

Community participation and voice mechanisms under performance-based financing schemes in Burundi

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Abstract

OBJECTIVE Community participation is often described as a key for primary health care in low-income countries. Recent performance-based financing (PBF) initiatives have renewed the interest in this strategy by questioning the accountability of those in charge at the health centre (HC) level. We analyse the place of two downward accountability mechanisms in a PBF scheme: health committees elected among the communities and community-based organizations (CBOs) contracted as verifiers of health facilities' performance.

METHOD We evaluated 100 health committees and 79 CBOs using original data collected in six Burundi provinces (2009–2010) and a framework based on the literature on community participation in health and New Institutional Economics.

RESULTS Health committees appear to be rather ineffective, focusing on supporting the medical staff and not on representing the population. CBOs do convey information about the concerns of the population to the health authorities; yet, they represent only a few users and lack the ability to force changes. PBF does not automatically imply more 'voice' from the population, but introduces an interesting complement to health committees with CBOs. However, important efforts remain necessary to make both mechanisms work. More experiments and analysis are needed to develop truly efficient 'downward' mechanisms of accountability at the HC level.

keywords community participation, performance-based financing, primary health care, health systems, rural health centres, Burundi

In 2008, WHO insisted that primary health care remains 'Now More than Ever' a key approach to 'raise the level of health in deprived populations' (WHO 2008). At the core of this strategy lies the long-promoted (Zachus & Lysack 1998; Morgan 2001; Rosato *et al.* 2008) and sometimes dogmatic (Cooke & Kothari 2001; Evans *et al.* 2010) concept of 'community participation' and the idea that accountability of health facilities towards the population improves healthcare delivery (World Bank 2003). Still, health systems struggle to achieve 'health for all' (Tizio & Flori 1997); they face crucial issues such as a lack of funding, low performance and poor governance (World Health Organization 2008). Recently, performance-based financing (PBF) strategies (Musgrove 2010) have tried to address the challenge of performance of health facilities (Meessen *et al.* 2006) and pushed for a clarification of the functions of health systems actors (provision, purchasing, regulation/stewardship, etc.) (Meessen *et al.* 2011). By doing this, PBF also questioned the accountability of those in charge of health at the community level. However, the

current debate on PBF (Macq & Chiem 2007; Ireland *et al.* 2011; Soeters & Vroeg 2011) has given relatively little attention to the actual interaction between PBF strategies that rely on market mechanisms, 'downward' accountability and (mainstream) practices of community participation. Burundi provides an interesting case: classic community participation mechanisms such as the elected 'Comités de Santé' [COSAs – health (management) committees] (McCoy *et al.* 2011) exist in most health centres (HCs), and PBF strategies are now widespread (Busogoro & Beith 2010).

This article analyses the current and possible place and organization of the complex notion of 'downward' or 'community' accountability (Mitchell & Shortell 2000; Brinkerhoff 2004; Molyneux *et al.* 2012) mechanisms in a PBF environment (Brinkerhoff *et al.* 2009). It is a contribution to this research on mechanisms of accountability towards the population in the health sector and adds to the growing list of studies on strategies of community accountability that already includes community action plans (Björkman & Svensson 2009), community score

cards (Misra & Ramasankar 2007) and the use of traditional community structures among others (Jacobs 2003). After providing some background information, we explain the theoretical role and functioning of the two main community participation mechanisms in Burundi – COSAs and community-based organizations (CBOs) enrolled as verifiers in PBF schemes – before describing and discussing how they function in practice through the results of a recent survey.

Background

Burundi is a small landlocked country in eastern Central Africa and one of the poorest nations on earth. Its health system is still recovering from a 13-year civil war that left the country short of health workers and funding (Wakabi 2007; Nimpagaritse & Bertone 2011). In 2009, Burundi's total health expenditure was one of the lowest in the world with only US\$20 per capita. The country counted only 0.3 physicians and 1.9 nurses per 100 000 inhabitants, and the health status of the population was awful with an under-5 mortality rate of 166 per 1000 life births and a maternal mortality of 960 per 100 000 life births (WHO 2009). Shortly after the peace agreement of 2006, contractual approaches were developed to revamp the health system and improve its service delivery. With the agreement of the Ministry of Health, PBF pilot schemes were first implemented by Cordaid in the provinces of Bubanza and Cankuzo and by HealthNet/TPO in Gitega Province in 2006, inspired by the example of Rwanda (Rusa *et al.* 2009). Once the logistic and staffing problems for implementing PBF had been solved, the strategy grew in popularity and by January 2010, 11 of the 17 provinces had a PBF system, with the Swiss Tropical Institute starting its PBF project in Ngozi Province in 2009. Under the PBF approach, Health Facilities (HCs) sign contracts with Purchasing Agencies that finance them according to their performance on a set of indicators. To be efficient, PBF systems require and sometimes introduce fundamentals: separation of functions, self-management of HCs, transparent finances and a strong verification mechanism of the performance HCs declare (Toonen *et al.* 2009; Meessen *et al.* 2011). This last mechanism is key; without it, Purchasing Agencies would run the risk of funding HCs based on incorrect performance records and therefore provide the wrong incentives.

