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SOCIAL ACCOUNTABILITY SERIES
SOUTH ASIA SUSTAINABLE DEVELOPMENT DEPARTMENT

Social accountability refers to a broad range of actions and mechanisms that citizens, communities, independent media, and civil society organizations use to hold public officials and public servants accountable. Social accountability tools include participatory budgeting, public expenditure tracking, citizen report cards, community score cards, social audits, citizen charters, people's estimates, and so forth. These mechanisms are being increasingly recognized worldwide as a means of enhancing democratic governance, improving service delivery, and empowerment.

CASE STUDY 5

Chhattisgarh, India: Performance Rating of Gram Panchayats through Community Score Cards

BACKGROUND

The World Bank–supported Chhattisgarh District Rural Poverty Reduction Project (CGDPRP), also called locally as *Nawa Anjor* (New Light), aims at improving opportunities for poor and vulnerable communities in Chhattisgarh State. To achieve this goal, the project creates infrastructure and income opportunities for the rural poor, empowers disadvantaged groups, and helps local governments[1] become more responsive and effective in assisting the poor. An important component of the Nawa Anjor project comprises community investments, such as matching grants for village funds that are entirely financed by community contributions and used to operate and maintain village infrastructure, and innovation funds.

CGDPRP sought to develop a performance monitoring and rating system to build local government capacity, especially the Gram Panchayats (GPs). In this context the project experimented with the use of the Community Score Card (CSC) for identifying crucial issues that affect local service delivery, measure user satisfaction, empower village citizens (especially the poor and women), and rate the performance of GPs. A comparative assessment of GPs was expected to further improve overall GP performance in terms of governance, management, and service delivery.

The Society for Participatory Research in Asia (PRIA), in partnership with the CGDPRP staff, undertook the pilot study to develop a performance monitoring and rating system for GPs using the CSC methodology in 30 GPs. Nine services were assessed using the CSC in the pilot study: management of Gram Sabhas by GPs, health, education (including the Mid-Day Meal Scheme), drinking water, public distribution system (PDS), physical infrastructure (mainly roads and drains), sanitation, taxation, and Nawa Anjor.

Service Delivery Context. The Gram Panchayat comprises of elected representatives from the village, and is directly responsible for services such as sanitation, street lighting, issuance of certificates, collection of property taxes, implementation of schemes handed over to GPs by the state, and liaison with

The current initiative was one of six pilot projects launched by the South Asia Sustainable Development Department (SASSD) of the World Bank. SASSD initiatives are aimed at the application of specific social accountability tools in different contexts of service delivery through the Trust Fund for "Capacity Building and Piloting of Social Accountability Initiatives for Community Driven Development in South Asia.". This note summarizes the findings, processes, concerns, and lessons learned from the Chhattisgarh pilot.

1. Chhattisgarh state has a three-tier system of local governance comprising the Zilla Panchayat (district council), Janpad (block level council), and Gram Panchayat (village council).

various departments for other functions such as health services, education, and water supply. GPs are also expected to supervise and monitor services and schemes run by other departments, in collaboration with special-subject village-level committees. For example, the Village Education Committee (VEC) is supposed to supervise all education activities in the village and the Village Water Supply Committee (VWSC) is supposed to monitor all village drinking water supply sources/schemes and liaise with the Public Health Engineering Department (PHED).

Accountability Context. The GP is accountable to the Gram Sabha[2] for all its actions. This is the only channel of "downward accountability" at the village level. In areas/programs such as organizing Gram Sabhas, drinking water supply, sanitation, and small infrastructure works, the GP is primarily responsible for service delivery. For Nawa Anjor, the GP is responsible for managing all village-level activities including fund management. For services such as health, education, midday meals, and ration distribution through the PDS, village-level committees or the GP do not have any direct control over the actual service providers. The service providers are upwardly accountable to their superiors in the respective line departments and downward accountability in any form is very weak. It was in this context that the Nawa Anjor project wanted to develop an approach that could make service providers more accountable to the villagers for all village-level services.

