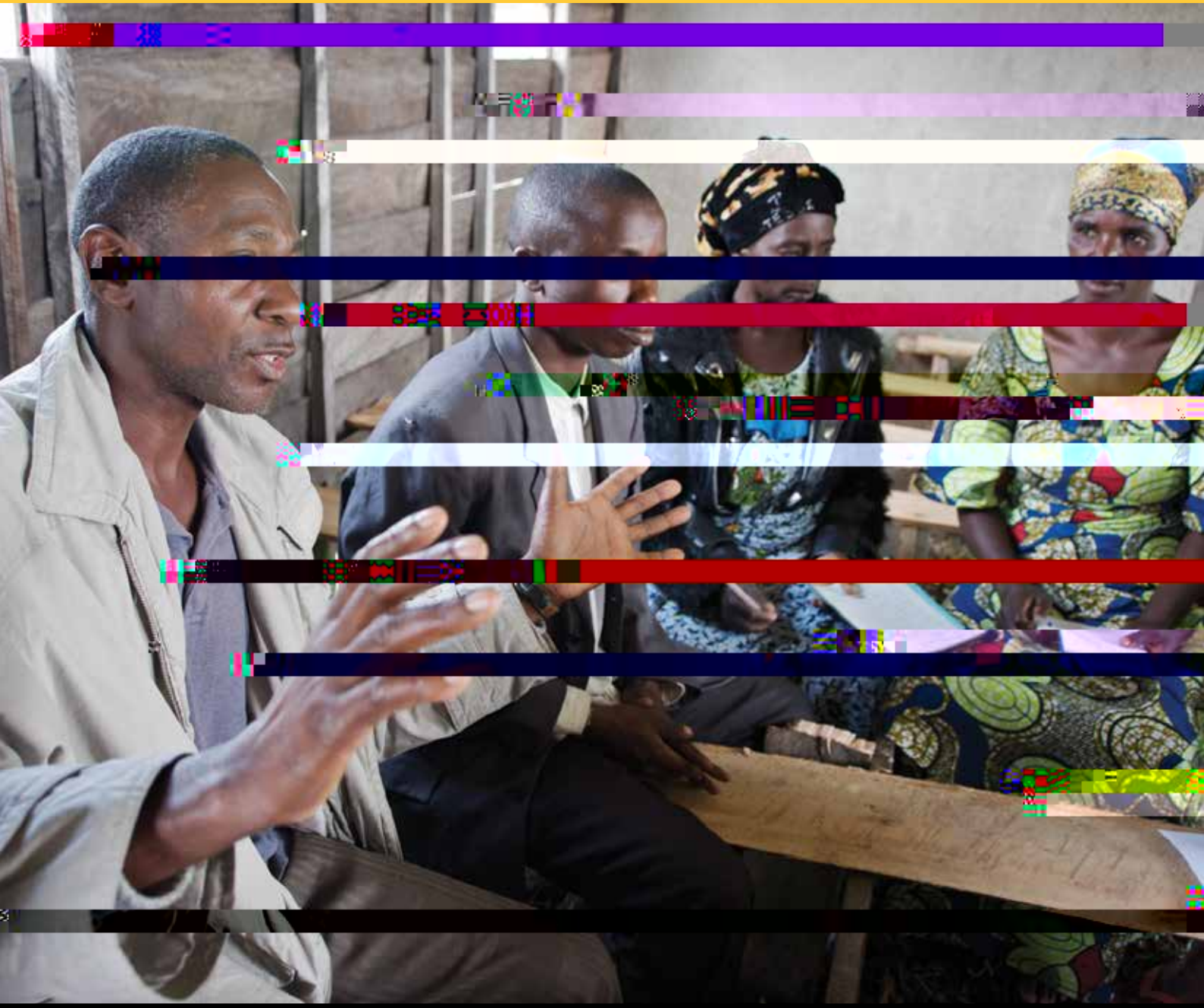
CUE COMMITTEE

Accountability in Local Service Delivery

The Tuungane Community Scorecard Approach



Policy and Practice Briefing Paper

Prepared by Guillaume Labrecque and Isatou Batonon


COMMITTEE

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1. Introduction

Community scorecards are often conceived, within academic and International Non Governmental Organization (INGO) literature[i], as a tool to exact greater accountability and responsiveness from service providers, as well as a strong instrument for community empowerment. However, little is known about the impact of this kind of social accountability tool[1], and even less so in conflict-affected and fragile contexts like that of eastern Democratic Republic of Congo (DRC).

Gaventa and McGee (2013) suggest the need to multiply efforts to understand how these tools and approaches function. They note that "we need more of the same. A number of good, specific studies exist, using a range of methods, but there are [currently] not enough of these, across enough settings and methods,

