



Ministry of Health Of THE FEDERAL
DEMOCRATIC REPUBLIC OF ETHIOPIA

SCORECARD FOR REPRODUCTIVE, MATERNAL, NEONATAL AND CHILD HEALTH (RMNCH)



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Acronyms

ALMA	African Leaders Malaria Alliance
ARM	Annual Review Meeting
BSC	Balanced Score Card
CSA	Central Statistics Agency
EFY	Ethiopian Fiscal Year
EHMIS	Electronic Health Management Information System
EPI	Expanded Program for Immunization
FMOH	Federal Ministry of Health
HEWs	Health Extension Workers
HEP	Health Extension Program
HIQIP	Health Information Quality Improvement Plan
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HDA	Health Development Army
ICT	Information Communication Technology
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
RMNCH	Reproductive Maternal Neonatal and Child Health
PMTCT	Prevention of Mother to Child Transmission
PPD	Policy Planning Directorate
RHB	Regional Health Bureau
SQL	Structured Query Language
TWG	Technical Working Group
WHO	World Health Organization
WoHO	Woreda Health Office
ZHD	Zonal Health Department

1. INTRODUCTION

Ethiopia is one of eight countries in Africa that has been successful in reducing mortality among children under five years of age by two thirds. Ethiopia achieved this MDG target three years ahead of schedule.¹ The country has also achieved a significant reduction of maternal mortality since 1990. The morbidity and mortality burden associated with the major communicable diseases has also been reduced by more than half. For example, Ethiopia has reduced the incidence of HIV in adults by 90% since 1990, has reduced the prevalence and incidence of TB by 50% since 2000 and the burden of malaria has been halved in the past decade.

Despite these encouraging results, more needs to be done to sustain and further scale up these positive developments. There remains a need to continue the expansion of health services in the country, improved quality of basic services, increase the utilization of services and ensure equitable access to services in the years to come.

One of the critical success factors for the various interventions being implemented in the Ethiopian health sector has been the use of an effective accountability framework. A component of this framework is the Reproductive Maternal Newborn and Child Health (RMNCH) Scorecard that was introduced by the Federal Ministry of Health in 2012. This document describes the accountability mechanisms introduced in the Ethiopian health sector and identifies key factors in its successful implementation. The RMNCH scorecard management tool has strengthened political commitment in the health sector and has generated significant interest among political leaders at national and sub national level, while enhancing the use of evidence for decision-making towards improving programme delivery.

The Federal Government of Ethiopia believes that the design and implementation of effective accountability mechanisms like the RMNCH scorecard deserve to be documented as a potential 'best practice' for adoption and scale-up by other countries and development sectors. Documentation of such practices will also assist in identifying possible challenges to implementation across all levels of the health system and inform the design of appropriate strategies to address the challenges identified.

2. BACKGROUND

Ethiopia is a pioneer in introducing a mechanism of accountability and action for the RMNCH scorecard management tool. This mechanism incorporates a scorecard, which functions as a management tool to enhance accountability, transparency and action in relation to priority RMNCH interventions. The concept of the RMNCH scorecard evolved from successful experiences gained in the implementation of the African Leaders Malaria Alliance (ALMA) Scorecard for Accountability and Action.

2.1 OBJECTIVE OF THE REPORT

The main objective of this report is to document the experiences gained in implementing Ethiopia's RMNCH scorecard accountability and action mechanism in order to highlight results achieved, best practices and lessons learnt, with the intention of further improving the functioning of the scorecard and sharing information with other countries interested in using similar mechanisms and approaches.

2.2. SPECIFIC OBJECTIVES

- Provide background information on the instigation and evolution of the RMNCH scorecard in Ethiopia.
- Document the process of developing and using the scorecard to identify what went well and why, what challenges were faced, how these were addressed and what, if anything, could have been done differently.
- Document results achieved to date, including tracking of recommended actions and responses, and how these led to improved performance or impact.
- Highlight requirements for institutional capacity building, including human resources, at regional and sub-regional levels.
- Document the positive impact of the process and lessons learnt.

2.3 METHODOLOGY

Information for this report was collected through document review, interviews and focus group discussions. See appendix 3 for details.

