# Creating Accountability Through Community Scorecards

## Implementation Manual

Federal Ministry of Health
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**Message from HE Dr. Amir Aman, Health Minister**

Large scale activities have been undertaken to enable the primary health care service accessible to all segment of country's population. According to standard for a health center to provide health services to a population of twenty-five thousand, it is possible to build more than 3,600 health centers and exceed the targeted plan. Similarly, in all rural kebeles, it was planned to construct a health post for up to five thousand people, more than 16,000 health posts have already been constructed. In recent years, the construction of primary and secondary hospitals, which provide services to more than 100,000 people in rural woredas, is progressing rapidly. At the same time, due attention has been given to training and capacity building of health care providers that resulted in alleviation of skilled health professionals' shortage at all levels of health care.

One of the focus areas identified in the GTP is the health service quality and equity. Although our basic health coverage has reached 100%, we realize that there are problems with service delivery quality and equity. The involvement of the beneficiary community is also to be strengthened in order to improve the quality of health services. Since the introduction of the Health Extension program in the health sector, community involvement has been growing but engagement in improving health service quality has not been achieved at the required level. Accordingly, a community score card, an approach used to make health facilities accountable to the community, has been prepared and implemented since the 2016 budget year as a pilot in four regions (Oromia, SNNPR, Tigray and Amhara) of the country.

As a result of heath service improvements achieved during the pilot implementation of the Community score card approach, pilot regions have begun expanding themselves to other woredas. It is therefore, the Ministry believed that the community score card approach should be initiated and implemented in all health facilities of the country within a short period of time. It is also important to expand best experiences in quality improvement of primary health care services through this approach to other health care facilities. Finally, I would like to commend the ministry staff and partners who assisted with this community score card piloting and guide development and deeply grateful for the dedication of the stakeholders who will be assisting in the implementation of this approach for improvement of health quality in primary health care services.

Thank you!

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# I. Background

Ethiopia's aggressive investment in primary health care services during the past decade is paying dividends. The country has rapidly expanded primary health care facilities, increasing the number of health centers to 3,547 and deploying 38,000 trained HEWs who run 16,440 health posts. Ethiopia has recorded a 67 percent drop in under-five mortality and a 69 percent decrease in maternal mortality from the 1990 (G.C.) estimate (HSDPV). The Health Extension Program is central to this success by expanding access to essential health, hygiene, and sanitation services to the community.

One of the strategies adopted by MOH to ensure sustainability of the gains in primary health care services is to create community ownership and participation in healthcare. To this end, the MOH has implemented the Health Development Army (HDA) approach to organize communities in one-to-five networks, with the goal of expanding the reach of the Health Extension Program (HEP) and facilitating active community engagement. A total of 442,773 HDA groups with 2,289,741 one-to-five networks have been formed with the aim of reaching every household and community. In addition, community conferences and town hall meetings are being organized to solicit feedback from the community.

These efforts to engage the community and promote ownership of primary health care services are being implemented with varying degrees of success. One common challenge is the lack of simple and easy-to-use instruments to capture community feedback and facilitate action by primary health care facilities and local government structures to respond to community needs and grievances. To overcome this challenge, the use of community score card was selected as a tool to capture community feedback. A community score card is a community-led governance tool which brings primary health care facilities, local government structures and the community together to promote accountability and responsiveness to community needs. A community score card can add value to already existing community engagement mechanisms by providing quantifiable and actionable data on community perceptions. The Ethiopian Social Accountability Program (ESAP) provides experience and lessons on implementing community score card in Ethiopia. The ESAP 2 program is engaged in social accountability activities in 223 woredas in Ethiopia under the leadership of Ministry of Finance and Economic Cooperation (MOFEC). The overall objective of the Ethiopia Social Accountability Program (ESAP2) is to strengthen the capacities of citizen groups and government to work together in order to enhance the quality of basic public services delivered to citizens. The Program seeks to give voice to the needs and concerns of all citizens on the delivery and quality of basic public services in the areas of education, health, water and sanitation, agriculture, and rural roads.

This implementation manual describes a path to the introduction and institutionalization of a community score card in the primary health care system of Ethiopia, taking lessons from experiences of ESAP in Ethiopia and other countries (Rwanda, Tanzania, Malawi, and Egypt).