NGOs chose to complete the verification of performance (records) assessed at the HC level by purchasing agencies with direct verification among users (Busogoro & Beith 2010). For this purpose, CBOs were contracted to verify – via community surveys – the performance (results) declared by HCs. This is often presented as the ‘voice of the

population’, that is, a new opportunity for the population to express its (dis)satisfaction with health services (Soeters *et al.* 2006). At the same time, PBF implementers had to take into account the old mainstream community participation mechanism: the health committees (COSAs) (Kahssay & Oakley 1999). The latter also take the interests of healthcare users into consideration.

In April 2010, PBF became a national strategy in Burundi's public health services, and the Ministry of Public Health took over the management and stewardship of existing projects (Basenya *et al.* 2011). Yet, an assessment of whether COSAs and CBOs are suitable mechanisms for the population to express its concerns is lacking so far. This article reviews the pre-2010 Cordaid and Swiss Tropical Institute experiences with PBF at COSA and CBO levels.

Two mechanisms of community participation

First, we consider the blueprints of CBOs and COSAs. On the one hand, PBF uses CBOs as verifiers of the actual performance of HCs. CBOs are existing local organizations, set up for other purposes (e.g. cooperatives, charities, etc.) and not necessarily representative of the population. They were selected through a bidding process by peer organizations (in the Swiss Tropical Institute model) or by a panel of experts (including local health authorities, in the Cordaid model). They are offered quarterly contracts by the Purchasing Agency to ‘authenticate’ with randomly selected users the declarations of the HCs on patients and care (Figure 1). CBOs' members are trained by the Purchasing Agency for the verification, but they organize the practical aspects themselves. The data collected through CBOs' verification regard (i) the existence of the users, (ii) the existence of the treatment these users received, (iii) their perception of the price, (iv) their perception of the quality of the services, and (v) their possible comments. This information is reported directly to the Purchasing Agency that pays CBOs between US\$1 and US\$2 per validated questionnaire.

On the other hand, PBF schemes also make use of the ‘classical’, pre-existing health committees (COSAs). COSA members are representatives elected by the population living in the catchment area of a HC. Although the PBF initiative did not directly back COSAs, it gave them a new role: COSAs' members are invited, along with the HC's medical staff, to design the HC quarterly development plan. This plan includes a decision on the allocation of the funds received through the PBF scheme. However, COSAs were initially created with a grander design (Ministry of Public Health of Burundi & WHO 2007): to be the voice of the population at the HC, to take part in its management and to facilitate relations between population

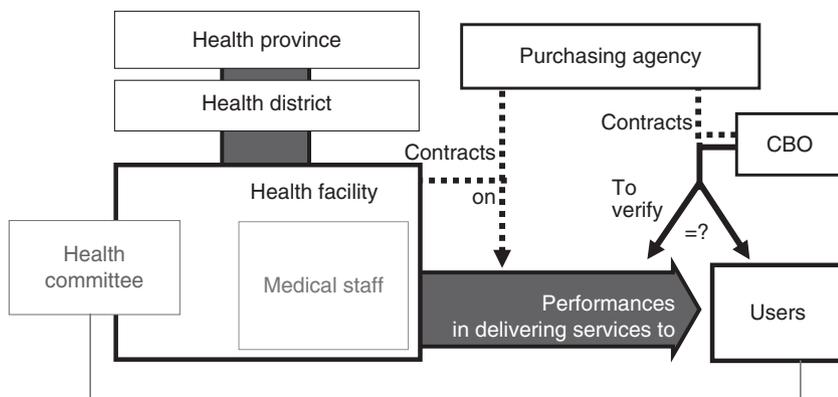


Figure 1 Functioning of the community-based organization (CBO) mechanism (*vs.* Comité de Santé) under performance-based financing.

