



# COMMUNITY-BASED MONITORING PROGRAMS IN THE HEALTH SECTOR

## A LITERATURE REVIEW

August 2012

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# EXECUTIVE SUMMARY

This paper summarizes the literature on community-based monitoring programs in developing countries, with particular focus on the health sector. It presents prominent examples of community-based monitoring approaches, highlights common design features and parameters, discusses challenges faced by these programs, and outlines knowledge gaps and areas of future focus. In particular it focuses on two recent successful community-based health sector monitoring projects, in India and in Uganda, and suggests that they provide promising models for future programs. \*Kevin Croke is a consultant to the Broad Branch Associates, the Bill & Melinda Gates Foundation and the World Bank and is an adjunct professor at Johns Hopkins-SAIS.



# I. INTRODUCTION

As global health has become a growing area of focus of the development world in recent years, the problems of governance in the health sector have gained new relevance for policymakers. In particular, the mounting evidence showing relatively weak links between quantity of public sector health spending and health outcomes (Filmer and Pritchett 1999, Filmer et al. 2000, World Bank 2004, McGuire 2010) has been a key motivation for attention to health sector governance as a significant intervening variable between inputs and outcomes. Various strategies to improve health sector governance have been attempted, from ministry-level training and capacity-building projects, to decentralization of health services, to contracting out of basic services, to public sector performance-based payment schemes. More recently, several countries have attempted to improve health sector governance by promoting greater community involvement in monitoring and oversight of health service providers. These community-based accountability programs will be the subject of this paper. The purpose of this paper is to survey the literature on community monitoring projects of this kind, to describe common features and shared challenges that these projects face, and to identify existing gaps in knowledge and practice. This literature review is intended to serve as an input to a broader discussion of the prospects for incorporation of community-based accountability mechanisms in performance-based incentive programs. The paper concludes by highlighting several recent, highly successful examples of community-based monitoring programs, and proposes that future efforts build on these promising models.



## 2. BACKGROUND AND THEORY

Community engagement has a long history in the development community and has been attempted in many contexts, with a wide range of rationales. Participatory development schemes were a major priority for USAID in the 1950s, only to fall out of favor a decade later (Mansuri and Rao 2004). More recently, the donor community's shift away from structural adjustment and policy-based lending has again led to greater emphasis on community groups as aid recipients, symbolized by the World Bank's embrace of community-driven development (CDD): by 2007, the World Bank reported that over 9 percent of its lending supported CDD projects (World Bank 2007). This trend has also been bolstered by the growing salience of governance issues in the development world, since community groups (and civil society more generally) are often seen as a potential source of oversight and accountability pressure on state institutions and service providers. The health sector has not been immune to this trend; many health projects include some form of community involvement. Community engagement for the purpose of *accountability*, however, has not traditionally been a major component of health programming. Health projects are often targeted at the community level in the sense of not being *facility-based*. Community health worker programs have been quite common as a way to enlist community members (as opposed to salaried health workers) in basic health care provision (Mason et al. 2006). Similarly, recent initiatives such as community-based fever management or malaria treatment are attempts to improve *home-based* (as opposed to facility-based) diagnosis and treatment of malaria. Programs that attempt to use community organizations or collective action to increase pressure for accountability on service providers have been less common than programs that use community members as direct providers of preventive health or first-level treatment services.

However, from the theoretical perspective, the rationale for community-based oversight of health programs has firm roots, above all in a branch of institutional economics known as principal-agent theory. Many standard "median voter" political economy models suggests that in democratic settings, politicians are likely to use at least some of their power and control over resources to deliver public services to voters, thereby increasing the chances that they will be reelected. However, principal-agent theory highlights the difficulties in this simple model for many public services by pointing out that even if politicians are genuinely motivated to deliver services to citizens, they must in turn delegate responsibility to ministries, who then must delegate responsibility to mid-level bureaucrats, who in turn delegate to front-line service providers. These subsidiary actors do not face the same incentives as elected politicians since bureaucrats and front-line services providers are not subject to electoral sanction and are often subject to weak supervision and monitoring. As a result, unless they are somehow intrinsically motivated to provide public services honestly, they may instead use the discretion that has been delegated to them to behave opportunistically. This problem is especially acute if the outputs of the bureaucracies in question are transaction intensive (Pritchett and Woolcock 2002) and hard to observe (Fukuyama 2004). The health sector in particular is vulnerable to principal-agent issues due to the asymmetries of information and expertise entailed in transactions between health service providers and citizens. These poorly aligned incentives lead, for example, to both the phenomenon of rampant absenteeism in health facilities (Chaudhury et al. 2006) and the low levels of physician effort (Das et al. 2008) that are often observed throughout the developing world.

This incentive mismatch is to some degree an unavoidable component of hierarchically organized public sector bureaucracies. By contrast, when individuals purchase health or education services in the private sector, they have more ability to deter opportunistic or corrupt behavior by service providers; for example, they can switch to another provider if services are poor. However, various reasons exist as to why market failure is a pervasive aspect of health services, ranging from equity concerns to externalities

to pervasive asymmetric information. For these reasons, despite the better incentive structure that exists in the private sector, there is a strong theoretical case that many of these services should be delivered through public sector bureaucracies. This has led once again to renewed efforts to alter the incentives that public sector actors face in order to improve service delivery performance. A recent influential statement of this problem came from the World Bank's 2004 World Development Report (WDR), *Making Services Work for Poor People*. The WDR classified basic service delivery accountability relationships as either "long route" (through politics) or "short route" (through market transactions). They note that this "long route" of accountability – from votes to politicians to ministry leaders to front-line health workers – has many opportunities to be attenuated or broken. This has led policymakers to explore mechanisms to provide *direct* accountability links, shortening the "long route" by giving community members direct voice over their service providers.

