TECHNICAL BRIEF

PARTICIPATORY ACCOUNTABILITY TOOLS FOR IMPROVING HEALTH SERVICE DELIVERY:
Lessons from the Community Score Card Process in Bangladesh
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Abstract

The United States Agency for International Development (USAID) -funded Advancing Adolescent Health (A2H) project began in January 2016 with the goal of improving sexual and reproductive health and family planning knowledge, access, and use of related services for married and unmarried adolescents. Understanding that one of the key barriers to improving adolescent sexual and reproductive health (ASRH) in Bangladesh is the lack of access to adequate, youth-friendly health services, the project sought to partner with local communities to improve understanding of, and norms around, ASRH needs and services.

In 2018, the project saw an opportunity to introduce the community score card (CSC), a participatory process for evaluating service delivery, to identify the gaps and challenges around ASRH service delivery in the Rangpur district. Through the use of the CSC, A2H aimed to empower adolescents and health service providers to engage in open discussion about service delivery and advocate with local authorities to improve these essential services. This technical brief discusses the project’s design of the CSC process and shares lessons learned from its implementation.
Background and Context

Despite Bangladesh’s progressive National Adolescent Reproductive Strategy (NARS), developed in 2006, and the subsequent National Action Plan (NAP) on ASRH, the Government of Bangladesh (GOB) has faced difficulty in translating its commitment to improving adolescent health into effective implementation. Early marriage (before age 18 for girls and 21 for boys), early pregnancy (before age 20), and poor family planning, particularly in rural areas, threaten adolescents’ health and well-being.

Plan International’s (Plan) 2013 Asia Child Marriage Initiative (ACMI) research report conducted in India, Nepal, and Bangladesh details the severe risks that child brides face, including higher instances of domestic violence, lower educational and economic attainment, and limited decision-making power around family planning and allocation of household resources. Child marriage also perpetuates poverty, gender inequality, and poor health and development.

Although the Child Marriage Act of 1929 set the legal age of marriage at 18 for girls and 21 for boys, the Millennium Development Goals (MDGs) Bangladesh Progress Report of 2015 identified early marriage and poor ASRH as key obstacles to progress, particularly on MDG 5 (maternal mortality). Furthermore, despite the GOB’s commitment to ending child marriage by 2030, the GOB’s 2017 Child Marriage Restraint Act includes a clause that girls can marry at 16 “in special cases.”

Key Statistics for Bangladesh

- Fourth highest rate of child marriage in the world, with 59% of girls married before age 18 and 22% married before age 15
- The median age at first marriage is 15 in the Rangpur district
- One of the highest rates of adolescent pregnancy in the world, with 40% of women ages 20-24 having given birth by age 18
- The national contraceptive prevalence rate is 62%, though only 47% for married adolescents ages 15-19
- Adolescent girls ages 15-19 have a higher unmet need for family planning (17%) compared to the national average (12%)
- Only 18% of adolescents ages 15-24 have comprehensive, correct knowledge of HIV/AIDS

The A2H project covered all eight upazilas in the Rangpur district of Bangladesh. Rangpur has the highest rate of early marriage in Bangladesh.
The overall lack of ASRH and negative effects of early marriage are illustrated by key statistics and is easily confirmed anecdotally throughout Bangladesh. In addition to the physical and social consequences of early marriage and poor ASRH, a 2017 study estimated that ending child marriage in Bangladesh could yield a 12 percent increase in economic activity.4

**Advancing Adolescent Health (A2H) Program**

Understanding the negative impacts of inadequate ASRH services and prevalence of child marriage, the USAID in its Bangladesh Country Development Cooperation Strategy7 committed to improving the health status in Bangladesh by increasing access to and use of family planning, reproductive health, and nutrition services, while also strengthening health systems and governance. The three-year USAID-funded A2H project, implemented by Plan

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**Key constraints to preventing child marriage and improving access to ASRH services:**

- Lack of facilities/services and access to them
- Absence of confidential, non-judgmental health service provider attitudes to adolescents seeking SRH care
- Lack of age-appropriate resources on young peoples’ SRH rights
- Educational barriers
- Unclear plans to implement policies
- Poor gatekeeper attitudes
- Poor family attitudes
- Underlying gender norms and values
- Economic pressures

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**Project Key Achievements**

- **307,914 adolescents** received life skills training
- **50,300 adolescents** received SRH services
- **53,702 parents and community leaders** engaged to promote ASRH
- **3,632 married adolescents** educated on family planning
- **250 adolescent girls** engaged in economic empowerment activities
and its national partners the World Mission Prayer League (LAMB) and the Eco-Social Development Organization (ESDO), leveraged the national government’s commitment to improve adolescent health and empowered local champions for adolescent rights to transform the underlying social norms that perpetuate early marriage and pregnancy.