PROCESS

The Methodology. The CSC process can be divided into six key stages (figure 1): (i) preparatory groundwork, (ii) developing the input-tracking score card, (iii) generation of the community performance score card, (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. The pilot was conducted in two phases, the first in two districts (Raigarh and Bilaspur) in February 2006 and the second in the remaining districts in March 2006.

GP Sample Selection. Thirty GPs from 14 blocks in 7 districts out of a total of 2,046 GPs from the central, north, and south regions of the state were selected for the pilot study. A multistage, stratified, random sampling technique was used to identify the 30 GPs. Selected districts exhibited high cultural and socioeconomic variations. Tribal and non-tribal blocks, as well as remote and proximate blocks to district headquarters, were included in the sample. The final identification and selection of GPs in each block was made in consultation with the Project Facilitation Team (PFT) and ensured the inclusion of single/multiple village(s) GPs, tribal/non-tribal Sarpanches,[3] and women Sarpanches in the selected sample.

Community Score Cards

The CSC is a community-based monitoring tool that is a hybrid of the techniques of social audit and citizen report cards. The CSC is an instrument to ensure social and public accountability and responsiveness from service providers. By linking service providers to the community, citizens are empowered to provide immediate feedback.

Social Profile of Pilot Districts. The population of the 30 GPs selected for the pilot was 52,975. The Scheduled Tribe (ST) and the Scheduled Caste (SC) populations in the pilot districts were 47 percent and 19 percent respectively. The overall literacy level of the population averaged 51 percent, with Dantewada District in the south having the lowest literacy level of 15 percent. The average male/female ratio in the pilot GPs was 1,010, while the average family size was five.

Field Research. Select staff from PRIA's partner organizations with extensive grassroots experience and an understanding of participatory research methodologies were identified across different regions in Chhattisgarh. Three Field Research Teams (FRTs), one for each region, composed of a field supervisor and three field investigators, were selected for conducting the pilot study. The FRTs were trained in the CSC methodology. Field research was carried out in two phases. In phase one, a field investigation plan detailing the investigation schedule, roles and responsibilities of each FRT member, the sampling plan, and methodology for conducting CSCs was made. The results of the first phase of field investigations in Raigarh and Bilaspur districts were discussed with the World Bank and Nawa Anjor project staff to assess whether outcomes met project requirements. Based on these discussions, the second phase of the field research produced a field manual to assist FRTs

