

The Challenge of Inducing Participation

THIS CHAPTER APPLIES THE ANALYTICAL FRAMEWORK OUTLINED in chapter 2 in order to better understand the challenges faced in resolving civil society failures, improving the interaction of civil society with markets and governments, and implementing participatory projects. What can participatory development achieve, and under what conditions? What do the structures of failure at the local level say about options for policy? What are some of the challenges of using policy interventions to repair civic failures and induce participation? How do incentives within donor institutions and government bureaucracies affect the implementation of participatory projects? The chapter uses the analytical framework to derive a set of hypotheses that guide the analysis of the evidence in the subsequent chapters.

Under the right conditions, effective local participation can be a powerful force for change and the achievement of various development objectives. Local development moves from being “participatory” to “empowered” when decisions made by ordinary people through deliberation are tied to policy decisions and actions—what Fung and Wright (2003) call “empowered participatory governance.” This process is characterized by three foundational principles:

- Participation must have a practical orientation.
- Participation must be “bottom up,” in the sense that all of the people most affected by the problem and knowledgeable about solutions to it should be involved in decision making.
- Participation must be deliberative.

Fung and Wright define deliberation as a process of collective decision making in which a group reaches a consensus across diverse points

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of view. It is an alternate to what economists call “preference aggregation” through electoral mechanisms. In electoral decision making, preferences are aggregated by counting votes. Deliberative decision making requires that participants listen to one another’s positions and generate group choices after due consideration of other points of view, even if they do not necessarily endorse those choices or find them optimal.

After examining various successful cases of empowered participatory governance around the world, Fung and Wright conclude that in order to advance these foundational principles, governance institutions need to incorporate three design features:

- *Devolution.* Local decision-making units should have meaningful power and be downwardly accountable.
- *Centralized supervision and coordination.* Local decision-making units need to share information, learn from one another, and discover what works by trial and error while being monitored and held accountable by the center.
- *State-centered, not voluntary.* Empowered participation should remake state institutions to align with their foundational principles rather than develop parallel structures.

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Ironically, empowered participation requires a strong, functioning state that has not only internalized the broad objective of deepening democracy and developed a much more astute view of citizens’ role in shaping policy but has also actively promoted and supervised the process by which this process happens.

The premise underlying participatory development is the power of the group—the notion that individuals are far more effective when they work together toward a common objective than when they attempt to achieve the same objective on their own. By mobilizing citizens to work together for their collective well-being, participatory development has the potential to redress some failures of the state and some failures of markets while improving the capacity of individuals to bond and work together.

One reason participation can do so is that it can have intrinsic value. People may value the simple courtesy of having their opinions heard, of being listened to. If public decisions are determined deliberatively rather than dictatorially, in a manner that gives everyone—poor and rich, female and male, lower and upper caste—an equal voice, the process by which decisions are made has, in itself, the potential to enhance agency.

Political theorists contend that participation has the potential to lead to a process of positive self-transformation by catalyzing a set of desirable changes in individuals: enhanced facility for practical reasoning, greater tolerance of difference, more sensitivity about the need for reciprocity, enhanced ability to think and act with autonomy on the basis of their own preferences, and the ability to engage in moral discourse and make moral judgments (Warren 1995).

Much of the value of participation can be encapsulated in Hirschman's (1970) view that "voice" has both intrinsic and instrumental value. The anthropologist Arjun Appadurai (2004) goes farther, describing voice as a "cultural capacity." Voice, he contends, is a matter not just of people demanding democratic rights but of engaging with social, political, and economic issues in terms of metaphor, rhetoric, organization, and public performance, in order to negotiate and navigate their worlds. This "capacity to aspire" is not evenly distributed. In situations where the rich have consistently benefited from better social, political, and economic connections and have the cultural tools to navigate those worlds, they are "more likely . . . to be conscious of the links between the more and less immediate objects of aspiration." The rich are thus better able to navigate their way toward actualizing their aspirations. If participation is to build this navigational capacity, then voice and the capacity to aspire need to be "reciprocally linked, with each accelerating the nurture of the other" (Appadurai 2004).

Participatory interventions are, however, more often justified by their instrumental value—their potential to make states and markets more accountable to the needs of citizens, to help communities mobilize to improve credit and livelihood opportunities and manage common property resources. The accountability function of participation requires groups to mobilize in a manner that changes the incentives of the agents of the state so that they act in the interests of citizens. State failure often occurs because the incentives of the individuals who comprise the state, and function as its agents, are not aligned with the needs of citizens; instead, these agents seek to maximize their own interests. In the absence of adequate oversight, this tendency could result in a range of adverse outcomes, from absenteeism to corruption and theft of public resources. Furthermore, if oversight of officials is largely managerial (that is, from the top rather than the bottom), local officials are accountable only upward, motivating officials to fulfill the dictates of their bosses rather than meeting local needs. The consequences—phantom

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schools with crumbling buildings and absent teachers, nonfunctioning toilets that are used to store fodder, roads that crumble at the first sign of rain—are ubiquitous in the developing world.

Participation has the potential to force agents of the state to act against their private interests and for the public good. It makes accountability—whether it be electoral, social, or “rude”—inherently conflictual. How this conflict is managed and channeled depends on the nature of the state, the institutional incentives of its agents, the division of power and responsibility between political leadership and bureaucrats, the nature and extent of the decentralization of authority, and the receptivity of the state to the demands of citizens.

Participation is also used to enhance livelihood opportunities and credit for the poor. Microcredit programs mobilize groups of individuals to collectively enforce the repayment schedule of every member, in an attempt to resolve coordination problems and asymmetries in information on the creditworthiness of individuals, which prevent banks and other large credit suppliers from servicing such communities. Self-help groups have also been mobilized to help expand livelihood opportunities more generally—by providing training in handicrafts and agricultural techniques, for example, and assisting in small-scale entrepreneurial and other activities. The group provides peer education and technical and moral support, using the power of networks to diffuse information and knowledge.

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Participation has been used to try to redress the underprovision of public goods and services such as roads, water tanks, schools, and health clinics, which local governments typically provide. In community-driven development interventions, such public goods and services may be handed over entirely to communities to manage. In times of unexpected crisis—when a typhoon or earthquake strikes and governments and markets are unable to respond quickly, for example—communities are mobilized to rebuild homes, roads, and bridges and manage emergency aid. When a country is emerging from a long war or civil strife, community-based aid is often used to lead postconflict efforts at reconstruction.

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Participation has also been used to try to reduce social, political, and economic inequality. By reserving leadership positions in civic bodies for women or other disadvantaged groups, participatory interventions have explicitly attempted to redress discrimination by promoting more egalitarian notions of leadership and breaking the power of traditional

elites. These interventions are inherently conflictual, in that they challenge the prerogatives of the people in authority.

Using civic groups to help reduce poverty usually involves far less conflict with elites, because it does not challenge the basis of their authority. In many countries, for instance, community-based participatory bodies select the beneficiaries of poverty reduction programs, an alternative method of targeting that even local elites may perceive as fair.

Participation and the Capacity to Engage

An important way in which participatory interventions can work is by changing the character of everyday interactions—a process that, over time, reshapes social relationships. In highly unequal environments, social status structures the way people talk to one another. Moving toward accountable government both requires and brings about a change in the tone and content of discourse. The conversation shifts from being embedded within existing power relationships and conditioned by social norms to one in which people confront authority, demand change, debate points of policy, and speak as citizens rather than as subjects. Such shifts in “recognition” can have important economic implications (Basu 2011).

To bring about this change, citizens must have access to a new toolkit of discursive strategies—conciliatory, confrontational, pleading, demanding, threatening—that they are able to strategically deploy. Even if these approaches do not have an immediate impact on the allocation of public resources, changes in the nature of speech can, over time, build what Gibson and Woolcock (2008) call the “capacity to engage.” Having the tools for “deliberative contestation” gives marginalized groups a more equitable shot at negotiating, asserting, and making demands that are in line with their interests and life experience. With repeated interaction, more equality in the ability to articulate demands can help move communities toward a trajectory of better and more equitable governance. This expansion in their strategic toolkits can change not only how people are perceived within their communities but also how they perceive themselves.

Rao and Sanyal (2010) analyzed the transcripts of 300 *gram sabhas* (village meetings) from India. This excerpt—from an interaction between the upper-caste president of the *panchayat* (village council),

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a poor upper-caste villager (Jayaraman), and a poor villager (Muniraj) from an untouchable (Dalit) caste—provides an example of deliberative contestation in which the Dalit villager asserts his rights as a citizen.

Jayaraman: There are 45 families in our village. None of us has any land. We work for meager daily wages. Whatever little we get we spend on our children's education. But it's impossible to educate our children up to high school because we don't have the money. . . . So we request that the government do something. . . . Our whole area is dirty. Even the water is muddy, and that's what we drink. . . . How many times we have requested a road near the cremation ground and for the supply for clean water?! We can only request and apply. The rest is up to you.

Panchayat president: If there are 20–25 houses in an area, a ward member should be appointed to represent the area. That ward member should listen to your problems and must do something to help you.

Muniraj: That way [if we have a ward member], we will have the guts to enter this room [where the *gram sabha* meeting is taking place]. If the required ward members are not with us, to whom can we voice our woes? Who will represent us? . . . If the ward member belongs to another community, he won't even listen to our problems. Earlier, there was a time when a backward caste person was not even allowed to sit in the same area with others! The officers and leaders who come here [to the *gram sabha* meeting] already have a preset plan about what to do and say. You come, sit on the chair, say something, decide among yourselves, and go away. What's there for us to do?! You've enjoyed power for all these years. Why don't you let us have a turn? . . . We don't want any problem at the communal level. For us, whether X comes or Y comes, it is the same. We vote, but what happens later? Whereas other people get water even before they ask for it, we have to ask endlessly, and even so, our demand is not fulfilled. . . . We don't want to fight with anyone. But at least there should be someone to listen to our problems. We've been without water supply for the past one month. Even the village president knows it. He has promised to send water. But the ward member is not allowing us to take water. The water is sent to all his relatives. We cannot do anything to stop it.

Panchayat president: In any competition, it's a rule that one should win and the other should lose. There's no community-based discrimination or problem. If all of you in booth number 1 join and vote for me, I become the president. On the other hand, if everyone in the other booths votes for another person, then he'll become the president. And then what will matter is what he can do for those booths that voted for him. Today, among youngsters, the level of public awareness is very high. Anyone can become a leader. . . . Even though there are problems between your two groups, I try to mediate. I don't encourage communal riots.

Muniraj: Everyone should be treated equally. No one should be treated as inferior to others. We should also be given a chance to sit on the dais [where the leaders sit]. Why should we be denied that right? Just because I talk like this, it doesn't mean that I fight with you or disrespect you. I am simply voicing my feeling.

Caste-based divisions have deep historical roots in India. They manifest themselves in practices such as physical distancing and symbolic deference. It is noteworthy that these traditional patterns of interaction are now being openly challenged in *gram sabha* meetings, as Muniraj's angry complaints indicate. Lower-caste challenges are not completely new; what makes the exchange excerpted above different is that it comes not from a member of the educated elite but from an ordinary villager embedded in everyday, local structures of inequality. Ordinary people from disadvantaged castes now have a stake in political participation, because the *gram sabha* allows them to momentarily discard the stigma of their ascriptive identity and low economic status and slip into their identity as citizens with equal rights in the eyes of the state. These public interactions have the potential to challenge entrenched social relations because they make overt the heretofore unseen "weapons of the weak"—the expression of dissatisfaction in private while presenting compliant demeanors in public, foot dragging in response to the demands of elites. Such interactions expose "hidden transcripts" (Scott 1990) such as the feelings of oppression and domination felt by lower castes and provide a means to challenge them.

Minor as it may seem, the fact that poor people and people from lower castes are able to make demands and voice complaints gives them a sense of possessing equal recognition as citizens. When—and

whether—such small-scale changes cascade into effective civic capacity depends on the community’s level of literacy and numeracy, the level of inequality, and the extent to which inequality is embedded within durable social and power relationships.

Diagnosing Failure Triangles

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Each type of participatory intervention can be associated with a different diagnosis of the failures it will confront—whether it is trying to generate an intrinsic or instrumental outcome, address a long-term development objective, or respond to a short-term crisis. Each type of intervention may employ a different definition of community (a micro-credit group is very different from a group of households mobilized to reconstruct homes after a hurricane). Not only can these groups differ in their composition, they may also have different geographic and social boundaries and incentives for collective action. Consequently, they may be subject to different types of failures.

Potential spillovers from one civic objective to another also need to be thought through. Will building microcredit groups also result in the formation of groups that can fight village council corruption? Will starting a social fund to deal with postearthquake reconstruction result in a community-based institution that can act as a substitute for a failed local state?

Government intervention may be justified when markets fail or economic and social inequalities need to be narrowed (see chapter 2). Theory also indicates that “each public service should be provided by the jurisdiction having control over the minimum geographic area that would internalize [its] benefits and costs” (Oates 1972, 55). Local needs are difficult for central governments to ascertain, because of the huge information costs of doing so and because of heterogeneities in preferences and variations in the condition and composition of communities. For this reason, theory suggests that decisions on such issues as the provision of local public goods need to be decentralized.¹

Justifications for government interventions are complicated by the fact that governments themselves are prone to failure, because of problems of coordination, commitment, and information asymmetries—locally as well as at the center. The power exercised by government can reflect and reproduce inequality. The degree to which community-based

bodies and local governments are embedded within structures of local inequality can be extremely heterogeneous, making central monitoring of local bodies very difficult. Consequently, local civic action (local participation) is seen as the most effective and sustainable way of redressing local government failure—dealing with corruption, giving the poor a greater say in policy decisions, and holding local governments more accountable.

There are, however, some omissions in this logic, which often tend to be ignored. First, civil society is subject to the same sorts of failures and inequalities as markets and states. Incorporating failures and inequalities in civil society makes the policy logic far more complicated and less prescriptive. Participation is usually not a substitute but a complement to the state. Civil society exists in a symbiotic relationship with the state: it both shapes and conditions the state and is shaped and conditioned by it.

Second, the development of civic capacity is not just a local challenge; civil society matters in checking the tendency of all levels of government—central and local—toward authoritarianism. In addition, civic groups play an important role in the development of markets, by creating an enabling environment for entrepreneurship; protecting the interests of workers; providing credit, and other functions that are important for inclusive economic growth. Thus, one challenge of development is to develop civic activity at both the micro and macro levels.

Third, civil society is not an abstract concept that exists outside local forms of knowledge, social structures, meaning and belief systems, and power relations. It is shaped by people, who are products as much of their social and cultural milieus as of economic and political systems. The manner in which people organize, the interests around which they mobilize, the styles and narratives of their discourse and resistance, and the objects of their resistance are hybrid products of local dynamics and national and global influences. Policy makers should therefore be careful not to impose conceptions of civil society that come from outside the local environment (for example, Western political theory). Instead, they should try to understand the meaning of terms such as “civil,” “society,” and “participation” from within indigenous frames. Indeed, policy makers should try to understand how history and the history of interventions—whether colonial or developmental—have shaped those frames (Comaroff and Comaroff 1999). Doing so calls for a less prescriptive and more adaptive approach to policy.

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. . . but civil society and government, which are subject to failure themselves, shape and condition each other, in a manner determined by the nature of the failure.

