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UGANDA: Does Information Matter?

In many poor countries, the quality of education, health care and other public services is low. Figuring out how to fix that is a key development goal. The World Bank and other donors often encourage community involvement as a way to improve the delivery of public services. This approach, known as Community Driven Development, seeks to create opportunities for people to participate in the planning, oversight, and implementation of public

services such as health care and education. In practice, this often means encouraging meetings between community members and providers, and having them work together on a plan for improving delivery of services. How effective is this approach? It's not clear.

Results have been mixed and even when there is a positive impact, there hasn't been a lot of follow-up work to measure whether gains are maintained over the long term.

The World Bank works closely with governments to improve the quality of services critical for reducing extreme poverty and improving shared prosperity. Understanding the impact of different initiatives is crucial for successful programs and policies. In Uganda, researchers supported by the World Bank evaluated a program that sought to boost the quality of healthcare by giving community members a voice in creating action plans with clinics for what needed to be done and how to do it. The evaluation found that when communities also received information about how well a clinic performed in areas such as wait time and provider absenteeism, there was more community involvement and an improvement in care. **The findings are important for governments and development groups looking to community involvement as a way to improve delivery of public services. As this evaluation shows, information is critical in order to make a difference.**

HEALTH

Context

Uganda has made important progress toward meeting the Millennium Development Goals, including halving its poverty rate to around 20 percent from more than 50 percent in the early 1990s. But healthcare, especially in the rural areas, is generally of poor quality. Small clinics, known as dispensaries, provide care to Uganda's rural residents. The clinics offer preventive, maternity, and outpatient care, as well as lab services. All services are supposed to be free. Six to 10 people staff most clinics, including a trained medical worker, nurses, nursing aides, and others. But roughly 50 percent of the staff are absent on a typical day and patients' average wait time exceeds two hours. Uganda's health sector is decentralized and Health Unit Management Committees are supposed to be the link between the community and the facility. In practice, there's little action on the part of the committees in terms of supervision or support.

In 2005, a World Bank supported team decided to test the impact of a program to encourage rural residents to get involved in local health care delivery. Community members and health staff were given report cards grading the quality of local clinics, including information about specific clinic operations, absences and the quality of care. Meetings were facilitated between community members and health facilities to allow them to draw up a shared vision of what was needed and make a plan to achieve this. A year later, the evaluation* found that the quality of healthcare improved, as reflected in lower child mortality and improved child weight. In 2007, the team expanded the project in order to test whether just bringing people together with health providers for meetings and encouraging community monitoring processes—without providing report cards—could be as effective.

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

Evaluation

The initial evaluation was implemented in 2005 in 50 rural communities in nine districts, covering all of Uganda's four regions. Twenty-five communities were randomly selected for the treatment group and the other 25 were assigned to a control group. The treatment group received report cards that contained detailed information about the quality of care and activities of their local health center, and then meetings were held between community members and health clinic staff to draw up a list of problems, goals and a plan of action. The control group didn't receive anything. In each treatment community, short follow up meetings were held between community members and health facilities in mid-2005, 2007 and 2008. Communities in the treatment and control groups were surveyed in 2006 and after four years to see whether the positive gains that had been reported in the treatment communities after the first year were sustained.

In the second phase, starting in 2007, a separate accountability program was put in place in a different set of communities and evaluated. This new program sought to mimic the earlier program but without giving people detailed information on health facility performance. Researchers wanted to understand whether the information, which had been expensive to collect, was necessary to improve quality of care or whether it was enough to bring the community together to meet with health clinic staff in order to create an effective community engagement program.

Twenty-five new communities were identified for this phase. Using the original study's procedures, researchers randomly assigned 13 to a treatment group and 12 to a control group. Communities in the treatment group were asked to attend meetings to identify the priorities for the local health clinic and how to improve quality. Separate meetings were held for community members and health facility staff, and then they were brought together in a third meeting to agree on a joint action plan. The communities in this second phase were surveyed at baseline in 2007 and then two years into the program, in 2009.

For the purposes of the evaluation, a community was defined as all households living within a five kilometer radius of the local health center. On average, there were 2,500 households per community. The communities were stratified by location and then population. In each location, half the communities were randomly assigned to the treatment group and the remaining to the control group. About 100 households were surveyed in each community. Researchers also reviewed health records. In order to measure how important the data was to changing quality of care, researchers reviewed health outcomes for households whose communities took part in the first participation-information evaluation and compared this with the control group. They then looked at health outcomes of households whose communities took part in the second, participation-only, phase, and compared the outcomes with those for the corresponding control group.

Findings

Giving people information specific to the performance of their local health facility led to better health outcomes, especially for young children.

