COMMUNITY SCORE CARD PROCESS
- A Short Note on the General Methodology for Implementation[1]

1. INTRODUCTION

The community score card (CSC) process is a community based monitoring tool that is a hybrid of the techniques of social audit, community monitoring and citizen report cards. Like the citizen report card, the CSC process is an instrument to exact social and public *accountability* and responsiveness from service providers[2]. However, by including an *interface meeting* between service providers and the community that allows for immediate feedback, the process is also a strong instrument for *empowerment* as well.

The CSC process uses the "community" as its unit of analysis, and is focused on monitoring at the local/facility level. It can therefore facilitate the monitoring and performance evaluation of services, projects and even government administrative units (like district assemblies) by the community themselves. Since it is a grassroots process, it is also more likely to be of use in a rural setting.

Using a methodology of soliciting user perceptions on quality, efficiency and transparency similar to citizen report cards, the CSC process allows for (a) tracking of inputs or expenditures (e.g. availability of drugs), (b) monitoring of the quality of services/projects, (c) generation of benchmark performance criteria that can be used in resource allocation and budget decisions, (d) comparison of performance across facilities/districts, (e) generating a direct feedback mechanism between providers and users, (f) building local capacity and (g) strengthening citizen voice and community empowerment.

As with any instrument of social and public accountability, an effective CSC undertaking requires a skilled combination of four things: i) understanding of the socio-political context of governance and the structure of public finance at a *decentralized level*, ii) technical competence of an intermediary group to *facilitate* process, iii) a strong publicity campaign to ensure maximum participation from the community and other local stakeholders, and iv) steps aimed at institutionalizing the practice for iterative civic actions.

2. THE COMPONENTS OF THE CSC PROCESS

As such the CSC process is not a long-drawn and can even be carried out in one public meeting. However, the purpose of the exercise is not just to produce a scorecard, but to use the documented perceptions and feedback of a community regarding some service, to actually bring about an improvement in it's functioning.

For this reason the implementation of a comprehensive CSC *process*, does not stop at just the creation of a CSC *document* that summarizes user perceptions. Instead, the CSC process that we envisage involves ***four components:***

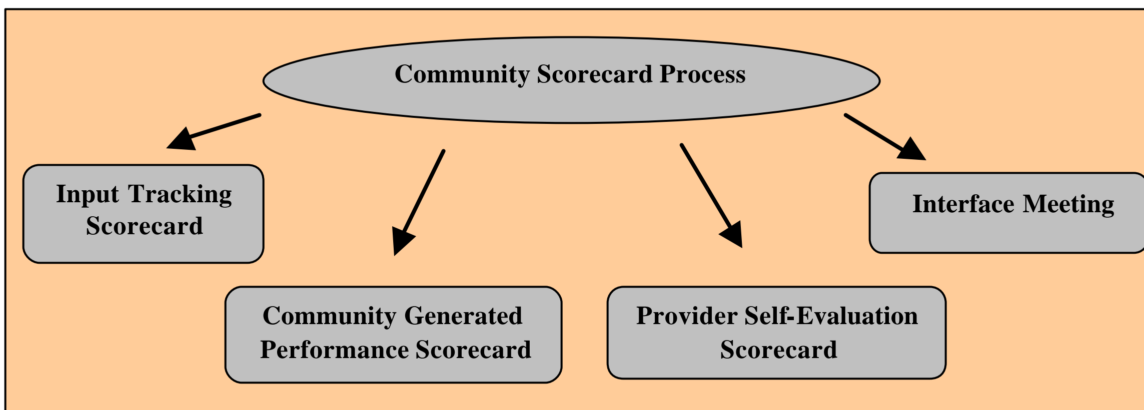
(i) the input tracking scorecard,
(ii) the community generated performance scorecard
(iii) the self-evaluation scorecard by service providers, and last but certainly not least,

[1] This note was prepared by Janmejay Singh and Parmesh Shah of the Social Development Department at the World Bank. It is derived in large part from the work by CARE's work in monitoring the performance of Health Services in Malawi through a community scorecard.

[2] A table summarizing the difference between the CSC and the CRC is presented at the end of this note as Annex 1.