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Finally, when all three spheres—markets, governments, and civil society—are beset by failures and inequalities, which is typically the case almost everywhere, policy becomes murky, leading back to a variant of the old balanced and unbalanced growth debates of the 1950s (Levy and Fukuyama 2010). Should development policy be sequential—focusing first, for example, on building markets and spurring industrial growth—in the expectation that better government and civic capacity will follow, or should it focus on first developing an effective government or effective civic sphere? Should the strategy attempt to be more balanced by simultaneously improving the functioning of all three spheres? How do market, government, and civil society capacities at the macro level affect policy options at the local level? At the local level—where every village and neighborhood faces a different set of problems and is conditioned by different social structures, geographies, climates, and levels of connectivity—answers to these questions are perhaps best drawn deductively by examining the evidence, as chapters 4–6 do.

Local Government Failure and the Nexus of Accommodation

In most communities in the developing world, both the state and the market have failed. Local market failures—in the provision of public goods, such as schooling, health, and local infrastructure; in access to credit, markets, and so forth—are easy to identify. Local government failure can, however, be dispersed across a variety of local institutions and individuals. A local government typically consists of leaders and bureaucrats. Leaders can be members of village councils, neighborhood committees, mayors and municipal councils, city administrators, or chiefs and their advisers. They function within various systems of accountability. They may be elected in regular, independently supervised elections or in “endogenous” elections that are organized and supervised locally; they may be appointed by upper-level political leaders and thus free of local accountability; or they may be hereditary.

Local government failure is dispersed across a variety of local institutions and individuals.

Even in formally constituted democracies, the theoretical logic of democratic accountability does not necessarily map into the real world logic of interactions between government and citizens. Locally organized elections can be manipulated by local leaders to their advantage; independent elections, although much more effective and important as accountability mechanisms, can be subject to clientelism and the appropriation of public funds to pay for electoral campaigns. Even if

leaders appointed by upper levels of government are accountable only upward, the central government can be effective in requiring good local government. Hereditary leaders selected in democratic settings, although often authoritarian, can be subject to various long-term commitments, contracts, and symbolic functions that obligate them to act in the interests of their subjects.

All local leaders are placed in the difficult position of negotiating power with the central government, within the context of central regulations and political incentives. The degree of autonomy enjoyed by local leaders depends on their bargaining power with the center. At the lowest tier of government, leaders may have limited room to maneuver and be constantly in the position of having to beg for resources from higher levels. They may, however, have established fiefdoms that are politically important to the center, giving them a measure of power and autonomy. The authority of local leaders and bureaucrats depends on the extent to which they control the funds and functions of government and on their local capacity to raise revenues. The less they depend on the center for funds, the greater their autonomy. But local governments often function within the domain of local strongmen, such as large landowners or warlords, who wield considerable influence and whose own demands and interests need to be satisfied.

Local leaders also have to share power with local bureaucrats, who are also subject to the institutional structures of government. Local bureaucrats often come from the lowest rung of government service; their professional incentives are geared toward pleasing their central bosses and moving up in the hierarchy. They often perform important functions at the local level and control an array of public resources, which gives them considerable power within the village or municipality. These local bureaucrats can range from district administrators to “street-level” officials, such as extension officers and junior engineers, to employees of local governments, such as janitors and bill collectors.

In participatory projects, it is the street-level bureaucrats (usually known as “project facilitators”) who have the most proximate impact on outcomes, because they are the people who deal with communities on a day-to-day basis. They are expected to mobilize communities; build the capacity for collective action; ensure adequate representation and participation; and, where necessary, break elite domination. These trainers, anthropologists, engineers, economists, and accountants must be culturally and politically sensitive charismatic leaders. It is ironic that

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Local politicians, bureaucrats, strongmen, and other elites often function in a “nexus of accommodation” that is hard to break.

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. . . but realizing this potential requires radical change, including confrontation with elites.

this difficult role, on which participation can succeed or fail, is usually entrusted to the least experienced, worst-paid, and most junior staff.

All of these weaknesses of local government can lead to situations in which resources would have been allocated more efficiently had the government not intervened. Weaknesses are caused by accommodations made to the center, by the manipulation of accountability mechanisms, and by accommodations to local strongmen and between local bureaucrats and politicians (Migdal 1988). The concentration of power in any of these actors—a local strongman who also heads the village council, for example—can lead to a strong local state but one that tends to be dictatorial in its decisions. When all actors are equally powerful, power and authority can be diffused in a way that makes actions unpredictable, dilutes responsibility for action, and weakens the cooperative infrastructure.

It is difficult for central governments to monitor the work of local governments because of the very imperfections in information and coordination that caused power to be devolved in the first place. The nexus of social structures, power relations, the management of accommodations, the needs of citizens, and the quality of personnel vary greatly from jurisdiction to jurisdiction, causing communities to have a high degree of heterogeneity. These variations place an untenable burden of monitoring and supervision on the central government; if power is decentralized, they can produce an entirely new set of government failures. The constant process of accommodation among the center, local strongmen, local government leaders, and bureaucrats, often makes the interests of citizens the last priority—the residual element in a hierarchy of interests that must be accommodated.

Participation has the potential to change this dynamic. It can move the actions of local governments toward the interests of citizens by adding their voice to the mix of necessary accommodations. If civic groups are sophisticated enough to understand the procedures of local governments and nimble enough to know how to exploit the political economy of accommodation, they can become a potent political force. If the cooperative infrastructure is strong and elite interests not dominant, citizens can be united, lobby effectively, and persuade local governments to listen to their points of view, furthering their interests by changing incentives within local governments.

Although participatory projects are packaged and promoted on the promise of “empowerment” or enhancing the “demand side of

governance,” they often downplay the fact that both outcomes require radical change—a confrontation with local elites and a shift, to use Migdal’s language, in the “nexus of accommodation.” If external donors and central and state governments have not completely internalized these radical goals and participation is instead nothing more than a donor-driven mandate, it is unlikely that interventions will be implemented in a manner that is truly empowering. Instead, the goals will be processed within the existing nexus of accommodation, and lasting change in outcomes will be unlikely—and may actually lead to elite capture. Participatory interventions then become archetypes of what Hoff and Stiglitz (2001) call “shallow interventions”—interventions that result in no sustainable and irreversible changes in political dynamics and therefore have a negligible impact on outcomes. To achieve a “deep intervention,” the state has to commit to a long-term process of engineering; a more downwardly accountable cooperative infrastructure that is equity enhancing and empowering. Doing so requires strong monitoring to avoid elite backlash, subversion, or capture, and the ability to distinguish between benevolent and malevolent elite engagement with communities.

Lasting change is unlikely if the radical process of breaking the local nexus of accommodation is not internalized and supported by donors and the central state.

Participation and Political Opportunity

Effective participation requires the skillful exploitation of local political opportunities (Kreisi 2007). An individual’s political opportunity set is determined by his or her interests (material, ideological, or identity based), as well as by the economic, social, political, or psychic constraints he or she faces. The decision to participate, however, depends largely on the actions of the other members of the group to which an individual belongs. A group’s willingness to mobilize and act collectively depends on its shared opportunity set, the gains that accrue from acting collectively, and the costs and other constraints associated with coordinating collective activity. It is not just individual and collective interests that influence the set of opportunities—it is also the beliefs about those opportunities (Elster 1989). These beliefs are important because they may cause actors to underestimate or overestimate their capacity to effect change. Sociologists call this mix of individual and group political opportunities and beliefs the “political opportunity structure” (Kreisi 2007).

Effective participation requires the skillful exploitation of local political opportunities.

Indonesia provides an interesting example of how a village group was able to exploit political opportunities for change by developing its capacity to engage (Gibson and Woolcock 2008). An extended conflict over a leaky dam served as a flashpoint for organizing farmers and other villagers who depended on its shrinking reservoir supply for irrigation and drinking water. Initially, villagers used bureaucratic channels to request repairs to the dam. When their demands fell on deaf ears, they began expressing their anger through arguments and small-scale violence among themselves, including a hoe fight between two family members that resulted in head injuries.

As unrest peaked in 2001, the villagers changed their tactics and began to mobilize hundreds of teachers, police, civil servants, and rice paddy owners and workers through a broad array of social networks. This mass mobilization caught the attention of a candidate for the local council, who used it as an opportunity to confront the incumbent. As hundreds of villagers blockaded a key road to the dam, the candidates sat in chairs facing the dilapidated structure until the deputy head of the council arrived and promised to make the repairs—which were completed within a year.

This victory gave rise to a flurry of peaceful and fruitful engagement aimed at forcing the government to compensate farmers for lands inundated by the dam. In using the original conflict to develop their capacity to engage with local officials—and exploit the competition between them—the villagers developed new open political opportunity structures and beliefs about themselves that will have a lasting impact on local power relations.

Localizing development can open up political opportunities by bringing the locus of decision making closer to citizens, increasing the benefits to participation while reducing its costs.

An open political opportunity structure is one in which civic action can exploit changes in the political system—in the structure of the state, in leadership, or in dominance by a particular elite—to further the interests of a particular group. Localizing development—through decentralization or a community-driven development project, for example—can open up political opportunities by bringing the locus of decision making closer to citizens, which increases the benefits to participation while reducing its costs. Because of the nexus of accommodation between local and central politicians and between local and central bureaucrats, however, the effectiveness of local civic mobilization can be modest. Although civic mobilization can potentially change the incentives of the agents of the local state so that they act more in the interests of citizens, these agents will have to balance the demands of local citizens against the demands of central authorities and the

competing demands of other local actors. In the absence of a sharp and sustainable shift in the nexus of accommodation, therefore, expansion of civic opportunities at the local level may have limited impact.

Acemoglu and Robinson offer some important insights into the process of participatory democratic change in *Economic Origins of Dictatorship and Democracy*. They find that the conditions under which political opportunities for citizens are maximized and the manner in which citizens can effect change in a manner that progressively empowers them depends on whether a particular group believes it has the capacity “to obtain its favored policies against the resistance” of the people in power and can convince other groups that it can do so (Acemoglu and Robinson 2006, 21). Before they can act, citizens have to be persuaded that any move toward an open political opportunity structure will be durable and that old political institutions enmeshed with old economic and social arrangements will give way to more accountable structures. If change is seen as temporary, individuals will tend to use the opportunity to maximize their immediate personal gains. Citizens will participate in a manner that challenges powerful elites only if they feel they can “lock in” political power in a way that is not easily reversed.

Citizens’ willingness to act is further complicated by uncertainty about decentralization, which could be recentralized during the next political cycle, as has happened in almost every developing country. Similarly, in the absence of durable shifts toward a more accountable state, participation in community-driven development projects may not lead to greater citizen mobilization on other issues, as the costs will exceed the benefits. In contrast, a genuine change in the political opportunity structure, accompanied by collective mobilization, can permanently increase the cost to elites of maintaining their domination.

Citizens thus make decisions about participation based on the likely success of a specific reform, their beliefs about how sustainable it is, and the potential for repression and backlash. Even with active participation, a small number of protagonists will lead the charge—spurred on by lower opportunity costs or greater altruism. Some people will prefer to have a free ride whereas others will play it safe, waiting to see how quickly the winds change before deciding to act. There will also be antagonists—people who actively oppose civic agents because those agents challenge their interests.

Elites who stand to lose under the new regime will include many local and central bureaucrats, local strongmen, and local and central politicians. Some elites may become protagonists, however, if they see a

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way that a change in policy could serve their own interests; there is, in fact, a risk of elite capture if gains from an intervention accrue mainly to these pro-reform elites and their supporters. A third category of elites—often better-educated citizens with high moral but low political authority, such as teachers, pastors, and imams—may help lead the process, either because they are altruistic and see doing so as a way of effecting positive change or because leadership gives them an opportunity to gain power and status. In this case, elite domination can facilitate an intervention and may even be essential to its success.

In some societies, there is no recognizable conception of citizenship in the textbook sense of the term . . .

. . . instead, leaders and subjects relate to one another through systems of mutual obligation.

Shifting from a gift-based to a competition- and negotiation-based model of governance and citizenship is a highly contentious process.

Part of the challenge of introducing decentralized and participatory government into societies with “traditional” authority structures is that traditional systems function with a different theory of governance, which the community generally accepts as just and legitimate. In some societies, there is no recognizable conception of citizenship in the textbook sense of the term; there are, instead, only leaders and subjects. The legitimacy of local leaders is based on a gift economy, a system of mutual obligation between leaders and subjects in which civic activity consists largely of subjects making requests to leaders. Leaders grant these requests if they are able to do so, expecting obedience in return. The resulting equilibrium creates elite dominance, authoritarian rule, and sharp inequalities in wealth, power, and social status.

Development projects come with “modern” notions of governance and citizenship, which are predicated on the assumptions that government and citizens represent separate and equal spheres and separate loci of power and that “good governance” requires leaders to be accountable to citizens. This notion of governance is based on competition and negotiation for power rather than on mutual obligation.

Shifting from a gift-based to a competition- and negotiation-based model of governance and citizenship is a highly contentious process. During periods of what can be called “traditional equilibrium”—when social and political roles are well defined and everyone’s actions and interactions are highly predictable—levels of conflict are low. Within this system, however, there may be few opportunities to break inequality traps or empower the poor. At best, the poor can employ Scott’s (1990) “weapons of the weak” to express resentment without explicit confrontation. Participatory interventions—along with other efforts to reduce inequalities, such as land reform—seek to disrupt this equilibrium by changing the local cooperative infrastructure, replacing leadership legitimized by mutual obligation with a relationship between leaders

and citizens based on democratic accountability. Unless traditional inequalities resting on inherited wealth, status, and identity are concurrently replaced by a system in which power and status reward ability and effort, however, the traditional order and existing power structures will subsume and subvert any nascent participatory institutions.

If, however, participatory interventions break down durable inequalities, collective well-being could well diminish in the short run, as elites resist, object to, and attempt to disrupt this challenge to their status. Some of their subjects will be left anchorless, not knowing how to navigate the new environment. Others will compete for power by using violence. The major challenge during this transition period is to channel conflicts into venues for deliberation and debate, in order to achieve a negotiated transition to a new regime. If the process is effective, it will lead to a new equilibrium in which leadership is legitimated by its ability to meet the needs of citizens and social status is based on achievement.

Implementation Challenges: The Role of Donors

Challenges in inducing participation lie not only in the power dynamics within communities; they are also deeply influenced by incentives within agencies tasked with funding and implementing participatory projects. In particular, donors—both multilateral and bilateral—have been key players in the spread of participatory innovations. They have been responsible for transferring ideas and techniques from one region of the world to another and actively scaling up interventions developed in a few communities to an entire country. Donors have tended to ignore the fact that context (historical trajectories, social and economic inequality, ethnic heterogeneity, and symbolic public goods) affects political and social institutions, especially at the community level, relying instead on “best practice” templates.

This tendency results in what Evans (2004) calls “institutional monocropping”—the “imposition of blueprints based on idealized versions of Anglo-American institutions, the applicability of which is presumed to transcend national circumstances and cultures.” Other critics, including Harriss (2001) and Cooke and Kothari (2001), argue that in participatory projects, complex and contextual concepts such as community, empowerment, and capacity for collective action are applied to large development projects on tight timelines. Consequently, project implementers, whose incentives are often poorly aligned with

Challenges in inducing participation lie not only in the power dynamics within communities . . .

