MINISTRY OF PLANNING AND INVESTMENT

unicef

COMMUNITY SCORECARD MANUAL

A SOCIAL AUDIT TOOL TO MONITOR THE PROGRESS OF VIET NAM'S SOCIO-ECONOMIC DEVELOPMENT PLAN

COMMUNITY SCORE CARD

Detailed methodological description, including report guidelines and feedback mechanisms1

INTRODUCTION TO COMMUNITY SCORECARDS

The community scorecard (CSC) is one of four social audit tools piloted in Viet Nam as part of an initiative by the Ministry of Planning and Investment (MPI) and the UN Children's Fund (UNICEF). It is designed to demonstrate the potential of the social audit approach in complementing existing mechanisms to plan, implement and monitor Viet Nam's Socio-Economic Development Plan (SEDP), with a focus on the SEDP's social dimensions [2]

> **Note of caution**
>
> Please note that this manual was developed as a supplement to PowerPoint presentations on CSC for training delivered to government officials and research institutes in the autumn of 2011. It is not meant to be a comprehensive training guide for trainers; rather, it provides a detailed overview on how to implement CSC.

The purpose of the initiative was to build capacity to use the social audit approach in monitoring progress ofsocial aspects of Viet Nam's SEDP in order to enhance the social performance of the plan, particularly with regard to reducing social and economic disparities and the continued improvement of living standards for Viet Nam's general population, especially vulnerable groups.

However, before providing details on how to implement a CSC, an overview of the social audit approach and its relevance to Viet Nam will be given.

The social audit approach proposed for Viet Nam

The social audit approach functions as a management and accountability mechanism that offers a range of methodologies, tools and techniques that are used to assess, understand, report on and improve the social performance of an organisation, a plan or a policy. Key features which systematically characterise the practice of social audits include a focus on stakeholder participation and accountability. The participation of rights holders ('people') and duty bearers ('government' or 'service providers') is critical for the success of a social audit. It facilitates transparency (availability and accessibility of information), knowledge generation (by bringing on board people's opinions, perceptions and experiences) and accountability (for the delivery of quality public services and policies). Strengthened transparency, participation in the decision-making process and duty bearer accountability are major conditions for the improved performance of public policy and are thus not only goods in themselves but a means to an end in improved performance. Social audits are therefore assessments not only of performance, but also of the integrity of the process that leads to the performance, and the impact of such performance.

As a pragmatic management tool in line with principles of good governance, social audits aim not only at revealing the normative 'good' but also at providing essential information and feedback for improved management decisionmaking, allocations and service delivery overall. Social performance can be measured and improved in a number of ways:

1   Methodology based on a collection of World Bank methodologies, including Akasoba and Robinson (2007); CARE Malawi (2007); (Heller and Razafimandimby (2007); Singh and Shah (2007)

2   As part of the project, in Phase 1 four social audit tools were piloted in Viet Nam: a PETS piloted in TraVinh, using Programme 167 on housing subsidies as a case, Ho Chi Minh City (HCMC) and Dien Bien provinces; Citizen Report Cards (CRCs) piloted in HCMC and Dien Bien provinces; and community score cards (CSC) and gender audits piloted in HCMC and Quang Nam provinces. In Phase 2, PETS were piloted in HCMC and Dien Bien.

- Through analysis of the degree of focus on social issues in plans and policies;

- Through analysis of the degree to which this translates into action (including the scope and quality of indicators that measure progress in stated priorities);

- Through assessment of the social impact of plans and policies; and

- Through generation of information through participatory methods that can complement existing information.

The social audit approach is particularly relevant in the current policy environment in Viet Nam, where ongoing 'DoiMoi' reforms aimed at creating a socialist-oriented market economy bring both opportunity and challenges for social policy. Policy discussion highlights a need to improve accountability and transparency and the government recognises the importance of enhanced citizen participation in policymaking and implementation. Recent decisions on planning reform in Viet Nam's SEDP for 2011–2015 reflect these priorities.

Among the key findings and lessons learned from Phase 1 of this initiative, it has been observed in a workshop that all of the piloted tools showed substantial potential as an additional means of assessing the social performance of SEDP based on the views of those to whom the programmes are directed as well as the government officials responsible for planning and assessing programme effectiveness.

The positive nature of the experience was confirmed by participants at a recent workshop on opportunities and challenges in the reform of SEDP's planning, monitoring and evaluation. They concluded that social audits are a powerful tool to collect people's feedback and assess service providers' performance, which can be an effective method for measuring the impacts of the SEDP in a more participatory and comprehensive manner. Introducing the social audit approach has been seen as a process to empower the poor and marginalised people in particular.

What is a community scorecard?

CSCs area community-level monitoring tool, where community members and service providers come together to provide feedback on service delivery. CSCs not only provide feedback on service quality but alsoinclude a dialogue process in which community members and service providers together discuss their impressions and work together to improve how services are delivered.

CSCs are targeted around specific services and so work best at a local level, where the 'community' and the service being evaluated can be fairly well defined. Services and projects that might be included in this are local health centres, local schools, administrative units or projects that have a specific target community.

