Federal Democratic Republic of Ethiopia

Ministry of Health

Connected Woreda Implementation Strategy
Draft

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V1.0

Contents

Connected Woreda Introduction

1.1 Overview and Definition

The Connected Woreda is Ethiopia's program to realize Ethiopia's "Information Revolution" at the woreda level and is an integral part of the Health Sector Transformation Plan (HSTP), which aims to provide quality and equitable service delivery for all.

The Connected Woreda program was borne out of the Information Revolution (IR) Roadmap, which calls for strengthening data use via enhancements in "Data Culture" and "Digitalization of HIS systems" (see IR objectives in text box at right).

Information Revolution Roadmap Objectives:

- Create a culture of data use that leads to evidence-based decisions and action at all levels of the health system.
- Significantly improve the methods and practices of the analysis and use of health information.
- Optimize data quality at all levels.
- Enhance access and visibility of health information for patients and the wider public.
- Establish an interoperable architecture to strengthen integration, standardization and harmonization among priority data sources and health information systems.
- Employ appropriate information and communication technologies to strengthen all aspects of data use.

While the Information Revolution roadmap charts a course for enhancing data culture and digitalization throughout all levels of Ethiopia's health system, the Connected Woreda program creates a plan to realize these innovations at the woreda and primary health care unit (PHCU) level. This ensures that data-use interventions target facilities and health care workers at the level where primary care is delivered.

The Connected Woreda plan operationalizes data-use innovations through instituting a tiered pathway for facilities and woredas as a whole to achieve the highest standards in data quality and use. This pathway begins with an accreditation process where facilities are evaluated and scored against a common set of criteria related to M&E infrastructure, data quality, and administrative and clinic data use. Facilities and woredas that meet the highest standards, and that are able to access and share data with higher levels through offline mechanisms, are recognized as "Model Facilities" and "Model Woredas". Model facilities and woredas that take this one step further by enabling online data access and transmission are recognized as "Connected Facilities" and "Connected Woredas".

The Connected Woreda program evolves over time in stages to take advantage of expanding technology adoption as capacity for data use is strengthened throughout the health system. Stage 1 includes initial program implementation. In Stage 2, assessment criteria related to data use via digital tools in the Connected Woreda can be defined following initial lessons learned from Stage 1. The program also evolves beyond the woreda. Once the Connected Woreda is implemented, connecting the zone, the region, and the national health system – where all levels are achieving the highest standards in data use and digitalization – is the 20-year vision for the end state of the program.

1.2 Rationale

The Health sector transformation plan (HSTP) sets the vision and goals for Ethiopia's health sector over the next five years, with the aim of extending quality and equitable services to all communities. The role of information is paramount for the success of this HSTP. Systematic use of data for decision making can yield not just operational efficiencies, but also support improvement of the quality and equity of care delivered. Decisions made at all levels of the health system will be effective when supported by accurate and timely information.

The health sector has taken steps in previous years to improve health information at all levels. Yet, even though a significant amount of data is collected at the facility level, only few are interpreted and used. In addition, the emphasis has been on a one-way transmission of information from facilities to higher levels of the health system, as opposed to using the information for decision making at the point of care. Today, the quality and use of information is insufficient for supporting effective decision making at all levels of the health system.

These issues underscore the need for radical change in the way information is collected, transmitted, analyzed, and used. The Information Revolution has been introduced as part of the HSTP to bring about the radical change on information quality and use by cultivating a data-use culture and leveraging digital information systems and tools.

This Connected Woreda plan directly links the Information Revolution to the HSTP and Woreda Based Health Sector plan and builds off the Minister's priority of digitizing the family folder. The Connected Woreda concept improves upon traditional health information system approaches by structuring the use of data around the woreda, taking advantage of the unique role it plays in translating policies and goals set at the national level into action within health facilities and kebeles. The Woreda Health Office (WoHO) is at the heart of this activity, orchestrating care and public health programming. This structure provides a systemic backbone for the Information Revolution that is measurable in terms of its impact on service delivery, as well as administrative process improvements.

1.3 Vision

The Connected Woreda is the first step towards a 20-year vision to support the delivery of quality and equitable health services via improved access to and use of quality health information for decision making at all levels. Fully implemented, the Connected Woreda allows for health data to be collected, shared and used in a timely, equitable and transparent manner among and between points of service throughout the Woreda and primary health care unit (PHCU) with linkages to the regional and national health systems, thereby improving health worker performance and the quality of care. Once the Connected Woreda is implemented, the program expands in a bottom-up fashion beyond the woreda to realize similar goals in the "Connected Zone", "Connected Region", and "Connected Nation". In the end state, administrators, clinicians and community members know the state of their populations' health. They understand the major causes and risks of ill health in their communities, they know how best to

intervene, and they can adapt to efficiently and effectively promote good health. The unknown becomes visible and actionable as a result of data and information.

The Federal Ministry of Health (FMOH) will set ambitious targets relating to the achievement of Model and Connected Woredas. For instance, an example might be that, within five years, 60% of woredas are Model Woredas, and 10-15% are Connected Woredas.

The Benefits of the Connected Woreda

The PHCU generates considerable amounts of data, ranging from the Health Extension Program Family Folder and supply chain information to monthly disease and service reports. The Connected Woreda will be supported by a health information system that is interoperable in that it allows different data systems to automatically exchange data. The Connected Woreda will ultimately link the community, the PHCU and the WoHO to the regional and national health information system, and shift ownership of health data to the PHCU. It will digitize prioritized health data, automate reporting, and optimize processes, reducing the administrative burden and making information available for use at all levels. The Connected Woreda will activate the information and cultural transformation that is necessary to drive systematic data use for decision making and improvement of the quality and equity of care.

The Connected Woreda improves performance and quality of care in many ways. A Connected Woreda:

Improves patient care

- Informs care through improved access to patient records, reducing medical errors and adverse events
- Increases the amount of time health workers spend with patient care due to decreased administrative burden
- Links patients to higher levels of care through a digital referral network, ensuring that patient medical history is available

Improves health service delivery and equity

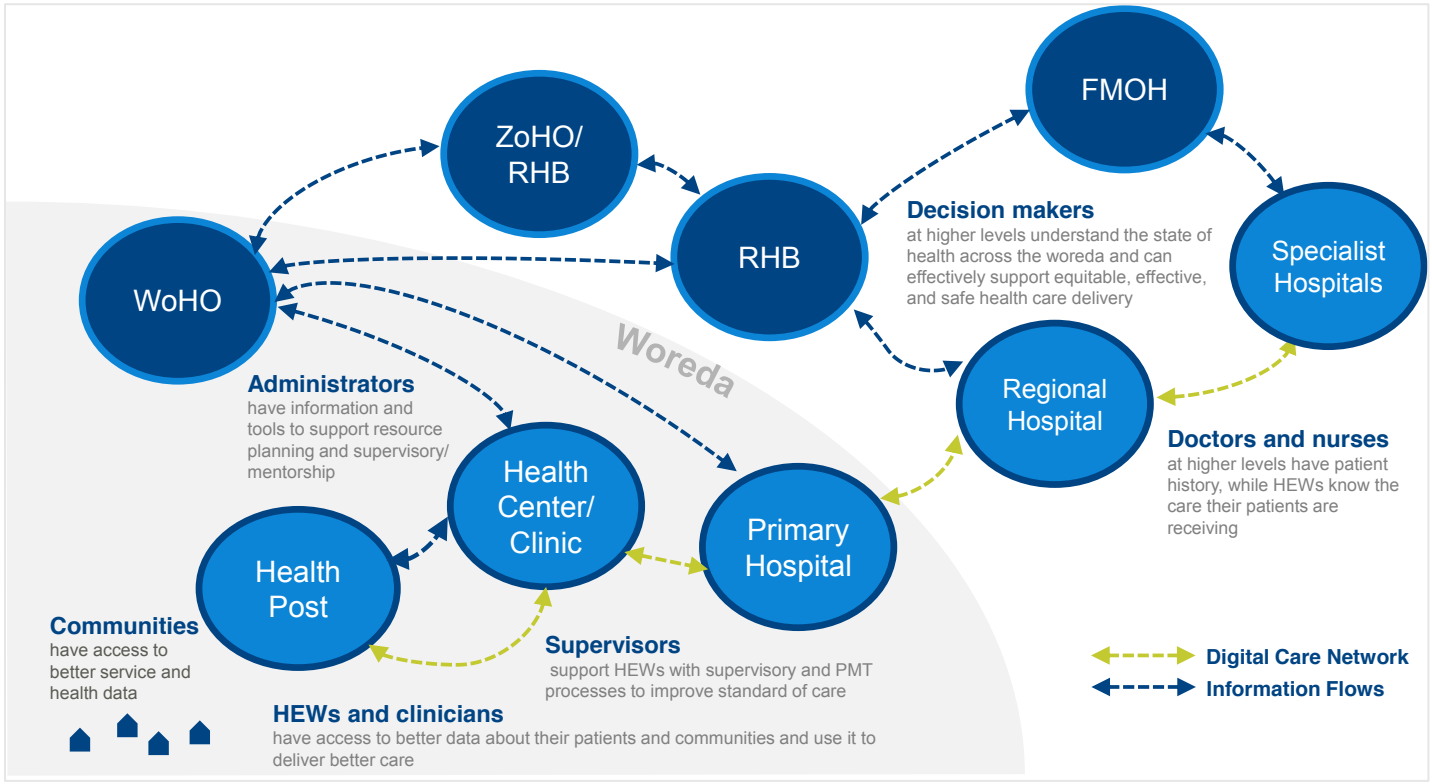
- Is able to monitor service coverage within its communities, allocate resources according to utilization, and compare performance, equity and utilization with other districts
- Has alerts and dashboards to allow health workers, administrators and M&E officers to respond quickly with targeted actions to service and surveillance reports
- Utilizes ICTs to raise public awareness and promote accountability

