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OPERATIONAL MANUAL
FOR IMPLEMENTING THE
COMMUNITY SCORECARD PROCESS

ANDHRA PRADESH RURAL POVERTY REDUCTION PROJECT

Draft, May 2004

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Preface

This Operational Manual is intended to provide implementation guidelines for running community-based performance and expenditure tracking that can be included in the operations of the Andhra Pradesh Rural Poverty Reduction Project (APRPRP). It details the context, objectives, and sequencing of tasks for community-based performance monitoring, and provides guidance points, answers to troubleshooting issues, and key points to remember for on-the-ground facilitators.

The specific mechanism that is elaborated on is the *Community Scorecard Process(CSC)* that is a hybrid of the different techniques of social auditing, various participatory rural appraisal (PRA) /participatory poverty assessment (PPA) tools and citizen report cards (CRC). This methodology is relatively new, and has only been applied in pilot contexts in a handful of countries, mainly in Africa. The tool originated through the work of CARE Malawi in the Health Sector where they came up with the community scorecard process as a means to put the 'Rights-Based Approach to Development' in action.

The learning from these pilot applications of the community scorecard process is still at a nascent stage. Consequently, the scope of this manual is only to provide operational guidance sufficient to bring the pilot activities to scale and to serve as a stimulant for the production of a similar Operational Manual by the APRPRP project staff. This homegrown manual would be based on the learning and examples from the pilot experience and will be directly relevant within the project context. This Operational Manual must therefore be treated as a "living document" that will be updated and improved upon with growing experience and learning from the field.

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PART-1: INTRODUCTION AND CONTEXT

The first part of this manual provides the context and background behind the application of the community scorecard process. Chapter 1 outlines the basic rationale and features of the APRPRP within which the CSC process will be applied and Chapter 2 highlights its relevance and application in the project.

Chapter 3 provides a quick overview of the CSC process methodology within the project context and Chapter 4 describes the main objectives and expected outcomes from the application of this community-based monitoring and empowerment tool.

The detailed methodology for implementing the CSC process will be outlined in Part-2 of the manual, while Part-3 will deal with follow-up, data management and logistical issues.

CHAPTER 1. BACKGROUND AND CONTEXT

Rural poverty in Andhra Pradesh is no different from poverty elsewhere in the world – it is a multi-dimensional phenomenon encompassing the inability to satisfy the basic needs, lack of control over resources, lack of education and skills, poor health and malnutrition, lack of shelter, poor access to water and sanitation, vulnerability to shocks, violence and crime, and lack of political freedom and voice. The challenges facing the poor are therefore, varied and complex. Especially in the context of Andhra Pradesh they include: limited access of anti-poverty programs, lack of empowerment (voice), limited livelihood opportunities, limited human capital development, risks faced by the poor and piece-meal approach to poverty reduction by the authorities.

Since the early 1950's the, the Government of India (GoI) has implemented many anti-poverty programs by providing wage employment, productive assets (tools, animals etc.), skills, credit, and food security. Government of Andhra Pradesh (GoAP) has complemented these GoI programs with additional funding for Self Help Groups (SHGs), Scheduled Casts/Scheduled Tribes (SCs/STs) programs and Janmabhoomi - a state-wide social program. However, these programs have only been partially successful. The key reasons cited for failure are: (i) lack of people's participation (ii) poor governance and (iii) inadequate incentives to government staff in implementing the programs.

1.1 Andhra Pradesh Vision 2020

In an attempt to overcome the policy failures thus far, in its "Andhra Pradesh Vision 2020"document, GoAP has articulated a growth-oriented poverty reduction strategy. The key elements of the strategy are:

Empowerment: Andhra Pradesh has been a leading state in forming and developing SHGs and will continue to pursue policies to promote the formation of SHGs and their federations (Mandal Samkhyas).

Viable Economic Activities: Emphasis will be placed on identifying non-farm employment opportunities especially the development of micro-enterprises and their linkages with markets and rural banks. Furthermore, GoAP will pursue a "Rural Livelihood Approach" to poverty eradication taking into account the need for more holistic approach to rural development.

Human Capital Development: GoAP's human capital development strategy will focus on health, nutrition and education. Specifically, improvement in mother and child health care (MCH), reproductive child health care (RCH), integrated child development services (ICDS), reduction in incidence of communicable diseases, and improvement in elementary education services.

Governance and PRIs: GoAP is committed to decentralization of decision-making power, including fiscal decentralization to PRI institutions and municipal government, devolving day-to-day details of administration to lower level governments. It recognizes the critical need to enhance the capacities of elected representatives to enable them to function in an efficient, pro-poor manner.

Public-management Reform: GoAP is also promoting a transparent and accountable government including freedom of information, citizen charters, procurement procedures and reporting.

1.2 The Strategic Context of Andhra Pradesh Rural Poverty Reduction Project (APRPRP)

While building on the two years of implementation experience of the Andhra Pradesh District Poverty Initiatives Project (APDPIP) that has validated the social mobilization and empowerment approach to poverty eradication, the APRPRP also fits into the overall poverty reduction of the GoAP. The following project objectives have been identified:

- To ensure that self-reliant and self-managed community-based organizations (CBOs) of the rural poor are established and through these empowered organizations they are able to take advantage of their new opportunities, in a risk-managed environment.
- To ensure that assets are created and incomes are improved for the CBOs established or strengthened under the project and to facilitate the poor to convert their secure asset base into an economically viable, improved and sustainable living.
- To test innovative programs to address risks related to health, ICDS, and land-based activities. To achieve higher educational levels particularly among girl children.
- To facilitate local institutions (PRIs) to operate in a more inclusive and responsive manner, especially with respect to education, health and credit services. To integrate bottom-up participatory development of the target groups with well-coordinated, transparent delivery of services at the local level (Mandal level primarily).

One of the major issues highlighted by the past experiences of GoAPs poverty programs, particularly the APDPIP is the precarious living condition of the poor which, among other things may be directly attributed to:

(i) Lack of empowerment or (voice) in accessing basic services, taking advantage of economically attractive opportunities, and exercising legal rights: Information is seldom available. Households, village, and local government decision-making is often exclusionary. Mechanisms to ensure accountable delivery of state and local government services are either non-existent or non-functioning. Moreover, social discrimination of caste and ethnicity still prevail and result in further disempowerment of the poor.

(ii) Severe deprivation among the poor as indicated by low health, nutrition and education indicators in the rural areas: The interdependence, complementarity, and synergy of health, nutrition and education in the context of human development are now universally recognized. Human capital is critical for the rural poor, because deprivation of health, nutrition or education limits the capacity to fully (a) utilize one's own asset (labor) and (b) access and utilize available services. The inability to tap either or both prevents people from escaping vicious poverty traps. If rural poverty is to be reduced, these low indicators emphasize the urgent need to address these concerns, largely through coordinated community mobilization and improved service delivery.

Moreover this kind of exposure to unanticipated loss from death, hospitalization, disability etc. is often devastating and can prevent households from escaping poverty and related debt traps. This vulnerability makes them highly risky and reduces their credit worthiness. Therefore, it is necessary to empower them, so they can hold the service providers accountable, which in turn will lead to good governance practices and increased accountability – two very important factors to bring about increased private sector confidence and eventually poverty reduction.

In recognition of the above issues, one of the project goals is to improve the quality of and access to basic health care services through empowerment of the rural communities. The project aims to develop innovative and sustainable models that seek to:

- Make health and nutrition services more responsive to the community, especially the poor
- Change the current approach of health and nutrition service providers towards the delivery of their services
- Increase access to basic health and nutrition services to the poor
- Increase community ownership of primary health and nutrition service delivery
- Improve community awareness of health and nutrition issues, especially high risk behaviors
- Develop safety nets for the poor during catastrophic illness

1.3 Private Service Provision in AP Health Sector

The National Sample Survey (NSS) and various Bank studies indicate that the private sector is a major player in healthcare provision and financing in Andhra Pradesh, accounting for almost 90% of all ambulatory care and more than 70% of hospitalizations. The private sector accounts for two thirds antenatal care, more than two-thirds of all institutional deliveries, and one-third of immunization. An increasing proportion (which is already very high) of healthcare consumers, including the poor, are turning to the private sector, despite considerable investment in the public sector over the last decade.

AP has had the good fortune of a strong political commitment to improving health outcomes. These goals, including infant and child mortality, maternal mortality, and communicable disease control, are clearly articulated in Vision 2020. Given that the health system in Andhra Pradesh is heavily reliant on the private sector, efforts to improve priority health outcomes will fail if they do not take this into account.

A strategy is being developed to ensure that the private sector contributes optimally to achieving the health goals of Vision 2020. This strategy will emphasize the oversight and enabling roles to be played by the public sector in ensuing the involvement of the private sector in meeting the health goals. GoAP will emphasize demand-side interventions to promote equity and improve quality, with initial emphasis on maternal and child mortality.

1.4 Incentivizing Healthcare for Improved Service Delivery

GoAP has been actively promoting greater transparency and accountability in all its programs in the last couple of years. An attempt has been made to develop “Performance Indicators” for both, departments and districts, to measure their performance. These performance indicators are designed to be included in the “Performance Budgets”, prepared by line departments, and were included in the 2003-2004 budget process. Hence, the concept of *performance monitoring* is not new in Andhra Pradesh. The challenge is the effective institutionalization of these improvements which depends on their translation into improved prioritization and service delivery by line departments. Therefore, performance budgeting needs to be further refined and developed and linked to performance-based incentives and disincentives (as the case maybe).

In the context of the health sector, in addition to developing performance monitoring systems, there is an initiative to provide *incentives*, primarily in the form of supplementary budgets for enhanced quality of services and promoting user charges etc.

Additionally, detailed plans for a pilot scheme are being developed, which will use health insurance instruments like vouchers to enable the poor to obtain essential healthcare services (including antenatal, delivery and postnatal care) through public or private healthcare centers. Life Insurance Company (LIC) and other private companies will be involved in the process. The insurance premium will be provided by the communities and the CBOs, VOs and MSs will play the role of insurance intermediation.

Therefore, it is essential that a ***performance rating system*** is developed for both private and public healthcare providers, that will (i) provide information on healthcare institutions to the people or the 'users' of services, (ii) assess the performance of healthcare institutions and, (iii) assess the responsiveness of the healthcare service providers.

This will not only induce a healthy competition among the various service providers (motivated by higher premiums through better performance) but will also inform people's choice while selecting a healthcare service provider for health insurance instruments.

It is important that while developing such a system , both the 'users, i.e., rural communities and the providers be involved in the process. Therefore the project will build collaborative capacity between the people and healthcare service providers, by implementing participatory community-based performance monitoring mechanisms such as the ***Community Scorecard Process,*** the subject of this Operational Manual.

CHAPTER 2. GENERAL ACCOUNTABILITY FRAMEWORK

The main emphasis of the APRPRP being social mobilization, community empowerment and integration of bottom-up participatory processes to enforce well coordinated, transparent public service delivery – the concepts of "Accountability" in general and "Social Accountability" in particular become indispensable within the project context.

2.1 What is Accountability and Social Accountability

Accountability can be defined as *"the obligation of power-holders to account for or take responsibility for their actions."*

"Power-holders" refers to those who hold political, financial or other forms of power. This includes conventional power holders like politicians and bureaucrats, but also local power holders such as Mandal Samkhyas (MS), contractors for community projects or service providers such as Primary Healthcare Centers (PHCs). These power holders can in turn be held accountable for both their (i) *conduct* (i.e. they must obey the law and not abuse their powers) and (ii) *performance* (they must serve the public interest in an efficient, effective and fair manner)..

It is easy to see how accountability is an integral component of 'empowerment' and hence poverty reduction as was argued in the World Development Report 2001. But accountability can also be analyzed differently from the perspective of - "making services work for the poor". The problem for low-income countries such as India is not just that they lack resources, but also, and sometimes more seriously, that the resources allocated and expenditures incurred do not yield the desired outcomes at the ground level. The World Development Report 2004, sites four possible causes for this limited effectiveness of public expenditure in the social sector:

(i) ***Either the government is misallocating resources*** – that is, it is spending on the wrong goods or the wrong people. This effectively is a budgeting or resource allocation problem.

(ii) ***Or, the resources never reach frontline service providers*** – thus even if the resource allocations are correct, it makes no difference since expenditure 'leakages' mean that no money actually reaches its ultimate destination and service delivery is not improved. This then is an expenditure-tracking problem.

(iii) Even when the money reaches the service provider, ***the incentives to provide the service may be weak***. This lack of incentives can be attributed to the problem of performance monitoring and evaluation.

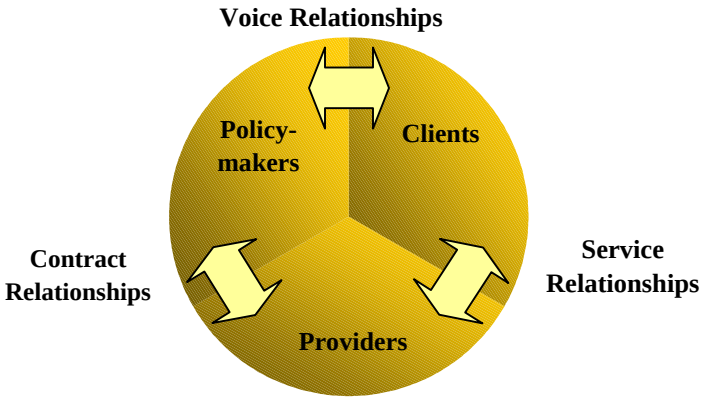
(iv) Finally, there may be a ***demand side failure*** – that is, people may not avail of the services provided to them. This is to a large extent a problem of awareness and participation.

These four problems hit at different parts of the service delivery chain, which can be unbundled into three kinds of accountability relationships –

- *Contracts* between the policy maker and the service provider,
- *'Client Power'* between the citizen-client and service provider, and
- *'Voice' relationships* between the citizen-client and the policy maker

As the WDR 2004 argues, services can be made to work for poor people if these three accountability relationships (depicted in Fig.1 below) can be strengthened.

Figure-1: Unbundling the Service Delivery Chain -Framework from WDR 2004[1]



Given the above generic problems with resource allocation and expenditures, accountability assumes a very important role because it influences each of these relationships to ensure smooth and timely flow of funds and their correct utilization so that poor communities get better outcomes from the money that is spent on them by the government. That being said, the obvious next question is , *how* can accountability be promoted – that is, *what are the mechanisms and what is the framework that can be used to make public institutions such as PHC's more accountable?*

2.2 How is Accountability Promoted – Introducing Social Accountability Mechanisms

Usual methods of enforcing accountability tend to be "supply-driven" and "top-down" using methods such as administrative rules and procedures, auditing requirements, and use of formal law enforcement agencies like courts and the police. Mostly the focus is on 'rule following' and rarely on actual performance.

These top-down accountability mechanisms have only met with limited success in all countries – be they developed or developing[2]. As a result, new measures such as the setting up of independent pro-accountability agencies like vigilance commissions and ombudsman have been tried, and in other cases public institutions have been privatized or contracted to the private sector to facilitate market based accountability into the public sector.

More recently, the focus has shifted to the demand side – that is on getting citizens and poor citizens to *directly* demand accountability through greater monitoring and vigilance of power holders. This approach towards exacting accountability that relies on community or citizen action is called *social accountability.*

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[1] From World Development Report 2004: "*Making Services Work for Poor People*", The World Bank, 2003, pp.6, fig.4 – yellow boxes added.

[2] This section draws on Ackerman, J.: "Civic Engagement for Accountability", Social Development Department Discussion Paper, Forthcoming.

Thus, social accountability mechanisms are *demand-driven*, and operate from the *bottom-up*. They refer to the broad range of actions and mechanisms (beyond voting) that citizens, communities, civil society organizations (CSOs) and independent media can use to hold government officials, bureaucrats, and service providers accountable. The power of these mechanisms is that, apart from enforcing accountability, they lead to empowerment, knowledge of rights, increased participation and joint planning, as well as strengthening of democracy and governance.