One attempt to improve these accountability relationships can be seen in performance-based approaches, which use top-down financial incentives to motivate providers. In traditional bureaucracies, implementers are paid a fixed salary, based on seniority or educational qualifications rather than performance, and they are typically protected from dismissal by civil service regulations. As a result, they may possess weak performance incentives. Results-based financing attempts to improve the top-down component of accountability by giving higher-level actors tools to incentivize front-line service providers' performance through the use of financial and other incentives. Another influential idea for improving service delivery incentives in this vein is decentralization of health services. Decentralizing control over health services in developing countries should in theory shorten the accountability route by giving local-level (often at the district or municipality level) governments statutory responsibility for provision of health services (Bossert 1998). While citizens might have trouble observing national politicians' behavior and linking it to the quality of their local health services, they might be able to more closely link those problems to the actions of local politicians. Decentralization could also allow for more use of localized information and could (at least in theory) result in greater resource allocation to rural areas. Moreover, many decentralization reforms incorporate community "voice" components, typically through some kind of community or district health board. In practice, however, decentralization has had a very mixed record (World Bank 2004). In many decentralized systems, especially in sub-Saharan Africa, community health boards meet infrequently and have little power (Devarajan et al. 2011).<sup>1</sup>

A final set of initiatives to improve governance of the health sector has come about through programs that support monitoring of public health services and facilities by local organizations (formal and informal) and/or by increasing the amount of information about local health service provision that is available to the public. These initiatives have roots in several broader trends in the development world. First, there has been a much greater focus on governance issues, including corruption, transparency, and institutions of accountability. Second, a sharp increase has occurred in development programs that prioritize community participation, often via some form of village council, meeting, or organization (Mansuri and Rao 2004). These trends have set the stage for a variety of projects and programs, discussed in more detail below, that attempt to use community involvement to increase accountability and improve service delivery in the health sector.

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<sup>1</sup> Another attempt to spur bottom-up oversight of health services is via use of "demand-side" initiatives, such as Conditional Cash Transfer programs or vouchers for use of health facilities. By giving resources to consumers of health services, public providers are put in more direct competition with private providers: public sector providers must now provide services or lose market share. Although this is an effective way of stimulating use of health services, its effect on service quality and bottom-up oversight is less clear.

## 3. EXAMPLES OF COMMUNITY-BASED MONITORING

Despite the growing recognition that governance is an important factor in health sector outcomes, community-based monitoring has not been a major element of health sector programs until relatively recently. This section reviews early community-based accountability programs for sectors other than health and describes a number of health sector programs.

### 3.1 NONHEALTH SECTOR EXAMPLES

The origins of community-based accountability programs, in health and other sectors, can be found in the 1990s, as governance became a larger priority and donors and implementers sought mechanisms to increase citizen oversight of government actors. Early examples of community-based monitoring include the Citizen Report Card pioneered in Bangalore, India, and the use of Public Expenditure Tracking Surveys in a number of countries. In Bangalore, a local nongovernmental organization (NGO), the Public Affairs Center, conducted a household survey about citizens' perceptions of various municipal public services, publicized the results captured in this Citizen Report Card through the media, and worked with willing service providers to enact relevant reforms. Subsequent surveys showed improved citizen satisfaction (Khemani et al. 2011). This program encompassed public services overall and included a health component; for example, the performance of maternity homes was one of the services the Citizen Report Card covered. The Bangalore experience was widely publicized, including in the 2004 VDR, and inspired many NGOs to imitate it. Public Expenditure Tracking Studies (PETS) have been another influential kind of accountability program. Many countries have sought to emulate the high profile success of the education PETS in Uganda, where Reinikka and Svensson (2004) showed the links between education expenditure tracking data, media campaigns about financial "leakage" in the education sector, and large reductions in funding leakage.<sup>2</sup> However, the role of communities in PETS-type interventions is more implicit than explicit; it is hoped that communities will use the information produced to take action, but the projects themselves typically do not focus on generating community action. Similarly, another class of accountability programs focuses on expanding access to media, through newspapers, Internet kiosks, or community radio. These programs similarly emphasize provision of information to communities, with the assumption that communities will then use the information productively to demand accountability from governments (Khemani et al. 2011).

The use of communities in accountability programs also gained momentum from the rise of randomized controlled trials as a means of measuring the effectiveness of development interventions. For all the attention that early accountability programs had garnered, it was hard to generate robust evidence of service delivery improvements from things like the Citizen Report Card experiments in various Indian communities. However, in recent years, researchers associated with the Massachusetts Institute of Technology's Poverty Action Lab and other academic institutions have been able to directly test the

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<sup>2</sup> There have been several attempts to apply the Uganda education example to health. A health PETS also took place in Uganda, although the results were not as impressive as in the education sector, and Wane and Gauthier (2007) show extremely high rates of health funding leakage from a similar exercise in Chad.

impact of several community involvement and monitoring programs in a number of instances. Many of these early experiments involved the education sector.<sup>3</sup>

