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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 world-wide as a means of enhancing democratic governance, improving service delivery, and creating empowerment.

CASE STUDY 4

Maharashtra, India: Improving Panchayat Service Delivery through Community Score Cards

Public Disclosure Authorized

BACKGROUND

The state of Maharashtra in western India adopted the three-tier Panchayati Raj[1] model of democratic decentralization in 1961. Today it has 28,000 Gram Panchayats, 350 Panchayat Samitis, and 33 Zilla Parishads (ZPs) delivering a variety of services such as health, education, sanitation, and water supply to a rural population of 56 million. This note summarizes the experiences from a pilot project undertaken by the Tata Institute of Social Sciences (TISS), Mumbai, in partnership with the World Bank-sponsored Jalswarajya[2] Project. In the pilot the community score card (CSC) methodology was applied to assess the performance of 14 Gram Panchayats in Satara District in four service sectors, namely Village Panchayat Services, water and sanitation, health, and education. The encouraging results from the pilot have led Satara Zilla Parishad to expand the pilot to 121 villages with the objective of achieving the Millennium Development Goals with regard to malnutrition and infant and maternal mortality. Eventually ZP, Satara, intends to expand the initiative to cover all villages in Satara District.

Service Delivery Context. In Maharashtra, Gram Panchayats (GP) are responsible for formulating village development plans, delivering various Panchayat services, and implementing numerous development schemes including water supply and sanitation. A Village Water and Sanitation Committee (VWSC), a subcommittee of the Gram Panchayat, looks after the operation and maintenance, quality control, and financial management aspects of water supply schemes. The delivery of other services, such as health and education, has been

The current initiative was one of six pilot projects launched by the South Asia Sustainable Development Department (SASAR) of the World Bank 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 Maharashtra pilot.

1. India has adopted a three-tier model of democratic decentralization under the 73rd amendment to the constitution of India. The Zilla Parishad is the district–level local self-government institution, while the Panchayat Samiti and the Gram Panchayat are the block- and village-level local self-government institutions.

2. The Jalswarajya Project is the local name for the Maharashtra Rural Water Supply Program. The project aims at providing potable drinking water in a sustainable way to rural people to improve health. The program departs from the usual government-led, supply-driven approach and promotes a community-led, demand-driven, and participatory approach with a preference for small, localized schemes that are managed locally by village-level water and sanitation committees.

entrusted to the Zilla Parishad, while the Gram Panchayat, through subject village-level committees,[3] performs a supervisory role, e.g., the Village Education Committee is supposed to supervise all education activities in the village.

A three tier health care system at the sub-block, block, and district levels forms the basis of the health care system in India. Primary health centers (PHCs) form the first level of contact and act as referral centers for the community health centers and public hospitals. Each PHC is targeted to cover a population of approximately 25,000 and is charged with providing preventive, curative, and rehabilitative care. Each PHC is staffed by two professionally qualified doctors supported by a similar number of paramedical staff. There are also 6–8 sub-centers under a PHC, each of which caters to a population of 5,000 and 3,000 in the plain and tribal areas respectively. The structure of the education system is similar to the health care system but for an additional cluster level between the block and school levels.

Accountability Context. The Gram Panchayat is statutorily accountable to the Gram Sabha[4] for all its actions including service provision. This is usually the only form of downward accountability that exists and is manifested weakly due to factors such as high levels of illiteracy; lack of knowledge about roles, systems, and processes; complex and mystified procedures; and noncooperation on the part of service providers. In the Jalswarajya Project, social audit committees that audit the social, technical, and financial performance of water supply schemes exist and offer another form of downward accountability.

In the case of services being delivered by the Zilla Parishad, such as health and education, staff is usually appointed by the Zilla Parishad. In such cases, service providers are upwardly accountable to their superiors in the respective line departments. Performance is usually measured in a top-down, target-driven manner, and the quality of service delivery, including user satisfaction, is rarely measured. Users often complain of rude staff behavior that discriminates against women and minorities. The lack of accountability leads to absentee and unresponsive staff, inconvenient service delivery hours, and little or no community participation. A description of services and accountability structures currently operating in Maharashtra in given in Table 1.