Table 1 CBO and COSA mechanisms compared

	COSA	CBO
Legitimacy	Elected	Chosen by the purchasing agency or peers
Relation with health facility	Board of trustees/steering committee	None (forbidden)
Relation with purchasing agency	None (coaching is possible)	Contract
Transmission of the concerns of the population	Straight to the medical staff at the health facility level	To the purchasing agency that can convey them to health facilities. The information can be used during the contracting of HC by the purchasing agency

CBO, community-based organization; COSA, Comité de Santé.

and medical staff (Table 1). COSAs have been around in Burundi since the early 2000s when they were created by NGOs. In 2007, they were reorganized by the Ministry of Public Health. Their role was broadly defined by MoH regulation as follows: participating in (i) technical co-management of the HFs (mostly planning and evaluation), (ii) administrative co-management (including controlling the finances), (iii) promotion in the population, and (iv) other (unspecified) activities. Official guidelines make provision for a small compensation for COSA members, but that recommendation seems to have been ignored. With PBF, most HFs choose to finally compensate COSA members with around 3\$/member/month. Only under the Swiss Tropical Institute scheme was this compensation conditional on services.¹ International support for

¹Hold meetings, transmit minutes and recovery of debt guaranteed by COSA members (Falisse *et al.* 2011).

COSAs has dropped in the last years (Ministry of Public Health of Burundi & WHO 2007; Falisse 2010), and their efficiency has been questioned (Deheneffe 2008). In Burundi, no reliable data on COSAs exist.

At least in principle, both mechanisms are ways to express the ‘voice of the population’ and enhance accountability towards the population. However, the situation in the field remains undocumented. What is the current place of COSAs and CBOs in PBF schemes? Are they competing or complementary?

Method and data set

At the end of 2009, Cordaid and its sponsor, the European Union, decided to conduct research to assess the level of ‘voice’ (Hirschman 1970) in the PBF scheme.² Data were collected at the HC level through semi-structured questionnaires combining a classical ‘community participation in health’ framework (Rifkin *et al.* 1988, 2000) and a New Institutional Economics inspired approach (Meessen 2009) Five key dimensions were identified to better describe COSAs and CBOs in practice (Table 2). Three of these dimensions, leadership, organization and needs assessment (link with the community), correspond to the ones described by Rifkin *et al.* (1988) in their seminal paper on evaluating community participation. Two other dimensions are slightly different. First, we wished to highlight that both COSAs and OBCs had expected activities formally defined by contract or rules and therefore replaced Rifkin *et al.*’s dimension of ‘resources mobilization’ by a larger ‘activities’ dimension that evaluates which expected activities are carried out (with a bonus for unexpected activities). Second, using our New Institutional Economics framework, we replaced the dimension ‘management’ by

²The extensive report is available in French at [http://www.cordaid.nl/nl/05-Patient-voice-in-PBF-Burundi-\(March-2010\)-\(FR\).pdf](http://www.cordaid.nl/nl/05-Patient-voice-in-PBF-Burundi-(March-2010)-(FR).pdf)

Table 2 Key indicators chosen to evaluate COSA

Dimension	Key indicators
Leadership	Socio-economic profile of the president and his/her knowledge of the COSA functioning, ease at explaining what the COSA does, proportion of members attending meetings, number of meetings, decision process
Organization	Nomination process for internal positions, internal regulations, meetings of COSA and management committee, existence of structured meetings (including minutes and agenda), existence of a process for financial decisions (signature of cheques)
Community	Election process, heterogeneity of the COSA (religious, ethnic, gender), renewal of the COSA, proportion of 'hills' of the catchment area represented, community meetings
Activities	Activities undertaken (declared by the COSA and HC medical staff)
Decision rights	Undisputed rights on (i) hiring/dismissing of qualified staff, (ii) hiring/dismissing of unqualified staff, (iii) defining the selling price of drugs, (iv) defining the consultation price, (v) ordering drugs, and (vi) deciding on new investments (participation to the development plan)

COSA, Comité de Santé; HC, health centre.

the evaluation of the OBC/COSA decision rights at the HF, this being another way to assess who does what at the HF level. Interviews were conducted in French and Kirundi with three groups: CBOs, COSAs and medical staff. The interviews with the medical staff were carried out to triangulate the declarations of the COSA.

The survey was carried out between October 2009 and February 2010 in 107 HCs in six provinces (of 17), including four PBF pilot provinces. In each province, the sample was randomly selected (Table 3). Data were collected in both public- and faith-based HC. The latter created COSAs when they entered into PBF schemes. Private-for-profit facilities were not part of the study, as they do not have COSAs. CBOs as verifier mechanism only existed in PBF provinces.

Main results

Profile of the members of CBO and COSA

Unsurprisingly, both CBOs and COSAs are mainly composed of people with above average socio-economic status, that is, a local elite (Table 4). The proportion of illiterate members is well below the 34.1% national average (World

Bank 2011), and key positions are filled by civil servants, mostly teachers. Overall, COSA members are more educated than CBO members. This less elitist nature is confirmed, as 70% of the CBOs define themselves as 'self-help groups of farmers'.

