Note No. 1 • August 2007

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 1

Andhra Pradesh, India: Improving Health Services through Community Score Cards

BACKGROUND

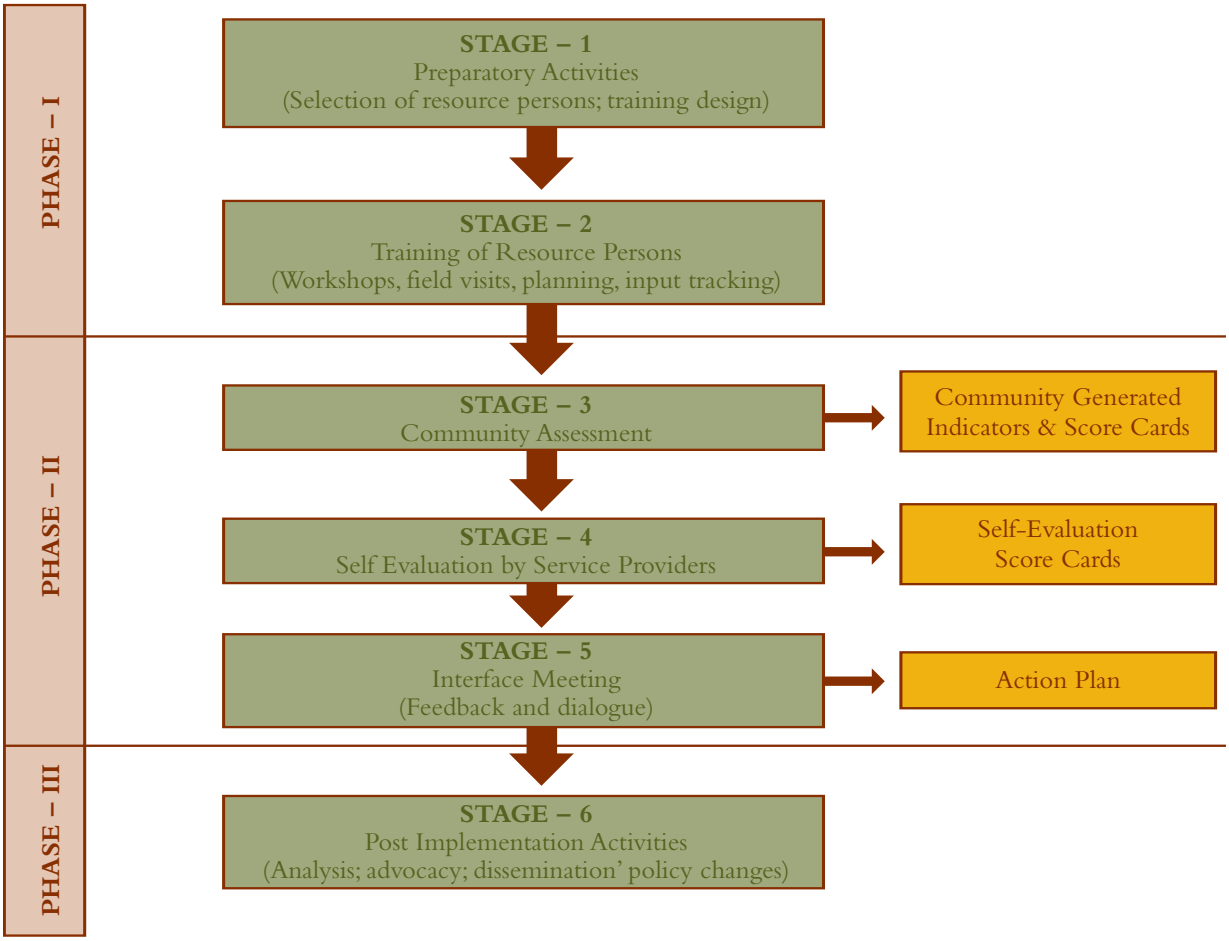
The state government of Andhra Pradesh provides primary, secondary, and tertiary level health care services to a rural population of 5.5 million through a chain of institutions under allopathic and other systems of medicine. There are 1,570 primary health centers (PHCs) in the state staffed by about 2,000 professionally qualified doctors and supported by a similar number of paramedical staff. They collectively conduct more than 300,000 deliveries and treat more than 30 million outpatients per year suffering from diseases such as gastro-enteritis, viral fever, acute respiratory infections, malaria, and so forth. The PHC system is the most important and often the only option available for the poor, vulnerable, and marginalized sections of the population.

