International Journal of Progressive Sciences and Technologies (IJPSAT)
ISSN: 2509-0119.

http://ijpsat.ijsht-journals.org
Vol. 30 No. 2 January 2022, pp. 468-476

Effectiveness of Implementing the Citizen's Charter at a Regional Health Services Directorate in Sri Lanka

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Abstract

Introduction - Unacceptable delays in providing services by the Regional Director of Health Services' Office, Kurunegala and subsequent re-visits had created customer dissatisfaction. A citizen's charter and supplementary interventions were developed and implemented to improve providing services. The objective of this study is to assess effectiveness of implementing citizen's charter and supplementary interventions at Establishment Branch of Regional Director of Health Services' Office, Kurunegala.

Methods - Methods involve developing process and outcome indicators to assess the effectiveness of charter and supplementary interventions, pre and post-assessments of developed indicators following implementing interventions for three months, and comparison of pre and post results for statistical significance to assess the effectiveness of implementations.

Results - Following implementations, compliance of personal files with service standards significantly increased ($p<0.001$) from 40% to 94% while average number of visits per service to Establishment Branch had a significant reduction ($p<0.001$) from 2.40 to 1.09. Nursing officers' overall satisfaction on receiving services improved significantly ($p<0.001$) from 11.5% to 75% as their satisfaction on all service attributes showed statistically significant improvements. Three attributes namely, awareness of place of formats, availability of contact details of responsible officer for services and courtesy exceeded expectations although the remainder showed expectation-perception gaps.

Conclusion - Charter and supplementary interventions proved to be effective in improving service provision at Establishment Branch of Regional Director of Health Services' Office, Kurunegala. It is recommended that Regional Director of Health Services' offices implement charters and supplementary interventions at Establishment Branches in a stepwise manner to improve service provision.

Keywords – Effectiveness; Citizen's Charter; Service delivery; Service standards; The Regional Director of Health Services' Office.

I. INTRODUCTION

The Office of Regional Director of Health Services is the administrative focal point for health institutions including hospitals (ranging from large to small) and Medical Officer of Health Offices offering comprehensive public health services in each district of Sri Lanka. The Office of Regional Director of Health Services, Kurunegala (RDHSK) is the administrative focal point for Kurunegala District and has four branches. Out of which the Establishment Branch (EB) has the largest customer interface of 5044 health workers in 63 categories of 129 health institutions coming under the directorate.[1] It deals with routine but critical personal file-related services. Consequently, catering with effective and efficient services to a large number of service recipients using limited resources has been a challenge for the management of RDHSK.

Lack of explicit service standards for the EB of RDHSK results in unacceptable delays in service provision and frequent unwarranted visits. Ineffective two-way communication between the EB and service recipients builds a dilemma among service recipients on documents that need to be submitted along with service requests, which adds up to the delay. Besides, there is no

existing mechanism to tackle customer grievances on poor service provision. These factors collectively create dissatisfaction among service recipients of EB. Therefore, a citizen's charter and several supplementary interventions were implemented to improve the service provision from the EB of the RDHSK. The objective of this study is to assess the effectiveness of implementing the citizen's charter and supplementary interventions at the Establishment Branch of the Regional Director of Health Services' Office, Kurunegala.

Citizen's charter is a useful way to fine-tune service delivery processes, improve overall performance and foster greater customer satisfaction.[2] A citizen's charter is a voluntary public commitment made by a service provider to uphold standards of quality, transparency and accountability.[3] It sets out the services provided from the institution, a list of documents to be submitted and other requirements to be fulfilled along with the written service request, standards of service that service recipients can expect, contact details of responsible persons in case the citizen needs help and makes complaints or suggestions.[4] Charters make administration accountable and citizen-friendly, ensure transparency, take measures to improve customer service, adopt a stakeholder approach and save the time of both administration and the citizen.[5] Its aim at continuously improving customer satisfaction was the key to success and spread throughout the world.[6] Encouraged by achieving great success and yielding desired results of the first articulation and implementation of citizen's/client's charter by the United Kingdom in 1991, governments of both developed and developing countries are increasingly adopting the concept.[5], [7] Sri Lankan Government initiated implementing the concept in 2008.[4] However, the charter initiative has not been implemented in many government institutions of Sri Lanka yet and so neither at the EB of RDHSK.

