NATIONAL BASIC SERVICE STANDARDS RELEVANT FOR SOCIAL ACOUNTABLITY PROCESSES IN ETHIOPIA

Draft for consultation during the Learning Benchmark Workshop
Adama Executive Hotel, 29-30 March 2017

By AbejeTeffera

Contents

1. National Service Standards for Social Accountability - CONSULTATION

Upon request of MoFEC, the ESAP2 Bridging Phase is working to identify and publish the national Service Standards for the PBS sectors to enrich the knowledge of Social Accountability Implementing Partners (SAIPs) and citizens about Service Standards. To this effect, a consultant undertook the following activities:

- Collecting all basic service standard used in ESAP1 and 2 documents;
- Reviewing policies and programs of the five basic services;
- Collecting service standard data from sector Ministries websites and documents;
- Reviewing gender sensitivity of service standards.

After the learning benchmark workshop in Adama Executive Hotel from 29-30 March 2017, the consultant will further incorporating all valuable inputs from stakeholders and SAIPs to improve this draft service standard assessment.

1.1 Why are service standards relevant for social accountability in Ethiopia?

- Citizens are entitled to understand what they can expect from the service providers in terms of services and their contribution as citizens to ensure the delivery of accessible, quality and equitable services;
- All stakeholders should understand their role and functions at all levels of government in service delivery;
- Service Standards are there to serve the communities and the service providers in assessing and monitoring overall service delivery performance.

1.2 What is a Service Standard?

A Service Standardis the ideal level of service that should be achieved, within the political, social, cultural and economic context (there is no true absolute and universal standard).Within a national Service Standards framework, each woreda in consultation with the regional administration sets service delivery targets (sector plans) and monitors the attainment of those targets. The Service Standards are also known as the **entitlements** of citizens, or the **norms** of service delivery that have to be met by the different sector offices and service delivery facilities.

For service providers, the Service Standards and targets serve as a mechanism to monitor their progress and to focus on delivering quality basic services to the communities they serve. If the information on Service Standards, S**ector Plans and Woreda Budget** and expenditure is displayed accurately and in a timely manner (e.g. a quarterly reporting on a public noticeboard), and awareness is created amongst citizens on what this information means, then it is possible for citizens to monitor the performance of service delivery facilities and progress with sector plans.

Citizens can demand service providers why certain targets were not reached during a specific financial year or quarter. Citizens can use the information to establish a dialogue with service providers and Woreda officials to discuss the various barriers to achieving these targets, and how citizens and other community members can contribute to reducing any barriers and achieving the targets.

Ultimately, the service standards help communities to hold service providers and Woreda officials accountable for their commitments to citizens. Such participation of the community to monitor the service delivery activities of public institutions is new to many communities and service providers. There may be a danger of creating demand that cannot be fulfilled by service providers. Initially, there is a need to find a balance between the needs of the service users and the capabilities and resources of the service providers. When government states the Service Standard for each sector, it avoids ambitious demands from citizen.

1.3 How can citizens monitor Service Standards?

Service users often do not know the entitlements available to them. What resources are allocated to a service delivery point in order to ensure efficient delivery of services in health, water supply, education, agricultural and rural road sectors? Basic Service Inputs include physical assets such as books, class furniture, drugs, items like staffing, nurses, doctors, teachers, water pump technician etc. Tracking of these inputs helps to monitor the flow of physical assets and service inputs from the federal, regional, and Woredas to the grass-root levels. Inputs can be tracked by conducted interviews with the service providers as well as by collecting service standards from policy/program/plan documents, for instance on gender equality in service delivery. These entitlements can serve as input indicators for a particular service performance measurement. Then, the variance analysis would help to reach agreements on performance indicators.

1.4. Input Tracking Matrix

The **Input-Tracking Matrix** records the differences between what users are entitled to receive and what a service provider is actually providing. Community perception refers to their understanding and view on the inputs and entitlements. The purpose of the activity is not only to increase transparency in relation to the availability of resources (thereby empowering communities) but also to identify areas in which there are discrepancies between entitled and actual resources.