2. The Gram Sabha is the Village Assembly, comprising of all adults residing in the village.

3. The Sarpanch is the elected head of the GP in the three-tier system of democratic decentralization in India.

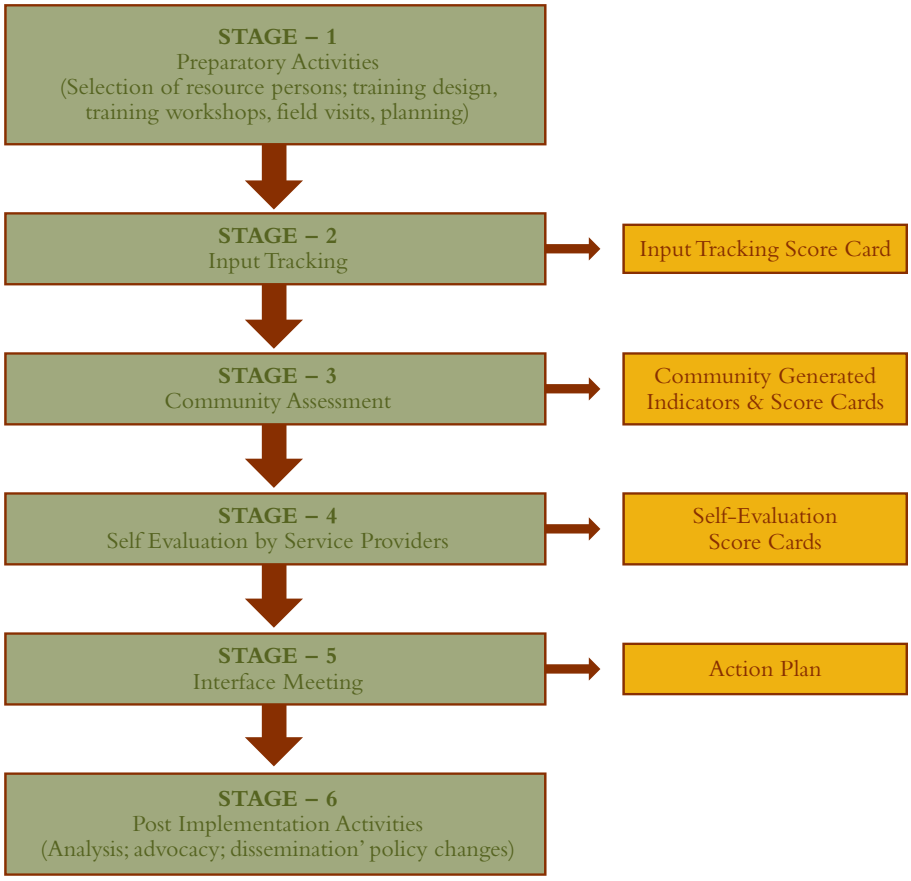
and appropriate modifications to the field investigation plan were made. The criteria, the indicators, and the priority sectors for GP ratings were generated during the first phase of field research through discussions with the communities and CGDPRP staff. The FRTs were in constant touch with both project staff and Panchayat members.

Input Tracking. The FRT collected supply-side data on services being offered by the GP. These data included budgetary allocations and entitlements of each village in the GP under various schemes, such as toilets under the Total Sanitation Campaign (TSC); houses under the Indira Awas Yojana (IAY); quantity of rations through the Public Distribution System (PDS); handpumps under the Drinking Water Supply Scheme; cement concrete roads and Panchayat Bhawans constructed under CGDPRP; and books distributed and classrooms constructed under the Sarva Shiksha Abhiyan (SSA). Subsequently, the data was discussed with participating community members and actual progress under each scheme was physically verified and recorded.

Community Assessments. The GP ratings were done primarily through Focus Group Discussions (FGDs). In the 30 selected GPs, 4,347 people (8.21 percent) out of a total population of 52,975 participated in the FGDs. A preliminary stratification of the community on the basis of usage of various services, participation in Gram Sabha meetings, poverty, landholding, and overall socioeconomic conditions assisted the FRT in conducting FGDs on homogenous groups. Three or four focus groups of 15–20 members each, comprising adult men, adult women, village elders, and Common Interest Group (CIG) members, were formed in each GP. All GP members and officials were excluded from the FGDs to avoid biases.

Each focus group awarded relative scores on a scale of 0–10 (higher score being "better") to each of the indicators and gave reasons for the scores. The groups also provided suggestions for improving poor performance resulting in low scores. After the FGDs, a common meeting was held to prioritize indicators and identify practical solutions to existing problems collectively. Two indicator scoring techniques were used: (i) an

Figure 1. Stages in the Community Score Card Process



average group score was assigned through the use of stones or marbles, and (ii) a weighted average group score was assigned by facilitators by categorizing individual responses into five scoring categories (0–2 for poor, 3–4 for below average, 5–6 for average, 7–8 for good, and 9–10 for excellent) and the weighted average of the responses was computed.

Self-Evaluations. The elected representatives and officials of the GP scored the indicators identified earlier using the same 10 point scale, separately stating reasons for low and high scores. Suggestions to improve poor performance were also recorded during the process.