3. PROCESS OF SCORECARD DESIGN AND IMPLEMENTATION

3.1 SCORECARD DESIGN

The Ethiopia RMNCH Scorecard evolved out of a need to address gaps and challenges in implementing effective RMNCH interventions in Ethiopia and was influenced by the success of the ALMA Scorecard for Accountability and Action in malaria. Following discussions with ALMA, senior officials in the Federal Ministry of Health (FMOH) launched the conceptualization, design and development of an accountability and action mechanism for RMNCH, through the introduction of the RMNCH scorecard management tool. The Policy Planning Directorate (PPD) was appointed as a lead to co-ordinate the tool. Officers from Policy Planning, Maternal and Child Health, and Public Health Infrastructure Directorates formed a technical working group (TWG), which developed Terms of Reference (TOR). The Office of the Federal Minister of Health oversees the work of the TWG.

The technical working group conducted a rapid desk review and 'brainstorming' sessions with inputs from key Ministry of Health staff and with support from ALMA, in order to better understand the current situation of RMNCH in Ethiopia, the structural organization of the FMOH and the potential for developing a scorecard and related accountability mechanism. Documents reviewed included the national RMNCH road map, Balanced Scorecard guidelines, and HMIS technical documents.

Based on the organizational situation and the demands of the scorecard, the TWG identified four principles to be adopted in the design of the scorecard. These were the following: Simplicity, Action orientation (Utility), Integration, and Participation. Subsequently, the TWG developed the RMNCH scorecard using the four steps described in box 1 below:



BOX 1: STEPS TO DEVELOP RMNCH SCORECARD

01

Step 1: Identifying Program thematic areas

The programmatic areas from across the continuum of care, taking into account the levels of the health system and in accordance with health priorities outlined in the health sector development plan and other key areas were selected, as follows: Maternal health, Child health, EPI, PMTCT, and nutrition.

02

Step 2: Identifying strategic clusters, initiatives and actions

Strategic objectives believed to impact health status were selected. Attempts were made to align them with WHO system building blocks. The strategic objectives selected were service delivery, supply chain, leadership, health work force, health financing, and community ownership.

03

Step 3: Identifying indicators:

Indicators were identified for each programmatic area and strategic cluster. The indicators include all component of the M&E framework. These are input, process, output, outcome and impact.

04

Step 4: Filtering indicators (pressure testing)

A preliminary list of desirable indicators was compiled and subjected to 'pressure testing' using pre-set criteria. These criteria included: current level of performance, potential for action, sensitivity for change in condition, relevance / priority, possibility to assign responsibility, reliability and availability of information and administrative levels to use the indicator. Initially, more than 46 indicators were proposed, from which 11 were selected for inclusion.

After selection of indicators, an indicator matrix was designed, which incorporated information on indicator definition, analysis method, frequency of data collection, source of information, organization responsible for information, level of use, and actions expected. The indicator matrix was used to design the appropriate software to run the scorecard.

Utilisation of the existing health management information system as the primary source of data for populating the scorecard was a key requirement to avoid the establishment of parallel data collection systems.

Challenges encountered during scorecard development included issues around the denominator used in the scorecard indicators. The national denominator for the population used at FMOH level is taken from the Central Statistics Agency (CSA) census report, but this is not the figure used by the regions to plan and measure their performance. This variation was mainly because Regions estimate their population every year and use it for planning and budgeting. This problem was solved through discussion with RHBs and harmonization of population data.

3.2 IMPLEMENTATION OF THE SCORECARD

The initial scorecard design was then tested at the FMOH for its applicability. Following the trial run, the scorecard was introduced to its users at the various levels of the health system. Advocacy and sensitization activities were conducted for higher officials at federal and regional levels. At regional level, advocacy and sensitization were conducted for regional health bureau heads. Regional presidents were also informed on the potential benefits of the scorecard. Initially, there was some resistance from some regions (e.g. Tigray), who were concerned that the scorecard system would overlap or conflict with existing performance monitoring systems. Concerns were also raised regarding a potential lack of technical capacity at regional level and the additional workload associated with implementation of the accountability and action mechanisms. However, as users became familiar with the tool, they instead appreciated the use of this management tool, especially given the scorecard builds on the existing management systems.

