

HEART

HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Costings for community accountability interventions

Date: 5 February 2013

Query: To compile value for money figures for community accountability interventions, based on programmes already implemented. Programmes should ideally come from the health sector and from Africa, but could come from other sectors that are likely to have similar activities/unit costs and other parts of the world. VFM figures could include

- * Cost/community monitoring systems established
- * Cost/community health committee trained
- * Cost/CHC functioning
- * Cost per district
- * Cost per capita

If available, some cost/outcomes eg

- * Cost/additional child vaccinated
- * Cost/assisted delivery by a health professional
- * Cost/additional CYP, etc

(these would presumably need a non-intervention comparable area to identify the added value)

Enquirer: DFID Harare

Content

1. Overview
2. Cost data
3. Community accountability descriptions and evaluations
4. Additional information

1. Overview

There are a number of community accountability mechanisms in health interventions which are included in this report. These range from community health committees which aim to represent the community in planning, monitoring and evaluating health services to those in which community members are actively involved in the delivery of health services as volunteers or community health workers. Other models of community accountability mechanism include pre-existing community-based organisations which are contracted to verify the performance of health services under performance-based financing schemes.

Section 2 reports on the costs related to the functioning of community health committees and other community accountability interventions and their cost-effectiveness.

The data on the costs of the functioning of community accountability interventions covers a range of interventions in Burundi, Zimbabwe, DR Congo and Kenya. This is drawn from research papers, reports and data provided by experts in the field. It includes:

- Monthly compensation payments made to committee members for their membership.
- Payments made to committee members for their attendance at meetings.
- Payments per questionnaire to community-based organisations contracted to verify the performance of health services.
- Budgets for the training of health committee members and community-based monitors.
- Estimated costs of community health committee functioning, cost per district and per capita.

The available literature on the cost-effectiveness of community accountability interventions was very limited. Björkman and Svensson (2007) reported on a randomised field experiment of a community-based monitoring project in Uganda. The intervention resulted in 1.7 percentage points fewer child deaths in the treatment communities during the first project year. This would imply that approximately 550 under-5 deaths were averted as a result of the intervention. A back-of-the-envelope calculation then suggests that the intervention, only judged on the cost per death averted, must be considered to be fairly cost-effective. The estimated cost of averting the death of a child under 5 is around \$300 in the Citizen report card project.

The Community Directed Intervention (CDI) study group (2010) reported on a multi-country study of community-directed interventions for priority health problems in Africa. They found that at the district level, delivering health care interventions through the CDI process is relatively cost-efficient. In the CDI districts, the median cost per district of implementing and delivering the five study interventions was a little above US\$ 15,000, while in the comparison districts it was about US\$ 30,000.

Section 3 includes descriptions of the organisation of different community accountability interventions, their functioning in practice, their impact on health outcomes and challenges to their effectiveness.

2. Cost data

Data on the functioning costs of community accountability interventions

Community participation and voice mechanisms under performance-based financing schemes in Burundi

Falisse J, Meessen B, Ndayishimiye J, Bossuyt M (2012) *Tropical Medicine and International Health* 17(5) pp 674-682

<http://bit.ly/118M4DW>

This paper analyses the roles of two community accountability mechanisms in a performance-based financing (PBF) scheme. It evaluates 100 health committees and 79 community-based organisations (CBOs) in six Burundi provinces (2009-2010).

CBOs are existing local organisations, set up for other purposes (e.g. cooperatives, charities, etc.) They were selected through a bidding process by peer organisations or by a panel of experts. They are offered quarterly contracts by the Purchasing Agency to 'authenticate' with randomly selected users the declarations of the Health Centres on patients and care. The data collected through CBOs' verification regard (i) the existence of the users, (ii) the existence of the treatment these users received, (iii) their perception of the price, (iv) their

perception of the quality of the services, and (v) their possible comments. This information is reported directly to the Purchasing Agency that pays CBOs between US\$1 and US\$2 per validated questionnaire.

