Technical guidance for pairing CARE's Community Score Card & Social Analysis and Action approaches

Overview

The Community Score Card (CSC)© and Social Analysis and Action (SAA) are two well established approaches that CARE has significant experience in implementing in different contexts and technical sectors. The Community Score Card, originally developed by CARE Malawi in 2002 to improve health services, is a citizen-driven accountability approach for the assessment and improvement of (health, education, agricultural) service delivery. Social Analysis and Action is a participatory reflection and dialogue approach for exploring and challenging the social factors that negatively impact individuals' lives and well-being, with the goal of creating a more gender equitable and enabling environment for women and girls.

There has been growing demand for technical support in how to combine these two approaches in the same project, as each approach can serve to address gaps in and strengthen the other (see box on gaps and synergy below). To respond to this interest, CARE USA's Sexual, Reproductive and Maternal Health team has put together this technical guidance to aid practitioners in identifying how each approach can strengthen the other and in planning for implementing these two approaches together. This document could also be useful when developing fundraising concept notes and proposals.

The guidance begins with a high-level comparison of the two approaches, including their purpose, the implementation process, and how their impact is achieved. The following section provides examples for how the two approaches could be linked and the potential benefit. However, these examples are not exhaustive, as pairing the two approaches is a relatively new endeavor and applied experience and evidence is still being built. As such, we welcome practitioners to contribute their practical learning.

Finally, a few disclaimers. This document is meant for those who have some experience with or understanding of both approaches and the implementation processes. If you are relatively new to both approaches, additional information and materials on each approach can be found at the links provided above and below. Also, this guidance note was prepared by the Sexual, Reproductive and Maternal Health Team at CARE USA. As such, definitions, references and examples tend to emphasize the health sector throughout; but as stated, both approaches can be and have been adapted to various technical areas and contexts.

CSC versus SAA

Broadly speaking, CSC involves citizen participation in service quality improvement through collaboration with service providers to develop a shared plan for improvement; while SAA involves a reflection and dialogue process that allows for communities to explore and challenge the social norms around gender and power that negatively affect individual's lives. The potential for synergy arises when SAA can reinforce both the voice and agency of individuals to participate in accountability processes, as well as introduce discussion of social norms and equity issues into that process. Conversely, CSC offers a platform for people who are increasingly aware of gender and social inequities to take action in their communities. Both approaches focus on empowering individuals, addressing inequitable power relations and building social-cohesion.

The following chart is a high-level comparison of the CSC and SAA approaches to highlight the similarities and differences, as well as how the two approaches can complement and reinforce each other.

	Community Score Card	Social Analysis and Action
What	A citizen-driven accountability[1] approach for the assessment, planning, monitoring and evaluation of (health) service delivery.	A facilitated process of ongoing individual and community level dialogue and reflection for exploring and challenging the social norms, beliefs and practices that shape individuals' lives and health.
Process	Brings together community members, service providers, and local government in an ongoing process of quality improvement, through which they identify service utilization and provision challenges; mutually generate solutions; and work in partnership to implement and track the effectiveness of solutions identified. See full process here and here.	Three core elements: 1) reflection, dialogue and exploration, 2) envisioning alternatives and challenging harmful norms/belief/practices, and 3) community-led action for improved health and rights. Unique and central to SAA is that the process of critical reflection and dialogue begins with CARE staff, partners and SAA facilitators to prepare ourselves for implementing SAA with the community. See full process here.
Objective: what we think each will accomplish…	**Improve coverage, quality and equity of (health) services** …	**Create a more equitable and enabling environment and community support for health and rights…**
…and how	…By empowering citizens and service providers; creating expanded, effective and inclusive spaces for negotiation between communities, service providers and local government; and enabling power holders to be effective, accountable and responsive.	…By catalyzing individuals and the community in challenging and changing restrictive norms related to gender, power and sexuality.
Primary level of intervention	Community, health system and local government level* **Potential to link to national level advocacy efforts*	Household and community level Potentially health provider level

[1] Also referred to as a participatory governance approach; different terminology is often used to describe this approach but the concept is the same.

Target participants	Service users (women, men, local leaders, adolescents, parents & students, etc.) Service providers (health providers, teachers, agricultural extension workers, CARE staff, etc.) Local government officials* **Potential to link to national level advocacy efforts*	CARE staff, civil society partners and SAA facilitators ('starts with ourselves') Individuals in the community (women, men, local leaders and officials, adolescents, service providers, etc.)* **Broad social norm change requires engaging influential leaders, role models and other stakeholders in communities*
Examples of barriers & norms identified & addressed through the approach	• Availability of resources (drugs, agricultural inputs, textbooks, money) • Poor transport to health facility or school • Lack of trained providers/teachers and supplies at health facility/school • Lack of proper WASH at school • Teacher or health provider absenteeism • Unallocated government finances • Poor relationship between service users and service providers • Non-commitment of service providers • Poor treatment of service users (poor reception at health facility, abuse in schools, etc.)	• Acceptance of family planning use • Male engagement in child care and support for healthy SRMH practices • Inequitable division of labor or decision making at household level • Couple communication • Inheritance and control over assets • Restrictions on female mobility • Support for girls' school attendance • Support for adolescent SRH • Inequitable household food distribution • Gender based violence • Traditional practices like child marriage and Female Genital Mutilation/Cutting
Examples of expected impact & outcomes	• Improved coverage, quality and equity of services • Improved health behaviors and outcomes --- • Greater knowledge of rights and duties • More utilization and satisfaction with services • System and institutional changes for improved delivery of services • Increased accountability and transparency • Improved communication and relationships between communities and service providers • Expanded, inclusive and effective spaces for negotiation • Empowered women/community and service providers	• More equitable gender attitudes and behaviors at household & community levels • Improved health behaviors and outcomes --- • Greater couple support and communication, improved relationships • Decreased gender-based violence and stigma • Changes in service provider attitudes and beliefs • More equitable division of labor, allocation and control of resources • More equitable household decision making • Support for women and girls' rights and access to resources (school, health, etc.) • Greater social cohesion and community