Table I: Example Input Tracking Matrix

Input	Entitlement (As specified by service mandate, national standard, etc.)	Actual (Community perception/ what is really happening)	Remark/Evidence
Teacher guide	One subject for each teacher	Don't have teaching guide	From actual observation
Water supply	Within one hour distance	Seven hours	From community interview

1.5 Introduction to relevant Sector Policies and Service Standards

To enable citizens' engagement, it is critical that citizens have access to essential government sector policies and Service Standards. Experience from ESAP2 shows that such policies and Service Standards are not easily accessible at woreda level. Even when they are available, it is not necessarily in a format that can be easily understood by citizens.

This document summarizes essential sector policies and Service Standards for each of the five Basic Service Sectors: education, health, water and sanitation, agriculture and rural roads. Regions and city administrations have a mandate to adjust the national policies and Service Standards to their specific needs. Yet, the national standards provide a framework in which this adaptation can happen.

A gender audit conducted by the ESAP2 Management Agency in 2013 reviewed gender sector policies. The research found gender mainstreaming policies and guidelines across all five basic service sectors. Overall, the policies offer practical steps for government officials at various levels, including local woreda administrators to incorporate gender mainstreaming steps in the methodology of sector projects as well as in monitoring and evaluation. Where relevant, a reference to sector specific **gender mainstreaming guidelines** has been included in the standards.

2. Education Sector Brief

The educational sector has separate standard guidelines prepared for primary schools, high schools, colleges and universities. The school building and fence material varies depending on the available local resource and climate. The 2009 primary school standard mentions that a student has to travel a maximum of two hours to reach the school. Every school needs to have a water supply system and a playground.

The Ethiopian gender survey of women aged 15 to 49 years in seven regions found that more urban (74.5%) than rural (30.9%) women had ever been to school. The main reason for girls not attending school or withdraw from school was family disapproval and marriage issues[1].

Although it may be a bit outdated, a brochure of the Ministry of Education on gender[2] indicates the following major challenges to Gender Equality in Education:

- Community attitudes prevent girls from attending school and are linked to traditional division of labour in homes, lack of finances, safe access to nearby schools, etc.
- Despite the policy to attract 50% females into teaching the gap is still wide;
- Females are grossly underrepresented in positions of educational leadership/management as well as in teaching, especially in secondary, TVETs and HLIs. Only 8.4% of CTE teachers are female, female graduates of CTEs = 36.4%;
- Pedagogy still reinforces gender stereo-types for males and females;
- Gender mainstreaming during planning, implementing, monitoring and evaluation remains low;
- Lack of segregated latrines/toilets;
- Gender based violence remains a problem in and around schools and higher learning institutions.

[1] Erulkar, A.S.; Ferede, A.; Ambelu, W.; Girma, W. (2010): "Ethiopia gender survey: A study in seven regions" (PDF). Population council. Retrieved 19 May 2014.
[2] **http://info.moe.gov.et/pdf/genbro.pdf**

2.1Education Sector Standards

Education Sector Input Tracking Matrix forPrimary School (1-4 first cycle and 5-8 second cycle)

S/N	Inputs	Entitlements /Standards	Evidence/Remarks
1	Area of primary school (1-8)	15,000-25,000 sq meter	National (2009) but this may be lower in urban
2	No class room for first cycle 1-4th	4 (minimum)	National
3	No class room for first cycle 5-8th	4 (minimum)	>>
4	No toilet for students in first cycle school	4 (two for boys and 2 for girls	
	Ratio of toilets to student population	No standard	
	Number of toilets for teachers and the staff in the first cycle school	2	
5	Library, pedagogy centre, science section, teachers' room, store, first aid, special need, guard, cleaners room.	One room for each with the necessary furniture and equipment	For primary school
6	Number of students per class room in the first cycle	Maximum 50 students	National
7	Number of students per class room in the second cycle	Maximum 40 students	>>
8	A primary school is not allowed to have --number of students	Maximum 2000 students	To respect the quality of education
9	Desk: classroom ratio	25:1	National standard
	Desk :student ratio	1:2	>>
	Total number of desk	*100 for 200 students or 120 for 240 students*	>>
	• Per class	1: 25	>>
10	Educational level of teachers for primary school	Diploma and above	Related to teaching subject & additional on-job trainings.

