THE WORLD BANK

SOCIAL DEVELOPMENT NOTES

PARTICIPATION & CIVIC ENGAGEMENT

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The Community Score Card Process in Gambia

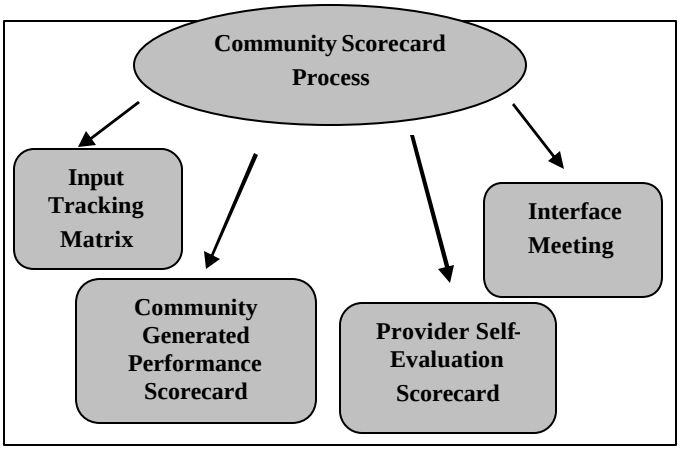
Monitoring and evaluating the effectiveness of poverty strategies are critical elements in the efforts to achieve sustainable and equitable development. Under its Poverty Reduction Strategic Papers (PRSP), Gambia has outlined its commitment to promoting accountability, transparency and effectiveness through broad-based community participation in monitoring and evaluation. In line with its broad development objectives, the government of Gambia, in collaboration with the Participation and Civic Engagement group of Social Development Department, developed the ***Accountability and Participatory Monitoring and Evaluation Program,*** *which seeks to broaden citizens' capacity, create opportunity for citizens' participation and feedback on the quality, adequacy and efficiency of key services largely through the* ***Community Score Card (CSC) process.***

WHAT IS A COMMUNITY SCORE CARD?

Community Score Card (CSC) is a community based monitoring tool - a hybrid of the techniques of social audit, community monitoring and citizen report cards. It has a strong focus on empowerment and accountability as it includes an interface meeting between service providers and the community that allows for immediate feedback on quality and adequacy of services provided in the community. The CSC is also used for:

- tracking inputs or expenditures
- generation of benchmark performance criteria used by communities and service providers to assess their services
- monitoring the quality of services over time
- comparison of performance across facilities/districts
- generating feedback mechanism between providers and users
- strengthening citizen voice and community empowerment

Four Components of the CSC Process



KEY ACTIVITIES OF THE CSC PROCESS IN GAMBIA

The CSC pilot project in Gambia was carried out in two priority sectors of the PRSP – health and education. Approximately 3,500 stakeholders participated in the process at the community level alone, including teachers, pupils, health workers and community members. The CSC process entailed the following activities.

Phase 1: National Orientation /Awareness Creation and Training

Stage		Activities
1	National workshop	• Introduced stakeholders to the CSC process • Trained development practitioners on elements and methodology of participatory monitoring and community score card • Field practice of the CSC methodology in Serekunda Health Center and Mohammendan lower basic school
2	Refresher Trainers	Trained trainers to conduct training for facilitators at the divisional level on techniques of the CSC process
3	Step-down training	Trained targeted facilitators at the divisional and community levels on the CSC process and methodology, and to plan for the field exercise.

