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Accountability in Local Service Delivery The Tuungane Community Scorecard Approach



Policy and Practice Briefing Paper
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May 2015



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Cover Photo: DRC - Village members discuss ideas for improving services in their community
- North Kivu. Photo: IRC/Wade

Acknowledgements



There are many people who deserve acknowledgement for their role in the development of this briefing paper. The paper was written primarily by Guillaume Labrecque with the support of Isatou Batonon – IRC Technical Advisors for Governance; however it was also the collective endeavor of the Governance and Rights Unit with many staff members contributing to the final product. Huge thanks must go to all the IRC staff of the Tuungane project in Democratic Republic of the Congo. A very special word of appreciation must go to the UK's Department for International Development (DFID) who have provided exclusive support to the Tuungane project since 2007.

Executive Summary

- Community scorecards are often conceived as a tool to exact greater accountability and responsiveness from services providers, as well as being a strong instrument for community empowerment. However, little is known about the impact of this type of social accountability tool, and even less so in conflict-affected and fragile contexts like that of eastern Congo.
- This brief attempts to capture one such effort to better understand the community scorecard by describing its methodology and sharing learning emerging from the Most Significant Change (MSC) technique and monitoring data, thereby contributing to IRC's commitment to pilot, test and modify its social accountability interventions to find the best and most cost-effective ways of improving service delivery and development outcomes through governance-related interventions.
- Since 2007, the IRC, in partnership with CARE, has implemented a Community-Driven Reconstruction (CDR) program in more than one thousand communities in eastern Congo. In 2010, the program entered its second phase and has strengthened and built on its community-driven approaches by fostering greater linkages between communities, frontline service providers, line ministries and nascent decentralized local government structures.
- These linkages are fostered, in part, through the implementation of a community scorecard (CSC) which aims to build the capacities of service users and providers to analyze and monitor service delivery, and to create spaces for constructive engagement to improve basic service provision.
- The Tuungane CSC approach is structured around four building blocks: (1) input tracking matrix, (2) community generated performance scorecard, (3) service provider self-evaluation scorecard, and (4) interface meeting. Each of these components contributes to the development of a joint service improvement plan (JSIP), which represents a key output of this process.
- The Tuungane CSC unfolds in ten steps: (1) training on the CSC process, (2) data collection on the priority service sector, (3) elaboration of the community generated performance scorecard, (4) elaboration of the service provider self-evaluation scorecard, (5) interface meeting between service users and service providers, (6) development of the joint service improvement plan (JSIP), (7) community endorsement and implementation of the JSIP, (8) first review of the scorecard and the JSIP, (9) second review of the scorecard and the JSIP, (10) meeting with local authorities to present progress on the JSIP and secure ongoing support.
- Stories of change collected using the MSC technique suggest that **the scorecard process contributes to better service delivery through improvements in the management, access and quality of services**. Program stakeholders attribute these changes to the increased involvement of health and education user committees in the management of the service, improvements in staff attendance and technical capacities and a reduction in barriers to accessing services. The stories also suggest that **change is happening through a variety of mechanisms, including through individual leadership, collective action and public pressure**. Overall, these changes are supported by scorecard performance indicator monitoring data which suggests that **community members perceive improvements in the quality and access to services following the introduction of the CSC process**.
- The Tuungane scorecard experience highlights the challenges of implementing a social accountability tool of this type at scale, particularly in terms of adopting a contextually adaptable methodology and the cost, time and facilitation skills required.
- Careful consideration should also be given to the monitoring and evaluation framework given the experimental nature of many community scorecard interventions. The use of the MSC technique has a lot of potential to provide critical information about stakeholders' perceptions of change pathways. However, this approach needs to be coupled with other sources of objective data about service delivery performance to allow program implementers to learn and better position themselves when designing and monitoring future scorecard interventions.

Keywords: Community Scorecard, Community-Driven Reconstruction, Tuungane, Democratic Republic of the Congo, Service Delivery, Most Significant Change, Theory of Change, Social Accountability.

1. Introduction



DRC - Community members in Haut-Katanga design their community scorecard. Photo: IRC

Community scorecards are often conceived, within academic and International Non Governmental Organization (INGO) literatureⁱ, 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 tool¹, 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, to begin to point unequivocally to overall patterns or to draw higher-order conclusions”ⁱⁱ.