Evaluation provides a systematic method of studying a program, intervention, or initiative to understand how well it achieves its goals. It helps to determine what works well and what could be improved in a program or initiative. Program evaluations can be used to suggest improvements for continued efforts, seek support for continuing the program and help determine if an approach would be appropriate to replicate in other locations with similar needs.[8] The evaluation will focus on assessing the extent to which the programme objectives have been met. An evaluation may take several forms i.e.; process, outcome and impact evaluation, and one or more may be appropriate, depending on the aims of the specific programme to be evaluated. Process evaluations are being carried out to provide information to guide programme improvement. However, the outcome evaluation is probably the most common form of evaluation as it provides information as to whether the programme or intervention has made a difference.[9]

II. Material And Methods

The methods involve developing process and outcome indicators to assess the effectiveness of the charter and supplementary interventions, pre and post-assessments of developed indicators following implementing the charter at EB for three months, and comparison of pre and post results for statistical significance to assess the effectiveness of implementations. The pre-assessment was carried out during August 2019 and the charter was implemented at the EB of RDHSK from the 1st of December onwards. A trial period of two weeks was set aside before actual implementation. The post-assessment was conducted during March 2020.

Pre and post-assessments involved both quantitative and qualitative research techniques. Key Informant Interviews (KIIs) were held with the Regional Director of Health Services, Deputy Regional Director of Health Services, Medical Officer of Quality Management Unit and Administrative Officer using two separate interviewer guides pre and post. Focus Group Discussions (FGDs) were held with Senior Management Assistant of EB, Management Assistants (n=6) of EB providing services to nursing officers, and the MA and the Health Activity Assistant at Tappal using two separate pre and post-FGD guides. A convenient sample (n=50) of personal files of nursing officers from files that had been completed in the selected services (five files per service) during a month was desk reviewed using the same checklist pre and post. All nursing officers who visited the EB during the pre (n=122) and post (n=32) assessments and completed receiving intervened service/s during four consecutive Wednesdays which is the public day, were surveyed using two separate structured interviewer-administered questionnaires (IAQs). Hence, no sampling method was adopted.

The process and outcome indicators that are shown in table 1 were developed and applied to measure the effectiveness of implementing the citizen's charter and supplementary interventions. Additionally, nursing officers' satisfaction over the compliance on service standards as per the charter was assessed post-intervention.

Data were collected by the principal investigator. Quantitative data were analyzed using Statistical Package for Social Sciences (SPSS) software. The statistical significance of the differences in pre and post-intervention results was analyzed by

applying the two-sample z test for percentages/means. The p-value <0.05 was considered as the level of significance. The KIIs and FGDs were recorded with the participants' consent for easy compilation. Narrative analysis was done for qualitative data.

Administrative approvals were obtained from the Provincial Director of Health Services of North-Western Province and the Regional Director of Health Services of Kurunegala District. Ethics clearance was obtained from the Ethics Review Committee of the Faculty of Medicine, the University of Colombo following the approval of the Board of Study in Medical Administration. Informed consent was taken from all participants. The confidentiality and anonymity were preserved.