Key factors that facilitated the adoption and acceptance of the scorecard as a management tool include:

- The RMNCH scorecard is seamlessly integrated with the existing health management information system.
- RMNCH scorecard uses objective measurements based on agreed criteria and targets already included in the strategic planning process.
- RMNCH scorecard had the support and commitment of senior officials at the ministry and was seen to be addressing identified gaps.
- The RMNCH development process was participatory, involving all key government stakeholders in its development.
- The RMNCH scorecard provided an opportunity for increased frequency and regularity of reporting.
- The scorecard enabled the narrative feedback to be provided alongside the quantitative objective measures. This facilitates understanding of the situation and challenges and facilitates identification of remedial actions where required.
- The RMNCH scorecard is backed by simple IT. It is built using SQL, which does not require extensive programming skills. Production of scorecard reports is relatively simple, requiring a maximum of seven keyboard entries.
- The success of the ALMA scorecard for Accountability and Action provided an incentive to develop and implement a similar mechanism for RMNCH.

3.3 MONITORING AND EVALUATION

Scorecard implementation is one of the top priority initiatives for the FMOH. Implementation of scorecard is closely followed by the management council every other week. The FMOH management council identified the scorecard accountability framework as a flagship initiative. Focal persons are assigned to follow its implementation from pertinent Directorates. Scorecard monitoring and evaluation is integrated into the overall monitoring and evaluation plan of the FMOH. Scorecard implementation is one of the key initiatives to appraise the performance of PPD.

4. CHALLENGES

While the design and implementation of the RMNCH scorecard has been a positive experience for Ethiopia, nevertheless, challenges were encountered.

4.1 Data Quality and Consistency

For it to result in appropriate decision-making and action, a scorecard requires quality data. If the data and information populating the scorecard lacks quality, then the scorecard will be negatively affected. Maintaining the quality and consistency of data is a challenge that needs to be continuously addressed.

4.2 Meeting Targets vs Performance

The RMNCH scorecard is a target-based tool that uses a red-yellow-green 'traffic light' system to highlight indicators that are on-track (green), off-track (red) and showing some positive progress (yellow). Setting realistic and achievable targets is the key to proper functioning of the scorecard. For example, Tigray region sets its target for skilled delivery at 90 percent for 2006 Ethiopian Fiscal Year (EFY)/ 2013 G.C. At the end of EFY 2006, performance had reached 50% of the target, which was in coverage terms a good performance compared to other regions. However, when measured against the target set, performance is low and hence indicated red on the scorecard. Whilst this could potentially de-motivate staff, this situation serves to illustrate an issue with 10 unrealistic target-setting, which can then lead to review and better planning in future. The FMOH also helps to address this issue by attaching a narrative explanation to indicate that the indicator marked red does not necessarily mean the region is a low performer, rather that there is still a long way to go in order to achieve the regional targets set. This associated narrative originally serves to address areas of concern identified by the PPD at the FMOH.

4.3 ENABLING TECHNOLOGY

In the initial phases of scorecard development, a Microsoft Office Excel-based spreadsheet was used to host the RMNCH scorecard. Whilst this resulted in a working prototype, managing thousands of data cells proved challenging. Subsequently, the RMNCH scorecard structure was transitioned to a web-platform linked to the health management information system. Challenges remain with importing data into the scorecard from the Excel spreadsheets that are still being used at regional level. The regions have yet to transfer over to the web-platform e-HMIS. The FMOH is working to improve the software into platform and add modules on linking lead and lag indicators, to perform trend analysis as well as link expected initiatives or activities performed with the result.

The regions still use the hard copy of the RMNCH scorecard and the software training is yet to be conducted at the regional level. There is a plan to implement the automated system in all RHBs. This will enable RHBs to follow up every facility under their borders using the scorecard accountability framework.

4.4 "UNDERSTANDING TERMINOLOGY: SCORECARD"

There have been some examples of regional leaders struggling to understand the terminology associated with the scorecard, e.g. eligible, denominator and target.

4.5 FEAR OF CHANGE

There was originally reluctance in some regions to the introduction of RMNCH scorecard as it was assumed it may conflict with the current system. There was also a fear that it creates additional work load that entails the recruitment of additional human resources specializing in IT and program management.



5. RESULTS

The scorecard has been implemented in Ethiopia for approximately two years. During these two years the following results have been achieved.

5.1 IDENTIFICATION OF AREAS FOR IMPROVEMENT AND ACTION TO TAKE

The scorecard colours; red, yellow and green enable the Federal Ministry of Health to easily visualise and identify areas in which progress has been good or is sub-optimal. Analysis of the 11 scorecard initiates discussions to solve any challenges or bottlenecks associated with under-performance. For example, if weak performance is registered in relation to skilled delivery in a specific region, then the regional authorities undertake investigations at district (woreda) level in order to better understand the factors contributing to the under-performance, and if specific districts are facing challenges. Discussions on the identified issues and challenges between the health bureau and the respective regional president's office provide an opportunity for specific actions to be identified to overcome the bottlenecks at district and/or regional level.