# II. Community score card and good governance

Good governance is one of the guiding principles for the health sector in Ethiopia. The government seeks to create space for citizens to provide feedback, which should then drive the decision-making process for political as well as health sector leaders.

Initiatives being implemented to enhance good governance include building leadership capacity to promote accountability and transparency, and promoting community representation at health facility governing boards, in regular town hall meetings, and at public conferences. In addition, the FMOH has developed a good governance package which identifies the establishment of client councils as a key component to ensure community participation in the monitoring and evaluation of good governance in the health sector. The client councils would play a vital role in conducting social accountability activities including implementation of community score card. Implementation of community score cards will build on these initiatives by strengthening accountability framework through measuring the responsiveness of the health system, satisfaction of the community and identifying priority areas for the health sector.

## III. Objective of the community score card

To enhance the existing mechanisms for community engagement to promote accountability and good governance at primary health care facilities.

- Capture community perceptions of primary health care services in a measureable and actionable way.
- Create a mechanism for woreda health offices, primary health care facilities, and the community to monitor service quality together and respond to community needs.
- Provide a tool for HEWs and HDA members to understand and relay community needs and perceptions.
- Reinforce accountability of primary health care facilities and woreda health offices to the community.

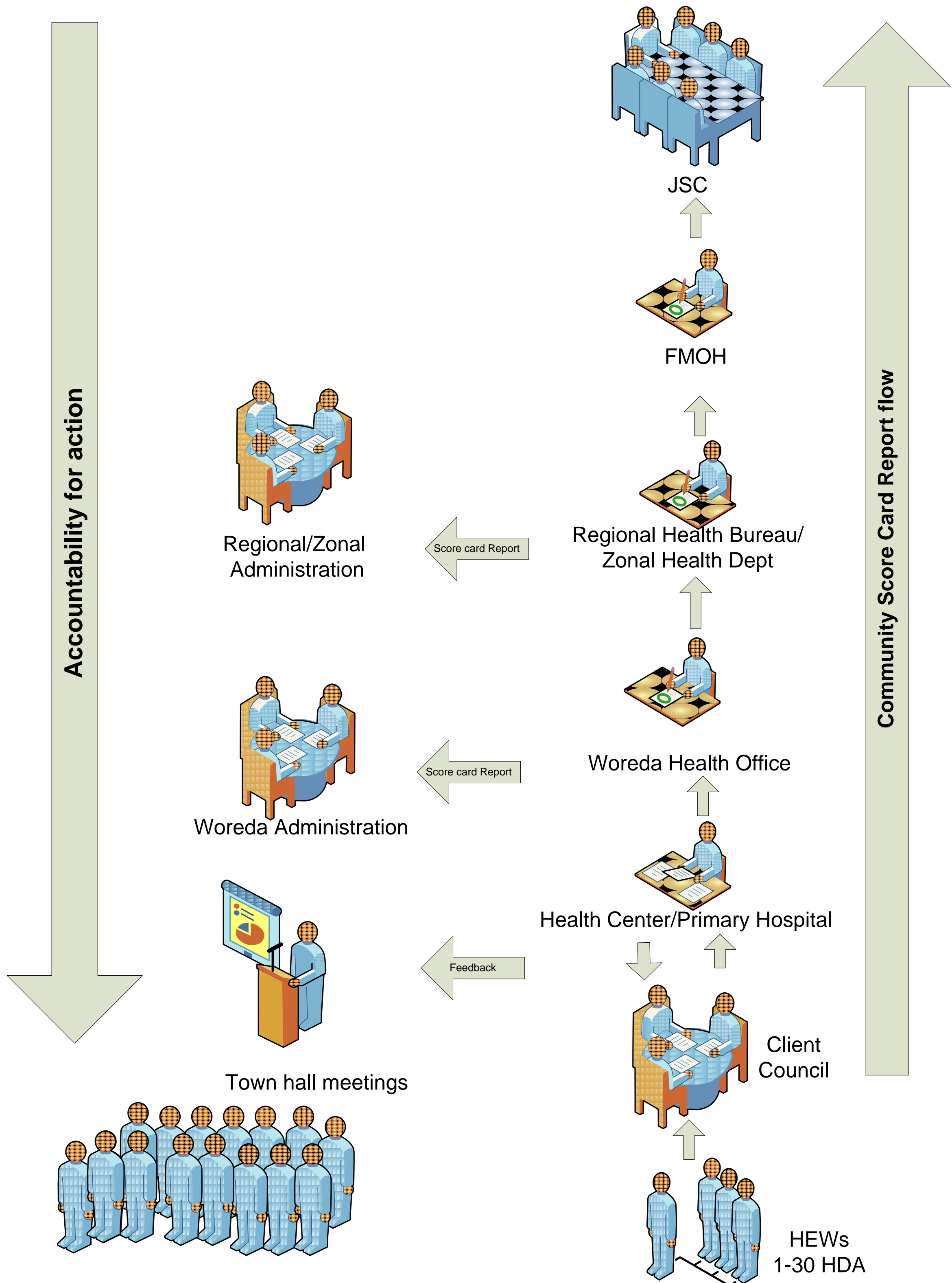
## IV. Methods

Primary Health Care in Ethiopia refers to a Primary Hospital and Primary Health Care Units (PHCUs) which are composed of a Health Center and up to 5 Health Posts. The Woreda Health Office plays the management and coordination role. Even though Primary Hospitals are not available in every woreda, a growing number of them are being built or upgraded from health centers.

Implementation of the community score card involves the participation of each of these entities and other relevant stakeholders in understanding, measuring, and responding to the community's perceptions and needs. Implementation will involve six steps:

Step 1: Understanding the community's perceptions and developing indicators
Step 2: Establishing social accountability client councils