In CSCs, each step takes no more than a few days,and they can even be completed in one day if required.Results are known and can be acted on immediately as well as transferred to more senior levels for aggregation,thus allowing for both improvements at the local level as well as monitoring atprovincial and national levels.
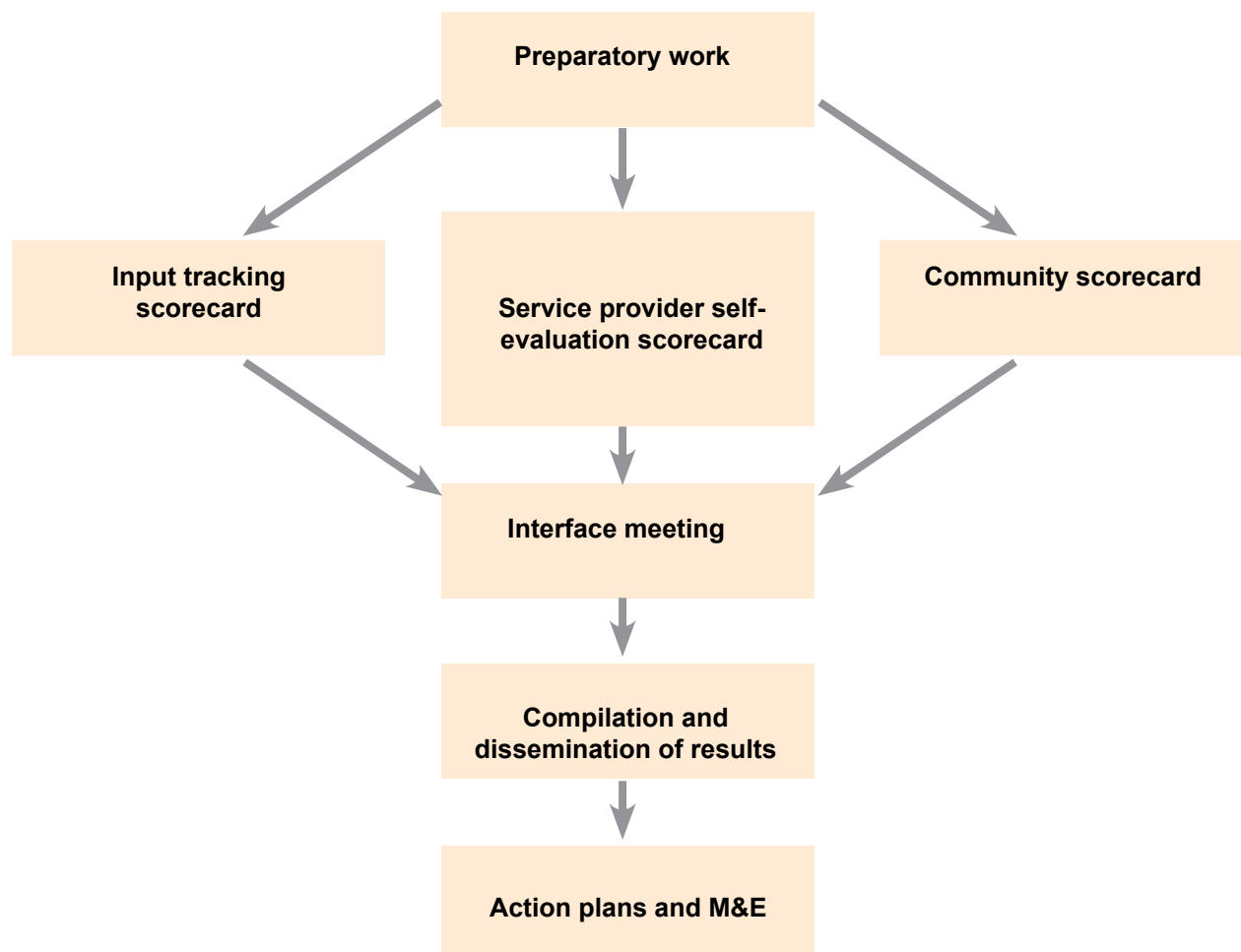
What can community scorecards be used for?

Community score cards can be used to:

1. Monitor and improvethe quality of services, facilities or projects;

2. Track inputs and expenditures (e.g. availability of drugs at a medical centre);

3. Identify community-approved 'benchmark performance criteria' for resources and budgeting decisions;

4. Compare functioning, performance and satisfaction across facilities and districts;

5. Improve feedback and accountability loops between providers and users;

6. Link CSC findings with internal management and incentive systems of ministries and service providers; and

7. Strengthen citizen voice and community empowerment – the reason for the community focus.

> *Requirements for effective community scorecards:*
>
> ● An understanding of the socio-political context of governance and the structure of public service delivery at the decentralised level;
>
> ● Technical capacity of facilitators – typically a third party group that can facilitate discussion impartially,for example personnel from a research institute;
>
> ● A strong publicity campaign to ensure maximum participation from the community (users), service providers and other stakeholders; and
>
> ● Institutional capacity to absorb and respond to

Steps in a community scorecard process

```
                          ┌─────────────────────┐
                          │   Preparatory work  │
                          └─────────────────────┘
         ┌──────────────────┐  ┌──────────────────┐  ┌──────────────────┐
         │  Input tracking  │  │ Service provider │  │ Community        │
         │    scorecard     │  │ self-evaluation  │  │ scorecard        │
         │                  │  │    scorecard     │  │                  │
         └──────────────────┘  └──────────────────┘  └──────────────────┘
                          ┌─────────────────────┐
                          │  Interface meeting  │
                          └─────────────────────┘
                          ┌─────────────────────┐
                          │  Compilation and    │
                          │ dissemination of    │
                          │     results         │
                          └─────────────────────┘
                          ┌─────────────────────┐
                          │ Action plans and M&E│
                          └─────────────────────┘
```

PREPARATORY WORK

Tasks in the preparatory work

Involvinglocal, ward and regional authorities:

> *Objectives for the preparatory work:*
>
> - To obtain government buy-in at local and higher levels;
>
> - To mobilise partners and participants;
>
> - To decide on the methodology;
>
> - To make all necessary training and logistical preparations; and
>
> - To gather data that will be used in the input tracking matrix.

- Inform them about the plans;

- Secure 'buy-in';

- Consider requesting official permission; this may be needed from provincial authorities before district officials will feel free to cooperate;

- Involve other institutions that can confer legitimacy, such as the National Fatherland Front; and

- If possible, involve these institutionsin the planning.

Definingthe level of scope,for example thedistrict, service, sector or project:

> *Important*
>
> In terms of stakeholder involvement, it is important to ensure adequate representation of both men and women in social audits so the views of both sexes are reflected in discussions and proposed solutions.

- Identify the services and facilities to be targeted and stipulate selection criteria;

- Identify the related 'community' for each service or facility;

- Identify and meet with local partners,for example local non-governmental organisations (NGOs),community-based organisations or self-help groups;

- Consider which government officials at local level need to be engaged;

- Manage expectations of the research and involve various authorities from the outset; it is valuable to provide them with detailed feedback and recommendations that maygo beyond the service providers' capacity to resolve independently.

