

COMMUNITY ENGAGEMENT AND PERFORMANCE-BASED INCENTIVES

THE VIEW FROM BURUNDI

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This case study discusses the ways in which Burundi's performance-based incentive (PBI) program has impacted social accountability by contracting local community-based organizations (CBOs) to conduct verification and gauge patient satisfaction with services. We describe how the mechanism is implemented, and measure it against two important elements of effective community engagement: access to information and channeling views. We conclude that combining bottom-up pressure with the top-down accountability strategy of PBI has significant potential to enhance social accountability, especially in Burundi, where PBI has been institutionalized and scaled up. But the use of local CBOs for verification raises questions of independence and patient privacy, and a lack of information provision back to the community hinders efforts to foster community-wide empowerment and participation.

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ABOUT THIS SERIES

This case study is one in a series examining performance-based incentive (PBI) programs that engage local communities in implementation. The series looks at Burundi's classic supply-side PBI program, which contracts community-based organizations to conduct verification; Mexico's conditional cash transfer program, *Oportunidades*, a classic demand-side PBI program, in which local beneficiaries are elected to oversee program administration at the local level; and a program in Indonesia that contracts civil society organizations (CSOs) to lead communities and health providers through a process of collective learning, needs prioritization, and action planning. Unlike Burundi and Mexico, the Indonesia program is a classic community engagement scheme that also happens to condition a portion of CSO remuneration on performance.

PBI, defined as “any program that rewards the delivery of one or more outputs with one or more incentives, upon verification that the agreed-upon result has actually been delivered” (Musgrove 2010), aims to strengthen accountability between payers and providers by giving higher-level actors (such as ministries of health) tools to incentivize greater performance among front-line service providers. PBI also enhances accountability within health facilities – because the efforts of each individual impact the team's performance payment, the team members hold each other accountable. And PBI can strengthen accountability between providers and patients, since rewards for increases in the quantity of health services encourage providers to attract patients by doing things like improving quality and being more responsive to patients.

Another way to strengthen accountability is through mechanisms that give average citizens channels through which to hold their providers accountable. Experiments with such community engagement mechanisms are growing in the health sector, from community scorecards to community-based monitoring.

The purpose of this series is to learn what happens when PBI and community engagement are combined. Our hypotheses were that engaging communities in the implementation of PBI programs might be a cost-effective approach to program administration, and that such engagement might also have broader benefits, enhancing social accountability and citizen empowerment.

We thought PBI could strengthen the impact of community engagement in two ways: first, because no amount of bottom-up pressure is likely to change health provider behavior if the environment in which the providers operate is dysfunctional. PBI explicitly addresses those dysfunctions. Second, most community engagement mechanisms presume that information about health services is being gathered and used by the community, and routine collection and verification of health data is part and parcel of PBI programs, and thus a potentially powerful asset for community engagement.

What we learned from the fieldwork challenged our assumptions, and highlighted the risks and tensions inherent in engaging communities. Engaging communities in the implementation of PBI may still be advantageous functionally, even if it does not foster community-wide empowerment and participation, but robust checks and balances are needed to mitigate risk. Our analysis also suggests that there is still scope to strengthen broader empowerment by using PBI as a platform: most community engagement mechanisms are meant, through limited formal commitments initiated by a project, to spark ongoing informal monitoring of providers. Sustainability is always an issue, but where PBI has been scaled up and institutionalized, there is an opportunity to use PBI's currency – information – to strengthen ongoing engagement between citizens and their health providers.

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ACRONYMS

CBO	Community-Based Organization
CE	Community Engagement
CHW	Community Health Worker
COSA	Health Committee
CPVV	Provincial Committee for Verification and Validation
DHS	Demographic and Health Survey
FP	Family Planning
MoPH	Ministry of Public Health and HIV/AIDS
NGO	Nongovernmental Organization
PBF	Performance-Based Financing
PBI	Performance-Based Incentives



THE BIRTH OF PERFORMANCE-BASED FINANCING² IN BURUNDI

Nestled in East Africa, between Tanzania, Rwanda, and the Democratic Republic of Congo, Burundi has, like many of its neighbors, a tragic history of violence. The country suffered a devastating civil war between 1993 and 2000, followed by sporadic fighting until 2009, when the last of several rebel groups was integrated into the political system.