The Directorate of Health is responsible for rendering primary health services under the allopathic system. The District Medical and Health Officer (DM&HO) is the district head of the Directorate of Health Services. At the primary level, the services rendered are mainly for the prevention and control of local endemic diseases, implementation of national health programs, and the promotion of health awareness among the community. A PHC is the nodal point of the rural health system. Each PHC caters to a rural population of approximately 35,000. There are, on average, 6-8 subcenters under a PHC, each of which caters to a population of 5,000 in the plain areas and 3,000 in the tribal areas.

The performance of a PHC is monitored by an Advisory Committee at the block (Mandal) level, by the DM&HO at the district level, and by the Director of Health and Commissioner of Family Welfare at the state level. The advisory committee, whose meetings are seldom held, includes Gram Panchayat members and eminent local citizens and is the only mode of downward accountability. In PHCs, user feedback, if

The current initiative was one of six pilot projects launched by the South Asia Sustainable Development Department 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 Andhra Pradesh pilot.

Figure 1. Stages in the Community Score Card Process



there is any at all, is usually limited to an abandoned complaint box. A monthly target-based approach is predominantly used to review PHCs with quantitative indicators such as number of outpatients treated, number of deliveries, number of lab tests, and so forth. There are no indicators to measure the quality of service delivery. Any improvements in the health care delivery system are largely individualized and rarely systemic, which invariably results in low user satisfaction levels.

The Center of Good Governance, Hyderabad, in partnership with the World Bank-sponsored Andhra Pradesh Rural Poverty Reduction Project (APRPRP),[1] undertook a pilot project in which the community score card (CSC) was applied to assess the performance of two primary health centers (PHCs) in two Mandals[3] of Visakhapatnam District, Andhra Pradesh, in the context of primary health care service delivery. The pilot commenced in March 2006.

PROCESS

The methodology adopted for undertaking the pilot project consisted of six stages of project activities undertaken in three phases as depicted in 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 selecting

1. The development objectives of the APRPRP or the Indira Kranti Patham (IKP), as it is commonly called, are to enable the rural poor in Andhra Pradesh to improve their livelihoods and quality of life and aims to eradicate poverty; promote human capital development; focus on the welfare of children, particularly girls, women, the old, and the infirm; and build an equitable society in which people participate in making decisions that affect their lives and livelihoods.

2. The Mandal, or subdistrict/block, is an administrative unit in Andhra Pradesh consisting of 30-50 villages with a population of approximately 50,000.

community resource persons (CRPs); designing the training program; preparing the training manual; conducting the training workshop; and operational planning for the pilot exercise. Phase II saw the actual implementation of the pilot through trained CRPs. 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 preparing action plans and conducting a dissemination workshop involving key stakeholders such as the state and local governments, civil society organizations, and so on.

Key Resource Persons. A small core team (3-4 people) of experienced professionals from the Center for Good Governance with a knowledge of participatory processes, supported by a team of local field workers provided by the project staff, were involved in guiding and monitoring the entire process. The project was executed by CRPs, suitably trained through classroom sessions and field activities. CRPs were selected community health workers, members of self-help groups, and community members who were articulate and acceptable to the community. These CRPs undertook the pilot application of score cards in two Mandals, Devarapalle and Golugonda, in Vishakhapatnam District.

Criteria for Selection. To get a clear picture of the health care service delivery status, PHCs in two Mandals that were distant from the district headquarters and which had sufficient geographic, economic, and social variations were identified. Subsequently, a group of 6 villages in the immediate service area of each Mandal were selected.