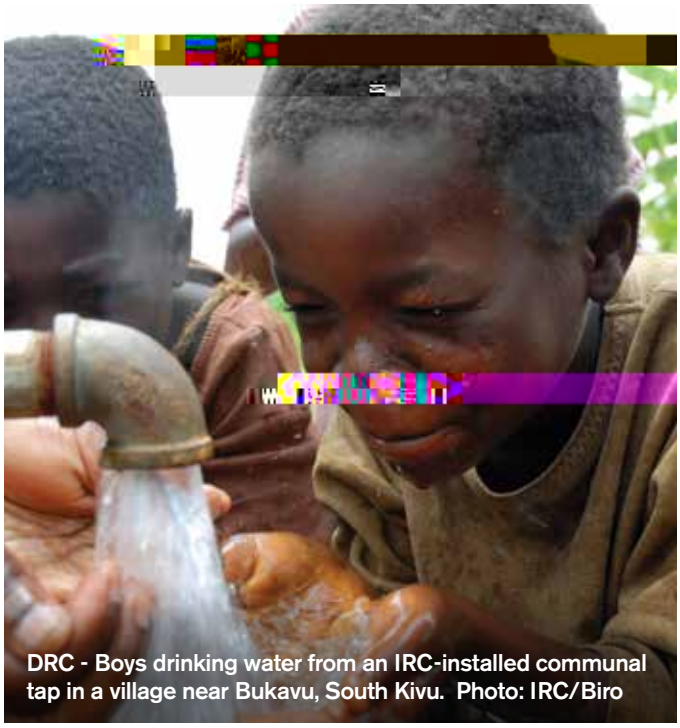
2. Tuungane - A community-driven reconstruction program

In 2007, the IRC, in partnership with CARE, began the implementation of a Community-Driven Reconstruction (CDR) program in the Democratic Republic of Congo funded by the UK Department for International Development (DFID). Tuungane – meaning Let's Unite – seeks to empower more than one thousand communities in four eastern provinces (North Kivu, South Kivu, Maniema and Katanga) to have greater voice and control over their own development. Tuungane operates on the premise that people's needs are best met when public authorities are capable of providing basic services, when they are responsive to citizens' needs and priorities, and when the general public can engage in decision-making and hold them to account.

Each community is supported to identify a sector in which they want to invest, make decisions regarding this investment and manage a block grant for the construction/rehabilitation of basic social infrastructure. For example, some of the projects involve the rehabilitation of health centers, school buildings, bridges, roads, public marketplaces or water points. While community members are free to decide where to invest their funds, approximately 70% of communities identify education or health as their priority sector. In each community where funds are invested, a Village Development Committee (VDC) is elected to facilitate community decision-making and manage funds on behalf of the population.

Village development committees (VDC) are composed of five elected posts (president, vice-president, secretary, treasurer and community mobilizer), as well as four appointed members of the sector user committee. Village chiefs are advisors to the VDC.

Since 2010, the program has strengthened and built on its community-driven approaches by fostering greater linkages between community members, frontline service providers, line ministries and nascent decentralized local government structures, thereby building foundations in the medium term for improved accountability in state-run service delivery. These linkages are fostered, in part, through the implementation of a social accountability tool: the community scorecard (CSC). In theory, this scorecard approach provides greater access to information and creates a space for dialogue between service users and providers, thereby supporting collective problem-solving and fostering greater accountability and responsiveness from service providers.



DRC - Boys drinking water from an IRC-installed communal tap in a village near Bukavu, South Kivu. Photo: IRC/Biro

3. Health and education service delivery in Eastern Congo

DRC – A doctor prioritizes medical emergencies in a newly constructed, IRC-supported health centre in North Kivu.
Photo: IRC/Demian

Eastern Congo has been plagued by a cycle of conflict which has destabilized the country and region, destroyed social infrastructure and weakened state and civil society-run mechanisms of service provision, severely restricting the population's already-limited access to basic services.[iii] Communities are often disengaged from decision-making processes around public service delivery, thus limiting their input into how these services function and address their needs.

Decades of neglect of the education system in the DRC has resulted in an adult literacy rate that was under 70 percent in 2006.[iv] Free education is a constitutional right, but in reality the education system is largely directly financed by parents through school fees and levies.[v] Part of the fees are ostensibly dedicated to the construction and maintenance of buildings, yet most schools still do not meet minimum Congolese education standards. Schools are overcrowded and often lack equipment, water and sanitation facilities, and adequate teaching and learning materials.[vi] The low – and irregularly[2] – paid staff are generally unmotivated. Few are officially registered on the government payroll, hence their reliance on locally collected school fees.[vii]

[2] Teacher Survey Results, presented in the baseline assessment of the IRC/USAID Opportunities for Equitable Access to Quality Basic Education (OPEQ) indicates that teachers are now more or less being paid regularly. However, it is very unlikely that teachers were regularly paid at the start of Tuungane (2007).

The International Network for Education in Emergencies (INEE) argues that "because of the decades' long history of conflict and transition, the power center for education service delivery exists at the local levels. The system is de facto decentralized, but in a manner that exacerbates problems of equity and quality for all Congolese students"[viii] as it gives school principals and teachers a lot of autonomy around service provision. It is important to note that the vast majority (approximately 70%) of schools in eastern Congo are managed by faith-based organizations[ix] that are operating under the auspices of the Congolese state, and are, in principle, conforming to state rules and mandates.

