Synthesis report

CARE's experience with community score cards: what works and why?

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Key messages

This report explores the experience of CARE International in implementing community score card programmes in four countries – Ethiopia, Malawi, Tanzania and Rwanda – and aims to address the significant research gap around cross-country comparative analysis of social accountability programmes.

The key findings of our research are that:

- CARE's Community Score Card programmes have contributed to strengthening service provision and community-state relations in each of these countries, in different ways.
- Often this requires high levels of engagement with, and working through, different levels of the state apparatus. For support based on the idea of civic engagement, this is a counter-intuitive finding.
- Impacts are often 'stuck' at the local level and have only translated into national level impacts where they have plugged into existing reform processes.

Acknowledgements

The authors would like to thank CARE International for their support of this work and for their contributions to the analysis. The staff of CARE Ethiopia, CARE Malawi, CARE Rwanda and CARE Tanzania gave vital assistance to the fieldwork and provided key and critical reflections on the programmes and context. We would like to particularly acknowledge the contributions of Gaia Gozzo and Muhamed Bizimana (CARE UK); Anteneh Gelaye, Esther Watts and Habtamu Engdawork (CARE Ethiopia); Rose Tchwenko, Thumbiko Msiska, Clement Bisai and Simeon Phiri (CARE Malawi); Sara Gullo (CARE US); Apollo Gabazira, Uwimpuhwe Sidonie and Matt Bannerman (CARE Rwanda); and Raymond Nzali (CARE Tanzania) for their support in the field and their review of the country case studies. We would also like to acknowledge the contribution of Likimyelesh Nigussie, who conducted the fieldwork research in Ethiopia. We are very grateful to Jonathan Fox for his insightful peer review. Responsibility for the content of this paper, however, rests with the authors.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CCM	Chama cha Mapinduzi
CSC	Community Score Card
CSO	Civil Society Organisation
DFID	Department for International Development
EPRDF	Ethiopian People's Revolutionary Democratic Front
GAP	Governance and Accountability Project
GBV	Gender-Based Violence
GTP	Growth and Transformation Plans
HIV	Human Immunodeficiency Virus
ICG	International Crisis Group
JADF	Joint Action Development Forum
MCP	Malawi Congress Party
MHAP	Maternal Health Alliance Project
MP	Member of Parliament
MWWa	Muuni Wauchembere Wabwino
NGO	Non-Governmental Organisation
NPA	Norwegian People's Aid
ODI	Overseas Development Institute
OPM	Oxford Policy Management
PPA	Programme Partnership Arrangement
PPIMA	Public Policy Information and Monitoring Advocacy
SMIHLE	Supporting and Mitigating the Impact of HIV/AIDS for Livelihoods
TANU	Tanganyika African National Union
TPLF	Tigray People's Liberation Front
UK	United Kingdom
US	United States
VSLA	Village Savings and Loan Association
WASH	Water, Sanitation and Hygiene
WASHCO	WASH Committee
WE-RISE	Women's Empowerment: Improving Resilience, Income and Food

Executive summary

Over the past two decades, there has been growing interest in supporting social accountability to improve the delivery of public services and empower citizens. This has prompted significant reflection on how best to provide support and how to ensure it translates into concrete outcomes in different contexts.

This research aims to shed further light on that issue, providing cross-country comparative analysis across four countries: Ethiopia, Malawi, Rwanda and Tanzania. It is the outcome of a collaborative project between the Overseas Development Institute (ODI) and CARE International, which aimed to analyse how CARE adapted its Community Score Card (CSC) programmes to a variety of national contexts and how this influenced their impact. It also aimed to generate further lessons and insights to inform wider debates around social accountability.

The research uses a political economy lens to map some of the key structures, formal and informal institutions, stakeholders and relationships at local and national level that interact with CARE's CSC programming in each country. It aimed to understand variation across these contexts – from strong central states to those that are more fragmented – to understand how CSC processes could be adapted to local conditions and the implications this has for programme impact. It utilised a mixture of desk reviews of existing literature and CARE programme documents and field research in cooperation with CARE country offices, which involved interviewing stakeholders involved in the CSC process. These identified the mechanisms that CARE's CSC programmes operated through, the adaptations made to the standard model in light of contextual factors and examples of impact achieved.

We find good evidence of CARE programmes being **adapted to different contexts** and enabling environments across all countries. While there is a general model that CARE promotes for score card programming, our findings confirm that, in practice, there is no single way in which change has been achieved in each context – instead, multiple pathways have been utilised within each country to take advantage of different opportunities and challenges. It is hoped that learning from this cross-country experience will support greater understanding of the nature of these multiple pathways of change and of the types of impact possible from this form of social accountability programme. Drawing across these contexts, we therefore identify a number of key findings and implications for future research and programming.

First, the research finds **support for the 'accountability sandwich' strategy** (Fox, 2007), in that, for 'demand-side' activities to have traction, they require an ability and willingness to respond on the supply side too. For example, CSC programmes can achieve some tangible outcomes, such as improvements in working practices of service providers or in the deployment of staff, but this often requires top-down pressures for reform too, and usually involves states with reform-minded central governments, with Rwanda as a case in point. In states lacking these conditions, such changes can be negotiated, but are often only sustained at the community level.

Second, **buy-in from decision-makers needs to be secured early on and maintained,** which can require framing the programme as one that will help rather than hinder decision-makers and service providers themselves. This means a strong emphasis on service delivery improvements, which can influence the overall objectives of the programme. We see this in the majority of impacts identified that relate to service delivery improvements of different kinds (such as resourcing, access and service provider behaviour). Framing CSC programmes in this way involves different trade-offs too. In Ethiopia, it meant the process itself was effectively co-opted and led by the government at the *woreda* level; in Malawi, local health teams were trained to help facilitate the process; in Tanzania, local councillors were brought into the process, especially in the run-up to elections. The interests of each of these had to be accommodated within the score card process, to ensure their buy-in and participation.

Third, **multi-stakeholder partnerships are key to achieving impacts.** In almost all cases, CARE's CSC programmes employed a highly collaborative approach, although this took multiple forms. The general model for CARE's CSC programmes involves a final step of an 'interface' meeting, which brings together relevant stakeholders to discuss the score card findings. This is a major venue for bringing different groups together and for supporting collective problem-solving.

However, our findings suggest building these partnerships requires much more than just attendance at an interface meeting. In some countries, such as Malawi, pre-interface meetings were introduced, giving officials and decision-makers an early view of findings to prevent them from feeling 'ambushed'. In Rwanda, there are instances where interface meetings were not held and instead score card findings were fed into pre-existing forums. Rather than a reliance on the existence of particular meetings, our findings

therefore point to the importance of an ongoing maintenance of strong links and relationships, between government officials, local leaders, implementing organisations and others to establish trust and facilitate the process.

Fourth, we find that, in many cases, an essential prerequisite to finding and acting on shared collective interests – an important outcome of multi-stakeholder partnerships – is **the solving of collective action problems for individual groups too.** For example, communities may not be able come together and work in their collective interests, including for effective maintenance of service points (such as water pumps or boreholes) or other community structures. Strong facilitation is therefore required by local organisations or local leaders (such as village chiefs, faith leaders or others) to broker collective action and enforce collective participation.

We find that service providers can also face collective action challenges, for instance where frontline staff do not feel able to report the constraints they face to superiors, or where there are coordination failures across departments. Again, this requires careful facilitation, and may need to be resolved before wider collective action is possible. There is, moreover, a consistent challenge of how to sustain and expand collective action and interests beyond the community level.

Fifth, we find **evidence of tangible impacts, clustered around service delivery improvements.** The exact form this impact takes varies from context to context. It ranged from what we term 'mid-point instrumental–institutional' impacts (such as improvements in trust between service users and service providers, or alterations in staff and community behaviour) to more purely instrumental impacts (including changes in the working practices of service providers and improvements in resourcing such as infrastructure, personnel and equipment). While we found little evidence of purely 'institutional' impacts, such as significant changes in power relations, there were some examples, including commonly reported feelings of community empowerment and increased responsiveness of officials, that may have a transformational impact in the long run. However, the causal chains for this are long and our research could not substantiate any clear links here.

Taken together, we hope these findings show how CSC programmes can operationalise the recognition that context matters for social accountability. In this way, we can highlight more precisely how differing enabling environments lead to different options – and pose their own opportunities and trade-offs for those wanting to support greater accountability for service delivery.

1. Introduction

First developed by CARE Malawi in 2002, CARE's Community Score Cards (CSCs) have become an internationally recognised approach, within CARE and beyond. Indeed, CARE now has more than a decade of experience in implementing this approach in a variety of contexts and sectors.

In January 2013, CARE's US and UK offices convened an expert working group of 23 CSC practitioners from a range of offices (including Egypt, Ethiopia, Malawi, Rwanda and Tanzania) and across a range of sectors (health, food security, water and sanitation and education). To build further on this experience, and gain a better understanding of the influence of context on implementation and sustainability, CARE International commissioned further analysis, which this report summarises.

This research therefore aims to analyse how CARE's CSC programmes have operated across different contexts. In doing this, it aims to understand how these programmes have adapted to different enabling environments and to identify those features that can constrain or enable different forms of social accountability.

1.1 The Overseas Development Institute's analytical approach

The key question for this research is, 'How do CARE's CSC projects interact with and influence the wider context, and how does this impact on their effectiveness and ability to secure long-term change?'

In order to unpack this research question, the research team explored two dimensions. First, it examined the political economy context in each country, and then it looked at the score card process itself, to understand how the wider context interacted with decisions on the design and implementation of programming.

We define political economy analysis as follows:

> *Political economy analysis is concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time (Collinson, 2003; DFID, 2009).*

Methods of political economy analysis are increasingly being applied to assess social accountability initiatives. They can usefully help unpack:

- Relevant structural features, including demography, geography, social structures, historical legacies and so on;
- The 'rules of the game': relevant institutions, including formal laws or regulations and informal social, political and cultural norms, that shape power relations and can influence economic and political processes;
- The motivations of relevant individuals, groups and organisations that shape their behaviour, as well as the types of relationships and balance of power between them.

Throughout, we do not analyse these concepts in depth, but rather look at the interactions between them, for instance between these systemic features (structures and institutions) and the incentives, power and behaviour of different actors relevant to the issue analysed. To give an example, in analysing how decentralisation for service delivery works in practice, our analysis looks at structural features like historic legacies of past regimes or social norms around those in authority; the nature of the formal policy framework and informal rules; and the behaviours of relevant individuals or groups, such as district-level authorities or community members. More detailed analysis is set out in the individual country notes (unpublished); only a synthesis is to be found here.

In each case study country, CARE's CSC programmes have been implemented in at least one, and often more than one, sector. As a result, we focused on sector-level political economy analysis – to understand the nature of the sector and key power relations and information flows within it – as well as on the particular issues identified for each score card programme. As the score card is implemented locally (at either community or district level), our analysis focused largely on local political economy dynamics in the regions visited in each country, although, where relevant, we refer to national-level dynamics too.

To understand the implications of context for programming, the research examines both the implicit and the explicit assumptions made about how change happens and the potential pathways for change that exist. In recent years, 'theories of change' – explicit expressions of how change can happen – have gained prominence as a tool to help articulate key preconditions and resulting processes through which change occurs (or does not occur), and the key assumptions underpinning programme strategy (see Stein and Valters, 2012). It is an approach that aims to make explicit some of the key choices and 'theories' held by those who have designed and implemented a given intervention.

A key strength of our approach was the focus on cross-country, comparative research and lesson-learning. The research was explicitly designed in order to map which elements were shared and which were different for CARE's CSC programmes in different countries and to assess this against key contextual conditions.

1.2 Methodology

In coordination with CARE International, the following countries were selected for analysis: Ethiopia, Malawi, Rwanda and Tanzania. These were identified according to the following criteria:

- Existence of project documentation including documentation of impact and effectiveness;
- Willingness of country office staff to collaborate on research, and ability to observe programmes in the field;
- Comparability across a range of contexts – with some shared features (e.g. both Rwanda and Ethiopia have seen strong central government oversight and leadership, whereas Malawi and Tanzania have experienced weaker and more fragmented oversight and governance systems), but also important differences between these (e.g. Tanzania's history of one-party rule versus Malawi's history of multi-party competition). Throughout, we examine this spectrum of contexts, rather than assuming a particular typology, and we aim to identify important similarities and differences across all four countries.

Resource constraints meant field visits were limited to one week per country. For Malawi, Rwanda and Tanzania, an Overseas Development Institute (ODI) researcher carried out the research; in Ethiopia, a national consultant conducted the study. Researchers were reliant on the quality of CARE documentation and the availability of CARE staff to help identify the best use of this limited time and to share adequate information as part of this timeframe. All researchers followed an interview guide, adapted to particular local specificities (see Annex), and reported their findings in a shared template.

The methodology involved a number of steps:

- **Desk review** of available CARE materials in each country: This was used to identify the implicit and explicit assumptions set out in key project documents that indicate how change is expected to happen. This step was also used to identify specific examples of impact or success, or examples of variance (differences in impact, e.g. by region/implementer etc.) to be explored further through fieldwork. This was supplemented by a limited review of select academic and grey literature for each country, with specific attention to broader political economy analysis.
- **Fieldwork** for one week in-country: One-to-one and focus group interviews were carried out with key stakeholders in select field sites. These included government officials, (national and local); international partners and international non-governmental organisations (NGOs) involved in the CSC initiative; civil society organisations (CSOs) and community-based groups; local sector experts, including academics; members of parliament (MPs) and local councillors (if relevant); relevant donor agencies; community members; community leaders including village elders or chiefs; and faith leaders.
- **Final reporting:** Individual field notes were produced for each country, and shared with and validated by CARE country offices. These are not published but are synthesised in this report, which consolidates the findings from all countries. This report will be accompanied by a shorter policy briefing and dissemination events.

