Community Scorecards: Linking Communities with Providers to Improve Services

Workshop with 3MDG Implementing Partners

June 14-15, 2016

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Workshop Summary

Community scorecards are a participatory approach for communities and service providers to engage in dialogue on the delivery of services under a government program or a project, often in rural areas. The community scorecard tool has been most commonly used in the health sector as a way for communities and service providers to work together on the planning and monitoring of specific health services and to jointly make efforts to improve service quality and access. It was piloted by CARE in Malawi in the early 2000's and has since been adopted across regions by many NGOs and institutions to bring community voice and participation into sector service delivery projects.

Over the two-day workshop, participants learned about the community scorecard model, the process for conducting scorecards, and how it has worked in other country cases. The group discussed **the tool's potential applicability in Myanmar** and **brainstormed practical ways for how it could be applied** in the sectors and geographic areas where 3MDG implementing partners work. The workshop was **a combination of presentation, discussion, and group-based work**.

Background and Objectives

Pact provides capacity development support to 3MDG implementing partners working in three categories: (1) C1 – maternal, newborn, and child health; (2) C2 –HIV/AIDS (harm reduction), tuberculosis (TB), and malaria; (3) Collective Voices – focused on community engagement. Within C1 and C2 organizations, there are focal points focused on Accountability, Equity, and Inclusion (AEI) and ensuring that programs integrate AEI aspects into 3MDG programming. Participants included not only AEI focal points but also senior project management staff with deep knowledge of how the programs are implemented in the field.

Given the opening of government and specifically a notable shift within the Ministry of Health (MOH) toward listening to the voices of the people of Myanmar and innovative people-centered approaches, 3MDG requested that Pact provide a training to all 3MDG implementing partners to introduce them to social accountability concepts. 3MDG staff and Pact jointly decided upon community scorecards as practical mechanism focused on improvement of service delivery at the local level.

The training aimed to:

1. **Raise awareness** of the 3MDG implementing partners about the concept of a community scorecard as one of many social accountability approaches;
2. **Offer a blend of conceptual and practical knowledge** on community scorecards with a focus on how they have been implemented in the health sector in the Asia Eurasia region; and
3. **Provide a learning space** for organizations to consider the applicability of a community scorecard within their organizations' portfolios and the communities with whom they work.

Conceptual Understanding of CSC

A community scorecard is a participatory, community-based approach to evaluate and improve public services, and inform and empower local actors. With strong facilitation, the CSC process brings together

Community scorecards are one of several social accountability approaches.

communities and service providers to discuss services in a constructive way. The CSC is led at the community level and conducted for and by health service users and provides with guidance from "neutral" intermediaries (NGOs/CSOs). The emphasis is more on the participatory process for monitoring public services than on the numbers on the paper. This approach is used as a tool to measure the perception of service delivery over time, usually focused on three main factors of (1) quality, (2) access, and (3) availability/quantity. The scorecard is typically repeated over time every 3-6 months depending on the type of service and the visibility of change.

Benefits of CSC

- Inform users (and providers) about their *entitlements, rights and responsibilities*
- Improve communication between providers and users
- Build *local capacity* and clarify roles
- *Direct feedback* between providers and users at local level
- Solution-focused and action-oriented
- CAN be relatively simple, fast, and cost-effective
- Flexible and *adaptable* to different contexts
- Potential to produce significant service *performance improvements and process outcomes* like institutional and behavioral change

Limitations of CSC

- *Cultural barriers* e.g. where there is no tradition of holding public service providers to account.
- Depends almost entirely on the *quality of facilitation*
- *Interface can get confrontational* if not well managed
- Tough to compare data across townships or regions
- *Small sample size* can bias perceptions
- *Difficult to link CSC findings* to national level reforms or issues that are handled centrally e.g. procurement of medicines

- Local officials may be unable to solve issues raised by communities if they do not have the *capacity* or *scope* to address the problems

International experiences with CSC

The first day focused on drawing findings and lessons learned from regional examples that could be relevant for Myanmar and 3MDG implementing partners. The four case studies were selected to demonstrate the following points:

Key lessons from regional experiences

Process matters

- Find ways for facilitators to legitimize the process
- Anchor the process in dialogue with the community and *existing structures*
- Consensus approach vs. voting in FGDs
- Inclusion is critical to make the CSC meaningful
- Some communities find it difficult to understand the process of scoring and voting procedures