PBF schemes also use pre-existing health committees (Comité de Santé, COSA). COSA members are representatives elected by the population living in the catchment area of a Health Centre. COSA's role is defined as participating in (i) technical comanagement of the Health Facilities (mostly planning and evaluation), (ii) administrative co-management (including controlling the finances), (iii) promotion in the population, and (iv) other (unspecified) activities. COSA's members are invited, along with the Health Centre's medical staff, to design the Health Centre quarterly development plan. This plan includes a decision on the allocation of the funds received through the PBF scheme. With PBF, most Health Facilities choose to finally compensate COSA members with around \$3/member/month.

This paper discusses how these two community participation mechanisms function in practice through the results of a recent survey. The authors conclude that the health committees appear to be rather ineffective, focusing on supporting the medical staff and not on representing the population. CBOs do convey information about the concerns of the population to the health authorities; yet, they represent only a few users and lack the ability to force changes. More experiments and analysis are needed to develop truly efficient 'downward' mechanisms of accountability at the Health Centre level.

Zimbabwe results based financing pricing final report

Basenya, O. et al., 2012, Sent by Itai Rusike (*not available online*)

Health facility committees and facility management - exploring the nature and depth of their roles in Coast Province, Kenya

Goodman C, Opwora A, Kabare M, Molyneux S (2011) BMC Health Services Research 11:229

<http://www.biomedcentral.com/1472-6963/11/229>

This paper explores the nature and depth of the roles of health facility committees in two rural districts of the Coast Province in Kenya through interviews with health workers, committee members, patients and district managers.

In 27 facilities Health Facility Committee members were reported to receive a sitting allowance ranging from USD 0.74 - 7.37 per meeting, funded from user fee revenues; at the remaining 3 facilities it was reported that no allowances were given.

	Median (Range)		
	Dispensaries	Health Centres	All facilities
HFC allowances per meeting (2007 US\$)	1.47 (0-4.42)	2.95 (1.47-7.37)	1.47 (0-7.37)

Direct Facility Financing (DFF) was said to have improved participation through the provision of meeting allowances for HFC members. Committee members reported that before DFF, facility funds were insufficient to pay allowances, but the introduction of DFF freed up some user fee revenues for this purpose. "Previously, we depended on the cost sharing money only and it was too little, just enough for drugs or syringes but not allowances...members would not come for meetings because there were no allowances." (HFC member, Tana River)

While they described their work in the facility as largely voluntary, allowances were seen as partially compensating members for the time spent on health-related activities, thus increasing commitment to facility management and improving general committee functioning. However, allowances were still viewed as insufficient in many cases, with several HFC

members recommending that they be increased, or introduced where they were currently not provided.

The authors reported that the HFCs were generally functioning well and played an important role in facility operations. The breadth and depth of engagement had reportedly increased after the introduction of direct funding of health facilities which allowed HFCs to manage their own budgets. Although relations with facility staff were generally good, some mistrust was expressed between HFC members and health workers, and between HFC members and the broader community, partially reflecting a lack of clarity in HFC roles.

Cost-effectiveness data

Power to the People: Evidence from a Randomized Field Experiment of a Community-Based Monitoring Project in Uganda

Björkman, M. & Svensson, J., 2007, Quarterly Journal of Economics

http://www.cid.harvard.edu/neudc07/docs/neudc07_s2_p11_bjorkman.pdf

To examine whether beneficiary control works, we designed and conducted a randomised field experiment in 50 "communities" from nine districts in Uganda. In the experiment, or intervention, communities were provided with baseline information on the status of service delivery, both in absolute terms and relative to other providers and the government standard for health service delivery. As a way to mitigate local collective action problems, community members were also encouraged to develop a plan that identified the most important problems in health service provision and ways to monitor the provider.

The intervention resulted in 1.7 percentage points fewer child deaths in the treatment communities during the first project year. To the extent that this number is representative of the total treatment population, this would imply that approximately 550 under-5 deaths were averted as a result of the intervention. A back-of-the-envelope calculation then suggests that the intervention, only judged on the cost per death averted, must be considered to be fairly cost-effective. The estimated cost of averting the death of a child under 5 is around \$300 in the Citizen report card project. This can be compared to the numbers reported by Filmer and Pritchett (1999, "The Impact of Public Spending on Health: Does Money Matter?", *Social Science and Medicine* 49). They contrast the cost of averting the death of a child derived from increasing public expenditures on health (regression estimates range from \$47,112 to \$100,927), to more conventional health interventions based on cost-effectiveness estimates of the minimum required cost to avert a death (ranges from \$1,000 to \$10,000 for diarrheal diseases, from \$379 to \$1,610 for acute respiratory infection, \$78 to \$990 for malaria, and \$836-\$3,967 for complications of pregnancy).