(iv) the interface meeting between users and providers to provide respective feedback and generate a mutually agreed reform agenda

Figure 1: The Four Components of the Community Scorecard Process



3. THE STAGES INVOLVED IN IMPLEMENTATION[3]

The above four components of the CSC process require a fair deal of preparatory groundwork as well as follow-up efforts towards institutionalizing the process into governance, decision making and management of service provision at the local level. Thus, all in all, we can divide the CSC process into ***six key stages*** – (i) preparatory groundwork, (ii) developing the input tracking scorecard, (iii) generation of the community performance, (iv) generation of the self-evaluation score card by facility/project staff, (v) the interface meeting between community and providers, and (vi) the follow-up process of institutionalization. These stages and the tasks involved in them are described below.

2.1 Preparatory Ground Work

First, identify the scope of the monitoring or performance evaluation – which sector (health, education, etc…) is going to be evaluated. The fact that the methodology of the CSC is most useful in monitoring performance of services that come in close contact with communities, should be kept in mind. The sample space of village clusters that will be used for the exercise must also be defined. These clusters should be cohesive, so that defining the members of different villages as a 'community' does not become unrealistic[4].

Second, given the high degree of facilitation and mobilization required in the CSC process it is important to find people or groups within the sample area who can help with the implementation of the scorecard. These can include traditional leaders, members of local governments, workers at the service facilities in the region, community volunteers, and staff from local/international NGOs.

[3] The methodology we describe should be seen as just one method of execution of the model. Depending on the context there can be variations in the way that the process is undertaken, and it is this characteristic that makes it very powerful. For instance, in the description below, the data collection is done through focus groups interactions. But with some iterations complete, the model can move to more questionnaire based data collection.

[4] It might be useful to start a widespread CSC initiative by piloting in a sample village cluster that is representative. For practical purposes, a sample of villages where work on participatory methods and community driven development has been undertaken could be chosen.

Third, as the process of drawing out community perceptions is done via a community meeting, one must ensure that the latter has broad participation from all parts of the community in the village cluster. For this purpose, the meeting must be preceded by full-scale mobilization of people in the community through an advocacy/awareness generating campaign that informs people about the purpose and benefits of the CSC. If a large segment of the community participates in the process, the first step towards success would have been achieved. Therefore it is useful if the facilitators have a history of work with the community so that trust has been built.

Fourth, since the data collection during the community gathering is done on the basis of *focus groups*, a preliminary stratification of the community based on usage of the service that is being evaluated needs to be undertaken. This includes finding out first who uses what, how much, and what the demographic and poverty distribution of usage is.This initial stratification can done by two means:

(a) either through field visits and informal interviews by the facilitating team, or
(b) by using existing social/poverty mapping data collected by previous participatory exercises.

The stratification will also give a first glimpse at the usage issues and performance criteria that one can expect to generate through the exercise.

2.2 Development of the Input Tracking Scorecard

First, in order to be able to track inputs, budgets or entitlements one must start by having data from the supply side about these. Therefore, the first job is clearly to *obtain this supply-side data*. This can be in the form of :

(a) inventories of inputs like drugs, textbooks, furniture, etc.,
(b) financial records or audits of projects,
(c) budgets and allocations of different projects, or
(d) entitlements based on some kind of national policy (e.g. one textbook per child).

Second, take this information to the community and the project/facility staff and tell them about it. This is the initial stage of letting the community know their 'rights'[5] and providers their 'commitments.' For instance, are workers' wages supposed to be 100 Kwachas per day, are households entitled to 10 kg of food ration per week, or are there supposed to be 1000 capsules of a certain drug available in the health center.

Third, one needs to divide participants into focus groups based on their involvement in the service/project – e.g., are they workers, aid receiving households, facility staff, users, etc…Usually one needs to separate the providers from the community, and then sub-divide each group. The resulting sub-groups should have sufficient numbers of respondents from each aspect of the project (users, workers, aid recipients, etc…) and should ideally also be mixed in terms of gender and age. They will then be able to provide information regarding different inputs.

Fourth, using the supply-side information above, and the discussions in the sub-groups one needs to finalize a set of *measurable input indicators* that will be tracked. These will depend on which project or service is under scrutiny. Examples include the wages received for different work programs, food rations or drugs received, sources of procurement under a project (were the cheapest sources used, was a friend/relative given a contract, etc.). In each case the aim is to come up with an indicator for which a variance between actual and entitled/budgeted/accounted data can be compared.

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[5] Giving community members access to information about their entitlements and local budgets is in itself a highly empowering process, and can be seen as an example of putting the *rights based approach* towards development into action.