CBOs and COSAs are bound by different types of regulations and show different levels of compliance with them. CBOs are only selected as verifiers if they respect a set of criteria, including recognition by the authorities, a minimum number of members and a high literacy level. They observe these criteria, even years after their selection. Conversely, most COSAs loosely follow the Ministry of Public Health's regulations. Each province seems to have developed its own model of COSA, with its own selection and composition process. The principle of two elected members per *colline* (hill – the lowest administrative level) is only respected in two provinces, and transparent elections had not been held in over a third of all cases.

Unlike the CBOs of which the contract with the Purchasing Agency can easily be evaluated, it is trickier to evaluate the COSAs according to their official guidelines. The legal framework of the COSAs remains incomplete, and the interviews revealed that most COSAs only had a vague idea of their terms of reference. In no province did more

Table 3 Sample (location and size)

Province	PBF	Surveyed HCs	Province coverage (%)	Data
Bubanza	Cordaid	18 (three faith-based)	100	COSA (18), CBO (18)
Makamba	Cordaid	20 (five faith-based)	63	COSA (20), CBO (19)
Rutana	Santé+/Cordaid	20 (three faith-based)	67	COSA (20), CBO (19)
Ngozi	Swiss Tropical Institute	20 (two faith-based)	38	COSA (20), CBO (20)
Muramvya	None	17 (four faith-based)	76	COSA (13)
Mwaro (Fota district)	None	9	100	COSA (9)

CBO, community-based organization; COSA, Comité de Santé; PBF, performance-based financing.

Table 4 Socio-economic characteristics of COSA and CBO members and presidents

	COSA (<i>n</i> = 100)	CBO (<i>n</i> = 76)
<i>Members</i>		
Average number	13 (median: 13)	27 (median: 22)
Gender balance	Male dominated, balance in 32% of the cases	Male dominated, balance in 3% of the cases (+4 women organizations)
Finished primary school	19% (SD: 14)	19% (SD: 22)
Illiterate	4% (SD: 11)	21% (SD: 25)
Non-farmers	16% (SD: 15)	11% (SD: 10)
<i>COSA/CBO president</i>		
Gender	97% male	87% male
Years of schooling	Average: 13,4 years (SD: 5,3)	Average: 9,7 years (SD: 3,9)
Speaks French* (%)	67	41
Farmer (%)	25	43
Civil servant (teacher) (%)	52	26
Other (%)	24	31

CBO, community-based organization; COSA, Comité de Santé.

*French is the administrative language in Burundi.

than 30% of the COSAs mention written rules. In half of our sample, these written rules were documents established by aid projects and health provinces before the 2007 Ministry harmonization of COSAs' composition and functioning.

Do they work?

Only CBOs present evidence of fulfilling their mission in a satisfactory way. COSAs appear confused: only 13% of them argued that they are a well-functioning interface between the population and the medical staff, transmitting information and acting in both directions. In 43% of the cases, COSAs described themselves as a means to communicate information in one way only, from the HC to the population. 42% of all the surveyed COSAs declared that they had no clear idea of what they are supposed to do. In practice, numerous conflicts exist with the medical staff over the decision rights inside the HC. In our 100 COSAs sample, only three experienced no contradiction between the COSAs' and medical staff interpretation of the decision rights of the COSAs (cf. Table 2). In practice, COSAs' decision rights seem often almost non-existent; COSAs mostly focus on facilitating HC's activities such as health sensitization, bringing patients to the HC, updating their files, etc. The evaluation of COSAs using the

five key dimensions identified in the methodology part³ shows a rather bleak picture (Figure 2).

COSAs are far removed from the ideal scenario in which they would have clear undisputed decision rights at the HC, leaders with a well-defined idea on how and where to lead their committees, internal mechanisms ensuring that the COSAs function efficiently, a set of activities that goes beyond the scope of purely supporting the medical staff activities and a strong relationship with the population they represent. COSAs located in areas covered by a PBF scheme performed better than the ones located in non-PBF areas, especially regarding their activities, decision rights and link with the population. It is important to underline that Cordaid and the Swiss Tropical Institute gave basic training to the COSAs. However, the training focussed on the participation of COSA members in the newly established HC development plans introduced by the PBF.

When we look at CBOs, the situation is much more clear-cut: 100% of CBOs had understood the mission defined by their contract. They stick to their verification task and did not claim to have anything to say at the HC. Purchasing Agencies were satisfied by the job CBOs were doing: less than 5% of the questionnaires were poorly completed, and the quality of the surveys had improved over time. In only two cases, we found that the CBOs had gotten in touch with the medical staff, something prohibited by their contract. It is interesting to point out that financial incentives remain the primary driver of CBOs; only 24% of the surveyed CBOs felt their mission also contributed to the improvement of the health system.