Community-directed interventions for priority health problems in Africa: results of a multicountry study

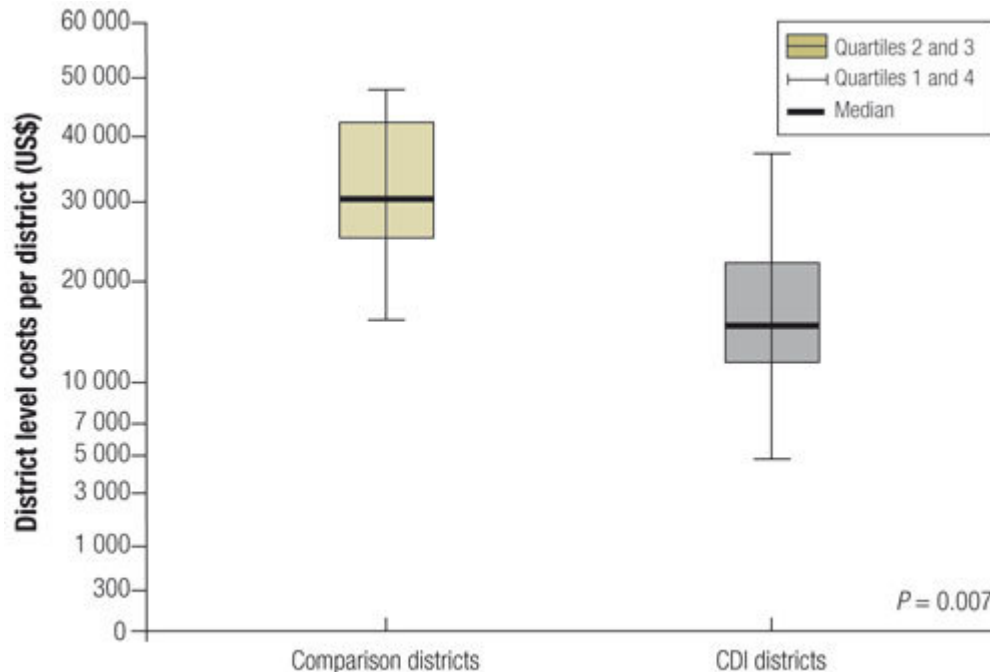
The CDI Study Group, 2010, Bulletin of the World Health Organization (88)

<http://www.who.int/bulletin/volumes/88/7/09-069203/en/index.html>

A community-directed intervention (CDI) is one that is undertaken at the community level under the direction of the community itself. Initially, local health services and their partners introduce the range of possible interventions in a participatory manner and explain the community-directed approach and how it can ensure community ownership from the outset. Subsequently the community takes charge of the process, usually through a series of community meetings where the roles and responsibilities of the community in the CDI process are discussed and the community decides how, when and where the intervention will be implemented and by whom; how implementation will be monitored, and what support (financial or otherwise), if any, will be provided to implementers. The community then collectively selects the implementers. Health workers train and monitor the latter, but the community directs the intervention process.

This study was designed to evaluate the effectiveness, cost and process of progressively adding four established health interventions of different complexity to the CDI process already used for the delivery of ivermectin. At the district level, cost analysis suggests that delivering health care interventions through the CDI process is relatively cost-efficient (see Figure 1).

Fig. 1. District-level annual provider costs of delivering five interventions in experimental study of the community-directed intervention (CDI) strategy in Cameroon, Nigeria and Uganda, 2005–2007



CDI, community-directed intervention; US\$, United States dollar.^a *P*-value applies to the difference between comparison and CDI districts (Mann–Whitney U-test). Source: UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases.