The scorecard has stimulated action to address weak areas, including enhanced resource commitment to underperforming woredas, improved communications with pregnant women to change behaviour around nutrition and skilled birth attendance, and has prompted bottleneck analysis to identify root causes and better identify key actions to address them.

5.2 ENHANCED A HEALTHY SPIRIT OF COMPETITION AMONG DISTRICTS AND REGIONS

The scorecard allows regions to assess their performance against other regions. This has created an environment of 'healthy competition' amongst regions and districts.

The decision of the WHO country office and Meles Zenawi Foundation to give maternal and newborn health awards to the best performing region in the country and the best performing woreda in each region based on performance against targets in the RMNCH scorecard will further enhance this spirit of competition, as well as raise visibility of the scorecard and highlight best practices.

5.3 IMPROVED COMMUNICATION AT ALL LEVELS

The RMNCH scorecard management tool is fully embedded and integrated into the existing and highly functional Ministry of Health management processes, data tracking, and accountability and action framework at federal and regional levels. The integration provides an opportunity for RMNCH issues to be discussed in various fora and enables sharing of information and design of appropriate actions to address challenges in RMNCH.

5.4 PROGRAM MANAGEMENT IMPACT

Scorecard implementation improved program management by motivating clinicians to think in terms of the wider public health perspective, leading to improved quality of care provided to clients by helping to elucidate the weakest link along the continuum of care. The continuum of care from ANC1 to ANC4 will be calculated and discussions will be held on the differences. This will also be checked with skill delivery and PNC.

5.5 ENHANCED ACCOUNTABILITY

The RMNCH scorecard is used at both technical and political levels, and this practice is replicated from Federal, to Regional, Zonal and District level. A number of positive experiences of enhanced political and technical commitment to health as a result of the scorecard have been documented:

12

– At Federal level, the scorecard is shared with the Prime Minister and parliament. In addition, Public Service and Human Resource Development Ministry has identified the RMNCH scorecard as a best practice that can be replicated more broadly, beyond health and into other sectors, so that the leadership in accountability and action demonstrated by the Federal Ministry of Health can be expanded nationally.



- At Regional level, the RMNCH scorecard is shared with regional presidents. In Oromia, when the first quarterly scorecard was issued, the regional president and the regional state council noted that skilled birth attendance was underperforming at around 24%. The regional president ordered all zonal health leaders to take immediate action to address this, and lobbied for rapid improvements. As a result, coverage of skilled birth attendants increased to over 50% throughout the region the following year, with some previously underperforming zones increasing coverage to over 75%.
- In Amhara, the regional president assigned three senior level technical staff to support the Regional Health Bureau in follow-up actions related to underperformance on the scorecard.

5.6 LEADERSHIP COMMITMENT

Commitment of FMOH and ownership of regions to refine and expand this to the overall public health program management ensures the sustainability of RMNCH projects. To sustain a project, the recipient or regions should own it. That means they have to lead the process of program implementation. If partners or private organizations do the scaling up, technical skill capacity building is limited and participation is lowered.



6. LESSONS LEARNT

This section highlights the lessons that have been learnt while developing and implementing the RMNCH scorecard

6.1 LEADERSHIP COMMITMENT IS CRITICAL FOR SUCCESSFUL IMPLEMENTATION OF THE SCORECARD

The top leadership in the Ministry needs to be committed to the use of the scorecard and be ready to provide guidance at all stages of its development and use. In the case of Ethiopia, the Technical Working Group was reporting directly to the Minister's office. This not only shows commitment of the Minister, but it also gives a visibility and prominence in the Ministry.

6.2 THE SCORECARD HAS TO BE INTEGRATED WITHIN THE EXISTING SYSTEM AND PROCESSES

The scorecard should not create new management processes. For example it should make use of existing management meetings and performance review mechanisms. This will ensure sustainability of the process.

6.3 PARTICIPATION OF KEY STAKEHOLDERS IN DESIGN AND DEVELOPMENT OF SCORECARD

Scorecard initiation should be built on the foundation of sound planning, monitoring and evaluation systems and active involvement of political leadership. Key stakeholders need to be involved from the start, so they can influence the design, selection of indicators, target setting, decision making processes, and mechanisms for selecting appropriate actions to resolve bottlenecks and their tracking.