Interface Meetings. The results of the community assessment and self-evaluation score cards were shared in an interface meeting attended by both community and GP members. All score cards were displayed at the venue of the meeting. A dialogue between the community and the GP members, facilitated by the FRT members, assisted participants in generating a final score card along with a list of actions to be implemented by the GP. The final set of common indicators for rating all GPs generated after completing the FGDs in all 30 sampled GPs is specified in Annex 1. This set of indicators forms the basis for a comparative assessment of GP performance.

KEY RESULTS

1. Identifying priority sectors and performance indicators. The pilot study assisted the community in identifying priority sectors and performance indicators in each of the 30 GPs. The priority sectors identified by the community during the FGDs and interface meetings were organizing Gram Sabhas, tax collection, health, education, drinking water, rations through the PDS, and Infrastructure projects.

2. Recognizing key problems and identifying their solutions. The CSC process enabled the recognition and documentation of major problems in various service delivery contexts. This led to constructive problem solving in the interface meetings, in which various innovative solutions were proposed by the community and accepted by GP members and officials. An illustrative list of issues identified by community members, reasons for dissatisfaction, and agreed action points with GPs is given in table 1. The community also learned to appreciate the problems faced by the service providers in some cases. For example, auxiliary nurse midwife (ANM)[4] visits to villages were few and sometimes irregular because each ANM, on the average, had to cover 20 villages in remote and sometimes unsafe locations. This knowledge increased user satisfaction levels for ANMs.

3. Generating community awareness and increasing empowerment. One of the strengths of the CSC process is that it generates community awareness and provides voice to users, which in turn empowers them. Actions such as the GP agreeing to - conduct immediate repairs to handpumps; provide information on tax rates in the Gram Sabha; put up display boards displaying information on expenses on infrastructure projects; collectively ban people under intoxication from participating in Gram Sabhas, not only empower the communities but also make the service providers directly accountable to the communities.

METHODOLOGICAL CONSTRAINTS

Even though the CSC process led to a number of interesting insights and local solutions, some limitations were observed while conducting the pilot.

1. Duration of CSC Field Work. Due to a lack of time, the field work in each village was completed in a day. Consequently, insufficient time for preparatory work, input tracking and discussions, and the inclusion of nonusers in the scoring process may have biased results. Ideally, three days should be assigned per village for the CSC process, with at least one day focusing on the input tracking exercise.

2. Quality of Facilitation. Most facilitators who participated in the pilot were local NGO/CBO workers who were helping facilitate the CSC for the first time. Their inexperience affected the quality of facilitation at the village level. Facilitation is key for the success of the CSC process. A comprehensive facilitator training program is desirable for eliciting positive community responses.

3. Choice of Indicators. In the pilot, given the inexperience of the field surveyors, the indicators for each service were finalized after discussions with senior officers and CSC field trials in a few villages. Consequently the indicators used by both users and providers were identical. In a typical CSC process, users and providers can select different indicators independently.

4. The ANM is a female health worker who is attached to the Primary Health Center or Sub-Center and visits villages for health outreach programs.

TABLE 1: PROBLEM SOLVING BY COMMUNITIES (ILLUSTRATIVE EXAMPLES)