In each country, fieldwork involved visits to areas where the score card project had been delivered, and where there were opportunities to interact with key participants in the programme. Initial desk review and consultation with CARE programme staff were used to highlight examples of impact or of variation in impact (i.e. if some areas/groups seemed to be more effective than others). Field visits were then used to understand better what explained areas of progress. Where possible, the researchers aimed to visit field sites where positive results had been validated independently (e.g. through evaluations, observations, data analysis). Researchers did not aim to independently evaluate these impacts, but rather to understand why and how they had been achieved.

Throughout, researchers sought to triangulate findings and explore key political economy features of the context and of programming decisions. The fieldwork drew significantly on the tacit knowledge of CARE country staff, particularly those who had been closely involved in implementation. This was crucial in assessing the 'fit' of the CSC programme to the broader context, and the team are grateful for all assistance. Some of the findings in country field notes were sensitive for CARE country offices and for in-country relationships; we reviewed these areas and issues in close coordination with the relevant CARE country offices and CARE International.

Fieldwork was carried out in a select number of sites and sectors, drawn from the following programmes in each country (see Table 1).

Table 1: CARE's Community Score Card programmes

Country	Title	Dates (from/to)	Areas covered	Sector/themes
Ethiopia	CSC Programme	2011-2014	Amhara region (3 kebeles)	Water, sanitation and hygiene (WASH)
Malawi	Muuni Wauchembere Wabwino (MWWa) (formerly known as Maternal Health Alliance Project, MHAP)	2011-2015	Ntcheu district	Health (sexual, reproductive and maternal)
	Women's Empowerment: Improving Resilience, Income and Food (WE-RISE)	2011-2016	Dowa district	Food security, women's empowerment and resilience
	Supporting and Mitigating the Impact of HIV/AIDS for Livelihoods (SMIHLE)	2003-2008/09	Dowa district	Food security, women's empowerment, HIV/AIDS
Rwanda	Public Policy Information and Monitoring Advocacy I (PPIMA I) consortium with Norwegian People's Aid (NPA) and Save the Children	2009-2013	Four districts in four regions (CARE implementation in Nyaruguru district)	Basic services (agriculture, health, education, infrastructure, WASH) Focus on poor women, youth, disabled, elderly and other marginalised populations
	IsaroProgramme Partnership Arrangement (PPA) Governance PPA4	2011-2014	Gisagara district (then rolled out to Nyanza and Ruhango districts)	Gender-based violence (GBV)
Tanzania	Governance and Accountability Project (GAP)	2007-2011	Mwanza region (8 wards in 4 districts i.e. Ilemela, Nyamagana, Sengerema and Ukerewe)	First round: range including microfinance to women, education, GBV Second round: health

2. Why social accountability matters

Over the past two decades, there has been rising interest in mechanisms and programmes to promote social accountability, often conceived of as attempts to establish transparency and accountability. Gaventa and McGee (2013) place this in the context of the third wave of democratisation that took place in 1980s and early 1990s, arguing that 'accountability failures' within these systems, whereby elections and other traditional accountability mechanisms were insufficient to create accountable government, created a need for these to be either augmented or circumvented by other forms of citizen-led accountability mechanisms.

The 2004 World Development Report, *Making Services work for Poor People* (World Bank, 2004), is also cited as a major framing report for this interest, particularly for its focus on the supply- and demand-side blockages. It emphasised the considerable blockages that occur on the 'long route' of accountability between citizens and politicians, and politicians and service providers. Given the difficulties of removing these blockages, transparency and accountability initiatives were framed as some of the mechanisms that could help improve the 'short route' of accountability between service users and service providers.

Gaventa and McGee (2013) note that there was initially a focus on mechanisms such as citizen budget participation and budget transparency initiatives, and that this was followed by efforts to expand freedom of information laws and encourage greater public release of information through mechanisms such as the Open Government Partnership. Alongside these, Joshi (2013) notes a wide range of other mechanisms, such as social audits, public hearings, community monitoring, community report cards and CSCs, some of which focus more on two-way information exchanges and the integration of facilitation mechanisms between major actors.

Recent developments in the social accountability field have seen an increasing emphasis on what has been dubbed 'the efficiency paradigm' (Gaventa and McGee 2013), whereby transparency and accountability mechanisms are promoted as improving particular service delivery outcomes and reducing inefficiencies, corruption etc., rather than as promoting deepened democracy or real shifts in power relations between groups.

Growing momentum around transparency and accountability themes has brought greater critical reflection too. In particular, a growing number of reviews and evaluations seek to understand the impacts of support to transparency and accountability (e.g. see Fox, 2014; Gaventa and McGee, 2013; World Bank, 2014). This process has identified a number of potential weaknesses or challenges for this field to address.

The most basic is the assumption made in much of the literature that there is a clear link between transparency and accountability. Fox (2007) argues that, while there is an intuitive link between these two processes, it is important to distinguish between them and to grasp that, although transparency may be a necessary condition for accountability, it is not sufficient for it. Fox argues that what he dubs 'hard' accountability requires agents that can put in place sanctions, compensation or remediation. In the absence of this, there will either be 'soft' accountability, where social norms mean public authorities are answerable, or no accountability, where 'shaming' of public officials through transparency simply has no effect.

World Bank (2014) adds to this analysis, highlighting a tendency in the literature to conflate participation with accountability and ignore the very real possibility that, even where citizens do participate in decision-making processes, they may simply be ignored or overridden by those in authority. Recognition of this has prompted greater reflection on the linkages between different concepts and outcomes, and on how change happens in different spheres.

A second, and related, area of debate has been the focus on state–citizen relationships being reduced to that of supply- and demand-side dynamics. Joshi (2013) points out that this framing is limited, as it ignores the fact that the state is only one of a range of legitimate actors that provide services and exercise public authority. More broadly, others have argued that a narrow supply-/demand-side framing misconceptualises development problems as 'principal-agent' problems when in fact they commonly constitute collective action problems, in which social groups cannot credibly commit to courses of action that would be mutually beneficial (see Booth, 2012).

Thus, focusing on either demand- or supply-side issues alone is unlikely to produce effective results. Research on CSCs in particular has highlighted how these mechanisms can act as a venue for problem-solving and overcoming collective action problems experienced by service users,

service providers and local governments (Wild and Harris, 2012). O'Meally (2013) also highlights the importance of coalitions of actors and bargaining between them to achieve changes in outcomes, and contrasts this with approaches that focus only on civil society or adopt more simplistic state–citizen dichotomies. This coalition-building approach has been dubbed the 'sandwich strategy' – as articulated by Fox (2004): 'Pro-empowerment institutional reforms are driven by mutually reinforcing cross-sectoral coalitions between state and society, grounded in mutually perceived shared interests' (p.84).

This leads to a third area of debate, which is a major motivation for this research. The acknowledgement that a focus on the demand side is insufficient and that the interactions between different state and non-state actors are important variables has led to a renewed focus on the importance of *context* in determining the success of interventions.

This reflects operational concerns too, that social accountability initiatives have increasingly been deployed as a depoliticised and technical tool implemented on the basis of standard templates, undermining their ability to work effectively and flexibly with contextual realities (Gaventa and McGee, 2013; O'Meally, 2013; World Bank, 2014). Joshi (2013) concludes in her overview of evidence on the effectiveness of transparency and accountability initiatives for service delivery that the political context in particular is a major explanatory factor; Gaventa and McGee (2013) also highlight its persistence as a research gap. These insights have also been a major motivating factor for research recently carried out by the World Bank examining context and social accountability (O'Meally, 2013, World Bank, 2014).

This research therefore fits into an evolving pattern of thinking on the functioning and role of social accountability issues, and aims to provide evidence to fill some of these important research gaps. By comparing the functioning of a single 'template' programme across a variety of political contexts, and systematically analysing the political economy of both CSC programmes and the outputs that have flowed from them, it aims to cast light on these issues.

3. CARE's Community Score Cards

This section explores CARE's general approach to CSCs and some of the specific ways this has been adapted across each of the four countries examined.

The CSC approach used by CARE was developed in 2002 by CARE Malawi as an element of a project aiming to develop innovative and sustainable models to improve health services. It is conceptualised in CARE literature primarily as a mechanism for joint problem-solving in service delivery, bringing together the 'demand side' of service users and the 'supply side' of service providers at the local level (CARE Malawi, 2013). In this way, it picks up on the emerging trend identified above – namely, a shift from a focus on social accountability exclusively as a tool for voice and empowerment to recognition of the 'accountability sandwich' and the need to bring together supply and demand to solve collective action problems.

As such, CARE strongly emphasises that the CSC mechanism is designed to encourage constructive and systematic feedback to service providers, rather than to create conflict within communities or provide a mechanism for the criticism of individual service providers. The CSC programme is presented primarily as a mechanism for the monitoring and evaluation of service provision, allowing authorities to engage in 'informed decision-making', as well as increasing transparency and accountability between citizens and service providers. While a theory of change is not explicitly set out, the framing of the CSC does highlight a number of key features.

There are a number of core activities for the CSC programme, in terms of initial sensitisation, development and conduct of the score card process (first in separate groups and then collectively as a village), and the use of interface meetings to report back on findings and identify action plans. In line with the focus on the 'accountability sandwich', emphasis is placed on interface meetings and facilitation of constructive feedback between service users, service providers, local leaders and local decision-makers.

The focus on community is important too, as the process aims to bring together communities to provide collective feedback (and, where scores conflict, these are mediated to collectively identify a shared score), rather than having an emphasis on individual-level feedback and response. The long-term objectives or outcomes sought are both improvements in service delivery (particularly better access or quality) and improvements in relationships, including accountability relationships, between service users and providers.

As such, we can identify a number of assumptions that might underpin such an approach. These include:

- That the state is prepared to be scrutinised by citizens and can exert control over service providers;
- That providing the state with additional evidence on citizens' perceptions of service delivery will contribute to evidence-based planning or resource allocations and their implementation;
- That citizens want to participate in decision-making processes, and are able to do so effectively;
- That bringing together different stakeholders at the interface meeting will result in stronger collective action and collaboration.

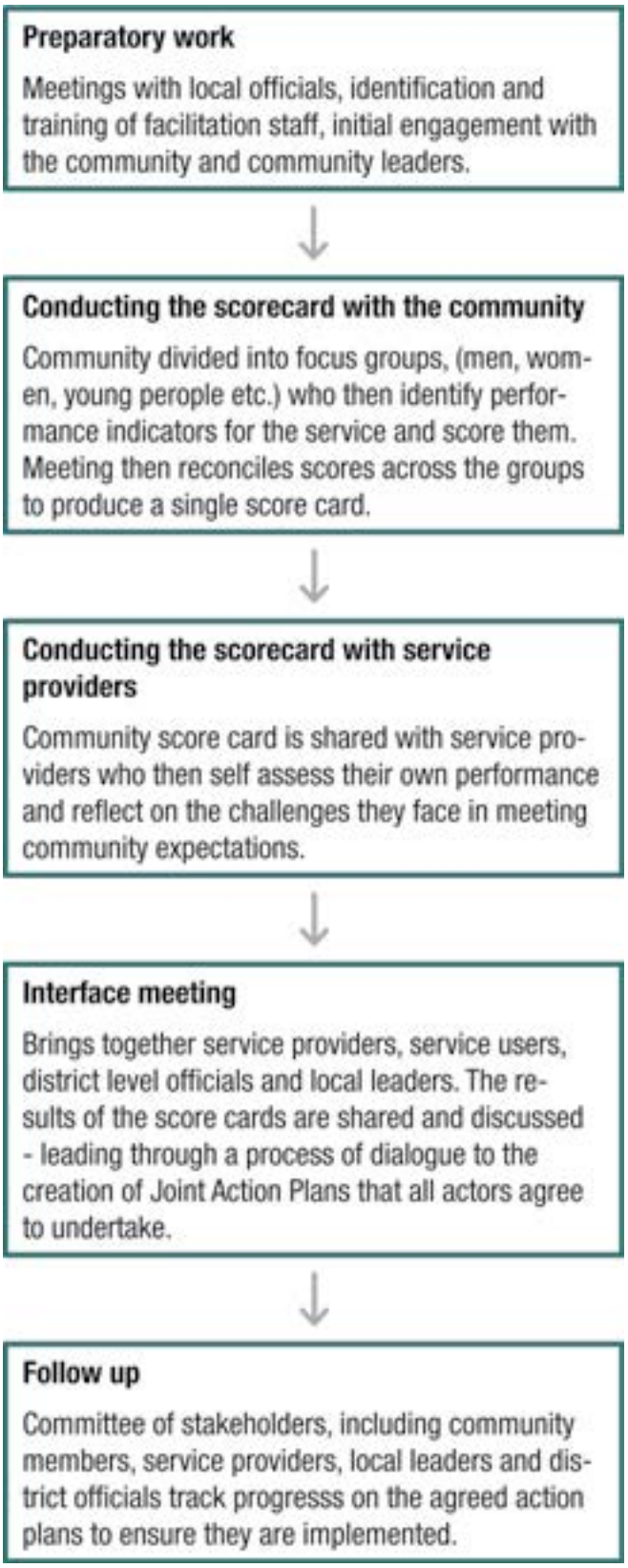
In the following sections, we explore how these assumptions compare against actual implementation in all four countries. Figure 1 (overleaf) sets out the basic steps of the process.