Schools are formally run by a school management committee consisting of the school director and her/his deputy (in large schools only), a teachers' representative, three representatives from the Parent Committee (COPA) and a representative from the student body/committee. However, as argued by the World Bank, "despite their pre-eminent role in financing school education, parent committees do not really have the 'voice' required to enforce accountability over management committees, and the administrative structures of the state and the religious schools."[x]

The health sector also faces dire challenges. Health services are often inaccessible and, even when within reach, essential inputs such as drugs and personnel are often unavailable. This in turn results in low utilization rates.[xi] Insufficient funding of the health sector and poor financial management results in a reliance on high user fees to cover staff salaries, operational costs and contributions to the health zone operations. In addition, patients are often required to purchase medicines and supplies for surgeries and other services. The high cost of health care also limits access, as a majority of households have difficulties paying for healthcare.[xii]

The poor health status of the Congolese population is evidence of weaknesses in the Congolese health system. Weak management and absent accountability relationships lead to corruption, lack of motivation, poor planning, and shoddy implementation of health services and policies. Mechanisms exist within the health system for users to give feedback and demand improvements, including the health development committee (CODESA), but these are often not functional. Even when functional, change is not necessarily happening because even when user voice is channeled appropriately, there is no incentive for service providers to improve their performance. In practice, the quality of, and access to, health services is variable and users' voices have little impact on service provision.

It is this lack of citizen voice and influence over education and health services that prompted efforts to improve service delivery in these sectors by working on the relationships between service providers and service users. Also, the existence of clearly identified local level service providers in these sectors, operating within formal service delivery systems for which Congolese norms and standards exist, offers opportunities to bring the demand (citizens/users) and supply (State, faith-based organizations, doctors, nurses, school principals and teachers) sides together through a governance intervention that addresses the problems described above.

4. Theory of change

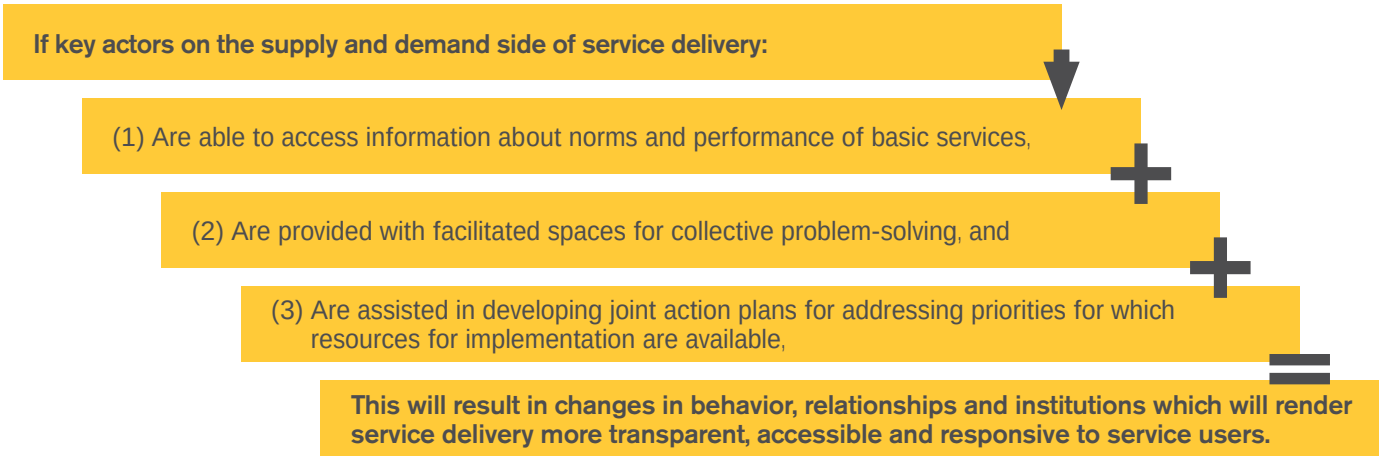
The community scorecard is one of many community-based monitoring tools and has been used for multiple purposes in a variety of contexts.[3] The Tuungane community scorecard (CSC) is seen as a way of empowering community members as service users, and supporting their constructive engagement with local service providers around the delivery of education and health services.

The underlying theory of change of this approach has been influenced by three major Congolese contextual factors:

- First, due to their **limited access to information**, service users, and often service providers, lack basic understanding as to what constitutes a 'public' service and what users and providers' rights and responsibilities are around service delivery. For example, there is a lack of awareness of the national Congolese standards for a functioning education/health service, the actors/bodies responsible for various elements of service delivery, what financial resources are available and how they are managed, and how service providers are performing. This widespread absence of information affects how service users relate to basic services and how service providers respond to users' preferences and priorities within the constraints of an existing public system.
- Second, the **culture of accountability is weak** between service providers and service users. This can be explained by the absence of public services in many areas where communities have to find their own solutions to access basic services or where there is substitution of the State by local civil society organizations, faith-based organizations and INGOs delivering basic services). In the absence of functioning accountability mechanisms, decentralization of services also means that local service providers may have more incentives to extract payments from service users than to provide equitable access to quality services.
- Third, **citizen voice in service delivery is rarely heard** because there are few spaces and little precedent for non-partisan and constructive dialogue across the demand-supply lines where service users can voice their preferences and priorities. In addition, functioning grievance and redress mechanisms are rare, and where these mechanisms exist and are known, they often remain underutilized or do not lead to any sanctions.

