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A ROUGH GUIDE TO COMMUNITY ENGAGEMENT IN PERFORMANCE-BASED INCENTIVE PROGRAMS

WITH LESSONS FROM BURUNDI, INDONESIA, AND MEXICO

August 2012

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Submitted to: Scott Stewart, AOTR
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Abt Associates Inc. | 4550 Montgomery Avenue | Suite 800 North | Bethesda, Maryland 20814 | P: 301.347.5000 | F: 301.913.9061 | www.healthsystems2020.org | www.abtassociates.com

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ACRONYMS

AusAID	Australian Agency for International Development
ANC	Antenatal Care
CBO	Community-based Organization
CE	Community Engagement
CHW	Community Health Worker
CM	Community Mobilizer
CSO	Civil Society Organization
DAH	Development Assistance for Health
DHO	District Health Office
EC	European Commission
FP	Family Planning
FFS	Fee for Service
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IDR	Indonesian Rupiah
IUD	Intrauterine Contraceptive Devices
LOGICA2	Local Governance for Innovations for Communities in Aceh-Phase 2
MSS	Minimum Service Standards
NGO	Nongovernmental Organization
P4P	Pay for Performance
PBC	Performance-based Contracting
PBF	Performance-based Financing
PBI	Performance-based Incentive
PNC	Postnatal Care
QA	Quality Assurance
SBMR	Standards-Based Management and Recognition
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant

TTM	Traditional Trained Midwife
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WB	World Bank

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1. INTRODUCTION AND PURPOSE OF THE GUIDE

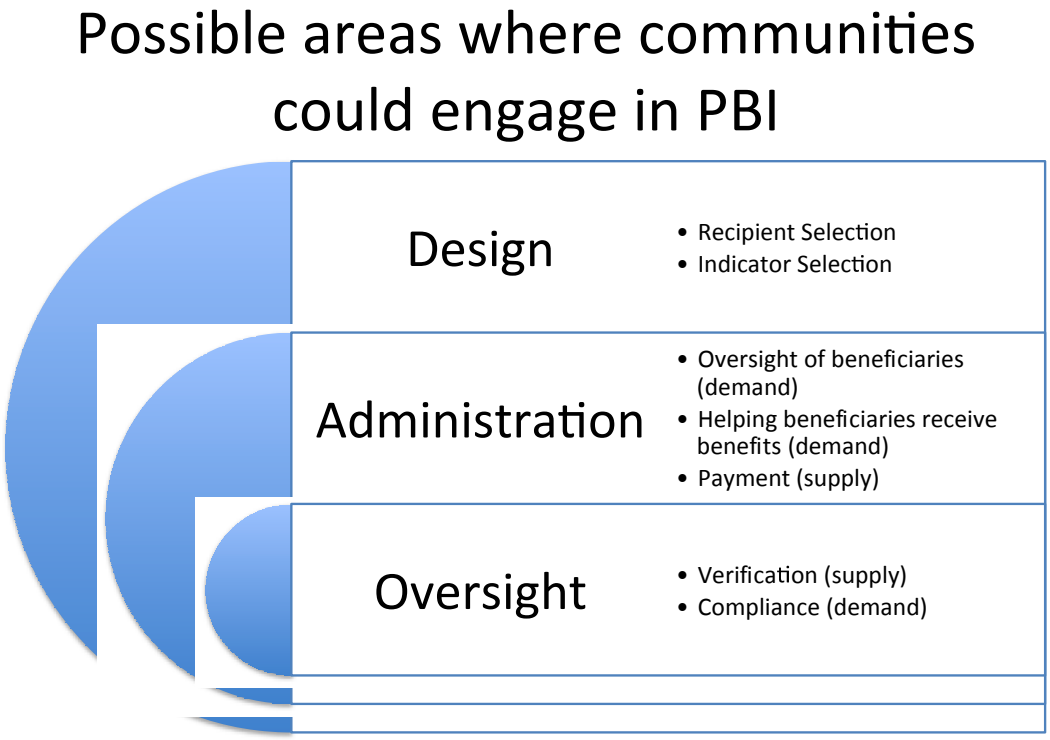
Evidence showing the relatively weak links between public sector health spending and better health has highlighted the importance of health sector governance as a key intervening variable between inputs and outcomes. Because of this, mechanisms that aim to strengthen governance and improve accountability have gained new relevance for policymakers and program managers. One such approach is performance-based incentives (PBI) – programs that provide rewards to patients, health care providers, or managers, once agreed-upon actions have been take or results delivered. Defined as "any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered" (Musgrove 2010), PBI is being implemented all over the world, and in some countries has become part of the national health financing strategy. Indeed, many countries currently piloting PBI intend to scale up the approach once it is tested and refined. In this sense, PBI is becoming much less another aid project, and more a fundamental part of the architecture for financing health services in developing countries.

Within PBI there is growing interest in engaging communities in the design and implementation of PBI schemes. This interest seems to be driven mainly by two things: first, the idea that engaging communities may be a cost-effective approach to program administration and verification; and second, that it might have additional positive spillover effects, such as enhancing social accountability and citizen empowerment (discussed in detail in Part 2).

This guide aims to help policymakers and program managers assess whether engaging communities makes sense in the context of the PBI programs they support; determine what is the best approach or mechanism for such engagement; and how to mitigate the risks. The guide focuses on community engagement (CE) in the sense of communities (whether individuals or organizations) playing an active role either in the design or implementation of schemes, as opposed to, for example, engaging communities by offering incentives to community health workers, or by encouraging health facilities to engage with community health committees. Though the latter are certainly forms of CE, this guide focuses on engagement in the substance of PBI.

As Figure 1.1 shows, there are many potential mechanisms through which communities can engage in PBI. In most PBI schemes there are various points or functions that might lend themselves to community involvement, which vary somewhat depending on whether the program is a "demand-side" PBI program (i.e., one that provides incentives to individuals conditional on them taking a health-related action) or a "supply-side" PBI program (i.e., a program that offers incentives to any of a range of possible actors, from community health workers, to health facilities, to managers at the district, provincial, or national level). Not all of the possibilities may be desirable or advisable, as discussed in Part 4.

FIGURE 1: POSSIBLE AREAS WHERE COMMUNITIES COULD ENGAGE IN PBI



In the realm of "setting priorities," it is possible to imagine that communities might be involved in deciding which indicators health facilities will be held accountable for delivering, as was attempted in a PBI pilot in Indonesia (described below). Most supply side PBI programs involve signing performance contracts between a payer and a provider, wherein the provider agrees to increase the quantity and sometimes quality of specific services, or indicators – for example, the number of children who are fully immunized with DPT3. These indicators are important in that they give the payer the power to signal priorities for to the provider.

It is also possible that communities could be consulted in regards to which services should be offered through a voucher program, for instance, or in regards to what conditions should be attached to conditional cash transfer payments. In practice, these latter two approaches are rarely done, but they remain possibilities worth considering.