Gathering supply-side information for input tracking:

- Meet with local authoritiesand/or departments which manage and monitor the issues in order to choose and discuss indicators for the input tracking matrix;for example, if conducting a CSC to assess the quality of healthcare services provided by ward health centres, you could meet with the Department of Health to discuss and choose indicators for the input tracking matrix. These indicators could include not only national but also local standards;

- Gather national and provincial norms and standards related to these services and inputs.

Key methodological decisions:

- How will the community be surveyed?

- Will everyone be invited or will there be a simple random sample?

- How will preliminary stratification of the community take place?

- How will communities be mobilised?

- What standard indicators will be used?

Identification andtraining of local facilitators:

- Ensure facilitators have the necessary skills and are able to probe, encourage deep thinking and summarise people's thoughts;

- Ensure facilitators understand the aims and procedures of the CSC exercise;

- Share orientation on the area, issues at stake and any essential sensitivities; and

- Ensure facilitators understand the reporting requirements.

Mobilising the community:

- Ensure participation, particularly of women, through field visits, awareness campaigns andadvocacy; and

- Consider conducting a fullcommunity meeting to explain the process.

Other logistical preparations:

- Selecting venues for focus group discussions;

- Facilitation materials (flipchart paper, markers, reporting forms, etc.);

- Identification of participants by obtaining a list of potential participants (users of the service) from the service providers or local authorities, for example a local health centre can provide a list of users or a primary school a list of families: Participants can then be randomly selected from the list.Invite participants to the focus group discussions and interface meeting.

Who will facilitate focus group discussions?

Identifying appropriate facilitators for the focus group discussions is critical.

Using facilitators from government agencies can cause hesitancy among participants and a reluctance to speak freely, even if he or she is from a 'neutral' agency not directly connected with the service provider, such as MPI.

People may feel more at ease if government officials do not participate in focus group discussions and facilitators instead come from research institutes, NGOs, local committees or community-based organisations.

In addition, staff of the service provider and other government officials should not normally be present, participating in or observing the community focus group discussions. They are, however, invited to the next stage: the interface meeting.

Case study: Organising focus group discussions –pilot CSC on community health care, HCMC, 2010

Having agreed to implement the pilot social audit tools, the People's Committee of Ho Chi Minh City appointed the Department of Planning and Investment (DPI) to be the focal point. The Project Management Unit (PMU), UNICEF and Central Institute for Economic Management (CIEM) had working sessions with DPI and agreed to select Tan Phudistrict as the site for pilot implementation of the project, with the involvement of three wards presenting different socio-economic conditions: PhuThoHoa (better-off), Tan Quy (average) and Tan Thanh (poor).

1. Selection of participating local partners: CIEM selected two local partners – one member of staff from both DPI and the Department of Health who facilitated CSC activities. These staff had previously attended CSC training courses in Ha Noi.

2. Selection of sites for implementing CSC: UNICEF and the PMU, under CIEM and MPI, selected HCMC as one of two provinces to pilot the CSC tools. MPI sent an official letter to HCMC People's Committee regarding implementation of a pilot social audit project inclusive of CSC tools to invite them to participate. The People's Committee then appointed DPI as the focal point. The PMU, UNICEF and CIEM had working sessions with DPI and selected Tan Phudistrict as the site for the pilot's implementation, with the involvement of the three wards mentioned above.

3. Selection of participants for focus group discussions: Generally, CSC processes try to achieve a gender balance. In this case, because most health station staff were women and it was impossible to know which member of the immigrant families with children under six could participate (i.e. father, mother, grandfather or grandmother),participant selection did not focus on gender but on technical aspects, that is, most of the invited participants should represent immigrant families with children under six who may or may not have used the ward's health care services. Some settlers were also invited to participate because they could express why they were not entitled or did not want to use the health care services, thereby enabling facilitators to assess for example if these groups felt they were treated differently than immigrants.

4. Focus group discussions with service users: CIEM coordinated with the ward People's Committee to make a list of potential participants (all immigrant families with children under six) and then randomly selected the group from different streets. As per the agreed criteria, the ward People's Committee made a list and sent invitation letters. Expectations were for 15 participants in each discussion (invitations were sent to 18 people to cover any non-attendance). Final participation included 13 representatives from families with children under six of which:

    •   Immigrant families: 10 people;

    •   Settlerfamilies: 3 people;

    •   Mass organisations: 2–3 people;

    •   Women's Union;

    •   Veterans' Association; and

    •   NGOs.

5. Focus group discussions with service providers: As per the agreed criteria, the ward People's Committee made a list and sent invitation letters. Expectations were again for 15 participants in each discussion (letters were sent to 18 people). The invited participants included:

    •   All health station staff, including leaders, nurses and guards, because each health station has approximately five to seven staff in total;

    •   A representative of a drugstore outside the health station;

    •   The officer in charge of health and labour in Tan Phudistrict People's Committee; and

    •   The chairperson or vice chairperson of the ward People's Committee.

INPUT TRACKING SCORECARD

Tasks and procedure for the input tracking scorecard

Before the meeting:

> **Objectives for the input tracking scorecard:**
>
> - To obtain real-time tracking of human resources and physical inputs both for government officials and for service users; and
>
> - To inform future steps in the CSC process with information on inputs.

- Compile all documents relating to norms, standards and, if applicable, documentation of what has been provided and is currently available at the facility;

- Determine a suitable time and place for focus group discussions;

- Ensure everyone involved with the service from senior staff to security and administrative staff participates

- Try to hold the input tracking scorecard activity at the same time as the service provider self-evaluation,usingthe same group of service providers as participants; and

- Prepare the first two columns of the input tracking matrix in advance.

At the meeting:

- Explain the objective;

- Explain the norms and/or standards to be evaluated;

- Fill in the remaining parts of the matrix following discussions with participants; and

- If an input exists but is not functional, do not count it as being present;if necessary, conduct a walk around the facility to verify.

> **Important**
>
> The development of the input tracking matrix requires the designer to have in-depth knowledge of the areas and/or fields under study to avoid a situation where indicators are redundant and/or inadequate. Questions must be clear and not have a double meaning.