Relation with the population

As we already pointed out, COSAs are not very effective in reflecting the concerns of the population. In addition to the often non-transparent election process of COSAs, half of the surveyed COSAs had never been renewed. Some COSAs had been in place for more than 7 years. Only 64% claimed they hold regular meetings with the population, a claim that could not be verified. During the interviews, few medical staff said they usually take into account the view of the COSAs when making decisions. We did not interview the population, but (unrepresentative) focus group research carried out in 2008 revealed that few people knew about COSAs (Deheneffe 2008). In the case of CBOs, who usually met between 60 and 80 users per quarter, no more than 20% (1–2 per province) felt that they were able to convey the concerns of the population to the health authorities.

³Detail of the calculation used to evaluate the criteria of each dimension is available in the full report.

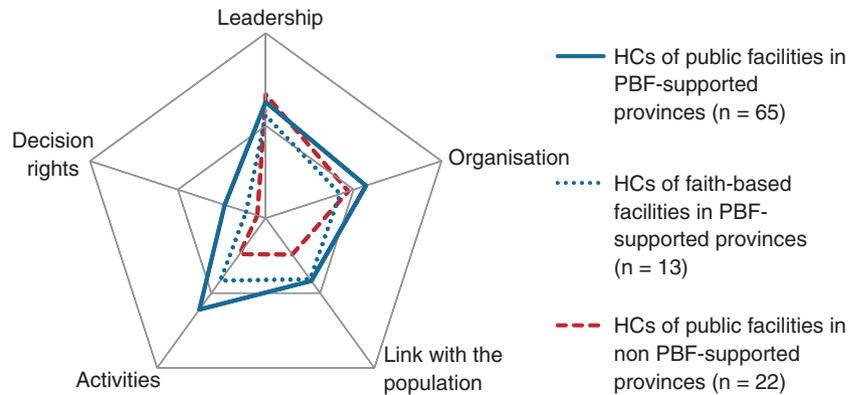


Figure 2 The situation of health committees, by type of health centre (HC).

The information collected by both COSAs and CBOs remains a bit of a mystery. In the case of COSAs, minutes of meetings are supposed to be transmitted to the district authorities for analysis and action. In the majority of cases, we could not access these files. Interviews conducted with the health district staff indicated that the data, when collected, were not exploited and poorly classified. The Burundian Health Information System does not use the information produced by COSAs either.

Data collected by CBOs are exploited, mostly for verification purposes. The information on the satisfaction of the users is eventually used as a component of the quality bonus that the Purchasing Agency may allow to HCs. The rest of the answers given by users to the CBOs on their perception of the costs and especially their comments seemed not exploited. In the best-case scenario, the comments were presented to the medical staff by the Purchasing Agency during quarterly meetings, without obligation to take action.

Comparing COSAs and CBOs using the COSAs 'spidergram' (Figure 3) sums up the main differences between the two structures. Because of their nature, CBOs have no decision rights at the HC and are not representative of the population. COSAs have low and disputed decision rights. They represent communities, but poorly communicate with them. CBOs perfectly verify PBF data, the only activity they are expected to do in the health system, whereas COSAs fail to perform quite a few activities one would expect them to do as they focus on selective activities dictated by the medical staff. CBOs have overall better leadership and organization than COSAs; this is perhaps connected to their spontaneous creation within the community, whereas COSAs were created from the outside.

Discussion

COSAs under PBF schemes seem to work better than non-supported ones. However, this finding should be

considered carefully as our sample covers only six of the 17 Burundian provinces and not every piece of information could be triangulated. The reliability of the data on the links between the population and COSAs/CBOs is not guaranteed. The survey provides only declarations of CBOs, medical staff and COSAs. Apart from interviews at Purchasing Agencies and Health District levels and observations at the HCs, we had few possibilities to check whether these declarations correspond to reality.

Our results seem to indicate that COSAs in provinces under PBF schemes outperform COSAs in the two non-supported provinces, especially regarding voice and decision rights issues. But a direct positive effect of the PBF mechanism on the performance of the COSAs cannot be proven. First, not all the external factors could be controlled; for instance, the 'control' provinces of Mwaro and Muramvya have been less supported by international aid. Second, it is difficult to ascertain whether it is the PBF mechanism that boosted COSAs performance or the mere presence of NGOs. Nonetheless, we believe