There is an extremely broad array of social accountability mechanisms that citizens can potentially undertake to hold government officials and bureaucrats accountable. Research and analysis[3] of different social accountability initiatives across the world show that those mechanisms that seek to directly involve ordinary citizens in processes of allocating, disbursing, monitoring and evaluating the use of public resources have proved very effective since it is this resource flow that puts policy into action.

These mechanisms can be categorized into *four processes* that form part of a strategy called ***Participatory Public Expenditure Management***. These four processes are:

(1) *Participatory budget formulation (PBF)* – wherein citizen groups either participate directly in actual allocation of resources, or formulate alternative budgets,

(2) *Participatory budget review/ analysis (PBA)* – the process of reviewing and demystifying actual budgets by CSOs, to assess whether allocations match the government's announced social commitments,

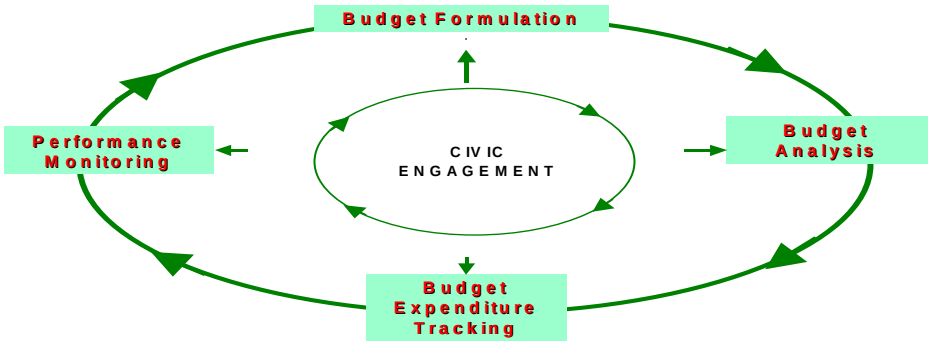
(3) *Public budget expenditure tracking (PBET)* – the mechanism of employing citizens and their representatives in tracking how the government actually spends the funds it allocated,

(4) *Participatory Monitoring & Evaluation (PME)* – which involves the monitoring of service delivery by communities, and the conduct of participatory client satisfaction surveys like *citizen report cards* or local engagements like the *community scorecard process*

Each of these processes forms one step in the overall public expenditure cycle. The essential element in these mechanisms is the introduction of *civic engagement* into the entire process of allocating, spending and monitoring public resources as is depicted in figure-2 below.

[3] An international workshop on "Voices and Choices at a Macro level: Participation in country owned Poverty Reduction strategies" organized by the World Bank was one of the important forums for sharing experiences amongst civil society practitioners, government officials, academics and Bank staff on such initiatives.

Figure 2: Accountability through a Participatory Public Expenditure Management Cycle



The eventual goal for a comprehensive accountability policy is to influence each of the four stages of the cycle. Our present community based performance monitoring initiative will cover the third and fourth stages of the cycle focusing on what happens at the local/community level. But bearing in mind the other parts of the cycle, that is the framework of accountability, is important because it will guide our future initiatives to attain the outcomes we are hoping for and which we describe in chapter 5.

Having described the general framework for social and public accountability and why accountability is important let us move on to see why the exercise that we are describing in this manual needs to be implemented in the health sector in Andhra Pradesh.

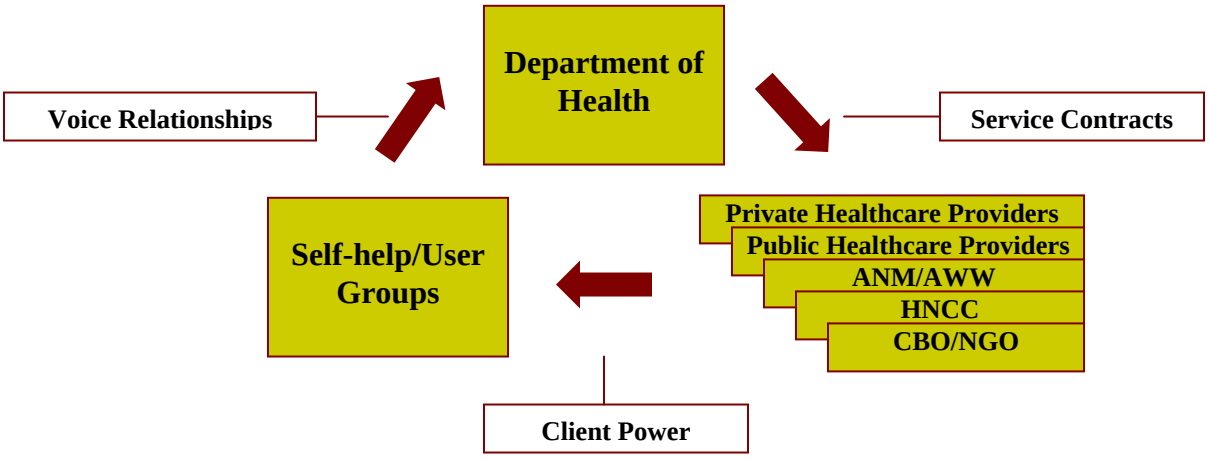
CHAPTER 3. ACCOUNTABILITY IN THE APRPRP CONTEXT

In the APRPRP institutional model, there are various key players involved in the provision of health care and associated services at different levels. The following players are directly serving the communities and can be classified as *"service providers"*:

- Private Healthcare Providers
- Public Healthcare Providers
- Auxiliary Nurse Midwives (ANM)
- Anganwadi Workers (AWW)
- Health and Nutrition Community Coordinators (HNCC)
- CBOs and NGOs

The primary decision-making body being the Department of Health, and the rural communities organized as self-help/user groups as "clients", accountability relationships within our context can be perceived as follows:

Figure 3: Accountability Relationships within the APRPRP Context



Three generic problems plague the accountability relationships depicted above:

- Distorted Information Flows
- Lack of Transparency
- Lack of User Feedback

To overcome these problems and support the Andhra Pradesh Vision 2020 the APRPRP is implementing a decentralized demand-driven approach. This approach empowers the rural communities and institutions that support them, to analyze the current conditions and take decisions collectively about the immediate and medium- term actions required to meet the needs of communities with respect to the provision of preventive and curative healthcare services especially with regard to women and disadvantaged groups.

Participatory planning processes are central to this approach and success of this approach is dependent on how successful and effective these processes are. Related capacity building programs assume importance in supporting these processes to be effective and efficient. The multiple accountability relationships necessitate the use of different social accountability tools, such as participatory monitoring, expenditure tracking and participatory budget that must implemented in a phased manner.

This approach, as adapted to healthcare service provision within the APRPRP , while increasing the awareness of the rural communities of their health rights and simultaneously building sustainable partnerships between the service providers and the users will have the following outcomes:

- Increased access to information
- Community Participation in the decision making process
- Increased Accountability and Transparency in service provision
- Equity and Inclusion of all section of the community
- Shared responsibility between service providers and users
- Effective bench-making system for provision of health insurance services

3.1 User Feedback and Performance Monitoring of Healthcare Service Providers

With the intention of improving healthcare service delivery in Andhra Pradesh, great emphasis is being laid on community-based performance monitoring of the service providers (both public and private) and their accountability towards the 'users' of healthcare services.

In the larger decentralization context, it is increasingly being realized that the much needed and missing "user perspective" is required to gain reliable and realistic feedback on both qualitative and quantitative dimensions of public service delivery. For example, *critical information like issues of inadequate and poor quality of preventive, diagnostic and curative healthcare services, doctor/nurse absenteeism, poor drug quality etc., which can only be obtained through direct user feedback* that has not been collected and analyzed in the past, will now be used to for the dual purpose of community empowerment and institutional strengthening of healthcare service providers, eventually leading to improved service delivery.

The innovative and community-centric accountability mechanisms such as the *Community Score Card* process – the subject of this manual - provides a channel for direct 'user' feedback.

The CSC process has emerged in recent years as a sustainable, easy-to-implement, local process of monitoring, feedback, and participatory planning that can be used to identify and directly reform local problems. While the process will be described in more detail in the next chapter, it is important to highlight that one of the main objectives of the CSCs is to make unheard voices heard, increase public awareness, and by so doing, generate collective action and bottom-up pressure against poor service delivery. This project will specifically build on the potential of CSCs, to be an effective local accountability and performance monitoring mechanism.

The CSC mechanism described in this manual is aimed at bringing the service providers and users together to devise a process towards greater transparency and accountability along with participation and shared responsibility in the delivery and the use of health services for all.

An important feature of the CSC process that must be highlighted is that, it not only benefits the 'users' of healthcare services but also the providers. The actual process, described in the subsequent chapters, while measuring the performance of the various service providers also brings to light the constraints that the service providers might be facing, that hamper their performance. If for e.g., one of the major constraints identified is lack of adequate training of healthcare professionals, a case can be made for increased budget allocations to take care for this problem.

Therefore, the CSC process can be perceived simultaneously as a deterrent of inadequate performance by the healthcare providers, as well as a stimulus for improved performance. So, while poor performance can result in penalties such as reduced budget allocations, good performance is rewarded via incentives such as increased budget allocations and higher premiums for further improvement of services.

3.2 Developing a Performance Rating System for Healthcare Service Providers

As mentioned in Chapter 1, the CSC process is aimed at the introduction and development of a performance rating system that allows comparative assessment of the performance of the various healthcare service providers. This rating system, drawing from the local level participatory engagements of the CSC process has the potential to provide robust district, provincial and national level performance benchmarks that will facilitate more aggregate level accountability and inform more macro reforms as regards healthcare service delivery. It gives organized user feedback the power to generate comparative profiles across Panchayats.

The pilot interventions are intended to make services providers directly accountable to the communities and empower and enable them (by incorporating user-feedback based indicators in the rating system) to negotiate with the service providers and monitor their performance. If successful, they can be gradually scaled up to the entire state

However, for these new mechanisms to be successful a large degree of supervision, technical guidance and management is needed. Moreover, the design and implementation stages have to be visualized in the form of a strategic continuum and hence, call for a blend of conceptual and operational expertise.

3.3 From Monitoring to Participatory Budgeting

Eventually, the accountability requirements of the decentralization process in Andhra Pradesh will require the participatory performance monitoring undertaken through the CSC process and the development of a performance rating system for healthcare service providers to influence the participatory budgeting/planning and resource allocation done by PRI institutions in Andhra Pradesh. This is a natural transition in the Participatory Public Expenditure Management cycle shown in Fig.2, and is a critical step forward in the process of financial devolution in the state.

CHAPTER 4. INTRODUCTION TO THE COMMUNITY SCORECARD PROCESS METHODOLOGY

The Community Score Card (CSC) process is a community based monitoring tool that is a hybrid of the techniques of social audit, different participatory rural appraisal (PRA) techniques and citizen report cards (CRC). Like the citizen report card, the CSC process is an instrument to exact social and public *accountability* and responsiveness from service providers[4]. 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.

A critical feature of the CSC process is the almost immediate feedback mechanism built in its execution. This is done by means of an interface meeting between the users and the service providers or local government officials as described below.

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.

4.1 The Components of the CSC Process

As such the CSC process is not 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 involves four components (fig.3):

(i) The ***Input Tracking Matrix*** – this is a simple comparison of inputs, physical outputs, budgets, or entitlements as recorded in financial accounts, audits or as stipulated in

[4] A table summarizing the difference between CSC and CRC is presented in Annex 1.

project and policy documents with what is *actually* present at or received by the community. This comparison gives us a basic idea of the 'variance' between official and actual statistics, and is a first warning signal of the presence of inefficiency and/or corruption. For e.g., in the case of the AP health sector, the number of healthcare services currently being provided compared with the number of healthcare services actually supposed to be provided would be an important inout indicator.

Often the mere process of letting communities know their entitlements or what official budgets for different projects in their area were is significantly *empowering* since most of the time common people, especially the poor, have no access to such information.

(ii) The ***Community Generated Performance Scorecard*** - this is the key output that is generated through community engagement. It is a quick table summarizing the community's feedback on the performance of different services or projects. The criteria used for judging performance are generated by the community *themselves* and often include various performance parameters like availability, access, transparency, reliability, quality and satisfaction. The community then scores these criteria through different focus groups and reasons for scores are shared using (as far as possible) actual evidence or personal anecdotes. The debate and discussion that surrounds the generation of the community scorecard becomes the basis for inviting suggestions from the community on what reforms can be made to improve the situation[5].

(iii) The ***Self-Evaluation Scorecard*** **by Service Providers** – the community scorecard process does not stop at the community, but goes on to engage in a similar feedback process with the "providers" (PHCs, NGOs, Private Healthcare providers), who will provide self-assessment on their performance.[6] Like with the community, this is done by a focus group discussion in which they come up with criteria to assess their own performance and score them. After discussing the reasons for their scores, the providers too reflect on how things can be improved and make suggestions for reform.

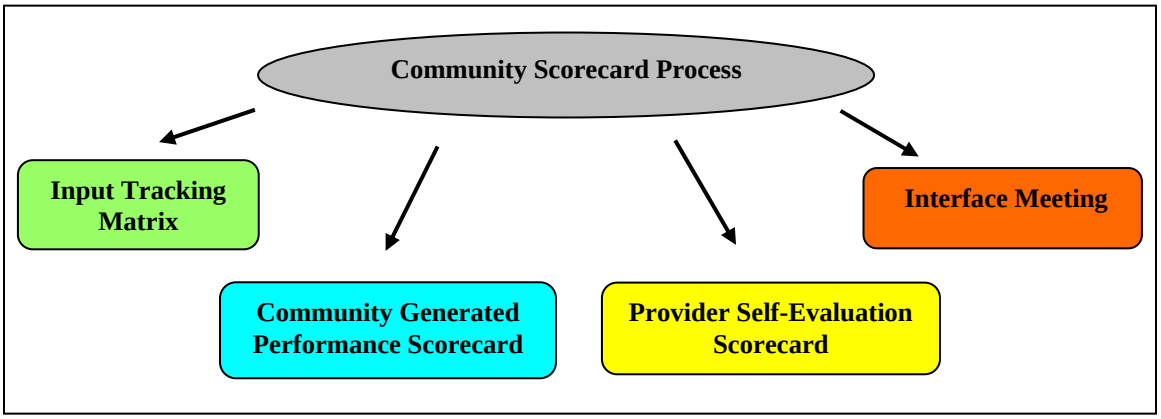
(iv) The ***Interface Meeting*** **between users and providers** - Finally and perhaps the most significant component of the CSC process is the interface meeting between the providers and the community. This meeting will be used to provide respective feedback from the community and self-evaluation score cards and generate a mutually agreed "reform" agenda (agenda for change) through action planning on the recommendations that both sides had made independently.

Even after the interface meeting, there is continued monitoring and follow-up. This drives home the fact that the CSC is indeed a *process*, that does not stop at generating scorecard tables, but intends to go further into a series of local interactions between the community and providers to

[5] The facilitators usually ensure that these recommendations include not just those actions that the providers and the district government can address, but also those that the community can put in place themselves.
[6] This component of the CSC process is very important for at least three reasons. Firstly, it helps to give a balanced perspective on performance – looking at both supply constraints and demand side factors. Secondly, it helps sensitize health facility staff and makes them less defensive and suspicious of the process. Finally, it is often the case that the lowest level frontline provider of health services is as disempowered as the community, and it is important to get their feedback to climb up to influence planning decisions.

put in place mutually agreed upon reforms and plans. It is through the elements of direct community feedback, joint planning, as well as the sharing of key supply-side information on budgets, inputs, and entitlements with the community, that the CSC becomes a strong tool for community empowerment, transparency and accountability.