In the CDI districts, the median cost per district of implementing and delivering the five study interventions was a little above US\$ 15 000, while in the comparison districts it was about US\$ 30 000. There was little difference in the relative allocation of costs between CDI trial sites and comparison districts. In both cases staff salaries comprised the major cost (51.2% versus 48.6%, respectively). Maintenance, training and social mobilisation each accounted for 10–17% of costs in both groups of districts. The cost of transport comprised less than 3% in the CDI districts and about 8% in the comparison districts.

At the first-line health facility level, the CDI strategy did not result in significant cost savings. While costs were slightly lower in the CDI districts (median: US\$ 1,025) than in the comparison districts (median: US\$ 1,170), the difference was not statistically significant. In this case as well staff salaries were the costliest component.

The median opportunity cost for community implementers per community was US\$ 65 in trial communities and US\$ 44 in comparison communities, where implementers were only involved in distributing ivermectin. However, opportunity cost estimates varied widely per community and did not differ significantly between CDI and comparison districts. In terms of costs to the health system, the CDI strategy also appeared more efficient than conventional delivery systems. It achieved greater coverage of health interventions of varying complexity with cost savings at the district level and no increase in implementation costs at the first-line health facility level.

Integrated delivery of different interventions through the CDI strategy proved feasible and cost-effective where adequate supplies of drugs and other intervention materials were made available. Communities, health workers, policy-makers and other stakeholders were quite supportive and their buy-in to the CDI approach increased significantly over time. Since intervention coverage also increased as more interventions were gradually included in CDI delivery, the results of the study are promising in terms of the sustainability of the CDI approach.

4. Community accountability descriptions and evaluations

Community participation in population-based non-insulin dependent diabetes mellitus control program: A paradigm

Abanobi, O (2012) International NGO Journal 7(1), pp 1-8

<http://www.academicjournals.org/INGOJ/contents/2012cont/May.htm>

A paradigm for community participation in population-based non-insulin-dependent diabetes mellitus (NIDDM) control program being used in rural south-eastern Nigeria is presented. The paradigm features the use of area primary health care district health committees as community-based diabetes control implementation committees (CDCICs). It also calls for the deployment of village health workers/volunteers as community-based diabetes control workers (CDCWs) with responsibility for suspect case search, community mobilisation, blood-sugar monitoring and referral, and health education. The model integrates population-based NIDDM into area primary health care system. It also aligns control activities with traditional authority hierarchies and political processes of rural communities. Experience from the implementation of the paradigm in five communities in South-eastern Nigeria is presented. Implications for achieving long-term sustenance, relating diabetes control to prevailing socio-cultural norms and practices as well as for demystification of diabetes control are discussed.

A systematic review of the literature for evidence on health facility committees in low- and middle-income countries

McCoy D, Hall J, Ridge M (2012) Health Policy and Planning 27:449–466

<http://0-heapol.oxfordjournals.org.wam.leeds.ac.uk/content/27/6/449.full.pdf>

Community participation in health (CPH) has been advocated as a health improving strategy for many decades. However, CPH comes in many different forms, one of which is the use of health facility committees (HFCs) on which there is community representation. This paper presents the findings of a systematic literature review of: (a) the evidence of HFCs' effectiveness, and (b) the factors that influence the performance and effectiveness of HFCs. Four electronic databases and the websites of eight key organisations were searched. Out of 341 potentially relevant publications, only four provided reasonable evidence of the effectiveness of HFCs. A further 37 papers were selected and used to draw out data on the factors that influence the functioning of HFCs.

A conceptual model was developed to describe the key factors. It consists of, firstly, the features of the HFC, community and facility, and their interactions; secondly, process factors relating to the way HFCs are established and supported; and finally, a set of contextual factors. The review found some evidence that HFCs can be effective in terms of improving the quality and coverage of health care, as well as impacting on health outcomes. However, the external validity of these studies is inevitably limited. Given the different potential roles/functions of HFCs and the complex and multiple set of factors influencing their functioning, there is no 'one size fits all' approach to CPH via HFCs, nor to the evaluation of HFCs. However, there are plenty of experiences and lessons in the literature which decision makers and managers can use to optimise HFCs.