The goal of the A2H project was to improve adolescent health and well-being by providing access to ASRH education, strengthening adolescent-friendly health services, and engaging community leaders and gatekeepers to change norms around ASRH and child marriage. One of the key issues that the A2H project addressed was access to sexual and reproductive health (SRH) information, resources, and services. In Bangladesh, availability and access to SRH services is restricted for unmarried girls and boys due to a lack of trained professional staff, age-appropriate resources, appropriate and accessible service facilities, and, perhaps most importantly, by the absence of confidential, nonjudgmental counseling by health service providers. Furthermore, sociocultural gender norms and taboos around young people’s sexuality prevent many adolescent girls and boys from discussing SRH concerns or questions with their family members or peers.

### Community Score Card

Building on the success of the USAID-funded PROGATI project in Bangladesh, Plan implemented a CSC process to engage youth and health service providers in identifying and prioritizing issues effecting ASRH service delivery. The CSC is a participatory tool that adolescents, along with their communities, can use to assess the quality of services such as health care, water and sanitation, education, or child protection and advocate for their improvement. Developed in 2002 by Care in Malawi, the CSC methodology has been used by many organizations to identify barriers and promote transparent and accountable service delivery in a range of sectors. One of the best uses of the CSC is World Vision’s Citizen Voice and Action approach, which demonstrated significant and sustainable improvement in child health and education service delivery. In general, score cards:

- Use a participatory method to produce subjective and objective evidence of service delivery quality;
- Stimulate constructive dialogue between service users and providers;

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1The USAID-funded Promoting Governance, Accountability, Transparency, and Integrity (PROGATI) project, implemented in Bangladesh from 2007-2012, sought to strengthen civil society to decrease corruption. PROGATI used the citizen score card to monitor the implementation of national-level services delivered at the local level.
• Are solution-oriented by engaging public officials and community members in developing joint action plans to resolved problems; and

• Equip communities to advocate and improve public services.

Building off of the general CSC methodology, Plan has developed a child-sensitive, gender-responsive, and inclusive score card approach called Young Citizens Score Cards. This approach:

• Helps communities identify and focus on the specific service needs of children and young people from vulnerable and excluded groups, with a special focus on girls;

• Creates special opportunities for participation and leadership by young people, especially girls; and

• Uses an inter-generational approach that brings together children, young people, and adults, including service providers, as partners in the scorecard process.

The Young Citizen Score Cards can help to improve public services for girls, boys, and excluded and vulnerable groups by helping them to:

• Understand their rights and entitlements;

• Assess whether services respond to these rights while meeting their real needs; and

• Develop and implement action plans and solutions together with service providers to ensure community services are improved for all citizens.

A participant in the A2H program meets with a health service provider.
THE A2H COMMUNITY SCORE CARD PROCESS

1. Conduct CSC with adolescents and health service providers
2. Analyze scores to identify service gaps and priorities
3. Present CSC findings to the FWC management committee
4. FWC management committee develops action plan for addressing key priorities
5. FWC provides continuous feedback to the health facilities

THE A2H COMMUNITY SCORE CARD STAKEHOLDERS

A random sample of adolescent girls and boys who received services from the target health facilities in the past week were selected to participate in the CSC process. Groups of 8-10 adolescents were convened and the CSC process was facilitated by A2H partners ESDO and LAMB. Adolescents provided feedback on their experiences receiving services at the health facility. At the end of the session the adolescents came to consensus on key issues and priorities to share with the health facility and FWC management committee.

All FWC health service providers who received A2H training on adolescent friendly health services were selected to participate in the CSC process. FWC health service providers completed the CSC process one-to-one rather than in a group. Health service providers were asked to provide a neutral assessment of their services as well as identify the gaps and areas for improvement.