Interviews with CARE country offices expanded on the contents and purposes of these phases and allow us to define a common process.

Phase 1 involves planning and preparation. There are a number of components to this. The first is the **sensitisation of officials and selected communities.** Before initiating the CSC process on the ground, all CARE offices engaged in a series of meetings with local government officials to outline the purpose and process of the CSC and to secure their permission, buy-in and support. These meetings usually began with the highest authorities in the local government structure and then cascaded down the hierarchy of the service sector and administrative areas concerned. The selection of communities intended to provide a focus on more marginalised and under-served communities. In addition, selection of areas was based on the operational presence/experience of implementing agencies and the preferences of or coordination with local government.

The second is the selection and **training of facilitators**. A wide range of implementing organisations and facilitators were used in different contexts, including CARE itself, CSOs, community volunteers and local government authorities. Different levels of training were provided – organisations were sensitised or given familiarisation

Figure 1 Basic phases of CARE's CSC process



Source: CARE Malawi (2013)

with the overall process, whereas selected facilitators were provided with tailored training to build their facilitation skills. The next section examines these in detail.

Moving on from the planning and preparation phase, Phase 2 involves conducting the score card in communities. A key step here is the **development and scoring of indicators by communities.** Participatory approaches were used in defining indicators for the score card, to reflect the priorities of communities. In some cases, a broad range of indicators was identified at the start (e.g. focus on health, or specific health issues); in others, communities were asked to define priority areas themselves. Selection of indicators and their scoring took place in a series of focus groups designed to encourage groups whose opinions might otherwise be marginalised – with separate groups for men, women, local leaders, youth etc. depending on the context. These groups would identify their priorities, and then come together (e.g. at community or village level) to agree a single set of indicators and performance scores across all groups.

These indicators were then **appraised and scored by service providers** (Phase 3) to evaluate their own performance and identify any problems they faced in delivering services to citizens.

Finally, in Phase 4, **interface meetings** were used to report back on score card results and to bring together service users and providers alongside a range of other stakeholders. In most cases, the entire community was encouraged to attend, along with service providers, local leaders and district-level officials, usually including the head of the local administration and high-level local officials within the specific sector of focus. Interface meetings provided a forum for discussion of the outcomes of the score card process, and for identification of joint action plans, with specific actions allocated to the different actors present.

Follow-up actions were developed, to monitor progress on action plans. This stage saw considerable variation across the different contexts, although almost all utilised meetings convening representatives of the main actors at regular intervals following the interface meeting.

As previous sections noted, the CSC programme operates at the community level and was conducted across a range of sectors within each country, from health to livelihoods and food security to WASH to women's empowerment. In some cases, programmes were implanted in rural and urban areas (e.g. Tanzania), but generally rural areas were the main focus across the countries reviewed. The nature of the sector and of the location of the programme, as well as the broader context, all shaped programme implementation in some important ways.

4. Adapting to context

4.1 Contexts for CARE's Community Score Card programming

The outline in the previous section set out some of the general steps envisaged for CARE's CSC model. However, as Section 2 noted, a key area of interest in recent years lies in understanding how social accountability programmes operate in different contexts, and how – and how well – they adapt to differing enabling environments.

To understand this, we first need to briefly review some of the core features of the contexts in which CARE is operating, namely, Ethiopia, Malawi, Rwanda and Tanzania. Although located in similar regions of Eastern and Central Africa, these countries have very different historical legacies, governance environments and service delivery modalities and outcomes. We briefly review below some of the main features of the political economy and service delivery contexts in each country, before looking at some of the trends and variance identified in how CARE's Community Score Card programmes operated.

Ethiopia

The national context

The Ethiopian People's Revolutionary Democratic Front (EPRDF), an organisation formed as an umbrella party of a number of ethno-nationalist groups, has ruled Ethiopia since the overthrow of the Derg military regime in 1991 (ICG, 2012). The leader of the Tigray People's Liberation Front (TPLF), Meles Zenawi, acted as chair of the EPRDF, serving first as the president of the transitional government and then, following a new constitution in 1994, as prime minister, until his death in August 2012. His successor, Haile Mariam Desalegn, is also chair of the EPRDF and has maintained the prevailing model of governance and development (The Economist, 2013).

The government has maintained a strong focus on long-term development, with improvements in growth and living standards seen as a major foundation for its legitimacy (Denney, 2013). Priorities are laid out in five-year Growth and Transformation Plans (GTPs), which set national targets and judge the performance of different subnational regions. Communities are involved in the process of national development through institutionalised public participation in committees at the local level, which undertake a range of administrative functions. This system is referred to in Ethiopia as 'revolutionary democracy'. In practice, it has meant strong government support to development projects has been accompanied by significant state oversight of citizens, emphasising past struggle and ideological commitment to 'revolutionary' reform (Hagmann and Abbink, 2011; Henze, 1998; ICG, 2012). In part, leaders have emphasised this in order to build unity in the face of significant diversity: Ethiopia is a multi-ethnic state with over 80 distinct ethnic groups and formally constituted in a system of 'ethnic federalism' (Clapham, 1988; Hagmann and Abbink, 2011).

Local governance and WASH service delivery

In recognition of significant regional diversity, the constitution formally allows for a high degree of decentralisation, albeit with a strong central state (Greene and Kebede, 2012). Ethiopia's nine regions are divided into a number of zones, which in turn are divided into *woredas* (districts) and *kebeles* (neighbourhoods). These are governed by elected regional parliaments and councils at the *woreda* and *kebele* level, with the EPRDF controlling the vast majority of seats following the 2010 local elections.

Research in Ethiopia focused on the WASH sector. At the subnational level, this sector is controlled by a WASH steering committee at the *woreda* level, water resource administration committees at the *kebele* level and WASH committees (WASHCOs) at the community level. Responsibilities descend from planning and authorisation at the *woreda* level to infrastructure management and maintenance at the community level.

The planning process for WASH programmes and construction is intended to be participatory, with opportunities to input into decision-making at different levels. Where there are resource constraints and limited ability to meet demand, for instance for the construction of water points, the *woreda* informs communities of available resources and provides application forms to stimulate demand; these applications can be proposed by WASHCO members and must be approved by the *kebele* before being passed on the *woreda* office for prioritisation and site selection.

Communities or their representatives will also participate during site selection. They contribute their labour through digging wells and site clearing, and provide local materials for construction (e.g. sand, stone, water etc.), initial capital savings at the beginning of construction work and monthly fees for guarding and maintenance of the water scheme. NGOs may contribute industrial materials and skilled labour, with the *woreda*

office responsible for monitoring and supervising construction quality. Following construction, communities are responsible for the management of the sites. Field interviews indicated, however, that WASHCOs in many areas were not highly active before the CSC process, and that there was a general lack of knowledge as to the respective responsibilities of these different levels and departments of government.

Ethiopia's history and structures, and the nature of formal and informal institutions, therefore create something of a contradiction. The formal rules support a highly decentralised system, with multiple opportunities for users to participate. Informal rules, however, mean power remains centralised around the president and at the centre, with a strong focus on oversight and supervision of citizens and local government. As a result, research by Dessalegn et al. (2013) has found that local government in practice can play the role of 'passive provider', lacking capacity, resourcing or substantive decision-making power to plan strategically or meet the needs of local populations fully.

Relationships between WASH service users and service providers

The relationship between service users and service providers in the Ethiopian context is complex, and difficult for external researchers to unpick, especially in light of the contradictions highlighted above (Denney, 2013; Epstein, 2010). While the formal commitment to decentralisation is recognised, others note that, in practice, there may not be substantive participation from communities and local government. For instance, Ludi et al. (2013) note that action plans for water sources and water basin management produced by higher levels of government do not always reflect the discussions and priorities that emerge from community involvement in planning processes at the *kebele* level. This can result in communities feeling a lack of ownership in practice over schemes in some cases.

Other studies have highlighted that, in some cases, there is a lack of clear feedback mechanisms between the community and the government, and find that '[l]ow capacity and insufficient skills of elected community representatives further limit "downward" accountability' (Aboma, 2009). Field research also highlighted information gaps citizens faced before the CSC programme, specifically community members and WASHCOs being unaware of the division of responsibilities between different departments, making it difficult to effectively raise issues or hold providers to account. Thus, while formal commitments to decentralisation and participatory approaches are in place, and there is relatively strong capacity in government at local levels, informal rules and norms can limit how well accountability functions in practice and the scope for users and lower levels of government to participate actively. In practice, this can limit the extent to which communities themselves feel they own development projects and participate in them.

Malawi

The national context

The introduction of multi-party democracy in 1994 in Malawi brought to an end almost 30 years of rule by one party (the Malawi Congress Party, MCP) and one president, Hastings Kamuzu Banda. Under this rule, all Malawians had to be MCP members and political opposition was banned. With the transition to democracy, the MCP disintegrated into several competing factions, and political parties became highly personalised, often held together by patronage networks (O'Neil and Cammack, 2014).

In practice, the introduction of multi-party democracy in Malawi, in the absence of well-institutionalised political parties, resulted in forms of what has been termed 'competitive clientelism' (O'Neil and Cammack, 2014). As parties did not have effective party structures, with links to grassroots bases, and as no one party was able to dominate, they tended to result in fluid coalitions based on clientelist networks. This undermined the establishment of a longer-term development vision, with few incentives for political parties to focus on more complex, longer-term development challenges (e.g. improving the quality of teaching or ensuring a reliable supply of medicines). Instead, they focused on solving localised problems, especially around elections, that required visible solutions. For instance, Constituency Development Funds were often used for activities like the quick construction of school toilets or classrooms, or borehole provision (DFID, 2011; O'Neil and Cammack, 2014; Welle, 2005).

At the time of this research, Joyce Banda, of the People's Party, held the presidency, having taken office after the death in office of the previous president (Bingu wa Mutharika).

Local governance and service delivery in Malawi

Malawi's constitution and legal framework enshrines the commitment to devolve political and administrative authority to local government, with elected local councils and popular participation in local development planning.

In practice, when multi-party democracy was introduced in 1994, local councils were dissolved, as they were seen to have been dominated by the MCP. In 2000, competitive local elections were resumed, but they dissolved again after the election of President Mutharika in 2004. At the time of writing, local council elections were scheduled for May 2014.

As a result, while Malawi has undergone some forms of decentralisation, there has not yet been significant political decentralisation, and administrative and fiscal decentralisation has been rolled out in *ad hoc*, uncoordinated and disrupted ways (Chiweza, 2010). While local councils have been suspended, *ad hoc* decision-making forums have developed at district level, in the form of the district consultative councils (with representation from district commissioners, MPs, chiefs and others), with the district executive committees as its technical arm. These are not legally constituted but have evolved as forums for

information-sharing and decision-making on a limited number of urgent issues (Ibid.).

This means 'dual administration' persists – in which there is divergence between how systems and decision-making should happen (the formal system) and how it happens in practice, with a proliferation of overlap and fragmentation within local governance. In practice, new local government laws and systems have been introduced, and some functions and resources devolved, but without clear direction, coordination or enforcement, leading to high levels of 'policy incoherence' (O'Neil and Cammack, 2014). For example, local officials are employed by a variety of departments with multiple lines of reporting, district-level planning is not well aligned with sector- and national-level planning processes and even financial systems (such as the Integrated Financial Management Information System) are not coordinated between district and national level (ibid.). Decision-making is often highly personalised, in light of this institutional fragmentation, and can be concentrated around the district commissioner, MPs or local leaders (such as traditional chiefs). While there are important differences between sectors, as some have been devolved more than others (e.g. education much more than water), these governance challenges have been identified as shared across basic service delivery sectors (ibid.).

Relationships between service users and service providers

While there is strong emphasis on local-level participatory approaches for development planning, in practice various reviews have found this to be weak or ineffective in practice (Chiweza, 2010; O'Neil and Cammack, 2014; OPM, 2013). Despite formal commitments, informal norms and rules and the system of 'clientelistic competition' referred to above, in practice decision-making is largely top-down.

This means officials and politicians tend to communicate information and decisions downward rather than allowing for feedback and effective participation by communities. Although a number of forums exist for community participation (such as village development committees, village health committees, school management committees and so on), these are often non-functional – unless there is support by a third party such as an NGO; if they do convene, they may have limited impact on actual planning and decision-making processes (O'Neil and Cammack, 2014; OPM, 2013). This has been identified as a particular challenge for health, although again similar dynamics are identified in other sectors too (OPM, 2013).

Downward accountability of service providers and government to communities is therefore generally weak, and local government is not seen as particularly responsive to civic pressure. Other stakeholders, such as traditional chiefs, can also be important gatekeepers between communities and providers. Research in Malawi examined the health sector and food security programming.

Rwanda

The national context

Rwanda has been profoundly affected by the events of the genocide in 1994 and the evolution of the state in the post-conflict era. The national context today is characterised by the presence of a strong state, led by a disciplined political leadership, with a strong commitment to achieving defined development goals (e.g. improvements in health, education, access to information and communication technologies and so on).