Between the years 2006 and 2009, the mortality rate for children under age five dropped by 23 percent, when compared with communities where no program was put in place. Similarly, infant mortality dropped by about 28 percent and the neonatal death rate for infants under the age of one month dropped by almost 44 percent.

In terms of height-for-age, an important accumulative measure of proper nutrition and health care, children who had lived for at least three years in communities that had received and discussed score cards were 10 percent taller than children in the communities without the intervention.

In communities where report cards were distributed and discussed, health facilities were in better condition and health workers appeared to do more for pregnant women and infants.

The general condition of the clinics—the floor, walls and furniture, as well as the clinic’s smell—was much better even four years after the initial intervention. Health workers were more active when it came to running routine tests and doing check-ups and they followed clinical guidelines more closely. Midwives were more likely to examine pregnant women, check their weight, draw a blood sample, check the fetus and tell the women about potential pregnancy complications. Post-delivery, the rate at which newborns were checked in the first two months rose by 24 percent.

Not surprisingly, in these communities there was also increased use of health services.

Four years after the project began, participants in the treatment group that received report cards and discussed them in community meetings continued to make use of local health clinics more often than those in the control group. Depending on which measurement tool the researchers used, the increase in use of outpatient services rose between 16 percent to 27 percent and the increase in use of services after delivering a baby varied from 21 percent to 25 percent. The increase in pregnant women going to health facilities to deliver their babies rose by around 50 percent. Some of this increased use came from people who stopped going to traditional healers—or trying to heal themselves and instead turned to the health facility.

Giving local residents and health staff information up front about the functioning of the health clinics—and comparisons with other clinics, along with the national standard for care—led them to draft an effective, long-term plan to solve local problems and improve health care service.

The information in the report cards allowed residents and health staff to focus on problems that could be solved locally, including: absenteeism, opening hours, waiting time, and patient-clinician interactions. Residents and health workers also could address these issues themselves. In short, the report cards provided key information allowing the two sides to create an effective reform agenda. Steps that improved service included having a suggestion box, numbered waiting cards, a staff duty roster, and posters notifying patients about their rights and that services were free.

However, there was little improvement in health outcomes in communities where meetings were held but information wasn’t first distributed on health facility quality and health indicators.

Efforts to spur more local participation in health care services had little impact on health workers’ behavior and health care delivery when this wasn’t combined with giving people information on the functioning of the local health facility. Two years after

the communities in the second evaluation were brought together with health facilities to draw up a joint plan, there was no impact on local residents’ use of clinics and little difference in health outcomes when compared with the communities where there were no facilitated meetings. The treatment group showed little difference from the control group in the following areas: under-5 mortality, infant mortality, neonatal mortality, the number of births, and the number of pregnancies.



Treatment and management practices in these health clinics didn’t change, which accounts for the lack of improvement in health outcomes.

In communities where facilitated meetings were held, but report cards weren’t distributed on the quality of care, there was no sign of increased exchange of information between residents and health staff. Similarly, there was no evidence that residents took a larger role monitoring health staff. Management of the clinics stayed the same, as did the degree of staff adherence to clinical guidelines.

Communities without report cards were less successful at drafting effective plans to solve local health care problems.

Health staff and residents in these communities identified issues that mainly required help from outside parties—such as more financial and other support from senior authorities and non-governmental organizations, as well as more timely delivery of medicine. They didn’t come up with plans that focused on local issues that facility staff and users could possibly resolve on their own, such as long waiting times, opening hours and absenteeism (something that communities that received report cards did do).

Baseline data showed that there was a gap between what community members reported as being problems, and what the real problems were, and this gap may be why communities that received report cards were able to improve services.

Staff at health facilities, for example, would say the wait time was usually two minutes, when the survey showed it was closer to two hours. They wouldn't say there was a problem with absenteeism, although unannounced surveys put the absenteeism

rate at around 50 percent. Staff also never mentioned other problems, such as mistreatment of patients or lack of adherence to clinical guidelines, as problems that could be harming health care quality and usage. Instead, staff would usually point to outside factors, like limited funding, as the main problem behind poor quality of care and health outcomes. When communities didn't have any other information, they ended up following what the health staff said was the problem; when they received the report cards with data, they were better able to pinpoint what needed to be fixed.

Conclusion

Information turns out to be a powerful tool in community-based monitoring programs aimed to fixing local service delivery problems. The findings of these two, related evaluations indicate that to ensure effective community participation, everyone needs to understand what the real service delivery

problems are. Relying on anecdotal evidence isn't sufficient. While it's costly and time consuming to gather such data, it may be necessary to avoid trying to implement even costlier community-driven interventions that fail because people don't have information on what the real problems are.

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