

THE POWER OF INFORMATION IN COMMUNITY MONITORING

A community-based monitoring program in Uganda led to large and sustained increases in health care utilization and improvements in child health. The key to success was providing communities with information on the performance of local health care providers.

Featuring evaluations by **Martina Björkman Nyqvist, Damien de Walque, and Jakob Svensson**



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Every year, an estimated 6.4 million children under five die of diseases, such as diarrhea, pneumonia, and malaria, that could have been prevented or treated with a small set of proven, inexpensive health services. Most of these deaths occur in developing countries. One possible reason that these services are not provided is that weak accountability systems affect health workers' performance. A 2003 survey of six developing countries found that, on average, 35 percent of health workers were absent on any given day, and among those who were present, many were not working.

In an effort to strengthen local accountability, many policymakers have invested in programs that enhance beneficiary involvement in monitoring service providers. In the last decade, the World Bank allocated close to US\$85 billion to local participatory development programs. Despite the enthusiasm for the approach, the existing evidence on its effectiveness is mixed, and little is known about the longer-run impacts and what program features make community monitoring more or less successful.

Between 2004 and 2006, J-PAL affiliates Martina Björkman Nyqvist (Stockholm School of Economics) and Jakob Svensson (Stockholm University) evaluated the impact of a community monitoring program on the performance of public primary health care providers in Uganda. In a follow-up study with Damien de Walque (World Bank), researchers evaluated the longer-term (four-year) impacts of the original program, and conducted a second randomized evaluation to test a less expensive version of the program that did not give communities information about provider performance.

KEY RESULTS:

Efforts to stimulate more beneficiary control, coupled with information on provider performance, led to substantial and sustained improvements in health. After the first year, the weight-for-age for infants was 0.14 z-scores higher and under-five mortality was 33 percent lower in program communities. These positive impacts were still present four years after the initial intervention.

Communities that received information on provider performance as a component of the community monitoring program were more involved in monitoring, and in response, health workers exerted more effort. Better treatment practices, clinic management, and more frequent use of health facility tools aimed at increasing patient satisfaction suggest that improvements in health care delivery were due to changes in staff behavior.

Providing communities with information about their health care providers' performance was likely important for the success of the community monitoring program. In a separate evaluation, efforts to stimulate community involvement without addressing communities' lack of information about the state of provider behavior and the relative quality of care had no impact on provider performance or patient health.

Without information on provider performance, communities could not identify and challenge poor behavior and this constrained their ability to hold providers accountable. Communities that did not receive information focused on issues that required third-party actions to fix (e.g. more support from upper-level authorities or ngos), while communities that received information focused on issues they could affect locally, such as absenteeism, opening hours, patient-clinician interactions, and wait times.

EVALUATION



PHOTO: JAVIER MERELO DE BARBERÀ LLOBET

Uganda, like many developing countries, faces poor public health service provision. Health workers have few incentives to work hard, as hiring, salaries, and promotions are largely determined by seniority and education, and not by performance. This study took place in public dispensaries—health facilities that provide preventive outpatient care and maternity and laboratory services, primarily in rural areas. Before the study began, roughly 50 percent of dispensary staff members were absent on a typical day and the average wait time was over two hours.

The Ugandan health sector is decentralized, and several actors are responsible for supervising public dispensaries. Local Health Unit Management Committees (HUMCs), which consist of health workers and community members, are responsible for monitoring their day-to-day operations. Yet baseline data suggest that HUMCs and other monitoring institutions were not actively involved in supervising health care providers.

Researchers designed an evaluation to examine whether community monitoring could improve local health service delivery, and whether a lack of information and failure to agree on what is reasonable to demand from providers constrained individual and group action to pressure and monitor health workers. Fifty public dispensaries were randomly assigned to a program or comparison group. In program communities, researchers generated local-language report cards for each dispensary using baseline survey data. They included information on the dispensary's service quality relative to neighboring facilities and health care users' rights and entitlements.

The report cards were disseminated in program communities through a series of three meetings facilitated by eighteen local NGOs. The first two-afternoon meetings brought together over 150 community members to discuss the status of health services and steps they could take to monitor providers. Next, the NGOs held a one-afternoon meeting with health workers to discuss their views on the key constraints in local health care delivery. The third meeting brought community members and health workers together to create a shared action plan outlining an agreement on what needed to be done, how, when, and by whom to improve health care, and how the community would measure progress and monitor the providers over time. After six months, the NGOs facilitated a half-day follow-up meeting with community members and health workers to review progress. In 2007 and 2008, researchers returned to program communities and repeated the same set of four meetings. No new information was provided the second time and communities and health care providers continued working on their original action plans. Researchers collected follow-up data in early 2009.