Figure 4: The Four Components of the Community Scorecard Process



4.2 Applications of CSC Process in APRPRP

Within the APRPRP, this operational manual will exclusively elaborate on the application of the CSC process to Health Care Service Provision. However, it must be emphasized that the CSC process can be adapted to other sectors such as education, water, electricity etc.

(1) Comparison of Primary Healthcare (PHC) Services Provided by Various Providers through Multi- Service Provider Scorecards – As mentioned before, the health care service providers can be public, private and CBOs/NGOs. To simultaneously compare these various entities to get a sense of inter-differences in standards of services provided, a "Multi-Service Provider Scorecard" can be used. Based on the components of the CSC process this leads to *three* "multi-service provider" scorecard outputs in the healthcare service context:

i. Multi-Service Provider Input Tracking Matrix
ii. Multi-Service Provider Performance Scorecard
iii. Multi-Service Provider Self-evaluation Scorecard

(2) Provision of Associated Services by ANMs and AWWs – ANMS and AWWs both are strategically positioned in the healthcare service delivery chain to improve the efficiency of services such as MCH (Mother and Child Health), RCH (Reproductive Child Health), reduction in the incidence of communicable diseases etc. The services provided by them have a huge impact at the community level and hence should be monitored and evaluated. As above, there will be three scorecard outputs here as well:

i. ANM/AWW Services Input Tracking Matrix
ii. ANM/AWW Performance Scorecard
iii. ANM/AWW Self-evaluation Scorecard

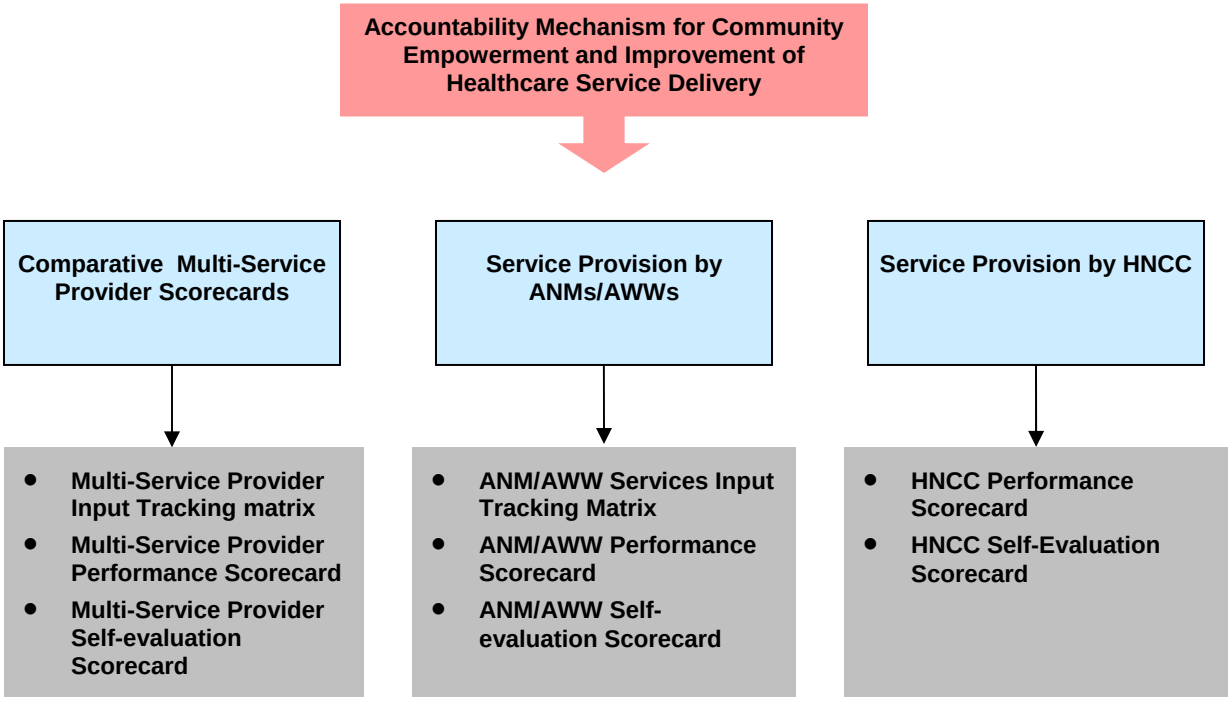
(3) Service Provision by HNCCs – The HNCCs are the link between the communities and the policy makers and are in charge of critical activities such as identifying HAs, organizing training workshops, etc. The focus will be on the effectiveness, adequacy, efficiency, and relevance of these critical activities. Since no 'tangible" output is being monitored/assessed

there will be no need for any form of 'input tracking'. Therefore, there will be only be two scorecard outputs in this application, namely:

i. HNCC Performance Scorecard
ii. HNCC Self-Evaluation Scorecard

These application contexts and the scorecard outputs specified are summarized in Fig.5 below.

Fig. 5. Use of Community Score Cards in Healthcare Sector within APRPRP Context



CHAPTER 5. OBJECTIVES AND OUTCOMES SOUGHT

If the accountability mechanisms outlined in this manual are implemented in all the three sets of activities we described above, the initiative can lead to tremendous changes in terms of empowerment, democratic decentralization and improved service delivery. Specifically, we envisage that the process that we describe will lead to five key types of outcomes:

(i) ***Process Outcomes*** – such as change in procurement rules, transparency requirements in service delivery and management, etc. at the community level.

(ii) ***Institutional Outcomes*** – like new forums for feedback, new community level organizations handling accountability initiatives like audit committees, new performance based incentives in management of facilities, etc.

(iii) ***Policy Outcomes*** – for example, changes in the resource allocation to district assemblies or facilities based on performance, new information/transparency laws, more transparent public record keeping, etc.

(iv) ***Empowerment Outcomes*** – through greater *information on entitlements* among the community, and more voice/influence in affecting policy choices.

(v) ***Capacity Building Outcomes*** – better financial management knowledge and performance monitoring skill of communities, service providers, and district assemblies.

For healthcare service delivery and village communities this means:

- **Community Empowerment:** Increased awareness and participation will empower the communities to affect change. By partnering with the service providers they will be advocates of their own welfare and help in the identification of relevant issues.

- **Behavior Change of Service Providers as well as the Communities:** This implies a change in the service providers approach to service delivery towards increased efficiency, transparency, accountability etc. Simultaneously, the communities will become more proactive through increased awareness and participation. Transforming themselves from being passive beneficiaries to informed, enlightened and consequently empowered communities, they will be able to exact accountability from the various service providers.

  The primary stimulus of this change will be the provision of incentives and disincentives for the service providers as well as the communities. For healthcare service providers the incentives and disincentives will essentially be in form of increased and reduced budget allocations, respectively. The possibility of higher premiums that will follow the introduction of health insurance instruments will be an added incentive. For the communities collectively, the incentives mainly translate into better access to improved healthcare services and personally, reduced exposure to health risks, better health and ultimately better living conditions. High risk behavior on their part is then automatically disincentivised.

- **Improved and Increased Access to Healthcare Services for the Poor:** Community Performance Monitoring will facilitate the coming together of the service providers and

users and will play a synergistic sole in enhancing the quality of life of the communities through better health. Additionally, the introduction of health insurance instruments will not only generate a healthy competition among the service providers but will also give the people a chance to choose for themselves the service provider that best suits their needs.

These outcomes and objectives need to be kept in mind when launching into the performance monitoring exercise we describe below, because the process requires a great deal of follow-up action and coordination if these results are to be achieved. Simply going in the field and generating score card documents and input tracking data is not enough – one needs to use this data productively. For this purpose, the manual has separate sections on follow-up /institutionalization as well as on analysis and dissemination of the information collected.

PART-2: METHODOLOGY FOR IMPLEMENTATION

The second part of this manual will outline the generic stages involved in the implementation of the community scorecard process, highlighting all the key steps that are involved in each stage.

Chapters 6 though 10 will each discuss one stage in the process, while chapters 11 and 12 will discuss issues of follow-up and logistics respectively. Each of these chapters will deal with the common steps in the methodology.

It should be kept in mind that the methodology we describe should be seen as just one method of execution of the model –one that has developed over different pilot initiatives undertaken in different parts of the world. The methodology is, however, very flexible and it is this characteristic that makes it so powerful. What must be kept in mind is that the end goal is to influence the quality, efficiency and accountability with which services are provided – therefore the mode of execution chosen should be such as to reach these goals.

CHAPTER 6. PREPARATORY GROUNDWORK

The first and in fact one of the most critical stages of the CSC process is the preparatory work that is done prior to the community level engagements. This ensures that there is adequate participation in the process, and that planning of logistics is complete. The steps involved with specific reference to the project are discussed below.

6.1 Steps and Tasks Involved

Step–1: Identifying and Training of Facilitators - The CSC process is heavily dependent on the quality of the facilitation and mobilization undertaken. The project must therefore start with a full training of facilitators, which would include sharing of this manual and ideally a 3-4 day workshop with a field exercise.

Step-2: Scoping Visits to Meet Community Representatives – The project staff must start by going to the field to meet with community representatives in a particular community. They should be introduced to the nature and purpose of the CSC exercise and the methodology should be explained briefly[7]. It is important to explain to them that the reason for engaging in this exercise is to (a) get their feedback, (b) track performance, and (c) plan jointly with Healthcare Service Providers on how we can make things better.

Step-3: Orientation Meeting with Service Providers – Along with the meetings with the community, separate orientation meetings are needed with the various Healthcare Service Providers. They too need to be told about the motivation for the CSC process i.e., improvement not criticism.

> **Note**: Providers are often suspicious and reluctant of being monitored in any way. Therefore care must be taken to ensure Healthcare Service Providers that the CSC process is not meant to attack them, but to come up with joint ways to improve performance.

Step-4*:* Get Basic Data on Community – Before beginning the local engagement with the community, the project team should also try and get some basic data on the community and facility. This includes:

- population data – total, male, female
- which services are provided by the various service providers in their respective capacity
- usage of services
- poverty profile – how many poor, where do they live, ….
- social profile – are there SC/STs, where do they live…

This initial stratification can done by two means:

(a) either through informal interviews by the facilitating team during scoping visits, or
(b) by using existing **'well-being ranking'** data collected by previous participatory exercises.

[7] The flow chart in figure –11 can be shared with them.

Step-5: Plan Basics of Methodology – As part of the preparation phase, the project team also needs to decide some basics for implementing the CSC process. These will become clearer after going through the later stages of the methodology, but should be considered upfront, before the full scale piloting. The main issues to consider are:

- how many facilitators will go to each village
- what time will the meetings be held
- will the interface be the same day or later
- what is the scoring method and what scale will be used
- what are the focus groups that will be made – it is important to decide this before hand in order to save time and also to standardize over all the communities.
- How many rounds of scorecards will be implemented

Step-6: Other Logistics – The organization of the community gatherings will also involve decisions about certain logistics. These include the deciding the venue for the gathering based on a sense of the number of participants that will take part. Materials for the gathering – paper, pencils, megaphone/PA system (optional), blackboard (optional), etc. – need to be procured.

Issue to Consider: 'Ensuring Participation of Poor and Vulnerable Groups'

A major objective of the CSC process is to ensure that voice is given to poor and vulnerable groups such as women and lower caste people. To ensure this, the preparatory groundwork must make a special effort to mobilize these groups and encourage them to participate in the process. Wherever possible, separate focus groups for them should also be created (see discussion below on choice of focus groups).

Likewise in order to cater to the **equity objectives** of the project, it is imperative that the poor are identified, encouraged to participate, and that their views are taken separately from the more well-off members of the community.

In particular 3 things need to be kept in mind during sampling and implementation of the pilot phase:

(i) Ensuring *all regions are covered*
(ii) Ensuring *all hamlets are covered* within the regions, and
(iii) Ensuring that all participatory planning data such as *well-being rankings* and *poverty mapping* are collected and used in the preparatory phase.

Step-8: Awareness Building and Mobilization – 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. This can include use of pamphlets, posters, community radio, and field visits. If a large segment of the community participates in the process, the first step towards success would have been achieved.

Step-9: Involve Other Partners - The involvement of traditional leaders, members of local governments, workers at the service facilities in the region, community volunteers, and staff from local CBOs and NGOs working in each of the village clusters is also important, as it will give greater credibility and momentum to the CSC process as a whole.

CHAPTER 7. DEVELOPING THE INPUT TRACKING MATRIX

The input tracking component of the CSC process aims to get a rough snapshot of inefficiency and corruption at the local level. It is called 'input' tracking rather than expenditure tracking, because in most local settings access and availability of budget expenditures is limited to poor communities. They do however, know and see what physical assets or service inputs are being used, and so are able to track inputs – i.e. the tangible assets and services money was spent on – instead of expenditures. Records or inventories of these inputs are usually also available in most facilities and project reports.

As we mentioned in Ch. 4, input tracking will be done for:

(a) Healthcare Service Provision by various service providers through the Multi-Service Provider Input Tracking Matrix
(b) Provision of Associated Services by ANMs and AWWs

The basic methodology is to obtain data on inputs, and then track these with the help of (a) key informant interviews with the service providers, (b) focus group discussions with community members, and (c) on-site physical inspections and transect walks. Data and evidence on inputs is then triangulated from each of these sources.

The steps involved in developing the input tracking matrix are listed below and summarized in Fig-6.

7.1 Steps and Tasks Involved

Step-1: Decide and Obtain Information on Inputs to be Tracked – The first step in generating the input tracking matrix, which actually falls mainly in the realm of preparatory groundwork, is to decide what inputs will be tracked and obtain adequate supply side data on them.

Identification of Inputs/Indicators: Identification of inputs to be tracked should be a participatory process involving project staff and the community members. Bringing together different people in a participatory process to identify indicators reveals their different needs and expectations. It also brings to light what is considered 'relevant' by the stakeholders.

Once a general list is generated, a good way to streamline that list (so that the task does not appear daunting) is to ask if the indicators are **SMART**, i.e., Specific, Measurable, Attainable, Relevant and Timely. It is better to track few inputs well than to track many ineffectively.

Sequencing of Inputs: Once a final list of inputs is generated, they should ideally be distributed over progressive cycles of the score card process in a logical manner. For the first round, a few key inputs should be chosen (e.g. number of doctors) that provide a general idea of the overall existing situation. With each additional round, the list of inputs to be evaluated should be reexamined and new and more relevant inputs may be added as deemed fit.

Once the focus services and inputs are identified, the next step is to get supply side data about each of them, so that we know what we are tracking. This supply side information includes:

- Budget allocations
- Recorded amounts spent as per financial and audit reports

- Official inventories of equipment and physical assets
- Official entitlements of certain inputs based on Andhra Pradesh State or National policy guidelines (e.g. entitlements on Healthcare facilities in decentralization policy)
- Contractor information such as for drugs, including amounts paid and system of contracting
- Community contributions raised, etc…

Step-2: Give Information on Entitlements – The next step is done in a gathering[8] with the community and the service providers. In a plenary meeting, the entire group should be informed about what their entitlements as per the decentralization policy are, what the budget for different projects is, what recorded infrastructure and facilities should be available (e.g. blood-test labs, kinds of drugs, kinds of treatments) etc. based on the information gathered in the first step. Knowing such entitlements is in itself a source of empowerment for the community.

Step-3: Divide Participants into Focus Groups – The gathering should then be divided into groups. As a first step, *separate the service providers from the rest of the community*. Then sub-divide the community into about 3 sub-groups with about 10-15 people in each. The resulting sub-groups should have sufficient numbers of respondents for each of the services (PHC, ANM/AWW and HNCC) and should ideally also be mixed in terms of gender and age. They will then be able to provide information regarding different inputs.

Step-4: Fill in the Input Details – The facilitating team then gathers and records the data on each of the inputs that have been chosen, from all of the groups. Wherever possible each of the statements of the group member should be substantiated with any form of concrete evidence (receipt, account, etc.). One can triangulate or validate claims across different participants as well.