Indicators and Scoring. At each community location, the users of PHC services were divided into male and female groups. A total of 24 group discussions were conducted across the 12 villages, generating a cumulative total of 153 indicators[3] (Devarapalle Mandal—67 indicators, Golugonda Mandal—86 indicators; male groups—72 indicators, female groups—81 indicators). The community rated the various indicators on a scale of 0-100 to indicate their perception regarding the quality of service delivery. They also expressed their qualitative views to justify their choice and rating of indicators.

Consolidation of Indicators. The CSCs generated at the community level were thereafter consolidated to provide a holistic perspective on the issues affecting the community across different villages. The methodology adopted for consolidation of the score cards consisted of the following three basic steps: 1. Aggregation—Issues identified by different groups in different ways were identified and aggregated. The aggregation resulted in 11 indicators (Figure 2). 2. Importance Estimation—A simple count of the indicators reflected their recall importance, and a composite ranking of indicators was done by assuming a simple weighted criterion. And 3. Composite Rating Calculation—Composite scores for each indicator were calculated using an average score (mean) as well as a min-max (range) criterion to assess the rating of service delivery on a particular attribute.

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.

The service provider self-evaluation elicited perspectives from the supply side. The PHC administration was informed well in advance, and CRPs, along with community coordinators, visited the PHC. A total of 29 indicators were generated in the two PHCs during the self-evaluation process. These indicators were aggregated into seven broad categories for the purposes of analysis and comparison with the indicators generated during the community assessments.

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. State and 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, the people responsible, and timelines were prepared for implementing improvements.

3. This is the sum total of all the indicators generated in all 24 discussion groups. Several of these indicators have been repeated across different discussion groups.

RESULTS

An evaluation of the scores given to various indicators (Figure 2) by each community suggests ***systemic and support-level weaknesses that plague health care delivery*** at the primary level. Three main observations emerge from the pilot study. 1. There are fundamental issues related to the operating style of functionaries, including low scores in indicators such as staff behavior and working style, hours of operation/availability of doctor/staff, medicine dispensing point, poor accountability, and weak responsiveness. 2. Service delivery is further undermined by ***weak support services and infrastructure*** issues. This is indicated by the scores in such categories as transportation, government schemes, subcentre linkages, waiting facilities, water supply, toilets, beds, waste management, and so on. 3. ***Low awareness among community members*** further complicates issues since most users are not aware of service entitlements, standards, or other government schemes.

The differences between the perceptions of the community and the service providers were quite stark, as depicted in Figure 2. On almost all indicators (except transportation facilities and doctor's availability in Golugonda), each community's scores are lower than the providers' scores.

Staff behavior and working style is the most important indicator to communities in both Mandals, clearly demonstrating the importance of the "human touch" in service delivery.

Dispensing of medicines is the second most important indicator. Community members felt that medicine prescribed by doctors was not being distributed and that there was no transparency on the availability of medicines in the PHC. ***Hours of operation/availability of doctor/staff is another important indicator.*** There are two dimensions to this problem: presence of the doctor/staff during official hours and the suitability of the official hours to the community needs. Both Mandals fared poorly in all three indicators discussed above. Many issues raised by the community were due to their poor levels of awareness, especially regarding the services that the PHC was mandated to offer.

Lack of basic infrastructure at the PHCs further compounded problems. The lack of waiting facilities, an irregular water supply, unclean toilet facilities, shortages of beds, and the absence of a scientific medical waste disposal process added to the inconvenience faced by patients. ***Weak support services*** such as the poor condition of village roads, the lack of information about government schemes, and the inability of PHCs to provide emergency services further increased the discontent levels of the community.

Overall, the ***quality of service delivery is quite poor***. The average score across all indicators was 34, and this reflects the state of primary health care delivery as perceived by the community. It is evident that the relative scores on the higher-ranked indicators are lower than those for the lower-ranked indicators.