Understanding government structures and incentives

- Important to understand *the "political" dynamics* with the local administrators and line ministry officials – what motivates and incentivizes them?
- *Buy-in* at higher levels of government facilitates the process and sets the tone for the CSC
- Lays the groundwork over more than one round of the CSC (6-12 months)

Constructive engagement is key

- CSC can *facilitate collaborative spaces* for problem solving e.g. bringing stakeholders together to devise joint action plans to tackle service delivery problems
- CSC can *reignite communities' capacity for self-help* (solidarity) and can provide structure for the work of existing community committees

Box 1. Cambodia Demand for Good Governance Project

Pilot project between Min. of Health, The Asia Foundation, World Bank with 6 CSO grant recipients

Results: higher level of engagement between citizens, services, and local authorities; health service improvements such as staff availability and better hygiene in health centers; increased trust between communities and government.

Box 2. Afghanistan CSC in 6 provinces

Implemented by a university consortium, Min. of Public Health, and NGOs, with support from DFID.

Results: A greater sense of community solidarity and partnership; awareness of a 'rights based approach' to the package of health services; and voluntary contributions by individuals and committees and the 'self-help' attitude to promote change in communities.

Box 3. Rural health CSC in Andhra Pradesh

Implemented by a university consortium, Min. of Public Health, and NGOs, with support from DFID.

Results: Innovative solutions to local problems, such as staff willing to undergo training to improve their attitudes; clinic staff would proactively raise awareness among communities; clinic hours changed to suit community needs; grievance system initiated.

Box 4. CSC "Light" in Tajikistan

Pilot program with UNDP and Min. of Water and Irrigation; focused on rural water supply/

Results/lessons learned: Without facilitation of CSC process, water users and providers may not be aware of possibilities of better standards; participant enthusiasm and the credibility of the methodology is linked directly to implementation of the action plan

Group discussion on regional cases

Findings from the cases provided the basis for a discussion on the following questions from participants:

- How is it possible for local organizations to establish neutrality with government? How could that be done in conflict areas?
- Often there is a difference between what is said at the higher level of government and what filters down to the local level. There may not be a willingness or any incentives to implement the vision of a ministry, especially if there are not resources and training dedicated to it.
- Trust building between the community and service providers is a key issue in Myanmar and the levels of trust can vary depending on different factors.
- How many facilitators are ideal? Should some work with government and others with communities?
- How to measure and gauge changes in trust?

- At what level of government is buy-in needed? Do organizations need an MOU with government?
- How to do this work if not funded directly funded by donors?

Community scorecard process – a step-by-step approach

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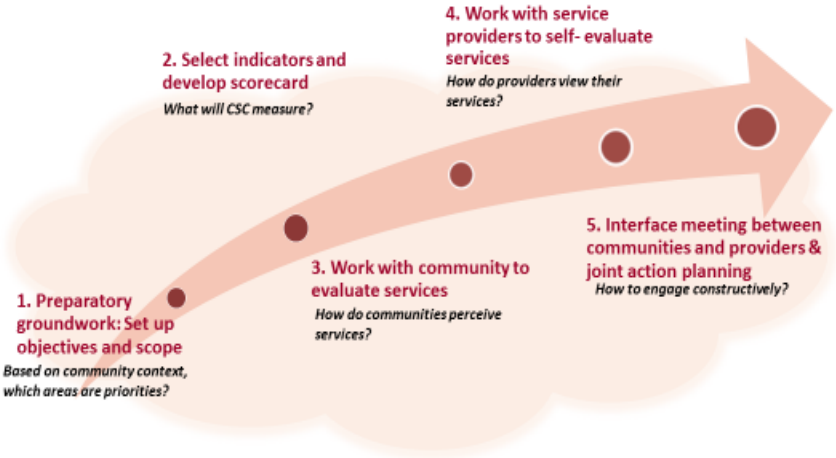


Simplified community scorecard model described in 5 phases.