The union level government health services management committee, the FWC management committee, was responsible for developing and implementing action plans to address the issues identified through the CSC process. The FWC management committee is made up of 18-20 community members, including at least two adolescent representatives.
Implementation

In year three of the project, A2H began implementing the CSC with adolescents and health service providers. The CSC was implemented in 77 Union Health & Family Welfare Centers (UH&FWC) across eight upazilas. The CSC was implemented three times during the final year of the project, involving 1,800 adolescents and 112 health service providers.

Prior to conducting the score card process, A2H solicited buy-in and established relationships with local governments for the CSC process. A2H also held training sessions with adolescents and health service providers to introduce them to the purpose, process, and potential benefits of the CSC. Local government and community buy-in and support for the process proved to be a key factor in the success of the activity.

1 An upazila is equivalent to a district-level government authority. As of 2017, there were 492 upazilas in Bangladesh.
2 Scores were calculated on a scale of 1-100 with “very good” (81 and above), “good” (61-80), “Satisfactory” (41-60), and “needs improvement” (40 and below).
Findings

Although the CSC process was only implemented in the last year of the project, the implementation yielded interesting findings and revealed trends that were used to inform programming. Overall, both adolescents and health service providers in the eight upazilas ranked service provision as “very good” or “good,” with health service providers ranking their services more highly than the adolescents. In quarter three of implementation, 39 of the 77 UH&FWCs were ranked as “very good” by adolescents, an increase from quarter one where only 35 UH&FWCs were ranked as “very good.” Comparatively, in quarter three 52 of the 77 UH&FWCs were ranked as “very good” by health service providers, an increase from quarter one where 37 UH&FWCs were ranked as “very good.” While the overall ratings revealed that service was generally acceptable, the difference in rankings between adolescents and health service providers indicated that there was still room for improvement.

In five of the eight upazilas the A2H project observed a general increase in adolescents’ perception of and satisfaction with service delivery over the CSC implementation period. A random sample of adolescents who received services in the last week were surveyed each quarter as part of the CSC process. While this methodology meant that the adolescents were recalling experiences from the recent past, thus limiting the potential for recall bias, it did limit the findings as the cohort completing the CSC was different each quarter. Because the cohort of adolescents was different each quarter, the project was not able to track changes in perceptions and satisfaction at the individual level.

Similar to the trend identified among the adolescents, in six of the eight upazilas the A2H project observed a general increase in health service providers’ perception of their own service delivery efforts over the CSC implementation period. Unlike the adolescent CSC, the same health service providers were asked to assess their services over the CSC implementation period. Through one-on-one interviews, A2H solicited feedback from the health service providers regarding their assessment of the service in their UH&FWC. The consistency of respondents allowed the project to track individual perception over time.

Despite some limitations, the A2H project was able to observe trends that were used to inform programming, including identifying upazilas that required additional attention or services. One such example was in Pirganj. The CSC revealed that both adolescents and health services providers in Pirganj rated service delivery as only satisfactory. This was particularly true of adolescents in the second quarter of implementation when A2H noticed a large discrepancy between adolescent ratings and health service provider ratings. Using this information, A2H staff increased both human and financial resources to the upazila to ensure that all suggestions provided through the CSC process were discussed and implemented, where appropriate. In addition, the project supported the continued upskilling of workers through refresher training and infrastructure improvements in the clinics including a functioning water point and hygienic latrines.

\*The average adolescent score in Pirganj in quarter 2 was 58.4 and the average health service provider score was 69.5, resulting in an 11-point difference in scores between the two groups.

\*FWVs provide services to female clients for family planning issues including anti-natal care and post-natal care. The SACMO provides services to both male and female clients for general treatment, as well as advising on some family planning issues. These positions are only able to prescribe medicines that are provided by the GOB to the UH&FWC.
While the quantitative findings provided the project with a general sense of perception of satisfaction with service delivery, the qualitative information collected through the CSC process was critical to understanding the specific issues and gaps affecting service delivery. Through the CSC process, adolescents and health service providers identified a number of physical and organizational issues that affected service delivery.