Step 3: Completing the community score card
Step 4: Facility visits and feedback
Step 5: Community interface meetings
Step 6: Taking actions and follow-up

**Fig 1: Community Score Card Framework**




**Step 1:** Understanding community perceptions and developing indicators

The FMOH has proposed a core set of indicators for the community score card which reflect common and recurring themes on community perceptions, concerns, and expectations. The core set of community score card indicators also represent key MOH priorities as outlined in the Health Sector Transformation Plan (HSTP) and the woreda transformation, information revolution, quality and equity, and compassionate and respectful care reform packages. The indicators are customized and additional indicators proposed based on regional and woreda contexts. Indicators are limited in number (from 5-7) to make the process manageable, and are designed to be simple to use and easily understandable in local languages. Indicators may not have the specificity and sophistication of HMIS-type indicators, instead they focus on simple ways of capturing community perceptions.

**Role of primary health care facilities, HEWs, HDA:** Document and provide emerging community perceptions to be used as an input for revision of indicators.

**Role of Woreda Health Office**: Review indicators and ensure appropriateness. Share indicators in town hall meetings to the community.

**Role of MOH and RHBs**: Develop and share indicators.

In most cases, community score card indictors are developed by the community. This approach proposes for the FMOH and RHBs to provide guidance on a core set of indicators at the same time allowing room for flexibility and for the local level stakeholders to amend, add, or remove indicators as appropriate.

Indicators will be refined and updated periodically based on emerging perceptions from the community reflected in town hall meetings or other forums. Indicators will be accompanied by data collection and summary/feedback tools, and sampling methods for data collection.

Studies in Ethiopia have shown that community perceptions on primary health care services focus on the following areas:

- Careering, respectful and compassionate care.
- Waiting time for provision of health care services.
- Availability of medicines, diagnostic services and medical supplies.
- Availability, accessibility and quality of health care service and infrastructure.

These areas have been further confirmed in ESAP community score card case studies. The indicator matrix below outlines list of proposed indicators with their respective definitions and detailed criteria for easy rating.