Myanmar, a less complex CSC model can be a useful starting point:

- Indicators based on essential elements of service delivery (quality, access, availability/quantity)
- Focus on the value of the dialogue and process
- *Fewer indicators* with basic rating system
- CSC approach can be *modified to fit the context*

Step 1: Preparatory groundwork

- Identify Objectives & Scope - e.g. Township, service, sector, project
- Understand the community makeup by gender, ethnicity, service usage, poverty levels
- Identify a facilitator (in NGO/CSO?)
- Mobilize key community leaders on the topic (e.g. user committees)
- Raise awareness about entitlements in the community and ensure participation of all community members, particularly women and marginalized groups
- Sensitize relevant government officials to the CSC concept – be strategic at different levels
- Identify the *best approach to get information from service providers* about what they provide.
- *Prepare for the first substantive meeting with line ministry to *understand government perspective* on service delivery with facilitators and key community leaders*

Step 2: Identify issues and develop scorecard indicators

Indicator	Score	Reasons
Indicator 1		
Indicator 2		
Indicator 3		

- *Critical first meeting with government to form a strong understanding of the "supply" side.*
- Identify entitlements and understand what is actually being delivered
- Talk to community about the issues related to services and cluster the issues

- Facilitators work with information from communities and from government to develop a set of indicators/issues
- Develop the performance scale
- *Practical tip:* Socialize the indicators and performance scale with stakeholders prior to scoring

Step 3: Work with community to evaluate services

- Convene community meeting
- 2 approaches to gathering community inputs on services:
    - Work through relevant user committees e.g. irrigation committees for water, VDC health committees
    - Divide participants into focus groups, ideally, 8-20 people per group. Women-specific group recommended.
- Use "facilitated brainstorming" to agree on how to evaluate performance e.g. How will someone know that a facility is operating well?
- Determine single scores per indicator/issue
- Ask participants to record explanations.
- *Practical tips:*
    - Voting versus consensus approach. Consensus is preferred unless there are dramatic differences in opinion that need to be taken into account.
    - Remind people that they are scoring services NOT people

Step 4: Work with service providers to evaluate services

- Convene service providers
- Facilitated brainstorming to think about self-evaluation and assign scores
- Consensus approach is ideal
- The group collectively scores each indicator and provides rationale for score
- Reflection on scores and practical suggestions for how to improve
- *Practical tip:* Hold one meeting/FGD for service providers instead of splitting into groups

Step 5: Interface meeting and joint action planning

- Community and service provider groups present their results – analyze commonalities and differences through productive dialogue
- Come up with some concrete action items
- Obtain some commitment for follow-up and identify volunteers (by name, if possible), and a date for follow-up
- Having an intermediary group helps; can invite outside people like local / township officials
- *Practical tips:*
    - Senior facilitator may be more effective, depending on the context
    - Find a "neutral" space
    - Depending on size of group, could take half to full day

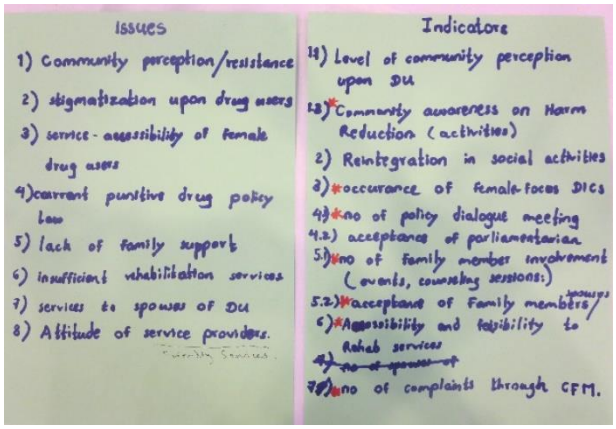
Table 1. Participants

Total # of participants	C1 organizations	C2 organizations	CV organizations	3MDG staff
54	17 (including 7 AEI focal points)	21 (including 7 AEI focal points)	10 (no AEI focal points in CV groups)	6

Group Work Sessions

Considering the community perspective

- Groups worked with their peer organizations to discuss what a rights-based approach looks like in current projects. They assessed the level of knowledge within communities about health rights and their needs.
- They brainstormed a set of issues from the community perspective (MCH, TB, HIV/AIDS, or Malaria – depending on working area) and converted the "issue areas" into indicators that could be measured.



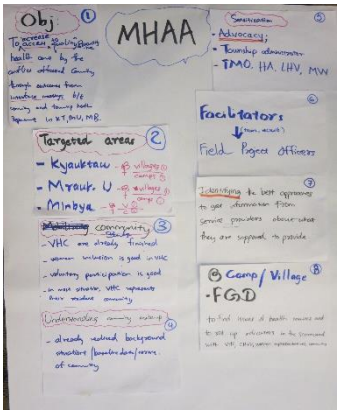
C1, C2, and CV organizations identified issue areas that they see at the community level and converted the issues into indicators that could be measured in a CSC.