This brief attempts to capture one such effort to better understand a community scorecard intervention by documenting the methodology as well as presenting the learning emerging from the monitoring data.

¹ Social accountability or citizen-led accountability refers to how key duty bearers (service providers and policy-makers) can be held accountable for the delivery of quality services to citizens/service users through engagement of the latter with the service delivery system. It is seen as a way of complementing system-led internal and external accountability mechanisms aimed at strengthening service delivery performance and outcomes.

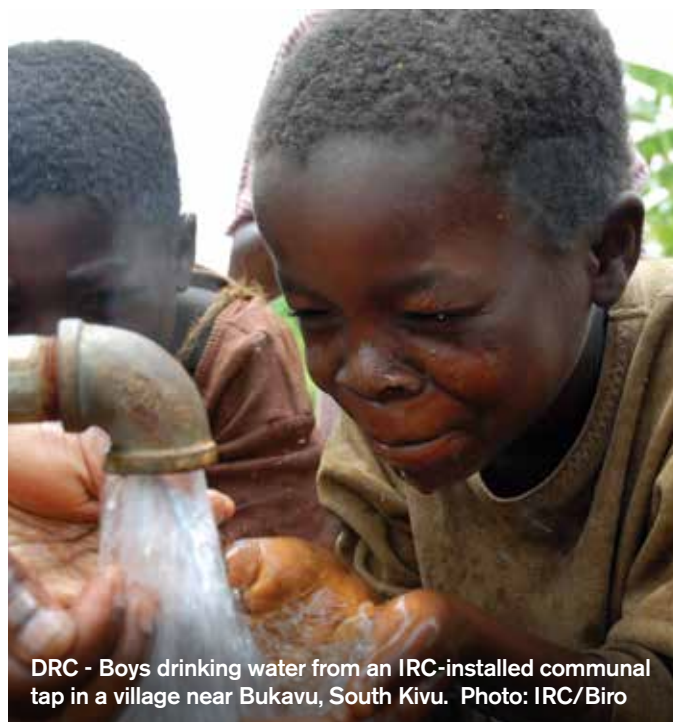
2. Tuungane - A community-driven reconstruction program

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 irregularly² – 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^x 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



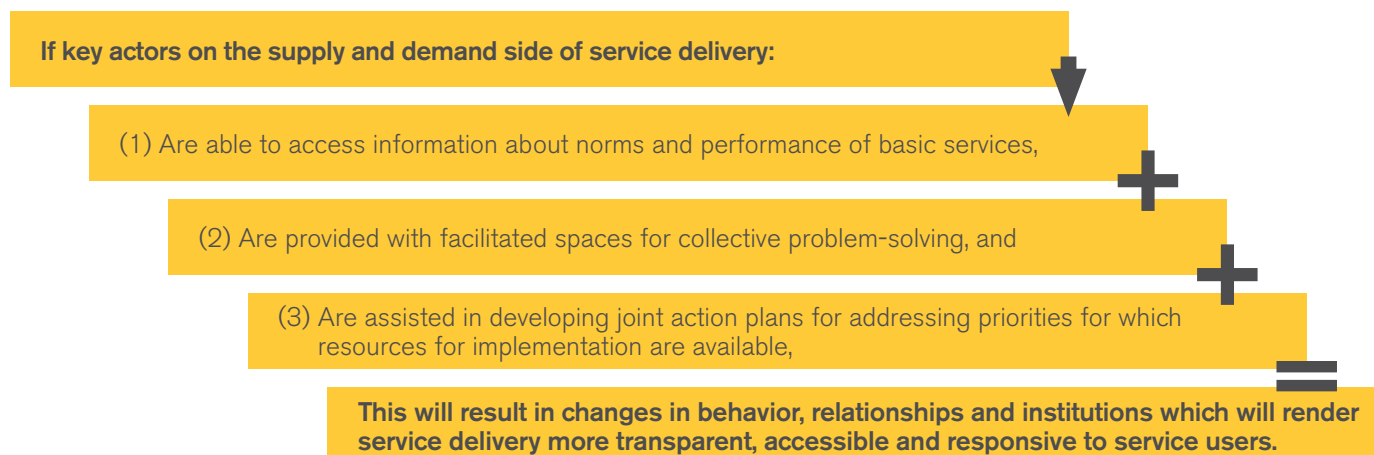
The community scorecard is one of many community-based monitoring tools and has been used for multiple purposes in a variety of contexts.³ The Tuungane community scorecard (CSC) is seen as a way of empowering community members as service users, and supporting their constructive engagement with local 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 World Bank. While the majority of applications have involved monitoring of basic service delivery in health and education (such as in India, Uganda and Zambia), others have focused on local government accountability (Zimbabwe) and monitoring and evaluating the effectiveness of poverty reduction strategies (The Gambia). The IRC is the first organization in eastern Congo to implement the community scorecard approach at scale.