Fifth, with the input indicators finalized the next step is to ask for and record the data on actuals for each input from all of the groups and put this in an input tracking scorecard as shown in table-1 below. Wherever possible each of the statements of the group member should be substantiated with any form of concrete evidence (receipt, account, actual drugs or food, etc.). One can triangulate or validate claims across different participants as well.

Sixth, in the case of physical inputs or assets one can inspect the input (like toilet facilities) to see if it is of adequate quality/complete. One can also do this in the case of some of the physical inputs – like number of drugs present in the village dispensary – in order to provide first hand evidence about project and service delivery.

Table-1: An Example of What an Input Tracking Scorecard Looks Like

Input Indicator	Entitlement	Actual	Remarks/Evidence
Textbooks per child			
Children per class			
Sanitation Facilities			
Furniture per classroom			
Wages of Teachers			

2.3 Generation of the Community Generated Performance Scorecard

First, once the community has gathered, the facilitators (both local and external) face the task of classifying participants in a systematic manner into focus groups. The most important *basis for classification must be usage*, in order to ensure that there are a significant number of users in each of the focus groups. Without this critical mass, no useful data can be solicited. Each group should further have a heterogeneous mix of members based on age, gender, and occupation so that a healthy discussion can ensue.

Second, each of the *focus groups must brainstorm to develop performance criteria* with which to evaluate the facility and services under consideration[6]. The facilitators must use appropriate guiding or 'lead-in' questions to facilitate this group discussion[7]. Based on the community discussion that ensues, the facilitators need to list all issues mentioned and assist the groups to organize them into measurable or observable performance indicators[8]. The facilitating team must ensure that everyone participates in developing the indicators so that a critical mass of objective criteria are brought out.

Third, the set of community generated performance indicators need to be finalized and prioritized. In the end, the number of indicators should not exceed 5-8.[9]

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[6] This is the critical feature of the CSC since these community based indicators are the basis for assessing the quality of services and soliciting user perceptions in a systematic manner.

[7] Example of lead in questions are: Do you think this facility/service is operating well? Why? How would you measure/describe the quality of the service?

[8] Examples of indicators include the attitude of staff (politeness, punctuality, etc.), the quality of services provided (adequate infrastructure and equipment, qualifications of staff, etc.), the maintenance of the facility, and access. The indicators should be *'positive'* in the sense that a higher score means better (e.g. 'transparency' rather than 'lack of transparency' should be used as the indicator)

[9] In addition to the community-generated indicators, the evaluation team as a whole can agree on a set of *standard indicators* (about 3) for each facility, project or service. These standard indicators can be compared across focus groups, and indeed across facilities and communities both cross-sectionally and over time.

Fourth, having decided upon the performance criteria, the facilitators must ask the focus groups to give relative scores for each of them. The scoring process can take separate forms – either through a consensus in the focus group, or through individual voting followed by group discussion. A scale of 1-5 or 1-100 is usually used for scoring, with the higher score being 'better'.

Fifth, in order to draw people's perceptions better it is necessary to ask the reasons behind both low and high scores. This helps explain outliers and provides valuable information and useful anecdotes regarding service delivery.

Sixth, the process of seeking user perceptions alone would not be fully productive without asking the community to come up with its own set of suggestions as to how things can be improved based on the performance criteria they came up with. This is the last task during the community gathering, and completes the generation of data needed for the CSC. The next two stages involve the feedback and responsiveness component of the process.

Table-2: A Sample Community Generated Performance Scorecard for Health from Malawi[10]

	Indicators	**Score out of 100**	**Scores after 6 months**	**Scores after 12 months**
1	Positive attitude of staff	40		
2.	Management of the health centre.	50		
3.	Quality of services provided	35		
4	Equal access to the health services for all community members	25		

Table-3: Another Example of What a Community Scorecard within a Focus Group Looks Like[11]

Community generated criteria	**Score**					**Remarks**
	1 Very Bad	2 Bad	3 OK.	4 Good	5 V. Good	
Availability of staff	Score: %:					
Availability of ambulance						
Availability of drugs						
Availability of furniture						
Attitudes of staff						

[10] From CARE Malawi's report on "*Outputs from the Community Scorecard on Performance of Health Services*".
[11] From draft operational manual on community monitoring by the Strategy for Poverty Alleviation Coordinating Office (SPACO) in the Gambia.

2.4 Generation of Self-Evaluation Scorecard by Facility Staff

First, in order to get the perspective of the providers, the first stage is to choose which facilities will undertake the self-evaluation. This choice depends to a large extent on the receptiveness of the staff at the facility, and so there is perhaps the need for some advocacy to them as well about the purpose and use of the CSC process.