## 3.2 EDUCATION SECTOR EXAMPLES

In some education sector cases, community monitoring has been effective: Duflo and Hanna (2005), for example, found that monitoring teacher attendance via a time-stamped camera, and tying incentive payments to teacher presence, was an effective community strategy for reducing teacher absenteeism in Rajasthan state, India. In Kenya, Duflo et al. (2009) found that allowing local school committees to hire contract teachers led to significant improvement in test scores. In Madagascar, Nguyen and Lassabille (2008) tested community-based monitoring versus top-down monitoring of the education system and found that, unless it was paired with bottom-up monitoring, top-down management reforms had no effect on student learning. However, in a number of cases, community monitoring strategies had mixed results: Kremer and Vermeersch (2004) found that giving school committees in Western Kenya prizes (such as a bicycle and cutlery sets) to reward top performing teachers was an ineffective tool to motivate performance and reduce absence. In India, Banerjee et al. (2010) found that informing parents about their rights regarding the village education committees and presenting parents with report cards about community learning outcomes were ineffective tools to improve outcomes.<sup>4</sup> Pandey et al. (2009) conducted a similar education campaign in three states in India that informed community members about their responsibilities and rights via the public education system. This intervention produced positive increases in teacher effort and in receipt of benefits to which students were entitled (such as stipends, uniforms, and school meals), but did not show any learning effects. Other similar experiments have addressed the different service delivery sectors. In Indonesia, for example, Olken (2007) found that increased community participation in village meetings did not reduce corruption in infrastructure projects, while increased top-down audits, by contrast, did in fact reduce corruption. These experiments suggest that while community participation in education and service delivery sectors has impressive potential as a tool to improve incentives and increase performance, participation programs must be carefully designed and evaluated, since success appears to be highly context dependent and is far from guaranteed.

## 3.3 HEALTH SECTOR EXAMPLES

Until recently, few projects directly targeted the health sector for community-based monitoring. This has begun to change, however, and the past decade has seen a growing body of evidence and practice on community-based monitoring programs in the health sector. This section discusses this in more detail, with particular attention paid to the design of these programs, who participated, how information was collected, and other related issues.

Some initial results on community-based monitoring of health from the impact evaluation community were discouraging. In Rajasthan state in India, Banerjee et al. (2008) show that having a community-based observer track nurse attendance had no effect on attendance. A similar project, which relied on top-down pay incentives for attendance (in the same region of India) and was based on information collected by a local NGO, also failed when higher level officials simply colluded with nurses to change the definition of absence (Banerjee and Duflo 2006).

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<sup>3</sup> Although the education sector differs from health in a number of ways and lessons are not likely to be identical, these experiments will most likely contain insights for health community programs.

<sup>4</sup> By contrast, mobilizing volunteers to hold remedial literacy camps brought impressive learning gains.

Meanwhile, in other parts of India, inspired in part by the well-known success of the Bangalore Community Score Card experience, a number of communities have experimented with using these cards to improve public services, including health. For example, in 2006, a community score card pilot project was implemented in two subdistricts of Andhra Pradesh state. Facilitators employed by the project convened community meetings, where they solicited feedback on health services. From this feedback, they created a set of indicators and assigned scores to these indicators based on community views. These score cards were then shared with the health facility staff, and action plans for improvement were developed. Descriptions of the program (World Bank 2007a) suggest that these initiatives were successful; however, no follow-up data appear to have been collected. The project was conducted in cooperation with a local NGO, the Bangalore-based Center for Good Governance.

A similar exercise was also conducted in 15 villages in Maharashtra state, using focus groups to generate community opinions about service delivery quality. This program was viewed as successful and expanded to an additional 41 villages in the same state. Again, project documentation reports describe the program as successful (World Bank 2007b), although follow-up data on service quality or availability do not appear to have been collected. Other similar community score card exercises in the health sector have been piloted in Gambia, Ukraine, and the Philippines, following the same basic model as in these Indian examples (McNamara 2006).

Karnataka state in India represents another example of a similarly designed program. Under the aegis of India's National Rural Health Mission program, 562 villages in Karnataka are implementing programs in which village committees participate in planning and monitoring health programs. However, the project, which was initiated in March 2009, has not yet produced results or evidence of impact (Hanumappa and Prashanth 2011). This could be a major test of community-based monitoring approaches implemented at scale, although it is not clear whether the existing data infrastructure will allow credible estimation of the program's impact.

These two previously mentioned trends – the use of community score cards and the rise of randomized controlled trials – came together in a recent community-based monitoring project in Uganda. This project is by far the most rigorous and most successful example of community-based monitoring in the health sector. Bjorkman and Svensson (2009) found that it reduced under-five mortality by an impressive 33 percent, increased infant weight significantly (a 0.14 z-score increase), increased outpatient visits by 20 percent, and improved service delivery quality across a wide range of indicators, including absenteeism (which decreased by 14 percent), quality of care, and immunization rates (BCG vaccination increased by 46 percent). By collecting and then distributing baseline information about the performance of village dispensaries compared to national standards and averages (summarized in report card form) to community members, and then facilitating public meetings where community members and health workers discussed this information, the program appears to have generated bottom-up pressure that led to dramatically improved health services by the time the follow-up survey was implemented. Moreover, the fact that the program was evaluated through a randomized, experimental design inspires confidence in Bjorkman and Svensson's causal identification of the program's impact. It is also notable that the program was done at a relatively large scale, in 50 health facility catchment areas across nine districts, in four regions of Uganda. This large-scale implementation was conducted via local NGOs in various communities in which the projects took place: a total of 18 local community-based organizations.

