ALINe Farmer Voice Award Winner 2010

ALINe PEOPLE-CENTRED PERFORMANCE

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Care Malawi Case Study

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Executive Summary

CARE Malawi's community scorecard is a simple, scalable, participatory monitoring and assessment tool that can make projects and local services more responsive to farmers' preferences. Using quantitative feedback, it brings together the demand side ("service user/farmer") and the supply side ("service provider/ project implementer") of a particular service to analyse issues and find shared ways of making the service more effectively meet farmers' needs.

This case study describes CARE Malawi's use of the community scorecard (CSC) in a livelihood security project in central Malawi. CARE staff remarked on how the CSC provided farmers with a simple method to enhance their influence on how project activities and local services were delivered, so they met farmers' needs better and increased the project's effectiveness. Service providers, including CARE Malawi, commented that the CSC enabled them to improve their responsiveness to the demands of farmers and to easily know what was and was not working in service delivery. A senior manager at CARE Australia, which routed funding to the project, remarked that the information generated by the CSC enabled an improved understanding of the project's progress and the changes that needed to take place.

Whilst there has been no conclusive evaluation of the beneficial impact of the CSC, from the information provided, this case study suggests that it could be used in different project locations[1] and may contribute to better, more sustainable results in agricultural projects. The CSC can enable services to be more responsive to farmers' priorities enabling agricultural inputs to be better tailored to contribute to poverty reducing outputs.

ALINe researched the CARE Malawi CSC with the objective of understanding the results of their approach to including farmers' voices and identifying related good practice in this area. This case study will start with a section on the context of the project before giving an overview of the approach used to listen and respond to farmers. It will then share some of the results, potential for scaling up, costs and good practice identified. The case study is based primarily on available secondary data, including project reports and CARE documents, as well as interviews and discussions with project management staff from CARE Malawi and CARE Australia.

Context

The Supporting and Mitigating the Impact of HIV/AIDS for Livelihoods (SMIHLE) project was funded by Australia Aid for International Development (AusAID) through CARE Australia over a six-year period from July 2004 to June 2010[2]. It was implemented in two Districts in the Central Region of Malawi reaching approximately 30,000 households with 165,000 secondary beneficiaries[3].

In the Lilongwe and Dowa districts, approximately 37% of people are reported as living below the income poverty line[4]. Services such as health and education are limited and often inadequately resourced. Approximately 40% of the population has easy access to clean water whilst electricity remains rare outside urban areas[5].

[1] CARE have promoted the CSC method in its other country offices/partners in East Timor, Cambodia, South Africa, Rwanda Ethiopia, Mali, Zimbabwe and Mozambique.
[2] The SMIHLE project built on a previous CARE Malawi project, the Central Region Livelihood Security Project (CRLSP), also funded by AusAID, that ran from 1999 to 2004
[3] Mid Term Evaluation of SMIHLE Project, 2007
[4] Integrated Household Survey, 2005, National Statistics Office of Malawi, http://www.nso.malawi.net/
[5] Additional information from CARE Malawi research data

The majority of the population in the project areas are farmers who grow and sell food and cash crops like groundnuts, maize and soya. Dependency on agriculture and limited access to input and produce markets has limited the income of the majority of farmers. Land rights are controlled by chiefs using customary law and most land plots owned by farmers are about 1 acre in size. The main problems in the area are low agricultural production, high illiteracy levels, environmental degradation, HIV and AIDS pandemic and lack of water and sanitation[6].

SMIHLE's objectives were to develop and promote operational models and practices that strengthen the delivery of food security services that mainstream HIV/AIDS and gender. SMIHLE primarily works through Village Umbrella Committees (VUC) which are composed of representatives from some existing and some new village level groups that were set up by the project in each village (see fig.1). In addition to building the capacity of the newly developed VUCs, the SMIHLE project created Village Savings and Loan Groups, Seed Bank Groups and Marketing Groups. These three groups received technical training and relevant inputs (seeds, loans etc) from the SMIHLE project.