Phase 2: Community Score Card Piloting

Stage		Activities
1	Selection of facilities	59 education and 15 health facilities were selected across the six main divisions in the country for the pilot program
Community Score Card Process		
2	Community Mobilization and Sensitization	▪ Facilitators organized the community and service providers through facility heads and community or traditional leaders ▪ Preliminary session of both services providers and users or beneficiaries was held to discuss the CSC objectives, methodology, significance and expectations
3	Input Tracking	▪ Facilitators determined with service providers the government entitlements for each facility ▪ Both service providers and beneficiaries discussed facility entitlements, and completed input tracking matrix –comparing expected amenities with what were actually provided
4	Community Performance Scorecard	Beneficiaries or the community developed facility performance assessment indicators and used the group generated and standard indicators to evaluate the adequacy of amenities in the health and education facilities
5	Service Providers Self Evaluation	By way of performance assessment, service providers evaluated their own performance using standard and group generated indicators
6	Interface Meeting (a conference meeting of both service providers and users or beneficiaries)	▪ Performance assessments and observations of each focus group were methodically discussed ▪ Problems inhibiting quality performance in the facilities were collated and harmonized ▪ Recommendations and feedback to service providers were proposed ▪ Action plans were mutually developed
7	Advocacy and dissemination	Project completion report will be widely published and a National workshop on the CSC report will beheld to elicit stakeholders feedback, and plans will be devised to institutionalize the CSC methodology

FINDINGS: EDUCATION FACILITY

Standard and Group Generated Indicator

Standard Indicators	Group Generated Indicators			Observations
	Pupils	Staff	Parents	**Pupils** favored amenities that create a conducive atmosphere for physical and academic development. **Teachers** believed in factors that enhance quality performance of teachers and pupils. **Parents** were much more concerned with the safety and academic performance of their wards.
Availability of Teachers	Food program	Teachers housing	Clean Environment	
Availability of Furniture	Transportation	Discipline	Discipline	
Availability of Learning materials	Teaching materials	Learning materials	Learning materials	
Availability of Toilet facilities	Teachers attendance	Toilet facilities	Health Services	
	Punctuality	Physical infrastructure	Good administration	

Satisfaction with Primary Education Services in the Six Divisions – Central River, North Bank, Upper River, Lower River, Western and Kanifing Metropolitan Council: Analysis of the Survey data indicated that:

- Teachers received more than 70% approval rating in all regions except KMC (an urban area and more likely to attract more pupils than available teachers).
- School facilities - furniture, core text books and toilets ranked below 40% in each region.
- Toilet facilities are either non- existent inadequate or appalling in NB, URD, LRD and WD

Recommendations for Improving Performance in Education Facilities

- Parents and school administration must lobby the ministry of education to ensure timely and adequate supply of the needed materials
- Pool resources together and repair broken chairs, benches and tables
- Bind torn textbooks with hardcover
- Collaborate and provide new toilet fiacilties in the schools and inprove the quality of the existing ones
- Create parent teacher associations (PTAs) in communties where they do not exist and support dormant PTAs to become effective
- Establish and implement a reward program for teachers in order to attract and retain qualifiied teachers
- Ensure that the CSC process is institutionalized, and implement the recommendations for improving education facilites at the grassroots level in an accelerated manner.

FINDINGS: HEALTH FACILITY

Standard and Group Generated Indicators

Standard Indicators	Group Generated Indicators		Observations
	Staff	Community/ patients	Both health workers and patients/communities favored health performance indicators that facilitate quality and effective service delivery. Beyond these, however, service providers would want conditions that enhance capacity and convenience to deliver service to be included in the performance indicators.
Staff	Running water	Standard infrastructure	
Ambulance	Electricity supply	Electricity supply	
Drugs	Clean environment	Clean environment	
Essential equipments	Furniture	Staff accommodation	

Satisfaction with Health Services in the Six Divisions – Central River, North Bank, Upper River, Lower River, Western and Kanifing Metropolitan Council

The overall level of satisfaction with the adequacy of health facilities was not vastly different compared with performance assessment for education.

- The survey indicated weak staff capacity with less than 30% satisfactory rating of adequacy of staff at health facilities across the regions.
- Availability of essential equipment received less than 15% satisfactory rating in all regions except KMC. It was recognized that lack of regular supply of electricity and water affects the provision of essential equipment. For instance, about 40% of the health facilities involved in the CSC process did not have regular supply of electricity, 20% relied on solar panel for energy and 40% used generator-supplied energy. These provisional sources of energy have inherent limited capacity and high maintenance cost.
- Although the overall rating for availability of drugs was fairly encouraging (40% overall), the community felt that drugs were almost always in short supply except essential drugs like anti-malaria drugs which were available during malaria season.
- About 69% of the health services surveyed had at least one ambulance although about 30% of them were in deplorable condition. Availability of ambulance, therefore, received the highest rating in CRD, NBD, and LRD but zero percent rating in KMC.