Another project similar in scale and design was implemented in Uttar Pradesh. Pandey et al. (2007) describe this project as a collaboration between the World Bank and an Uttar Pradesh NGO called Sabhagi Shiksan Kendra. Like the Uganda experiment, this was also a large-scale project, working in 105 villages across 21 of Uttar Pradesh's 70 districts. The project team held two rounds of community mobilization and information dissemination meetings (each round comprised two to three meetings with a 15-minute audio presentation, posters, leaflets, and a question and answer session). The information provided regarded rights of citizens to receive health care, hours of operation for various services and

facilities, and venues for citizen complaints. Pandey et al. (2007) observed 30 percent more prenatal examinations, 27 percent more tetanus vaccinations, 24 percent more prenatal supplements, 25 percent more infant vaccinations, and 21 percent more village council meetings. They also noted that improvements were observed across all castes.<sup>5</sup> While these results are suggestive, Kremer and Glennerster (2012) note that since the district was the unit of randomization and the sample included only 21 districts, the observed positive results might be due in part to district-specific trends.

A final category of a community-based health campaign is one that focuses on a particular function of health services rather than health services more generally. The Rajasthan experiments mentioned above, which focused specifically on nurse absenteeism, are an example of this. Community monitoring of drug stock outs, such as the “Stop Stock Outs” campaign currently underway in Kenya, Uganda, Zambia, Malawi, and several other countries, is another example. Supported by the Open Society Institute, Oxfam, and Health Action International, the Stop Stock Outs campaign is an attempt to mobilize civil society to monitor and publicize stock outs through media activism and online mapping of drug shortage sites, thereby increasing pressure on public authorities to reduce outages.

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<sup>5</sup> Pandey et al. did not capture data on mortality outcomes.

## 4. COMMON CHALLENGES AND BEST PRACTICES

While the model of using community groups to increase public monitoring of health services is an appealing one, it also faces challenges. Indeed, a number of challenges are shared across many of the programs discussed above. These challenges include effective program design, identification of local implementing partners, collection of appropriate data, identification and mobilization of community members and groups, evaluation of program impact, and strategies for program scale-up and sustainability.

### **a) How are these programs designed, and for what purpose?**

An initial challenge for implementers and donors relates to program design. Thus far, many of the health sector community monitoring programs appear to have been funded by the World Bank and designed by Bank staff and Bank-affiliated researchers, in coordination with local governance think tanks or community-based organizations. A possible advantage of this is that in theory, a community of program designers and implementers from the same institution can collaborate and learn from each other's successes and failures. A disadvantage is that programs may be "cookie cutter" in design, with insufficient input from local collaborators and scant attention to local context. Certainly the programs surveyed above have strong elements of commonality. However, an important factor of those that are most successful appears to be a genuine focus on learning from past failures. This is particularly apparent in the Uganda project. Bjorkman and Svensson explicitly describe the ways in which their approach was heavily informed by the previous failure of Banerjee et al.'s (2008) Rajasthan nurse monitoring project. In their view, the Rajasthan project showed that it is not enough to give communities information about service failures. In that project, community members had detailed and accurate information about nurse absenteeism, yet they took no steps to address the problem. This led the Uganda project team to focus on both relaxing the "information constraint" (as in Rajasthan) as well as on relaxing what they describe as the "collective action constraint." In their project, they relaxed this constraint by involving many community members in the meetings (as opposed to the single monitor of nurse attendance) and also by facilitating the writing of an action plan at the community meeting.

### **b) What responsibilities do community members have and who manages them? Are they responsible for operationalizing the program and how?**

Community participation or mobilization can be a nebulous concept and it can be unclear how such participation directly translates into improved health services. Therefore, an important component of project design is to specify the responsibilities of community members and how these tasks are expected to contribute to improved services. Most of the programs discussed above give community members a simple job: show up to a small number of community meetings facilitated by project (or partner NGO) staff. For example, in the Uganda case, community members were simply tasked with attending two meetings: a community meeting and an "interface" meeting with health center staff. Health workers were similarly tasked with attending a meeting for health staff only and an interface meeting that included community members. At those meetings, health workers and community members worked together to develop a plan to improve services. For the Pandey et al. (2007) intervention in Uttar Pradesh, four to six community meetings were held; however, no meetings were held with health facility staff. The non-experimental community score card examples from India discussed in the previous section also follow a similar pattern. Often, these limited formal commitments are designed to spark ongoing, informal monitoring or sanctions. For example, in the failed nurse monitoring experiment in

Rajasthan, villagers were implicitly expected to apply social sanctions to the absentee nurses. Similarly in the Uganda example, Bjorkman and Svensson note that “the primary objective of the intervention was to initiate a process of community-based monitoring that was then up to the community to sustain and lead.” In some cases, it may be envisioned that these interventions will rejuvenate official health facility committees, which are in many cases moribund.

In certain cases, specific members of the public are tasked with discrete monitoring tasks. For example, in the Rajasthan nurse monitoring project, one member of the community was responsible for checking if the nurse was at work, and if not, whether the nurse could be found in the community. This person was paid for his or her work. In the Stop Stock Outs.” campaign, it is not clear who is specifically responsible for checking on stock levels. The campaign has sent data collectors to check on medicine stocks during “pill check weeks,” but it is unclear whether this person is a paid staffer or volunteer. If the program relies on voluntary or crowd sourced reporting, it may well fall victim to free riding and low participation levels.

This raises an important issue. Monitoring health services is challenging in part because people have less sustained contact with the health system than they do with other service delivery sites, such as water points and schools. Even in high disease burden environments, most people do not visit health facilities on a daily, weekly, or even monthly basis. As a result, any one individual negative experience with health services may not generate action, and broad social consensus about service delivery quality may be difficult to generate. Poor service delivery in the other sectors, by contrast, might be more consistently visible and might be a more likely basis for collective action (one example might be the rural water sector, since most rural households must collect water every day). There appears to be solid ground for Bjorkman and Svensson’s thesis that “information is not enough”; collective action constraints that prevent effective mobilization around health sector issues must also somehow be relaxed.