[3] The community scorecard has been used primarily in Asia and Africa by a number of international and national NGOs, as well as agencies like the he[(seral)-40latt and Africa by a ce roa]TJ-./e1atfriale..der of intET/T1S0 CS .7303 Tm(3)Tj-0.0SCNcount w497M q

Based on this understanding, the Tuungane CSC theory of change was articulated as follows:



Although, it was anticipated that the community scorecard would progressively lead to greater transparency in service delivery, more accessibility to services and more responsiveness to service users' demands, these changes were expected to be incremental in nature, given the realities of state-society relations in the Congolese context[4]. Expected changes resulting from the scorecard process were detailed as follows:

- **Changes in awareness:** these include service users and service providers becoming more informed and aware of norms and standards around service delivery in their sector.
- **Changes in behavior:** service users and service providers begin to adapt their behavior (e.g. increased presence of health personnel at local health facilities) as a result of engaging in the scorecard process and implementing their action plans.
- **Changes in relationships:** changes in the way service users and their elected representatives on the user committees interact, and in the way user committee members and frontline service providers interact in co-managing and overseeing education and health services.
- **Changes in institutions:** the key institutions targeted by these changes are user committees which are often dormant in eastern Congo communities. It was expected that user committees would become more active and start to fulfill their representation, outreach and co-management functions.
- **Changes in community processes:** community members were expected to begin to use similar participatory and transparent community decision-making processes (such as holding general assembly and interface meetings, and designing/implementing improvement plans) to address priority issues, with the support of local leaders (such as VDC members).
- **Changes in access:** improvements were expected in physical access to services through the rehabilitation of basic infrastructure. Improvements were also expected in the management of existing resources at the community level (textbooks, medical supplies and equipment) to ensure greater access to these for students and patients. In addition, community members would begin to understand issues of exclusion from services and progressively start to tackle them.

Ultimately, the contextual factors and the theory of change presented above have guided both the design of the Tuungane CSC methodology and its monitoring framework. The following sections present the Tuungane scorecard methodology and some of the learning emerging from the monitoring data.

[4] The modest expectations of the program in this regard reflect an understanding of the fragile and often predatory nature of the Congolese state, the weak social contract that exists between citizens and duty bearers and the absence of incentives provided by Tuungane to improve performance on the supply side.

Step 1: Training on the Community Scorecard Process

The objective of the CSC training is to develop the capacity of members of the elected VDC, user committees (representing the interests of health or education service users) and frontline service providers (e.g. teachers, school directors, health workers) to participate in and support the CSC process. The two-day training provides them with the skills and knowledge to analyze and monitor the performance of service providers in either the education or health sectors depending on the priority sector identified by community members, and also to explore the Congolese norms and standards that structure their priority sector.

DRC - Village Development Committee (VDC) members discuss the democratic process followed recently when planning for the construction of a community center. Photo: IRC/Ferland

Step 2: Data Collection on the Priority Sector

At the local level, objective data on the priority sector (e.g. health or education) is collected by VDC members in collaboration with user committee members, and is recorded in a systematic manner using an input tracking matrix. As illustrated below, this is a very simple table which presents existing inputs against the norms and standards[5] established by the Congolese State (e.g. number of health personnel per health facility, pupil/book ratio, etc.).

This information is then shared with community members and service providers when they generate their performance scorecards (step 3 and 4). It allows them to develop an understanding of the status of their education and health services and use this information to work toward collectively solving service delivery problems.

Example of an Input Tracking Matrix in the Health Sector

INPUT	ENTITLEMENT	ACTUAL	REMARKS
Number of nurses	Health Centre: 2-4 nurses Outreach Post: 1-2 nurses	Health Centre: 1 Outreach post: 1	Insufficient number of nurses

[5] Each norm and standard is thoroughly explained during the training on the CSC process (see step 1).

Step 3: Elaboration of the Community Generated Performance Scorecard

Community members, once mobilized by VDC members and the Village Chief, come together to complete the performance scorecard. Approximately 60 to 100 people are typically present and are divided into three sub-groups for this exercise (women, men, and youth for communities that have selected education as their priority sector, and women, men and elders for communities that have selected health as their priority sector[6]). Under the facilitation of Tuungane staff, each sub-group engages in a conversation about what constitutes a quality service. The sub-group discussions reveal themes that are then translated into a series of qualitative indicators (e.g. attitudes of service providers, cleanliness, presence of frontline service providers, availability of drugs, etc.) against which each sub-group will score based on their experiences and perceptions of the service.

In addition to these community generated indicators, community members are also invited to score four standard indicators: (a) access to service, (b) user committees' involvement in financial management, (c) general quality of services and (d) equitable treatment amongst users. These indicators, developed by the IRC, allow program staff to compare perceptions of service delivery performance across multiple sites.

Community members use the following five-level qualitative scale to score each indicator: Very bad, Bad, OK (average), Good, Very good. Visual depictions are used to support the participation of those who are not literate.

Once each sub-group has scored their indicators, they come together as one large group. A representative from each sub-group, starting with the women's sub-group, presents each indicator and score. Once every group has presented, Tuungane staff and VDC members calculate the average across sub-groups, and report it in the overall community scorecard (which will later be shared during the interface meeting). Through facilitated discussions, community members are able to reach a consensus on their rationale for the score for each indicator. Indicators that came up in only one sub-group are debated by the larger group for inclusion in the final community scorecard which represents the community's overall assessment of the quality of services offered in their sector.