The pilot aimed at testing the efficacy of the Community Score Card as a tool to measure user satisfaction and improve service delivery, in this context.

3. A number of subject committees (usually 4-6, depending on the size and population of the village) composed of GP members, village-level government officials, and co-opted members of the Gram Sabha are constituted for the proper implementation of specific sector-related activities.

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

Table 1: Services and Accountability Structures in Maharashtra

Service	Service Delivery Agency	Staff Appointed by[a]	Monitoring of Service Delivery	Degree of Accountability to Users
Water Supply and Sanitation	GP through Village Water and Sanitation Committee (VWSC)	GP/VWSC	Gram Sabha	Medium to high[b]
Primary Health	Primary Health Center catering to a cluster of villages; sub-centers catering to 3-4 villages through village-level extension workers	Doctors appointed by state; other staff appointed by ZP	District Health Officer (DHO) at district level; Block Development Officer (BDO) at block level; Village Health Committee at village level (but it has no punitive powers)	Low
Primary Education	Primary schools	Teachers appointed by ZP	Block Education Officer at block level; Village Education Committee at village level	Low

a. In Maharashtra, Class 3 and 4 employees are appointed by the ZPs and are transferable within the ZP area, while Class 1 and 2 officers are appointed by the state through respective line departments and are transferable across the state.

b. In Maharashtra, water supply management functions such as needs assessment, design, construction, up-gradation, levy of user fees, and regular operations and maintenance were devolved to GPs in the year 2000, and ZPs play only a supportive role.