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 context⁴. 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.

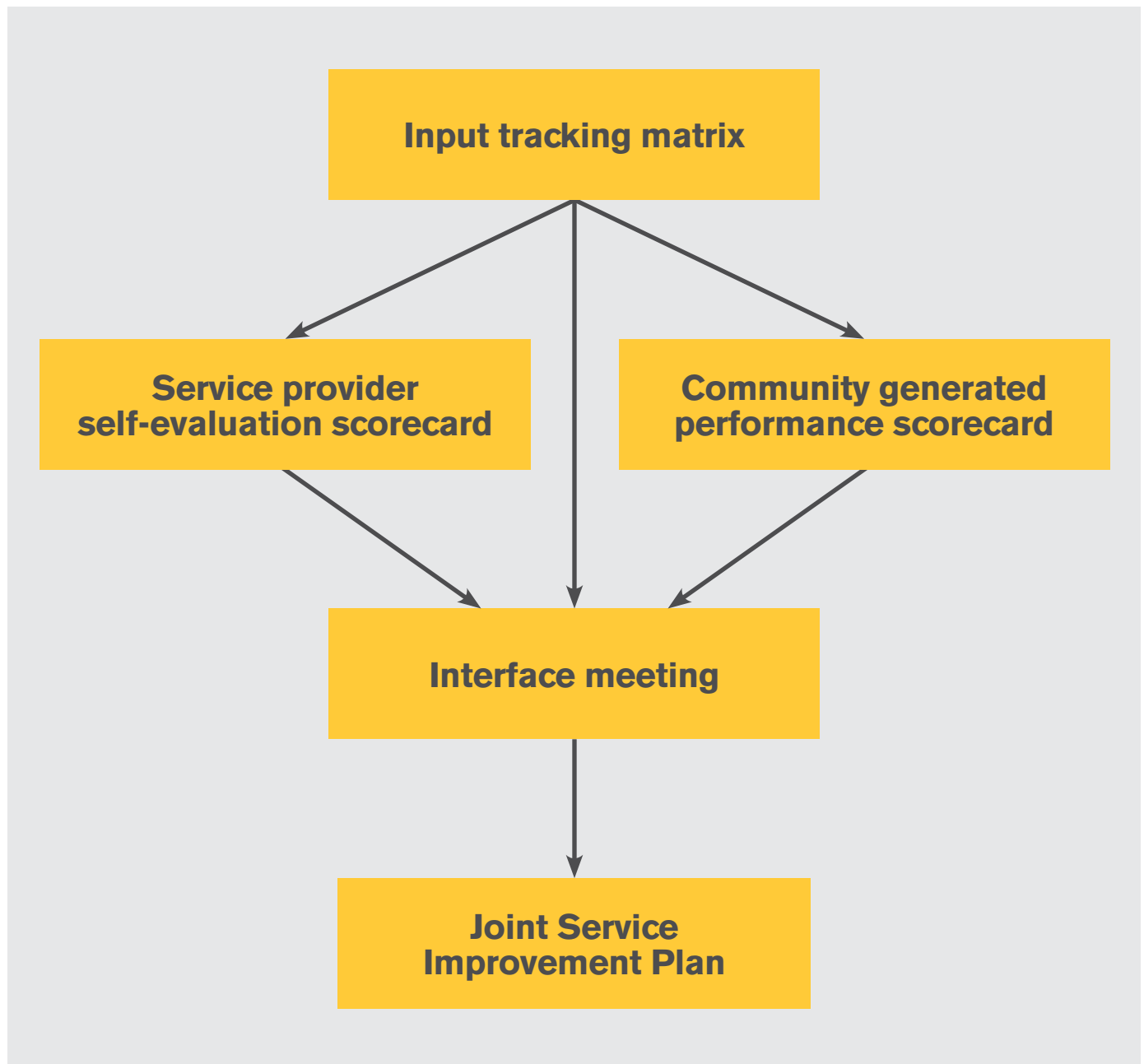
Ultimately, the contextual factors and the theory of change presented above have guided both the design of the Tuungane CSC methodology and its monitoring framework. The following sections present the Tuungane scorecard methodology and some of the learning emerging from the monitoring data.