. . . they are also deeply influenced by incentives within agencies tasked with funding and implementing participatory projects.

the needs of the project, may gloss over differences within target groups that underscore local power structures and sidestep the difficult task of institution building in favor of more easily deliverable and measurable outcomes.

Mosse's (2005) ethnography of the Indo-British Rain-Fed Farming Project (IBRFP), funded by the United Kingdom's Overseas Development Administration (ODA) and Department for International Development (DFID), illustrates how the process of induced participation works in a large, scaled-up, donor-driven project. Mosse studied the project over several years and was involved in it in various capacities—as a planner, social expert, soil and water conservation consultant, and adviser—as it evolved through different planning and implementation phases. He studied all of its phases, from inception, in 1992, as a participatory project geared toward bringing agricultural technologies and innovations to the tribal Bhil population in central India; to its assessment by the development community, in 1995, as an “exemplary success”; to its culmination, in 1998–99, by which time it was declared a failure. ODA–DFID's Indian partner organization was a fertilizer company, which Mosse found to be unusually committed to the participatory ethic. The company hired a large field staff of community organizers and trained a large number of village-level volunteers, called *jankars* (“knowledgeable people”), who gradually emerged as crucial local mediators and brokers.

The project began with a “village entry” participatory rural appraisal. The very nature of a participatory rural appraisal—which is typically held in the courtyard of a village headman or other notable—subjects it to a high degree of bias and reflects the effects of local power. The type of knowledge that was communicated, the tone of the discourse, and the words used all reflected the biases of the more active, articulate members of the village, who defined the community's needs and then became crucial links for the community organizations in the initial trust-building phase of the project. The poorer members of the community were usually unwilling, inarticulate participants in such processes. In response, the community organizations gradually changed their tactics. They approached women and nonelites for more discreet, informal rural appraisal-type exercises, which had repercussions for their position in relation to village elites.

Matters were hardly as simple as ensuring that all points of view were represented, however: villagers quickly learned to anticipate the outsider's point of view, sense project staff's capacities for providing

assistance, and structure their demands accordingly. The project soon came to be seen as a patron of particular activities and constituencies. The participatory rural appraisal and planning stage became, in effect, a process of mutual collusion in which “local knowledge” and desires were effectively domesticated by the project’s vocabulary, as community perspectives seamlessly melded with the project’s interests. Although planners continued to use the language of participation and empowerment, villagers viewed the project as just another kind of patronage. Better-off villagers hoped for various forms of assistance in terms of capital investment (seeds, inputs, loans for pump sets); worse-off villagers came to view the project as a source of wage labor and credit.

Was there anything wrong with the way this participatory project progressed? The answer depends on what hopes one harbors for “participation.” Rather than evaluating the project from an abstract ideal, Mosse studied various dynamics. The community organizations and other field staff had to undergo a tricky process of earning the trust of community members. Doing so required them to become familiar with local notables, institutional figures, and bureaucrats. As they did so, they gradually became implicated in various village hierarchies and factions and in local networks of exchange, favors, and mutual assistance. The village-level *jankars* became more or less “empowered” over time (although their fortunes could wax and wane with the fortunes of the project), although this empowerment arose mainly through relations with outsiders. This process, Mosse argues, is one of the generic dilemmas of participatory approaches: such projects often demand not less but more intensive agency presence, they may be less cost-efficient, and they may foster dependency and patronage (Mosse 2005).

So when did things begin to go “wrong” with this project? Two interpretations must be separated: Mosse’s evaluation of the implementation stage of the project and the organizational judgments that first declared the project a success and then a failure.

In Mosse’s view, the implementation stage brought with it entirely new organizational dynamics: prioritizing quantifiable targets, setting numerical goals, moving away from learning and experimentation. This transition created a “regime of implementation” (2005, 109). Staff members faced growing pressure to meet implementation targets, set from above and demanded from below. The *jankars*, working closely with but junior to the community organization project staff, began to “regard themselves primarily as project employees (if not private contractors),

with the power to assess work and sanction payment” (Mosse 2005, 114). As one senior project employee reported, “we rather skewed the potential of *jankars* as real agents of a more indigenous type of development. They became the delivery mechanisms, which [was a departure] from the original thinking” (114). As for the villagers, “although they were now familiar with the official rhetoric of ‘people’s participation’ (*janasabhagita*), in common parlance ‘participation’ (*bhagidari*) implied simply that a contribution (of money or labor) had to be made . . . the extent and nature of villager’s *bhagidari* (contribution) was a matter for negotiation and agreement with outsider patrons” (114). By this phase, participatory rural appraisal “became largely symbolic. Staff now knew how to write them [participatory appraisals] up; how to move swiftly to expenditure. . . . As the logic of implementation pushed practice toward standardization, it was virtually impossible to ensure that ‘participatory planning’ involved local problem solving or even choosing between alternatives. In fact, the ‘quality’ of the ‘participatory process’ mattered less and less” (116).

Mosse’s analysis describes the phase shift typically experienced by most participatory projects, from a somewhat open-ended planning phase to a more structured implementation phase. It is possible to conceive of it as a kind of rhythm of participatory projects, which could, therefore, have been anticipated.

More damaging, according to Mosse, was the effect of this shift on the service delivery aspect of the project and the kind of demands that should have been but were not factored in. “Villagers themselves had little control over project processes and budgets. Rather than implementing their own ‘village development plan,’ they found that components of the plan (individual schemes and subsidies) would be delivered on an item-by-item basis—instead of in logically related bundles—by an administrative system that was unknown and unpredictable. One example of a logical bundle was a request by a group of women in a village for support for a project consisting of an interlinked package of activities—ducks, goats, *rabi* seeds, and a pump set” (Mosse 2005, 263). Mosse argues that one of the key problems in the shift from the planning to the implementation phase is that once a set of practices is in place, the system generates its own priorities, activities, and goals, which may be quite different from the formal goals regarding community participation and empowerment expressed in policy papers or even project design documents. The relationship between policy and practice in participatory interventions therefore needs careful consideration.

Another problem is that there are stratified, relatively autonomous levels of project actors with narrow points of overlap (Mosse describes this relationship as an “hourglass”), as illustrated in Mosse’s multisited ethnography of head offices, consultants, budget specialists, project staff, village-level community organizations, volunteers, and villagers. This hourglass relationship is crucial to the question of how to scale up projects. Mosse describes a wrong turn, a transition point in the project, as “DFID–imposed disorder” caused by a “grossly simplified view of ‘up-scaling,’ ‘mainstreaming,’ ‘fast-tracking,’ and ‘replication.’” As a result, “a huge burden was placed on a complex and shaky system: the project had to create a new organizational structure, to quadruple the size of its operations . . . fast-track its process (reduce village entry time) . . . create further linkages [to both the local government and the rural commercial sectors], while retaining its intense focus on participation . . .” (Mosse 2005, 185).

Most strikingly, throughout the period in which the project was first declared a success and then a failure, field activities, levels of work, and modes of engagement remained more or less the same, and project actors maintained relative autonomy. This meant, according to Mosse, that the project’s “fall from grace” was not a result of a shift in design or implementation but a result of changing policy fashions. The late 1990s saw an increased emphasis on partnerships with state structures; parastatal projects lost favor, as they were not seen to be “replicable models” (Mosse 2005, 199). What Mosse finds worrisome is that with policy fashion cycles becoming shorter, the ability to gain the trust of local populations may be increasingly compromised, as projects abruptly dispense with groups that no longer serve their policy objectives.

Several lessons emerge from Mosse’s account:

- The expectation of abrupt shifts in policy has adverse effects at every level of the project—and crucially contributes to the shallowness of the intervention. If the project is seen as ending within a very proximate period rather than contributing to sustainable change, higher-level project officials will spend their time trying to frame the intervention as a success rather than working to lay the foundation for lasting change.
- The expectation of abrupt shifts in policy influences the quality and character of mobilization. Because the intervention is seen as time bound, people participate largely in order to reap material gain. They take what they can from the resources the

project brings and say what they have to say to gain access to those material benefits. Although such behavior may create some short-term improvements in material well-being, it does not result in a lasting shift in power relationships and stronger mechanisms for voice and mobility.

- Even if the intervention is long lasting, participatory change takes time. A short project cycle that initiates but then terminates a trajectory of change can leave communities hanging off a cliff.
- Participatory projects work well when they are given the freedom to learn by doing, to constantly experiment and innovate based on feedback from the ground. As the project expands, however, experimentation becomes more difficult, and efforts are directed more toward meeting the letter rather than the spirit of project goals.
- Facilitators play a crucial role in participatory projects.

Implementation Challenges: The Role of Facilitators

Facilitators are at the frontline of induced participation . . .

Facilitators are at the frontline of induced participation. They identify the failures of local civil society, markets, and government; design interventions to repair them; and look for ways to repair the associated civic failures, seek political opportunities, and mobilize the community to exploit them. Facilitators are paid to play the role that the social activist would play in an organic participatory movement. Their incentives are rarely aligned in a manner that results in truly empowered change, however. For example, although their job requires flexibility, time, and constant engagement with experimentation, facilitators are given targets (mobilize X communities in Y days). Because they are poorly compensated and know the project will end in two or three years, they are constantly looking for other work. They are often poorly monitored, allowing them to submit false reports on the achievement of project targets.

Perhaps of greatest concern, facilitators working under these conditions may take shortcuts to persuade or force people to participate, using messages for recruitment that are quite different from stated project goals. For example, they may try to meet their participation targets by using messages with a strong emotional impact or by luring people with the implicit promise of monetary benefit. Instead of being seen as agents

of change, facilitators may be perceived as part of the existing nexus of accommodation. The question, then, is whether they can legitimately affect radical change when they are perceived as part of the state apparatus? When change requires radical advocacy, do these facilitators, who report upward to people who may not permit them to advocate radical change, face the right incentives? More fundamentally, what can facilitators accomplish? Within which spaces can they work for change? Can induced participatory development really generate political and social empowerment? Many factors affect the answers to these questions, but it is clear that interventions will not succeed without higher levels of government being actively committed to the development of active civic engagement at the local level.

Implementation Challenges: Trajectories of Change

A major problem with donor-induced participation is that it works within an “infrastructure template.” Donors’ institutional structures and incentives are optimally suited to projects with short timelines and linear trajectories of change with clear, unambiguous projected outcomes. When a bridge is built, for instance, the outcome is easily verified, the trajectory of change is predictable, and the impact is almost immediate. Participatory interventions, which engage in the much more complex task of shifting political and social equilibriums, have very different trajectories.

Unfortunately, most participatory projects that emerge from donor agencies are designed within the same assumed trajectory and three- to five-year cycles as infrastructure projects. At the end of the project cycle, these projects are expected to have met various civic objectives (better social capital, community empowerment, improved accountability). Almost all community-driven projects go farther, projecting gains in outcomes such as a poverty reduction, school enrollment, sanitation and health, and so forth. The assumption is that within the period of the project cycle, the intervention will activate civic capacity to the extent that it will repair political and market failures enough to have an observable impact on “hard” outcomes.

Three assumptions are inherent in this thinking:

- Civic engagement will be activated in the initial period of the project.

... but their incentives are often not set up to truly empower communities.

Donors’ institutional structures and incentives are optimally suited to projects with short timelines and linear trajectories of change with clear, unambiguous projected outcomes . . .

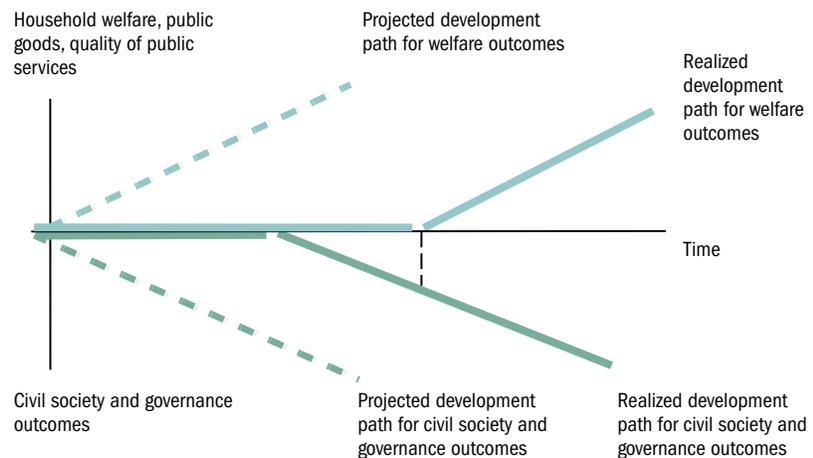
... but civic change is a highly unpredictable process.

- Civic capacity will be deepened enough to repair government and market failures.
- This improvement in the quality of governments and markets will result in a measurable change in outcomes.

Figure 3.1 illustrates the problems with these assumptions. The project-based assumption (illustrated by the dotted lines) shows a path in which civil society and governance outcomes improve in a predictable linear manner that is congruent with changes in measurable outcomes. The problem with this reasoning is that civic change is a highly unpredictable process; many things have to take place to make it happen. Individuals have to believe that collective mobilization is worth the effort and be willing to participate; civic groups have to solve the collective action problem and exploit political opportunities to effect change; the nexus of accommodation in government has to be disrupted by the rising cost of ignoring citizens' interests, so that politicians and bureaucrats change their actions; and their new actions have to result in changes in outcomes. A change in outcomes has to be preceded by an improvement in civic capacity, which possibly unleashes a series of changes that will change outcomes (Woolcock 2009). The reality is depicted by the solid lines in figure 3.1.

Predicting when meaningful change will occur in each node is extremely difficult because a number of factors come into play,

Figure 3.1 Possible trajectories of local participation



including the nature of the cooperative infrastructure; the history of civic engagement and politics; the level of development; the extent to which the state has committed to the process of change and is therefore effectively incentivizing, enforcing, and monitoring the actions of its agents; the level of literacy; information flows—in other words, all of the factors that affect civic failure. Social equilibrium is hard to change because it has evolved after years of repeated interactions within particular economic, political, and social environments.

Therefore, whether at the micro or the macro level, civic engagement often tends to be absorbed, in its early stages, within the nexus of accommodation, with the leaders co-opted by elites. Furthermore, as discussed earlier in this chapter, until citizens are convinced that the high cost of fighting for their interests and resisting elite domination is worth the effort, they are unlikely to engage in an effective manner. Widespread participation occurs when a tipping point is reached—when enough people are convinced of the value of participation, when they sense a fundamental change in the nature of politics and power, and when enough people convince enough others to engage, resulting in a participatory cascade. Borrowing from evolutionary biologists, sociologists describe this process as one of “punctuated equilibrium” (Koopmans 2007)—a process in which long periods of stability are punctuated by brief periods of extremely rapid change. At the local level, the wide diversity in the nature of communities reinforces this unpredictability in the timing of change. Each community is likely to have a different change trajectory.

Thus, particularly when it is packaged within a project, induced participation is almost set up for failure because of unrealistic predictions that emerge from bureaucratic imperatives. The challenge of policy interventions is to figure out where each community is within this complex trajectory of change and to create an enabling environment in which that change can occur in a manner that improves development objectives. For induced participatory projects to have a chance of meeting their objectives, they have to attempt to adopt the spirit of experimentation, learning, and persistent engagement that characterizes organic participatory change. Unfortunately, donors are bound by strict timelines; imperatives to disperse money quickly and effectively; and internal incentives that make honest and effective monitoring and evaluation a low priority at the project level, despite the rhetoric in support of it.