The main issues identified by the adolescents included:

**Inadequate time spent with clients.** Adolescents reported that they felt the health service providers did not allocate appropriate amounts of time to address issues when providing services. This appeared to be caused by understaffing and insufficient operating times at the health centers. The average UH&FWC in the Rangpur district only has two health service providers: one Sub-Assistant Community Medical Officer (SACMO) and one Family Welfare Visitor (FWV). Key positions such as a Medical Officer and Pharmacist are typically vacant, despite having the staffing structure and demand for those positions. Therefore individual consultations are often limited due to the volume of patients that each health service provider has to see. Additionally, adolescents reported that the health centers were either open at inconvenient times, specifically during school hours, or were open on an inconsistent basis. Inconvenient and inconsistent timing made it difficult for adolescents to seek services from the health care providers.

**Lack of privacy.** Despite many health centers having private consultation areas or separate adolescent corners, adolescents reported that many of the health care providers routinely did not use the counseling rooms for consultations. Due to the lack of privacy, adolescents reported feeling uncomfortable discussing their health issues with the service providers. The lack of privacy was further exacerbated by the fact that there was often overcrowding at the health centers due to inconsistent or restricted open hours at the centers.

*Paracetamol is a pain reliever and fever reducer. It is used to treat conditions such as headaches, muscle aches, colds, and fevers. Calcium lactate is used to treat calcium deficiencies.

“We do not have adequate staff/sitting arrangement to deliver SRH services to the adolescents as they demand. However, we try to provide minimum services to them so that they don’t lose heart.”

– Health Service Provider, Badarganj
Lack of resources.

The GOB is responsible for supplying local health clinics with essential medicines on a quarterly basis. However, due to shortages in the GOB’s medicine supply and irregular delivery schedules, many health centers have insufficient supplies to treat the volume of patients. Adolescents and health service providers both reported that the health centers often lacked basic medicines such as paracetamol and calcium lactate. Additionally, common medicines prescribed to adolescents such as Ciprofloxacin, Naproxen, Levofloxacin eye drops, Gentamicin ointment, and Permethrin cream were routinely unavailable at the UH&FWC, which meant adolescents were required to purchase the medicines at local drug distributors, paying for services that should otherwise have been provided by the health centers.

The main issues identified by the health service providers included:

Inadequate training on adolescent healthcare.

Health service providers reported that they felt they had inadequate training to deal with adolescent health issues. Due to prevailing cultural norms around sexual and reproductive health, the government’s health service provider curriculum does not address adolescents as a unique population with specific care and service needs. Health service providers therefore felt uncomfortable discussing and providing guidance to adolescents on health issues.

Conflicting service times.

Health service providers noted that the clinics’ hours of operation conflicted with school times. Conflicting service times led to overcrowded centers, inadequate time spent with patients, and inability to address all patient issues. Furthermore, inconvenient hours of operation paired with often long transportation times to the health center meant that many adolescents did not seek services even when they had a referral.

Lack of resources and utilities.

Similar to the issue raised by adolescents, health service providers cited a lack of resources and utilities—including items such as chairs, medicine,
“From the community score card we could assess the quality of our service. It helps us to understand whether adolescents are getting appropriate service or not.”

– SACMO, Badarganj

electricity, and Information, Education and Communication (IEC) materials—as being barriers to effective service delivery. Lack of resources such as chairs worsened overcrowding and service delays, while lack of IEC materials made it difficult for service providers to counsel adolescents given their unfamiliarity with, and lack of training on, adolescent-specific health issues.

Physical issues such as cleanliness, insufficient seating, and lack of private spaces could be addressed by the UH&FWC management committees. Organizational issues such as understaffing, open hours that conflict with school time, and inadequate drug supply are part of systemic issues within the health care system and could not necessarily be addressed at the local level.

Lessons Learned

Although A2H was only able to implement the CSC process in the last year of the project, the implementation proved to be a useful tool for engaging youth and health service providers in identifying and prioritizing issues and priorities for improving service delivery. Lessons learned from the implementation of the CSC process go beyond health service delivery and can be applied to CSC implementation for a variety of service delivery issues such as education, transportation, security, and many more.

“This is, in fact, the first chance for us in evaluating the preformance and quality of services for the adolescents at the UH&FWCs. We would request to forward our evaluation findings to the higher authority.”