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.

5. Tuungane community scorecard methodology

The Tuungane CSC approach is structured around four main building blocks: (1) input tracking matrix, (2) community generated performance scorecard, (3) service provider self-evaluation scorecard, and (4) interface meeting.

The figure below illustrates how each of these components contributes to the elaboration of a joint service improvement plan (JSIP), which represents a key output of this process.



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 standards⁵ 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 sector⁶). 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

Indicator	Score					Reason	Solution
	Very Bad 	Bad 	OK 	Good 	Very good 		
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

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.

Example of a Joint Service Improvement Plan in the Health Sector

Problem	What (Action / Task)	Who (Responsible)	When (Deadline)	How (Resources required)
Insufficient numbers of nurses	Advocate to Health Zone personnel for more staff	User Committee in collaboration with the Head Nurse	Within 3 months	Tuongane funds for travel
User committee nonexistent	Election of a user committee	Village Development Committee	Within 3 months	No resources required
Nurses share confidential information	Sensitizing nurses on the importance of confidentiality	Head Nurse	Within the next week	No resources required
No birthing room	Build an additional room for deliveries	Village Development Committee	In the next 6 months	Tuongane funds, community contribution

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.

Step 8: First Review of the Scorecard and JSIP

Mid-way through the Tuungane project cycle, community members and service providers are supported to review the scorecard by repeating steps 2 to 7. They are able to update the input tracking matrix, revisit the performance indicators and scores, and determine whether or not there have been any improvements to the service or any new problems have arisen. The progress made on the JSIP is also discussed, and if needed adjustments are made. This first review is co-facilitated by Tuungane staff and VDC members.



DRC – A woman celebrates her election to represent her community in the Ndekemanga Village Development Committee - Kailo, Maniema Province. Photo: IRC/Quina

Step 9: Second Review of the Scorecard and JSIP

At the end of the Tuungane project cycle, VDC members facilitate a similar process as described in step 8. However, instead of being co-facilitated by the Tuungane staff, this second review is exclusively led by VDC members.

The objective of the second review is to gauge progress in the quality of and access to basic services in the priority sector and encourage ownership of the CSC process. It also represents an opportunity to ensure that most actions in the JSIP have been completed, and to determine any follow up actions required to further improve local service delivery.

Step 10: Meeting with local authorities to present progress on JSIP and secure ongoing support

A few weeks after the second review of the scorecard, VDC representatives from multiple communities come together to present their respective JSIPs to local line ministries and local officials. During the meeting, VDC representatives highlight outstanding needs that require external or higher-level support. Local authorities are encouraged to commit, in writing, to providing financial, material and/or human resources to support the realization of the JSIPs.

This meeting represents a space for communities to advocate for continued support from local line ministries and decentralized authorities beyond the duration of Tuungane project support. It also gives local line ministries and local government officials an opportunity to better understand the problems faced by their constituents, and perhaps include actions from the JSIPs in their own development/action plans. Following this meeting, the VDCs are encouraged to follow-up on commitments made by local authorities to ensure that they lead to concrete action.

6. Learning from monitoring data



DRC - Community representatives transparently report to their community. Walungu, South Kivu. Photo: IRC/Quina

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 tool⁷, 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 users⁸, 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 richer pathways of change than stories collected during the first phase. This is mainly due to a better understanding of the tool by program staff and the use of a refined data collection methodology in the second phase.

⁷ The Most Significant Change technique involves the collection of stories of change that are significant to a variety of stakeholders (program participants, program staff, etc.). These are stories of change that are, according to program stakeholders, caused by the intervention. Through an iterative consultative process, most significant stories of change are selected and discussed in order to bring their attention to the impact of the program. For more information on this technique, please refer to Rick Davies and Jess Dart (2005) *The Most Significant Change (MSC) Technique: A Guide to Its Use*.