Particularly when it is packaged within a project, induced participation is almost set up for failure because of unrealistic predictions that emerge from bureaucratic imperatives.

Deriving Hypotheses

Public spending to improve living conditions for the most disadvantaged is widely accepted as the cornerstone of any credible development strategy. There is also a sense that any serious policy shift in this direction needs to include a larger role for civil society. In line with this, many developing countries have devolved the management of key public services, have decentralized the implementation of targeted poverty reduction programs, and are increasingly providing local public goods through mechanisms that induce some type of community participation. At the core of these efforts is the idea that greater civic engagement can make resource allocation both more responsive and more accountable, with the greatest benefits realized by people with the least influence and the least capacity to opt for private alternatives.

The traditional economic justification for local provision of public goods and services is that it allows jurisdictions to tailor the level, quality, and cost of services to the preferences of local residents. Governments are assumed to be largely benign and citizens mobile, able to “vote with their feet” by moving to areas where regulations, taxes, and services best match their preferences and needs.

Most public goods and services (schools, drinking water, sanitation, roads) are inherently local; they serve a reasonably well-defined group from which nonresidents can be effectively excluded. In such cases, devolution should increase both efficiency and equity, because it frees up a distant center from having to acquire costly information on local preferences and the supply of local public goods. Local agents may also have access to emerging information, such as recent adverse shocks, that may be only poorly reflected in the types of data available to distant central administrators. To the extent that some of the salient characteristics of poverty are also location specific, decentralizing the identification of beneficiaries may also increase the efficiency of resource allocation. Citizen mobility also creates external performance pressure on sub-jurisdictions to compete for the best talent and the most productive and profitable businesses, which curbs excessive rent-seeking by public officials and increases service quality. Menes (2003) argues that this process accounts for the decline in municipal corruption in the United States at the turn of the 20th century. As railroads were developed and the frontier became accessible, the capacity of local government officials to extract rents declined (see also Rondinelli, McCullough, and Johnson 1989; Khan 2002).

If citizens are mobile and governments benign, there seem to be few efficiency arguments for centralized resource allocation, except when significant intercommunity coordination problems arise from spillovers, externalities, or economies of scale that require centralized management. (Rules and regulations regarding environmental pollution, vaccination programs, and defense are good examples.)

The situation is quite different in most developing countries, where the main arguments for decentralization center on accountability. In this view, the fundamental problem with the central provision of public goods and services is bureaucratic inefficiency and rampant rent-seeking. Localizing resource allocation decisions brings ordinary citizens, who have the greatest stake in the quality of services provided as well as the greatest incentive to restrict rent-seeking, into closer proximity with relevant decision makers. Decentralization allows citizens to observe the actions of officials and providers, to use this information to induce higher levels of transparency, and to generate social pressure for policy reform.

Concerns about corruption have amplified the accountability argument for decentralization.² Over the past decade, the view that corruption poses a major threat to development has acquired considerable currency. Corruption is seen as adding substantially to the cost of providing basic public goods and services; dampening the redistributive objectives of poverty reduction programs; and, perhaps worst of all, changing the incentives facing both citizens and public officials.³ As reform efforts directed at legal and financial institutions at the center have produced little success, the push for more local solutions has grown, with the greatest emphasis on civil society oversight and monitoring of public officials and providers.⁴

This emphasis on local accountability has effectively created a new justification for the decentralization of resource allocation decisions that remains relevant even when there is no significant variation in preferences for public goods. Arguments for state and donor support to local participatory institutions are couched in terms of giving voice to the most disadvantaged members of society in order to create demand for better governance.

Influential voices on the other side of the debate over participation point out that shifting the locus of decision making downward need not have salutary effects if social structures reflect long histories and deeply entrenched power hierarchies. In such contexts, they argue, local inequalities of wealth and power can acquire much greater significance,

The main argument for decentralization in most developing countries is that it increases accountability, thereby reducing corruption.

as important resource allocation decisions shift downward; in the extreme, they can exacerbate local inequality and perpetuate or even reinvigorate local power relations.

Where localities are also heterogeneous in other respects, such as in their ethnic, racial, or tribal composition, there may be additional coordination challenges and greater potential for redistributive projects to generate or exacerbate local conflicts. Some researchers, such as Henkel and Stirrat (2001), even argue that although the language used by participatory programs is designed precisely to manage such underlying dissent, the search for “consensus” often simply results in the subordination of minority voices or the proliferation of formal governance rules that make participation costly, particularly for the people with the least capacity. In the presence of significant group heterogeneity, electoral incentives can also induce political agents to allocate resources to satisfy more parochial interests, at the cost of broader investments in public goods and services.

Whether local governments or participatory programs can be responsive to local needs may depend to a significant degree on the resources they can access relative to their mandate . . .

. . . and the discretion they have over the allocation of resources across diverse needs.

Whether or not local governments or participatory programs can be responsive to local needs may depend to a significant degree on the resources they can access relative to their mandate and the discretion they have over the allocation of resources across diverse needs. For many reasons, including the political context in which central governments undertake decentralization, in most developing countries, devolution of responsibility for taxation has been far more contentious than the devolution of responsibilities for expenditure, particularly when local governments are elected. With few exceptions, however, and regardless of the type of decentralization undertaken, local governments obtain the bulk of their resources as transfers, whether formula based or discretionary and ad hoc, from central or intermediate-level governments; taxation authority is rarely devolved to any substantial degree. As a result, there is an unavoidable tension between central and lower levels of governments regarding accountability and fiscal discipline at the local level. Local officials blame the center for their failures in service provision by claiming that the center has assigned unfunded mandates to them, limiting their ability to meet their responsibilities. Discretionary transfers from the center are considered particularly detrimental for local provision of public goods and services, because they not only limit the local government’s ability to plan investments and expenditures, they also leave local governments vulnerable to various types of manipulation from the center. For their part, central governments bemoan

local governments' "soft budget constraints," a situation in which local governments that are unconstrained by their revenue-raising capacity are tempted to overspend and then ask the center for a bailout in the form of supplemental transfers from tax revenues generated elsewhere. Of course, such overspending may itself be a response to an unfunded expenditure mandate.

In principle, local governments could raise some or all of their resources directly from their constituents, through taxes and fees, and there are important arguments in favor of devolving revenue-raising responsibilities. Some researchers have even gone as far as to argue that central transfers should be contingent on such revenue-raising efforts, as such a move would force local governments to accept responsibility for poor service provision and incentivize citizens to monitor local officials' performance more closely. In practice, however, devolving revenue raising to the local level is difficult.

Central governments also have a mandate to mitigate interregional disparities through appropriately targeted fiscal transfers, which can include considerations of need intensity and demographic size. As Cai and Treisman (2004) argue, when regional differences in the productivity of specific factors are significant (because of location, agglomeration externalities, or the endowment of resource), local taxation authority can unleash a race to the bottom. As local governments compete to attract the wealthy, less well-endowed localities become weaker and more dependent on central transfers. This situation can exacerbate regional disparities in government services and increase horizontal wealth inequality. The worst-off areas may also have the least incentive to give up rent-seeking activities.

Some observers suggest that the timelines and objectives of donor-funded projects can exacerbate these challenges. Donor-funded projects, they argue, value the rapid disbursement of inputs, the creation of community organizations, the achievement of predetermined rates of return on investments, and improvements in the income and assets of beneficiaries. These evaluation criteria create an incentive to select areas that are easily reached and organized and to target project benefits to households that are able to quickly absorb project funds in productive activities.⁵

A key concern is the possibility of civil society failure (defined in chapter 2). A group might be unable to act collectively, or collective action could occur in a well-coordinated but dysfunctional manner that

In practice, devolving revenue raising to the local level is difficult.

Donors' evaluation criteria create incentives to select areas that are easily reached and organized . . .

. . . and to target project benefits to households that are able to quickly absorb project funds in productive activities.

When civic participation is likely to be the best solution to government and market failures, and when it is not, is highly contextual. . . .

. . . and thus best determined by turning to the evidence.

reduces the welfare of the average citizen (as in the case, for example, of an organized fringe group that uses terror and violence to further its extremist ends at high social cost).

When is civic participation likely to be the best answer to government and market failures, and when is it not? The answers are deeply contextual, fundamentally conditioned by social structures and historical trajectories, and different for every community. A policy that works in one village may fail miserably in another. Moreover, as effective collective action depends on the cooperative infrastructure provided by a strong state, it is not at all clear that strong civil society creates strong governments; the reality is more complex and nuanced. Similarly, although empowering civic groups may often lead to good outcomes, doing so is not always superior to a pure market-based strategy for raising incomes or to a strategy that strengthens the role of central bureaucrats to, say, improve social services. Keeping this in mind, the decision about whether, when, and how to promote local participation should be made with an understanding of the tradeoffs involved in moving decisions to local communities—in a particular country, within a particular region in a country, and at a particular time.

Theorizing and thinking through the conceptual foundations of these questions can yield important insights, but several open questions are best answered by examining the evidence. When does participation work, and when does it fail to achieve specific objectives? How important is capture? Does handing over large sums of money to community groups empower the poor, or do elites use it to enrich themselves? What mechanisms are most effective in improving the capacity for collective action and building social capital? What methods reduce civic inequality and elite capture and truly empower the poor? Do participatory projects result in choices that are better aligned with people's preferences? Does fostering participation enhance social cohesion? Does it strengthen civil society? Does it produce more resilient and inclusive local institutions? To what extent does group heterogeneity and illiteracy affect the quality of participation? Does participation improve development outcomes at the local level? Does it help the sustainable management of local resources? Chapters 4–6 provide a broad and comprehensive review of the evidence on these and many related questions.

For the reasons outlined in chapter 1, the focus of the review of the evidence is on large-scale participatory projects that have been

evaluated based on representative samples of target populations with good counterfactuals—studies that have a valid control group for the communities targeted (or “treated”) by the intervention. Generally speaking, this means that the findings come from econometric analysis, although some well-designed qualitative research is examined to inform the results.

Notes

1. Needs can be unlimited, however. Normative theories of fiscal federalism and decentralization consequently pay equal attention to the budget constraints associated with financing expenditure and the tax assignments of federal and local jurisdictions. Although these fundamental issues on the supply side of decentralization are not the focus of this report, they are important to keep in mind.
2. The World Bank and the U.S. Agency for International Development (USAID) have been leading champions of this new emphasis on fighting corruption. See the *World Development Report 2004* (World Bank 2004) on the effect of corruption on service delivery.
3. Tanzi and Davoodi (1997) show that corruption can reduce public revenue and increase income inequality by allowing well-positioned individuals to benefit unduly from government programs intended for the poor.
4. Myerson (1993) and Persson, Roland, and Tabellini (1997) provide theoretical arguments for the relationship between political institutions and corruption. Bardhan and Mookherjee (2006) provide a good overview of the conceptual literature on the relationship between decentralization and corruption and review much of the empirical evidence.
5. Bernard and others (2008) find evidence on the proliferation of community organizations in Burkina Faso and Senegal that appears to be consistent with this hypothesis. They report a dramatic growth in both market- and community-oriented village organizations over the two-decade period between the early 1980s, when participatory approaches first became popular popularity, to about 2002. In Burkina Faso, where 22 percent of sample villages had village organizations in 1982, 91 percent had at least one village organization by 2002; in Senegal, where 10 percent of sample villages had at least one village organization in 1982, the figure rose to 65 percent. Household participation in village organizations also rose dramatically, with 57 percent of households in Burkina Faso and 69 percent in Senegal participating in at least one village organization. However, one-fifth of all registered organizations had not undertaken any activity by the time of the survey, and among those that had, most members reported that the projects undertaken were either incomplete or had not yielded any significant benefits.

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POWER TO THE PEOPLE: EVIDENCE FROM A
RANDOMIZED FIELD EXPERIMENT ON
COMMUNITY-BASED MONITORING IN UGANDA*

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This paper presents a randomized field experiment on community-based monitoring of public primary health care providers in Uganda. Through two rounds of village meetings, localized NGOs encouraged communities to be more involved with the state of health service provision and strengthened their capacity to hold their local health providers to account for performance. A year after the intervention, treatment communities are more involved in monitoring the provider and the health workers appear to exert higher effort to serve the community. We document large increases in utilization and improved health outcomes – reduced child mortality and increased child weight – that compare favorably to some of the more successful community-based intervention trials reported in the medical literature.

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I. INTRODUCTION

Approximately 11 million children under five die each year and almost half of these deaths occur in sub-Saharan Africa. More than half of these children will die of diseases (e.g. diarrhea, pneumonia, malaria, measles, and neonatal disorders) that could easily have been prevented or treated if the children had had access to a small set of proven, inexpensive services (Black et al. 2003; Jones et al. 2003).

Why are these services not provided? Anecdotal, and recently more systematic, evidence points to one possible reason – ineffective systems of monitoring and weak accountability relationships.¹ This paper focuses on one of these accountability relationships, citizen-clients’ ability to hold providers accountable, using primary health care provision in rural Uganda as a testing ground.

To examine whether community-based monitoring works, we designed and conducted a randomized field experiment in 50 communities from nine districts in Uganda. In the experiment, local NGOs facilitated village and staff meetings in which members of the communities discussed baseline information on the status of health service delivery relative to other providers and the government standard. Community members were also encouraged to develop a plan identifying key problems and steps the providers should take to improve health service provision. The primary objective of the intervention was to initiate a process of community-based monitoring that was then up to the community to sustain and lead.

The community-based monitoring project increased the quality and quantity of primary health care provision. A year after the first round of meetings we find a significant difference in the weight of infants – 0.14 z-score increase – and a markedly lower number of deaths among children under five – 33 percent reduction in under-five mortality – in the treatment communities. Utilization for general outpatient services was 20 percent higher in the treatment compared to the control facilities and the overall effect across a set of utilization measures is large and significantly positive. Treatment practices, including immunization of children, waiting time, examination procedures, and absenteeism, improved significantly in the treatment communities, thus suggesting that the changes in quality and quantity of health care provision are due to behavioral changes of the staff. We find evidence that the treatment communities became more engaged and began to monitor the health unit more extensively. Using variation in treatment intensity

¹For anecdotal and case study evidence, see World Bank (2003). Chaudhury et al. (2006) provide evidence on the rates of absenteeism. On misappropriation of public funds and drugs, see Reinikka and Svensson (2004) and McPake et al. (1999).

across districts we show that there is a significant relationship between the degree of community monitoring and health utilization and health outcomes, consistent with the community-based monitoring mechanism.

Community-based, randomized, controlled field trials have been used extensively in medical research to evaluate the effectiveness of various health interventions (see footnote 14). Our paper is related but differs in one important dimension. While the medical field trials address the question of impact of a biological agent or treatment practice when the health workers competently carry out their tasks, we focus on how to ensure that the health workers actually carry out their tasks and the impact that may have on health utilization and health outcomes.