**Table 1: Community Score Card Indicators Matrix**

| Proposed CSC Indicators | Measures | Criteria for rating (data elements) | | | | |
|---|---|---|---|---|---|---|
| | | 1=Very low | 2= low | 3=ok | 4=Good | 5=Very good |
| 1. Caring, respectful, and compassionate care. | a) Shows respect to patients<br>b) Shows compassion<br>c) Receives patients well<br>d) Has passion for the patient service | Fulfils none of the measures | Fulfils one of the measures | Fulfils two of the measures | Fulfils three of the measures | Fulfils all of the measures |
| 2. Waiting time for provision of health care services | a) Fast service<br>b) Efficient service | Very slow and inefficient service | Slow service | Average service | Fast service | Very fast and efficient service |
| 3. Availability of medicines, diagnostic services and medical supplies. | a) Availability in amount and kind<br>b) Availability in time | Very dire unavailability all the time | Frequent unavailability of most | Partly available | Available with some interruptions | Available all the time |
| 4. Infrastructure of health facilities | a) Availability of water, electricity, road, buildings.<br>b) Regularity of availability | Severe unavailability of infrastructure resulting in interruption of services for days | Unavailability of infrastructure resulting in inefficient services | Partially available | Sufficient availability of infrastructure | All infrastructure needs are fulfilled |
| 5. Availability and management of ambulance services | a) Utilization of ambulance services<br>b) Satisfaction with ambulance services | Service is not available or very inefficient with management problems | Does not meet the community's needs most of the time | Meets the community's needs some of the time | Meets the community's needs most of the time | Sufficiently meets the community's needs |
| 6. Cleanliness and sanitation of healthcare facility | a) Clean and comfortable area for healthcare service provision<br>b) Patient safety | Has sever cleanliness, comfort and safety problems | Not clean, comfortable or safe for patients | Only partially clean, comfortable, and safe for patients | Sufficiently clean, comfortable and safe for patients | Very clean, comfortable and safe for patients |

**Step 2:** Establishing social accountability client councils

In its good governance package, the FMOH has identified establishment of client councils to coordinate and lead social accountability activities. In line with this, client councils will be established for every primary health care facility (primary hospitals, health centers). The client councils will be composed of various constituencies, such as women's groups, youth groups, associations and other segments of the community. In woredas where the ESAP program is being implemented social accountability committees set up by ESAP will serve as client councils. The role of the client councils is to coordinate and lead the community score card process. The client councils coordinate with woreda health office and healthcare facilities to plan one community score card discussion in every health post every quarter facilitated by Health Extension Workers (HEWs). Health Extension workers use one 1-30 development group on rotation every quarter to conduct community score card discussions.

> **Role of Woreda Health Office**: propose client council members and hold establishment meetings for each of client council identified. Provide briefing to client council members on their roles and responsibilities.
>
> **Role of MOH and RHBs**: provide guidance on establishing client counsels for each primary health care facility (health centers, primary hospitals)

**Step 3**: Completing the community score card

At this stage, community score card indicators are measured and scored by the community. This is done in 1-30 development group discussions facilitated by HDA leaders and HEWs in every health post under the leadership of client councils. Each health post is expected to conduct one community score card discussion with 1-30 development groups. In woredas where the ESAP 2 program is under implementation, the HEWs should coordinate with social accountability committees to conduct the community score card.

> **Role of HEW and HDA**: Coordinate with HDA to plan 1-30 development group discussions.
>
> **Role of Woreda Health Office**: Plan and coordinate 1-30 HDA discussions working closely with client councils. Aggregate scores for health facilities and woreda.

The score cards should use a rating scale for each indicator (1=Very low, 2= low, 3=ok, 4=Good, 5=Very good). This is preferably use color codes to make it simple and easy to understand. A discussion facilitation guide is included (page 11) to help structure the discussions.

Once score cards are completed, HEWs compile and share scores to client councils. Client councils collect the scores of multiple health posts and compile a score for the health facility they are responsible for. The woreda health office collect scores for primary health care facilities in its catchment from client councils and work to aggregate the average community score cards for the woreda. The woreda health office should compile and share community score card to zones and regional health bureaus which should then compile zonal and regional scores. Use of technology to facilitate and make data collection efficient is recommended.

**Step 4**: Facility visit and feedback

The client councils share aggregated score cards to primary health care facilities to reflect on and further review feedback from the community. This is done during a facility visit by client council members. During the visits clients counsel enquires on score and comments provided by the community. The scores are shared to staff, management teams of the health facilities, and governing boards and will be a standing agenda in management and staff meetings of facilities to ensure adequate attention and preparations for action.

**Role of primary health care facilities**: Review and investigate community score card feedback (staff, management and governing board).

**Role of Woreda Health Office**: ensure that community score card are reviewed by staff and management bodies of health facilities.

**Role of client councils:** share community core card results of with facilities and learn more about community concerns through facility visits.

**Step 5:** Community interface meetings

Town hall meetings and community conferences will be used to discuss the community score card results. These community meetings attract a larger audience and relevant people from the health facility and woreda health office participate which provides an opportunity to further discuss feedback given by the community. During these meetings, client council members, health center directors, and woreda health offices present plans to address concerns raised by the community and commit to provide continuous updates on progress.

**Role of HEWs HDA**: Work at household and individual level for active participation of the community in town hall meetings.