S. No.	Service	Problems Identified	Solution/Recommendation
Services Managed by GP			
1	Organizing Gram Sabhas	Lack of quorum to conduct Gram Sabha	Information about Gram Sabha to be given twice, seven days in advance; Kotwal should take the signatures of five people from each hamlet after announcement of the Gram Sabha meeting; the Gram Sabha venue should be centrally located in a government building.
		Low participation by women as they are not informed about or not heard in Gram Sabha meetings	A motion to conduct a women's Gram Sabha to be raised in next Gram Sabha; women GP members should bring women to the Gram Sabha; place and date of Gram Sabha should be finalized after consultation with women.
		Some people attend Gram Sabha meetings in a drunken state	People should not attend Gram Sabha in an inebriated state and if they do they shall be punished.
		Development issues are not discussed in the Gram Sabha	Information about development schemes should be disseminated in the Gram Sabha; an agenda for the Gram Sabha should be prominently displayed.
2	Infrastructure projects	Poor and irregular maintenance of construction works	Transparency in procurement of material and amount spent by GP. The GP should erect a board displaying information about the construction work at the work site.
3	Taxation	Lack of transparency in tax collection and utilization (people not aware of the annual land tax rates being collected by GP officer; some have paid an unofficial collection fee of Rs. 5 per person)	Information about tax rates to be given in Gram Sabha.
Services Supervised by GP through Special Committees			
4	Education	Shortage of buildings/classrooms	More classrooms should be constructed; GP should send proposals to Block Panchayat for construction of classrooms.
		Irregularity of teachers	VEC to monitor attendance of teachers; submit written complaints to education department about errant teachers.
5	Drinking water & maintenance of hand-pumps (HPs)	Red-colored water due to iron contamination from iron mining (Isku Para in Dhurlee, Bade Kameli villages)	Inform Public Health and Engineering Department (PHED) for remedial action.
		Large time delay in repairing HPs (sometimes as much as 6 months) due to a lack of technicians or spare parts	GP should buy and provide spare parts and tools to the local technicians immediately and ask them to undertake repair jobs.
		Installation of HPs without consultation with GP resulting in inequitable distribution of HPs in some hamlets	GP to send proposal for additional HPs to PHED.
		Irregular and inadequate water supply	Construct a water tank under the Nawa Anjor scheme (Mauhapalli GP).
6	Health	Low frequency of ANM visits to villages as ANMs had to cover an average of 20 villages in unsafe terrain	Arrangements for stay of the nurse will be made in the village (Gemawada Village).
		Insufficient supply of medicines	The depot holder of the health center should come to the Gram Sabha and give an account of medicines used.
7	Nawa Anjor	Lack of awareness about scheme benefits	Information about Scheme to be given in Gram Sabha; training of GP members to be conducted.

4. Inconsistency in Scores. Users and providers usually assign numeric scores to identified indicators in a typical CSC exercise. The nominal differences in community and self-evaluation scores and inconsistencies between scores and their justifications lead to the conclusion that numeric scores to measure satisfaction rating may not have been the preferred method for measuring performance.

a. Nominal differences in community and self-evaluation scores. The difference between average community and self-evaluation scores for various services was nominal (figure 2). The maximum difference was 1.0 in the health sector. An analysis of the indicators shows that the differences between the community and self-evaluation scores for various indicators varies from a maximum of 2.0 for the indicator "Regularity in Tax Collections" (implying that the community's score was higher than the service providers) to a minimum of –1.3 for the indicator "Transparency in Tax Collection" (implying that the community score was lower than the service provider score). In 6 of the 37 indicators, the difference between the two scores was 0, while for most indicators (25 out of 37) the difference was less than 0.5 (Annex 1).

b. Disagreement in scores and their justifications. There are many instances in which user groups have assigned high scores (indicating high satisfaction), while the reason cited indicates poor performance. For example, in Jamwantput village, Sarguja district, the indicator "adequate number of handpumps for water supply" has been given 10/10, but the reasoning for the indicator states that the "number of handpumps is inadequate." Similarly in Chakki village, Sarguja district, the indicator "quantity of mid-day meal at primary school" has been given 10/10, but the reasoning states that "insufficient quantity is being given to children."