Second, as with the community, the facility staff need to go through a brainstorming session to come up with their own set of performance indicators. These should then be classified in a manner that is easily comparable with the indicators chosen by the community.

Third, as in the community gathering, the staff of the facility (be it a school, or health clinic) need to fill in their relative scores for each of the indicators they came up with. These are again averaged to get the self-evaluation score card.

Fourth, the facility staff too need to be asked to reflect on why they gave the scores they did, and to also come up with their own set of suggestions for improving the state of service delivery. One can even for the record ask them what they personally consider would be the most important grievances from the community's perspective, and then compare and see the extent to which the deficiencies are common knowledge[12].

2.5 Interface between Community and Facility Staff

First, both the community and providers need to be prepared for the interface meeting. This final stage in the CSC process holds the key to ensuring that the feedback of the community is taken into account and that concrete measures are taken to remove the shortcomings of service delivery. To prepare for this interface, therefore, it is important to sensitize both the community and the providers about the feelings and constraints of the other side. This ensures that the dialogue does not become adversarial, and that a relationship of mutual understanding is built between client and provider. The sensitization task can be done through a series of training sessions with members of both sides, and through sharing the results of the two scorecards.

Second, a major task for the implementing team will then be to ensure that there is adequate participation from both sides. This will require mobilization at the community level, and arrangements so that facility staff are able to get away from their duties and attend the meeting. One can further involve other parties, like local political leaders, and senior government officials in the interface meeting to act as mediators, and to give it greater legitimacy.

Third, once both the groups have gathered in a meeting, the implementing team has to facilitate dialogue between the community and the service providers and help them come up with a list of concrete changes that they can implement immediately. This will give credence to the entire process from both the community's and provider's perspectives, and make it easy to undertake such exercises in the future. Senior government officials and/or politicians present can also endorse the reforms.

2.6 Follow-up and Institutionalization

First, CSC initiatives, especially those that arrive as one-off experiments will serve little long-term purpose unless implementation is followed through on a sustained basis. Both demand and supply side measures can be undertaken to ensure this institutionalization. From the supply side, the key is to get local governments and district assemblies to create forums for feedback from communities via the CSC so that performance based policy action can be taken.

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[12] If the facility staff are pretty much aware of the complaints the community have of them, it is an indication that the problem is not information gaps, but bad incentives.

Second, the regional and national governments can integrate CSC findings in their decentralization program, by making the results of the scorecards the basis for allocation of resources or perforamance based incentives across local governments, sectors, and/or facilities.

Third, from the demand side, community based organizations can train their staff on how to conduct a CSC, so that they become the institutions responsible for undertaking the exercise on a sustained basis.

Fourth, links can also be made with existing community organizations such as PTAs, or health committees, so that they get involved in facilitating and implementing CSC processes. This will reinforce the sustainability and legitimacy of the process.

Fifth, various indirect uses of the data and findings of CSCs can be promoted by ensuring that the information contained in them is disseminated into the public domain. This can be done via grassroots media like community radio, or through the national press and television.