There are differing interpretations of this context: some perceive the current government as a dictatorship, in which political and policy debates are highly constrained (Reyntjens, 2011). However, others argue the post-conflict political settlement in Rwanda may be somewhat more inclusive; Golooba-Mutebi and Booth (2013), for instance, argue the political settlement is based on a commitment to three central pillars: power-sharing and the avoidance of ethnic politics at all cost; the rejection of competitive clientelism, which translates into a zero tolerance of corruption; and reconciliation through development.

Since the post-conflict state-building process began, the government of Rwanda has made remarkable progress on a number of development indicators. This has been attributed partly to a strong, top-down and coherent policy direction and the introduction of effective performance monitoring systems (Chambers and Golooba-Mutebi, 2012). Intentional or not, these systems have included local-level input into national planning processes and forms of bottom-up feedback. For instance, *ubudehe*, a national poverty reduction initiative, is a mechanism through which fellow villagers identify the poorest and most vulnerable households as priority recipients of assistance and villagers are able to identify priority concerns as an input into district development plans.

Local governance and service delivery

There has been a strong commitment to decentralised structures in Rwanda. In practice, as long as they remain in strong alignment with the government's national plans and its development and political agendas, district authorities are able to function autonomously from the centre. They have control over their budgets (how funds are raised, allocated and spent), district development plans and facilitating collaborative arenas for involving citizens in these processes. In addition, district authorities exercise administrative control of service delivery facilities (such as schools and hospitals) and make decisions around staffing issues.

District local authorities (and their lower administrative levels – sectors, cells and villages) are answerable to locally elected councils at various administrative levels (and elections are not conducted along political party lines, as all councillors formally stand as independents). Responsibility for monitoring and supervising basic development and service delivery objectives (i.e. in health and education) is shared by local authorities and service

providers, undertaken within policy frameworks enacted at the central level. Collaborative spaces that bring together technical and administrative providers exist and function (i.e. forums like the Joint Action Development Forum, health committees etc.).

Relationships between service users and service providers

A number of mechanisms have been introduced to enable citizens to participate in local development planning processes, and through which they can theoretically hold local leaders and service providers to account for the services they deliver (*imihigo*, *ubudehe*, *umuganda*, district open days). While these spaces exist, they have been fostered in a framework of top-down, centrally driven policies and within an arena whose boundaries are defined by the state (Chambers and Golooba Mutebi, 2012).

While concerns are often expressed that local leaders and service providers are more accountable to the central level than to the local population, and that the local population's willingness and capacity to challenge local leaders and service providers is constrained, other accountability mechanisms are in place in an attempt to counter this. The annual national dialogue is one example of a high-level accountability mechanism that attempts to bridge the gap between the local and the national level. It provides a forum through which Rwandan citizens can openly challenge the effectiveness of their district authorities in a national arena. The Rwandan government has also embraced social media as a means of providing local populations with channels for holding local government to account at the national level. Overall, strong accountability mechanisms are built into service provision, from the local level to the national, and these are enforced.

Tanzania

The national context

The political landscape of Tanzania remains dominated by the Chama cha Mapinduzi (CCM) party, which has ruled the country since independence in 1961.[1] As a result, power is thought to be highly concentrated within the executive branch of the government, with the civil service and machinery of the state deeply intertwined with the structures of the CCM (Hoffman, 2013; OPM et al., 2005).

The political dominance of the CCM is based in part on its ability to use its control of the state to provide public goods with mass appeal and to give representatives access to resources that can be channelled to citizens (Hoffman, 2013; OPM et al., 2005). At the same time, the CCM has maintained considerable support and political legitimacy in its own right and seeks to maintain this, while balancing its own internal politics (Hoffman, 2013; Hussman and Mmuya, 2007).

At the national level, relevant ministries determine overall policy and have a major influence on budget allocations to particular programmes and regions. MPs have an oversight role and are able to raise issues in parliament to gain national attention, but in practice have little influence over policy, given the strength of the executive. Their main impact at the district level seems to lie in their ability to secure and broker resources for their constituencies, and they are generally more active around elections.

Local governance and service delivery

While service delivery has been largely decentralised in Tanzania, the way this has been implemented has meant that, at the district level, lines of authority can be unclear. The district executive director is the head of the civil service at the district level and so has considerable formal power, as do district officials beneath him. The district commissioner, however, is head of the district, and acts as representative of the president and the ruling CCM party at the district level. This reflects historical legacies in which local councils and local government have been vehicles for entrenching the authority of the ruling party, which has sought to dominate at local level too. Local government positions can be important sources of informal power.

The district commissioner therefore has considerable influence over the district civil service and politicians, while local councils and councillors exercise informal power through their links to higher levels of political authority, both within and outside the CCM, as well as having formal power over local budgets and policies. The ruling CCM has considerable influence through a network of patronage and political clientelism too, which reaches through all levels of the governance structure, although this influence is not always coherent in its aims. The degree of engagement these actors demonstrates varies dependent on the individuals involved and also the electoral cycle, with councillors seen as much more engaged during and immediately after elections.

Research in Tanzania focused on the health sector. Within the health system, at the district level, power is concentrated in the district medical officer and the council health management team. These actors have a major role in oversight, planning and distribution of local resources. At the health facility level, the clinical officer-in-charge also has considerable influence on village decision-making on health matters, sitting on several major committees, and in theory, acting as the link to the health service at large. These officials and health workers also have a formal role in terms of conducting outreach to communities, both to mobilise them around health issues and to respond to their views and concerns. Interviews suggest these activities are neglected in many cases, because of a combination of heavy workloads and inadequate resources. However,

1 The CCM was formed in 1977, but was the successor party to the Tanganyika African National Union (TANU), which led the independence movement in mainland Tanzania in 1961 and ruled from that point onwards.

this neglect also fits into broader patterns of top-down decision-making and vertical accountability.

Relationships between service users and service providers

In theory, mechanisms for citizen and civil society representation play a considerable role in planning and oversight. These include village social welfare committees, ward health committees and health facility/dispensary committees. However, in practice, many of these institutions have little impact on plans and are either moribund or effectively co-opted. At the district level, the council health board has more of a role but still acts largely in an advisory capacity. Moreover, citizens may be reluctant to engage with officials because of a perception that their views will not have an impact and local governments may privilege their own knowledge and prioritise implementing projects and targets set at the national level (see Hoffman, 2013; Mollel, 2010).

Village leaders, both elected (hamlet leaders and village chairs) and appointed (village executive officers), play a key role in terms of mobilising their communities for specific health-related construction projects, such as building or expanding dispensaries, health centres and other structures. However, they rarely take the initiative to engage in these without support from district officials or local councillors. It was also noted by some project staff that the chair of the health facility/dispensary committee can have influence under certain, unspecified, circumstances. Traditional leaders or governance systems appear to play a limited role outside of these positions, and were not mentioned in interviews conducted for this study. The role of these figures is generally agreed to be less prominent in Tanzania than in many other Sub-Saharan African countries (see Logan, 2008 for analysis of recent trends in traditional authority).

Accountability relationships between communities and politicians are based largely on patron–client relations, with interactions becoming more intense during election periods. Councillors and MPs are expected to deliver resources to their communities, but there is little direct accountability, particularly given the long dominance of the CCM and the top-down nature of its rule. However, it was noted that politicians had generally become more responsive to public demands since the 2010 election, with this being credited to the consolidation of the multi-party system, more widespread knowledge among the public and the strengthening of opposition movements.

4.2 Common and divergent themes across contexts

There is significant diversity across the countries analysed for this study, as the previous section highlighted, but a common theme of a gap between formal rules or institutions and informal norms and rules that can determine why things work as they do. These informal norms might reflect historical legacies and power relations; the nature of patronage and clientelistic networks; or social norms. Rwanda stands out in this context, in that its formal and informal rules are relatively consistent – not least because, in a number of examples, formal rules have sought to build on pre-existing informal norms (such as the concept of *ubudehe*). Where formal and informal rules diverge, this can create particular challenges for designing and implementing projects of any kind, as these need to pay attention to both formal policy frameworks (laws, policies) and informal realities that shape how systems really work. Understanding the extent to which CARE's CSC programmes was able to operate in these environments was therefore a first key issue for analysis.

Moreover, all contexts analysed have formally decentralised service delivery, but, in line with the point above, closer attention is needed to how this has been implemented, for what purposes and to levels of political backing and support. For instance, in Malawi there has been very little political decentralisation in practice, owing to fears that local councils would become vehicles for opposition parties. This has led to highly fragmented and incoherent systems, whereby some aspects of administrative decentralisation have taken place but with limited financial and political decentralisation. For Rwanda, decentralisation has been implemented by, and remains in the context of, a strong central state. There has been political decentralisation, but in ways that are seen as less threatening to the ruling party (e.g. local councillors are not elected on party lines). As a result, there is a highly coherent policy framework, in which district, sector and national plans and processes are aligned. Related to this is variance in the capacity of decentralised authorities to act autonomously and control budget, services and so on – some level of autonomy (if aligned to central plans) was identified in Rwanda, with increasingly more centralised decision-making in Ethiopia, Malawi and Tanzania, linked to the way decentralisation operates in practice.

Both Rwanda and Ethiopia are recognised as having strong central states, oversight mechanisms and leadership, with political leaders focused on achieving particular development objectives. However, there are important differences too, highlighting the need to pay attention to how these objectives are achieved within this overall political framework. For instance, Ethiopia operates in a federal model, with a high degree of ethnic fragmentation; in Rwanda, there is a strong commitment not to recognise ethnic differences, as a legacy of the conflict in the 1990s. There are also differences in the processes and mechanisms of control. In Rwanda, there is strong emphasis on performance, and strong accountability upward for performance; in Ethiopia, there is greater emphasis on top-down supervision and surveillance.

Malawi and Tanzania also show some similarities, in terms of their characterisation as more fragmented

governance environments, in which there are limited performance monitoring systems, and where political interference to direct resources towards patronage networks is recognised. Again, however, there are important differences too. Tanzania operates in the context of one-party rule, in which the CCM seeks to maintain its power through both maintaining its perceived legitimacy and the use of patronage networks. In Malawi, several parties compete for power, and do so using patronage networks and highly personalised party structures. As successive parties gain and compete for power, they have sought to dominant local structures for service delivery. In Tanzania, there has been greater continuity of control.

All of this poses implications for the capacity of citizens to participate in decision-making or to have a say in how services are delivered. Overall, citizen involvement in service delivery is generally weak in all countries analysed, although there were important differences here too. In Ethiopia, there are institutionalised provisions for citizen participation in service delivery, as the WASH examples described above show. However, this is highly circumscribed, in that it takes places within very specific parameters and does not allow much space for providing feedback or altering decisions. In Rwanda, again there a number of formal mechanisms for citizen participation that are operational, but again this is very much framed by the state, and fieldwork highlighted that citizens can lack the willingness to challenge those in authority. In Tanzania and Malawi, formal spaces for participation are often non-functional and lack institutionalisation.

4.3 Adapting the model to context

CARE's CSC model was adapted across these contexts by CARE staff seeking to contribute more effectively to change. This section identifies the most significant adaptations and their contribution to the impacts achieved. A striking finding of this research is that there is no single way in which change has been achieved in each context. Instead, multiple pathways have been utilised within each country to take advantage of different opportunities and challenges. The ability to work effectively in different settings appears to reflect the ability to operate flexibly, and to adapt and respond to changes over time, something we return to in Section 4.

4.4 Sensitisation and engagement with local stakeholders

The most basic enabling factor needed for CARE's CSC processes across all four countries was the cooperation and support of the community in question *and* government actors. The formal decentralisation of service provision in all of these contexts meant local government was the crucial government actor to secure support from, and this was in line with the overall emphasis on collaboration across supply and demand sides.

Moreover, in all contexts, we noted the difficulties communities faced in effectively holding service providers to account and the failures of formal mechanisms in terms of providing feedback to the government, as described above. This is driven by different factors in each country, and varies in its intensity, but nonetheless remains a common theme.

For example, in Tanzania, many of the mechanisms designed to provide community oversight and accountability have been co-opted or are essentially moribund, while health worker outreach responsibilities are generally given a low priority – creating a gap between service users and providers. In these cases, the CSC process had to overcome a degree of mistrust as to the prospect of citizen voice having an influence on service delivery decisions.

Similarly, in Malawi, downward accountability of service providers and government to communities is generally weak, with citizens having little faith that local governments will respond to civic pressure or has the capacity to respond. In both Rwanda and Ethiopia, there was a perception that service providers were responsive to the hierarchy of the state, rather than to citizens, and so willingness to challenge service providers was initially limited. In recognition of this, there was a common emphasis on the need to build trust between the actors involved in the process as a crucial first step, which often meant overcoming low expectations based on past experiences of engagement too.

One of the main mechanisms used across CARE's CSC programmes to do this was the selection of implementing organisations that already had links and established credibility with the community and government. In the case of Tanzania, for instance, CSOs and NGOs were selected on the basis of having existing or historical operations in the areas the CSC programme was to be implemented in, thus ensuring links with communities and local officials. In Rwanda, the Isaro/PPA programme was implemented through existing village savings and loan associations (VSLAs) and the PPIMA programme through NGOs already operating in the region. This ensured these organisations were known to officials and had an existing organisational structure. In Malawi, the long history of CSCs saw experimentation with a range of approaches. Some programmes were implemented through a locally embedded community-based organisation (e.g. SMIHLE), whereas a more recent, large health programme was implemented by CARE but designed to be embedded within local district structures (such as district health management committees).