Example of a Community Scorecard in the Education Sector

	Score						
Indicator	**Very Bad**	**Bad**	**OK**	**Good**	**Very good**	**Reason**	**Solution**
Equitable treatment of students		X				Teachers favor boys in the classroom when distributing books or answering questions	Sensitization of teachers
User committee participates in the management of the service	X					They have never been invited to school meetings and we don't know who they are	Re-election of user committee members and training management of the service

[6] The rationale is that youth (boys and girls) would have a particular perspective on education services (as the primary beneficiaries), and the same is thought to be true of elders for health (as they might be high users of health services). That being said, for focus groups in the education sector, elders are either included in the women or men sub-groups and the same is true for youth engaging in discussions in the health sector.

Step 4: Elaboration of the Service Provider Self-Evaluation Scorecard

Service providers go through a similar (but separate) exercise to carry out a self-evaluation of the quality of basic services they offer. This process unfolds exactly in the same way as with community members (although providers are not divided into focus groups since there are usually only four or five teaching or health staff in a particular facility): service providers reflect on what a quality service would look like and translate their conclusions into a series of indicators; indicators that they then assess and score against.

Once they have scored every self-generated indicator (using the same qualitative scale as community members), they also provide scores for community generated indicators that did not come up in their own performance scorecard, as well as the four standard Tuungane indicators.

Step 5: Interface Meeting between Service Users and Service Providers

DRC - Villagers meet to discuss the community scorecard process. Nkanga Village, South Kivu. Photo: IRC/Demian

The aim of the interface meeting is to create a space for constructive dialogue between service users and service providers. The meeting is an opportunity for them to discuss service quality, identify gaps in service provision and manage expectations with regard to service improvements. Representatives selected from each community sub-group are invited by the VDC to attend the meeting on behalf of community members.

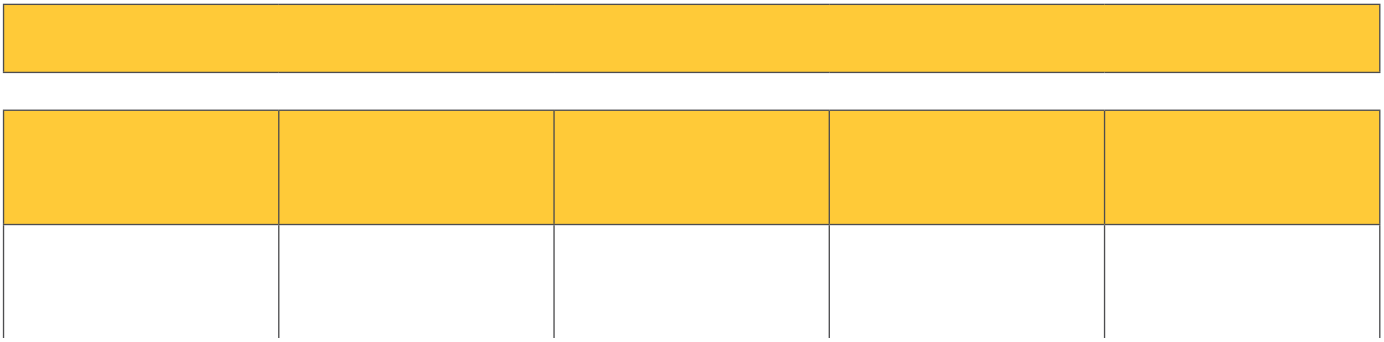
Firstly, VDC members briefly present the content of the input tracking matrix (entitlements vs. existing inputs). Secondly, a community representative presents the community generated scorecard. Then a representative of the frontline service providers shares their performance scorecard, as well as their responses to the community generated performance indicators. At this stage, the aim is not to arrive at a consensus on the different scores and their justifications, but rather, for each group to appreciate each others' perspectives on service quality and access.

Whenever possible, higher level health or education line ministry staff (e.g. District Health Officers, Provincial Director for Education, etc.) and local government representatives are invited to attend the interface meeting to better understand communities' development priorities and provide support, as necessary.

Step 6: Development of the Joint Service Improvement Plan

The collaborative space of the interface meeting allows community members and service providers to work together, negotiate and mutually agree on an action plan to improve services – the joint service improvement plan (JSIP).

Emphasis is placed on solutions which can be tackled at the local level, as well as on advocacy actions towards higher level authorities that can be taken to improve service delivery (sometimes jointly by community members and service providers). These suggestions are then translated into concrete actions, responsibilities are determined, deadlines are set, and required resources are identified.



Step 7: Community endorsement and implementation of the JSIP

Approximately one week after the development of the JSIP, a general assembly is called during which the wider community is given an opportunity to become acquainted with the plan, to propose amendments if needed, and ultimately to approve it (through a public vote for which a majority plus one is required). Once approved by the community, the VDC starts to lead the implementation of the JSIP.

Once approved by community members, the JSIP is also shared by VDC members with all relevant local stakeholders, including local government officials and line ministry staff. This represents an occasion to sensitize them on opportunities and challenges faced by community members around the access and quality of public services.

6. Learning from monitoring data

The program adopted two strategies for monitoring and learning from the Tuungane community scorecard process: collection and analysis of stories of change from project stakeholders using the Most Significant Change (MSC) technique, and tracking of standard performance indicators.