PROCESS

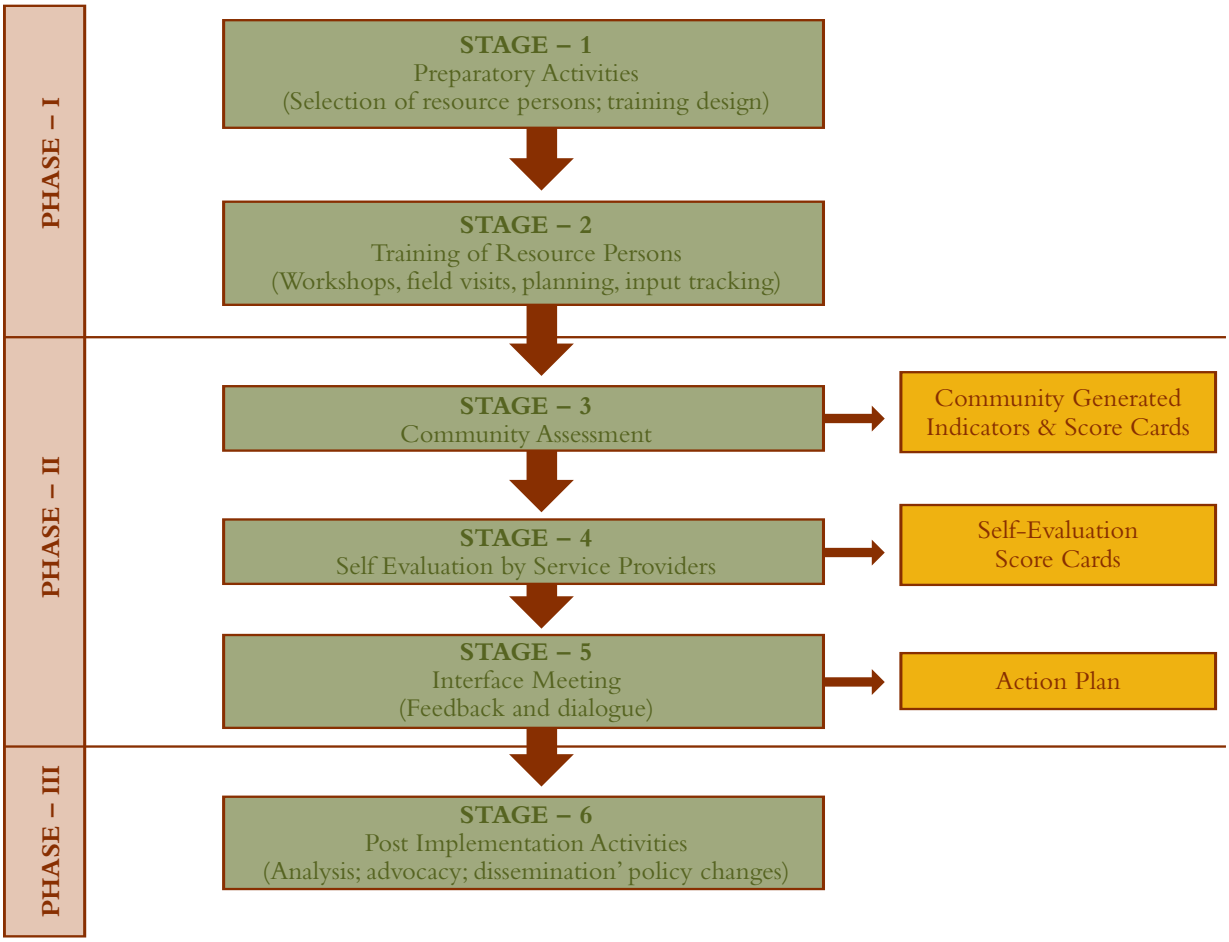
Methodology. The methodology adopted for undertaking the pilot project consisted of six stages of project activities undertaken in three phases (Figure 1). Phase I consisted of preparatory activities and building capacity for undertaking the implementation of the pilot project with community participation. The key activities undertaken in this phase involved identifying villages, selecting facilitators, designing the training program, conducting the training workshop, and operational planning for the pilot exercise. Phase II saw the actual implementation of the pilot through trained facilitators. All key activities involved in the score card process, such as input tracking, community assessment, self-evaluation by service providers, consolidation of score cards, and the interface meeting, were undertaken during this phase. Finally, during phase III, post-implementation activities were conducted. This involved analysis, documentation, and dissemination through a workshop involving all key stakeholders.

Community Score Cards

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

Responsibilities. The Zilla Parishad, Satara, team was responsible for overall supervision, facilitation, village identification, and interdepartmental co-ordination, and for providing personnel to carry out the field exercise. TISS was responsible for capacity building, field exercise support, analysis, and documentation of the entire exercise.

Figure 1. Stages in the Community Score Card Process



Selection Criteria. The CSC process for each service sector was conducted in 4–5 villages. The methodology for selection of villages to participate in the pilot program involving the CSC tool was as follows: (i) health: PHC and four villages that use the same PHC services; (ii) water supply: Jalswarajya villages in operations and maintenance (O & M) stages; (iii) education: villages having both primary and secondary schools; and (iv) Gram Panchayat functions: all 14 villages were spread over two blocks,[5] *Patan and Karad,* and have populations ranging from 445 to 15,000.

Key Resource Persons. The Deputy CEO of the ZP was the overall coordinator for the pilot. He was supported by a team from TISS which guided and monitored the entire process. Facilitators of the CSC process were primarily senior Zilla Parishad staff working at the block level drawn from the health, Integrated Child Development Scheme, education, water supply, and Gram Panchayat departments.

Training. The facilitators, along with their heads of departments, were trained in a two day workshop that introduced them to social accountability approaches and the CSC methodology. Mock exercises and fieldwork were integrated into the training sessions to provide a clearer understanding of the CSC process.