– Adolescent, Gangchara
A basic understanding of participatory processes is essential for ensuring buy-in from communities.
The health service providers were not used to using participatory accountability tools to solicit feedback from the community. This was the first time that many were asking youth for their input, as well as the first time they were being asked to evaluate themselves in an honest and open manner. In order for the CSC to be useful, service providers must buy in to the participatory process. As such, basic training and socialization on the use and benefits of participatory processes was essential to ensuring that the service providers were open to feedback from community members, in particular from youth.

Engaging key stakeholders in co-design can promote ownership.
Participatory accountability processes can only be successful if the decision makers, in the case of A2H the local government authorities, buy in to the findings and take ownership over the subsequent action plans to address the issues. To ensure that local government authorities felt ownership over the CSC, A2H engaged the government in a co-design process of the tool. A2H identified the Civil Surgeon and Deputy Director of Family Planning at the district level as key stakeholders and partnered with them to design and adopt the tool as a local government accountability mechanism.

Linkages to the central government are critical for sustainability.
Many of the challenges identified by both the adolescents and the service providers were outside of the scope of the local governments’ authority. For example, lack of electricity, poor road conditions, and inadequate medicine and supplies were issues that were routinely identified as barriers. A2H found that while local governments sought to address the issues and priorities within their control, they were often reluctant to elevate the larger, more systemic issues with the relevant state and central government authority. In order for the CSC process to be effective and sustainable, there must be linkages to the state and central government to address the systemic issues around service provision.

Recommendations
The following recommendations are intended for organizations, donors, and host governments looking to incorporate participatory accountability tools for improving service delivery.

Leverage existing structures to promote sustainability.
The CSC process is a tool that should be conducted iteratively in order to identify service delivery gaps and track changes over time. Where possible, implementers should identify and build the capacity of existing governance structures to implement the CSC process. A2H originally planned to conduct the CSC process through a Community Review Committee (CRC), an A2H-established community structure with seven to nine members including representatives from the government, community, and service providers. However, after forming the CRCs, A2H realized that the CRCs were not well-positioned to lead the CSC process. The CRC members were volunteers who had other responsibilities and jobs and therefore did not feel accountable for conducting the CSC process. Rather than creating a new structure, A2H recommends that implementers identify existing governance structures that can drive the CSC and integrate it into larger governance work planning processes.

Training is essential to ensure effective CSC implementation.
Implementers should ensure that local governance structures, service delivery providers, and adolescents are all trained on the CSC process and purpose. Training will look different for each stakeholder in the process. In the A2H context, many adolescents did not understand their SRH rights and were not used to providing feedback to service providers. It is important to make sure that youth are trained both to understand their rights, as well as how to constructively advocate for those rights. Similarly, health service providers were not used to soliciting feedback from adolescents, nor were they familiar with providing neutral assessments of their own services. It was therefore critical to train health service providers on the importance of feedback mechanisms, including how to interpret and respond to feedback. Local governance structures
were also not used to soliciting feedback from communities or providing feedback to higher government authorities. Local government structures should be trained both on administering feedback mechanisms and on using this information to elevate issues to higher authorities.

Integrate collaboration throughout the process. Where possible, conduct the CSC with service delivery professionals, in this case health service providers, in a group setting. Given the geographic coverage of the project and the logistical challenges around transportation, it was difficult to convene health service providers to complete the CSC as a group. To adjust for this, A2H conducted the CSC process with health service providers one-on-one. While the process still yielded useful information and insights from the health service provider perspective, the tool is most effective when completed in a collaborative environment, as it encourages respondents to prioritize and come to consensus on issues.
Acronym List

ACMI  Asia Child Marriage Initiative
ASRH  Adolescent Sexual and Reproductive Health
A2H  Advancing Adolescent Health
CRC  Community Review Committee
CSC  Community Score Card
ESDO  Eco-Social Development Organization
FWV  Family Welfare Visitor
GOB  Government of Bangladesh
IEC  Information, Education, and Communication
LAMB  World Mission Prayer League
MDG  Millennium Development Goal
NAP  National Action Plan
NARS  National Adolescent Reproductive Strategy
SACMO  Sub-Assistant Community Medical Officer
SRH  Sexual and Reproductive Health
UH&FWC  Union Health and Family Welfare Centers
USAID  United States Agency for International Development

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