Ethiopia provides the largest contrast, in that local government at the *woreda* level was the main implementing actor, with the support and permission of the zonal government. This reflected the nature of the operating environment in Ethiopia, as, for any programme to have traction, it needed to be closely associated with, and

sanctioned by, the government, especially for external NGO initiatives. At the local level, the lead role the government played and its authorisation of the process made it acceptable for service providers and users to participate.

The framing of CARE's CSC programme played a role in ensuring government cooperation. As the main providers of services, local government officials were generally targeted for sensitisation and familiarisation very early on in the process. The main tactic used was to frame CARE's CSC programme as a mechanism that would provide higher-level district officials with information that would allow them to improve service provision.

This is not currently stressed in CARE policy documents, beyond recognition of the use of the CSC as a mechanism for service providers to monitor progress and service quality (e.g. CARE Malawi, 2013) but seems to have been a particularly important ingredient. A strong emphasis was placed on the CSC as a positive process of exploring and solving problems collectively, rather than as something that would create additional burdens for decision-makers. This made the programme easier to justify to lower-level officials and service providers too, who – interviews suggested – otherwise would have worried about individual criticism and scapegoating.

The precise targets of this sensitisation varied across the different contexts. Countries with stronger hierarchies within the state saw more of a focus at the regional level as well as on local government officials, whereas in Tanzania and Malawi the focus was strongly on local (district) government officials but also included important political actors, such as elected local councillors and village leaders in Tanzania and traditional authorities in Malawi. In many cases, officials were initially sceptical about the process but more enthusiastic once they had experience of its operation and outcomes. In Tanzania, in particular, there was a much higher level of enthusiasm for the second round of the CSC programme than for the first, as officials had seen the benefits the process could bring.

4.5 Working with communities

As Section 2 discussed, the broad approach for CARE's CSC programme contains a number of assumptions, regarding first the willingness of communities to share information on service provision with the relevant authorities and second the willingness and ability of those authorities to act on that information. CARE staff adapted the CSC process in most contexts to help create incentives for participation in a number of ways.

CARE's CSC programmes were adapted to ensure community engagement partly through the trust-building strategies noted above, but also through a number of adaptations to ensure the process reflected community priorities. In most cases, the CSC programme covered a predefined service sector, but within this the communities had varying degrees of freedom in choosing their priorities for setting service provision indicators.

For instance, in Malawi, MWWa gave communities the freedom to select their own indicators, whereas in Tanzania the process was guided by national standards for service delivery. PPIMA in Rwanda arguably provided the greatest degree of flexibility, with communities able not only to select their own indicators but also to define the sector of focus for the CSC process (drawing from agriculture, health, education, infrastructure and WASH). A significant contrast is found in Ethiopia, however, where communities discussed and scored the problems they had experienced with service delivery but government facilitators were then responsible for developing and evidencing indicators. This adaptation reportedly reflected in part a desire by the state to maintain influence over the process, but also served to ensure the issues raised and supporting information were credible to service providers and local officials.

All CSC programmes had a stated aim to address those service provision issues facing more marginalised groups, particularly women. Ensuring the participation of these groups was challenging in practice, however. Most of the programmes attempted to integrate them by creating subgroups during the process of discussing and scoring service provision issues, before then reconciling them at community level. However, it is notable that there were relatively few examples of specific gains made for more marginalised groups (see sections 5 and 6).

The only major success noted was in Rwanda, where Isaro/PPA programme focused chiefly on GBV and VSLA groups facilitated the process. However, in practice, our research found these VSLA groups in fact often comprised local elites, and they were able to have impact precisely because their members were well respected and listened to, rather than because they represented the poorest or were working substantively to support the most marginalised. Overall, it would seem the adaptations to the process were a success for generating community participation and information generally, but that the elements around marginalised groups required further development.

4.6 Working with local leaders and decision-makers

The second element, a willingness and ability of authorities to act on the information they receive, was also the subject of adaptions to CARE's CSC process in several instances, allowing strategies akin to that of the 'accountability sandwich' idea described in preceding sections.

In contexts where there is a strong central state and an emphasis on top-down accountability, as in Ethiopia and Rwanda, the balance of power at the local level is determined more by government officials than by elected politicians, and their incentives are strongly shaped by performance targets set at the national level. The framing of CARE's CSC programme as a mechanism through

which local government officials could improve the performance of services was thus a highly effective way in which CARE could ensure interest and action based on the information produced by the process.

There were some important differences between Ethiopia and Rwanda, however, in terms of how this was implemented. In the case of Ethiopia, the national GTP set out targets for all levels of government on a range of socioeconomic and development indicators, whereas in Rwanda there are district performance contracts based on service targets as a part of the *imihigo* system. In practice, this meant the latter was more institutionalised, with more incentives for civil servants to act on the basis of information provided. For instance, in the case of several villages (10 out of 25) involved in PPIMA, the implementing organisation made a decision to bypass the interface meeting – usually a key element of the CSC process. However, this did not undermine the service provider's commitment to finding and implementing a solution in response to the priorities and problems the communities raised during the scoring process. This reflected the fact that spaces for feedback were already well institutionalised in Rwanda, hence the CSC programme could use them rather than having to invent them as part of programme activities. This was the only example identified of this across all four countries.

The adaptation of CARE's CSC process in Tanzania adopted a different strategy, to reflect the presence of elected politicians, the relatively weak insulation of the civil service to political pressures and the lack of institutionalised community participation. CARE ensured local councillor attendance at the inception and interface meetings and politicians were notably engaged and active in the follow-up processes for the action plans, engaging with government officials and each other to improve services as required. Given the prevalence of patronage politics in Tanzania, and the strength of the CCM, it was not guaranteed that politicians would have strong incentives to engage with the process. However, the CSC programme took place in the run-up to the 2010 elections and in a region where opposition parties had been making electoral gains. This timing, and the competitive nature of Mwanza region, provided an additional incentive for politicians to monitor and act on information from the community; it is notable that the engagement of councillors diminished significantly following the election.

In contrast, the absence of local councillors in Malawi meant a strong focus on district-level government (including individuals like district health officers and groups like district health management committees). In practice, implementation needed to involve a wide range of other actors involved in local-level service provision too, including local leaders such as traditional chiefs.[2] Involvement of more senior representatives, such as paramount chiefs, was deemed an important part of the process, alongside working with local government, and reflects the institutional diversity and fragmentation in Malawi.

4.7 The role of service providers

In several circumstances, CARE's CSC programme seems to have empowered service providers to raise the difficulties they face in delivering services with their superiors in local government. This is an interesting finding, as it is not something currently highlighted in much of the prevailing social accountability literature or in CARE's CSC guidance.

In all the countries studied, frontline service providers reported challenges they faced in raising problems to higher-level managers or supervisors, especially where this involved criticism of government policy or superiors' actions, or would involve revealing the extent to which local conditions had forced them to deviate from established regulations. In Malawi and Tanzania, service providers stated that they were unwilling to criticise people more senior than them and that it could be risky to speak out. Similar issues emerged in Rwanda, but were related more to service providers not wishing to acknowledge to their superiors that they were adapting government regulations.

In practice, implementation of the CSC programme in these countries provided a forum in which service providers could explain the challenges they faced to both citizens and their superiors. In Tanzania, for instance, issues around medicine stock-outs and staff shortages that affected both service providers and service users were raised at the interface meetings by the community – allowing staff to expand on these questions and receive information from their superiors without the risks associated with raising challenges and problems themselves. Links between service providers and individual superiors also seem to have been built up and maintained in some cases, allowing issues to be raised as they emerged as well as at the interface meeting. However, it is important to note that these do not seem to have been systematically maintained beyond the programme cycle.

An interesting example can be seen in Ethiopia, where the CSC process revealed issues around systemic errors in pay for service providers and enabled higher-level local government officials to intervene where previously no action had been taken. In Rwanda also, there were numerous examples of service providers taking the concerns of service users to the district authorities and achieving a redistribution of resources at this level. While similar redistributions occurred in Malawi and Tanzania, it is notable that in Rwanda this occurred through information passed up through the service providers, as a result of programme activities, rather than commitments

2 In Malawi, the structure of traditional authorities means every village contains a local chief (a village headman), with tiers of more senior traditional authorities at various levels.

made by district-level staff at the interface meetings themselves. It is possible that this empowerment to pass information upwards is more systematic and effective in strong and coherent states such as Rwanda, whereas individual linkages and commitments between service providers and district officials are more important in less coordinated states such as Tanzania and Malawi.

These dynamics do not seem to have been foreseen by CARE and the programmes were not explicitly adapted to produce them. However, adaptations made for other purposes (such as the framing of the CSC process as a mechanism to improve service provision, facilitation of interface meetings to be non-adversarial and the use of follow-up committees that mixed service providers and district-level officials) seem to have enabled actors within these different contexts to take advantage of the opportunities provided by the mechanism. Therefore, it may be important in terms of understanding what impacts might be expected in different contexts, rather than having explicit programming implications.

4.8 Interface meetings and collaboration

The interface meeting is generally seen as the main venue for negotiating effective forms of collaboration, as Section 3 noted. This is also the main area of adaptation by context. These adaptations focus on the actors who are present at the meeting, with priority given at local levels to those who have credibility to play a brokering role between groups or actors whose behaviour could be altered. These are necessarily framed by the level at which problems are occurring and the nature of the context.

In Ethiopia, Malawi and Tanzania, for instance, the presence of local authority figures and higher local government authorities was a major aid to brokering in each. In Malawi, these include traditional chiefs, while in Tanzania local councillors played a more major role. This reflects the lack of elected authority at the local level in Malawi, but also the fragmentation of local government decentralisation processes. In contrast, Tanzania has less fragmentation, given its long history of one-party rule, but the credibility of formal government contributions may be in doubt because of the intertwining of the state with the ruling party. In both Malawi and Tanzania, there are examples of these local leaders being able to negotiate and enforce agreements outside of the context of official commitments and mechanisms. The role of local leaders and credible CSC facilitators in brokering between actors therefore seems to have been a key strategy pursued in these contexts, but was less important in Ethiopia and Rwanda.

In Rwanda, actions were undertaken largely by local government and service providers, without significant community involvement. In some cases, it was not deemed necessary for interface meetings to take place, and information from the community was simply passed up through the existing hierarchy, which then responded.

In contrast, Ethiopia had several examples of collective action solutions, but with less of an emphasis placed on community self-organisation than on improved enforcement of agreements by local government. For example, the revitalisation of committees responsible for water facility maintenance was achieved less through renewed community action than through improved and more focused oversight from the local government. However, there was some evidence in Ethiopia of agreements being reached by communities outside of official mechanisms, for example water use rationing being agreed at a community level following the construction of a new water point.

In light of these differences, choices of implementing organisations and decisions as to which actors to engage at the various stages of the process (initiation, interface meetings, follow-up) were very important. To a lesser extent, the manner in which communities are engaged and the degree of control they have over the process seems to be relevant too.

It is striking that these elements are not always explicitly outlined in programme documents or reported against, and that the alterations and adaptations of the programme away from initial plans were not recorded. Some examples were noted where lessons may be passed informally, however. For instance, the experience of the CARE Tanzania CSC programme led to a new programme, initiated in another region, to prioritise implementing agents with a programmatic connection to the area. Isaro/PPA in Rwanda also seems to have drawn similar conclusions from its experiences with PPIMA – prioritising VSLAs that were rooted in their communities over national-level NGOs with district offices. In Malawi, MWWa placed a much stronger emphasis on local government as the implementing agent following the experience of the WE-RISE CSC programme, where sustainability following the formal end of the programme was a major issue.

5. What types of impact have been achieved?

As the previous section demonstrated, while CARE's CSC programmes follow a similar model across all four countries, there are some important differences in how it is implemented, to whom and by whom in each context. This section analyses the types of impacts that have been achieved across these different contexts.

It is important to note these observations are not necessarily representative, as the research specifically concentrated on areas of high and low impact in order to analyse important elements for successful impact. The impacts examined here are therefore selected to highlight the range of impacts observed and to demonstrate the different actors, levels of government and elements of service delivery involved in these changes.

5.1 Types and levels of impact

This report utilises the framework developed by the World Bank (2014), drawing on a large World Bank review of social accountability initiatives, to classify the types of impact observed across the various CSC programmes examined here. Figure 2 outlines this framework and usefully highlights how different types of impacts reflect changes for state actors, for societal actors or for state–society relationships. It posits these impacts across an 'instrumental' to 'institutional' spectrum – that is, where impacts are felt in terms of improvements in particular sectors or development processes (e.g. improved provision of public goods) through to more intrinsic outcomes, in terms of deepening democracy or improving governance.

From the results described below, we can see that the majority of the changes realised by CARE's Community Score Card programmes across all four countries are clustered around instrumental changes. These include both state-led actions (e.g. improved infrastructure or facilities, improved resourcing) and improvements in state–societal relationships (e.g. channels for interaction, collective action and problem solving). Some improvements were identified that are classified towards the 'mid-point' of the 'instrumental to institutional' scale, such as improvements in the behaviour and responsiveness of public officials (i.e. through the empowerment of frontline providers); improvements in trust between service users and service providers; and feelings of empowerment that were commonly reported by community members involved in the process – often framed in terms of increased respect and recognition from authorities.

The long-term sustainability of these 'mid-point' impacts and their transformational potential are unclear from this research. In the case of Tanzania, where the programme was completed several years ago, there was evidence that changes in behaviour and trust at the facility level had been maintained, but that impacts on empowerment and relations with the district level had deteriorated, except in cases where there were highly engaged district officials maintaining the process. In Ethiopia and Rwanda, where the state had a strong role in implementing and following up on the CSC programme, it is unclear whether these impacts were gradually transforming or actually reinforcing existing institutions and social relations. This requires further research.