PBI programs may also involve communities in another aspect of design – that is, in the selection or approval of incentive recipients. This is rarely done in supply-side programs (i.e., the author knows of no example of communities deciding which health facilities should participate in a PBI program, for example), however, in some conditional cash transfer programs (Honduras and Brazil), communities are involved in approving centrally generated beneficiary lists (i.e., to identify errors of inclusion and exclusion).

In terms of implementation, communities can be engaged in various ways around verification, monitoring and general oversight. As this guide discusses, in supply-side programs, community groups can be

engaged to verify the results reported by health facilities. We explore how this model for CE works in Burundi; CBO verification is a model also seen in Zambia, Zimbabwe, Cameroun and other countries in sub-Saharan Africa.

Also in the realm of oversight, in supply-side programs, where information about health services is routinely collected and verified, it is possible to imagine engaging communities by sharing this information downwards, in order to provide added accountability and transparency on facility performance. In practice, however, this is rarely done.

In demand side programs, such as Mexico's *Oportunidades* conditional cash transfer program, community members or organizations may be engaged to administer the program at the local level and to provide some sense of oversight, whether to assure beneficiaries adhere to the conditions of the program, or to ensure beneficiaries receive their payments in the correct amount and to help them claim redress in the case there is an error.

Some countries and programs, where opening facility bank accounts is challenging, are also considering whether there is a role for communities to act as intermediaries between payers and providers.

This guide bases lessons and recommendation (Part 4) on the author's own knowledge of PBI programs and on detailed research conducted in three countries:

- Burundi – since 2010, Burundi has implemented a supply-side PBI program nationwide that offers incentives to health facilities conditional on the quantity and quality of services delivered (the program also provides incentives to subnational levels of government). As part of the program, community-based organizations (CBOs) are contracted to verify health facility results and conduct patient satisfaction surveys, a model, as noted above, being tried increasingly in other countries.
- Mexico – Mexico has implemented one of the best-known conditional cash transfer (CCT) programs in the world since 1997, now known as *Oportunidades* (formerly *Progresa*). At the local level, the nationwide program is administered with the help of committees comprised of volunteer beneficiaries called *vocales* who conduct administrative and oversight functions in the program. Community advocates akin to the *vocales* in Mexico are part of conditional cash transfer programs in other countries such as Nicaragua and Peru.
- Aceh, Indonesia – beginning in 2010, an NGO supported by the Australian Agency for International Development (AusAID) piloted a classic CE scheme in post-tsunami Aceh. The program facilitates a participatory needs assessment and action planning process between citizens, civil society and health service providers, during which health priorities are determined. These form the basis for performance contracts with health facilities. Civil society organizations (CSOs) are contracted to help facilities achieve targets and in a PBI twist, a portion of CSO remuneration is based on performance.

Though these three countries do not cover the entire range of possibilities, they do cover some of the most dominant mechanisms for engaging communities in PBI. From their experiences, we extract lessons on the realities and risks involved in engaging communities.

What follows is not a "how to" guide. It does not intend to lay out clear steps to take to engage communities – the topic is far too broad; there are far too many kinds of PBI programs and far too many ways to engage communities in them, to do that. Furthermore, implicit in "how to" guides is the message that you should do this or that. But the evidence on CE in PBI is still too limited to unreservedly recommend it.

Rather, this guide offers readers a sense of the possibilities. It is organized as follows: first, we offer background on concepts and theory behind PBI and CE; then we look briefly at the experiences of Burundi, Indonesia and Mexico in engaging communities in their PBI programs (for a detailed look at the ins and outs of these programs, please refer to detailed country case studies[1]); and finally, we discuss the potential risks and benefits of various approaches, and suggest strategies for mitigating risks and the way forward.

[1] Bhuwanee and Morgan 2012, Scaife-Diaz 2012; and Morgan et al 2012.

2. CONCEPTS: PERFORMANCE-BASED INCENTIVES AND COMMUNITY ENGAGEMENT

2.1 THE ACCOUNTABILITY PROBLEM

Spending on global health – both public sector spending and development assistance for health – has increased dramatically over the last decade. Increased financial and political commitments have done a significant amount of good, but in many countries, serious gaps persist, particularly in areas that require a functioning health system. Maternal mortality is still unacceptably high in many countries; more than 200 million lack access to modern contraception despite the fact that it is one of the most cost-effective mechanisms available to reduce maternal deaths; and children continue to die from diseases that are entirely preventable and treatable.

Increases in health spending do not automatically produce better health, a fact that has highlighted the importance of governance as a key intervening variable between inputs and outcomes. Governance is an amorphous term but accountability for results – between citizens/patients, service providers, and the state – is at the heart of it (Brinkerhoff and Bossert 2008). USAID, for example, has noted that governance pertains to the "effectiveness as well as transparency, accountability, and participation in government institutions and public policy reform processes at all levels."[2]

But what is accountability? "Accountability can be defined as the obligation of power-holders [i.e., those who hold political, financial or other forms of power and include officials in government, private corporations, international financial institutions and civil society organizations] to account for or take responsibility for their actions" (Malena et al 2004 p 2).

The World Bank distinguishes two types of service delivery accountability relationships between citizens, service providers, and the state: the first is the "long route" of accountability through electoral sanction, whereby citizens elect their leaders to represent their interests. "This accountability is a consequence of the implicit 'social compact' between citizens and their delegated representatives and agents in a democracy. A fundamental principle of democracy is that citizens have the right to demand accountability and public actors have an obligation to account" (Malena et al 2004 p. 2).

The problem with the "long route" is that it can be easily broken: politicians, to whom citizens have delegated responsibility, must in turn delegate responsibility to many layers of actors – from mid-level bureaucrats to health service providers – who do not face the same incentives (i.e., they are not subject to electoral sanction). Those actors may therefore use their discretion to behave opportunistically, a problem compounded by the information asymmetries between payers of health services, providers, and patients. In addition, front line health workers are typically paid low, fixed salaries, irrespective of performance, and are protected from dismissal by civil service regulations.

[2] http://www.usaid.gov/our_work/democracy_and_governance/technical_areas/governance/

The weakness in accountability between these actors often results, in the health sector, in weak incentives for healthcare providers to exert the effort necessary to deliver high quality care that results in better health, and may lead to low productivity, absenteeism, poor quality, and lack of innovation.

2.2 STRENGTHENING ACCOUNTABILITY FROM THE BOTTOM UP

This is where the "short route" of accountability comes in. The 2004 World Development Report describes the "short route" as mechanisms that give patients/clients power over providers, whether through the competition inherent in market transactions, but most often by other means, since providers in developing countries, public but also private, are often not subject to the sanction of competition in the "markets" for "customers" for health services. (World Bank 2004)

These "other means" are known collectively as social accountability, which can be defined as "an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting accountability" (Malena et al 2004).

Working with and engaging local communities is not new in the health sector. But CE in health has often referred to things such as community health worker involvement in basic health care provision; health projects that are targeted at the "community" level in the sense of not being facility-based; and initiatives such as community-based fever management or malaria treatment. "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" (Croke 2012).