S/N	Inputs	Entitlements /Standards	Evidence/Remarks
11	Educational level of school directors for first cycle	Minimum diploma	
12	Educational level of school directors for second cycle	Minimum degree	
13	When student number is above 1000 in second cycle school	Assign one Assistance director having a degree	
14	Number of school days in a year	203-206	Unnecessary spent days will be compensated
15	All the school communities have to respect the norms and standard of the school	It specified in detail on the standard	
16	Teacher: student ratio	1:45	National standard
17	Set of text books student ratio	1:1	National standard
18	Chalk	20 gross; mixed colour	For four months
19	Blackboards	One per classroom	National standard
20	Teachers guide	One per subject for each teacher	National standard
21	Student: classroom ratio	45: 1	National standard
22	Number/availability of library	One (sufficient number of text books and supporting learning materials)	National standard
23	Telephone	Has to be available	There is a national direction but it depends on local standards
24	Drinking water	Has to be available (but water taps ratio /per student is very low)	>>
	Electricity/solar or any	Has to be available	>>
25	Science laboratories (for second cycle)	Has to be available	>>
26	IT laboratory (for second cycle)	Has to be available	>>
27	Uniform	Has to be available	>>
	• *For Teachers* • *For Students*	*Equal to # of teachers* *Equal to # of students*	

S/N	Inputs	Entitlements /Standards	Evidence/Remarks
28	Mini-media	Has to be available	>>
29	Clubs	*Standard not found*	>>
30	Parents' day	Two times a year	>>
31	School garden	*Standard not met*	>>
32	School sanitation	Has to be clean	>>
33	Sport materials	All materials has to be available	>>
34	Sports Field:		>>
	• Play ground • Football field • Basket ball • Volley Ball • Sport material	Has to be available Has to be available Has to be available Has to be available Has to be available	
35	Pedagogical Centre	Has to be available with full facility	National standard
36	School board which consists Kebele administrator as a chair and school director as a secretary oversees the school performance	Has to be available (citizens and teachers are also included)	>>
	Parent, Teacher and Student Association (PTSA)	Has to be available	>>
37	First Aid	Has to be available with full facility	>>
38	Primary school (first cycle) gender diversity ratio	0.93 in 2014/15 and until the end of GTPII (2019/20) expected to be 0.99.	GTPII
39	A minimum five special need students per each class can be enrolled with others	Trained teachers and necessary materials for special need student to be fulfilled	National Standard
	Primary School special need enrolment	4.4 % in 2014/15 and until the end of GTPII (2019/20) expected to be 15%.	GTPII
40	Counsellor	Has to be available	Depend on local standards
41	In- service training	Has to be available	>>
42	Experience sharing	Has to be available	>>

3.Health Sector Brief

The **Health Extension Programme** serves as the primary vehicle for implementation of community-centred essential health care packages and as an effective referral system from the grass-roots level to broaden access to care at secondary and tertiary levels. A large **Health Development Army** was initiated to expand the success of the Health Extension Programme deeper into the community to improve community ownership and scale-up best practices[3].

The Ethiopian health service is restructured into a three tier system, with primary, secondary and tertiary levels of care. The primary level of care includes primary hospital, health center and health post. The Primary Health Care Unit is composed of a **health center (HC) and five satellite health posts (HPs)**. These provide services to approximately 25,000 people altogether. A HCis staffed with an average of 20 staff. It provides both preventive and curative services. It serves as a referral center and practical training institution for HEWs. A HC has an inpatient capacity of 5 beds.

A **primary hospital** provides inpatient and ambulatory services to an average population of 100,000. A primary hospital provides emergency surgical services, including cesarean sections and gives access to blood transfusion service. It also serves as a referral center for HCs under its catchment areas, a practical training center for nurses and other paramedical health professionals. A primary hospital has an inpatient capacity of 25-50 beds and is staffed by an average number of 53 persons.