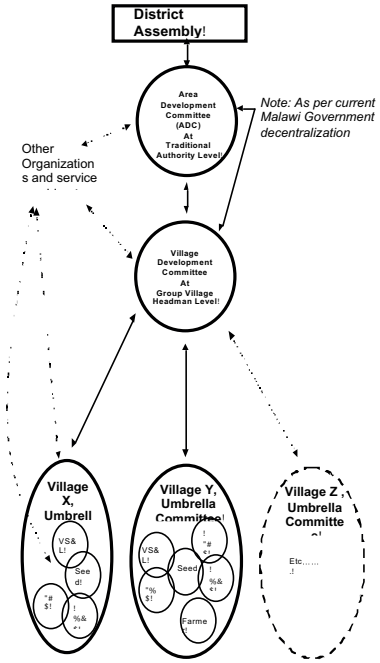
The VUC Model aimed to ensure that villages planned, monitored and managed their own development activities. This included beneficiary targeting and inclusion of the vulnerable, HIV and AIDS affected and infected households in activities that mitigate the impact of HIV and AIDS. Members of the VUC were expected to be democratically elected with a precondition that 40% of the leadership should be women.

Through this model of strengthening community institutions at the village level, it was hoped that community members would be empowered to manage and sustain development activities themselves.

The CSC was not originally part of the SMILHE project. It was introduced after a mid-term evaluation found that monitoring and feedback was insufficient at field level (Mid Term Evaluation of SMIHLE Project, 2007).

CARE staff commented that the previous monitoring system did not offer communities enough opportunity to negotiate with CARE Malawi or service providers on changes they wanted to see in the way services were implemented. Instead, it was like a 'one way traffic'[7] with project staff collecting data related to pre-defined indicators and later analyzing it at the office. Therefore, having seen its success in CARE Malawi's Local

Figure 1.
The Village Umbrella Committee (VUC) model



Initiatives for Health (LIFH) project[8], the CSC was introduced to the SMIHLE project in 2007.

Approach: CSC activities

CARE Malawi Scorecard Toolkit describes the CSC as a "two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services" (CARE Malawi 2007:1). CARE Malawi has implemented 21 scorecard processes in the SMIHLE project involving approximately 3,600 stakeholders.

[6] Information in this section taken from SMIHLE Baseline Survey Report, 2004, CARE Malawi
[7] Correspondence from CARE Malawi program
[8] See Ackerman 2005 for a summary of this project's CSC

Figure 2.
Scorecard for service users rating CARE Malawi and a Village Umbrella Committee (VUC): Location A[9]

INDICATORS	CONSOLIDATED SCORE / 100	REASONS
1. Monitoring development activities by VUC and Chiefs	50	• The VUC does not monitor frequently • Chiefs do not monitor frequently
2. Planning development activities	40	• There are no plans for development activities • The chief or field advisor tell the community what to do
3. CBO training progress	20	• Field Advisor does not come regularly for the trainings • Attendance to the trainings is poor • Members come late
4. Attendance to meetings by community members	25	• Most people do not attend meetings • Chiefs do not encourage their subjects to attend meetings • People come late to meetings
5. Quantity of seed for multiplication	40	• Amount of seed received was small • Most people do not receive the seed • The amount of seed received by each beneficiary is small
6. Quality of seed	55	• Most of the seed was looking good • Some of the seed was of poor quality resulting into poor germination rate.
7. Storage of seed	90	• There is good storage of seed
8. Seed distribution time	45	• We receive seed very late
9. VUC performance	70	• Performance is good Sometimes there is poor collaboration with local leaders
10. Community facilitator performance	50	• Performance is good but sometimes not clear on what their responsibilities.
11. HIV/AIDS and positive living	40	• Some sensitisation on HIV/AIDS • We don't receive information materials

The CSC uses dialogue, based on quantitative feedback, to bring service users and service providers together in a participatory way. This is achieved in five phases[10]:

1. Planning and preparation

Project staff identified key local services (including CARE Malawi's own projects), their user groups and visited local leaders, the community and other key stakeholders to raise awareness about the scorecard process. Facilitators were trained.

2. Implementing the scorecard with the community

Day 1: Participants were selected from the community with the help of a social map to ensure inclusion of all vulnerability groups. Participants were divided into separate interest groups (10-15 in size) of women, men and local leaders. Groups discussed what inputs they actually received from a service compared to what they are entitled. The facilitators from each group then met to convert these issues into common indicators that summarised the factors that influenced how effective the service was for the community.

