CARE’s Community Score Card©

Overview
CARE’s Community Score Card© is a citizen-driven accountability measure for the assessment, planning, monitoring and evaluation of service delivery. The CSC can be used to gather feedback from service users and improve communication between communities and service providers. As such, it is designed to complement conventional supply-side mechanisms of accountability by bringing together service users and service providers first to identify the underlying obstacles to effective service delivery, and then develop a shared strategy for their improvement. The CSC is simple to use and can be adapted to any sector entailing service delivery.

How is it used?
The CSC brings together community members, service providers, and local government to identify service utilization and provision challenges; to mutually generate solutions; and to work in on-going partnership to implement and track the effectiveness of solutions identified. Given its adaptability and the wide range of contexts within which it is used, the CSC implementation process varies according to what is appropriate within different settings. Broadly speaking, however, the CSC application consists of five phases:
1. Preparatory work and planning (including identification and training of facilitating staff, community research, introductory engagement with community, development);
2. Community scoring of performance by community members and service providers (including division into focus groups, development of performance indicators and scoring system);
3. Self-evaluation by service providers;
4. Interface meeting between service users and providers, and action planning (including district-level meetings, feedback and dialogue, consolidation of findings across communities);
5. Post-implementation activities (including training a cadre of facilitators, standardizing indicators, collecting and consolidating feedback).

The CSC should form part of an on-going assessment process, and is commonly repeated on a biannual basis.

What is CARE’s experience with the CSC?
CARE Malawi developed the CSC methodology in 2002 as part of a project aimed at developing innovative and sustainable models to improve health services. The CSC was intended to support the participatory assessment of health needs and service provision as a means of proposing action for more appropriate services. CARE’s CSC tool was rapidly taken up by the World Bank, who used the CSC tool in the education and health sectors of The Gambia. Since 2002, the CSC has become an internationally recognized tool for improving service delivery, and has been a central component of many of CARE’s governance programs across a range of sectors. CARE has made use of the CSC methodology in a wide range of sectors, in countries that include Rwanda, Tanzania, Malawi, Ethiopia and Egypt, taking on a variety of roles that range from direct implementation to providing technical training and support.

For more information, please contact: Sara Gullo, Senior Technical Advisor, CARE USA sgullo2@care.org
Community Score Card Process Diagram

**Phase I: Planning and Preparation**

**Phase II: Conducting the Score Card with the Community**
- **Community Score Card:**
  - Community level assessment of priority issues in one village – what are the barriers to delivery of quality services
  - Develop indicators for assessing priority issues
  - Complete the Score Card by scoring against each indicator and giving reason for the scores
  - Generate suggestions for improvement
  - Complete community Score Card for the village
- **Cluster Consolidation Meeting:**
  - Feedback from process
  - Consolidate scores for each indicator to come up with representative score for entire village
  - Consolidate community priority issues and suggestions for improvement
  - Complete (consolidated) Score Card for the cluster

**Phase III: Conducting the Score Card with Service Providers**
- Conduct general assessment of health service provision – what are the barriers to delivery of quality health services?
- Develop indicators for quality health service provision
- Complete Score Card by scoring against each indicator
- Identify priority health issues
- Generate suggestions for improvement

**Phase IV: Interface Meeting and Action Planning**
- **Interface Meeting:**
  - Community at large, community leaders, committee members, health center staff, district officials and process facilitators
  - Communities and health center staff present their findings from the Score Cards
  - Communities and health center staff present identified priority health issues
  - Prioritize the issues together (in a negotiated way)
- **Action Planning:**
  - Develop detailed action plan from the prioritized issues – agreed/negotiated action plan
  - Agree on responsibilities for activities in the action plan and set time frames for the activities (appropriate people take appropriate responsibility – community members, community leaders, health center staff, government staff and community committees and process facilitators)

**Phase V: Action Plan Implementation and M&E**
- Execute action plan
- Monitor and evaluate actions
- Repeat cycles to ensure institutionalization
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Reason for Score</th>
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<tbody>
<tr>
<td>1- Referral system – availability of transportation for pregnant women</td>
<td>45</td>
<td>• Ambulance is rarely available in cases of emergency • Fuel scarcity affects referral of clients • Providers make clients use public transport • Delays in decision to refer clients</td>
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<tr>
<td>from health center to hospital</td>
<td></td>
<td></td>
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<tr>
<td>2- Availability of transport from the community to the health facility</td>
<td>20</td>
<td>• Long distance to health facility • Sometimes women delay doing to the facility during delivery • Rainy season poses a challenge to reach facility</td>
</tr>
<tr>
<td>3- Availability of resources (i.e. drugs, supplies, space)</td>
<td>50</td>
<td>• HIV test kits stock outs occur regularly • Drug stock outs are frequent • Clients told to buy medication which should be free • Lack of space in delivery room (only 1 bed) • No waiting room for pregnant mothers (sleep on floor)</td>
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<tr>
<td>4- Availability and accessibility of health services (MNH, FP, PMTCT)</td>
<td>80</td>
<td>• Most service are available • Some family planning service are provided (depo, pills) and long term methods provided once in a while by BLM • PMTCT services are available • No MNH services provided in community, but US clinic provided</td>
</tr>
<tr>
<td>5- Availability and accessibility to information (MNH, FP, PMTCT)</td>
<td>80</td>
<td>• The messages are only available at the health facility not in the community • The messages do not reach men • PMTCT information is in adequate (women don’t know the guidelines) • Family planning myths are prevalent</td>
</tr>
<tr>
<td>6- Level of male involvement in MNH, FP, PMTCT</td>
<td>50</td>
<td>• Few men accompany their wives to antenatal care • Some men assist their partners with birth planning • Most men refuse to get tested for HIV with their wives • Some men don’t allow their wives to use family planning</td>
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<tr>
<td>7- Level of youth involvement in reproductive health issues</td>
<td>10</td>
<td>• Most girls get married too young • Most girls are getting pregnant and ending up with complications in birth • There are no youth clubs so most youth have little information on family planning, MNH or youth friendly services</td>
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<tr>
<td>8- Reception of clients at the facility</td>
<td>40</td>
<td>• Some health workers have good attitudes and respect clients • Some women deliver on their own at the health facility with no provider support • Some women are shouted at during delivery</td>
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<td>9- Relationship between providers and communities</td>
<td>40</td>
<td>• There is no health advisory committee or village health committee • The hospital tries to supply clients with supplies, but doesn’t always happen • Meetings between health providers and clients is rare • Especially poor relationship during delivery</td>
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<tr>
<td>10- Health seeking behavior</td>
<td>50</td>
<td>• Most women are delivering at the hospital • Some women delay in going to the hospital for delivery • Most women start antenatal care very late • There are cultural beliefs that family planning use with affect sex</td>
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<tr>
<td>11- Fertility levels</td>
<td>20</td>
<td>• Most people experience too many pregnancies • Some people do not use modern family planning • People marry very young</td>
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<td>12- Commitment of service providers</td>
<td>30</td>
<td>• Some are so dedicated to their work • Some are disrespectful and not kind • There are few health workers to serve lots of clients • They start work late • Delays in attending clients at night</td>
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<tr>
<td>13- Availability of supervisory support (for the health center)</td>
<td>70</td>
<td>• Poor supervision by the District Health Management team • Poor response from the DHMT on some matters • Quarterly supervision only happens with EGAPF for PMTCT and ART • Maternity needs support — (From Katsekera Health Facility Score Card )</td>
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