But experience with such mechanisms – from community scorecards to community monitoring of drug supplies or nurse attendance – is growing. "Reflecting a sharp increase in development programs that prioritize community participation, often via some form of village council, meeting, or organization… there have been in recent years a growth of programs that support monitoring of public health services and facilities through local organizations (formal and informal) and/or increased information availability to the public" (Croke 2012).

The rationales and assumptions behind engaging communities for the purpose of enhancing social accountability are many, varied, and connected. Malena et al 2004 identify three main arguments underlying the importance of social accountability: improved governance, increased development effectiveness, and empowerment.

Improved governance comes from the ability of citizens to hold public officials accountable for delivering services, as discussed above, which is a critical element of effective democracy. "Groups exercising … social accountability [may] lack the ability to impose formal sanctions, but they can have an impact by making the failures of government and service providers public, thus imposing reputational and political costs, and in some cases triggering formal accountability mechanisms (for instance through the courts, or an ombudsman)" (IDS 2010 p. 41).

Social accountability can also improve development effectiveness because communities know best how to make good decisions for their lives; know better their needs, the constraints they face, and what is

happening in their communities than outsiders. Engaging them can lead to better informed program and policy design, and improved service delivery.

Finally, social accountability initiatives can lead to empowerment, particularly of poor people, something that necessarily implies increasing the availability of information related to health services, thereby increasing citizen knowledge. This knowledge and empowerment is thought create pressure that leads to better service delivery; better quality services through improved provider norms; increased demand from informed citizens; and better health outcomes.

Twaweza, an East African citizen empowerment initiative, puts it like this: "When exposed to the ferment of information and ideas, and having access to practical tools, pathways and examples of how to turn these ideas into actions, ordinary citizens can become the drivers of their own development and act as co-creators of democracy" (Twaweza 2008).

The literature on the health impact of CE is limited and far from conclusive, but results from some experiments that have been rigorously evaluated suggest that well-designed and implemented social accountability mechanisms can complement traditional accountability mechanisms, strengthening the relationship between provider and client and helping to improve service delivery and even health outcomes. For example, a randomized field experiment in Uganda tested the effect of increasing community-based monitoring, and found that when communities more extensively monitored providers, both the quality and quantity of health services improved, including reducing infant mortality by a third. (Björkman and Svensson 2009)

2.3 PBI AND COMMUNITY ENGAGEMENT: STRENGTHENING ACCOUNTABILITY FROM THE TOP DOWN *AND* THE BOTTOM UP

As noted above, performance-based incentives,[3] like bottom-up social accountability mechanisms, also aim to fix broken accountability relationships by providing payers of health services tools to hold providers accountable through provision of incentives for verified increases in the quantity and quality of health services. As Eichler et al. say, "performance-based payment establishes indicators of performance that make clear what principals [payers] want and give agents [health care providers, patients] financial incentives for achieving defined performance targets" (2007, 3).

In addition to strengthening accountability between payer and provider, PBI aims to strengthen accountability among providers: for example, because teams are jointly held accountable for performance (in almost all supply-side PBI schemes, the incentive is paid to the facility team), they hold each other accountable – as the efforts of each individual team member impacts the performance payments earned. PBI can also enhance accountability between providers and patients because rewards for increases in the quantity of health services give providers an incentive to attract patients – i.e., to compete for the market of patients. Such competition may lead to improvements in quality – particularly in areas most noticeable by patients such as friendliness, cleanliness, and attractiveness of the structure.

[3] PBI interventions are promising tools in the tool box of health systems reform. For more, see: Performance Incentives for Health: Potentials and Pitfalls.

Can combining CE and PBI be a potentially potent way to increase accountability in the health sector? There are several reasons to think that this might be the case. First, most CE mechanisms presume that information about health services (number of deliveries attended, for example) is being gathered and used by the community (Croke 2012). This knowledge and empowerment is thought to create pressure that leads to better service delivery; better quality services through improved provider norms; and increased demand from informed citizens. It implies an investment that is often abandoned once the project ends. In supply-side PBI programs (such as in Burundi, described below), collection and verification of health data is routine, and thus a potentially powerful asset for CE.[4]

Monitoring and oversight are also part and parcel of any PBI program, and engaging communities in an oversight role may have advantages. As Björkman and Svensson 2009 outline, community monitoring and oversight of heath service providers may be less expensive than traditional approaches to oversight and accountability; communities are likely better informed about the status of service delivery than external monitors; they may also have means of punishing providers that are not available to outsiders (i.e., for example social sanctions), and may be able to induce increased effort by providing non-financial rewards for good performance (i.e., such as recognition at community gatherings, or enhanced status in communities, etc.); and to the extent that the service is valuable to them, communities have strong incentives to monitor providers, which an external agent may lack.

Another reason in favor of combing CE and PBI is that no amount of bottom-up pressure is likely to change health provider behavior if the environment in which they operate in is dysfunctional (i.e., unmotivated health workers; weak and supervision health management information systems; rudimentary supply chains). PBI aims to address those dysfunctions, possibly improving the impact of CE.

And finally, most CE schemes assume that limited formal commitments facilitated by time-limited programs will spark ongoing informal monitoring, and continued engagement by community members, but it is far from clear that this happens. In places such as Burundi and Mexico, where PBI is institutionalized nationwide, the opportunity exists to use the information in an ongoing way to empower citizens, thus increasing the likelihood of such efforts being sustained.

[4] Routine collection and verification of heath data are not necessarily routine in demand-side PBI programs, such as conditional cash transfer programs.

3. ENGAGING COMMUNITIES IN PBI: HOW THREE COUNTRIES HAVE DONE IT

3.1 BURUNDI

Following positive experience with several pilots, in 2010, Burundi launched a national PBI[5] program, which provides incentives to health facilities (public and NGO) and national and sub-national bodies (national technical unit, and provincial and district health offices). The PBI system is meant to improve health by increasing utilization of health services and improving the quality of care; motivating the health workforce; establishing an effective system to verify health facility services; and improving retention rates, stabilizing personnel (Ministry of Health and the Fight Against AIDS 2010).

In the program, facilities have the opportunity to earn monthly fees on a specified list of 22 services[6] (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 twice a year by local organizations.

Facilities have considerable autonomy in allocating the incentive payments to staff or to service quality improvements, but there is a limit on the amount that can go toward individual staff bonuses.[7]

3.1.1 COMMUNITY ENGAGEMENT: CBO VERIFICATION & PATIENT SATISFACTION SURVEYS

In the Burundi program, CBOs are contracted to verify the results reported by health facilities – both to confirm the existence of patients and that services were delivered, and to conduct patient satisfaction surveys. A facility's score on the "community survey" as they are called, determines 40 percent of a facility's quality bonus.

The CBOs are selected by local committees[8], with assistance from the Provincial Committee for Verification and Validation (the French acronym for which is CPVV). There are several criteria that CBOs must meet to participate:

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[5] PBI is referred to as performance-based financing or PBF in Burundi; but for consistency in this report, we refer to all schemes as PBI.