Decades of war devastated the health system, which suffers from the usual grim recital – a shortage of qualified human resources (particularly for specialist services), infrastructure, and equipment, along with poor health indicators. The country’s maternal mortality ratio is stunningly high, hovering at about 499 per 100,000 live births; infant and under-five mortality rates are also exceptionally high, at 59 and 96 per 1,000 live births, respectively (Measure DHS 2011). The average life expectancy for Burundians is just 50 years, and Burundi is ranked 185 out of 187 countries in the Human Development Index (United Nations Development Programme 2012).

² Performance-based financing (PBF) is the term Burundi uses for its program. PBF is typically associated with a particular kind of PBI model, often seen in the Great Lakes region of sub-Saharan Africa, wherein facilities are paid fees for services and incentives for quality. Henceforth, we refer to Burundi’s program as PBF.



Prior to 2006, health care services were provided under a user fee system, which, according to Médecins Sans Frontières (2008), posed a significant barrier to accessing health care and excluded some of the poorest members of the population. In May 2006, in an effort to jumpstart improvements in maternal and child health, and in recognition of the impact the user fee system was having on access to health care, the government abolished health service fees for children under five and pregnant women at public health facilities.

Use of health services increased dramatically: the number of medical consultations involving children increased by 42 percent, and the health facility delivery rate increased from 22.9 percent in 2005 to 60.0 percent in 2010 (Measure DHS 2011). Increased utilization placed pressure on health facilities already struggling for human and financial resources: there were shortages of equipment, drugs, and qualified staff, and government reimbursements to health facilities were often delayed. Health workers organized several month-long strikes, protesting poor working conditions and low wages, and many left public facilities for better-paying private sector jobs.

Six months later, two Dutch NGOs – HealthNet-TPO and CORDAID – began implementing a handful of PBF pilots in three provinces in partnership with the Ministry of Public Health and HIV/AIDS (MoPH).³ Two evaluations – one by an MoPH unit and another by the Royal Tropical Institute of Amsterdam⁴ – found positive results: complete child vaccination coverage increased, as did the rate of assisted births and the number of women who used contraception.

In 2009, the pilots were extended to six additional provinces,⁵ and beginning in April 2010, PBF was rolled out nationwide. The national program combines design features from the various pilots, which were negotiated with key donors, NGOs, and key government departments. The PBF system covers all qualified health facilities (health centers, district hospitals, and tertiary hospitals) in all 17 provinces in the country.

³ Apart from Cordaid and HNI-TPO, the Swiss Development Cooperation had a PBF pilot and the European Commission funds “Santé Plus,” which also implements the Cordaid model. All together, there are PBF programs in about 10 out of 17 provinces.

⁴ Additionally, Cordaid does its own routine household surveys.

⁵ Apart from Cordaid and HealthNet TPO, the Swiss Development Cooperation had a PBF pilot, and the European Commission funds “Santé Plus,” which also implements the Cordaid model. Altogether, before the full scale-up, there were PBF programs in 10 out of 17 provinces.



THE NUTS AND BOLTS OF BURUNDI'S PBF SYSTEM

The objectives of the national PBF system are to improve utilization of health services and the quality of care; motivate the health workforce; establish an effective system to verify health facilities' provision of services; and improve retention rates and reduce staff turnover (MoPH 2011).

Under the system, public, private, and religiously affiliated health facilities receive monthly fees for each service delivered on a specified list of 22 services⁶ (for health centers) and 24 services (for district and national hospitals). The most disadvantaged health facilities, i.e., those located in poor and/or remote locations, receive unit fees that are up to 80 percent higher than the most advantaged facilities. The indicators cover curative care, preventative care, and reproductive and child health care. Facilities can also earn additional bonuses of up to 30 percent of total fees earned the previous quarter depending on their quality performance, which is determined by an assessment of over 100 composite indicators and community client surveys conducted randomly each quarter by local organizations.

⁶ In April 2010, 24 indicators were contracted but two were removed following the revision of the Procedures Manual in September 2011.



Not counting the quality-related bonus, health centers typically receive an average of \$1,839 per month, while district hospitals receive approximately \$12,373 per month, not counting quality bonuses (PBF Database 2011). Bonuses as they related to salaries vary, but it can be significant, generally 50 percent of worker salaries.

Facilities have considerable autonomy in allocating the bonus payments to staff or to service quality improvements. There is a limit, however, on the amount that can go toward individual staff bonuses, as the MoPH was concerned with potential misuse of these funds.⁷ Still, while staff incentive payments from the bonuses vary, they can be significant relative to worker salaries (generally 50 percent).

