



# Data Informed Platform for Health

## Feasibility Study Report

Amhara and Oromia Regions, **Ethiopia** 2012



LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



**Multi-country feasibility study for the 'Data Informed Platform for Health' (DIPH): India, Ethiopia and Nigeria.**

**This report is one of three country-specific reports and is based on research findings from Amhara and Oromia Region, Ethiopia.**

**The concept note describing the overall premise of the DIPH is on page 4.**

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# Data Informed Platform for Health

## Concept note

### Plans based on local data

In low-resource settings, the use of local health data for planning is usually limited. In the context of maternal and newborn health (MNH) it is difficult to ascertain the causes of changes in MNH outcomes. Sharing information across governmental and other service providers would reduce duplication of effort and ensure resources are not wasted. In India, Nigeria and Ethiopia, multiple sources of data exist at the level of the district, Local Government Area (LGA) or woreda. The Health Management Information System reflects health facility utilisation and performance; local programme staff report on human and physical resources; and non-governmental organisations report on community-based activities. Programme managers could work together to share this information, with technical support acting as a catalyst. The shared data could empower local decision making and reposition health service delivery in line with the available resources and community maternal and newborn health needs.

### Data Informed Platform for Health

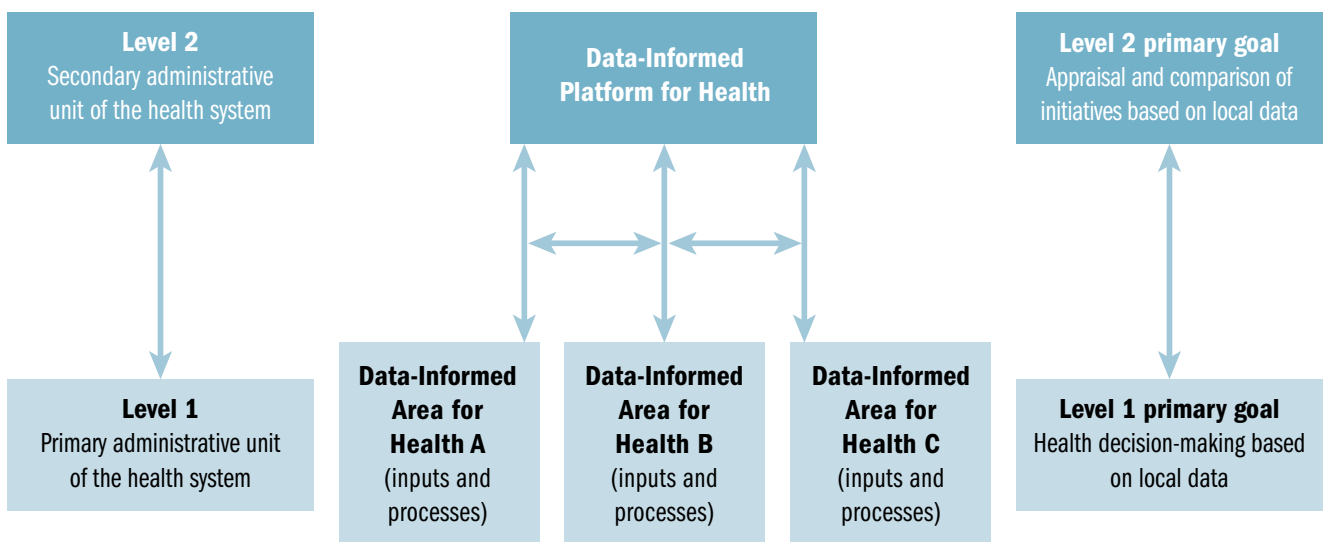
We propose the “Data Informed Platform for Health” (DIPH), a framework to guide coordination, bringing together key data from public and private health sectors on inputs and processes that could influence maternal and newborn health. The aims of the DIPH are:

1. to promote the use of local data for decision-making and priority-setting at local health administration level;



The key data will be synthesised to create a measure of programme implementation strength for each local area, which in turn can be used in the evaluation of the effects of large-scale programmes on health outcomes.”

Figure 1 – Data Informed Platform for Health Framework



2. to promote the use of local data on inputs and processes for programme appraisal and comparison at the regional or zonal level.

The DIPH concept has its roots in the “District Evaluation Platform” approach (Victora, Lancet 2010)<sup>1</sup>. The framework should be embedded, owned and sustained by local health departments. The DIPH operates at local area and regional level, and includes both the “data informed area for health” and the “data informed region for health”. Networks for coordination and feedback are shown in *Figure 1*. Area health administration will periodically assess the available resources and activities (inputs and processes) by all key health providers and will share this information for mutual decision making on health service provision and research.

A local health area is considered as the operating unit for the DIPH, assuming that this is the lowest effective level of decision making in a health system – in Ethiopia, this would be the woreda; in Nigeria, the Local Government Area; and in India, it would be the district.

### Features of the DIPH

At the local area level, the DIPH approach provides a mechanism to bring governmental and non-governmental service providers to a common forum on a regular basis, to share data in a systematic manner, and to use the resulting information as a tool for priority setting for resource allocation and needs assessment for further acquisition of funds.

At regional, zonal or national levels, the DIPH provides information for the appraisal of effectiveness of programmes or initiatives across local areas and regions. Data from

local areas will reflect inputs and processes for initiatives and programmes affecting maternal and newborn health. These can be synthesised to create a measure of programme implementation strength for each local area, which in turn can be used in the evaluation of the effects of large-scale programmes on health outcomes.

### Data sources: links to the Health Management Information System

The DIPH is complementary to the Health Management Information System. It differs as follows:

1. The DIPH focus is on inputs and processes in health service provision – as compared to service uptake and health outcome recorded through routine HMIS.
2. The DIPH will bring together key data from both governmental and non-governmental service providers. The focus is on effective use of existing data sources for local level planning and decision making.
3. The DIPH will focus on a few key indicators rather than the comprehensive range of data encompassed within the HMIS.

The DIPH will use some HMIS data as well as data on commodities, training, monitoring, and supervision, from government and non-governmental sources. A limited amount of primary data collection may also be carried out.



The DIPH is an innovative approach that could be equally meaningful for Governments, funding agencies and other health stakeholders in terms of assessment of their implementation efforts and necessary course correction.”



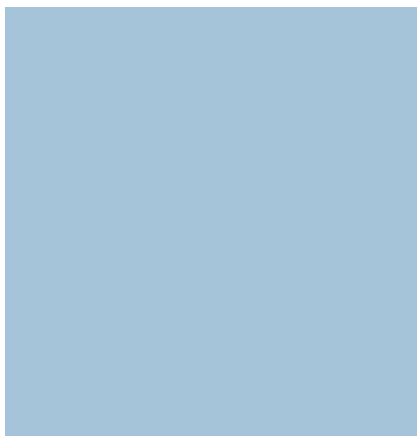
Photo above: Spice market  
© Kate Sabot

### Next steps

The IDEAS project team ([ideas.lshtm.ac.uk](http://ideas.lshtm.ac.uk)) is interested to explore interest in and potential of the DIPH to assess the scale up of maternal and newborn health initiatives in India, Ethiopia and Nigeria. The feasibility phase for DIPH has been successfully completed and, based on the findings, detailed pilot work will be carried out in 2013. ■

<sup>1</sup> Victora CG, Black RE, Boerma JT, Bryce J. Measuring impact in the Millennium Development Goal era and beyond: a new approach to large-scale effectiveness evaluations. *Lancet*. 2011 Jan 1;377(9759):85-95.

## Executive summary



Most maternal and newborn deaths are preventable with simple, low-cost interventions. As innovations to reduce this burden are scaled up, new approaches are needed to evaluate their impact. To this end IDEAS proposes to establish the “Data Informed Platform for Health” (DIPH), to promote data for evaluation and collective decision making.

The DIPH aims to provide a framework to bring together key data from the public health system, Non-Governmental Organisations (NGOs) and private health sectors on inputs and processes that could assist in estimating the impact of Maternal and Newborn Health (MNH) innovations implemented at scale.

To assess the technical feasibility of establishing a DIPH at the district level in Ethiopia, a study team comprised of members from IDEAS and JaRco Consulting conducted a

**Photos above:** Right: Waiting outside a health centre © Dr Bilal Avan

feasibility study in June-July 2012. The objective of the study was to determine whether the DIPH approach is technically feasible to implement in select woredas (districts) in Ethiopia, by investigating the public and private health system organisational structures, supervisions, interactions, information flows, data sources, categories and quality of data, level of receptiveness, and also determine the utility and key challenges of establishing the DIPH. For this purpose the study team, with the assistance of the Ethiopian Federal Ministry of Health, identified two woredas in Oromia and Amhara regions, and focused on MCH related services being offered by the public and private health system in the selected districts. In addition to the Ministry, the study team met with key informants from the Regional Health



The prerequisite for a DIPH implementation includes coordination of stakeholders, quality of data and availability of skilled human resources.”

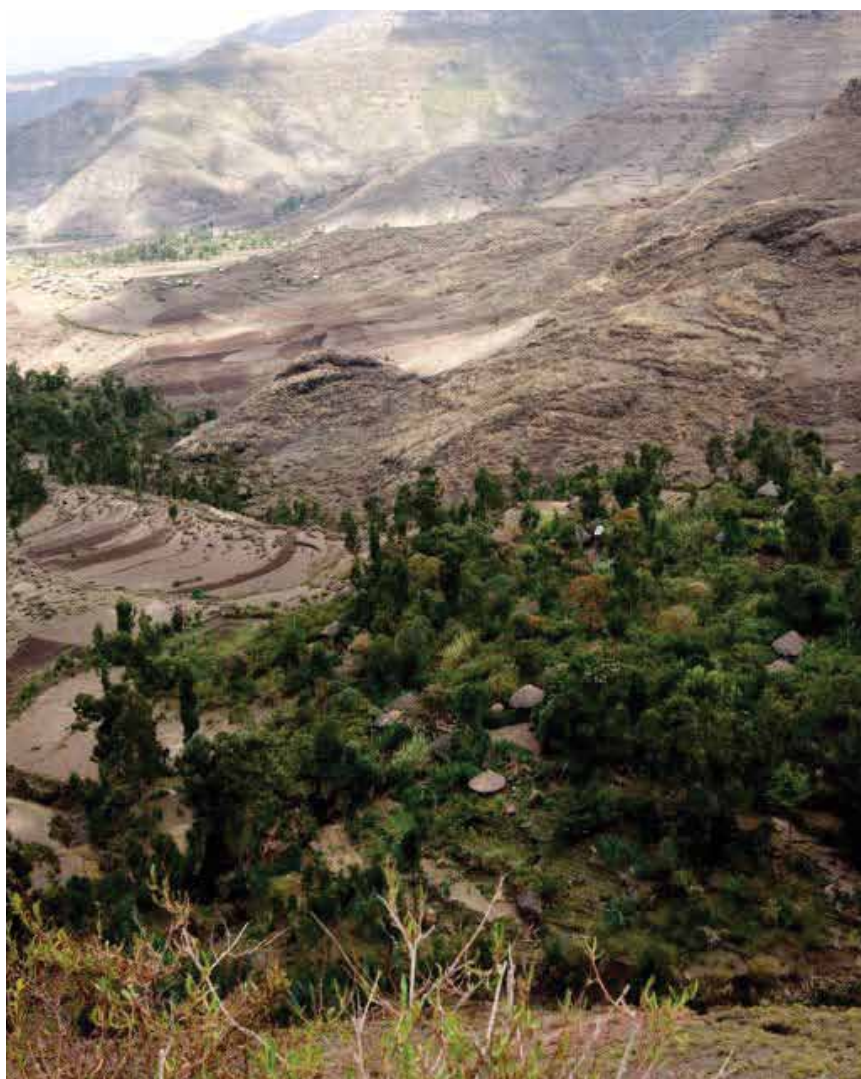
Bureaus, Zonal Health Departments, and Woreda Health offices. Facility visits were also conducted in the Government run health centres and health posts. The team also conducted interviews and site visits at not-for-profit and for-profit private clinics in the study woredas.

In both woredas visited the organisational structure of the primary health care unit, which includes the health post and health centre, were similar. Supervisions were hierarchical: at the woreda level, the Woreda Health Office oversees the health posts and health centres, and the health centres in turn supervise the Health Extension Workers' activities in the community. However, there were differences in the frequency of the supervisory visits between and within woredas. In both woredas visited, data are collected at the district level and reported regularly through the Health Management Information System (HMIS). At woreda level data are collected and reported in paper format; computerised data transfer starts at the Zonal Health Department. At the woreda level, completeness and timeliness of data were mentioned as major obstacles, particularly among remote health facilities. The HMIS is also formatted to collect data from the private sector; however this process has not yet been systematised. The study team also observed a strong interest from the Ministry to engage with the DIPH concept so as to increase the utility of data collected through the HMIS, particularly at the woreda level where data are not maximally analysed and interpreted for decision making. NGOs were also receptive to the establishment of the Platform; both woredas visited lacked a regular forum for NGOs to engage at the district level. The DIPH could serve to coordinate the existing system to be more inclusive, regular and formal.

The DIPH approach is feasible to establish at the woreda level and may facilitate the optimal use of collected data for decision making. However, in planning the implementation of the DIPH, due consideration needs to be given to address potential challenges such as the coordination of stakeholders, quality of data and availability skilled human resources. Once formed, the DIPH has the potential to measure key indicators of the scale-up of MNH innovations and to estimate impact on newborn survival.■

<sup>2</sup> Victora CG, Black RE, Boerma JT, Bryce J. .Measuring impact in the Millennium Development Goal era and beyond: a new approach to large-scale effectiveness evaluations. *Lancet*. 2011 Jan 1;377(9759): 85-95.

**Photo below:** Outskirts of Lalibella  
© Tania Ghosh



# Context

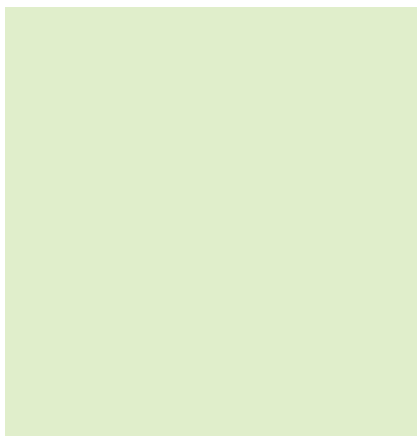


Photo left: Church, Ethiopia  
© Dr Neil Spicer



The Health Sector Development Programme serves as the reference for planning the annual health plans at different levels of the health system.”

## Brief background: focus geographical areas and their relationship with the DIPH

Covering over 1.1 million square kilometres, Ethiopia is the second most populous country in Sub-Saharan Africa<sup>3</sup>. The annual population growth rate is 2.6%, and over 80% of the country's 80.7 million people live in rural Ethiopia<sup>4</sup>. There are 80 ethnic groups in the country and more than 80 recognised languages<sup>5</sup>.

Ethiopia is a federal democratic republic with two city administration (Addis Ababa and Dire Dawa) and nine regional states: Oromia, Amhara, Tigray, Southern Nation Nationalities and People (SNNP), Benishangul Gumuz, Afar, Somali, Gambela and Harrari. Regions are further divided into administrative units of zones (85), woredas (817) and kebeles (over 15,000). Approximately 85% of the population lives in Amhara, Oromia, Tigray and SNNP<sup>6</sup>.