Input tracking matrix

Input	National/regional standard	Reality	Responsible factors/ explanation	Recommendations for improvement

Example: Input tracking matrix in TienKytownship

Input	Standard	Actual	Reason for difference	Recommendations
1. Healthcare education through commune and/or village speakers	>2 times/ month	No	The town does not have the programme	Need separate programme on healthcare education
2. Organise the campaign on worm-killing medicine for children	Yes	No	Have not had medicine fortwo years	Provide medicine
3. The health station should have an aerosol machine, microscopes and simple testing machines	Enough	No	No doctors, many districts do not have doctors	Send more doctors
4. Equipment for examination and treatment in obstetrics and gynaecology, family planning, neonatal and newborn emergency child care	Enough	Not enough	Noneonatalemergencycare equipment (newborn warmlights, foetal heartbeat monitor, etc.)	Provide missing equipment
5. Equipment to implement the national health programme, blindness prevention, school oral and dental care and other school healthcare programmes	Enough	Not enough	No dental chairs or instruments to prevent blindness	Provide more
6. Equipmenttocarry out healthcommunication and educationin the community	Enough	Not enough	Amplifier available but no CD player or radio	Providemissing equipment
7. Interior furniture such as cabinets, patient beds, tables, chairs andbedsidecabinets	Enough	Not enough	No bedside cabinets, one damaged patient bed	Provide one or two beds (no room for more)
8. Doctororgeneral practitioner, midwife orobstetrician and nurse	Enough	No doctor	District does not send doctors or doctors do not want to work here	Need to send doctors

Input	Standard	Actual	Reason for difference	Recommendations
9.Health station hasfour staff; it needs staff specialising in traditional medicine	Yes	Three nurses	Not trained	Needs one trained member of staff
10. Specialised books and monthly professional meeting	Yes	One midwife	Not provided	Provide one cabinet
11. Average number of health checks	0.6 times/	No	Close proximityof district health station to the district centre	No recommendation
12. The village has health staff who are trained for at least three months (six months in Quang Nam) according to materials issued by the Ministry of Health; they must work regularly	100%	3 months 50%	Two people not trained	Cần đào tạo thêm
13. Commune People's Committee invested its budget in maintaining and repairing facilities and improving and providing equipment annually for the health stations	Yes	No	People's Committee does not have budget	
14. Public health agencies are responsible for receiving and providing timely treatment	Free	Free for patients with health insurance card	No budget	Need budget for emergency cases
15. Annual expenses of the health station is not under the minimum standard	10 million/ station/ year	8.8 million 8.8 million	State provides 11 million dong and commune health centre 8.8 million dong State provides 11 million dong and commune health centre 8.8 million dong	

Tasks and procedure for the service provider self-evaluation scorecard

Before the meeting:

- Determine a suitable time and place for the focus group discussion;you may wish to combine this meeting with the input trackingactivity; and

- Ensure everyone involved with the service from senior staff to security and administrative staff participates.

> **Objectives for the service provider self-evaluation scorecard:**
>
> • To determine how service providers evaluate the service; and
>
> • To identify opportunities for improvement.

At the meeting:

- Explain the objectives;

- Identify indicators:

  - There will be two types of indicators used – those generated by the providers and standard indicators used by everybody;

  - Ask service providers to think about what constitutesgood service for them, for example in health care, schooling, etc.;

  - Generate a list of indicators with service providers; facilitators help to narrow these down to between three and five, voting if necessary;the results are entered in the self-evaluation matrix;

  - Add any remaining standard indicators not yet identified by the providersto the matrix and explain them;

- Rate indicators:

  - Explain the voting and scoring system;

  - Where possible, service providers should try to identify objective measures for the indicators, forexample if the indicator is 'number of patients attended to' they should discuss what would constitute a score of 1 (how many patients per day?), what would constitute a score of 2 etc;these should be noted on the matrices;

  - Facilitators ask providers to rate how well their service performs on each indicator, recording resultsonpaper;

  - Perhaps ask service providers to vote on a practice indicator first, such as quality of the road to the school and/or health centre; performance of the local football team;

- ○ Tally up the scores and enter them in the matrix;

- ○ Calculate the average scores and enter these in the matrix;

- Discussion:

  - ○ Transfer the average scores to the summary scoring table;

  - ○ Once service providers have voted and scores have been recorded, facilitators guide the discussion to identify why service providers gave the scores they did and elicitsuggestions they might have for improving these conditions;

  - ○ Facilitators guide service providers towards locally practical suggestions,that is, steer away from suggestions requiring major government expenditure and instead identify causes and solutions that might be addressed locally;

  - ○ Summarise key points in the 'Reasons' and 'Recommendations for improvement' columns of the table;

- Be sure to copy and leave the original scorecardand summary table with the service providers.

QUY NHON, Viet Nam (5 June 2010). Lt. Cmdr. Laurel Christians, a family nurse practitioner assigned to the Military Sealift Command Hospital Ship USNS Mercy (T-AH 19), examines the mouth of a Vietnamese child during a pediatric evaluation supporting a Pacific Partnership 2010 medical civic action programme at the PhuocHoa Secondary School. (US Navy photo by Mass Communication Specialist 2nd Class Jon Husman.) Image courtesy of Flickr, by Official U.S. Navy Imagery.

Indicator	Number of people who gave ascore					Average score
	1 Very bad	2Bad	3Neutral	4Good	5 Very good	
Service provider indicators						
SP-1 e.g. Sanitation						
SP-2 e.g. Number of patients attended to <3 per hr = 1 (Very bad) 3–5 per hr = 2 (Bad) 6–7 per hr = 3 (Neutral) 8–10 per hr = 4 (Good) >10 per hr = 5 (Very good)						
SP-3 Attitude of staff						
SP-4etc….						
SP-5 ….						
Standard indicators						
SI-1 ….						
SI-2 ….						
SI-3 ….						

Service provider summary scoring table

Indicator	Average score	%	Reasons	Recommendations for improvement
Service provider indicators				
SP-1 e.g. Sanitation				
SP-2 e.g. Number of patients attended to				
SP-3 Attitude of staff				
SP-4etc ….				
SP-5 ….				
Standard indicators				
SI-1….				
SI-2 ….				
SI-3 ….				