Field Work and Data Collection. Field work in the selected 14 villages was conducted during 18th to 30th May 2006. To avoid biases in the CSC process, teams were formed to ensure that facilitators were not from the same service sector being assessed in the focus group, e.g., education department officials conducted the CSC for health services. A total of 21 focus discussion groups (FDGs) comprising a minimum of 11 people (six men and five women) to a maximum of 69 people (36 men and 33 women) were conducted in the 14 villages. Indicators for assessing various services were generated during the FDGs and scored on scales of 0-5, 0-10, or 0-20 by both the community and service providers. The providers, by and large, used the same indicators generated by the users for self-evaluation, in order to make comparisons easy. Both the community and the service providers also recorded reasons justifying their rating of indicators.

Interface Meetings and Action Plans. After the community assessment and self-evaluation exercises, interface meetings brought the community and service providers together, and the results of the exercises were shared. District-level administration officials were also present for greater impact. In these meetings the service providers and the users discussed issues that they felt were important. Subsequently, action plans that clearly identified activities to be undertaken, people responsible, and timelines were prepared for making improvements.

RESULTS

A number of interesting results emerged from the pilot study. The key results have been classified into six categories: (i) identification of priority issues; (ii) comparison of user and provider scores; (iii) problem solving by communities; (iv) information dissemination and transparency; (v) user satisfaction and empowerment; and (vi) low awareness of responsibilities.

(i) Identification of Priority Issues. Most of the priority issues in all the four service sectors were identified during input tracking or focus group discussions. The community was concerned about issues such as lack of resources, staff functioning/behavior, optimal use of resources, convenience of services, information dissemination, and transparency. In education, the lack of infrastructure (school buildings, toilets, drinking water, sports facilities, benches, desks, etc.), equipment (sports equipment, educational material, etc.), quality teachers and adequate supervision (by Village Education Committees, Parent-Teacher Associations, and line department officials) were primary community concerns. In health, the lack of facilities, staff availability (especially the female medical officers) and behavior, and transparency in medicine distribution were the key concerns. In the Gram Panchayat sector, issues such as behaviour of GP staff toward villagers, especially the marginalized; transparency in management finances; nondisclosure of information about government schemes; and not holding Gram Sabhas, especially women Gram Sabhas,[6] were key concerns in many villages. In water supply service delivery, the community's concerns related to the quality and timing of the water supply, untimely pipeline maintenance, lack of transparency, and the water supply in habitations of marginalized sections. The service providers were more concerned about physical, financial, and human resources or the lack of community response/support during awareness-generation activities.

(ii) Comparison of User and Provider Scores. A comparison of user and provider scores reveals that there is a large difference in indicators dealing with transparency and behavioural issues,

5. This excluded one village, Bhondavade, where training was conducted in Satara Block.

6. Interestingly enough, the issue of women's Gram Sabha featured in all FDGs assessing Panchayat services.

while there is a nominal difference in indicators dealing with basic infrastructure, support services, and resources issues. Table 2 below illustrates indicators where the difference in user and provider scores was high. However, there were a large number of indicators in which user and provider perceptions were similar. As an example, in Bhondawade Village, 21 out of 22 indicators to assess water supply services, 10 out of 15 indicators to assess health services, and 5 out of 10 indicators to evaluate Panchayat services were given identical scores by both users and providers. In Adhul Village, both users and service providers

Table 2: Illustrative Indicators (High Differences in Scores and Actions Proposed)

