An impact evaluation of a citizen/community report card on performance in health care delivery in Uganda

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INTRODUCTION

Identifying and implementing incentives that give rise to a strong relationship of accountability between service providers and beneficiaries is critical for improving service delivery. Systematic evaluation of service delivery innovations to increase accountability can show what works, what doesn’t and why, a first step to scaling up success.

To date, most countries rely on legal and financial management methods to monitor public sector performance. However, evidence from a wide spectrum of countries shows that these systems can, at best, provide only a limited form of monitoring (see box 1).

A complementary approach, highlighted in the 2004 World Development Report *Making Services Work for Poor People*, emphasizes citizens’ voice and “client power” as important elements of making services work for poor people. Examples of this approach include participatory budgeting in Porto Allegre, Brazil, citizen report cards in Bangalore, India, public information campaign to reduce capture of school funds in Uganda, and community scorecards in Malawi. These innovations share some common features. First, a key ingredient is better information about the users’ needs, experiences, and entitlements. Second, and in particular for the citizen report cards and community scorecards, the information is actively disseminated to the users in order to create awareness and invoke participation and monitoring of service providers.

Specifically, the idea behind both the Bangalore-type citizen report cards and the Malawï-type community scorecards is that the open comparison of cost, quality, and performance of public sector units will generate incentives to improve the system, hence improving client responsiveness and diminishing inefficiency and misuse of public resources. By providing information on both the relative and absolute performance of similar units, citizens will be empowered with quantitative information that is more difficult for service providers to brush aside as anecdotal, partial, or simply irrelevant. This in turn can provide a spark for public pressure and a user-feedback system that can potentially have a large effect on the public sector’s performance.

The open comparison of performance of service providers in the public sector has several important benefits:

- Promotes transparency and increases accountability of the public sector by giving citizens access to information needed to understand, examine, and challenge service providers. This can empower citizens to demand better standards and to monitor and challenge abuses of the system.
- Provides a user feedback mechanism for public sector authorities and a benchmark both for the authorities and the public to compare a given service delivery unit with other similar units, and to evaluate improvements over time.

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• Gives service providers an opportunity to compare inputs, outputs and performance with other similar units and thus highlights both allocative and technical efficiency of the services being provided.

• Provides a tool to identify and recognizes public sector units that are performing well, and thus increases competition across these units.

**Box 1. Accountability through legal and financial management systems**

In most countries it is the government and the existing legal institutions devise and enforce public accountability. However, the reliance solely on legal and accounting institutions is often problematic. First, as government’s role and services have expanded considerably during the last few decades, it has become apparent that conventional mechanisms, such as audit and legislative reviews, may not be adequate. Collusion, organizational deficiencies, abuse, and lack of responsiveness to citizens’ needs in public agencies and units cannot easily be detected and rectified even with the best of supervision.

Second, legal processes and systems to control public sector mismanagement rely on the existence of a trustworthy (benevolent) legal machine (judges, court personnel, and police) to investigate and enforce existing rules. For many countries, in particular those characterized by systemic corruption, such legal machinery does not exist. The financial management approach suffers from a similar dependency of a credible institutional framework. A credible financial system relies on a functioning enforcement mechanism and the ability to delegate the reviews to trustworthy auditors.

Third, while a well-functioning legal and financial system minimizes obvious cases of mismanagement (such as theft of public funds), rules and accounting systems only partially constrain the discretionary power of public sector managers and employees. The complexity of the task that a typical public sector unit performs and the informational advantage it has relative to customers effectively hinders the design of legal and accounting measures (or makes it extremely costly) to address all types of inefficiencies. Thus, less obvious measures of mismanagement (such as shirking, budget priorities that favor staff instead of customers, certain procurement procedures, and implicit political considerations) will typically not be captured.

Fourth, audit reports and legal procedures are often difficult for a layman to interpret, and reports therefore often do not lead to action (and go unnoticed) unless the one that has commissioned the audit (e.g., local authority) acts up on it. The problem is compounded by the fact that in many countries there is a long lag between the period under review and the publication of the audit report. In fact, when the time has come to evaluate the actual outcome, many of those responsible will have already changed positions. Finally, many countries simply lack an independent and well-functioning legal or audit systems at the local level where most services are being delivered.

**CITIZEN REPORT CARDS AT THE COMMUNITY LEVEL**

This project evaluates a citizen/community report card for impact on performance in health care delivery in Uganda. The proposed project, the Citizen Report Card at the Community Level (CRCCL), has many similarities with both the Citizen Report Card (CRC), as implemented in urban services in Bangalore, and the Community Scorecard (CSC), as implemented in rural Malawi. In fact, the implementation process is similar to the latter with a few exceptions.

1. In the CRCCL the unit of analysis is both the household and the community. The unit of analysis in the CRC is a household alone, while the unit of analysis in the CSC is a community alone. In the latter, each community sets their own performance criteria for

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2 Paul (2002)
3 Singh and Shah (2002)
evaluating service providers through focus groups, and there is no sharing of information across communities.

2. As in the CRC (the Bangalore model), the CRCCL will collect information from users of the service(s) through a survey questionnaire from several sub-populations (communities). Thus, for each community participating in the project, a random (stratified) sample of community members will be surveyed. The sample of households to be surveyed needs to be large enough to yield a representative picture of the households’ experiences and perceptions of the services being provided at the community.

3. Unlike the CSC, a common survey questionnaire (in the CSC it is a community scorecard produced in a focus group) is designed ex ante (through piloting) and implemented across communities. This implies that the set of criteria to assess performance of service providers is determined beforehand, based on relevant information available (such as the recent Uganda participatory poverty assessment, UPPAP).