A **general hospital** provides inpatient and ambulatory services to an average of 1,000,000 people. It is staffed by an average of 234 professionals. It serves as a referral center for primary hospitals. It serves as a training center for health officers, nurses and emergency surgeon's categories of health workers. A specialized hospital serves an average of five million people. It is staffed by an average of 440 professionals. It serves as a referral for general hospitals[4].

Overall, the existing health coverage 98% (2014/15) is estimated to be 100% at the end of GTPII (2019/20)[5]. The health sector provides **key health services and interventions free of charge**, including immunization, counselling, testing and treatment of HIV/AIDS and tuberculosis, and prevention of mother-to-child transmission. These services help to improve the health status of vulnerable segments of society, including mothers and children.

[3] MOH (2015):http:/www.moh.gov.et/index aspx

[4] The FDR of Ethiopia Ministry of Health (2015/16 - 2019/20): HSTP; Health Sector Transformation Plan.

[5] Federal Democratic Republic of Ethiopia (2016): GTP-II (2015/16-2019/20).

The **Health Standard** has been prepared under the direction of the Technical Committee for Medical Care Practices (TC90) and was published by the Ethiopian Standards Agency (ESA)[6]. The standard covers the minimum requirements with respect to practices, premises, professionals and products or materials put into use for health posts and the health center[7].

3.1.Health Post Standards

Health Post shall mean a health facility at the primary level of healthcare that provides mainly essential promotive and preventive services and limited curative service as indicated.

<table>
<tr><th colspan="2">Health Post Health Service Practice Standards</th></tr>
<tr><td rowspan="3">Prevention and promotive services</td><td>Maternal and Child Health
The HEW shall register and provide care to pregnant women as per the guideline for ANC at that level;
The HEW shall conduct normal deliveries;
The HEW shall undertake a minimum of two postpartum home visits;
The HEW shall provide the following types of contraceptives such as condoms, oral pills, emergency contraceptives and injectable;
The HEW shall administer Pentavalent vaccines, oral poliomyelitis vaccine, measles vaccine, and BCG vaccine to all infants and children as per the national immunization guideline;
Health education on breast feeding, malnutrition etc.</td></tr>
<tr><td>Prevention and Control of local Communicable diseases
The service shall have promotive and preventive service programs including malaria, TB/Leprosy, HIV/AIDS PMTCT, STI, and other locally important;
The HEW shall provide malaria prophylaxis in malaria endemic zones as per the National Guidelines for Malaria Treatment.</td></tr>
<tr><td>Curative Services and Infection Prevention
The HEW shall undertake rapid test for case having fever or giving history of fever and provide anti-malarial as per the malaria treatment guideline.
The HEW shall provide first aid for accidents and emergencies and ORS for diarrheal cases and refer cases beyond her competence to the next level;
The service shall be available at least during working hours;
The service shall have written referral policies;
The service shall have a system to handle patients referred back from others.</td></tr>
<tr><td rowspan="2">Professionals</td><td>At least two HEW and one cleaner</td></tr>
<tr><td>The HEW shall be supported by model house holds</td></tr>
</table>

[6] *Health Post and Health Center Requirements/Standards (2012)*
[7] *Ethiopian Food, Medicine & Healthcare Administration and Control Authority (FMHACA) 2013*

	HEW shall be supported by the nearest health center technical staff.
Products	The health post shall have all lists of medicines as per the health post list of medicines.
	In addition, the following equipment shall be available:Stethoscope, Sphygmomanometer, Thermometer, Kidney basin, Delivery set, Delivery coach, Examination coach, Storage shelves for medical equipment, medicines and supplies, Cold box, Adult& child weighing scale, Autoclave or any of similar functional, equipment, Stretcher as needed.
	IEC material
	House Keeping, waste management and IP Equipment and supplies
Physical Facility Standard	
Waste management systems	• The HP shall provide and maintain a safe environment for the public and clients; • There shall be properly designed placenta pit within the facility; • The health post shall follow the waste disposal guideline or directives

3.2. Health Center Standards

Health Centre shall mean a health facility at primary level of healthcare which provides promotive, preventive, curative and rehabilitative outpatient care including basic laboratory and pharmacy services with the capacity of 10 beds for emergency and delivery services.