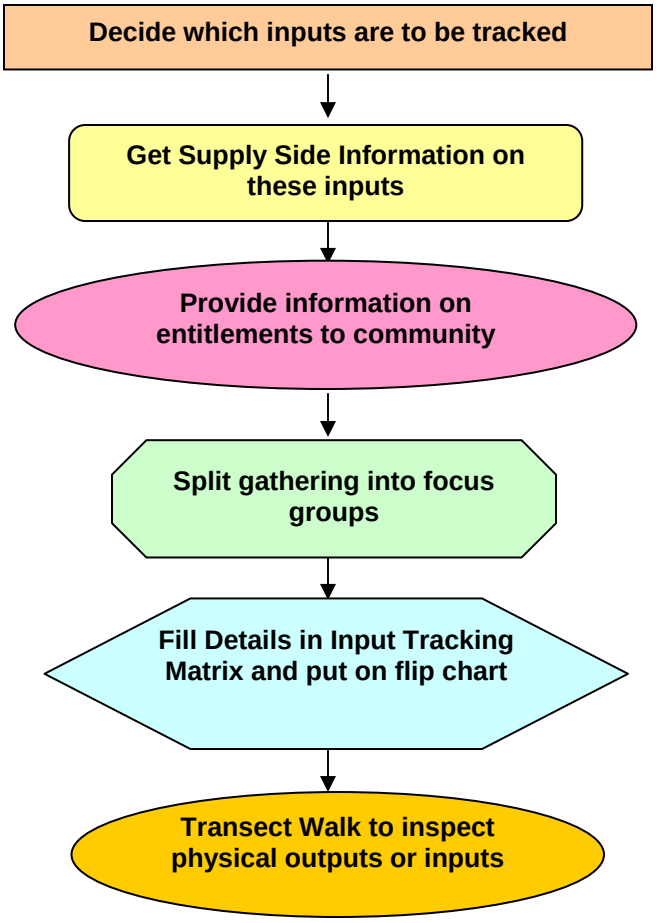
Step-5: Recording Data – The data collected about the receipt, use, or expenditure on inputs is summarized in the form of an input tracking matrix. This records in the rows each of the input indicators chosen during the community gathering, and then feeds into the columns the actual data as provided by each group/household/individual depending on the case at hand.

Note: Two copies of the input tracking matrix should be made – one in the notebook of the facilitating team, and one on a flip chart for the community to see. Leave the latter with the community.

Step-6: (Optional) Inspection of Physical Output or Inputs – For cases when the scrutiny is of a physical outputs such as existence of adequate healthcare center furniture (beds for inpatients), equipment (doctors tools), and/or supplies (drugs) - the last stage must be an inspection to see if they are there in adequate quantity and quality.

[8] As such, the input tracking, community scorecard, self-evaluation scorecard and indeed the interface meeting can be completed in one full day gathering with the community and providers. However, it is usually advisable to spread the process over a few days. See fig.12 for a flowchart of the entire CSC process which shows the length of time each stage should take.

Fig. 6.: Summary of Steps for Developing Input Tracking Matrix



Frequently Asked Questions:

1. What if no supply side budget data or inventory record is available?
Ans. In this situation, do an input tracking without the entitlements. This on its own will be quite revealing, and can be used to demand more transparency from higher authorities.

2. What if there is a very high evidence of corruption?
Ans. If there is very big variance between entitlement and actual, then it is likely that there is some corruption happening. In such a situation remember that the facilitating team's role is as a neutral intermediary. Data should simply be presented during the interface. Let the community and the service providers decide what to do after that. Of course, adequate chance for justification and cross checking of claims should be given.

3. What if the statements/claims of different groups don't match?
Ans. As a first step do a direct physical inspection to check for sure. If the input is not tangible, then try and triangulate with another group and with the service providers. Finally, if it could be a case of not remembering, then take the value that is most common across groups.

7.2 Hypothetical Examples of Input Tracking Matrices

In order to get a sense of what the input tracking matrices might look like in a real application of the CSC process in the Health sector, we present in this section some hypothetical input tracking matrices. As mentioned earlier, we will be generating two kinds of input tracking matrices – one for healthcare service provision by various service providers and the other for Associated service provision by ANM/AWW.

Table-3(a): Hypothetical Multi-Service Provider Input Tracking Matrix

	INPUT INDICATOR	Service Provider 1 (Public)	Service Provider 2 (Private)	Service Provider 3 (NGO)	Remarks
A.	**Number of Services Delivered**	5	7	6	-
A.1	Diagnostic	2	2	2	-
A.2	Preventive	0	3	1	-
B.	**Quality of Drugs Provided**	Poor	Good	Ok	SP2 is good but expensive
C.	**Number of Patients treated/month**	20	60	30	-

Based on the above scores, the following recommendations can be made for immediate action.

Table 3(b): Corresponding Hypothetical Recommendations

	Recommendations for Action
	Service Provider 1 (Public)
1.	Inquiry into why no preventive services are provided, why is quality of drugs poor etc.
2.	Explore ways of increasing number of patients treated /month.
	Service Provider 2 (Private)
1.	Explore ways of providing services at more affordable costs.
	Service Provider 3 (NGO)
1.	Asses constraints in provision of hospitalization services and ways to over come them.
2.	Improve overall performance to be more comparable to the SP 2
	General
1.	Overall improvement in provision of other healthcare services by all SPs required – poor service will result in lower insurance premiums.
2.	Explore ways of increasing 'other' healthcare services. Especially, HIV/AIDS kits.

As has been mentioned, the CSC process must have several rounds of implementation to be effective. By repeating the CSC process every six months, for all the three scorecards (input tracking matrix, community performance scorecard and the self-evaluation scorecard), the difference in the performances are highlighted by the changing scores for the indicators for each of the service providers.

A hypothetical example of a repeat score card for 'Multi-Service Provider' Input-tracking Matrix is shown below:

REPEAT SCORE CARD – AFTER SIX MONTHS

Table-4(a): Hypothetical Multi-Service Provider Input Tracking Matrix

		Service Provider 1 (Public)		Service Provider 2 (Private)		Service Providers 3 (NGO)	
	INPUT INDICATOR	**Original Score**	**After 6 months**	**Original Score**	**After 6 months**	**Original Score**	**After 6 months**
A.	**Number of Services Delivered**	5	**7**	7	**9**	6	**7**
A.1	Diagnostic	2	**2**	2	**2**	2	**2**
A.2	Preventive	0	**2**	3	**4**	1	**2**
B.	**Quantity of Drugs Provided**	2	**12**	10	**15**	8	**14**
C.	**Quality of Drugs Provided**	Poor	**Ok**	Good	**Good**	Ok	**Ok**
D.	**Number of Patients treated/month**	20	**25**	60	**60**	30	**40**

Community Remarks
• There is a general improvement in overall service provision. • Types and adequacy (in numbers) of drugs has greatly improved. Most needs are satisfied. SP 1 and SP 3 should better quality of drugs. • Improvement in provision of 'other services' but we need more

**** Since the community is more or less satisfied with the quantity of drugs, in the next round of CSC process, this indicator can be replaced with the next indicator from the priority list of indicators generated by the community, earlier in the process.***

Table-4(b): Hypothetical Comparative Observations and Recommendations

Recommendations for Action	
	Service Provider 1 (Public)
1.	SP 1 has improved the quality of drugs provided but this should be further monitored until the quality of drugs is to the community's satisfaction.
2.	Number of patients /month must be further increased - currently under utilization of resources.
3.	Explore ways of allocating additional resources to the provision of 'other services'.
	Service Provider 2 (Private)
1.	Explore ways of providing services at more affordable costs.
2.	Inquire into what 'other services' are needed by the community and attempt to provide them.
	Service Provider 3 (NGO)
1.	Hospital service provision must be a top priority – lack of provision of this service will result in premium losses.
2.	Focus on improving the quality of drugs provided.

Next, let us consider some possible inputs for ANMs. Just as we compared the status of service delivery by various service providers above, in this case as well, we can compare service delivery by say, two ANMs assigned to a village to guage if both are performing as they should.

Table-5 (a): Hypothetical Input Tracking Matrix for ANMSs

	INPUT INDICATOR	ANM 1	ANM 2	ENTITLEMENT	REMARKS
A.	**Frequency of visit**	Once a week	Once in 4 days	Once in 3 days	-
B.	**Number of Services Delivered**	5	5	8	-
C.	**Cost of Services Delivered**	Charge for some services	Charge for all services	Free	-
D.	**Medicines/Nutritional Supplies Delivered**	None	Only nutritional supplies	Both and of good quality	ANM 1 says to purchase them from market
E.	**Number of Patients attended to/month**	20	20	-	
F.	**Number of cases referred to the hospital**	6	3	-	ANM 1 unable to diagnose properly, refers everyone to hospital

Table-5 (b): Corresponding Hypothetical Recommendation

	Recommendations for Action
1.	Take action to resolve the problem of "Absenteeism" i.e., ANMs are not showing up as often as they should.
2.	Inquiry into why number of services delivered is low.
3.	Inquiry into why ANMs are charging for services – are their salaries inadequate or are their other reasons.
4.	Inquiry into training of ANM1 to figure out why she is not able to diagnose properly
5.	Investigate the missing medicines and nutritional supplies

The Repeat Score Card process for the ANM/AWW Input tracking matrix can be based on the example shown in Table 4 (a).

These hypothetical examples are ***only indicative***. They should eventually be replaced by real examples once the CSC process has been piloted in some villages.

Note: As mentioned in the steps for implementation the input categories and indicators need to be developed by the project team *beforehand* and they should by-and-large be common across all villages. That being said, one should always ask the community to go over the inputs and suggest any additions or deletions to those that the project team has come with.

CHAPTER. 8. DEVELOPING THE COMMUNITY GENERATED PERFORMANCE SCORECARD

The community generated performance scorecard is what is usually referred to as the 'community scorecard'. It is the key output of the entire CSC process - an assessment of the performance of a particular service, or service provider based on criteria developed and scored by the community. The reasons for these scores are documented and become the basis for obtaining suggestions for reform, which is the objective of the process.

The main methodology is facilitated brainstorming of indicators and scoring in small groups, consisting of local service users only. The focus group discussions are undertaken in one large gathering of the community or in separate meetings with specific groups over a 1-2 day period.

We will be developing community scorecards for Healthcare services provision by 'Multi-Service' Providers, ANM/AWW services, and one for HNCC services. The basic steps involved in developing each of these community scorecards are common and are presented in the next section. Later, in section 8.2, specific instructions will be given to facilitators and note takers.

8.1 Steps and Tasks Involved

Step-1: Divide Gathering into Focus Groups Based on Usage – As with input tracking the participants need to be classified in a systematic manner into focus groups based on usage of the service being evaluated. This will ensure that the focus groups are able to capture different aspects of the service.

Issue to Consider: "Choosing Focus Groups"

At a general level, one could have the following 3 focus groups: (i) Adult Men, (ii) Adult Women, and (iii) Village Elders. Alternatively one could use only the male-female distinction and then separate between *users* and *non-users* of the particular service. However, the **division of focus groups eventually depends on which service is being evaluated and on targeting of certain groups**. For instance, for education we may want to separate parents, pupils and teachers, while for health we may want to keep inpatients, pregnant mothers, and outpatients separate. Similarly we may want a separate focus group for orphans or people from lower castes.

Whatever focus group divisions are decided upon, there must to be a critical mass of persons in each group because without this no useful data can be solicited. Also, since we are running the community scorecard for 3 or 4 contexts, to save time, it is probably advisable that the groups be divided in such a way that each focuses on only one or maximum two contexts. **This would mean about 6-9 focus groups in all**.[9]

Note: **Focus groups should not be larger than 25-30** or else they become very difficult to handle. Also, there should be at least **one facilitator and one note taker with each group.**

[9] See chapter 13 for a discussion on the implications of the focus group divisions on logistics of implementation.

Step-2: Develop Community Generated Performance Criteria – Each of the focus groups now go through a discussion of each of the services under scrutiny to come up with a set of criteria with which to evaluate them. Facilitators initiate the discussion using some basic '**guiding questions**' such as the following:

- Are your Healthcare services running well? Why do you say so?
- How will someone know that this service is operating well?
- How do you judge the performance of the facility/service (what specifically do you look for)? If you don't use it, why not?

The aim of these questions is to evoke a discussion amongst the group, from which ***some generic performance criteria*** will emerge as the broad headings under which to put the issues discussed. Further, there may be several issues raised that, although distinct, come under the same broad heading or performance criteria. These should be placed as ***sub-criteria under the broad performance criteria.***.

Note: **Criteria should be '*positive'*** so that higher scores mean better performance. For instance use 'adequacy of Healthcare services' rather than 'lack of Healthcare services'

Issue to Consider: "Performance Criteria vs. Indicators vs. Inputs"

In the focus group discussion for developing criteria, it is important to note the difference between 'criteria', 'indicators' and 'inputs'. A **criterion** is a broad performance assessment category that is *usually qualitative.* But even if it cannot be measured, a performance criterion can be subjectively scored. E.g. 'transparency' or 'attitude of staff ' would be performance criteria.

An **indicator** is a *measurable or quantitative* measure of performance – it usually measures a particular performance criteria. Eg. 'whether budget was shared' or 'whether the staff is polite to the patients' would be indicators of the above criteria.

Finally, **inputs** are measurable quantities that determine and influence performance, but are in themselves not measures or aspects of performance of a service. Eg. 'Healthcare Equipment' could be an important input or determinant of performance, but by itself is not an indicator of performance. Usually the discussion on performance criteria will throw up not only criteria, but several indicators and inputs and it is up to the facilitating team to be aware of what is what. As a first cut, our focus is only on what are strict performance *criteria*. Performance indicators, and service inputs could possibly enter the scorecard as sub-criteria, but often their place is in the 'reasons for scores' column discussed below.

Step-3: Decide Standard/Benchmark Performance Criteria – In addition to the community-generated criteria above, the evaluation team as a whole should agree on a set of standard performance criteria (about 3) for each service being assessed[10]. The purpose of using these standard criteria is to allow cross comparison as well as comparison over time. They provide some basic benchmarks of performance, beyond what the community comes up with. If the

[10] Ideally this step should be undertaken during the preparation phase.

community-generated criteria are the same as the standard ones, then one should try and dig deeper to get sub-criteria from the community for how they assess each of them.

Step-4: Narrow Down and Finalize Criteria – If many criteria are identified, help the group to prioritize these to a reasonable number. This can be done by clustering them under broad headings and putting some down as sub-criteria, or by asking the group to prioritize what are the most important ones. ***Ideally one should have about 5-8 performance criteria with the possibility of 2-3 sub-criteria for some of them.*** In each case, the final set of criteria that will be used in the scorecard should be agreed upon by the group.

Step-5: Scoring by Focus Groups - Having decided upon the performance criteria, the facilitators must ask the focus groups to give scores for each of them on a predefined scale (see text box below). To ensure that the community understands the scoring process it is usually good to start with a trial run, on something easy – e.g. 'how would you rate the performance of the Indian cricket team'. One can also use visual aids such as 'smiley faces' or rocks to help in the scoring.

Issue to Consider: 'Scoring Methodology and Scale'

1) Scoring Method: Different methodologies can be adopted to score the group-generated indicators and national benchmarks. Whichever methodology is adopted however, the team must ensure that it

(a) Helps achieve consensus
(b) Is usable in resource-poor environment
(c) Minimizes lateral influence
(d) Is meaningful/user friendly
(e) Ensures Integrity, and
(f) Offers equal opportunity to all.

Two common, yet different methods are *individual voting* and *group consensus.* The advantage of voting is that ensures participation and equal opportunity and minimizes lateral influence. The advantage of group consensus, apart from the agreement on a single score, is that is quicker, and often the debate that it causes amongst the group to arrive at a common score is very informative. Usually, the best option is to use the consensus method for big groups (>10), and use votes (and average) when the group is small (<10). But in either case it is important to (a) allow and encourage debate between group members on scores, and (b) record differences of opinion in the notes, even if following a consensus model so that only one score will be put up.