⁸ Direct service users interviewed as part of the MSC initiatives did not hold another status (e.g. service providers, user committee members, VDC members and/or community leaders). While a community leader is also a direct service user, through this initiative, service users are only service users, and do not hold a second status.



DRC - Village members meet to discuss improving services in their community in North Kivu. Photo: IRC/Wade

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

“ Since the creation of the health center, the user committee existed in name only. The members knew nothing about their roles. They were even afraid of approaching the head nurse to share complaints from the community, or even to ask about the status of the medical supplies. Worse, no one had the courage to ask how the center operated. So everything was done without the knowledge of the user committee, and it was the private domain of the head nurse and his nurses. For the head nurse, the data collected on the sector raised his awareness of the lack of involvement of the user committee in the management of the health center. For the president and other members of the user committee, they realized through the community scorecard process that they were not very active, even during the interface meeting. That is why the president organized a meeting to be coached and take on more leadership. Since then, user committee members play their roles easily, they work closely with the health staff, they are also available to respond to complaints from the community and to raise these at the health center.”

(Health Service Provider, Katanga)

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

“*The situation of our health center before was really catastrophic mainly because there was a very high user fee for receiving healthcare services. This was due to the fact that the management of the health center was done exclusively by the head nurse. He, with his staff, did what they wanted. This is what has been done to resolve this situation: we, members of the user committee, with the VDC members, have organized a meeting with the frontline service providers to discuss a reduction in the healthcare cost. The head nurse told us that it is very difficult to reduce user fees, and yet most nurses are not registered by the State. Our resolution to this meeting was to send a correspondence to the health zone. The letter was signed by the president of the VDC and user committee members, as well as the head nurse and the local authority (Village Chief). In the letter, all the difficulties of the health center which could be addressed by the health zone were presented, among others the construction of a nutrition center, the lack of registration of nurses by the State, and the lack of medical supplies. After the change, user fees were significantly reduced to approximately 0.5 USD for a child, and approximately 1 USD for an adult.*”

(Health User Committee member, South Kivu)

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.



DRC - Community members present their scorecard in Kalehe, South Kivu. Photo: IRC

These three examples illustrate some of the changes that program stakeholders attribute to the Tuungane community scorecard process, as well as some of the factors contributing to these changes. Most stories report a change in the relationship between service users, their representatives and frontline service providers. They offer examples of service users and their representatives applying pressure on their frontline service providers, service users and service providers acting collectively to bring about change and individual community members, local authorities (Village Head) and service providers (Head Nurses and School Directors) taking initiatives to improve service delivery in the face of new information.

Example of increased access to services

“ Before this change happened, teachers taught classes without following the methodology. They also did not prepare before a class, and when teaching, they did not follow time allotted for each subject. They often came late, and when they showed up, they spent a lot of time talking about random subjects not linked to the educational program. The reasons that can explain the change in their behavior are the different awareness-raising efforts carried out by the user committee on the need to make the school more effective, the sensitization of teachers about their professional responsibilities, and also the oversight of teachers by the school principal. There was also greater awareness among teachers themselves. Moreover, the school principal constantly reminds us of the need to change our behavior. In various meetings, he told us how to improve our teaching methodology (that is to say, according to current education recommendations) – thanks to the training received by Tuungane. Now, there is order at the school and teachers respect the hours of service. There are morning sessions at school for pupils. The success rate of pupils has encouraged some parents to send more children to school, which resulted in an increase in the number of students which in turn resulted in improved salary payment of teachers.”