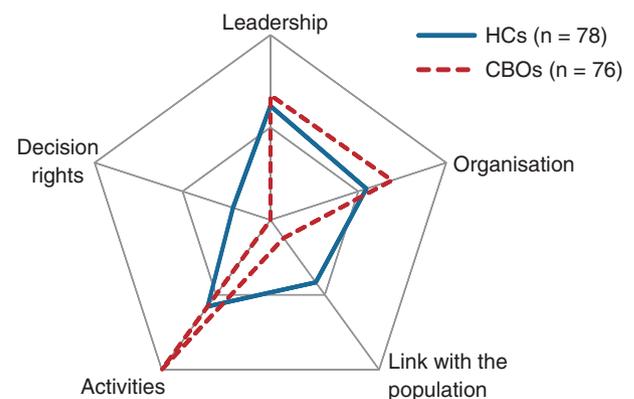


Figure 3 How OBCs would perform on the Comité de Santé (COSA) spidergram [only in performance-based financing provinces (PBF)].

that PBF made a difference for COSAs in at least three respects: (i) it brought money to underfunded HCs (in our sample, PBF funds comprised on average 40% of the HCs' budget), so that the COSAs now have a more substantial budget, (ii) it introduced another role for COSAs that is clearly defined – that they participate in the quarterly development plan – and (iii) PBF money has been used to pay a compensation to COSAs' members that was not paid in non-PBF areas. These represent three clear incentives for COSAs to resume or improve their work.

It is also possible to analyse both systems using the debate on community participation as a means *vs.* a tool (Rifkin 1996). CBOs clearly appear as (efficient) 'tools' of the PBF system, whereas COSAs are supposedly closer to the idea of being both a tool for the health system and a way of 'empowering' community people to gain control over their own health resources. However, as the results show, COSAs are often no more than 'tools' used by the HF staff who dictate COSAs members what to do.

COSAs and CBOs were both described as 'key' by the PBF implementers we interviewed, in spite of the many issues described and although the PBF model is an 'exit' rather than a 'voice' mechanism – the HC is rewarded per service and a patient not coming is tantamount to an income loss, whereas in a 'voice' system, people would exert pressure to improve the service rather than go to another HC (World Bank 2003; Meessen 2009). We believe there are at least two reasons for this: (i) the feedback from users helps control the actual performance of HCs (Basinga *et al.* 2011), and (ii) PBF also aims at fostering self-management and capacities at the HC-level (Rusa *et al.* 2009), and it seems a good idea to have a management in line with the community's concerns.

This being said, one wonders whether CBOs really convey the 'voice of the population'. The data they collect are limited to a small, unrepresentative sample of HC users and is only partly exploited, although CBOs are a unique way to collect routine data in a context of ill-equipped Health Information Systems. CBOs should, thus, be seen as a 'limited voice', as the voices of non-users and users not selected in the randomized verification process have no chance to be heard. Moreover, the users' information is conveyed only indirectly to the HCs and does not oblige the medical staff to any change. This limited voice has therefore only the power of persuasion: it does not give the agent who transmits it (i.e. the CBO) any decision right at the HC. If we define accountability in terms of both answerability and sanctions (Brinkerhoff 2004), CBOs indeed appear as a chance for the population to ask questions, but sanctions may only come from an external actor unrelated to the community, the Purchasing Agency, that judges the 'answers'.

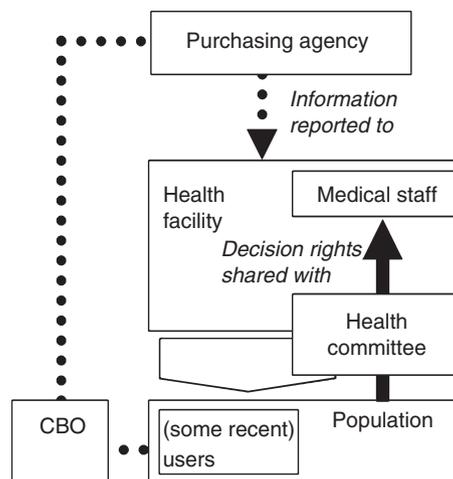


Figure 4 Possible two-ways voice mechanism.

Overall, the COSA and CBO mechanisms of accountability towards the population appear not fully functional; possibilities for the population to ask questions, obtain answers and take sanctions (Berlan & Shiffman 2011) remain weak. Yet, we think it is worth continuing working on their effectiveness. One reason for that is the fact that without these mechanisms, the provider – that is, the chief nurse at a HC – is too often in a *de facto* monopoly situation over healthcare delivery in low-income rural fragile countries such as Burundi. As Health Management Committees models have been proven to be sometimes complicated and under-performing (Rifkin 1986; Musembi & Kilalo 2000), new mechanisms may complement them such as community score cards or CBOs as verifiers in output-based financing models. We think these mechanisms are complementary rather than concurrent: using CBOs as verifiers amounts to a 'soft' mechanism that influences HC from the top, while COSAs represent a 'harder' voice mechanism at the HC that comes from the bottom (Figure 4). Merging the two mechanisms is not recommended, as it would go against the principle of separating the functions in a PBF scheme (Bertone & Meessen 2011) and create a conflict of interest: the 'administrators' of a HC would be paid to evaluate their own facility (Falisse *et al.* 2011).