In all of the cases above, the responsibility for organizing these community meetings is given to a local partner NGO. In the Bangalore case, the Center for Good Governance provided facilitators, while in Maharashtra, it was the Tata Institute of Social Sciences, and in Uttar Pradesh, it was the local NGO Sahbagi Shiksan Kendra.<sup>6</sup> In cases where the project is much larger in scale, such as in Uganda, a wider range of rural community-based organizations were used. Donor involvement in implementation of mobilization will likely vary inversely with the capacity of the partner NGO – in the case of large, established urban NGOs, involvement will be less than in situations where, as in Uganda, donors work with many smaller community-based NGOs. In cases in which community-based monitoring is supposed to become a national, ongoing program (as in several Indian states as part of the National Rural Health Mission), it is less clear who or what organization (governmental or NGO) will be charged with convoking and training community-based monitors on an ongoing basis.

This is a key design element, since it separates potentially successful community engagement schemes from existing (and often failing) formal citizen participation channels. It raises questions about what makes a citizen participation scheme organized by an NGO different from the typically ineffective government-organized health facility committees. A recent education sector impact evaluation, which showed differing program impacts when a previously effective intervention was implemented by NGOs (in one treatment arm) versus the Kenyan government (in another), suggests that this problem is more than hypothetical (Bold et al, 2012). If the program (as in India’s case) goes to scale, but is implemented by the exact same health sector institutions that are themselves responsible for low levels of accountability, success seems unlikely.

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<sup>6</sup> In the “Stop Stock Outs” campaign, donors partner with local civil society groups, such as Action for Development (AFCODE) in Uganda.

**c) How is information collected from or given to the community? What information is collected or provided? What are the channels for communities to send information up to higher levels of political or bureaucratic authority?**

A further challenge for community-based monitoring programs relates to the nature of information. The idea of community-based monitoring of public services presumes (at least implicitly) that information about the service being monitored is gathered in some form, is being made available to the community in a comprehensible and usable form, and is then being used in some way by the community in the process of bringing accountability to bear on service providers. However, a number of choices need to be made with respect to the generation and distribution of information. Key choices relate to whether information is subjective or objective and whether it comes from communities directly or whether project teams conduct surveys and present the resulting information to community members. Project designers must also decide whether information should be presented in a comparative context, or in raw form and devoid of comparison. In addition, choices must be made regarding whether communities should be provided with quantitative data about service delivery outcomes (or data about community *perceptions* of service quality), or rather with information about their rights to receive services, such as which groups are eligible for free care or free drugs, how much money the facility receives from higher levels of government, the legal opening hours of clinics, and the like. Most interventions discussed above provide the former type of information; the Pandey et al. (2007) intervention in Uttar Pradesh simply provided information about rights to medical care; and some projects provide some hybrid of the two kinds. For detailed comparative information about service outputs and outcomes to be presented in comparative context (as in the Uganda case), some investment in preliminary data gathering, analysis, and presentation is needed.

In the case of the Community Score Card model, information about health services is garnered in one of two ways. In the Bangalore model, a household survey was implemented in which pre-specified questions were asked across a range of categories related to satisfaction with public services. In the Andra Pradesh and Maharashtra examples, community views appear to have been garnered based on unstructured feedback from community meetings. Here the community itself is actually producing (as well as eventually receiving) the information, and the role of the project team is simply to translate the community feedback into a structured form. However, such an unstructured approach to data collection clearly leaves major discretion in the hands of the project team and complicates any attempt to evaluate the program.

By contrast, in the Uganda and Uttar Pradesh cases, researchers collected data through household surveys. Data collection was largely focused on objective service delivery outputs, such as births attended, immunizations delivered, and the like, although in Uganda, researchers also collected information about subjective perceptions of service delivery. Another key component of this is that the data were presented in a comparative context, so that local outcomes, as well as national averages, were presented to the community. Data were then summarized by the project team and presented to communities at meetings convened for that purpose.

This latter approach appears to have tangible advantages. Because of the technical nature of health services, using only subjective community evaluations will bring challenges. For example, many recipients may not be able to judge whether they have received good care or not. A parent bringing his or her febrile child to a clinic is unlikely to recognize when the nurse has misdiagnosed acute respiratory infection for malaria. Consumers may also be more likely to prefer suboptimal treatment, as in the oft-noted preference for injections over oral formulations. This suggests that citizen oversight based on purely subjective data is more likely to work for easily observed factors like health worker attendance or drug stock outs rather than for more difficult issues like quality of care or accuracy of diagnosis. Moreover, the comparative context may be helpful, in that it lets citizens see that better care is possible

within their own country (and perhaps within their own subdistrict, district, or region), even in the more general context of poverty and limited government capacity.

#### **d) How is community defined?**

Any program focused on mobilization of community groups must spend time defining who the “community” is and how community groups are mobilized. In most of the models described above, facilitators employed by the project mobilized community meetings, targeting all adults living in the community. In some cases, project designers took care to shape the dynamics of these meetings; for example, in the Andhra Pradesh project, separate meetings were held for men and women, while in the Uganda project, Bjorkman and Svensson (2009) note that “to avoid elite capture, the invited participants consisted of a selection of representatives from different spectra of society (i.e., young, old, disabled, women, mothers, leaders).” Pandey et al. (2007) held separate meetings in low, middle, and high caste communities. These safeguards are appropriate but sometimes ignored when program designers romanticize village-level “civil society” in the form of community groups or village assemblies, and fail to remember that unequal political dynamics and elite domination may be as likely at the village level as elsewhere (Mansuri and Rao 2004).<sup>7</sup> Moreover, the specific details by which community groups operate can make a big difference in the resulting outcomes: Olken (2007) demonstrated that in Indonesia, village meeting dynamics were quite different based on whether villagers were invited according to universal, impersonal criteria (i.e., via letters sent home with all schoolchildren) or at the discretion of village elites.<sup>8</sup>

