



Bottom-up Accountability of Health Care Providers in Uganda



PHOTO: WILL BOASE

In Uganda, researchers conducted a large-scale randomized evaluation of a program called Accountability Can Transform (ACT) Health. The program provided community members and health care workers information about the quality of their local health services and brought them together to create action plans for how to improve local health service accountability, delivery, and quality. The study built on previous research of a similar program called Power to the People, which was found to greatly improve child health.

Key Findings

Twenty months after the program began:¹

- » The program marginally improved the quality of treatment patients received and increased patient satisfaction.
- » However, the program did not affect how often people sought health care (utilization rates) or improve health outcomes; child mortality rates were unchanged.
- » Results were similar one and two years into the program and were consistent across different groups; no health effects were found in any subgroup.
- » Contrary to the theory of change motivating the intervention, there was no evidence that the program caused citizens to more closely monitor or apply pressure on service providers.
- » Overall, the findings suggest a combination of information provision and increased oversight can marginally change the behavior of frontline service providers, but cast doubt on the power of information to foster community monitoring or to generate improvements in health outcomes, including child mortality, at least in the short term.

¹ On average the time between the launch of the program and the final survey was 20 months.

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COUNTRY

Uganda

TIMELINE

2014-2017

SAMPLE

376 health centers (14,609 households) in 16 districts

The Challenge

POOR HEALTH SERVICE DELIVERY IN RURAL AREAS

Poor health service delivery is a major challenge in many low-income countries, particularly in rural areas. Staff at rural government-run clinics are often absent, adherence to clinical guidelines is inadequate, and services such as family planning and antenatal care are underprovided. Due in part to these reasons, utilization rates at government clinics are low.

While Uganda has seen a decline in child, infant, and neonatal mortality rates in recent years—under-five mortality rates were cut in half between 2006 and 2016—the country still falls in the bottom quartile of the world distribution on most basic health measures. Since 2001, public health services in Uganda have been free of charge. However, Ugandan health staff are underpaid and facilities are poorly funded. Resource management tends to be weak, resulting in missing medicines and high absenteeism rates among health workers.

To address these issues in Uganda and across the region, the development sector has embraced a potentially promising approach: the bottom-up monitoring of service providers by community members. The idea is that providing citizens with information about service delivery

shortfalls—along with information allowing them to compare local outcomes with national standards and with outcomes in other communities—will put them in a position to monitor and apply pressure on underperforming service providers.

A 2009 study of a program that followed this model, called Power to the People (P2P), validated this approach. It generated striking results: infant weight increased, under-5 mortality declined by 33 percent, immunization rates rose, waiting times at clinics fell, staff absenteeism dropped, utilization increased, and communities became more engaged and monitored clinics more extensively.

Yet, in other research, the effectiveness of information provision and citizen monitoring has been mixed.

Researchers sought to evaluate a scaled-up program modeled after P2P to see if it would produce similar health improvements as the original program did on a smaller scale ten years earlier. The second objective was to determine which aspects of the program were driving the effect, if any.

The Program

BOTTOM-UP COMMUNITY MONITORING

The ACT Health program was implemented by a consortium of civil society organizations coordinated by GOAL Uganda.

The program consisted of three components:

1. Information: Citizen Report Card (CRC)

These cards were provided to health centers and included information gathered from surveys of people in the catchment area about the health services. This included: citizens' knowledge of their rights and responsibilities; utilization of the various services offered at the health center; citizens' perceptions of the quality of these services; and overall satisfaction with the health care they received. For most outcomes, the health center data was presented alongside district averages to offer a benchmark of relative performance.

2. Mobilization: Health Center and Community Dialogues and Action Plans

Facilitators worked with local leaders and Village Health Team members to organize community meetings where the CRC results were presented and discussed. At the meetings, participants developed an action plan to identify specific steps that community members could take to improve health service delivery. Facilitators made significant efforts to ensure that the meetings included representatives from all major social groups in the community. Facilitators also held separate meetings with health center staff, to discuss the CRC results and formulate a health center action plan which listed steps that the staff could take to improve health outcomes.