Table 1: Process and outcome indicators used to measure the effectiveness of implementing the citizen's charter

	Indicators	**Method of measurement**
Process indicators		
1	Percentage of files complying with service standards of intervened services	Checklist
2	Percentage of nursing officers revisited RDHSK for receiving intervened service/s	IAQs
3	The average number of visits to RDHSK per service by a nursing officer	IAQs
4	The proportion of service providers aware of the importance of the charter	KIIs and FGDs
Outcome indicators		
5	The proportion of service providers who are satisfied with the service/s provided by the EB to nursing officers	KIIs and FGDs
6	Nursing officers' satisfaction on following service attributes of EB regarding intervened ten services A. Awareness in advance of all documents required along with a service request B. Awareness in advance of the place where formats are available C. Awareness of the time taken to deliver the services D. Immediate notification of applicant nurses by RDHSK in a delay of providing the requested service/s (*If relevant only*) E. Availability of the contact details to the nursing officers of a responsible officer for providing services F. Complaints and feedback management system G. Promptness of service delivery H. Easiness of getting services I. Courtesy of the staff of RDHSK towards the service recipients J. Overall satisfaction of nursing officers in getting intervened services at EB of RDHSK	IAQs

III. RESULTS

The pre and post-assessments of selected process and outcome indicators following implementation of the charter and supplementary interventions for three months at EB of RDHSK revealed that the interventions were effective. The qualitative and quantitative results of pre and post-assessments are shown below.

Qualitative results of KIIs and FGDs

Qualitative results indicated that the services provided by the EB became faster due to receipt of completed documents along with service requests, committed staff of the RDHSK to comply with service standards and more productive time available for actual work due to fewer visitors and minimum re-work. Almost all service requests of nursing officers were accompanied by all required documents facilitating compliance with service standards by the RDHSK staff. Nursing officers proactively contacted the support person in need without hesitance. Complaints/grievances highlighted weak areas that need improvement. Services could be tailored to nursing officers' expectations incorporating their suggestions. Overall, the staff of the RDHSK perceived interventions were worker-friendly and suggested expanding those to other worker categories.

Quantitative results

The results of the checklists and quantitative components of the customer satisfaction surveys, KIIs and FGDs for selected indicators before and after interventions are depicted below.

Checklist data to assess the percentages of files complying with service standards and the survey results to find out the percentages of nursing officers who revisited the RDHSK for receiving intervened service/s before and after interventions are presented in table 2.

Table 2: Pre and post-intervention distribution of the percentages of files complying with service standards and the percentages of nursing officers revisited RDHSK for receiving intervened service/s

Indicator	**Pre-intervention**	**Post-intervention**	
	Percentage (P)	**Percentage (P)**	**z test statistic**
The percentage of files complying with service standards	40.0 (20/50)	94.0 (47/50)	z=-5.7421 **p<0.001**
The percentage of nursing officers revisited the RDHSK for receiving intervened service/s	56.6 (69/122)	6.2 (2/32)	z=5.081 **p<0.001**

P=Proportion

Table 2 shows that there was a significant increase in compliance with service standards after the interventions ($p<0.001$). At the post-intervention assessment, there was a significant decrease in the percentage of nursing offices revisiting RDHSK to get the intervened service/s ($p<0.001$).

The average number of visits paid to the RDHSK per selected service by a nursing officer pre and post-intervention were calculated using survey data and the results are presented below (Table 3).

Table 3: Pre and post-intervention distribution of the average numbers of visits to the RDHSK per selected service by a nursing officer

Indicator	**Pre-intervention**	**Post-intervention**	**z test statistic**
	Mean (SD)	**Mean (SD)**	
The average number of visits to the RDHSK per selected service by a nursing officer	2.40 (0.915)	1.09 (0.246)	z=14.002 **p<0.001**

Survey data showed that on average a nursing officer paid 2.4 visits to the RDHSK for receiving a selected service before and 1.09 visits after implementing the initiatives indicating a significant reduction in visits. Quantitative data gathered from KIIs and FGDs to assess the proportions of RDHSK staff aware of the importance of the charter and the proportions of service providers satisfied with service provision to nursing officers at EB before and after interventions are presented in table 4.