Another challenge for program design is determining whether community monitoring and pressure are targeted at the right level. The accountability problems that many community mobilization programs target occur at all levels (central/ministry/donor, regional, district, and local), but community groups in most the cases detailed above only target their oversight at the village or facility level. Moreover, not all of these problems are amenable to community mobilization. For example, if anti-malarial drugs are stocked out, not because of theft at the facility level but because a Global Fund grant is delayed by Ministry of Finance bureaucratic inefficiency, then community mobilization at the village level is not likely to help. Similarly, if local activist groups see that a health worker is not doing his or her job, yet that worker’s employment is controlled centrally by the Ministry of Health and civil service regulations rather than by the local facility or the village or even district government, then community pressure may be ineffective.

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<sup>7</sup> Moreover, making them a focus of aid resources may also distort the group’s behavior and have unforeseen consequences (Kremer and Gugerty 2000).

<sup>8</sup> It is also important to note that defining “community” and convening community meetings in this way may be much more difficult in urban areas.

## 5. GAPS IN THE KNOWLEDGE BASE

Participatory programs with a focus on community-based monitoring are relatively new in the health sector, and rigorous evaluation of these programs is also new; consequently, there are many gaps in the knowledge base. The following are some of the largest gaps that exist.

Two recent programs stand out as more successful than the others: the community mobilization programs described in Bjorkman and Svensson (2009) and in Pandey et al. (2007). However, a major gap in the knowledge base is the *external validity* of the Uttar Pradesh/Uganda model. At first glance, it seems like an extremely attractive model that donors should be eager to implement. As Bjorkman and Svensson note, the Uganda program is quite cost-effective and produced dramatic results. What might be the challenges for broader replication and scale-up? One possibility is that the program effect was so large in both the Uganda and Uttar Pradesh cases because it was implemented in contexts of extremely high health sector corruption. India's health sector is notoriously corrupt: it was recently rated the second most corrupt sector in the country (Hanumappa and Prashanth 2011), and the state of Uttar Pradesh is notable for high absenteeism rates (Kremer et al. 2005) and poor development outcomes (Pandey et al. 2007). Corruption in Uganda's health sector has been demonstrated by incidents such as its suspension of Global Fund funding in 2005. In a sense, these kinds of community mobilization interventions might be most effective in places where the binding constraint on health services is outright corruption, thereby enabling large gains to be made from stronger local oversight. In other contexts, however, where the biggest constraint in the health system might not be outright corruption but supply-side issues such as health worker shortages, community mobilization might be less effective.

A second issue these kinds of interventions is whether they are scalable and sustainable (Devarajan et al. 2011). In all of the programs discussed above, for example, outside NGO-based mobilizers played a crucial role in mobilizing and shaping the nature of community engagement in the health sector. For community engagement to be a permanent feature of health systems, this function would have to be institutionalized. It seems less likely that government would institute this function nationally on an ongoing basis in an effective manner. One suspects that if governments took over this function, it would quickly take on the pathologies of the formal health sector (and formal health sector participation institutions, such as facility committees).

There are two related issues here. The first relates to the health and vitality of civil society in the country as a whole. This broad-based mobilizing function could be played by already existing civil society groups, if they have a strong presence in the health sector. A robust constellation of health sector civil society groups is clearly possible in some developing countries: in Brazil, for example, civil society has played an important role in expansion of health access (Nunn 2008, Paim et al. 2011). Other middle-income countries in Latin America and East Asia have similar histories of civil society pressure leading to improved basic health services (McGuire 2010). Positive examples also exist in some of the lowest-income countries in South Asia and Africa, such as Uganda's nascent HIV/AIDS-focused civil society, or the role that the Bangladesh Rural Advancement Committee (BRAC) has played in Bangladesh. In such circumstances, it is possible to imagine programs that leverage this preexisting civil society infrastructure to manage a mobilization process at the community level. However, many of the Latin American and East Asian countries where civil society has been a key leverage point to improved health system performance are richer and more developed than the poorest countries in sub-Saharan Africa and South Asia where many current community mobilization efforts are being attempted. Civil society is accordingly less developed, and in many cases a locally rooted and politically influential set of health-

focused civil society groups does not yet exist. This makes the challenge of finding a platform for going to scale with community mobilization programs more acute.

The second issue relates to the functioning of already existing institutional mechanisms for community engagement in the health sector. As discussed in section I, many countries have some preexisting provision for community participation in the health sector, which in many cases was created or strengthened as part of decentralization reforms. In some cases – Brazil, for example – these new participatory mechanisms have served as channels for greater bottom-up feedback and participation in health policy (Paim et al. 2011). But more frequently, this has not been the case – as in Indonesia, for example. Indonesia implemented a dramatic health sector decentralization in 2001. The goal was to increase bottom-up participation in the health sector via various mechanisms developed by the *Koalisi untuk Indonesia Sehat* NGO coalition (Coalition for Health Indonesia), which focused on creation of structures for participation at local levels. But these initiatives were ineffective in practice and were largely ignored by policymakers, and participation in health service governance appears to have actually decreased since decentralization (Halabi 2009).