Tasks and procedure for the community scorecard

COMMUNITY SCORECARD

Objectives for the community scorecard:

- To determine how various groups of users of a service evaluate it;

- To identify opportunities for improvement; and

- To empower service users with objective data to allow them to interact confidently with service providers.

Encouraging thoughtful and objective scoring:

- Before starting the scoring, lead a discussion amongcommunity members to identify objective measures for some or all of the indicators;

- Remind them you will also record reasons they give for the scores.For each indicator, they should think about those reasons before deciding on a score; and

- Remind them that truthful, objective scores accompanied by detailed explanations of the reasons are more likely to lead to a positive reaction and improvements from the service provider than low, middle or high scores with no justification.

Before the meeting:

- If necessary, divide participants into user groups;

- Determine a suitable time and place for focus group discussions:set focus group schedules around community schedules;

- Select the participants: alist of potential participants should be generated by the service provider agency or local authority (Commune People's Committees). Final participants are then randomly selected from this list(see Part 1).

At the meeting:

- Explain the objectives;

- Briefly present and discuss the input tracking matrix prepared by service providers (see Part 2);

- Identify indicators:

  - There will be two types of indicators used – those generated by focus group participants and standard indicators used by everybody;

  - Ask participants to think about what constitutes good service for them, for example health care, schooling, etc;

  - Generate a list of indicators with participants; facilitators help narrow these down to between three and five, voting if necessary; the results are entered in the self-evaluationmatrix;

○ Add any remaining standard indicators not yet identified by the participants to the matrix and explain them;

● Rate indicators:

○ Explain the voting and scoring system;

○ Where possible, ensurecommunity members identify objective measures for the indicators, for example if the indicator is 'minimal waiting times', they should discuss what would constitute a score of 1 (how long a wait on average?), what would constitute a score of 2, etc. These should be noted on the matrices;

○ Perhaps ask participants to vote on a practice indicator first:some practice indicators might include quality of the road to the school and/or health centre; performance of the local football team;

○ If participants are illiterate, the facilitator should assist them to write down their score or use the smiley face system.

○ Tally up the scores and enter them in the matrix;Calculate the average scores and enter these in the matrix (see below);

Ask probing questions in the discussion after scores have been tallied:

● Many of you gave this indicator a very low score: in what ways is the service provider not performing well on this indicator?

● Why did these indicators get low scores and these other indicators high scores?

● Of these various criteria and indicators we have listed, which ones concern you the most?

● Discussion:

○ Transfer the average scores to the summary scoring table;

○ Facilitators guide the discussion to identify why participants gave the scores they did and elicitsuggestions they might have for improving these conditions;

○ Facilitators guide participants towards locally practical suggestions,that is, steer away from suggestions requiring major government expenditure instead identify causes and solutions

that might be addressed locally;

- ○ Summarise key points in the 'Reasons' and 'Recommendations for improvement' columns of the table;

- ○ Note points of disagreement and dissent;

- Invite participants to the interface meeting and explain what will happen there;

- Be sure to copy and leave the original scorecard and summary table with the community.

Calculating the average score

The average satisfaction rating is obtained through a weighted average.

Average score

$$\frac{(n1*1)+(n2*2)+(n3*3)+(n4*4)+(n5*5)}{n1+n2+n3+n4+n5 \text{ (no. people)}}$$

Nx = number of people who gave a specific score from 1 to 5

Example : 10 participants, of whom 5 gave 1; 3 gave 2; 0 gave 3; 2 gave 4; and 0 gave 5

$$\frac{(5*1)+(3*2)+(0*3)+(2*4)+(0*5}{10} = \text{ Average score of 1,9}$$

The average satisfaction as a percentage :

$$P\,(\%) = \frac{(\text{average score}*100)}{5}$$

Example : P (%) = (1.9*100)/5 = 38%

Community performance scorecard matrix

Group: _____

Facilitator: _____

(Female community members, male community members, youth. etc.)

Indicator	Number of people who gave a score					Average score
	1Very bad	2Bad	3Neutral	4Good	5Very good	
Community indicators						
C-1 e.g. Minimal waiting times <20 min. = 5(Very good) 20–30 min = 4(Good) 30–60 min = 3 (Neutral) 1–2 hours = 2 (Bad) >2 hours = 1 (Very bad)						
C-2 Staff are respectful						
C-3….						
C-4….						
Standard indicators						
SI-1 ….						
SI-2….						
SI-3….						

Community summary scoring table

Group: _____

Facilitator: _____

(Female community members, male community members, youth, etc.)

Indicator	Average score	Percentage	Reasons	Recommendations for improvement
Community indicators				
C-1 Minimal waiting times				
C-2 Staff are respectful				
C-3 ….				
C-4 ….				
Standard indicators				
SI-1 ….				
SI-2 ….				
SI-3 ….				

Example: community performance scorecard matrix for service users in TienKy township

Indicator	Số người cho điểm					Điểm số trung bình
	1 Rất kém	2 Kém	3 Trung bình	4 Tốt	5 Rất tốt	
Service attitude			5	7	1	3,69
Professional qualification			9	4		3,31
Infrastructure		3	8	2		2,92
Equipment			11	2		3,15
Sanitary conditions			2	10	1	3,92
Communication	1		6	6		3,31
Working hours			3	9	1	3,85
Location				8	5	4,38
Management capacity			3	7	3	4,00