Day 2: The common indicators were checked back with the groups. The groups then used a matrix (see fig. 2) to score services against these indicators (scores out of 5, 10 or 100 were used depending on group preferences).

[9] Data taken from a CARE Malawi scorecard process in 2008, location anonymised.
[10] See CARE Malawi 2007 for a more in depth description of the scorecard process.

Figure 3.
Scorecard for service providers: Location A[11]

INDICATORS	CONSOLIDATED SCORE / 100	REASONS
1. Monitoring development activities by VUC and Chiefs	60	• Some people are lazy • Chiefs do not monitor frequently
2. Planning development activities	25	• There are no plans for development activities • Have just started trainings on planning • The chief of field advisor tell the community what to do
3. CBO training progress	30	• Field Advisor does not come regularly for the trainings • Attendance to the trainings is poor • Members come late • Trainings are well facilitated
4. Attendance to meetings	50	• Most people do not attend meetings • People come late to meetings
5. Quantity of seed for multiplication	50	• Amount of seed received was small • Most people do not receive the seed • The amount of seed received by each beneficiary is small
6. Quality of seed	60	• Most of the seed was looking good • Some of the seed was of poor quality resulting into poor germination rate.
7. Storage of seed	100	• Some have applied actellic (an insecticide).
8. Seed distribution time	50	• We receive seed very late

Day 3[12]: Following the group scoring meetings, facilitators met with two or three representatives[13] from each of the groups to review the scores and, in a participatory manner, consolidated the scores to derive one community score per indicator. This was typically the average score, but also took into consideration minorities' views. See fig. 2 for a scorecard created in the SMIHLE project.

3. Conducting the scorecard with service providers

Similar processes of identifying issues and scoring were conducted with the service providers. In the example below, the indicators identified by service providers were similar to that of the service users. CARE Malawi staff reported that this occurred as the analysis process with service providers was conducted just after that with service users. This allowed facilitators to work with providers to make the indicators as comparable as possible.

4. The interface meeting

Service users, service providers and other influential stakeholders such as local leaders and officials were then brought together at interface meetings. Representatives[14] from service users and service providers presented their scores and recommendations to the meeting. Following this there was open participatory dialogue to discuss, clarify and respond to each other's presentations. The meeting's participants then worked with CARE Malawi staff to develop a joint action plan to improve the service. Action plans included specific actions, the people responsible for completing them, timing and the resources needed. CARE Malawi staff reported that they found that it best to keep the duration of the plan between 6 – 12 months.

Figure 4 provides a sample action plan, resulting from the scorecards shown in figures 2 and 3.

[11] Data taken from a CARE Malawi scorecard process in 2008, location anonymised. Same process as the service user scorecard above.
[12] These days were not necessarily one after the other, but at times suitable for the group. Ideally they were as close together as possible.
[13] These were selected by the group members themselves
[14] These are chosen by the group and typically included two men and two women.

Figure 4.
Action plan: Location A

ACTION	TIME FRAME	RESPONSIBLE PERSON	RESOURCES
1. Conduct meetings with local leaders to remind them on their roles and responsibilities in SMIHLE and development programmes	January 2008	Field Advisors	Transport Stationery
2. Conduct monthly meetings with VUC and village members on the implementation of development activities	January to June 2008	Local leaders	Stationery
3. Conduct training sessions on participatory planning of development activities	January to March 2008	Field Advisor	Transport Stationery
4. Conduct meetings on importance of attending development meetings and develop village constitution to enhance attendance and participation to development	February – March 2008	Chiefs Field Advisor	Stationery
5. Timely distribution of: • Good quality seed • Fruit tree seed and budding materials, and • Polythene tubes, for communities to produce their own fruit tree seedlings enough for everybody	April to June 2008	Agriculture Coordinator	Seed, polythene tubes, budding materials, transport
6. Conduct four sensitization meetings on the roles of community facilitators	February to March 2008	Community facilitator, FA, VUC	Transport
7. Conduct training sessions on HIV/AIDS and positive living	Feb to April 2008	FA	Transport Stationery
8. Source and distribute IEC materials on HIV/AIDS.	February 2008	VUC VDC FA	Transport
9. Conduct monitoring visits on crop performance for both upland and winter farming, twice every month	Jan to June 2008	VUC Agric FA C.F	Transport

5. The follow-up and institutionalisation phase

The action plans identified who would monitor each activity as it was carried out. The scorecard process was repeated after 6 months to institutionalize the practice and ensure information is continually fed back into the service providers' decision-making and monitoring systems. Facilitators wrote up reports of the process to share with all key stakeholders including community organisations, government officers and extension staff.