Most Significant Change Stories

The Most Significant Change (MSC) technique, a participatory monitoring and evaluation tool[7], is the key strategy adopted by the program to capture learning from the implementation of the CSC process. Though still in the preliminary stages of story analysis, some interesting patterns of change stimulated by the CSC approach have started to emerge.

By the end of 2013, Tuungane staff had collected approximately 125 stories of change from a variety of individuals engaged in the scorecard process: direct service users[8], frontline service providers, community leaders, user committee members and VDC members. Stories were collected in two phases in order to facilitate data collection, story selection and analysis, as well as to learn about the types of changes that occurred at specific times during the implementation of the scorecard. While there are many stories of change, learning presented below is based on analysis of stories collected during the second phase (76 stories) because they portrayed richerg p change,thatnstories collected during the s037crt Shase . chos

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As a means of organizing the data contained in the stories of change, each story was reviewed and clustered into one of three families of change: (a) **improved management of services**, (b) increased access to services and (c) improved quality of services. To learn more about the mechanisms through which changes were stimulated by the CSC process, these changes were further analyzed to explore the conditions under which they emerged. Three illustrative examples of this exploration are presented below.

Improved management of services: Many stories (25%, 19 out of 76) document a positive shift in the involvement of users and user committees in the management of the service. For example, according to project stakeholders, this change resulted from the space created by the scorecard process which allowed community members to raise concerns about the weak role of user committees. As a result, they were able to identify strategies for addressing their concerns, including through training of user committee members on their roles and responsibilities. This in turn empowered user committees to challenge service providers' monopoly over the management of schools and health facilities and play a greater role in this regard.

Example of improved management of services

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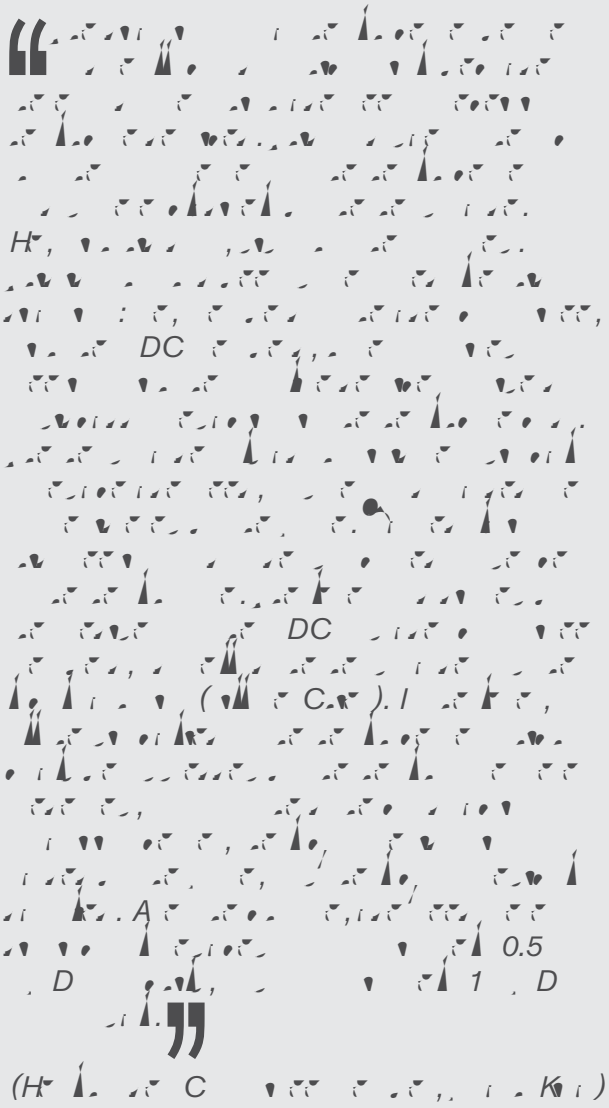
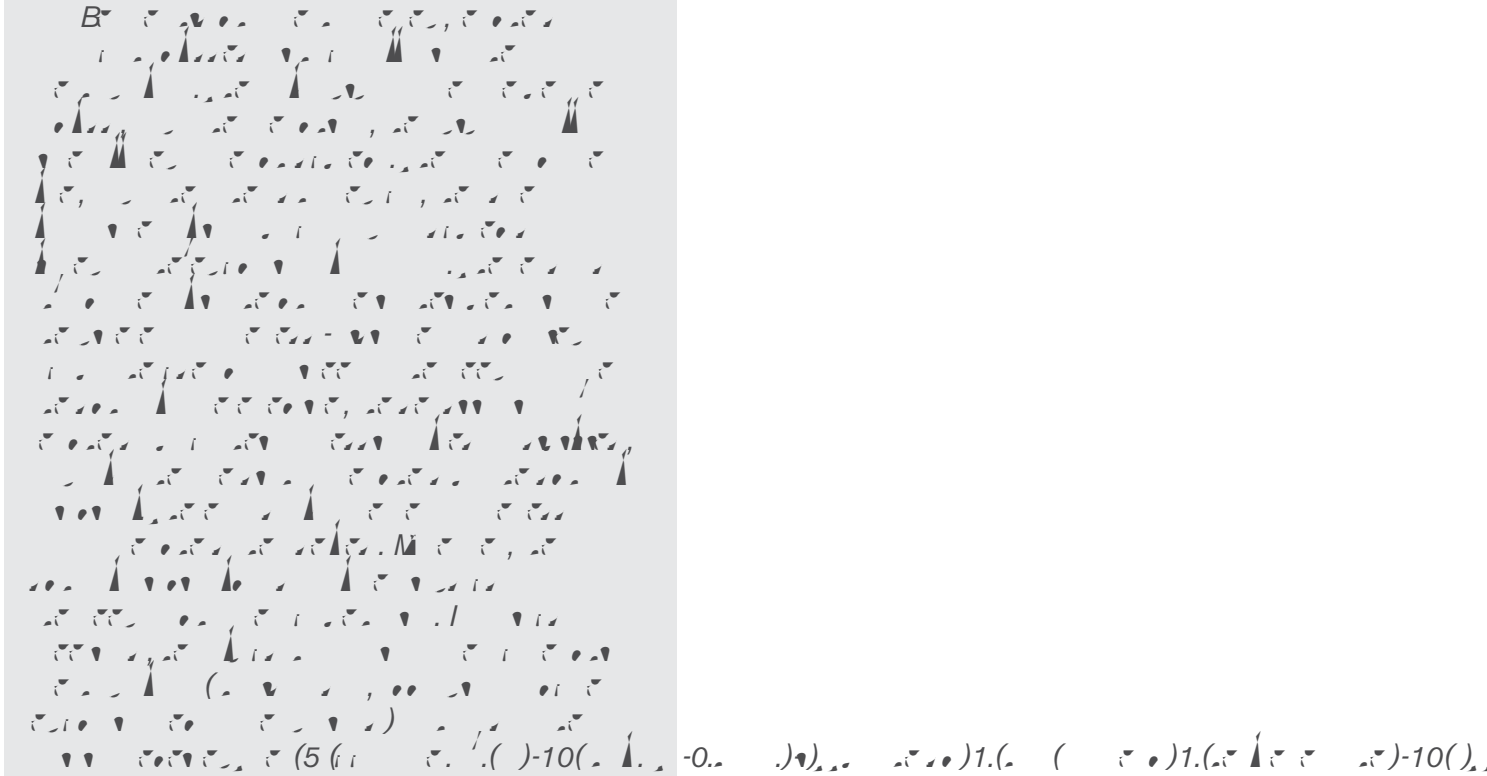
Increased access to services: A number of stories of change (17%, 13 out of 76) describe how the Tuungane CSC process has contributed to a decrease in financial barriers to accessing services. The scorecard process, and more specifically the input tracking matrix, was perceived to increase community members' knowledge of their basic rights to access public services. This has prompted some user committees to identify strategies to reduce user fees and tackle corruption as a means of ensuring greater access to services. In some cases, user committee members have, together with frontline service providers, advocated at higher levels to increase oversight from line ministries (as a way of dissuading some providers from demanding bribes) and for regular payment of salaries (as a way of decreasing local service providers' reliance on direct user fees to supplement their incomes). Other strategies included user committees requiring that teachers no longer withdraw students who are unable to pay their school fees without first informing the committee and giving a few days of notice to parents. In certain cases, frontline service providers have also negotiated repayment schedules with user committee members and parents.