Assessing the impact of Health Centre Committees on health system performance and health resource allocation

Loewenson R, Rusike I, Zulu M (2004) EQUINET Discussion Paper 18. Harare, Zimbabwe
<http://www.equinet africa.org/bibl/docs/DIS18%20res.pdf>

In this study in Zimbabwe, four wards serviced by clinics with a Health Centre Committee were compared with four wards with clinics without a Health Centre Committee. Clinics with Health Centre Committees (HCCs) had, on average, more staff and there was some evidence of higher budget allocations from the Ministry of Health and Child Welfare than those without HCCs.

Annual budget allocation to health centre from MoHCW Z\$	Average for wards/clinics with HCCs	Average for wards/ clinics without HCCs
2002	212,674.13	74,736.80
January-June 2003	131,989.84	70,129.65

They also had more Expanded Programme on Immunisation campaigns than those without HCCs. Drug availability at the clinics with HCCs was better than those without HCCs, although drug availability was generally poor. It could be argued that improved health performance and staffing in these areas is associated with an improved capacity to draw and use health resources. If this is the case then there is a virtuous cycle for those clinics with HCCs and a vicious cycle for those without.

The study indicated also that areas with HCCs performed better on primary health care (PHC) statistics (EHT visits, ORS use) than those without, and that there is improved contact with the community in areas with HCCs. Community health indicators (health knowledge, health practices, knowledge and use of health services) were higher in areas with HCCs than in those without. Communities in areas with HCCs had a better knowledge of the organisation of their health services from the indicators assessed, making services more transparent to them. There was also evidence of improved links between communities and health workers in these areas.

The evidence indicates that areas with HCCs thus perform better on a range of health indicators compared to those without, both in the level of resources within the clinics, in PHC coverage and in community health indicators.

Community, HCC and health authority sources all reported that HCCs have taken up environmental health and service quality issues. They find out community needs and organise service inputs such as drug purchases, building waiting mothers' shelters, water tanks and toilets. They also provide health information. These roles appear to enhance their credibility with the community and the health staff. In two cases they have also been able to mobilise additional resources for health from community and other sources. Two HCCs used community funds to buy drugs for the clinic.

A case study example is the HCC of Mwanza clinic in Goromonzi district who agreed on a fee paid by all members of the community and users of the clinic to employ a security guard after an increase in thefts. In 2001 this fee was \$5 and it was increased to \$100 in 2003. For transparency, the community elected a treasurer from the HCC. The HCC opened a bank account to place their funds. At the time of publication, the fund had a balance of about \$90,000. The fund has been used for various health activities including paying the security guards, building toilets and pits for clinic waste, to purchase benches and make a signpost for the clinic. It has also paid for transport costs for health staff and HCC members when they visit the District Hospital to request for drugs or when banking. The HCC and the community decide on its use and all have benefited from the improvements made on the clinic.

HCCs have not had direct influence over core health budgets and have little influence in how their clinics are managed and run. The improved resources to clinics in areas with HCCs indicates some indirect association between HCCs and primary care resources. This may be exerted through support for clinic security, for staff needs, for clinic facilities and outreach and other services.

Sohani S (2005) Health care access of the very poor in Kenya. Workshop Paper 11. Meeting the health related needs of the very poor, DFID Workshop 14-15 February. Kenya: Aga Khan Health Service.
http://www.eldis.org/fulltext/verypoor/11_agakhan.pdf

This paper describes a before-and-after intervention study in two districts of the Coast province of Kenya. The intervention consisted of organising local communities to form representative Dispensary Health Committees (DHCs) that would allow people to govern the health and development activities at the dispensary level. The DHCs were given authority to manage revenue generated from user fees, to establish fee levels and to shape the local policy for user fee exemptions and waivers. Other functions included identifying and supporting village health workers; facilitating outreach health care and health education; and helping to improve the supply of essential drugs.

The intervention was found to have had a number of positive impacts. Health care utilization and revenue generation increased in all clinics. The original model at six sites in Kwale implemented in 1998-2000 showed a significant increase in utilisation of the preventive and promotive services and in the revenue collection at various sites. The table below shows similar trends when the model was replicated in 4 sites in Kilifi district.