It is thus important that key stakeholders, especially those who dealt with RMNCH, planning, monitoring and evaluation and health information systems be involved in the design and implementation of the scorecard and that the Ministers office be informed at all stages of design and development. This will ensure that the scorecard is practical and will enhance ownership and sustainability.

6.4 AWARENESS CREATION TO INTENDED USERS, BOTH AT TECHNICAL AND POLITICAL LEVELS.

It is important that intended users, both at political and technical level are trained on the scorecard and its uses so as to maximize the benefits of the scorecard.

6.5 ON ICT

- ICT need to be user friendly i.e. simple to manage by any person
- Should be integrated with the existing ICT platform (eHMIS)
- Flexible to modify with the local capacity
- It could be synchronized with different sources. There are different source of data in health information system in addition to HMIS. These are logistics data, human resource data, financial data etc. The scorecard module in HMIS should take information from this data source, too.

6.6 CAPACITY BUILDING IS ESSENTIAL

Whilst operation of the scorecard is relatively simple, interpretation of the scorecard results requires monitoring and evaluation skills as well as detailed RMNCH programming knowledge and experience. In this regard, a team of three focal points (information technician, M&E professional and maternal health program expert) are required to implement scorecard at national level and would require capacity building to efficiently and effectively manage the scorecards.

Regarding use of the tool, any monitoring and evaluation focal point would be able to generate and interpret the report once he/she is trained on the scorecard. In a place where e-HMIS has not yet started, the scorecard implementation requires further skill to use excel based data into the scorecard.

Finally, it is important to understand that a scorecard is a management tool that enhances accountability and allows actions to be undertaken to address the gaps identified. It is not a tool to blame each other.

7. EXAMPLES OF POSITIVE USE OF THE SCORECARD

7.1 CONTRIBUTION OF RMNCH SCORECARD TO IMPROVE SKILL DELIVERY IN OROMIA

The Oromia Health Bureau has made remarkable improvement in maternal health within the past 18 months. Skill delivery sharply improved from 47% in 2006 to 61% in the first six months of 2007EFY. On average 5% improvement was recorded every month. The success factors, as outlined by the regional health bureau officials and experts, are improved political commitment, periodic follow up of performance, and active involvement of the community.

The following are identified as key RMNCH scorecard contributions:

01

RMNCH scorecard dissemination to regional president, zonal administrators and other decision makers initiated discussion. The high variability of performance across zones and woredas underscores the need to give more attention and allocate resources to low-performing woredas in order to close the gap. Zonal administrators identified maternal health performance as a measure of overall leadership in their respective locality.

02

Feedback mechanism is in place at all levels of the health system. The immediate higher level provides feedback to lower level facility that shows their commitment to action and provide experience and lessons learned from similar facilities.

03

The positive improvement recorded at regional level was also a reflection of change in all districts. This is due to the fact that both well performing and poorly performing woredas are conducting/reviewing performance by disaggregating into different socio-demographic strata. For example, the woreda supports health centres to categorize service delivery further by kebele, sub-kebele, age group etc.

7.2 CONTRIBUTION OF SCORECARD TO IMPROVEMENT IN EPI-TIGRAY REGION

The RHB planned to expand the success on maternal health to prevention and control of TB program.

Best Practice 2: Contribution of RMNCH scorecard to improve EPI program management to lower level in Tigray region

Tigray region has achieved a high level of performance in EPI (Expanded Program for Immunization) program. In the past two years, the performance of the region in immunization indicators had plateaued at 90%. The introduction of RMNCH scorecard has contributed to improvement in EPI.

The regional health bureau conducted operational research on selected woredas based on their scorecard ratings.

- A regionally representative sample was drawn to conduct a population based survey on the number of children vaccinated. In selected areas, the number of eligible children estimated from the national CSA projection was found to be different from the actual number of children present in the locality. The survey findings triggered the regional management to question the reliability of the routine information system and performance measurement and stimulated the regional management team to strengthen the community information system in order to better define the actual eligible population for every service. As a result, the lower levels of the health system can accurately determine their actual performance against targets and the community is beginning to be involved in the identification of barriers to improved service delivery.

The regional health bureau is planning to develop a community scorecard, which will enhance community involvement in planning, implementation and evaluation of service delivery.