Empowers the health workforce

- Electronically captures and automatically reports routine service data from health centers to higher levels, significantly reducing the administrative burden
- Has a health workforce that understands the value of data and is motivated and trained to collect, use and share it

The example in Figure X below illustrates how stakeholders at all levels, from community members and health workers to administrators and decision makers, will experience the benefits of the Connected Woreda in its fully implemented end-state.

Figure X: The Connected Woreda End-state



Objective

To support the delivery of quality and equitable health services through improved access to and use of quality health information for decision making at all levels.

2.1 Specific objectives

1. To improve the quality and transformation of health information at all levels
2. To improve the culture of using health information for decisions at all levels
3. To strengthen HIS infrastructure through improved connectivity and digitalization of HIS tools
4. To strengthen information revolution implementation and expansion to all regions

Implementation Strategy

3.1 Implementation Overview

Core elements of the program include the **Connected Woreda Pathway**, which charts a tiered path for facility and woreda progress towards Connected Woreda goals; **Assessment Criteria** used to evaluate woreda and facility positioning within the tiers; and **Supporting Capacity and Tools** that will be applied at the facility and woreda level to support improvements along with pathway.

3.2 Stages of Connected Woreda Implementation

The Connected Woreda plan considers the fact that establishing a widespread culture of using health information for decisions at all levels, where decisions are fully capacitated and supported with digital tools, is a process of iterative change. At the core of this iterative change is the need to improve both the supply of and demand for better-quality data. Improved decision making happens when both the supply of, and demand for, better data exist. At the same time, the expanding state of connectivity and technology adoption that is happening through Ethiopia can support and accelerate program progress.

The implementation is stage-gated to take advantage of these dynamics and allow for learnings to be integrated into the program. The implementation will begin in Stage 1 to establish key structures of the program to facilitate the access, use, and sharing of high-quality data within and between woreda facilities. This includes assessment of facilities along Connected Woreda pathway, supporting capacity building to support facility advancement within the program, and implementation of M&E processes, including defining initial targets for number of Model and Connected Woredas. This stage also includes strengthening the use of tools that enable data to be accessed and shared via offline mechanisms (e.g., paper, flash drive). Also in Stage 1, digital tools that support online access and sharing of data will be tested and refined, including those that support clinic data use (e.g., Digital Family Folder).

In Stage 2, assessment criteria related to data use via digital tools in the Connected Woreda can be defined following initial lessons learned from Stage 1. In Stage 2, it is envisioned that digital tools are rolled out more broadly to augment foundational systems and support the use of data to improve standards and continuity of care.

3.3 Connected Woreda Pathway

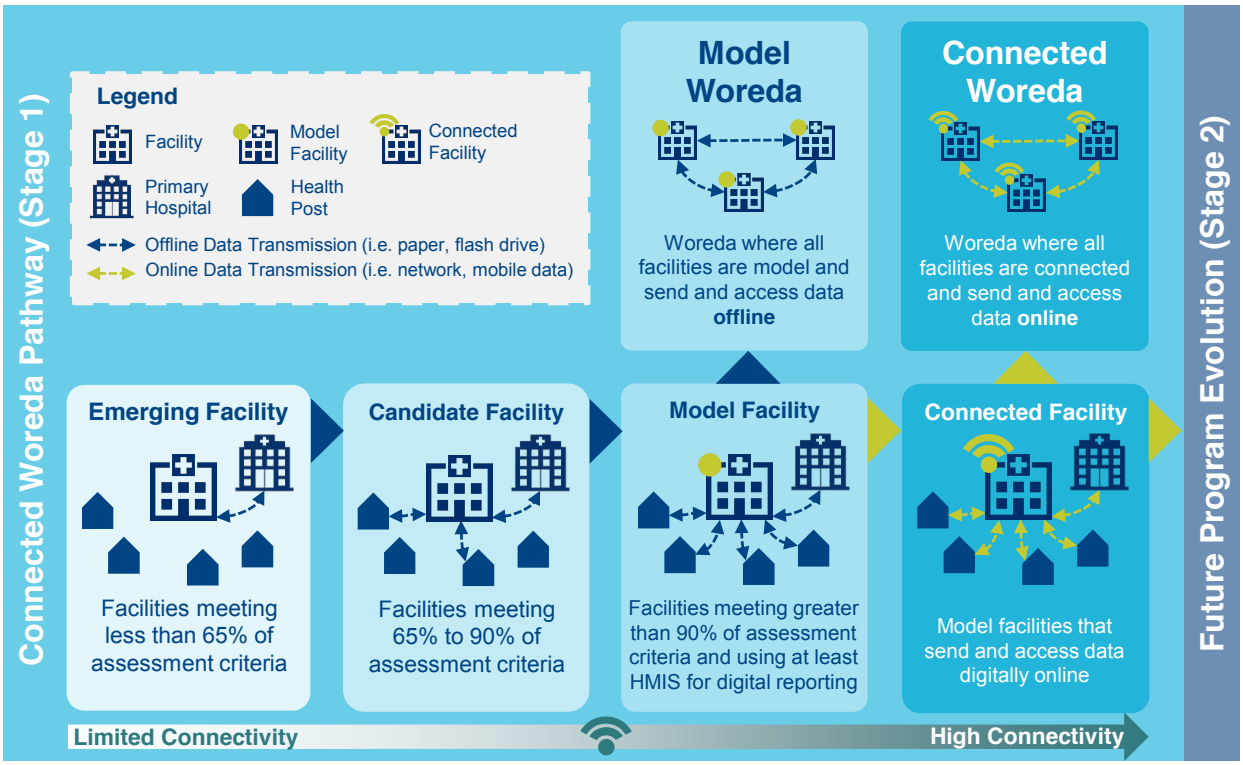
Within the Connected Woreda program, there is a tiered pathway for facilities to be measured and accredited as an “Emerging Facility”, “Candidate Facility”, “Model Facility” or “Connected Facility”. This accreditation is based on an ongoing measurement process that will score individual facilities across assessment criteria in the areas, including:

- M&E Infrastructure
- Data Quality
- Administrative Data Use
- Clinic Data Use

Building on this pathway, a woreda where all of its facilities are Model Facilities - and that are able to send and access data through offline tools (e.g., paper, flash drive) -- is a “Model Woreda”. A woreda

where all facilities are connected and can send and access data with online technologies (e.g., network, mobile data) is a "Connected Woreda". Figure X, below, illustrates the Connected Woreda Pathway.