Example of increased access to services



Improved quality of services: A smaller number of stories (12%, 9 out of 76) describe how the Tuungane CSC process has contributed to an improvement in staff presence and technical capacities. The stories of change suggest that the Tuungane CSC process stimulated community members, user committees and frontline service providers to hold meetings outside of the Tuungane-facilitated scorecard process, where they further explored issues like teacher absenteeism and teaching practices, and negotiated mutually agreed solutions.

Example of increased access to services

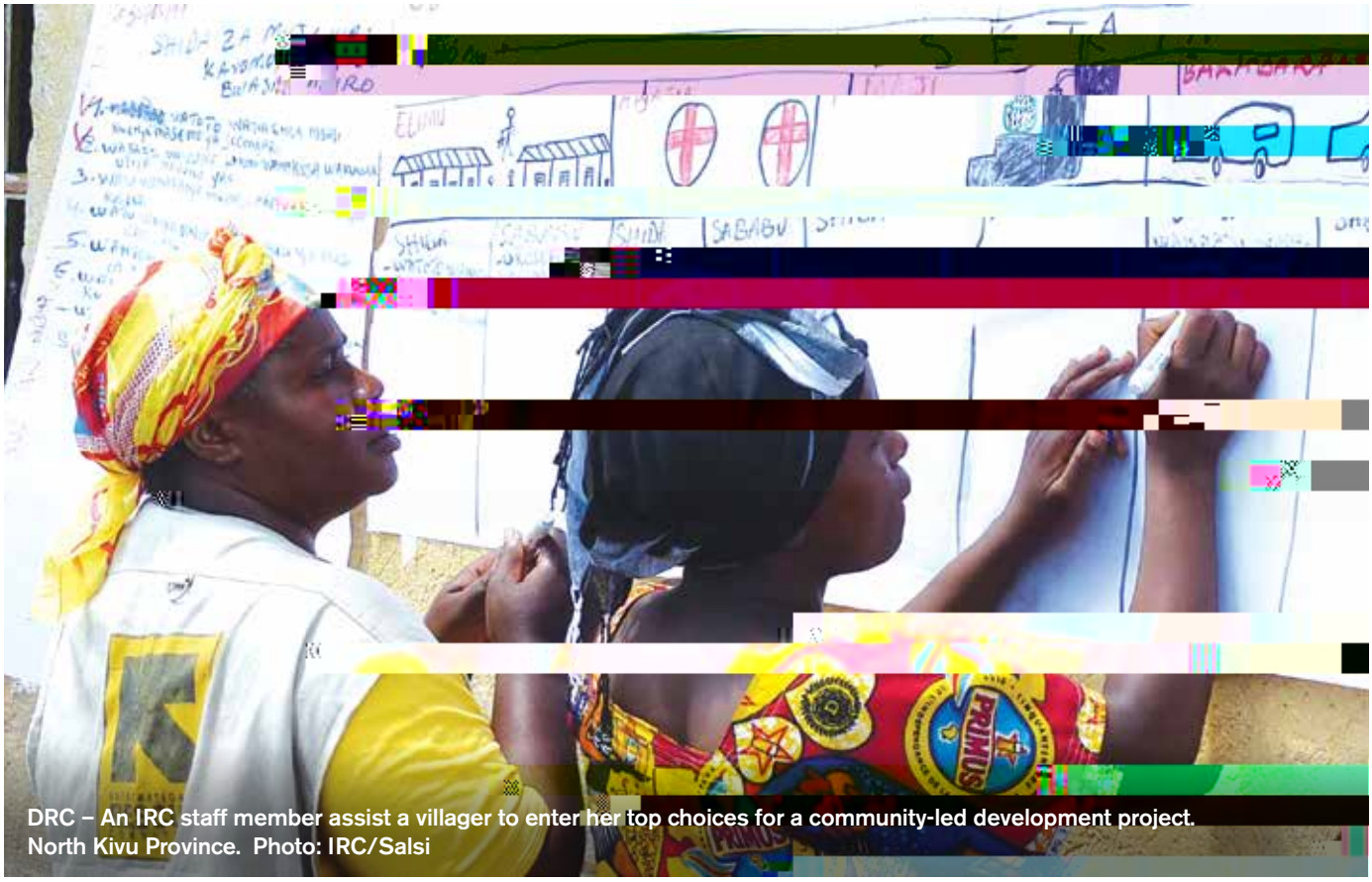


For example, figure 1 below illustrates the distribution of scores at the time of the initial scorecard and of the first review for one of the four standard indicators: access to education services.

Table 2. Quality of health services scores, progress from initial to first review

	# of communities	%
Up	21	47
Same	22	49
Down	2	4
Total	**45**	**100**

In light of the scores and improvement in scores presented presented in this paper, it is important to note that, like the stories of change collected through the MSC technique, scores given by community members and service providers for each of the performance indicators are based on their own perceptions of change, rather than on objective data (e.g. attendance/utilization rates as recorded in official records, fees as actually paid by service users, etc.). A complementary analysis of the information contained in the input tracking matrix, together with a longitudinal analysis of routine data collected in each facility would provide a richer picture of the contribution of the CSC approach to change in quality and access to services.



DRC – An IRC staff member assist a villager to enter her top choices for a community-led development project. North Kivu Province. Photo: IRC/Salsi

7. Implementation considerations

The Tuungane experience has been rich in lessons about the implementation of a community scorecard approach at scale.

Contextually adaptable methodology: The large number of sites and staff involved in implementing the scorecard led the program to adopt a standard set of implementation protocols. While this approach ensured that minimal standards for quality were respected, it did not allow program staff to fully embrace local dynamics and sufficiently tailor the scorecard process to the context of each community.

The uniform manner with which the CSC was

Cost and time requirements: To facilitate its full implementation (steps 1 through 10), the scorecard approach required two staff members each dedicating fifteen days of labor (over the 12-15 months of the project cycle) in each community. This represents a considerable staff investment given the scale at which the scorecard was implemented (in over 700 communities). At the time of program design, it was not anticipated that more than 70% of the communities would choose either education or health as a priority sector, and therefore would implement the community scorecard. As a result, the IRC greatly underestimated the financial, human and material resources needed to support the scorecard process.

Champions of change: The CSC approach inevitably challenged local power dynamics and had the potential to trigger conflict among local actors. It therefore required highly skilled facilitation on the part of program staff as well as VDC members. The Tuungane coordination team, in addition to providing standard training to all staff and VDC members on the CSC process (over approximately three to five days), made the decision to invest in a small team of experienced staff who could be deployed across program sites to reinforce the facilitation skills of their colleagues by providing on-the-job support. These 'champions of change' played a critical role in the successful implementation of the scorecard activities and ensured that certain community members were not at risk of victimization by powerful interests.

Monitoring and Evaluation: Given the experimental nature of many community scorecard interventions, particular attention should be paid to monitoring and evaluation, particularly at the design phase. It is important to invest in developing a theory of change and identifying progress markers or performance indicators which can be tracked over the lifetime of the intervention. By building opportunities for learning about the changes elicited by these initiatives, the pathways through which they occur and the

8. Conclusion

[i] See among others: Malena, C., Forster, R., & Singh, J. (2004). Social Accountability: An introduction to the concept and emerging practice. Social Development Papers Participation and Civic Engagement. Paper no. 76. and Wild, L. & Harris, D. (2012). More than just 'demand': Malawi's

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