In addition to incentivizing health facilities, the MoPH enters into contracts with national and subnational bodies, including the National Technical Unit, which is responsible for overall management and oversight of the scheme; provincial and district health teams; and the provincial verification and validation committees (*Comité Provincial de Vérification et de Validation*, or CPVV). These administrative structures receive incentive payments each quarter, depending on their performance on process measures, such as how well they manage contracts, conduct audits, verify data, submit data on time, and prepare invoices.

The PBF system is managed and financed by the MoPH, with technical and financial support from USAID, the World Bank, the European Commission, the Belgian Technical Cooperation, and the GAVI Alliance, as well as NGOs such as Cordaid, HealthNet TPO, and Gruppo Volontariato Civile.

⁷ For the provincial and district authorities, a maximum of 80 percent of the PBF bonus can be allocated to individuals. For health facilities, a tool has been developed to help calculate whether they meet the criteria for paying individual bonuses, based on certain “financial viability” conditions.



ENGAGING COMMUNITIES: CBO-LED VERIFICATION AND PATIENT SATISFACTION SURVEYS

As part of the PBF system in Burundi, CBOs are contracted to conduct community surveys with a random sample of patient households. Health facility scores on the community surveys determine 40 percent of their quality bonuses. The survey is broken into two parts: 20 percent of the facility's overall quality bonus depends on patient satisfaction as measured by the survey (see Box 1), and 20 percent depends on confirmation by the CBO of the existence of the patient and that services reported were received. It should be noted that some have questioned the utility of rewarding facilities an additional bonus based in part upon confirmation that what they have already been paid for is real.



Box I. The Burundi PBF Patient Satisfaction Survey

Having identified the patient and confirmed the type of service they last received in the health center or hospital, the questionnaires consist of the following questions (all question except for the last three are answered on a three-level scale):

- Were you satisfied with the service you received at your health center/hospital? (Very satisfied/reasonably satisfied/not satisfied)
- How was the waiting time?
- Were you well greeted?
- Did the staff who treated you explain what you were suffering from, the medication that was given to you, and how to take the medication?
- Was confidentiality respected?
- In your opinion, are the personnel at the facility competent?
- Is the facility you visited open 24/7?
- Are the prices offered by the facility reasonable?
- Was the payment of the service transparent (on the basis of fixed charges displayed at the facility, provision of a receipt, and children under 5 and pregnant women not charged)
- Are the hygienic conditions of the facility acceptable (general cleanliness, clean latrines, electricity, clean water, shower)
- Were the medications prescribed to you available at the facility?
- What were the positive aspects you observed at the health center?
- What were the negative aspects of your visit?
- What recommendations would you give to the facility to improve the services provided?

CBOs are typically assigned one health center for which they conduct the surveys. There are several criteria that CBOs must meet to participate:

1. CBOs must be registered with the Ministry of Interior, or if they are not, they must be recognized by the community within which they will conduct the surveys. The Burundi PBF Procedures Manual does not elaborate on what “recognized” means.
2. They must have been operational for at least two years, and preferably have been involved in health- or poverty reduction-related activities.
3. The CBO staff must not be related to any health center staff whose results it will verify, to avoid conflicts of interest.
4. CBOs must have at least six members who are fluent in Kirundi, and preferably fluent in French.



A local committee⁸ selects CBOs with the assistance of the CPVV. Contracts with CBOs are signed for one year, after which time they may be renewed if CBO performance is deemed acceptable. Until the end of 2011, the CBOs conducted community surveys on a quarterly basis, but beginning in 2012, the frequency was reduced to once every six months. This was due to concerns that quarterly reviews did not give CBOs sufficient time to conduct the surveys, or the CPVVs sufficient time to properly analyze the results. The financial and administrative costs of conducting quarterly verification were also substantial.

When the PBF program began, six members from each CBO attended a three-day training on PBF generally, and more specifically about the role of the community surveys, how to conduct the surveys, and strategies for communicating with households. Subsequently, prior to each survey, the CPVV convenes the CBOs in the province for a one-day refresher training, during which the CPVV (accompanied by the NGO providing technical assistance in that province) explains how the surveys should be conducted, addresses issues that arose during the last survey, and answers any questions the CBOs raise. This is the only venue in which the CBOs meet with the CPVV alone, and where they can feel free to raise concerns as well as any technical issues relating to the survey. During the meeting, the CPVV provides the CBOs with the sample of patients to visit, their contact details, and blank questionnaires.