Trends in health services utilisation and revenue (Kshs) at four intervention sites in Kilifi District, Coast, Kenya

Indicators	2000 (baseline)	2001	2002	2003	2004
Total utilisation	28,837	36,113	54,062	55,981	70,598
Total revenue in Kshs	No data	No data	627,940	1,006,254	617,292

Weekend outreach services for the most distant villages were initiated; medicines became more readily available; and village health workers were trained to promote health messages and services. These activities were made possible since the dispensaries were better resourced due to increased efficiency in revenue collection. Fee levels were decided by the DHC members based on what they thought the majority of villagers could afford. Transparent financial systems, which displayed a record of fee collection on a board at the dispensary, allowed all the members of DHC to keep track of and question revenue collection. This made it difficult for anyone to siphon off funds. The treasurer and other DHC members were made aware of simple audit methods to calculate what revenue was to be expected and to compare that with actual collection. Confidence building exercises also helped the DHC members to raise questions if they were not comfortable with the findings. Additionally, surplus funds were regularly banked.

At the same time, cost barriers for the poorest were reduced through the more effective implementation of fee exemptions and deferrals. The table above shows an increase in revenue collection in 2003 compared to 2002. The subsequent decrease in revenue collection in 2004 is due to the fact that cost sharing was abolished on 1st July 2004. The new policy only allowed a registration fee of Kshs 10 at dispensaries and Kshs 20 at the health centres but charges related to all other services were abolished.

The study concluded that a pro-poor health system can be developed if the true representatives of the poorest are enabled to participate in health care delivery and good governance and proper systems are established, and that semi-literate community members can be trained to collect, aggregate and use health and financial information for decision making and taking corrective action against the misuse and appropriation of scarce resources.

Macha J, Mushi H, Borghi J (2011) Examining the links between accountability, trust and performance in health service delivery in Tanzania. Consortium for Research on Equitable Health Systems (CREHS). Ifakara Health Institute, Tanzania.

http://www.crehs.lshtm.ac.uk/tan_accountability12jul.pdf

Health Facility Governing Committees (HFGC) are run within health facilities of all levels of the health system in Tanzania. The aim of this study was to examine the pre-conditions for the effective functioning of the committees, both in terms of representing community voice and in improving health worker performance and resource mobilisation in relation to the Community Health Fund (CHF), a voluntary health insurance scheme over which the committees have some responsibility. This report examines case studies of a “well performing committee” and a “less performing committee” in Ulanga District.

Both committees had some impact on health worker performance in terms of health worker availability and opening hours. The impact of the committees on resource mobilisation was examined in terms of how money was spent by the committees. In Kivukoni, the committee approached the district about drug shortages but no response was received. In Sofi Majiji, the committee approached the district about drug shortages and was encouraged to use CHF money to purchase more drugs. Efforts to mobilise communities to join the CHF were mostly undertaken by health care providers in both sites although this is officially a role of the HFGCs. In Sofi Majiji, the committee also mobilised labour from the community for construction of the health facility and provider houses. They managed to levy funds from an NGO to support construction activities. In both sites, the committees managed to use user fee funds to finance small expenses at the facility, with Sofi Majiji also managing to use CHF money to buy drugs. Generally, however, the committees were limited in their availability to decide how to spend user fee and CHF revenue.

One constraint against effective action of the HFGC identified in this study is the absence of meeting and transport allowances. Committee members can be unwilling to give up their time in the absence of allowances to attend meetings or activities.

A summary of this study is available at:

Macha J, Borghi J (2011) Health Facility Committees: Are they working? Ifakara Health Institute Spotlight, Issue 7

http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/Health%20Facility%20Committees_Are%20they%20working.pdf

Morgan, L (2012) A Rough Guide to Community Engagement in Performance-Based Incentive Programs: With Lessons from Burundi, Indonesia, and Mexico. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

http://www.healthsystems2020.org/files/92722_file_CE_Guide_5_editor_MA_FINAL_mm.pdf

The role of Community-based Organisations (CBOs) in verifying health centres' performance in Burundi is described in the paper above. Verifying results for every health facility in a country (even one as small as Burundi) implies significant costs; engaging Community-based Organisations to carry out this function is likely to be significantly cheaper than other independent auditing agencies – not only because their professional fee expectations are

lower, but also because the programme does not incur the same magnitude of transportation costs, since the CBOs are physically closer to households.