Table 4: Pre and post-intervention distribution of proportions of RDHSK staff aware of the importance of the charter and the proportions of service providers satisfied with service provision to nursing officers at EB

Indicator	**Pre-intervention**	**Post-intervention**	**Percentage increase**
	Proportion (N=13)	**Proportion (N=13)**	
The proportion of RDHSK staff aware of the importance of a charter	0/13	13/13	**100%**
The proportion of service providers satisfied with service provision to nursing officers at the EB	3/13	13/13	**77%**

N=Total staff

There was a 100% increase in awareness among the RDHSK staff of the importance of charter post-intervention. Table 4 shows a 77% increase in the satisfaction of service providers at the post-intervention assessment.

The significance test statistics for nursing officers' satisfaction on selected attributes about pre and post interventional services at EB of RDHSK are presented in table 5.

Table 5: Pre and post-intervention distribution of the level of satisfaction of nursing officers on selected service attributes of EB

	Indicator	**Satisfaction (P)**		**z test statistics**
		Pre-intervention (N=122)	**Post-intervention (N=32)**	
A.	Awareness in advance of all documents required along with a service request	0.0 (0/122)	71.9 (23/32)	z=-10.153 **p<0.001**
B.	Awareness in advance of the place where formats are available	9.0	78.1	z=-8.2216

		(11/122)	(25/32)	**p<0.001**
C.	Awareness of the time taken to deliver the services	1.6 (2/122)	93.8 (30/32)	z=-11.4306 **p<0.001**
D.	Immediate notification of applicant nurses by RDHSK in a delay of providing the requested service/s (*If relevant only*)	0.0 (0/122)	9.4 (3/32)	z=-3.4154 **p<0.001**
E.	Availability of the contact details to the nursing officers of a responsible officer for providing services	60.6 (74/122)	81.2 (26/32)	z=-1.9401 **p<0.001**
F.	Complaints and feedback management system (*If relevant only*)	0.0 (0/122)	87.5 (28/32)	z=0.02619 **p<0.001**
G.	Promptness of service delivery	22.1 (27/122)	71.9 (23/32)	z=-5.3488 **p<0.001**
H.	Easiness of getting services	4.1 (5/122)	87.5 (28/32)	z=-10.2339 **p<0.001**
I.	Courtesy of the RDHSK staff towards the service recipients	9.8 (12/122)	59.4 (19/32)	z=-7.4537 **p<0.001**
J.	Overall satisfaction of nursing officers in getting intervened services at EB	11.5 (14/122)	75.0 (24/32)	z=-7.4188 **p<0.001**

P=Proportion

There was a significant increase in the levels of satisfaction on all attributes at post-intervention assessment (p<0.001).

Nursing officers' satisfaction on the compliance of service standards by RDHSK was assessed after the intervention only and depicted below. (Figure 1)

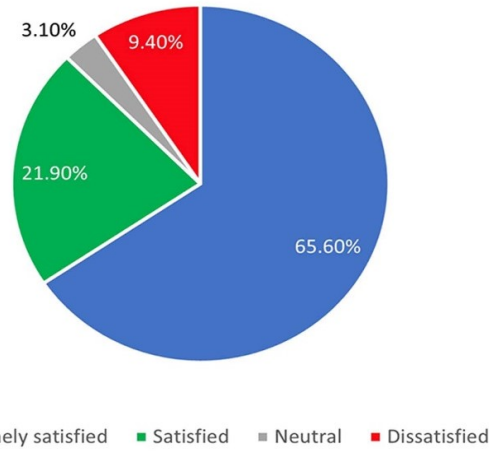

Figure 1: Post-intervention nursing officers' satisfaction over the compliance on service standards by RDHSK staff as per the charter

Figure 1 reveals that 87.5% (n=28) of nursing officers were satisfied with the compliance of service standards by the RDHSK staff. Only 9.4% (n=03) were dissatisfied while none were very dissatisfied.

The pre-intervention nursing officers' expectations were compared with pre and post-intervention nursing officers' satisfaction on selected service attributes of EB. Results are demonstrated in figure 2.