**Role of primary health care facilities**: Organize community town hall meetings to allow community to express concerns and providers to understand common perceptions about primary health care services.

**Role of Woreda Health Office**: Work with providers and community to plan and coordinate systems by which community perceptions are expressed, understood, and addressed.

**Role of client counsels:** share results of community score card and create the opportunity to discuss plans to address them and hold stakeholders accountable.

**Step 6:** Taking action and follow-up

Working closely with client councils, woreda health office ensures that primary health care facilities develop plan of actions and implement activities to respond to feedback given by the community. As mentioned above, results of the community score cards, plans for action, and progress on implementation will be presented to the community in town hall meetings.

Woreda health office also makes sure that issues raised in the community score cards will be integrated in operational plans of health facilities.

**Role of primary health care facilities**: take action to respond to community feedback on community score card.

**Role of Woreda Health Office**: present community score card results to the community. Ensure that action plans are developed and implemented to address community feedback and community are updated on progress.

**Role of RHBs:** ensure that community score card are integrated with KPIs for the health facilities woreda performance ranking criteria.

## V. Community score card discussion guide

The purpose of this community score card discussion guide is to serve as a tool for a step-by-step process for conducting community score card discussions and scoring. The guide has five sections; A) preparation section which outlines the steps to be taken prior to conducting the community score cards discussions, B) discussion section which outlines in detail how to conduct and document community discussions, C) a section on community score card score aggregation process at different levels. D) a section on facility visits and feedback, and E) a section on community face-to-face meetings (town hall meetings).

### A. Preparation

- Establish a Client Council that conducts social accountability activities at health center level comprised of community constituencies as outlined in FMOH good governance document.
- Give orientation to the Client Council, woreda health office head/woreda management, primary health care facilities, and HEWs on the purpose and process of the Community Score Card (CSC).
- Schedule the community score card discussions quarterly with one 1-30 HDA groups (Female or Male HDA group can be selected from a Gote/Gere) in each health post, if possible integrated with their regular meetings.
- HEW organizes data collection sheets, pen, calculator, and other materials required to conduct the community score card discussion.
- Client council member maybe present during discussion but not the health center, woreda health office, or Kebele representatives.
- Client council member or HEW can facilitate the CSC discussion.

### B. Community discussion

i. ***Facilitator and participant introduction (5 minutes)***: Facilitator introduces him/herself briefly and invites the participants to do the same and records the attendance of participants.

ii. ***Discuss objective of the community score card as below (10 Minutes):*** Facilitator presents the objectives of the community score card process. The community score card is designed to:
   - Capture community perceptions of primary health care services in a reliably measured and actionable way
   - Monitor service quality together and respond to community needs
   - Enable HEWs and HDA members to understand and relay community needs and perceptions
   - Reinforce accountability of primary health care facilities and woreda health offices to the community

iii. ***Highlight the discussion process and how scoring is conducted (5 Minutes):*** explain how the discussion is going to be conducted and get clarification questions on the subsequent steps. Reassure the participants that CSC is conducted only for the above objectives and for them to freely discuss and score the facility.

Explain to participants that they will look into five indicators and rate each indicator on a scale of 1-5 (1- Very low, 2- Low, 3- Ok, 4-Good, 5- Very good) for specific facility (health center or primary

hospital). For participants who can't read, different colors corresponding to the rating will be explained to participants (1-Red, 2-Orange, 3-Yellow, 4-Blue, 5-Green).

**Table 2: Color code for scoring**

| 1- Very low | Red |
|---|---|
| 2- Low | Orange |
| 3- Ok | Yellow |
| 4-Good | Blue |
| 5- Very good | Green |

For participants who don't want to answer, have no experience, or have other reasons not to participate in specific indicator voting, they will be considered as neutral (N) and excluded from counting during voting process. After each indicator is discussed for 5-10 minutes, the meeting will rate the facility under discussion and the average vote count will be taken.

***iv. Explain the indicators and facilitate scoring (60 minutes):***

Elaborate each indicator and ensure that community participants understand what each indicator means. Use the below indicator definitions when explaining to participants. After defining each indicator, facilitate discussion and scoring. For example, the facilitator asks the participants to consider indicator #1 which is discussed for 5-10 minutes. Then the facilitator asks how many rate it as very low, low, ok, good, very good. Then the facilitator counts how many hands went up for which rating and multiply by the score. Then the average of the vote will be taken for an indicator. If for instance in 30 participants, 15 score 2, 10 score 5 and 5 score 3, the score for indicator 1 will be (15*2 + 10*5 + 5*3 /30=3.1). Thus, the overall score would be the sum of the average scores for each indicator with a range of 6-30.