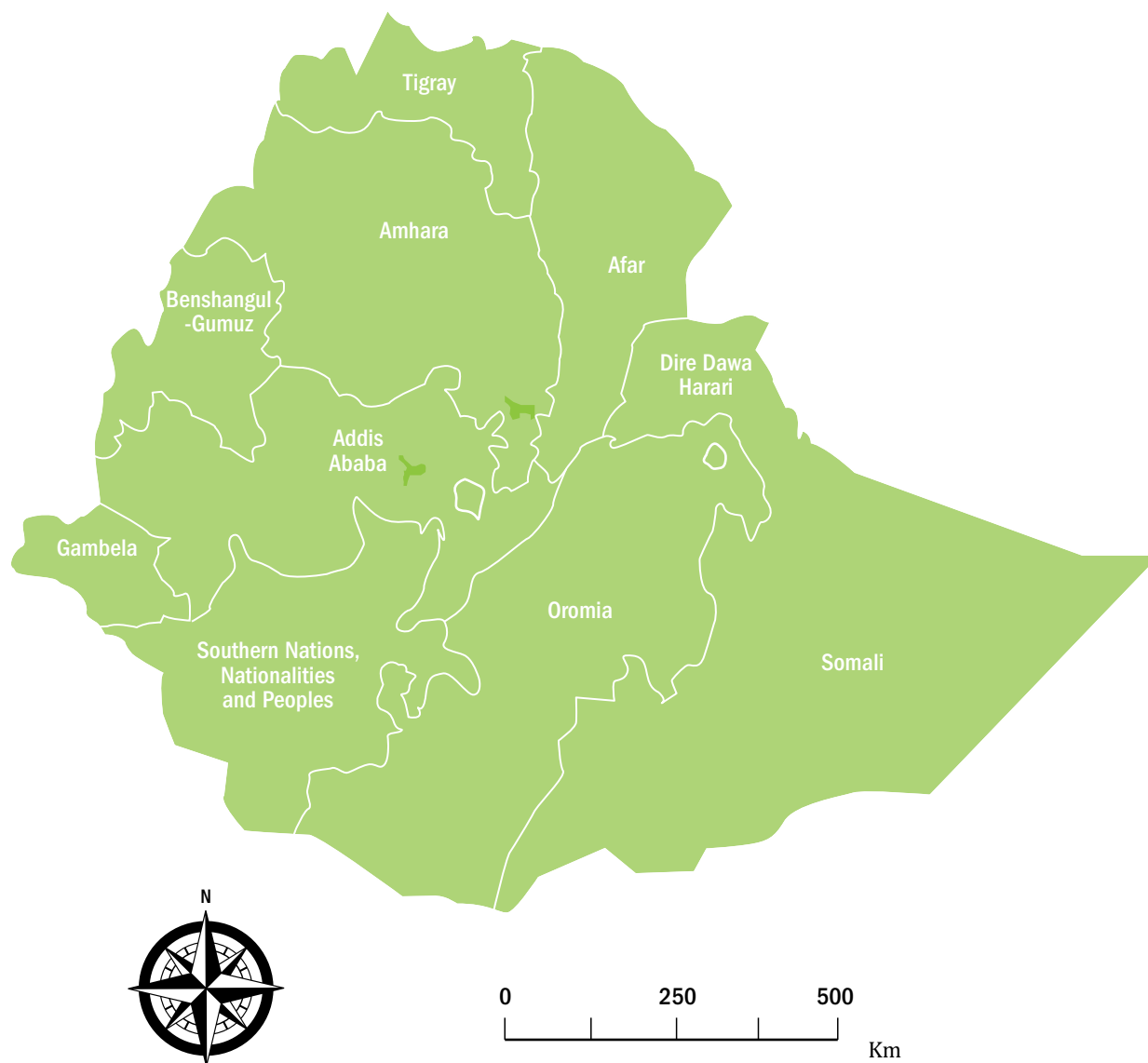
Communicable diseases and nutritional disorders account for a majority of the country's morbidity and mortality. The average life expectancy in Ethiopia is 54 years and the average fertility rate for females aged 15-49 year is 4.8<sup>3</sup>. Despite significant declines over

the last decade and half, maternal and infant mortality still remain high; 676 deaths per 100,000 live births and 59 deaths per 1000 live births, respectively<sup>4</sup>. These high mortality rates are attributed to poor nutritional status, high fertility rates, infections as well as low levels of access to reproductive health and emergency obstetric services<sup>2</sup>. Another major health challenge facing Ethiopia is a shortage of health workers (2.6 physicians per 100,000 people)<sup>7</sup>.

Ethiopia is one of the signatories that committed to achieve the Millennium Development Goals (MDGs) by 2015. To achieve these goals and also address the major health challenges facing the country, the Federal Ministry of Health (FMoH) has developed a 20-year Health Sector Development Plan (HSDP), with four consecutive programmes each lasting for 5 years. Currently in its fourth phase, the HSDP aims to improve health service delivery, infrastructure and resources, as well as improve leadership and governance. It aims to achieve this through decentralisation of the health care delivery, development of the preventive, promotive and curative components of health care, assurance of accessibility of health care for all segments of the population,



Figure 1 – Ethiopia with Regional borders, showing Dendi and Baso woreda



<sup>3</sup> Health Sector Development Programme (HSDP) II, 2005, Federal Democratic Republic of Ethiopia Ministry of Health

<sup>4</sup> Health Sector Development Programme (HSDP) IV, 2011, Federal Democratic Republic of Ethiopia Ministry of Health

<sup>5</sup> Ethiopian Demographic Health

Survey (EDHS), 2011, Central Statistical Agency (CSA)

<sup>6</sup> Summary of Statistical Report of the 2007 Population and Housing Census, Federal Democratic Republic of Ethiopia Population Census Commission

<sup>7</sup> The World Health Report, 2006, World Health Organisation



**Photo above:** Mother with children © Bill & Melinda Gates Foundation

and promoting the participation of the private sector and NGOs in health care delivery. The HSDP serves as the reference for planning the annual health plans at different levels of the health system.

#### Rationale for the selection of the two districts for the feasibility study

To better inform our understanding of the health systems in Ethiopia and investigate the feasibility of establishing the Data Informed Platform for Health (DIPH), the study team, in collaboration with the FMoH, identified two woredas in Amhara

and Oromia regions. In the selected woredas, the study team visited health facilities, administrative offices, private clinics and non-governmental offices.

In selecting the woredas from the two regions the study team took into consideration the following factors:

- Language: ensured that language would not be a barrier
- Accessibility: woredas had to be accessible by vehicle.
- Proximity: preference was given to woredas that were no more than a day's drive from the capital, Addis Ababa.
- Variability: able to capture variability between, regions, zones and woredas.



To achieve MDGs and also address the major health challenges facing the country, the Federal Ministry of Health (FMOH) has developed a 20-year Health Sector Development Plan (HSDP), with four consecutive programmes each lasting for 5 years.”

Using these criteria the study team selected Dendi and Baso woreda which are located in Oromia and Amhara region, respectively (Figure 1).

### Oromia

Oromia region, with an estimated area of 353,006 square kilometres, has a population of 32.1 million people. The population density is 104.5 people per square kilometre. The region has 26 zones, 304 woredas, 1109 health centres (5 NGO operated), 6432 health posts (4 NGO operated) and 56 Hospitals (4 NGO operated and 4 private). There are also 43 higher, 253 medium and 1343 lower clinics.

In Oromia the study team visited the Regional Health Bureau (RHB) and the Woreda Health Office. With the assistance of the Dendi Woreda Health Office deputy head, the study team selected two health centres, two health posts (to be able to capture variability between health facilities within a woreda), two private clinics (one for-profit, and the other not-for-profit) and an NGO. Dendi is located in West Showa and has a total population of 193,338. There are 8 health centres (5 functional and 3 under construction) and 48 health posts (15 equipped and functional, 30 unequipped and 3 under construction).

### Amhara

Amhara region has an estimated area of 159,173 square kilometres. It has a population of 20.1 million, with a density of 117.4 people per square kilometre. There are 11 zones and 141 woredas in the region. With respect to health facilities there are 17 hospitals (10 district, 4 referral, and 3 zonal), 254 health centres (5 NGO operated), and 2,856 health posts (4 NGO operated). There are also 14 higher (3 NGO operated), 122 medium (9 NGO operated), 404 lower and 16 special clinics.

In Amhara region the study team visited the Zonal Health Department and the Woreda Health Office. With assistance from to the deputy head of Baso Woreda Health Office, the study team again selected two health centres, two health posts, and an NGO. Baso has a population of 130,538, four health centres and 31 health posts. ■

**Photo below right:** Rural health centre, Amhara region © Dr Neil Spicer

**Photo below middle:** Market, Bahir Dar © Tania Ghosh

**Photo below left:** Rural huts, Amhara region © Dr Neil Spicer



# Structures and Governance

## Public Health System

This section begins with an explanation of the Ethiopian health care delivery system and the Health Extension Programme. Following this is a description of the organisational structure of the different levels of the Health System (federal, regional, zonal and woreda), and at each level, an account of the existing contact opportunities, supervisory structures and activities, and supply systems and record keeping of commodities.

### Brief structure of health ministry and departments and how they are related to the woredas

In order to achieve access to the basic package of primary health care services that includes preventive, promotive and basic curative services, the HSDP introduced a three-tier health care delivery system (*Figure 2*).

The following is a description of the health system organisation provided by the health ministry:

5000 people. The primary aim of a health post is to provide preventative health care and mobilise communities. Health posts are staffed by two female Health Extension Workers (HEWs) with a 10th grade education plus one year technical and vocational training in health. In areas where the population density is high, three HEWs can be assigned to one health post. HEWs spend 80% of their time in their community working in the area of preventative health care and health education, including services such as family planning, EPI, Outpatient Therapeutic Programme (OTP), clean delivery and essential newborn care services, diagnosis and treatment of malaria, diagnoses and treatment of pneumonia, and management of diarrhoea and dehydration using ORS. HEWs speak the local language and reside in the kebele where they are posted. They perform their duties with the supervision and technical support of a nurse from the health centre in their catchment area.



The primary aim of a health post is to provide preventative health care and mobilise communities and it is staffed by two female Health Extension Workers.”

1. The Primary Health Care Unit (PHCU) is found at the woreda level and its primary objective is to ensure the provision of comprehensive integrated and community-based preventative and basic curative services. The PHCU plays a major role in delivering primary health care, with a focus on the rural population. The PHCU has the following three components:
  - a. The PHCU at the district level consists of health posts, each serving up to 5000 people.
  - b. A Health centre, with five satellite health posts, serves up to 25,000 people and is the primary-level of referral for health posts. On average a health centre has 20 staff members and provides curative care as well as some minor emergency surgery in selected health areas. Health centres also serve as practical training institutions for HEWs.
  - c. Primary hospitals provide secondary referral care to health centres and serve 60,000-100,000 people.

Figure 2 – The Primary Health Care Unit (PHCU) and Health Extension Programme (HEP) in Ethiopia

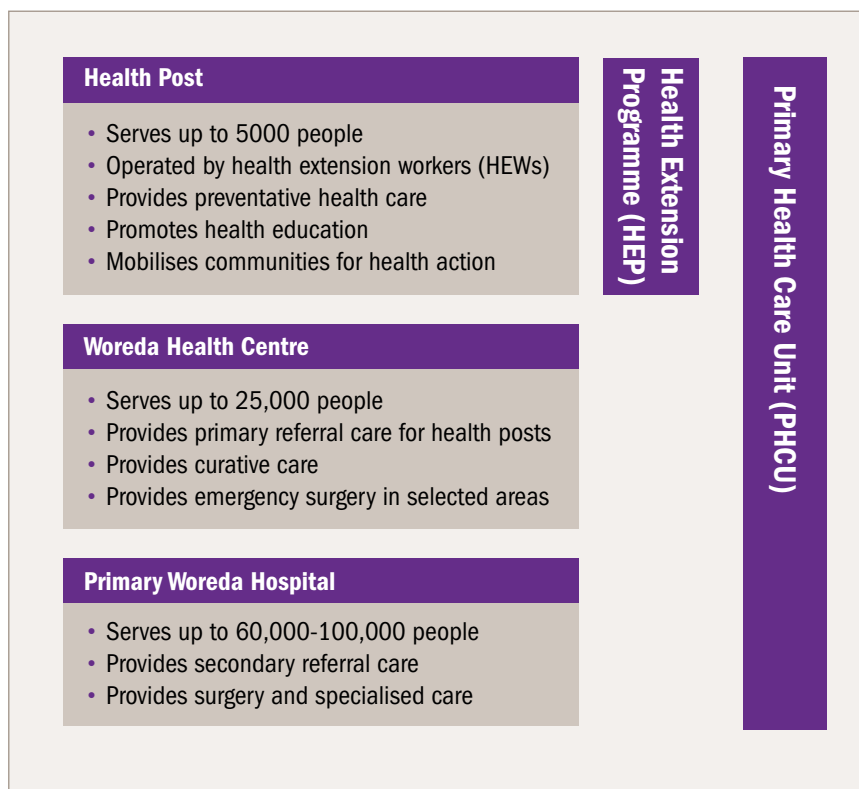


Photo below: Health data files, Woreda Health Centre © Dr Bilal Avan



Table 1 – Major Areas and Packages of the Health Extension Programme, Objectives and Associated HMIS Indicators.

Type of Package	Objective	Indicators
<b>A. Hygiene and Environmental Sanitation (seven packages)</b>		
<b>Proper and safe excreta disposal system</b>	To help the community build and use sanitary latrine systems, thereby reducing or eliminating excreta borne disease.	1. Latrine Coverage
<b>Proper and safe solid and liquid waste management</b>	To develop awareness, knowledge and skills to address problems associated with improper disposal of solid and liquid wastes on community health.	
<b>Water supply safety measures</b>	To develop community awareness, knowledge and skills to address water contamination from common sources in rural settings.	1. Safe water coverage
<b>Food hygiene and safety measures</b>	To develop food safety skills and awareness through household and community level training on types and sources of food-borne illness.	
<b>Healthy home environment</b>	To enable the community to build their own houses and safeguard themselves against health risks which might result from unhealthy living environment.	
<b>Arthropods and rodent control</b>	To help the community identify and control the disease carrying vectors and biting species.	
<b>Personal hygiene</b>	To prevent and control communicable diseases that occur due to poor personal hygiene.	
<b>B. Disease Prevention and Control (four packages)</b>		
<b>HIV/AIDS prevention and control</b>	To raise community awareness about HIV, promote behaviours that reduce risk of HIV infection, and educate communities on how to provide support for AIDS patients.	
<b>TB prevention and control</b>	To prevent and control the spread of tuberculosis by increasing community awareness on the modes of transmission of TB and promoting the use of control measures.	
<b>Malaria prevention and control</b>	To educate communities on the modes of malaria transmission and promote malaria control activities	1. ITN Distributed 2. RS sprayed 3. Malaria cases reported per 1000 population in under 5 children 4. Malaria cases reported per 1000 population in age groups 5 years and above
<b>First aid</b>	Raise community awareness on the importance of first aid, and refer severely sick or injured people to nearby health facilities.	
<b>C. Family Health Services (five packages)</b>		
<b>Maternal and child health</b>	To provide antenatal, delivery, postnatal and child health services as a package to prevent illness, death and disability among mothers and children in the community.	1. Antenatal care coverage 2. Postnatal care coverage, 3. Delivery attendant HEW 4. Delivery attendant TBA 5. Low birth weight proportion 6. Total neonatal tetanus cases

Type of Package	Objective	Indicators
Family planning	To reduce morbidity and mortality of mothers and children by spacing child-bearing, and preventing unplanned and unwanted pregnancies.	1. Contraceptive acceptance rate
Immunisation	To increase coverage of vaccination services by raising community awareness of the importance of vaccination, and providing increased access to vaccines.	1. DPT1+HepB1+Hib1 coverage 2. DPT3+HepB3+Hib3 coverage 3. Measles immunisation coverage 4. Full immunisation coverage 5. Vaccine wastage rate 6. PCV-1 immunisation coverage 7. PCV-3 Immunisation coverage
Adolescent reproductive health	To promote healthy physical, social and mental development of youth by providing health education, increasing access to health resources, and raising community awareness on youth-related issues.	
Nutrition	To educate communities on nutrition, nutritional care of infants and children, food preparation for a balanced diet and the diseases caused by malnutrition.	1. Proportion of moderate/severe malnutrition amongst weights recorded for children under 3 years
D. Health Education and Communication (one package)	To educate communities on health issues through various appropriate communication methods to motivate behavioural change.	

Primary hospitals provide emergency surgical services, including Caesarean Section and blood transfusion services. On average primary hospitals have an inpatient capacity of 35 beds and a staff of 53 individuals. These hospitals also serve as practical training centres for nurses and other health professionals.

- General Hospitals provide secondary referral care for primary hospitals. These hospitals are located in the capital city of the zone. A general hospital provides inpatient and ambulatory services to 1-1.5 million people. Staffed with an average of 235 individuals, it has an inpatient capacity of 50 beds. General hospitals also serve as training centres for health officers, nurses, emergency surgeons and other health professionals.
- Specialised hospitals serve as referrals for general hospitals. These hospitals are located at the regional

and federal level and are staffed with an average of 440 health professionals. Specialised hospitals serve 3.5-5 million people and have an inpatient capacity of 110 beds. These hospitals are also teaching hospitals where medical students and other health professionals are trained.

The Health Extension Programme (HEP) was launched in order to achieve universal primary health care coverage, with a focus on preventative and promotive services at the kebele and household level (*Figure 2*). The HEP is a community-based health service delivery programme introduced in 2003 with the philosophy that if the right knowledge and skills are transferred to households, they can enhance and maintain their own health. At the core of the HEP is the training and deployment of 35,000 HEWs who are posted in urban and rural communities to provide primary health care coverage at the kebele and



The Health Extension Programme is a community-based health service delivery programme introduced in 2003 with the philosophy that if the right knowledge and skill is transferred to households, they can enhance and maintain their own health.”

**Photo right:** Ethiopian countryside

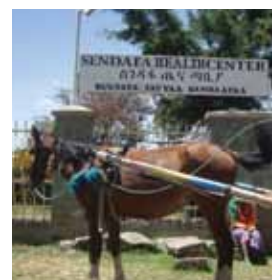
© Kate Sabot

**Photo middle:** Health Extension

Worker © Dr Bilal Avan

**Photo far right:** Rural health centre

and cart ambulance, Oromia region ©  
JaRco Consulting



household level. The HEP programme relies on four major areas and 17 packages (*Table 1*).

In addition to the HEWs and their supervisors, the HEP also relies on model families (families in the community who easily adopt and transfer the technology and ideas disseminated by HEWs to others), Community Health Promoters (CHPs- consists of women from graduated model households), and Health Development Army (HDA). The HDA aim to increase awareness and change health seeking behaviour at the kebele level. The HDA relies on 1 to 5 networking of females, among whom a leader is chosen by the community to lead five households. Five networks are then organised into development groups. The HEP as a whole is the main avenue for bringing key maternal, neonatal and child health interventions to the community.

#### **Federal Ministry of Health**

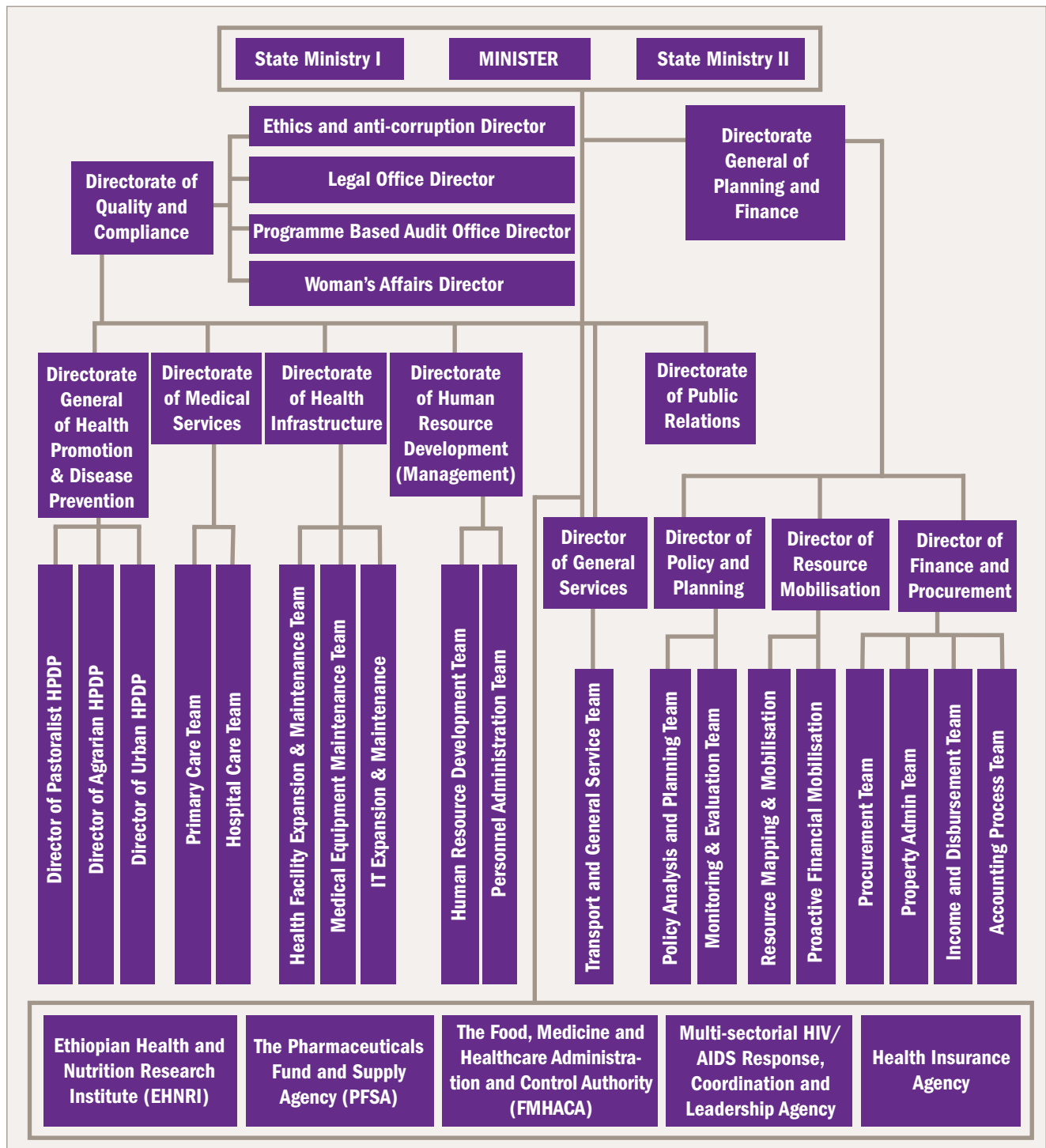
Overall the FMoH is responsible for health policy and regulation. The Ethiopian health policy focuses on prevention and promotion of health services. The budget assigned for the prevention programme is approximately 30% of the total budget allocated for the health sector. The parliament appointed Minister, along with two state ministers, oversees seven directorates and one director: Quality and Compliance; Health Promotion and Disease Prevention; Medical Services;

Health Infrastructure; Human Resource Development; Planning and Finance; Office of the Minister; and General Services. In addition they also oversee the activities of five agencies: Health and Nutrition Research Institute (HNRI); Pharmaceuticals Fund and Supply Agency (PFSA); Food, Medicine & Health Administration & Control Authority (FMHACA); Multi-sector HIV/AIDS Response, Coordination & Leadership Agency; and Health Insurance Agency (*Figure 3*). Of the two state ministers, one is tasked to oversee the operational aspects of the ministry (e.g. Directorate of Human Resource Management) and the other the technical side (e.g. Directorate of Medical Services). The federal ministry prepares an annual core plan that includes activities for all directorates as well as agencies.

Within the Ministry, the Maternal and Child Health (MCH) programme focal department is integrated into the Health Promotion and Disease Prevention Directorate (HPDP-D). This directorate also includes focal departments for the following: Communicable Disease Prevention and Control; Hygiene and Sanitation; Information, Education, Communication (IEC) and Advocacy; and Nutrition programmes. The major roles of the HPDP general directorate include development of strategic plans, manual and guideline development, monitoring of implemented programmes, and health professionals'



Figure 3 – Federal Ministry of Health organisational structure



Though the system keeps updating, this is the organisational structure of the FMOH at the time of data collection.

training facilitation.

Recognising the different cultural and socio-economic backgrounds of communities and households, and their unique health needs, the HPDPD is further divided into Agrarian (Amhara, Oromia, Tigray and SNNP region), Urban (Addis Ababa, Dire Dewa and Hariri) and Pastoralist (Afar, Somali, Gambela and Beneshangul-Gumuz) departments.

Each of these departments plan, coordinate and execute health promotion and disease prevention activities in their respective regions based on the Health Ministry’s annual core plan.

Monitoring and evaluation of activities is overseen by the Policy and Planning Department (PPD) which

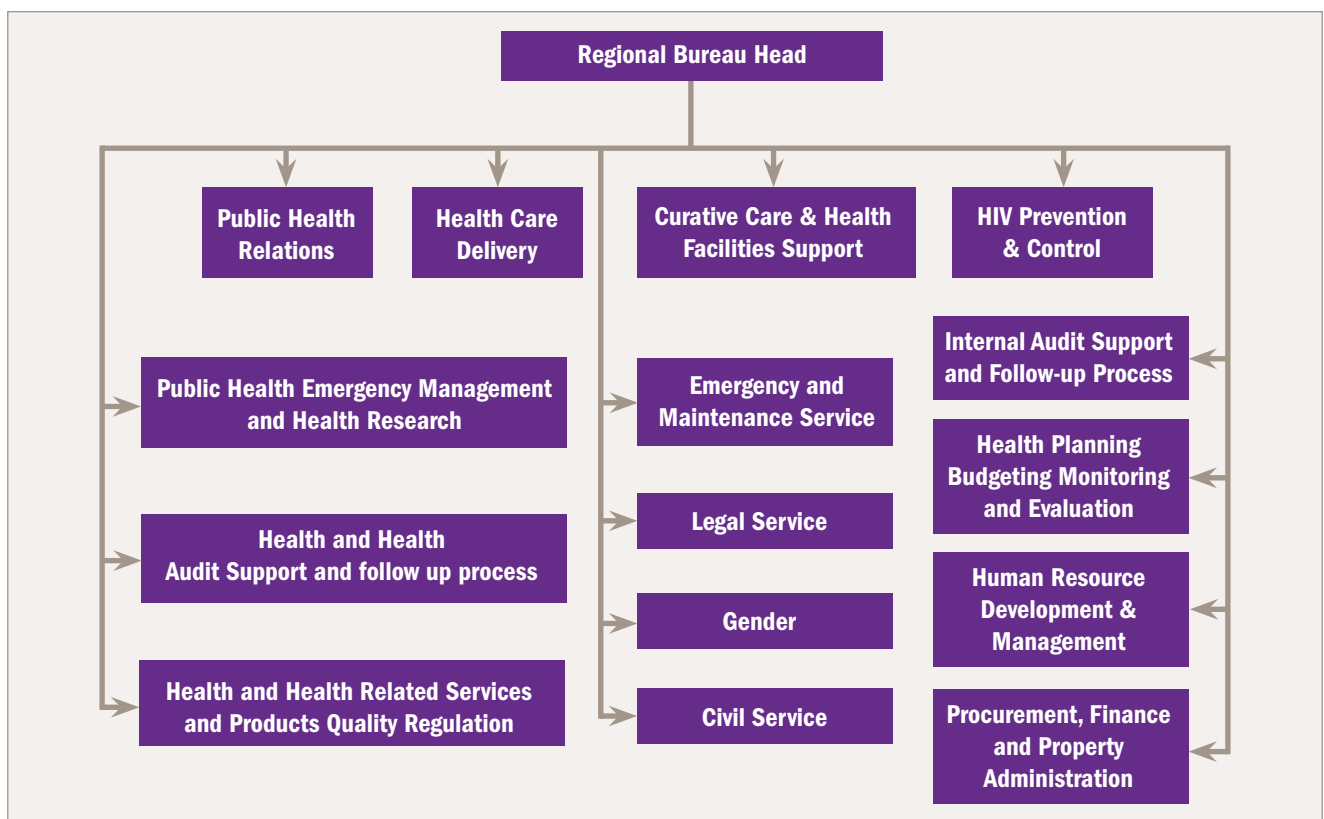
is under the Planning and Finance Directorate. This department receives quarterly progress data on health indicators from the different regions and prepares a report based on 50-60 (46%-56%) indicators from the total 108 Health Management Information System (HMIS) indicators. However, more indicators are included on the annual reports (e.g. nutrition indicators and HEP indicators). This report is then sent to the Prime Minister’s office and is followed by a presentation by the Health Minister (or State Minister) and Director General of Planning and Finance (or Director of Policy and Planning). The Prime Minister’s office then evaluates FMOH’s activities and achievements using information obtained through

the HMIS as well as administrative reports from the Urban, Agrarian and Pastoralist HPDP directorates. Administrative reports consist of input indicators which include details on trainings, supportive supervisions, supplies, campaigns, and development of manuals, guidelines and forms.

**Regional Health Bureau**

Management of health service delivery falls under the responsibility of the Regional Health Bureaus (RHBs). As such RHBs manage personnel, health facilities and health training institutions within their respective regions. The head of the RHB is appointed by the regional government and approved by the regional council.

Figure 4 – Oromia Regional Health Bureau (RHB) organisational structure



Facilitated by a coordinator from the FMOH, each region prepares an annual plan in the presence of Zonal Health Department representatives. At the RHBs, the Health Planning Budgeting Monitoring and Evaluation Department monitors and evaluates the regional activities based on quarterly HMIS reports from the various zones as well as from administrative reports. The reports from the different zones are compiled for a regional aggregate and are sent quarterly to the Federal Ministry of Health.

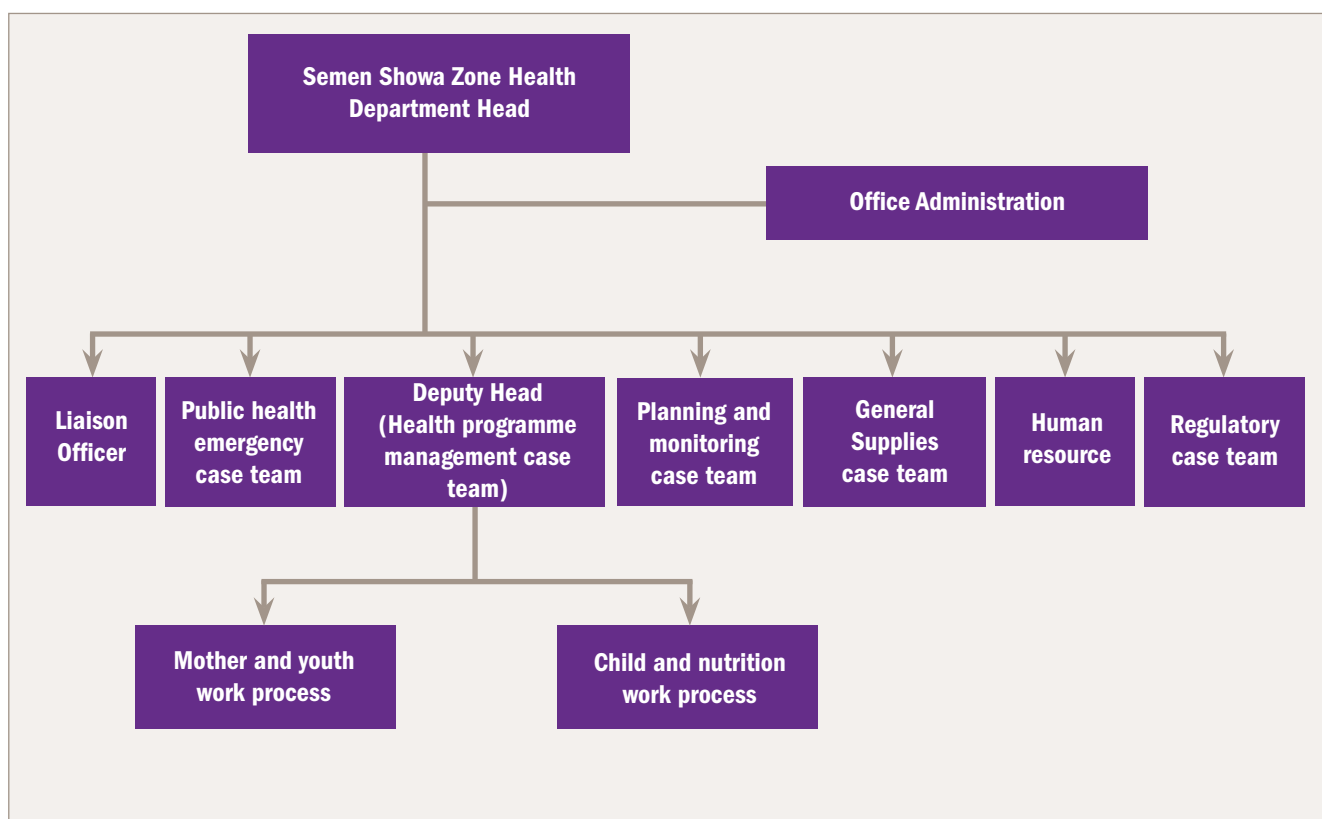
At the RHB visited by the study team, the head of the bureau oversees 15 departments. Maternal and Child Health at the regional level is integrated into the health care delivery department (*Figure 4*).

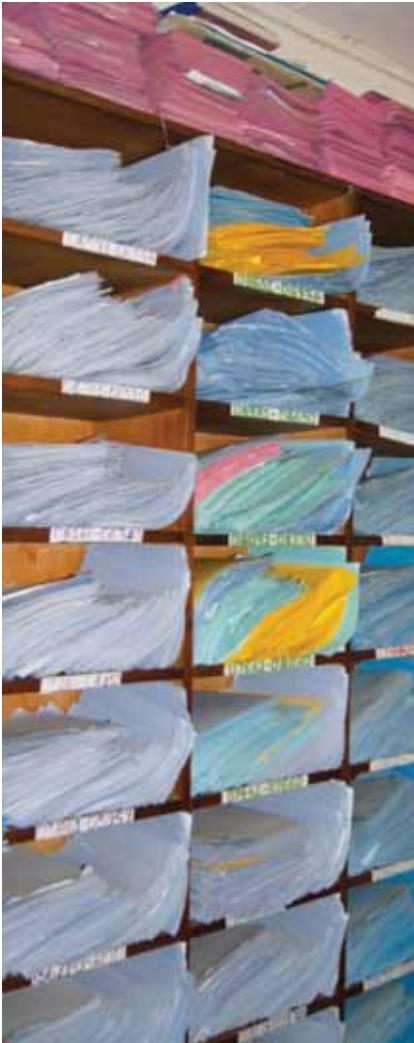
### Zonal Health Department

The Zonal Health Departments support both the RHBs and the Woreda Health Offices in the management of health service delivery. The Zonal Health Department is managed by the head and deputy head who oversee the operational and technical activities of the different sections (e.g. regulatory, prevention, reproductive health, and maternal and child health). It is important to note that the urban administrative units (Addis Ababa and Dire Dewa) as well as Tigray, Afar, Somali and Harari regions do not have Zonal Health Departments. The respective RHBs are responsible for the management of health services delivery in the Region.

Though the Zonal Health Department is involved in planning the regional and woreda level health programmes, actual planning at the zonal level appears to be minimal. Zones monitor the activities of woredas through quarterly HMIS reports sent by the Woreda Health Offices, which are then summed up across all woredas in the zone by the Planning and Monitoring Department and sent to the respective RHB. In addition to quarterly reports, the zone also receives monthly reports from the Woreda Health Office on immunisation of mothers and children, and also Prevention of Mother to Child Transmission (PMTCT) of HIV. HMIS data at the zone level is computerised

Figure 5 – Semen Showa Zonal Health Department organisational structure





**Photo above:** Health data files, Woreda Health Centre, Ethiopia © Dr Bilal Avan



The Health Development Army aims to increase awareness and change health seeking behaviour at the kebele level. HDA relies on 1 to 5 networking of females, among whom a leader is chosen by the community to lead five households.”

and the data are sent to the region as both a soft (via e-mail) and hard copy.

In North Showa Zone (Amhara region), the head of the zonal office oversees eight departments (*Figure 5*). Within the Zonal Health Department, MCH and Nutrition activities are overseen by the Health Programme Management section.

#### **Woreda Health Office**

Woredas have their own budget, which is locally divided among the different sectors (e.g. health, education and agriculture). Experts from the different sectors estimate and present the required amount of budget to the Woreda Cabinet. The elected Woreda Council then approves the budget that is proposed by the Woreda Cabinet.

#### *Woreda-Based Planning*

The woreda-based planning aims to meet the local level health needs within the context of national targets. At the federal level, a technical working group provides direction and selects indicators based on HSDP and Millennium Development Goals. At each level (region, zone and woreda) of the health system, indicators and targets are then added and/or reprioritised based on local needs.

At the woreda level, the planning is undertaken by a team (which includes individuals from the financial and administrative departments) trained to utilise the Marginal Budgeting for Bottlenecks (MBB) tool. The team utilises the MBB for costing and/or indentifying

obstacles for achieving the health goals of the woreda. The woreda-based plan is then sent to the Regional Health Bureau and also presented to health development partners to ensure integration of plans and budget at the woreda level. Through the Joint Steering Committee, the woreda based plan is then integrated into the national core plan.

#### *Woreda Health Office*

At the district level, the health administrative body is the Woreda Health Office. The head of the Woreda Health Office visited, with assistance from the deputy, oversees five departments: MCH, prevention (mainly relating to TB and Malaria), health services delivery, finance and human resources. Each department head is called a process owner and leads a team who plan and work together to achieve set goals (*Figure 6*).

The MCH department is further divided into three sections: family planning, Health Extension Programme (HEP), and Ante Natal Care (ANC), Post Natal Care (PNC) and delivery. Theoretically an MCH department should include 5 individuals: two health extension workers experts; two family health experts; and the MCH head. However, the Woreda Health Office visited had only three individuals.

#### *Health Centre*

A health centre is headed by a public health officer who has four of years training with BSc degree in public

Figure 6 – Dendi Woreda Health Office organisational structure

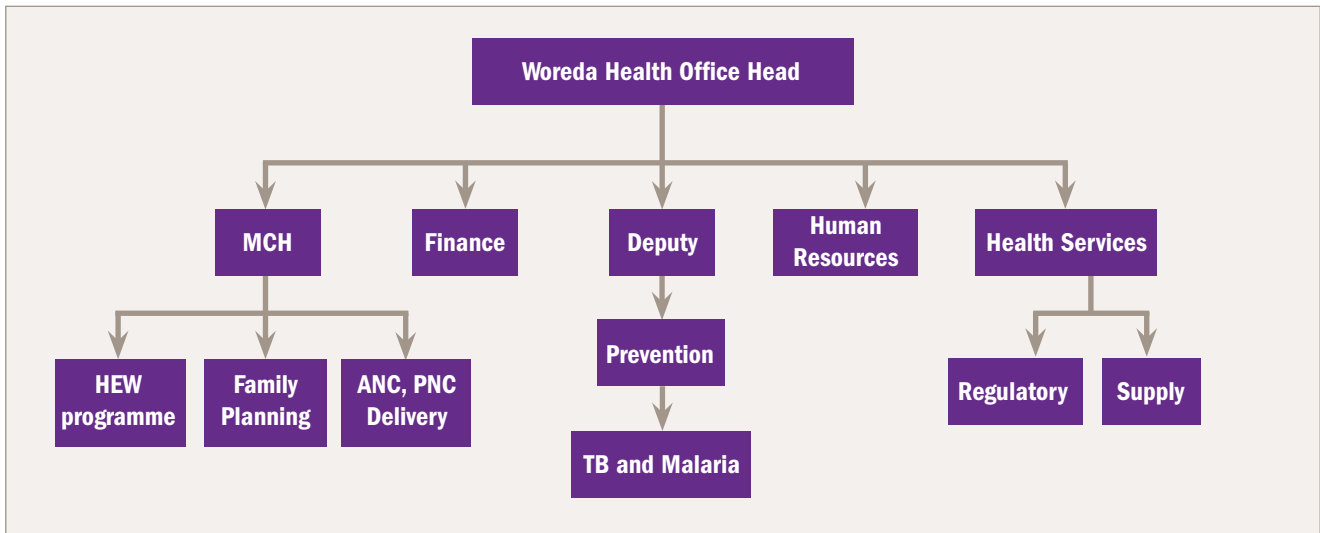
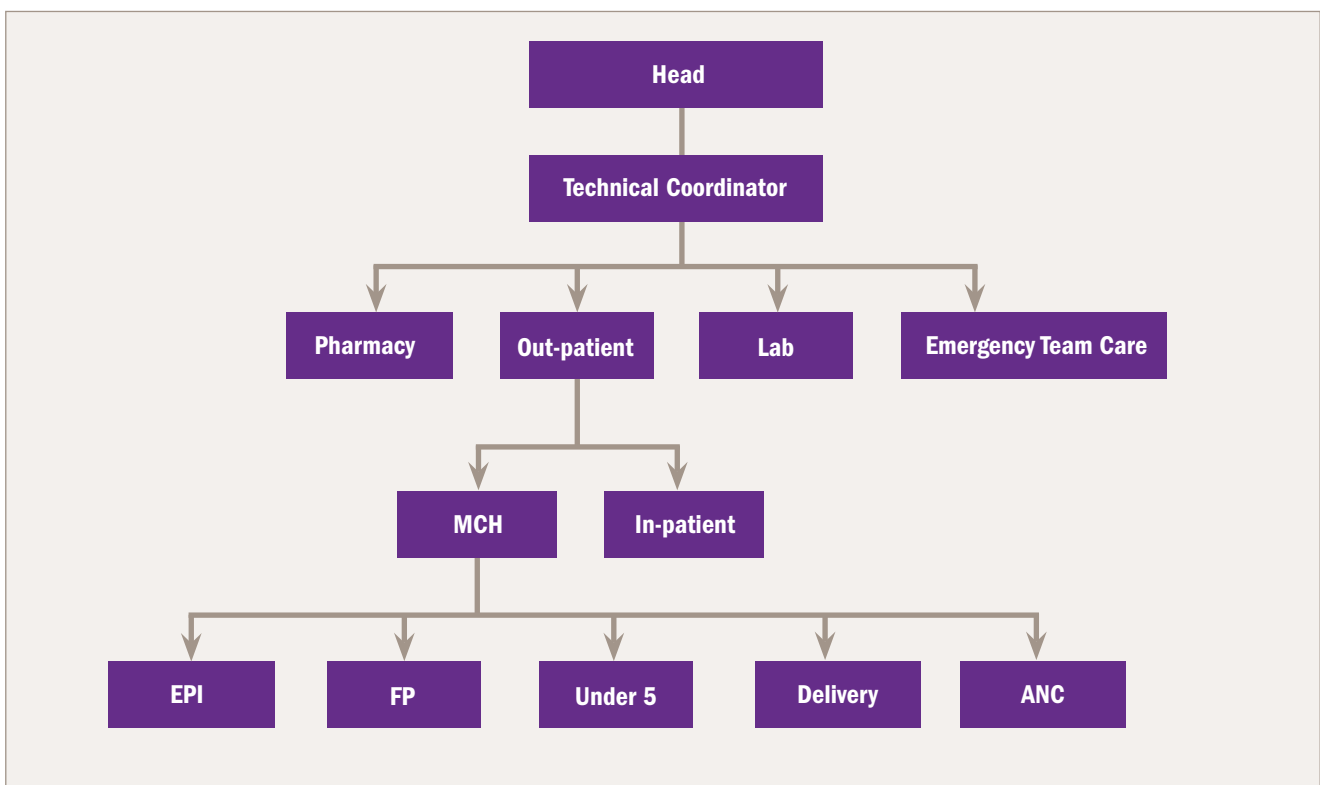


Figure 7 – Health Centre organisational structure, including programme officers for different departments





**Photo above:** © Bill & Melinda Gates Foundation

health and clinical medicine. Under the head of the health centre there are technical coordinators who oversee four departments: pharmacy, OPD (outpatient department), laboratory and emergency care. MCH and inpatient care are found within OPD. Under MCH there are five process owners responsible for EPI, family planning, under 5 care, delivery and ANC care (Figure 7).

#### *Health Post*

At the health post, HEWs maintain separate registers for each of the 17 packages to record their activities, clients consulted and services provided. They also provide first aid, STD education and condom distribution. With respect to MCH they provide ANC, TT vaccination and HIV referral services. They also provide vaccinations for newborns (45 days) and provide education on nutrition to mothers with infants 6 months and older.

At the health posts visited, HEWs attended 1-2 deliveries per month. Most mothers in the community use Traditional Birth Attendants (TBAs) or Trained Traditional Birth Attendants (TTBAs) to support them in their home delivery. HEWs in both

woredas perform their activities in collaboration with the HDA.

Existing contact opportunities between the different levels of the health system.

#### **Federal**

1. The *FMoH-RHBs Joint Steering Committee*, chaired by the health minister (and composed of state ministers, directorates and RHB heads), meets every two months to promote and monitor the objectives of the HSDP.
2. The *Central Joint Steering Committee (CJSC)* is the highest governing body of the health sector and meets quarterly. It is composed of the Federal Minister of Health, the State Minister of Health, the State Minister of Finance and Economic Development, the State Minister of Education, the State Minister of Water Resources, and other members representing development partners, the private sector and various health professional associations.
3. The *Joint Consultative Forum (JCF)* is chaired jointly by the Federal Minister of Health and one of the co-chairs of the Health Population and Nutrition (HPN) Development Partner (DP) Group. The JCF serves as a forum for high level policy dialogue and meets on a quarterly basis. It is attended by DP Heads of Agencies, technical level representatives, and representatives from across the FMoH.
4. The *Joint Core Coordinating Committee (JCCC)* is the technical arm of the JCF and is involved in health sector planning, monitoring and evaluation. The JCCC is chaired by the Director General of the Policy, Planning and Financing Directorate (PPFD) of the FMoH, and is attended by nominated representatives from

the HPN DP Group, key members of the PPF and other representatives from the FMOH. Annual plans including reallocation of funds and quarterly reports are initially reviewed and agreed by the JCCC.

5. The *Annual Review Meeting (ARM)* is a joint performance review comprised of government, NGOs and development partners, which is organised by the Central Joint Steering Committee and the Regional Joint Steering Committees.
6. Quarterly forum held by the *Federal Ministry of Finance and Economic Development (MoFED)*. This is a joint performance review meeting to review the performance of NGOs and other organisations working on health programme.

### Region

1. The *Regional Joint Steering Committee (RJSC)*.
2. *Regional Cabinet Meetings* are held every month. The regional cabinet members are representatives from

the different sector Bureaus at the regional level (including representatives from the RHB, women and child affairs, sport, education and regional HAPCO), and are headed by the regional president. The cabinet plays both administrative and programmatic roles. The legislative body for the regional cabinet is the regional council whose members represent each woreda in the region and are directly elected by the people.

3. Quarterly regional meetings involving representatives from RHBs, Zone Health Departments, and Woreda Health Offices.
4. Annual planning meetings with FMOH and zonal representatives.
5. Quarterly forum held by the *Regional Bureau of Finance and Economic Development*.

### Zone

1. *Zonal Joint Steering Committee*.
2. The *Zonal Cabinet Meetings* (inter-sectoral collaboration) is chaired

by the zonal political administrator and on a monthly basis reviews the progress made by the different sectors. There is no council at the zonal level.

3. The Zone Health Department meets with the Woreda Health Office heads on quarterly basis. This is an opportunity for different Woreda Health Office heads to interact with one another.

### Woreda

1. *Woreda Joint Steering Committee (WJSC)* meets monthly.
2. *Woreda Cabinet* (inter-sectoral collaboration) meets frequently (weekly) to discuss progress and to plan future activities. The woreda cabinet consists of the heads of each sector office in the woreda and is headed by the woreda administrator. This cabinet is the executive body of the woreda and makes decisions on the local political administration and basic service delivery. The administrative body for the cabinet is



Monitoring and evaluation of health activities is overseen by the Policy and Planning Department which is under the Planning and Finance Directorate.”



### Photos below:

**Left:** Roads from villages to health facilities can get blocked, Ethiopia © Dr Bilal Avan

**Right:** Children in a rural village, Ethiopia © Dr Bilal Avan





Woredas have their own budget, which is locally divided among the different sectors via mutual consultative process. A Woreda Cabinet has the mandate to approve the budgetary allocation for a respective sector. The elected Woreda Council then approves the budget that is proposed by the Woreda Cabinet.”

the woreda council which is comprised of elected delegates from each kebele. In Baso, the Woreda Health Office, health centre, health post and woreda administrative cabinet members also meet on a quarterly basis to discuss their achievements and goals.

3. Annual planning meeting with regional and zonal representatives.
4. *Internal Performance Review Forums* at the health centre: each department meets individually within their department on a weekly (and when necessary on a daily) basis. All of the departments in the health centre also meet as a group in the presence of the health centre head on a weekly basis to assess their accomplishments vs. plans.
5. Quarterly forum held by the *Woreda Finance and Economic Development* office.

### Supervisory structures and activities

#### Federal Ministry of Health

From the FMoH, different department heads and/or other experts provide quarterly department specific supportive supervisions (*Figure 8*). Using a structured checklist, specific department representatives visit the RHBs, Zone Health Departments, and Woreda Health Offices, health centres, health posts and households. Feedback is given on-the-spot as well as in written form.

#### Region

On a quarterly basis, the RHBs representatives from all the different departments conduct an integrated supportive supervision of the Zonal Health Department in which all aspects of operations, including administration, are reviewed by a single team. In addition, they also visit a selected number of Woreda Health Offices,

health centres, health posts and households. Supervision involves the use of a checklist to assess performance. Different departments have their own checklists and feedback is given on-the-spot as well as in written form. The region also recognises zones who perform well on certain indicators (ANC, skilled delivery, HEW delivery, PMTCT, vaccination rates etc).

At the Regional Health Bureau visited, integrated supervisory visits were said to take place every two months.

#### Zone

Zone Health Departments are scheduled to perform quarterly integrated onsite visits of all Woreda Health Offices. Baso woreda reported receiving less frequent (1-2/year) visits. The zone provides on-the-spot feedback and also sends a written feedback, which provides an opportunity for lesson sharing by including the achievements/shortcomings from other woredas in the zone. Similar to the regions, woredas with good performance are recognised by the Zonal Health Department.

#### Woreda

##### *Woreda Health Office*

There are three main ways that the Woreda Health Office conducts supervision of the health centres in its cluster:

1. Integrated supervisory visits: using a semi-structured checklist the heads of the different departments from the Woreda Health Office travel to each health centre to assess their performance. This is done through onsite observations of activities and registers, as well as through discussions of problems faced by the department heads. The Woreda Health Office also checks HMIS



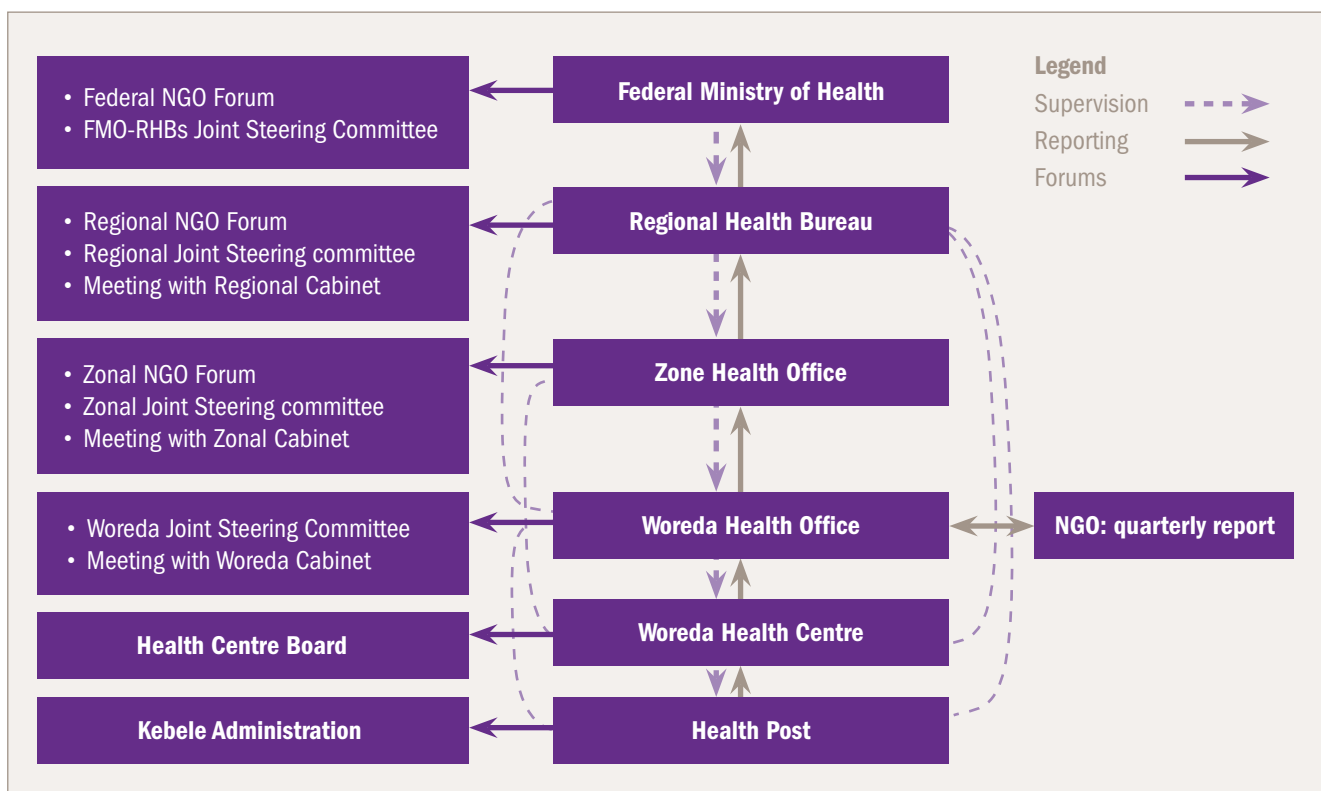
record keeping and crosschecks that the information reported to the Woreda Health Office matches what is recorded at the health centre. Feedback is provided on-the-spot and also in written form. The written feedback includes the achievements/shortcomings from other health centres in the woreda, which provides an opportunity for lesson sharing.

The integrated supportive supervision checklist obtained from Dendi woreda collected information on Human resources, EPI, MCH, communicable diseases control, OPD service activities, health centre/health post linkage, infection prevention, environmental health activities, recording and reporting,

availability of supplies, problems encountered, and solutions attempted. These integrated supervisory visits are scheduled to take place quarterly. However, a health centre visited in Dendi reported more frequent (monthly), while a health centre in Baso woreda reported receiving less frequent visits (2-3 times a year).

2. Weekly review meetings: to review weekly progress, the Woreda Health Office head meets with the entire health centre heads in the woreda.
3. Assigned supervisors: one person from the Woreda Health Office is assigned to each health centre in the cluster. Using a checklist, this individual reviews the activity of the health centre and health post in the

Figure 8 – Existing Contact opportunities, supervision and reporting pathways



cluster on weekly basis. The checklist is discussed together in a meeting where strengths and weaknesses are identified and addressed. Furthermore health centres also receive written feedback.

Woreda Health Office also performs onsite supervisory visits at the health posts. However, the study team observed that there is no defined schedule for these visits. Annually (or biannually) health centre and health post staff members in the woreda also meet at the Woreda Health Office to review progress and address existing problems.

**Photo below:** Outskirts of Lalibela, Ethiopia © Tania Ghosh

**Photo below right:** Waiting for a clinic appointment, Woreda Health Centre, Ethiopia © Dr Bilal Avan

#### *Health centre*

The head of the health centre monitors the day to day activities of the facility and organises frequent planning and review meetings both at the health centre and health posts. The different departments in the health centre also meet separately on a weekly (and when necessary on a daily) basis. The health posts in the catchment area also receive technical support and supervision from the health centre. This system of supervision was similar across health centres visited.

#### *Health post*

One of two HEWs is designated to be the head of the health post and a nurse from a health centre is assigned to supervise their activities. The assigned nurse visits the health post once a week to provide technical

support, plan future activities, and also to facilitate the working condition for the HEWs (e.g. working with the kebele to improve the working environment of the HEWs within the community). All the assigned nurses then meet with the health centre head once a week (in some instances once a month) to discuss issues and review the performance of the HEWs at the health posts.

Some health posts visited reported less frequent visits (1-2 visits/month) and one reported not having received a visit in the last two months. In addition, all HEWs from the health posts in the cluster meet once a month with the head of the health centre. In the past this used to be done at the Woreda Health Office but it has now shifted to be at the health centre so as to include the participation of the nurses assigned to the health posts.





Within the federal Ministry of Health, the Maternal and Child Health programme focal department is integrated into the Health Promotion and Disease Prevention Directorate.”

HEWs are also administratively supervised by the kebele manager who oversees their level of presence and work in the community. In one woreda visited HEWs report to the kebele manager daily. Prior to receiving their salary, HEWs in the same woreda were also required to obtain a signed performance report from the kebele manger.

### Supply system and record keeping of commodities

The Pharmaceuticals Fund & Supply Agency (PFSA) and The Food, Medicine and Healthcare Administration and Control Authority (FMHACA) of the FMOH are responsible for pharmaceutical supplies, and health service and product regulation. The PFSA is responsible for ensuring supply of essential drugs, medical supplies and equipment, while the quality control and inspection of health and health related products, premises, professionals and health delivery processes falls under the mandate of FMHACA.

To procure and distribute drugs and pharmaceuticals, PFSA has developed an Essential Pharmaceuticals List, which is periodically updated using the Ethiopian Essential Health Services Package and the Standard Treatment Guidelines. Use of this list ensures that the procured and distributed drugs are essential and meet the needs of the primary health care programmes. PFSA communicates directly with the

federal level HPDP and RHBs to plan the supply of essential drugs, medical supplies and equipment.

Under the mandate of the PFSA the Integrated Pharmaceutical Logistics System (IPLS) was developed in 2007. IPLS is a single health commodities reporting and distribution system. Using this system, supplies flow from Central to Regional PFSA hubs, and then to hospitals and health centres. Nationally, PFSA has 21 hubs (9 in the regions, 2 in the city administration and 10 scattered around the country). From these hubs, PFSA distributes commodities and supplies to each health centre and hospital within a radius of 160 kilometers. Health centres in turn supply health posts. IPLS is automated at the Central and Regional PFSA, as well as in a few health facilities. Regional PFSA hubs directly deliver supplies to hospitals and health centres; when this is not possible, health facilities arrange to transport their own supplies. At the health facility level, revenue generated internally can also be used for purchasing drugs from PFSA or from other pharmaceutical suppliers.

To implement IPLS at the facility level, the Logistics Management Information Systems (LMIS) was created in both electronic (for hospitals and a selected number of health centres) and paper-based (for the majority of health centres) formats. Requesting and record keeping of supplies at the facility level involves:

1. *Report and Requisition Forms (RRFs)* which are prepared quarterly by health centres. Three copies of RRFs are prepared for HIV commodities, TB medicine and Contraceptives. One copy is retained at the health facility, and the remaining two are sent to the Woreda Health Office and Regional PFSA, respectively.
2. *The Internal Facility Report and Resupply Form (IFRR)* is used by health posts and different departments within the health facility.
3. Store and bin cards are also used at the health facility dispensary units to facilitate the management of drug supplies (e.g. amount available and drug expiry dates).

IPLS has not been fully implemented nationally. Where IPLS is not operational, supplies still flow vertically from the Federal to the Woreda Health Office (via the region and sometimes the zone), and finally to the health facilities.

In both Amhara and Oromia regions, some Woreda Health Offices are connected by internet to pharmaceutical supply agency that can monitor their inventory and restock supplies when they are low.

In both woredas visited, IPLS has not yet been implemented. In Dendi woreda, to request for drug supplies each health facilities submits a request letter to the Woreda Health Office. The woreda supplies the health centre, which in turn supplies the health post.

In Baso woreda the health centres are allocated an annual budget directly by the woreda council. The health centres use this budget as well as their internal revenue to buy drugs and supplies. Internally the health centres prepare a monthly cash flow report and the zone performs a yearly audit; the Woreda Health Office receives minimal information relating to drug supplies. ■

**Public Health Organisations (Non-Governmental Service Delivery Organisations)**

This section presents the organisational structures of the two NGOs that were visited by the study team and lists the contact opportunities NGOs have at the federal, regional, zonal and woreda level. In addition, this section provides details on the NGOs’ supervisory structures and activities, as well as supply systems and record keeping of commodities.

There are seven NGOs working in MCH in Dendi and Baso woredas: Save the Children, Intrahealth, Catholic Clinic, IPAS, JSI (L10K), Semen Showa Tesefa Birhan Children and Family Development Association (SSTBCFDA), and EngenderHealth. With the assistance of the Woreda Health Offices in both woredas, the study team selected two NGOs: Save the Children and SSTBCFDA. These NGOs were

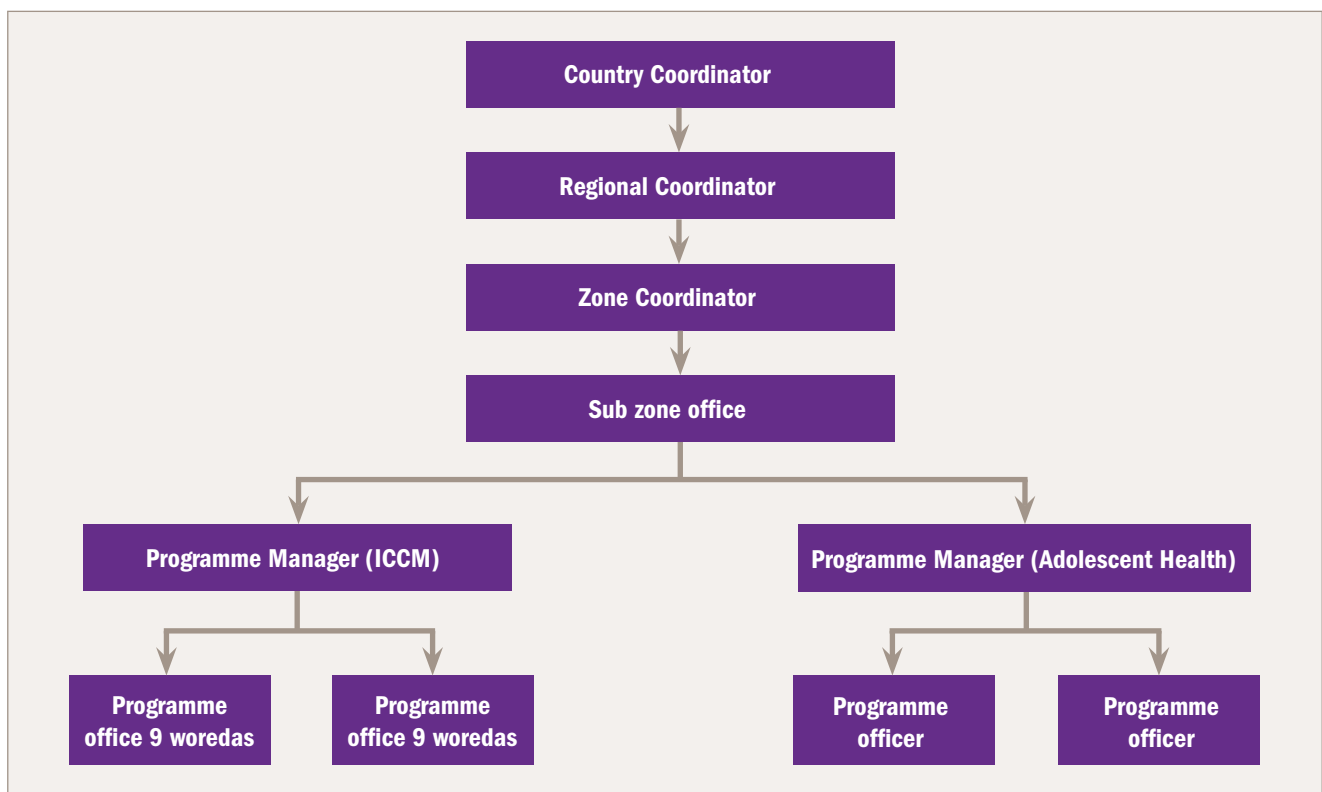
identified by the Woreda Health Office as fulfilling the selection criteria of having a district level office and a major presence in the community.

**Brief structure of public health organisation and their programmes in the areas.**

**Save the Children USA**

Save the Children has been working in Dendi woreda for several years and has had a sub-office in the woreda for the last two years. The head of the sub-office oversees the activities of the different programme managers, who in turn oversee the programme officers’ activities in the different woredas (Figure 9).

Figure 9 – Save the Children organisational structure



Save the Children has two major projects in Dendi woreda:

1. The Integrated Community Case Management (ICCM) of childhood illness programme which has been running for the last 8 months. The ICCM activities mainly focus on providing training for volunteers and local level health workers. The actual training is provided by experts from the health centres, community health workers and Woreda Health Officers. Save the Children plans, sponsors, facilitates and supervises the volunteers' training.
2. The Adolescent Reproductive Health programme has been running since 2004. Save the Children again facilitates and supervises the training of HEWs and selected youth from the

community on reproductive health. Trained HEWs and volunteers then work together to mobilise youth in the community.

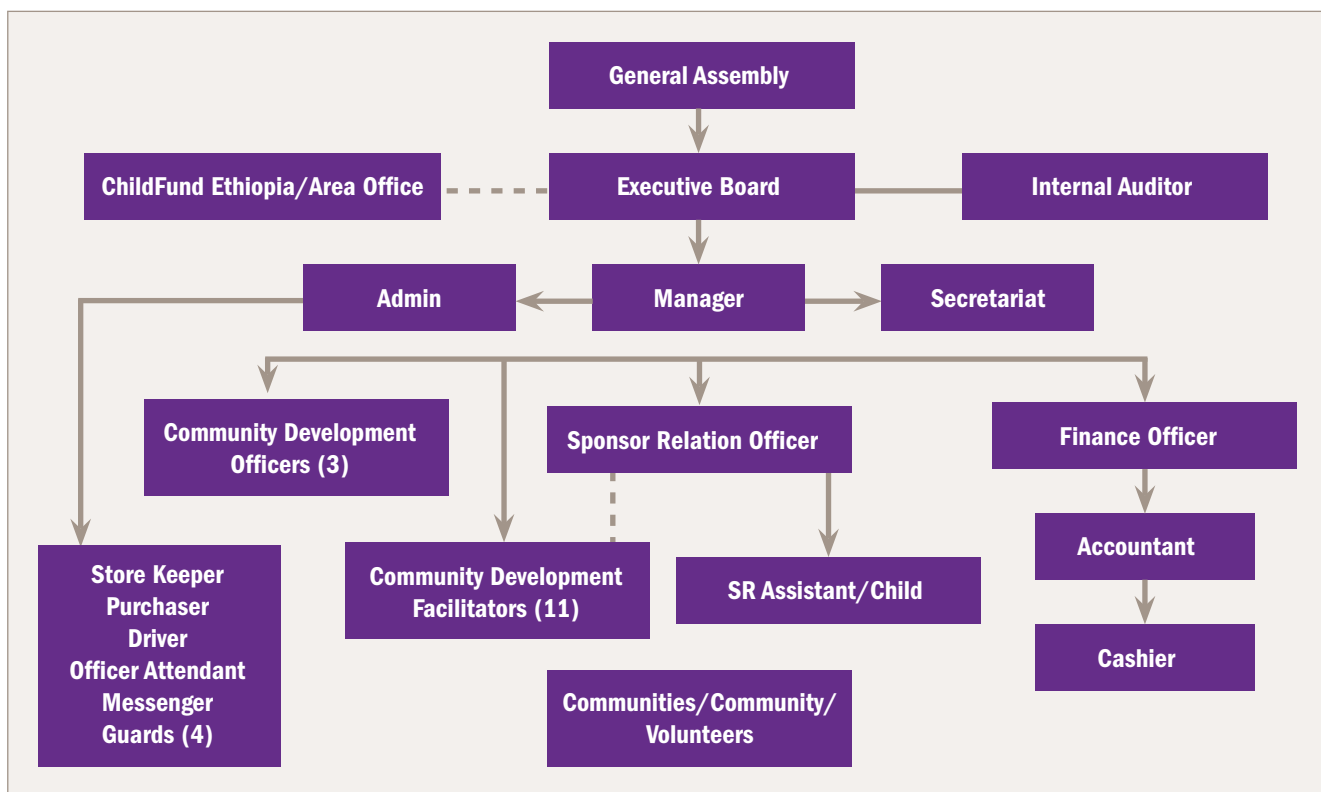
**Semen Showa Tesefa Birhan Children and Family Development Association (SSTBCFDA)**

SSTBCFDA is a local NGO and is one of the 14 organisations funded by the Christian Child Fund. It is run by a General Assembly and Executive Board who oversee the activities of the General Manager. The manager in turn oversees the activities of the different programme officers and community development officers (Figure 10).

SSTBCFDA has been working in the woreda for 21 years and has 3 main activities:

1. Integrated community management of childhood illness and nutrition
  - a. Aims to improve the health and security of infants and under 5 children by building, furnishing and providing drugs for health facilities.
  - b. Performs anthropometric measurement of all under 5 children. SSTBCFDA also provides supplementary feeding of moderately and severely malnourished children.
  - c. Training of HEWs, health centre staff and volunteers in EPI activity, growth monitoring, ANC, and PNC.
2. Safe motherhood and neonatal care services
  - a. SSTBCFDA financially supports a government training programme to mobilise and encourage females/ mothers to use the MCH services

Figure 10 – Woreda level Semen Showa Tesfa Berhan Child and Family Development Association





**Photo left:** Rural Health Centre, Oromia region © JaRco Consulting

- provided by the health centre.
  - b. Provides folic acid to health centres.
3. Early childhood development (education and cognitive development of under 5 children)
- a. SSTBCFDA has constructed, furnished and equipped 25 schools in 2 woredas and also pays 75% of teachers' salaries in these schools.

### Existing networking/contact opportunities between organisations and different levels of the health system

The Charities and Societies Agency is the responsible body for the registration of NGOs, allowing an organisation to legally operate in Ethiopia. In instances where operation is limited to a particular region, registration takes place at the Regional Bureau of Justice of some regions. In addition, there is also an NGO coordinating body known as Consortium of Christian Relief and Development Association (CCRDA). This organisation is an indigenous non-profit umbrella organisation comprised of NGOs and Civil Society Organisations (CSOs) engaged in relief, rehabilitation, and diverse developmental activities focusing on poverty alleviation. CCRDA allows

resource mobilisation and the sharing of experiences for effective and sustained impact. Furthermore, CCRDA ensures that efforts are not duplicated and also builds the capacity of the NGO staff to ensure efficiency and quality.

Overall NGOs have different forums and communication opportunities at all levels of the health system. RHBs are responsible for reviewing project documents prior to approval, and monitor the NGO's activities. NGOs work together with the health departments at the federal, regional, zonal and woreda levels to assess gaps in the health service delivery system and plan activities to address the identified gaps. In some cases they also directly work with local health service providers (hospitals, health centres and health posts). NGOs are also required to provide quarterly reports to the Regional, Zonal and Woreda Health Offices.

#### Region

At the RHB visited, there are three main avenues for the interacting with NGOs:

1. Quarterly review meeting with representatives from the RHB, Zone Health Department, Woreda Health Offices and major NGOs (those working in a vast number of woredas in the region).
2. Department specific task force meetings with NGO staff to plan and discuss ongoing work in the region (takes place every two months).
3. Need based department specific meetings which include members of the RHB, Zonal Health Departments, Woreda Health Offices and partners that work in an area related to the department hosting the meeting.

4. Annual NGO forum that includes all NGOs working in the different sectors.

#### Zone

At the zone level NGOs work with the health department to ensure that the proposed activities are in line with the government's health plan and together identify areas of implementation. In rare cases when an NGO intends to work in a specific woreda they may, after signing an agreement with the region, bypass the zone.

North Showa zone holds quarterly NGO review meetings. The review system is the same as the one followed at the regional level. In North Showa zone there are several NGOs operating, and as a result the forums were reported to be more formal and regular than in West Showa zone where there are fewer NGOs. Some NGOs submit activity progress reports to the Zonal Health Department, however the submission process is not closely monitored and regulated by the health department.

#### Woreda

In theory NGO review meetings at the woreda level should be conducted following the submission of the quarterly report. After submission, the Woreda Health Office visits the NGO operational areas to validate the report submitted, through observations of the output in the field and/or through interviewing the beneficiaries. The woreda then prepares feedback on the findings. This is then followed by a meeting with NGOs to discuss the progress, challenges, the way forward and also acknowledges the strengths of programmes. Such a forum is usually

organised when there is more than one NGO operating in the woreda.

In addition to these review meetings, the federal, regional and woreda Finance and Economic Development office also coordinates and monitors NGO activities at each level through quarterly review meetings with the NGOs. Representatives from the RHB, Zone Health Departments and Woreda Health Offices are invited to these meetings to ensure that the NGOs working in the health area are in line with the government health plan.

### Save the Children

In Dendi woreda there are no formal and regular NGO forums and as a result Save the Children interacts with the woreda level health office during:

1. Quarterly meeting with the Woreda Health Office to discuss performance and outcome (but not input and processes).
2. The facilitation and supervision of health extension worker trainings.

### SSTBCFDA

SSTBCFDA has the following contact opportunities with different levels of the health system:

1. Planning meeting with the Woreda Health Office and health centres. SSTBCFDA also submits quarterly reports to the Woreda Health Office.
2. Quarterly meetings with government cabinet members and other NGOs in the woreda (in the previous year this meeting took place twice).
3. Quarterly meeting with the zonal Finance and Economic Development

(this meeting took place once the previous year).

4. Biannual NGO forum meeting at the zonal level.

## Supervisory structures and activities

### Save the Children

Save the Children performs an internal supervision of the ICCM and Adolescent Reproductive Health programme (including supervision of trained HEWs and community members), using its own checklist. Furthermore, for the ICCM programme, Save the Children employees conduct monthly supervision at the health post and submit a report to the field office. The field office in turn submits the report to the sub-office, where information is summarised and submitted to the Save head office in Addis Ababa, and from there it is submitted to the appropriate donor (in this instance to UNICEF). One copy of the report is left with the HEWs and another is submitted to the Woreda Health Office.

Save also reported receiving regular supervisory visits from the Woreda Health Office. Supervision is conducted using a checklist prepared by the Zone Health Department. The health centre head and other section heads (MCH, EPI, ANC, PNC and EPI) monitor the NGO's activity by assessing the knowledge and activities of the trained health extension workers and community volunteers.

### SSTBCFDA supervision

SSTBCFDA programme officers conduct regular supportive supervision visits in the operational kebeles and meet community facilitators at the grassroots level. Supervision is done using an internal checklist containing detailed questions on the performance of the programme (e.g. problems encountered and reasons for under-performance). Feedback is given on-the-spot at the end of the supervision and also in written format and sent to the community facilitators.

The community development officers submit regular reports to the Manager of SSTBCFDA. Submission of the report is followed by a review meeting through which the manager monitors the activities of the officers and community development facilitators. The manager then compiles the monthly reports and submits it to the SSTBCFDA executive board for further review.

As stated earlier, SSTBCFDA activity is also monitored by the woreda through the submission of quarterly reports and quarterly meetings with the woreda cabinet.

### Supply system and record keeping of commodities

In Dendi woreda, Save the Children's MCH related programmes do not provide any drug and other medical supplies to the local health facilities.

In the past, SSTBCFDA used to provide drugs (e.g. iron supply for pregnant women) and equipment to health centres by way of the Woreda Health Office. However, currently SSTBCFDA directly supplies the health centres to avoid unnecessary delays in distribution. SSTBCFDA programme officers then collect data from health centres on the utilisation of drugs supplied, aggregate the data and then submit a report on the items distributed to the Woreda Health Office. ■



The Charities and Societies Agency is the responsible body for the registration of NGOs, allowing an organisation to legally operate in Ethiopia.”

## Private for profit sector



**Photo left:** Ethiopian child  
© Dr Bilal Avan

This section outlines the organisational structure, existing contact opportunities between private clinics and public health system, and supervisory structures of the private clinic visited by the study team. Private health facilities are licensed by the Woreda Health Office regulatory department. In Dendi, the Woreda Health Office head stated that the number of private clinics and pharmacies in the woreda are increasing. However patient flow is much higher at health centres due to the fact the health centres provide services free of charge. In addition the health centres have better capacity in terms of health professionals and drugs.

### Brief structure of formal private health facilities and their programmes in the area

#### Medium Level Private Clinic

Clinics are categorised into higher, medium (equivalent to health centre) and lower clinics. Higher clinics are run by specialists and/or a few General Practitioners (GPs) and have a nursing staff. Higher clinics can have 1-5 beds for delivery and emergency cases and offer a diverse set of out-patient medical services

including: antenatal outpatient emergency services; diagnostic services (laboratory, x-ray, sonography); and minor surgery. Medium clinics have a GP or health officer responsible for clinical services and usually have a few nurses and other auxiliary staff. Medium clinics provide diverse outpatient medical services such as diagnostic and other curative services. Lower clinics are run by nurses or other midlevel providers and provide limited outpatient services.

Information on the number and type of private clinics is recorded and maintained at woreda, zonal and regional health offices. However, the study team was unable to find information on the proportion of people utilising private health system in these woredas.

In Dendi woreda the study team visited a medium clinic which mainly provides outpatient medical care, ANC and family planning. The clinic was not equipped to provide delivery services, but plans to provide this service in the near future. On average the clinic sees 15 individuals per day and 4-6 ANC patients per month.

#### Catholic Clinic

The Ethiopian Catholic Church, under its health development arm, runs 13 private not-for-profit clinics around the country (*Figure 11*). The Dendi woreda Catholic Clinic was established 40 years ago. Currently it operates as one of the health centres in the woreda, supervising four health posts in its catchment area. The clinic's MCH activity includes ANC, delivery, PNC, nutrition, EPI, growth monitoring and under 5 treatments.



### Existing contact opportunities between private facilities and the public health system

#### Medium Level Private Clinic

There is a referral linkage between private health facilities and public health centres, particularly with respect to MCH services. Cases that need further diagnosis and treatment are referred to the public health system.

The private sector has minimal interaction with Woreda Health Office, which is mainly limited to regulatory visits.

#### Catholic Clinic

The Catholic Clinic interacts with the woreda in much the same way as other health centres interact with the Woreda Health Office.

### Supervisory structures and activities

#### Medium Level Private Clinic

The Woreda Health Office monitors the activity of private clinics to see if the services they provide are in accordance with the standard and regulation set for private health facilities. The Zone Health Department similarly monitors private clinics, though with less frequency.

#### Catholic Clinic supervision and review meeting

The Catholic Clinic has an internal weekly meeting. Once a month, a representative from the clinic meets with the Woreda Health Office for a performance review meeting. Assigned nurses from the clinic also supervise and provide technical

support to the health posts on weekly or biweekly basis.

### Supply system and record keeping of commodities

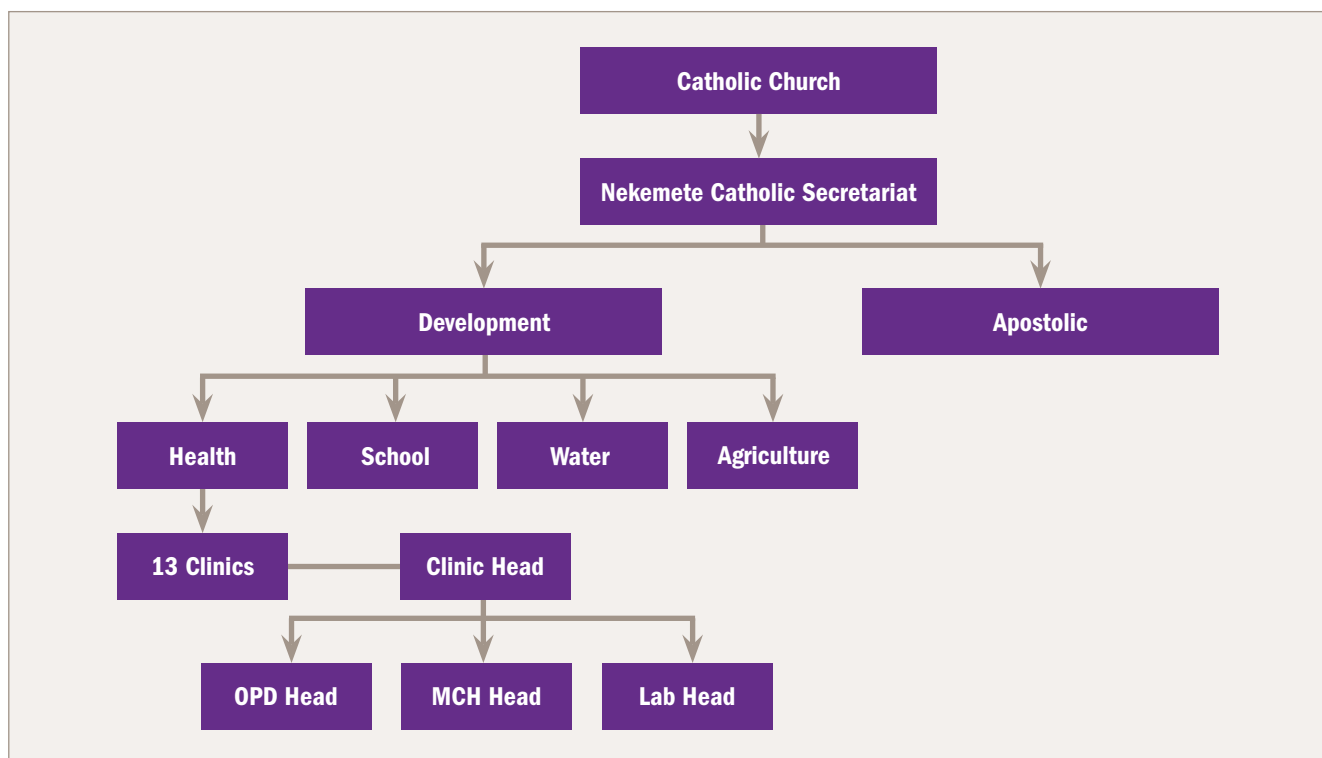
#### Medium Level Private Clinic

Private clinics receive TB medication, ART, vaccines and contraceptive directly from the government and as a result provide reports to the government on services delivered associated with these supplies. This information is reported using either HMIS or other customised forms.

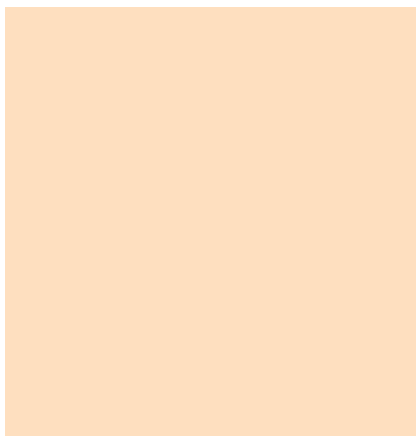
#### Catholic Clinic

The Catholic clinic gets drugs and supplies from both the Catholic Church as well as the woreda health centre. ■

Figure 11 – Catholic Clinic organisational structure



# Data review



**Photo left:** Blue Nile Falls, Ethiopia © Tania Ghosh

This section gives details on the potential sources and quality of data available from the different health facilities/departments and NGOs visited, as well as a description of their level of interest in sharing the data. Furthermore, this section lists the categories of data available using WHO Framework of Health System Blocks, and concludes with information on how data are used at the woreda level.

## Data sources

### *Public Health System*

The major data source for health programmes in Ethiopia are from two main areas: population-based health information sources (e.g. Ethiopian Demographic Health Survey-EDHS) and health service-based records (e.g. Integrated Pharmaceutical Logistics System-IPLS, Laboratory Information System-LIS, and Human Resource Management Information System-HRMIS). Health service-based facilities generate data on outcome of health-related administrative and operational activities. Health Service Records are mostly generated by front line health workers in the course of recording and reporting on services delivered and include: facility-based data

on morbidity and mortality among those using services; types of services delivered, drugs and commodities supplied; information on the availability and quality of services; and financial and management information.

From the public health system, the study team was able to obtain information on health service-based data which are mainly collected through the HMIS system. The HMIS is based on 108 core indicators. The selection of these indicators has been guided by the following: national monitoring requirements of the Plan for Accelerated and Sustained Development to End Poverty (PASDEP), HSDPIII, regional and woreda requirements, and by international agreements such as the Millennium Development Goals (MDGs) and the United Nations General Assembly Special Session (UNGASS). The HMIS draws data from routine service outputs and administrative records and provides indicators that are reviewed frequently to monitor and refine programme implementation.

### *Health Post*

At the health post, HEWs maintain separate registers/records for all the preventative packages and some curative service they provide in the community (*Table 1*). HEWs record, summarise and send a hard copy of the report to the health centre. Activities not captured in the existing format (e.g. number of home visits) are included as text in the report. HEWs, with the assistance of the supervising nurse, prepare three kinds of reports:

1. Weekly IDSR (Integrated Disease Surveillance Report) and in some cases family planning, EPI, Model Family, and ANC reports



**Photo above:** Ethiopian Health Extension Workers © Dr Bilal Avan



The major data records of health programmes in Ethiopia are from two main areas: population-based health information and health service-based sources.”

2. Monthly reports
3. Quarterly reports

#### *Family Folder*

HEWs are also responsible for preparing and maintaining information using Family Folders. The Family Folder is a family centred tool designed to provide information to allow family-focused promotive, preventive and environmental health services at the household level. A family folder is maintained for each

family in the kebele and contains data on family members, household characteristics (environmental sanitation), malaria prevention, status on household HEP package training and implementation, health cards, and integrated ANC, Delivery, PNC and Newborn Card. Nationally Family Folder coverage is 30% and in Dendi woreda it has reached 20%. At the time of the study team’s visit, the HEWs in Baso woreda had not started the Family Folder programme.



**Photo left:** Waiting for a clinic appointment, Health Centre, Ethiopia  
© Dr Bilal Avan



Though the HMIS is formatted to collect information from private clinics, the system is not yet operationalised.”

#### *Health Centre*

At the health centre level each department (MCH, HIV VCT and ART, TB, Lab and Pharmacy) has a separate register. The department heads submit a tally sheet of indicators on a weekly/monthly basis to the health centre head (or to the HMIS focal person when available) who then compiles data (from both the health posts and health centre) and sends weekly/monthly/quarterly HMIS reports to the Woreda Health Office.

#### *Woreda Health Office*

At the Woreda Health Office, data from all the different health centres in the cluster are summed to give the woreda total and sent to the Zone Health Department. Certain indicators are reported to the zone monthly (e.g. ANC and EPI) and full reports on all collected indicators are sent quarterly. Data not captured by the HMIS indicators are footnoted as text. Besides the data obtained from government owned facilities, efforts are also made to capture service records from the private sector as

well as communities and civil society organisations.

#### **Public Health Organisations**

The study team was also able to obtain the internal reporting form from Save the Children’s ICCM programme in Dendi woreda. The ICCM project supervisors collect data on a monthly basis from the health posts (HEWs). Data are then summarised and submitted to the Save the Children head office in Addis Ababa and from there to the donor (UNICEF). Three copies are prepared: one copy is given to Save the Children field office; second copy is left with the HEWs; and the third copy is submitted to the Woreda Health Office.

Semen Showa Tesefa Birhan Children and Family Development Association (SSTBCFDA) also provided the study team with a sample of the data (e.g. data on birth, death, migration) they collect from every household in their catchment kebeles. These data are collected every 6 months by the 98 community development facilitators (CDFs). The project uses a

computerised database for the information collected from every household in the target operational areas.

### Private Sector

Though the HMIS is formatted to collect information from private clinics, the system is not yet operationalised. The Ministry's pilot study of the HMIS in private health facilities suggested the need to customise the format to be more simplified and less time consuming. However, no further action has been taken by the ministry. Currently, a majority of the private health facility activities are not captured by the system. However, private clinics report to the government on HIV, TB and immunisation activities, which are consequently captured in the HMIS.

The Catholic Clinic also reports to the woreda health centre using the HMIS format. Furthermore, the clinic also reports internally to the development section of the Nekemte Catholic Secretariat (NCS). The NCS in turn submits a report to the West Showa Zone finance and planning office. The internal reporting format used by the clinic contains some data that is not captured by the HMIS (e.g. nutrition programme or feeding of twins and malnourished children).

### Quality of data

#### Public Health System

Staff members, particularly at the peripheral levels (HEWs), lack adequate skills in data collection and synthesis. At the health post, the supervising nurse provides assistance in proper recording of data. However, in Dendi woreda one of the health posts had not received a supervisor visit in two months. Remote health posts in Dendi woreda were also unable to submit their reports on time.

The woreda health office reported that, those with a reliable mobile network call in their reports to the health centre. Some health posts also report directly to the Woreda Health Office instead of the health centre. The study team also observed a shortage of official forms at the health posts and as a result HEWs in Baso woreda used hand drawn forms to summarise and report data. Computers, internet access, databases and transport facilities are very important to ensure data quality and enhance data analysis, feedback and data use. However, most of the health posts and some the health centres visited are poorly equipped in this regard. Data are collected, summed and sent to the Woreda Health Office in paper format. At the woreda level data are entered in a computer but the report is sent to the zone in paper format.

#### Public Health Organisations

NGOs also prepare and submit a regular report to their respective headquarters. Information for this report comes from their own records as well as from health posts, health centres and Woreda Health Offices supported by the NGOs. This results in a parallel reporting system with no integration among the various subsystems and different stakeholders working in the health programme. For example, SSTBCFDA project prepares its own report obtaining data from the health centres and directly from the households in the community. SSTBCFDA was not at all aware of the HMIS system.

A majority of NGOs submit the same report to the Woreda Health Office and/or Zone Health Department. However indicators that fall outside of the HMIS format are not incorporated into the report. NGO reports are archived in the Woreda Health Office/Zone Health Department but the information contained is not maximally utilised.



Photo above: Health Extension Worker, Ethiopia © Dr Neil Spicer

## Willingness to share

### Public Health System

Overall the study team experienced a high level of receptiveness and cooperation. Furthermore, all levels, starting from the federal ministry all the way to the health posts, showed willingness to share information and data.

### Public Health Organisations

Similarly NGOs, recognising the DIPH's potential for creating an engagement forum at the woreda level, were willing to share information and explain their database. SSTBCFDA also provided the study team with a sample of the data they collect in the community while Save the Children provided their reporting format.

### Private Sector

The private clinics visited were also cooperative in sharing information. As stated earlier, the non-profit Catholic Clinic, which serves as one of the health centres in the woreda, reports its activities to the Woreda Health Office using the HMIS format. In contrast, the private level medium clinic does not report their service delivery activities to the Woreda Health Office. The clinic nurse further elaborated that their



The HMIS is based on 108 core indicators. It draws data from routine service and administrative records and provides indicators that are reviewed frequently to monitor and refine programme implementation. ”

interaction with the government was minimal (mainly involving regulation and licensing) and stated that the DIPH could serve to strengthen this link.

### Categories of data available

The data sources available from the government health system, NGOs and private sector were categorised into the following six WHO Framework of health system blocks (Table 2):

#### 1. Workforce Data

Human Resources data collected by the Woreda Health Office and reported through the HMIS annually.

#### 2. Service Delivery Data

Information available on Reproductive Health, Child Health, EPI, Nutritional Status, Prevention and Control of Major Communicable Diseases (including malaria, TB, HIV/AIDS and leprosy), Prevention and Control of Non-communicable

Diseases, Hygiene and Environmental Health, and Laboratory and Blood bank. Data are collected at population and health facility level and reported through Ethiopian Demographic Health Survey (EDHS), administrative reports, HMIS and surveys. Periodicity of data collection and reporting varies (quarterly, annually, every 2-3 years and every 5 years).

#### 3. Medical Supplies

This includes data on essential drugs available, average stock out duration for essential drugs, and stock wasted. Data are collected at health facilities and PFSA and reported through administrative reports (annually), HMIS (quarterly) and surveys (2-3 years).

#### 4. Information

Information is available on HMIS and M&E activities (including completeness and timely submission of routine health and administrative reports). These data are collected

## Summary table

Table 2 – Framework of health system blocks for Government, NGO and Private Sector

WHO Framework of health system blocks	Govt	NGO	Private sector
Workforce	✓	✓	✓
Service delivery	✓	✓	✓
Information	✓	✓	
Medical supplies	✓	✓	✓
Finance	✓	✓	✓
Governance	✓	✓	

at all levels of the health system reported through the HMIS, surveys, and administrative reports (some quarterly and others annually).

#### 5. Finance

Information on budget (e.g. internal revenues generated and drug per capita expenditure) is reported annually through administrative reports and the HMIS.

#### 6. Governance

Regulation (e.g. licensing and monitoring of standards) and management (e.g. supervisory visits and self-assessment and participatory review meetings held) information is reported annually through the HMIS.

### Use of Information by districts

At the federal and regional level data collected are used for planning, monitoring and evaluation of key health services coverage. Furthermore, at the federal level HMIS data are used for the following three annual publication prepared by the FMOH:

#### 1. Health and Health Related Indicators

based on 85 to 90 (79%-84%) of the 108 HMIS indicators.

2. Health Bulletin (summarises the best practices and experiences of woredas).
3. Annual Performance Report which is distributed at the ARM and includes information on the progress made in the health sector development programme.

Information that is gathered by the Woreda Health Office is mainly used to assess plans against accomplishments and also to estimate and monitor the coverage of some key health services. The Woreda Health Office also uses this information to give monthly performance feedbacks to the health centres. Data on outbreaks and epidemics are also used to address and to control the spread. Outside of the above mentioned uses, data at the woreda level are not analysed and interpreted for decision making. ■



A majority of NGOs submit their reports to the Woreda Health Office and/or Zone Health Department. However indicators that fall outside of the HMIS format are not incorporated into the report.”

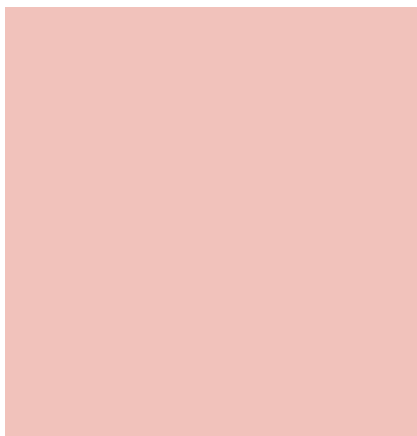
#### Photos below:

**Left:** Village children, rural Ethiopia © Dr Bilal Avan

**Right:** A delivery bed in a Health Centre, Oromia region, Ethiopia © Dr Bilal Avan



# Forward Planning



This concluding section describes the level of receptiveness to the DIPH concept shown by stakeholders at all levels of the health system, how to ensure their participation in forming the Platform, and finally, the anticipated challenges in implementing the DIPH.

## General receptiveness of local stakeholders to DIPH approach

At the Federal Ministry of Health the study team met with the Policy and Planning Directorate Director and presented the IDEAS project, with a focus on the DIPH concept and associated activities. The Director in turn gave an overview of the department and activities. Significant amount of data are collected through the HMIS but are not maximally analysed and interpreted for decision making, particularly at the woreda level, where data are mainly used to assess plans against accomplishments. The Director also stated that improving Maternal and Newborn Health is a priority. To this end the Ministry showed strong interest in engaging with the DIPH concept and took the following actions:

1. Assigned a focal person from the

**Photo above:** Blue Nile River  
© Tania Ghosh

M & E team at the Ministry as a contact person to support DIPH related activities.

2. Provided study team with support letters to the Oromia and Amhara RHBs to ensure their cooperation during the feasibility study.
3. Initiated a request for a Memorandum of Understanding (MOU) between IDEAS and FMOH on work relating to the DIPH.

Similar level of interest was shown at all levels (regional, zonal and woreda) of the health system. Like the FMOH, the regions also wrote support letters requesting the zones cooperation, and the zones in turn wrote to the Woreda Health Offices. Members of the Woreda Health Office visited stated that the DIPH would facilitate exchange of knowledge, identification of problems and also provide evidence for decision making. NGOs were also receptive to the DIPH concept and noted that it would serve as an engagement forum at the woreda level. Such a Platform would coordinate the existing system to be more inclusive, regular and formal. Some also stated that the DIPH would





The receptiveness for the DIPH by FMoH was shown at all levels (regional, zonal and woreda) of the health system.”

prevent duplication of efforts, assist in impact assessment and provide evidence for decision making.

### Engagement strategy

#### Public Health System

##### Federal

At the federal level the following engagement strategy is proposed:

1. Prepare and present to the Ministry's M & E team a summary of feasibility findings identifying the critical gaps for establishing the DIPH, resource implications (e.g. finance, human resources and time requirements), and a clear articulation of the value added by implementing the DIPH.
2. With the collaboration of the M & E team identify other relevant directorates and present the feasibility study findings to key MCH stakeholders to ensure their acceptance of DIPH concept.

3. Sign a TOR with FMoH.
4. Joint planning of the DIPH formative research plan with the FMoH and other key stakeholders.
5. Obtain a letter of support from FMoH to the RHBs.

##### Region and Zone

At the regional and zonal level, it will be important to ensure similar level of receptiveness to the DIPH concepts received at the federal level. The following actions are proposed:

1. With the assistance of representatives from the FMoH, present the IDEAS project and DIPH concept and associated activities to key individuals at the RHBs and Zone Health Department.
2. Include key MCH and M & E experts from the RHBs, Zone Health Department and NGOs for the DIPH formative research planning.
3. Obtain a letter of support from the RHBs and Zone Health Department.

##### Woreda

1. With the assistance of the RHBs and Zone Health Department, present an orientation of the IDEAS project and the DIPH concept to the Woreda Health Offices, health facilities and major NGOs working in the woreda.
2. Joint planning of the DIPH formative research implementation with government (e.g. woreda-based planning group), NGOs and other key stakeholders, including key MCH and M & E representatives.
3. Obtain a letter of support from the Woreda Health Office to facilitate the cooperation of health facilities in the woreda.
4. Begin field work to collect data on input and process from all relevant stakeholders working in the woreda.

#### Public health Organisations



#### Photos left:

**Far left:** Pinard used to listen to the fetal heart rate and tape measure to measure a pregnant woman's belly  
© Dr Bilal Avan

**Left:** Mother with child waiting for a clinic appointment, Health Centre, Ethiopia © Dr Bilal Avan



**Photo above:** Waiting for a clinic appointment, Health Centre, Ethiopia  
© Dr Bilal Avan

#### *Federal*

To ensure the receptiveness from NGOs the following steps are recommended:

1. Identify NGOs that have significant presence and coverage at the woreda level.
2. Once identified prepare and present the DIPH concept to key individuals from the different NGOs either collectively or individually.
3. Present a summary of feasibility findings, identifying the critical gaps for establishing the DIPH, resource implications and a clear articulation of the value added by implementing the DIPH.
4. To further increase the participation of relevant NGOs obtain consent

from funding agencies.

5. Obtain support letters from federal level NGO offices to ensure cooperation of regional and zonal and woreda level offices.

#### *Region and Zone level*

1. With the assistance of representatives from the federal level NGO offices, present the IDEAS project and DIPH concept and associated activities, to key individuals at the regional and zonal level NGO offices.
2. Ensure the inclusion of key MCH and M & E experts from the NGOs for the DIPH formative research planning.

3. Obtain a letter of support to the woreda level offices.

#### Woreda

1. With the assistance of the regional and zonal NGO representatives, present an orientation of the IDEAS project and the DIPH concept to woreda level NGO representatives.
2. Joint planning of the DIPH formative research with key individuals from government, NGOs and public sector, including MCH and M & E representatives.

#### Private Sector

Private sector engagement strategy will have to be facilitated through the government since this sector is not organised by itself.

### Potential challenges in the implementation of DIPH

In planning the implementation of the DIPH the following factors need to be taken into consideration:

**Capacity:** Skilled human resources, particularly at the woreda level, are insufficient. Furthermore, there is a high rate of turnover. Establishing the DIPH would require a significant capacity strengthening to obtain adequate and skilled individuals, capable of collecting good quality data. Further strengthening is also necessary in the area of data synthesis and interpretation for decision-making.

**Coordinating stakeholders (NGOs, Government and Private Sector):**

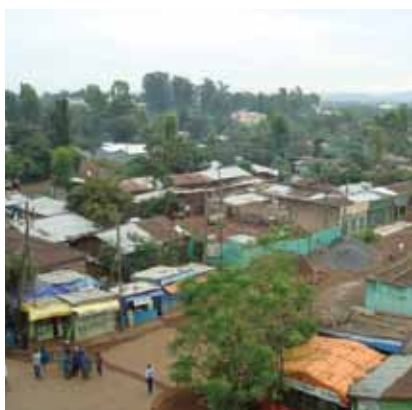
Obtaining the consent of necessary stakeholders to share information on a regular basis might pose a challenge. Some also stated that there were already several steering committees, taskforces and forums with similar aims. Furthermore, the study team noted that even though NGOs showed willingness to share programmatic data, they were less willing to disclose financial information. Given the regulatory role of the government, private sectors might also be suspicious of such a forum.

**Quality of the Data:** The data quality in terms of completeness, timelines, and relevance is an area that needs due consideration. National HMIS coverage has yet to be achieved; currently coverage is at 85%. At the federal level, it was reported that timeliness and completeness of data were significant problems. However, though late and incomplete, data from almost all facilities where HMIS was implemented are received. At the other levels of the health system

visited, HMIS reporting was said to be fragmented, cumbersome and not sufficiently robust.

**The study team concludes that despite existing challenges, establishing the DIPH is feasible. Key elements to support the Platform are present in the health information systems (e.g. data are collected at the district level and reported regularly through the HMIS). The DIPH concept was also well received by the public health system, NGOs and private health sectors. Furthermore, at the district level data are mainly used to ensure that targets are met and the formation of the Platform may facilitate the optimal use of collected data for decision making. ■**

**Photos below:** Cityscape and marketplace, Ethiopia © Kate Sabot



“NGOs were receptive to the DIPH concept and noted that it would serve as an engagement forum at the woreda level.”

# Appendices

## Appendix I – Nationally agreed HMIS framework and indicators

	Monthly/Quarterly						Annual					
	Facilities			Administration			Facilities			Administration		
	HP	HC	Hosp	WorHO	RHB	FMoH	HP	HC	Hosp	WorHO	RHB	FMoH
total indicators: 108	28	63	63	66	65	65	16	28	30	39	39	42

### A. Family health – total indicators: 21

A1. Reproductive Health – total indicators: 12													
1. Contraceptive prevalence rate											X	X	X
2. Contraceptive acceptance rate	X	X	X	X	X	X							
3. Antenatal care coverage	X	X	X	X	X	X							
4. Abortion care		X	X	X	X	X							
5. Delivery attendant													
a. Skilled attendant (WHO definition)		X	X	X	X	X							
b. HEW	X			X	X	X							
c. tTBA	X			X	X	X							
6. Caesarean section rate		X	X	X	X	X							
7. Proportion of maternal deaths (institutional)		X	X	X	X	X							
8. Stillbirth rate (institutional)		X	X	X	X	X							
9. Neonatal death rate (institutional)		X	X	X	X	X							
10. Postnatal care coverage	X	X	X	X	X	X							
A2. Child Health – total indicators: 3													
1. Low birth weight proportion	X	X	X	X	X	X							
2. Proportion of moderate/severe malnutrition amongst weights recorded in children under three years	X	X	X	X	X	X							
3. IMNCI implementation											X	X	X
A3. EPI – total indicators: 6													
1. DPT1+HepB1+Hib1 coverage	X	X	X	X	X	X							
2. DPT3+HepB3+Hib3 coverage	X	X	X	X	X	X							
3. Measles immunisation coverage	X	X	X	X	X	X							
4. Full immunisation coverage	X	X	X	X	X	X							
5. Protection at birth (PAB) against neonatal tetanus	X	X	X	X	X	X							
6. Vaccine wastage rate	X	X	X	X	X	X							

Monthly/Quarterly						Annual					
Facilities			Administration			Facilities			Administration		
HP	HC	Hosp	WorHO	RHB	FMoH	HP	HC	Hosp	WorHO	RHB	FMoH

**B. Disease Prevention and Control – total indicators: 47**

Facility-based morbidity and mortality rates for specific diseases available as needed from disease reports

<b>B1. All diseases – total indicators: 5</b>												
1. Top 10 causes of morbidity amongst children under 5 years							X	X	X	X	X	X
2. Top 10 causes of mortality amongst children under 5 years								X	X	X	X	X
3. Top 10 causes of morbidity, 5 years and above							X	X	X	X	X	X
4. Top 10 causes of mortality, 5 years and above								X	X	X	X	X
5. In patient mortality rate								X	X	X	X	X

**B2. Communicable diseases – total indicators: 39**

<b>B2a. Malaria – total indicators: 4</b>												
1. Malaria cases reported per 1000 population (reported by clinical/confirmed (p. falciparum/ other)												
a. in under 5 children	X	X	X	X	X	X						
b. in age groups 5 years and above	X	X	X	X	X	X						
2. Case fatality rate of malaria												
a. in under 5 children [in patients]		X	X	X	X	X						
b. in age groups 5 years and above [in patients]		X	X	X	X	X						
<b>B2b. TB and Leprosy – total indicators: 10</b>												
1. Case detection rate of new smear positive pulmonary TB patients	X	X	X	X	X	X						
2. Treatment results of smear-positive pulmonary TB cases (DOTS cohort)												
a. treatment success rate	X	X	X	X	X	X						
b. cure rate	X	X	X	X	X	X						
c. defaulter rate	X	X	X	X	X	X						
d. death rate	X	X	X	X	X	X						
3. New cases of leprosy	X	X	X	X	X	X						
4. Grade II disability rate amongst new cases of leprosy	X	X	X	X	X	X						
5. Proportion of leprosy cases amongst children under 15 years of age	X	X	X	X	X	X						
6. Leprosy treatment completion rate												
a. Multi-bacillary (MB) leprosy	X	X	X	X	X	X						
b. Paucibacillary (PB) leprosy	X	X	X	X	X	X						
<b>B2c. TB/HIV coinfection – total indicators: 2</b>												
1. Proportion of registered TB patients who are tested for HIV				X	X	X						
2. Proportion of registered TB patients who are HIV positive				X	X	X						
<b>B2d. HIV/AIDS – total indicators: 17</b>												
1. Number of health facilities, by type, providing VCT services.								X	X	X	X	X
2. VCT counselling and testing												

	Monthly/Quarterly						Annual					
	Facilities			Administration			Facilities			Administration		
	HP	HC	Hosp	WorHO	RHB	FMoH	HP	HC	Hosp	WorHO	RHB	FMoH
<b>B2d. HIV/AIDS – total indicators: 17 (continued)</b>												
a. Clients receiving pretest counselling		X	X	X	X	X						
b. Clients receiving HIV test		X	X	X	X	X						
c. Clients with positive HIV test		X	X	X	X	X						
3. PIHCT counselling and testing												
a. Clients receiving pretest counselling		X	X	X	X	X						
b. Clients receiving HIV test		X	X	X	X	X						
c. Clients with positive HIV test		X	X	X	X	X						
4. Number of health facilities, by type, providing PMTCT services								X	X	X	X	X
5. Pregnant women receiving PMTCT services												
a. Clients with at least one ANC visit (at PMTCT site)		X	X	X	X	X						
b. Clients receiving HIV test		X	X	X	X	X						
c. Clients with positive HIV test		X	X	X	X	X						
d. HIV-infected pregnant women receiving full course of ARV prophylaxis		X	X	X	X	X						
6. Number of health facilities, by type, providing ART services								X	X	X	X	X
7. AIDS patients receiving ARV combination therapy												
a. Persons ever enrolled in HIV care		X	X	X	X	X						
b. Persons ever started on ART		X	X	X	X	X						
c. Persons currently receiving ART (by regimen)		X	X	X	X	X						
d. Survival rates at 6, 12, 24, 36, etc months		X	X	X	X	X						
<b>B2e. Other communicable diseases targeted for eradication of elimination – total indicators: 6</b>												
1. Case fatality rate for meningitis [inpatients]		X	X	X	X	X						
2. Polio cases	X	X	X	X	X	X						
3. Acute flaccid paralysis (non-polio) (AFP) rate	X	X	X	X	X	X						
4. Measles cases	X	X	X	X	X	X						
5. Neonatal tetanus cases	X	X	X	X	X	X						
6. Guinea worm cases	X	X	X	X	X	X						
<b>B3. Noncommunicable diseases – total indicators: 1</b>												
1. Cataract surgical rate									X	X	X	X
<b>B4. Hygiene and Environmental Health – total indicators: 2</b>												
1. Latrine Coverage								X	X	X	X	X
2. Safe water coverage								X	X	X	X	X
<b>C. Resources – total indicators: 28</b>												
<b>C1. Assets – total indicators: 7</b>												
1. Facility to population ratio (by type of facility)										X	X	X
2. Number of hospitals, HCs and HPs newly constructed and upgraded										X	X	X
3. Proportion of HIs with communication equipment: a. telephone or b. radio												
a. telephone								X	X	X	X	X
b. radio								X	X	X	X	X
4. Proportion of HIs with electricity								X	X	X	X	X

	Monthly/Quarterly						Annual					
	Facilities			Administration			Facilities			Administration		
	HP	HC	Hosp	WorHO	RHB	FMoH	HP	HC	Hosp	WorHO	RHB	FMoH
<b>C1. Assets – total indicators: 7 (continued)</b>												
5. Proportion of HIs with water supply							X	X	X	X	X	X
6. Proportion of HIs with latrine with functioning water supply							X	X	X	X	X	X
5. Pregnant women receiving PMTCT services												
a. Clients with at least one ANC visit (at PMTCT site)		X	X	X	X	X						
<b>C2. Finance – total indicators: 9</b>												
1. Share of health budget as a proportion of total budget										X	X	X
2. Government budget allocation to the health sector (absolute amount)										X	X	X
3. Ratio of Health budget utilisation to allocation										X	X	X
4. Per capita public expenditure on health										X	X	X
5. Percentage of non-salary recurrent budget from total recurrent budget at woreda level										X	X	X
6. Proportion of drug budget out of the total recurrent budget										X	X	X
7. Share of internal revenue generated to total health budget								X	X	X	X	X
8. Proportion of reimbursed amount out of total patient fees waived		X	X	X	X	X						
9. Proportion of hospital recurrent expenditures spent on administration									X	X	X	X
<b>C3. Human Resources – total indicators: 4</b>												
1. Health Staff to population ratio by category (doctor, health officer, nurse, midwife, health extension worker)							X	X	X	X	X	X
2. Proportion of institutions staffed as per standards by level (FMoH, RHB, woreda, hospital, HC, HP)							X	X	X	X	X	X
3. Attrition rate by category ( doctor, health officer, nurse, midwife, health extension worker)							X	X	X	X	X	X
4. Proportion of health professionals who have undergone in service training during the last one year							X	X	X	X	X	X
<b>C4. Logistics – total indicators: 2</b>												
1. Essential drugs availability (tracer drugs including contraceptive) by health facility level	X	X	X	X	X	X						
2. Average stock out duration for essential drugs (tracer drugs including contraceptive) by health facility level		X	X	X	X	X						
<b>C5. Laboratory and blood bank – total indicators: 6</b>												
1. Total number of units of blood collected by the National Blood Transfusion Service (NBTS)												X
2. Number/percentage of facilities accessing service through the National Blood Transfusion Service (NBTS).												X
3. Percentage voluntary non-remunerated blood donations												X
4. Capacity for malaria parasite diagnosis							X	X	X	X	X	X

Monthly/Quarterly						Annual					
Facilities			Administration			Facilities			Administration		
HP	HC	Hosp	WorHO	RHB	FMoH	HP	HC	Hosp	WorHO	RHB	FMoH

**C5. Laboratory and blood bank – total indicators: 6 (continued)**

5. Laboratory capacity for pulmonary tuberculosis (PTB) diagnosis							X	X	X	X	X
6. Quality control in laboratories							X	X	X	X	X

**D. Health Systems – total indicators: 12****D1. Health service and utilisation – total indicators: 8**

1. Primary health care coverage							X	X	X	X	X	X
2. Outpatient attendance per capita							X	X	X	X	X	X
3. OPD visits per practitioner per day, disaggregated by level	X	X	X	X	X	X						
4. Admission rate		X	X	X	X	X						
5. Bed occupancy rate		X	X	X	X	X						
6. Average length of stay		X	X	X	X	X						
7. Availability of BEOC										X	X	X
8. Availability of CEOC										X	X	X

**D2. Management – total indicators: 2**

1. Number of supervisory visits received	X	X	X	X	X	X						
2. Number of self-assessment and participatory review meetings held	X	X	X	X	X	X						

**D3. HMIS and M&E – total indicators: 2**

1. Completeness and timely submission of routine health and administrative reports				X	X	X						
2. Data quality	X	X	X	X								

**E. Population Denominators: supplied by Central Statistics Authority**

1. Total population												
2. Estimated number of households												
3. Population growth rate												
4. Expected pregnancies												
5. Expected deliveries												
6. Live births												
7. Children under 1 year												
8. Surviving infants												
9. Children under 5 years												
10. Females 15-49 years												

Note: Health Stations use the same indicators as Health Posts



## Appendix II – Brief outline of visits, meetings and contacts made

	Institution/Facility	Department	Title	Name	
June 22	MOH	Policy and Planning directorate	Director	Mr. Dereje	
	MOH			Mr. Mebrehatom	
June 26	Oromia Region (Dendi Woreda) Health Office		Head	Nedessa Damessa	
			MCH Staff	Ayantu Kedida	
	Ginchi Health Centre (Higher performance)		Head	Tesafye Girma	
	Worka Worbo Health Post		HMIS coordinator HEW HEW	Mr. Kebede Keneni Tigist Desta Tabotwa	
June 27	Save the Children (NGO)	Oromia Region (Dendi Woreda) Sub-Office	Sub-Office Manager	Mr. Girma Regassa	
			ICCM Coordinator	Mr. Shibiru Komsa	
	Wolenkomi Health Centre (lower performance)			Head	Dibaba Meko
				Health Officer (MNH)	Berhanu Bayicha
				MCH dept	Sis Berhane Duguma
				EPI	Sister Alem
	Catholic Clinic (non-profit)			EPI	Sister Milise
				MCH	Genet
				Head	Sis. Askale
				Nurse	Mr. Tesfaye Fikru
			Nurse	Mr. Desaleng Mamo	
Ehud Gebeya Health Post			Nurse	Melkamu Bekele	
			Nurse	Worknesh Regessa	
			HEW	Hablework Demisse	
			HEW	Yeiteref Tadesse	
June 28	L10K		MCH project manager	Ms Wuleta Betemariam	
June 29	Keyet Health Centre (Amhara Region) (Higher performance)		Head	Mr. T/Haregay T/Hana	
	Bakelo Health Post		HEW	Hirut	
			HEW	Tsegemariam	
	Travel to Goshe Bado Health Centre (Lower performance)		Head	Mr. Kebde Demisse	
	Goshe Bado Health Post		HEW	Ehetaferhu	
July 2	Baso Werana Zonal Health office (Amhara Region)		Head	Mr. Nega Haile	
			MCH Head	Sister Zenebech	
			Deputy Head	Mr. Belayhun	
	Woreda Health Office		Deputy Head (MCH)	Mr. Tedross	
			MCH	Mr. Taye Ambesse	
	Christian Relief Fund (NGO), Keyet		Head	Mr. Terefe Sisay	
MoH		New born health	Mr. Mesfin Almeu		
				(Meeting with to synthesise Woreda visit findings)	
July 4	Meeting with MaNHEP		MCH project coordinator	Dr. Abebe Gebremariam	
July 13	Oromia Regional Office		Family Health Expert	Mr. Alemu	
			Health Research Head	Mr. Tesfaye	
			Health Research Officer	Mr. Tujuma	
			Head of Planning, Budget, Monitoring and Evaluation	Mr. Lema	

# Acronyms

Acronym	Meaning
ANC	Ante Natal Care
ARM	Annual Review Meeting
ART	Anti-Retroviral Therapy
BSC	Balanced Scorecard
DIPH	Data Informed Platform for Health
DP	Development Partner
CHPs	Community Health Promoters
CJSC	Central Joint Steering Committee
EDHS	Ethiopian Demographic & Health Survey
EPI	Expanded Programme of Immunisation
FMoH	Federal Ministry of Health
FP	Family Planning
HAPCO	HIV/AIDS Prevention & Control Office
HDA	Health Development Army
HEP	Health Extension Package
HEWs	Health Extension Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPN	Health, Population & Nutrition
HRIS	Human resources information system
HSDP	Health Sector Development Programme
IDEAS	Informed Decisions for Actions
ITN	Insecticide Treated Nets
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
LMIS	Logistics Management Information System
M&E	Monitoring & Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MNH	Maternal & Newborn Health
NGO	Non-governmental organisation
PFSA	Pharmaceutical Fund & Supply Agency
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission
PNC	Prenatal Care
PPD	Planning & Programming Department
RHB	Regional Health Bureau
RJSC	Regional Joint Steering Committee
STD	Sexually transmitted diseases
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TBAs	Trained Traditional Birth Attendants
WHO	World Health Organisation
WJSC	Woreda Joint Steering Committee



### **IDEAS project**

IDEAS (Informed Decisions for Actions) aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, northeast Nigeria and the state of Uttar Pradesh in India, IDEAS uses measurement, learning and evaluation to find out what works, why and how in maternal and newborn health programmes.

IDEAS is funded between 2010 and 2015 by a grant from the Bill & Melinda Gates foundation to the London School of Hygiene & Tropical Medicine.

[ideas.lshtm.ac.uk](http://ideas.lshtm.ac.uk)

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