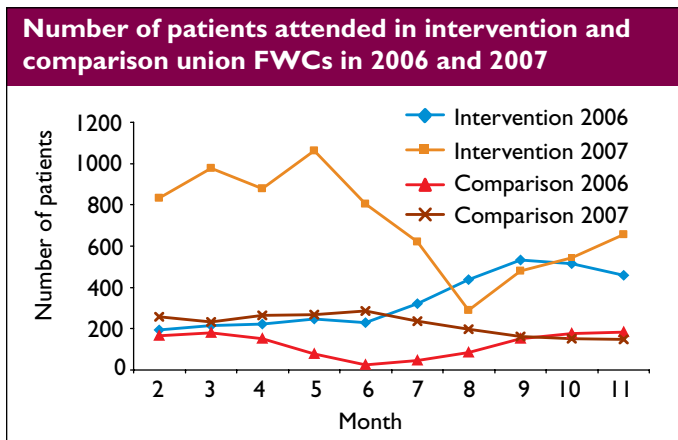
Results of facilities level data collected for a period of one year indicated that the working days of the SACMO (sub assistant community medical officer) at the FWC in the study union increased from 116 days to 181 days (56% increase) during the year compared to 92 days to 103 days (12% increase) in the comparison union.

A successful dialogue with local level government officials and the community was developed through this process of monitoring. Government representatives and elected leaders, the Union Parishad officials, played a leadership role in the monitoring process and also helped influence changes in the performance of health facilities staff.

Conclusion

A community can be mobilized using the methods developed in this model of a community empowerment tool. A tool such as this can work if it is well-planned, if it has clear achievable goals that answer a clear need in the community, a method that develops over time and in logical stages.

In essence, this whole process of developing a community empowerment tool resulted in a dialogue that has the potential to make a real change in the health services and in the relationship between provider and recipients.



were composed by each monitoring team and displayed as posters in the Purboborobheola Union

Prepared by Rumesa R. Aziz. Source: Aziz RR, Bhuiya A, Hanifi SMA, Iqbal M, Hoque S. Better health services through community monitoring: A local health watch model. Unpublished.

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