2) Scale: Different scales can be used for scoring, e.g. 1-5 (indexed to very bad, bad, OK, good, very good), 0-10, 0-100, etc… Again there are pros and cons to each – a 1-5 scale is easy to understand, and one can use visual aids for it, but a 0-100 scale is better for capturing change over time. The choice is to a large extent a cultural issue based on what the project team and the communities are more comfortable using, but it also depends on what the eventual data analysis and monitoring system for the project will be. Once decided though, **all focus groups should use the same scale**.

Step-6: Securing Explanation/Evidence to Back Rankings - 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 often provides extremely valuable evidence and useful examples regarding service delivery. Note that many of the reasons would already have been coming up in the earlier discussion on criteria – these should have been recorded earlier and need not be reiterated here.

Step-7: Recording Data – The scoring of the focus groups for each of the performance criteria chosen by the community are recorded in the community scorecard. This has as its rows each of the performance criteria and sub-criteria, followed by a column for scores and one for brief reasons/remarks as shown in the *real* example below in table-6.

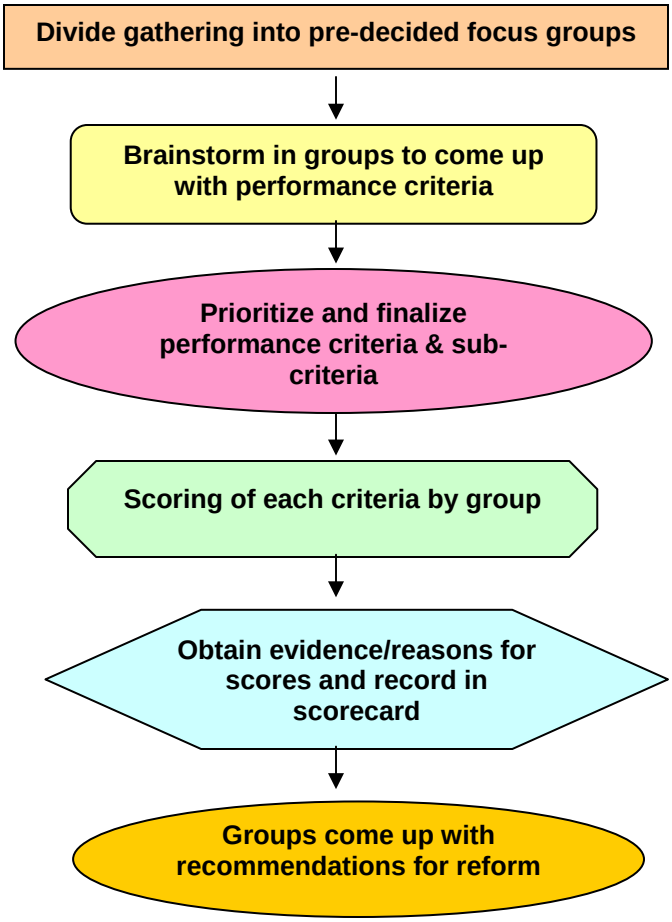
Table-6: A Sample of an *Actual* Community Score Card for Evaluating Health Services[11]

	Performance Criteria	Score (0-100)	Reasons/Remarks
1.	**Positive Attitude of Staff**	**45**	
1.1	Punctuality of staff	50	Start late, but some work after hours
1.2	Polite behavior	40	Many staff shout at patients, rude to children
1.3	Listening to patients' problems	50	Don't give a chance to explain problems; cannot express opinions freely
1.4	Respect for patients	25	Disrespectful
1.5	Respect for patients' privacy	70	Never heard of sensitive information being revealed
2.	**Management of the health facility**	**50**	
2.1	Cleanliness	70	Center is clean, rooms mopped
2.2	Observing working hours	40	Open on time, but come late, long lunch
3.	**Quality of services provided**	**35**	
3.1	Adequate supply of drugs	25	Drugs mostly not available
3.2	Adequate equipment	20	No admission wards, other rooms not functional, no dental, surgery services…
3.3	Adequate and qualified staff	15	Health workers qualified but not enough in number and they are not dedicated
3.4	Providing multiple services every day	75	Antenatal services available apart from outpatient services
3.5	Emergency transport service	2	One ambulance for several health centers, so virtually non-existent
3.6	Communication facilities (telephone, wireless)	75	Telephone is available
4.	**Equal access to the health services for all members of the community**	**25**	
4.1	No discrimination in providing drugs to the patients	30	Health staff favor friends and relatives
4.3	No preferential treatment	35	Some workers favor friends and relatives
4.4	Maintaining a first come-first serve policy	25	No queues or numbers for attention

Step-8: Obtaining Community's Suggestions for Reform/Improvement - 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. These suggestions should include not only what the GP and VWSC should do, but also what the community can do to make things better.

[11] Based on Shah, Meera K.: *Using Community Scorecards for Improving Transparency and Accountability in the Delivery of Public Health Services – Evidence from the Local Initiatives for Health (LIFH) Project"*, CARE-Malawi, April 2003. Note that not all the sub-criteria have been shown in this scorecard.

Fig. 7.: Summary of Steps for Developing Community Scorecard



Note: There are **5 stages of Focus Group Discussions** involved in developing the community scorecards:

1. To identify criteria
2. To prioritize and finalizing criteria
3. To give scores
4. To give reasons for scores
5. To suggest recommendations for improvement

8.2 Hypothetical Examples of Community Scorecards for Multi-Service providers, ANMs/AWWs and HNCC

As for the input tracking matrices, in this section we will present some hypothetical examples of community scorecards for the different service providers.

Table 6 above provides an example of what a comprehensive community scorecard for evaluating Healthcare facilities should look like. We have adapted that example to our present 'Multi-Service Provider' context using only the core indicator categories of (i) positive attitude of staff, (ii) Management of the health facility (iii) Quality of Services and (iv) Equal access to health services for all members of the community. But when implementing, the sub-indicator categories as shown in the example in table 6, must be incorporated.

Table-7 (a): Hypothetical Example of Multi-Service Provider Community Scorecard

		Score (1-100)			
	Performance Criteria	**Service Provider 1 (Public)**	**Service Provider 2 (Private)**	**Service Provider 3 (NGO)**	**Reasons/Remarks**
1.	**Positive Attitude of Staff**	**40**	**60**	**45**	SP 1 – Not punctual, shout at patients etc.
2.	**Management of the health facility**	**40**	**70**	**50**	SP 3 – Never come on time
3.	**Quality of Services**	**50**	**70**	**35**	SP 3 – Qualified but not enough in number
4.	**Equal access to health services for all**	**55**	**40**	**25**	SP 2 – Good service but difficult to afford

REPEAT SCORE CARD

Table-7 (a): Hypothetical Example of Multi-Service Provider Community Scorecard

		Service Provider 1 (Public)		Service Provider 2 (Private)		Service Providers 3 (NGO)	
	INPUT INDICATOR	**Original Score**	**After 6 months**	**Original Score**	**After 6 months**	**Original Score**	**After 6 months**
1.	**Positive Attitude of Staff**	40	**50**	60	**65**	45	**55**
2.	**Management of the health facility**	40	**45**	70	**70**	50	**55**
3.	**Quality of Services**	50	**50**	70	**70**	35	**55**
4.	**Equal access to health services for all**	55	**60**	40	**50**	25	**50**

Below we give hypothetical examples of community scorecards for evaluating ANM/AWW performance as well as HNCC performance.

Table-8: Hypothetical Example of ANM/AWW Community Scorecard

Focus Group: Women			
	Community Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	**Availability**		
1.1	General availability		
1.2	Emergency availability		
1.5	Affordability		
2.	**Attitude**		
2.1	Polite behavior		
2.2	Overall relationship with patients		
3.	**Quality and Range of Services Provided**		
3.1	Ability to provide quality treatment		
3.2	Ability to provide services needed in the particular community		
3.3	Follow-up visits		
	Standard Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
3	**Satisfaction with Services Provided**		
3	**Availability**		

There will be similar scorecards for the other focus groups.

Table-8: Hypothetical Example of HNCC Community Scorecard

Focus Group: Men			
	Community Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	**Effective Functioning and Use of Services**		
1.1	Functioning System		
1.2	Effective Use		
1.3	Effective Financing		
1.4	Effective Management		
2.	**Demand Responsiveness of Service**		
2.1	Is demand of users being met		
2.2	Quality of training and technical support		
2.3	Cost effectiveness		
	Standard Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	**Knowledge of HNCC activities**		
2.	**Effectiveness and Relevance of activities**		
3.	**Participation in Planning & Organization**		

8.3 Special Instructions for Facilitators[12]

- The **opening of the discussion is critical** since it usually sets the tone of the entire process that follows. Explanation of objectives is key – often the community or the GP will think that the project team is there to give money, and so they will only raise demands in the hope that you will fund them. Therefore the *opening line should not be 'what are your problems'*, but should focus more on monitoring performance.

- Likewise, facilitators need to bear in mind the **sequencing of the discussion** to avoid repetition and respondent fatigue. Often groups will move straight into a discussion of reasons for a particular criteria before scoring – here the facilitator will have to either ask the person to hold their thought, or else bring that point up automatically in the discussion of reasons and not have the community member repeat themselves.

- Also, it is important to **move the pace of the discussion swiftly**. While sufficient time should be given for discussion, the movement from issues raised to actual criteria lies in the hands of the facilitator and this should be done relatively quickly to avoid repetition later.

- Scoring should be done **one criterion/benchmark at a time**. Participants should vote on one criterion and never be asked to vote on all the criteria at once. This again is an issue of sequencing – the ideal is to start by putting all criteria up first, then score and give reasons one by one for each criterion.

- As mentioned before, it is best to work through the scoring procedure with a **practice run on a "dummy criterion"** to ensure that the focus group participants understand and are comfortable with the procedure. Examples of practice/dummy criteria are: "The quality of the road outside the village"; "The weather today"; "The performance of the Indian cricket team", etc.

- Facilitators should guide and help participants in scoring, but should **avoid influencing the scoring or criteria development process** by suggesting criteria and scores or asking the group to change their ratings. The community generated criteria are meant to be just that. In order to capture scores on criteria the project team is interested in, one should use the standardized criteria.

- One should **avoid the discussion from getting too negative**, that is a situation where only problems and criticisms are being raised and all scores seem to be 'unduly' low[13]. In this situation the best strategy is to *ask for positive counter examples.*

- Since the scoring technique is essentially subjective and highly influenced by expectations which will differ across different villages, a it is **useful to ask a benchmarking question** to the group right at the outset. An example of such a benchmark question would be 'what would you say is 'reasonably good'?' or 'what characteristics should the service have for you to give a 4 or 5 score?' During comparisons across focus groups and across villages, this benchmark question could be cited.

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[12] Apart from the instructions above, Annex-2 also summarizes a general presentation on facilitation that can be used by the project team during training and as a quick reference guide.

[13] Of course this may genuinely reflect the state of affairs, but sometimes groups can get into a negative mode in which all scores get biased downwards.

- Throughout the scoring and reason/explanation phase, facilitators should **always ask for *personal* examples/experiences.** This will keep out 'opinions' on service, and ensure that the scores and reasons reflect actual *user* feedback and perceptions. These reasons and anecdotes are summarized in the 'reasons' column of the scorecard and recorded in more detail in the team's notes.

- It is also critical throughout the discussions to **ensure maximum participation** of the group members. This can be done by asking direct questions to those who are not speaking, or cross-checking the opinions of the more vociferous speakers with the more quiet ones. Special care needs to be taken to ensure that women and vulnerable groups speak if there is a mixed group.

- Finally, it is very important to **end the discussion with suggestions for improvement**. The guiding questions to use include:
  - What can be done now to improve the service?
  - What support is needed from the community to improve?
  - What needs to be done for the community to be able to do that?
  - What support is needed outside the community and within?
  - How and when will support be obtained?
  - What can community members do themselves to improve the service?

8.4 Special Instructions for Note Takers

- As the group discussions move at a fast pace and a lot of what the community says is in the form of issues or personal stories, it is up to the note taker **to be attentive and quick to recognize and note down performance criteria.**

- The note takers are also chart writers, so they also have the **responsibility for putting up scorecards on charts, blackboards, or on the ground so that they are *visible***. This means that they have to move quickly between their own notes and the charts, and must decide when they should move from one to the other. In this context it is **useful to have pre-prepared matrices and scorecard templates** on the charts, which only have to be filled in.

- Some of the most valuable data generated during the CSC process is in the form of personal anecdotes and stories. Therefore it is critical that the note taker **write down these anecdotes and examples in full.** They will most likely become mini-cases used during the interface meetings and when scaling up the CSC process.

- Even if the personal notes are done in English, **all charts should use local language** so that they are understandable by the community. In the case of high illiteracy areas, one should also use some kind of symbols in the charts for the different criteria and scores.

- Towards the end of the group discussion, the note taker should **count and record the final number of participants in the group** along with the overall notes. This will keep a record of the extent of participation during the process.

- Does the community have a clear idea of what improvements need to be made in the light of their scores?

Issue to Consider: 'Biasing of Scores due to Incentives or Fear of Retribution'

This is a genuine risk in the community scoring process – community members may be reluctant to be honest and give poor scores for fear of later retribution. This factor should be kept in mind by the project team all the time. The only way to tackle it is to (a) be clear in explaining the objectives of the exercise – highlight that it is not about finger pointing, (b) try and solicit personal examples, objective explanations, and where possible concrete evidence to back scores, and (c) ensure that there is regular follow-up to see that there was no backlash from the service providers.

Frequently Asked Questions:

1. What if there is great divergence and disagreement on scores within a group?
Ans. This is a situation that usually arises when the group is not homogenous (e.g. a mix between users and non-users). One should dig deeper into the reasons behind the different scores and an encourage a debate that leads to some common consensus. If that is not possible, then there are two options – (a) if there is a large number that is dissenting with the majority, and have valid reasons and evidence for this, then *split the focus group*, or (b) if it is a few who have different views then keep the group intact, but *note both scores down* and the separate reasons for them. *Do not average the scores* (e.g. put 3 as the group score when half the group says 4 and the other 2) as this average would have little meaning and would hide the reality of the situation.

2. Do scores have to be reconciled across focus groups?
Ans. No. The objective of dividing into different focus groups is to bring out the differences of perception and feedback that they may have. If however, there are two similar groups (e.g. two women's groups) that were created because of large numbers then one can do some consolidation.

3. Can/Does one aggregate the scores?
Ans. As above, if the focus groups are different then one cannot aggregate the scores across them (e.g. average the scores of men and women). But if they are similar groups (this will be the case when there are more than one village in a GP, so that there will be two or three sets of similar groups) then it is possible to aggregate them. (See discussion on 'cluster meetings' below).

4. Should reasons be written only in notes or also on the visible charts?
Ans. While the more detailed notes on explanations and anecdotes should be in the project team's notes, a summary should be put up on the charts. This will be used in the interface meeting discussion.

5. Are we 'scoring' or 'ranking'?
Ans. We are scoring – that is the idea is not to rank performance criteria, but to individually rate them. The only ranking that is done is during the prioritizing of criteria to narrow them down to an acceptable number.

6. What if all the scores are looking the same?
Ans. This may well be an honest reflection of the service, but is often the result of either lateral influence, or of the group dynamic moving into a negative or positive mode. As suggested earlier, in this situation the best thing to do is to ask for counter-examples and counter-scores to initiate some kind of debate and discussion.

CHAPTER 9. DEVELOPING THE PROVIDER SELF-EVALUATION SCORECARD

The provider self-evaluation is the component of the community performance monitoring process that tries to draw out the perspective on performance from the supply-side. In our case this will be done by the line departments for PHCs and CBOs/NGOs for their respective healthcare facilities, ANMs/AWWs, and HNCC.

The methodology is almost identical to the generation of the community scorecard described in the previous chapter and involves facilitated brainstorming on criteria for self-evaluation and scoring done in small groups of the providers. The main steps are given below.