Figure 2: Comparison of Average Scores

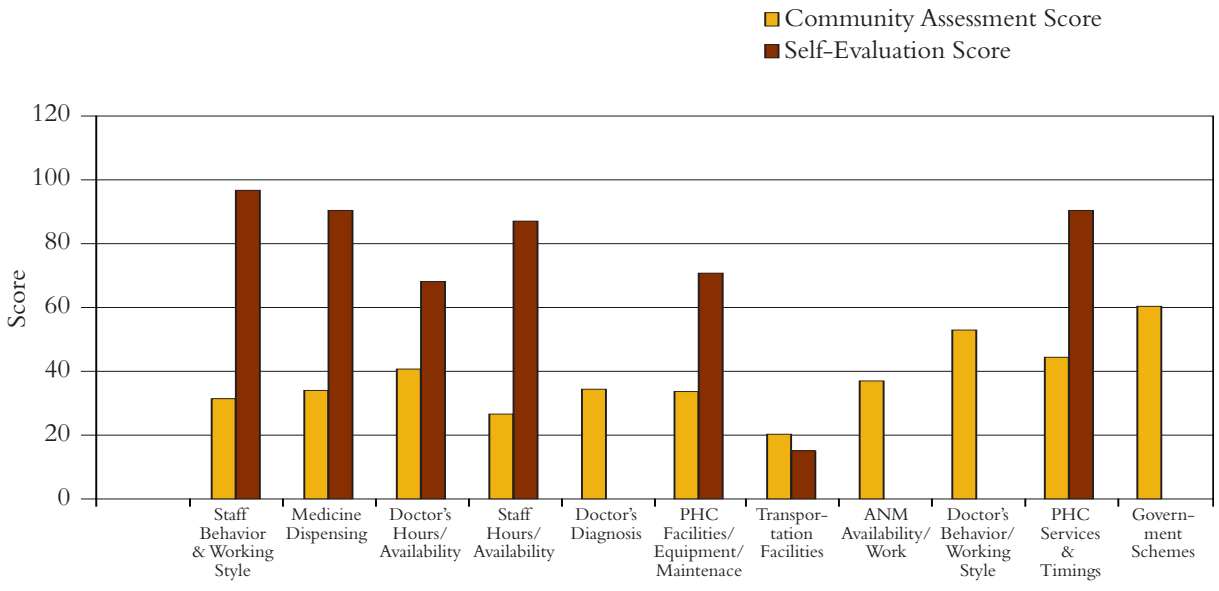
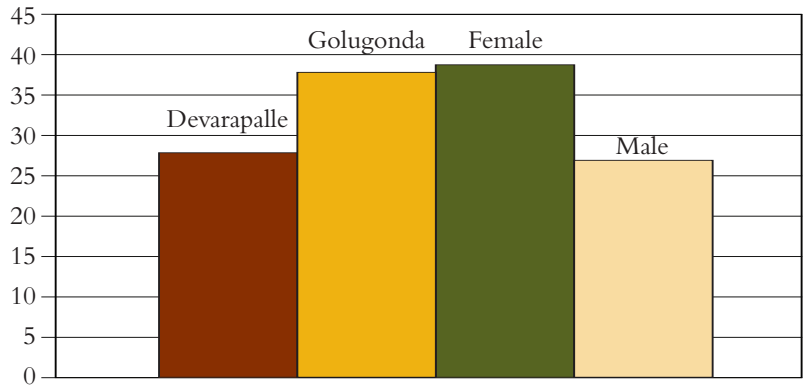


Figure 3: Comparison of Scores by PHC and Gender



A comparison between the two PHCs (Figure 3) reveals that the facilities in Devarapalle have been rated lower than Golugonda's. While most of the key issues are the same in both the Mandals, a few indicators were seen to be more important in one Mandal as compared to the other, e.g., in Devarapalle Mandal, the doctor's availability was a relatively bigger issue than in Golugonda, while the doctor's diagnosis was more important in Golugonda. Both gender groups attach similar importance to key issues highlighted. It is also evident that female groups have given a higher rating to the PHCs than male groups.