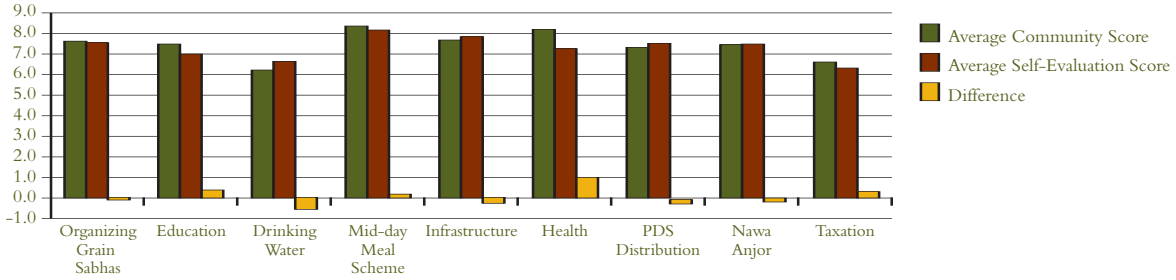
In the case of communities that are not comfortable with the concept of scoring (such as those in this pilot), facilitators encourage communities to use rating scales to measure satisfaction, such as a five-point scale of excellent, very good, good, bad, and very bad, to. Alternate performance evaluation criterion such as rating scales should have been explored in Chattisgarh.

KEY LESSONS AND FUTURE IMPLICATIONS

The CSC process provides voice to communities. The pilot has established that, irrespective of the type of the GP (tribal, non-tribal, literate, and so forth), the CSC is a powerful process that provides voice to communities. The process clearly established the kind of service improvements people expect from the programs in existence. For example, citizens voiced a need for small investments in additional school rooms, repair of nonfunctional handpumps, and so forth. No existing government program caters to such needs adequately. The infrastructure grants component of the Nawa Anjor project could facilitate a process by which GPs receive untied infrastructure funds while making GPs more accountable to communities to ensure such funds are used in a judicious, transparent, and participatory manner. The CSC process can disseminate information to users, identify issues that affect service delivery, and empower users to negotiate immediate improvements.

Incentives and disincentives to improve performance of GPs need to be instituted. The CSC process enabled expression of many qualitative issues related to the governance of GPs. The citizens clearly articulated the drawbacks of the manner in which Gram Sabhas are managed today. There is a need for the higher tiers of government to work on making the Gram Sabha an effective forum for self-governance. For this, there is

Figure 2: Comparison of Average Community & Self-Evaluation Scores



a need for capacity building across the three tiers of local government and incentivizing better performance. A performance-based system of incentives and disincentives—such as additional untied funds for development works for the best-performing GPs and action in the form of withdrawal of project benefits from the worst-performing GPs—may help improve the quality of governance in GPs and institutionalize the performance rating process.

Institutionalization needs higher-level support. For institutionalization of the CSC process, project authorities and government officials need to accept and act upon the CSC-generated action plans. On the supply side, CBOs and citizens' groups (such as Village Education Committees, Parent-Teachers Associations, Village Sanitation Committees, and so forth) need to train their staff on CSC methodologies, so that a cadre of organizations and professionals is created that can demand and undertake the CSC exercise on a sustained basis. Various direct and indirect uses of the data and findings generated from the CSCs, such as the utilization of data in creating annual block, district, and state plans by disseminating CSC results into the public domain, may increase the acceptance, credibility, and legitimacy of the CSC process.

Solutions to local problems are generated despite handicaps. The effectiveness of the CSC depends on the levels of community awareness and participation, the effectiveness with which service delivery institutions perform, and the level of support from higher authorities. Exercises such as micro-planning and input tracking assist in increasing awareness and participation. The pilot demonstrated that even if communities were unaware of their entitlements, lacked access to information, or were unable to score performance, constructive solutions to local problems were generated. This demonstrates of the power of the CSC. However, the CSC process also revealed issues that were beyond the mandate of GPs. For example, in the education sector, most parents expressed a high level of dissatisfaction with the teacher's attendance and quality of teaching. While VECs are responsible for "managing the attendance of teachers and quality of teaching," they do not have powers to take action against the erring teachers. At best, VECs can send a memorandum to the Block Panchayat. Similar problems exist with medicine distribution, visits of health workers, and timely maintenance of handpumps by the PHED. In the absence of institutional/project support it is still unclear how the agreements reached during the process should be implemented and monitored. This situation highlights the need to revisit the roles of different tiers and departments of service providers and also the rules and regulations of service delivery. Roles and rules should be redesigned to make the service provider accountable to the users either directly or indirectly through GPs.