Additionally, to determine whether report cards and facilitated meetings were both necessary for community monitoring to be effective, researchers conducted a second randomized evaluation with a new sample beginning in 2007. The new intervention mimicked the original program in all aspects but one—communities did not receive report cards with quantitative information on the performance of their dispensary, which was the most costly component of the original program. A total of 25 new facilities were randomly assigned to receive this alternate version of the program or serve in the comparison group. The original program was not re-tested with this new sample.

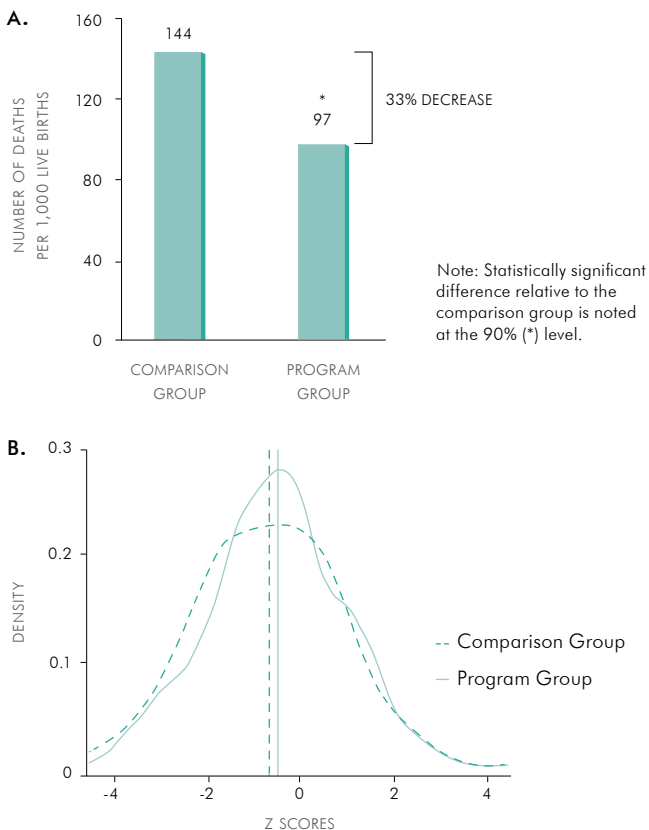
RESULTS

The community-based monitoring program, coupled with information on provider performance, led to significant improvements in health care delivery and health outcomes.

One year after the first meetings, the average weight-for-age of infants—a summary measure of current nutrition and illness—was 0.14 z-scores higher in program communities, relative to -0.71 in comparison communities (see figure 1B).¹ The under-five mortality rate also dropped to 97 per 1,000 live births—a 33 percent reduction relative to comparison communities (see figure 1A). Utilization of general outpatient services was 29 percent higher in program relative to comparison facilities, and more household members reported switching from traditional healers and self-treatment to program facilities.

There was a significant positive relationship between the degree of community monitoring and health care utilization and health outcomes. Program communities monitored local health facilities more extensively than comparison communities. Health workers’ performance was discussed more frequently in local council meetings and community members were better informed about the roles and responsibilities of the local Health Unit Management Committee. Program health facilities also used more monitoring tools, such as suggestion boxes, numbered waiting cards, and posters with information on free services.

FIGURE 1. THE COMMUNITY MONITORING PROGRAM COUPLED WITH REPORT CARDS LED TO A DECREASE IN UNDER-FIVE MORTALITY RATE (A) AND AN INCREASE IN WEIGHT-FOR-AGE Z-SCORES (B) AFTER ONE YEAR.



Treatment practices improved significantly in program facilities, suggesting that the improvements in the quantity and quality of care were due to behavior changes among staff.

Program health facilities saw a 12-minute (9 percent) reduction in waiting time, a 13-percentage-point (28 percent) reduction in absenteeism, and a 15-percentage-point (30 percent) reduction in the frequency of drug stock-outs. Program facilities were also in better physical condition relative to comparison facilities.