A third knowledge gap relates to the need to know whether the political accountability link is worth fixing (through community-based monitoring or other tools) versus situations when a demand-side fix is more likely to succeed. In other words, when are demand-side interventions such as conditional cash transfers, for example, or prevention or health promotion programs (which can be implemented by individuals or households) better than attempts to “fix” the public sector? Many analysts have argued that since so many people in poor countries already show a strong preference for private sector care, in some contexts it may make sense to improve access and quality in this sector than to fix potentially intractable governance problems in the public sector. Similar arguments could be made about the relative benefits and cost-effectiveness of mobilizing community groups for health promotion rather than for the difficult task of monitoring the public sector. An analogy could be drawn from the education sector. Banerjee et al. (2010) found that despite tremendous efforts to generate accountability pressure in the education sector, the intervention with the highest payoff was a simple promotion of volunteer activities outside the formal education system, which households could produce themselves.

## 6. CONCLUSION

Community-based monitoring and oversight programs are a relatively new phenomenon in the health sector. As with any new development enterprise, many challenges and unforeseen difficulties will arise in design, implementation, and evaluation. Health services are often highly technical, many people do not use them frequently or have trouble judging their performance, important decisions are made in capital cities where communities have little voice, and many people lack the time or inclination to get deeply involved in monitoring or otherwise working to improve their local health services. Effective and sustained “bottom-up” oversight is clearly a challenge, and will rarely be the first best option for generation of effective service delivery. After all, most developed countries with high-performing health systems do not rely on community meetings or direct citizen monitoring to ensure high-quality health services. However, in many cases in developing countries, accountability is so poor in the public sector that it is worth experimenting with community-based monitoring, especially given that several recent programs have been extremely successful.

In particular, the striking success of the Bjorkman/Svensson community mobilization program in Uganda is suggestive, and calls for replication and fine tuning in a range of different situations. In particular, the dramatic impact on health outcomes combined with the project’s cost-effectiveness (the implementation of the intervention, consisting of data collection, report card creation, and community mobilization, came to only \$160,000) suggests that the intervention is potentially scalable and worthy of testing in different settings.

Examples such as these suggest that with careful attention to project design, community-based monitoring initiatives have great promise as a tool for global health policymakers and program managers in the years to come. However, the relatively underdeveloped nature of the evidence base to date also suggests that for this promise to be realized, a robust program of experimentation and evaluation is needed. Such experimentation is needed before the policy community can be confident that it understands which *specific community interventions* in which *contexts* are truly effective catalysts for sustained improvements in health service delivery and in population health outcomes.



# BIBLIOGRAPHY

- Banerjee, Abhijit, Esther Duflo, Rachel Glennerster, Rukmini Banerji, and Stuti Khemani. 2010. Pitfalls of participatory programs: Evidence from a randomized evaluation of education in India. *American Economic Journal: Economic Policy* 2(1): 1–30.
- Banerjee, Abhijit, Esther Duflo, and Rachel Glennerster. 2008. Putting a band aid on a corpse: Incentives for nurses in the Indian public health care system. *Journal of the European Economic Association* 6(2–3):487–500.
- Banerjee, Abhijit, and Duflo, Esther. 2006. Addressing absence. *The Journal of Economic Perspectives* 20(1): 117–132.
- Björkman, Martina, and Jakob Svensson. 2009. Power to the people: Evidence from a randomized field experiment on community-based monitoring in Uganda. *Quarterly Journal of Economics* 124(2): 735–69.
- Bold, Tessa, Justin Sandfur, Mwangi Kimenyi, Germano Mwabu, and Alice Ng'ang'a. 2012. "Organizational Changes and Pupil Performance in Kenya: Heterogeneous Effects." Working paper, accessed at [http://www.cgdev.org/doc/kenya\\_rct\\_webdraft.pdf](http://www.cgdev.org/doc/kenya_rct_webdraft.pdf).
- Bossert, Thomas. 1998. Analyzing the decentralization of health systems in developing countries: Decision space, innovation and performance. *Social Science and Medicine*.
- Chaudhury, Nazmul, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan, and F. Halsey Rogers. 2006. Missing in action: Teacher and health worker absence in developing countries. *Journal of Economic Perspectives* 20(1):91–116.
- Claasen, Mario, and Alpín-Lardiés, Carmen, eds. 2010. *Social Accountability in Africa: Practitioners' Experiences and Lessons*. Cape Town: IDASA/ANSA Africa.
- Das, Jishnu, Jeffrey Hammer, and Kenneth Leonard. 2008. The quality of medical advice in low-income countries. *Journal of Economic Perspectives* 22(2): 93–114.
- Devarajan, Shantayanan, Stuti Khemani, and Michael Walton. 2011. *Civil Society, Public Action and Accountability in Africa*. World Bank Policy Research Working Paper No. 5733 Washington DC: World Bank.
- Duflo, Esther, and Rema Hanna. 2005. *Monitoring Works: Getting Teachers to Come to School*. NBER Working Paper 11880. Accessed at <http://www.nber.org/papers/w11880.pdf>.
- Duflo, Esther, Pascaline Dupas, and Michael Kremer. 2012. "School Governance, Teacher Incentives, and Pupil-Teacher Ratios." Accessed at <http://economics.mit.edu/files/7660>.
- Filmer, Dean, and Lant Pritchett. 1999. The impact of public spending on health: does money matter? *Social Science and Medicine* 49: 1309–1323
- Filmer, Deon, Jeffrey S. Hammer, and Lant H. Pritchett. 2000. Weak links in the chain: A diagnosis of health policy in poor countries. *World Bank Research Observer* 15(2): 199–224. Oxford University Press.
- Fukuyama, Francis (2004) *Statebuilding*. Ithaca, NY: Cornell University Press.