Example: community summary scoring table for service users in TienKy township

Indicators	Average		Reasons for the scores	Recommendations for improvement
	Score	%		
Service attitude	3,69	73,85%	Health staff receive patients warmly and attentively,but some staff keep patients waiting.	Need to give reminders/ comments/criticism via meetings; invite district health department staff to attend those meetings.
Human resource	3,31	66,15%	No doctors; just four nurses.	Health staff need more training; doctors should be provided/ rotated here.
Infrastruc- ture	2,92	58,46%	Noultrasound orX-ray, only foetalstethoscope andfoetalmeasuring tape; dental care equipment and scales are broken.	Repair dental care equipment and scales and provide other antenatal examination equipment.
Equipment	3,15	63,08%	No private room (obstetric andpae- diatricexaminations andvaccinations are done in the same room); there is a broken bed, no yard andbroken toilets.	Have separate examination rooms, provide beds, repair toilets and pave the yard with concrete.
Sanitary conditions	3,92	78,46%	Old and deteriorating toilets; flooded rooms on rainy days; no cement grounds so very dirty in rainy weather.	Repair the toilets and cement the grounds.
Communi- cation	3,31	66,15%	Education, communication and information sessions (IEC) organised regularly but the communicators did not perform well: There were an insufficient number of leaflets and the sessions were held at unreasonable times and were unsuitable for target groups.	Have the meeting in the evening (7pm) and avoid the agricultural peak seasons; better to deliver IEC sessions to target groups (groups of people who usually throw rubbish on the streets, e.g. food vendors).
Working hours	3,85	76,92%	Staff are not always available; the rooms are sometimes closed.	Make sure staff are always available:Health staff should have meetings with villagers to hear their feedback on working hours.
Location	4,38	87,69%	Near the centre and main roads.	None.
Manag- ement capacity	4,00	80,00%	Staff haveonly intermediate professional qualifications; staff do not strictly follow rules;however, village health workers are good.	The head of the station should be more active and responsible;be a good example; arrive at work on time and participate in village meetings to learn and cooperate in actions.

Tasks and procedure for the interface meeting

Objectives for the interface meeting:

- To promote dialogue and accountability among service users and service providers; and

- To facilitate the development of a local action plan for making improvements to the service.

Before the meeting:

- Prepare carefully;

- Establish dates for the meeting as far ahead as possible;

- Invite external participants such as regional authorities and   NGOs operating in the sector etc;

- Where a subset of the community was engaged in the CSC, invite everyone to the interface meeting, even if they did not participate in the focus group discussions;

- Aggregate all of the user focus group scores and all of the service provider focus group scores into combined average satisfaction scores (see below);

- Present two tables showing results from service providers and service users next to each other; and

- Prepare one table showing a combined average score given by service users and service providers for the standard indicators.

At the meeting:

- Representatives of users and service providers present theirfindings.

- Discussion:

  - Facilitators lead a discussion regarding why different indicators were chosen and why different scores were assigned;

  - Recommendations for improvements should also be discussed.

- At least one facilitator should (at all times) be assigned to take notes.

- Action plans should be determined jointly by users and service providers;

- One facilitator needs to make a copy of the summary tables as the originals will be left within the ward.

Calculating the combined average satisfaction score (CASS)

$$CASS = \frac{AS1*NP1) + (AS2*NP2) + (AS3*NP3) + (AS4 *NP4)}{NP1 + NP2 + NP3 + NP4}$$

ASx = Average satisfaction score in a given focus group

NPx = Number of participants in a given focus group

Interface meeting:suggested tool for action planning

Activity	Who is responsible for implementing the activity?	Timeline	Expected results	Who is responsible formonitoring and follow-up?
Priority 1				
Priority 2				
Priority 3				

Example: action plan of TienKytownship's health station

Priority actions	Responsible for implementation	Timeline		Expected results	Responsible for monitoring
		Start	Finish		
Service attitude: 1. Set up a public opinion mailbox; 2. Organise voting for emulation purposes; 3. Invite staff from the district health centre to attend semi-annual meetings; 4. Schedule the vaccination by hours.	Head of commune health station	10/2010	10/2010	1. Voting organised monthly; 2. One public opinion mailbox initiated; 3. Representatives from district health centre attend meetings; 4. Vaccinations scheduled by hours.	Commune People's Committee vice-chair (in charge of socio-cultural affairs)
Expertise: 1. Send nurses to advanced training to become doctors; 2. Offer retraining and refresher courses.	Head of commune health station	2011	2015	1. Nurses retrained as doctors; 2. Other health staff provided with additional training.	District health centre (division)
Equipment: Sufficient equipment needs to be provided	Head of commune health station	2011		Sufficient equipment provided	Planning division of district health centre
Infrastructure: 1. Build four additional rooms: examination room, obstetrical room, medicine room, treatment room; 2. Upgrade the toilets, grounds and gates.	Head of commune health station	2011		1. Four additional rooms built; 2. Toilets repaired; grounds cemented.	Planning division of district health centre
Communication: 1. Train health workers; provide an allowance for village health workers; 2. Provide CD players and loudspeakers for villages.	Head of commune health station	2011		1. Village health workers trained and provided with allowance; 2. CD players and loudspeakers provided.	Commune's People's Committee vice-chair (in charge of socio-cultural affairs)

COMPILATION AND DISSEMINATIONOF RESULTS – ACTION PLANS AND MONITORING AND EVALUATION

Tasks for dissemination and M&E

Write up results for each scorecard:

Objectives for dissemination and M&E:

- To ensure follow-up and accountability; and

- To institutionalise the process for ongoing impact.

The pilot CSC on community health care in HCMC in 2010 provided a rare opportunity for service users to express their opinions to those concerned. It enabled management bodies to gain a multidimensional perspective of the situation, problems and shortcomings and to observe the good practice occurring in public service delivery in the geographical areas under their management. It provided a welcome opportunity for service providers and those directly involved in public service delivery to show state management bodies the difficulties, deficiencies and/ or problems in management of and investment in public service delivery units (such as health stations).

On the basis of the action planagreed on by the two sides (service provider and service users), management bodies and local governments made commitments to actions aimed at improvingservices, requiring only a few additional resources.

- If multiple CSCs are being conducted as a part of a cohesive exercise, the overall results need to be analysed and a synthesis report prepared.

- Copies of the report should be shared with government officials, service providers and communities.

Hold a dissemination meeting at commune/ward level:

- To share results;to share the action plan with more senior authorities;

- To communicate problems and the reasons behind them;

- To express what is requested from the government in terms of support and improved services; and

- To bring together regional and/or provincial authorities, as well as representatives of the communities and service providers.

Think of dissemination and advocacy as taking place at multiple levels, for examplecommune/ward, provincial, national:

- Identify what problems and recommendations require action from higher levels, for example provincial or national.

- Identify what problems and recommendations require local- or ward-level action with monitoring and follow-up from higher levels.