This paper also relates to a small literature on improving governance and public service delivery through community participation. Olken (2007) finds minor effects of an intervention aimed at increasing community participation in the monitoring of corruption in Indonesia. Our work differs in several ways. First, the intervention we evaluate was structured in a way to reduce the risk of elite capture. Second, unlike corruption which is not easily observable, the information discussed in the meetings were basic facts on utilization and quality of services based on the community's own experience. Finally, the intervention sought to address two constraints highlighted in the literature on community monitoring: lack of relevant information and inadequate participation. Banerjee, Deaton, and Duflo (2004) evaluate a project in Rajasthan in India where a member of the community was paid to check whether the nurse-midwife assigned to the health center was present at the center. The intervention had no impact on attendance and the authors speculate that a key reason for this is that the individual community member did not manage to use his or her information on absenteeism to invoke community participation. Here, on the contrary, we explicitly try to address the participation constraint by involving a large number of community members and encourage them to jointly develop a monitoring plan.

Finally, the paper links to a growing empirical literature on the relationship between information dissemination and accountability (Strömberg 2004; Besley and Burgess 2002; Ferraz and Finan 2008). In this paper, however, we focus on mechanisms through which citizens can make providers, rather than politicians, accountable. Thus, we do not study the design or allocation of public resources across communities, but rather how these resources are utilized. Second, we use micro data from households and clinics rather than disaggregated national accounts data. Finally, we identify impact using an experimental design.

The next section describes the institutional environment. The community-based monitoring intervention is described in section 3. Section 4 lays out the evaluation design and the results are presented in section 5. Section 6 concludes. Details about the experiment and additional results are reported in a supplemental appendix.

II. INSTITUTIONAL SETTING

Uganda, like many newly independent countries in Africa, had a functioning health care system in the early 1960s. The 1970s and 1980s saw the collapse of Government services as the country underwent political upheaval. Health indicators fell dramatically during this period until peace was restored in the late 1980s. Since then, the Government has been implementing major infrastructure rehabilitation programs in the public health sector.

The health sector in Uganda is composed of four types of facilities: hospitals, health centers, dispensaries, and aid posts or sub-dispensaries. These facilities can be government, private for-profit, or private not-for-profit operated and owned. The impact evaluation focuses on public dispensaries. Dispensaries are in the lowest tier of the health system where a professional interaction between users and providers takes place. Most dispensaries are rural. According to the government health sector strategic plan, the standard for dispensaries includes preventive, promotional, outpatient care, maternity, general ward, and laboratory services (Republic of Uganda 2000). As of 2001, public health services are free of charge. In our sample, on average, a dispensary was staffed by an in-charge or clinical officer (a trained medical worker), two nurses, and three nursing aids or other assistants.

The health sector in Uganda is decentralized and a number of actors are responsible for supervision and control of the dispensaries. At the lowest tier, the Health Unit Management Committee (HUMC) is supposed to be the main link between the community and the facility. Each dispensary has an HUMC which consists of both health workers and non-political representatives from the community. The HUMC should monitor the day-to-day running of the facility but it has no authority to sanction workers. The next level in the institutional hierarchy is the Health Sub-district. The Health Sub-district monitors funds, drugs and service delivery at the dispensary. Supervision meetings by the Health Sub-district are supposed to appear quarterly but, in practice, monitoring is infrequent. The Health Sub-district has the authority to reprimand, but not dismiss, staff for indiscipline. Thus in severe cases of indiscipline, the errand will be referred to the

Chief Administrative Officer of the District and the District Service Commission, which are the appointing authorities for the district. They have the authority to suspend or dismiss staff.

Various local NGOs, so-called Community-based organizations (CBOs), focusing primarily on health education, are also active in the sector.

III. EXPERIMENTAL DESIGN AND DATA

III.A. Overview

In response to perceived weak health care delivery at the primary level, a pilot project (Citizen report cards) aimed at enhancing community involvement and monitoring in the delivery of primary health care was initiated in 2004. The project was designed by staff from Stockholm University and the World Bank, and implemented in cooperation with a number of Ugandan practitioners and 18 community-based organizations.

The main objective of the intervention was to strengthen providers' accountability to citizen-clients by initiating a process, using trained local actors (CBOs) as facilitators, which the communities themselves could manage and sustain.

Based on a small but rigorous empirical literature on community participation and oversight, and extensive piloting in the field, our conjecture was that lack of relevant information on the status of service delivery and the community's entitlements, and failure to agree on, or coordinate expectations of, what is reasonable to demand from the provider, were holding back initiatives to pressure and monitor the provider. While individual community members have private information, for example they know whether their own child died or not, and whether the health workers did anything to help them, they typically do not have any information on aggregate outcomes, such as how many children in their community did not survive beyond the age of 5 or where citizens, on average, seek care, or what the community can expect in terms of quality and quantity of service provision (Khemani 2006). Partly as a response to this information problem, and partly because monitoring a public facility is a public good which may be subject to serious free-rider problems, few people actively participate in monitoring their service providers. Relaxing these two constraints was therefore the main objective of the intervention.

The key behavioral change induced by more extensive community-based monitoring was expected to be increased effort by the health unit staff to serve the community. In Uganda, as in many other developing countries, health workers have little pecuniary incentives to exert high effort. Public money does not follow

patients and hiring, salaries, and promotions are largely determined by seniority and educational qualifications – not by how well the staff performs. An individual worker may of course still put in high effort if shirking deviates from her ideal choice (Akerlof and Kranton 2005). The effort choice may also be influenced by social rewards from community members or social sanctions against shirking workers. Social rewards and sanctions are key instruments available to the community to boost health worker’s effort.

III.B. Experimental Design

The experiment involved 50 public dispensaries, and health care users in the corresponding catchment areas, in nine districts covering all four regions in Uganda. All project facilities were located in rural areas. We define a facility’s catchment area, or the community, as the five-kilometer radius around the facility.² A community in our sample has, on average, 2,500 household residing within the 5-kilometer radius of the clinic, of which 350 live within a one-kilometer radius. For the experimental design, the facilities were first stratified by location (districts) and then by population size. From each group, half of the units were randomly assigned to the treatment group and the remaining 25 units were assigned to the control group.

III.C. Data

Data collection was governed by two objectives. First, data were required to assess how the community at large views the quality and efficacy of service delivery. We also wanted to contrast the citizens’ view with that of the health workers. Second, data were required to evaluate impact. To meet these objectives, two surveys were implemented: a survey of the 50 providers and a survey of users. Both surveys were implemented prior to the intervention (data from these surveys formed the basis for the intervention) and one year after the project had been initiated.

A quantitative service delivery survey was used to collect data from the providers. Since agents in the service delivery system may have a strong incentive to misreport key data, the data were obtained directly from the records kept by facilities for their own need (i.e. daily patient registers, stock cards, etc.) rather than from administrative records. The former, often available in a highly disaggregate format, were considered to suffer the least from any incentive problems in record-keeping. Data were also collected through visual checks by enumerators.

²Dispensaries are designed to serve households in a catchment area roughly corresponding to the five-kilometer radius around the facility (Republic of Uganda 2000).

The household survey collected data on both households' health outcomes and health facility performance as experienced by the household. A stratified random sample of households within the catchment area of each facility was surveyed. In total roughly 5,000 households were surveyed in each round.³ To the extent that it was possible, patient records, i.e., patient exercise books and immunization cards, supported the household's response. The post-intervention household survey also included a shorter module on health outcomes. Specifically, data on under-five mortality were collected and we measured the weight of all infants in the surveyed households.

III.D. Intervention

A smaller subset of the findings from the pre-intervention surveys, including utilization, quality of services, and comparisons vis-à-vis other health facilities, were assembled in report cards. Each treatment facility and its community had a unique report card, translated into the main language spoken in the community, summarizing the key findings from the surveys conducted in their area.

The process of disseminating the report card information, and encouraging participation, was initiated through a series of meetings: a community meeting; a staff meeting; and an interface meeting. Staff from various local NGOs (CBOs) acted as facilitators in these meetings.⁴ A time-line of the intervention is depicted in Figure I.

The community meeting was a two-afternoons event with approximately 100 invited participants from the community. To avoid elite capture, the invited participants consisted of a selection of representatives from different spectra of society (i.e. young, old, disabled, women, mothers, leaders). The facilitators mobilized the village members by cooperating with village council representatives in the

³The sample strategy for the baseline household survey was designed to generate representative information on the core users' variables in each community (such as the proportion of patients being examined with equipment). In total, 88 percent of the households surveyed in the baseline survey were resurveyed in the ex-post survey. The households that could not be surveyed were replaced.

⁴The participating CBOs, 18 in total, had been active in 64% of the treatment communities and half of the control communities prior to the intervention. A handful of them covered more than one treatment community. The CBOs were primarily focused on health, including issues of health education and HIV/Aids prevention, although other objectives such as agricultural development, women empowerment, support of orphans and vulnerable children, and peace building initiatives, were also common. The CBO facilitators were trained for seven days in data interpretation and dissemination, utilization of the participatory methodology, and conflict resolution and management. Various other CBOs also operate in the project communities.

catchment area. Invited participants were asked to spread the word about the meeting and, in the end, a large number of uninvited participants also attended the meeting. More than 150 participants per day attended a typical village meeting.

In the community meeting, the facilitators used a variety of participatory methods to disseminate the information in the report cards and encouraged community members to develop a shared view on how to improve service delivery and monitor the provider. Information on patient's rights and entitlements was also discussed. The participants were divided into focus groups so that also more marginalized groups such as women and youth could raise their voices and discuss issues specific to their group. At the end of the meeting, the community's suggestions for improvements, and how to reach them without additional resources, were summarized in an action plan. The action plan contained information on health issues/services that had been identified by the community as the most important to address; how these issues could be addressed and how the community could monitor improvements (or lack thereof). While the issues raised in the action plans differed across communities, a common set of concerns included high rates of absenteeism, long waiting-time, weak attention of health staff, and differential treatment.

The health facility meeting was a one-afternoon event held at the facility with all staff present. In the meeting, the facilitators contrasted the information on service provision as reported by the provider with the findings from the household survey.

An interface meeting with members from the community, chosen in the community meeting, and health workers followed the community and health facility meetings. During the interface meeting, the community representatives and the health workers discussed suggestions for improvements. The participants discussed their rights and responsibilities as patients or medical staff. The outcome was a shared action plan, or a contract, outlining the community's and the service provider's agreement on what needs to be done, how, when and by whom. The "community contract" also identified how the community could monitor the agreements and a time plan. Because the problems that were raised in the community meetings constituted the core issues discussed during the interface meetings, the community contract was in many respects similar to the community's action plan.

The three separate meetings aimed at kick-starting the process of community monitoring. Thus, after the initial meetings the communities were themselves in-charge of establishing ways of monitoring the provider. After a period of six

months, the communities and health facilities were revisited. The CBOs facilitated a one-afternoon community meeting and a one-afternoon interface meeting with the aim of tracking the implementation of the community contract. Health facility staff and community members jointly discussed suggestions for sustaining or improving progress, or in the case of no improvements, why so.⁵

IV. EVALUATION DESIGN AND EXPECTED OUTCOMES

IV.A. Outcomes

The main outcome of interest is whether the intervention increased the quantity and quality of health care provision and hence resulted in improved health outcomes. We are also interested in evaluating changes in all steps in the accountability chain: Did the treatment communities become more involved in monitoring the health workers? Did the intervention change the health worker’s behavior?

As a robustness test we also assess alternative explanations. One concern is spillovers. Another concern is that the intervention did not only (or primarily) increase the extent of community monitoring, but had an impact on other agents in the service delivery chain, such as the Health sub district. The intervention could also have affected the health workers’ behavior directly, or affected it through the actions of the CBOs, rather than through more intense community-based monitoring as we hypothesize. While this would not invalidate the causal effect of the intervention it would, of course, affect the interpretation. Therefore, these alternative hypotheses are also subject to a battery of tests.

IV.B. Statistical Framework

To assess the causal effect of the intervention we estimate,

$$(1) \quad y_{ijd} = \alpha + \beta T_{jd} + X_{jd}\pi + \theta_d + \varepsilon_{ijd} ,$$

where y_{ijd} is the outcome of household i (when applicable), in community/health facility j , in district d , T_{jd} is an indicator variable for assignment to treatment, and ε_{ijd} is an error term. Equation (1) also includes a vector, X , of pre-intervention facility-specific covariates and district fixed effects (θ_d).⁶ Due to random assignment, T should be orthogonal to X , and the consistency of β does not depend on

⁵Details on the report cards and the participatory methods used, as well as an example of an action plan, are provided in the supplemental appendix.

⁶The baseline covariates included are number of villages in catchment area, number of days without electricity in the last month, indicator variable for whether the facility has a separate maternity unit, distance to nearest public health provider, number of staff with less than advanced A-level education, indicator variable for whether the staff could safely drink from the water source, and average monthly supply of Quinine.

the inclusion of X in the model. The regression adjustment is used to improve estimation precision and to account for stratification and chance differences between groups in the distribution of pre-random assignment (Kling, Liebman, and Katz 2007).

We report the results of estimating equation (1) with X and θ excluded in a supplemental appendix.

For a subset of variables we can also stack the pre and post data and explore the difference-in-differences in outcomes; i.e., we estimate⁷

$$(2) \quad y_{ijt} = \gamma POST_t + \beta_{DD}(T_j * POST_t) + \mu_j + \varepsilon_{ijt},$$

where $POST$ is an indicator variable for the post-intervention period, μ_j is a facility/community specific fixed effect, and β_{DD} is the difference-in-differences estimate (program impact).

For some outcomes we have several outcome measures. To form judgment about the impact of the intervention on a family of K related outcomes, we follow Kling et al. (2004) and estimate a seemingly unrelated regression system,

$$(3) \quad Y = [I_K \otimes (T \ X)] \theta + v ,$$

where I_K is a K by K identity matrix. We then derive average standardized treatment effects, $\tilde{\beta} = \frac{1}{K} \sum_{k=1}^K \frac{\hat{\beta}_k}{\hat{\sigma}_k}$, where $\hat{\beta}_k$ and $\hat{\sigma}_k$ are the point estimate and standard error, respectively, for each effect (see Duflo et al. 2007). The point estimate, standard error, and p-value for $\tilde{\beta}$ are based on the parameters, $\hat{\beta}_k$ and $\hat{\sigma}_k$, jointly estimated as elements of θ in (3).

V. RESULTS

V.A. Pre-intervention Differences

The treatment and the control group were similar on most characteristics prior to the intervention. Average standardized pre-treatment effects are estimated for each family of outcomes (utilization, utilization pattern, quality, catchment area statistics, health facility characteristics, citizen perceptions, supply of resources, and user charges) using pre-intervention data. As shown in Table I, we cannot reject the null hypotheses of no difference between the treatment and the control group.⁸

⁷It is a subset of variables since the post intervention surveys collected information on more variables and outcomes.

⁸We report the test of difference in means across control and treatment groups for each individual variable in the supplemental appendix.

V.B. Processes

The initial phase of the project; i.e., the three separate meetings, followed a pre-design structure. A parallel system whereby a member of the survey team originating from the district participated as part of the CBO team also confirmed that the initial phase of the intervention was properly implemented. After these initial meetings it was up to the community to sustain and lead the process. In this section we study whether the treatment communities became more involved in monitoring the providers.

To avoid influencing local initiatives we did not have external agents visiting the communities and could therefore not document all actions taken by the communities in response to the intervention. Still we have some information on how processes in the community have changed. Specifically, the CBOs submitted reports on what type of changes they observed in the treatment communities and we also surveyed the local councils in the treatment communities. We use facility and household survey data to corroborate these reports.