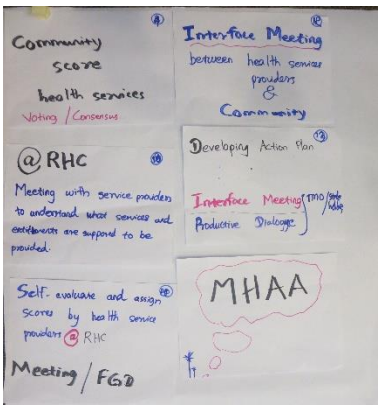
Understanding relationships between government/service provider and communities

- Groups discussed the current level of community interaction with government service providers.
- Tables were asked to think of concrete examples of constructive relationships with key officials such as township medical officers (TMOs).

CSC Implementation Plans

Organizations considered if a CSC approach would be appropriate for their work developed an approach for how to integrate the CSC. They considered how to start a dialogue on service delivery with the community and mapped out a strategy for engaging government at different levels, including getting buy-in at a higher level as needed. Each organization had a different approach for the CSC, depending on their organizational business model and whether they work more with communities or as service providers.





MHAA presented a potential plan for how to implement a CSC in the context of its programs.

Group discussion: Lessons learned from CSC simulation exercise

Facilitation is essential

- Role of facilitator is critical for preventing conflict. In the interface meeting, s/he needs to work hard to control the two groups before going into the details for the scoring and discussion.
- The identity of the facilitators is important as they will need credibility with the community as well at higher

Box 5. Simulation Exercise Instructions

1. Split into "government", "community", and "facilitators" based on MCH case study with draft indicators provided.
2. Facilitators select scoring method and work with each group to score the service
3. Groups simulate an interface meeting and action planning session

level e.g. at township level and possibly with district/state health department officials.
- Facilitator needs to turn community feelings into indicators. Most communities will focus more on their specific feelings and less on the process. Facilitators and community leaders really have to work with them to understand this better.
- Facilitators need to be trained on time management.

Service provider perspective is critical for CSOs that want to do a CSC

Groups simulated an interface meeting between communities and service providers based on a fictional case study on maternal and child health.

- TMOs face pressure from above and from below. It is important to understand his perspective and the real constraints of being part of the bureaucracy. Most of the time he is aware of these challenges from both sides but does not feel like there is much that he can do about it.
- BHS might complain about additional duties. The TMO already faces challenges staffing those positions, so he cannot push them beyond their current workload. He has incentive to protect them to prevent high turnover rates.
- Midwives are already overloaded and not paid that well. There are sometimes issues with midwives selling drugs that are supposed to be free of charge because they are so underpaid.
- If TMO is not interested in the concept, a CSO would struggle to move it forward.

CSC process could be further customized for Myanmar health sector context

- CSOs need to socialize the process and objectives or it could divide the groups even further.
- One suggestion is to add two steps into the process – show the community and the government the scorecards before scoring in separate meetings.
- Some contexts might need an interface meeting in two parts – one at the lower level (sub-center), where the communities might feel more comfortable speaking up. Then a second meeting could be held at the TMO level/township level. This could eliminate issues.
- Before the meeting, should both sides have a chance to review the others' scores.

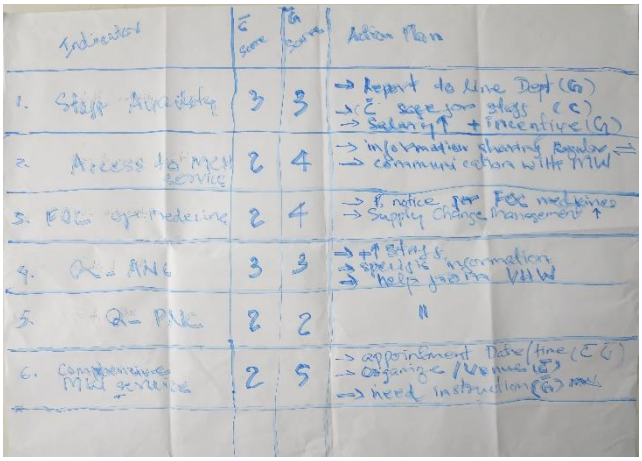
Interface meeting is a key an opportunity, if managed well

- The grounds found that there were big gaps in scoring between communities and government, which meant that the interface meeting took a long time to explain/rationalize each of the scores and discuss them.
- Interface meetings depends on the TMO and could potentially invite more conflict if the facilitation of poor or the CSC is not introduced in advance.
- Communities may be able to be influential if their leaders know the government officials well.
- There is a need to socialize the design and the indicators and objectives well in advance.
- Some participants were concerned that the interface meeting could negatively impact the cohesion between a community and the service provider. Hence they need to focus on engaging positively.