9.1 Steps and Tasks Involved

Step-1: Orient the Service Providers– As with the community, the first step in developing the self evaluation scorecard for providers is to orient them properly about the purpose and use of the CSC process. This will probably have been done during the preparatory phase, but will have to be repeated when actually starting the scorecard process with them.

Step-2: Ensure adequate Participation – Since the service providers may be busy with their duties it is important to set out a time in advance for completing the exercise, so that an adequate number of members (ideally all of them) participate.

Step-3: Divide into focus 'groups' – All the three service providers being evaluated must be split into separate groups. For PHC staff, it may make sense to further divide them into Doctors, Nurses, Maintenance staff etc. depending on the situation.

Step-4: Deciding on Performance Criteria - As with the community, the service providers need to go through a brainstorming session to come up with their own set of performance criteria. Ideally, these should then be classified in a manner that is easily comparable with the indicators chosen by the community. Also, the *standard criteria used with community are repeated with the service providers.*
Step-5: Provider Ranking - The service providers then need to fill in their relative scores for each of the indicators they came up with. *The scale used should be the same as with the community.*

Step-6: Reflection and Explanation of High/Low Scores - The service providers also need to be asked to reflect on why they gave the scores they did, and to provide evidence and explanations from personal experience. 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[14].

Step-7: Recording Data – The data from the self-evaluation is also recorded in the form of a score card, which looks exactly like the community scorecard.

[14] If the GP and VWSC 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.

Issue to Consider: ' Self-evaluation of Service or of Service Providers'

One clarification that is often asked about during the self-evaluation is whether providers like PHCs and HNCC are evaluating the service as a whole, or just their own performance. In fact, the same issue can come up with the community as well - for instance should they be assessing Healthcare services (access, availability, quality) or the performance of the provider, viz., the (for which criteria would be different – like responsiveness, efficiency to deal with complaints, resource mobilization, etc…).

The answer quite simply is *both*! That is part of the evaluation is of the service, and part of the service provider. In the case of the self-evaluation therefore, the first focus should be on evaluating own performance (issues such as management quality, resource mobilization etc.) and then also on the general performance of the service in question.

Table-11: Example of an *Actual* Self-Evaluation Scorecard by Health Center Staff (also from CARE Malawi's LIFH Project)

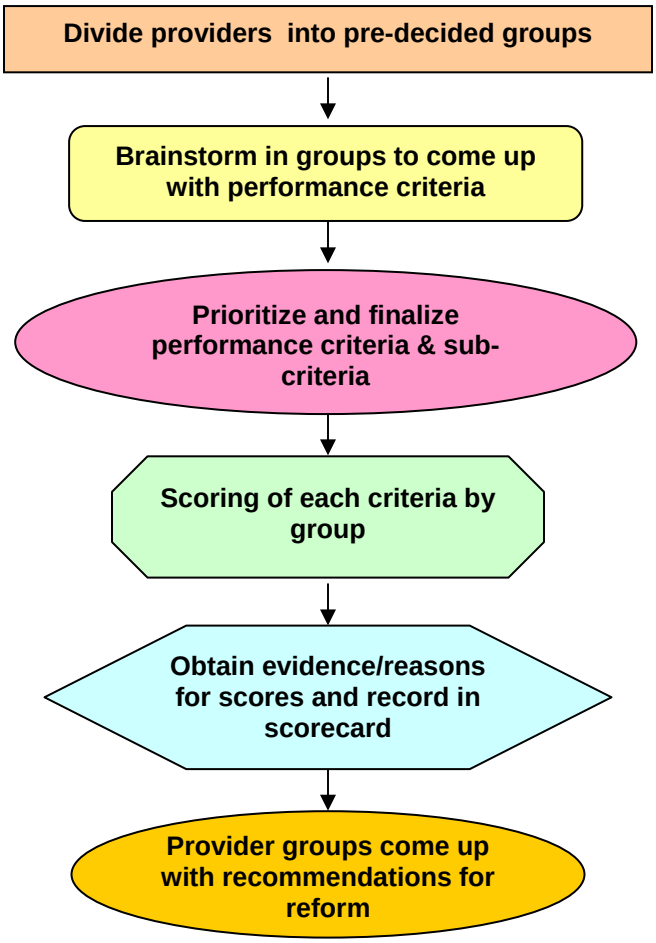
	Performance Criteria	Score (1-100)	Reasons/Comments
4.	**Relations with the patients**	**40**	
	Reception of patients	60	Few staff are not very friendly
	Positive relationship between staff and patients	30	Communities don't see aim of some services; demand too much; high expectations
5.	**Infrastructure and equipment**	**50**	
	Availability of good and safe water	100	There is a bore hole and tap water
	Availability of transport	20	One ambulance for several health centers
	Adequate number of staff houses	60	Not enough
	Adequate toilets, kitchen, and shelter	40	Available but not in use
	Availability of beds and beddings	0	No bedding supplies
	Communication facilities	80	Telephone available

The categories above can easily be compared with those in the community score card for health services that was shown in table-5.[15]

Step-8: Suggestions for Reform/Improvement – Like one did with the community, the service providers are then asked about what reforms or suggestions they have for improving the quality and efficiency of the services they provide. These, too can be compared with the suggestions of the community to see to what extent the demands for reform are common.

Fig. 9: Summary of Steps for Developing Provider Self-Evaluation Scorecard

[15] Note again that not all the sub-criteria that were actually generated in Malawi have been shown here.



Note: Instructions for facilitators and note-takers are pretty much the same as with the community scorecard. The only thing to remember is that the need for monitoring and feedback has to be sold more carefully to the GP and VWSC since they will usually be more reluctant to accept the exercise. They must be told that the focus is on improving services and joint planning and not on singling out and castigating certain people. Also the providers should be reminded to think beyond 'inputs' like infrastructure (which they do more than the community), and focus instead on performance criteria.

9.2 Hypothetical Examples of Self-Evaluation Scorecards for ANMs/AWWs and HNCC

The example shown in Table 11 above can be adapted to our context i.e., a Multi-Service Provider Self-evaluation scorecard, as was done earlier for the Multi-service provider community performance score card.

Below, we will provide hypothetical examples for Self-evaluation scorecards for ANMs/AWWs and HNCC.

Table-12: Hypothetical Example ANM/AWW Self Evaluation Scorecard

Focus Group: Women			
	Provider Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	**Attitude towards patients**	**4**	
1.1	Politeness	4	
1.2	Responsiveness		
2.	**Reliability**	**4**	
2.1	Emergency availability	4	
2.2	Adequate drugs given to patients	3	
3.	**Training and Expertise**	**3**	
3.1	Relevance of training	3	
3.2	Quality of Training	3	
3.3	Level of expertise		
4.	**Quality of Services Provided**	**3**	
4.1	Correct diagnosis and treatment	2	
	Standard Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	**Satisfaction with Services Provided**	**3**	It is active, but needs more capacity building and training
2.	**Availability**	**4**	Listen to community needs

Table-14: Hypothetical Example of HNCC Self Evaluation Scorecard

Focus 'Group': Men			
	Provider Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	Participation and inclusion	4	Ensure full participation of community, no one is excluded
2.	Transparency	3	Decisions are done publicaly
3.	Fair election of HA	4	All elections are free and fair
4.	Quality and fairness in decisions	5	Always seek majority consensus
5.	Dispute Resolution	4	Disputes settled amicably
6.	Resource Mobilization	4	Have mobilized significant resources

7.	Entrepreneurship and Innovation	3	Setting up new internet kiosk; vocational training for youth
	Standard Performance Criteria	**Score (1-5)**	**Reasons/Remarks**
1.	**Effectiveness and Relevance of Services Provided**	**3**	It is active, but needs more capacity building and training
2.	**Participation in Planning and organization**	**4**	Listen to community needs

It is important to reiterate at this stage that these examples are only indicative – they should not bias the process in the communities or the kinds of scorecards that are eventually generated. It might well be that the real scorecards look quite different. Our goal here is just to provide a glimpse of what may result from the community interactions.

CHAPTER 10. THE INTERFACE MEETING

The interface meeting is perhaps the most critical stage in the CSC process, since it 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. Therefore, it is usually preceded by some degree of planning and preparation. The meeting itself is a facilitated plenary discussion of the outcomes of the scorecards, followed by joint action planning on reforms for improvement.

The steps involved are given below, followed by a set of special instructions for the facilitators.

10.1 Steps and Tasks Involved

Step-1: Prepare Both Parties for Meeting - Both the community and providers need to be prepared for the interface meeting. They should therefore be sensitized 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 can be done by explaining the motivation for the interface and *sharing the results* of the different scorecards.

Step-2: Community Cluster Meetings for Service Providers Providing Service in More Than One Village - Service Providers that cater to more than one village it is important to go through a *cluster meeting* in which the representatives of each of the member villages come together to share the results of the community scorecards from their village. These scorecards are compared, and are *aggregated across similar focus groups* (that is men to men, women to women, and so on). The aggregation methodology is simply to brainstorm on what main performance criteria should be retained across a particular focus group category (like women) across the villages, and then simply report all the scores and reasons for each of these narrowed down criteria.

The purpose of this cluster meeting is to aggregate the feedback of the community, so that there are not too many different views being expressed during the interface meeting.

Step-3: Ensure Adequate Participation from Both Sides - This will require mobilization at the community level, and arrangements so that service providers 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 and backing.

Step-4: Present Scorecards in Plenary Gathering – Once both parties are in one plenary gathering and the interface meeting begins, the first thing to do is to put up all different scorecards (input-tracking, community and self-evaluation) so that they are clearly visible to all.

Step-5: Summarize Scorecard Results – The next step is to summarize fairly quickly the results of all the different scorecards, taking one service/context at a time. Ideally, this presentation should be done not by the facilitating team but by one of the members of each of the focus groups that generated the scorecard. This helps to give a sense of ownership to the groups for the scorecards, and also can be an empowering moment for the members of vulnerable groups.

Step-6: Analysis of Results in Plenary Discussion – One or two of the facilitators from the scoring process should now take the lead during the interface meeting, and engage the community

and providers in a short analysis of the scorecard results. The focus should be on *highlighting common criteria and similar scores.* From these, the main problem areas, as well as those on which there is a positive consensus amongst both parties will be identified, and this will lead on to the discussion of how to make things better.

Step-7: Brainstorming to Come Up with Concrete Reforms – Using the previous analysis, as well as the set of recommendations that were developed during the scorecard generation, the plenary should now be asked to think more concretely on which key reforms are needed and can be realistically achieved. Focusing on what can be done immediately is important since the evidence of some positive change will give immediate credibility 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.

Step-8: Develop an Action Planning Matrix – Based on the reforms arrived at above, the facilitators need to help the community and the service providers to jointly come up with an *action planning matrix*. This specifies what actions will be undertaken under each of the agreed upon reforms, who will do them, when, and finally, who will monitor the progress.

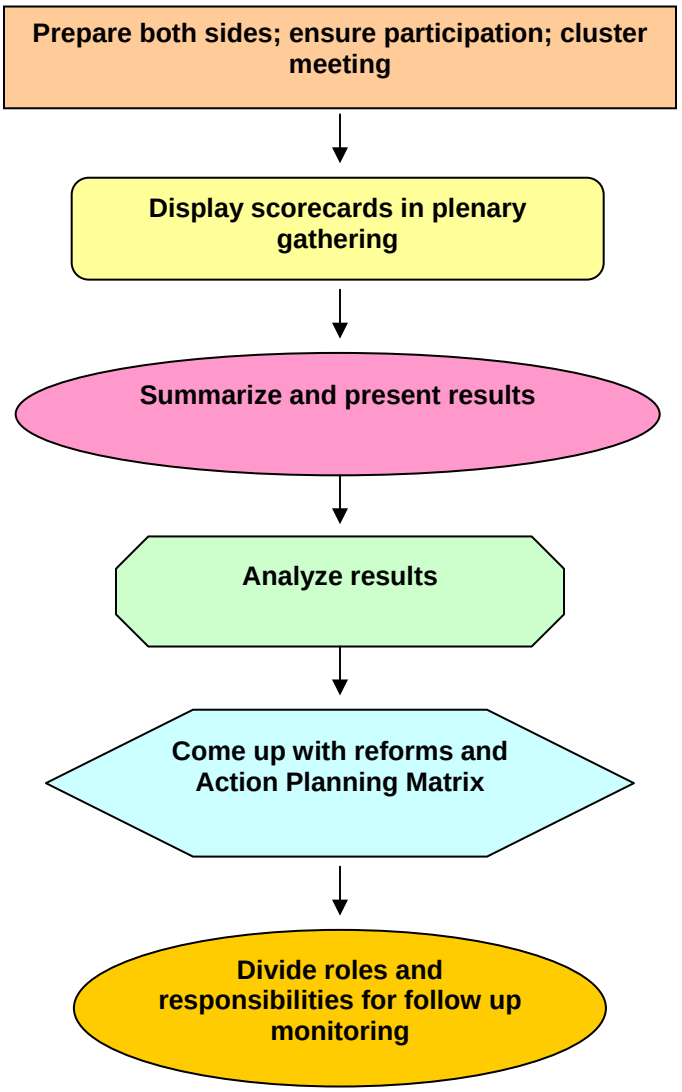
Table-6: Sample of *Actual* Action Planning Matrix Developed During Interface Meeting at a Health Dispensary in Tanzania

No.	Problem Area	What will we Do? (STEPS TO BE TAKEN)	Who will do it? (RESPONSIBLE PERSON/GROUP)	When will they do it? (TIMING)	SUPERVISOR
1	Availability of drugs	Upgrade dispensary to a health center	Village Chairperson	In next few months	Ward Councilor
2	Cost sharing	Need for explanation of official rules	Medical Officer	Next week	Village Chairperson
3	Tools and Equipment	Upgrade dispensary to a health center	Village Chairperson	In next few months	Ward Councilor
4	Water services	Rainwater Harvesting Tank (short term) and Construction of Wells (long term)	Village Chairperson	In next few months	Ward Councilor
5	Community Health Fund	Clarification of rules	Health/Medical Officer	Next week	Village Chairperson
6	Participation	Village meetings should be done frequently	Village Chairperson	Annual meetings starting 15th Dec	Ward Councilor

Step-9: Divide Roles and Responsibilities for Follow-up and Monitoring – Finally, before leaving the community the community and providers need to agree upon what will be the follow-up actions that will be undertaken to ensure that the action plans developed are put into practice. This could take the form of repeat meetings, visits by external parties, some kind of report, etc. It is also advisable for the project team to appoint someone as the overall monitor for the action plan on behalf of the community, who will report directly to the project staff in case of any

problems. A second person should be given charge of supervising the follow up actions that require external support or partnership such as with the Zilla Parishad.

Fig. 10: Summary of Steps for Running Interface Meeting



10.3 Special Instructions for Facilitators and Note Takers during Interface Meeting

- The facilitators role during the interface meeting is quite key, because they are the **neutral intermediary** that will ensure that a productive dialogue ensues between the community and the service provider.

- Usually it is advisable to have **two facilitators during the interface -** one was previously with a community group, and another who has been with a provider group. There are two reasons for this – (i) firstly, it is simply tiring and unwieldy for only one facilitator to manage such a large gathering, but (ii) secondly, because facilitators who have only interacted with either a provider group or a community group will perhaps be biased in their facilitation since they have much better understanding of the position of one of the parties.