**Table 3: Community Score Card facilitation and scoring**

| Indicator | Definition (explanatory notes to the community) | Discussion Points* | Scoring |
|---|---|---|---|
| Indicator 1: Caring, respectful, and compassionate care. | • Consider patients as human beings, and provide person-centered care with empathy<br>• Effective communication with health care teams, and in interactions with patients<br>• Respect for and facilitation of patients' and families' participation in decisions and care<br>• Pride in the health profession they are in and satisfaction of serving the people and the country | Participants to reflect on the attitude of health workers in the health facility with regard to caring, respectful, and compassionate care. | After 5-10 minute discussion, put the issue to a vote and record an average score on a scale of 1-5 |
| Indictor 2: Waiting time for provision of health care services. | • Waiting time refers to the time that patient arrives at the health center/primary hospital to the time the patient receives services | Participants reflect on the ideal waiting time to get services and their actual experiences with waiting time at the facility. Discuss on some bottle necks if appropriate to identify specific service delivery areas with long waiting time. | After 5-10 minute discussion put the issue to a vote and record a majority score on a scale of 1-5 |
| Indicator 3: Availability of medicines, diagnostic services and medical supplies. | • Availability of medicines, diagnostic services and medical supplies | Participants reflect on their experiences on the availability of medicines, diagnostic services and medical supplies. | After 5-10 minute discussion put the issue to a vote and record an average score on a scale of 1-5 |
| Indicator 4: Availability of health center infrastructure (electricity, water, rooms etc.) | • Does the health facility have adequate infrastructure such as appropriate building, electricity, water, etc.?<br>• Is infrastructure functional when required for patient care? | Participants reflect on their experiences on availability and functionality of infrastructure. | After 5-10 minute discussion put the issue to a vote and record an average score on a scale of 1-5 |
| Indicator 5: Availability and management of ambulance | • Is ambulance service readily available whenever it is required by the community?<br>• Is there transparent and appropriate ambulance car service management? | Participants reflect on their experiences on the ambulance service availability and appropriate management by the facility under discussion. | After 5-10 minute discussion put the issue to a vote and record an average score on a scale of 1-5 |

| | | | |
|---|---|---|---|
| Indicator 6: Clean and safe health center | • Is the compound of health center clean, green, and pleasing?<br>• Are clinical service areas such as the outpatient rooms, inpatient beds, laboratory safe, hygienic and without smell?<br>• Are waste disposal mechanism without risk to the patient and the community? | Participants reflect on their experiences on the cleanness and safety of the facility under discussion. | After 5-10 minute discussion put the issue to a vote and record an average score on a scale of 1-5 |

***Please see Table 1 (Community Score Card Indicators Matrix) for scale of each indicator.**

### v. *Conclude discussion (5 Minutes):*

- Summarize discussion and scores for each indicator. Points will be given for each indicator based on the 1-5 scale. The facilitator can notify the community points out of 25 or convert it in percent.

**Table 4: Summary of score for 1-30 HDA score**

| 1-30 HDA Score Card | |
|---|---|
| **Indicator** | 1. Very Low<br>2. Low<br>3. Ok<br>4. Good<br>5. Very Good |
| Indicator 1: Caring, respectful and compassionate care. | |
| Indictor 2: Waiting time for provision of health care services. | |
| Indicator 3: Availability of medicines, diagnostic services and medical supplies. | |
| Indicator 4: Availability of health center infrastructure (electricity, water, rooms etc.) | |
| Indicator 5: Availability and management of ambulance | |
| Indicator 6: Clean and safe health center | |
| **Score out of 30 and convert to %** | |

The average score for a facility from the 1-30 HDA discussion will be interpreted using the below range.

- Very Good- 25-30 Points (81-100%)
- Good - 20-24 points (65-80%)
- Ok- 15-19 points (50-64%)
- Low- 10-14 points (30-50%)
- Very Low- 6-9 points (<30%)

- Discuss with the group on the appropriateness of the 5 indicators, open the floor for discussion on ideas for modifying indicators or proposing new ones.
- Provide the copy of the score card to 1:30 leader and relevant HEW.
- Remind the community (1-30 HDA group) that they will conduct the same community score card process every quarter.
- Thank the community for their participation and conclude meeting.