(Teacher, South Kivu)

Monitoring of Scorecard Performance Indicators

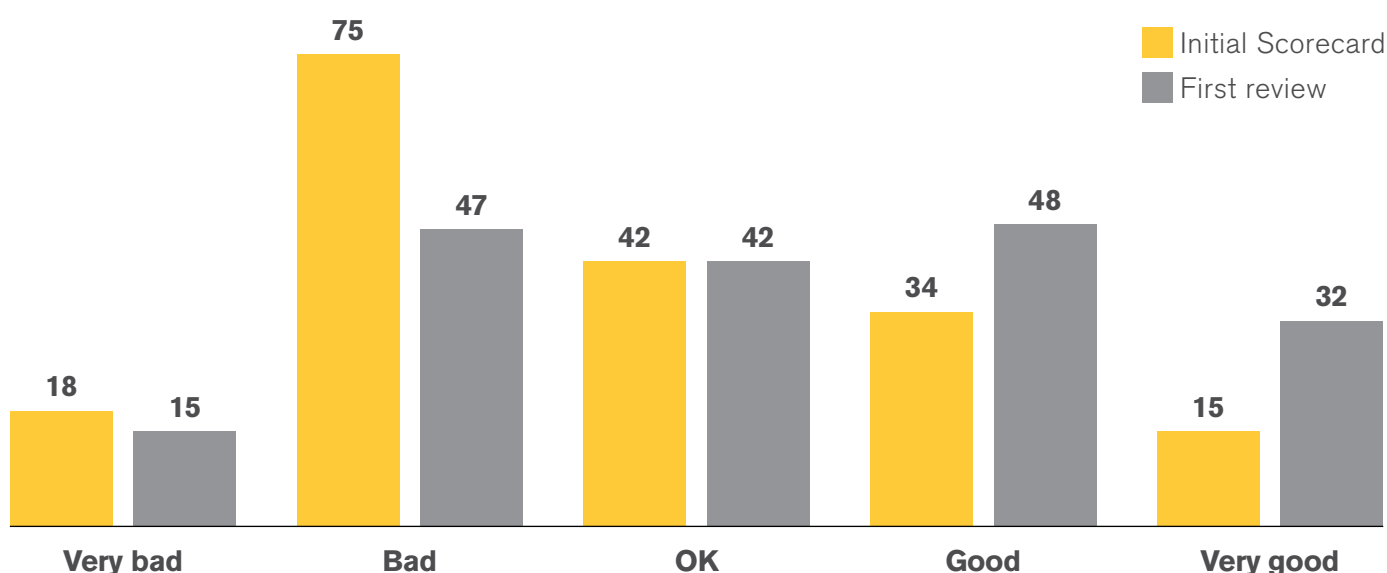
In addition to monitoring the CSC process using the MSC technique, aggregated scores given by community members for each of the four standard performance indicators are also monitored. By the end of March 2014, all the communities had completed the initial scorecard process (step 2-7) but only 229 out of 719 communities (32%) had conducted the first review of their community scorecards (step 8). As a result, there is a limited amount of data available to illustrate changes in performance indicator scores at the time of writing this brief.

Nonetheless, it is possible to illustrate some of the changes in perception resulting from the CSC process by analyzing the data set of communities that have conducted the initial scorecard process and also completed their first review (229 communities, respectively 184 communities in the education sector and 45 communities in the health sector).

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. Approximately 51% of communities choosing education (93 out of 184) initially considered access to education services as bad or very bad, and 27% (49 out of 184) as good or very good.

At the time of the review, only 34% (62 out of 184) considered education services as bad or very bad, and 43% (80 out of 184) considered access as good or very good. This suggests that service users generally perceive an improvement in the access to education services between the initial scorecard and the first review.

Figure 1. Access to education services scores, initial and first review n=184



A closer look at the data regarding the change in the scores given by each community for this indicator (up/same/down), supports this conclusion (see Table 1 on the next page). A significant proportion of communities (45%, 82 out of 184) gave a higher score during the first review than they did during the initial scorecard. It should be noted, however, that 39% (71 out of 184) gave the same scores during the initial scorecard as they did at the time of the review, suggesting that it may be too soon to see changes in access to education. However, surprisingly, 31 communities (17%) gave a lower score at the time of the review than they did initially. When asked, program staff explained that these most likely relate to cases where there was a turnover in service provider

staffing (e.g. the head teacher was replaced by a new one with lower capacities or not yet sensitized to the CSC process), where community members developed a better understanding of the indicator itself and became more self-critical when assessing the situation, or where schools were supported by other IRC/CARE programs or other organizations at the time of the initial scorecard, but not at the time of the review (e.g. closure of a program that had partly covered school fees for girls or teacher salaries and therefore had facilitated access to services). A closer look at the reasons given by community members to justify their scores would be required, combined with a thorough analysis of other contributing factors, to understand the influence of the CSC process on the improvements in scores.