[6] In April 2010, 24 indicators were contracted but 2 were removed following the revision of the Procedures Manual in September 2011.

[7] For the provincial and district authorities, a maximum of 80% of the PBI 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.

- CBOs must be registered with the Ministry of Interior, or if they are not, they must be recognized[9] by the community within which they will conduct the surveys.
- They must have been operational for at least 2 years, and preferably have been involved in health or poverty-reduction related activities.
- The CBO must not have any links to the health center whose results it will verify (e.g., CBO staff must not be related to health facility staff).

Contracts with CBOs are signed for one year, after which time they may be renewed if CBO performance is deemed acceptable by the CPVV. The CSOs are paid a fee per survey completed.

3.2 MEXICO

Mexico's *Oportunidades* conditional cash transfer (CCT) program aims to invest in human capital development through a bi-monthly transfer of 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 themselves attend a monthly class on health topics (these conditions are called "co-responsibilities"). The CCT is intended to supplement spending on food, clothing, and other basic needs for children, and to create incentives for families to ensure that children attain higher levels of schooling and that their health needs are promptly attended to.

Implemented since 1997, the program now reaches almost 6 million households (about a third of the country) and has an annual budget of $5.2 billion in 2012. In addition to the original subsidies for health and education, the program now offers cash support for elderly family members, energy costs, and in-kind nutritional supplements.[10]

3.2.1 COMMUNITY ENGAGEMENT: COMMITTEES OF BENEFICIARIES EXTEND PROGRAMS REACH AND ENSURE ACCESS

Oportunidades engages program beneficiaries, known as *vocales*, as local arms of program administration. *Vocales*, whose name in Spanish roughly translates to "community voice," are volunteers, responsible for:

- Contributing to strengthening the social fabric and social capital in the communities served by the program.
- Improving communication between program participants and education and health services staff, local authorities and civil society organizations in a way that strengthens the program's local operation.
- Promoting the fulfillment of program co-responsibilities among beneficiary families.
- Contributing to ensuring non-partisanship and transparency by involving the beneficiary population in program oversight.
- Participating with local authorities to improve the quality of education and health

[8] In the Burundi PBF manual this is referred to as a "communal commission," which essentially represents the selection committee. The manual does not elaborate on who are members of this committee.
[9] The Burundi PBI manual does not elaborate on what "recognized" means.
[10] Scholarships for school attendance have also been extended to include assistance for children finishing high school.

services

- *Vocales* are organized into Community Promotion Committees (CPC). Every locality that has more than 25 participant households elects a CPC with four *vocales*.

Though their mandate is broad, in practice, *vocales'* primary responsibility is to provide participants with program information and answering questions – for example, if a beneficiary feels an error was made regarding the amount of benefits s/he was awarded, the *vocale* can inform and assist the beneficiary to claim redress through the appropriate channels. *Vocales* also hold bimonthly program workshops about *Oportunidades* and other self-help topics (self-esteem, motherhood, and self-improvement) and help to administer the program at the local level, for example by keeping attendance at health lectures and program meetings; supporting health clinics by maintaining order at mass vaccination days; and organizing the women during mass payment days. In terms of oversight, *vocales* see their role predominantly as one that ensures beneficiary compliance with the program, and less one of oversight of any other entity (for example, health providers).

3.3 INDONESIA

Unlike the examples of Burundi and Mexico, which are PBI programs that have adopted a CE mechanism, the Indonesia program is fundamentally a CE program that folded a modest PBI element into the larger project – i.e., it conditioned a portion of CSO pay on performance. Implemented by Local Governance for Innovations for Communities in Aceh – Phase 2 (or LOGICA2), a project funded by AusAID, the CE program was implemented for two years in six districts in the province of Aceh.[11]

In the program, CSOs could received incentives if certain conditions were met by health centers:

- Health centers develop and implement a mission, job descriptions, complaint handling, standard operational procedures, written service standards and service charter; and
- Health centers meet 1-2 minimum service standards (MSS) target indicators specified in the action plan (such as increasing the number of women who complete four antenatal visits and increasing the number of children who are fully vaccinated).[12]

In Indonesia, conditioning a portion of CSO pay on results is an interesting innovation to consider as CE mechanisms grow. Part of the rationale behind conditioning their payment on results was to introduce accountability among CSOs for the vast sums of money they had become responsible for managing after the tsunami. Performance-based contracting is often introduced in post-conflict countries for similar reasons: to rein in nongovernmental organizations during the bonanza of aid inflows that typically follow peace agreements, wars and natural disasters.

The rationale for rewarding incentives to CSOs conditional on what health centers achieved was that it would give the CSOs a strong incentive to help the facility achieve, and strengthen ties between the health system and civil society. However, it may have been demotivating, since health center achievement was ultimately outside CSO control. Furthermore, verification of results was weak in the

[11] The districts are: Pidie Jaya, Bireuen, Aceh Timur, Aceh Tamiang, Aceh Barat Daya, and Aceh Tengah. Within these districts are thirty-six sub-districts (*kecamatan*) and 432 village communities across all six districts.
[12] The MSS is nationally decreed performance tool specifying eighteen composite indicators that aim to capture the content of the priority health services heath centers are required to provide.

program: it was essentially a check – by the CSO – to verify that what was in the registers at the village health post level was consistent with what was in the registers at health centers. This is an important first step toward ensuring the integrity of the health information system – ensuring that what is reported in lower level facilities is consistent with what is recorded at higher levels. However, if what is recorded in health post registers is incorrect, all this does is verify that the health centers carried through incorrect figures consistently.

Though the program did not meet the criteria of a full-fledged PBI scheme, it was an initial experiment with holding CSOs accountable for results.

3.3.1 COMMUNITY ENGAGEMENT: COMMUNITY PRIORITY SETTING AND CSO TECHNICAL ASSISTANCE TO HEALTH FACILITIES

The community activities in the Indonesia program can best be described as a "menu" approach to CE that aims to provide a range of activities for a range of community members – from community leaders to people on the margins; from individuals to various groupings with various levels of formalization and capacity – from new and mostly informal health committees to local CSOs. At the heart of the CE effort is a process facilitated by the project and the CSOs of collective learning, needs prioritization, and stakeholder dialogue that results in two action plans – one for the community and one for the health centers. The community thus actively participates with health facilities in determining priorities, which ultimately become the indicators and targets the health facility agrees to meet. This is uncommon in PBI – normally, communities are not involved at the outset, in actually determining needs and setting the terms. It is an interesting and potentially powerful innovation.

The plans of action are then funded with small grants from the project. Following creation of the actions plans, the CSOs, per above, work with health facilities to achieve service delivery targets.

4. SHOULD YOU ENGAGE COMMUNITIES IN YOUR PBI PROGRAM? THREE THINGS TO CONSIDER

4.1 CLARIFY YOUR OBJECTIVES

Implicit in the idea of engaging communities in PBI is that there are other goals beyond just getting the job done – namely, as mentioned earlier, cost savings and empowerment. Sometimes these goals compete with one another, and programs considering engaging communities should think through the implications and decide what to prioritize: the programmatic function itself or cost savings and empowerment.