Conclusions

More rigorous evaluation and documentation of existing mechanisms of accountability towards the population still appear necessary. In the case of Burundi, the relations between COSAs and third parties remain

undocumented, and the long-run effect of PBF on community participation mechanisms is unknown (Basinga *et al.* 2011).

In many countries, health systems may benefit from stronger accountability mechanisms towards communities (Brinkerhoff 2004; Björkman & Svensson 2010). Our study shows how entrusting some monitoring functions to CBOs in a PBF system may increase accountability and complement COSAs. However, the current situation is not satisfactory; ineffective COSAs do not focus on their mandate of representing the population, and CBOs have a limited potential to channel the 'voice' of the population. Community participation remains a possible way to improve primary health care in low-income countries. Yet, we must beware of overly optimistic discourses and models and continue working on these issues, keeping a close eye on field experiences that give communities the possibility to express their 'voices'.

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References

- Basenya O, Nimpagaritse M, Busogoro F *et al.* (2011) Le financement basé sur la performance comme stratégie pour améliorer la mise en œuvre de la gratuité des soins: premières leçons de l'expérience du Burundi. *PBF CoP Working Paper* 4, 1–17.
- Basinga P, Mayaka S & Condo J (2011) Performance-based financing: the need for more research. *Bulletin of the World Health Organization* 89, 698–699.
- Berlan D & Shiffman J (2011) Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship. *Health Policy and Planning* (forthcoming, Advance Access published May 5, 2011) doi: 10.1093/heapol/czr036.
- Bertone MP & Meessen B (2011) Applying an institutional economic framework to the analysis of two PBF projects in Burundi: an exploratory study. (also see *Presentation at the 3rd International Conference Health Financing in Developing and Emerging Countries*. CERDI: Clermont-Ferrand).
- Björkman M & Svensson J (2009) Power to the people: evidence from a randomized field experiment on community-based monitoring in Uganda. *Quarterly Journal of Economics* 124, 735–769.
- Björkman M & Svensson J (2010) When is community-based monitoring effective? Evidence from a randomized experiment in primary health in Uganda. *Journal of the European Economic Association* 8, 571–581.
- Brinkerhoff DW (2004) Accountability and health systems: toward conceptual clarity and policy relevance. *Health Policy and Planning* 19, 371–379.
- Brinkerhoff DW, Fort C & Stratton S (2009) Good governance and health: assessing progress in Rwanda. TWUBAKANE Decentralization and Health Program Rwanda Report.
- Busogoro JF & Beith A (2010) Pay for performance for improved health in Burundi. P4P Case Studies (Health Systems 20/20). USAID, Washington.
- Cooke B & Kothari U (2001) *Participation: The New Tyranny?* Zed Books, London.
- Deheneffe J-C (2008) *Rapport de mission d'étude des couts et du financement du système de santé au Burundi (mission financée par la Commission Européenne)*, Cordaid Report.
- Evans D, Pilkington P & McEachran M (2010) Rhetoric or reality? A systematic review of the impact of participatory approaches by UK public health units on health and social outcomes. *Journal of Public Health* 32, 418–426.
- Falisse J-B (2010) Participation communautaire et financement basé sur la performance. *CoSa et Associations Locales dans les provinces de Bubanza, Makamba, Muramvya, Mwaro, Ngozi et Rutana, Burundi. Rapport de mission d'étude*. Cordaid Report.
- Falisse J-B, Meessen B, Bossuyt M & Ndayishimiye J (2011) Le financement basé sur la performance, une opportunité pour redynamiser la participation communautaire? L'expérience du Burundi. *PBF CoP Working Paper* 1, 1–18.
- Hirschman A (1970) *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States*. Harvard University Press, Cambridge.
- Ireland M, Paul E & Dujardin B (2011) Can performance-based financing be used to reform health systems in developing countries? *Bulletin of the World Health Organization* 89, 695–698.
- Jacobs B (2003) Community participation in externally funded health projects: lessons from Cambodia. *Health Policy and Planning* 18, 399–410.
- Kahsay HM & Oakley P eds (1999) *Community Involvement in Health Development: A Review of the Concept and Practice*. Public Health in Action, 5, World Health Organisation, Geneva.
- Macq J & Chiem J-C (2007) Looking at the effects of performance-based financing through a complex adaptive lens. *Bulletin of the World Health Organization* 85, 699.
- McCoy DC, Hall JA & Ridge M (2011) A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy and Planning* (forthcoming, Advance Access published December 8, 2011) doi: 10.1093/heapol/czr077.