Figure X: Connected Woreda Pathway



The main facility of focus for Connected Woreda interventions is the health center. That said, the program also seeks to improve standards of data collection, quality, and use within the administrative unit (i.e., the Woreda Health Office), health posts, and primary hospitals. Health centers within a given woreda will be scored and accredited as belonging to one of the tiers on the Connected Woreda pathway. In order for this facility to advance to the next level, it must be exchanging information with health posts in its catchment area at a level deemed sufficient for the facility to move to the next level. While health posts will not be evaluated separately, this mechanism ensures that health centers and health posts meet a common standard and advance along the Connected Woreda pathway together.

3.3.1 Emerging Facilities

A facility that meets less than 65% of assessment criteria is classified as an **Emerging Facility**. In general, these are facilities that are working to improve core M&E infrastructure and practices across the board. As such, the focus for interventions at these sites will be capacity building (e.g., training, tools) to support M&E infrastructure and process improvements.

3.3.2 Candidate Facilities

A facility that meets between 65% and 90% of assessment criteria is classified as a **Candidate Facility**. These are facilities that have basic M&E infrastructure in place, but have room to improve in data quality and use. The overall focus for interventions at this tier is continued capacity building, particularly in the areas of data quality and use.

3.3.3 Model Facilities

A facility that scores above 90% of assessment criteria and uses at least HMIS for digital reporting is classified as a **Model Facility**. If there are no facilities that can meet above90% of the assessment criteria within the woreda, facilities scoring in the top 10% will be classified as a Candidate facility. (In the current environment, achieving Model Facility status may be difficult for certain woredas. Extending the classification to facilities in the top 10% in these cases ensures that each region has facilities that are recognized as Candidate Facilities and graduate into Model Facility in a short period of time).

The focus of interventions at the Model Facility is to share and diffuse data-use innovations to other woredas, such as: improved processes, training tools or practices, non-monetary incentives, person-to-person sharing and learning collaboratives. To do this, the facility must be resourced and capacitated to support sharing of best practices to other facilities, such as through compiling audio-visual documents and other methods of dissemination.

Model Facilities can also be used as a site to test and demonstrate how digital tools such IVR/SMS, HMIS, and eCHIS complement processes in limited-connectivity settings. Limited-connectivity settings are those where there is intermittent electricity and internet connectivity available to woreda facilities. Minimum requirements for integrating these limited-connectivity tools may include:

- Intermittent electricity and connectivity (e.g., internet connectivity at WoHO with 2G coverage at facility level)
- HEW basic literacy and numeracy
- WoHO has digital reporting capabilities to replace paper submissions
- HEWs use standard processes (i.e., non-standard processes may not function correctly with eCHIS)
- Minimum training requirements met by relevant health workers and administrators

3.3.4 Connected Facilities

A Model Facility that sends and accesses data digitally online is classified as a **Connected Facility**. In addition to demonstrating online data access and transmission, Connected Facilities can also test and demonstrate how digital tools such as eCHIS technologies (e.g., Digital Family Folder, Clinical Portal, and Administrative Portal) or the eCHIS-enabled Digital Care Network complement care processes in high-connectivity setting. Minimum requirements for this includes:

- Reliable electricity and connectivity throughout the woreda
- HEW basic literacy and numeracy
- WoHO has digital reporting capabilities to replace paper submissions
- HEWs use standard processes (i.e., non-standard processes may not function correctly with eCHIS)
- Minimum training requirements met by relevant health workers and administrators

3.3.5 Model Woreda

Woredas where all facilities accredited as a Model Facilities and that are accessing and sending data offline – such as through paper systems and/or flash drives - are **Model Woredas**. These are woredas that have uniformly established foundational HIS systems, are capturing and transmitting quality data, and have inculcated a data use culture.

3.3.6 Connected Woreda

Woredas where all facilities are Connected Facilities and are accessing and transmitting data online via digital or mobile data networks are **Connected Woredas**. The main distinction between Model and Connected Woredas is that the latter is utilizing digital systems to access and transmit data online, whereas Model Woredas are accessing and sharing data via offline mechanisms.

3.6.7 HIT Support for the Connected Woreda

HIT is working with the Ethio telecom (ET) and the Ministry of Communication and Information Technology (MCIT) to support the implementation of the Connected Woreda program by providing connectivity to health institutions. HIT has a plan to connect all health centers, hospitals and health offices to a government-supported multiprotocol label switching (MPLS) virtual private network (VPN). The plan includes connecting 1,903 health centers to this network in next 8 months. This connectivity provides an enabling mechanism for Model Woredas to become a Connected Woreda.

3.4 Demonstration & Dissemination of Best Practices and Digital Tools

Demonstrating innovations is core mechanism for expanding best practices to other facilities and woredas. Best practices will be documented at each level of the Connected Woreda pathway, and within different types of facilities. In addition, Model and Connected Facility sites can test, demonstrate, and diffuse innovations, including digital tools that support a high standard of data use. In this way, all Model Facilities, including Connected Facilities, are “demonstration sites”, though sites may be demonstrating different data-use tools. For instance, as described above, Model Facilities serve to demonstrate best practices and capacity-building mechanisms that do not require connectivity. Some Model Facilities may also provide a site to test and refine digital tools, such as eCHIS, in limited-connectivity settings. Meanwhile, Connected Facilities provide locations to demonstrate digital tools that support continuity and standards of care in high-connectivity settings. In Stage 2, assessment criteria related to clinical data use via digital tools in the Connected Woreda can be defined following initial lessons learned from Stage 1.

3.5 Assessment Criteria Overview

A common set of assessment criteria are used to accredit Emerging Facilities, Candidate Facilities, Model Facilities, and Connected Facilities. These assessment criteria include indicators to assess performance in four categories: Strengthened M&E Infrastructure, Data Quality, Administrative Data Use, and Clinic Data Use. The criteria in each category are summarized below and fully articulated for the administrative unit and health care facilities in Annex 1 and Annex 2. **It is envisioned that this common criteria will be adapted for urban, agrarian, and pastoralist settings, such that there are three different sets of criteria.**

3.5.1 M&E Systems & Capacity

This category includes measures to determine that the minimum base infrastructure and capacity to support M&E is in place within administrative unit and health care facilities. This includes criteria to assess that supervision, mentorship, and performance improvement activities are in place to support health facilities

1. **Structure, HR, Facilities**: The WoHO, hospitals, and PHCUs have approved structure, human resource, and other basic facilities for M&E
2. **Budget**: Sufficient budget is allocated for strengthening HIS
3. **Supportive Supervisions:** Supportive supervisions are conducted to facilities based on plan.

3.5.2 Data Quality

This category includes criteria to assess the timeliness, completeness, and quality of data that is captured at the point-of-care and transmitted to higher levels. This includes regular data quality monitoring using LQAS and/or other tools.

1. **On-time, Complete Reporting:** Health facilities admin report is complete, timely, and accurate (i.e., 100% for report completeness and timeliness and 95-105% for data accuracy).
2. **High-quality Data:** LQAS is implemented and used to standard (i.e., LQAS score is at least 95%)
3. **Proper Use:** Health services registers and forms are used properly and closure and file transfer processes are followed and on schedule.

3.5.3 Administrative Data Use

Administrative Data Use includes criteria to assess how well performance monitoring and management systems and practices are used across the woreda facilities.

1. **Functioning PMT:** A Performance Management Team (PMT) that evaluates quality of data, analyzes performance of projects and programs, identifies challenges of low performing projects and programs, provides decision points supported by minutes, and follows up on its implementation is in place and functioning to national standard.
2. **Data Analysis & Dissemination:** Main indicators for decision making in relation to coverage, equity, and data quality are analyzed, used, and disseminated to all stakeholders in easily consumable formats such as graphs and tables.