In the longer-run, communities continued to monitor health facilities and the positive impacts on health and health care delivery were sustained.² Four years after the original meetings, utilization of program facilities remained significantly higher in program relative to comparison facilities. Program communities continued to see a higher average weight-for-age among infants and a reduction in child mortality similar to the short-run findings, albeit somewhat smaller in magnitude (a 24 percent lower risk of under-five deaths).

Efforts to stimulate beneficiary involvement without addressing users’ lack of information about staff behavior had no impact on the quality or quantity of care.² In the separate sample in the second evaluation, communities that received the intervention without the report cards saw no change in health outcomes or health care utilization. There was also no significant change in monitoring practices in the communities or in the management of health facilities.

Informed users were better able to distinguish between the actions of health workers and factors beyond their control, and consequently focused on issues they could affect locally.

Without information on provider performance, health workers and community members identified issues that required third-party actions, such as more financial support from higher-level authorities and more timely delivery of medicines to the dispensary. In contrast, the communities that received information focused almost exclusively on monitoring local problems that either the health workers or the users could address themselves, including absenteeism, opening hours, waiting time, and patient-clinician interactions.

The community monitoring program led to a greater increase in health care utilization in communities that were more ethnically similar.

Communities with more ethnic variation had problems turning the community engagement and discussion into action. Researchers hypothesize that ethnically similar communities, where the same social norms apply to everyone, were better able to come to an agreement on how to improve service provision.

¹ A z-score represents the deviation of an individual value from the median value of a reference population, transformed to the normal distribution. A z-score of zero represents the median value.

² Note: these results were drawn from the working paper “Information is Power: Experimental Evidence of the Long Run Impact of Community Based Monitoring” from August 2014.

POLICY LESSONS

Providing communities with information about provider performance may be critical for the success of community monitoring programs. In Uganda, providing communities with information about their health care provider's performance and quality of care helped them better identify health care delivery problems that could be addressed locally, such as health worker absenteeism and patient wait times. Without this information component, communities created action plans that focused on issues outside their control, that relied on public support and action for their health center, and this limited their ability to hold health care providers accountable.

Yet related evidence suggests that providing information alone may not be sufficient if community members are not given a clear avenue or sufficient power to effect change. In an evaluation in India, informing people about low learning levels and high teacher absenteeism in their communities and the school provisions they were entitled to had no impact on parents' engagement or student learning.³ However, when school committees in Kenya were given specific training on how to monitor and assess teachers' effort and performance, and a set of parents were asked to perform teacher attendance checks on a regular basis, learning outcomes improved significantly.⁴ In the highly effective community monitoring program in Uganda, information was paired with a series of facilitated meetings that helped community members and health care providers develop joint action plans that outlined specific next steps to improve care, deadlines for achieving improvements, and how the community would monitor progress.

While the results suggest that information was crucial for the success of the program, further research is needed on more cost-effective ways to collect this information. Collecting data on performance using traditional survey methods is costly and technically complex, making it unclear whether such an intervention is practical to scale up. This opens up important questions for future research. For example, is it possible to provide beneficiaries with the tools to collect performance data themselves, instead of directly providing them with report cards? Can advances in information and communication technology be used to collect and disseminate information more cheaply?

¹ Banerjee, Abhijit, Rukmini Banerji, Esther Duflo, Rachel Glennerster, and Stuti Khemani. 2010. "Pitfalls of Participatory Programs: Evidence from a Randomized Evaluation in Education in India." *American Economic Journal: Economic Policy* 2(1): 1–30.

² Duflo, Esther, Pascaline Dupas, and Michael Kremer. 2015. "School Governance, Teacher Incentives, and Pupil–teacher Ratios: Experimental Evidence from Kenyan Primary Schools." *Journal of Public Economics* 123: 92–110.

Featured Evaluations: Björkman, Martina, and Jakob Svensson. 2009. "Power to the People: Evidence From a Randomized Field Experiment on Community-Based Monitoring in Uganda." *The Quarterly Journal of Economics* 124(2): 735–769.

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Björkman, Martina, Damien de Walque, and Jakob Svensson. "Information is Power: Experimental Evidence of the Long Run Impact of Community Based Monitoring." World Bank Policy Research Working Paper No. 7015, August 2014.

For Further Reading: Banerjee, Abhijit, Rukmini Banerji, Esther Duflo, Rachel Glennerster, and Stuti Khemani. 2010. "Pitfalls of Participatory Programs: Evidence from a Randomized Evaluation in Education in India." *American Economic Journal: Economic Policy* 2(1): 1–30.

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