J.-B. Falisse *et al.* **Community participation under PBF**

- Meessen B (2009) *An Institutional Economic Analysis of Public Health Care Organisations in Low-Income Countries*. Université Catholique de Louvain, Louvain-la-Neuve.
- Meessen B, Musango L, Kashala J-P & Lemlin J (2006) Reviewing institutions of rural health centres: the performance Initiative in Butare, Rwanda. *Tropical Medicine & International Health: TM & IH* 11, 1303–1317.
- Meessen B, Soucat A & Sekabaraga C (2011) Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform? *Bulletin of the World Health Organization* 89, 153–156.
- Ministry of Public Health of Burundi & WHO (2007) *Guide pour l'Organisation des Comités de Santé du Burundi*. Ministry of Public Health of Burundi & WHO, Bujumbura.
- Misra V & Ramasankar P (2007) Case study 1 Andhra Pradesh, India: improving health services through community score cards. *Social Accountability Series – World Bank* 1, 1–8.
- Mitchell SM & Shortell SM (2000). The governance and management of effective community health partnerships: a typology for research, policy, and practice. *The Milbank Quarterly* 78, 241–89, 151.
- Molyneux S, Atela M, Angwenyi V & Goodman C (2012) Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. *Health Policy and Planning* (forthcoming, Advance Access published January 25) doi: 10.1093/heapol/czr083.
- Morgan LM (2001) Review article community participation in health: perpetual allure, persistent. *Health Policy and Planning* 16, 221–230.
- Musembi F & Kilalo C (2000) Between communities and health facilities in health service delivery: reality or myth? *IDS Bulletin* 31, 64–68.
- Musgrove P (2010) Financial and other rewards for good performance or results: a guided tour of concepts and terms and a short glossary. Results-Based Financing for Health. The World Bank, Washington. <http://www.rbhealth.org/rbhealth/system/files/RBF%20Glossary%20long.pdf> (Accessed on 15 September 2011).
- Nimpagaritse M & Bertone MP (2011) The sudden removal of user fees: the perspective of a frontline manager in Burundi. *Health Policy and Planning* 26(Suppl. 2), ii63–ii71.
- Rifkin SB (1986) Lessons from community participation in health programmes. *Health Policy and Planning* 1, 240–249.
- Rifkin SB (1996) Paradigms lost: toward a new understanding of community participation in health programmes. *Acta Tropica* 61, 79–92.
- Rifkin SB, Muller F & Bichmann W (1988) Primary health care: on measuring participation. *Social Science Medicine* 26, 931–940.
- Rifkin SB, Lewando-Hundt G & Draper AK (2000) *Participatory Approaches in Health Approaches in Health Promotion and Health Planning: A Literature Review*. Health Development Agency, London.
- Rosato M, Laverack G, Grabman H *et al.* (2008) Alma-Ata: rebirth and revision 5 community participation: lessons for maternal, newborn, and child health. *Lancet* 372, 962–971.
- Rusa L, Schneidman M, Fritsche G & Musango L (2009) Rwanda: performance-based financing in the public sector. In: *Performance Incentives for Global Health: Potential and Pitfalls* (eds R Eichler & R Levine) Center for Global Development, Washington, pp. 189–214.
- Soeters R & Vroeg P (2011) Why there is so much enthusiasm for performance-based financing, particularly in developing countries. *Bulletin of the World Health Organization* 89, 700.
- Soeters R, Habineza C & Perenboom PB (2006) Performance-based financing and changing the district health system: experience from Rwanda. *Bulletin of the World Health Organization* 029991, 884–889.
- Tizio S & Flori Y-A (1997) L'initiative de Bamako: santé pour tous ou maladie pour chacun. *Tiers-Monde* 38, 837–858.
- Toonen J, Canavan A, Vergeer P & Elovainio R (2009) *Learning Lessons on Implementing Performance-Based Financing*. KIT, Amsterdam.
- Wakabi W (2007) Ethnic war leaves Burundi's health sector in ruins. *Lancet* 369, 1847–1848.
- WHO (2009) Burundi data. Available at: <http://apps.who.int/ghodata/#> (accessed January 20, 2012).
- World Bank (2003) *World Bank Development Report 2004: Making Services Work for Poor People*. World Bank & Oxford University Press, Washington.
- World Bank (2011) World Bank Development Indicator – Burundi. World Bank, available at: <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/BURUNDIEXTN/0,,menuPK:343777~pagePK:141132~piPK:141109~theSitePK:343751,00.html> (accessed 2011).
- World Health Organization (2008) *The World Health Report 2008. Primary Health Care, Now More than Ever*. WHO, Geneva.
- Zachus ZD & Lysack CL (1998) Revisiting community participation. *Health Policy and Planning* 13 1–12.

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