Service	Indicator	User Score	Provider Score	Village Name(s)	Justification for Scores
Water Supply and Sanitation	Water purification scheme	0/10	5/10	Rethare (Bdk)	***Users***—Water purification machine is out of order, new water purification project required immediately; ***Providers***—Machine needs repair; ***Action Proposed*** – People's contribution and government grants sought.
	Sanction for expenditure and its audit	4/10	10/10	Girewadi	***Users***—Authorized person does not verify budget or get expenditures audited, auditors remarks are not made public; ***Providers***—Sanction for each expenditure is taken from appropriate authority; budget painted on wall for public display ***Action Proposed***—Audit all new works and show report to villagers on demand.
	Guidance to people about water supply issues	2/10	8/10	Chavanwadi	***Users***—no guidance is provided by GP; ***Providers***—guidance is given to people if and when they ask for it; ***Action Proposed*** – GP to launch an awareness campaign to educate villagers.
Education	Transparency (VEC and PTA meeting reports, audit of accounts)	1/5	5/5	Keral, Hingnole	***Users***—No reports are made public; ***Providers***—All reports are kept systematically; ***Action Proposed*** – PTA meeting will be held quarterly and reports made public.
	Punctuality of staff	1/5	5/5	Keral	***Users***—Teachers do not live in village and not punctual; ***Providers***—Punctuality is maintained; ***Action Proposed*** – Teachers should live in headquarters so that they are punctual.
	Seating arrangements	0/10	6/10	Chore	***Users*** & ***Providers***—mats and desks for students are not available; ***Action Proposed*** – Mats will be provided from the Gram Panchayat fund.
Health	Basic infrastructure (drinking water, toilet facilities, mats, and table for checkups)	0,1,1/10	5,9,10/10	Talbid	***Users***—no drinking water and toilet facilities, mat and table are not large enough; ***Providers***—facilities are available; ***Action Proposed*** – A big mat will be provided by Gram Panchayat; a proposal for a table will be sent to the health dept.
Panchayat Services	Transparency	0/10	10/10	Umbraj	***Users***—No information is disseminated; ***Providers***—Pamphlets of audit reports are distributed and reviewed in the Gram Sabha; ***Action Proposed***—None.
	15% subsidy for toilet construction	0/10	10/10	Umbraj	***Users***—Villagers are not getting benefits of this scheme; ***Providers***—GP distributes 15% aid; ***Action Proposed*** – GP should provide place and vessels for construction of individual toilets for free; each family will make soak pits.

gave 5 out of 5 to most teaching quality indicators, as parents were satisfied with efforts made by teachers to assist both weak and brilliant students, and this had resulted in 100 percent of the students being named to the merit list. A large number of similar examples emerged during field research.

(iii) Problem Solving by Communities. In most cases interface meetings resulted in solutions whose implementation was the responsibility of either the Gram Panchayat or block/district level officials. Some illustrative examples of such problems and solutions are given in Table 3.

In a few cases innovative solutions were provided by the community. For example, in Keral village, the community recommended that leave sanction authority for teachers should be granted to the VEC so that the misuse of the authority to authorize leaves is checked and the syllabus is completed on time. They also suggested that teachers should submit their work plan and training program details, if any, to the VEC. In Indoli village, the community insisted that the school should send a proposal for conducting students' health check-ups to the health department. The people in the village also contributed so that the school could buy enough mats, benches, and desks and construct a new water tank. In several villages, health committees agree to support health staff so that their performance could be improved.

(iv) Information Dissemination and Transparency. In most villages the community expressed a belief that information about procedures, implementation processes, and financial management practices needs to be widely disseminated. People are aware of the constraints faced by service providers but not policy-level procedures to overcome these bottlenecks. The need for simplifying procedures has also been articulated. Transparency was an indicator in almost all villages, and the lack of it was a topic for hot discussion in almost all focus groups, with the users demanding more transparency in operations from service providers.

(v) User Satisfaction and Empowerment. It should be mentioned that for most users, the CSC process was the first time they participated actively in service delivery management. This led to a feeling not only of user satisfaction but of empowerment as well. Information disseminated during focus groups and interface meetings on expected levels of service delivery, responsibilities of GPs, and subject committees empowered the community substantially. In most pilot villages the demand for a repeat CSC after every three to six months was made, demonstrating the value of the exercise. On the whole the CSC exercise was effective in not only drawing up an action plan for the future but also reducing the gap between the service providers and the users, in turn leading to enhanced overall satisfaction levels.