In Mexico, the *Oportunidades* conditional cash transfer (CCT) programme provides cash stipends to mothers in poor households, conditional on them ensuring that each family member attends a health check-up once a year, that their children attend school, and that the mothers attend a monthly class on health topics. Volunteer programme beneficiaries, known as *vocales* are engaged as local arms of programme administration, providing participants with programme information and conducting workshops on self-help topics. In terms of oversight, *vocales* see their role predominantly as one that ensures beneficiary compliance with the programme, and less one of oversight of any other entity (for example, health providers). Engaging the *vocales*, to administer the programme at the local level, effectively cuts the cost of implementation. The lowest level of programme staff in *Oportunidades* are the *Responsable de Atención* (RA), who are responsible for overseeing large numbers of beneficiaries: in one locality called Queretaro, for example, there are 25 RAs who each coordinate an average of 3,600 households. By contrast, the almost 250,000 registered *vocales* in the *Oportunidades* programme represent on average 25 beneficiary families each. Replacing them with paid staff would increase the cost of administering *Oportunidades* considerably.

But this apparent cost savings is not as straightforward as it might appear at first glance. In Burundi, for example, the PBI unit in the Ministry of Health decided in 2011, to reduce the frequency of verification – from once per quarter to twice per year – while maintaining the household sample size (80 households per facility), thus effectively reducing the sample. Part of the reason for doing so was to give CBOs sufficient time to conduct the surveys, and the provincial authorities sufficient time to analyse the results, but the decision was also driven by the substantial financial and administrative costs of conducting quarterly verification. Verifying results is at the heart of any PBI scheme: paying for reported results gives providers an incentive to over-report, thus it is essential to verify and counter verify what is reported.

Regarding the role of the *vocales*, their importance creates enormous potential for the abuse of power, yet their supervision is extremely limited. This is partly due to cost. Additionally, *vocales* sometimes ask participants for volunteer contributions, or to give them a portion of their cash transfer, to reduce the cost of materials, food, and travel they undertake as part of their duties. This may point to a programme design issue: programmes cannot expect volunteers to incur expenses to conduct the functions they are responsible for.

The bottom line is that even if engaging communities saves money in terms of the direct costs of hiring them, there are nonetheless other costs related to the function and role the community is playing that must be considered if the function is to be robust. In the Mexican example, these costs may include budget for more and better training for *vocales*, including training on how to report “up” to the programme; for visits by higher level authorities to check on the programme; in advertising channels among beneficiaries where they can report abuse by *vocales*; and even by paying *vocales* modest salaries for their work.

In regards to the CBOs role in verification, these costs certainly include the cost of conducting verification at a frequency that will ensure the programme is paying only for real, verified results; and the cost of counter-verifying what the CBOs report. For example, in Senegal, CBOs make quarterly visits to households to, as in Burundi, verify results reported by health facilities; but the subsequent quarter, an external auditing agency also counter-verifies a small sample of households – i.e. goes back to the household to ensure the CBO was in fact making the visit and recording information accurately.

Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework

Molyneux, S. Atela, M. & Angwenyi, V. & Goodman, C. (2012) Health Policy and Planning

<http://heapol.oxfordjournals.org/content/early/2012/01/24/heapol.czr083.full>

A search of PubMed using a systematic approach, supplemented by a hand search of key websites, identified 21 papers from low- or middle-income countries describing at least one measure to enhance community accountability that was linked with peripheral facilities. In this paper we summarise the data presented in these papers, including impact, and factors influencing impact, and conclude by commenting on the methods used, and the issues they raise. We highlight that the international interest in community accountability mechanisms linked to peripheral facilities has not been matched by empirical data, and present a conceptual framework and a set of ideas that might contribute to future studies.