4.1.1 COST SAVINGS

In Burundi and Mexico, contracting CBOs to verify the results reported by health facilities, and delegating aspects of program administration and oversight to *vocales* are cheaper ways to carry out these functions than hiring external, professional auditors or hiring additional program staff. Verifying results for every facility in a country (even one as small as Burundi) implies significant costs; engaging CBOs 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 program does not incur the same magnitude of transportation costs, since the CBOs are physically closer to households.

Similarly, in Mexico, engaging volunteer beneficiaries, the *vocales*, to administer the program at the local level, effectively cuts the cost of implementation. The lowest level of program 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* program represent on average 25 beneficiary families each.[13] Replacing them with paid staff would increase the cost of administering *Oportunidades* considerably.

But this apparent cost savings is not as straightforward at 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 analyze the results, but the decision was also driven by the substantial financial and administrative costs of

[13] Needless to say, the number of *vocales* which *Oportunidades* registers in its database may not reflect the actual number of *vocales* actively representing their community. *Vocales* do not register themselves in the database, but rather are listed there upon their election. As is discussed below, vocal's election does not ensure her active participation.

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. Moreover, it is this verification function that provides one of the important benefits of PBI – strengthening the health management information system, which is unreliable in many countries.

Take also the role of the *vocales*. Clearly it saves money to rely on volunteers to administer *Oportunidades* at the local level, and the *vocales'* role in representing the program and ensuring that it functions well at the local level is critical. As one RA put it, "After we leave, they are in charge of the program." But the importance of the *vocales'* creates enormous potential for the abuse of power, yet supervision of *vocales* is extremely limited. This is partly due to cost. Additionally, Scaife-Diaz 2012 found that *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.[14] This may point to a program design issue: programs 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 one sense this is a design issue – for example, the cost of necessary supervision in *Oportunidades* should be considered from the onset – but it also illustrates the tradeoff between saving money by engaging community volunteers and ensuring the quality of this role.

4.1.2 EMPOWERING COMMUNITIES

In addition to bringing cost savings, one of the rationales behind engaging community members in the implementation of PBI is that it might have the added benefit of strengthening and empowering the specific elements of the "community" that are engaged – CBOs, *vocales,* and CSOs in Indonesia – building their skills; formalizing their role in communities (which may enhance their stature and power in communities); facilitating and building their connections and networks; and providing them with resources. But the goal of empowerment can at times be at odds with ensuring the rigor of the programmatic functions community members are tasked with carrying out.

For example, in Burundi and Indonesia, there are discrepancies between the desire to build the capacity of communities in order to empower them, and the need to engage community members who already have the capacity necessary to properly carry out the PBI program function.

In Burundi the capacity of CBOs varies widely, and in some cases is quite low. A study of CBOs across six provinces in Burundi in 2010 found that less than one-fifth of CBO members had completed primary schooling.[15] Seventy percent of the CBOs identified themselves as "self-help groups of farmers," [16] which suggests that their engagement as part of the PBI program may be their first experience outside of

[14] One CPC travelled to the UAR in representation of the locality to follow-up on various questions participants had. The cost of travel amounted to MX$300 ($22) per person, and they passed around a collection asking for five pesos ($0.40) per person. Some people contributed one peso, others 25 or 50 cents. The contributions were enough to send two people with some money left over, and upon their return the *vocales* made a public accounting of their expenditures and the additional purchases of supplies they made. Program participants from the community affirmed that all contributions were voluntary.
[15] Falisse et al 2012.
[16] Ibid.

subsistence farming. This can impact the quality of their work, both in organizing the surveys and the quality of the data collected.

In Indonesia, one of the rationales behind engaging CSOs was to leverage their networks and influence, particularly to engage government entities, the idea being that they will remain in communities after the project ends, so strengthening their networks will contribute to sustainability. In practice, however, CSOs had little capacity and poor reputations (and thus limited influence and connections with) among government officials.[17] Through the LOGICA2 program, their skills and capacity grew, and their reputations improved, which may have set the stage for more robust engagement and network building with government in the next phase of the program and beyond. But there was a tradeoff between effectively playing the role they were supposed to play in the program and engaging them as a way of coaching them to be effective in the future.

Finally, in Mexico *Oportunidades* staff expressed concern that information provided to *vocales* during training was not being transmitted to beneficiaries during workshops. Concern about the *vocales'* ability to educate beneficiaries has been expressed in other CCT initiatives. For example, "In Peru's *Juntos* program administrators report that high illiteracy rates among the promoters have hindered their ability to capture and impart information … While the *vocales* interviewed in Mexico were all literate, in more rural or indigenous communities it is likely *vocales* are semi-literate or illiterate, limiting their capacity to teach and share information" (Scaife-Diaz 2012 p 10).

None of this may be a bad thing, if the goal is to build the capacity of communities, particularly the marginalized. But where engaging communities to carry out PBI programmatic functions requires skills and experience – or where skills and experience are highly desirable in order to ensure the function is done properly – CE may be at odds with a desire to engage a broad, representative swath of the community, and to ensure the marginalized and poorest are included. There is a tension, in other words, between program needs and community level capacity building.

This is not a new puzzle: participatory CE typically depends not only on individuals who have certain needs (the poor, marginalized), but also individuals who have certain skills and adequate education to carry out the organization's activities. But community members with formal education are more likely to belong to the social and economic elite (Beard 2005).

Another issue, particularly when it comes to involving CBOs in verification, is the discrepancy between the need for the entity doing the verification to be independent and free from a conflict of interest, and the desire to engage community members to carry out the function in the first place.

In Burundi, typically CBOs are assigned one facility each, whose results they must then verify. Being based in the community means that members of the CBO may know the personnel of the health facility that they are being asked to assess, which can create a conflict of interest for CBOs and may result in collusion.

Of course the CBOs may also know the patients whose households they visit – they are likely to be, after all, their neighbors – and this raises important questions about patient privacy and the ethics of having community members question their neighbors about the health services they received. This may be especially sensitive for particular services, such as HIV testing and treatment or family planning.

[17] A baseline survey conducted to gauge CSO capacity found it to be almost nonexistent.

Ironically, in Burundi, this was one of the rationales behind engaging them for this in the first place: it was hypothesized that households would be more willing to open up to people they know rather than to strangers. But clearly the opposite might be true: that households would be more likely to be open and honest about their medical experiences if the survey were carried out by a stranger whom they would have no further interaction with after the survey. (See Bhuwanee and Morgan 2012.)

4.2 CONSIDER THE RISKS

Community engagement is sometimes romanticized, but as the programs discussed here highlight, individuals and organizations at the "community" level have the potential to be just as political, coercive, and unrepresentative as anyone. There is no guarantee, in other words, that pre-existing, indigenous community structures are representative, fair, or "owned" by communities. Indeed, community structures may be deeply flawed and corrupt, and engaging them – i.e., equipping them with resources and power – may exacerbate these issues.