The CBOs have 15 days to conduct the surveys and submit the results to the CPVV. The CPVV then inputs the answers into the PBF Database and calculates the overall quality score of each facility. The CPVV also meets to decide whether any questionnaires should be counter-verified.

Following analysis and any counter-verification, the CPVV organizes a feedback meeting to present the results of the quality checklist, patient satisfaction surveys, and performance on quantitative indicators. Stakeholders at the feedback meetings include the provincial and district health authorities, the head of each health facility and the president of the facility health committee, the CBOs that conducted the survey, and local administrators and governors.

⁸ The Burundi PBF Procedures Manual refers to this as a “communal commission.” The manual does not elaborate on who the members of this committee should be.



ISSUES RELATED TO COMMUNITY EMPOWERMENT: ACCESS TO INFORMATION AND FACILITATION OF COLLECTIVE ACTION

According to Bjorkman and Svensson (2009), there are two major areas that are important for community empowerment: (1) relaxing the information constraint, and (2) relaxing the collective action constraint. That is, for communities to effectively participate and engage, they need information, and the ability to do something with that information.

The community survey is the only formal mechanism in Burundi that systematically collects the views and perceptions of patients and links them to a reward or sanction for health providers. This creates a potentially powerful mechanism by which to hold service providers accountable.

However, this exercise is not effectively empowering communities, for several reasons. First, the sample of patients selected for the surveys is fixed at 80 patients every six months for each health center regardless of the number of patients served, thus capturing only a small proportion of the total number of patients. The surveys also do not capture the population who do not visit a health center. Furthermore, the lag time between receipt of a service and the survey can be several months, which diminishes the likelihood that patients remember details of their experience. This is an important issue if a portion of provider payment depends on this information.

The utility of the data may also be diminished by the fact that there is no community education or sensitization about the survey or the larger PBF system. Community members do not know what services they are entitled to receive at health facilities, what they are entitled to in terms of quality, what the facilities are being held accountable (and being paid bonuses) for by the CPVV, or how facilities are performing relative to one another. This decreases the ability of survey respondents to provide useful information – and a common complaint from facilities is that patients often express dissatisfaction with things they do not realize are not in the facilities' control. To a certain degree this is unavoidable whenever patient perceptions are gauged, but this issue could be mitigated with community-wide sensitization about the survey.

A lack of community-wide sensitization also limits the degree to which the surveys build community awareness and the space for collective action and channeling of views. While the program engages individuals



through the survey, these are isolated encounters controlled from the top down, with all information flowing vertically rather than horizontally. The exercise appears more squarely focused on feeding small bits of information back to the program and up the chain, without sharing this information among the broader community. Results of the community surveys are channeled first to the CPVV, which is charged with analyzing the results. They are then channeled to the health facilities, as part of the feedback session where they obtain their quality score. Because of the limited feedback with the community about the surveys and the PBF system, it is unclear whether patients or the larger community are aware of their sanction power over facilities.

If social accountability is the aim, communities need information upon which they can act. In Burundi's PBF program, there is ample opportunity to provide this information, since it is already being systematically collected. Provision of information to residents about the objectives of the verification, why their contribution is important, and how their contribution will be used could not only help the communities to be more open (since they would understand the context within which their comments are being used), but it could also help ensure that the community provides information that is useful to improving the health system. Having information about facility performance presented relative to a standard would also empower communities to hold the facilities accountable for results. But provision of this information to communities is lacking.

There is an infrastructure in place to help facilitate the education and representation of communities, in the form of the health committees (known by the acronym COSA, which stand for *Comite de Santé*) and cadres of community health workers (CHWs). Theoretically, it is the responsibility of both of these parties to provide information about health services but there is little evidence that this information-sharing happens consistently. Health committees are responsible for ensuring that community concerns and priorities are well-represented in the activities of the health facilities; in theory, they can refuse to sign the facility's PBF contract if progress is not being achieved (they are signatories on facility's bi-annual performance contract with the CPVV). However, this is unlikely given that their budgets come from the health facility – a conflict of interest that raises questions about their effectiveness as an independent monitor.

Furthermore, there is evidence that some patient concerns are not being channeled to the people empowered to act on them. For instance, human resourcing and infrastructure issues are under the purview of the central



ministry, but it is not clear that this type of information is being filtered and channeled to the right central-level departments. This can weaken social accountability because the community may feel disempowered if they have expressed their concerns about health services, but do not see evidence of a response to their concerns.