- Garg, Suneela, and Anyanya Ray Laskar. 2010. Community-based monitoring: Key to success of national health programs. *Indian Journal of Community Medicine* 35(2): 214–216.
- Halabi, Sam. 2009. Participation and the right to health: Lessons from Indonesia. *Health and Human Rights Journal*. 11(1): 49-59.
- Hanumappa, Sudarshan, and N. S. Prashanth. 2011. Good governance in Healthcare: The Karnataka experience. *The Lancet* 377(9768): 790–792.
- Heywood, Paul, and Yoonjoung Choi. 2010. “Health system performance at the district level in Indonesia after decentralization.” *BMC International Health and Human Rights* 10(3).
- Hubbard, Paul. 2007. *Putting the Power of Transparency in Context: Information’s Role in Reducing Corruption in Uganda’s Education Sector*. Working Paper Number 136. Washington, DC: Center for Global Development.
- Kremer, Michael and Christel Vermeersch. 2004. *School Meals, Educational Achievement, and School Competition: Evidence from a Randomized Evaluation*. World Bank Policy Research Working Paper No. 3523. Washington: World Bank.
- Kremer, Michael and Rachel Glennerster. 2012. Improving Health in Developing Countries: Evidence from Randomized Evaluations. In *Handbook of Health Economics*, pp.201-315. Eds. Mark V. Pauly, Thomas G. Mcguire and Pedro P. Barros. Amsterdam: Elsevier.
- Lewis, Maureen. 2006. *Governance and Corruption in Public Health Care Systems*. CGD Working Paper No. 78, Washington DC: Center for Global Development.
- Mahmud, Simeen. 2004. Citizen Participation in the Health System in Rural Bangladesh. *IDS Bulletin* 35(2).
- Malena, Carmen, with Reiner Forster and Janmejay Singh. 2004. *Social Accountability: An Introduction to the Concept and Emerging Practice*. Social Development Papers 76. Washington, DC; World Bank.
- Mansuri, G., and V. Rao. 2004. Community-based and -driven development: A critical review. *World Bank Research Observer* 19(1): 1–39.
- Mason, John B., David Sanders, Phillip Musgrove, Soerkirman, and Rae Galloway. 2006. Community Health and Nutrition Programs. In *Disease Control Priorities in Developing Countries*. 2<sup>nd</sup> edition. Washington, DC, and New York: World Bank and Oxford University Press.
- McGee, Rosemary, and John Gaventa. 2010. *Review of Impact and Effectiveness of Transparency and Accountability Initiatives: Synthesis Report*. Brighton, UK: Institute for Development Studies.
- McGuire, James. 2010. *Health, Wealth, and Democracy in East Asia and Latin America*. New York: Cambridge University Press.
- McNamara, Peggy. 2006. Provider-specific report cards: A tool for health sector accountability in developing countries. *Health Policy and Planning* 21(2): 101–109.
- McNeil, M., and C. Malena. 2010. *Demanding Good Governance: Lessons from Social Accountability Initiatives in Africa*. Washington, DC: World Bank.
- Nguyen, Trang, and Gerard Lassibille. 2008. “Improving Management in Education: Evidence from a Randomized Experiment in Madagascar.” Working paper. Accessed at <http://www.povertyactionlab.org/publication/improving-management-education-evidence-randomized-experiment-madagascar>.
- Nunn, Amy. 2008. *The Politics and History of AIDS Treatment in Brazil*. Springer: New York.
- Olken, Benjamin. 2007. Monitoring corruption: Evidence from a field experiment in Indonesia. *Journal of Political Economy* 115(2): 200-249.

- Paim, Jairnilson, Claudia Travassos, Celia Almeida, Ligia Bahia, and James Macinko. 2011. The Brazilian health system: History, advances, and challenges. *Lancet* 377: 1778–97.
- Pandey, Priyanka, Ashwini R. Sehgal, Michelle Riboud, David Levine, and Madhav Goyal. 2007. Informing resource-poor populations and the delivery of entitled health and social services in rural India: A cluster randomized controlled trial. *Journal of American Medical Association* 298(16):1867–75.
- Pandey, P., S. Goyal, and V. Sundararaman. 2009. Community participation in public schools: Impact of information campaigns in three Indian states. *Education Economics* 17(3): 287–89.
- Pritchett, Lant, and Michael Woolcock. 2002. *Solutions When the Solution Is the Problem: Arraying the Disarray in Development*. Center for Global Development Working Paper 10, Washington DC: Center for Global Development.
- Ravindra, A. 2004. *An Assessment of the Impact of Bangalore Citizen Report Cards on the Performance of Public Agencies*. World Bank.
- Reinikka, Ritva, and Jakob Svensson. 2004. Fighting corruption to improve schooling: Evidence from a newspaper campaign in Uganda. *Journal of the European Economic Association* 3(2-3): 259–67.
- Rocha Menocal, Alina and Bhavna Sharma. 2008. *Joint Evaluation of Citizens' Voice and Accountability: Synthesis Report*. London: Department for International Development.
- World Bank. 2007a. *World Development Report 2008: Agriculture for Development*. Washington, DC: The World Bank.
- World Bank. 2007b. *Maharashtra, India: Improving Panchayat Service Delivery through Community Score Cards*. Social Accountability Series, World Bank South Asia Sustainable Development Department. Accessed at [www.sasanet.org](http://www.sasanet.org).
- World Bank. 2007c. *Andra Pradesh, India: Improving Health Services through Community Score Cards*. World Bank South Asia Sustainable Development Department. Accessed at [www.sasanet.org](http://www.sasanet.org).
- World Bank. 2004. *Making Services Work for the Poor*. *World Development Report 2004*. Washington DC: World Bank.