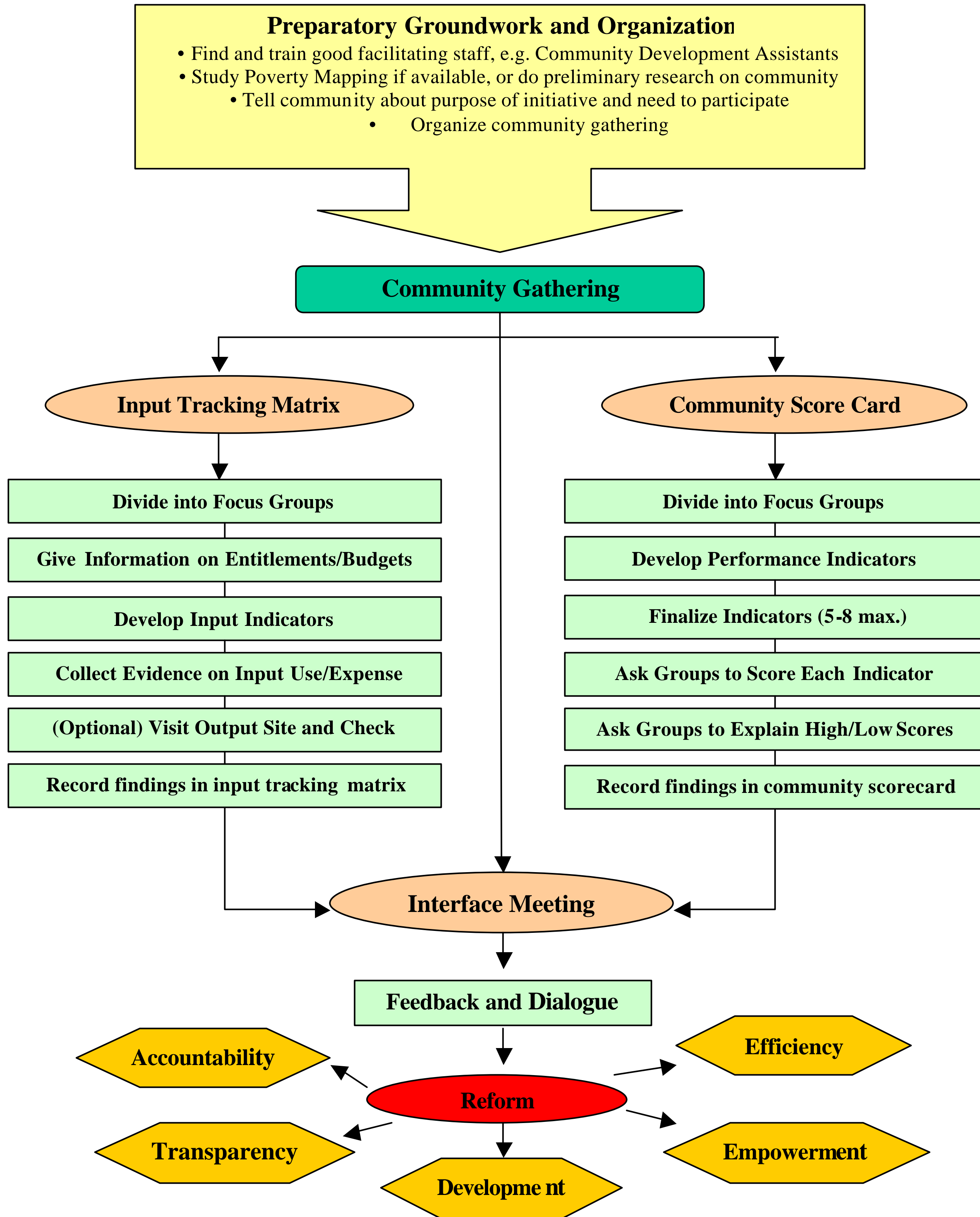
3. FURTHER REFERENCE

For further reference on the methodology and results of community score card initiatives, please consult:

- SPACO (Gambia): Draft Operational Manual on Community Based Monitoring of the Strategy of Poverty Alleviation (SPA-II), April 2003. Available at www.worldbank.org/participation

- CARE Malawi: Report on "*Outputs from the Community Scorecard on Performance of Health Services",* 2002.

Figure-2: Flowchart of Stages in Comprehensive Community Score Card Process (Provider Self-Evaluation Separate)



ANNEX –1: DISTINGUISHING BETWEEN THE COMMUNITY SCORECARD AND THE CITIZEN REPORT CARD

The Citizen Report Card	The Community Scorecard
• Unit of analysis is the household/individual • Information collected via a survey questionnaire • Relies on formal stratified random sampling to ensure that the data is representative of the underlying population • The major output is the actual perceptions assessment of services in the form of the report card • The media plays the major role in generating awareness and disseminating information • Conducted at a more macro level (city, state or even national) • More useful in urban settings • Time horizon for implementation is long (about 3-6 months) • Intermediary plays a large role in conducting the survey and data analysis • Feedback to providers and the government is at a later stage after media advocacy	• Unit of analysis is the community • Information collected via focus group interactions • Involves no explicit sampling. Instead the aim is to ensure maximum participation of the local community in the gathering. • Emphasis here is less on the actual scorecard and more on achieving immediate response and joint decision-making • This relies more heavily on grass-roots mobilization to create awareness and invoke participation • Conducted at a micro/local level (village cluster, and set of facilities) • More useful in rural settings • Time horizon for implementation is short (about 3-6 weeks) • Role of intermediary is mostly as facilitator of the exercise • Feedback to providers is almost immediate and changes are arrived at through mutual dialogue during the interface meeting