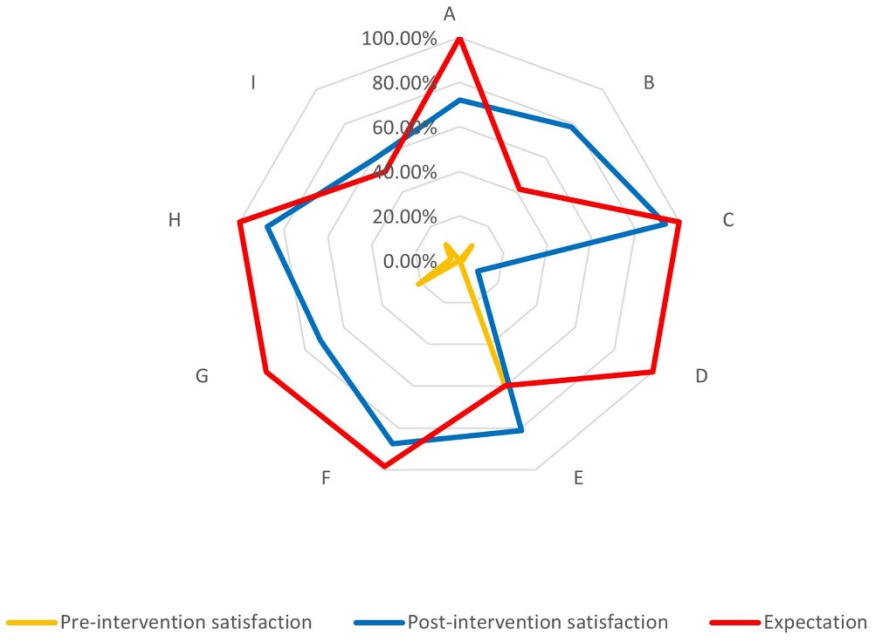

Figure 2: Comparison of pre-intervention nursing officers' expectations with pre and post-intervention nursing officers' satisfaction on selected service attributes

Figure 2 exhibits that the gap between the nursing officers' expectations and satisfaction has considerably narrowed down after implementing the charter and supplementary interventions.

IV. Discussion

The current study revealed that the citizen's charter for selected ten services to nursing officers and supplementary interventions implemented at the EB for three months are effective overall.

Both process and outcome indicators were used for the evaluation. Pre and post-assessments incorporated multiple methods for triangulation. The modifications of the content of pre-assessment instruments to correctly capture the post-assessment results created different pre and post-assessment instruments. As the entire population of nursing officers who visited EB and completed receiving selected key service/s during pre and post-intervention were the respondents of the customer survey representing primary beneficiaries, no sampling method was adopted. The nursing officers' expectations on receiving services from RDHSK were assessed during the pre-intervention IAQ to identify service recipients' needs so that to tailor-made the interventions to match their needs. The nursing officers' satisfaction over the compliance on service standards as per the charter was assessed at post-intervention IAQ only because the service standards had not been established by the time of performing the pre-intervention assessment. A trial period of two weeks was set aside before actual implementation to identify whether standards are realistic or need adjustments.

Following the intervention, the percentage of files complied with service standards had increased from 40% to 94% while the percentage of nursing officers revisiting for receiving the intervened services reduced significantly by 50.4%. The average visits by a nursing officer per service to EB had a reduction from 2.4 visits to 1.09 visits after the intervention. The completeness of documents submitted mainly contributed to this change. Further, the Management Assistants had more productive work hours due to less rework and revisits.

All the staff of RDHSK who was not aware of the importance of charter to a public service institute became well aware of its importance following the training provided to all relevant service providers of RDHSK. The proportion of service providers satisfied with providing services to nursing officers by the RDHSK staff increased and the staff perceived charter as worker-friendly. Praises of nursing officers brought a sense of accomplishment among RDHSK staff and the commitment of the Medical Officer of the Quality Management Unit as the focal point also supported the positive outcome.

Overall satisfaction of nursing officers in getting intervened services at EB was also considerably improved from 11.5% to 75%. Accessibility of formats, awareness of documents and other requirements to be fulfilled for receiving services, minimized travelling to RDHSK and overall easiness of getting services had an impact on this attribute. The ability to contact support personnel minimized difficulties faced by applicant nurses and the incorporation of nursing officers' suggestions for service improvements enhanced their satisfaction.