(vi) Low Awareness of Responsibilities. During the input tracking exercise, it was evident that a large number of Gram Sabha members, including some GP members and Sarpanches, were not aware of the budgetary allocations of most GP

Table 3: Problem Solving Examples (From Action Plans)

Service	Problem	Solution	Village(s) Name
Water Supply	Inadequate water supply	New well to be constructed through people's contribution	Indoli
	Water tax collection and scheme maintenance	Hand over responsibility for water tax recovery, water testing, and O&M of water supply scheme to women	Bhondawde
Education	Insufficient bowls and plates for students to eat the mid-day meal	Villagers and teachers will provide utensils from their own contributions	Bhondawde
	Insufficient seating arrangements and sports equipment	Benches, mats, desks, and sports equipment will be bought from people's contribution	Indoli, Chore
	Poor performance of some children	Extra periods by concerned teachers; parents to visit school to see their ward's answer sheets	Hingnole
Health	Mat for patient checkups and table for pregnant women is too small	GP will provide bigger mats and tables	Talbid
Sanitation	Drainage repair and maintenance; village cleanliness	Villagers will do Shramdaan to clean village	Keral, Indoli
	Shortage of individual toilets, soak pits	Each house should make soak pits; GP will provide materials	Umbraj

schemes. Similarly a large number of oversight subject committees were either nonexistent or not functioning. In some villages committee members were ignorant of their roles and in some cases even their membership.

METHODOLOGICAL CONSTRAINTS

The CSC process led to a number of interesting insights and local solutions. A few limitations observed while conducting the pilot, were: (i) ***Duration of CSC Field Work:*** The field work was completed in one day per village, instead of the suggested two to three days per village. Consequently, preparatory work in some cases was not of expected quality due to factors such as inclusion of nonusers in focus groups, incomplete information dissemination, paucity of time for discussions, etc.; (ii) ***Facilitation Quality:*** The facilitators used for the CSC were all local government employees from the sectors being assessed. Even though care was taken to rotate staff between sectors, their objectivity and neutrality are questionable. This could have affected community opinion and participation; (iii) ***Choice of Indicators:*** The indicators used for assessing services were the same for users and service providers. While this helped simplify the process, some feel that service providers should have been permitted to choose their own indicators; and (iv) ***Unaddressed Issues:*** Despite extended discussions during interface meetings, a number of critical issues were not discussed, e.g., low user charges that are inadequate to cover the recurring costs of the water supply scheme in most villages. In some villages, key issues such as the insufficient number of subject committee meetings, the lack of staff for ensuring expected service delivery levels, and the absence of transparency in operations were not discussed by the community or service providers.

POLICY IMPLICATIONS

The CSC exercise resulted in a number of findings that have policy implications, three of which are discussed below:

(i) Revival of Village-Level Committees. A number of village-level committees (including the Gram Sabha or the Mahila Gram Sabha[7]) are supposed to be "supervising" local-level service delivery. It is evident from the pilot that most of these committees are either non-existent or not functioning. Ways to revive these committees, including capacity building of committee members, need to be explored and addressed on a priority basis.

(ii)Voluntary Disclosure of Information and Procedure Demystification. Despite the existence of the Right to Information Act (RTI) and citizens' charters, users are unaware of local service entitlements and standards, allocations and expenditures, beneficiary selection, and procedures to obtain benefits. A proactive effort to demystify procedures and disclose information needs to be made by governments and CSOs.

(iii) Performance Evaluation and Incentives. Performance evaluation of local service providers is devoid of all user feedback. Mechanisms to include user satisfaction levels should be incorporated in the performance evaluation of service providers. Performance incentives, if any, should also be linked to user satisfaction levels. This will go a long way in promoting downward accountability.

