

Key Activities of the CSC Process

The National Community Score Card Process entailed **two** broad phases.

Phase 1: National Orientation /Awareness Creation and Training

Stage	Activities
1	National workshop <ul style="list-style-type: none"> Trained a large number of development practitioners on elements and methodology of participatory monitoring and community score card Field practice of the CSC methodology in Serekunda Health Center and Mohammendan lower basic school
	Refresher Trainers Trained individuals/corporate trainers who conducted training for facilitators at the divisional level on techniques of the CSC process
4	Step-down training Trained targeted facilitators at the divisional and community levels on the CSC process and methodology

Phase 2: Community Score Card Piloting

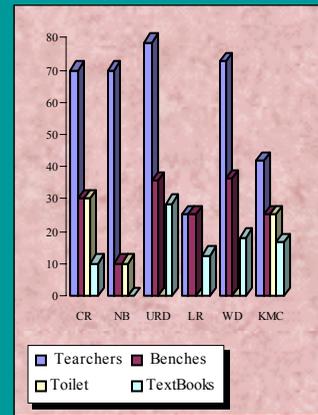
Stage	Activities
1	Selection of facilities In all, 59 education and 15 health facilities were selected across the six main divisions in the country for the pilot program
Community Score Card Process	
2	Community Mobilization and Sensitization <ul style="list-style-type: none"> Facilitators organized the community and service providers through facility heads and community or traditional leaders Preliminary session of both services providers and users or beneficiaries was held to discuss the CSC objectives, methodology, significance and expectations
3	Input Tracking <ul style="list-style-type: none"> Facilitators determined with service providers the government entitlements for each facility Both service providers and beneficiaries discussed facility entitlements, and completed input tracking matrix –comparing expected amenities with what were actually provided
4	Community Performance Scorecard Beneficiaries or the community developed facility performance assessment indicators and used the group generated and standard indicators to evaluate the adequacy of amenities in the health and education facilities
5	Service Providers Self Evaluation By way of performance assessment, service providers evaluated their own performance using standard and group generated indicators
6	Interface Meeting (a conference meeting of both service providers and users or beneficiaries) <ul style="list-style-type: none"> Performance assessments and observations of each focus group were methodically discussed Problems inhibiting quality performance in the facilities were collated and harmonized Recommendations and feedback to service providers were proposed Action plans were mutually developed
7	Advocacy and dissemination Project completion report will be widely published and a National workshop on the CSC report will be held to elicit stakeholders feedback, and plans will be devised to institutionalize the CSC methodology

EDUCATION FACILITIES

Standard and Group Generated Indicators

Stand. Indicators for Assessing facility performance	Some Key Indicators Generated by Groups to Assess Facility Performance			Pupils favored amenities that induce conducive atmosphere for physical and academic development Teachers believed in factors that enhance quality performance of teachers and pupils Parents were much more concerned with the safety and academic performance of their wards
	Pupils	Staff	Parents	
Availability of Teachers	food program	teachers housing	Clean Environment	
Furniture	transportation	discipline	discipline	
Learning materials	teaching materials	learning materials	Learning materials	
Toilet facilities	pupil attendance	toilet facilities	Health services	
	Punctuality	physical infrastructure	Good administration	

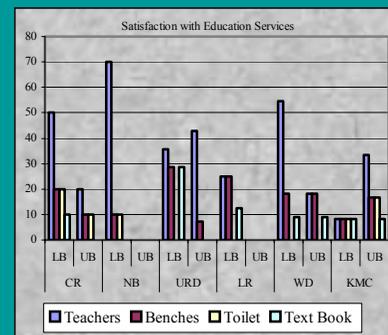
Satisfaction with Primary Education Services in the Six Divisions – Central River, North Bank, Upper River, Lower River, Western and Kanifing Metropolitan Council



An analysis of survey data showed marked differences in overall performance of schools across the six regions

'Adequate teachers' received more than 70% approval rating in all regions except KMC (an urban area and more likely to attract more pupils than available teachers)
'Adequacy of school facilities' including furniture, core text books and toilet ranked below 40% in each region
Toilet facilities are either non-existent inadequate or appalling in NB, URD, LRD and WD
Pupils enrolment and school facilities

Performance Assessment: Lower and Upper Basic Schools Compared



Level of services provided varied considerably between Lower and Upper basic schools