Table 1. Access to education services scores, progress from initial to first review

	# of communities	%
Up	82	45
Same	71	39
Down	31	17
Total	184	100

Figure 2 below illustrates the distribution of scores at the time of the initial scorecard and of the first review for another of the four standard indicators: quality of health services. At the time of the initial scorecard a significant proportion of communities (58%, 26 out of 45) considered the quality of services as being bad or very bad.

However, at the time of the first review, a significant proportion of communities (75%) perceived the quality of services as OK (23 out of 45, 51%), good (9 out of 45, 20%) or very good (2 out of 45, 4%). There is a marked trend toward increased satisfaction with the quality of health services.

This upward shift in scores is also confirmed in table 2 on the next page. While positive changes in scores may reflect the presence of favorable external factors which supported service improvements, making it difficult to attribute them exclusively to the scorecard process, the table suggests that 47% of the communities choosing health (21 out of 45) gave a higher score at the time of the review than initially. However, the table also indicates that scores remained unchanged for 49% of communities (22 out of 45).

Figure 2. Quality of health services scores, initial and first review n=45

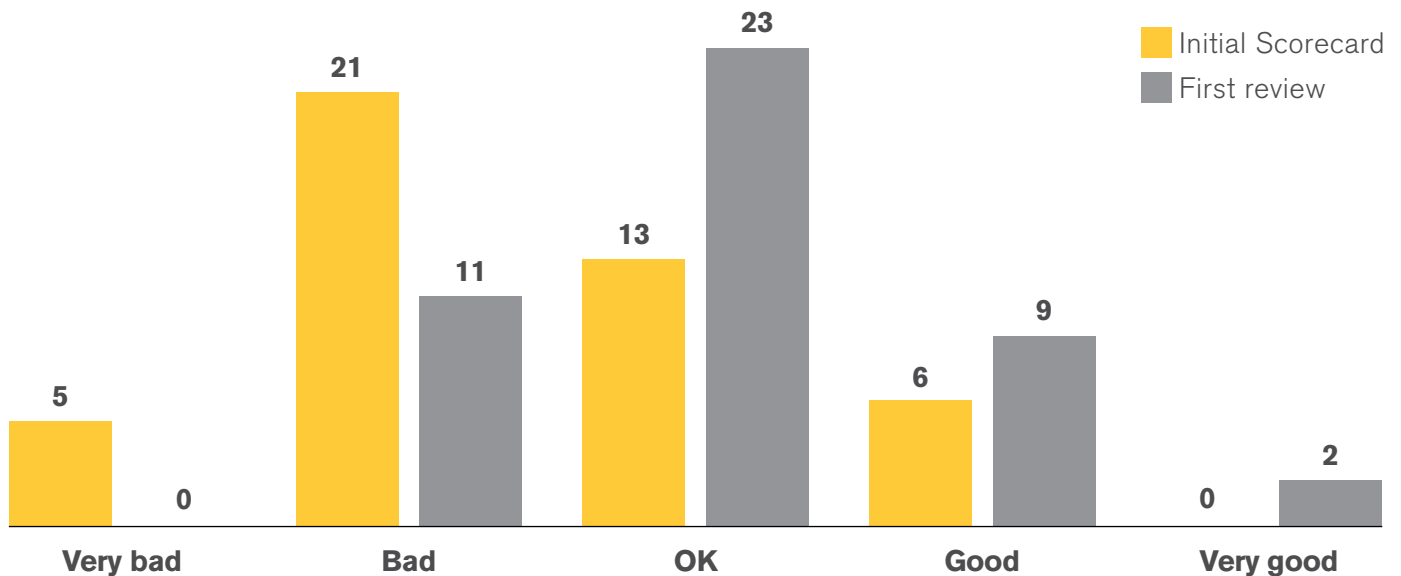


Table 2. Quality of health services scores, progress from initial to first review

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

In light of the scores and improvement in scores presented 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



DRC - Community members vote in elections for their Village Development Committee (VDC) in South Kivu. Photo: IRC

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 implemented may have resulted in missed opportunities to further strengthen relationships between users and providers of basic services. For example, religious leaders in some communities are particularly invested in service delivery issues and have considerable influence over service providers. More deliberate engagement of these stakeholders in training sessions and community meetings would have allowed program staff to leverage this influence so as to support greater responsiveness from service providers to users' demands.