Lack of incentives was highlighted in several papers. Meuwissen, for example, reported that committee members complained often about lack of financial rewards: *'Committee members complained a lot about the lack of incentives for their time and investment. Being in need of money, handling thousands of [local currency] and having to understand that there is no money to be paid, appeared to be very difficult.'* (Meuwissen, Problems of cost recovery implementation in district health care: a case study from Niger. Health Policy and Planning)

Possibly linked to a lack of incentives, in one study committee members were reportedly seeking exemptions for themselves and their families, leading to concerns among health workers that committee members were potentially reducing facility revenue (Khumalo, 2001, How can household-health system accountability mechanism at primary health care level be strengthened to support provision of chronic disease care?, Centre for Health Policy, University of Witwatersrand). Meuwissen (2002) highlights the centrality of the issue of motivation by suggesting that a fundamental question is *'why should community members be motivated to commit themselves to the tedious task of regularly performing administrative supervision correctly over a long period of time'*.

Building upon existing well-functioning community-based structures appeared to overcome some of the above challenges. For example, the success in rural Cambodia was largely attributed to the existing system of formally elected volunteers who were held in high esteem within their local communities (Jacobs and Price, 2003, Community participation in externally funded health projects: lessons from Cambodia. Health Policy and Planning; Jacobs *et al.*, 2007, A sustainability assessment of a health equity fund initiative in Cambodia. International Journal of Health Planning & Management 2007;22). Pagodas and associated volunteers appeared to offer the advantages of established (and apparently trusted) leadership, local organisation, resource mobilisation and management. These are all areas that need to be carefully built up in new organisations, a process that takes time and resources. Within the Pagodas the pivotal role of key authorities, and the importance of involving them in facility interactions, was also noted.

The Returns from Reducing Corruption: Evidence from Education in Uganda

Reinikka, R. & Svensson, J., 2007, World Bank & SIDA

<http://people.su.se/~jsven/TestingJune2007.pdf>

What is the most effective way to increase primary school enrolment and student learning? The authors argue that innovations in governance of social services may yield the highest return since social service delivery in developing countries is often plagued by inefficiencies and corruption. The authors examine this hypothesis by exploiting an unusual policy experiment: A newspaper campaign in Uganda aimed at reducing capture of public funds by providing schools (parents) with information to monitor local official's handling of a large education grant programme. Combining survey and administrative data, the authors show that the campaign was successful, and the reduction in capture of funds had a positive effect on enrolment and student learning.

5. Additional information

Author

This query response was prepared by **Imogen Featherstone** and **Laura Bolton**

Contributors

Agnes Apolot, Uganda Debt Network

Shireen Huq, Naripokkho

Zahidul Quayyum, University of Aberdeen

Jean-Benoît Falisse, St Antony's College, Oxford

Artwell Kadungure, Training and Research Support Centre, Zimbabwe

Itai Rusike, Community Working Group on Health, Zimbabwe

Rene Loewenson, Training and Research Support Centre, Zimbabwe

Vinay Viswanatha, Open Society Foundations

Christine Munduru, Open Society Initiative for Eastern Africa

Walter Flores, Center for the Study of Equity and Governance in Health Systems in Guatemala

Catherine Goodman, LSHTM

About Helpdesk reports: The HEART Helpdesk is funded by the DFID Human Development Group. Helpdesk reports are based on 2 days of desk-based research per query and are designed to provide a brief overview of the key issues, and a summary of some of the best literature available. Experts may be contacted during the course of the research, and those able to provide input within the short time-frame are acknowledged.

For any further request or enquiry, contact info@heart-resources.org

HEART Helpdesk reports are published online at www.heart-resources.org

Disclaimer

The Health & Education Advice & Resource Team (HEART) provides technical assistance and knowledge services to the British Government's Department for International Development (DFID) and its partners in support of pro-poor programmes in education, health and nutrition. The HEART services are provided by a consortium of leading organisations in international development, health and education: Oxford Policy Management, CiBT, FHI360, HERA, the Institute of Development Studies, IPACT, the Liverpool School of Tropical Medicine and the Nuffield Centre for International Health and Development at the University of Leeds. HEART cannot be held responsible for errors or any consequences arising from the use of information contained in this report. Any views and opinions expressed do not necessarily reflect those of DFID, HEART or any other contributing organisation.