Health CenterHealth Service Practice Standards	
Professionals required	**Minimum number required**
Health Officer	2
General Practitioner (optional)	1
Midwife	3
Nurse	5
Ophthalmic nurse	1
Psychiatry nurse	1
Environmental Health professional	1
Laboratory technician or technologist	2
Pharmacist or pharmacy technician	3
Cleaners	5
Archive workers	6
Maintenance officer	1
Morgue attendant	1

Health Center General Medical Service	
Practice	**The health center general medical service shall provide the following core functions as per the outpatient service standard:** • Ambulatory patients and Follow up of ambulatory patients for common chronic conditions including TB/Leprosy, HIV and other acute and chronic diseases management; • MCH services with new born corner; • Basic ENT, Dental, Eye, and Mental health services • Basic rehabilitative service; • Preventive and health promotive services;
	The general medical service shall be available in working days for at least eight hours a day;
	The outpatient service shall have functional referral system.
Health Center Minor Surgical Services	
Practice	The Health Center shall provide minor surgical services
Premises	Health Centers shall have minor procedure room
	Minor procedure room shall have access- restricted environment with controlled access over all persons and materials entering and leaving the area.
Professionals	Minor surgical procedures shall be performed by licensed GP or HO
Health Center Nursing Service	
Practice	Nurses shall work with others to protect and promote the health and wellbeing of those under their care.
Premises	The health center shall have: Hand washing basin at each room, Toilet rooms, Procedure room, Nurse changing room with cabinet, chairs, and cupboard.
Professionals	The nursing staff shall have a minimum of diploma from a recognized college or university.
Health CenterEmergency Services	
Practice	The emergency service shall be available 24hrs a day and 365 days a year.
	The emergency service unit shall provide basic life support as indicated for any emergency cases , which may include the following: a) Cardiopulmonary resuscitation (CPR) airway management and/or oxygen supply b) bleeding control c) fluid resuscitation
	The health center emergency service shall have protocol for the initial

	management of Emergency cases
	Other service that assist the emergency service shall be available for 24hrs with adequate staffing
Professionals	• The emergency service shall have a minimum of health officer and nurse. And this service shall have access to laboratory and emergency medicine; • All health professionals working in the emergency room shall be trained on at least cardio-pulmonary resuscitation.
Health Center Delivery and MCH Services	
Practice	The health centre shall provide delivery services 24 hours a day (365 days a year)
	The health centre shall provide MCH services during regular working hours which includes: a) ANC and PMTCT services b) PNC services c) Immunization service d) Growth monitoring services e) Sick baby clinic/ under five clinic services f) Comprehensive Family planning services
	The health center shall make Basic Emergency Obstetric Care available 24 hours
	The health center shall provide Essential new-born care at dedicated new born corner: with basic new-born care: TTC eye ointment, vitamin K
Professionals	• The MCH and delivery service of the health center shall be directed by midwife • There shall be licensed nurses available to meet the service demands
Health Center Laboratory Services	
Practice	The laboratory shall have written policies and procedures.
	The health center shall have standardized data collection instruments and including at least the followings: a) Laboratory request forms b) Laboratory report forms c) Laboratory specimen and results registers d) Quarterly/monthly reporting forms including • Summary of tests conducted • Summary of tests referred • Summary of quality assurance report e) Equipment and supplies inventory registers f) Quality assurance record forms g) Referral forms