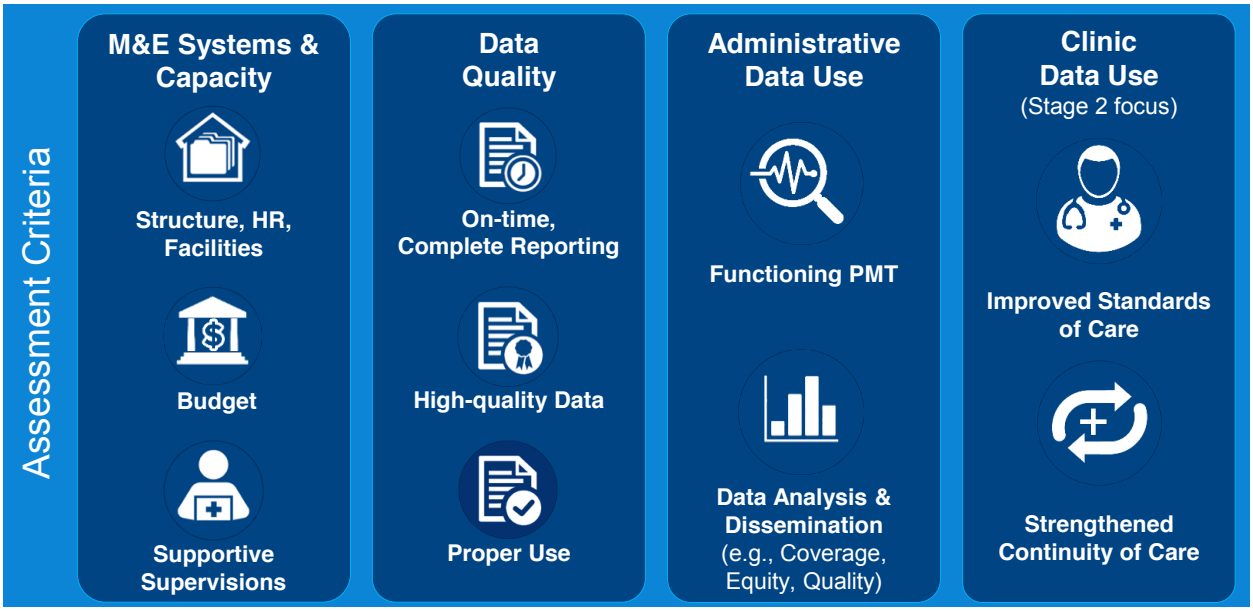
3.5.4 Clinic Data Use

Clinic data use is a category that has been included as a focus for future program evolution in Stage 2. This category refers to patient data that is used by clinicians in the health facility to support the delivery of patient-centered, timely, efficient, and effective healthcare. This data may include information on services rendered to the patient in health posts, hospitals, or the clinic itself, as gathered through the proposed Digital Family Folder (DFF) or EMR/EHR systems. The criteria associated with this category would be developed and tested in Stage 1, as tools such as the DFF are developed and tested. The criteria would include those that assess the level of access to and use of data at the point-of-care. The criteria would also assess data-use practices that support the continuity and quality of care for patients between community health posts, health centers, and higher levels, such as through the Digital Care Network (i.e., referral network).

1. **Standards of Care**: Patient and community-based data is readily available and used by clinicians and HEWs - Includes strengthened processes and tools (e.g., eCHIS, EMR/EHR) to improve real-time access to data at point of care; and increased incentive, motivation and capacity of PHCU healthcare workers to collect, use, and share data.
2. **Continuity of Care**: All critical points in the referral network are able to share and use relevant patient information in order to provide informed and high quality care to patients. Decision making regarding distribution of services, skills, and resources to each level of the healthcare system is enhanced from access to higher quality referral data from the community level.

Figure X, below, summarizes the facility-level assessment criteria.

Figure X: Assessment Criteria Summary



3.6 Accreditation & Support Process

An assessment process is conducted every six months to rate facilities according to assessment criteria. The assessment criteria total 100% and are further detailed in Annexes 1 and 2. Through this process, facilities are classified as an Emerging Facility (i.e., facilities scoring less than 65% against the criteria), Candidate Facility (i.e., facilities scoring between 65% and 90% against the criteria), or Model Facility (i.e., facilities scoring at least 90% against the criteria). Continuous support (e.g., technical assistance) will be given to Candidate and Emerging Facilities over six months. After this six-month period, these facilities will be re-evaluated by the same checklist and upgraded to the next tier if the facility meets the scoring threshold for that tier. This selection and upgrading of facilities will be done every six months. Given that the health system currently lacks capacity to undertake an accreditation process of every health center and woreda, it is expected that NGO and other development partners will support this support this process.

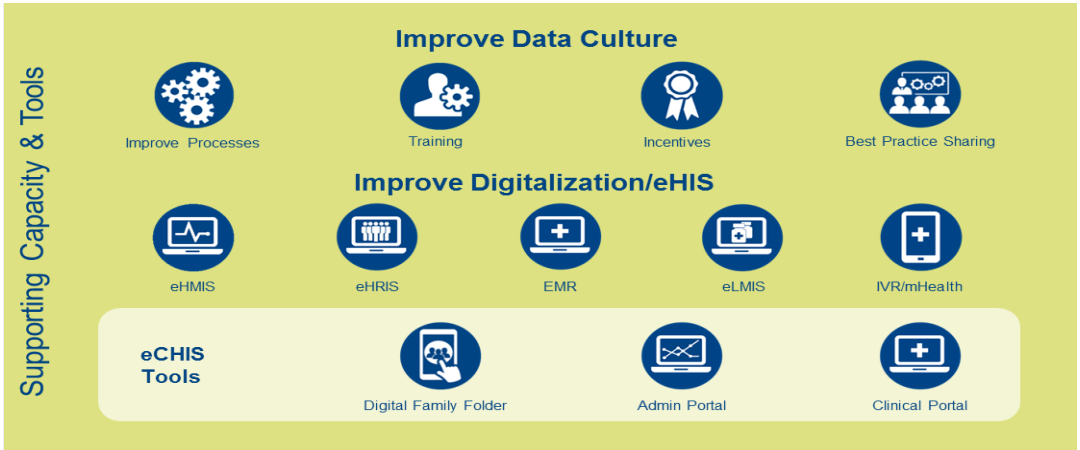
Incentives towards achieving Model or Connected Facility accreditation

The Federal Ministry of Health (FMOH) will recognize facilities that have met the Model or Connected Facility threshold for their achievements in health information use. Facilities that are accredited as Model or Connected Facilities by the FMOH can also get similar accreditation by RHB, ZHB or WoHO. Non-monetary incentives will be given to facilities to support improvement to Model or Connected Facility status.

3.7 Supporting Capacity and Tools

The Connected Woreda program leverages supporting capacity and digital tools that tie back to the pillars of the Information Revolution: strengthened data culture and digitalization of health information systems. These capacity-building elements and digital tools are integrated in relevant stages to support improvements in the use of health information for decision making at administrative unit and health service levels.

Figure X: Supporting Capacity and Tools



4. Activities

Implementing the Connected Woreda program involves four distinct categories of activities to:

1) Implement the structure of the program, including structures that support the assessment and accreditation of health institutions as Emerging Facility, Candidate Facility, and Model Facility, Connected Facility, as well as woredas as Model Woreda and Connected Woreda;
2) Support facilities to advance along the Connected Woreda pathway;
3) Demonstrate and disseminate best practices to other facilities, and;
4) Ensure continuity of Model Facilities, including Connected Facilities, and ensure learnings are fed back into program design and Stage 2 plans

The following provides detailed activities in each of these four categories.