- Identify what problems and recommendations require changes in policy.

- How will advocacy at those higher levels be carried out and by whom?

- Hold a dissemination meeting at provincial or national level.

- When disseminating the results to higher levels, report on both the local-level CSC activities and the outcomes of commune/ward-level dissemination meetings.

Consider other forms of dissemination and advocacy:

- In addition to reports, shorter documents such as brochures or briefing notescould be produced.

- Results could be publishedin the media.

Action plans,monitoring and evaluation:

> *Important aspects of community scorecards:*
>
> - They are a process – including feedback, dissemination, and follow-up – not just a scorecard.
>
> - They need to be adapted to the local context.
>
> - They can be used at the local level but can also be combined with various communities for broader monitoring.
>
> - They can have an even greater impact if they are institutionalised and are repeated at regular intervals.

- At the interface meeting, stakeholders develop an action plan.In order to ensure maximum impact, it can beuseful to develop ward, provincial and/or national-level action plans.

- Establish a monitoring committee to followup and report on progress of the action plans.

- Those responsible for followingup on actions plans should report progress to both the communities and authorities.

- When multiple CSCs are conducted as part of a cohesive exercise, it is important to give attention to analysis of the results of scorecard activities, action plans and follow-up activities. Such analysis should involve appropriate government officials and the people who are planning the round of CSC activities.

At a predeterminedtime after the CSC process, a follow-up CSC should be conducted to determine how satisfaction levels have changed and to promote feedback and accountability. Ideally, thisexercise could be repeated regularly, such as every six months or every year.

Institutionalising the CSC process:

- Repeat the CSC process at regular intervals;

- Ensure qualitycontrol:considerusing an agency such as a research institute to 'audit' the process and to reapply some of the tools in a small number of locations to double-check results;

- Link the CSC process to government systems, for example sector annual plans. It can be used:

  ○ In the creation of governance rating systems in a decentralisedsetting;

  ○ To inform performance-based budgeting;

  ○ For public input into budgeting;

  ○ To generate benchmark performance criteria that can be used in resource allocation and budget decisions;

  ○ By ministries and service providers to link CSC findings with their internal management and incentive systems;

- In the Vietnamese context, institutionalisation will require finding or creating an appropriate legislative framework within which the CSC process will sit: This may include a legal decision followed by detailed guidance.

- Monitor and document implementation and outcomes of all CSC activities.

- Eventually, evaluatethe CSC process itself.

Managing the community scorecard process

ORGANISING AND MANAGING THE CSC PROCESS

A variety of organisations either individually, or preferably in teams, could commission a CSC process. Thetechnical capacity of the organisation undertaking the process must be considered, including characteristics such as project management ability, availability ofskilled facilitators and previous experience with participatory approaches:However, another consideration just as important as technical capacity must be brought into the equation: the ability to mobilise buy-in and cooperation from local authorities, especially service-providing agencies. The service-providing agency itself or other government institutions such as MPI may wish to commission a CSC process: if support for the process comes from senior levels, it has a greater chance of being effective. In such cases, teaming up with other partners, research institutes or NGOs, for example, can help to ensure neutrality while bringing appropriate skills into the team.

If, on the other hand, non-governmental or quasi-governmental organisations wish themselves to spearhead a CSC evaluation of some government service provider, it will be essential to have strong support from appropriate government officials from the start and to have them facilitate cooperation of service providers at the local level.Of course, none of this eliminates the need to 'sell' the process to local service providers and demonstrate to them the value-added of the process.

Adapting the community scorecard methodology to the local context

The CSC is a social scientific tool which is participatory and primarily qualitative. While the tool must be adapted to the local context, there are certain elements which might be considered non-negotiable and which, if neglected or lost, would compromise the validity and integrity of the process:

- *Selection of community participants must be random:* It is important that community members selected to participate in focus group discussions be chosen at random.A list of all users of a particular service is provided by local authorities (or the service provider) and participants are chosen randomly from that list (e.g. the name of the 10th, 20th, 30th, 40th user on the list is selected).

- *Focus group discussions need to be conducted in a neutral*, *safe environment.* Participants must feel secure inexpressing their true feelings without fear of repercussions. Creating a safe environment is not only about choosing an appropriate location but also about controlling who is allowed to be present. In most cases, only the participants and the facilitator should be present. Other stakeholders can be invited to attend the interface meeting.

- *Facilitators must be neutral*. For similar reasons as those above, careful thought must be given to who will facilitate focus group discussions. It should be someone who is neutral and who community members perceive as neutral. Whether or not personnel from a government ministry or department (other than the service-providing agency) can fulfill these criteria would need to be assessed in each case. Normally, a better option would be to have facilitators from civil society organisations such as research institutes or NGOs.

- *The interface meeting is a key component of the CSC process*: The information, feedback and mutual problem solving that happens at this stage is crucial. Sacrificing the interface meeting and simply

collecting information through focus group discussions would create a process that is something quite different than a CSC.

- ***Participants generate their own indicators***: While you may choose to adopt some common indicators that are used in all focus group discussions in all communities where the scorecard process is carried out, it is important to also let participants identify their own indicators. What indicators they choose for evaluating a service is useful information in and of itself.

- ***Follow-up is needed***: The process does not end when the scores have been generated.

Suggested outline for CSC report

Below is a suggested outline for compiling a report on each CSC activity. A report like this should be done for each facility or service provider.

A one-page summary:

- Brief description of the service provider or facility being assessed;

- Summary of the results; and

- Brief description of the action plan and/or outcomes of the process.

Introduction:

- Province, city, district;

- Commune/ward;

- Facility or service provider;

- If relevant, towns/villages which use this facility;

- A brief summary of the main steps that were followed.

Results of input tracking scorecard:[3]

- Briefly describe participants;

- Include the input tracking matrix;

- Briefly describe the process;

- Include a brief discussion and analysis of the main findings of the input tracking scorecard.

Results of service provider self-evaluation:

- Briefly describe participants;

---

3   For this and the next three parts of the report you can include the appropriate facilitator reporting sheets (see reporting sheets).