Professionals	All laboratory services shall be directed by a licensed medical
Health Center Pharmaceutical Services	
Practice	**Follow guideline and SOP of Dispensing and Medication Use Counselling**
	Follow SOP of **Control of Drug Abuse, Toxic or Dangerous Drugs**
	Assign focal person for adverse Drug event (ADE)/ Pharmacovigilance
	Medicines Supply and Management • A drug and therapeutics committee (DTC) • written policies for the procurement of medicines from government and private suppliers. • Firefighting equipment or system shall be installed to medicines storage places
	Medicines Waste Management and Disposal - compliance with the appropriate medicines waste management and disposal directives by FMHACA.
	Recording - There shall be a standardized Prescription Registration Book for recording prescriptions and dispensed medicine.
	Billing - Medicines shall be received and issued using standard receiving and issuing vouchers with serial number licensed by the appropriate finance bureau of the government.
	Organization Management and Quality Improvement A multidisciplinary drug and therapeutic committee chaired by the medical director and supported by a licensed pharmacist/pharmacy technician representing the health center pharmacy services
Professionals	• The health center pharmacy shall be directed by a licensed pharmacist or pharmacy technician ; • The health center pharmacy shall have pharmacy clerks, cashiers, cleaners and porters
Products	The health center may have its own medicine list in accordance with the prevailing diseases epidemiology and within the framework of the national health center's medicine list prepared by the FMHACA
	The health center's outpatient and its central medical store shall have fire extinguisher, refrigerators, deep freezers, security alarms and racks/shelves.
	Hand-washing facilities shall be provided in the toilet area together. Facilities must include readily available water, soap and clean towels or other satisfactory means of drying the hands.
	The health center pharmacy shall be provided with consistent electricity, telephone, office furniture and optional facilities such as internet services,

	computers and other necessary supplies.
Health Center Patient Flow	
Practice	The health center shall have a written protocol of patient flow which at least describes the following: a) The presence, roles and responsibility of a receptionist at the gate b) Triaging of patients c) How to get into emergency and delivery services d) How to get into regular outpatient case teams and chronic illnesscase teams e) How to be admitted if admission is needed f) How to get pharmacy, laboratory and other diagnostic services g) The process of discharge h) The procedures of payment for services
Premises	Service areas shall be labelled in bold at a recognizable location
Professionals	The health center shall have runners to facilitate patient flow
Products	The following minimum equipment and consumables shall be required • Wheelchairs • Stretchers with wheels
Health Center Medical Recording	
Practice	Medical record shall be maintained in written form for every patient seen at all points of care including emergency, outpatient, labor& delivery, inpatient and minor operation theatre.
	A patient shall have only one medical record in the health center.
	The health center shall establish a master patient index with a unique number for each patient
	The health center shall have a written policy and procedure
Professionals	• There shall be a full-time custodian/medical record personnel (Health Information Technician) with basic computer skill and ability to organize medical records responsible for medical records management. • Additional staffs like card sorter and runner may be available to perform patient registration, retrieving, filing and recording chart location may be • The actual number of staff shall be determined based upon the total number of active charts in a day (Workload analysis)
Health Center Health Promotion Services	
Practice	The health center shall have a written policy and procedures for health promotion
	The health center shall plan, schedule, coordinate, lead, monitor health promotion activities

Professionals	A designee shall coordinate health promotion activities in the health • There shall be licensed nurses available to meet the service demands in the delivery unit. • All health professionals who have got a special training on health promotion and prevention may participate in health promotion activities
Health Center Morgue Services	
Practice	The health center shall have written policies and procedures for morgue (dead body care) services.
	There shall be a death certificate issued by authorized physician or health officer or nurse for each death and this shall be documented.
	The service shall be available for 24 hours a day and 365 days of ayear
Professionals	Morgue attendant and cleaner
Health Center Infection Prevention	
Practice	Infection risk-reduction activities shall include: a) equipment cleaning and sterilization; b) laundry and linen management; c) disposal of infectious waste and body fluids; d) the handling and disposal of blood and blood components; e) disposal of sharps and needles; f) separation of patients with communicable diseases frompatients and staff who are at greater risk due to immunosuppressionor other reasons; g) management of haemorrhagic (bleeding) patients; h) Engineering controls.
	The health center shall provide regular education on infection prevention and control practice to staff, patients, and as appropriate, to family, visitors and caregivers including the followings.
	The health center emergency service shall have protocol for the initial management of Emergency cases
	Other service that assist the emergency service shall be available for 24hrs with adequate staffing
Professionals	• The emergency service shall have a minimum of health officer and nurse. And this service shall have access to laboratory and emergency medicine; • All health professionals working in the emergency room shall be trained on at least cardio-pulmonary resuscitation.
Health Center Sanitation and Waste Management	
Practice	The health center shall be sanitary, clean and safe environment. There shall be regular basic cleaning such as dusting, sweeping, polishing and washing of the health post premises and equipment.