ISSUES RELATED TO ENGAGING CBOs: INDEPENDENCE, FRAUD, AND PATIENT PRIVACY

There are also issues related to the contracting of CBOs for verification. While CBO may strengthen civil society by formalizing and building the capacity of CBOs, whose capacity varies widely and in some cases is quite low, the fact that their capacity is low can negatively impact their ability to effectively carry out this programmatic function. A study of CBOs across six provinces in Burundi in 2010 (Falisse et al. 2012) found that less than one-fifth of CBO members had completed primary schooling. Seventy percent of the CBOs identified themselves as “self-help groups of farmers,” which suggests that their engagement as part of the PBF program may be their first experience outside of subsistence farming.

This can impact the quality of their work, both in organizing the surveys and the quality of the data collected. Consider two CBOs in the program, the Bujumbura-based CBO Anakan, and TIC Kumbizi, a CBO based in Muramvya. At the time of this writing, Anakan had 61 members and was helping to implement projects funded by large donors such as the United Nations Development Programme. Representatives from Anakan said that they convene verifiers halfway through the exercise to ensure survey administration is going smoothly and to discuss challenges. The verifiers then group into pairs for the second week of verification in order to address any problems experienced by team members during the first week; finally, they reconvene prior to survey submission to check that the questionnaires have been correctly filled in.

In contrast, TIC Kumbizi has 12 members and trains local youth in information technology skills. This CBO does not convene members while surveys are being conducted, or conduct quality assurance before submitting the surveys. The motivation of the CBOs also appears weak in some cases, and there have been numerous complaints from facilities of fraud; health facility informants frequently suggested that some CBO assessors were filling out the questionnaires “under a tree.” The



CPVVs have instituted one check against fraudulent CBO behavior: they withhold some patient details that can only be gleaned by actually speaking with the patient (or with someone from his or her household). Thus, by comparing these details as completed by the CBO with those that the CPVV already possesses, the CPVV can check whether the CBO actually visited the household.⁹

But counter-verification of the community surveys is not done systematically, despite the fact that in instances where CPVV members have re-done surveys (when they believe that the CBO made an error), the quality of the CBO surveys has been questionable. For example, in Makamba, the few times that the questionnaires have been counter-verified fraudulent questionnaires were found and several CBOs were suspended. A Cordaid representative and CPVV member helping to manage Ankana in Bujumbura noted that counter-verification had been conducted two or three times and that each time the CBO was suspended.

The requirement that CBOs be based in the community also causes a potential conflict of interest. Being based in the community means that members of the CBO may know the personnel of the health facility that is being assessed (they may be neighbors or go to the same church). This is exacerbated by the fact that when the CPVV presents the results of the survey to the health facility at the feedback meeting, the members of the CBO that conducted the survey are also invited. Therefore, the objectivity of the CBO in assessing the facility is brought into question.

The requirement that CBOs be based in communities also raises important questions about patient privacy and the ethics of having community members question their neighbors about the health services they receive. This may be especially sensitive for particular services, such as HIV testing and treatment or family planning.

In Senegal, which will also contract CBOs to conduct verification and patient satisfaction (at the time of this writing, the program was still being designed), there will be only one CBO per district, as opposed to one CBO per facility in Burundi. This may increase the likelihood that the CBO is independent from the community or facility it is surveying.

⁹ In Senegal, in order to ensure that the local NGOs/CBOs contracted to verify results at the household level are indeed visiting households, the external auditor (who audits health facility records once per quarter) picks a sample of users, and checks with them that they were surveyed in the previous quarter.



WHY ENGAGE CBOS AS PART OF THE PBF SYSTEM?

A key question is whether the rationale behind engaging CBOs and conducting community surveys was to strengthen social accountability and improve health governance – or not.

CBO-led community surveys were part of the PBF pilot projects implemented by Cordaid between 2006 and 2010, and there appear to be several objectives behind their engagement in the pilots and subsequent national roll-out. On the one hand, they are contracted because it is hypothesized that their proximity to households will make those households more willing to open up to people they know rather, than to strangers. However, the opposite might be true: that households would be more likely to be open and honest about their medical and health facility experiences if the survey were carried out by a stranger with whom they would have no further interaction after the survey.

Another rationale for engaging CBOs to conduct verification is that they are significantly cheaper than other independent auditing agencies – not only because their professional fee expectations are lower, but also because the program does not incur the same magnitude of transportation costs, since the CBOs are physically closer to households. In Burundi, the CBOs receive less than US\$3 for every questionnaire that is correctly filled in.