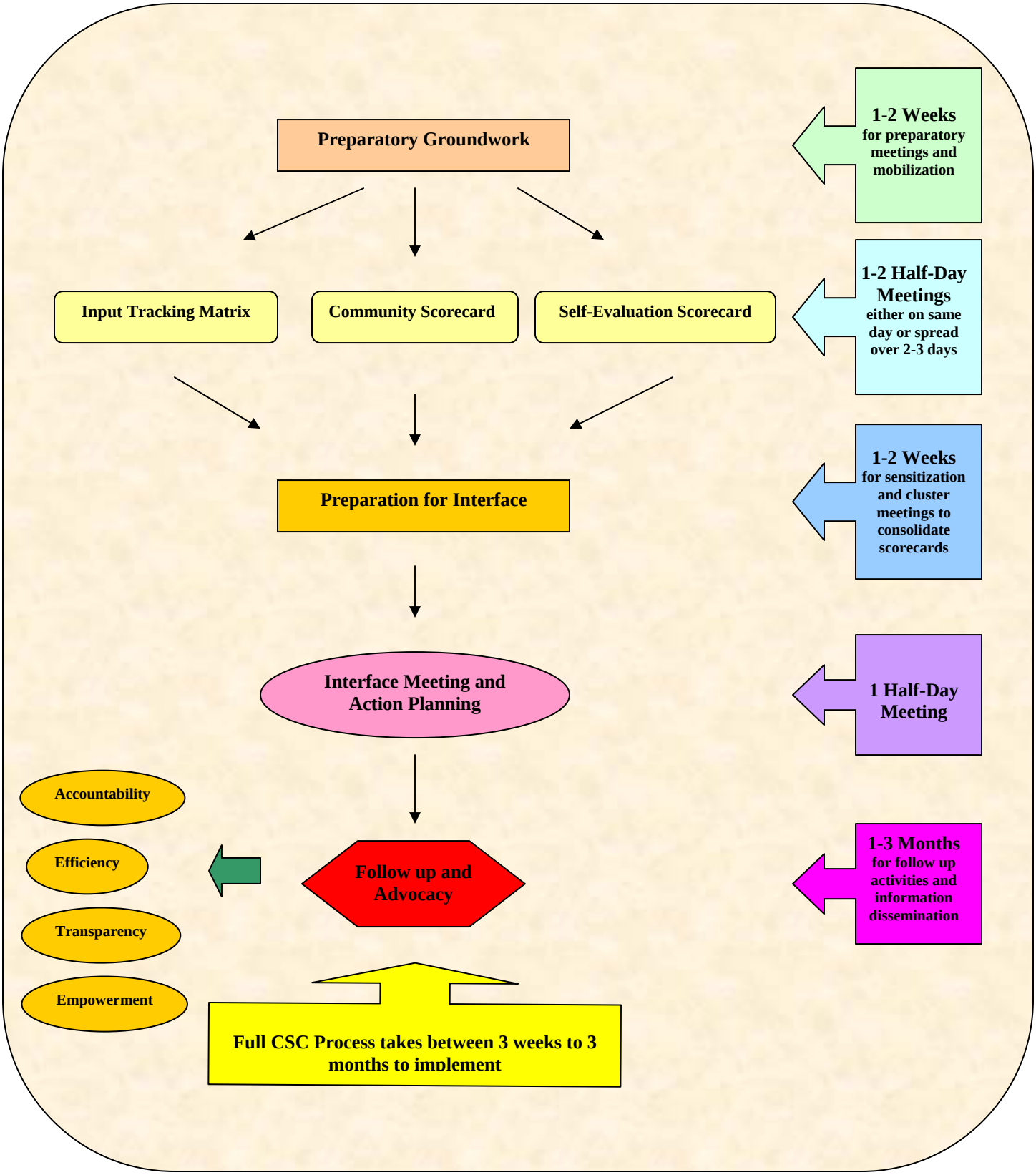
- Facilitators must **be careful in case of volatile situations,** which may arise if there is overall dissatisfaction with service provision or when there is evidence of corruption and leakage in the input tracking. In these situations it is important to *remain neutral* and *try to move discussion into the more positive tone of what can be done to make things better rather than on accusations.*

- Often in the case of interface meetings there is **need for being innovative** about ways to get the community and the providers to move beyond their differences and agree on a reform agenda and action plan.

- Note takers need to **continue to take notes during interface meeting** and one of the group should volunteer to put up the action planning matrix.

- Finally, it is important that the facilitating team **ensures everyone leaves in good spirits** and there is no fear of backlash and retribution.

Fig.12: Summary of Entire CSC Process and the Time Involved for Implementing Different Stages



PART-3: FOLLOW-UP, DATA MANAGEMENT AND LOGISTICS

The final part of this manual will outline the follow up actions and steps that need to be undertaken after the CSC process is completed in a particular set of villages. In a sense, these follow up steps form as much a part of the overall CSC process as the components described above, since they ensure that the process is sustained and institutionalized.

We also briefly consider both issues of data management and logistics, which are important given the anticipated large scale application of the CSC process.

The Manual ends with some annexes, including a list of further references on the CSC process and its applications, as well as on other social accountability tools.

CHAPTER 11. FOLLOW-UP AND INSTITUTIONALIZATION

The CSC process we have described above is only one part of the overall initiative of community empowerment and accountability. Indeed, one can quite rightly argue that what we have described in Part-2 of the manual is only that part of the CSC process that is done at the community gathering, the next stage in the process is what happens *after* the interface meeting. And more often than not this turns out to be more important than what happened in the gathering and the interface, because it is then that the action plans developed by the providers and community get put into practice.

Within the follow-up category, there are actions that need to be taken in the short run, and actions that are needed more in the long run to institutionalize the CSC process into the governance at the Gram Panchayat level. In this chapter we will give some suggestions for both the short term steps needed, as well as some ideas about how to institutionalize the CSC process. A lot of the follow-up actions will, however, need to be developed at the local level based on the immediate context (as shown in the action planning matrices), and several will emerge organically out of the initiative of both the community and the service providers.

11.1 Basic Follow-Up Steps

1) **Monitoring Visits and Spot Checks** – The project team needs to set up a timetable for undertaking monitoring and spot checks to the villages to see the progress done on the action plans. These should ideally be every month or 3 weeks, or based on the timeline that was suggested in the action plans. The formal monitoring visits should be pre-announced to the community and the service providers to put some pressure on them to move ahead with the implementation of their plans.

2) **Obtain Updates from M&E Officers at Village Level** – As mentioned in the last step of the interface meeting, in order to ensure the sustainability of monitoring and reforms, the project team should identify the contact person in each of the villages who will be the monitoring in-charge overseeing the progress on action plans. This person can be the *Case Manager* appointed under the Project. They should be responsible for ensuring that the progress and monitoring reports sent to the project team include the progress on the CSC action plans.

3) **Publicize Results of CSC Process in Local Media** – In order to raise awareness, increase participation and also to put some performance pressure on the providers, the results of the CSC process across villages should be publicized using local media forms such as community radio, posters, pamphlets, advertisements, public interest films, etc. Comparative statistics across villages can also be made public to foster healthy competition amongst them using the results of the data analysis that is suggested in the next chapter.

4) **Training of Community Members on CSC Methodology** – In order to scale up and sustain the CSC process at the local level it is important for the project team to train certain community volunteers on the CSC process methodology so that they can run it independently in the villages after the project team has left. This has in fact been the main approach towards scaling up the CSC process that has been successfully applied in other countries. The training can actually start as early as the pilot implementation where the project team should let one or two focus groups be facilitated jointly by community members so that they get first hand practice of the process.

5) **Plan schedule for Repeat Intervention** – Finally, the project team must also design the schedule for the repeat CSC process intervention. This should ideally happen about 6-8 months after the first round, so that there is sufficient time for some progress to have been made, and yet not be too far removed for the community and the service providers to forget about the process.

11.2 Institutionalization Measures

While the above follow-up actions will ensure sustainability and momentum in the short term, more concrete steps will be needed to institutionalize the CSC process, and more generally the process of community feedback and social accountability, and scale it to the state level. Over here we provide only a set of suggestions of what can be aimed for by the project team.

Suggestions:

- ***Creation of Official Public Forums for Community Feedback and Participatory Budgeting*** – The interface stage of the CSC process can be converted into an official forum between the service providers and the community for feedback from the community about their demands. These forums should ideally be held periodically, and should eventually take this feedback to the next stage of the participatory public expenditure management cycle that was shown in Figure –2, viz. to the stage of *Participatory Budgeting*. Using the kind of action planning done in the CSC process, the community and the Gram Panchayats can then decide jointly take decision on local budget allocations. This will create greater ownership and transparency over the use of decentralized resources at this local level.

- ***Performance-Based Resource Allocation by GoAP for Health Sector*** – The element of performance and community feedback using the CSC process can perhaps be scaled up at a later stage to develop some kind of a Performance Rating System for the various healthcare service providers. This will initiate a healthy competition among them and will enhance the efficiency, quality and demand responsiveness of their service delivery. It will also contribute towards strengthening the process of financial decentralization in Andhra Pradesh.

- ***Link with the Planned Insurance Instruments*** – Development of a Performance Rating System will also be useful with regard to the proposed insurance instruments for reduced health-related expenditure and risk mitigation. CSC results can be used to identify and then standardized indicators for the performance rating checklist that can be used to rate healthcare service providers. These ratings will help the people to choose wisely among the various healthcare service providers.

- ***Use of CSC results in Policy Formulation*** – The CSC Process will generate a lot of demand side information about the needs and concerns of the poor and vulnerable across the state. This will ensure that the State Government's policies are more responsive and pro-poor.

- ***Extending CSC Process to Other Sectors and Public Services*** – Using the example fro Health Care Service Provision communities should be encouraged and trained to run the CSC process in other sectors and public services such as education, water and san This will help sustain the community monitoring ethic at the local level.

These are only some of the possibilities for institutionalization that can happen after running the CSC. The project team should continue to think up innovative ways to scale up and sustain the process of community monitoring and social accountability throughout the running of the project.

CHAPTER 12. DATA ANALYSIS AND MANAGEMENT

The CSC process throws up a lot of very valuable qualitative and quantitative data. The personal experiences, anecdotes, and feedback of community's on performance of services are highly useful demand side data that is rarely captured by more standardized survey instruments. The project team must therefore plan for and invest in a data management and analysis system to record all this data, right from the outset.

There main application for the data collected under the CSC process in our context will be for developing a performance rating system for the various healthcare service providers.

12.1 Using CSC Data for Designing a Performance Rating System for Healthcare Service Providers

The immediate application of the CSC data will be in the design of the rating system for the healthcare service providers. At this stage, it is expected that the *first round application of the CSC process will provide baseline benchmarks on performance of the various healthcare providers* on the various services provided.

The *actual performance rating system is likely to involve a standardized checklist that combines elements of the CSC process*, because the checklist will bring the objectivity and standardization needed to compare the public and private service providers in a fair and transparent manner.

The performance criteria, sub-criteria, and reasons for scores that are thrown up in the CSC process will be used to develop indicators and weights for developing the instrument for the performance rating system. Thus, if 80% of communities used 'transparency' as a performance criterion, and felt that performance was low on this, then the rating instrument will have to include a section on transparency with high points accorded to it. Further if the community gave reasons such as 'did not share budgets', 'do not inform us when new resources are available' etc. then 'shared last 2 budgets with community' and 'put up information of new resources on notice board' could be two of the indicators within the transparency category for which points are given.

Therefore, a first level of data management will be to analyze performance criteria and reasons for scores across all the healthcare service providers to find the most common ones and use these to design the performance rating system.

At a bare minimum this requires the project team to *enter the data* into some database software like Excel or Access. Beyond that some simple methods one could use are:

- Start by *post-coding similar sounding criteria*. E.g. 'Adequate number of healthcare services', 'Availability of required services' and 'Availability of essential services' are essentially referring to the same thing, and be post-coded to say, just 'Adequate Provision of Healthcare Services'.
- Then tabulate the criteria and do a tally of which 5-8 are most common, i.e., repeated the most across GPs
- For these, look at the scores and reasons for scores, and repeat the frequency count to see what the most common score (or range of scores) was, and what the most common reasons for scores were
- From these, devise appropriate indicators to be used in the design of the performance rating instrument.

12.2 Using CSC Data for Monitoring & Evaluation of Healthcare Service Provision and Learning for the Project

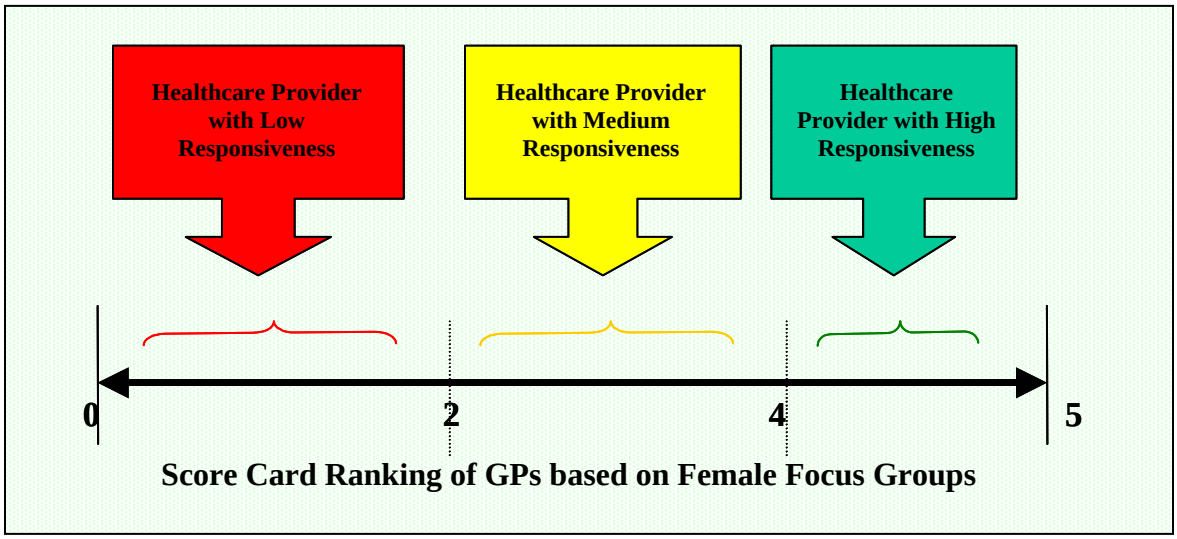
The second, and broader more sustained application of the CSC data will be in the overall monitoring and evaluation system for Healthcare service providers and also learning for the APRPRP.

There are some immediate data products that emerge from the CSC process, viz. the input tracking, community and self-evaluation scorecards, as well as the action planning matrix, and field notes from the process. These provide some direct qualitative caselets that can be used to modify and improve the design of the project, as well as to get a picture of the overall performance of the various healthcare service providers.

From these outputs and primary use of data, however, one could also invest in some secondary data analysis that can be done at a more ***comparative*** and ***aggregate*** level. The facilitating team needs to decide which one is most useful and indicative of the kind of data that has been collected. Several visual aids can be used which will present the data in a concise and clarifying manner. What we present below are just some examples of the kind of analysis and presentation that can be done.

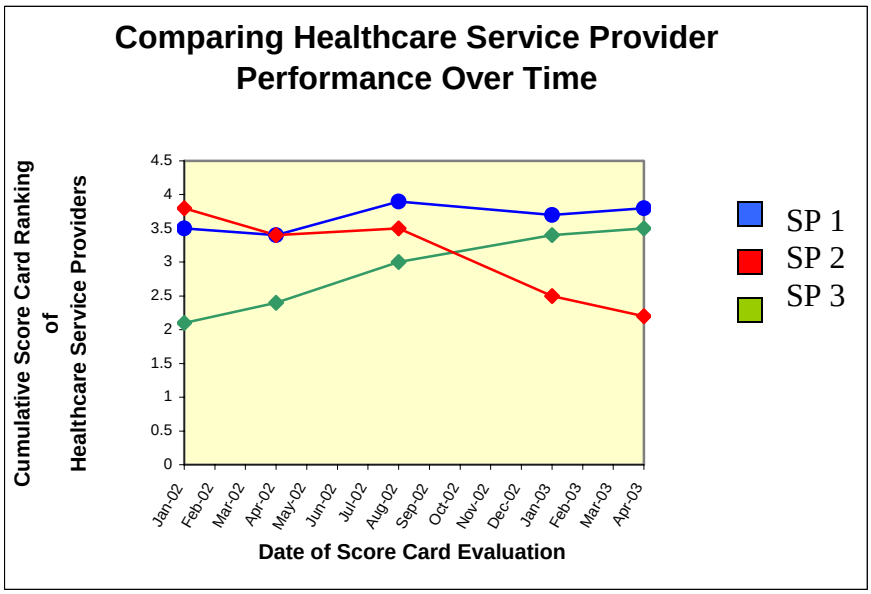
1) **Cross Comparison of Healthcare Service Providers (Public/Private/NGO)** – One useful form of analysis that can be done using the standard criteria used in the CSC is to do cross-comparison and ranking of the different healthcare providers, based on the scores given by the generic focus groups on any of the criteria. For instance, if one of the criteria were 'responsiveness', and focus groups were men and women, one could do a ranking of all the evaluated healthcare service providers on the scores given by men and by women. Then the following scatter line can be drawn for the sampled districts.