Impacts classified as changes in state–society relations and those at the instrumental–institutional 'mid-point' were found in all country contexts, as Figure 2 notes, and seem to have occurred mainly at the level of the community. These included improvements in trust between service users and service providers as well as alterations in staff and

Table 2: Types of social accountability impact

	States ⟷	State–society ⟷	Social actors
Instrumental	Reduced corruption	Institutional channels for interaction	Improved provision of public goods
	Responsive public officials	Trust	Empowered citizens
		Legitimacy	
	Better policy design	State-building	Social cohesion
		Democratic deepening	
Institutional	Good governance		Inclusive social norms

Source: World Bank (2014).

community behaviour. They seem to have been the result of genuine improvements in respect and greater mutual understanding between groups. For instance, in Malawi, district-level officials felt that through the CSC programme they were better able to explain their own limits and capacity constraints, and service users felt they had a better understanding of the pressures health workers and district officials faced. There were documented instances too where relationships and linkages had improved between service providers and the local administration; the example from Rwanda discussed in the previous section highlights where frontline providers were able to share fuller information with their supervisors than was previously the case.

The instrumental category incorporates both changes in the working practices of service providers, including addressing corruption and improving staff discipline, and improvements in resources (such as infrastructure, personnel and equipment). Improvements in resources were common across all contexts, while alterations in working practices were more common in Ethiopia and Rwanda, and of a different nature than those observed in Malawi and Tanzania. In the former, these changes were enacted in a corporate manner – in other words, through enforced alterations to working practices of entire departments. In Malawi and Tanzania, in contrast, they focused on removing or transferring particular individual workers suspected of corruption or who showed poor working practices.

In part, these differences reflect some of the institutional dynamics explored in earlier sections, with Ethiopia and Rwanda possessing stronger, coherent governing structures that allowed local government authorities to act on information from the community and enforce revised practices. The lack of such structures in Tanzania and Malawi meant the response of the authorities was necessarily limited and they are able to act only on individual cases. This is supported by the fact that the only major alteration in working practices noted in these countries, namely, the creation of an out-of-hours service in Tanzania, occurred at the community level, outside of the official structures of the state, and contradicted national policies regarding the charging of user fees. It is also striking that the only instances of corruption tackled were in Malawi and Tanzania, where rent extraction systems are less centralised and so political cover may be more limited. There are also different sector dynamics here, in that, in health (a major focus for Tanzania and Malawi), the main focus is on relationships between users and frontline providers (e.g. a particular nurse, doctor or birthing attendant), whereas in Rwanda, the CSC focus was multi-sectoral and tended to involve actors working at different levels. We do not look at this issue in detail but do note that sector differences need to be taken into account too.

While local authorities were linked closely to most changes in working practices in Ethiopia, it is striking that in Rwanda there were numerous instances in which individual service providers and health facilities took the initiative to alter working practices following the CSC programme, rather than this being imposed from above. This may relate to the nature of relationships between service providers and policymakers in Rwanda, coupled with incentivising performance monitoring mechanisms that mean service providers feel a degree of ownership over service delivery targets and greater independence in terms of actions that can be justified as contributing to these goals. The existence of collaborative spaces in which service delivery staff can work with local government is also important in this respect.

In terms of improvements in resources, these were noted mainly at the local government level, with resource budgets and staff reallocated to areas covered by the CSC programme, often in cooperation with local communities (which, for example, may commit to provide labour towards certain infrastructure projects). No examples of additional resources channelled from higher levels of government were clearly identified, although in Tanzania shifts in national resource availability unrelated to the process did mean additional resources were channelled. Moreover, in some instances, also in Tanzania, local government officials did not reallocate budgets or staff *per se*, but rather allocated newly acquired resources to areas covered by the CSC process.[3]

It is notable that only in Rwanda do we have a clear example of information being channelled to the national level and contributing to policy dialogue at this level. Findings regarding practices for enforcing health insurance targets, derived from the CSC programme, were inputted into the district dialogue process, which was a complementary component of the wider programme (PPIMA). This information was then passed to several ministries and contributed to the government decision to review these categories at the national level. This particularly advanced national feedback loop seems to be a function of the strength and coherence of the Rwandan state. There were some attempts to escalate issues to national levels in Ethiopia as well;[4] at the time of the research these were not realised into concrete actions.

3 This may relate to the structure of local government there, with local councillors strongly defending existing allocations of resources to their constituencies but having less knowledge of or influence over the deployment of new resources. However, as only areas covered by the CSC process were visited, it is possible that councillors in other areas received some form of compensating inputs.

4 The question of improved access to electricity was discussed in several interface meetings during the Ethiopian CSC process; however, this is not an area that local government has authority over, so officials relayed this information to the appropriate higher authorities. No actions had been agreed at the time of writing.

5.2 Impacts arising from CARE's Community Score Card programming

In Table 2, we break down these impacts into seven broad types under the categories discussed above, outlining their distribution across contexts and providing brief examples of the different ways in which they were implemented.

Table 2 sets out a set of seven categories of impact observed across the four countries:

'Mid-point' instrumental–institutional:

- Improved trust and mutual respect (between users and providers);
- Changed attitudes and behaviours (of users or providers).

Instrumental:

- Altered working practices of frontline providers;
- Improved performance discipline of frontline providers;
- Reduced corruption;
- Changes in resource allocation;
- Infrastructure construction or rehabilitation.

Across these, it identifies the lead stakeholder for this impact, ranging from service users to service providers, local government or politicians. To understand better how these impacts manifest themselves, we document a range of examples in more depth below.

Table 3: Mapping impacts across context by type and key implementing actor

	'Mid-point' instrumental–institutional		Instrumental				
	Improved trust and mutual respect	Changed attitudes and behaviours	Altered working practices	Improved discipline	Reduced corruption	Changes in resource allocation	Infrastructure construction or rehabilitation
Ethiopia	Improved relationships between service users, service providers and local authorities	Increased sense of community ownership over services [SU] Agreement to ration water usage from improved sources [SU]		Chlorination of water sources [SP/LG] Reversed systemic errors in salary payments [SP/LG] WASHCO oversight [SU/LG]		Increased WASHCO activity [SU]	Water point [SU/LG]
Malawi	Improved relationships between service users, service providers and local authorities	Greater politeness to service users [SP]		Transfer of aggressive staff [LG]	Ending of attempts by primary education advisor to extort funds from parents [SU/LG]	Altered use of revenues from fines for non-health facility births [SU]	Staff house [SU/LG] Health centre [SU/LG]
Rwanda	Improved relationships between service users, service providers and local authorities	Challenged 'culture of silence' over GBV [SU] Greater politeness to service users [SP]	Creation of mobile HIV and reproductive service [SP] Alterations in staff schedules and deployment [SP]			Staffing for new nurseries [SU] Hiring of community members [SP] Additional staff [LG] Ambulance [LG]	Water pipeline [SU/LG] Health centre [LG] Road rehabilitation [LG] Nurseries [LG]
Tanzania	Improved relationships between service users, service providers and local authorities	Increased usage of health facility for births [SU] Men more engaged in health decisions of wife and children [SU] Patients more presentable when visiting health facilities [SU] Greater politeness to service users [SP]	Creation of after-hours service [SU/SP/P]	Transfer of aggressive staff [LG]	Head teacher dismissal [SU/LG]	Additional staff [LG] Health centre resources [LG/P]	Health centre [SU/LG] Staff houses [SU/LG] Health centre infrastructure [SU/LG]

Note: Key implementing actors: SU = service user; SP = service provider; LG = local government; P = politician.

'Mid-point' instrumental–institutional impacts

In almost all cases, CARE's CSC programme was accompanied by improvements in trust and relationships between service users, service providers and local authorities. Service users testified that they felt service providers and district authorities treated them with greater respect as a result of the process, that they took their complaints and concerns more seriously and that there was less of a barrier in relation to them approaching service providers.

Focus groups in Rwanda, for example, reported that, before the programme, local authorities were perceived as treating them as ignorant, but that the CSC programme had increased their credibility in the eyes of local authorities. Service providers reported that citizens were now more understanding of the difficulties providers faced in delivering services and less inclined to blame them for problems when they occurred.

In an example from Tanzania, service providers noted particularly that the input tracking and benchmarking

against national standards community volunteers undertook had helped service users appreciate the difficult circumstances under which service providers were operating and to better understand their perspective. This was also striking in Malawi, where one of the most commonly cited impacts by district officials was that the CSC process had given them a forum to explain their own limitations (something particularly pronounced in Malawi, with formal and informal recentralisation of power undermining the capabilities of local government).

Changes in attitudes and behaviour were seen among both service users and service providers. These were wide-ranging and included improvements in everyday interactions, altered attitudes towards accessing health services and a greater sense of community ownership. In Tanzania, both service users and service providers noted that, since the start of CARE's CSC programme, women were more likely to give birth in facilities and men were increasingly engaged and involved in health care decisions regarding their wives and children.[5] Patients were also apparently making more of an effort to be presentable and pleasant when attending health facilities. In several cases, most notably in Ethiopia, users reported an increased sense of ownership over service delivery and a greater willingness by service users to actively engage in provision and expansion (in this case for WASH). This helped enable other forms of outputs, particularly around collective action and infrastructure construction.

In terms of service providers, a range of relatively low-level changes in behaviour were noted, many of which corresponded with the improved relationships with service users described above – that is, being more polite and considerate towards patients. In Malawi, the process of engaging with communities, analysing the CSC results and conducting self-assessments was credited as having helped service providers better understand the impact of their actions and behaviours, leading to improved attitudes (specifically for health workers). Similar responses were also noted across a variety of other contexts.

The most remarkable alteration in attitudes and behaviours was documented in Rwanda. Women interviewed there stressed that before CARE's CSC programme there had been a culture of silence between women concerning gender-based violence (GBV). They credited the CSC process and the training surrounding it with empowering them to successfully bring these issues into the open, to challenge their husbands and to assert the rights they were previously unaware they had. Although it is unclear from this research what the long-term impact of this shift might be, it is a development in terms of the increased level of empowerment the women within these communities claimed to have experienced. Across these examples, a key element was sensitisation (bringing greater awareness of the impacts of individuals' own behaviour and that of others), supported by a third-party facilitator, who often provided ongoing support and encouragement to this process.

Instrumental impacts

A limited number of examples were identified of alterations in service provider working practices. Rwanda provides the main example of this, with several public workers altering their schedule in response to feedback from the community, and one health facility in particular altering its work patterns in order to provide a mobile service for HIV testing and family planning in villages. In Tanzania, CARE's CSC process and facilitation from a local councillor helped create an agreement between the service providers of a particular health facility and surrounding communities to pay user fees for service access outside of official opening hours.[6]

Some alterations in practice were the result of the imposition of changes from the district level on service providers too. Although in many cases these reflected disciplinary actions (see details below), there were some more positive examples, whereby district government appeared to respond to the concerns and difficulties facing service providers. Ethiopia provides the most interesting example of this: the CSC process enabled service providers to voice grievances that otherwise appear to have been neglected, specifically problems with wage payments, which were addressed as a result.

Improvements in frontline staff discipline and the enforced fulfilment of obligations more generally were manifested in several ways. In a number of cases in Malawi and Tanzania, there were transfers of personnel whom the community felt were particularly aggressive or antagonistic towards patients. A more generally observed phenomenon was district governments ensuring service providers were implementing policies thoroughly and in a way that did not unduly inconvenience citizens. This was observed particularly in Rwanda and Ethiopia, in the former case related to the way citizens' financial situation was assessed to determine the enrolment rates paid for health insurance; in the latter case it was the local health sector staff not taking responsibility for water purification. In Ethiopia, there was also a phenomenon of district governments being able to exert greater discipline and oversight over community committees in the performance of their duties, ensuring WASHCOs, whose role includes protecting and maintaining local water points, were performing adequately. Across all these cases, CARE's CSC process enabled information to better flow upward, from frontline providers to district staff who otherwise lacked the capacity to effectively monitor frontline staff.

5 This research was unable to verify these phenomena in medical records, although they were documented in CARE reports.

6 Pregnant women, children and the elderly were exempt from these charges.

Instances of corruption being addressed as a result of CARE's CSC processes were relatively rare. The single example from Tanzania operated through largely informal channels rather than due process. Community volunteers conducting input tracking during the CSC process came across evidence that the head teacher of the local school had been misappropriating funds. This resulted in public outcry from community members, following which the head teacher voluntarily accepted a demotion and transfer to another community. It is unclear if any official process of investigation accompanied this.

In Malawi, the SMIHLE programme uncovered cases of corruption, but successful outcomes seem to have occurred only where the case dealt with lower-level officials. For example, one community was able to use the CSC process to highlight attempts by a primary education advisor to extort funds from parents and successfully stop this practice. However, corruption identified in the management of the Constituency Development Fund, where accounts for a bridge-building project appeared to have been doctored, had not been resolved by the time of the fieldwork. The community had attempted to present this information to the local MP, responsible for the fund, and to local government officials. They reported a lack of follow-up, which was unsurprising given the influence of MPs and their ability to use these funds to further their own interests (see O'Neil and Cammack, 2014).