3. Interface: Meeting and Joint Social Contract

Facilitators brought the health staff together with representatives of the community to discuss how they might work together to improve the quality of health care in the community. The output of the meeting was a social contract between the citizens and health care workers laying out specific steps that each could take to contribute to improvements in health outcomes.

Implementation teams spent several days in each catchment area to organize the community and health center dialogues and interface meetings, and they returned every six months to meet with community members and HC staff to check on the progress that had been made toward the commitments made in the social contract.

The Evaluation

WHAT ARE THE IMPACTS OF THE FULL PROGRAM AND ITS COMPONENTS?

Researchers and IPA conducted a randomized evaluation to measure the impact of the full ACT Health program and individual components of the program on utilization rates, treatment quality, patient satisfaction, and health outcomes, including child mortality.

Before the program began, the research team collected data about health delivery in facilities in each of the communities and used this information to write CRCs. Then, researchers randomly assigned the 376 health centers and their catchment areas to one of four groups:

1. Full ACT Health program: information, mobilization, and interface (92 health centers)



2. Partial ACT Health program: information and mobilization (92 health centers)

3. Partial ACT Health program: interface only (97 health centers)

4. Comparison: No program at the time of study (95 health centers)

The research team conducted three rounds of data collection using a household survey, a health clinic survey, and administrative data from the health centers (verified with physical checks of drug stocks and storage conditions). Surveys were conducted before the program was rolled out, and one and two years later.



Results

Overall, communities that received the full program reported receiving marginally better care and were more satisfied with their care than communities that did not receive any program. However, no version of the program increased utilization rates or improved health outcomes.

Households that received the full ACT Health program received better care than those in the comparison group. Quality of care improved by 0.059 standard deviations, a very small effect. People in ACT Health program communities were more likely to report having had privacy during their most recent exam and having had their diagnosis clearly explained to them. Health centers in program communities were also less likely to have had stockouts of key drugs during the previous three months.

Patient satisfaction improved for those in the full ACT Health group. Households in program communities were more likely to report that the services offered at the health center were of “very” or “somewhat” high quality; that they were “satisfied” or “very satisfied” with the quality of the

care they received during their most recent visit to the clinic; that the person conducting their examination behaved politely, showed respect, appeared interested in their health condition, and listened to what they had to say; and that, compared to the year before, the availability of medical staff had improved. Patient satisfaction overall improved by 0.079 standard deviations, also a very small effect.

No version of the program had any impact on health outcomes on average or on specific groups in the short-term or longer-term (at midline or endline). The program also did not affect utilization rates (how much people sought care).

There is no evidence that the improvement in treatment quality was caused by an increase in monitoring or bottom-up pressure by community members. Indeed, the study provides suggestive evidence that providing information to top-down, as well as bottom-up, principals may be a stronger lever for changing the behavior of frontline service providers than mobilizing pressure from the bottom-up alone.



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Conclusion

The lack of an effect on health outcomes is a stark contrast to the results from the P2P evaluation. There are several possible explanations for the divergent results. First, while both studies took place in Uganda, the ACT health study drew a different sample of health centers and occurred nearly a decade after P2P. Health outcomes and service delivery are now much improved, and it may have been easier for the P2P intervention to foster change when baseline levels were worse. Second, there were subtle differences in the ways the two programs were implemented. In particular, implementers in the P2P study, but not in ACT Health, had some prior relationship with community members, and it is possible that these prior

relationships bolstered the impact of the P2P intervention. Other explanations are also possible, but one reason that researchers rule out is poor implementation. The ACT Health program was closely monitored and implemented with fidelity.

Overall, the findings suggest a combination of information provision and increased oversight can marginally change the behavior of frontline service providers, but cast doubt on the power of information to foster community monitoring or to generate improvements in health outcomes, including child mortality, at least in the short term.

This project was conducted in cooperation with the ACT Health consortium, which includes the Coalition for Health Promotion and Social Development (HEPS Uganda), Kabarole Research & Resource Centre (KRC), and the Multi-Community Based Development Initiative (MUCOBADI).

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