

The project

The Burkina Faso Community Monitoring for Better Health and Education Service Delivery Project (P121714; CMP) aims to increase the quality and quantity of health and education services through empowering, capacitating, and stimulating individuals and communities to demand good governance and through increasing transparency and accountability of service providers.

This is achieved through a community scorecard mechanism which evaluates the quality of services in health and education facilities. Previously scarce information is provided through community core cards, increasing individual and community-level knowledge of the quality of service and, it is hypothesized, demand for and supply of higher quality services.

In each village, the community itself defines evaluation criteria for schools and health facilities. They then use these criteria to identify service delivery issues and develop strategies to solve these, and progress is discussed at quarterly meetings. It is expected that this monitoring, coupled with public praising or shaming (through dissemination of scores), will elicit increased effort by health and education service providers (intermediate outcomes), which in turn will yield improvements in health and education outcomes. Additionally, the CMP is expected to induce greater participation of households in the management of community affairs and, potentially, improve social capital.

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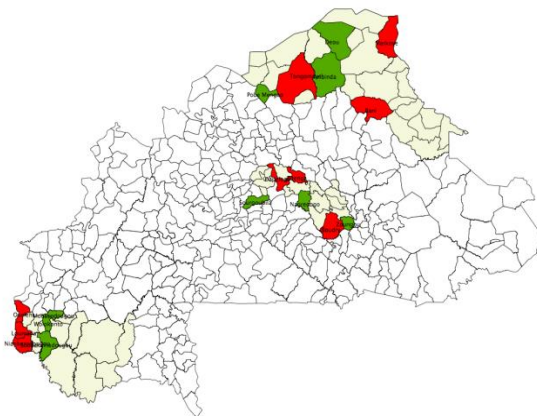
Research questions

1. What are the impacts of the community monitoring intervention on health and education service delivery and on human development outcomes?
2. Do these impacts differ across health and education services?
3. How does the level of social capital within communities affect the outcomes of community monitoring?
4. Does the community monitoring intervention build informal institutions (social capital)?

Impact evaluation design

This is a pilot project targeting 18 health facilities and 18 schools in nine poor rural municipalities in three of Burkina Faso's thirteen regions.

The IE uses a cluster-randomized controlled design, with 36 health facilities and 36 primary schools randomly assigned to either the treatment or control group.



Baseline results

Data collection

Baseline data was collected in July 2011 and February 2012. Data was collected from

- 36 health facilities and 36 primary schools
- 3,840 households
- "Lab-in-field" behavioral activities in 67 villages with 1,000 participants

Key health and education outcomes

Literacy rates

85% of women and 64% of men over 15 years old cannot read and write.

49% of children aged between 5 and 15 years old cannot read and write.

The burden of disease

10% of the respondents got sick during the last 30 days. The most common diseases were malaria, diarrhea and fever.

Poor child health

37% of children aged between 0 and 5 years old are stunted, and 21% are malnourished

Infrastructure

Primary schools

67% of primary schools have no source of drinking water

Health facilities

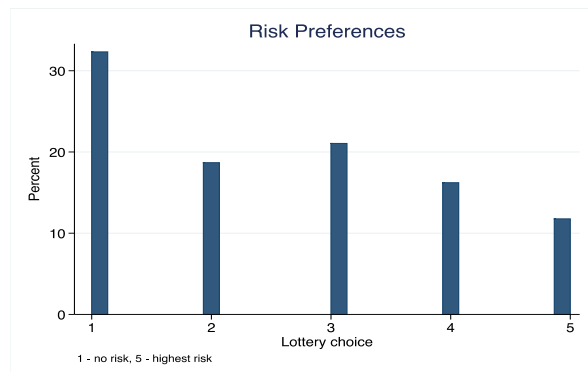
28% of health centers have no electricity



Behavioral measures

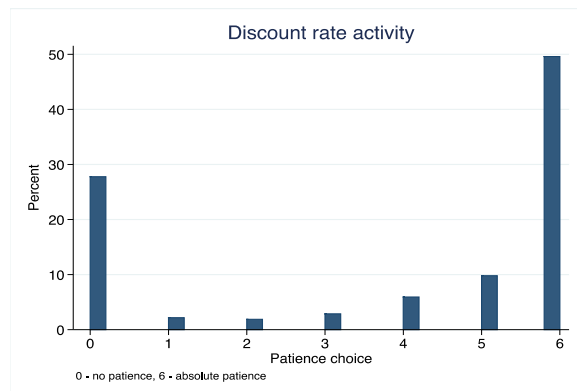
Risk preferences

To measure risk preferences we asked the subjects to choose between *five lotteries*, each with two possible outcomes. A high numbered lottery indicates increased risk. Participants were generally **risk-averse**