According to the CBO-reports, and the local council survey, the community-based monitoring process that followed the first set of meetings was a joint effort mainly managed by the local councils, HUMC, and community members. A typical village in the treatment group had, on average, six local council meetings in 2005. In those meetings, 89 percent of the villages discussed issues concerning the project health facility. The main subject of discussion in the villages concerned the community contract or parts of it, such as behavior of the staff.

The CBOs reported that concerns raised by the village members were carried forward by the local council to the facility or the HUMC. However, although the HUMC is an entity that should play an important role in monitoring the provider, it was in many cases viewed as being ineffective. As a result, mismanaged HUMCs were dissolved and new members elected. These claims are confirmed in the survey data: More than one third of the HUMCs in the treatment communities were dissolved and new elected or received new members following the intervention, while we observe no dissolved HUMC in the control communities. Further, the CBOs report that the community, or individual members, also monitored the health workers during visits to the clinic, when they rewarded and questioned issues in the community contract that had or had not been addressed, suggesting a more systematic use of non-pecuniary rewards. Monitoring tools such as suggestion boxes, numbered waiting cards, and duty rosters, were also reported to be put in place in several treatment facilities.

In Table II we formally look at the program impact on these monitoring tools.

We use data collected through visual checks by enumerators during the post-intervention facility survey. As shown in columns (i)-(ii), one year into the project treatment facilities are significantly more likely to have suggestion boxes (no control facility had these, while 36 % of the treatment facilities did) and numbered waiting cards (only one control facility had one, while 20 % of the treatment facilities did). Columns (iii)-(iv) show that a higher share of the treatment facilities also post information on free-services and patient’s rights and obligations. The enumerators could visually confirm that 70 percent of the treatment facilities had at least one of these monitoring tools, while only 4 out of 25 control clinics had at least one of them. The difference is statistically significant (supplemental appendix, Table A.II). The fifth column reports the average standardized effect of the monitoring tools. The estimate is significantly different from zero at the 1-percent level.

The results based on household data mirror the findings reported in columns (i)-(v). The performance of the staff is more often discussed in local council meetings in the treatment communities, shown in column (vi), and community members in the treatment group are on average better informed about the HUMC’s roles and responsibilities, as reported in column (vii). Combining the evidence from the CBO reports and the household survey data thus suggests that both the “quantity” of discussions about the project facility and the subject, from general to specific discussions about the community contract, changed in response to the intervention.

V.C. Treatment Practices

The qualitative evidence from the CBOs and, to the extent that we can measure it, the findings reported in Table II, suggest that the treatment communities became more involved in monitoring the provider. Did the intervention also affect the health worker’s behavior and performance? We turn to this next.

We start by looking at examination procedures. The estimate based on equation (2) with the dependent variable being an indicator variable for whether any equipment, for instance a thermometer, was used during examination is shown in the first row in Table III. 50 [41] percent of the patients in the treatment [control] community reported that equipment was used the last time the respondent (or the respondent’s child) visited the project clinic. The difference-in-differences estimate, a 20% increase, is highly significant. The cross-section estimate in row (ii), based on equation (1), is less precisely estimated.

In row (iii) we report the result with an alternative measure of staff performance – the waiting time – defined as the difference between the time the user left

the facility and the time the user arrived at the facility, subtracting the examination time. On average, the waiting time was 131 minutes in the control facilities and 119 in the treatment facilities. The estimate based on equation (1), shown in column (iv), is less precisely estimated.

The results on absenteeism is shown in the third row.⁹ The point estimate suggests a substantial treatment effect. On average, the absence rate, defined as the ratio of workers not physically present at the time of the post-intervention survey to the number of workers on the list of employees as reported in the pre-intervention survey, is 13 percentage points lower in the treatment facilities. Thus, in response to the intervention health workers are more likely to be at work.

Enumerators also visually checked the condition of the health clinics; i.e. whether floors and walls were clean, the condition of the furniture and the smell of the facility. We combine these variables through principal components analysis into a summary score. Treatment clinics appear to have put more effort into keeping the clinic in decent condition in response to the intervention. The point estimate, reported in row (vi), implies a 0.56 standard deviations improvement in the summary score in the treatment compared to the control facilities.

According to the government health sector strategic plan preventive care is one of the core tasks for health providers at the primary level. A significantly larger share of households in the treatment communities have received information about the dangers of self-treatment, reported in row (vii), and the importance of family planning, reported in row (viii). The difference is 7 and 6 percentage points, respectively.

There is no systematic difference in the supply of drugs between the treatment and control groups (see section V.F). However, as shown in row (ix), stock-outs of drugs are occurring at a higher frequency in the control facilities even though, as reported below, the control facilities treat significantly fewer patients. These findings suggest that more drugs leaked from health facilities in the control group.¹⁰

⁹The post-intervention survey was not announced in advance. At the start of the survey the enumerators physically verified the provider's presence. A worker was counted as absent if, at the time of the visit, he or she was not in the clinic. Staff reported to be on outreach were omitted from the absence calculation. Four observations were dropped because the total number of workers verified to be present or reported to be on outreach exceeded the total number of workers on the pre-intervention staff list. Assuming instead no absenteeism in these four facilities yields a point estimate (standard error) of -0.20 (0.065).

¹⁰The dependent variable is the share of months in 2005 in which stock-cards indicated no availability of drugs, averaged over Erythromycin, Mebendazole, and Septrin. We find no significant difference between treatment and control clinics for Chloroquine – the least expensive

The findings on immunization of children under five are reported in Table IV. We have information on how many times (doses) in total each child has been immunized with polio, DPT, BCG, A-Vitamin supplements and measles. Based on the recommended immunization plan we create indicator variables taking the value of one if child i of cohort (age) j had received the required dose(s) of measles, DPT, BCG, and polio, respectively, and zero otherwise.¹¹ We then estimate (3), for each age group, and calculate average standardized effects.

The average standardized effects are significantly positive for the younger cohorts. Looking at individual effects (supplemental appendix Table A.IV), there are significant positive differences between households in the treatment and control community for all five vaccines, although not for all cohorts. For example, twice as many newborns in the treatment group have received Vitamin A supplement, 46% more newborns have received the first dose of BCG vaccine, and 42% more newborns have received the first dose of polio vaccine as compared to the control group.

V.D. Utilization

To the extent we can measure it, the evidence presented so far suggests that treatment communities began to monitor the health unit more extensively in response to the intervention and that the health workers improved the provision of health services. We now turn to the question of whether the intervention also resulted in improved quantity and quality of care.

Cross-section estimates based on equation (3) are given in Table V, Panel A. For out-patients and deliveries, we have pre-intervention data and can also estimate difference-in-differences models, shown in Panel B, and value-added models, shown in Table A.V in the supplemental appendix.¹²

of the drugs we have data on. Not all clinics had accurate stock-cards and these clinics were therefore omitted.

¹¹According to the Uganda National Expanded Program on Immunization each child in Uganda is suppose to be immunized against measles (one dose at 9 months and two doses in case of an epidemic); DPT (three doses at 6 weeks, 10 weeks and 14 weeks); BCG (one dose at birth or during the first contact with a health facility); and polio (three doses, or four if delivery takes place at the facility, at 6 weeks, 10 weeks and 14 weeks). Because measles vaccination should not be given at birth, we exclude immunization against measles in the plan for infants under 12 months.

¹²The value added specification is

$$y_{jt} = \alpha_{VA} + \beta_{VA}T_j + \lambda y_{jt-1} + \varepsilon_{jt} .$$

One year into the program, utilization (for general outpatient services) is 20 percent higher in the treatment facilities as shown in specification (i). For the difference-in-differences and the value-added models (reported in specification (ix) in Table V and specification (ix) in Table A.V), the coefficients on the treatment indicator are larger both in absolute magnitude and relative to their standard errors. Thus, controlling for baseline outcomes y_{jt-1} , improves the precision of the treatment effect, which is to be expected given the persistent nature of the outcome variable. The difference in the number of deliveries, shown in specification (ii), albeit starting from a low level, is 58 percent and is fairly precisely estimated. There are also positive differences in the number of patients seeking antenatal care (19 percent increase) and family planning (22 percent increase), although these estimates are not individually significantly different from zero. The average standardized effect, reported in specification (v), however, is highly significant.

The last three columns in Table V, Panel A and B, report changes in utilization patterns based on household data. We collected data on where each household member sought care during 2005 in case of illness that required treatment and collapse this information by community. There is a 11-13 percent increase, specifications (vi) and (xii), in the use of the project facility in the treatment as compared to the control group – a result consistent with that reported in specification (i) using facility records.

Households in the treatment community also reduced the number of visits to traditional healers and the extent of self-treatment, specifications (vii) and (xiii), while there are no statistically significant differences across the two groups in the use of other providers (not reported). Thus, as summarized in the average standardized treatment effects, specification (viii) and (xiv), households in the treatment communities switched from traditional healers and self-treatment to the project facility in response to the intervention.

V.E. Health Outcomes

We collected data on births, pregnancies, and deaths of children under five years in 2005. We also measured the weight of all infants (i.e., under 18 months of age) and children (between 18 and 36 months of age) in the surveyed households.

Health outcomes could have improved for several reasons. As noted in the Introduction, access to a small set of proven, inexpensive services could, worldwide, have prevented more than half of all under-five deaths. For a country with an epidemiological profile as in Uganda, the estimate of preventable deaths is 73% (Jones

et al. 2003).¹³ In the community monitoring project specifically, increased utilization and having patients switching from self-treatment and traditional healers to seeking care at the treatment facility could have an effect. Holding utilization constant, better service quality, increased immunization, and more extensive use of preventive care could also have resulted in improved health status.

As a reference point we review the set of health intervention feasible for delivery at high coverage in low-income settings with sufficient evidence of effect on reducing mortality from the major causes of under-five deaths (Jones et al. 2003). We focus on community-based, randomized, controlled field trials that bear some resemblance (because they are community-based) to our project. Several of these field trials document reductions in under-five mortality rates of 30-50% one to two years into the project.¹⁴ There is, however, a fundamental difference between the

¹³This is likely to be a conservative number since only medical interventions for which cause-specific evidence of effect was available were included in the estimation. For example, increased birth spacing, which has been estimated to reduce under-5 mortality by 19% in India, was not considered. Several perinatal and neonatal health interventions that could be implemented in low-income countries were not included either (Darmstadt et al. 2005).

¹⁴For example, a project in Tigray, Ethiopia, in which coordinators, supported by a team of supervisors, were trained to teach mothers to recognize symptoms of malaria in their children and provide antimalarials, reduced under-5 mortality by 40% (Kidane and Morrow 2000). Bang et al. (1990) document a 30% reduction in under-five mortality from an intervention that included mass education about childhood pneumonia and case management of pneumonia by trained village health workers — a result similar to the meta-analysis estimate of Sazawal and Black (2003). Bang et al. (1999) evaluate a project in which trained village health workers, assisted by birth attendants and supervisory visits, provided home-based neonatal care, including treatment of sepsis. Two years into the project they document a reduction in infant mortality by nearly 50%. Rahmathullah et al. (2003) assess the impact of a community-based project in two rural districts of Tamil Nadu, India, where newborn infants in the treatment group were allocated oral vitamin A after delivery. The intervention resulted in a 22% reduction in total mortality at age 6 months. Manandhar et al. (2004) evaluate a project in which a facilitator convened nine women’s group meeting every month in the Makwanpur district in Nepal in which perinatal problems were identified and strategies to address them formulated. Two year into the project they document a 30% reduction in neonatal mortality. Rahman et al. (1982) evaluate the impact of immunization of women with tetanus injections during pregnancy in rural Bangladesh. The intervention reduced neonatal mortality by 45%. Mtango and Neuvians (1986) evaluate a project in rural Tanzania in which trained village health workers visited families at their homes every six to eight weeks, giving health education on recognition and prevention of acute respiratory infections, treating children with pneumonia with antibiotics or referring them to the next higher level of care. Within a two-year period, they document a 27% reduction in under-five mortality — a reduction slightly lower than that found in a similar study in rural Bangladesh (Fauveau et al. 1992).

interventions discussed in footnote (14) and our work. The medical field trials study the impact of a biological agent or treatment practice in a community setting when the community health workers and/or medical personnel competently carry out their tasks. In the experiment we consider, on the contrary, no new health interventions were introduced and the supply of health inputs were unchanged. Instead we focused on incentivizing health workers to carry out their tasks through strengthened local accountability.

Estimates for births and pregnancies are given in Table VI, columns (i)-(ii). To the extent that the intervention had an effect on fertility, for example through increased use of family planning services, it would primarily affect the incidence of pregnancies in 2005, given the 40-week period between conception to birth. The incidence of births is not significantly different across treatment and control groups. However, the treatment groups have 10 percent fewer incidences of pregnancies in 2005.

The third column shows the treatment effect on under-five mortality.¹⁵ The point estimate suggests a substantial treatment effect. The average under-five mortality rate in the control group is 144, close to the official figure of 133 for 2005 (UNICEF 2006). In the treatment group, the under-five mortality rate is 97, that is a 33 percent reduction in under-five mortality. The difference is significant (and somewhat larger in absolute magnitude) when controlling for district fixed effects as reported in column (iii). While the effect is large, it is worth emphasizing that the 90 percent confidence interval of our estimate also includes much lower effects (90% CI: 8%-64% reduction in under-five mortality rate). With a total of approximately 55,000 households residing in the treatment communities, the treatment effect corresponds to approximately 550 averted under-five deaths in the treatment group in 2005.

Column (iv) shows the age range of the mortality effects. We have information of the birth year of all children (under-five) alive at in the beginning of 2005 and the birth year of all deceased children in 2005. Using this data we estimate (1), replacing the treatment indicator with a full set of year-of-birth indicators and year-of-birth-by-treatment interactions. We can then address the question: Conditional on having a child of age x in the end of 2004, or a child born in 2005, what is the probability that the child died in 2005? As evident, children less than two years old drive the reduction in under-five mortality. The point estimate for the youngest cohort, for example, implies a 35% reduction in the likelihood of

¹⁵The under-five mortality rate is the sum of the death rates for each cohort (0-1s, 1-2s, 2-3s, 3-4s, and 4-5s) per community in 2005, expressed per 1,000 live births.

death of a child born in 2005 in the treatment compared to the control group.

The program impact on the weight of infants is reported in columns (v)-(vi). Based on weight-for-age z -scores, Ugandan infants have values of weight far lower than the NCHS/CDC international reference and the gap increases for older infants, consistent with the findings in Cortinovis et al. (1997).¹⁶ The difference in means of z scores of infants between the treatment and the control group is reported in column (v). The estimated effect (difference) is 0.14 z score in weight-for-age. Figure II plots the distribution of z scores for the treatment and the control groups. The difference in measured weight is most apparent for underweight children. This is consistent with a positive treatment effect arising from improved access and quality of health care, rather than a general increase in nutritional status, since underweight status causes a decrease in immune and non-immune host defenses and as a consequence underweight children are at a higher risk of suffering from infectious diseases, or severe complications of infectious diseases, and therefore in higher demand of health care. In column (vi), we add controls for age and gender. The results remain qualitatively unchanged.