Self-evaluations and interface meetings provided some explanations to the differences in perceptions between the users and service providers, e.g., the PHC staff are overburdened and stressed resulting in irritated responses to patients; medicines were in short supply (dispelling the belief that medicines were being sold elsewhere); and action plans that resulted in constructive problem solving (Annex 1). The pilot was successful in demonstrating how the CSC exercise can provide ***innovative solutions to local problems***. Some such solutions were (i) the medical officer and the staff expressed their willingness to undergo training to improve their attitudes and orientation to service delivery and also proactively generate awareness among the community so that the satisfaction levels of the patients can be improved; (ii) the hours of the doctor and staff were changed to suit community needs; and (iii) a system to redress grievances and display an inventory of available medicines was agreed upon and implemented. On the whole, the CSC exercise reduced the gap between users and service providers, in turn increasing overall satisfaction levels.

IMPLICATIONS FOR INSTITUTIONALIZATION AND SCALING UP

Implications can be drawn at two levels from an analysis of data generated from the pilot: i) for operational field staff at the village, block, and district level; and ii) for health policy makers at the state level.

At the operational level, measures such as the following will be effective in creating and institutionalizing user feedback mechanisms: continuous self-evaluation by PHC staff on points raised by the community; display of action plan progress cards in PHCs and associated villages; prominent display of citizens' charters; and the holding of PHC advisory committees on a regular basis. ***Facilitation is key*** for the success of the CSC exercise. Even though the availability of articulate and committed local resource persons did not hamper the pilot, an increased use of the CSC that involves a larger number of PHCs will not be possible without having a ***large pool of high quality local facilitators***.

At the policy level, guidelines that create institutional capacity and mechanisms that create spaces to integrate the CSC process into existing service delivery channels are needed now. The creation of an enabling framework will go a long way toward increasing user satisfaction levels and improving service delivery. Timely implementation of action plans is vital to the success of the CSC process. In the absence of legal sanction for the CSC, it is unclear who should follow up: the health department or the APRPRP project implementing staff?

Often support and ownership from higher level officials and key decision makers, which are vital to the success of the CSC process, particularly during self-evaluation and interface meetings, are also lacking. At the micro level, the attitude of the service providers toward a local community member who is acting as a resource person and lacks legitimate authority is often dismissive. This was evident in the PHC staff as well. The absence of such a sanction restricts the CSC from being conducted on a regular basis. Legal sanction for the CSC from the state government will assist in institutionalizing the process.

IMPACT OF SOCIAL ACCOUNTABILITY MECHANISMS ON HEALTH AND SERVICE DELIVERY OUTCOMES

Under the APRPRP, a number of health innovations have been introduced in 45 health Mandals in 22 districts of Andhra Pradesh to help individuals and communities manage health risks. The two Mandals in which this pilot was conducted were chosen from these 45 health Mandals. Community participation in all health activities in the pilot Mandals increased substantially as a result of the CSC. Most of the suggestions in the action plans, e.g., change in doctors' and staff hours, behavioral/attitudinal training and motivational sessions to sensitize staff, provision of an ambulance by the Mandal Samakhya,[4] and so forth, have been implemented. The feasibility of implementing other suggestions is being evaluated by Mandal/District level officials. The encouraging results from the pilot have led the Society for Elimination of Rural Poverty (SERP), the APRPRP Project Management Unit, to scale up the CSC to all health Mandals. Proactive community participation in health activities has enabled SERP to introduce several other community-managed health interventions, most of which have been now institutionalized through the issuance of operational guidelines by the Health Department of the Government of Andhra Pradesh. Some of these innovative interventions are described below:

1. Fixed Nutrition and Health Days (NHD): The auxiliary nurse midwife's (ANM)[5] visits to the village are usually irregular. Consequently not everyone is able to access immunization and health services. To ensure access and availability of health and nutrition services to the rural poor, schedules for fixed NHDs have been drawn out at the Mandal level keeping in mind the ANM's tour program. The NHD has been institutionalized in over 800 villages.

2. Nutrition Centers: The nutrition center caters to the nutritional needs of pregnant and lactating women and children up to two years of age. The center aims at the holistic development of women, especially those from the most vulnerable sections, by focusing on improving their health and nutrition. These centers provide health education and a nutritious diet to its members. Twenty-seven nutrition centers have been established in 6 health Mandals out of which 20 are in the pilot Mandals.