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ANNEX 1: SERVICES AND INDICATORS

S. No.	Services	Indicators	Average Community Score	Average Self-Evaluation Score	Average Final Score
1	Organizing Gram Sabhas	• Information about the Gram Sabha meetings	8.3	8.3	8.3
		• Participation of women and marginalized sections	6.7	6.3	6.5
		• Quorum/participation	6.7	6.7	6.7
		• Discussions on development issues	8.0	8.0	8.0
		• Environment for participation (timing, venue, people's behavior e.g. drinking)	8.0	8.5	8.3
		Total	7.5	7.6	7.6
2	Education	• Distribution of textbooks and other learning material	9.0	8.7	8.8
		• Attendance of boys	8.0	7.3	7.7
		• Attendance of girls	7.7	7.0	7.3
		• Punctuality of teachers	7.0	6.7	6.8
		• Adequate building/classrooms	6.7	6.3	6.5
		• Quality of teaching	6.7	6.0	6.3
		Total	7.5	7.0	7.3
3	Drinking water	• Adequate number of handpumps	6.3	6.7	6.5
		• Quality of drinking water	6.3	7.3	6.8
		• Non-functional handpumps	5.7	6.7	6.2
		• Un-repaired handpumps	6.0	6.7	6.3
		• Time delays in repairing	6.0	5.7	5.8
		Total	6.1	6.6	6.3
4	Mid-day meal scheme	• Quality of food	8.3	8.0	8.2
		• Quantity of food	8.3	8.3	8.3
		Total	8.3	8.2	8.3
5	Infrastructure	• Quality of construction works	8.0	8.0	8.0
		• Maintenance of works	7.3	7.7	7.5
		Total	7.7	7.8	7.8
6	Health	• Frequency of visit of ANM	7.0	6.0	6.5
		• Availability of medicines in the PHC	7.3	6.0	6.7
		• Frequency of immunization	9.3	8.3	8.8
		• Behavior of staff in PHC	9.0	8.5	8.8
		Total	8.2	7.2	7.7
7	Ration distribution through PDS	• Information about distribution (date, time, place)	7.3	8.0	7.7
		• Quality of ration	7.7	7.3	7.5
		• Quantity of ration	7.0	7.0	7.0
		Total	7.3	7.4	7.4
8	Nawa Anjor	• Information about the project	7.7	7.3	7.5
		• Selection of beneficiaries	7.7	7.3	7.5
		• Support from the project staff	7.0	7.3	7.2
		• Behavior of project staff	7.7	7.3	7.5
		• Support from GP	7.0	8.0	7.5
		Total	7.4	7.5	7.4
9	Taxation	• Information about taxes	6.0	5.0	5.5
		• Information about rates of taxes	6.7	6.3	6.5
		• Regularity in collection of taxes	7.7	5.7	6.7
		• Transparency in tax collection	6.7	7.0	6.8
		• Transparency in tax revenue utilization	6.0	7.3	6.7
		Total	6.6	6.3	6.4

Note: Scores from two other services, namely Sanitation and Other Schemes, have not been included in the Annex due to lack of data.

This note was prepared by J.V.R. Murty of the Water and Sanitation Program, South Asia Region of the World Bank, and Sanjay Agarwal and Parmesh Shah of the South Asia Sustainable Development Department in the World Bank as a case study for the workshop on "Capacity Building and Piloting of Social Accountability Initiatives in South Asia" in Hyderabad, India, in March 2007. The authors would like to express their gratitude to the Governments of Norway and Finland for supporting this initiative through the Trust Fund for Environmentally and Socially Sustainable Development (TFESSD). The findings, interpretations, and conclusions expressed in this note are entirely those of the authors and should not be attributed in any manner to the World Bank, to its affiliated organizations, or to members of its Board of Executive Directors or the countries they represent.