Figure-13: Comparing Responsiveness of Healthcare Service Providers



The publishing of these rankings in this manner can inform decisions about resource allocation, and also provide a basis for incorporating incentives for performance.

2) **Tracking the Performance of Healthcare Service Providers Over Time** – Just as cross-sectional comparisons were done above, one can also do time series comparisons of how the scores of a single healthcare service provider (public/private/NGO) on a particular standardized criteria have changed over time. This is obviously only possible once several iterations of the CSC process have been conducted, but it would provide very valuable information about which service providers are improving performance and which are remaining stagnant. In cases where there has been a deterioration in the community's scoring, it would provide a case for more detailed scrutiny as to the reasons why such a fall in score happened. Thus more targeted reforms can be taken before the condition becomes worse.

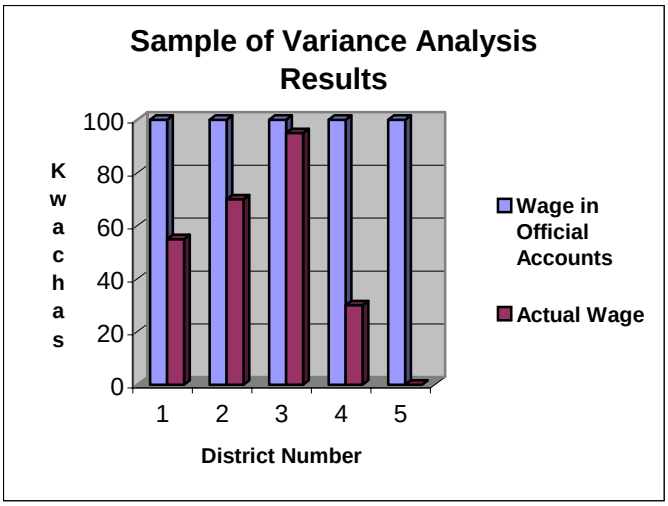


3) **Analysis of Discrepancies between Entitlements and Actual Inputs (Variance Analysis)** – From the data collected in the input tracking matrix, one can conduct *variance analysis* across healthcare providers over particular inputs. This involves calculating the discrepancy between actual input use/receipt and the official entitlement/record within a community and then comparing these between GPs at a point in time, or within the same GP over a period of time.

For instance, suppose one of the inputs is staff/labor wages. Here the official record would be the bank statement of that particular healthcare provider or the amount they claimed to have paid in an official document. The community would of course be the source to get the actual wages they received. The difference if any between the two amounts would be the 'discrepancy' or 'variance' for wages for this particular healthcare provider. The same can then be done for all the rest and one could get a sense of which healthcare providers are the ones that have the highest variance. Also, for the project's M&E, one could keep track of how long it takes to plug all leakages.

Figure – 15:The discrepancy between official and actual wages can be averaged and compared over GPs to get a sense of the level of leakage occurring

	Wage in Official account	Actual Wage Received
District 1	100	55
District 2	100	70
District 3	100	95
District 4	100	30
District 5	100	0



These are only some suggestions for the kind of data analysis that can be done. Other innovative techniques for using and analyzing CSC data in a concise and provocative manner can be devised over time with the help of different partners like the media.

CHAPTER 13. LOGISTICS

Last but not least, it is important to raise some logistical issues that will have to be kept in mind by the project team in implementing the CSC process. The answers to most of these will have to be eventually finalized at a local level after the process has been tried in a sample of villages. However it is important to at least flag them here so that one can keep them in mind when doing the initial pilot trials.

13.1 Key logistical issues to keep in mind

- **Identification and Training of Trainers and Facilitators** – As should be evident from the description of the CSC process in this manual, its success depends heavily on the quality of facilitation. For this reason, a primary logistical issue will be to locate adequate trainers and facilitators for the CSC and train them in the methodology for implementation. These facilitators should ideally have skills in supporting a participatory process at the community level. Having this training at the very outset will help in building a team spirit among the staff and promote a shared understanding of the goals and objectives and the process to be established.

- **Deciding Number of Facilitators/Note Takers Per Village** – As discussed in the methodology section, the CSC process requires at least one facilitator and one note taker per focus groups. Since we have at least 3 contexts that we will be dealing with (Healthcare services by 'Multi-Service Providers', ANM/AWW Services and HNCC Service Provision) and each of these will on average have about 3 focus groups, there are in all at least 9 focus groups per village that one is dealing with. One could of course run all three contexts with each group, but that tends to take a long time, and assumes that each context would require the same classification of focus groups. If one ran all these focus group discussions simultaneously we would need about 18 people to go to the community, which is quite impractical! Instead, if we run them separately, and stagger the meetings it would still require at least 3 facilitator-note-taker pairs to go to each village – so 6 in total. Other alternatives are possible, but this logistical issue will be a very important one to consider upfront and would depend on (a) how many facilitators are available, and (b) how many GPs are to be covered. Even after that one would need to be prepared for contingencies, e.g. what if 500 people showed up to the community gathering (as once happened in Malawi!) – are there enough facilitators to handle such a situation?

- **Ensuring Adequate Participation of Communities through different IEC techniques** The above discussion also raises another logistical issue that for a high level of participation by the community, one needs proper advertising and preparatory groundwork. Consider the above example where we are looking at Healthcare services by 'Multi-service Providers', ANM service provision, and HNCC service provision, and that we are making 3 focus groups for each (men, women and elders). In that case, there are 9 focus groups in all, and if we want about 15 people in each group, then there should be at least 135 community members attending the gathering. Otherwise, one would have to stagger the meetings over a couple of days with set timings to meet with a particular group. Thus, depending on the strategy one would have to invest in more or less advertising and mobilization to ensure community participation.

- **Deciding the Sequence and Timeline for the Group Discussions and Interface** – Linked to the above two points will be the key implementation issue of how the group discussions in the community and with the Healthcare service providers will be sequenced. Will one do all discussions in one go, over the course of a day, or will they be staggered? How much later will the interface meeting be held from the scorecard meetings? Will the interface be village by

village or at a more aggregate level? As figure 11 indicates there are various possible timelines for implementation of the CSC process, and these will have to figured out after a trial run in the field.

- **Data Management and Analysis** – As the previous chapter showed, there is a lot of data management and analysis that needs to be done after the CSC process has been run in a number of villages. The logistics of who will do this, where, and how will also have to be decided pretty early on to ensure that this rich data is properly used.

- **Sensitization of the various Healthcare Service Providers** – As we have seen, one of the most critical factors in successfully using the CSC process is ensuring an open and positive dialogue among the main partners in this process i.e. the service providers and the users. Several delicate and debatable issues will come up and since this process is envisioned as one leading to tangible results and not just as an information gathering exercise, it is important that conflict be avoided and the dialogue be held is a positive open environment. To this end, a training workshop on behavior and attitudes can be conducted as a sensitization exercise to enable the healthcare service providers from across the state to handle the interface dialogue with the communities. The emphasis will be on listening and dialoguing skills and to make the participants more aware of their own attitudes and behavior. This can also be integrated into the scoping visits that are to be done during the preparatory groundwork.

- **Materials and Resources** – Last but not least, an important logistical issue that can be flagged at this point is of materials and resources that will be involved in running the CSC process. These will become clear once the pilot trials are completed.

- **Deciding the Different Strategies for Large and Small Villages** – Finally, an important logistical issue that will have to be tackled once the CSC process is implemented on scale is to develop separate logistical plans for small and large villages. In general, one would have to scale up the materials and human resources needed per village according to its size.

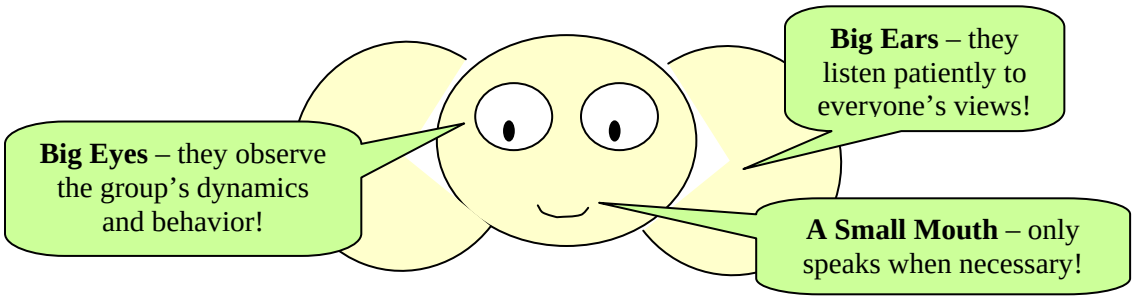
ANNEX-1: DISTINGUISHING BETWEEN THE COMMUNITY SCORECARD AND THE CITIZEN REPORT CARD GUIDANCE POINTS FOR FACILITATORS

The Citizen Report Card	The Community Scorecard
• Unit of analysis is the household/individual	• Unit of analysis is the community
• Information collected via a survey questionnaire	• Information collected via focus group interactions
• Relies on formal stratified random sampling to ensure that the data is representative of the underlying population	• Involves no explicit sampling. Instead the aim is to ensure maximum participation of the local community in the gathering.
• The major output is the actual perceptions assessment of services in the form of the report card	• Emphasis here is less on the actual scorecard and more on achieving immediate response and joint decision-making
• The media plays the major role in generating awareness and disseminating information	• This relies more heavily on grass-roots mobilization to create awareness and invoke participation
• Conducted at a more macro level (city, state or even national)	• Conducted at a micro/local level (village cluster, and set of facilities)
• More useful in urban settings	• More useful in rural settings
• Time horizon for implementation is long (about 3-6 months)	• Time horizon for implementation is short (about 3-12 weeks)
• Intermediary plays a large role in conducting the survey and data analysis	• Role of intermediary is mostly as facilitator of the exercise
• Technical skills are needed	• Facilitation skills are needed
• Feedback to providers and the government is at a later stage after media advocacy	• Feedback to providers is almost immediate and changes are arrived at through mutual dialogue during the interface meeting

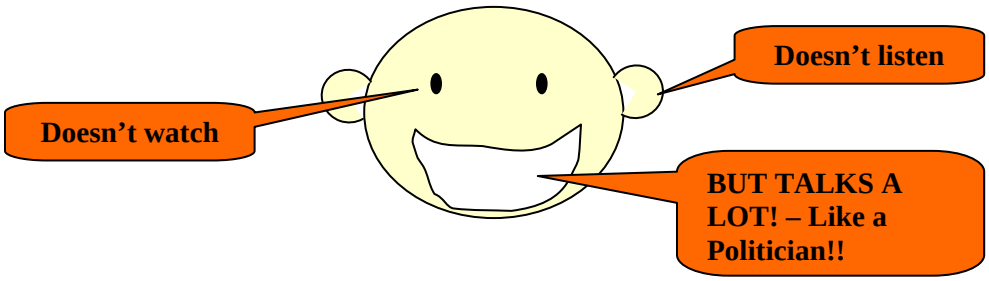
The Goals of Facilitation:

- *To guide…*
- *To enable…*
- *To provoke…*
- *To create a conducive environment…*

A good facilitator looks like this…



And a bad facilitator looks like this…



Facilitation… 'the basics':

- **Be *visible*** – stand and face group
- **Be *loud* and *clear*** – use the local dialect and elaborate questions clearly
- ***Control* conversations** – let one person speak at a time, and sequence discussions
- **Ensure *participation*** – don't let someone take over the discussion
- ***Summarize* points and statements**
- ***Listen* and *understand* different points of view**
- **Periodically *check* if they are understanding the process**
- ***Avoid conflict* and act as *neutral intermediary*** - avoid personal prejudice
- **Know *when to dig deeper* and *when to move on* –** have clear understanding of issues
- **Use and observe *body/ non-verbal language***

Facilitation "Do's and Don'ts"

• Listen and observe • Know your audience • Be patient • Encourage participation • Use simple language • Be humble and respectful • Respect opinions • Be creative and flexible • Be engaging/humorous	• Don't talk too much • Don't be a FACIPULATOR (manipulator in disguise!) • Don't be condescending • Don't cut/preempt answers • Don't speak to one person (beware of the dominant spokesperson) • Don't lose sight of the objectives of the exercise

Facilitation Notes for Different Stages of the Community Scorecard Process:

I. Opening the Dialogue

- Explanation of objectives is key
- How the discussion is started will set the tone of what follows
- Important to use good 'lead-in' questions
- Plan the sequence for the discussion beforehand to avoid repetition and respondent fatigue

II. Running the Discussion on Performance Criteria

- Don't give them criteria – let them generate
- Remember the discussion is about 'performance' not 'problems' or 'demands'
- Ask groups (especially providers) to think beyond infrastructure
- If discussion is too negative, ask for positive counter examples
- Benchmarking is also useful – eg. What would you say is 'reasonably good'?
- Need to get down to criteria fast so examples can come after scoring and are not repeated

III. Scoring

- Don't influence or change scores – let them score
- Useful to do a trial run
- Always ask for personal examples/ experiences
- Try to ask for counter-examples or counter scores in case others are not speaking
- Note points/examples of dissent

IV. The Interface Meeting

- Usually two facilitators needed
- Be careful in case of volatile situations – act as neutral intermediary
- Have to be innovative – both to tame volatile spirits, but also to suggest ideas for reform
- Focus on the way forward, not on accusations
- Try and solicit points of agreements/ disagreements between the scorecards – no need to reconcile
- Develop an action planning matrix
- Ensure everyone leaves in good spirits

ANNEX-2: RESOURCES FOR FURTHER REFERENCE

1) Operational Manual for Community Based Performance Monitoring, Strategy for Poverty Alleviation Coordination Office (SPACO), The Gambia, January 2004

2) Operational Manual for Community Based Performance Monitoring by the Malawi Social Action Fund, World Bank, November 2002

3) Participation Website of the World Bank – www.worldbank.org/participation

4) Public Affairs Center Website – www.pac-india.org

5) Shah, Meera K.: *Using Community Scorecards for Improving Transparency and Accountability in the Delivery of Public Health Services – Evidence from the Local Initiatives for Health (LIFH) Project"*, CARE-Malawi, April 2003

6) Singh, J. and Shah, P.: "*The Community Scorecard Process: A General Note on the Methodology for Implementation*", Draft, Participation & Civic Engagement Group, The World Bank, April 2003

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8) Wagle, S. and Shah, P.: "*Participation in Public Expenditure Systems – An Issue Paper*," Social Development Note No. 69, The World Bank, March 2003

9) Wagle, S., Singh, J. and Shah, P.: *"Citizen Report Card Surveys: A Note on the Concept and Methodology,"* Social Development Note No.82, The World Bank, February 2004

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    Case Study 5: "Uganda",
    Case Study 1: "Bangalore, India"
    Case Study 3: "Gujarat, India"
    Action Learning Program on Participatory Processes for Poverty Reduction Strategies, The Participation Group, Social Development Department, 2001

11) World Development Report 2004: *"Making Services Work for Poor People"*