In the SMIHLE project the CSC was used to assess CARE Malawi as service provider and community facilitator, and also the effectiveness of the VUCs, VDCs, local leaders, project related service providers and government officials.

Results

Using the CSC, communities have successfully advocated for and achieved changes to project activities with CARE Malawi and other stakeholders. The following bullet points provide examples of changes that have improved the likelihood of achieving poverty reducing outcomes from the agricultural inputs:

- The timing of the distribution of seeds to communities was changed as communities wanted the seed before the rains. This allowed them to decide what should be planted during a particular season.

- The method of distribution was changed. Previously seeds had been distributed from a number of sources including Agriculture HQs, Community Facilitator, Chiefs etc. The community said that due to factors of distance, irregular availability and

inconsistent distribution methods they could not rely on getting seeds when they needed them. In response, the Village Umbrella committees (VUC) managed distributions at agreed distribution points.

- The amount of seed given to the VUC was also an issue with beneficiaries who said that the amount was not enough for worthwhile cultivation. The project responded by increasing the amounts from 3kg to 5kg soya and from 5kg to 10 kg groundnuts.

- Adult education activities were added to the project based on issues uncovered by the scorecard.

- Some communities expressed that trainings for VUC were being conducted too far from their village, and this led to poor attendance, especially by women. Training venues were changed to locations that were more suitable for women.

- More training was organized in Village Savings and Loans (VSL) in response to the requests of women.

- The roles of field staff were changed so they served communities more effectively. In one area, the community asked a member of Field Staff to improve on time management as it was noted that sometimes he came late for meetings. This was changed accordingly.

- District officials were more open to criticism and learning and built skills in community participation[15].

Costs

The training for CARE Malawi facilitators of the CSC lasted 6 days on a residential basis for 20-25 people and cost $30,000.

The costs of group meetings varied depending on location and size of the group but were no different from the costs of standard participatory meetings. The CSC process took about 2 months for the first time, including initial one-off awareness raising, and a month subsequently.

Scaling up

Based on the learning from CARE Malawi's use of CSC in multiple projects, CARE Australia has also promoted the approach in East Timor, Cambodia, South Africa, Rwanda Ethiopia, Mali, Zimbabwe and Mozambique. It has been used both for improving project delivery and to improve the services provided by other service providers and government organisations such as Municipalities in South Africa and church based services PNG. This suggests that the approach can be flexibly scaled up and applied in a wide range of different contexts.

Key learning from CSC tool

CARE has not carried out a formal evaluation of the contribution of CSC. But staff at CARE Malawi[16] and CARE Australia believe that the CSC makes a substantial contribution to strengthening local development by enhancing the responsiveness of projects and local services to farmers' preferences.

Farmers identify the activity issues and indicators

By allowing farmers to identify indicators of service provision success and assess performance using these indicators, the CSC facilitated a simple method for project activities to be more responsive to farmers' priorities (see results section) and remain relevant to their needs, even as these needs change. During interviews carried out in July and August 2010, some beneficiaries commented that they never thought they could talk about things that they felt were not working to service providers but the tool has enabled them to do that[17].

Quantitative indicators facilitate communication

The use of jointly agreed numerical scores to represent service users' opinions on performance was likely to make it easier to communicate farmers' voices to other actors. Compared to numerous anecdotal stories, numerical scores are likely to have been easier and quicker to understand (and compare) from the point of view of the service provider and/or outsider (government official, CARE staff). Additionally, they allow the opinions of numerous individuals to be understood using a reduced number of agreed community scores[18]. These points are reinforced by the literature on participation and participatory numbers (for example see Chambers 2010).