### C. Aggregating scores

After concluding the community score card discussion at the HDA meeting, the next step would be to aggregate multiple score cards from multiple health post. The aggregated CSC is reported to the health center and Client Council. Aggregate scores of multiple health posts to arrive at a score for health centers and primary hospitals.

**Table 5: Community score card summary table for Health center/Primary hospital**

| **Indicator** | **Health Post 1 Average Points** | **Health Post 2 Average Points** | **Average (HC/PH)** |
|---|---|---|---|
| Indicator 1: Caring, respectful and compassionate care. | | | |
| Indictor 2: Waiting time for provision of health care services. | | | |
| Indicator 3: Availability of medicines, diagnostic services and medical supplies. | | | |
| Indicator 4: Availability of health center infrastructure (electricity, water, rooms etc.) | | | |
| Indicator 5: Availability and management of ambulance | | | |
| Indicator 6: Clean and safe health center | | | |
| **Score out of 30 convert to (%)** | | | |

Interpret and share results of health center/primary hospital based on the below range.

- Very Good- 25-30 Points (81-100%)
- Good - 20-24 points (65-80%)
- Ok- 15-19 points (50-64%)
- Low- 10-14 points (30-50%)
- Very Low- 6-9 points (<30%)

The aggregate of health center community score card report from the health center will be sent to the woreda heath office and client council.

### D. Facility visits

- Client council prepares a schedule with the health center management to conduct visit to health center
- The visit is conducted by making facility walk-through observing the comments and score provided during the community scoring.
- Client council organizes feed-back meeting with the health center management.
- Joint action plan will be developed with health center management.
- Review of action plan will be made every quarter prior to discussion with the community feedback.

**E. Interface with the community during the town hall meeting**

- Client council presents the results of the community score card and facility observations during the town hall meeting.
- An action plan is developed are enriched with the feedbacks from the community.
- Actions taken by the health center are regularly reported to and evaluated by the community.

## VI. Governance of community score cards

As mentioned in the previous section, management and decision-making bodies at all level of the health sector will take ownership and play a role in implementing the community score card approach. Considering that community scorecard is an instrument for good governance, the political leadership at all levels of administration will use the score card to urgently and effectively respond to community needs in the health sector. In addition, community score card reports should be integrated with and use similar reporting channels as the routine Heath Management Information System (HMIS) reported quarterly.

**Health Extension Workers (HEWs):** HEWs are responsible for planning and conducting community discussions with 1-30 Health Development Army (HDAs) under the leadership of client councils for a designated primary health care facility (health center or primary hospital). HEWs should work closely with HDAs to integrate community score card discussions with preexisting meetings and discussions. HEWs are also responsible for compiling the community score cards and sharing with client councils and utilizing the information to address concerns which can be resolved at the HEW level.

**Primary health care facilities** (Health Center, Primary Hospital): Primary health care facilities should move urgently to action and closely follow-up to address community concerns when low scoring areas identified in the community score card. They should also share results and progress in addressing community concerns through town hall meetings and community conferences.

**Client council:** Working closely with health centers and the woreda health office, the client councils have the responsibility for ensuring that HEWs plan and execute community score card discussions. In addition, client councils aggregate community score card by averaging scores submitted from HEWs and sharing with their designated facilities. Client counsels also have a responsibility to make primary health care facilities and woreda health office accountable and responsive to community needs.

**Woreda Level:** The Woreda Health Office and Woreda Administration have the responsibility of reviewing community score cards for each primary health care facility, aggregating scores for the woreda, and reporting scores to the Regional Health Bureau. Woreda Health Office and Woreda Administration should provide support and closely follow those primary health care facilities with low scores to ensure that adequate response is provided to community concerns.

**Regional Health Bureau (RHB):** RHBs aggregate the community score card score for the region. The RHBs are also responsible for providing support to low performing woredas, disseminating good practices from well performing woredas, and reporting woreda and regional level community score cards to the Federal Ministry of Health (FMOH).

**Federal Ministry of Health:** The FMOH is responsible for creating forums such as the Joint Steering Committee (JSC) to share community score cards of RHBs, create an opportunity for learning from one another, and establish a mechanism for peer review.