In addition to these rationales – proximity, efficiency – respondents did note that contracting CBOs provides potential for strengthening civil society and contributing to social accountability. It helps to empower CBOs by giving them a challenging activity that requires them to engage with members of their own community. It also helps to instill a culture of accountability, by demonstrating to the CBOs that community members are entitled to give their views about health service delivery in their villages. Empowering these CBOs, as well as community members who give feedback, may provide a foundation for strengthening civil society over the long term.



CONCLUSION: POTENTIAL EXISTS, BUT GAPS REMAIN

Burundi's PBF system has the potential to enhance social accountability. The approach is scaled up across the country; the program regularly collects subjective and objective data, and links subjective data to a powerful incentive for health care providers, thus giving their views “teeth”; and the program already has several years’ worth of experience working with CBO intermediaries.

But as a mechanism to enhance collective citizen engagement in the health system, the approach still has a long way to go. As it currently stands, Burundi's community engagement approach is succeeding in extracting some information from communities and sending that information up the chain to facilities and provincial managers, but those actors are not being effectively held accountable for progress, and the community is not being empowered to collectively hold them accountable. Instead, citizens are engaged sporadically and individually without receiving the relevant contextual information to inform their feedback, which dampens the potential to create a sense of collective citizen engagement and social accountability.



Having only recently emerged from decades of war, it is possible that there is little appetite for this kind of citizen empowerment (i.e., enabling collective action). In an illustration of this, the CBO community surveys were originally called “reinforcing the voice of the population”; as one key informant said, the idea was that health workers were getting money from PBF and therefore should be held accountable for it by citizens. But the name of the mechanism was changed to the more nondescript “community surveys” because, as several informants noted, “reinforcing the voice of the population” was considered too politically sensitive.

Engaging CBOs in the implementation of PBF may still be advantageous, even if it does not appear to foster community-wide empowerment, but more experimentation and innovation is necessary to determine the best role for them. Contracting CBOs to conduct verification and patient satisfaction surveys raises important, unanswered questions: for example, about the tension between needing entities with capacity to carry out this critical function, versus the desire to build the capacity of civil society; and the inherent contradiction of contracting community members to serve as independent auditors in their own communities. It also raises questions about potential patient privacy issues, and highlights the need for robust checks and balances to prevent abuse and fraud.

Finally, there is still an opportunity to foster wider community engagement in the Burundi PBF program. Most community engagement schemes imply an investment in data collection, and are meant, through limited formal commitments, to spark ongoing informal monitoring and continued engagement. Cost and sustainability are always issues. PBF in Burundi presents an opportunity because it is a nationwide, institutionalized program, and routine collection of data is part and parcel of the program. In the future, the program could consider revitalizing and leveraging the role of health committees to channel information to communities, empowering them with knowledge about how well their providers perform relative to national standards. Investing more in educating communities could also help to ensure that they understand what is in the power of their health care providers to improve, as opposed to issues that are outside their control and under the purview of higher levels in the MoPH. This could help to strengthen the whole health system – from communities, to CHWs and health committees, to health facilities – providing accountability and support for service delivery.



REFERENCES

- 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.
- Busogoro, Jean-Francois and Alix Beith. 2010. *Pay-for-Performance for Improved Health in Burundi*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.
- Croke, Kevin. 2012. *Community-based Monitoring Programs in the Health Sector: A Literature Review*. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.
- Falisse, J-B, B. Meessen, J. Ndayishimiye, and M. Bossuyt. 2012. Community Participation and Voice Mechanisms under Performance Based Financing schemes in Burundi. *Tropical Medicine & International Health*.
- Measure DHS. 2011. *Enquête Démographique et de Santé Burundi 2010*. Calverton, MD: ICF Macro.
- Ministère de la Santé Publique et de la Lutte Contre le SIDA (MoPH). 2011. *Manuel des Procédures pour la Mise en Œuvre du Financement Basé sur la Performance au Burundi*. Version Révisée. Bujumbura, Burundi.
- Ministère de la Santé Publique et de la Lutte Contre le SIDA (MoPH). 2012. <http://fbpsanteburundi.bi/>
- Musgrove, Philip. 2010. *Rewards for Good Performance or Results: A Short Glossary*. Washington, DC: World Bank.
- Médecins Sans Frontières. 2008. *No cash, no care: how “user fees” endanger health*. Brussels.
- United Nations Development Programme (UNDP). 2012. *Human Development Index and its Components*. http://hdr.undp.org/en/media/HDR_2011_EN_Table1.pdf



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