4. Both the providers and the communities (i.e., a sample of households in each community) will be surveyed. For the household, a short “report-card” instrument will be used to collect both quantitative and perception based data on performance. For the health units, a so-called Quantitative Service Delivery Survey (QSDS) will be implemented. The QSDS will be extended to include a self-assessment module for health care providers.

After the initial survey of households in the selected communities and that of health facilities (QSDS) that serve these communities, the process will be similar to the CRC. That is,

1. Data analysis of the household survey. While the first-round QSDS data will also be analyzed, only a subset of the information (mainly the self-assessment and cost/funding information) will be part of the CRCCL process. However, the QSDS will form the basis for the impact evaluation of the CRCCL.

2. Presentation of results of the household survey to the communities and discussions with the community members, including suggestions for reforms and improvements in health care. To allow comparison, key survey results from other communities will also be presented.

3. Presentation of the household survey results to the communities and the self-assessment data to the health facilities separately and a discussion about suggested reforms and improvements, facilitated by a third party.

4. Interface meeting(s) between the health service providers and communities, facilitated by a third party.

The participating health facilities and communities will then be revisited after six months and the above process will be repeated. A question remains whether a new round of “report-card” information will need to be collected from the users and whether a new self-assessment of providers is required.5

After about one year, the impact evaluation will take place, which implies that new information is collected both from users (“report-card” survey of households will be repeated) and providers (a repeat QSDS).

4 The data collected from the health facilities also form basis for another research project – an assessment of the removal of user-fees in public health facilities.

5 In any case, a new QSDS will not be implemented after 6 months.
**RANDOMIZED EVALUATION OF THE CRCCL**

Identifying a causal effect from a project like the CRC or the CSC using non-experimental data is problematic, even when information on outcomes is available, both ex ante and ex post. In short, the fundamental problem arises from the impossibility of observing what would happen to a health clinic/community in both the state where the CRCCL is in effect and that where it is not. Using the pre-CRCCL outcome as a counterfactual state against which the post-CRCCL outcome will be compared is “only” a valid evaluation method if the evaluator can control for all other (time-varying) factors that may have affected the health clinic/community during the implementation (of the CRCCL) phase. Moreover, the evaluator must be certain that the data collection exercises per se do not influence the behavior of users and providers. These conditions may be difficult to ascertain.

The proposed strategy is therefore to evaluate the impact of the CRCCL using an experimental design. The source of identification will thus come directly from a randomized experiment.

The strategy is to randomly assign $x$ government health clinics and the communities they are serving to participate in the CRCCL. This will be the treatment group. Another $y$ government health clinics and the communities they serve will “only” be surveyed (but no treatment, i.e., no advocacy and awareness raising will be carried out), and these $y$ units thus belong to the control group. The treatment effect can be derived by comparing outcomes (in different dimensions) between the treatment and control groups.

It is important to ensure that, ex ante, the treatment and control groups are similar. Thus, after the data is collected from the providers and users in the $(x + y)$ units and communities, we will need to stratify the sample on observable characteristics and then randomly assign the units into treatment and control groups. Preferably, the number of units will be similar in the control and treatment groups.

The recently implemented QSDS in Uganda includes 80 government operated health facilities (dispensaries and dispensaries with maternity units). As discussed in the sample note for the CRCCL, all these facilities cannot be included in the evaluation. Household information is collected from users of around 50 facilities. A first cut would be to split this sample into two, one control group with 25 units and one treatment group with 25 units. However, the exact number of units $x$ ($y$) that will be in the treatment (control) group will be determined once the household survey is finalized.

**ISSUES**

The issues to be addressed before an evaluation along the above lines could be carried out. Below we list some key ones:

1. **Linking the health facility and the users.** To make the evaluation feasible, it is crucial to use a common definition of the “community that the health unit serves” across the treatment and control groups. The defined community must be the principle user of the facility and must also be large enough to be able to credibly monitor the facility. At the same time, the geographical area where the community (or cluster of communities) is situated must be sufficiently small to enable survey work (given financial and time constraints). Balancing all these needs, we have chosen to operationalize a facility’s catchment area as the 5-kilometre radius around the facility.

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6 This is a second round QSDS. The first round was implemented in 2000, including 155 dispensaries.
7 To detect significance, one needs a large enough effect of the intervention. The required effect is a negative function of the sample size, i.e., the larger sample size, the easier it is (in expected terms) to detect significance of the intervention.
2. Surveying a representative sample of users in the community. Three general principles governed the choice of sampling the users in the community. First, we wanted our sample of households to be representative of the potential users of the facility in the CA. This in turn is a function of both the size of the population in the CA and the distance to the facility. Second, for the intervention to be feasible (and within our budget constraint), we wanted to restrict the number of villages to be surveyed within a given CA. For the same reason, we wanted to ensure that the villages surveyed are clustered together in a smaller set of clusters within each CA. Finally, we wanted to include the village where the facility was located (typically the village where the staff resides). To ensure this, a four-stage sampling design was implemented. For further details see the sample note on the CRCCL.

3. Identifying a NGO(s) that can facilitate the interface process. In the CSC and CRCCL, an intermediary (for example, an NGO) plays an important role in facilitating the interface meeting between the service providers and the community, presenting and leading the discussions about the data collected, and guiding the formulation of reforms and improvements. Local civil society groups may have a key role at the community or district level, working in collaboration with the overall coordinating team. Similarly, health management committees at the facility level or village health teams may become important collaborators.

References