IMPACTS ON OUTCOMES AND PROCESSES

The encouraging results of the pilot have led Zilla Parishad (ZP), Satara, to carry out a second pilot in 41 villages in which they have used the CSC process to converge child health and nutrition services. A few key innovations and outcomes from these pilots are discussed below:

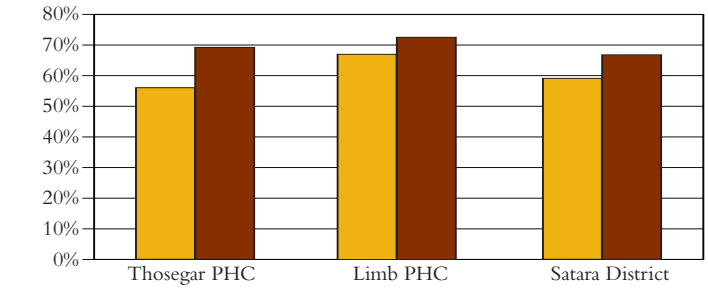
1. Reduction in Malnutrition: The percentage of normal grade[8] children improved from 56 to 69 percent in Thosegar PHC and from 67 to 73 percent in Limb PHC in six months (October 2006 to February 2007), while the percentage of normal grade children in Satara District improved from 59 to 66 percent in 11 months (April 2006 to February 2007) as depicted in Figure 2. The number of Grade 3 and 4 children (severely malnourished) in both PHCs was reduced from 7 to 0 in six months (October 2006 to February 2007). The corresponding reduction in Grade 3 and 4 children in Satara District was from 399 to 58.

2. Sensitization of Parents and Villagers: As part of the public awareness campaign, an IEC van toured each village weighing all children in the 0-6 year age group in the presence of all

7. A Gram Sabha held exclusively for and by women to enable them to discuss gender-related issues. The Government of Maharashtra has made it mandatory to organize Mahila Gram Sabhas before the Gram Sabha to facilitate the participation of women in the local decision-making process.

8. Under the Integrated Child Development Scheme, children are classified into five grades according to their degree of malnourishment: normal, Grade 1, Grade 2, Grade 3, Grade 4, and Grade 5. Grade 5 children are the most malnourished.

Figure 2. Percentage of Children in the Normal Category



	Thosegar PHC	Limb PHC	Satara District
Oct-06	56%	67%	59%
Feb-07	69%	73%	66%

parents and conducting medical check-ups of all pregnant women. Growth charts have been painted on the floors of all Anganwadi[9] Centers. The sight of children standing on these growth charts according to their degree of malnourishment publicizes the children needing attention to all parents, ensuring that they are paid adequate attention. Regular health checkups for all children in the 0-6 year age group and special pediatric camps for Grade 3 and 4 children are now regularly held every three months.

3. Mobilization of Community Resources: Monthly community contributions of Rs. 3 per child for Anganwadi attending children and Rs. 1 per adult requiring health services has helped raise a corpus fund of over $100,000 to strengthen Anganwadi Centers and prevent malnutrition. Severely malnourished grades 3 and 4 children have been adopted by prominent members of the community and are now under their care. Ayurvedic medicines are being regularly distributed to all severely malnourished children through contributions.

The ZP is now conducting micro-planning and community monitoring, primarily through the CSC in another 121 villages in Satara District, with the objective of achieving the Millennium Development Goals of reducing malnutrition and infant and maternal mortality. UNICEF has expressed an interest in adopting the "micro-planning with CSC based community monitoring" model in their work area. Eventually ZP, Satara, intends to expand the initiative to cover all villages in Satara District.

The pilot study was conducted in only 14 villages and engaged over 600 participants. If the CSC methodology were to be conducted in all 44,000 villages in Maharashtra State, a conservative estimate of the number of users that could provide feedback and participate in the development process would easily exceed 1,800,000. This shows how the systematic use of the CSC can make it a powerful tool of civic engagement and empowerment. This was echoed in the words of the chief executive officer of Zilla Parishad, Satara:

"Good governance at the Gram Panchayat level means transparency, participation, accountability, effectiveness, and efficiency in program implementation. The Community Score Card method ensures good governance at the local level".

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9. An Anganwadi is a center built under the Integrated Child Development Scheme where all children in the age group 0-6 years collect and are provided supplementary nutrition and pre-primary education.

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