Implement Connected Woreda Program Structure

- Preparation of checklists that helps to identify Emerging Facilities, Candidate Facilities, Model Facilities, Connected Facilities, Model Woredas and Connected Woredas
- Share Connected Woreda plan and checklists at each level of the health system
- Assessment and accreditation of health institutions as Emerging Facility, Candidate Facility, Model Facility, Connected Facility, as well as woredas as Model Woreda and Connected Woreda based on the checklists
- Develop guidelines to help Model Facilities demonstrate data-use tools to other sites and woredas

Support Facilities to Advance along Connected Woreda Pathway

- Assign resources to provide support to Emerging and Candidate Facilities
- Conduct M&E based on the gaps of Emerging and Candidate Facilities
- Perform ongoing evaluation to certify progress of Emerging and Candidate Facilities accreditations based on evaluation
- Support advancement of facilities along Connected Woreda pathway through targeted activities

Demonstrate and Disseminate Best Practices

- Document best practices of Model Facilities
- Establish and mobilize support for Model Facility demonstration sites
- Facilitate experience sharing among the Model Facility demonstration sites through site visit and documentation
- Facilitate the implementation of the best practices to the other sites
- Define and test new digital tools that support M&E processes and standards and continuity of care
- Roll out new tools that are effective in supporting M&E processes and standards and continuity of care (Stage 2)

Ensure Continuity of Model Facilities and Ongoing Integration of Learnings

- Maintain consistency of the Model Facilities through continuous M&E
- Feed learnings back into future evolution of the program

5. M&E Framework

The following M&E Framework details Project Inputs (and Indicators), Project Key Activities/Process (and Indicators), Project Outputs, and Project Outcomes pertaining to the establishment and ongoing refinement of key Connected Woreda program structures.

Project indicators/ domain of indicators	Project Inputs (Indicators)	Project Key Activities/Processes (Indicators)	Project Outputs	Project Outcome
Assess and Create Model and Connected **Facilities**	• Information Revolution road map (Number of health facilities and admin units with the IR roadmap) • IR implementation guideline (Number of facilities and admin units with IR Implementation Manual) • HIS implementation guidelines (Number of facilities and admin units with HIS implementation guidelines) • Health facilities that fulfilled the eligibility criteria for Emerging/Candidate/Model/Connected Facility (Number of health facilities that fulfill the criteria for each tier) • Woredas that fulfill criteria for Model/Connected Woreda (Number of woredas classified as each type of woreda) • Finance (Number of health facilities/admin units with adequate amount of financial resource) • Human resource (Number of health facilities/admin units having adequate human resource to support and expand Model Facility practices) • Information communication technologies (Number of health facilities/admin units with functional ICT in accordance with Information Revolution Roadmap)	• Evaluate eligibility and accredit facilities at each facility level: Emerging/Candidate/Model/Connected Facility (Number of health facilities identified as Model Facility) • Resource mobilization and budgeting to help Emerging and Candidate sites become Model Facilities, or for Model facilities to become Connected Facilities(Assigned budget for filling the gaps identified) • Provide support to the identified sites based on identified gaps (Support given based on gaps) • Measure the ongoing performance of Emerging/Candidate/ Model/Connected Facility sites (Provide Model/Connected Facility recognition and accreditation; Coverage of facilities accredited) • Connect Model Facilities located in high-connectivity areas with digital tools to enable them to become Connected Facilities (Number of Model Facilities becoming Connected Facilities).	Number of health facilities assessed as a Connected Facility, Model Facility, Candidate Facility, and Emerging Facility.	Data quality and utilization improved and scaled up to more health facilities
Disseminate Model/Connected Facility Best Practices		• Document best practices from the Model/Connected Facility sites (Coverage of identified best practices) • Scale up best practices to other facilities (Coverage of facilities adopting Model/Connected Facility best practices) • Ensure woredas are using lesson-sharing mechanisms (Number of health facilities practicing the identified best practices)	Number of facilities that implemented best practices obtained from the Model or Connected Facility sites	
Assess and Create Model and Connected **Woredas**		• Evaluate eligibility and accredit woredas as Model or Connected Woredas, as applicable (number of woredas classified as Model/Connected woreda) • Test and evaluate performance of those tools in improving clinic data use for improved health outcomes • Codify assessment criteria linked to clinic data use for improved health outcomes for integration in Stage 2. • Provide follow up support to sustain the best lessons among top performing facilities (Number of connected woredas creating and disseminating best practices)	Number of woredas that created and scaled up Model Facility health facilities that are connected with information. Number of woredas classified as Model and Connected Woreda.	

Project indicators/ domain of indicators	Project Inputs (Indicators)	Project Key Activities/Processes (Indicators)	Project Outputs	Project Outcome
	Commitment by health managers at all levels			
Data/ information sources	Registration books that captures inputs at FMOH, RHB, ZHD, WoHO and HF: Log books at each level (FMOH, RHBs, ZHDs, WoHOs and HF) will be available for Presence/absence of important indicators listed based on plan for the implementation of the intended project, accomplishment of activities based on plan, implementation of practices and responsibilities at every steps.	Project performance monitoring registration book at FMOH, RHB, ZHD, WoHO and HF	RDQA: Information collected using RDQA check list, listed inputs, goals set and implementation status will be available	
Data analysis, interpretation and report writing	It will be performed at all levels starting from woreda to FMOH: Report that shows the project performance will be prepared by all levels ranging from WoHO to FMOH based on available data sources.			
Project decision making and dissemination of reports	1st – HMIS review meetings 2nd – JSC and JCCC 3rd – Annual review meeting (ARM)			

5.1. Data analysis, interpretation, and report writing schedule

The following table details the reports to be provided within this program and frequency. These reports will be used to make internal, informed program decisions. They may also be shared with partners.

Figure X: Report Type and Frequency

SN	Type of reports	Time Schedule			Comment
		Monthly	Bi-annually	Annually	
1	Report on selection of Emerging/Candidate/Model/Connected Facility sites				At the start of the project-once
2	Report on support provided to different tiers of health facility	X			
3	Report on performance of Emerging/Candidate /Model/Connected Facility sites		X		

4	End-line overall performance report of Emerging/Candidate/Model/Connected Facility sites			X	At the end of the project
5	Report on lessons learned and best practices from Model/Connected Facility sites				After end-line report is submitted
6	Prepare strategy and action plan on to implement best practices and lessons learned from Model/Connected Facility sites				After end-line report is submitted
7	Report on coverage of Emerging/Candidate facilities that implemented best practices/lessons learned from Model/Connected Facility sites	X	X	X	
8	Report on the supportive follow up to Emerging/Candidate Facility sites	X	X	X	

5.2 Result report dissemination and decision making

The following are report dissemination processes that need to be carried out to create Model and Connected Facilities, disseminate the best practices to other health facilities, and support the implementation of the Information Revolution nationally at the woreda level.

1. **Panel/presentation to stakeholders evaluating and accrediting facilities at each level**
    a. Agreement of the stakeholders on the presented report
    b. Determine decisions regarding type and level of support to be provided to Emerging and Candidate Facilities, support process, stakeholders who will provide that support, and timeline for result evaluation (e.g., midterm and final evaluation)
2. **Presentation of reports to the stakeholders about identification of fulfilment the Model/Connected Facility criteria on set time.**
    a. Agreement of the stake holders on the presented report
    b. Make decisions regarding who, where, and when the strategy for best practices of Model/Connected Facilities will be disseminated.
3. **A place where documented best practices and national strategies presented as well as detailed implementation plan will be discussed and scale up initiated;**
    a. Discussion on documented best practices with stakeholders and make agreement
    b. Decision on the strategy how to implement and scale up at national level in discussion with the stake holders
    c. Discussion and come to agreement on the implementation manual
    d. Launching of the best practices of the Model Facility at national level based on the decision made against the implementation manual.
4. **Evaluation of implementations of Connected Woreda documented best practices**

6. Roles and Responsibilities

The following identifies roles and responsibilities at each level of the health system.