4.2.1 RISK OF ELITE CAPTURE

Though an implicit goal of community engagement is equity and empowerment for the marginalized, it is always possible that community members picked for engagement will end up being people and organizations who already have status and standing in communities – i.e., elites. This risk is what prompted the Government of Mexico to bypass CBOs entirely in favor of engaging directly with individual beneficiaries. Says Scaife-Diaz 2012: "*Oportunidades* was implemented during Mexico's democratic transition, and was designed to avoid political capture by corporatist bodies at the local levels. Local institutions developed during the 70-year rule of the Institutional Revolutionary Party (PRI) would have been logical mechanisms for extending the program's reach and ensuring communication with local beneficiaries, but their strong affiliation with one political party and years of clientelistic practices made such institutions politically and economically inadequate. *Oportunidades'* designers worried that local institutions would siphon off cash transfers for personal enrichment and bestow or withhold beneficiary status according to party affiliation." Instead, *Oportunidades* identified new leaders, the *vocales*, to represent the program. (Although the *vocales* are for the most part poor women, it remains possible and even likely that those who volunteer to be *vocales* are nonetheless already leaders in their communities – since women who are already leaders/outspoken/well-known are more likely in the community meetings where *vocales* are elected, to volunteer or be nominated.)

The Indonesia program's "menu" was also designed explicitly to mitigate the risk of elite capture and/or political capture. The governing structures of LOGICA2 are based on equity for the marginalized, particularly women, and one of the ways the project has tried to ensure equity and inclusion is by giving a *range* of citizens, from elites who already have standing and capacity, to ordinary citizens, particularly women, a chance to "plug in" somewhere: elites may engage in health committees (which were put in place by the project or revitalized where they already existed). CSO staff can grow in skills and capacity through their work with health centers. Individual women and other marginalized community members may benefit from skills-building activities designed for them; and the priority-setting meetings bring the whole community together – anyone who wants to can come. It may be that in some cases, women do not assert themselves in the village meetings, but it is likely they participate in other ways; in fact, women are the *primary* beneficiaries of some of the program's activities, such as microfinance.

4.2.2 RISK OF ABUSE OF POWER

When programs empower community members – whether elites or the marginalized – there is always the possibility that they may abuse the power delegated to them. For example, in Mexico, the

importance of the *vocales'* role creates space for potential abuses of power; the fact that the re-election process is complicated and unclear, and supervision limited, increases these opportunities.

Scaife-Diaz (2012) found that *Oportunidades* beneficiaries identified multiple responsibilities they fulfilled beyond the requirements of *Oportunidades*; however, respondents did not identify these tasks as invented by the *vocal*. "Rather, it was more likely that the doctor, school principal, mayor, or municipal liaison requested the participants undertake additional tasks. While the women viewed them as their responsibilities, the majority understood the tasks to be additional, and that they would not face repercussions if they did not complete them." However, research from other countries suggests that the oversight role can be misapplied. As Scaife-Diaz 2012 notes her review, v*ocales* in Nicaragua's *Red de Protección Social* program were charged with ensuring that beneficiaries spend the cash transfer appropriately, "a responsibility which some interpreted to mean accompanying the beneficiaries in their purchases, requiring beneficiaries to make purchases in certain stores (often run by family members or friends of the vocal), and/or reviewing their receipts…". This example suggests that the *vocales'* supervision and/or oversight can evolve from friendly encouragement to requirement. And the potential for abuse of power is exacerbated when supervision and oversight of *vocales* is weak. Furthermore, if the *vocales* are the source of a beneficiary's complaint, poor, marginalized women may not feel comfortable or knowledgeable enough to address the large bureaucracy of *Oportunidades* in order to resolve it.

Another risk of abuse can be seen in the role of CBOs in Burundi. There have been numerous complaints from facilities of fraud – i.e., that the CBOs were filling out the questionnaires "under a tree." Yet counter-verification of the CBO community surveys is not done systematically.[18] In instances where it has been done (when the provincial authorities believe the CBO made an error), the quality of the CBO surveys has been found highly questionable. For example, a program representative in one district noted that counter-verification had been conducted two or three times and that each time the CBO was suspended for fraud.

4.2.3 RISKS TO COMMUNITY MEMBERS

One of the assumptions behind engaging communities in an oversight and monitoring role is that this will have an empowering effect and be welcomed by and beneficial for communities. But the example of *Oportunidades* demonstrates that the reality is much more nuanced.

Early in *Oportunidades'* implementation, Mexico piloted community assemblies to approve centrally generated beneficiary lists and identify errors of inclusion or exclusion. Research found, however, that the communities were ill-informed of their role and/or preferred not to identify potential errors, and the mechanism was eventually eliminated. It is a similar to the experience of Peru's *Juntos* program, which assembles community members, program administrators, and local officials to identify and/or exclude program participants. However, "community members prefer not to use this public forum for declaring a potential beneficiary 'too well off' for the program. Since wealthier community members tend to have more social and political capital, beneficiaries found it difficult and ill-advised to publicly demand those households be taken off the beneficiary list" (Scaife-Diaz 2012).

[18] 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—which also heads the team that verifies health facility records once per quarter, picks a sample of users (among those that should have been visited by the CBO), and checks with them that they were surveyed in the previous quarter.

Furthermore, as Scaife-Diaz 2012 shows, *Oportunidades* beneficiaries do not always welcome the responsibility of being a *vocal*. Community meetings in which *vocales* are elected often devolve into women shirking in corners to avoid being nominated, and voting for a nomination even if they do not know or do not like the nominee – because it is better for the other person to be *vocal* than risk being nominated.

Once elected, *vocales*, though they appear well-placed to submit complaints on behalf of beneficiaries (and research elaborated in Scaife-Diaz 2012 suggests there are numerous complaints about mistreatment at health clinics among program beneficiaries) tend to prioritize oversight of other beneficiaries rather than of health providers or program management – two entities upon which the *vocales* themselves also depend. *Vocales* prefer not to undertake oversight of providers for two main reasons: first because they view issues between patients and providers as private; and second, because of fear of retaliation by health clinics, including concerns that doctors might refuse to treat them if they are viewed as antagonists. It is possible to imagine similar concerns arising in a set-up such as is seen in Burundi, where CBO verification has the potential to reduce the incentive payments that facilities receive.

4.3 REVIEW YOUR OPTIONS

Engaging communities in the implementation of PBI may hold promise, despite the risks and tensions described above. Certainly, in countries where PBI has been scaled up nationally, as in Burundi and Mexico, engaging or contracting community members is likely to bring cost savings, and to build their capacity, even if it does not appear to foster community-wide empowerment. But some areas are better than others for community engagement.

TABLE 1: HOW CAN YOU ENGAGE COMMUNITIES IN CCT OR VOUCHER PROGRAMS?