7.3 CONTRIBUTION OF RMNCH SCORECARD TO ENCOURAGE TRANSFERABILITY OF LESSONS ACROSS SIMILAR SETTINGS IN AMHARA REGION

In Amhara region, coverage of skilled delivery showed a slight improvement from 14.6% in 2002 to 27% in 2006. Variability in performance was found to be high across woredas and zones. Furthermore, woredas that performed well in one year could sometimes underperform in the following year without any noticeable change in leadership or external influence.

- Looking at the high variability in performance, the Amhara Regional Health Bureau conducted further analysis and held performance review meetings that included all stakeholders from zones, woredas, facilities and community representatives. The in-depth analysis revealed that the observed changes in performance year after year appeared to be related to attitude and behaviour of the staff. The low performing woredas usually ascribe their performance level to lack of infrastructure or inadequate resources instead of striving to find a creative solution for the existing challenge. The meeting underscored similar settings should exhibit similar results in performance with minimal variance. Subsequently, high performing woredas are expected to share/transfer skills and experiences to low performing woredas.
- The region started to distinguish between the high performing and the low performing woredas by making its staff wear red, yellow or green coloured T-shirts according to their performance. The RMNCH scorecard implementation helped to identify priority problems at local level and enable heads of regional health bureaus to take managerial decisions and actions based on sound evidence. The region identified that there was a critical shortage of an examination coach at the facility level and the region has provided this and other medical equipments and supplies as per the woredas request. As a result, the woreda has substantially improved its performance.

7.4 CONTRIBUTION OF THE RMNCH SCORECARD IN SNNPR

In SNNP, the office of Regional President sent a letter to low performing zones and Woredas requesting explanation based on the Scorecard Accountability Framework. The Regional Health Bureau head also uses the scorecard during regional review meetings. The scorecard is accepted as it is a simple way of communication for performance monitoring.

Following the colour coding, political officials at various levels in SNNP conduct discussion with their higher levels. The discussion is supportive as they are used to mobilize additional support in terms of availing relevant resources and political backing.

8. CONCLUSION

Application of the RMNCH scorecard and related accountability and action mechanisms at the national and sub national levels has enabled political leaders and implementers of maternal and child health interventions to monitor progress against defined targets. In addition to its informative role, the RMNCH scorecard serves to garner the support of the political leadership towards improving maternal and child health in Ethiopia. The data used in the scorecard originated from the national health management information system, thereby contributing to the increased use of evidence for decision making. It is also believed that the application of the RMNCH scorecard has made a significant contribution in improving the quality of information at all levels of the health sector.

The Government of Ethiopia has decided to scale up the application of the RMNCH scorecard to the lowest level of the health sector. Efforts to introduce similar scorecards for Disease Prevention and Nutrition Programs are also underway.

The MoH of Ethiopia believes that ensuring proper accountability boosts the outcomes of health sector interventions. The benefits of using such accountability systems are multiplied especially for countries with decentralized administrative levels like that of Ethiopia by involving political leaders at all levels starting from the Prime Minister up to Heads of Woreda. There is also a solid belief by the Ethiopian government that regional and continental accountability mechanisms should be in place so as to ensure global targets are met.

Accordingly, Ethiopia has called for the development of a Pan African RMNCH scorecard. This scorecard will assist African nations to consolidate efforts towards ending preventable maternal and child deaths on the continent. The Government of Ethiopia had also expressed its commitment to share best practices experienced in the past three years for interested African nations.

Implementation of the RMNCH scorecard has contributed to health system strengthening in general and the decision-making process in five specific ways. First, scorecard implementation reinforces generation of objective data as it communicates performance to political leaders and facilitates comparisons. Second, the scorecard gives an opportunity to categorize facilities as high performing and low performing respectively for taking action. Third, it provides interpretation of result and proposes alternative solutions in narrative form for decision makers to act up on. Fourth, encourages respective facilities to find a solution on their own local context. Fifth, constantly alert all responsible bodies to take their respective decision based on identified bottlenecks.

As a result, data quality and consistency in reporting have been strengthened, as has the feedback system. In addition, a competitive environment has been created across woredas, zones and regions. Regions have undertaken in-depth research to identify bottlenecks and foster information use and evidence based decision making culture. It also creates synergy between health facilities and administrative wings.