6.1 Federal Ministry of Health (FMOH)

- Set uniform criteria for facility and woreda accreditation
- Lead and coordinate the implementation of facility and woreda accreditation at the national level
- Provide the necessary technical support for regions
- Coordinate regional plans; monitoring, evaluation and discussion forums
- Provide supportive supervision and mentoring
- Accredit sites selected by the regions

6.2 Regional Health bureaus (RHB)

- Lead and coordinate the implementation of facility and woreda accreditation in the region
- Mobilize and allocate the necessary resource for the implementation
- Provide technical support for zonal, woreda and health facilities
- Coordinate the planning process in the region
- Provide supportive supervision and mentoring
- Identify Emerging Facilities, Candidate Facilities, Model Facilities, and Connected Facilities selected by the Zone and Woreda against the criteria
- In collaboration with Zonal health desk , conduct semiannual survey of woredas under the region against the criteria and select Model and Connected Woredas
- Deliver semiannual report to the MOH that lists Emerging Facilities, Candidate Facilities, Model Facilities, Connected Facilities, Model Woredas, and Connected Woredas in the region
- Accredit sites selected by the zone

6.3 Zonal Health Desk (ZoHO)

- Lead and coordinate the implementation of facility and woreda accreditation in the zone
- Mobilize and allocate the necessary resource for the implementation in the zone
- Provide technical support for woreda and health facilities
- Coordinate the planning process in the zone
- Provide supportive supervision and mentoring
- Identify Emerging Facilities, Candidate Facilities, Model Facilities, and Connected Facilities selected by Woreda against the criteria
- Conduct semiannual survey of woredas against the criteria and select Model and Connected Woredas

- Deliver semiannual report to the RHB that lists Emerging Facilities, Candidate Facilities, Model Facilities, Connected Facilities, Model Woredas, and Connected Woredas in the region
- Accredit sites selected by the woreda

6.4 Woreda Health Office (WoHO)

- Lead and coordinate the implementation facility and woreda accreditation in the woreda
- Mobilize and allocate the necessary resource for the implementation in the woreda
- Provide technical support for Health facilities
- Coordinate the planning process in the woreda
- Provide supportive supervision and mentoring
- Identify Emerging Facilities, Candidate Facilities, Model Facilities, and Connected Facilities within the woreda against the criteria
- Conduct semiannual survey of woredas against the criteria and select Model and Connected Woredas
- Deliver semiannual report to the ZoHO that lists Emerging Facilities, Candidate Facilities, Model Facilities, Connected Facilities, Model Woredas, and Connected Woredas in the region
- Accredit the selected sites within the woreda

6.5 Health Centers and Hospitals

- Participate in the Connected Woreda program assessments
- Build capacity at the facility level under the guidance of the WoHO
- Mobilize resources to support sharing of best practices

Annex I: Health Administrative Unit Assessment Checklist

Note: Criteria that is not applicable won't be included in the calculation and hence percentages are calculated accordingly.

6.6 NGOs and other stakeholders

- Participate on advocacy work
- Provide the necessary Input and technical support to health administration units and facilities at all levels, including Model and Connected Facility demonstration sites
- In collaboration with health administrators at each level, qualify facility accreditation after comparing against the criteria

I.A Structure and implementation of HIS (30%)

SN	Indicators	Possible Points	Points Given	Remark
1	**The health administrative unit has put in place the inputs needed to strengthen HIS**	**5**		
	• The health administrative unit has put in place standard chart room and shelves for its health facilities and clients' charts are appropriately filed.	1		
	• The health administrative unit has a well-organized health monitoring and evaluation unit	1		
	• The health administrative unit has a computer dedicated only for e-HMIS and the computer is currently being used for this purpose.	1		
	• Manuals such as minimum information use, indicator definition and HMIS procedure manuals that facilitate implementation of HIS are in place.	1		
	• The administrative unit has assigned a personnel dedicated for the implementation of HIS as per the standard.	1		
2	**The health administrative unit has budgeted and allocated funds for its health facilities for the strengthening** of the implementation of HIS. • If the budget for HIS is greater or equal to 15% of the overall health budget – 4 points • If the budget for HIS is 10-15% of the overall health budget – 3 points • If the budget for HIS is 5-10% of the overall health budget - 2 points • If the budget for HIS is less than or equal to 5% of the overall health budget – 1 point • If there is no budget allocated for the implementation of HIS – 0 points	**4**		
3	**The health administrative unit has a system for timely supportive supervision with fixed schedule**.	**4**		
	• M&E framework/system is in place.	0.5		
	• The health administrative unit is conducting supportive supervision supported with checklist as per the national standard Rating instruction - All the health facilities under this health administrative unit have received supportive supervision using a checklist as per the standard - 2 points - Supportive supervisions that have not reached all health facilities and/or are not done according to the national standard - 1 point - No supportive supervision has been conducted – 0 points	2		
	• Supportive supervision report was produced and feedback have been given to facilities	1		
	• Monitoring system is in place to track priority actions identified in the action plan prepared during the feedback process	0.5		
4	**Mentoring conducted to strengthen the HIS**	**4**		

SN	Indicators	Possible Points	Points Given	Remark
	Rating instruction • All health facilities have received mentoring ; report is produced and feedback is provided to facilities based on the national standard - 4 points • Some health facilities have received mentoring ; report is produced and feedback is provided to facilities based on the national standard - 3 points • Some health facilities have received mentoring even though national standard has not been followed – 1 point • No mentoring was done at all - 0 points			
5	**The health administrative unit has built the capacity of its personnel on health information management, use, monitoring and evaluation** Rating instruction • Capacity needs was addressed based on capacity gap assessment – 4 points • Capacity needs was addressed even though capacity gap assessment was not done – 3 points • Capacity needs was not addressed at all – 0 points	**4**		
6	**A system that can provide health service information to partners is in place.** • Quarterly discussion forum that included all partners is held – 2 points • Bi-annual discussion forum that included all partners is held – 1 point • No discussion forum is held at all – 0 points	**2**		
7	**The health administrative unit has implemented eHIS**	**4**		
	• The health administrative unit has implemented eHMIS	1		
	• The health administrative unit has implemented eHRIS	1		
	• The health administrative unit has implemented eLMIS	1		
	• The health administrative unit has implemented IVR and 80% of the health posts are reporting using IVR	1		
8	**The status of the implementation of eHIS under the health administrative unit** Instruction for rating • The health administrative unit has implemented eHIS in all the health facilities (>95%) - 3 points • The health administrative unit has implemented eHIS in 75-95% of the health facilities – 2 points • The health administrative unit has implemented eHIS in 50-75% of the health facilities – 1 point • The health administrative unit has implemented eHIS in <50% of the health facilities – 0 points	**3**		

I.B Data Quality (20%)

SN	Indicators	Possible Points	Points Given	Remarks
1	**In the last six months, the woreda has conducted LQAS** • Conducted LQAS in all the health facilities for all the months and have scored a value of greater or equal to 90% - 4 points • Conducted LQAS in all the health facilities and have scored a value of less than 90% only once – 2 points • Conducted LQAS in all the health facilities and have scored a value of less than 90% more than one times – 0 points	**4**		
2	**In the last six months, health facilities have produced completed reports**	**5**		
	• Representative completeness - Completeness in the last six months for all health facilities was greater than or equal to 90% - 2 points - Completeness in the last six months for all health facilities was less than 90% only once – 1 point - Completeness in the last six months for all health facilities was less than 90% more than one times - 0 points	2		
	• Content completeness Rating instruction - The 'content completeness' of reports already sent to the next health administrative level were greater or equal to 90% for all the reports – 2 points - The 'content completeness' of reports already sent to the next health administrative level was less than 90% only one times - 1 point - The 'content completeness' of reports already sent to the next health administrative level was less than 90% more than one times – 0 points	2		
	• Completeness tracking register/chart that helps to track report completeness is available	1		
3	**Reports in the last six months are submitted in a timely manner**	**6**		
	• Reports are submitted according to the national reporting schedule - All the last six reports were submitted according to the national reporting schedule – 2 points - All the last six months reports were submitted according to the national reporting schedule except for only one instances – 1 point - Reports were not sent to the next level according to the national schedule in more than one instances – 0 points	2		