	• Enhanced social cohesion, social participation and collective action • Enhanced self-efficacy, voice and confidence for women and adolescents	support • Enhanced self-efficacy, voice and confidence for women and adolescents
Example of gaps & areas for synergy	Service delivery and system issues can be addressed through the CSC, but you may find that services are still not being accessed and utilized due to social and cultural barriers; for example: • Health providers are trained and family planning methods are fully stocked, but women or adolescents still do not go to the facility for fear of stigma or reprisal in the community or by their family • Health providers are trained to include men in ANC counseling and there is a waiting room for men, but men still aren't attending with their wives because they think birth-planning is a woman's issue This is where SAA can help!	SAA can create demand for services in the community but you may find a gap in service utilization because supply and system barriers have not been addressed; for example: • Increased acceptance and demand for family planning services but there isn't a trained health provider or supplies at the health facility • Increased support from male partners to attend ANC visits with their wives, but the policies at the health facility prevent men from accompanying their spouses to exam rooms or there is not a male-friendly waiting room This is where CSC can help!
A note on overlap …	Primarily addresses health system and supply side issues *but* can also generate similar benefits to that of SAA in some respects. For instance the process empowers citizens' voice and raises awareness of one's rights, potentially leading to shifts in gender roles and/or social norms at the community and household level. Due to outcomes such as improved relationships between the community and providers, the process has led to increased demand from the community. And both processes foster social cohesion.	Primarily addresses community level social factors that prevent women and girls from accessing services. *But* if done with providers either purposefully or as part of the community, SAA can addresses issues of provider stigma and bias to create an enabling environment in the health facility, thus improving the supply side of services. SAA also potentially develops people's confidence and self-efficacy for participation in the community, potentially leading into a process for action to address gender and social barriers.

Linking the CSC and SAA

As demonstrated above, there are gaps in each approach, which the other can help address. The two approaches are quite complementary and linking the Community Score Card and Social Analysis and Action can help strengthen interventions. There are a number of ways these two tools can supplement and reinforce each

other. Below are a few examples, but as our practice in linking the two approaches is newer, there are certainly other innovative ways to pair the two and we look forward to learning from other practitioners.

Linking SAA norms with CSC indicators

The SAA process will identify the underlying social norms that are preventing women and girls access to family planning, education, etc. To link this to the CSC, one approach that CARE Timor-Leste has employed in their Safe Motherhood Project is to develop one or two indicators, during the CSC indicator generation, that pertain to the norms identified. In this way, the CSC indicators can act as a monitoring tool for progress in addressing & changing the norms over time *and* the CSC action plans can help further reinforce change.

For example, imagine during SAA a social norm identified is a belief that youth should not be using reproductive health services. As a result, there is no support from the community for adolescents to access these services and the health providers are not responsive to youth needs. In this case a possible CSC indicator could be youth involvement in the CSC process, which would provide youth a platform for voicing their issues and for talking with other community members about the importance of youth-access. This dialogue could help challenge the biases surrounding the norm and provide a platform for adolescents to demand that services be more responsive to their needs. Another CSC indicator could track the availability of youth-friendly services at the facility, for which an action plan may include training providers on youth-friendly services, which in turn helps reduce provider stigma.

Using SAA to prepare for CSC

SAA activities can create an enabling environment for addressing tough and sensitive issues during the CSC process. For example some CARE projects have conducted SAA activities, such as participatory theater, prior to CSC focus group discussions and interface meetings to "warm the crowd up" and prepare them for discussing and being open to the issue at hand – such as, a parody on provider and patient relationships.

Further, an outcome of SAA is often enhanced self-efficacy and confidence to voice one's concerns and demand their rights. As such, conducting SAA prior to implementing the CSC process can aid in empowering individuals to participate in CSC and encourage the voice of groups who are often excluded, such as women and adolescents.

SAA and CSC as actions

In some cases, SAA may be identified as an action item to address gaps identified through the CSC process and vice versa, creating a more comprehensive approach. For instance, during the CSC process an indicator may be that women do not have access to family planning methods; resulting actions could include addressing supply chain issues so as to ensure family planning supplies are available at the health facility or training providers in counseling on the methods. But imagine that when the CSC process is conducted again 6 months later, it is found that the number of women accessing family planning at the facility has not risen, and through further discussions it is identified that men in the community are not supporting their wives in using family planning. At this time, the project could introduce SAA with the community for addressing the social norms that prevent men from supporting their wives' decision to use family planning.

Or in the reverse, the SAA process may create an enabling environment for women to access family planning by increasing their self-efficacy to do so and enhancing male partners support, but when the women go to the facility they are met with stock-outs and absentee providers. In response, an action could be to implement the CSC process to engage the community and providers in addressing these supply side issues.

Areas for further inquiry

While there is increasing interest in pairing these two approaches there is a lack of applied experience and evidence. Going forward the following areas, in particular, require further inquiry to help us advance our thinking and practice:

- Documenting case studies and learning from pairing the two approaches so we can build on this guidance; and
- Evaluating the effectiveness of combining these approaches versus one or the other alone.

Additional information

For further information on the Community Score Card please contact Sara Gullo at sgullo2@care.org and for more information on Social Analysis and Action please contact Feven Tessaw at ftessaw@care.org.

Other relevant resources:

- Community Score Card Toolkit
- Social Analysis and Action Implementation Training Toolkit on this site
- Community Score Card Implementation Guidance Notes

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