Recommendations for Improving Performance in Health Facilities

- Establish a health committee representing the community, and health staff should develop strategies and rules for enhancing efficient and effective health services delivery in the community
- Health Committee should ensure government meets entitlement packages including adequate supply of drugs, water, electricity, equipment, training and supply of health workers
- Health Committee should champion an agenda for promoting cleanliness and clean habit in and around health centers
- Establish a health supplemental funding program to ease reliance on government support (inadequate and unpredictable government flows have affected the quality of services provided in the hospital). In a few communities, individuals took the initiative and made voluntary contributions to help repair broken facilities in the clinic.

Lessons Learned and Corresponding Recommendations	
Community Empowerment: One of the important lessons learned in the implementation of the CSC was the role of the interface meeting between service users and providers to empower the community, through immediate feedback and mutually developed action plans.	This notwithstanding, an evaluation of participants perceptions on the entire CSC process, using post program evaluation questionnaire would have provided a fairly elaborate information on the general acceptability of the methodology.
Community Participation: The CSC Process enabled maximum participation of a wide range of stakeholders from various towns and villages. More than 55 development practitioners took part in the national refresher training and about 3,500 participants were involved in the CSC process at the community level.	An extensive community focused program of this kind requires adequate time for consultation and sensitization. Participants indicated that an extended time for sensitization would have been appropriate.
Self-help spirit: The CSC process revived the self-help spirit among communities expressed largely through individual voluntary financial contributions, and the emphasis on community roles in addressing majority of the problems confronting facilities in the community.	Importance of information sharing, dissemination of project outcomes, advocacy efforts and planning for how to institutionalize CSC and social accountability processes at community level would further resonate with community driven initiatives in addressing development problems.
Awareness Creation: Community members were enlightened about expected quantity and quality of selected services in the their communities	Institutionalization of the CSC process would be critical in opening opportunities for community members to express grievances about the quality of services provided
The Scope of the CSC Process: The CSC project was ambitious in terms of coverage. Though a pilot program, it expanded across the entire country involving 59 education facilities and 15 health services.	Though nation wide coverage was laudable, the program's scope ought to be considered in the context of available resources and capacity. For example, the scale of the exercise presented challenges which could be revisited, including balancing a focus on the use of the CSC as a data management tool versus an empowerment process.
The CSC Focus: Performance indicators were focused more on measuring quantity and less on quality and output of the facilities	Measuring adequacy of services is important, but a CSC process that is designed to measure both quality and adequacy of services would fairly reflect community preferences in identifying performance targets.
Data Management and Analysis: Data management and analysis posed a challenge for the CSC resulting in some delays in producing survey results.	Making adequate provision for capacity and resource needs for data management and analysis would greatly enhance the CSC process. Quality training at the beginning of exercise and close supervision throughout the CSC exercise ought to be considered.

General Observations on the Community Score Card Process in Gambia

- There was strong support for the CSC methodology and recommendation for the tool to be nurtured for fostering community empowerment and participation at the local level.
- The CSC process succeeded in extracting community grievances about the quality and adequacy of health and education services at the community level.
- The process created a great deal of awareness on the relevance of CRC and empowered the community to appreciate its value.
- The pilot project revealed that both service providers and the community were adequately informed about the nature and scope of their education and health needs.[•]

[•] This note was prepared by Gabriel Dedu and Gibwa Kajubi of the Participation and Civic Engagement Group of the Social Development Department. For more information on Social Accountability and Participatory Monitoring and Evaluation, visit http://www.worldbank.org/participation. Additional copies can also be requested via e-mail: socialdev@worldbank.org