SN	Indicators	Possible Points	Points Given	Remarks
	• The health administrative unit has received reports from its health facilities according to the national schedule - The timeliness of all the last six months reports received from all health facilities was greater or equal to 90% - 3 points - The timeliness of the six months reports received from the health facilities was less than 90% only in one instances – 1 point - The timeliness of the six months reports received from the health facilities was less than 90% in more than one instances – 0 points	3		
	• Timeliness tracking register/chart that helps to track report timeliness is available	1		
4	**The health administrative unit has done data verification**	**2**		
	• Data verification was done according to the standard set	1		
	• Action plan was prepared based data verification findings in order to address gaps	1		
5	**Scores are obtained by the health administrative unit on data verification**	**3**		
	• Data verification score is 85-115% - 3 points • Data verification score is less than 85% or greater than 115% - 0 points • No data verification is done – 0 points			

I.C Administrative Data Use (50%)

SN	Indicators	Possible Points	Points Given	Remark
1	**Performance management team (PMT) is in place and assembled according to national standard** • PMT is in place and the members are put together based on the national standard – 2 points • PMT is in place but the members are not put together based on the national standard -1 point • PMT is not established at all – 0 points	**2**		
2	**PMT is convening on monthly basis** • PMT has met for six or more times in the last six months – 3 points • PMT has met for five times in the last six months - 2 points • PMT has met for less or equal to four times in the last six months – 0 points	**3**		
3	**PMT is currently functioning**	**15**		
	The health administrative unit is tracking key quality and equity indicators from the transformation plan • Health quality and equity indicators are included in the list of indicators being tracked – 3 points • There is no quality and equity indicators in the list of indicators being tracked – 0 points	3		
	Plan versus achievement based on the key indicators • There is documented information that shows comparison was made between what is planned and what is achieved on the key indicators – 2 points • There is no documented information that shows comparison is made between what is planned and achieved based on the key indicators - 0 points	2		
	Data analysis is done and indicators were sorted based on low and high performing	1		
	Root cause analysis is done for low performing key indicators • Root cause is identified for all low performing key low performing indicators – 3 points • Root cause is identified for only some low performing indicators – 2 points • Root cause is not identified for all the low performing indicators – 0 points	3		
	Action plan is prepared for the identified priority problems/challenges • Action plan is prepared for all the identified priority problems/challenges – 3 points • Action plan is prepared for some of the identified priority problems – 2 points • Action plan is not prepared at all - 0 points	3		

SN	Indicators	Possible Points	Points Given	Remark
	The action plan is being implemented • Roles are divided among all concerned bodies based on the action plan and implementation is underway – 3 points • Roles are divided among all concerned but implementation has not yet started – 2 points • Roles are not divided among implementing bodies – 0 points	3		
4	**Written feedback was given to work owners or information sources on strengths and weaknesses based on the analysis of information collected** • The health administrate unit has provided written feedback to all its health facilities six times in the last half year -10 points • The health administrate unit has provided written feedback to all its health facilities five times in the last half year – 8 points • The health administrate unit has provided written feedback to all its health facilities less than five times in the last half year – 6 points • The health administrate unit has provided written feedback to only some of its health facilities- 3 points • The health administrative unit has not provided written feedback to its health facilities – 0 points	**10**		
5	**The health administrative unit has presented or disseminated at least one research/assessment findings in the last six months** • The health administrative unit has presented and disseminated at least one research/assessment findings – 5 points • The health administrative unit has presented at least one research/assessment findings but couldn't able to disseminate - 3 points • The health administrative unit has not presented or disseminated any research/assessment findings - 0 points	**5**		
6	**Every case team has a program performance monitoring chart** • All case teams have a program performance monitoring chart – 5 points • Only some of the case teams have a program performance monitoring chart – 3 points • None of the case teams have a program performance monitoring chart – 0 points	**5**		

SN	Indicators	Possible Points	Points Given	Remark
7	**The administrative unit has made available information in the form of table, chart, etc. based on selected indicators has presented it to the society and other concerned bodies using different channels** • Information is presented in the health administrative office compound and other places using chart, tables and etc. – 5 points • Information is presented only in the health administrative office compound using chart, tables and etc.- 3 points • No information was presented using chart, table and etc through any channels – 0 points	**5**		
8	**A brochure or newsletter that shows the woreda performance is printed and disseminated every quarter** • A brochure or newsletter that shows the woreda performance was printed and disseminated every quarter - 5 points • A brochure or newsletter that shows the woreda performance was printed and disseminated every six months – 3 points • No brochure or newsletter is printed and disseminated in the last six months – 0 points	**5**		

Annex II: Health facility assessment checklist

Note: Criteria that is not applicable won't be included in the calculation and hence percentages are calculated accordingly.

II.A Structure and Implementation of HIS (25%)

SN	Indicators	Possible Points	Points Given	Remarks
1	**The health facility(HF) has put in place the inputs needed to strengthen HIS**	**13**		

	• The HF has standardized chart room, shelves and charts are properly filed and easily accessible for clients - If the three criteria are fulfilled – 4 points - If one from the three criteria is not fulfilled - 3 points - If two of the three criteria are not fulfilled - 2 points - All the three criteria are not fulfilled – 0 points	4		
	• The chart room service is assisted by the use of a computer	1		
	• There is a well-staffed and organized health information and M&E unit	1		
	• A computer dedicated for eHMIS is in place and it is currently functioning	1		
	• At least four manuals which facilitate the implementation of HIS are in place	1		
	• All service outlets have cards, registers and tally sheet which will be sufficient for the next three months - All service outlets have cards, registers and tally sheet which will be sufficient for the next three months – 4 points - Only some of the service outlets have cards, registers and tally sheet which will be sufficient for the next three months – 2 points - No service outlets has cards, registers and tally sheet which will be sufficient for the next three months – 0 points	4		
	• The health facility has assigned a personnel who will be responsible in the implementation and monitoring of HIS	1		
2	**The health facility has assigned budget for the strengthening and implementation of HIS** • The health facility has assigned budget - 3 points • The health facility has not assigned budget – 0 points	**3**		
3	**A monitoring and evaluation system with corresponding time frame is in place and is being implemented**	**5**		
	• Monitoring and evaluation framework /system is in place	1		

	• Monitoring and follow up is being done based on a prior set schedule using a checklist according to the national standard - A supportive follow up visit is being done to all heath posts using a check list according to the standard – 2 points - A supportive follow up visit is not being done to all health posts and a check list is not used – 1 point - No supportive follow up visit is done at all – 0 points	2		
	• A review of the monitoring and evaluation system is performed and a report is generated	1		
	• A monitoring mechanism is in place to track the status of written feedback to health posts based on action plan	1		
4	**There is a documented evidence that shows capacity building is done on health information management, data use and M&E for the staff**	**4**		
	• Four or more capacity building activities have been performed – 4 points • Three capacity building activities have been performed - 3 points • Two capacity building activities have been performed – 2 points • Only one capacity building activity has been performed - 1 point • No capacity building activity has been performed at all - 0 points			
5	**The health facility has implemented eHIS**	**6**		
	• Implementation of eHMIS - eHMIS is implemented – 2 points - eHMIS is not implemented – 0 points	2		
	• Implementation of eHRIS - eHRIS is implemented – 2 points - eHRIS is not implemented – 0 points	2		
	• Implementation of eLMIS - eLMIS is implemented – 2 points - eLMIS is not implemented – 0 points	2		

II.B Data quality (20%)

