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Action brief

Use of the child scorecard to accelerate the reduction of stunting in Rwanda

Country: Rwanda

Date: December 2022

Themes: Monitoring systems and tools for health and nutrition interventions

Sub-themes: Data exploitation

Overview

The child scorecard is an innovative mechanism for quickly identifying households and areas at risk of child stunting and defining necessary nutrition interventions. This practice is important because it identifies households that have not benefited from interventions despite being targeted. Although many countries face similar challenges, few examples exist showing how data can be exploited to inform interventions and policy changes.

Objectives of the action brief

1. To demonstrate the effectiveness of the system to collect and share data for monitoring the nutrition interventions implemented in the first 1,000 days of a child's life.
2. To describe an effective government initiative aimed at accelerating the reduction of child stunting.

Period covered

The child scorecard initiative was launched in 2019. The model was first piloted in a limited number of villages in one district and then rolled out to all districts. The card is currently being used in 26 of the 30 districts in Rwanda.

What action was taken?

Context:

After identifying a national stunting rate of 38 percent in 2015,[1] the Government of Rwanda launched several initiatives to promote healthy child growth, focusing on the first 1,000 days of life. The child scorecard is one such initiative. Developed by the National Child Development Agency (NCDA), the data collection and management tool includes two modules: 1) a list of 22 indicators of children's needs for normal growth; and 2) regular measurements of stunting, including weight, height and oedema. Data are collected monthly from all households with pregnant women and children under 2 years of age across the country, and information on child growth is shared with all relevant stakeholders (e.g. State authorities and parents) to enable the rapid implementation of appropriate interventions and to adjust interventions already being implemented.

Implementation:

The process of data collection and dissemination takes place on multiple levels:

1. **Village level:** Community health workers trained by the NCDA collect data on the two modules of the scorecard during monthly visits to pregnant women and children under 2 years of age. The card is kept by the parents. The data collected by all the workers is then compiled into a village scorecard. The village leader, supported by community health workers, uses the card to identify households at risk of stunting and decide how to help them. Gaps in interventions are identified, and advocacy is conducted at the higher (cell) level.

2. **Cell level:** The cell leader, in collaboration with village leaders and community health workers, compiles data from all village scorecards to determine what nutrition interventions are needed in the villages. Together, the actors analyse the gaps in interventions in the villages and propose solutions. Advocacy is conducted at the sector level for gaps that cannot be filled at the cell level.

3. **Sector level:** The sector-level official, in collaboration with the cell leaders and the cell-level community health worker coordinator, compiles data from all cell scorecards to determine which nutrition interventions are needed in those areas. Together, the actors analyse gaps in interventions and propose solutions. Advocacy is conducted at the district level for gaps that cannot be filled at the sector level.

4. **District level:** The district-level official compiles data from all sector scorecards to determine what nutrition interventions are needed in the sectors. The official coordinates to resolve identified gaps and advocates at the national level for gaps that cannot be resolved at the district level.

5. **National level:** Relevant officials within the NCDA compile data from all districts or provinces to determine what nutrition interventions are needed in the districts or provinces and to inform any policy changes.

[1] Between 2010 and 2020, chronic malnutrition rates among children under 5 (stunting) fell from 44 per cent to 33.1 per cent.

Adaptation and Applicability

Although the child scorecard model could be adopted by other countries, it is important to note some key social and political factors that have contributed to its success in the Rwandan context:

- **The existing network of community health workers. The implementation of this initiative has been supported by an existing network of community health workers at the cell and village levels. The State relies on these community health workers to implement other health-related initiatives.**
- **The existing information system. The scorecard was incorporated into a proven information system, the District Health Information Software (DHIS). Prior to this, a similar but more general tool known as "Reproductive, maternal, new-born, child and adolescent health" had been incorporated into the DHIS.**
- **Political will. Since 2015, the Government of Rwanda has set a target of reducing child stunting from 38 per cent to 19 per cent by 2024 and to 10 per cent by 2030. The various initiatives being implemented are in line with this stated ambition on the part of the Government.**

Next steps

To facilitate compilation, access to information, and real-time data analysis, and in collaboration with the Ministry of Health and its partners, the NCDA plans to digitize the child scorecard. A number of mechanisms are currently being considered by which to facilitate access to the different information. Some of the indicators in the child scorecard already are being collected through existing information systems (Health Management Information System, etc.). Digitization would allow data to be collected for indicators that are not usually measured and to analyse them in a timely manner.

The child scorecard will also form a tool for planning and evaluating malnutrition elimination plans at village, cell, sector and district levels.

What would the country do differently?

Compiling and analysing the data is a major challenge for local authorities, at both village and district levels, as it requires the presence of all stakeholders at discussion meetings. This is a new process for some people, and it takes them time to adapt. There is also a high turnover of local authority representatives, which means training has to be provided for new appointees. Meetings often are not held, and village, cell or sector scorecards often are not filled out on a monthly basis. Incentives are therefore needed, and the ministry with responsibility for local government needs to be mobilized. Districts have been approached and have undertaken to address this issue and follow it up at the quarterly District Plan for the Elimination of Malnutrition (DPEM) implementation monitoring meetings.

Additional information

- Tackling stunting in Rwanda to build human capital: early achievements and strategic priorities
- Vidéo Youtube – Ifishi y'imikurire y'umwana
- The child scorecard to accelerate the reduction of stunting among children
- Rwanda RMNCAH scorecard tool

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