Changes in resource allocation were found at the level of the district government and primarily involved the provision of additional staff or of specific materials, for instance an ambulance in Rwanda and additional beds and birthing kits for a health facility in Tanzania. In contrast, examples in Ethiopia and Rwanda mainly involved utilisation of citizens' labour. For instance, in Ethiopia there was an increased level of activity from local WASHCOs (citizen committees with responsibility for protecting and maintaining water points), linked to increased community knowledge of their responsibilities and increased oversight from programme facilitators.

In Rwanda, for example, members of certain communities volunteered to staff nurseries if the local authorities committed to constructing and equipping them. In another example, a sector agronomist agreed to provide work for parents who were unable to pay school fees for their children. In Malawi, CARE's CSC also led to changes in the distribution of funds controlled by some local leaders. For instance, chiefs levy fines on women who do not give birth in health facilities;[7] as a result of the CSC process, where these funds were raised, in some cases they were directed towards investment in strengthening local facilities (rather than being kept by chiefs themselves). These illustrations highlight how the CSC process could support changes in the reallocation of resources or the raising of additional resources in a limited number of cases.

Infrastructure construction and rehabilitation emerged as one of the most common outcomes of CARE's CSC processes and covered a wide variety of sectors. In almost all cases, this involved a combination of communities providing labour and/or basic materials, while local governments provided a combination of materials, machinery or skilled personnel.

In Tanzania, there was a series of construction projects around health facilities (including staff houses, health facility extension and infrastructure such an incinerators). In these cases, the bulk of construction was undertaken by the community under the instruction of local government architects, with local government providing finishing materials such as roofs and equipment. In Ethiopia, a water point was constructed with the community contributing part-financing and basic construction materials (such as sand, stone, water etc.) and the work undertaken by the *woreda* water office, which hired artesian workers and provided equipment and oversight. The *woreda* contribution is particularly notable as it involved changes to the annual plan, with resources being reallocated for construction. CARE also provided industrial materials. Rwanda and Malawi had a number of similar arrangements, as detailed in the table above, but it is notable that, in Rwanda, there appear to have been fewer cases of joint community-local authority construction, with the latter undertaking the bulk of these tasks.

These projects rarely involved the provision of additional resources beyond existing local government allocations, something that holds across most other outcomes categories here, so these processes can be considered a form of collective action solution. The CSC process was able to facilitate both communities and providers or local government coming together and addressing shared problems. For communities, this meant mobilising them collectively, for instance to provide labour and to mould bricks or collect sand, and often involved the use of local leaders to ensure everyone contributed what they could. For service providers and politicians, a third-party facilitator (CARE or its local partners) was often able to mobilise different offices or individuals to collectively strategise and take action, for instance to identify different materials or contributions they could make. This was particularly important in contexts characterised by high levels of policy coherence and fragmentation, such as Tanzania and Malawi.

7 Historically, there has been a lack of clarity and consistency regarding Malawian policy on traditional birth attendants. Since 2007, traditional birth attendants have been banned, although in 2010 then-President Mutharika announced that it was wrong to ban these attendants. Since 2007, commentators have suggested that banning them drove them further underground, and international policy advice has moved from an emphasis on sanctions to one of incorporating them within the formal framework (see Cammack, 2012). Research carried out elsewhere suggests traditional birth attendants have continued to practise. Chiefs have also introduced by-laws to prevent or discourage women from giving birth at home. Given the vacuum created by the suspension of local councils, the legality of these bylaws has been questioned.

6. Why is change possible?

As our findings so far reveal, there is evidence that CARE's CSC programmes have been adapted to differing contexts in a number of ways, and have achieved a number of results and tangible impacts. Determining causal links is not straightforward, but, based on qualitative research including field-based interviews, we identify a number of factors that seem to have influenced whether and how different results have been achieved. These give us some insights into the key contextual features future programming needs to pay attention to.

CARE's policy guidance and practice already explicitly emphasise bridging supply and demand, highlighting the importance of collaboration, coalitions and joint working, and very much in the spirit of an 'accountability sandwich' strategy (Fox, 2007). By placing particular emphasis on shared community monitoring, the CSC programmes aim to facilitate local-level 'compacts' between communities and frontline service providers, emphasising information mobilisation of communities, rather than individually (of citizens), and placing greater emphasis on the collective experience of services and collective action to address problems.

Our findings reinforce that these are important components, and highlight that there can be numerous pathways and strategies to achieve them. Often, it can require working in highly flexible ways, and the involvement of a range of formal and informal actors and processes. It also requires highly adapted strategies for working with individual groups (communities, service providers, officials, decision-makers), highlighting the significant groundwork that needs to be put in before forms of joint action are possible. We discuss each of these in turn.

First, in Section 3 we noted the extent to which most of the CSC programmes analysed needed to operate in contexts where informal rules diverged from formal. This requires a high degree of flexibility and strong use of local knowledge to get at how things really work, as well as connected local partners who can broker relations and build networks. For example, we point to examples in Malawi where programmes have worked closely with and through traditional chiefs at different levels, or in Ethiopia, where the decision was made to work solely through the government in order to have sanction to operate locally.

In some cases, this can in fact seek to take advantage of informal room for manoeuvre. In Tanzania, a multi-stakeholder agreement was brokered between several communities and service providers to set up a mechanism for out-of-hours medical care. The villages in question were far from health facilities with longer opening hours and, in order to access services, had to pay for transportation or disturb off-duty health workers living in the community. These issues were raised by the CSC programme and led to an agreement that service providers would provide an out-of-hours service but that they would receive an informal fee from community members in return for this. This fee would be less than the costs of transportation to alternative health facilities and services would be provided without charge to pregnant women and the elderly. The local councillor for the area played an important follow-up role, by brokering an agreement between all village-level authorities in the health facility catchment area they would abide by these conditions too. This highlights effective, networked working and an innovative response that may have been difficult to implement through official channels, given the stated commitment at the national level to end user fees in health provision.

Second, a key first step – common across all the programmes analysed – was the emphasis placed on building strong relationships with local leaders and decision-makers. This required a number of strategies to build such relationships. Where they were most strongly established, emphasis was commonly placed on CARE's CSC programmes as a tool for decision-makers and local leaders, to support them in improving their delivery of services. It was often framed as a way of reducing the burden on these actors and service providers, by supporting collective problem solving and helping them become better informed about realities on the ground.

For instance, in Malawi, government officials emphasised that their engagement was made possible because the CSC programme was perceived as one that aimed to help rather than criticise government – as one respondent noted, 'It's not a witch hunt.' This went furthest in Ethiopia, where the notion of 'forward accountability' was developed specifically to tie into prevailing discourse and the operating environment for government. This emphasises the importance of getting buy-in for the process (and securing this relatively early on) and traction with providers and decision-makers. Often, this happens by presenting CARE's CSC approach as one of 'problem-solving' for all sides, rather than as one of criticising or improving the supply side only.

As discussed above, this engagement occurred at multiple levels. In Rwanda and Ethiopia, efforts were made to build relationships at the regional level of government, whereas in Malawi and Tanzania, only very local (district) levels were targeted. Sometimes, focus was

really at the level of the village itself. Thus, while the CSC is often promoted as a 'local-level' initiative, this highlights the need to unpack what is meant by 'local'. For some programmes, it may require working at multiple levels of 'local government' (regional, district and sub-district).

There were examples of this form of local-level working effectively capitalising on external events or windows of opportunity too. For instance, Tanzania provides an interesting example of proactively using the run-up to the 2010 election to widen the space for change, and benefited from a more competitive electoral climate in the chosen region (Mwanza). In Malawi, in contrast, there was less evidence of seeking to use an election period for change: the general climate was one of worry over the implications in terms of curtailing or undermining programme plans.

This initial framing on working with local leaders and decision-makers to improve service delivery, moreover, can then shape the overall aims of the programme as a whole. The primary emphasis in most of the programmes focused on ensuring forms of 'instrumental' impact – that is, improvements in terms of access to services or availability of resources, for instance. This type constituted the highest number of impacts identified, as Figure 2 highlighted.

Third, insights from engaging with service providers highlight some of the challenges that may need to be resolved in the supply side before links to demand side can be made. While there was an initial process of ensuring the buy-in of local leaders – by positing the CSC programme as one that could solve problems or make things better for decision-makers – this was often followed by localised strategies for solving short-term problems facing frontline service provider staff.

For example, across all the countries reviewed, frontline provider staff faced challenges in raising issues with their managers or supervisors or with those at higher levels. While this partly reflects the realities of functioning in a resource-constrained environment, this was especially the case where it meant criticism of government policy or the actions of superiors, and where it meant admitting they had to deviate from set regulations (even if this was the most practical/effective response). It was often reinforced by cultures where the questioning of peers was not seen as socially acceptable (as in Malawi, for instance).

Use of CARE's CSC provided opportunities for this information to be shared, sometimes for the first time, or taken more seriously (i.e. when presented as a group/collective concern rather than by one individual). Often, it gave frontline staff the 'cover' to raise issues they were otherwise uncertain of.

Rwanda provides an interesting example in this respect. As mentioned in brief above, the CSC programme brought attention to challenges with household poverty classification bands that provided guidelines on what household members paid for their health insurance (with those in higher bands paying more). Households reported being classified into the wrong categories, with this information then reported (via the CSC) at national level to several ministries. This contributed to a government decision to review these categories across the country. In this instance, frontline staff were empowered to raise an issue upward where otherwise they lacked the mechanisms to do so, demonstrating the creation of a real feedback loop between local and national policy decisions.

Interestingly, this emphasis on solving problems faced by frontline service provider staff often linked to some of the impacts on state–society relations identified above. One of the common benefits of the programmes cited was that it enabled frontline providers and staff to better explain their own constraints to users and communities. Malawi is illustrative in this respect, as in the current governance and economic climate service providers and local authorities find themselves facing very significant resource constraints and highly curtailed powers. In this context, the MWWa score card programme provided a forum where these actors could better explain their own limitations to communities, and hence better manage expectations, but often they faced real constraints in their ability to act on much of the information generated. Thus, it became less a model of using community-generated data to ensure better monitoring or resourcing, and more a forum for greater interaction and a better understanding of limitations and expectations on both sides. There were similar reports in other contexts too: in Tanzania, there were reports of greater understanding of local capacity constraints and in Ethiopia, greater trust and cooperation between users and frontline providers, for instance around WASH infrastructure construction.

This adds some interesting insights to the findings of others, which suggest equal attention needs to be paid to the responsiveness of frontline providers and that of state actors (both ability and willingness), and that a strong capable state might in fact be a prerequisite. As Section 2 noted, Jonathan Fox's work has emphasised the importance of building up interactions *between* citizens and public officials, and that these should trigger other formal processes (e.g. internal investigations, judicial reviews etc.). Similarly, in a large-scale review of World Bank projects that supported citizen engagement, Mansuri and Rao (2012) conclude 'there appears to be little reason to be sanguine about community-based monitoring or improving information provision to service users in the absence of a strong reform-minded centre, an active and independent media, and highly able communities' (p.124). Findings from Rwanda confirm this, in that the presence of a strong, reform-minded centre did drive uptake of information emanating from service users, in ways not possible for the other countries visited. However, findings from other contexts suggest there are ways of building up responsiveness, not least by helping solve some of the problems frontline service providers themselves might face, and these can take multiple forms.

Moreover, this form of 'empowerment' of frontline service providers themselves needs to be nested within indigenous accountability systems. Here, reflecting on comparisons between Ethiopia and Rwanda are useful. In Rwanda, strong upward accountability systems – reinvented from pre-existing cultural practices to fit contemporary circumstances – are accompanied by some forms of bottom-up feedback (such as *ubudehe*[8] and *imihigo*[9]). This creates space for linking this feedback to upward accountability, as seems to have been achieved in a number of examples. In Ethiopia, there is a strong sense of top-down accountability, and the score card programme explicitly became an oversight mechanism for *woreda* authorities. However, in this case accountability runs to this administrative level, rather than to local communities, and limited opportunities for these types of upward feedback loops.

Finally, it is worth noting effective implementation of CARE's CSC programmes involved sustained work within communities, to build up their trust and confidence in the programme. A key element here was often the ability to work with or through locally embedded organisations. These range from community-based organisations to VSLAs, and usually comprised people within a given community. These groups were given facilitation training, but were often selected because of a proven track record (or known history) of working well in identified communities.

One area where there was much less evidence of effective working was in efforts to reach the most marginalised or to secure significant improvements for particular marginalised groups. The research was not able to investigate this fully, but our findings suggest it may partly reflect the emphasis on collective responses and agreement for score card scoring, which may dilute individual claims and makes it more challenging to identify issues that affect one group only.

8 *Ubudehe* is a national poverty reduction eradication initiative, whereby villagers identify the poorest and most vulnerable households as priority recipients of assistance and through which villagers are able to identify their priority concerns as an input into the preparation of district development plans.

9 The concept of *imihigo* refers to the traditional practice of warriors making public pledges to their kings to engage in specific accomplishments. It was revived in 2005 to provide incentives to local government leaders to implement and meet local and national development targets. An annual *imihigo* contract is signed between the president and district mayor based on a clear set of national and local priorities and specific targets, selected by the district, backed by measurable performance indicator targets. Performance is evaluated on an annual basis and the mayor must report back on the progress towards the objectives directly to the president during a public meeting.

7. Conclusions: adapting programmes to context

CARE has more than a decade of experience implementing CSCs in a variety of contexts and sectors. This research has sought to assess how CARE's CSC programmes interact with, and influence, the wider context. From this, it aimed to assess impacts on their effectiveness and ability to secure long-term change.