Mechanism	Possible Benefits	Possible Risks/Downsides	The Verdict?
Selection or approval of Incentive Recipients in CCT or voucher programs	Most CCT and voucher programs target the poor and marginalized. Recipients are typically identified by the central Ministry of Health or by the donor project using geographic targeting or means-testing. These targeting mechanisms are useful, but imperfect. Communities, on the other hand, have first-hand knowledge about who is poor in their villages, and can thus, in the case of CCT programs,	Community members may not wish to identify errors of inclusion – especially publicly – if the person wrongly included on a beneficiary list is powerful in the community, for fear of negative repercussions. Community members may also use this power to wrongly identify errors of inclusion or exclusion for their personal benefit. For example, in order to get back at someone who has wronged them, a	Community involvement in beneficiary selection should only be done to cross-check lists of beneficiaries who are identified through other means (i.e., geographic targeting or other mechanism). It may be best not to carry out community cross-checking publicly – for example, the gathering might be in a public space, but errors would be identified in writing, privately, similar to a polling station.

	identify errors of inclusion (i.e., instances where someone too well off is included) and exclusion (instances where someone who is poor was not included on the list). In the case of voucher programs, community-based voucher distributors are likely to know who is poor and where they live and can thus target voucher sales in those areas. This harnesses the intimate knowledge communities have about their members to ensure cash transfers or vouchers reach those who need them.	community member might say that someone should not qualify for a program. By contrast, in *Bolsa Familia*, a CCT program in Brazil, "the same local committee that participates in beneficiary selection also provides program oversight and responds to beneficiary complaints, including those about health services provision … *The fact that the oversight committee is not made up of program beneficiaries may increase the committee's leverage and their sense of autonomy* when health services are sub-par." (Scaife-Diaz 2012)	Where errors of inclusion are identified, they should be thoroughly investigated before they are removed from the list.
Selection or approval of conditions or subsidized services	Community members are rarely consulted in determining the conditions attached to conditional cash transfers or the services vouchers subsidize. Consulting with community members for the former could help to ensure that conditions are reasonable and relevant for the beneficiary; and for the latter, may help programs target their efforts towards services which community members are in greatest need of.	Involving communities in selection of services covered in voucher programs may not be realistic, since program funders typically come with priorities already set to reflect the greatest health needs of the population (as well as political and other realities faced by the donor/payer). Involving communities in setting the conditions of CCTs may be unnecessarily complicated and costly.	Community involvement in setting conditions for CCT program, and in selecting services to be subsidized by voucher programs, may not be the best mechanisms for engaging communities. It may be more efficient, since there is ample experience with CCTs, particularly in Latin America, to review other program experience about what works and what doesn't in selecting conditions.

Administering the program locally	In any CCT or voucher program, there are various functions that must be carried out at the local level. In Mexico, recruiting beneficiaries for such a role – which involved helping women obtain their cash transfers, helping facilities at vaccination days – is a good model: because *vocales* are community members, they are a more accessible – both geographically and interpersonally – information source for beneficiaries, the majority of whom are poor, marginalized, and indigenous women. In voucher programs, voucher distributors – often local community members – are contracted to sell vouchers and promote the program. As with the *vocale*, they are accessible, non-threatening, and they know their communities and may be better placed than outsiders to build relationships with community members.	Community members sometimes have limited education and skills, which may limit their ability to adequately communicate the program to beneficiaries. Furthermore, delegating responsibility to community members, particularly where supervision is weak, may lead to abuses of power. For example, in a voucher program in Kenya, it was found that voucher distributors, who received a fee per voucher sold, sold vouchers to women who did not quality (i.e., the nonpoor). This prompted the program to switch to a monthly salary regardless of the number of vouchers sold and to increase supervision of VDs.	Overall, involving community members in administering the program locally appears to be a good model – one that builds the skills of community members and that offers beneficiaries an easy-to-approach face of the program to ask questions and get help. However, programs should consider carefully whether these positions should be paid – *vocales* are volunteers and there is evidence that they "push" the costs of being a *vocale* onto other beneficiaries.
Oversight of beneficiaries	Community members are well-placed to provide oversight of program beneficiaries; since they live in the same community they can more routinely observe beneficiaries	Since, community members, particularly in small villages, are likely to know beneficiaries, they may collude with them for personal gain. In contrast, they may also abuse the	There are risks to this mechanism, but with proper checks and balances, this may be good good approach.

	to ensure, for example, that they meet the conditions attached to a CCT program and provide friendly support. The case of Mexico suggests that this was a role *vocales* were happy and able to take on, and that beneficiaries appreciated the support.	oversight role and make demands on beneficiaries that beneficiaries may interpret as program requirements.	
Oversight/Advocacy – of the program and facilities	Community members akin to the *vocales* in Mexico would seem well placed, not only to hold other beneficiaries accountable, but also to hold the program accountable – for example, ensuring CCT funds are not siphoned off; that the correct amount of money reaches the right women; and that higher-level program managers are not using their power for political purposes. Similarly, they seem well placed to report abuse or other problems at health facilities, since they have frequent interaction with women and as noted above, are an entity women are likely to feel comfortable sharing concerns with.	As Mexico demonstrates, *vocales* may not welcome this broader oversight role, given that they are also dependent on the program and facilities – many *vocales* cited fear of repercussions as a reason for not engaging in these activities. These are also broad, far-reaching responsibilities given that *vocales* are not paid.	It is probably better not to engage program beneficiaries in oversight of programs and facilities upon which they depend, but it may be advantageous to consider engaging other community members or CBOs in this function.

TABLE 2: HOW CAN YOU ENGAGE COMMUNITIES IN PBI PROGRAMS TARGETED AT HEALTH FACILITIES?

Mechanism	Possible Benefits	Possible Risks/Downsides	The Verdict?
Selection or approval of performance indicators	Most supply-side PBI programs involve performance contracts that specify certain indicators and targets to meet (facility delivery is an example of an indicator). Indicators are important because they send signals – to providers and their managers – about priority services. The Indonesia model of involving communities in determining indicators for the performance contract is unique in the world of PBI and potentially powerful. Involving communities in setting the performance priorities sends a strong signal that their voice "counts." Furthermore, involving communities in indicator selection can help to sensitize them to the PBI program, which can set the stage for future monitoring of their health facility's performance.	This mechanism raises questions of whether it would work at scale, or whether community-identified priorities can be translated into indicators and targets that work for PBI programs.	With proper education for communities, this is an approach worth exploring in the future, however, it implies an investment – in educating communities, convening meetings, etc. – that may not be sustainable.
Monitoring Achievement	Monitoring is an essential function in PBI programs – facilities must routinely report data on health services delivered, which is then verified and reviewed prior to payment. Typically, this process is one that goes upwards – to the	The downside to this is that it requires facilitation – someone has to convene communities, communicate information in a way that is comprehensible, and, ideally, give community members	This holds promise, especially in places where PBI is institutionalized, and collection and verification of data is routine and nationwide, but facilitation is key. It may be an opportunity for

	program, the Ministry of Health, etc. Seldom do we see information shared "downwards" to the community, to enable them to monitor facility performance. But this is a potentially powerful way to involve communities, since it would equip them with information about health facility performance and give them a means to pressure facilities to deliver results.	a channel to hold facilities accountable for improving their performance.	revitalizing the role of health committees to facilitate communities to monitor achievement.
Verification	Verification of results – whether those reported by health facilities or by managers at the district, provincial or central level – is an essential function in any PBI program. It is also one of the most expensive aspects of implementing PBI, and contracting community groups with lower fee expectations may save money and build their capacity/job skills.	However, verification requires the verifier to be an entity that is independent from facilities – free from conflicts of interest – and skills and capacities are required for the function to be carried out well. CBOs, since they are based in the community, may lack independence; they may also lack skills and capacity. Furthermore, in cases where, as in Burundi, CBOs are contracted not only to verify results but also to administer patient satisfaction surveys, this calls into question patient privacy, given that CBO member may know the patient.	Despite the challenges, this appears to be a promising mechanism for engaging communities, but it is probably wise to contract CBOs on a district- or provincial-basis, rather than one CBO per facility, as is often done in Burundi. This reduces the likelihood that the CBO is familiar with the facility or patients, thus increasingly the likelihood of independence. Furthermore, programs should err on the side of contracting CBOs with the capacity to carry out this important function, in favor of aiming to build the capacity of very weak CBOs, which could jeopardize verification, and thus the credibility of the program.
Payment	Once results are	One of the theories	The best solution is

	verified, PBI programs provide incentive payments to health facilities. Ideally, facilities have their own bank accounts, but in some countries this is proving challenging. Some programs are thus considering alternatives, some of which involve communities. For example, a health committee could open a bank account jointly with health facilities, and as signatories on the account, ensure the incentive payment is spent properly.	behind PBI is that giving facilities discretion over the incentive payment (which is usually a modest amount) is itself motivating – i.e., it is not only the money but the power to choose, as a facility team, how to spend it. Giving the communities power to be part of the decision-making process diminishes the motivating power for facilities; and communities may request the money be spent on things the facility does not think is necessary or most important. The facility is in the best position to know what their facility needs.	bank accounts for facilities, and in a case where arrangements that involve communities are being considered, it is important to ensure the autonomy of the facility in decision-making power over the incentive payment.

5. THE WAY FORWARD: THREE THINGS YOU SHOULD REALLY DO

You've read about the risks and the possibilities. There are still many possibilities and many potential ways to get even the riskiest mechanisms for engaging communities right. No matter what you decide to try, what are the most important things for you to do?

5.1 DON'T CUT COSTS

Even though engaging communities may result in some cost savings, there will always be costs associated with ensuring the functions – whether verification or program administration – are carried out well and properly. These costs may include budget for more and better training for *vocales*, including training on how to report "up" to the program; for visits by higher level authorities to check on the program; 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 verification, these costs certainly include the cost of conducting verification at a frequency that will ensure the program 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.

The bottom line: engaging communities may result in some cost savings, but don't cut corners on essential PBI functions.

5.2 GET THE PROGRAMMATIC FUNCTIONS RIGHT

As discussed above, there are often multiple goals associated with engaging communities, including empowering the marginalized. These are laudable goals, and engaging communities in PBI may go part of the way towards doing so but the rigor of PBI functions should not be sacrificed in favor of empowerment. If there is a choice to be made between engaging a marginalized, low-capacity entity in the community or engaging an entity with more capacity, that may already have standing and power in the community, it is probably best to opt in favor of the latter. Community engagement will not go far if the PBI program itself is weak. The first objective should be to get the programmatic functions right.

5.3 ESTABLISH CHECKS AND BALANCES

As these and experiences from other countries show, it is critical to build in robust checks and balances to avoid potential dangers and abuse. For example, where CBOs are contracted to conduct verification, their results should always be systematically counter-verified. To mitigate the risk of collusion with facilities, it may also be beneficial to contract CBOs on a per-district basis, rather than on a facility basis, since if CBOs are from the same community they are verifying, their independence is diminished. This

may also go some part of the way towards addressing privacy concerns about having CBOs verify the health services received by their neighbors – if the CBO is not from the community, they are less likely to know patients. This, along with obtaining informed consent from patients at the point of service (i.e., obtaining their permission to be contacted later for the purpose of verification) can help to uphold patient rights to privacy, while also sending a signal to patients that they have a choice to make.

In another example, in CCT programs with community advocates akin to Mexico's vocales, it is important to ensure that they are supervised and that beneficiaries have channels to report abuse. All this implies the need to balance oversight – which costs money – with the desire in the first place to save money by engaging communities. A balance must be struck.

6. CONCLUSION

Engaging and empowering communities to enhance accountability in the health sector is a trend that is probably set to continue given growing interest in health sector governance. Mirroring that broader trend, it seems likely that PBI programs will increasingly look for ways to engage local communities in various programmatic functions, and this may hold promise, despite the risks and tensions described above. Certainly, in countries where PBI has been scaled up nationally, as in Burundi and Mexico, engaging or contracting community members is likely to bring some cost savings, and to build the capacity of individuals and organizations in local communities. CBO verification is a model being considered and adopted increasingly, including in Zambia, Zimbabwe, Cameroon and other countries in sub-Saharan Africa. And community advocates akin to the role of the *vocales* in Mexico is a part of conditional cash transfer programs in other countries such as Nicaragua and Peru.

Among the challenges highlighted in this guide is the need to balance cost savings with ensuring these important functions are robust. There are risks of elite capture and exclusion, and tensions between the goals of CE – for example, the desire for CE to be inclusive and representative – and the needs of the programs, which requires individuals and entities with skills, experience, and independence/objectivity.

It is also important to recognize the limits of engaging communities in the design and/or implementation of PBI. Despite building up the capacity of CBOs and *vocales*, the programs in Burundi and Mexico do not appear to be fomenting community-wide participation and empowerment to bring accountability to bear. Only Indonesia fosters CE in that way, and that is because the program was designed firstly with that in mind. Indonesia's CE model is broad, robust and powerful, and it embodies many of the elements common to other successful CE schemes (see Morgan forthcoming).

Furthermore, insofar as these mechanisms enhance community monitoring and pressure, programs must keep in mind that such pressure is only likely to be effective if it is targeted at the right level. As Croke 2012 notes in his review of community-based monitoring schemes, the accountability problems that many community mobilization programs target occur at all levels – ministry/donor, regional, district, and local – but community groups in most cases target their oversight at the village or facility level. But not all problems are amenable to change because of community pressure. "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 procedures, 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 that community pressure may be ineffective" (Croke 2012).

Finally, a major lesson is the obvious missed opportunity in all these programs: none of them used the chief currency of PBI – reliable, routine, verified information about health services – as a tool for community empowerment. In other words, none of them systematically shared information on performance with communities or gave them channels with which to use such information for accountability purposes.

If the goal is wider CE, feeding back performance data to communities could be built into programs by, for example, leveraging and/or revitalizing the role of health committees.

Giving communities an opportunity, a forum, for ongoing engagement with their health providers, and ongoing information about their performance, would go a long way towards creating long-lasting positive bottom-up pressure to hold providers accountable for results.

ANNEX A: BIBLIOGRAPHY

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