SN	Indicators	Possible Points	Points Given	Remarks
1	**All registers and checklists are being appropriately used in all service outlets** • All registers and tally sheet are being appropriately used in all service outlets – 3 points • Some registers and tally sheets are being properly used in only in some service outlets -1 point • Registers and tally sheets are not appropriately being used in all service outlets – 0 points	**3**		
2	**In the last six months, the health facility has conducted LQAS:** • LQAS has been performed for all the last six months and the score is greater or equal to 90% - 5 points • LQAS has been performed for all the last six months but the score is less than 90% - 3 points • LQAS is being performed in an interrupted way – 1 points • LQAS has never been performed at all – 0 points	**5**		
3	**Report completeness tracking mechanism is in place**	**6**		
	• Representative completeness is 100% - Representative completeness reports have been submitted to the next level for all the six months – 3 points - Representative completeness reports have been submitted to the next level for five months – 1 points - Representative completeness reports have been submitted to the next level for only four or less months - 0 points	3		
	• Content completeness - The content completeness of all the six months reports that were submitted to the next level was 90% or greater – 3 points - The content completeness of the six months reports that were submitted to the next level was less than 90% only in one instance – 1 point - The content completeness of the six months reports that were submitted to the next level was less than 90% in more than one instance – 0 points	3		
4	**Reports in the last six months are submitted in a timely manner**	**5**		

SN	Indicators	Possible Points	Points Given	Remarks
	• Reports are submitted to the next level according to the national reporting schedule - All the last six reports were submitted according to the national reporting schedule – 2 points - All the last six months reports were submitted according to the national reporting schedule except for one instances – 1 point - Reports were not sent to the next level according to the national schedule in more than one instances – 0 points	2		
	• The health center has received reports from its health posts according to the national schedule - The timeliness of all the last six months reports received from all health posts was greater or equal to 90% - 2 points - The timeliness of the six months reports received from the health posts was less than 90% only in one instances – 1 points - The timeliness of the six months reports received from the health posts was less than 90% in more than one instances – 0 points	2		
	• Timeliness tracking register/chart that helps to track report completeness is available	1		

II.C Administrative Data use (25%)

SN	Indicators	Possible Points	Points Given	Remarks
1	**Performance management team(PMT) is in place and assembled according to national standard** • PMT is in place and the members are put together based on the national standard – 1 points • PMT is in place but the members are not put together based on the national standard – 0.5 point • PMT is not established at all – 0 points	**1**		
2	**PMT is convening on monthly basis** • PMT has met for six or more times in the last six months - 1.5 points • PMT has met for five times in the last six months – 0.75 points • PMT has met for less or equal to four times in the last six months – 0 points	**1.5**		
3	**PMT is currently functioning**	**7.5**		
	The health facility is tracking key quality and equity indicators from the transformation plan • Health quality and equity indicators are included in the list of indicators being tracked -1.5 points • There is no quality and equity indicators in the list of indicators being tracked – 0 points	1.5		
	Plan versus achievement based on the key indicators • There is documented information that shows comparison was made between what is planned and what is achieved on the key indicators - 1 points • There is no documented information that shows comparison is made between what is planned and achieved based on the key indicators - 0 points	1		
	Data analysis is done and indicators were sorted based on low and high performing	0.5		
	Root cause analysis is done for low performing key indicators • Root cause is identified for all low performing key low performing indicators – 1.5 points • Root cause is identified for only some low performing indicators – 1points • Root cause is not identified for all the low performing indicators – 0 points	1.5		
	Action plan is prepared for the identified priority problems/challenges • Action plan is prepared for all the identified priority problems/challenges – 1.5 points • Action plan is prepared for some of the identified priority problems – 1 points • Action plan is not prepared at all – 0 points	1.5		

	The action plan is being implemented • Roles are divided among all concerned bodies based on the action plan and implementation is underway – 1.5 points • Roles are divided among all concerned but implementation has not yet started – 1 points • Roles are not divided among implementing bodies – 0 points	1.5		
4	**Written feedback was given to work owners or information sources on strengths and weaknesses based on the analysis of information collected** • The health center has provided written feedback to all its health posts six times in the last half year – 5 points • The health center has provided written feedback to all its health posts five times in the last half year – 4 points • The health center has provided written feedback to all its health posts less than five times in the last half year – 3 points • The health center has provided written feedback to only some of its health posts – 1.5 points • The health center has not provided written feedback to its health posts - 0 points	**5**		
5	**The health facility has presented or disseminated at least one research/assessment findings in the last six months** • The health facility has presented and disseminated at least one research/assessment findings –2.5 points • The health facility has presented at least one research/assessment findings but couldn't able to disseminate - 1.5 points • The health facility has not presented or disseminated any research/assessment findings - 0 points	**2.5**		
6	**Every case team has a program performance monitoring chart** • All case teams have a performance monitoring chart -2.5 points • Only some of the case teams have a performance monitoring chart – 1.5 points • None of the case teams have a performance monitoring chart – 0 points	**2.5**		

7	**The health facility has made available information in the form of table, chart, etc. based on selected indicators has presented it to the society and other concerned bodies using different channels** • Information is presented in the health facility compound and other places using chart, tables and etc. – 2.5 points • Information is presented only in the health facility compound using chart, tables and etc – 1.5 points • No information was presented using chart, table and etc through any channels – 0 points	**2.5**		
8	**A brochure or newsletter that shows the health facility performance is printed and disseminated every quarter** • A brochure or newsletter that shows the health facility performance was printed and disseminated every quarter - 2.5 points • A brochure or newsletter that shows the health facility performance was printed and disseminated every six months – 1.5 points • No brochure or newsletter is printed and disseminated in the last six months - 0 points	**2.5**		

II.D Clinic Data Use (25%)

SN	Indicators	Possible Points	Points Given	Remarks
"Patient Data Access" (i.e., Health worker access to patient records at point of service delivery or care).				
1	• Patient-level data records are complete and accurate ○ All impatient and outpatient individual medical are complete – 3 points ○ Demographic data, HMIS disease classification, summary sheet and other additional forms are complete – 2 points ○ A minimum of demographic data, HMIS disease classification, and summary sheet are complete – 1 points ○ Below the minimum requirement – 0 points	**3**		

SN	Indicators	Possible Points	Points Given	Remarks
	Reporting Health Posts/HEWs have access to relevant tools to support effective CHIS processes • All reporting Health Post/HEWs have access to CHIS/FF records (via paper systems or DFF) according to national guidelines/standards – 2 points • Some reporting Health Posts/HEWs have access – 1 points • No reporting Health Posts/HEWs have access – 0 points	**2**		
3	Health facilities are able to access CHIS/FF data to provide support to health posts • Yes – 2 points • No – 0 points	2		
"Patient Data Use"				
4	Effective data use at point of service delivery/care • Clinical staff make patient management decisions based on complete information ○ Always – 2 points ○ Sometimes– 1 points ○ Never– 0 points • Clinical staff review all available patient information during patient encounters ○ Always – 2 points ○ Sometimes– 1 points ○ Never– 0 points • Data from patient encounter is routinely reviewed by clinical staff for learning and capacity building ○ Regularly – 2 points ○ Irregular – 1 points ○ Never– 0 points • HC/hospital uses relevant tools and standards (e.g., paper-based or digital decision support tools available through Clinical Portal or EMR) to support care processes ○ Yes– 2 points ○ No– 0 points • Reporting Health Posts use relevant tools and standards (e.g., paper-based or digital decision support tools) to support HEP service delivery (e.g. which households to visit when, and what services to provide).	2 2 2 2 2		

SN	Indicators	Possible Points	Points Given	Remarks
	○ Yes– 2 points ○ No– 0 points			
5	Referral processes (Note: most of these except the first one only relate to the Connected Woreda scenario though could also be evaluated at the facility level) • HCs/hospitals perform referral practices to national standards ○ Yes – 2 points ○ No– 0 points • Facilities/hospitals are able to access referral information through the Digital Care Network – ○ Yes– 2 points ○ No– 0 points • % of referrals sent by facilities through digital referral system per month ○ 100%– 2 points ○ 50-100%– 1 points ○ 25-50%– 0.5 points ○ <25%-0 • % of referrals received by HCs/hospitals through digital referral system - High usage=most points ○ 100%– 2 points ○ 50-100%– 1 points ○ 25-50%– 0.5 points ○ <25%– 0 points	2 2 2 2		

Annex 3: Connected Woreda Overview Graphic