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 contextual factors contributing to their success or failure, implementers are able to better understand how social accountability interventions operate and make more informed decisions regarding their scale-up and sustainability. Moreover, in order to fully explore pathways of change, it is crucial to ensure that monitoring approaches complement one another. For example, the Tuungane CSC monitoring framework has been adapted over the course of the program and now combines qualitative data – collected through the MSC technique – together with quantitative data – collected through the national health/education management information system. As a result, the program is better able to not only determine whether or not, and the extent to which, perceived changes are confirmed by other data, but also help to unpack pathways of change through which changes are likely to occur.

8. Conclusion



DRC - A community member carries building materials across a river for a Community-Driven Reconstruction project in South Kivu. Photo: IRC

Recognizing that little is known about the impact of community scorecard approaches, and even less so in conflict-affected and fragile contexts, this brief represents an attempt to explain the context in which such an approach was implemented at scale in eastern Congo, to document the underlying theory of change as well as describe the methodology and the changes it has elicited, as observed through analysis of the monitoring data available to date.

Stories of change have begun to paint a picture of the types of change, from program stakeholders' points of view, that have been elicited through the community scorecard process. Most significant are changes in people's access to services and in the way health and education user committees understand their role and engage with service providers and service users. While these remain perceptions of change, the pathways through which they are taking place have started to emerge. The stories suggest that change is happening through a variety of mechanisms, including through individual leadership, collective action and public pressure. However, this requires further investigation through the systematic collection of complementary data (e.g. performance indicator scores, input tracking matrix data and comparative analysis of longitudinal data) in order to corroborate these perceived changes and determine the extent to which the CSC process has contributed to them.

In order to continue to capitalize on the richness of the Tuungane program and its CSC approach, a second brief will be prepared and shared in 2015. This brief will further explore and analyze all monitoring data available at the end of phase 2 of Tuungane as well as use complementary sources of information to present more in-depth findings and draw further learning about the CSC process. The IRC has identified the following learning priorities with regard to the CSC: developing greater understanding of the types of improvements in service delivery that are elicited through the CSC process, understanding which CSC building blocks (input tracking, scorecard, interface, joint action plan) are most important for stimulating change, determining the mechanisms and pathways through which change is taking place and under what conditions.

Going forward, the IRC will pursue these priorities and remains committed to piloting, testing and adapting its social accountability tools and approaches to find the best and most cost-effective ways of improving service delivery and development outcomes through governance-related interventions.

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 public-service community scorecard. ODI Project Briefing. No 69.

ⁱⁱ Gaventa, J. & McGee, R. (2013). The Impact of Transparency and Accountability Initiatives. Development Policy Review. 31(S1). S22.

ⁱⁱⁱ The DRC ranked last in the 2011 Human Development Report based on its annual ranking of achievement in health, education and income.

^{iv} UNDP. (2008). Rapport National sur le Développement Humain 2008. Restauration de la paix et reconstruction.

^v Titeca, K. & de Herdt, T. (2011). Real Governance: Beyond the 'Failed State': Negotiating Education in the Democratic Republic of the Congo. African Affairs. 110(439), p.22.

^{vi} The World Bank. (2005). Education in the Democratic Republic of the Congo. Priorities and Options for Regeneration.

^{vii} The World Bank. (2005). Education in the Democratic Republic of the Congo. Priorities and Options for Regeneration.

^{viii} INEE. (2013). Democratic Republic of the Congo Report.

^{ix} Seay, L., E. (2012). After Peace: Education, Non-State Actors, and the Erosion of State Authority in the Eastern DRC. L'Afrique des Grands Lacs Annuaire 2010-2011. Gouvernement de la RDC. (2010). L'annuaire statistique de EPSP 2009-2010.

^x The World Bank. (2005). Education in the Democratic Republic of the Congo. Priorities and Options for Regeneration. p.XXIII.

^{xi} The World Bank. (2005). Democratic Republic of the Congo. Health, Nutrition and Population. A Country Status Report. p.4

^{xii} Idem. p.9



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