Scorecard initiation should base itself on sound planning, monitoring and evaluation system and active involvement of political leadership. Key stakeholders need to be involved starting from the design such as target setting, formulation of justification for decision making.

The assessment further revealed that RMNCH scorecard has a potential to be replicated elsewhere in the country and beyond.



9. RECOMMENDATIONS

The following points are recommended to improve the RMNCH scorecard in Ethiopia.

9.1 STRENGTHENING TRAINING

- Develop training module for RMNCH scorecard functions.
- In the short-term, train and build capacity at regional, zonal and district levels for the RMNCH scorecard tool.
- Incorporate the RMNCH scorecard management tool as an essential component of the pre-service training for Health Information Technicians to ensure long term sustainability
- Provide in-service training on RMNCH scorecard software for pertinent regional health bureau experts to ensure ownership and sustainability.
- Familiarize the regional political leaders with frequently used terminologies such as eligible, denominator, target, etc.

9.2 BROADENING WEB PLATFORM ACCESS AND FUNCTIONALITY

- Rollout the RMNCH scorecard web platform to regions, zones and districts.
- Enhance the existing web platform functionalities including sub-national scorecards (regional, zonal, district/woreda), consolidation of existing action items from management meetings into an action tracker, mapping and graphing functionalities, indicator wave tracking and easier uploading of excel data.
- Consider the procurement of colour printers for regions to print RMNCH scorecards in colour.
- Expedite shift of the RMNCH scorecard from paper-based to web-based management tool to improve efficiency.

9.3 IMPROVE ON INDICATOR SETTING AND DATA QUALITY.

- Standardize target setting process to ensure selection of attainable targets
- Actively involve regions in indicator selection and judgment criteria setting.
- Further improve data quality (accuracy, completeness, timeliness).
- Revisit the issues of population estimation for national and local use.