This is a timely moment to reflect on this form of social accountability support. There is growing international policy interest in social accountability. However, we know the evidence is still mixed. What emerges from the growing evidence base is that we need to broaden beyond narrow 'supply' versus 'demand' perspectives, to look not only at whether information is available but also at who can access and use it, and the incentives to do so, as well as recognising that the nature of the enabling environment can have the largest influence on the results achieved (see Gaventa and McGee, 2013; Joshi, 2013; O'Meally, 2013; World Bank, 2014).

Comparing CARE's CSC programmes across four diverse contexts is particularly valuable. We identify a number of important contextual trends and insights, based on political economy assessments, across Ethiopia, Malawi, Rwanda and Tanzania. While all have some form of decentralised service delivery, in practice the extent to which this is realised and implemented remains very different, with contrasts between, for instance, Rwanda's strong state institutions and a highly incoherent and fragmented system in Malawi. Both Ethiopia and Rwanda have strong central states, but again there is also significant variance; the former is a large federal state, characterised by ethnic fragmentation, whereas Rwanda is a smaller, more unitary developmental state with a strong commitment to improved local service delivery. The other countries show greater fragmentation, but for Tanzania this is in the context of one-party dominance, whereas as in Malawi it is characterised by a highly fluid political system. These differences reflect the differing histories and realities today in these countries. Adaptation is required, of both the overall design of programmes and their implementation, to adjust to these differences.

Across all the country programmes analysed, we find there is good evidence of adapting to different context factors. This is mostly clearly seen in the variety of relationships established with government actors, and the different strategies taken to achieve this. In Ethiopia, it required working through government (and allowing parts of the programmes to be effectively co-opted); in Rwanda, it meant building strong links across different levels of government; in Malawi, it required working closely with district-level teams and local leaders. In this section, we summarise some of the core findings across our four case studies, and point to the implications for future policy and programming.

1. **The accountability sandwich strategy is the right one, but looks different depending on levels of commitment to reform**

   Our evidence supports the 'accountability sandwich' hypothesis, and emphasises the importance of framing a CSC programme in terms of building collaboration and collective interests, rather than a focus only on citizen voice and empowerment. It adds some important layers of depth too. We find that CSC programmes will need to adapt to whether they are working in contexts with a reform-minded centre or not.

   Our analysis highlights that CSC programmes can help alter working practices, for instance through providing information to higher levels of local government, but that this occurs only in states with reform-minded centres, and, even then, the impacts on national policy are rare. These programmes can contribute to improving service delivery access and resourcing in countries without a strong reform-minded centre, but will use different mechanisms and will produce different outcomes as a result – for instance, changes in working practices and service provider behaviour can be negotiated, but will often occur outside of state frameworks and remain at the community level; changes in resource distribution and co-production of services can be facilitated too, but rely on the involvement of credible local leadership (e.g. traditional leaders in Malawi or councillors in Tanzania) whose involvement may vary with important external factors, such as the opening-up of new national-level resources or election periods.

   Despite strong recognition of the need to frame the CSC as a highly collaborative approach, it is not clear that existing policy guidance gives adequate weight to these issues and the need to closely adapt strategies in different environments.

2. Buy-in from local leaders needs to be secured early on and maintained, which can mean framing the programme as one that will help, not hinder

The importance of getting buy-in for the process early on with local leaders and decision-makers is a common theme across all the programmes, yet there are a variety of options for exploring this, which again require paying attention to some core contextual features.

Securing buy-in and ensuring decision-makers proactively respond to score card information can rely on the existence of a reform-minded centre or particular reform-minded and influential individuals, as noted above. It may work best when there are forms of top-down (hierarchical) oversight and where there are clear performance measures and mechanisms. In Rwanda, there were a number of examples of information gaps effectively being closed; in Malawi and Tanzania, political leadership or allegiances served to undermine or overshadow technical reforms and made this more challenging.

Where there is not a clear reform-minded agenda, there are still opportunities for a CSC programme, but these may need to vary by level and in terms of methods of engagement. In contexts where government itself was heavily constrained, and particularly where stalled processes of decentralisation (political, administrative and financial) had curtailed powers at local levels, very localised strategies (at the village and sub-district level) were possible. These often required working with local leaders, such as chiefs or faith leaders. Where there was a clearer policy framework that could link across multiple levels, as in Ethiopia, more regional levels could be engaged too.

3. Building multi-stakeholder partnerships is key and requires more than interface meetings

The importance of forums for interface and for building multi-stakeholder partnerships emerges across all countries. Paying attention to the nature of the enabling environment for this type of collaboration is therefore important, especially in countries with a less reform-minded centre.

Some of the key factors identified for this include the nature of government and civil society or citizen interactions; as the case of Ethiopia shows, it may require working directly through local government structures, and various compromises as part of this. Another important factor is the presence of and commitment to identify and expand on shared collective interests. This is often easier to achieve at a very localised level (and around a specific problem, such as a non-functional water source or a lack of infrastructure in a health facility), but can become more diffuse at larger or more complex levels. It reinforces the need for strong facilitation, by those who are well connected and respected locally, in order to help broker these collective interests.

Interface meetings themselves may not be the crucial mechanism for some of these activities. In some countries, such as Malawi, pre-interface meetings were introduced, to share findings with service providers, district officials and decision-makers in advance and to allow them to plan their response. This was seen as a crucial vehicle for ensuing their participation and action after the interface meeting itself. In Rwanda, interface meetings were not always held, partly because there were pre-existing forums in which users and providers could come together and the programme was able to work from these, or to find other routes to have influence (e.g. targeting national-level stakeholders, as seen in the health insurance example).

The existence of links and relationships between government officials and the agents of the implementing organisation plays an important role in underpinning this, by establishing trust between different actors and willingness to follow up on agreed actions. Many of the examples explored utilised organisations that were already operating in the areas the CSC was implemented in, but there may also be implications for the type of individuals it is useful to hire and train as facilitators.

4. Collective action problems for individual groups need to be solved before shared collective interests are identified

Our findings reveal that collective action problems might first need to be solved for individual groups (such as communities or service providers) before addressing broader collective action problems (e.g. those facing communities *and* service providers can be solved). For instance, communities themselves can face collective action challenges in their ability to come together and work in their collective interests; strong facilitation by local organisations, often working with and through local leaders (such as village chiefs, faith leaders or others) was often key in helping broker collective action and enforcing collective participation.

For service providers too, we identify a number of examples where it is challenging for them to come together around shared interests, for instance where frontline staff are not able to report on realities or challenges faced to superiors or to coordinate effectively with those in other departments or areas of government. Again, this required strong facilitation, alongside sustained trust-building and positioning the CSC programme as something that will help rather than hinder their activities.

Attention needs to be paid to how to sustain and expand collective action and interests beyond the community level too, something on which there was much more mixed success for most of the programmes reviewed. Our findings suggest CSC programmes are often located at the community level and sustained at the level of the district only during the lifetime of the programme, where the state has institutionalised the process and/or where individual political actors or district officials make it a priority. This requires close attention to whether these conditions exist or can be built for broader engagement.

5. CSCs can achieve tangible impacts, and these are likely to concentre on access to services and use of resources

Our research points to further reflections on the types of impacts likely to be achieved as a result of a CSC programme. Based on these case studies, we find that these programmes often make the biggest contribution to improving service provision (in terms of access, resourcing and the relationships between users and service providers). We find far less evidence of this approach leading to substantial changes in power dynamics and the nature of citizen–state relations.

This is perhaps expected, given the local nature of its implementation and the common framing as a tool to help service providers, but it requires realistic objective-setting in terms of what can be achieved. Moreover, adopting such an approach does involve some trade-offs, for instance in relation to freedom of discussion and action of some issues, particularly in strong central states, and this needs to be carefully considered when weighing options for support.

All of the above reinforces a call for more adaptive programming that can respond to changing realities. Across the CSC programmes analysed, there was evidence of this in practice, but it often relied on the 'savviness' of individual staff and their local knowledge, rather than being formalised as part of programme approaches.

In light of the need to build coalitions, maintain strong relationships across government and outside of it and help solve collective problems, we find it is important to clearly enshrine the commitment to adaptive and flexible programming approaches in this area. This requires reviewing existing reporting and programme management tools and frameworks to ensure, for instance, log frames and other reporting frameworks do not commit to a linear, prescribed process of change and rather allow for considerable adaptation of activities against some clearly defined goals. Recognising these multiple pathways for change, and multiple ways of working to deliver score card approaches, could be a crucial first step.

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Annex: Interview guide

The guide below was used as a template for fieldwork; in practice, for each country, it was adapted to the particular contexts, sectors and issues assessed.

General questions on context (all groups)

- What are the key service delivery challenges in the region(s)/district(s) visited?
- Who are the key decision-makers (formal and informal) for service delivery? Who are key veto players/gate keepers?
- How well are local service providers thought to perform and why?
- How would you characterise relations between service users and providers (including in terms of power relations, accountability relations etc.)?
- How would you characterise relations between users and politicians/local decision-makers?
- What are the key information gaps/imbalances?
- What issues of inequality/exclusion are there?
- What are the key characteristics of communities (socioeconomic indicators but also issues of community cohesion etc.)?

CARE CSC programme details (CARE staff and government facilitators only)

- Dates, areas where implemented, level of resourcing, staffing etc.
- Original theory of change/model, as set out in programme documents etc.
- Broad overview of the key stages of the score card process
- Could you describe to me how the CSC programme was first initiated?
- What factors made the CSC approach seem like the most viable and useful one?
- Could you describe to me how the CSC process was implemented?
- Breakdown by stages:
- Identification of local implementers/training (e.g. how did you select implementers, why?)
- Sensitisation with communities (how did you identify specific communities, why?)
- Conducting score card process (how was the process implemented, what were the key stages, what were the key parts of the process of delivery, who did you work with?)
- Feedback meetings/identification of feedback (how were these conducted, how well did they work, what sorts of changes were identified as a result etc.?)
- What follow-up activities were conducted?
- What factors influenced your decision to implement in this manner?
- What were the major challenges you faced during implementation? Was it possible to overcome all of these and how was this achieved?
- Was there a lot of variation in challenges and implementation strategies between different areas?
- What was the role of the government in the CSC process? Who were the most important actors within the government in implementation in terms of gate-keeping and actions? What were the initial reactions of officials at different levels to the idea of the CSC processes? Did this change over time?

Impacts and outcomes of the CSC process (all groups)

- What were some of the main issues identified by the score cards?
- Were there any surprises or did the information mainly fit with what was expected? Why?
- What information gaps/issues do you think the score cards were able to address?
- Who were the major actors who displayed particular support or opposition? What do you think their motivations were? How did you persuade potential blocking agents to support you?
- What were the reactions from chiefs/village elders, local councillors, local MPs, district officials (WASH, administrative etc.)?
- What would you say the major achievements of the CSC process have been? Could you describe how these were achieved? Who were the major actors in this process?
- What key areas of tangible impact can be identified?
- Follow-up questions:
- What contributed to these successes or areas of impact?
- What features of programme implementation or of the process of implementation were particularly important?
- What networks or relationships were important?
- What key constraints or challenges had to be overcome – and how were these addressed?
- What other factors shaped the potential for impact (e.g. broader windows of opportunities, changing conditions, e.g. new appointments or changes to leadership, etc.)? Did central government policies, performance expectations or incentives play a role?
- What areas were less successful and why? What seems to explain areas of variation in terms of impact? To

what extent are political economy variables (e.g. institutions, actors and their incentives) shaping these?
- What was the role of different levels and actors within the government in ensuring action plans were carried out? What do you think their motivations were? Were there differences in how cooperative different groups or types of officials were? Who seemed the most important individuals to convince in order to achieve results?
- What areas were less successful and why? What seems to explain areas of variation in terms of impact? To what extent are political economy variables (e.g. institutions, actors and their incentives) shaping these?
- What do these specific examples of impact highlight in terms of broader effectiveness of the programme?
- What ways of working seem to be more effective, given the contextual factors identified? (E.g. any evidence of 'learning by doing' or adaptive processes?)
- What key relationships, networks or coalitions have contributed to effectiveness and why?
- What key characteristics of the political economy context, and characteristics of communities themselves, seem to have been most significant in determining or influencing effectiveness? What were the main barriers and constraints – if these were overcome, how? If not, how did they impact on effectiveness?
- How has the programme adapted to differences or variation, e.g. across areas, communities and so on?
- Were there problems identified that could not be dealt with at the local or district level, but only at the regional or national level? What actions were taken on these issues? Were there any successes? If so, how were they achieved? If not, what were the main barriers?
- Was the CSC programme adapted to address issues faces by marginalised groups (e.g. women, girls, minority ethnic, religious or linguistic groups)? In what ways was it adapted for this purpose? What were the challenges you faced in doing this? How successful were these adaptations for this purpose?
- Were any of the issues generated by the score card process specific to marginalised groups? Were any sensitive issues identified and how were these dealt with? How did you work with different vulnerable groups to ensure their views were represented? How easy was it to give voice to these groups?

Broader CSC usage and sustainability (variations for all groups)

- Was the information and experiences gathered in the course of the CSC programmes used more broadly at a regional or national advocacy by CARE, government officials or others? Who were the key actors involved in this? What types of information were used and how?
- Are there plans for the CSC processes to continue after the completion of the CARE programmes? Who are the main actors interested in their continuation? What factors to you think will determine whether they are continued?
- What are the key things other organisations should bear in mind if they were trying to implement a CSC programme in a different context altogether?

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 ISSN: 2052-7209
Acknowledgements: