

# ANNUAL REPORT 2019

## STRENGTHENING THE HEALTH SYSTEM IN JIMMA ZONE (OROMIA REGION, ETHIOPIA) THROUGH PERFORMANCE BASED FINANCING (2019-2023)

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## LIST OF ABBREVIATIONS

ANC	Antenatal Care
AMTSL	Active Management of the Third Stage of Labor
CBHI	Community Based Health Insurance
DHIS2	District Health Information System 2
EDD	Expected Date of Delivery
EFY	Ethiopian Fiscal Year
EPI	Expanded Program on Immunization
EPSA	Ethiopian Pharmaceuticals Supply Agency
FMOH	Federal Ministry of Health
FGD	Focus Group Discussion
FP	Family Planning
HC	Health Centre
HEP	Health Extension Package
HF	Health Facility
Hgb	Haemoglobine
HMIS	Health Management Information System
HSEP	Health Service Extension Programme
HSTP	Health Sector Transformation Plan
IMNCI	Integrated Management of Childhood Illness
KPI	Key Performance Indicator
LMP	Last Menstrual Period
MNCH	Maternal Newborn and Child Health
MRN	Medical Record Number
OPD	Out Patients Department
ORHB	Oromia Regional Health Bureau
PBF	Performance Based Financing
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PIM	Project Implementation Manual
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PPA	Performance Purchasing Agency
SOP	Standard Operating Procedure
TT	Tetanus
USAID	United States Agency for International Development
WHO	Woreda Health Office
ZHD	Zonal Health Department
ZOFED	Zonal Office for Economic Development

## EXECUTIVE SUMMARY

In this annual report, we report the progress made in the implementation of Performance Based Financing in Jimma Zone in 2019. Out of these first nine months of the project, the first six months (April to September) were used as an Inception Phase for the project, whereas the last three months (October to December) together formed the first quarter of PBF implementation. Inception phase activities, such as the finalization of the project design, preparatory activities and the concrete set-up of the project, have thus constituted a large part of Cordaid's work. The successful completion of most of these activities enabled a timely start of the regular implementation of PBF in 68 health facilities, of which the first results are already becoming visible. Most notably, we are observing progress towards the objectives under Outcome Pathway 1, which directly target *Improved Health Service Delivery*. For Outcome Pathways 2 (*Improved Governance of Health Service Delivery*) and 3 (*An Enhanced Health Information System*), a lot of foundational work has been done, and more tangible results will become visible in the course of 2020. Below, we will briefly summarize the main achievements and challenges encountered during the Inception Phase, as well as the milestones for each of the three Outcome Pathways.

The **Inception Phase** was informed by two scoping missions by Cordaid HQ staff to the Jimma Zone, in November 2018 and April 2019. Immediately after the approval of the project proposal and the start of the project by April 1<sup>st</sup>, 2019, two senior representatives from the Jimma Zonal Health Department attended the International RBF Course in Mombasa, giving them a good understanding of PBF from the start of the project. In May and June 2019, two international PBF experts were recruited at the level of Cordaid Ethiopia (Addis Ababa), as well as an Ethiopian team leader for Cordaid Jimma, who all started their work in July. Simultaneously, Cordaid identified appropriate office space in Jimma Town. In July 2019, a PBF design workshop was organized, during which key stakeholders from all levels of the health system were familiarized with the PBF approach and methodology and, in a participatory process, validated the project set-up. This included the selection of participating woredas, as well as the selection of quantity and quality indicators and the prices and weights attached to them. Directly following the workshop, the first version of the Project Implementation Manual (PIM) was finalized, including a cost projection of the performance based payments during the project period. The newly recruited international staff and Jimma team leader then recruited a team of nine local verifiers in August 2019, who were trained in the PBF approach. In September, a further cascade of trainings to local stakeholders was organized: from each participating entity (the Zonal Health Department, 13 woreda health offices, 64 health centres and 4 hospitals) two to four representatives were trained. On October 7<sup>th</sup>, 2019, an official PBF launch event was organized in Agaro Town, in the presence of representatives from all government levels as well as the Embassy of the Kingdom of The Netherlands. In the direct aftermath of this event, the baseline study was conducted, to collect quantitative and qualitative information about baseline performance at all levels. These baseline visits were also used to sign the first performance agreements with facilities and local authorities, starting by the first of Tikamet (EFY 2012), with which the official implementation of PBF began. Due to a busy schedule, as well as a delay in obtaining necessary project agreements with the regional and federal governments, some of the Inception Phase activities had to be postponed to the fourth quarter of 2019 and first quarter of 2020. Most importantly, this concerned the recruitment and training of local CBOs for community verifications, which was done in December, and the development of the DHIS2 data system, which was finalized by BlueSquare in February 2020. It also concerned the gender analysis, which was completed by a local Ethiopian consultant in the month of December.

Looking at the intended outputs under **Outcome 1, *Improved Health Service Delivery***, most progress on outputs 1A (the finalization of a Project Implementation Manual) and 1B (the training of the health workforce in PBF), had already been realized during the Inception Phase. For all the other outputs (1C to 1F), the work began in earnest with the start of actual PBF implementation in the fourth quarter of 2019. All health facilities developed their first business plans, and signed their first performance agreements, after which the first rounds of performance verifications took place. In November, the first quantity verifications were conducted (by Cordaid Jimma, as the PPA), followed by the first quality verifications in December (by local health authorities, assisted by Cordaid Jimma) and the first community verifications in January (by the recruited CBOs). Based on the outcomes, all entities received their first performance based payment in February 2020.

Comparing the outcomes of these first verifications to the outcomes of the baseline study (which had looked at the performance in September), we can already see some remarkable progress, most notably in the reliability of the reported data and in the quality scores obtained by the facilities. During the baseline, verifiers were only able to fully verify 11.4% of all services reported by the health centres (all indicators together), but during the fourth quarter of 2019 this had already increased to 51.0%. For four types of services at health centres, the overall rate of verification had gone up to more than 60%: i.e. for adult OPD consultations, for HIV testing, for mothers receiving PMTCT option B+ and for the treatment of

STI. This is all the more remarkable since for two of these services (mothers receiving PMTCT option B+ and the treatment of STIs), the rate of verification had been lower than 10% during the baseline study. For family planning services too, the increase in data accuracy and reliability was very promising at health centres: from 1% of the cases being fully verified during the baseline assessment (for both family planning by short term methods and by long term methods) to more than 50% during the 4<sup>th</sup> quarter of 2019. This is even more so at the hospitals, where long term family planning methods could be verified for 91.4% during the first verification compared to 0% during the baseline. Not all indicators showed the same progress though: the cases of ANC4 being fully verified only rose from 1.2% to 6.1%. This is understandable, as this is an indicator which is notoriously difficult to register fully correctly. The overall improvement can be explained by the level of awareness that facilities have adopted to properly document cases on patient cards and in registers, as well as by the coaching and supervision they received from verification officers and regulators. Disaggregating the health centre numbers by woreda, the highest ratio of verified cases versus reported cases in the 4<sup>th</sup> quarter of 2019 was achieved by Botor Tolay (71.0%), followed by Chora Botor (68.5%), while the lowest ratio was recorded by Omo Nada woreda (32.6%). A similar improvement in data accuracy, although less dramatic, can be observed in hospitals, where the number of fully verified cases (all indicators together) rose from 7.6% to 26.4%. However, the outcomes varied significantly across the hospitals with 93.4% of cases fully verified in the best performing hospital, Omo Nada, but only 9% in the worst performing, Agaro.

While data quality improvement is one of the first visible effects of PBF, the effect on the reported level of service utilization is more mixed. On the one hand, service providers under PBF are more motivated to see and treat more patients. Similarly, due to improving quality of care, more health care seeking behaviour can be expected from patients. After only three months of project implementation, however, these effects may not be very substantial. On the other hand, the strict verification of data and application of the 10% discrepancy rule (no payment on an indicator if the difference between reported and verified numbers is more than 10%) will encourage facilities to no longer cook their data. As a result, we can expect *reported* service utilization to decrease. In Jimma Zone, the latter effect, seems to have been stronger initially: calculated on an annual basis, the total number of cases during the first quarter of verifications was 2% lower than during the baseline. This decrease would have been 12% if it wasn't for the significant increase of 78% in declared cases of testing for HIV/AIDs. This decrease may very well have to be attributed to the fact that health centres are starting to report more accurate figures to the authorities. The largest drops in declared cases are in Omo Beyyam (-/- 36%), Tiro Afeta (-/- 33%) and Omo Nada (-/- 25%). These drops in declared cases are especially seen across multiple maternal and child health indicators, which alleviates the fear heard at the start of the project that PBF could cause an increase in the declared figures.

In addition, the introduction of PBF seems to have had quite an immediate effect on the quality scores of health facilities. At health centre level, there is good improvement across all domains, with the average total quality scores going up from 19.3% during the baseline verification to 35.2% during the first regular verification in the fourth quarter of 2019. The highest average scores per domain are being recorded on antenatal care services, nutrition services and logistics, medicines and supplies. A very pronounced improvement was also recorded on referral services. On the contrary, despite slight improvement, average scores remained very low on emergency services, on outreach services and health post supervision, and on nutrition services. The worst performing woreda in Q4 2019 was Omo Beyyam woreda, where health centres on average obtained only a 21% quality score (compared to Mancho woreda being the worst during the baseline, with an average of 12%). The best performing woreda in Q4 2019 was Chora Botor, with an average of 50% (compared to 29% in Botor Tolay, the highest woreda average during the baseline). The best performing health centres generally outperformed the others in the domains of infection control and waste management, emergency services and inpatient services.

In hospitals, too, there was good improvement, the average score going up from 29% during the baseline to 52% during the fourth quarter of 2019. Omo Nada Hospital continues to be the highest performer, scoring 45% during the baseline and no less than 81% in Q4 2019. Also in Setema (from 14% to 47%) and Limu Genet (from 26% to 47%), there was marked improvement. Agaro Town was the least performing hospital in the fourth quarter, with a 36% score, slightly up from 31% during the baseline. The best performing domains are surgical services and laboratory services, which were already performing high during the baseline assessment as well. The best improvement compared to the baseline is observed on emergency services, logistics, medicines and supplies and administration, finance, HRM and planning. Average scores remained very low on inpatient services and infection prevention and waste management, although Omo Nada Hospital is a positive exception in the last area. In general, the way in which Omo Nada Hospital has proactively taken up the PBF approach – conducting internal quantity and quality verifications prior to the visits of verifiers – can serve as an example. All improvements in quality performance are all the more remarkable since they were achieved by health facilities before they received any performance based payments. This shows that already at the start of implementation, there was a high

level of motivation and commitment among health professionals to make this project a success, as well as a solid understanding of how PBF works. In as far as possible without substantial financial investment, facilities put considerable effort into addressing the gaps that had been identified during the baseline assessment, in order to be entitled to a higher first quarterly payment. In stating this, we can already observe tangible progress towards Medium Term Outcome 1.1 of the project: 'health professionals function as a team, are motivated, pro-active and are respectful and caring towards their patients'. As illustrated above by the improved accuracy and reliability of the data, progress is also being made towards Medium Term Outcome 1.5: 'monthly HMIS data of the facilities is of good quality (reliable, accurate, timely and complete) and is used to take informed decisions.' Surprisingly, the level of perceived quality by patients is quite high at the start of the project, as the outcomes of 1,275 surveys show: 70% on average for health centres, and 78% for hospitals.

Under **Outcome 2**, the project aims to contribute to *Improved Governance of Health Service Delivery*. Similarly as for health facility staff, this process started with familiarizing representatives from both the Jimma Zonal Health Department and all 13 Woreda Health Offices to the PBF approach and methodology. This was done firstly through a theoretical PBF training in September (as described above) and secondly by on-the-job training. In October, baseline quality verifications were conducted by mixed teams of health office staff, in which experienced staff from Borana (where the PBF approach has been in use since 2015) took the lead and oriented the health office staff from Jimma on how to verify in practice. In December, the first round of regular quality verifications took place, conducted by the Jimma health office staff with support from Cordaid Jimma. Despite some challenges – most notably a limited availability of staff – all WHOs and the ZHD managed to conduct the quality assessments within the stipulated timelines. In general, they have showed commitment and enthusiasm to make this project a success. In their turn, all WHOs and the ZHD have also signed their first performance agreements with Cordaid Jimma (as the PPA) and have been subject to a first evaluation of their own performance. All entities managed to come up with action plans, although they still need to improve in making them even more SMART. Some of the strategies proposed in the action plans by WHOs were not very realistic and the responsible people and timelines were not well specified. The only indicator which was not implemented at all across all WHOs is the indicator related to the level of CBHI enrolment. Due to the low enrolment rate of households at woreda level, none of the woredas scored the minimum requirement to get paid for this indicator. Based on their verified performance during the 4<sup>th</sup> quarter of 2019, the ZHD and 13 WHOs, like the health facilities, received their first PBF payment in February 2020.

In addition to the progress on outputs 2A to 2E, as described above, Outcome 2 also aims to contribute to the long term institutionalisation of PBF in the Ethiopian health system. Under output 2F, the project envisions that a Technical Assistance (TA) plan on how to integrate PBF into the Ethiopian health system, health policies and health financing strategies will be approved by the Federal Ministry of Health (FMOH), and implemented in a phased way. In working towards this goal, Cordaid has liaised proactively with key directorates of the FMOH and developed a draft TA Plan for 2020. Due to the COVID-19 crisis, unfortunately, concrete activities envisioned in that plan could not yet be implemented.

Activities under **Outcome 3**, which aims at *An Enhanced Health Information System*, were mostly work in progress by the end of the period under review. In 2019, BlueSquare was contracted by Cordaid to develop a PBF data system linked to the national DHIS2, as well as to develop the necessary tools for digital data collection (using smart phones and tablets) by the local verifiers and regulators (outputs 3A and 3B). This was all work in progress by the end of 2019, but was all but finalized in March 2020: the system was tested and is ready for use. Cordaid staff and representatives of the regulators have been trained on the use of both the data system and the digital data collection. Work on output 3C, which aims at developing more advanced data visualization tools (DataViz) is scheduled to start in the first half year of 2020. In 2019, Cordaid also contracted Proof of Impact to develop a blockchain platform. The focus so far has been on Output 3D (the tokenisation of a selection of verified impact events, which can then be recorded on a blockchain) and Output 3F (the development of an economic model for the tokenised impact events). The progress in 2019 has been satisfactory and a first demo was presented during a blockchain workshop organized by the Embassy in Addis Ababa in November 2019. An independent verification of this work (first phase) has been conducted by Blockchainlab Drenthe, showing some areas of attention, but generally confirming that the work is on track. In April 2020, the first actual verified data from Jimma are intended to be made available for purchase on the platform for a panel of test users, although some delay might now occur due to the COVID-19 crisis. Work on Output 3E, enhanced verification at the point of care, has not yet started.

All in all, the project is very well on track. Despite some small delays, all essential implementation processes, including the contracting and verification, as well as the execution of the PBF payments, are taking place according to schedule. As a result, we may expect further improvement in health service delivery, governance and information systems in 2020.

## PROJECT BACKGROUND

In Ethiopia, Cordaid started to showcase PBF in the arid and pastoralist Borana Zone. After a participatory design process of six months, the project officially started on May 1st, 2015. Stakeholders involved in the design of the PBF project in Borana were among others the Oromia Regional Health Bureau (ORHB), the Borana Zonal Health Department (ZHD) and 4 Woreda (district) Health Offices. Phase I of the PBF project ended on the 30th of June 2018. Since the results were positive (which was also found in an external project evaluation done in November 2018) and contributed to an increase in both the utilisation and the quality of health care services, the Borana ZHD and Cordaid jointly designed a Phase II for the Borana zone: PBF is scaled up from 4 to 8 Borana woredas, from 9 to 25 health facilities and from a catchment population of 125,918 to a population of 488,556. Phase II started in July 2018. Both phases are supported by Cordaid funds.

In March 2018 a PBF workshop, jointly organised by the FMoH and Cordaid, took place in Debre Zeit in which representatives of the FMoH, ORHB, the Borana Zonal Health Department, the EHIA, Cordaid, the Embassy of the Kingdom of the Netherlands and DFID participated. One of the subjects discussed was the need to scale up PBF in a non-pastoralist area. This to showcase that PBF also works in other settings than the arid and pastoralist Borana Zone. Introducing PBF in an area where people are largely living from subsistence farming might change the dynamics around PBF and will thus generate additional evidence about the effectiveness of PBF. Most participants advised that it would be preferred to focus on a non-pastoralist area in the Oromia Region, a region where also the existing Borana PBF project is implemented. The idea was discussed with the Netherlands Embassy. The latter suggested it would be interesting to create synergy with income generating projects supported by them, such as the interventions of the Dutch company Moyee Coffee, who buys its coffee from farmers in the Limu Kossa woreda located in the Jimma Zone. After that the idea of scaling-up PBF in the Jimma Zone was discussed with both the Oromia Region and the Jimma Zonal Health Department: both supported the project idea.

In mid-2018 Cordaid was invited by the Netherlands Embassy to formulate a four (4) year proposal and budget for scaling up PBF to the Jimma Zone. Cordaid presented this proposal to the Embassy on the 10th of October 2018. Early April 2019 the Embassy approved the four (4) year project proposal using as starting date the 1st of April 2019.

### **The overarching objective of scaling up PBF in the Jimma Zone is:**

“Improved availability and accessibility of good quality healthcare at primary and secondary level in the Jimma Zone (Oromia Region, Ethiopia), and a stronger health system at large, which supports the progressive realization of Universal Health Coverage (SDG 3.8) in this geographical area.”

### **The three (inter-related) targeted Outcomes are:**

1. Improved Health Service Delivery in the selected woredas of the Jimma Zone, reflected in:
  - A. Increased utilization of good quality services
  - B. Increased equity in access
2. Improved governance of health service delivery through:
  - A. Increased capacity at the level of Woreda Health Offices and Zonal Health Department to perform their regulatory tasks and provide supportive supervision
  - B. Institutionalisation of PBF in the Ethiopian health system
3. An enhanced health information system that supports:
  - A. Data based decision making at Woreda, Zonal and Regional level
  - B. Additional financing potential for the health system through enhanced transparency

This report describes the progress in the period April – December 2019, against the Theory of Change and the Logical Framework of the project. These were developed as part of the proposal and can be found in Annex 1 and 2 respectively. One chapter is dedicated to each of the three outcomes, in which results are reported per output. Naturally, during implementation deviations may occur from the original framework. Wherever this is the case, this will be mentioned below.



## 1. OUTCOME 1: IMPROVED HEALTH SERVICE DELIVERY

The focus of this outcome is to ensure increased utilization of good quality services and increased equity in access. This while the baseline study noted that the utilisation of services is already improving since the introduction of CBHI. The health facilities under PBF are divided into 3 categories of remoteness based on the criteria outlined in the PIM.

The accuracy of data is one of the gaps that still needs to be addressed, though we have already noted significant improvement comparing baseline and Q4 2019 data<sup>1</sup>, due to rigorous verification process which include coaching and mentoring of staff in the health facilities. For the health centres during the baseline study 11.4% of the reported cases were verifiable, while this improved to 51.0% during the Q4 2019 verifications. For the hospitals these percentages were 7.6% during the baseline and 26.4% in Q4 2019 respectively.

Due to the nature of the quantity indicators, which are directly linked to quality indicators, there has been remarkable improvement with regard to quality of services in most health facilities. The average quality score for health centres during the baseline was 19.25% and increased to 35.2% during Q4 2019. This, while at hospital level the average improved from 29% to 52.4%. The staff of most facilities showed a lot of motivation and enthusiasm even before the first PBF payments were made. Some Woredas were pro-active to invest in facilities to address some basic infrastructural needs. Community verifications were also conducted and the average perceived score for health centres was 70% and 78% for hospitals.

The Fund Holder (Cordaid Ethiopia) made timely payments for Q4 2019 to all contracted health facilities and CBOs. A total of 2,912,497.17 ETB was paid for all health centres (with an average of 45,508 ETB for a health centre) and a total amount of 350,358.31 ETB to the hospitals, of which 57% was earned by Omo Nada, with Agaro earning only 6% of the total amount. Generally as was noted also during the baseline, there is still a shortage in key medical equipment and medicines in most health facilities. Hence the reason for prioritising these in the business plans. Sanitation and waste management infrastructure is also a priority in the business plans. This chapter will describe in detail the general progress made during the Inception phase and gives a comparison (of both quantity and quality performance) between the baseline and Q4 2019.

### **Output 1A: An approved PBF PIM is in place / Inception Phase**

The activities planned for the inception phase were successfully implemented, though some were delayed a bit due to the time it took the Oromia region to sign the project agreement. A successful *PIM validation workshop* was held in July 2019. All relevant stakeholders participated in the validation process. The stakeholders consisted of the FMOH, ORHB, EHIA, BoFEC, Jimma University, Jimma Zonal Health Department, Jimma and Borana zone woreda representatives, Hospital and health centre representatives and Cordaid. The suggestions from the stakeholders were incorporated into the draft PIM before it was finalised and shared with them.

*Recruitment* for project staff was also successfully done during the six months inception period. The two expat PBF experts (the Program Manager and the PBF Data Expert), the Jimma Project Coordinator and the Project Financial controller were recruited during the period under review. This core team recruited nine (9) verification officers and other support staff based in the Jimma zone. The core project team managed to provide intensive *PBF training* to the verification officers, who on their turn also participated in the rigorous training of the regulators and health facilities staff.

A successful *launch* event was held in Jimma in October 2019 which was attended by various stakeholders including representatives of the Embassy of the Kingdom of Netherlands.

The *gender analysis* was done by an external consultant, and the report was submitted to the Embassy. For more details, the reader is referred to this separate report. The local *exposure visits* were moved to the last half of 2020 due to the busy schedule of all stakeholders in 2019.

<sup>1</sup> In the Ethiopian calendar, the first quarter of PBF implementation was the second quarter of the Ethiopian Fiscal Year 2012 (12 EFY). These are also the months for which DHIS2 data have been verified: Tikamet, Hidar and Tahesas 2012. However, in order to not create confusion with the project implementation schedule, which is in Gregorian calendar, throughout this report we will refer to this quarter as Q4 2019, a shift of only a few days.

**Output 1B: There is a trained and regularly mentored Health workforce on PBF**

The below table summarises the number of representatives from health facilities that were trained on PBF. The focus of the training was to have staff understand PBF as a Health Systems Strengthening approach, to understand the indicators (both quantity and quality), the associated processes (such as business planning, performance agreements & community verification by CBOs, and the way in which verification are conducted. Above all the training clearly highlighted how the PBF project fits withing the existing Ethiopia's Health Sector Transformation Agenda (HSTP).

**TABLE 1 » NUMBER OF HEALTH PROFESSIONALS TRAINED IN PBF (SEPTEMBER-OCTOBER 2019)**

NO	WOREDA	# OF HEALTH FACILITIES	TOTAL STAFF TRAINED	MALE	FEMALE
1	Agaro Town	2	4	50%	50%
2	Botor Tolay	4	8	100%	0%
3	Chora Botor	3	6	100%	0%
4	Gumay	3	6	100%	0%
5	Kersa	7	14	100%	0%
6	Limu Kossa	8	16	100%	0%
7	Mancho	6	12	92%	8%
8	Omo Nada	7	12	83%	17%
9	Omo Beyyam	4	8	88%	13%
10	Setema	5	10	100%	0%
11	Shabe	5	10	90%	10%
12	Sigmo	5	10	90%	10%
13	Tiro Afeta	5	10	70%	30%
<b>Total</b>		<b>64</b>	<b>126</b>	<b>91.3% (n=115)</b>	<b>8.7% (n=11)</b>

In the hospitals, 100% of participants were men. This is partly due to the fact that the number of female health workers in the hospital is limited.

**Output 1C: Business planning and contracting**

In accordance with the PIM, each health provider has to develop a quarterly business plan as a prerequisite before signing a performance contract with the Performance Purchasing Agency (PPA, Cordaid Jimma office). In total 68 health facilities were contracted to implement PBF in Jimma Zone. This includes 4 hospitals and 64 primary health centres. The PPA staff, in collaboration with the WHOs, managed to assist the HFs to develop their first business plans for the implementation of the first PBF quarter (4<sup>th</sup> quarter 2019). The quality of the business plans is still to be improved, since the process was new for both health facilities and the PPA staff. Generally the HFs were able to identify their key priorities to focus on, including infrastructure rehabilitation, procurement of medical supplies and running costs.

TABLE 2 » NUMBER OF CONTRACTED HOSPITALS AND HEALTH CENTRES PER WOREDA

WOREDA	TOTAL POPULATION	# OF HEALTH POSTS	# OF HEALTH CENTRES	HOSPITALS	HOSPITAL POPULATION
Agaro Town	41,793	2	2	Agaro Hospital	846,995
Botor Tolay	63,201	17	4		
Chora Botor	79,077	20	3		
Gumay	84,268	14	3		
Kersa	227,959	32	8		
Limu Kossa	221,036	38	8	Limu Genet Hospital	786,500
Mancho	177,009	23	6		
Ommo Beyyam	134,650	16	4		
Omo Nada	208,517	22	7	Omo Nada Hospital	345,916
Setema	142,635	20	5	Setema Hospital	273,234
Shebe Sombo	154,896	20	5		
Sigmo	127,911	19	5		
Tiro Afeta	165,196		5	under construction	
<b>TOTAL</b>	<b>1,828,148</b>	<b>243</b>	<b>65</b>	<b>5</b>	<b>2,252,645</b>

Before the health centres were contracted, the level of their equity bonus (among others based on their remoteness) were determined using the equity-bonus criteria defined in the PIM. Note that an equity bonus is only applicable to the health centres and not to the hospitals. Based on its geographic, socio-demographic and infrastructural context, a health centre might be entitled to an equity subsidy additional to their general PBF subsidy. This subsidy/bonus is measured by: the size of a HC's catchment population, its distance from the nearest hospital, the state of the access roads, and the availability (or non-availability) of both public transportation and communication.

The equity determination tool (included in the PIM) uses detailed criteria determine the eligibility for an equity bonus. Based on this criteria a health centre can fall into one of the following three categories:

- Total score of 0-3 Points on these indicators: 0% equity bonus
- Total score of 4-6 Points on these indicators: 10% equity bonus
- Total score of 7-10 Points on these indicators: 20% equity bonus

The PPA staff, in collaboration with Woreda representatives and the director of each health centre, discussed and agreed upon the equity scores for each of the assessed health centres. During these assessments, see the table below, 26 out of 64 facilities fall in the 0% equity bonus category (so these HCs are not entitled to an equity bonus), while 27 HCs scored in the 10% category and 11 ranked in the 20% category. This last category of health centres are located in very hard to reach areas.

In Agaro Woreda all the facilities are located in town, and well accessible so not eligible for any equity bonus. To the contrary, Botor Tolay Woreda has 3 out of 4 health centres working in difficult to reach areas. These HCs will therefore earn the maximum of a 20% equity bonus. Next to Botor Tolay woreda, there are two other woredas where all health centres earn an equity bonus: Mancho and Omo Beyyam.

TABLE 3 » NUMBER OF HEALTH CENTRES PER EQUITY CATEGORY

WOREDA	CATEGORY 0%	CATEGORY 10%	CATEGORY 20%
Agaro Town	2	0	0
Botor Tolay	0	1	3
Chora Botor	1	1	1
Gumay	1	2	0
Kersa	3	3	1
Limu Kossa	5	3	0
Mancho	0	5	1
Omo Beyyam	0	2	2
Omo Nada	4	2	1
Setema	2	3	0
Shabee	3	0	2
Sigmo	1	4	0
T/Afetaa	4	1	0
<b>TOTAL</b>	<b>26</b>	<b>27</b>	<b>11</b>

### Output 1D: Quantity and quality verifications

#### Data in relation to the Quantity verifications

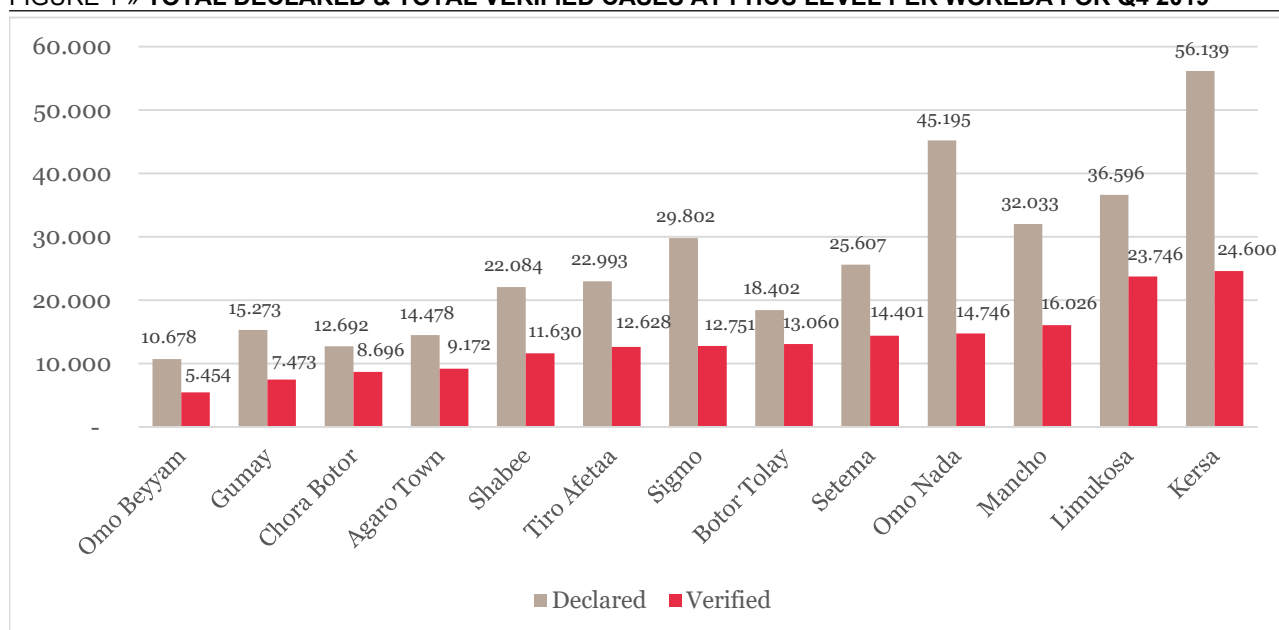
During baseline *quantity verifications*, a high discrepancy was found between declared and verified data. For example at the health centre level, only 11.4% of all declared cases could be fully verified, while this percentage at hospital level was 7.6%. However, within only three months there was already a significant improvement, to 51% of the declared cases verified during Q4 2019 at health centre level and 26.4% at hospital level, as shown in Table 4 and Figures 1 and 2.

TABLE 4 » TOTAL DECLARED AND VERIFIED CASES AND PERCENTAGE VERIFIED AT PHCU LEVEL PER WOREDA

WOREDA	BASELINE DECLARED	BASELINE VERIFIED	BASELINE % VERIFIED	Q4 DECLARED	Q4 VERIFIED	Q4 % VERIFIED
Botor Tolay	4,674	655	14.0%	18,402	13,060	71.0%
Chora Botor	4,040	583	14.4%	12,692	8,696	68.5%
Limu Kossa	10,953	1,860	17.0%	36,596	23,746	64.9%
Agaro Town	2,459	9	0.4%	14,478	9,172	63.4%
Setema	5,226	462	8.8%	25,607	14,401	56.2%
Tiro Afetaa	11,401	1,549	13.6%	22,993	12,628	54.9%
Shabee	7,866	789	10.0%	22,084	11,630	52.7%

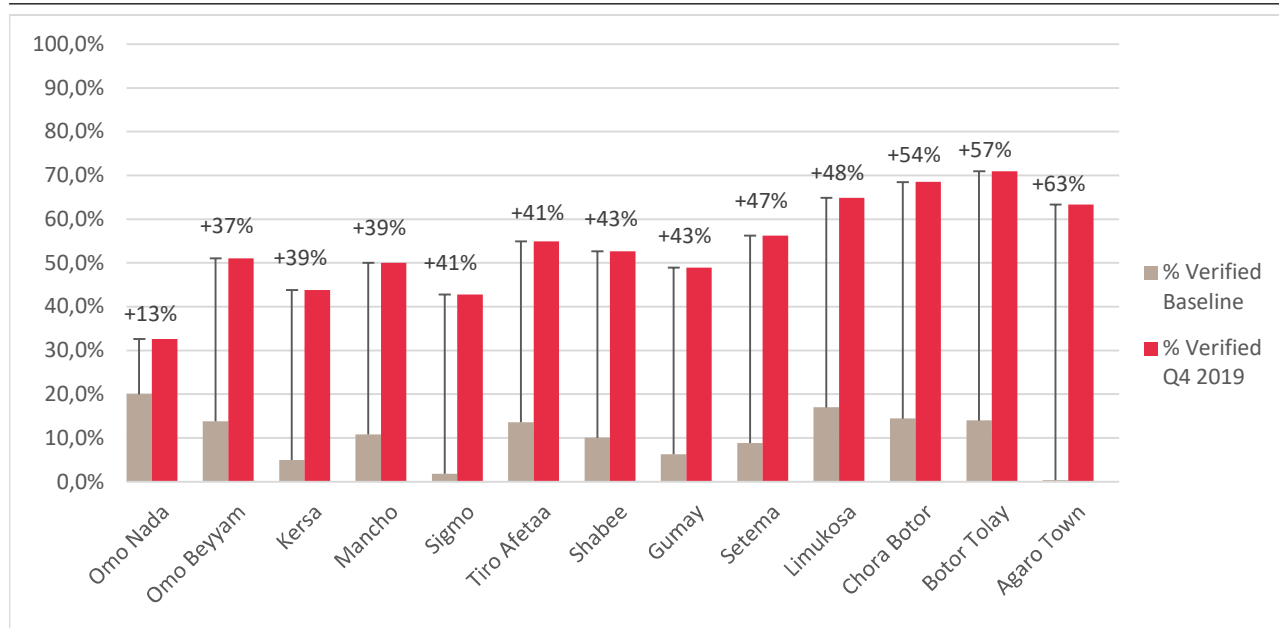
Omo Beyyam	5,590	773	13.8%	10,678	5,454	51.1%
Mancho	11,573	1,251	10.8%	32,033	16,026	50.0%
Gumay	4,974	313	6.3%	15,273	7,473	48.9%
Kersa	18,327	907	4.9%	56,139	24,600	43.8%
Sigmo	9,528	174	1.8%	29,802	12,751	42.8%
Omo Nada	20,217	4,041	20.0%	45,195	14,746	32.6%
<b>TOTAL</b>	<b>116,828</b>	<b>13,366</b>	<b>11.4%</b>	<b>341,972</b>	<b>174,383</b>	<b>51.0%</b>

FIGURE 1 » TOTAL DECLARED &amp; TOTAL VERIFIED CASES AT PHCU LEVEL PER WOREDA FOR Q4 2019



The main contributing factors (during the baseline study) for the low verified quantity scores included: poor documentation of cases and use of old versions of HMIS registers which did not meet all PBF validation criteria. Some facilities did not have standard registers; instead they recorded patient information on a piece of paper which often does not have all required reporting data elements such as service date, Medical Record Number (MRN) and serial number. Still, other health facilities did not use the updated registers even when they are available in their offices. However, most of these causes were addressed during the Q4 2019 verifications through the intensive coaching of staff by the PPA staff. Generally the prevailing enthusiasm among the staff of the health facilities has largely contributed also to the noted improvement as shown in Figure 2. Compared to the baseline it was noted that most health facilities started using the standardized DHIS 2 registers, properly filling each and every column based on the guideline and properly reporting of the data in each register. Another contributing factor is that in most health facilities the performance monitoring teams are becoming more active and conduct regular verification of their data before sending the reports to their respective Woreda.

FIGURE 2 » PERCENTUAL CHANGE OF SERVICES VERIFIED AT PHCU LEVEL PER WOREDA



During Q4 of 2019, the PPA conducted monthly quantity verifications and 51.0% of all declared cases could be fully verified at PHCU level (Table 4). The percentage of cases being fully verified has increased across the Woredas, as it was only 11.4% during the baseline. This is essentially linked to the level of awareness that health facilities have adopted to correctly document the cases into their reporting tools (DHIS2 registers, patient cards, etc.), properly filling each and every column based on the guidelines. This while the performance monitoring teams of most facilities became active, performing data verification before sending the reports to the woredas. In addition, coaching and supervision activities performed monthly by the verification officers and regulators contributed to assist facilities to improve their documentation and reporting.

FIGURE 3 » TOTAL DECLARED & VERIFIED CASES AT PHCU LEVEL PER INDICATOR Q4 2019 (ONLY SHOWS INDICATORS > 1,300 VERIFIED CASES)

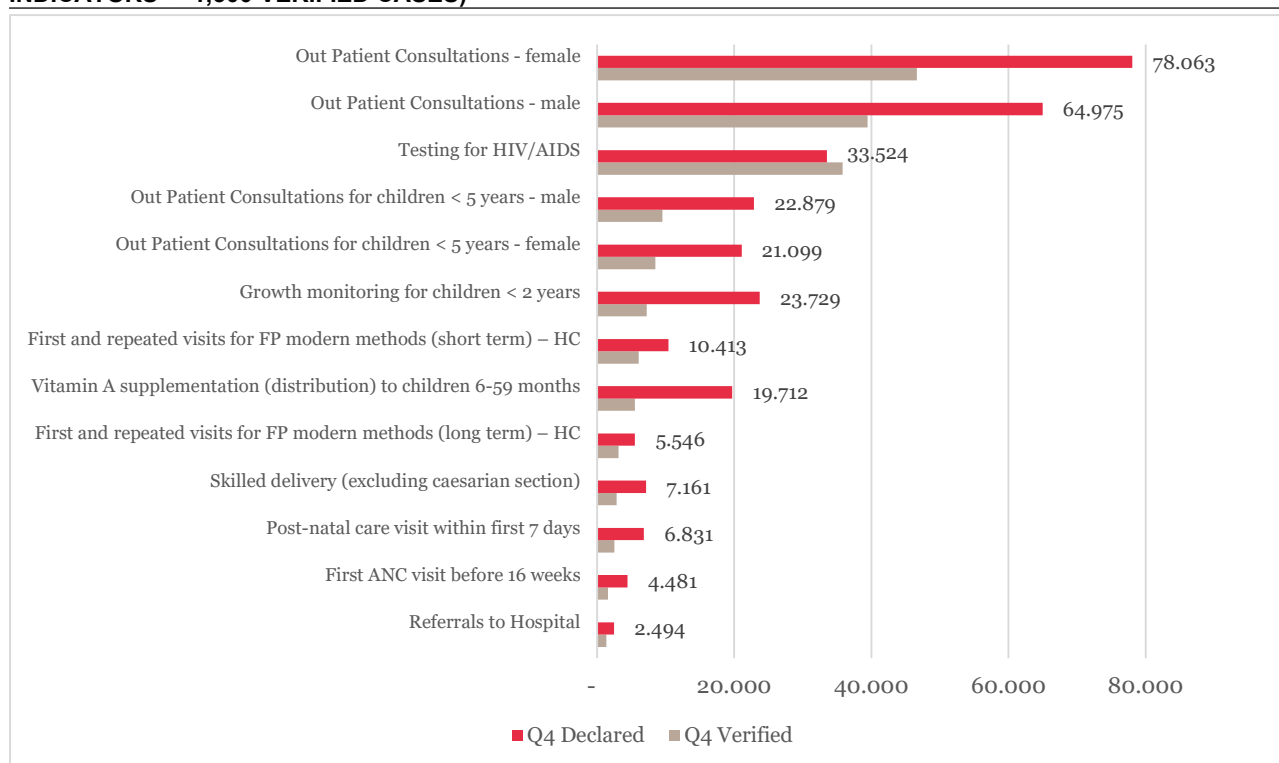


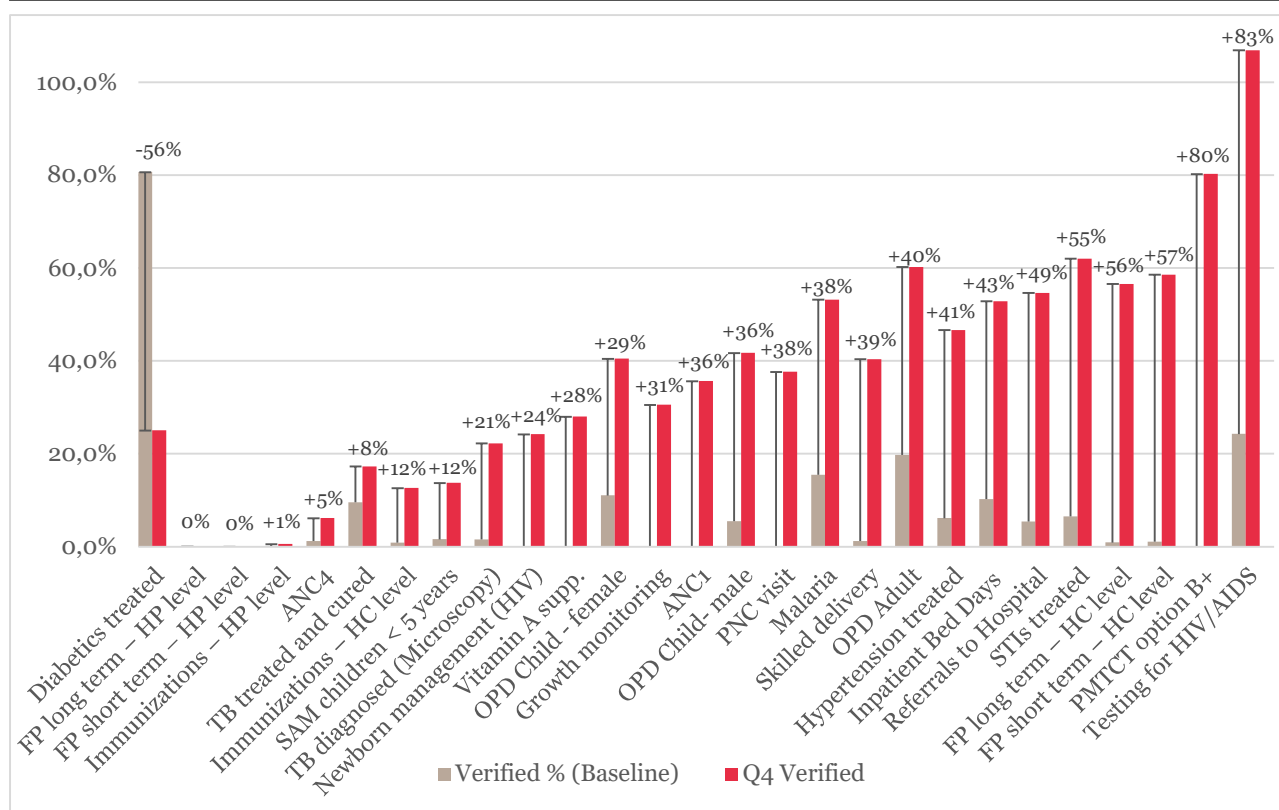
Table 5 and Figure 4 below present a comparison per indicator of declared and verified data during the baseline and for Q4 2019. The lowest performing indicator at health centre level during Q4 verifications was “Four Antenatal Care Visits (ANC4)”, with 6.1% of cases being fully verified, while this was verified at only 1.2% during the baseline. Cases of Severe Acute Malnutrition (SAM) children < 5 years were verified at 1.6% during the baseline, and now during the fourth quarter of 2019, 13.7% are being fully verified. We noted significant improvement in reporting of HIV indicators at PHCU level, where 100% of cases of HIV testing and 80.2% of cases of positive tested pregnant women put on PMTCT, option B+ were fully verified in Q4 2019, while we had been able to fully verify the two indicators at 24.2% and 0.0% respectively during the baseline. For all OPD indicators, one of the contributing factors to the wide error is the fact that according to DHIS2 reporting guidelines health facilities are supposed to report *all* visits, and not just OPD consultations. As a result, there is a default difference as under PBF only specific OPD consultations are counted, to avoid duplications. As to not penalize the facilities for this discrepancy between the DHIS2 guidelines and the setup of the PBF project, we effected a waiver to the 10% penalty rule and all verified cases are paid.

TABLE 5 » TOTAL DECLARED AND VERIFIED CASES AND PERCENTAGE VERIFIED AT PHCU LEVEL PER INDICATOR

INDICATORS	BASELINE DECLARED	BASELINE VERIFIED	BASELINE % VERIFIED	Q4 DECLARED	Q4 VERIFIED	Q4 % VERIFIED
Testing for HIV/AIDS	6,279	1,522	24.2%	33,524	35,824	106.9%
HIV positive tested Pregnant Women put on PMTCT option B+	1	-	0.0%	86	69	80.2%
Cases of STIs treated - female	100	6	6.0%	263	172	65.4%
Out Patient Consultations (new and repeat cases) - male	23,662	5,236	22.1%	64,975	39,479	60.8%
Cases of STIs treated - male	115	8	7.0%	497	299	60.2%
Out Patient Consultations (new and repeat cases) - female	28,219	4,998	17.7%	78,063	46,626	59.7%
First and repeated visits for FP modern methods (short term) – HC	4,943	52	1.1%	10,413	6,096	58.5%
Cases of Malaria diagnosed positive and treated - male	464	100	21.6%	984	558	56.7%
First and repeated visits for FP modern methods (long term) – HC	2,805	25	0.9%	5,546	3,135	56.5%
Referrals to Hospital	518	28	5.4%	2,494	1,362	54.6%
Inpatient Bed Days	127	13	10.2%	920	486	52.8%
Cases of Malaria diagnosed positive and treated - female	344	25	7.3%	750	364	48.5%
Cases of hypertensive patients receiving treatment	507	31	6.1%	1,420	662	46.6%
Out Patient Consultations for children < 5 years (new and repeat) - male	7,298	398	5.5%	22,879	9,539	41.7%
Out Patient Consultations for children < 5 years (new and repeat) - female	7,243	798	11.0%	21,099	8,532	40.4%
Skilled delivery (excluding caesarean section)	3,068	37	1.2%	7,161	2,889	40.3%
Post-natal care visit within first 7 days	3,091	-	0.0%	6,831	2,569	37.6%
First ANC visit before 16 weeks	1,256	1	0.1%	4,481	1,597	35.6%
Growth monitoring for children < 2 years	9,879	-	0.0%	23,729	7,241	30.5%

Vitamin A supplementation (distribution) to children 6-59 months	4,911	-	0.0%	19,712	5,513	28.0%
Cases of diabetic patients receiving treatment	31	25	80.6%	80	20	25.0%
Newborn management of a baby born to an HIV positive mother	7	-	0.0%	62	15	24.2%
Cases of TB diagnosed positive by Microscopy	130	2	1.5%	207	46	22.2%
Cases of TB treated and cured	63	6	9.5%	145	25	17.2%
Severe Acute Malnutrition (SAM) children < 5 years	321	5	1.6%	1,490	204	13.7%
Immunization of Children < 1 year (fully vaccinated) – HC level	1,527	13	0.9%	4,646	586	12.6%
Four Antenatal Care Visits (ANC4)	3,094	37	1.2%	7,372	452	6.1%
Immunization of Children < 1 year (fully vaccinated) – HP	1,244	-	0.0%	4,191	23	0.5%
First and repeated visits for FP modern methods (long term) – HP	1,453	-	0.0%	3,765	-	0.0%
First and repeated visits for FP modern methods (short term) – HP	4,128	-	0.0%	14,187	-	0.0%
<b>Total</b>	<b>116,828</b>	<b>13,366</b>	<b>11.4%</b>	<b>341,972</b>	<b>174,383</b>	<b>51.0%</b>

FIGURE 4 » PERCENTUAL CHANGE OF SERVICES VERIFIED AT PHCU LEVEL PER INDICATOR





Data quality improvement is one of the first visible effects that PBF has within a system, as is shown by the above presented data. Within only a 3 month period significant results can already be seen. An increase in service utilization, on the other hand, is not always immediately visible in the data as it is not something that can be immediately improved, requires reliable data and is also influenced by outside factors. Considering that the data sets being compared are within a four month period, a significant change cannot yet be seen; though there is still something to be said.

***An explanation for the method of comparing the service utilisation for various quantity indicators:***

For the comparison of the service utilization for the various indicators (between the baseline period, September 2019, and the first PBF Quarter verified, Q4 2019), the *declared data* is used. In doing so the declared data is presented as a percentage of an annual target. These targets are calculated based on the catchment populations received from the Jimma Zonal Health Department and the available population statistics for the Oromia Region. For those indicators discussed, the annual target-calculations are available in Annex 8. These figures are the most reliable data available and although they may not be fully accurate, they are still useful in trying to get some perspective on the coverage of various services.

When comparing all declared data in an annual figure, the total number of cases during the first quarter of verifications (Q4 2019) decreased by 2% against the baseline. This decrease would have been 12% if it wasn't for the significant increase of 78% in declared cases of testing for HIV/AIDs. 7% (2,300) more HIV/AIDs cases were verified by the Cordaid verification officers compared to the declared data within DHIS2. This suggests that the 78% increase in cases of testing for HIV/AIDs was likely because health centres were not reporting all their cases from the various registration books used to capture this service. A decrease of 12% across all other declared cases may be attributed to the fact that health centres are starting to report more accurate figures to their health authorities. It was previously reported during the baseline study that health centres tend to exaggerate their figures due to the pressure to improve performance in order to meet targets. However, within a PBF program it is common to first see a drop in declared cases so health centres do not miss subsidy earnings due to the 10% discrepancy rule. The largest drops in declared cases are seen across the following districts: Omo Beyyam (-36%), Tiro Afeta (-33%), Omo Nada (-25%). Furthermore, drops in declared cases are especially seen across multiple MCH indicators discussed below. This alleviates the fear heard by various local authorities that PBF would cause an increase in the declared figures.

***Comparing the declared data for the Outpatient Consultations indicators:***

To get a perspective of the overall utilization of health services all outpatient consultations (both adult and children) are compared. In doing so, the declared data shows that between the baseline period and first three months of verification the service utilization across the PBF districts decreased by 3%. During the baseline 44% of people appear to be visiting the health centre for an OPD consultation on an annual basis compared to 41% based on Q4 2019 data. The decrease in utilization of OPD services is mainly seen in adult visits while OPD visits for children less than 5 remains constant. There is no visible trend as districts both increase and decrease in utilization. However, there is visibly significant change in the number of declared OPD cases at Agaro Town district. During the baseline period Agaro Town had the lowest and second lowest utilization of child and adult OPD visits, respectively. The declared data for Q4 2019 shows Agaro Town with the highest and second highest utilization for adult and child OPDs, respectively, as shown in figures 5 and 6 below with 74% and 103% service utilization. 82% of Adult OPDs could be verified and 77% of child OPDs which is much higher than the average of cases that could be verified. Thus, an explanation could be that Agaro Town was not declaring all its OPD cases. Botor Tolay is the only district outperforming Agaro Town for child OPDs with a utilization rate of 130%, meaning that children visit a health centre approximately 1.3 times per year based on declared data. However, only 27% of these cases could be verified. These two districts are generally performing well in this service area as they also achieved the highest quality score during Q4 2019 verifications, as will be shown later. On the other hand, Chora Botor is the only district which has a lower utilization in child OPDs compared to adult OPDs in Q4 2019.

The Q4 2019 findings regarding gender distinction between OPD visits remains constant when compared to the baseline findings. For adult OPDs more women tend to visit a health centre with 54% of all adult OPD visits made by women and 46% by men. Child OPDs are made equally between male and female.

FIGURE 5 » PERCENTAGE OF ADULTS UTILIZING OPD SERVICES COMPARED TO THE ANNUAL TARGET

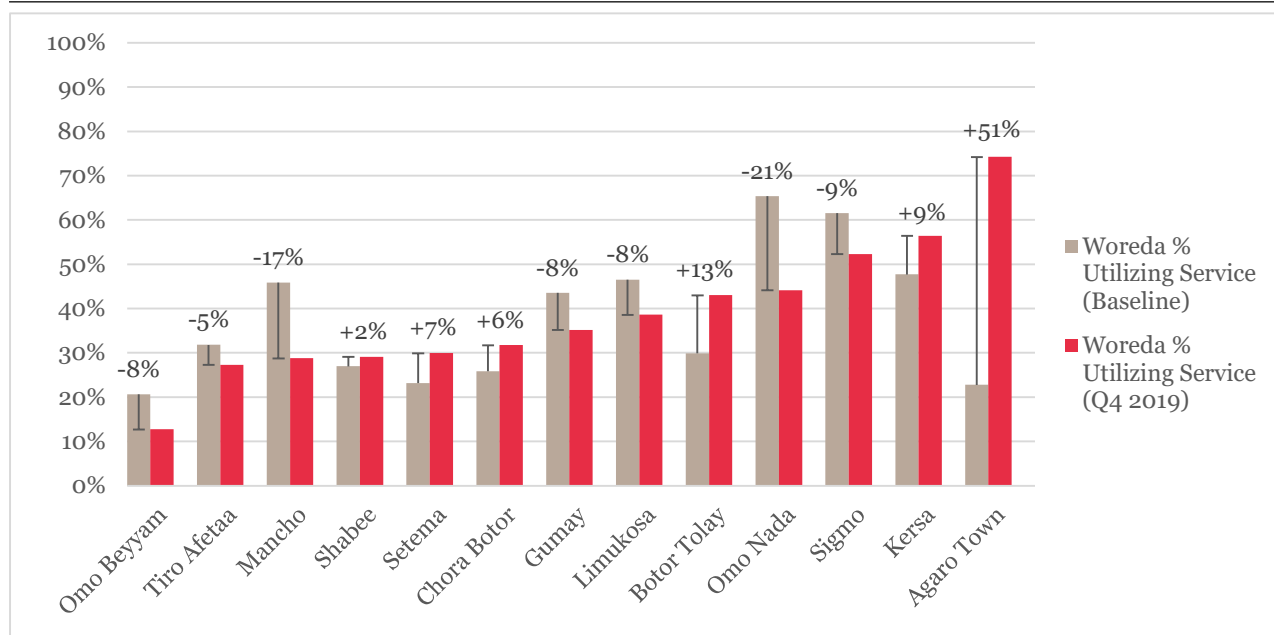
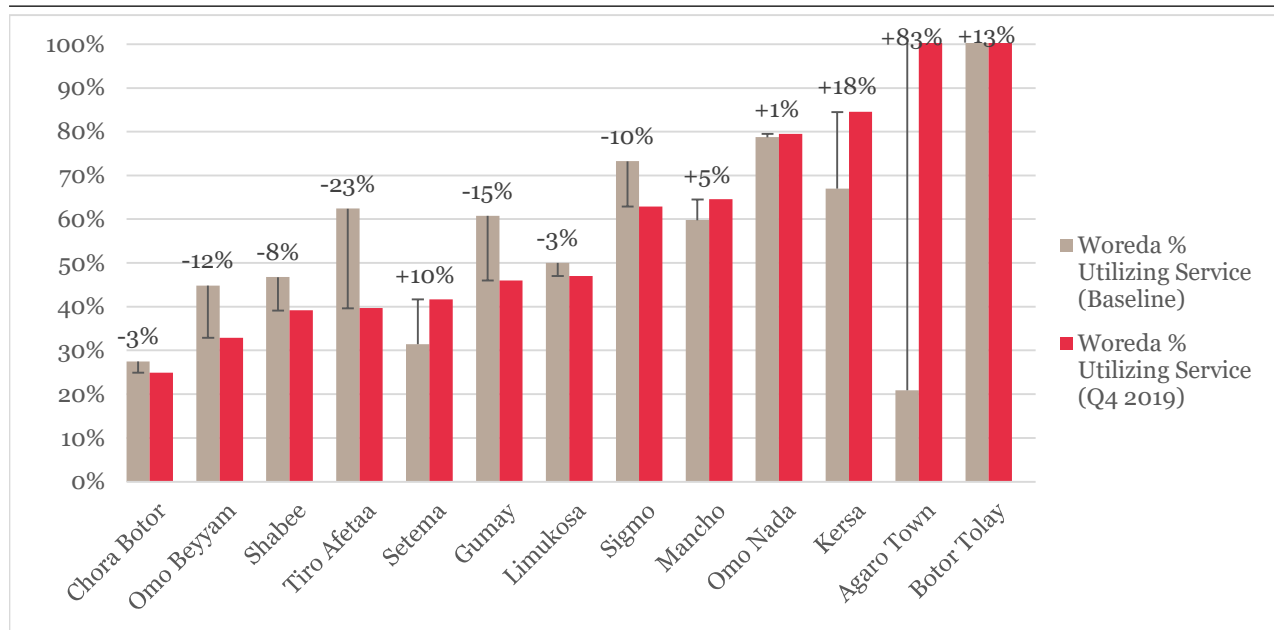


FIGURE 6 » PERCENTAGE OF CHILDREN <5 UTILIZING OPD SERVICES COMPARED TO THE ANNUAL TARGET



Comparing the declared data for the *Family Planning (Short and Long Term Methods)* indicators:

Similar to our experience during the baseline assessment, during the Q4 2019 verifications, no cases could be verified for short and long-term family planning services at health post level. There is no standardized registration system at health post level with required registration books such as exists in health centres. There is only a Community Health Information System available at health post level whereby Health Extension Workers use family folders. The PPA is currently adjusting and testing verification guidelines around the use of the standardized family folders at health post level, so health post services can be verified in the near future. Service utilization for short and long term family planning (FP) – based on declared data – is shown in Figures 7 and 8. For both FP methods, only 24% of the total expected number of women to

practice family planning are actually seeking these services at PHCU level. This is a decrease in utilization compared to the baseline period by 3% and 9% for short and long term methods, respectively. Moreover, both FP methods at health centre level (excluding health posts) saw the largest drop in declared figures since the baseline study when compared to other service areas. While Tiro Afetaa appeared to have the highest utilization of these services during the baseline, they have significantly dropped in declared cases since then. They dropped a significant 53% in utilization of long-term methods and are no longer the best performing in this service area. Furthermore, only 46% and 24% of its declared cases in Q4 2019 could be verified for short and long-term methods, respectively. Omo Nada and Omo Beyyam also saw drops in utilization for both FP methods. Interestingly, on the other hand, some of the more remote districts Gumay, Sigmo and Setema saw some of the largest increases in declared cases, while these districts showed low utilization during the baseline period.

FIGURE 7 » PERCENTAGE OF PEOPLE UTILIZING SHORT-TERM FAMILY PLANNING SERVICES COMPARED TO THE ANNUAL TARGET

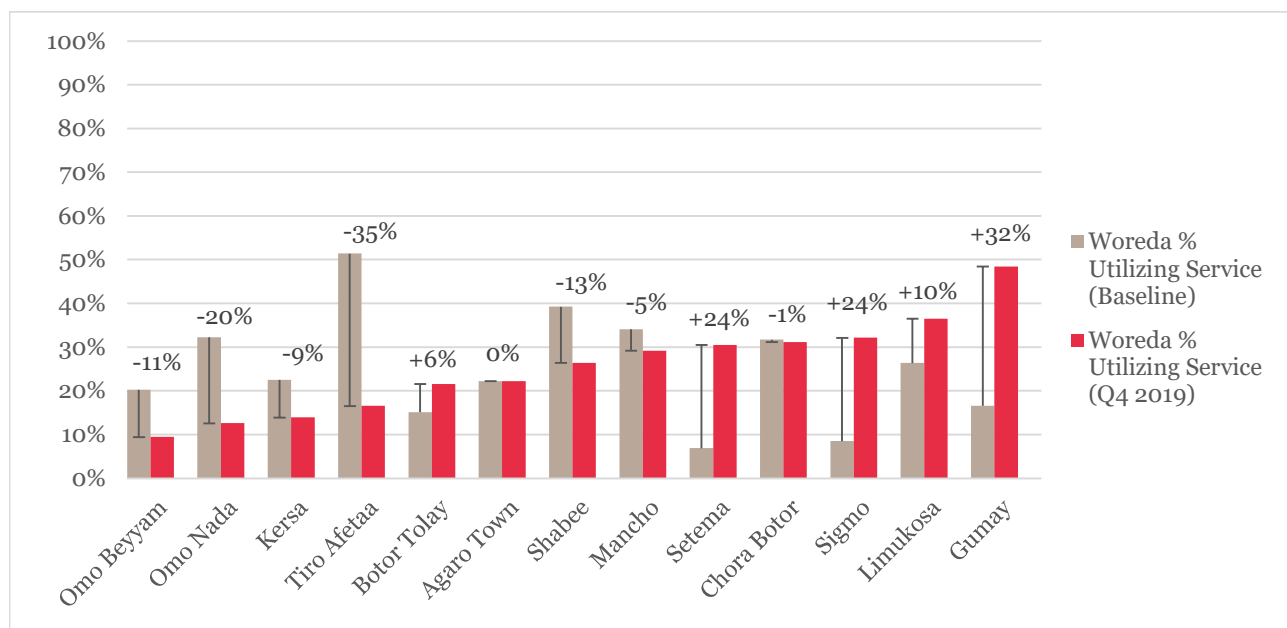
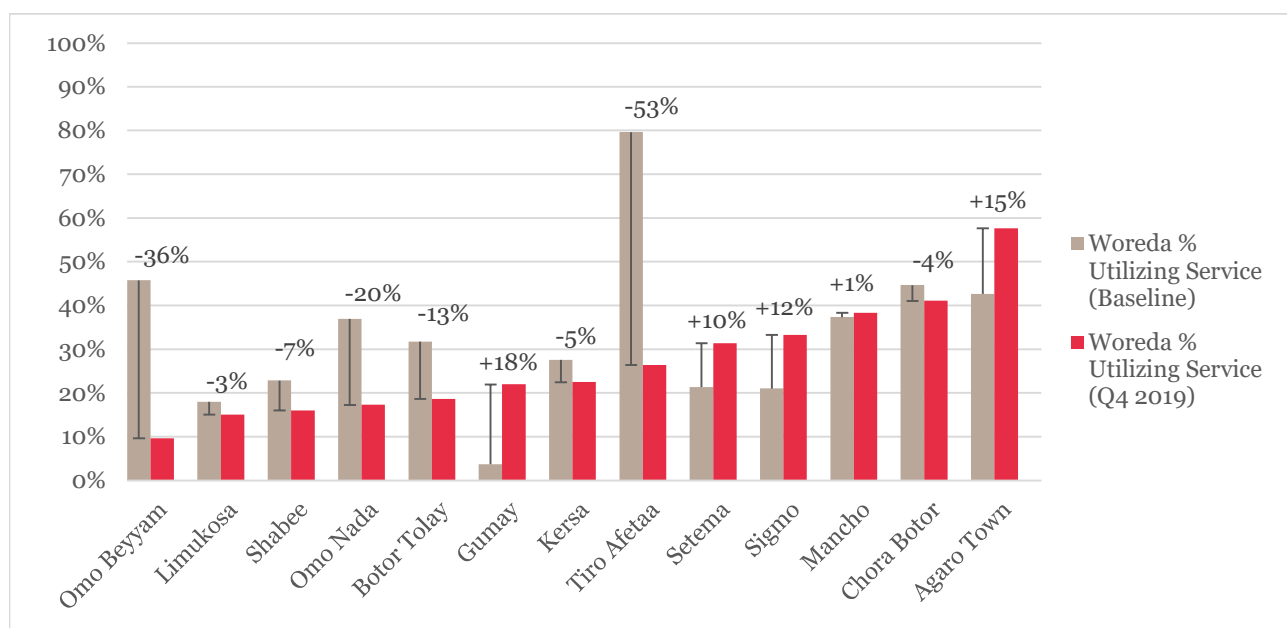


FIGURE 8 » PERCENTAGE OF PEOPLE UTILIZING LONG-TERM FAMILY PLANNING SERVICES COMPARED TO THE ANNUAL TARGET



Comparing the declared data for the *Antenatal Care indicator*:

ANC1 services is one of the only MCH indicators that saw a small uptake in utilization since the baseline period with an increase of 4.5%. The increase is mostly due to the uptake in declared cases in Botor Toley and Chora Botor districts respectively with 36% and 39% of the expected pregnant women seeking the service on time as shown in figure 9 below. However, the service uptake for early ANC visits before 16 weeks is still low in all health facilities with an increase from 24% to 28.5% utilization rate. This is partly due to the lack of early care seeking behaviour. ANC4 services saw a decrease of 12% in the utilization rate, though its utilization is still higher than that of ANC1 services moving from a rate of 59% to 47%. Figure 10 illustrates that the largest utilization drops in ANC4 were seen by Chora Botor, Mancho and Omo Beyyam districts. The general drop in declared cases, and thus, utilization could be related to health centres reporting more realistic figures.

FIGURE 9 » PERCENTAGE OF PEOPLE UTILIZING ANC1 SERVICES COMPARED TO THE ANNUAL TARGET

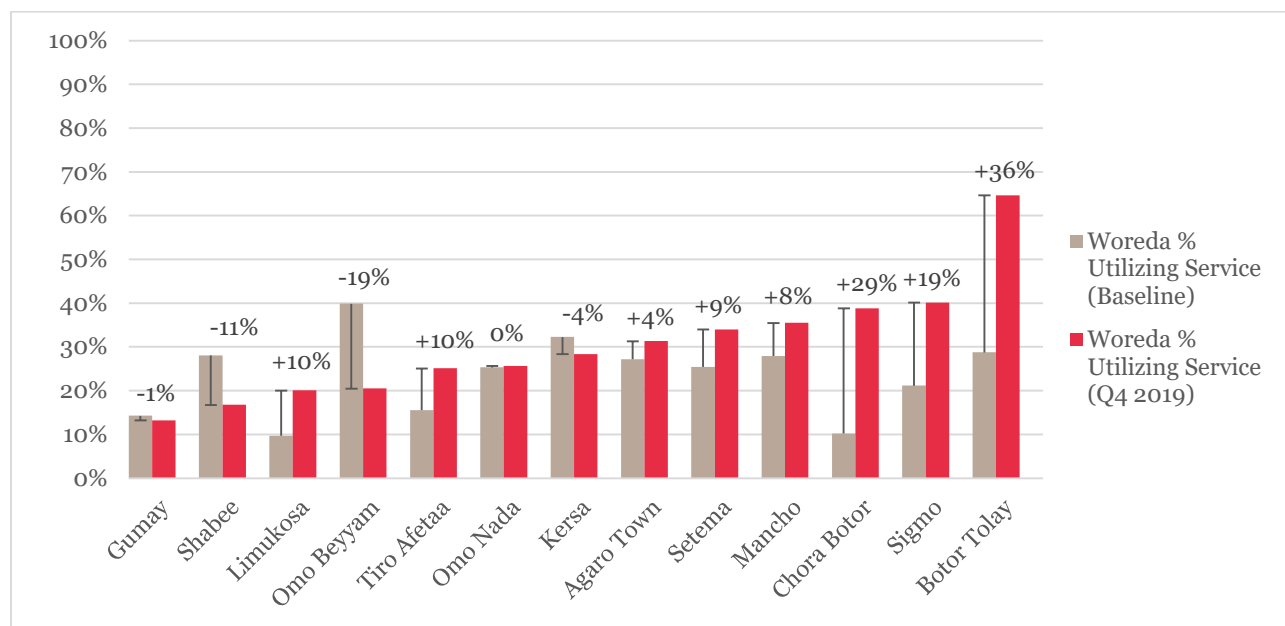
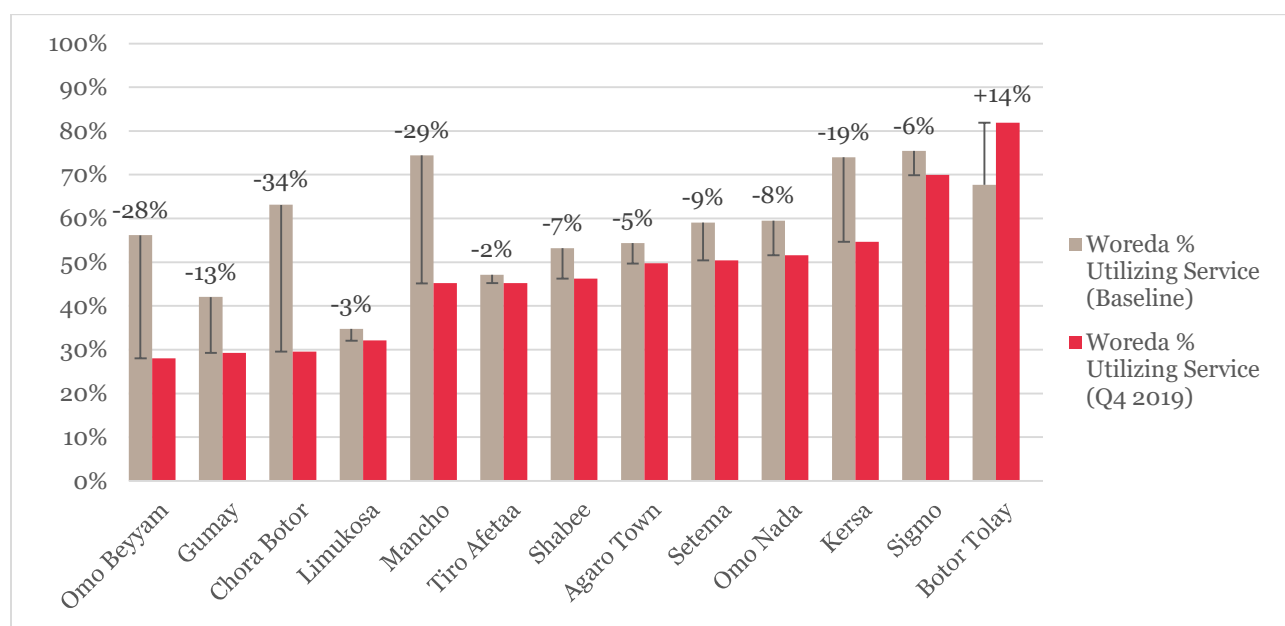


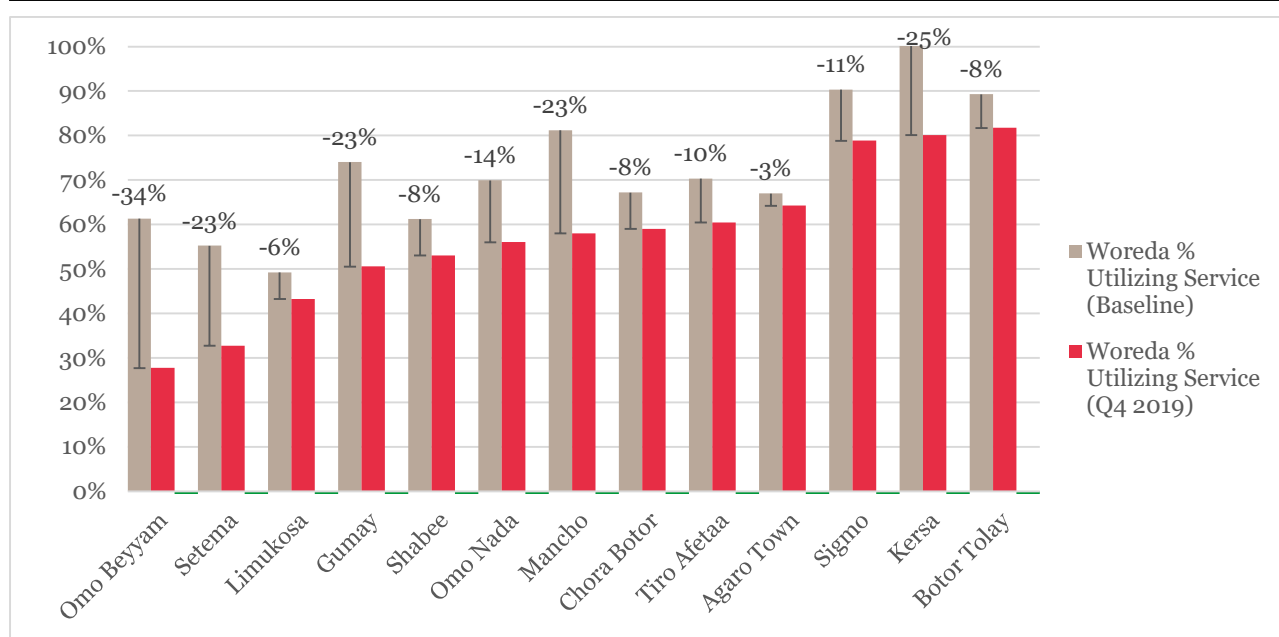
FIGURE 10 » PERCENTAGE OF PEOPLE UTILIZING ANC4 SERVICES COMPARED TO THE ANNUAL TARGET



### Comparing the declared data for the *Skilled Deliveries* indicator:

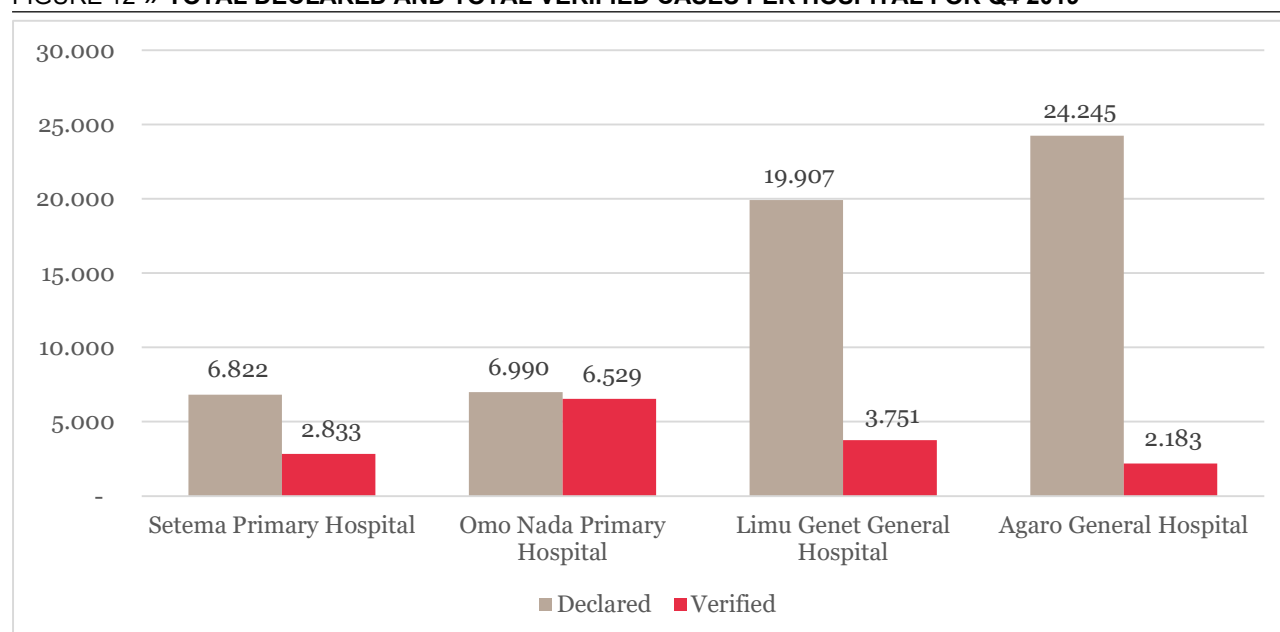
Like other MCH indicators, skilled delivery also reported lower in Q4 2019 in comparison to the baseline. In the PBF woredas, 57% of the target deliveries in health centres were achieved based on Q4 data. This is 16% lower than the utilization rate of 73% from September 2019 (baseline data). Still only 40% of these cases could be verified, so the actual utilization may still be lower. The largest decrease in utilization were seen at Omo Beyyam (34%), Kersa (25%) and Gumay (24%) districts presented in Figure 11, though utilization decreased across all 13 districts. This is not surprising. The Skilled deliveries indicator has the highest price linked to it. Therefore health centres can earn a large part of their subsidies from this indicator if reported correctly and if the verified cases are within the 10% error margin allowed for the declared cases. Notably, Kersa district achieved 105% compared to the target calculation during the baseline while during this first quarter of verifications the figure declined by 25% to 80%. This is quite a significant drop given that they almost declared 1,300 skilled deliveries in Q4 2019. This translates into approximately 400 less births in a three-month period, which further point to the fact that health centres may have been exaggerating their figures. On the other hand, the low utilization in Setema and Limu Kossa districts was evident within the baseline data but also within the Q4 verifications. This remains consistent with the findings that many births still occur at home in these areas.

**FIGURE 11 » PERCENTAGE OF PEOPLE UTILIZING SKILLED DELIVERIES COMPARED TO THE ANNUAL TARGET**



**At hospital level**, there was substantial improvement in data verification when compared with the baseline data. While during the baseline only 7.6% of all services could be verified during Q4 verifications 26.4% of cases could be validated. Improvement was especially visible at Omo Nada Hospital where more than 90% of declared cases were verified. The narrow error margin recorded in Omo Nada Hospital is due to a self-verification process initiated by the hospital management team. Prior to the monthly verification activity by the PPA's Verification officers, the Omo Nada Hospital Performance Monitoring Team conducted a self-verification using the same PBF checklist and this exercise was counter checked by the Hospital CEO. This exercise helps the hospital to be realistic and accurate in reporting their cases. This is a Omo Nada hospital success story that other hospitals could learn from. The number of declared data is fewer than the other Hospitals due to the fact that Omo Nada Hospital only covers the population of three districts. Agaro Hospital declares more cases than other Hospitals. This is due to the fact that it covers more districts than other Hospitals, while it is also one of the General Hospitals in the Zone. Both Agaro and Limu Kossa Hospitals need to improve on the documentation of their cases as shown in Figure 12.

FIGURE 12 » TOTAL DECLARED AND TOTAL VERIFIED CASES PER HOSPITAL FOR Q4 2019



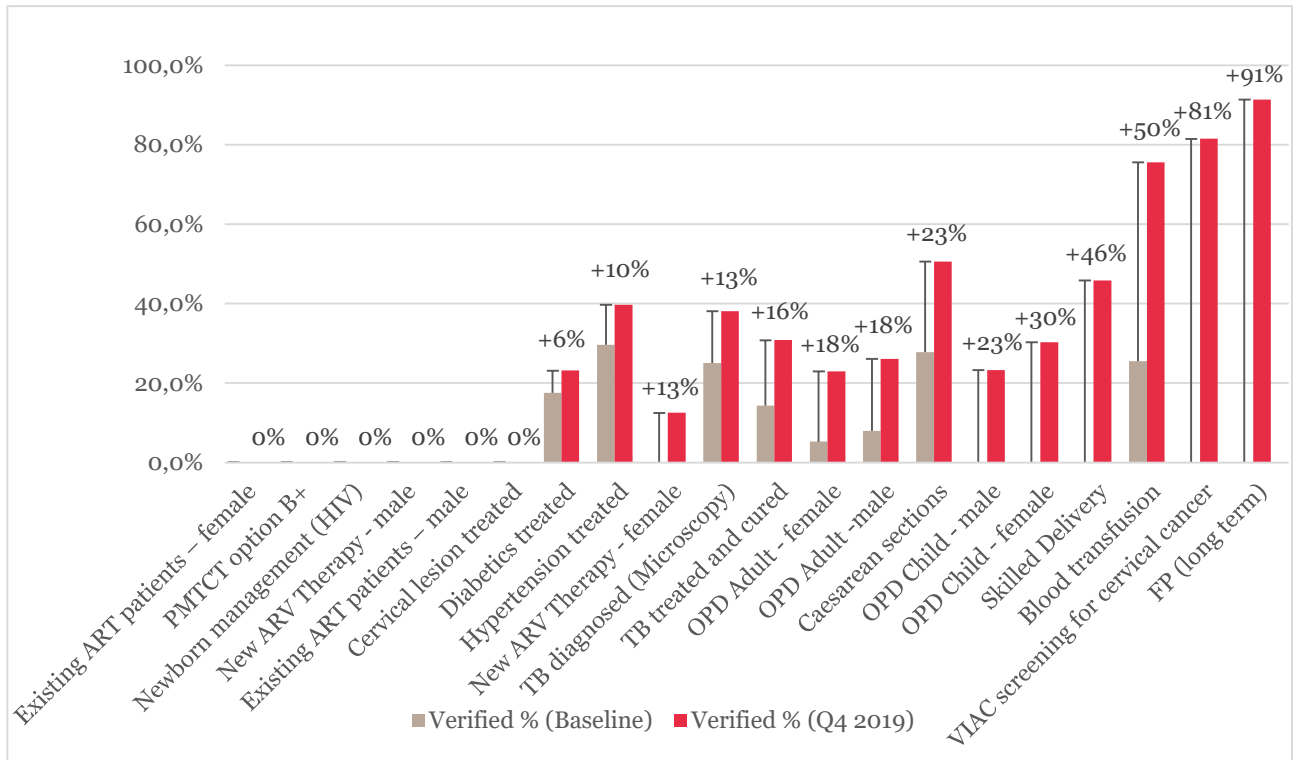
Across the various hospital indicators, data quality improvement varied as shown in Table 6 and Figure 13. Significant improvements were seen for long-term FP methods and VIAC Screening for Cervical Cancer. These services could be verified for 91.4% and 81.5%, respectively, while during the baseline none of these cases could be verified. While data quality improved for almost all indicators, there were still six indicators for which no cases could be verified. These services, as shown in Table 6, typically do not have a high volume compared to some others which may have led hospitals to prioritize other indicators. At the same time, since the first verification was only within three months of the baseline, data quality is still expected to improve.

TABLE 6 » TOTAL DECLARED AND VERIFIED CASES AND PERCENTAGE VERIFIED AT HOSPITAL LEVEL PER INDICATOR

INDICATORS	BASELINE DECLARED	BASELINE VERIFIED	BASELINE % VERIFIED	Q4 DECLARED	Q4 VERIFIED	Q4 % VERIFIED
First and repeated visits for FP modern methods (long term)	65	-	0.0%	360	329	91.4%
Women 30-49 years screened with VIAC for cervical cancer	7	-	0.0%	27	22	81.5%

Blood transfusion	102	26	25.5%	86	65	75.6%
Caesarean sections	72	20	27.8%	176	89	50.6%
Skilled Delivery (excluding caesarian sections)	526	-	0.0%	1,476	676	45.8%
Cases of hypertensive patients receiving treatment	1,209	358	29.6%	2,372	941	39.7%
Cases of TB diagnosed positive by Microscopy	8	2	25.0%	21	8	38.1%
Cases of TB treated and cured	7	1	14.3%	13	4	30.8%
Out Patient Consultations for children < 5 years (new and repeat) - female	941	-	0.0%	3,395	1,027	30.3%
Out Patient Consultations (new and repeat cases) - male	7,781	618	7.9%	20,969	5,468	26.1%
Out Patient Consultations for children < 5 years (new and repeat) - male	959	-	0.0%	3,448	802	23.3%
Cases of diabetic patients receiving treatment	1,021	179	17.5%	2,503	579	23.1%
Out Patient Consultations (new and repeat cases) - female	9,836	515	5.2%	23,067	5,284	22.9%
New HIV/AIDS cases placed on ARV Therapy (ever started) - female	5	-	0.0%	16	2	12.5%
Existing patient on ART for 12 months – female	7	-	0.0%	15	-	0.0%
HIV positive tested Pregnant Women put on PMTCT option B+	3	-	0.0%	-	-	0.0%
Newborn management of a baby born to an HIV positive mother	3	-	0.0%	5	-	0.0%
New HIV/AIDS cases placed on ARV Therapy (ever started) - male	3	-	0.0%	5	-	0.0%
Existing patient on ART for 12 months – male	2	-	0.0%	10	-	0.0%
Women 30-49 years with cervical lesion treated	1	-	0.0%	-	-	0.0%
<b>Total</b>	<b>22,558</b>	<b>1,719</b>	<b>7.6%</b>	<b>57,964</b>	<b>15,296</b>	<b>26.4%</b>

FIGURE 13 » PERCENTAGE CHANGE OF SERVICES VERIFIED AT HOSPITALS PER INDICATOR

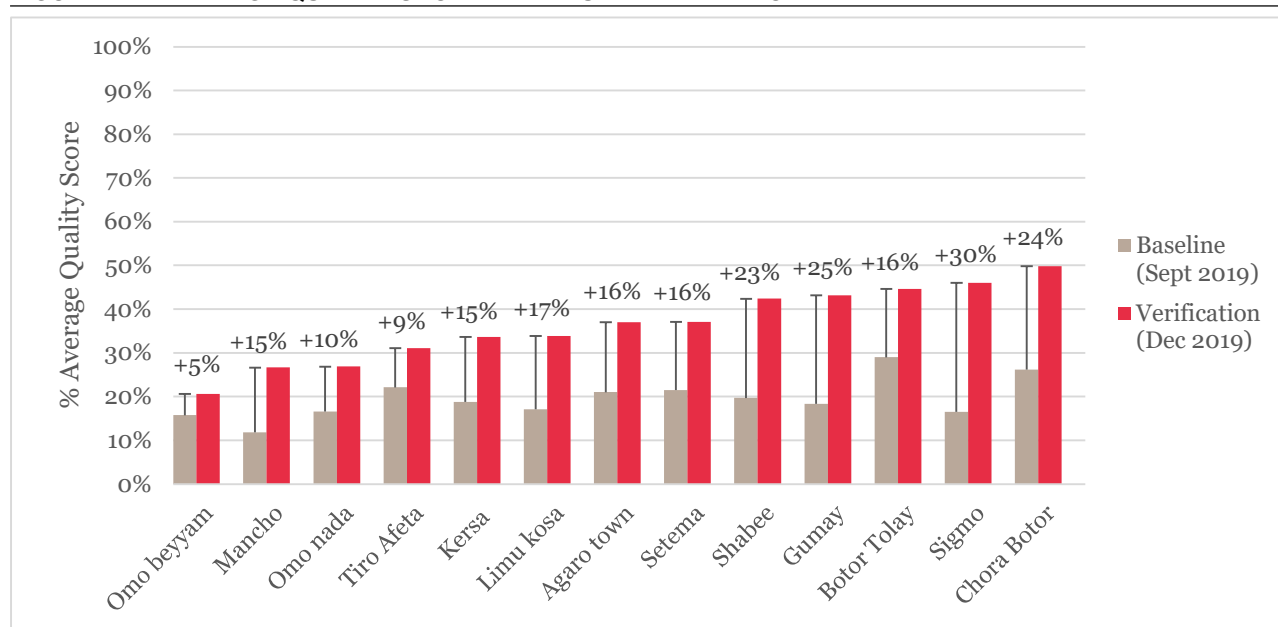




### Data in relation to the quality verifications:

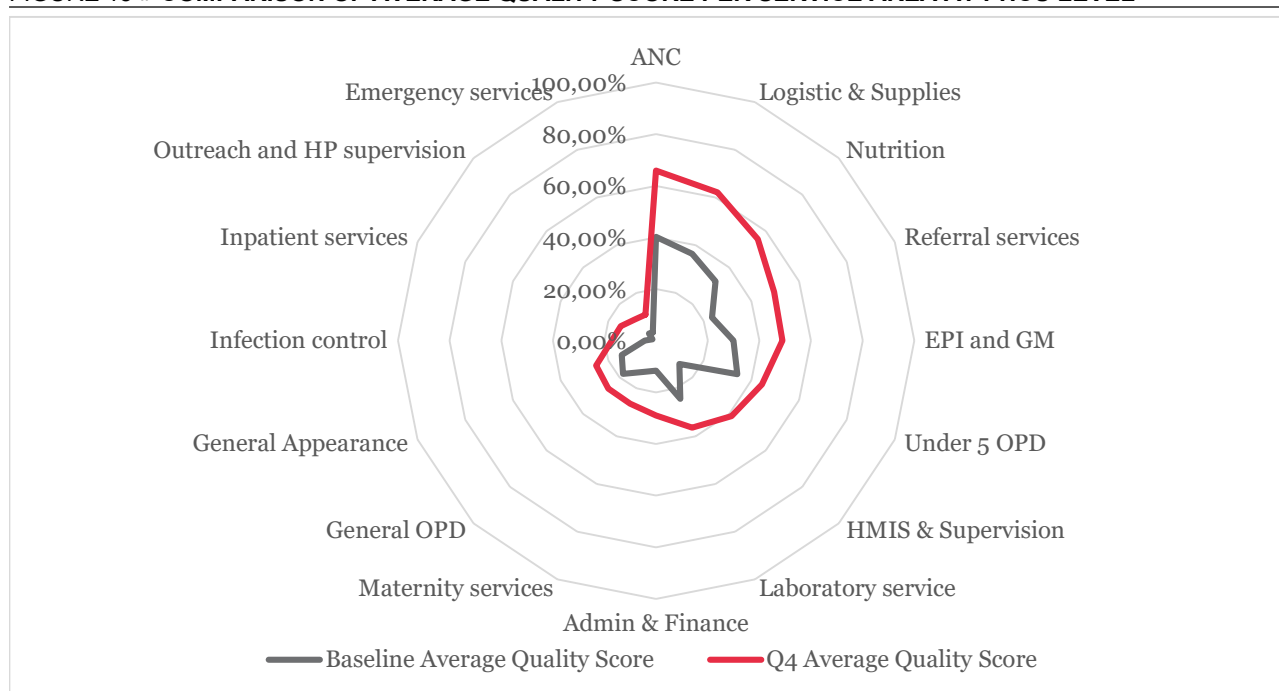
In all participating facilities the quality of services was also assessed during the baseline study. The baseline findings demonstrated that the quality of services was not satisfactory: at health centre level, facilities on average obtained only 19.25% of the total quality score. This improved, during Q4 2019, to 35.2%. Following the rigorous coaching from the PPA staff, there was quite some improvement during Q4 2019 as shown by the following detailed information. Overall, there is a promising improvement in *quality of services* in Jimma Zone health centres across all the woredas as shown by the comparison in Figure 14 between the baseline and the Q4 2019 data. The highest performing during the 4<sup>th</sup> quarter of 2019 was Chora Botor with an average of 49.8% compared to 29% recorded in Botor Tolay during the baseline. The lowest performing woreda was Omo Beyyam with 21% (compared to 11.8%; the lowest average woreda score in Mancho district during the baseline). The highest performing health centre of all 64 facilities was Sigo HC in Sigo woreda with 65.5%, compared to 44.5% for Waayu HC during the baseline, which is located in Botor Tolay woreda. The least performing health centre was Sombo Badalla in Omo Beyyam woreda with 17.0%. The best performing Health Centres generally outperformed the others in the area of infection control, emergency services and inpatient services. In general, these are some of the worst performing services across the woredas in the PBF program.

FIGURE 14 » AVERAGE QUALITY SCORE AT PHCU LEVEL PER WOREDAS



As figure 15 clearly indicates, there has already been improvement in indicator performance when comparing the baseline study and Q4 data to each other. In fact, all service areas saw improvement though some more than others. ANC remains the highest performing indicator with 66% up from 40% during the baseline. Emergency services still remains the lowest performing indicator with only 11% compared to 1.6% during the baseline. The other low performing quality indicators are inpatient services, Outreach and Health Post supervision and infection control while logistics & supplies, nutrition, referral and EPI services are among the better performing quality indicators. Considering that during this first quarter of the PBF program (Q4 2019) no PBF subsidies or start-up funds were paid, the improvement is mainly attributed to the motivation and enthusiasm of the staff of the Health Facilities to attend to low hanging fruits which do not need any financial resources (like adhering to guidelines and proper documentation). The section below provides a detailed analysis for each category of the quality services, comparing between the baseline and Q4 2019.

FIGURE 15 » COMPARISON OF AVERAGE QUALITY SCORE PER SERVICE AREA AT PHCU LEVEL

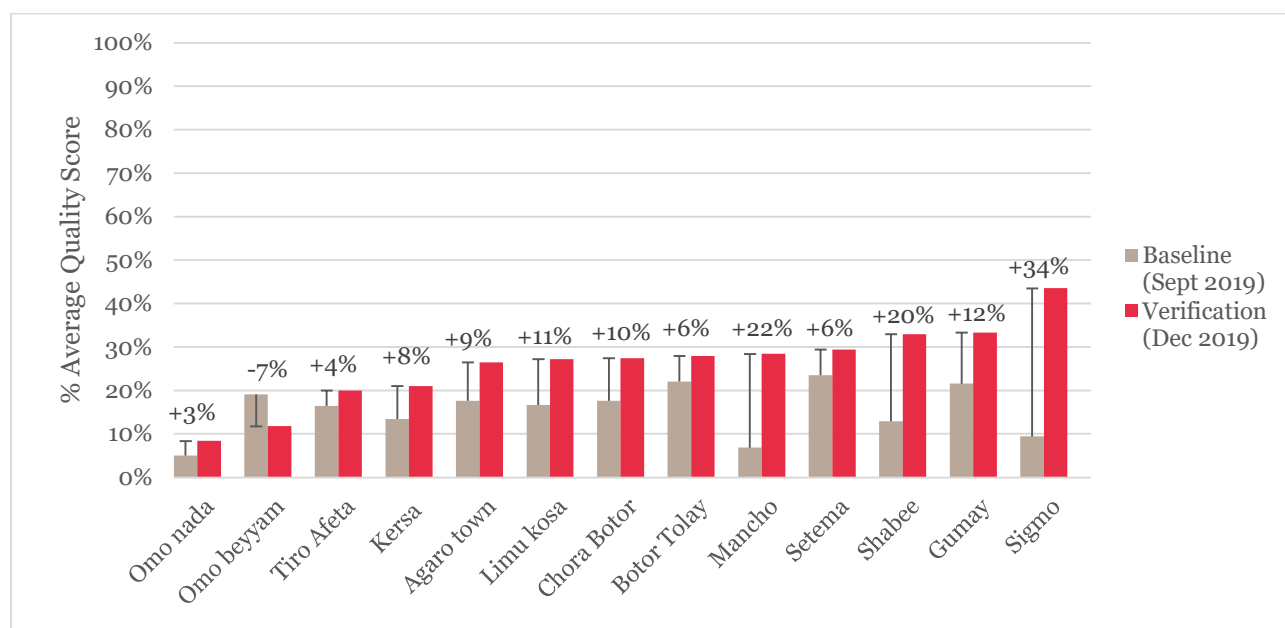


**Quality in relation to the general appearance category:**

The *General Appearance category* includes: outside appearance, courtyard, building appearance (both inside and outside), fire protection system, staff dress code, information and feedback, electricity, water and communication. During the baseline, almost all health centres scored only 2 or 3 out of the 17 total available points for the general appearance category. Compared to the baseline, there was some improvement in most of the health facilities on activities that do not require financial means such as cleanliness of the courtyard and the health facilities buildings.

Most woredas recorded positive change in this service area except Omo Beyyam which recorded 7% decline due to low performance of 2 out of 4 its health centres located in rural area, Yale Sasecha HC and Dakano Ilke HC, which scored 0% and 5.9% respectively for this indicator. Dakano Ilke HC is in remote area and still under construction. Sigmo HC recorded the highest increase, with 34% change, while Omo Nada HC recorded the least positive change of 3%. During the baseline, the highest average score of 24% was recorded in Setema woreda while the lowest average score was recorded in Omo Nada Woreda. During Q4 2019, Sigmo had the highest average score, with 44%, while Omo Nada was still the least with 8%. The best performing individual facility for this service indicator during Q4 2019 was Kanchu Health Centre in Sigmo Woreda with a score of 58.8% and the least were Y/secha health centre in Omo Beyyam and Aalee Health centre in Omo Nada woreda with 0 % respectively. 12 out of all 64 health centres scored 0% for this service during the baseline, while during Q4 2019 only 4 health centres scored 0%. The overall average score for general appearance at health centre level was 25.6% during Q4 2019 compared to 14.4% during baseline.

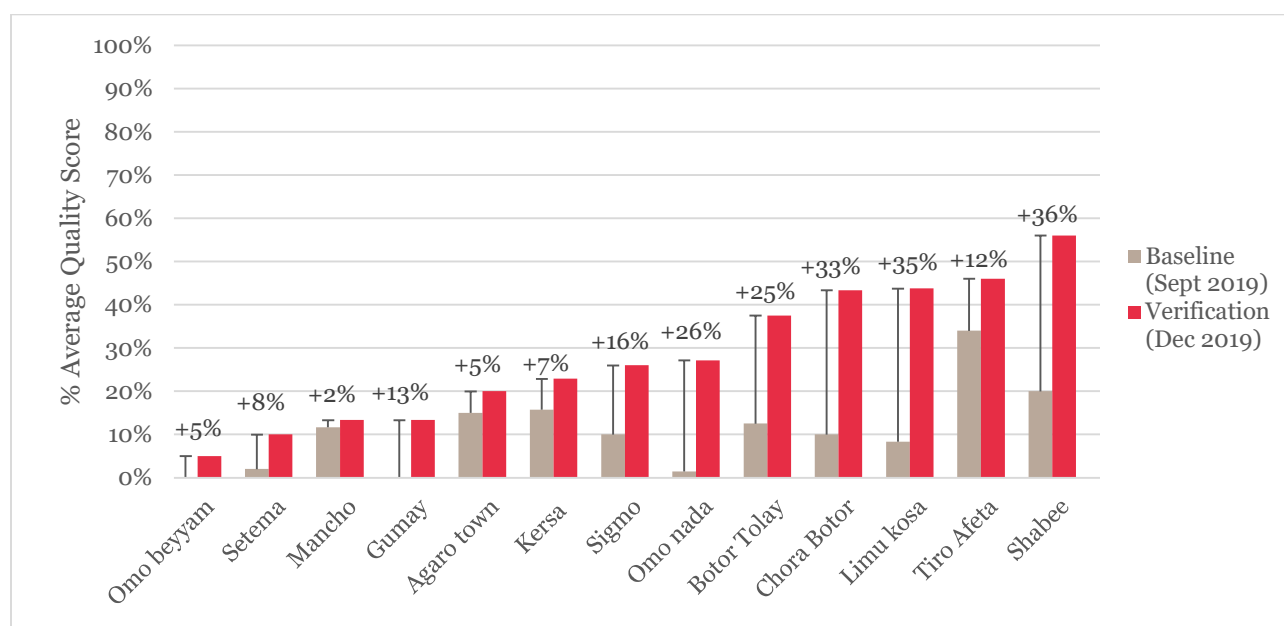
**FIGURE 16 » HEALTH CENTRES QUALITY SCORE FOR GENERAL APPEARANCE AND SAFETY PER WOREDA**



**Quality in relation to the administration and finance category:**

The overall average quality score for the category Administration and Finance during the baseline study was 11.6% and improved to 29.4% during Q4 2019. The highest performing woreda for this category during the baseline was Tiro Afeta and the lowest were Omo Beyyam and Gumay districts with 0%. However during Q4 2019 there has been some remarkable improvements across all woredas with Shabe district recording the highest percentage change of 36% while Omo Beyyam recorded the lowest percentage change of 5%. Shabe was the highest performer for Q4 2019 with 56% while Omo Beyyam remained the lowest at 5%. The best performing HC is Asandabo Health Centre in Omo Nada Woreda (50%). All health centres in Gumay and Omo Beyyam Woredas scored 0% on the Admin and Finance service category during the baseline study but one health centre in Gumay woreda and 3 health centres in Omo Beyyam woreda scored 0% during the comparison period. While there is some improvement, gaps still exist in most health facilities with regards to staff documents (including job descriptions) that could not be found. The majority of files only contain assignment letters. Furthermore documents such as catchment maps do not have complete information, such as keys. There is no monitoring of KPIs, annual plans are not approved by the governing body and there are no separate quarterly and monthly plans. Additionally, there are no complete healthcare financing reports, invoices and revenue utilization are not approved by the governing body. Monthly staff and quarterly governing body meetings are not recorded. Health centre management committee meetings are also not regularly held and in some facilities were not conducted at all. This is one area where the WHOs need to build the capacity of HC staff, who are usually not trained as administrators or managers.

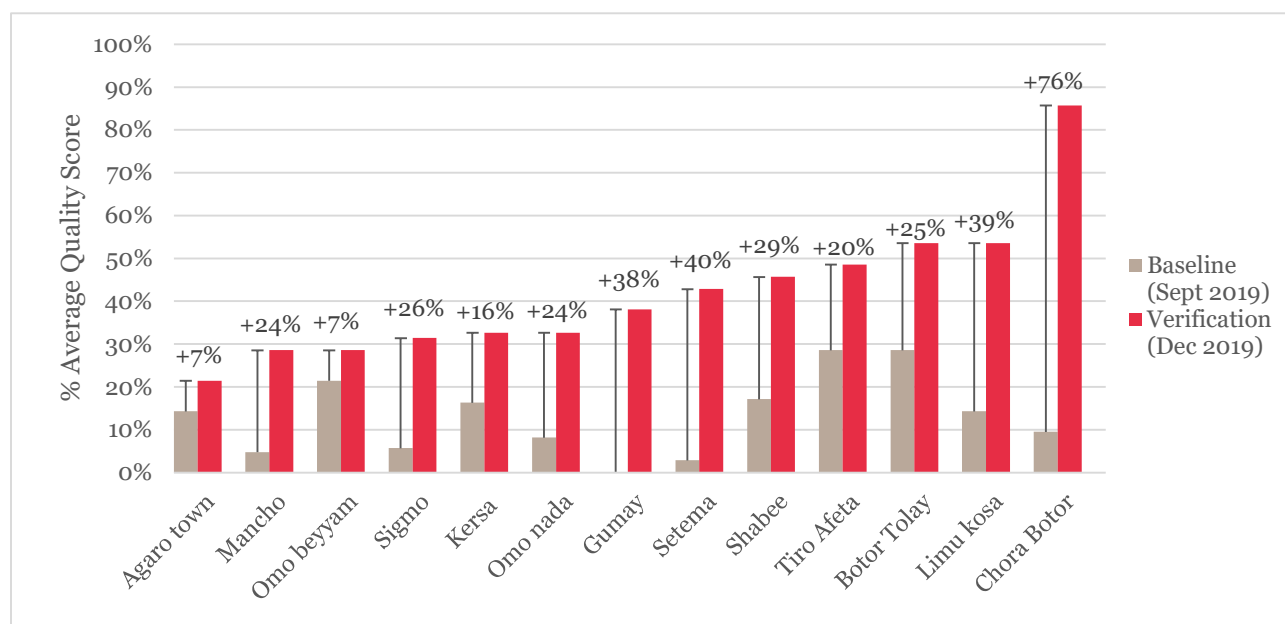
**FIGURE 17 » HEALTH CENTRES QUALITY SCORE FOR ADMINISTRATION, FINANCIAL MANAGEMENT, HRM AND PLANNING PER WOREDA**



**Quality in relation to the HMIS and supervision category:**

For this quality category the best performing facilities are Bage, Shabee and Walensu health centres from Chora Botor, Shabee and Limu Kossa woredas respectively. During the baseline 59% (38 out of 64) facilities scored 0% compared to 9.4% (6 out of 64) in Q4 2019 on this category. The average score was 12.7% during the baseline and has improved to 42.0% during the quality assessments of Q4 2019. On average, the highest performing woredas for this quality category are Tiro Afeta and Botor Tolay, while Gumay woreda was the lowest performing one with all health centres scoring 0% during the baseline study. During the quality assessments of Q4 2019, all woredas recorded positive percentual change ranging from 7%-76% in Agaro town and Chora Botor respectively. Although there has been some remarkable improvement, there are still some gaps which need to be fully addressed since the procedures for reporting are not followed (i.e. reports not sealed and signed by concerned body, health centres not meeting, monthly reporting deadlines not met and the management team committee being only structural). Furthermore, some health centres still do not have means for self-assessment, while only a few woreda health offices conduct integrated supportive supervision due to a shortage of transport resources. Few health centres use old registers which are not consistent with the latest HMIS registers following the use of DHIS2

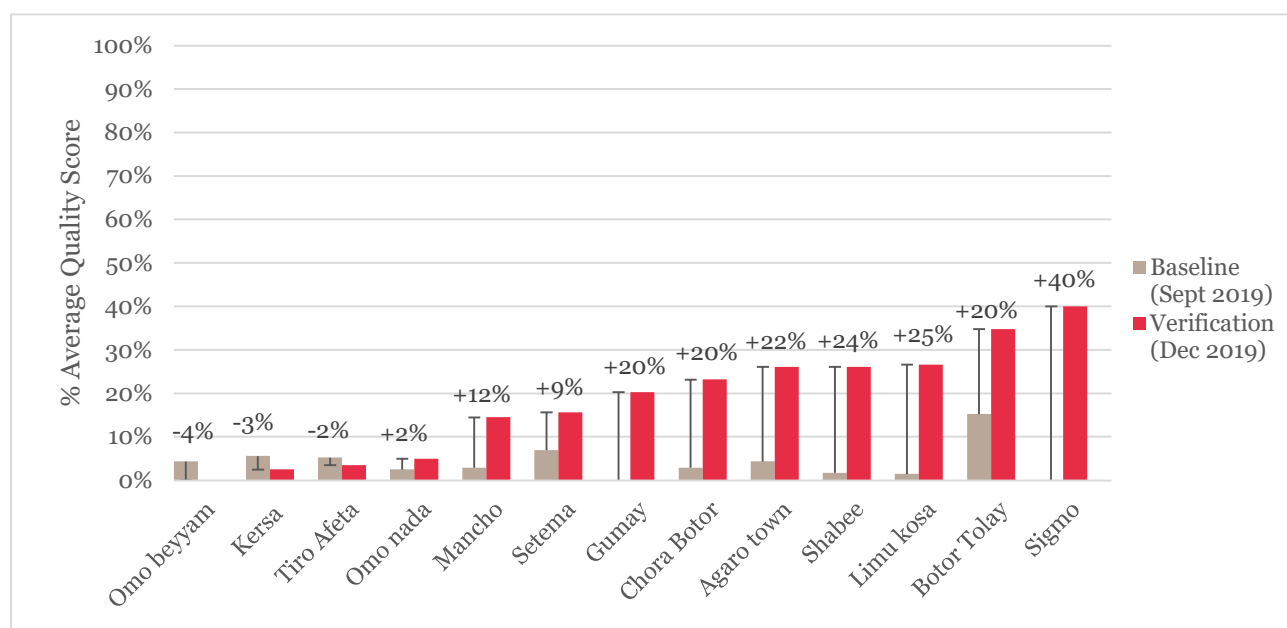
**FIGURE 18 » HEALTH CENTRES QUALITY SCORE FOR HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) AND SUPERVISION PER WOREDA**



**Quality in relation to the infection control and waste management category:**

The quality score for infection prevention is still 0% in all facilities in Omo Beyyam woreda. Figure 19 shows that three woredas recorded a negative average percentual change owing to less effort and commitment in addressing basic things like general hygiene of HCs. The other woredas however managed to record positive percentual change ranging from 2% in Omo Nada to 40% in Sigmo. The highest performing health centre was Sigmo health centre in Sigmo woreda. Knowledge and practice of IPC procedures needs special attention for all health centres and Woreda Health Offices as it poses a serious risk for health service provision for those who seek services at the health facilities. While most of the gaps identified during the baseline are still there (especially those that require financial resources to improve), there has been improvement on staff's common understanding on how to prepare chlorine and when to change water. Waste management sites have been cleared up though they still need renovations and proper fencing. Most HFs prioritised the purchase of IPC materials.

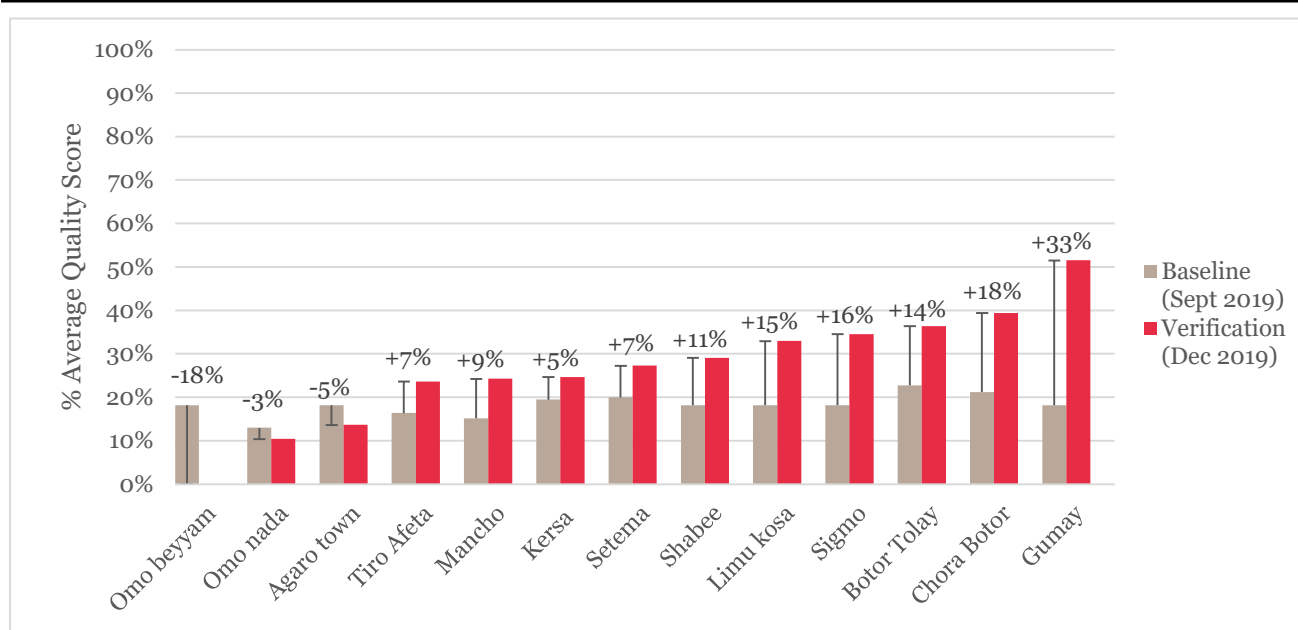
**FIGURE 19 » HEALTH CENTRES QUALITY SCORE FOR INFECTION CONTROL & WASTE MANAGEMENT PER WOREDA**



**Quality in relation to the Out-Patient Department category:**

For the general OPD quality-category there is positive improvement with a percentual change ranging from 5% to 33% in Kersa and Gumay respectively. The highest performing woreda is Gumay with an average score of 52% followed by Chora Botor woreda with a score of 39%. The woreda with the lowest average is Omo Beyyam with 0% (100% (4 out 4) health centres from this woreda scored 0% in this service-category). The overall average score across the assessed facilities is 26.6% for general OPD. Examples of reasons for the low score on this category are: a shortage of medical equipment, lack of guidelines and protocols required in the OPD consultation room and lack of privacy in the majority of the health centres. Health centres that recorded improvement on this category managed to ensure that staff started using the guidelines. The main reasons for decline in Omo Beyyam, Omo Nada and Agaro town are mainly: non availability of treatment guidelines in the consultation room during the assessment time. On the other hand, almost all service providers are able to name the criteria for tuberculosis screening and the signs of dehydration for under five children.

**FIGURE 20 » HEALTH CENTRES QUALITY SCORE FOR GENERAL OUT-PATIENT DEPARTMENT (OPD) PER WOREDA**

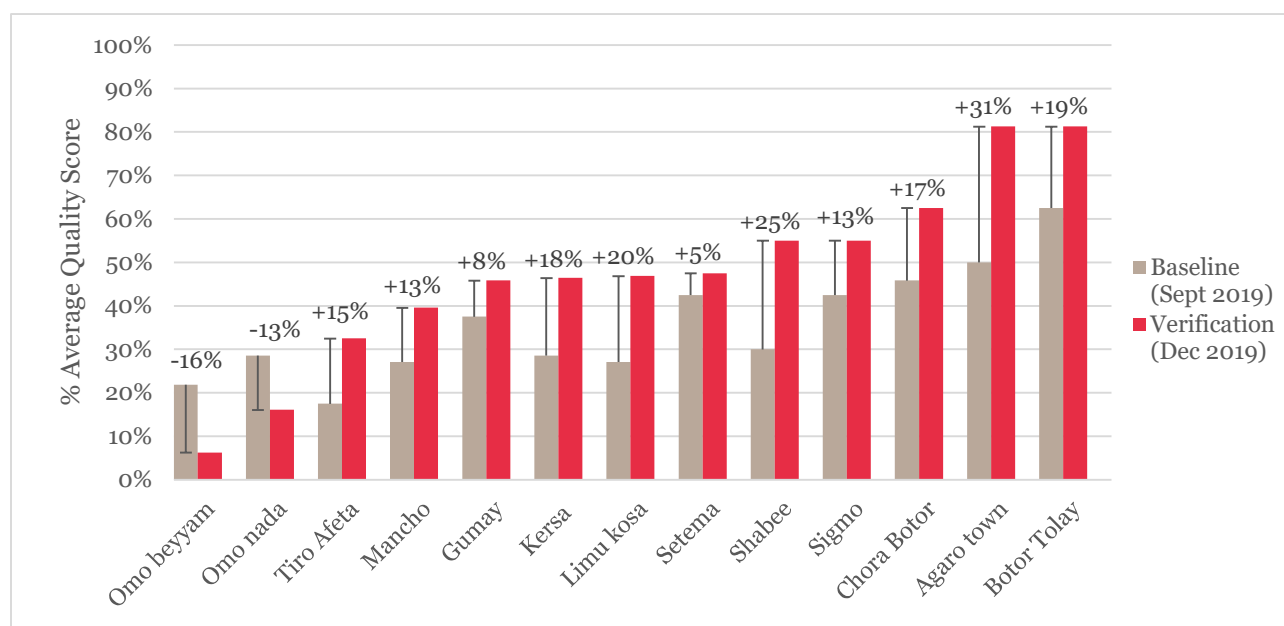


**Quality in relation to the Under 5 OPD category:**

Across all woredas the HCs seem to perform better on the Under 5 OPD category than on the general OPD category. This is partially due to the IMNCI which most staff seem familiar with. It is the third highest performing category, though there are still gaps to be addressed. There was positive percentual change in most woredas ranging from 5% to 19% in Sentema and Botor Tolay woreda respectively. During Q4 2019 Botor Tolay woreda was the highest performing with an average of 81%, while Omo Beyyam was lowest performing with 6%. Agaro Health Centre in Agaro town woreda recorded the highest score, while 3 health centres from Omo Nada and 3 from Omo Beyyam woreda recorded the lowest score (0%). The average score for this category during the baseline was 34%, compared to 45 % in Q4 2019 (58% (37 out of 64) health centres had averages above 34% while 44% (28) health centres score above average during Q4 2019).

Health facilities with improvement for this category tried to improve the availability of water, ORT corners and have IMNCI charts posted making reference to them. Facilities which perform poorly mainly do not adhere to the guidelines and do not have the ORT corners, curtains and an examination couch (items that result in a higher performance score). Adequate equipment in some health facilities is still a problem. Reasons for decline in Omo Beyyam and Omo Nada woredas are for example: lack of IMNCI guidelines in the consultation room and some basic equipment in the consultation room not available or not functioning (such as an otoscope).

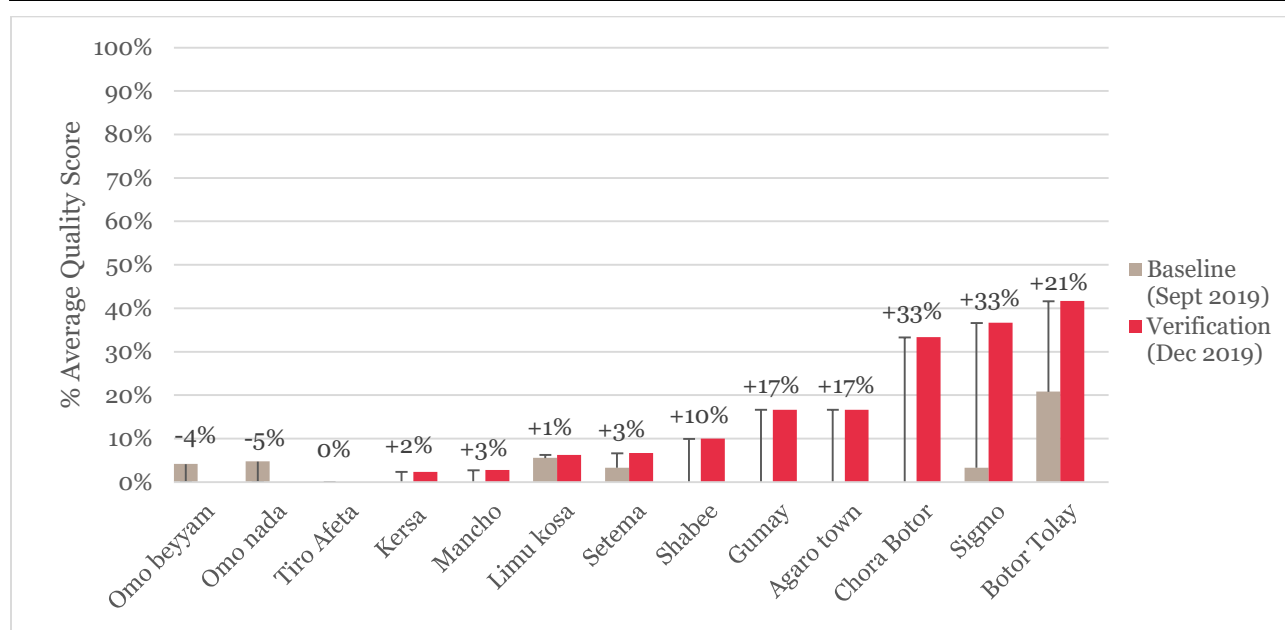
**FIGURE 21 » HEALTH CENTRES QUALITY SCORE FOR UNDER 5 OUT-PATIENT DEPARTMENT (OPD) PER WOREDA**





**Quality in relation to the emergency services category:**

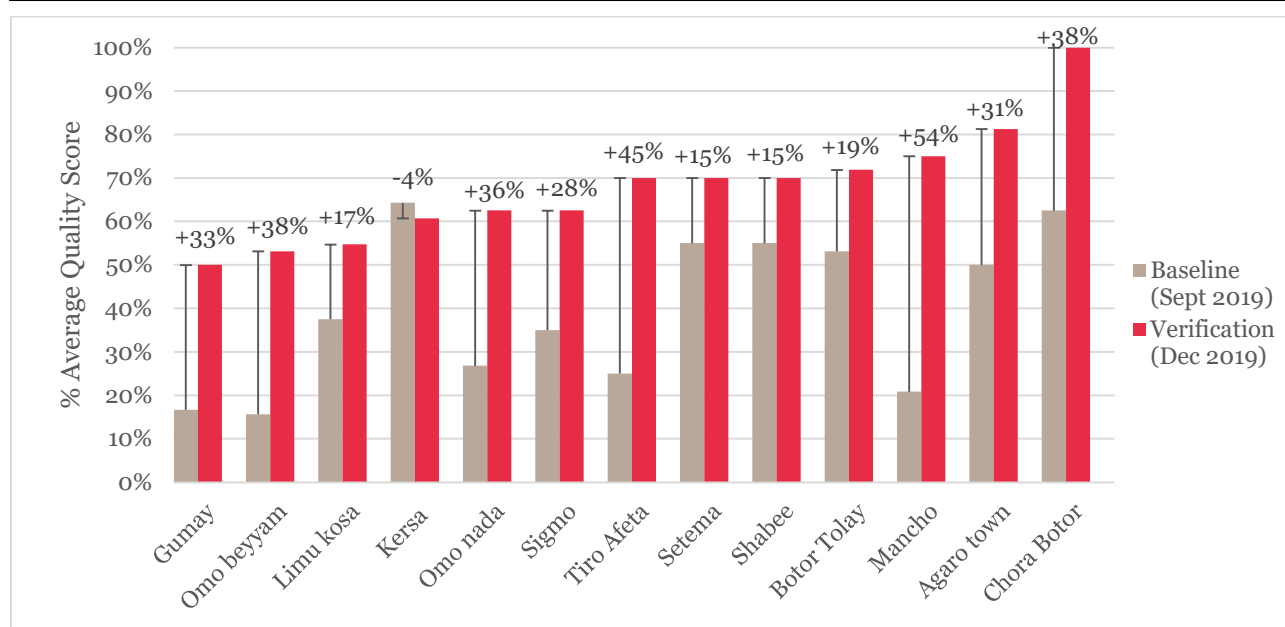
Emergency services is the second worst performing healthcare provision quality category for the PBF woredas in the Jimma Zone. This, with an average score of 3.4% during the baseline: 89% (57 out of 64) of the HCs scored 0% during the baseline study on this category, meaning that emergency preparedness is not up to standard in most health centres. During the quality assessments of Q4 2019 the average score for this category was 11%: 23 (15 out of 64) health centres scored 0%. There has been a slight improvement in some woredas as shown in figure 22 with percentual change ranging from 2%-21% in Kersa and Botor Tolay woredas respectively. The highest performing woreda is Botor Tolay with an average score of 42% (compared to 21% during the baseline). The highest score was recorded by Sigmo health centre with 100% while 23% (15 out of 64) facilities scored 0%. Generally, in most health centres the emergency rooms are available but there is no equipment, no medicines/supplies and no set-up of the emergency trays. Furthermore, a full package of personal protective equipment is not available. The emergency room mainly serves as an injection room only. This is therefore a category that almost all facilities prioritised in their business plans.

**FIGURE 22 » HEALTH CENTRES QUALITY SCORE FOR EMERGENCY SERVICES PER WOREDA**

**Quality in relation to the ANC category:**

The ANC services-category continued to be the highest performing one during the quality assessment of Q4 2019 with an average of 66%. For the woredas 12 out of the 13 recorded positive percentual change ranging from 15% to 54% in Setema and Mancho woredas respectively. Negative change was recorded in Kersa woreda mainly due to the absence of qualified staff for the ANC services in Adi Dika health centre (the midwife was not in service during the assessment time). The highest performing woreda during Q4 2019 was Chora Botor with 100%, while Gumay woreda performed the lowest with 50%. The best performing health centres are 14 health centres from different woredas and each scored 100% quality for this service category. The lowest performing facility is G/Jimate health centre with 0% quality score.

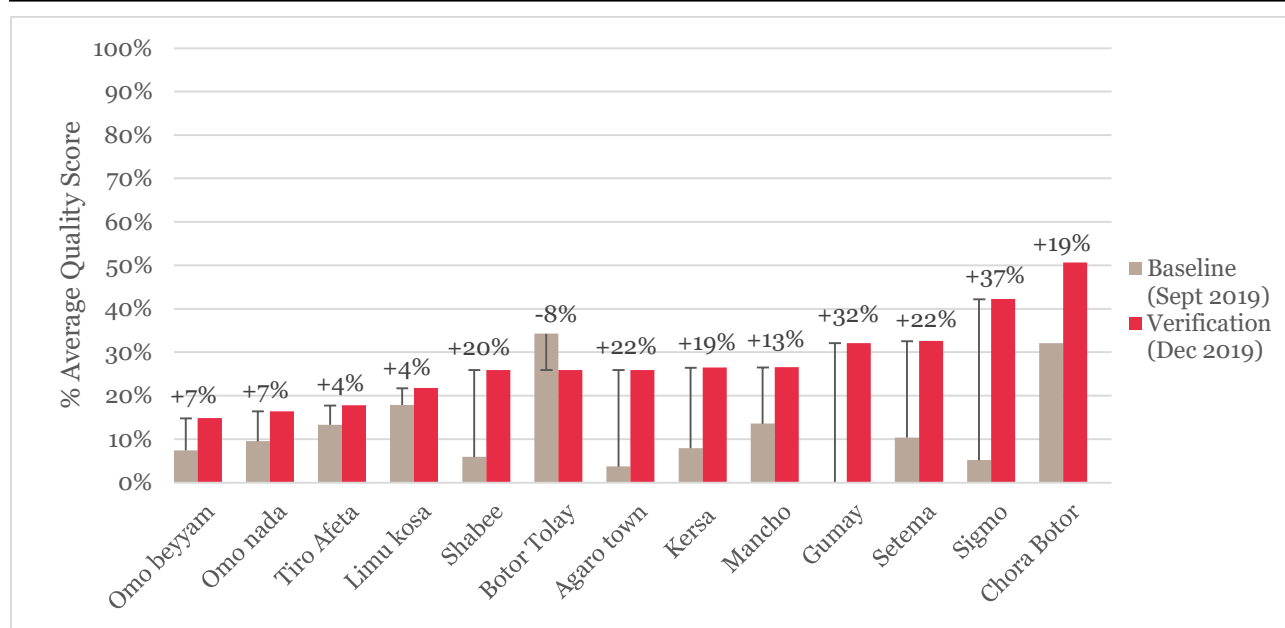
The positive elements for this category include: health providers being able to name danger signs during a pregnancy at the tip of their tongue and able to fill the ANC cards correctly. Other best practices include: proper recording of obstetric history and health providers ability to conduct or refer ANC patients for vital laboratory tests. The only service not performed in most health centres is the Haemoglobin (Hgb) test. Gaps that still need to be addressed include: lacking reagents for tests, the knowledge of staff for identifying danger signs, inadequate history taking and incomplete documentation on ANC cards. However, lab technicians are available in most centres.

**FIGURE 23 » HEALTH CENTRES QUALITY SCORE FOR ANTENATAL CARE (ANC) PER WOREDA**

**Quality in relation to the maternity services category:**

Figure 24 shows that 69% of the woredas did not record an average nor maximum quality score above 20% for the maternity services-category during the baseline study, while 23% still remain below 20% during the quality assessment done for Q4 2019. This indicate a slight improvement, though there is still dire need for more positive change. For the woredas 12 out of 13 recorded positive percentual change ranging from 4% to 37% in both Tiro Afeta, Limu Kossa and Sigmo respectively. The highest performing woreda for Q4 2019 was Chora Botor with 50%, while Omo Beyyam performed the lowest with a score of 15%. Botor Tolay woreda recorded a 8% decline in average score compared to the baseline. This was due to a lack of some equipment and instruments in the delivery room that scored down Waayu and Kata health centres. Tolay, Chora Botor and Limu Kossa health centres are the highest performing woredas for this category, even for ANC services they performed above average. The Continuum of care seems to be disjointed at some points, as some health centres score high on ANC but very low on maternity services. The highest scoring facility is Sigmo Health Centre in Sigmo (74%) while the least performing ones are Limu Genet, Chime, and W/koticha health centres from Limu Kossa and Bilu health centre from Mencho woreda which scored 7% respectively. The average score for all health centres was 13.1% during the baseline and 26% during the quality assessment of Q4 2019.

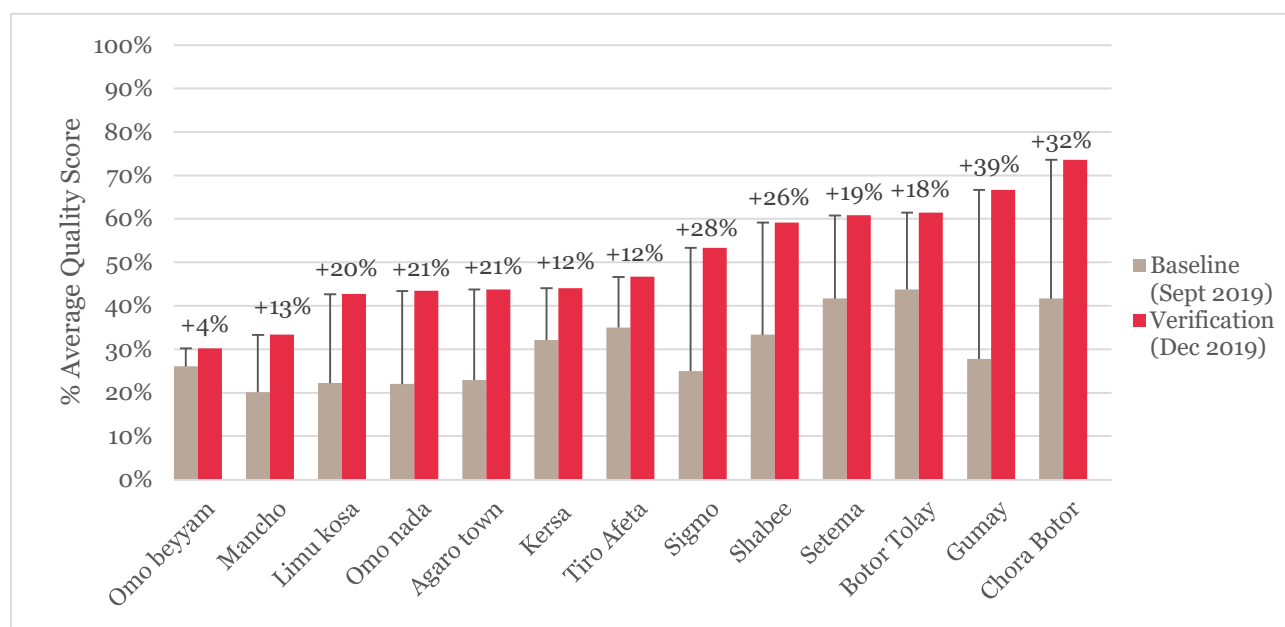
In almost all health centres there was inadequate medical equipment and essential medication and no running water. These issues are therefore prioritised in the business plans. In health centres where there was improvement for this category, staff could easily mention the danger signs of a new-born, while also the cleanliness of the labour wards improved. However, in most health centres sanitation in delivery- and postnatal rooms is not in a good state as there are no functional toilets and bathrooms next to the labour ward. Also there was no separate room available for pre-natal care, no refrigerator in the delivery room and no oxytocin in the majority of the health centres. This means that the Active Management of the Third Stage of Labour (AMTSL) is not managed properly. Also the quality for new-born care is poor as the 'new-born care corners' are not fully equipped in most health centres.

**FIGURE 24 » HEALTH CENTRES QUALITY SCORE FOR MATERNITY SERVICES PER WOREDA**

### Quality in relation to the EPI and growth monitoring category

The overall quality performance for the EPI and GM services-category was 30% during the baseline study and 49% the during the Q4 2019 assessment. All woredas recorded positive percentual change on this category ranging from 4 to 39 percentage points, in Omo Beyyam and Gumay woreda respectively. The highest performing Woreda during Q4 2019 was Chora Botor with an average quality score of 74% (compared to 44% during the baseline study), while Omo Beyyam woreda recorded the lowest average score on this category of 30% (it however improved from the baseline score of 20%). The highest score was recorded by Kishe Health Centre in Shabee Woreda while the lowest scoring was Bilu Health Centre in Mancho with 13%. There is some improvement on this category in most health centres because most of the improvements do not require any additional resources. Therefore, some of the gaps noted during the baseline study are already addressed. Examples of challenges are: the EPI monitoring chart is not consistent with the tally report, sometimes facilities use one monitoring chart for both health centres and health posts while this should be separate. In most health centres there is poor wastage monitoring and vaccine order forms and stock cards are not properly used. There is no outreach contingency plan in the majority of the health centres. Also there is poor cold chain system management (temperature monitoring change, multi dose vial policy).

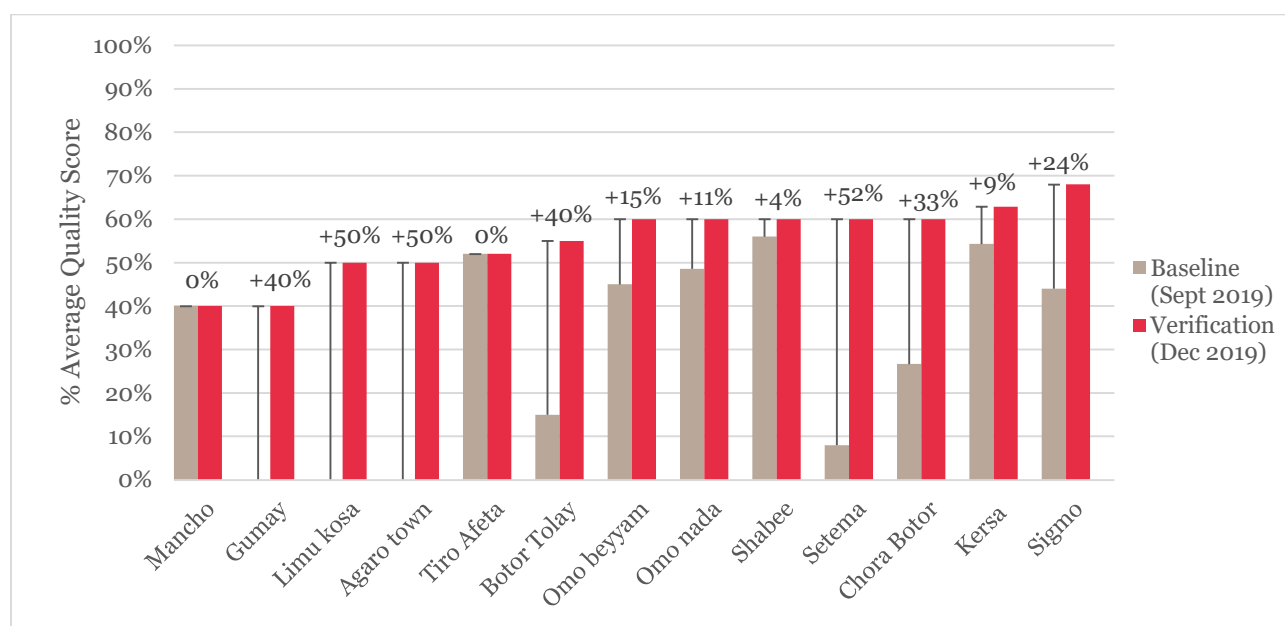
FIGURE 25 » HEALTH CENTRES QUALITY SCORE FOR EXPANDED PROGRAMME ON IMMUNIZATION (EPI) AND GROWTH MONITORING (GM) PER WOREDA



**Quality in relation to the nutrition services category:**

The Nutrition Services category is one of the top three performing indicators and recorded remarkable improvement during the quality assessments for Q4 2019 when compared to the baseline study. The positive percentual change ranges from 4% to 52% in Shabe and Setema woreda respectively. The highest performing woreda for Q4 2019 was Sigmo with 68% up from 44% during baseline. This with the lowest performing woredas being Mancho and Gumay woreda both with a score of 40%. No change in the average score for Mancho woreda when compared to the baseline, while Gumay woreda improved from a score of 0% during the baseline. Sigmo Health Centre was the highest scoring on the nutrition services category with a score of 100%, while Bara inchini, Buusa, Darge, H/Jimate and Irigbo Health Centres were scoring the lowest with 0%. While 38% of the health centres scored 0% on this quality category during the baseline only 8% scored 0% during the quality assessment for Q4 2019. The average score for all health centres on this category during the baseline was 32.5%: it increased to 56% during the assessment of Q4 2019.

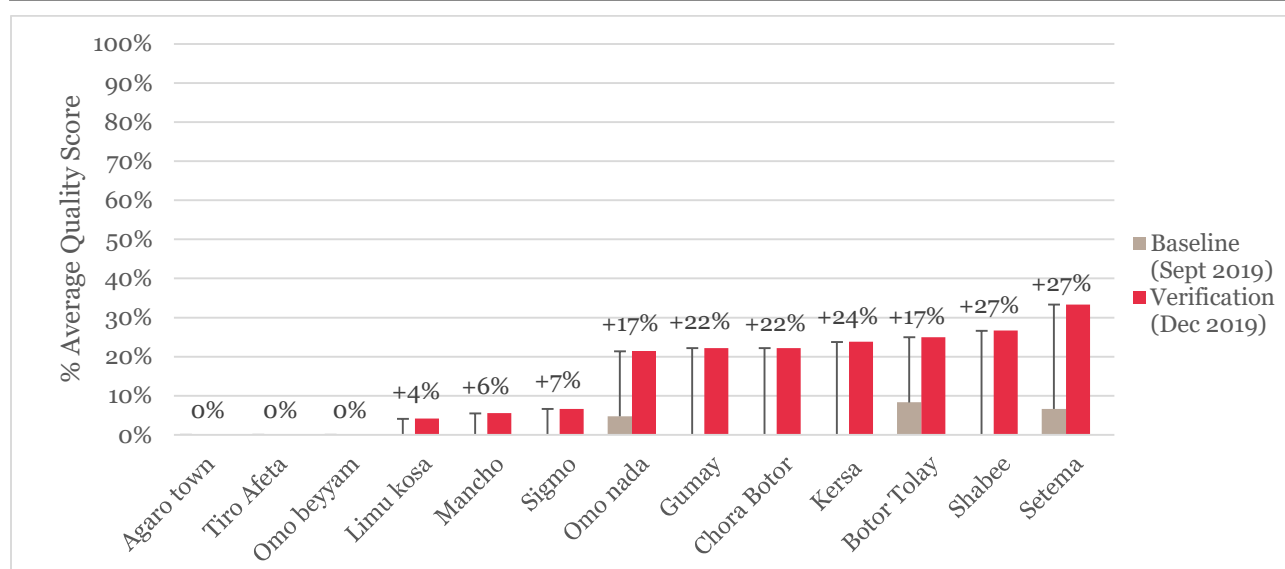
While there was positive change in most health facilities on this category, there is still a need to improve the availability of functional equipment like weighing scales and matrasses in the stabilisation centre. There has been improvement in knowledge of the admission and discharge criteria, though this change is not consistent across all staff in all health facilities. Also most health centres have started adhering to treatment guidelines though some still need to ensure the availability of such documents. The main reasons for a low performance on this category are: lack of severe acute malnutrition guidelines, no functional nutritional stabilisation centre and no equipment available or not equipped according to the national standard. Moreover, health workers do not stick to the discharge criteria.

**FIGURE 26 » HEALTH CENTRES QUALITY SCORE FOR NUTRITION SERVICES PER WOREDA**

**Quality in relation to the inpatient services category:**

The Inpatient services category is amongst the least performing quality-category across all woredas regardless of some little improvement noted during the quality assessments of Q4 2019. It scored the lowest quality performance in almost all health centres with an average of 1.6% during the baseline study. There was positive percentual change ranging from 4% to 27% in Limu Kossa and Shabe and Setema respectively. The highest performing woreda was Setema with a score of 33%, while Agaro town, Tiro Afeta and Omo Beyyam woredas scored the lowest with 0%.

Bulbul and Serbo health centres from Kersa woreda scored the highest (67%) while 38 health centres scored the lowest on this quality category (0%). All health centres assessed in Limu Kossa woreda did not have adequate in-patient facilities during the baseline study, the Q4 2019 assessments showed that there are some efforts to improve some rooms. While 95% (61 out of 64) health centres scored 0% on this service during the baseline study, 59% (38 out of 64) health facilities scored 0% during Q4 2019. All low performing health centres shared common challenges in this service-category: all health centres are using inappropriate registers and therefore information on registers and patient cards do not match (note that some health facilities have already improved on this area). In some health centres there is no admission room while in some others there are no separate male and female wards.

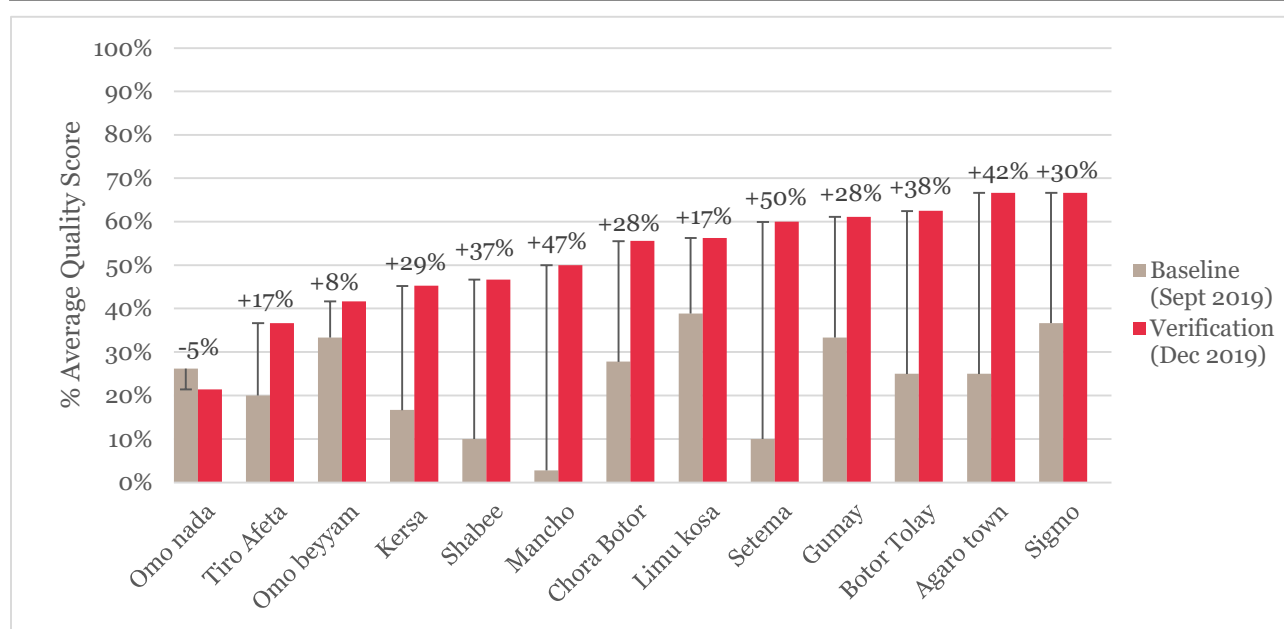
**FIGURE 27 » HEALTH CENTRES QUALITY SCORE FOR INPATIENT SERVICES PER WOREDA**

**Quality in relation to the referral services category:**

This is one of the most improved quality-categories: 12 out of 13 woredas recorded positive percentual change ranging from 8% to 50% in Omo Beyyam and Setema woreda respectively. The highest performer was Sigmo woreda with 67%, while Omo Nada woreda was the lowest scoring one with 21% (this is a 5% decline when compared to the baseline). The main reasons for this decline in Omo Nada woreda is that more than 50% of its health centres (4 out of 7) performed low being the lowest performing ones of all reporting health centres during Q4 2019. Their referral feedback from the hospitals was not available during the quality assessment due to the fact that they are all located in a remote area.

The highest performing health centre on this category during the Q4 2019 quality assessment was Gesecha HC with a 100% score, while the lowest performing ones were Chafe Naga and Nadaa health centres with score of 0%.

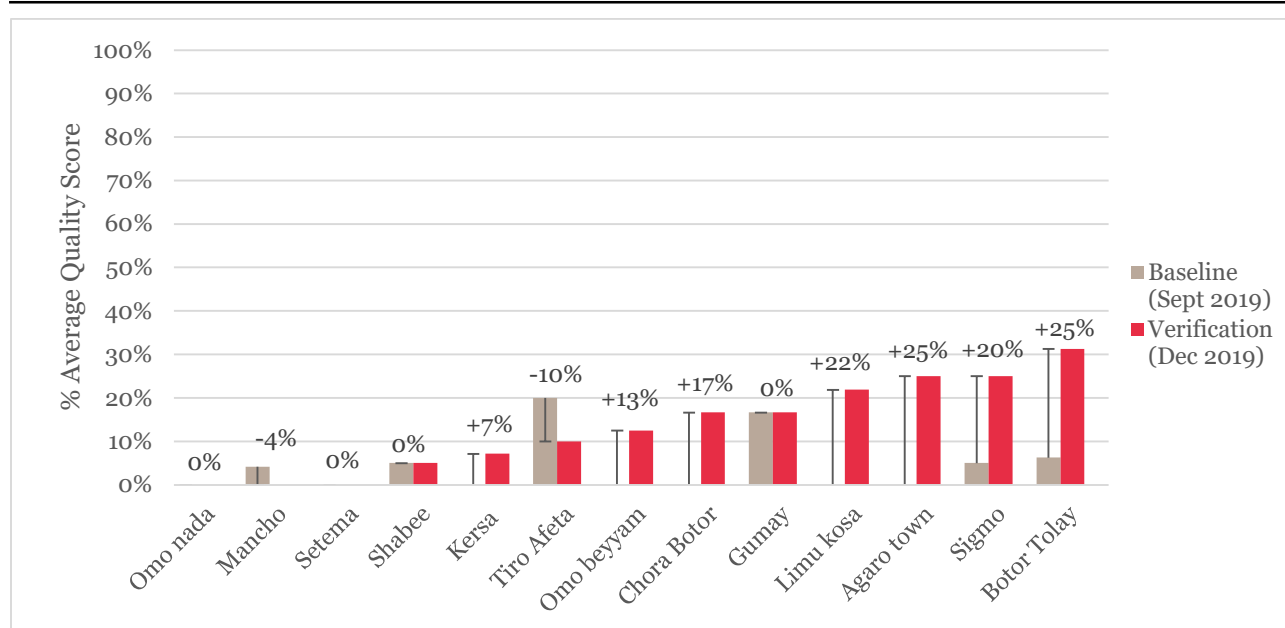
In most Health centres that performed well on this category the hospital phone number is posted on a wall, clearly visible and readable. It was noted that all these health centres had a sufficient number of standard referral forms. Furthermore, referral related documentation generally improved in most health centres, though the challenge of receiving feedback from the hospitals is still the major one.

**FIGURE 28 » HEALTH CENTRES QUALITY SCORE FOR REFERRAL SERVICES PER WOREDA**

**Quality in relation to the outreach and health post supervision category:**

For the outreach and health post supervision category the percentual improvement range changed from 7% to 25 % in Kersa and tie of Agaro town and Botor Tolay. The highest performing woreda was Botor Tolay with 31% while the lowest performing ones were Omo Nada and Setema woredas where the supervision of the health posts is still not done since the baseline study took place. The highest performance score on this category was recorded in Bara Inchini (75%), Robe (75%) and H/Jimate (75%) Health Centres from Gumay, Sigmo and Limu Kossa woredas respectively. Woredas which improved from 0% include Kersa, Omo Beyyam, Chora Botor, Limu Kossa and Agaro town. In Mancho woreda the main contributing factors for low performance on this category include: lack of outreach health promotion plans and lack of health education schedules. Health education sessions are not conducted regularly in some of the assessed health centres. Facilities which improved have started conducting health education sessions. Also in these facilities the plans and reports were well filed and accessible during the baseline assessment. The main reasons mentioned for not conducting outreach activities are related to shortage of resources and lack of structured supervision mechanism.

FIGURE 29 » HEALTH CENTRES QUALITY SCORE FOR OUTREACH AND HEALTH POST SUPERVISION PER WOREDA

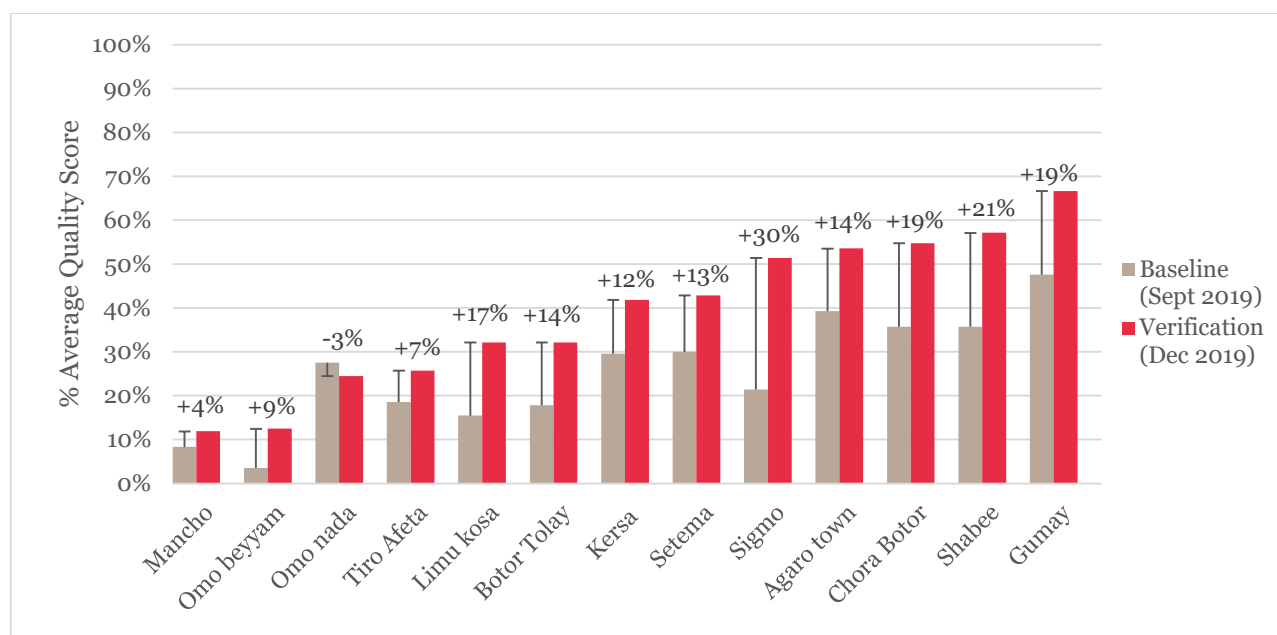




**Quality in relation to the laboratory services category:**

Figure 30 shows that, on this quality-category, Gumay woreda was the best performing woreda with an average score of 67% (coming from a score of 48% during the baseline study). This, while Mancho woreda was the lowest scoring one with 12% (compared to a score of 8% during the baseline study). Positive percentual changes range from 4% to 30% in Mancho and Sigmo woreda respectively. The highest performing health centre was Shabee health centre in Shabe woreda, while 14 health centres from Mancho (3), Limu Kossa (4), Omo Beyyam (2), Omo Nada (3) and Tiro Afeta (2) were the lowest scoring ones with all a percentage of 0%. During the baseline study 30% (19 out of 64) facilities recorded a 0% on this category, while during Q4 2019 quality assessment 22%(14 out of 64) recorded a score 0%. The slight decline of 3% in average for Omo Nada was due to the low performance of 3 out of 7 health centres which scored 0% on this service-category. This was mainly due to the non-availability of Standard Operating Procedures in the laboratory during the assessment time, while also some laboratory examination fees were not clearly displayed for the patients.

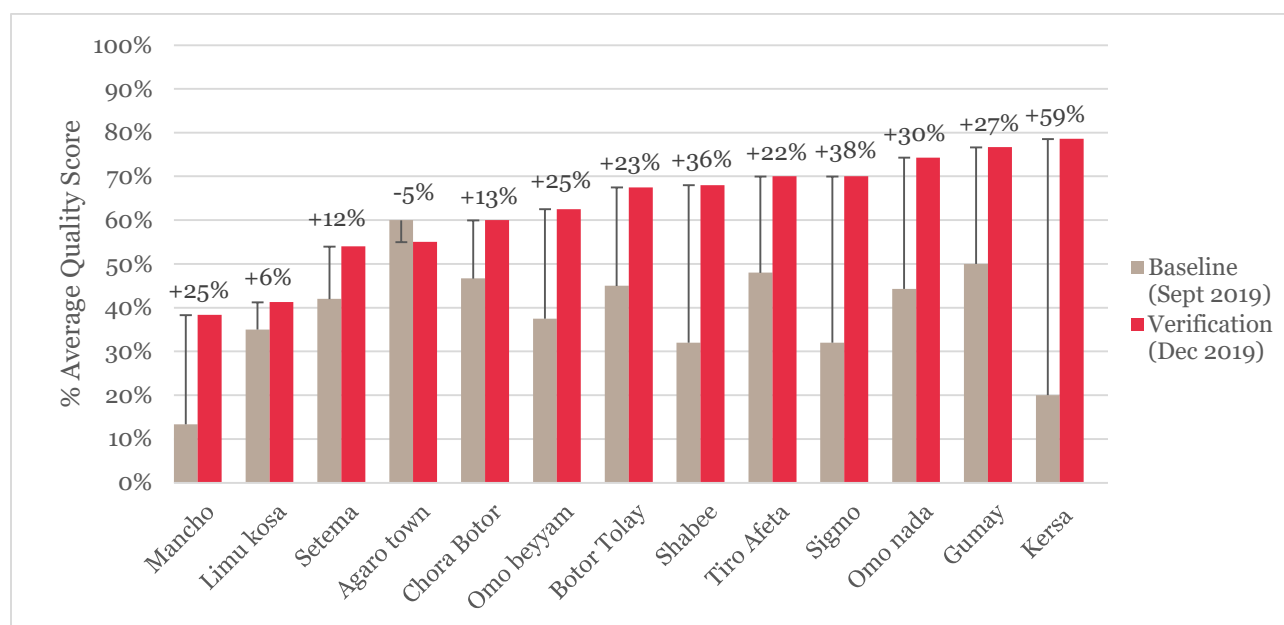
Almost all health centres have laboratory departments and lab technicians available but during the baseline study only a few had Standard Operating Procedures (SOP) or guidelines available for tests (note that during the quality assessments for Q4 2019 this aspect already started to improve). The lowest performing health centres need to improve on functionality of their laboratories by making services available during the weekend and after working hours (some health centres have started to do so).

**FIGURE 30 » HEALTH CENTRES QUALITY SCORE FOR LABORATORY SERVICES PER WOREDADA**

**Quality in relation to logistics, medicines and supplies services category:**

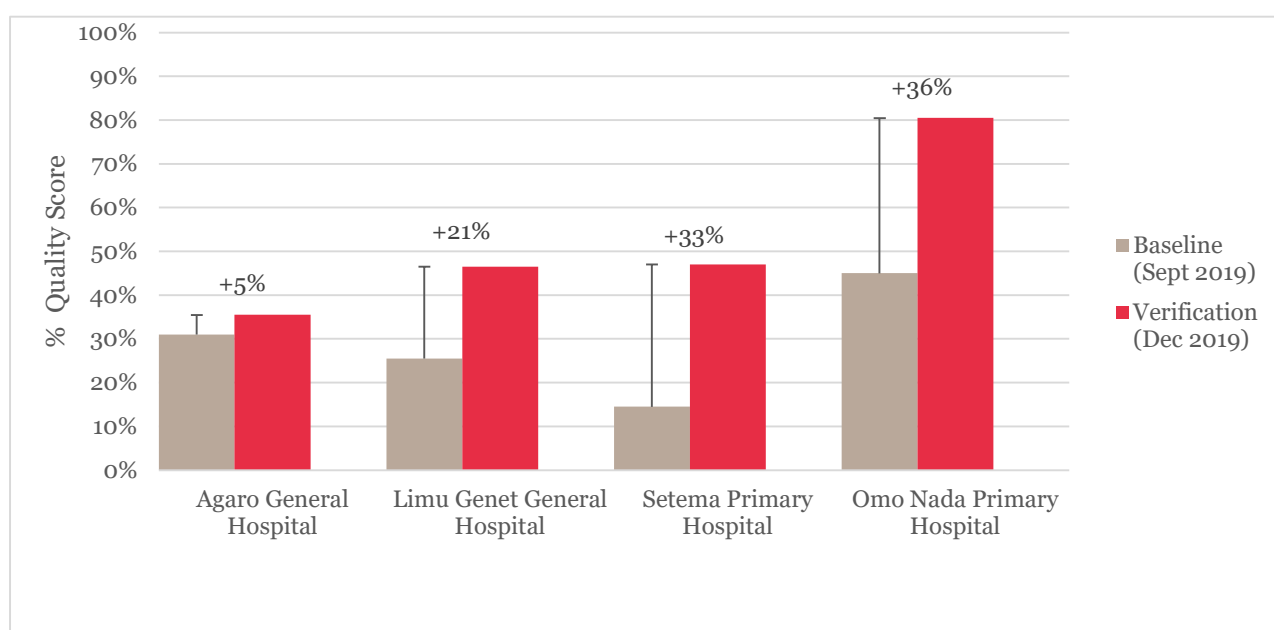
This is the second best performing services-category with a quality performance score of 36%, though there is still a need for improvement in several aspects of this category. Kersa Woreda scored highest with an average score of 79% (coming from a score of 60% during the baseline), while Mancho Woreda still remained the lowest performer with a score of 38% (coming from a score of 13% during the baseline). The positive percentual average changes range from 6% to 59% in Limu Kossa and Kersa woreda.

The highest performing health centres are Chafe Naga and Raga Siba HC with 80% respectively while the least performing one was Irigbo health centre from Mancho woreda with a score of 0%. In the best performing health centres staff know and are able to clearly explain the drug request mechanism, are able to maintain stock cards for essential drugs and adequately calculate Monthly Average Consumption (MAC). In these centres drugs were also correctly stored, while there were no expired drugs or consumables in the pharmacy during the time of the baseline study. The most challenging aspect for the lowest performing health centres on this category was the management of essential drugs where the Monthly Average Consumption (MAC) was not properly calculated. To avoid any drug shortages or stockouts, it is important that HCs will improve this. Additionally, most HCs do not register drugs dispensed, while stock cards do not match the actual counts.

**FIGURE 31 » HEALTH CENTRES QUALITY SCORE FOR LOGISTICS, MEDICINES AND SUPPLIES PER WOREDA**

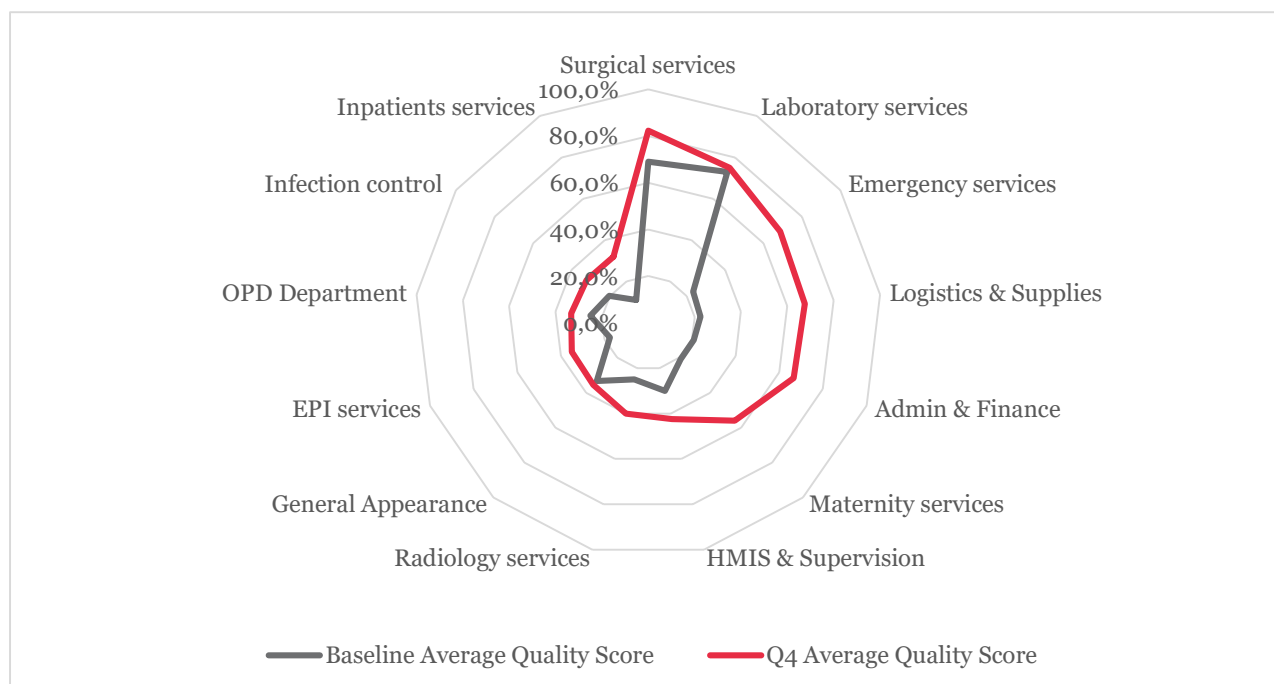
***The performance of the HOSPITALS in relation to the Quality assessments:***

Although, in general there was some improvement, the quality of services at hospital level remains low except in Omo Nada hospital. The latter hospital scored 81% on the quality assessment for Q4 2019 and continues to be the highest performing hospital. Agaro hospital continues to be the lowest performer with a score of 36% (up from 31% during the baseline study). Limu Genet and Setema hospital both scored 47%, which is a 21% and a 33% improvement respectively when compared to the score during the baseline study. Apart from being the newest hospital, the management of the Omo Nada hospital seems committed and well organised: most staff in this hospital were showing ownership of the process of improving the quality of services. One best practice noted in Omo Nada hospital is that the medical director ensures that the internal quantity and quality verifications are conducted well before the Cordaid verifiers and the ZHD arrives to perform the verifications. This already makes all staff members aware of what is expected from their departments. Because of this they put effort into addressing the identified gaps accordingly. It would therefore be useful to organise an experience sharing visit to Omo Nada hospital for staff from the other hospitals under the PBF program.

**FIGURE 32 » OVERALL QUALITY SCORES PER HOSPITALS*****Comparison of the average quality score per service-category for the HOSPITALS***

Generally there was improvement on all quality service-categories during the Q4 2019 assessment when compared to the baseline. Most improvements were noted in the categories for emergency services, logistics & supply, administration & finance and for maternity services. The lowest improvement was recorded mainly for the categories in EPI and Lab services. Surgical services was the highest performing with a score of 82.4%, this while the EPI category was the lowest performer with a score of 35%. Further analysis per services category is provided in the below sections.

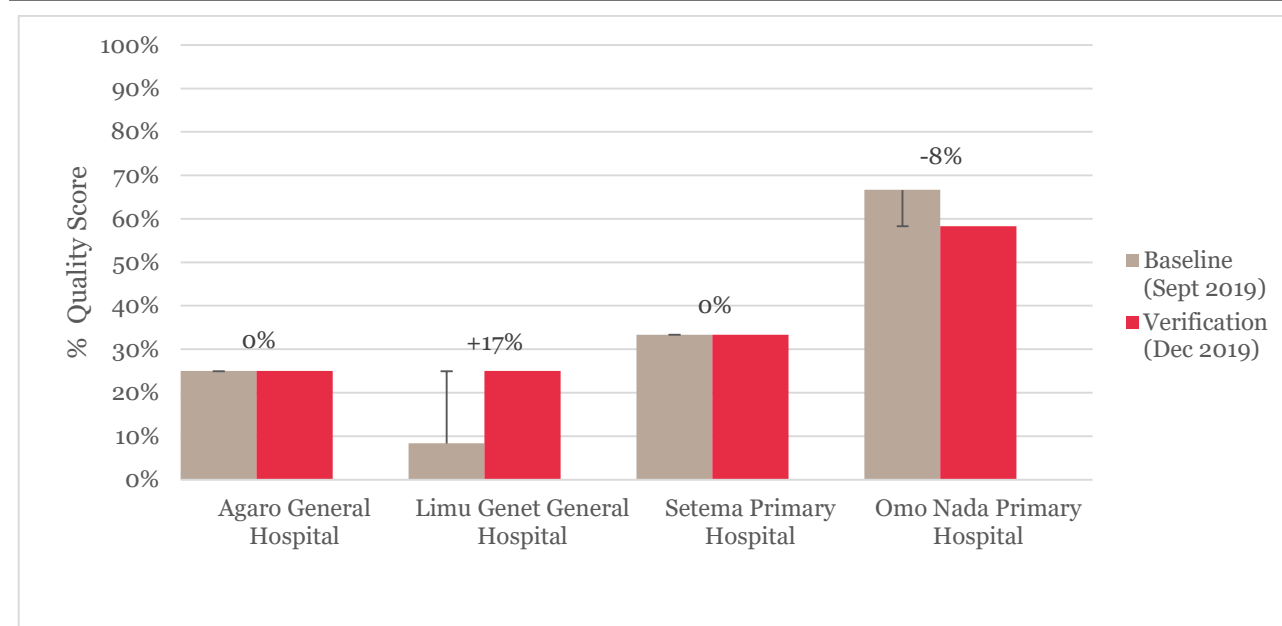
FIGURE 33 » COMPARISON OF AVERAGE QUALITY SCORE PER SERVICE AREA AT HOSPITALS



**Quality in relation to the general appearance and safety category per hospital:**

The best performing hospital on the quality category General appearance and Safety is Omo Nada Hospital with a score of 58% (compared to a score of 67% during the baseline study), while both Limu Genet and Agaro hospital were the least performing ones with a score of 25%. No improvement on this category was noted in Agaro and Setema hospitals. Omo Nada hospital has a new building and its outside and inside appearance looks quite good with visible and readable sign posts, a fence without holes and a lockable gate. In this hospital, walls are clean and painted and electricity is available 24 hours a day with a functional generator for back-up. There is also a functional mobile phone dedicated for communication with health centres for referring patients. However, the grass was not cut during the Q4 2019 quality assessment. Medical waste should not be visible in the courtyard in order to prevent any risk of contamination. In this service category a lot of improvement are still needed in most hospitals, since most of the findings during the baseline study are still the same.

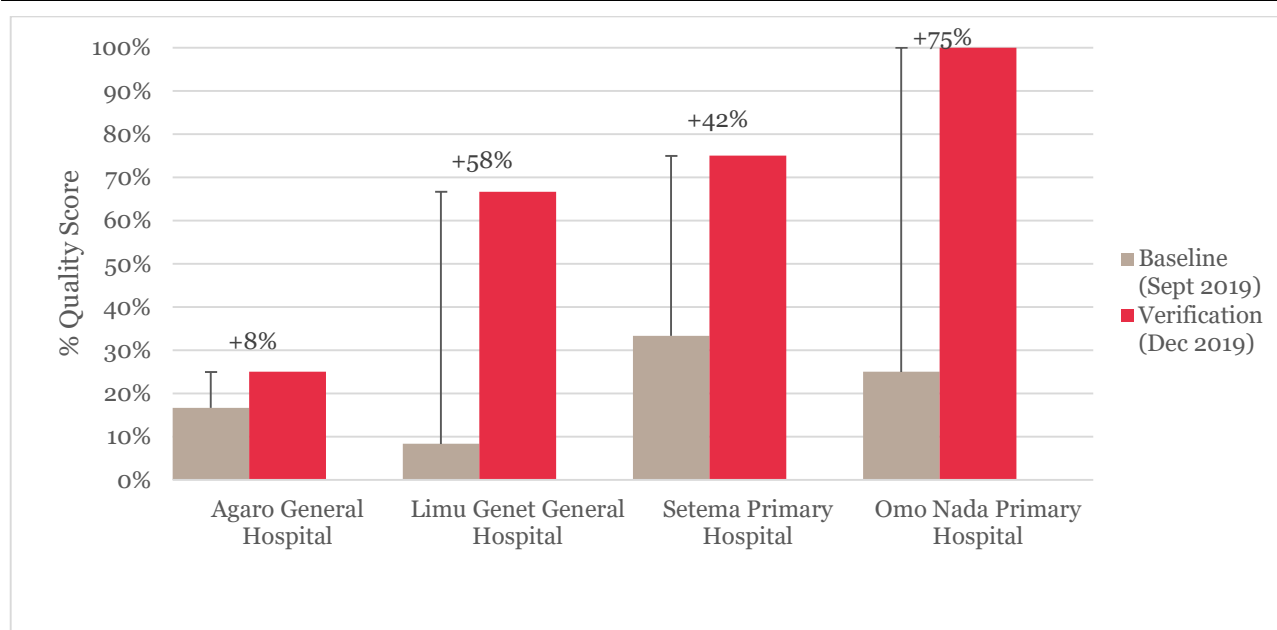
FIGURE 34 » QUALITY SCORE FOR GENERAL APPEARANCE AND SAFETY PER HOSPITAL



**Quality in relation to administration, financial management, HRM & planning category per hospital:**

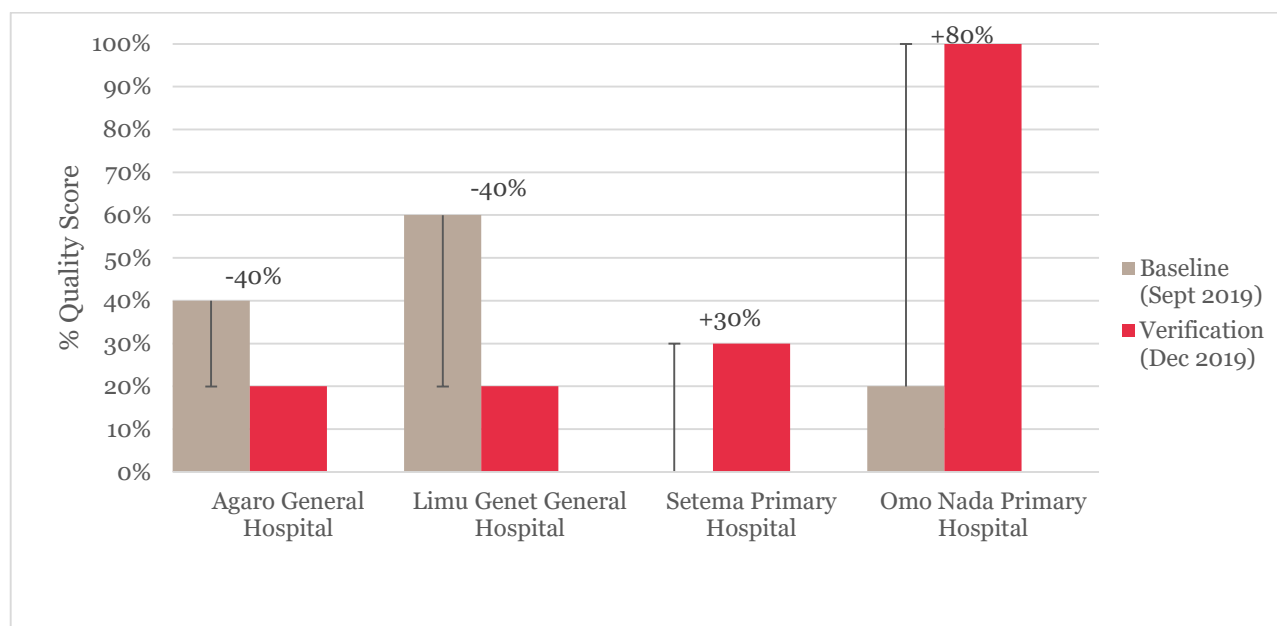
During the baseline study, on this quality category, Setema hospital scored highest with a score of 33%, while Limu Genet hospital scores the lowest with a score of 8%. However, during the quality assessments done for Q4 2019 Omo Nada hospital out performed all the hospitals with a score of 100% on this category, which is a 75% increase from its score during the baseline study. Agaro General hospital scored the lowest on this category with a score of 26%, corresponding to a 8% improvement from the score during the baseline study. In both Setema and Omo Nada Hospital staff files were well managed with the job descriptions available in each staff file, while also the hospital's mission, vision and values were well pasted on walls so that they were clearly visible and readable in the local language. In addition, staff duty rosters are displayed on the wall and accessible to all staff. Staff duty rosters are available and implemented in all assessed hospitals. The hospitals need to improve on annual, quarterly and monthly plans and financial management. The three (3) hospitals (except Omo Nada) should put more effort in reporting on their activities; monthly general staff meetings, quarterly hospital board meetings and quarterly progress reports should be available and well documented.

FIGURE 35 » **QUALITY SCORE FOR ADMINISTRATION, FINANCIAL MANAGEMENT, HRM AND PLANNING PER HOSPITAL**

**Quality in relation to the HMIS and supervision category per hospital:**

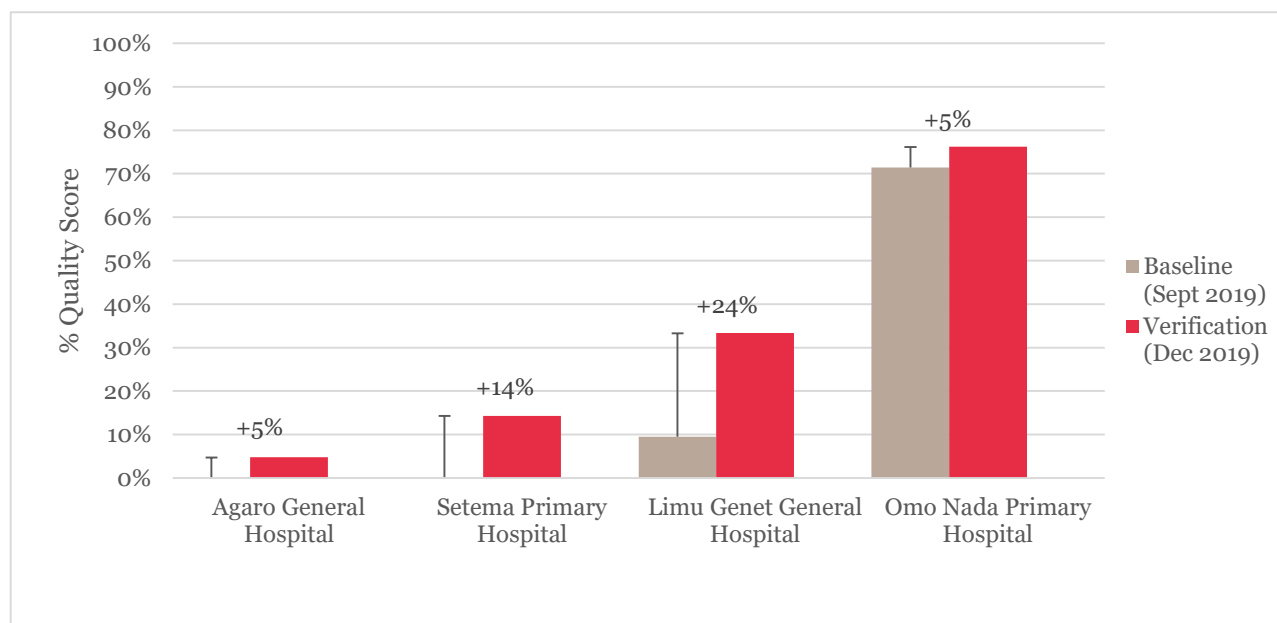
Omo Nada Hospital is the best performing hospital on this service-category with a 100% quality score (which is a 80% improvement when compared to their score from the baseline study). Setema hospital is the lowest performing one on this category with a score of 30% (coming from a score of 0% during the baseline study). It was noted that in the Omo Nada Hospital monthly and quarterly HMIS/DHIS2 reports are submitted on time respecting the deadline of the 26th of the month, and these reports are filed and stored in a chronological order. Furthermore, contrary to the other hospitals, in Omo Nada Hospital monthly performance monitoring charts were well displayed on the walls. Agaro Hospital is the only hospital that conducted supervision to their health centres. All its monthly supervision reports were available, filed and easily accessible to the assessment team. Reasons for the decline on this category in Agaro and Limu Genet hospital was that their monthly HMIS reports were not submitted to the ZHD nor available in the hospital during the quality assessment time and that HMIS/DHIS analysis was not done. The team of verifiers also noted that the performance monitoring for a 3 months period was not displayed in the hospitals as required by the standard quality checklist. Overall, three (3) hospitals failed to perform activities related to quality assurance, while there also was no documentation to prove that integrated supervision from the Zonal Health Department (ZHD) was conducted on a regular basis.

FIGURE 36 » QUALITY SCORE FOR HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) AND SUPERVISION PER HOSPITAL

**Quality in relation to the infection control and waste management category per hospital:**

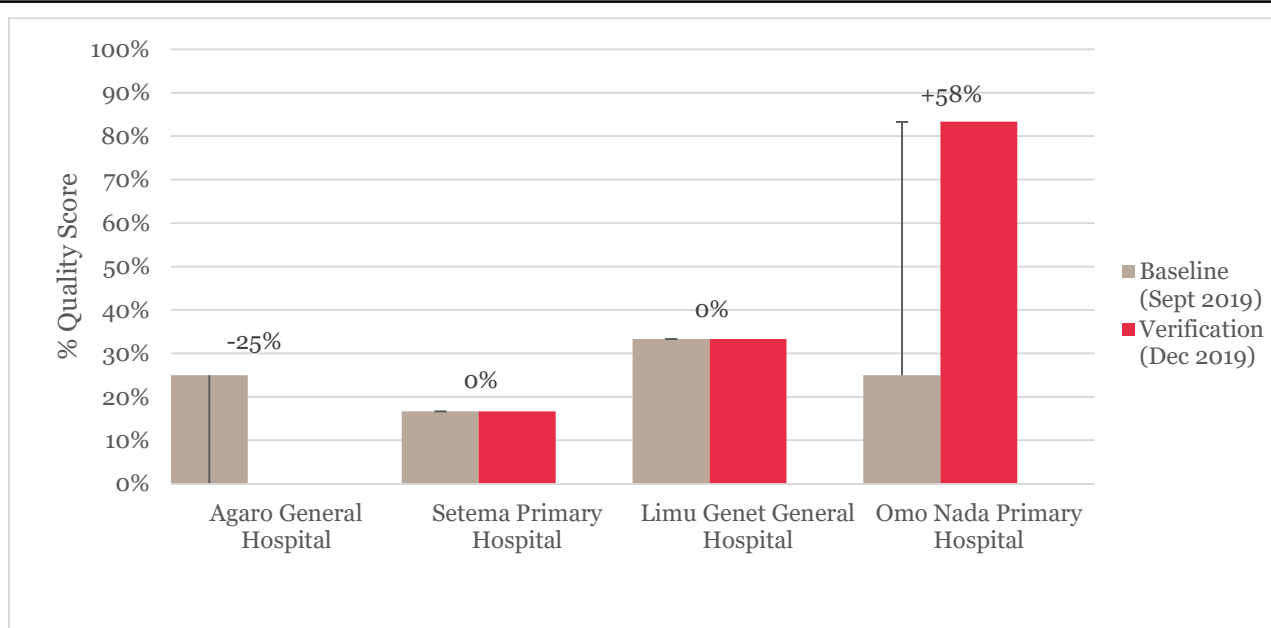
The best performing hospital in relation to the Infection Control and Waste Management service-category is Omo Nada Primary Hospital with a score of 76% (coming from a score of 71% during the baseline study). In this hospital waste management is properly handled and the incinerator is functional (though it needs minor renovations of the chimney). Omo Nada is the only hospital that has five well cleaned latrines for females and five for males with a functional hand washing system. Limu Genet hospital (with a score of 10% on this category) has tried to dispose of solid waste properly and it has appropriate drainage of waste water. Agaro hospital (with a score of 0% on this category) and Setema hospital (also with a score of 0%) failed to perform any of the standard elements listed in PBF quality assessment checklist during the baseline study. However, both hospitals slightly improved to 5% and 14% respectively during the Q4 2019 assessments.

FIGURE 37 » QUALITY SCORE FOR INFECTION CONTROL AND WASTE MANAGEMENT PER HOSPITAL



**Quality in relation to the out-patient department services category per hospital:**

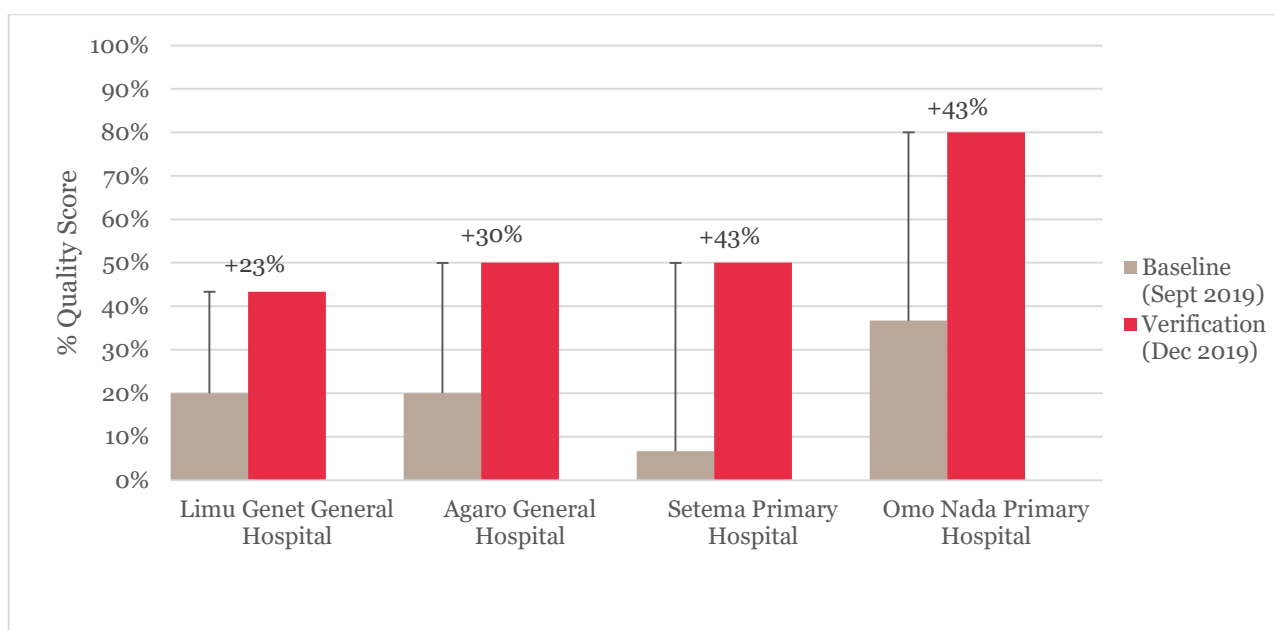
The Omo Nada Hospital is the best performing hospital on this category with a score of 83% (coming from a score of 25% during the baseline study). This, while Agaro hospital scored the lowest on this category: 0% coming from a score of 25% during the baseline study. Limu Genet Hospital and Omo Nada hospital are the only hospitals where Post Exposure Prophylaxis (PEP) kits were available and all OPD attendants correctly know when these kits should be used. It was also noted that in all the assessed hospitals OPD staff were able to clearly name criteria for TB screening. Overall, the quality score for OPD services in the four hospitals is low except in the Omo Nada hospital. For the OPD service provision there were no sufficient benches or chairs for patients in the waiting area available and there was no proper documentation of vital signs at any of these three (3) hospitals. The supervising entity (ZHD) and each hospital should ensure that guidelines/protocols for STD/STIs and pain management are available and accessible to staff. However, Omo Nada hospital has been pro-active and ensured that they received the guidelines and started adhering to them. Furthermore, there is an urgent need for all hospitals to have sufficient and functional equipment in the consultation room such as an otoscope, sphygmomanometer, infantometer and height scales.

**FIGURE 38 » QUALITY SCORE FOR OUT PATIENT DEPARTMENT SERVICES PER HOSPITAL****Quality in relation to the maternity service category per hospital:**

Improvement was noted across all four hospitals with the percentual change ranging from 23% in Limu Genet hospital to 43% in Omo Nada hospital. Omo Nada hospital scored best in the maternity services-category with a score of 80% (up from a score of 37% during the baseline study). The least performing hospital was Limu Genet with a score of 43% compared to a score of 20% during the baseline study. It was noted that in the Omo Nada hospital the waiting area was in good condition, guidelines/protocols on MNCH care were available and used properly and an emergency tray was available. In this hospital partographs are properly used and maternal health service providers have knowledge of the general danger signs during and after delivery. In Limu Genet hospital (43%) partographs are properly used, while in Omo Nada hospital 80% of the partographs are used properly, while the service providers have proper knowledge on maternal and new born care. However, there is a need to improve on the availability of guidelines/protocols, emergency services and the presence of a new born delivery room.

Generally there is still need to improve on using the partographs properly, guidelines/protocols should be made available and prenatal and post-natal rooms need to be cleaned. Hospital management teams should stick to the quality standards. Equipment and instruments should be made available in all delivery rooms and prenatal and postnatal rooms should be separated and cleaned, allowing staff to bring their knowledge into practice. Most of these gaps were addressed in Omo Nada hospital, while the other three hospitals still need to address them.

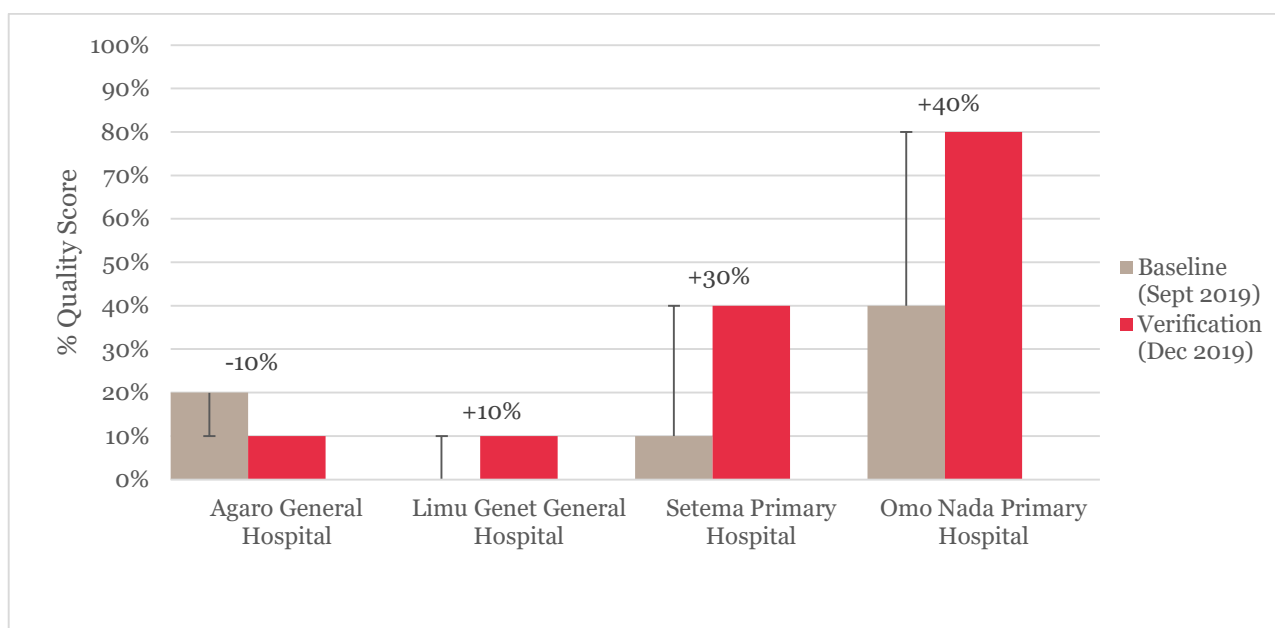
FIGURE 39 » QUALITY SCORE FOR MATERNITY SERVICES PER HOSPITAL



**Quality in relation to the expanded program on immunization category per hospital:**

The best performing hospital in EPI is Omo Nada hospital with a score of 80% (coming from a score of 40% during the baseline study). This, while both Limu Genet and Agaro hospital scored the lowest with a score of 10%. Omo Nada Hospital staff correctly calculates Monthly Average Consumption (MAC) and the refrigerator is clean and kept properly. The performance of Agaro hospital on this category declined due to the fact that the cold chain was not properly maintained and the temperature monitoring chart was not consistently filled. Last year in Limu Genet hospital this service was interrupted because the EPI fridge could not maintain the temperature for the antigens. Thus, all antigens were transferred to Limu Genet health centre. Overall, all hospitals need to put in place major efforts to improve on their EPI services.

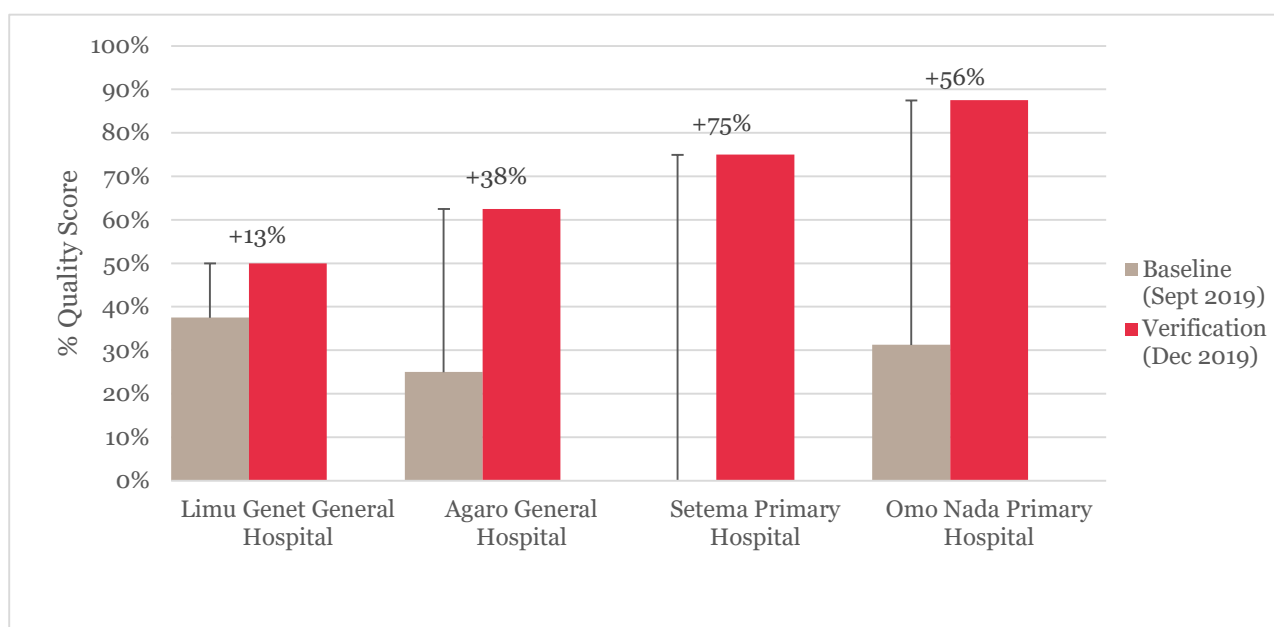
FIGURE 40 » QUALITY SCORE FOR EXPANDED PROGRAM ON IMMUNIZATION PER HOSPITAL





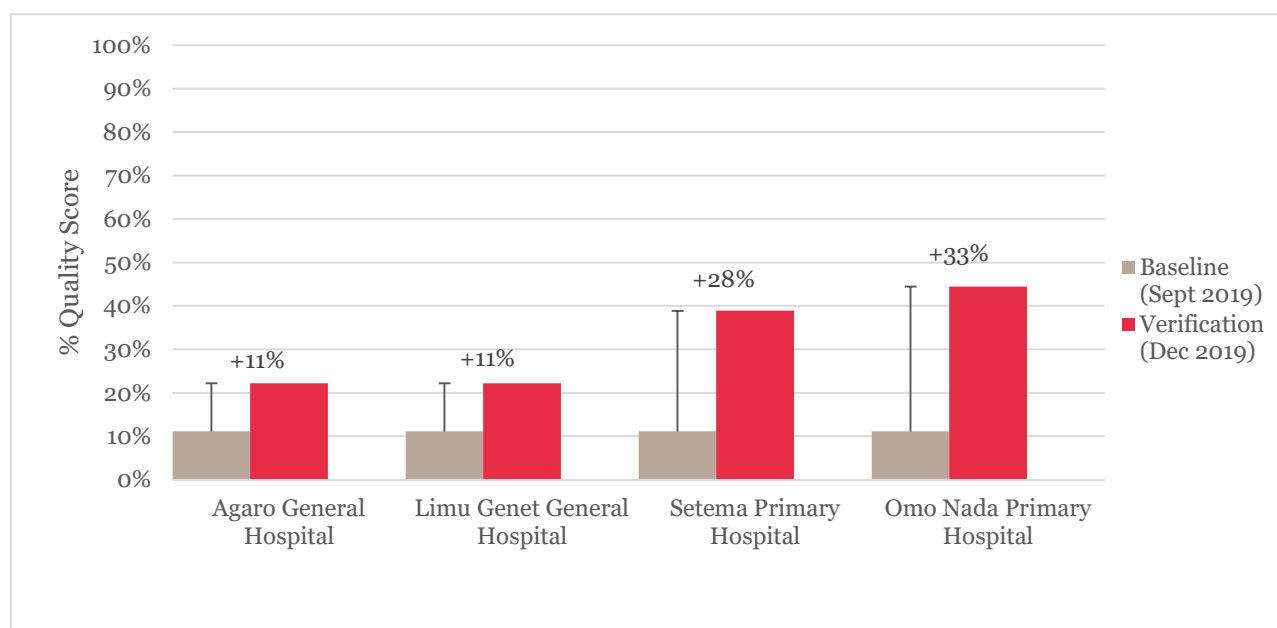
**Quality in relation to the emergency services category per hospital:**

Figure 41 shows that there is improvement in all hospitals for this service-category: it was one of the best performing categories during the quality assessment of Q4 2019. The best performing hospital on the Emergency Services category is Omo Nada hospital with a score of 88% (coming from a score of 38% during the baseline study). Limu Genet hospital was the lowest performing hospital with a 50% quality score on this category (coming from a score of 38% during the baseline study). In Setema and Omo Nada hospitals, staff correctly understand protocols for emergency management. However, there is room for improvement in the management of ambulances. Limu Genet Hospital also needs to improve on the management of the OPD emergency tray. Omo Nada Hospital scores well on: privacy in the emergency consultation room, its referral system and the management of the hospital ambulances. Areas of improvement in most hospitals include: training of staff to understand and be able to state all emergency protocols as listed in PBF quality checklist. Specifically Setema Hospital needs to improve both on practical and theoretical aspects of managing emergency services. In this hospital staff do not seem to understand the national protocol for initial management of seizures nor understand initial management of a suspected poisoned patient. This is a critical issue for any emergency service. There should be interconnection between knowledge and practice for better management of emergency services. Omo Nada hospital has made significant progress in addressing most of these gaps which were identified during the baseline study.

**FIGURE 41 » QUALITY SCORE FOR EMERGENCY SERVICES PER HOSPITAL**

**Quality in relation to the in-patient services category per hospital:**

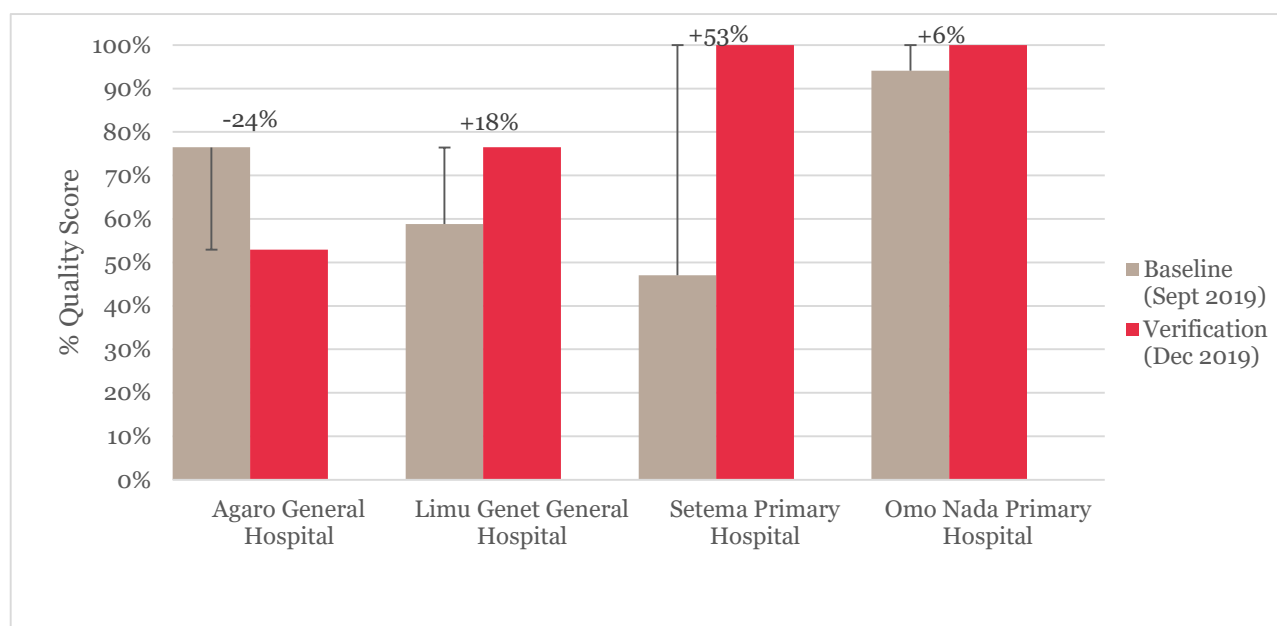
The Inpatient service-category is among the least performing services in the hospitals with a score of 11% during the baseline study (with the highest score of 44% in Omo Nada hospital and the lowest score of 22% in both Agaro and Limu hospital, who both improved from 11% during the baseline study). Though all four hospitals have the required number of wards (three separate wards: for male, female and children), none of the wards met the standard requirements as defined in the quality checklist. All the assessed hospitals need to improve on information management both on registers and patient cards. Furthermore, all hospitals failed on the management of the inpatient pharmacy and patient management.

**FIGURE 42 » QUALITY SCORE FOR IN-PATIENT SERVICES PER HOSPITAL****Quality in relation to the surgical services category per hospital:**

Surgical services is the best performing category with an average score of 82.4%. Based on the quality checklist, all hospitals scored near or above 50% as shown in figure 43. This figure shows that Omo Nada hospital is the best performing one with a score of 100%, even though it has less medical doctors (10) compared to the other hospitals. Contrary to the other hospitals, it was noted that in Omo Nada hospital basic equipment and consumables and emergency surgical packs are available and meeting quality checklist requirements. The least performing hospital was Agaro Hospital: it scored 53% compared to a score of 76% during the baseline. The reasons for this decline is that existing sterilization SOPs were not respected and emergency surgical packs available were not sterilised. This hospital, staffed with 15 medical doctors and 154 staff in total, has made available all emergency surgical packs and the operating theatre is clean as per standards. However, the hospital failed to make available the basic equipment and consumables.

The hospitals need to improve on the availability of basic equipment and emergency surgical packs, clean sets of surgical clothing, a disinfecting device in the staff changing room, while nursing care for patients should be documented. Generally, protocols for patient transfers from operation theatre to the inpatient ward is well understood by all interviewed nurses in all hospitals. Thus, hospitals need to link this knowledge with the practice of documenting their activities in the surgical department as they all failed to document the process of surgical interventions; there was no written informed consent documented in patient files and nursing care of patients was not included in the medical reports.

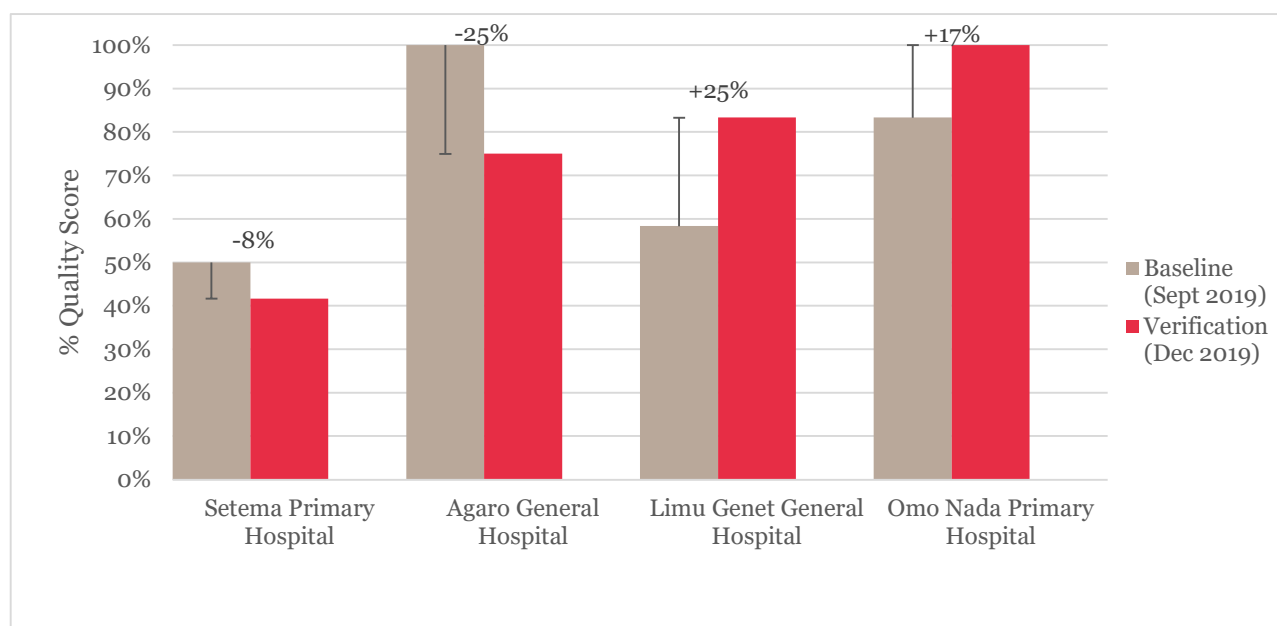
FIGURE 43 » QUALITY SCORE FOR SURGICAL SERVICES PER HOSPITAL



#### **Quality in relation to the laboratory services category per hospital:**

In relation to the Laboratory services category, Agaro Hospital performed as required; all the 12 expected points were awarded, resulting in a 100% quality score during the baseline study, while dropping to a score of 75% during the quality assessment performed for Q4 2019. This was due to the lack of qualified staff. The laboratory service in Agaro hospital was managed by a newly graduated staff with no sufficient experience. The highest performing hospital was Omo Nada with a score of 100% on this category, while Setema hospital had the lowest score of 42%. All basic equipment is available and functional in most hospitals. It is worth noting that Agaro Hospital has eight (8) laboratory technologists and two laboratory technicians. During the baseline study in Limu Genet and Setema hospital staff failed to maintain stock cards for laboratory reagents, but there have been some improvement during the quality assessment of Q4 2019. Monthly Average Consumption (MAC) was not properly calculated and the list of laboratory examinations was not displayed during the baseline study, but there have been efforts by the hospitals to address this gap. Particularly, Setema hospital failed to show all monitoring and evaluation tools that are used to assess laboratory activities. Overall, in all assessed hospitals the laboratory department is managed by qualified staff. Standard Operating Procedures (SOP) and guidelines for all tests and equipment are also available and functional. It was noted that laboratory services were available for emergencies even during weekends in these hospitals.

FIGURE 44 » QUALITY SCORE FOR LABORATORY SERVICES PER HOSPITAL

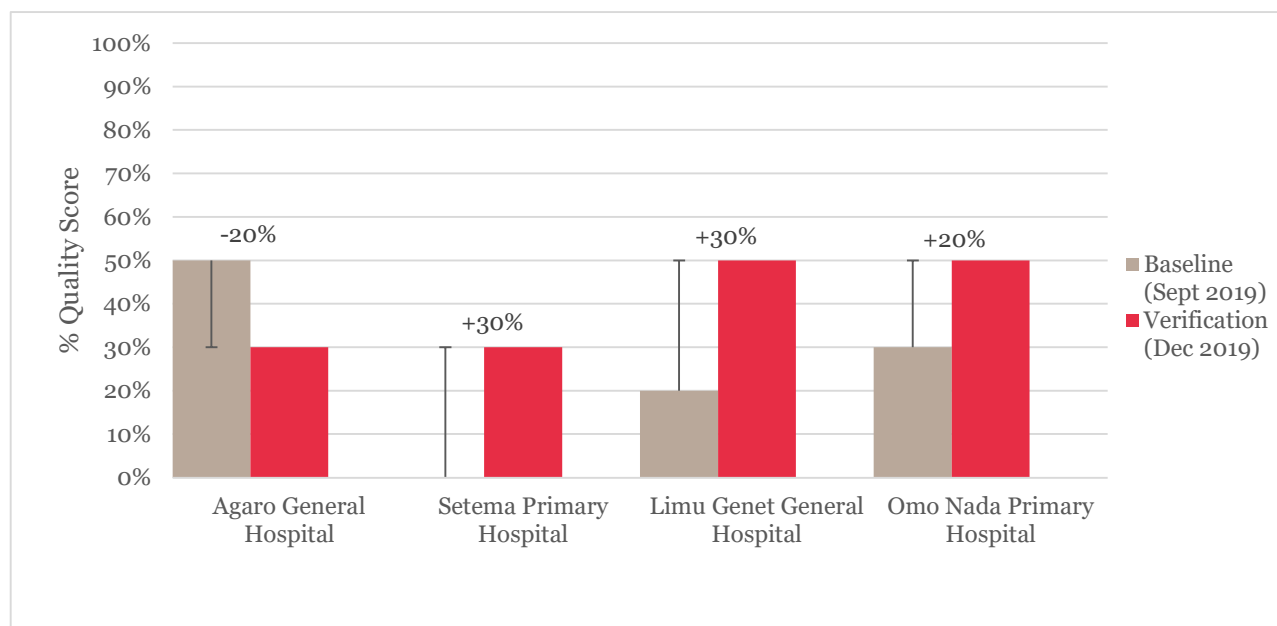


#### **Quality in relation to the radiology category per hospital:**

Generally this is one of the categories for which all hospitals need to improve their score. Agaro Hospital recorded a quality score of 50% on the Radiology Services category during the baseline study, though it dropped to 30% during the quality assessment for Q4 2019. This was due to the fact that policies and procedures for radiology services are not available for staff and due to a lack of adequate radiation protection equipment. Both Limu Genet and Omo Nada hospital were the highest performers on this category with a score of 50% each. Setema and Limu Genet hospital both recorded an 30% increase when compared to their score on the baseline study. This while Omo Nada hospital recorded a 20% increase. Some hospitals still do not have basic required functional radiological equipment. The Radiology attendants in most hospitals now are able to explain the proper use of protocols. Omo Nada hospital needs to improve on the quality control program, while radiation protection equipment should be made available. Agaro and Omo Nada hospitals perform quarterly assessments for radiological exposure of staff.

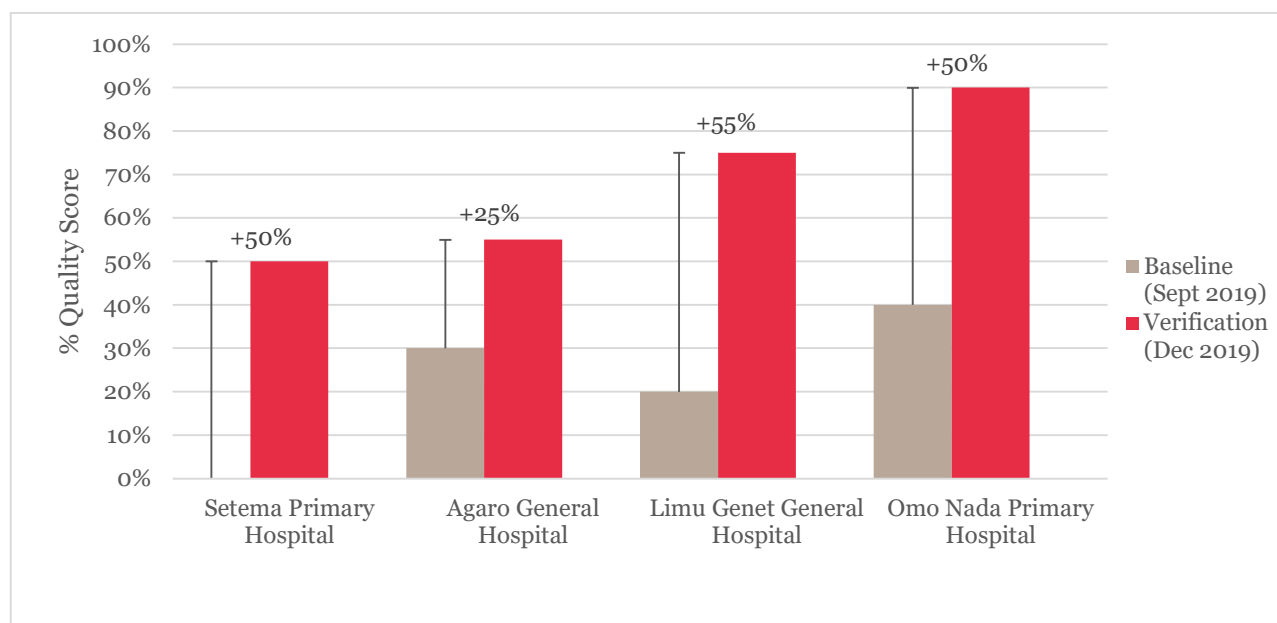
Generally, all hospitals failed to put in place all necessary safety precautions as per the National Radiation Protection Authority. In addition, the quality control program covering the inspection, maintenance and calibration of all equipment is not followed. There is a need to critically look at the compliance with national radiation standards. Hospitals may also look at the possibility to train radiology attendants on the proper use of radiology protocols.

FIGURE 45 » QUALITY SCORE FOR RADIOLOGY SERVICES PER HOSPITAL

**Quality in relation to the logistics, medicines and supplies category per hospital:**

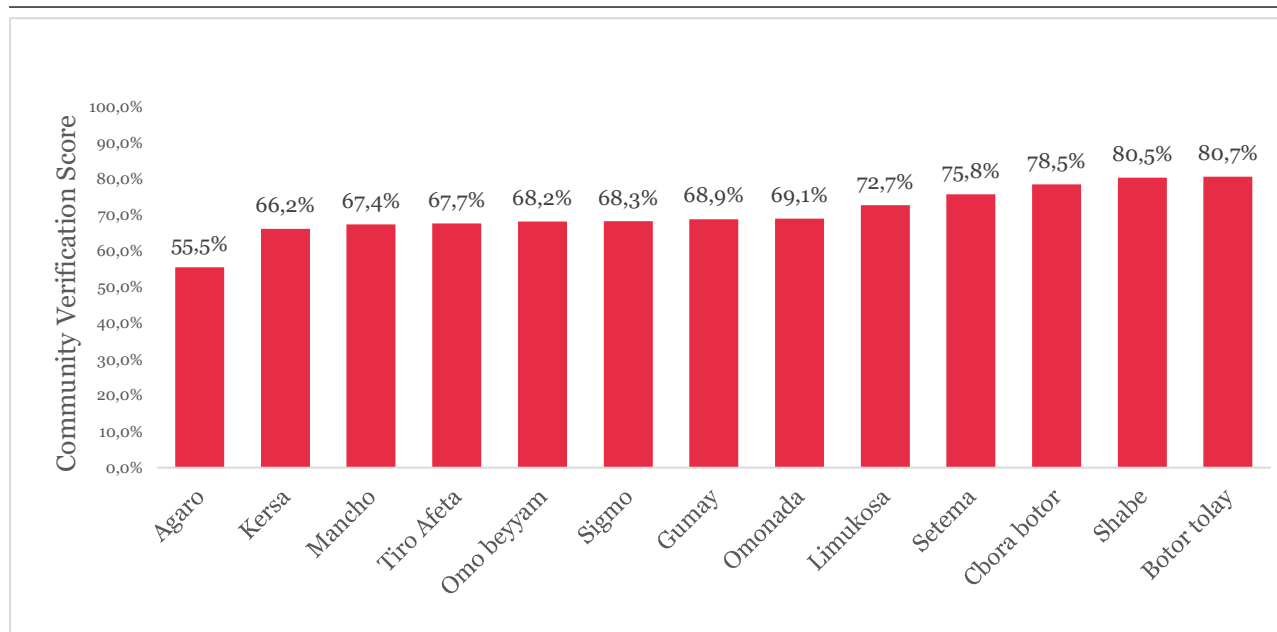
All hospitals managed to remarkably improve their performance on this category. However, Setema and Agaro hospital still need more improvements especially in maintaining the 3 months stocks of most essential medicines. Omo Nada hospital scored 40% on this quality category in managing Logistics, Medicines and Supplies during the baseline study and improved this score to 90% during the quality assessment of Q4 2019 (becoming the best performing hospital on this category). Setema hospital performed the lowest with a score of 50%, which was an impressive improvement from a score of 0% during the baseline study. It was noted that in most hospitals the bin cards for essential medicines were properly maintained and MAC was properly calculated. Improvements were noted in the availability of the inventory register for both equipment and drugs and daily drug dispensed register availability at the dispensary. The management of the expired drugs still needs to improve. It was noted that there are a lot of expired medicines on shelves which indicates the gaps in application of FEFO principle and the use of a push rather than a pull system responding to demand by the hospitals.

FIGURE 46 » QUALITY SCORE FOR LOGISTICS, MEDICINES AND SUPPLIES PER HOSPITAL



**Output 1E: Community Verification (Patient Satisfaction Surveys)**

Sixty-six (66) community based organisation were recruited in Jimma Zone to conduct community verifications which aims to confirm if the reported clients at the health facilities indeed visited for the claimed services and also measure how satisfied they are with the services. The recruitment process included advertisement, shortlisting by the PPA staff, WHOs and Cooperatives offices. The shortlisted CBOs were then interviewed by the same stakeholders using the criteria in the PIM to ensure transparency of the process. The recruitment process took longer due to the challenge of getting adequate CBOs who meet the criteria. Trainings for all the CBOs were conducted by the PPA staff during the period under review; the training focused on general overview of the PBF approach in Jimma, the process of community verification, the tools used and the performance agreement. These CBOs managed to conduct their first verifications for the first implementation quarter and below is the summary of findings.

**FIGURE 47 » AVERAGE COMMUNITY VERIFICATION SCORE PER WOREDA**

As per the PBF approach and the Jimma PIM, community verification activities were conducted for the fourth quarter of 2019. From a total of 67 health facilities, a total sample of 1,405 were collected and given to CBOs for community verification. Out of the total sample provided to CBOs a total of 1,275 (more than 90%) clients were interviewed. Analysis of the specific community verification indicators, shows that two majors indicators recorded the highest performance on average, namely “Caring, Respectful and Compassionate health workers” and “Appreciation of waiting time” with an average of 3.74 and 3.73 respectively, on a scale of 1 (lowest) to 5 (highest). “Availability of ambulance”, “Infrastructure” and “Availability of medical supply and drugs” were the least performing indicators based on the community interviews, with a score of 3.28, 3.33 and 3.41 respectively. The best performing woreda was Botor Tolay with 80%, while Agaro was the least performing with 56%. The average perceived quality score for all health centres was 70% while the average for all hospitals was 78%. The highest scoring health facility was Gatta Health Centre of Botor Tolay woreda which scored 93% and the lowest performing Health centre is A/Dika Health centre of Kersa woreda with a community quality score of 49%. The highest performing hospital was Setema with 93%, while Agaro was the least with 57%. The perceived quality scores are high already at the start of the project partly because there is already the community score-card system which is implemented by all health centres in line with and the “Caring, Respectful and Compassionate health workers” transformation agenda and PBF community verification complements the system.

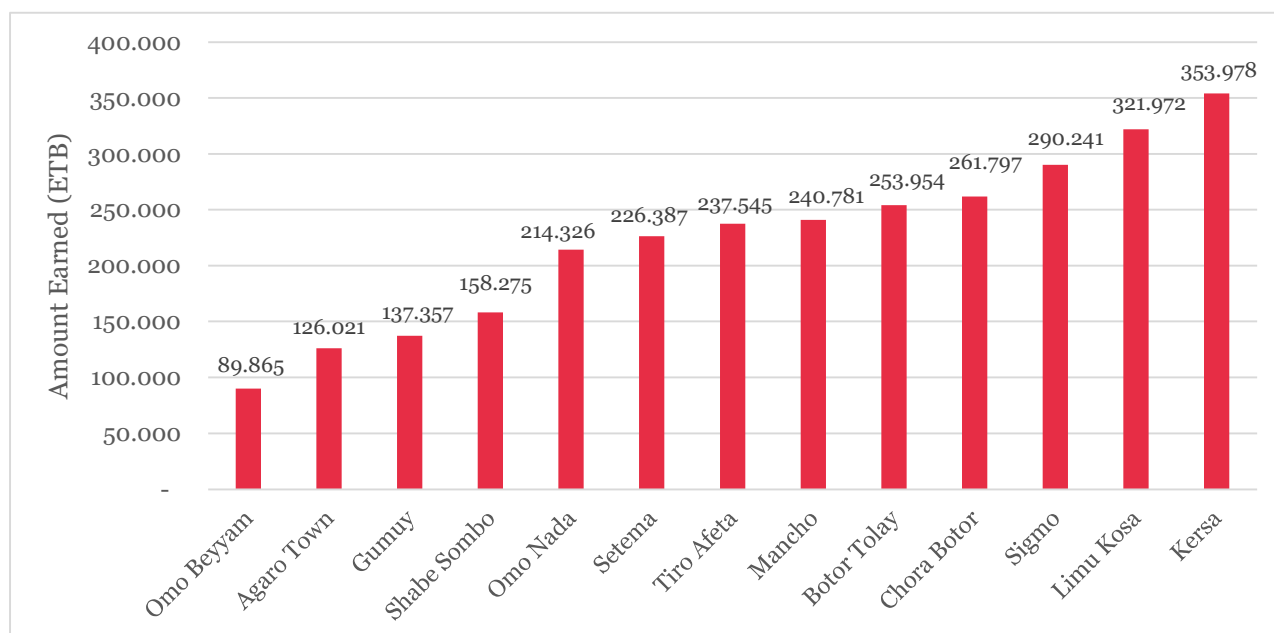
At the end of each community verification exercise, feedback sessions were organized and outcomes were provided to all Health facilities on a summary sheet of CBOs reporting format. the findings were then also communicated to WHOs/ZHD by the PBF verification officers. Communities have formulated suggestions on how service providers should improve on service delivery in their health facilities. Some of the major suggestions are summarized here:

- Health facilities should make available water
- Health facilities should purchase solar for light and/or alternative light sources
- Government should make available experienced health professionals at health centres
- Employ nonmedical staffs at card room and for cleaner
- Improve cleanliness of Health Facilities, Toilet and compounds
- Make available better food service for mothers in labour in waiting area by community mobilization
- Conduct regular meetings with community to identify the gaps of the service providers
- The staff of health facility should be available on duty and on time
- Construct roads to improve ambulance service utilization

### **Output 1F: Quarterly PBF invoicing and timely payments to the health facilities**

The invoicing process was done timely to ensure timely disbursements of subsidies to all the contracted health facilities. Below is the summary of subsidies paid to the health facilities for the 4<sup>th</sup> quarter of 2019. The highest earning indicators were all OPD indicators combined, Family Planning and Skilled Delivery with respectively 33%, 19% and 15% of the total payments to health centres. On the other hand the lowest earners were “Cases of diabetic patients receiving treatment”, “Cases of TB treated and cured” and “Newborn management of a baby born to an HIV positive mother”.

**FIGURE 48 » TOTAL SUBSIDIES PAID TO PRIMARY HEALTH CENTRES AGGREGATED PER WOREDA (ETB)**



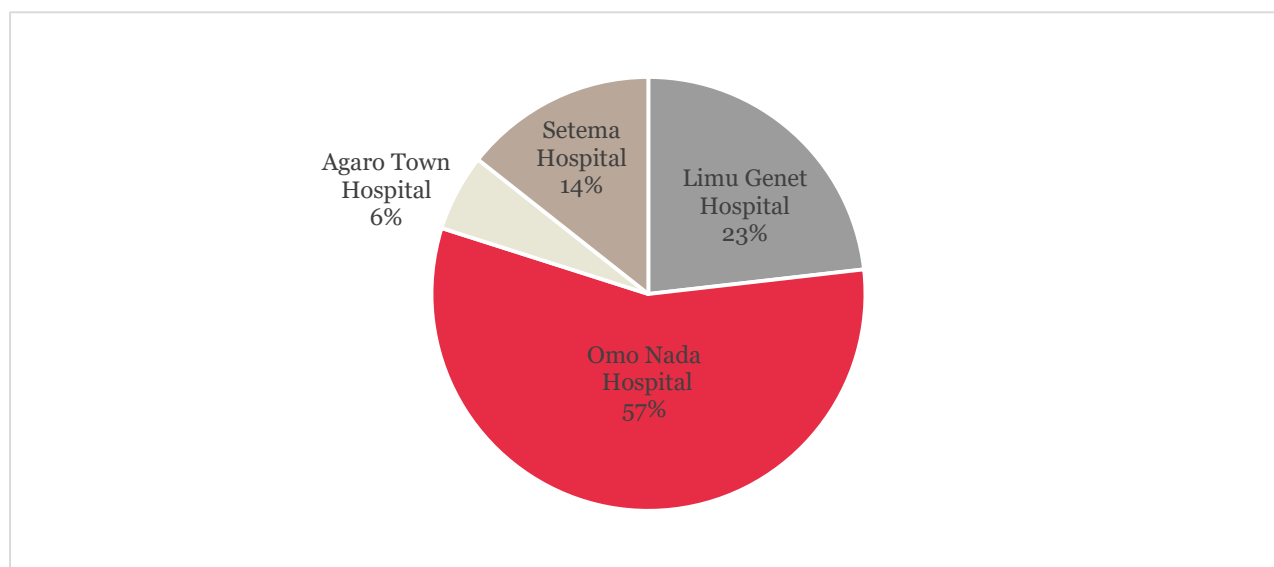
A total of 2,912,497.17 ETB was paid to the health facilities for Q4 2019. The highest paid health facility is Bage HC (116,734.97 ETB) in Chora Botor Woreda. Bage HC is among the 15 facilities with the highest catchment population in the PBF project area, with 36,901 inhabitants, and is well located, with a remoteness score of 0%. The least paid is D/Gibee (5,366.62 ETB) from Tiro Afeta Woreda. On average, the payment per HC was 45,508 ETB, with 40,937 ETB as the median.

With a total number of 7 Health centres, Kersa Woreda is the highest paid with a total amount of 353,977.89 ETB, while Omo Beyyam, with 4 Health centres, is the least paid woreda (89,865 ETB). Kersa Woreda is also the most populated woreda with 230,394 inhabitants. Considering the equity component of the PBF in Jimma project, Adare Dika health centre is the only unfavoured health centre falling in the 20% remoteness/hardship category in Kersa woreda, and definitely is the least paid among others. The same situation was observed in Omo Beyyam woreda, where Sombo Badalla Health centre is the most hard to reach and is the least paid. On the other hand, Chora Botor earned on average the highest amount of subsidies per health centre with facilities earning on average 87,266 ETB for Q4 2019. The lowest average earning per health centre was seen in Omo Beyyam Woreda with facilities earning on average 22,466 ETB.

**TABLE 7 » TOTAL SUBSIDIES PAID TO HOSPITALS**

#	DISTRICT	HOSPITAL	AMOUNT
1	Agaro Town	Agaro General Hospital	20,081.41
2	Sentema	Setema Primary Hospital	50,341.35
3	Limu Kosa	L/genet General Hospital	81,304.55
4	Omo Nada	Omo Nada Primary Hospital	198,631.00
		<b>TOTAL PAID</b>	<b>350,358.31</b>

As figure 49 shows, Omo Nada Hospital earned more than 50% of the total amount paid to all contracted hospitals. The total number of services declared in Agaro and Limu Kossa hospitals were three times more than those declared in Omo Nada hospital, however, 93.4% of declared services at Omo Nada hospital were fully verified, which made them the best paid hospital. The reason of the high performance of Omo Nada hospital has been described above. Overall, OPD indicators and skilled delivery (excluding CS) are the most paid indicators with 40.6% and 30.5% of total subsidies respectively.

**FIGURE 49 » PERCENTAGE OF TOTAL SUBSIDIES EARNED PER HOSPITAL**



## 2. OUTCOME 2: IMPROVED GOVERNANCE OF HEALTH SERVICE DELIVERY

This outcome focuses on how to increase capacity at the level of Woreda Health Offices and Zonal Health Department to perform their regulatory tasks and provide supportive supervision, and also on ensuring institutionalisation of PBF in the Ethiopian health system. A total of 45 representatives of the regulators were trained on PBF during the period under review and were also exposed to the on-the-job orientation of quality assessment during the baseline where the assessment was conducted by the Borana counterparts. All WHOs and ZHD were able to successfully and objectively conduct their first quality assessment for Q4 2019, though more technical support is still needed. However the main gap which still needs to be addressed is the ability to conduct routine supportive supervision to the health facilities, for which they cite financial and transport related challenges. Generally the capacity of regulators at woreda and zonal level needs to be addressed as some have less years of experience and sometimes supervision teams lack people with certain technical expertise. Mobilisation of communities for CBHI still needs to improve in most woredas and also woredas still need to ensure timeliness of HMIS reports. Use of data for decision making still needs to be improved, for example by prioritizing underperforming health facilities using the quantity and quality assessment data which is shared with them routinely. In the midst of scarcity of resources, use of data is critical to inform the most efficient way to perform supportive supervision.

Part of the efforts towards institutionalization of PBF was setting up of the regional PBF steering committee and also organise the study tours to Rwanda and Liberia for decision makers. While the regional steering committee has been set up, they are yet to hold their first meeting since they have been seized with COVID-19 response preparation since early 2020. The same reason coupled with restrictions in international travels have also resulted in indefinite postponement of the study tours which were meant to expose the decision makers, so that they can make an informed decision about considering PBF as one of the healthcare financing mechanisms in Ethiopia, and PBF institutionalisation in the long term.

### **Output 2A: Staff at WHOs and ZHD are trained on PBF**

Table 8 below summarises the number of representatives of the regulators that were trained on PBF by Cordaid. The focus of the training was to have regulators understand PBF as an approach and also understand their role in the institutional arrangement. Also for them to understand their own indicators as regulators, as well as the indicators for HFs (both quantity and quality), including the associated processes like business planning, performance agreements, and how to conduct the quality verifications. Above all the training clearly highlighted how the PBF project fits withing the existing Health Sector Transformation Plan (HSTP).

**TABLE 8 » NUMBER OF REGULATORS TRAINED IN PBF CATEGORIZED BY GENDER**

NO	WOREDA	# OF PARTICIPANTS	MALE	FEMALE
1	Agaro	3	67%	33%
2	Botor Tolay	3	100%	0%
3	Chora Botor	3	100%	0%
4	Gumay	3	100%	0%
5	Kersa	3	67%	33%
6	Limu Kossa	3	100%	0%

7	Mancho	3	67%	33%
8	Omo Nada	3	67%	33%
9	Omo Beyyam	3	100%	0%
10	Setema	3	100%	0%
11	Shabe	3	100%	0%
12	Sigmo	3	100%	0%
13	Tiro Afeta	3	67%	33%
14	JZHO	6	100%	0%
<b>TOTAL</b>		<b>45</b>	<b>89%</b>	<b>11%</b>

39 regulators were trained from the 13 woredas and 6 regulators from the ZHD making a total of 45 participants. Out of all the 45 trained regulators only 11% of participants were female. Generally there are few women within the health care system in Jimma as was also confirmed by the Gender analysis report at health facility, woreda health office and Zonal Health department level.

#### **Output 2B: Quality assessments and supportive supervision of HFs by WHOs and ZHD**

All the WHOs and the ZHD managed to conduct the quality assessment in their respective Woredas within the stipulated timelines. This was their first time to conduct the assessment following the practical orientation they got during the baseline assessment from their Borana counterparts. All Woreda Health Offices and the Zonal Health Department conducted the quality assessments in collaboration with Cordaid field staff. Continued technical support was provided during the process to ensure that the assessment is conducted in a thorough and objective manner. While they still face challenges with regard to transport and other logistical requirements, they managed to plan ahead and ensured these are done timely. The major challenge noted was that some WHOs and ZHD were availing few officers to conduct the assessment. This limits the expertise within the assessment team and makes the process longer and tiresome thereby posing a risk of compromised quality. This issue was discussed with the ZHD to ensure that in the next assessment the issue is resolved and also during PIM review the minimum number for team composition is going to be reviewed. It was also noted that some WHOs did not manage to conduct the routine supervision during the period under review due to transport challenges which were highlighted even during the baseline.

#### **Output 2C: A quarterly cycle of assessments of the performance of the WHOs & ZHD**

The PPA conducted the performance evaluation of all the WHOs and the ZHD during the period under review. Generally all WHOs were motivated to execute their roles. The only indicator which was not implemented fully across all WHOs is the CBHI indicator. All woredas managed to come up with action plans though they still need to improve in making them even more SMART, however this is work in progress, as the verification officers are continuously providing coaching to the WHOs. Four (4) Woredas namely Kersa, Omo Beyyam, Omo Nada, and Tiro Afeta had their health centres failing to meet the reporting timelines and completeness as stipulated in the HMIS guidelines. Two (2) WHOs did not manage to support the health centres in developing their business plans and they were only supported by the verification officers. Below is the overview of the performance of the WHOs and ZHD with regards to the indicators.

**TABLE 9 » QUALITY PERFORMANCE OF WOREDA HEALTH OFFICES**

No	INDICATORS	# OF WOREDA HEALTH OFFICES <u>NOT</u> COMPLETING ACTIVITY	# OF WOREDA HEALTH OFFICES COMPLETING ACTIVITY
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1	Woreda Health Office quarterly Action Plan	0	13
2	Strengthening the use of HMIS / DHIS2 by the health centres and Woreda Health Office	4	9
3	Percentage of households enrolled in CBHI and received their annual ID card (if CBHI is not applicable: number of quarterly PBF review meetings organized by the Woreda Health Office)	13	0
4	Support of the health centres in the development of their quarterly business plans	2	11
5	Carry out quarterly quality assessments of the Health centres and submit timely to the PPA	0	13
6	Carry out quarterly supervision in the Health centres	8	5

Regarding the CBHI indicator, none of woredas scored the minimum requirement to get paid for this indicator. Simply this is due to the low enrolment rate of households at woreda level. In addition, as per Oromia Regional Health Bureau each Woreda can only start implementing CBHI when at least 50% of households is enrolled in the program. Now, most of Woreda are still on the stage of enrolment of households. However, PBF indicator consider the total number of households in the Woreda as denominator for this specific indicator and this is the source of the huge gap that all Woreda health offices are missing to get the targeted subsidies.

**TABLE 10 » QUALITY PERFORMANCE OF THE ZONAL HEALTH DEPARTMENT**

No	INDICATORS	PERFORMANCE Q4 2019
1	Zonal Health Department quarterly Action Plan	1
2	Strengthening the use of the HMIS / DHIS2 by the hospital and Zonal Health Department	13
3	Organization of PBF Joint Review meetings.	1
4	Support of the hospitals in the development of their quarterly business plans	4
5	Carry out quarterly quality assessments of the Hospitals	4
6	Carry out quarterly supervision in the hospitals (7) and the woreda health offices (21), so also those not participating in PBF	9

While the ZHD managed to conduct all other indicators more effort is still needed in providing regular support supervision to hospitals. The team composition should also be reviewed to ensure that all relevant departments are included in the team to provide comprehensive technical support to the hospitals. The major challenge that still needs to be addressed is conducting routine support and supervision in the hospitals. No hospital was visited for supportive supervision during period under review except one. The main reason given is the shortage of financial and transport resources.

#### **Output 2D: Operational planning, contracting for the WHOs and ZHD**

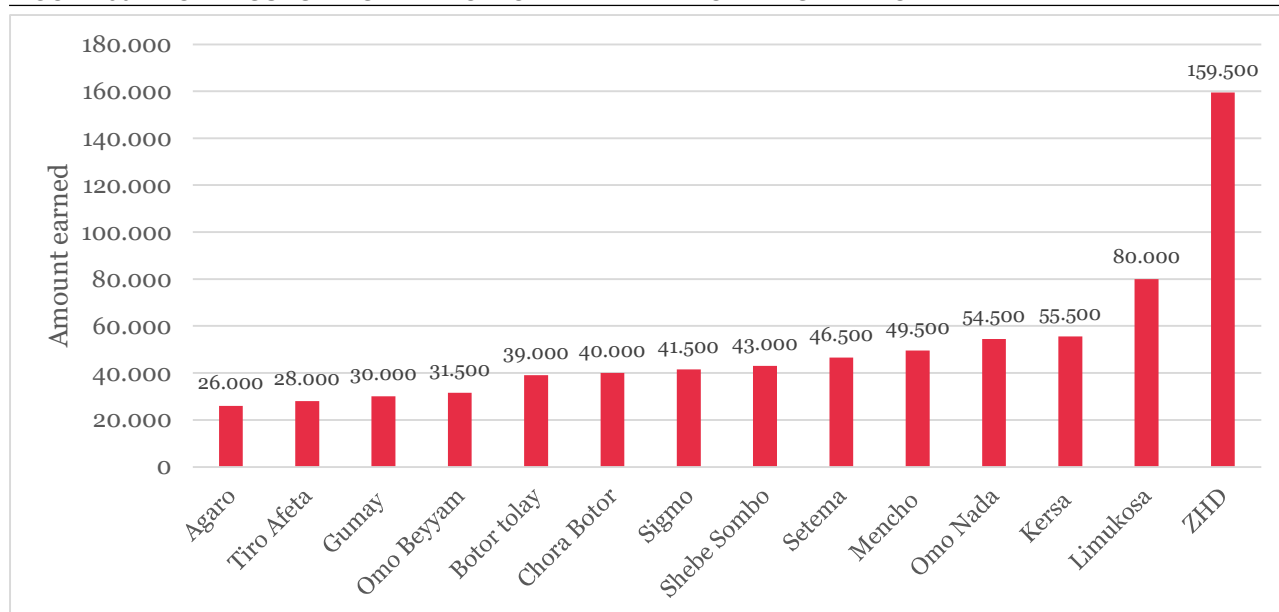
13 WHOs and 1 ZHD were contracted during the period under review. This followed the successful submission of their action plans. The quality of action plans however still needs to be improved and therefore the PPA staff has prioritised to continue assisting them to improve. The action plans still need to be more SMART. Some of the strategies proposed in the action plans by some WHOs were not very realistic and the responsible people and timelines were not well specified. Generally it was noted that WHOs knew and appreciated the importance of action plans but the demoralisation factor

which had resulted in the negligence of doing action plan was continuous lack of resources. All WHOs and ZHD who signed the contracts showed commitment and enthusiasm to make the project a success.

### **Output 2E: PBF invoicing and timely payments to the WHOs and the ZHD**

Timeliness of PBF subsidies payment is very important in PBF cycle to maintain the direct link of payment and performance, thereby maintaining some level of trust in the process, as well as to ensure motivation. In this regard invoices for the regulators were prepared and processed timely. The invoices were generated manually using Excel since the database system was not yet finalised. Being the first time there were some few errors from the field staff in the process but with the close technical support from the national Cordaid office the invoicing and payment process was completed within the stipulated timelines. Below is the overview of the payment made to the regulators.

**FIGURE 50 » TOTAL SUBSIDIES PAID TO WOREDA HEALTH OFFICES AND ZONAL HEALTH DEPARTMENT**



In total, the 13 woreda health offices earned 565,000 ETB, and Jimma ZHD earned 159,500 ETB. The total amount earned per woreda is proportional to its performance coupled with the number of health centres under supervision of each woreda. The least paid Woredas are mostly those with small number of facilities under their supervision that is Agaro and Gumay Woredas with 2 and 3 health centres respectively. Limu Kossa, Kersa and Omo Nada woredas have the highest number of health centres to supervise and consequently earned 34% of the total subsidies paid to all woredas.

### **Output 2F : A Technical Assistance (TA) Plan**

While the implementation of PBF in Borana and Jimma is ongoing, Cordaid is also involved in a continuous discussion with FMOH and ORHB about the future of PBF in Ethiopia, including possible further scaling up as well as integration of PBF (elements) into the Ethiopian health policies. If PBF is to become a sustainable health financing strategy in Ethiopia in the longer term, it is paramount that these discussions take place at an early stage. Hence these discussions started already during the period under review. Various directorates at FMOH were engaged like the directorate for Medical Services, Directorate for Partnerships and Coordination, Health Financing and other key directorates. These discussions are even more relevant as the current Health Sector Transformation Plan (2015-2020) will soon expire and authorities were in the process of drafting the next Health Sector Transformation Plan (2020-2025). If proven to be effective, PBF could be considered as one of the strategies for upcoming years. Discussions were initiated with the FMOH and ORHB on possible areas of TA and the prioritised ones were study tours to Liberia and Rwanda during 1<sup>st</sup> quarter of 2020 however these were delayed due to the recipient countries indicating the need to postpone because of the global COVID-19 epidemic.

### 3. OUTCOME 3: AN ENHANCED HEALTH INFORMATION SYSTEM

To strengthen the health information system that supports data based decision making at Woreda, Zonal and Regional level, a data base system which is linked to DHIS2 has been successfully developed by BlueSquare. Both PPA staff and regulators have been trained on the use of the system which included electronic data collection. The system was tested and is now ready for use. Cordaid also contracted Proof of Impact to develop the blockchain platform for the project, which will create additional financing potential for the Ethiopian health system through enhanced transparency. The progress has been satisfactory to date and on target with regard to timelines. An independent verification of this work has been conducted by *Blockchainlab Drenthe*, the first phase of which covered those elements which could meaningfully be assessed at this stage, i.e. the governance of the system, its interoperability, scalability and flexibility, security and privacy and the operational model. The report has been submitted to the Embassy simultaneously with this Annual Report 2019.

***Output 3A: A PBF data and invoicing system (Open-RBF) is in use, integrated into (or compatible with) the national DHIS2 warehouse***

BlueSquare conducted the scoping mission in 2019 and submitted a report with timelines of the implementation. The progress has been satisfactory during the period under review and they managed to all but finalize the PBF data system, which is compatible with the DHIS2, in March 2020. The testing of the system was successful and the training of staff and regulators have been conducted in February 2020. Although the invoicing for 4<sup>th</sup> quarter of 2019 was done manually because the system was at that time still being finalised, data was entered retrospectively after the finalisation of the system.

***Output 3B: Electronic data collection, using tablets***

The tablets were procured for the verification officers and the regulators, to be used for data collection for quantity and quality verifications respectively.

***Output 3C: Advanced data visualization tools (DataViz)***

The DataViz component is yet to be added to the system. The idea here is to get the system up and running perfectly and also upgrade the Borana data system, before the DataViz component can be added to the system in the course of 2020.

***Output 3D: A selection of verified impact events has been tokenised and is being recorded on a blockchain***

By the end of 2019, this was work in progress. The first full round of quarterly verifications is expected to be finalized in February 2020, after which data needs to be entered into the newly developed data system, and the first fully verified impact events can be pushed to the blockchain based platform of Proof of Impact. This is expected to happen in April 2020.

In the meantime, a lot of work has been done by Proof of Impact to develop the necessary data architecture. An independent verification of this work has been conducted by *Blockchainlab Drenthe*, the first phase of which covered those elements which could meaningfully be assessed at this stage, i.e. the governance of the system, its interoperability, scalability and flexibility, security and privacy and the operational model. Additionally, the criteria of the Amsterdam Blockchain Lab were applied to the project. The first phase report is due for submission to the Embassy on March 31<sup>st</sup>, 2020 and will be shared separately. A full assessment of the data architecture will be conducted later, and the final report submitted in December.

***Output 3E: The selected impact events can be verified, recorded and tokenised at the Point of care***

Work on this output has not yet started in 2019. In close consultation with Proof of Impact and other stakeholders, it was decided to first focus on getting outputs 3D and 3F right, and then focus on output 3E in later years of the project.

***Output 3F: An economic model for the tokenised impact events has been developed***

Proof of Impact was contracted by Cordaid in June 2019, and initial activities focused on developing an economic model for the tokenised impact events. In July 2019 and October 2019, a representative of Proof of Impact (Irene Visser) visited Cordaid project sites in Borana and Jimma respectively, to get a good understanding of how Performance Based Financing works, what is technologically feasible in the context and how verified events could be presented/ marketed to potential donors. In September 2019, a workshop was organized at Cordaid The Hague, during which representatives of Cordaid and Proof of Impact (four each) brainstormed about how to package the impact events and which audiences to target. As an outcome of the process, it was decided to develop three baskets of verified impact events – around essential healthcare, around maternal care and around child care – initially to be marketed primarily towards private donors. Subsequently, one of the baskets (around essential healthcare) was elaborated further, and a demo of what the user experience could look like was successfully demonstrated by Proof of Impact at the Blockchain Workshop organized by the Netherlands Embassy in Addis Ababa in late November 2019. Based on this, the work continues in 2020 to further elaborate the other two baskets and illustrate them with photographic material from the Jimma Zone. Once actual verified impact events will become available (March/April 2020), they will be presented in the chosen formats to a panel of test users. An important discussion still to be had – first with the Embassy, and then with the Ethiopian authorities – is about where any additional funds raised through the Proof of Impact platform (the ‘Global Impact Marketplace’) should eventually be channelled.

## CONCLUSIONS

In this annual report, we have reported the progress made in the implementation of Performance Based Financing in Jimma Zone in 2019. Out of these first nine months of the project, the first six months (April to September) were used as an Inception Phase for the project, whereas the last three months (October to December) together formed the first quarter of PBF implementation. Inception phase activities, such as the finalization of the project design, preparatory activities and the concrete set-up of the project, have thus constituted a large part of Cordaid's work. The successful completion of most of these activities enabled a timely start of the regular implementation of PBF in 68 health facilities, of which the first results are already becoming visible. Most notably, we are observing progress towards the objectives under Outcome Pathway 1, which directly target *Improved Health Service Delivery*. For Outcome Pathways 2 (*Improved Governance of Health Service Delivery*) and 3 (*An Enhanced Health Information System*), a lot of foundational work has been done, and more tangible results will become visible in the course of 2020. Below, we will briefly summarize the main achievements and challenges encountered during the Inception Phase, as well as the milestones for each of the three Outcome Pathways.

The **Inception Phase** was informed by two scoping missions by Cordaid HQ staff to the Jimma Zone, in November 2018 and April 2019. Immediately after the approval of the project proposal and the start of the project by April 1<sup>st</sup>, 2019, two senior representatives from the Jimma Zonal Health Department attended the International RBF Course in Mombasa, giving them a good understanding of PBF from the start of the project. In May and June 2019, two international PBF experts were recruited at the level of Cordaid Ethiopia (Addis Ababa), as well as an Ethiopian team leader for Cordaid Jimma, who all started their work in July. Simultaneously, Cordaid identified appropriate office space in Jimma Town. In July 2019, a PBF design workshop was organized, during which key stakeholders from all levels of the health system were familiarized with the PBF approach and methodology and, in a participatory process, validated the project set-up. This included the selection of participating woredas, as well as the selection of quantity and quality indicators and the prices and weights attached to them. Directly following the workshop, the first version of the Project Implementation Manual (PIM) was finalized, including a cost projection of the performance based payments during the project period. The newly recruited international staff and Jimma team leader then recruited a team of nine local verifiers in August 2019, who were trained in the PBF approach. In September, a further cascade of trainings to local stakeholders was organized: from each participating entity (the Zonal Health Department, 13 woreda health offices, 64 health centres and 4 hospitals) two to four representatives were trained. On October 7<sup>th</sup>, 2019, an official PBF launch event was organized in Agaro Town, in the presence of representatives from all government levels as well as the Embassy of the Kingdom of The Netherlands. In the direct aftermath of this event, the baseline study was conducted, to collect quantitative and qualitative information about baseline performance at all levels. These baseline visits were also used to sign the first performance agreements with facilities and local authorities, starting by the first of Tikamet (EFY 2012), with which the official implementation of PBF began. Due to a busy schedule, as well as a delay in obtaining necessary project agreements with the regional and federal governments, some of the Inception Phase activities had to be postponed to the fourth quarter of 2019 and first quarter of 2020. Most importantly, this concerned the recruitment and training of local CBOs for community verifications, which was done in December, and the development of the DHIS2 data system, which was finalized by BlueSquare in February 2020. It also concerned the gender analysis, which was completed by a local Ethiopian consultant in the month of December.

Looking at the intended outputs under **Outcome 1**, *Improved Health Service Delivery*, most progress on outputs 1A (the finalization of a Project Implementation Manual) and 1B (the training of the health workforce in PBF), had already been realized during the Inception Phase. For all the other outputs (1C to 1F), the work began in earnest with the start of actual PBF implementation in the fourth quarter of 2019. All health facilities developed their first business plans, and signed their first performance agreements, after which the first rounds of performance verifications took place. In November, the first quantity verifications were conducted (by Cordaid Jimma, as the PPA), followed by the first quality verifications in December (by local health authorities, assisted by Cordaid Jimma) and the first community verifications in January (by the recruited CBOs). Based on the outcomes, all entities received their first performance based payment in February 2020.

Comparing the outcomes of these first verifications to the outcomes of the baseline study (which had looked at the performance in September), we can already see some remarkable progress, most notably in the reliability of the reported data and in the quality scores obtained by the facilities. During the baseline, verifiers were only able to fully verify 11.4% of all services reported by the health centres (all indicators together), but during the fourth quarter of 2019 this had already increased to 51.0%. For four types of services at health centres, the overall rate of verification had gone up to more than 60%: i.e. for adult OPD consultations, for HIV testing, for mothers receiving PMTCT option B+ and for the treatment of



STI. This is all the more remarkable since for two of these services (mothers receiving PMTCT option B+ and the treatment of STIs), the rate of verification had been lower than 10% during the baseline study. For family planning services too, the increase in data accuracy and reliability was very promising at health centres: from 1% of the cases being fully verified during the baseline assessment (for both family planning by short term methods and by long term methods) to more than 50% during the 4<sup>th</sup> quarter of 2019. This is even more so at the hospitals, where long term family planning methods could be verified for 91.4% during the first verification compared to 0% during the baseline. Not all indicators showed the same progress though: the cases of ANC4 being fully verified only rose from 1.2% to 6.1%. This is understandable, as this is an indicator which is notoriously difficult to register fully correctly. The overall improvement can be explained by the level of awareness that facilities have adopted to properly document cases on patient cards and in registers, as well as by the coaching and supervision they received from verification officers and regulators. Disaggregating the health centre numbers by woreda, the highest ratio of verified cases versus reported cases in the 4<sup>th</sup> quarter of 2019 was achieved by Botor Tolay (71.0%), followed by Chora Botor (68.5%), while the lowest ratio was recorded by Omo Nada woreda (32.6%). A similar improvement in data accuracy, although less dramatic, can be observed in hospitals, where the number of fully verified cases (all indicators together) rose from 7.6% to 26.4%. However, the outcomes varied significantly across the hospitals with 93.4% of cases fully verified in the best performing hospital, Omo Nada, but only 9% in the worst performing, Agaro.

While data quality improvement is one of the first visible effects of PBF, the effect on the reported level of service utilization is more mixed. On the one hand, service providers under PBF are more motivated to see and treat more patients. Similarly, due to improving quality of care, more health care seeking behaviour can be expected from patients. After only three months of project implementation, however, these effects may not be very substantial. On the other hand, the strict verification of data and application of the 10% discrepancy rule (no payment on an indicator if the difference between reported and verified numbers is more than 10%) will encourage facilities to no longer cook their data. As a result, we can expect *reported* service utilization to decrease. In Jimma Zone, the latter effect, seems to have been stronger initially: calculated on an annual basis, the total number of cases during the first quarter of verifications was 2% lower than during the baseline. This decrease would have been 12% if it wasn't for the significant increase of 78% in declared cases of testing for HIV/AIDs. This decrease may very well have to be attributed to the fact that health centres are starting to report more accurate figures to the authorities. The largest drops in declared cases are in Omo Beyyam (-/- 36%), Tiro Afeta (-/- 33%) and Omo Nada (-/- 25%). These drops in declared cases are especially seen across multiple maternal and child health indicators, which alleviates the fear heard at the start of the project that PBF could cause an increase in the declared figures.

In addition, the introduction of PBF seems to have had quite an immediate effect on the quality scores of health facilities. At health centre level, there is good improvement across all domains, with the average total quality scores going up from 19.3% during the baseline verification to 35.2% during the first regular verification in the fourth quarter of 2019. The highest average scores per domain are being recorded on antenatal care services, nutrition services and logistics, medicines and supplies. A very pronounced improvement was also recorded on referral services. On the contrary, despite slight improvement, average scores remained very low on emergency services, on outreach services and health post supervision, and on nutrition services. The worst performing woreda in Q4 2019 was Omo Beyyam woreda, where health centres on average obtained only a 21% quality score (compared to Mancho woreda being the worst during the baseline, with an average of 12%). The best performing woreda in Q4 2019 was Chora Botor, with an average of 50% (compared to 29% in Botor Tolay, the highest woreda average during the baseline). The best performing health centres generally outperformed the others in the domains of infection control and waste management, emergency services and inpatient services.

In hospitals, too, there was good improvement, the average score going up from 29% during the baseline to 52% during the fourth quarter of 2019. Omo Nada Hospital continues to be the highest performer, scoring 45% during the baseline and no less than 81% in Q4 2019. Also in Setema (from 14% to 47%) and Limu Genet (from 26% to 47%), there was marked improvement. Agaro Town was the least performing hospital in the fourth quarter, with a 36% score, slightly up from 31% during the baseline. The best performing domains are surgical services and laboratory services, which were already performing high during the baseline assessment as well. The best improvement compared to the baseline is observed on emergency services, logistics, medicines and supplies and administration, finance, HRM and planning. Average scores remained very low on inpatient services and infection prevention and waste management, although Omo Nada Hospital is a positive exception in the last area. In general, the way in which Omo Nada Hospital has proactively taken up the PBF approach – conducting internal quantity and quality verifications prior to the visits of verifiers – can serve as an example. All improvements in quality performance are all the more remarkable since they were achieved by health facilities before they received any performance based payments. This shows that already at the start of implementation, there was a high



level of motivation and commitment among health professionals to make this project a success, as well as a solid understanding of how PBF works. In as far as possible without substantial financial investment, facilities put considerable effort into addressing the gaps that had been identified during the baseline assessment, in order to be entitled to a higher first quarterly payment. In stating this, we can already observe tangible progress towards Medium Term Outcome 1.1 of the project: 'health professionals function as a team, are motivated, pro-active and are respectful and caring towards their patients'. As illustrated above by the improved accuracy and reliability of the data, progress is also being made towards Medium Term Outcome 1.5: 'monthly HMIS data of the facilities is of good quality (reliable, accurate, timely and complete) and is used to take informed decisions.' Surprisingly, the level of perceived quality by patients is quite high at the start of the project, as the outcomes of 1,275 surveys show: 70% on average for health centres, and 78% for hospitals.

Under **Outcome 2**, the project aims to contribute to *Improved Governance of Health Service Delivery*. Similarly as for health facility staff, this process started with familiarizing representatives from both the Jimma Zonal Health Department and all 13 Woreda Health Offices to the PBF approach and methodology. This was done firstly through a theoretical PBF training in September (as described above) and secondly by on-the-job training. In October, baseline quality verifications were conducted by mixed teams of health office staff, in which experienced staff from Borana (where the PBF approach has been in use since 2015) took the lead and oriented the health office staff from Jimma on how to verify in practice. In December, the first round of regular quality verifications took place, conducted by the Jimma health office staff with support from Cordaid Jimma. Despite some challenges – most notably a limited availability of staff – all WHOs and the ZHD managed to conduct the quality assessments within the stipulated timelines. In general, they have showed commitment and enthusiasm to make this project a success. In their turn, all WHOs and the ZHD have also signed their first performance agreements with Cordaid Jimma (as the PPA) and have been subject to a first evaluation of their own performance. All entities managed to come up with action plans, although they still need to improve in making them even more SMART. Some of the strategies proposed in the action plans by WHOs were not very realistic and the responsible people and timelines were not well specified. The only indicator which was not implemented at all across all WHOs is the indicator related to the level of CBHI enrolment. Due to the low enrolment rate of households at woreda level, none of the woredas scored the minimum requirement to get paid for this indicator. Based on their verified performance during the 4<sup>th</sup> quarter of 2019, the ZHD and 13 WHOs, like the health facilities, received their first PBF payment in February 2020.

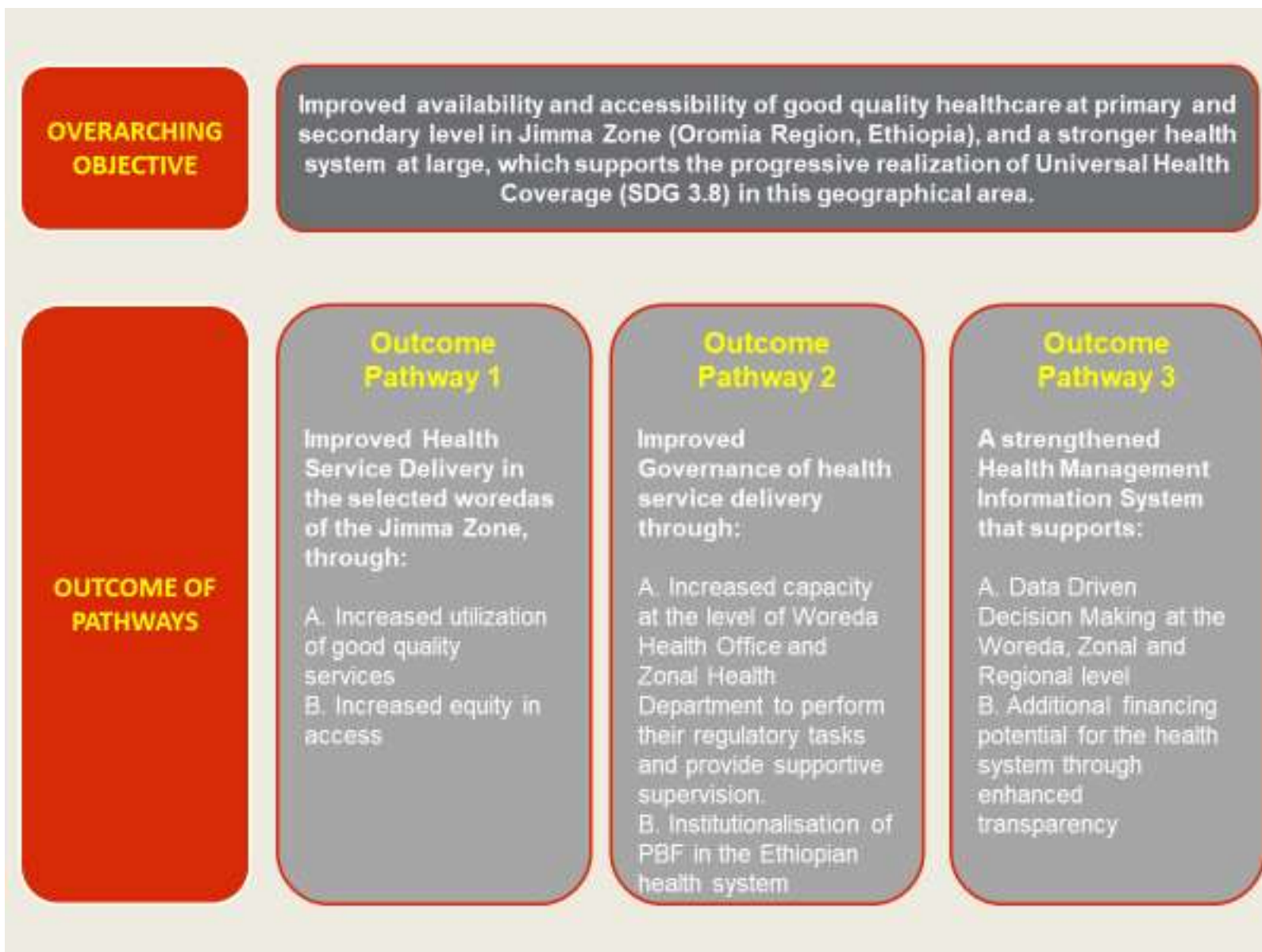
In addition to the progress on outputs 2A to 2E, as described above, Outcome 2 also aims to contribute to the long term institutionalisation of PBF in the Ethiopian health system. Under output 2F, the project envisions that a Technical Assistance (TA) plan on how to integrate PBF into the Ethiopian health system, health policies and health financing strategies will be approved by the Federal Ministry of Health (FMoH), and implemented in a phased way. In working towards this goal, Cordaid has liaised proactively with key directorates of the FMoH and developed a draft TA Plan for 2020. Due to the COVID-19 crisis, unfortunately, concrete activities envisioned in that plan could not yet be implemented.

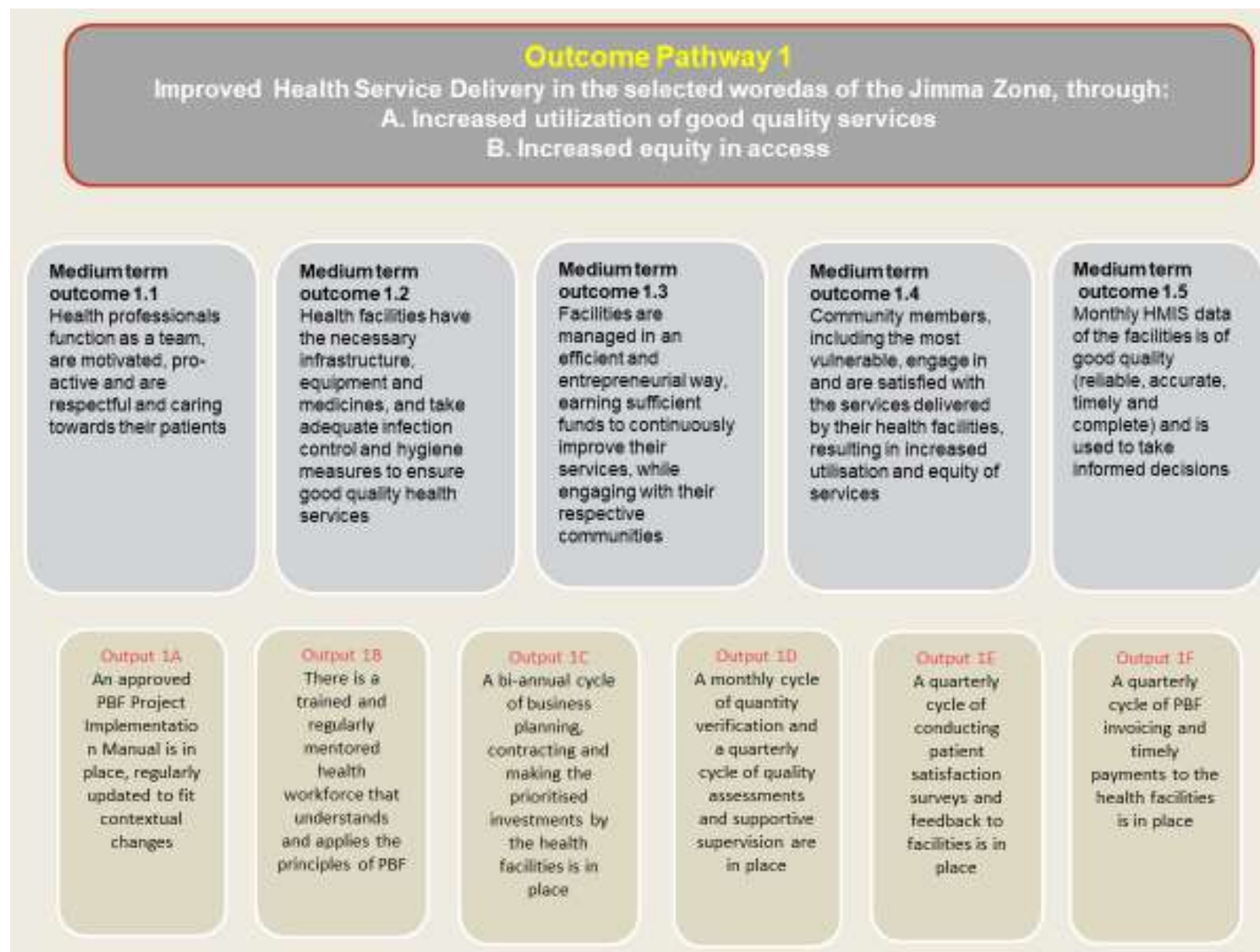
Activities under **Outcome 3**, which aims at *An Enhanced Health Information System*, were mostly work in progress by the end of the period under review. In 2019, BlueSquare was contracted by Cordaid to develop a PBF data system linked to the national DHIS2, as well as to develop the necessary tools for digital data collection (using smart phones and tablets) by the local verifiers and regulators (outputs 3A and 3B). This was all work in progress by the end of 2019, but was all but finalized in March 2020: the system was tested and is ready for use. Cordaid staff and representatives of the regulators have been trained on the use of both the data system and the digital data collection. Work on output 3C, which aims at developing more advanced data visualization tools (DataViz) is scheduled to start in the first half year of 2020. In 2019, Cordaid also contracted Proof of Impact to develop a blockchain platform. The focus so far has been on Output 3D (the tokenisation of a selection of verified impact events, which can then be recorded on a blockchain) and Output 3F (the development of an economic model for the tokenised impact events). The progress in 2019 has been satisfactory and a first demo was presented during a blockchain workshop organized by the Embassy in Addis Ababa in November 2019. An independent verification of this work (first phase) has been conducted by Blockchainlab Drenthe, showing some areas of attention, but generally confirming that the work is on track. In April 2020, the first actual verified data from Jimma are intended to be made available for purchase on the platform for a panel of test users, although some delay might now occur due to the COVID-19 crisis. Work on Output 3E, enhanced verification at the point of care, has not yet started.

All in all, the project is very well on track. Despite some small delays, all essential implementation processes, including the contracting and verification, as well as the execution of the PBF payments, are taking place according to schedule. As a result, we may expect further improvement in health service delivery, governance and information systems in 2020.

## ANNEXES

**Annex 1: Theory of Change (From: Original Proposal PBF Jimma Zone, October 2018)**





## Outcome Pathway 2

Improved governance of health service delivery through:  
A. Increased capacity at the level of Woreda Health Offices (WHOs) and Zonal Health Department (ZHD) to perform their regulatory tasks and provide supportive supervision  
B. Institutionalisation of PBF in the Ethiopian health system

### Medium term outcome 2.1

The WHOs and ZHD actively contribute to quality health service delivery and a caring & motivated health workforce, through facility supervision, coaching and quality assessments

### Medium term outcome 2.2

Planning and decision making at WHOs & ZHD level are increasingly data driven, and appropriate management actions are taken, enhancing the performance of the health system in the Jimma Zone

### Medium term outcome 2.3

A roadmap for institutionalisation and integration of PBF within the Ethiopian health system is approved by the FMOH

### Output 2A

Staff at WHOs and ZHD are trained, they understand and apply the principles of PBF

### Output 2B

A quarterly cycle of quality assessments and supportive supervision of the health facilities, performed by the WHOs and ZHD, is in place

### Output 2C

A quarterly cycle of assessments of the performance of the WHOs & ZHD is in place

### Output 2D

A bi-annual cycle of operational planning, contracting and making the prioritised investments by the WHOs and ZHD is in place

### Output 2E

A quarterly cycle of PBF invoicing and timely payments to the WHOs and the ZHD is in place

### Output 2F

A Technical Assistance plan on how to integrate PBF into the Ethiopian health system, health policies and health financing strategies is approved by FMOH and implemented in a phased way



### Outcome Pathway 3

A strengthened health information system that supports:  
A. Data based decision making at the Woreda, Zonal and Regional level  
B. Additional financing potential for the health system through enhanced transparency

#### Medium term outcome 3.1

The WHO, ZHD and ORHB can generate, analyse and use DHIS2 and verified PBF data, translating them into appropriate actions

#### Medium term outcome 3.2

Through Blockchain technology, verified PBF impact events such as outpatient consultations (OPDs) and institutional deliveries are being tokenised and donors/investors can purchase outcomes

#### Output 3A

A PBF data and invoicing system (OpenRBF) is in use, integrated into (or compatible with) the national DHIS2 warehouse

#### Output 3B

Electronic data collection, using tablets and Android based applications, is in use

#### Output 3C

Advanced data visualization tools (DataViz) are in use for the DHIS2 and PBF generated data

#### Output 3D

A selection of verified impact events has been tokenised and is being recorded on a blockchain

#### Output 3E

The selected impact events can be verified, recorded and tokenised at the point of care

#### Output 3F

An economic model for the tokenised impact events has been developed

## Annex 2: Logical Framework (From: Original Proposal PBF Jimma Zone, October 2018)

	<p>“Improved availability and accessibility of good quality healthcare at primary and secondary level in the Jimma Zone (Oromia Region, Ethiopia), and a stronger health system at large, which supports the progressive realization of Universal Health Coverage (SDG 3.8) in this geographical area.”</p>		
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Long-term outcomes</p>	<p><b>Pathway 1:</b></p> <p>Improved <b>health service delivery</b> in the selected woredas of the Jimma Zone, reflected in:</p> <ul style="list-style-type: none"> <li>A. Increased utilization of good quality services</li> <li>B. Increased equity in access</li> </ul>	<p><b>Pathway 2:</b></p> <p>Improved <b>governance</b> of health service delivery through:</p> <ul style="list-style-type: none"> <li>A. Increased capacity at the level of Woreda Health Offices and Zonal Health Department to perform their regulatory tasks and provide supportive supervision.</li> <li>B. Institutionalisation of PBF in the Ethiopian health system</li> </ul>	<p><b>Pathway 3:</b></p> <p>An enhanced <b>health information system</b> that supports:</p> <ul style="list-style-type: none"> <li>A. Data based decision making at Woreda, Zonal and Regional level</li> <li>B. Additional financing potential for the health system through enhanced transparency</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Medium-term outcomes</p>	<ul style="list-style-type: none"> <li>1.1 Health professionals function as a team, are motivated, proactive and are respectful and caring towards their patients</li> <li>1.2 Health facilities have the necessary infrastructure, equipment and medicines, and take adequate infection control and hygiene measures to ensure good quality health services</li> <li>1.3 Facilities are managed in an efficient and entrepreneurial way, earning sufficient funds to continuously improve their services, while engaging with their respective communities</li> <li>1.4 Community members, including the most vulnerable, engage in and are satisfied with the services delivered by their health facilities, resulting in increased utilisation and equity of services</li> <li>1.5 Monthly HMIS data of the facilities is of good quality (reliable, accurate, timely and complete) and is used to take informed decisions</li> </ul>	<ul style="list-style-type: none"> <li>2.1 The WHO's and ZHD actively contribute to quality health service delivery and a caring &amp; motivated health workforce, through facility supervision, coaching and quality assessment</li> <li>2.2 Planning and decision making at WHO's &amp; ZHD level are increasingly data driven and strategic, and appropriate management actions are taken, enhancing the performance of the health system in the Jimma Zone</li> <li>2.3 A roadmap for institutionalisation and integration of PBF within the Ethiopian health system is approved by the FMOH</li> </ul>	<ul style="list-style-type: none"> <li>3.1 The WHO's, ZHD and ORHB can generate, analyse and use the verified data from DHIS-2 and the OpenRBF application, translating them into appropriate actions</li> <li>3.2 Through Blockchain technology, verified PBF impact events such as outpatient consultations (OPDs) and institutional deliveries are being tokenised and donors/investors can purchase outcomes</li> </ul>

Key Performance Indicators linked to the Medium- term and Long-term Outcomes

- Number (and percentage) of health facilities showing improvement in the total % score obtained during quality assessment
- Number (and percentage) of health facilities showing improvement in the % score obtained on patient satisfaction surveys
- Number (and percentage) of health facilities that report HMIS Data timely, completely and accurately: for the majority of PBF quantity indicators, the difference between reported and verified data is below the applied margin of error (10%)

**Depending on the final composition of the package of PBF incentivized services, other potential outcome indicators include:**

- Number of institutional deliveries assisted by skilled health personnel
- Number of pregnant women receiving at least one antenatal care (ANC) visit
- Number of pregnant women receiving at least four antenatal care (ANC) visits
- Number of women receiving postnatal care
- Number of fully immunized children
- Number of (young) people tested for HIV
- Number of women of reproductive age using modern short-term FP methods
- Number of women of reproductive age using modern long-term FP methods
- Number of out-patient consultations for patients 5 years and older (adult OPDs)
- Number of out-patient consultations for patients under 5 years (OPDs under 5)

- Number (and percentage) of WHOs and ZHDs showing improvement in the total % score obtained during performance assessment
- Number (and percentage) of WHOs and ZHDs actively supervising and coaching facilities, in line with agreed tasks, norms & frequency
- Number (and percentage) of WHOs and ZHDs actively using performance data to compile and implement bi-annual operational plans
- Improved accountability and governance at local, regional and national level

- Number (and percentage) of WHOs and ZHDs actively using performance data to compile and implement bi-annual operational plans
- Amount of additional funding attracted for health through impact tokens



**Related to Medium-term Outcomes 1.1 - 1.5:**

1A. An approved PBF Project Implementation Manual is in place, regularly updated to fit contextual changes

1B. There is a trained and regularly mentored Health workforce that understands and applies the principles of PBF

1C. A bi-annual cycle of business planning, contracting and making the prioritised investments by the health facilities is in place

1D. A monthly cycle of quantity verification and a quarterly cycle of quality assessments and supportive supervision are in place

1E. A quarterly cycle of conducting patient satisfaction surveys and feedback to facilities is in place

1F. A quarterly cycle of PBF invoicing and timely payments to the health facilities is in place

**Related to Medium-term Outcomes 2.1. and 2.2:**

2A. Staff at WHOs and ZHD are trained, they understand and apply the principles of PBF

2B. A quarterly cycle of quality assessments and supportive supervision of the health facilities performed by the WHOs and ZHD, is in place

2C. A quarterly cycle of assessments of the performance of the WHOs & ZHD is in place

2D. A bi-annual cycle of operational planning, contracting and making the prioritised investments by the WHOs and ZHD is in place

2E. A quarterly cycle of PBF invoicing and timely payments to the WHOs and the ZHD is in place

**Related to Medium-term Outcome 2.3:**

2F. A Technical Assistance plan on how to integrate PBF into the Ethiopian health system, health policies and health financing strategies is approved by FMoH and implemented in a phased way

**Related to Medium-term Outcome 3.1:**

3A. A PBF data and invoicing system (OpenRBF) is in use, integrated into (or compatible with) the national DHIS2 warehouse

3B. Electronic data collection, using tablets and Android based applications, is in use

3C. Advanced data visualization tools (DataViz) are in use for the DHIS2 and PBF generated data

**Related to Medium-term Outcome 3.2:**

3D. A selection of verified impact events has been tokenised and is being recorded on a blockchain

3E. The selected impact events can be verified, recorded and tokenised at the Point of care

3F. An economic model for the tokenised impact events has been developed

Activities	<p><b>Output 1A: (partly during inception phase)</b></p> <ul style="list-style-type: none"> <li>• Scoping Mission to Jimma Zone</li> <li>• Gender Analysis</li> <li>• Exposure visit for Jimma Zone representatives to Borana PBF project</li> <li>• Design Workshop</li> <li>• Costing of Quarterly Subsidies</li> <li>• Compilation of Project Implementation Manual (PIM) and Finalization of Tools</li> <li>• Recruitment of Cordaid PBF staff</li> <li>• Training of Cordaid PBF staff</li> <li>• Launching Event for the Zonal PBF Steering Committee</li> <li>• Annual PIM Review by Zonal PBF Steering Committee</li> </ul> <p><b>Output 1B: (partly during inception phase)</b></p> <ul style="list-style-type: none"> <li>• 4-day PBF training for staff of the selected health centres and hospitals</li> <li>• Coaching of health staff during monthly quantity verifications (see output 1D)</li> <li>• Coaching of health staff during quarterly quality assessments (see output 1D)</li> <li>• 4-day refresher training for health staff during the third year of implementation</li> </ul> <p><b>Output 1C:</b></p> <ul style="list-style-type: none"> <li>• Coaching of health staff during bi-annual business plan preparation</li> <li>• Signing of bi-annual contracts with facilities, after approval of business plans by both Cordaid and the WHO / ZHD</li> </ul>	<p><b>Output 2A: (partly during inception phase)</b></p> <ul style="list-style-type: none"> <li>• Participation of four key representatives from Jimma Zone in Mombasa PBF flagship course</li> <li>• 3-day PBF training for staff of the selected WHO and the Jimma ZHD</li> <li>• 3-day refresher training for WHO / ZHD staff during the third year of implementation</li> </ul> <p><b>Output 2B:</b></p> <ul style="list-style-type: none"> <li>• Quarterly quality assessments of health facilities by WHO and ZHD – assisted by Cordaid – including coaching of health staff and data entry into the PBF data system (see output 1D)</li> </ul> <p><b>Output 2C:</b></p> <ul style="list-style-type: none"> <li>• Quarterly performance assessments of WHO and ZHD by Cordaid, including coaching and data entry into the PBF data system</li> </ul> <p><b>Output 2D:</b></p> <ul style="list-style-type: none"> <li>• Coaching of WHO/ZHD staff during bi-annual operational plan preparation</li> <li>• Signing of bi-annual contracts with WHO / ZHD after approval of operational plans</li> </ul>	<p><b>Output 3A: (partly during inception phase)</b></p> <ul style="list-style-type: none"> <li>• Site visits for DHIS2 analysis and initial policy dialogue</li> <li>• Analysis and presentation of the approach and tools to the HMIS team</li> <li>• Configuration of the PBF data elements in DHIS2</li> <li>• Set-up of OpenRBF, including rules and payment flow for health centres, hospitals, WHO and ZHD</li> <li>• Training of trainers</li> <li>• Continuous policy dialogue on data and HMIS integration</li> <li>• Support and Maintenance</li> </ul> <p><b>Output 3B:</b></p> <ul style="list-style-type: none"> <li>• Setup of Android based data collection</li> <li>• Health facility identification</li> <li>• Setup of verification tools for quantity, quality and patient satisfaction</li> <li>• Training of verifiers</li> </ul> <p><b>Output 3C:</b></p> <ul style="list-style-type: none"> <li>• Configuration of the RBF portal on DataViz</li> <li>• Licensing RBF Portal on DataViz</li> <li>• Training of intended users</li> </ul>
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**Output 1D: (partly during inception phase)**

- Baseline assessment on the uptake & quality of services at selected facilities
- Monthly quantity verifications of reported data by Cordaid Jimma, including coaching of health staff and data entry into the PBF data system
- Quarterly quality assessments of health facilities by WHO's and ZHD – assisted by Cordaid – including coaching of health staff and data entry into the PBF data system (see output 2B)

**Output 1E: (partly during inception phase)**

- Selection of (a maximum of) 73 CBOs to conduct patient satisfaction surveys
- Training and contracting of the 73 CBOs
- Quarterly patient satisfaction surveys conducted by the CBOs, for a sample of the patients of each health facility
- Feedback of survey outcomes to facilities

**Output 1F:**

- Monthly data entry for quantity verification data (see output 3A and 3B)
- Quarterly data entry for quality assessments and patient satisfaction survey data (see output 3A and 3B)
- Quarterly generation of PBF invoices for health centres and hospitals
- Quarterly payments to the health centres and hospitals by the fund holder, after a double check of the invoices generated
- Quarterly performance analysis and compilation of PBF progress report

**Output 2E:**

- Quarterly data entry for WHO and ZHD performance assessments by Cordaid
- Quarterly generation of PBF invoices for WHO's and ZHD
- Quarterly payments to the WHO's and ZHD by the fund holder, after a double check of the invoices generated
- Quarterly performance analysis and compilation of PBF progress report

**Output 2F:**

- Technical Assistance to FMOH (different directorates), MOFED, ORHB and the EHIA
- Development of a PBF Technical Assistance plan or roadmap. in close consultation with all stakeholders. Potential elements:
  - In house trainings
  - Exposure visits
  - Participation in PBF flagship course in Mombasa
  - Temporary secondment of a PBF expert at the FMOH
  - Assistance in policy development
- Development of materials for PBF visibility

**Output 3D:**

- Design (co-creation) workshop with key stakeholders
- Site visits to gather insights on the existing PBF process and workflow
- Development of a pre-ledger for tracking verified impact events
- Manual data capturing of impact events off invoices onto the pre-ledger
- Setup of a dashboard to track impact events over time

**Output 3E:**

- Site visits to understand the existing workflows and design considerations
- Development of low fidelity prototypes of verification mechanisms
- User testing with key beneficiaries
- Design, development and iterations of appropriate verification mechanism
- Training of key stakeholders on the verification mechanism

**Output 3F:**

- Creation of pricing structures of multiple indicator tokens
- Placing of the impact tokens on a marketplace
- Development and implementation of a go-to-market strategy for the sale of impact tokens

**Output 1A:**

- A Project Implementation Manual tailor made to Jimma Zone and approved by the Jimma ZHD & the ORHB

**Output 1B:**

- Number of health facility staff members trained in PBF

**Output 1C:**

- Number of health facilities contracted, based on approved business plans

**Output 1D:**

- Number of monthly quantity verifications of health centres and hospitals conducted timely and completely
- Number of quarterly quality assessments of health centres and hospitals conducted timely and completely

**Output 1E:**

- Number of CBOs recruited, contracted and trained
- Number of quarterly patient satisfaction surveys conducted timely and completely

**Output 1F:**

- Number of quarterly PBF invoices for health centres and hospitals prepared and paid timely

**Output 2A:**

- Number of WHO and ZHD representatives trained in PBF

**Output 2B:**

- Number of quarterly quality assessments of health centres and hospitals conducted timely and completely by WHOs and ZHD

**Output 2C:**

- Number of quarterly performance assessments of WHOs and ZHD conducted timely and completely by Cordaid

**Output 2D:**

- Number of WHOs and ZHDs contracted, based on approved operational plans

**Output 2E:**

- Number of quarterly PBF invoices for WHOs and ZHD prepared and paid timely

**Output 3A:**

- A properly functioning PBF data system, integrated with DHIS2
- Number of government staff (WHOs, ZHD, ORHB and FMoH) trained in the adequate use of the data system

**Output 3B:**

- Properly functioning tools for electronic data collection
- Number of verifiers trained in electronic data collection

**Output 3C:**

- Properly functioning tools for advanced data visualization
- Number of government staff (WHOs, ZHD, ORHB and FMoH) trained

**Output 3D:**

- Number of impact events (PBF indicators) recorded on blockchain

**Output 3E:**

- Number of impact events (PBF indicators) that are verified, recorded and tokenised at the Point of care

		<b>Output 2F:</b> <ul style="list-style-type: none"><li>• Number of regional and national representatives trained in PBF</li><li>• A PBF Technical Assistance plan / roadmap finalized and approved by the FMoH</li></ul>	<b>Output 3F:</b> <ul style="list-style-type: none"><li>• Number of impact events (indicators) for which an economic model was developed</li></ul>
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## Annex 3: Quantity Indicators – Health Centre

NO	INDICATORS	PRICE ETB
1a	First and repeated visits for FP modern methods (short term) – HC level	48
1b	First and repeated visits for FP modern methods (short term) – HP level	48
2a	First and repeated visits for FP modern methods (long term) – HC level	96
2b	First and repeated visits for FP modern methods (long term) – HP level	96
3	First ANC visit before 16 weeks	80
4	Four Antenatal Care Visits (ANC4)	80
5	Skilled delivery (excluding caesarean section)	160
6	Postnatal care visit within first 7 days	40
7	HIV positive tested Pregnant Women put on PMTCT option B+	48
8	Newborn management of a baby born to an HIV positive mother.	48
9a	Immunization of Children < 1 year (fully vaccinated) – HC level	64
9b	Immunization of Children < 1 year (fully vaccinated) – HP level	64
10	Growth monitoring for children < 2 years	8
11	Severe Acute Malnutrition (SAM) children < 5 years	40
12	Vitamin A supplementation (distribution) given to children 6-59 months	8
13	Testing for HIV/AIDS	8
14m	Cases of STIs treated - male	32
14f	Cases of STIs treated - female	32
15m	Cases of Malaria diagnosed positive and treated - male	64
15f	Cases of Malaria diagnosed positive and treated - female	64
16	Cases of diabetic patients receiving treatment	48
17	Cases of hypertensive patients receiving treatment	48
18m	Out Patient Consultations for children < 5 years (new and repeat) – male	16
18f	Out Patient Consultations for children < 5 years (new and repeat) - female	16
19m	Out Patient Consultations (new and repeat cases) - male	8
19f	Out Patient Consultations (new and repeat cases) - female	8
20	Inpatient Bed Days	80
21	Referrals to Hospital	64
22	Cases of TB diagnosed positive by Microscopy	120
23	Cases of TB treated and cured	80

## Annex 4: Quantity Indicators – Hospital

NO	INDICATORS	PRICE ETB
1	First and repeated visits for FP modern methods (long term)	144
2	Skilled Delivery (excluding caesarean sections)	288
3	Caesarean sections	396
4	HIV positive tested Pregnant Women put on PMTCT option B+	252
5	Newborn management of a baby born to an HIV positive mother	252
6m	New HIV/AIDS cases placed on ARV Therapy (ever started) - male	90
6f	New HIV/AIDS cases placed on ARV Therapy (ever started) - female	90
7m	Existing patient on ART for 12 months – male	216
7f	Existing patient on ART for 12 months – female	216
8	Women 30-49 years screened with VIAC for cervical cancer	216
9	Women 30-49 years with cervical lesion treated	270
10	Cases of diabetic patients receiving treatment	54
11	Cases of hypertensive patients receiving treatment	54
12m	Out Patient Consultations for children < 5 years (new and repeat) - male	36
12f	Out Patient Consultations for children < 5 years (new and repeat) - female	36
13m	Out Patient Consultations (new and repeat cases) - male	18
13f	Out Patient Consultations (new and repeat cases) - female	18
14	Blood transfusion	180
15	Cases of TB diagnosed positive by Microscopy	270
16	Cases of TB treated and cured	180

## Annex 5: Quality Checklist – Health Centre

NO	INDICATOR CATEGORY	INDICATORS	TOTAL POINTS
1	General Appearance and Safety	10	17
2	Administration, financial management, HRM and planning	7	10
3	Health Management Information System (HMIS) and Supervision	4	7
4	Infection control and waste management	8	23
5	General Out-Patient Department (OPD)	6	11
6	Under 5 OPD	5	8
7	Emergency services	4	6
8	Antenatal Care (ANC)	3	8
9	Maternity services	13	27
10	Expanded Programme on Immunization (EPI) and growth monitoring (GM)	14	24
11	Nutrition services	4	5
12	Inpatient services	3	6
13	Referral services	4	6
14	Outreach and health post supervision	4	8
15	Laboratory service	10	14
16	Logistics, medicines and supplies	8	20
<b>TOTAL</b>		<b>107</b>	<b>200</b>



## Annex 6: Quality Checklist – Hospital

NO	INDICATOR CATEGORY	INDICATORS	TOTAL POINTS
1	General Appearance and Safety	9	12
2	Administration, financial management, HRM and planning	7	12
3	Health Management Information System (HMIS) and supervision	6	10
4	Infection control and waste management	10	21
5	Out Patient Department	7	12
6	Maternity services	18	30
7	Expanded Program on Immunization	8	10
8	Emergency services	8	16
9	Inpatient services	8	18
10	Surgical services	9	17
11	Laboratory services	10	12
12	Radiological services	7	10
13	Logistics, medicines and supplies	9	20
	<b>TOTAL</b>	<b>116</b>	<b>200</b>

## Annex 7: Demographical Scope of PBF Programme (EFY 2011)

DEMOGRAPHICAL SCOPE AND CHARACTERISTICS OF PBF PARTICIPATING WOREDAS								
Name of Woreda	Total Population	Total Households	Live Birth (3.47%)	Less than 5 Years of Age	# of Health Posts	# of Health Centres	Hospitals	Hospital Population
Agaro Town	41,793	8,707	1,450	6,867	2	2	Agaro Hospital	846,995
Botor Tolay	63,201	13,167	2,193	10,384	17	4		
Chora Botor	79,077	16,474	2,744	12,992	20	3		
Gumay	84,268	17,556	2,924	13,845	14	3		
Kersa	227,959	47,491	7,910	37,454	32	8		
Limu Kossa	221,036	46,049	7,670	36,316	38	8	Limu Genet Hospital	786,500
Mancho	177,009	36,877	6,142	29,083	23	6		
Ommo Beyyam	134,650	28,052	4,672	22,123	16	4		
Omo Nada	208,517	43,441	7,236	34,259	22	7	Omo Nada Hospital	345,916
Setema	142,635	29,716	4,949	23,435	20	5	Setema Hospital	273,234
Shebe Sombo	154,896	32,27	5,375	25,449	20	5		
Sigmo	127,911	26,648	4,439	21,016	19	5		
Tiro Afeta	165,196	34,416	5,732	27,142		5	under construction	
<b>TOTAL</b>	<b>1,828,148</b>	<b>380,864</b>	<b>63,437</b>	<b>300,365</b>	<b>243</b>	<b>65</b>	<b>5</b>	<b>2,252,645</b>

## Annex 8: Annual Health Utilization Target Calculations for Health Centres

HEALTH CENTRE INDICATOR	ANNUAL TARGET CALCULATION
Family Planning (short term)	Catchment population x 18,63% non-pregnant fertile women x 30% women using short-term FP x 4 visits per year
Family Planning (long term)	Catchment population x 18,63% non-pregnant fertile women x 50% women using long-term FP x 90% at PHCU
First ANC visit before 16 weeks	Catchment population x 3,47% live births
Four Antenatal Care Visits (ANC4)	Catchment population x 3,47% live births
Skilled Deliveries (excluding caesarean section)	Catchment population x 3,47% live births
Out Patient Consultations (adults)	Catchment population x 83,57% population => 5
Out Patient Consultations for children < 5 years	Catchment population x 16,43% population children < 5

## Annex 9: Overall Quality Scores per Health Centre (Baseline and Q4 2019)

Health Centre	District	Baseline (Sept 2019)	Verification (Dec 2019)
Sigmo HC	Sigmo	18.0%	65.5%
Baabuu	Limu Kossa	31.5%	55.0%
Bage	Chora Botor	31.5%	53.0%
Golu	Chora Botor	24.0%	49.5%
Shabee	Shabee	25.0%	49.0%
Robe HC	Sigmo	16.0%	48.5%
Baraha Incinni	Gumay	15.5%	47.5%
C/Ancabbii	Botor Tolay	16.0%	47.5%
Machii	Shabee	11.0%	47.5%
Waayyuu	Botor Tolay	44.5%	47.5%
Agalo	Chora Botor	23.0%	47.0%
K/gorree	Kersa	22.0%	46.5%
Somboo	Shabee	24.5%	46.5%
Kattaa	Botor Tolay	29.0%	45.5%
Sadu HC	Setema	21.5%	45.0%
Gatira HC	Setema	29.5%	44.0%
Kanchu HC	Sigmo	19.0%	44.0%
Molee	Mancho	13.0%	44.0%
Diimtuu	Tiro Afeta	31.5%	43.5%
Asandaaboo	Omo Nada	27.5%	42.0%
Gato Kure	Gumay	16.0%	42.0%
Ambuye	Limu Kossa	21.0%	41.0%
Tora HC	Sigmo	13.5%	40.5%
Bulbul	Kersa	13.5%	40.0%
Toba HC	Gumay	23.5%	40.0%
Wolda HC	Agaro town	19.0%	40.0%

Booroo	Botor Tolay	26.5%	38.0%
Harawa Jimate	Limu Kossa	21.0%	38.0%
Kishee	Shabee	21.5%	37.0%
Gesecha HC	Setema	20.0%	36.5%
Sarbo	Kersa	25.0%	35.0%
Kallacha	Kersa	15.0%	34.5%
Agaro HC	Agaro town	23.0%	34.0%
Limu Genet	Limu Kossa	26.0%	34.0%
Akkoo	Tiro Afeta	25.5%	33.0%
Wolensu	Limu Kossa	8.0%	32.5%
Aanjaa	Shabee	16.5%	32.0%
Gata HC	Sigmo	16.0%	31.5%
Naaddaa	Omo Nada	18.0%	30.0%
Setema HC	Setema	20.0%	30.0%
Yira Docha HC	Setema	16.5%	30.0%
Raagaa Siibaa	Tiro Afeta	17.5%	29.5%
Galle Jimate	Limu Kossa	19.0%	29.0%
Hasanuphe	Mancho	11.0%	28.5%
K/beru	Kersa	25.0%	28.0%
A/dikaa	Kersa	12.0%	27.5%
Buusaa	Tiro Afeta	18.0%	26.5%
Aallee	Omo Nada	18.0%	25.0%
B/wajao	Kersa	19.0%	24.0%
Ciime	Limu Kossa	25.0%	24.0%
Darge	Mancho	14.5%	24.0%
Gonnaa	Omo Beyyam	13.0%	24.0%
Café nagaa	Omo Nada	12.0%	23.5%
Dakkana Ilkee	Omo Beyyam	18.0%	23.5%

N/Bidaaruu	Omo Nada	16.0%	23.5%
D/Gibee	Tiro Afeta	18.0%	23.0%
Kusaye	Mancho	10.5%	23.0%
Bonayyaa	Omo Nada	14.0%	22.5%
G/bulaa	Omo Nada	10.5%	21.5%
Biluu	Mancho	9.5%	20.5%
Irgibo	Mancho	12.5%	20.0%
Y/sesechaa	Omo Beyyam	13.0%	18.0%
Wabe joticha	Limu Kossa	8.5%	17.5%
Somboo Baddalla	Omo Beyyam	19.0%	17.0%
<b>Overall Average:</b>		<b>19.3%</b>	<b>35.2%</b>

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## ABOUT CORDAID

Cordaid is based in the Netherlands and has country offices in 10 countries. It has been fighting poverty and exclusion in the world's most fragile societies and conflict-stricken areas for a century. It delivers innovative solutions to complex problems by emphasizing sustainability and performance in projects that tackle security and justice, health and economic opportunity. Cordaid is deeply rooted in the Dutch society with nearly 300,000 private donors. Cordaid is a founding member of Caritas Internationalis and CIDSE.

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