3. Health Risk Fund (HRF): Many people, especially the poor, borrow money at significantly higher rates of interest to meet costs of hospitalization in emergency situations. To safeguard self-help group (SHG) members from such vulnerabilities, HRFs have been formed in a number of villages. HRFs operate as separate funds, earmarking expenditures for health-related problems such as transportation, medicines, diagnostic tests, consultation fees, hospitalization, and so forth. The HRF runs as a savings and loan mechanism that is operated by the village organization at the village level. Members save anywhere between $0.50 and 1.00 per month. HRFs are being run in 32 of the 45 health Mandals.

4. Arogya Rakhsha (Health Insurance): To ensure that SHG members get timely medical care, a comprehensive package of health services targeted to the rural poor is being provided by a private hospital in Karimnagar District. The annual premium for a family of five members is $10. Case managers at the hospital have been appointed to assist members navigate hospital procedures and get quick medical attention. Currently, 22,000 SHG members have enrolled for Arogya Rakhsha.

5. Community Managed Ambulance Services and Drug Depots: Ambulance services and drug depots in some health Mandals have been outsourced to village organizations and Mandal Samakhyas. Most PHCs have neither ambulances nor an adequate supply of medicines. Community managed depots are able to ensure timely availability of medicines at reasonable prices for all PHC patients.

The above interventions and their effects demonstrate that the Community Scorecard process is a powerful tool of civic

4. The Mandal Samakhya is a federation of village organizations which are registered cooperative federations of women's self help groups (SHGs).

5. The ANM is the multipurpose extension health worker who works at the interface between the community and the public health system.

engagement and empowerment. If the CSC methodology is applied to all the 1,570 PHCs in the state, a conservative calculation assuming 12 focus groups per PHC estimates that the number of users providing direct feedback and being engaged easily exceeds 600,000. The CSC can be an effective channel through which communities can articulate their concerns, voice their needs, and engage with service providers.

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ANNEX 1: ACTION PLANS

Golugonda Mandal

S. No.	Indicator	Action to Be Taken	Responsibility for Action
1	Doctor's Hours/Availability	Hours of operation to be announced (Since doctor was on additional charge)	ANMs, health professionals, and community coordinators
2	Staff Behaviour and Working Style	Talk to staff	Doctor; immediately
3	PHC Services	Gram Panchayat to be informed; PHC staff to attend the meetings of Gram Sangha (village organisations)	ANMs, PHC staff; immediately
4	Transportation Services	Feasibility to be evaluated	DRDA and Health Department
5	PHC Infrastructure	Feasibility to improve waiting hall, beds, and basic amenities like drinking water, toilets, etc. to be evaluated	DRDA and Health Department
6	Staff Behaviour	Training to be conducted for the staff	DRDA and Health Department

Devarapalle Mandal

S. No.	Indicator	Action to Be Taken	Responsible for Action
1	Doctor's Hours/Availability	Change of hours: 9 am–12 noon and 3–5 pm to change to 10 am–1 pm and 4–6 pm; 1–4 pm staff nurses to be available; Inform Panchayat and staff about new hours; announce new hours in Mandal Parishad meetings; Alternative awareness campaigns to be planned	Doctor, ANMs, community coordinators; immediately
2	Staff Behaviour and Working Style	Talk to staff; discuss in staff meetings; introduce complaint box and redress complaints received between 11 am–12 noon every Saturday	Doctor; immediately
3	Medicine Dispensing	Translate medicine names into local language and display list on notice board	Community coordinators, store in charge; 2 months
4	PHC Services	Gram Panchayat to be informed; PHC staff to attend meetings of Gram Sabha	ANMs, PHC staff; immediately
5	Transportation Services	Feasibility to be evaluated	DRDA and Health Department
6	PHC Infrastructure	Feasibility to improve waiting hall, beds, and basic amenities like drinking water, toilets, etc. to be evaluated	DRDA and Health Department
7	Staff Behaviour	Training to be conducted for staff	DRDA and Health Department