- Include the self-evaluation matrix;

- Briefly describe the process;

- Include a brief discussion and analysis of the main points of the self-evaluation scorecard.

Results of community performance scorecards:

- Briefly describe participants;

- Include all the focus group performance scorecard matrices and a summary showing the combined average satisfaction score;

- Briefly describe the process;

- Include a brief discussion and analysis of the main points of the community performance scorecards.

Results of the interface meeting:

- Briefly describe participants;

- Include main discussion points;

- Include the action plan.

Suggestedoutline for synthesis report

If multiple CSCs are being conducted as a part of a cohesive exercise, a synthesis report should also be prepared, bringing together the results from all facilities or local-level service providers scored.

A one-page summary:

- Brief description of the service provider or facilities being assessed;

- Summary of the results;

- Brief description of the action plans/outcomes of the process.

Introduction:

- Province, city, district;

- Service provider and list of facilities scored.

Methodology:

- Description of the CSC process and its key aspects;

- Steps and methods used:

  - Selection of participants;

  - Selection of venues;

  - Etc.

Results for Facility 1:

- Province, city, district;

- Commune/ward;

- Facility or service provider;

- If relevant, towns/villages which use this facility;

- Input tracking matrix, service provider self-evaluation, community performance scorecard summary table and action plan;

- Summary of the main issues, problems and plans for that facility or service provider.

Results for Facility 2 etc.

Summary of the results:

- Present overall summary tables for the all of the scorecards.

Follow-up

- If there were dissemination meetings at higher levels (e.g.at provincial level), describe these.

- Describe other dissemination, advocacy and monitoring and evaluation activities that have taken place and/or been planned.

Conclusion:

- Conclusions drawn from the results of the CSCs;

- Lessons learnt and recommendations for the service assessed;

- Conclusions on the process and implementation;

- Lessons learnt and recommendations for the process including suggestions for institutionalisation.

A teacher helps her student at an orphanage in central Viet Nam. The orphanage caters to many abandoned and disabled children - through education and communication programmes they are able to have a life thatotherwise would not be possible.
Image courtesy of Flickr,

SUPPORTING DOCUMENTS

Reporting sheets

Community focus group reporting sheet:

This sheet is for facilitators to fill in for each community. It is not to be distributed to users and should not be seen as a questionnaire for users. It is merely meant as a guide for facilitators. Depending on how a CSC is being incorporated into a larger M&E framework, not all of the subjective information may be necessary.

A. INFORMATION

1. Province, city, district:

2. Commune/ward:

3. Facility:

4. If relevant, names of towns/villages which use this facility:

5. Date:

6. Time of meeting: start   end

7. Meeting place:

8. Participants (use another sheet if necessary. This sheet may be distributed to participants)

Name	Sex	Role at the facility	Contact

9.   Service provider scoring matrix

Indicator	Number of people who gave each score					Average
	1	2	3	4	5	

10.   Service providerfeedback matrix

Indicator	Average	Reasons for average score	Suggestions for improvement

B. QUALITATIVE ASSESSMENT OF CSC PROCESS

11. How many participants took part in the meeting, disaggregated by sex and age

Group	Number
Men	
Women	
Youth	

12.   Were all of the facility staff present? If not, why not?

13.   Were there any participants who were not members of the facility staff?

14.   During the meeting, did anyparticipants dominate the debate? Who were they and how did they dominate?How were their interventions received by the other participants? Did all participants participateactively?

15. What were the main topics of discussion during the focus group discussion? Were there certain dominant topics?

16. What challenges did you the facilitators face in leading this discussion, and how were these difficulties handled?

17. Please describe any additional anecdotes or information.

18. Information on the facilitators:

    a) Name of the facilitator in charge of calculations:

    b) Name of the principal facilitator:

19. Input tracking matrix

Inputs	Norm	Reality	Reasons for the gap	Suggestions for improvement

Interface meeting reporting sheet

A. INFORMATION

1. Province:

2. Commune:

3. Facility:

4. If relevant, names of towns/villages which use this facility:

5. Date:

6. Time of meeting: start   end

7. Meeting place:

8. Participants(this may be distributed to participants. Use another sheet if necessary)

Name	Sex	Role	Contact

9. How many participants came to the meeting? From which villages? How many women were present? How many local authorities?

10. Did all of the service providers attend? If not, why not?

11. Did any people dominate the discussion and, if so, who?

12. How was the meeting held? Please describe the procedures applied?

13. How were disagreements managed?

14. Please summarise the main concerns of the users and then of the service providers?

15. Through what mechanisms will the results of this exercise be communicated to the rest of the community?

16. Please ensure the community and service providers have a publicly posted copy of the action plan.

17. Facilitator information:

    a) Name of the facilitator in charge of calculations:

    b) Name of the principal facilitator:

RESOURCES/ BIBLIO- GRAPHY

Resources/bibliography

Akasoba, C.A. and Robinson, L.W. (2007)'Holding Service Providers to Account: Community Scorecards and District-Level Forums'. Participatory Learning and Action Note 56. London: International Institute for Environment and Development.

CARE Malawi (2007)'The Scorecard Toolkit: A Generic Guide for Implementing the Scorecard Process to Improve Quality of Public Services'. Lilongwe: CARE Malawi.

Commonwealth Education Fund (2008)'Making the Budget Work for Education: Experiences, Achievements and Lessons from Civil Society Budget Work'. London: Commonwealth Education Fund.

Heller, Njie and Razafimandimby, L. (2007)'Fiche d'EvaluationCommunautaire: Manuel Opérationnel'. Washington, DC: World Bank.

Robinson Orozco Associates (nd) 'Community Scorecards: A Tool for Accountability and Information Flow'. Available athttp://www.roboroz. ca/scorecard/ (accessed 29 March 2012).

Schnell, A. and Coetzee, E. (2010) 'People's Action for Just & Democratic Governance: Using Evidence to Establish Accountability'. Copenhagen:ActionAid Denmark.

Singh, J. and Shah, P. (2007) 'Community Scorecard Process: A Short Note on the General Methodology for Implementation'. Washington, DC: World Bank.

World Bank (2005)Social Accountability Sourcebook. Washington, DC: World Bank.