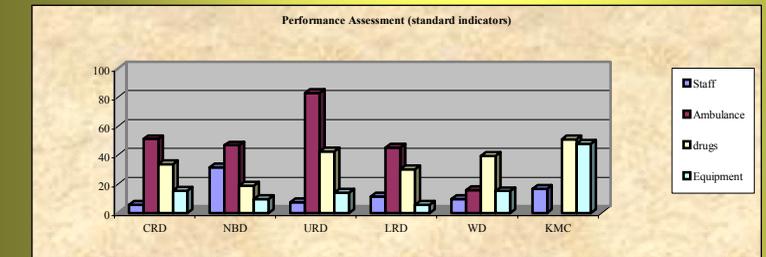
The satisfaction rating of availability of teachers is highest in Lower basic schools
 Provision of furniture was more satisfactory in LBs than in UBs
 The most visible area of equal performance in LB and UB was poor provision of toilet

HEALTH FACILITIES

Standard and Group Generated Indicators

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

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



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

Availability of Staff

The survey indicated weak staff capacity with less than 30% satisfactory rating of adequacy of staff at health facilities across the regions.

Equipment

Availability of Essential Equipment received less than 15% satisfactory rating in all regions exception KMC. *It was recognized that lack of regular supply of electricity and water affects the provision of essential equipment. For instance, about 40% of the health facilities involved in the CSC process did not have regular supply of electricity, 20% relied on solar panel for energy and 40% used generator-supplied energy. These provisional sources of energy have inherent limited capacity and high maintenance cost.*

Drugs

Although the overall rating for availability of drugs was fairly encouraging (40% overall), the community felt that drugs were almost always in short supply except essential drugs like anti-malaria drugs which were available during malaria season

Ambulance

About 69% of the health services surveyed had at least one ambulance although about 30% of them were in deplorable condition. Availability of ambulance, therefore, received the highest rating in CRD, NBD, and LRD but zero percent rating in KMC.

Recommendations from Service Providers and the Community for Improving Performance in Health Facilities

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

General Observations on the Community Score Card Process in Gambia

- There was strong support for the CSC methodology and an expressed indication for the tool to be nurtured for fostering community empowerment and participation at the local level
- The CSC process succeeded in extracting community grievances about the quality and adequacy of health and education services at the community level
- The process created a great deal of awareness on the relevance of CRC and, empowered the community to appreciate the implementation of the community score card. Approximately 3,500 stakeholders participated in the process at the community level alone including teachers, pupils, health workers and the community.
- The pilot project revealed that both service providers and the community were adequately informed about the nature of and scope of their education and health needs

Lessons Learned and Corresponding Recommendations

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

Community Score Card in Gambia

Monitoring and evaluating the effectiveness of poverty strategies are critical elements in the efforts to achieve sustainable and equitable development. Under its Poverty Reduction Strategic Papers (PRSP), Gambia outlined its commitment to promoting accountability, transparency and effectiveness through broad-based community participation in monitoring and evaluation. However, there are critical challenges that need to be addressed in order to pursue these goals more resolutely and consistently – including the need to strengthen the capacity of stakeholders and enhance citizen participation.

*In line with its broad development objectives, the government of Gambia in collaboration with the Participation and Civic Engagement group of Social Development Department of the World Bank, developed the **Accountability and Participatory Monitoring and Evaluation Program** which seeks to broaden citizens' capacity, create opportunity for citizens' participation and feedback on the quality, adequacy and efficiency of key services largely through the **Community Score Card (CSC) process**. The CSC is a community based monitoring tool that is a hybrid of the techniques of social audit, community monitoring and citizen report cards. It has a strong focus on empowerment and accountability as it includes an interface meeting between service providers and the community that allows for immediate feedback.*

The CSC process in Gambia, though a pilot program, involved 59 public schools and 15 health services. A large spectrum of stakeholders participated in the process- there were approximately 3,500 people from 650 towns and villages at the community level including teachers, pupils, health workers and community members.

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For more information on Community Score Card or Participation and Monitoring tools contact:

Sering Falu Njie
 Coordinator,
 Strategy for Poverty Alleviation Coordination Office (SPACO)
 15/16 Marina Parade Banjul, Gambia
 Tel: 220 422 9761 Email: falugalas@hotmail.com or
 Visit <http://www.worldbank.org/participation>