Patience

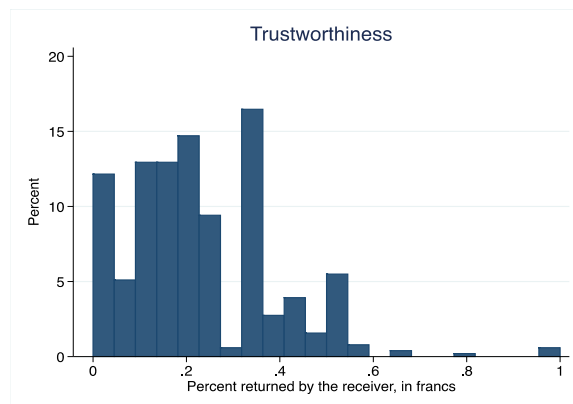
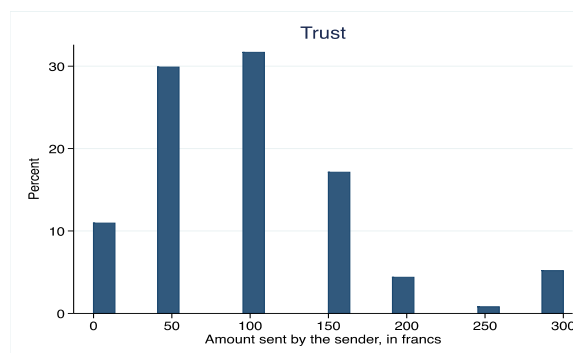
We measured patience in a *discount rate activity* by offering the subjects a choice of receiving an amount on the day of the games or to opt for a larger amount to be disbursed in three days. Each subject was presented with six different scenarios, with a higher number indicating a higher level of patience required. Participants were either **extremely impatient** or **extremely patient**.



Trust and trustworthiness

We used the standard trust game protocol (Berg, Dickhaut and McCabe, 1995) to measure trust and trustworthiness. First, subjects were randomly divided into a group of senders and a group of receivers. The senders were endowed with 300 francs. In the first round senders were asked how many coins they wanted to send to their receiver, knowing that we would triple that amount and that in the second round their receiver would decide how much to return to their sender. The sent money measured trust, while returned money measured trustworthiness.

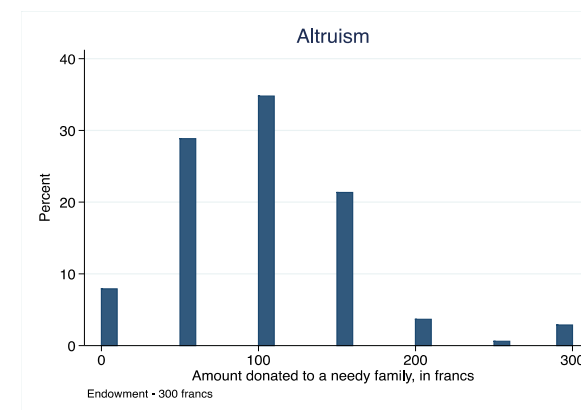
We found that the average amount sent in the first round was about 1/3 of the pot. The average amount returned by the receiver to the sender was less than a 1/4 of the total amount available to the receiver.



Altruism

The participants were endowed with 300 francs. We asked the subjects to decide if they would like to donate to a needy family. Before the subject played the *altruism game* he or she randomly drew a card from a bag. The card determined whether their donation would go to a needy family in their village or to a needy family in another village somewhere else in Burkina Faso.

We found that the average donation amounted to 1/3 of the pot, and it did not depend on whether the donation was for a needy family in the subject's village or in another village in Burkina Faso.



Willingness to donate to public good

The final game was a public goods game similar to the one described in Barrett (2005). The subjects made a choice whether to donate to public good or not.

Just under 3/4 of the subjects contributed to the collective good.

References

Barret, S. (2005). Environment and statecraft: the strategy of environmental treaty-making. New-York: Oxford University Press.

Berg, J., Dickhaut, J., & McCabe, K. (1995). Trust, Reciprocity, and Social History. Games and Economic Behavior, 10(1), 122-142.