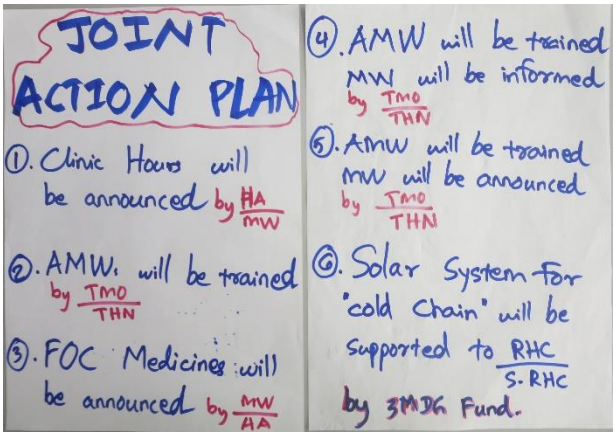
- The community really struggled to speak up at the meeting despite the scores being on paper, and there is a risk that the community could deny the scores at the meeting. One approach to deflect responsibility on one single community would be to aggregate their scores and have multiple villages meet together.

Communities and service providers should have a clear understanding of the CSC process and goals

- Preparation is extremely important – both sides need to be involved in the design.
- Communities and service providers need to fully understand the concept of CSC and focus on how to find the best solution to mutually agreed problems.
- Participants thought that it could take a lot of time to sensitize people to the idea of a CSC.
- In reality, the issues that were suggested as indicators in the project won't be the real issues identified by the community. They will have their own ideas about what services matter to them and why – perhaps unexpected issues.
- Scoring is simple conceptually but may be difficult to implement in the field.



The interface meeting was guided by the scoring of services by both communities and service providers; facilitators led discussion about discrepancies in scoring and the rationale for scores.



After discussing the scores by each group, interface meeting participants collaborated to form a joint plan of action.

Participant Feedback

Participants expressed satisfaction on the quality and clarity of the workshop in terms of the mixture of group work and presentations and the duration. Some participants found the conceptual presentation materials to be more challenging. While a vast majority of participating implementing partners found the workshop useful or highly useful, many also expressed doubts about how and whether they would ever implement a CSC in their projects (3MDG or other projects). Reasons given for this include:

1. Not all implementing partners function in the same role in the field. Some are service providers (C1, C2) while others are community facilitators and mobilizers (CV).
2. Some implementing partner service providers operate in a narrow space where the government does not provide many alternative services (e.g. HIV), so the CSC model may not be seen as helpful for their business model.
3. There may be an unclear organizational mandate for the learning agenda in terms of funding, resources, and leadership to implement social accountability within existing programming.
4. The team perceived some uncertainty about the applicability of a community scorecard in the Myanmar context without high-level buy-in.

Appendix 1. Workshop Agenda

DAY ONE – Tuesday, June 14

9am Introductions: Pact Capacity Development team & 3MDG

9:15am Session 1: Overview of Community Scorecard

10:30am Tea

10:45am Session 2: International examples of CSC implementation

12pm Lunch

1pm Icebreaker

1:15pm Session 3: Five-step CSC rollout process

3pm Tea

3:15pm Session 4: Group table discussion on community perspective

4:30pm Session 4 continued: Share group findings

DAY TWO – Wednesday, June 15

9am Session 1: Group exercise! Review CSC process

10am Session 2: Community scorecard in Myanmar – Adapting the model to work in context

10:30am Tea

10:45am Session 3: Table discussion on government/service provider and community relationships

11:15am Session 4: Team CSC process development based on your project areas

12pm Lunch

1pm Icebreaker

1:15pm Session 5: CSC simulation & role play

3pm Tea (groups continue together after tea break)

4:00pm Session 5 continued: Simulation presentation findings

4:45pm Workshop closing