The satisfaction of nursing officers on all attributes showed statistically significant improvements (Table 5), even though attributes D (Immediate notification in delay) and I (Courtesy) showed relatively low improvements. The attribute D received a lower post-assessment score of 9.4% since the majority of the post-assessment sample were first-time visitors to the RDHSK who responded to attribute D as 'irrelevant'. The reason for the low improvement in attribute I (59.4%) might be because personal attributes are not easily amenable to rapid changes. Nursing officers' satisfaction with the compliance of service standards by RDHSK was high as 87.5% indicating the timeliness of providing services from EB. The comparable attribute of 'courtesy', the 'staff friendliness' in Nepal[10], had scored 74% which can be explained by having two years of implementation periods before evaluation. The satisfaction with the complaint system in Nepal (100%) was above this study (87.5%) which may be due to a well-established system for years. The promptness score of 75% in Nepal closely resembles the 71.9% in the current study.

Kotler et al.[11] describe satisfaction as a feeling that surfaces from an evaluation process when the consumer compares what is received against what is expected from the utilization. Therefore, nursing officers' expectations of service provision were compared with pre and post-intervention stages to identify further gaps. It was evident that attributes B (Awareness of place of formats), E (Availability of contact details of responsible officer) and I (Courtesy) have performed well although the remaining attributes had an expectation-perception gap. Attributes B, E and I yielded greater satisfaction than their expectations because nursing officers had relatively low expectations on these. Some nursing officers did not expect to be aware of the place of formats (attribute B) as they knew traditionally those were kept at the RDHSK. Attribute E had almost reached the nursing officers' expected level before interventions because most of them had contact details of EB and RDHSK even before. Nursing officers may think that courtesy of staff (attribute I) does not matter if they receive timely services.

Attributes A (Awareness in advance on all documents required with service request), C (Awareness of the time taken to deliver services), D (Immediate notification in delay), F (Complaints handling), G (Promptness) and H (Easiness) had significant improvements after the intervention, but not up to the nursing officers' expectations as shown in figure 2. The gap observed in awareness on required documents and service standards might be due to inadequate clarity of new developments among nursing officers working in Divisional Hospitals and Offices of Medical Officer of Health. Satisfaction on immediate notification and feedback system scored low because most in the post-intervention sample had responded as 'irrelevant'. Promptness received a low score because participants in the post-sample consisted of a group who came to submit applications for W&OP, following a notification to complete necessary documents in personal files due to delays.

The current study had several limitations. Pre and post-intervention study samples might not be representative of the general population of nursing officers who received services from EB of RDHSK since the sample consisted of only nursing officers who visited the RDHSK to get the service completed. Nursing officers working in Divisional Hospitals and Medical Officer of Health Offices were not accessible to the principal investigator in a single forum to make them aware of new developments. The limited-time duration between pre and post-assessments prevented the assessment of sustainability and the impact of the charter and related interventions.

V. Conclusions

The implementation of the charter and supplementary interventions significantly increased the compliance of RDHSK with service standards and decreased revisits by nursing officers ultimately resulting in improved satisfaction on service delivery both among service receiving nursing officers and the service providing staff of the RDHSK. Hence, it could be concluded that the charter and supplementary interventions were effective in improving providing services to service recipients at EB of RDHSK.

The comparison of post-interventional satisfaction with nursing officers' expectations showed further avertable gaps in awareness in required documents and service standards, and the easiness of receiving services.

It is therefore recommended that the other Regional Director of Health Services' offices should implement charters for service recipients in a stepwise manner to improve the service delivery. The arrangements should be made to aware the nursing officers working in Divisional Hospitals and Medical Officer of Health Offices on new developments in future research. Future research should evaluate the long-term sustainability of implementing charters in the Regional Director of Health Services' offices.

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