Annex 1: Ethiopia RMNCH scorecard

ETHIOPIA MNCH SCORECARD

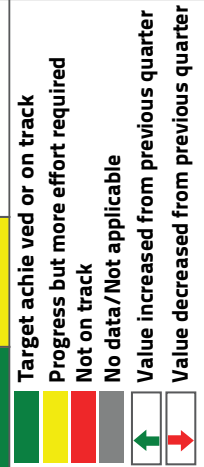
Federal Ministry of Health

year- 2007 6 Months

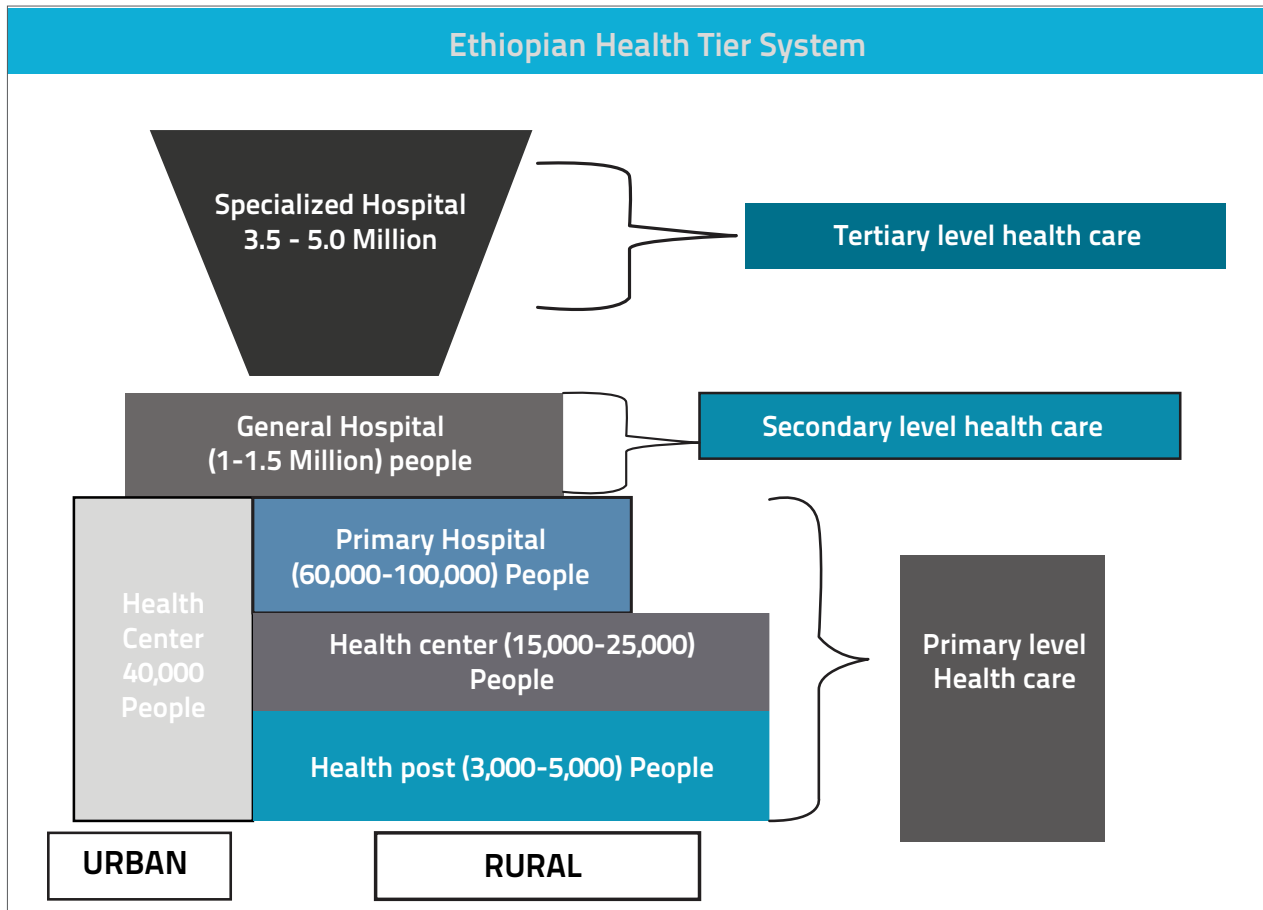
National Indicators

National Priorities

	Contraceptive Acceptance Rate	ANC-at least four visit	Births Attended by Skilled Health Personnel	Postnatal Care Coverage	Measles Immunization Coverage	76.62			
	64.48	49.30							
Regions with Federal	Contraceptive Acceptance Rate	ANC-at least four visit	Births Attended by Skilled Health Personnel/ Coverage	PMTCT testing/# of woment received ART based on option B+	Penta-3 vaccinated in infants	Measles Immunization Coverage	Rotavirus vaccine first dose (Rota1) immunization coverage (<1 Year)	Infants fully Immunized	Neonatal Tetanus immunization -PAB
Addis Ababa	25.92	99.92	80.99	115.60	102.00	90.70	109.52	91.28	
Afar	24.23	29.66	18.92	48.26	70.37	65.32	74.63	63.63	
Amhara	91.22	49.16	33.49	82.06	78.96	74.07	79.46	71.54	
Beneshangul Gumuz	42.13	32.54	28.28	67.08	59.66	52.38	65.34	46.98	
Dire Dawa	38.00	26.94	59.03	119.82	68.02	58.61	77.28	56.96	
Gambella	7.87	5.88	13.48	35.86	30.13	28.92	41.28	23.23	
Harari	38.75	45.25	97.09	198.56	105.06	81.34	119.56	77.58	
Oromiya	65.14	50.92	61.88	107.11	88.36	82.45	94.77	76.26	
SNMNP	69.92	80.12	50.60	107.34	97.44	92.96	93.62	90.02	
Somali	0.85	3.80	2.17	23.36	9.14	7.61		8.11	
Tigray	60.04	49.18	56.95	99.42	83.46	75.84	86.53	74.70	
Federal	64.48	54.84	49.30	94.52	81.92	76.62	83.96	73.17	
				35.24					



ANNEX 2 ETHIOPIAN HEALTH TIER SYSTEM



ANNEX 3. DATA COLLECTION

Type	Participant(Number)	Number	Duration	EncodingMechanism
Document Review (the documents – include scorecard analysis, narrative descriptions of performance, minutes from management and review meetings, and other MTR reports.	-	All Necessary: All documents are available at the MOH, RHB and regional Presidents' office both in hard and soft copy.	-	Obtaining, Copying, Printing Scanning and Photograph
Key Informant Interview	FMOH top officials (4) FMOH Directors (3) RHB Heads (2) Deputy RHB Heads (2) Regional Presidents office representative (2) Zonal Administrators	15	40 Minutes/ Participant	Hand written Notes Voice recorders
Focus Group Discussion	National Level (10) Regional Level (10)	2	1 hour and 30 Minutes/ FGD	Hand written Notes

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