[15] Presentation by Christopher Mzilahowa, Dowa District Assembly, at The Role of Civil Society in Good Governance Forum, 6-7 September, 2010, Johannesburg.
[16] Staff at CARE South Africa and CARE Ethiopia also believe in these benefits – presentations at The Role of Civil Society in Good Governance Forum, 6-7 September, 2010, Johannesburg.

[17] During July and August 2010 CARE Malawi were visited by a media team from CARE Australia to make videos on the CSC. The beneficiary and field staff views are a summary of the information captured during this video process.

[18] CARE Malawi are aware of the potential dangers of reducing numerous opinions to one score and train faciliators to try and ensure all views are considered and separate groups (women, youths, ethnic groups) during the scoring process to avoid influence by powerful individuals. Further, the scores are a method to facilitate more constructive dialogue and understanding in the interface meeting. They are not just absolute or final measures of activity

Facilitates responsive stakeholders

The meetings between service providers and users and the development of an action plan meant that service providers could be immediately responsive to farmers' expressed needs and ensure that farmers' expectations of changes in services were managed. By including criteria for oversight in the plan with an agreement that the CSC process would be repeated in 6 to 12 months time, responsiveness to farmer voice may have become more institutionalized within the project. Similarly, by involving service providers from the outset and in the scoring it is likely to increase their openness to the process of responding to farmers' preferences. The CSC enabled CARE Malawi and service-providers to quickly respond by jointly working with communities to develop farmer-driven action plans to improve activities[19].

Enhances responsiveness of Senior Managers to farmer demands

Senior managers reported that the tool gave them greater confidence in approving and responding to field level suggestions about making changes to project activities[20].

Challenges

CARE Malawi has identified that the scorecard approach is highly dependent at each stage on the quality of the facilitator and their ability to both accurately draw out the views of the community and to deal with challenges related to dealing with power relations. CARE has responded to this by requiring facilitators to have training on both theory and practical aspects of the process. This includes considering local power relations, adapting the tool to the local context and focusing on constructive discussion rather than personal finger-pointing.

However, it is noticeable that there does not seem to be a systematic or transparent way that the representativeness of the CSC process or the quality of CSC facilitator's performance is checked. Therefore, there is no way of being sure that the scorecard, such as the one reviewed in this case study, is representative of different groups views or that the action plan is empowering. It is also striking that the performance assessments made by service users and service providers were not reported to CARE Australia, in its role as donor or conduit of funds. There may be a number of reasons for this, including sensitivity to local context or internal power dynamics. For whatever reason, this method of holding CARE Malawi to account appears to have been available but not used. This may have also limited learning at the senior decision-making level.

CARE Malawi identified a number of other challenges including that people in developing countries may not expect to be able to hold service providers to account and that it can take a lot of time for them to see these relationships in new ways[21].

Conclusion

CARE Malawi's experience of CSC suggests that it is an adaptable and effective approach to helping projects respond to farmers' preferences and so increase the impact projects inputs can have on poverty reducing outcomes.

The approach brings together practical ways of tackling some of the potential problems with participatory approaches, including quantitative scoring, involving service providers and holding interface meetings for joint action planning. In this case, CARE Malawi implemented it in response to limitations in their previous monitoring system. CSC has subsequently appeared to deliver benefits for farmers, local service providers and both CARE Malawi and CARE Australia staff. Notably, the CSC has supported community empowerment more generally as it helped community members negotiate better with powerful service providers such as the Dowa District Assembly.

The CSC method appears to face similar challenges to other participatory approaches. In particular, it depends on high quality facilitation to ensure that the most marginalised members of communities are properly involved and to handle conflict between different interest groups. CARE Malawi responded to this by providing facilitators with training that covered both the theory and the practice of CSCs. However, the absence of a quality control on facilitation and the CSC process and the fact that data is not reported upwards from field level may limit the effectiveness and empowering potential of the tool.

The simplicity, adaptability and success of the approach has resulted in CARE Australia and other development agencies promoting the CSC widely.

[19] From CARE Australia videoing process, July and August 2010.
[20] Interview with CARE Australia staff member
[21] Correspondence from CARE Malawi program staff

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