The treatment effect is quantitatively important. For this purpose, the baseline proportion of infants in each risk category (severe, < -3 z scores; moderately, $-3 \leq z$ scores < -2 ; mild, $-2 \leq z$ scores < -1) in the control group was calculated. Applying the shift in the weight-for-age distribution (adding 0.14 z score) with the odds ratio for each category – children who are mildly [moderately] {severely} underweight have about a two-fold [five-fold] {eight-fold} higher risk of deaths from infectious disease (Jones et al. 2003) – the reduction in average risk of mortality is estimated to be approximately 7 percent.¹⁷

V.F. Getting Inside the Box and Robustness Tests

The findings of large treatment effects on our proxies of community-based

¹⁶The z -score is a normally distributed measure of growth defined as the difference between the weight of an individual and the median value of weight for the reference population (2000 CDC Growth Reference in the U.S.) for the same age, divided by the standard deviation of the reference population. We exclude z scores $> |4.5|$ as implausible and omit observations with a recorded weight above the 90th percentile in the growth chart reported in Cortinovis et al. (1997). Since weight is measured by trained enumerators, the reporting error is likely due to misreported age of the child. The coefficient estimate (standard error) on the treatment indicator is 0.16 (0.09) when including these outliers.

¹⁷To put this into perspective, a review of controlled trials designed to improve the intake of complementary food for children aged six months to five years showed a mean increase of 0.35 z score (Jones et al. 2003). Jones et al. (2003) argue that this is one of the most effective preventive interventions feasible for delivery at high coverage in a low-income setting.

monitoring and outcomes are consistent with the community-based monitoring mechanism. But the findings do not rule out other explanations. In this section we assess a number of these alternative hypotheses.

To examine the plausibility of community-based monitoring as a key mechanism for the health utilization and health outcomes treatment effects, we follow the methodology used by Kling, Liebman and Katz (2007). Specifically, we test whether the differences in treatment-control in outcomes across districts are larger in districts with large treatment-control differences in monitoring and information outcomes. This relationship is summarized by the parameter δ , the coefficient on the summary index of monitoring and information, in the outcome equation

$$(4) \quad y_j = \delta M_j + X_j \pi + \varepsilon_j .$$

The summary index of monitoring M in (4) is the first component from a principal components analysis of the six monitoring and information variables in Table II. We examine two outcome measures (y_j), under-five mortality and number of out-patients.

Following Kling, Liebman, and Katz (2007), we estimate (4) by 2SLS, using a full set of district-by-treatment interactions as the excluded instruments for the monitoring index M , while controlling for district fixed effects. The IV estimation of (4) will be consistent if M is the mediating factor between treatment and outcomes.

The IV approach is depicted graphically in Figure III.¹⁸ There is a consistent pattern across districts and groups that larger differences in monitoring (relative to the district mean) are associated with larger differences in outcomes – a result in line with the community-based monitoring mechanism.

Estimates based on equation (4) are given in Table VII. The first two columns show 2SLS estimates of δ with district-by-treatment interactions as excluded instruments for the the monitoring index M . To increase precision, we control for baseline outcomes y_{jt-1} , when data allow it (i.e. for number of out-patients treated). The estimates are large in absolute terms and precisely estimated.

A stricter test of whether the extent of the program impact varies with the size of the community monitoring impact is to add a treatment dummy (an over-

¹⁸If X contains only district indicators, the 2SLS estimate of δ using the district-by-treatment interactions instruments is the slope of the line fit through a scatterplot of the outcome and monitoring index means for the treatment and control groups in each of the nine districts, normalized so that each district has mean 0 (Kling, Liebman, and Katz 2007). We plot the average values by group (treatment and control) for each district for y and M expressed in standard deviation units relative to the control group overall standard deviation for each variable.

all treatment effect regardless of the community monitoring impact) to the IV regressions in equation (4). The community monitoring index is then identified by cross-district variation in changes in community monitoring by treatment from the district-by-treatment interactions as the excluded instruments, with the main effect for treatment no longer excluded; the results are reported in columns (iii) and (iv) of Table VII. Comparing the results without and with controls for treatment are quite similar for both out-patients and under-five mortality, while the coefficients on the treatment indicator have the wrong sign and are small relative to their standard errors, providing some evidence that community monitoring had the primary effects on outcomes as opposed to other effects induced by the intervention.

To examine the hypothesis that differences in monitoring are driving the results as opposed to the supply driven hypothesis that health workers, once being informed that their effort deviates from what is expected (in the health facility staff meeting), decided to exert higher effort into serving the community, we augment specification (4) with a measure of the staff’s knowledge about patient’s rights and obligations.¹⁹ This model thus have two endogenous variables. If large treatment effects on outcomes across districts are associated with differences in staff knowledge about patients’ rights rather than more intense community monitoring, this would be evidence against the community-based monitoring hypothesis. As reported in columns (v)-(vi), the coefficients on community monitoring remain largely unaffected, while the coefficients on staff knowledge are insignificant and with the wrong signs, providing additional evidence, albeit not conclusive, that the demand driven mechanism is more important than the supply driven mechanism.

The CBOs played an integral role in the intervention as facilitators of the meetings. However, it is possible that these CBOs had a role (as educators or activist, for example) beyond the described treatment itself. There is no definitive way to sort out the role of community-based monitoring from the possible roles of the CBOs, but since around 60 percent of the CBOs that took part in the intervention had been operating in the communities before the intervention, and several of them also had activities in the control areas, we can investigate whether

¹⁹The in-charge was asked to list the patient’s rights and obligations according to the Ministry of Health’s plan for basic health service delivery. Patient’s rights were discussed in the interface meeting. Each correct answer (out of five) was given a score of 0.2, so this test score ranges from 0-1. We also examined other measures of staff engagement, including number of staff meetings in 2005 and if the in-charge had initiated training of staff on proper conduct. The results using these alternative proxies mirror those reported in Table VII.

the outcomes are correlated with pre-intervention CBO activity. This would be the case if the CBOs that participated in the experiment, and that had been present in the communities prior to intervention, had a direct impact on health outcomes (through various preventive activities for example) or indirectly by being more involved in monitoring the provider. The number of out-patients treated per month, shown in column (vii), and the under-five mortality rate, shown in column (viii), are not significantly different in communities where the CBOs had been active prior to the intervention. We have also examined whether the treatment effect vary conditional on observable CBO characteristics/actions. For example, CBOs that are located (have an office) in the community might, everything else equal, be in a better position to monitor the health provider. Moreover, in ten of the treatment sites, the CBOs reported that it regularly visited the clinic. If the CBOs, rather than the community, were pushing the service providers into action, presumably, the effect would be more pronounced in sites where the CBO actually visited the clinic regularly. However, the treatment effects are independent of whether the office of the CBO is located within a five kilometer radius of the health facility or if the CBO reported that it regularly visited the clinic.²⁰

Given that within each district there are both treatment and control units, one concern with the evaluation design is the possibility of spillovers from one catchment area to another. In practice, there are reasons to believe spillovers will not be a serious concern. The average (and median) distance between the treatment and control facility is 30 kilometers and in a rural setting it is unclear to what extent information about improvements in treatment facilities has spread to control communities. Still, the possibility of spillovers is a concern. Following Miguel and Kremer (2004), and taking advantage of the variation in distance to nearest treatment clinic induced by randomization, we estimate spillovers from treatment to control groups by enriching X in equation (1) to include an indicator variable for if the control clinic is within 10 kilometers of the nearest treatment clinic. The results are presented in the supplemental appendix (for utilization,

²⁰Given the small sample size, we test whether the distribution of outcomes in the subsample $\{T = 1 \ \& \ CBO \ located \ in \ community = 1\}$ is the same as in the subsample $\{T = 1 \ \& \ CBO \ located \ in \ community = 0\}$, and whether the distribution of outcomes in the subsample $\{T = 1 \ \& \ CBO \ regularly \ carries \ out \ monitoring \ visits \ to \ the \ facility = 1\}$ is the same as in the subsample $\{T = 1 \ \& \ CBO \ regularly \ carries \ out \ monitoring \ visits \ to \ the \ facility = 0\}$, using the Wilcoxon rank-sum test. The test statistics (with p-values in parentheses) are 0.88 (0.38) and -1.10 (0.27) for outpatients and 0.31 (0.76) and -0.03 (0.98) for under-5 mortality rate. We get similar results if we enrich equation (1) with an interaction term $T \times CBO \ characteristic$. The estimates of the interaction term are not statistically different from zero in any of the specifications.

delivery, and child death). We do not find evidence in favor of the spillover-hypothesis.

Another concern is if the district or sub-district management changed their behavior or support in response to the intervention. For example, the Health Sub-district or local government may have provided additional funding or other support to the treatment facilities. The results in Table A.VIII in the supplemental appendix do not provide any evidence of this being the case. The treatment facilities did not receive more drugs or funding from the sub-district or district as compared to the control facilities during 2005.

Upper-level authorities could also have increased their supervision of treatment facilities in response to the intervention. As shown in Table A.IX, however, supervision of providers by upper-level government authorities remained low in both the treatment and the control group. As a complement we also assessed sanctions. There is only a handful of staff that have been dismissed or transferred in 2005 and there is no systematic pattern that distinguishes treatment from control facilities. There is also no difference between treatment and control facilities in the number of staff that voluntarily left the facility during 2005 (Table A.IX).

VI. DISCUSSION

Based on a small but rigorous empirical literature on community participation and oversight, and extensive piloting in the field, our conjecture was that lack of relevant information and failure to agree on, or coordinate expectations of, what is reasonable to demand from the provider were holding back individual and group action to pressure and monitor the provider. We designed an intervention aimed at relaxing these constraints. Through two rounds of community meetings, local NGOs initiated a process aimed at energizing the community and agreeing on actions to improve service provision.

We document large increases in utilization and improved health outcomes that compare favorably to some of the more successful community based intervention trials reported in the medical literature. However, while the medical field trials address the question of impact of a biological agent or treatment practice when the health workers do what they are suppose to do, we focus on a mechanism to ensure that health workers exert effort to serve the community.

The project was implemented in nine districts in Uganda with an estimated catchment population of approximately 55,000 households. In this dimension, therefore, the project has already shown that it can be brought to scale. However, the literature on how to enhance local accountability and participation is still in its

infancy. And while the results in the paper suggest that community monitoring can play an important role in improving service delivery when traditional top-down supervision is ineffective, there are still a number of outstanding questions. For example, we know little about long-term effects and cross-sector externalities. It may also be the case that combining bottom-up monitoring with a reformed top-down approach could yield even better results. Before scaling up, it is also important to subject the project to a cost-benefit analysis. This would require putting a value on the improvements we have documented. To provide a flavor of such a cost-benefit analysis, consider the findings on averting the death of a child under five. A back-of-the-envelope calculation suggests that the intervention, including the cost for collecting data for the report cards (the main cost item), at a cost of \$3 per household in the catchment areas or \$160,000 in total, only judged on the cost per death averted must be considered to be fairly cost-effective. The estimated cost of averting the death of a child under five is around \$300, which should be compared to the estimate that the average cost per child life saved through the combined and integrated delivery of 23 interventions shown to reduce mortality from the major causes of death in children younger than 5 years is \$887 (Bryce et al. 2005).

As argued in a recent *Lancet* article, a systematic program of research to answer questions about how best to deliver health (child survival) interventions is urgently needed (Bryce et al. 2003). In this paper we have focused on a mechanism that have been highlighted, but not examined, in the literature – a mechanism of accountability enabling (poor) people to scrutinize whether or not those in authority have fulfilled their health responsibilities. Future research should address long term effects, identify which mechanisms or combination of mechanisms that are important, and study the extent to which the results generalize to other social sectors.

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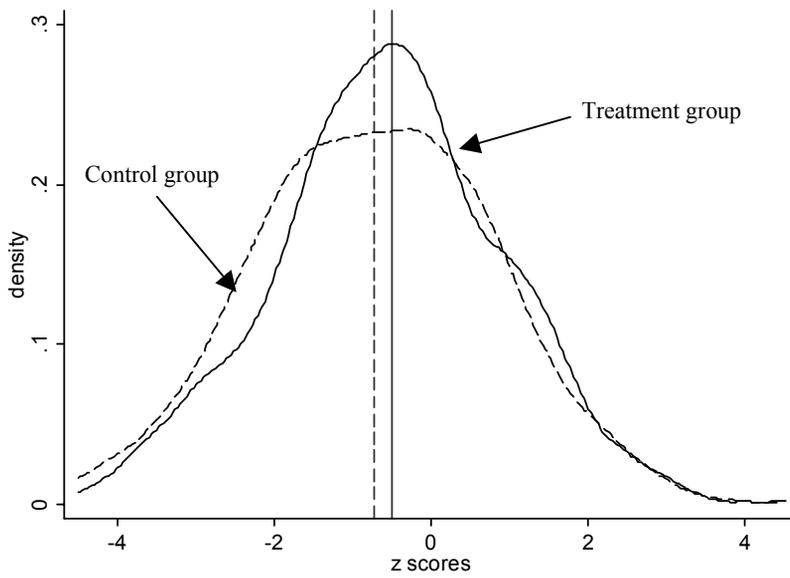


FIGURE II

Distributions of weight-for-age z-scores for treatment and control groups

Notes: Weight-for-age z-scores for children under 18 months excluding observations with recorded weight above the 90th percentile in the growth chart reported in Cortinovis et al (1997). Sample size is 1135 children. Vertical solid line denotes mean in treatment group, dashed line denotes mean in control group.

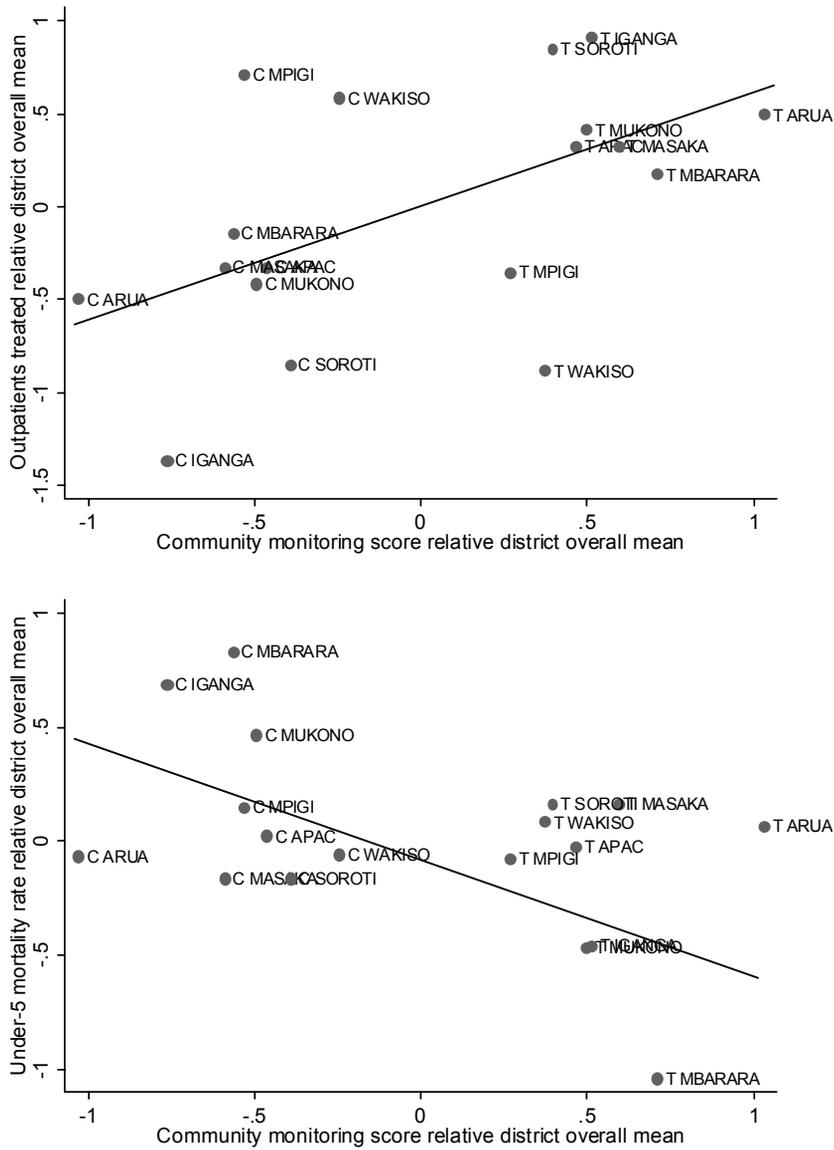


TABLE I
PRE-TREATMENT FACILITY AND CATCHMENT AREA CHARACTERISTICS AND
AVERAGE STANDARDIZED EFFECTS

Variables	Treatment group	Control group	Difference
<i>Key characteristics:</i>			
Out-patient care	593 (75)	675 (57)	-82 (94)
Delivery	10.3 (2.2)	7.5 (1.4)	2.8 (2.6)
No. of households in catchment area	2140 (185)	2224 (204)	-84.4 (276)
No. of households per village	93.9 (5.27)	95.3 (6.32)	-1.42 (8.23)
Drink safely today	0.40 (0.10)	0.32 (0.10)	0.08 (0.14)
No. of days without electricity in last month	18.3 (2.95)	20.4 (2.90)	-2.12 (4.14)
<i>Average standardized pre-treatment effects:</i>			
Utilization			0.11 (0.77)
Utilization pattern			-0.48 (0.33)
Quality measures			-0.35 (0.84)
Catchment area statistics			0.11 (0.66)
Health facility characteristics			0.14 (0.31)
Citizen perceptions			0.37 (0.67)
Supply of drugs			0.73 (0.83)
User charges			-0.65 (0.63)

Notes: Key characteristics are catchment area/health facility averages for treatment and control group and difference in averages. Robust standard errors in parentheses. Significantly different from zero at 99 (***), 95 (**), and 90 (*) percent confidence level. Description of variables: Out-patient care is average number of patients visiting the facility per month for out-patient care. Delivery is average number of deliveries at the facility per month. Number of households in catchment area and number of households per village are based on census data and Uganda Bureau of Statistics maps. Drink safely today is an indicator variable for whether the health facility staff at the time of the pre-intervention survey could safely drink from the water source. Number of days without electricity in the month prior to pre-intervention survey is measured out of 31 days. Average standardized pre-treatment effects are derived by estimating (3) on each family of outcomes. Utilization summarizes outpatients and deliveries. Utilization pattern summarizes the seven measures in Table A.I., reversing sign of traditional healer and self treatment. Quality measure summarizes the two measures in Table A.I., reversing sign of waiting time. Catchment area statistics summarize the four measures in Table A.I. Health facility characteristics summarize the eight measures in Table A.I. and drink safely today and days without electricity, reversing sign of days without electricity and distance to nearest local council. Citizen perceptions summarize the four measures in Table A.I. Supply of drugs summarizes the five measures in Table A.I. User charges summarize the four measures in Table A.I. reversing all signs. The Chi(2) test-statistic on the joint hypothesis that all average standardized effects are zero is 4.70 with p-values = 0.79.

TABLE II
PROGRAM IMPACT ON MONITORING AND INFORMATION

Dependent variable	Suggestion box	Numbered waiting cards	Poster informing free services	Poster on patients' rights	Average standardized effect	Discuss facility in LC meetings	Received information about HUMC
Specification	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)
Program impact	0.32*** (0.08)	0.16* (0.09)	0.27*** (0.09)	0.14 (0.10)	2.55*** (0.55)	0.13*** (0.03)	0.04*** (0.01)
Mean control group	0	0.04	0.12	0.12	-	0.33	0.08
Observations	50	50	50	50	50	3119	4996

Notes: Robust standard errors in parentheses. Disturbance terms are clustered by catchment areas in columns (vi)-(vii). *** [**] (*) denote significance at the 1 [5] (10) percent level. Point estimates, standard errors, and average standardized effect, columns (i)-(v), are derived from equation (3). Program impact measures the coefficient on the assignment to treatment indicator. Outcome measures in columns (i)-(iv) are based on data collected through visual checks by the enumerators during the post-intervention facility survey. Outcome measures in columns (vi)-(vii) are from the post-intervention household survey. The estimated equations all include district fixed effects and the following baseline covariates: number of villages in catchment area, number of days without electricity in the last month, indicator variable for whether the facility has a separate maternity unit, distance to nearest public health provider, number of staff with less than advanced A-level education, indicator variable for whether the staff could safely drink from the water source, and average monthly supply of Quinine. Specification: (i) Indicator variable for whether the health facility has a suggestion box for complaints and recommendations; (ii) Indicator variable for whether the facility has numbered waiting cards for its patients; (iii) Indicator variable for whether the facility has a poster informing about free health services; (iv) Indicator variable for whether the facility has a poster on patients' rights and obligations; (v) Average standardized effect of the estimates in columns (i)-(iv); (vi) Indicator variable for whether the household discussed the functioning of the health facility at a Local council meeting during the past year; (vii) Indicator variable for whether the household has received information about the Health Unit Management Committee's (HUMC's) roles and responsibilities.

TABLE III
PROGRAM IMPACT ON TREATMENT PRACTICES AND MANAGEMENT

Spec.	Dep. variable	Model	Program impact	2005	Mean control group 2005	Obs.
(i)	Equipment used	DD	0.08** (0.03)	-0.07*** (0.02)	0.41	5280
(ii)	Equipment used	OLS	0.01 (0.02)		0.47	2758
(iii)	Waiting time	DD	-12.3* (7.1)	-12.4** (5.2)	131	6602
(iv)	Waiting time	OLS	-5.16 (5.51)		131	3426
(v)	Absence rate	OLS	-0.13** (0.06)		0.47	46
(vi)	Management of clinic	OLS	-1.20*** (0.33)		0.49	50
(vii)	Health information	OLS	0.07*** (0.02)		0.32	4996
(viii)	Importance of family planning	OLS	0.06*** (0.02)		0.31	4996
(ix)	Stock-outs	OLS	-0.15** (0.07)		0.50	42

Notes: Each row is based on a separate regression. The DD model is from equation (2). The OLS model is from equation (1) with district fixed effects and baseline covariates as listed in Table II. Robust standard errors, clustered by catchment areas in columns (i)-(iv) and (vii)-(viii), in parentheses. Significantly different from zero at 99 (***), 95 (**), and 90 (*) percent confidence level. Program impact measures the coefficient on the assignment to treatment indicator in the OLS models and the assignment to treatment indicator interacted with an indicator variable for 2005 in the DD models. Specification: (i)-(ii) Indicator variable for whether the staff used any equipment during examination when the patient visited the health facility; (iii)-(iv) Difference between the time the citizen left the facility and the time the citizen arrived at the facility, subtracting the examination time; (v) The ratio of workers not physically present at the time of the post-intervention survey to the number of workers employed pre-intervention (see text for details); (vi) The first component from a principal components analysis of the variables Condition of the floors of the health clinic, Condition of the walls, Condition of furniture, and Smell of the facility. Each condition is ranked from 1 (dirty) to 3 (clean) by the enumerators; (vii) Indicator variable for whether the household has received information about the importance of visiting the health facility and the danger of self-treatment; (viii) Indicator variable for whether the household has received information about family planning; (ix) Share of months in 2005 in which stock-cards indicated no availability of drugs (see text for details).

TABLE IV
PROGRAM IMPACT ON IMMUNIZATION

Group Specification	Newborn (i)	Less than 1-year (ii)	1-year old (iii)	2-year old (iv)	3-year old (v)	4-year old (vi)
Average standardized effect	1.30* (0.70)	1.44** (0.72)	1.24** (0.63)	0.72 (0.58)	2.01*** (0.67)	0.86 (0.80)
Observations	173	929	940	951	1110	526

Notes: Average standardized effects are derived from equation (3) with the dependent variables being indicator variables for whether the child has received at least one dose of measles, DPT, BCG, polio, and Vitamin A supplement, respectively (see text for details) and with district fixed effects and baseline covariates listed in Table II included. Robust standard errors clustered by catchment areas in parentheses. *** [**] (*) denote significance at the 1 [5] (10) percent level. Groups: (i) Children under 3 months; (ii) Children 0-12 months; (iii) Children 13-24 months; (iv) Children 25-36 months; (v) Children 37-48 months; (vi) Children 49-60 months.

TABLE V
PROGRAM IMPACT ON UTILIZATION/COVERAGE

Dep. variable	Out-patients	Delivery	Antenatal	Family planning	Average std effect	Use of project facility	Use of self treatment /traditional healers	Average std effect
<i>PANEL A: Cross-section data</i>	(i)	(ii)	(iii)	(iv)	(v)	(vi)	(vii)	(viii)
Program impact	130.2** (60.8)	5.3** (2.1)	15.0 (11.2)	3.4 (3.2)	1.75*** (0.63)	0.026* (0.016)	-0.014 (0.011)	1.43* (0.87)
Observations	50	50	50	50	50	50	50	50
<i>PANEL B: Panel data</i>	(ix)	(x)			(xi)	(xii)	(xiii)	(xiv)
Program impact	189.1*** (67.2)	3.48* (1.96)			2.30*** (0.69)	0.031* (0.017)	-0.046** (0.021)	1.96** (0.89)
Observations	100	100			100	100	100	100
Mean control gr. 2005	661	9.2	78.9	15.2	-	0.24	0.36	-

Notes: Panel A reports program impact estimates from cross-section models with district fixed effects and baseline covariates as listed in Table II, with robust standard errors in parentheses. Panel B reports program impact estimates from difference-in-differences models with robust standard errors clustered by facility in parentheses. *** [**] (*) denote significance at the 1 [5] (10) percent level. Point estimates, standard errors, and average standardized effects in specifications (i)-(v), (vi)-(viii), (ix)-(xi), and (xii)-(xiii) are derived from equation (3). Program impact measures the coefficient on the assignment to treatment indicator in the OLS models and the assignment to treatment indicator interacted with an indicator variable for 2005 in the DD models. Specification: First column is average number of patients visiting the facility per month for out-patient care; Second column is average number of deliveries at the facility per month; Third column is average number of antenatal visits at the facility per month; Fourth column is average number of family planning visits at the facility per month; Fifth column is average standardized effect of estimates in specification (i)-(iv) and (ix)-(x), respectively. Sixth column is the share of visits to the project facility of all health visits, averaged over catchment area; Seventh column is the a share of visits to traditional healers and self-treatment of all health visits, averaged over catchment area; Eighth column is average standardized effect of estimates in specification (vi)-(vii) and (xii)-(xiv), respectively, reversing the sign of use of self treatment/traditional healers.

TABLE VI
PROGRAM IMPACT ON HEALTH OUTCOMES

Dependent variable	Births	Pregnancies	U5MR	Child death	Weight-for-age z-scores	
Specification	(i)	(ii)	(iii)	(iv)	(v)	(vi)
Program impact	-0.016 (0.013)	-0.03** (0.014)	-49.9* (26.9)		0.14** (0.07)	0.14** (0.07)
Child age (log)						-1.27*** (0.07)
Female						0.27*** (0.09)
Program impact×Year of birth 2005				-0.026** (0.013)		
Program impact× Year of birth 2004				-0.019** (0.008)		
Program impact× Year of birth 2003				0.003 (0.009)		
Program impact× Year of birth 2002				0.000 (0.006)		
Program impact× Year of birth 2001				0.002 (0.006)		
Mean control gr. 2005	0.21	0.29	144	0.029	-0.71	-0.71
Observations	4996	4996	50	5094	1135	1135

Notes: Estimates from equation (1) with district fixed effects and baseline covariates as listed in Table II included. Specification (iv) also includes a full set of year-of-birth indicators. Robust standard errors in parentheses (iii), clustered by catchment area (i)-(ii), (iv)-(vi). *** [**] (*) denote significance at the 1 [5] (10) percent level. Program impact measures the coefficient on the assignment to treatment indicator. Specification: (i) Number of births in the household in 2005; (ii) Indicator variable for whether any women in the household are or have been pregnant in 2005; (iii) U5MR is under-5 mortality rate in the community expressed per 1,000 live births (see text for details); (iv) Indicator variable for child death in 2005; (v)-(vii) Weight-for-age z-scores for children under 18 months excluding observations with recorded weight above the 90th percentile in the growth chart reported in Cortinovis et al (1997).

TABLE VII
MECHANISMS AND ROBUSTNESS

Dep. variable	Out-patients	U5MR	Out-patients	U5MR	Out-patients	U5MR	Out-patients	U5MR
Specification	(i)	(ii)	(iii)	(iv)	(iii)	(iv)	(vii)	(viii)
Community monitoring index	0.77*** (0.22)	-0.43* (0.25)	0.86* (0.53)	-0.43 (0.82)	0.77** (0.21)	-0.54* (0.30)		
Staff's knowledge about patients' rights					-0.01 (0.28)	0.47 (0.29)		
Program impact			-0.12 (0.66)	0.01 (0.88)			190.5** (92.6)	-41.3 (45.8)
CBO presence							-8.3 (69.4)	-21.0 (37.9)
Program impact×CBO presence							-127.9 (126.1)	-4.0 (58.4)
F-test on program impact							6.17 (0.05)	
F-test on CBO presence							0.37 (0.83)	
F-test on Program impact×CBO presence							1.03 (0.60)	

Notes: Columns (i)-(iv) report 2SLS estimates from equation (4) with district-by-treatment interactions as the excluded instruments and district fixed effects and outpatients_{t-1} (in specifications (i) and (iii)) as controls. The variables in columns (i)-(iv) are expressed in standard deviation units relative to the control group overall standard deviation for each variable. Robust standard errors in parentheses. *** [**] (*) denote significance at the 1 [5] (10) percent level. Program impact measures the coefficient on the assignment to treatment indicator. F-test statistics (with p-values in parentheses) on the excluded instruments Community monitoring and Staff's knowledge about patient's rights are 15.9 (0.00) and 7.23 (0.00), respectively. Point estimates and standard errors in columns (v)-(vi) and columns (vii)-(viii), respectively, are jointly estimated from equation (3). Explanatory variables: Community monitoring is the first component from a principal components analysis of the six monitoring and information proxies presented in Table II. Staff's knowledge about patients' rights is a measure of the in-charge's knowledge about patients' rights and obligations (see text for details). CBO presence is an indicator variable for whether a participating CBO had been operating in the community before the intervention. F-test on program impact [CBO presence] {Program impact×CBO presence} is the test statistic, with p-values in parenthesis, on the test that the coefficients on program impact [CBO presence] {Program impact×CBO presence} are jointly zero in columns (v)-(vi) and (vii)-(viii), respectively.