	There shall be written procedures to govern the use of aseptic techniques and procedures in all areas of the health center.
	Placenta disposal pit shall be available in the health center and shall be secured
	Sewage disposal shall be according to Health Care Waste Management National Guideline
	The health center shall have supportive sanitation majors: a) Clean water where there is no plumbing b) Hand hygiene practice c) Sterilization of medical instruments d) Isolating infectious patient in special isolation room e) Alternatives to protective equipment.
	Treatment or disposal of infectious medical waste shall be performed according to *Health Care Waste Management National Guideline* by one of the following methods: a) Incineration b) Steam sterilization c) Discharge via approved sewerage system d) d) Chemical sterilization
	Wastes shall be segregated and segregation of the healthcare waste shall include the following procedures: a) Separate different types of waste b) The health center shall provide colored waste receptaclesspecifically suited for each category of waste c) Segregation shall take place at the source, like ward bedside,minor OR, laboratory etc d) There shall be 3 bin systems used to segregate different types of waste in the health center.
Professionals	The health center sanitation and waste management shall be directed by a licensed environmental health professional or any related licensed professional trained on sanitary sciences.
Health Center Facilities	
Health center environment	**Toilet Rooms:** a) The health center shall have a separate toilet at delivery rooms and a common toilet rooms with hand-washing sinks. b) If there is a central water supply system, the health center shall provide flushable toilets. In addition the following requirementsshall be ensured: • Posted signs (written and/or visual messages) shall be indicated describing which is for ladies and gentle • Indicating arrows shall be located on the corridors

	Delivery Rooms: the health center shall provide rooms for delivery which allow the provision of medical intervention shall have space for sleeping, afford privacy, provide access to furniture and belongings
	In addition the Rooms: a) Shall be arranged to maximize staff supervision and nursing assistances. b) No patient room shall be located away from nursing stations c) If they have multiple beds, shall allow for an accessible arrangement d) of furniture, which provides a minimum of three (3) feet between beds.
	Examination Rooms: Each examination room shall have a minimum floor area of eighty (80) square feet and a minimum of three (3) feet clear dimension around three (3) sides of the examination table or chair.
	Treatment Rooms: Treatment room for procedures performed under topical, local anesthesia without pre-operative sedation shall have a minimum floor area of one hundred and twenty (120) square feet and a minimum of ten (10) feet clear dimension.
	Procedure Rooms: Procedure rooms for minor surgical procedures performed in conjunction with oral sedation or under analgesic drugs shall have a minimum floor area of two hundred (200) square feet and a minimum of fourteen (14) feet clear dimension.
Treatment Areas& Care	The care and treatment areas of the health center shall comply with the requirements stipulated under the premises of each service standards.
Ancillary Areas	**Laundry:** The health center shall provide laundry services by contract or on-site.
	Administrative Areas: Administrative Offices shall be located separately from care and treatment areas and it shall be clearly labeled and easily accessible to both patients and visitors. It includes; a) Administration office. b) Staff rooms with toilet separate for male and female c) General cafeteria d) Spaces for conferences and in-service training e) General Library
	General Storage areas. There shall be a two hour fire rated lockable room large enough to store
	Maintenance Area: Sufficient area for performing routine maintenance activities shall be provided
	Janitor room: the health center shall have separate janitor room.
	Green area: The health center shall dedicate at least 20% of the total health center compound for green area.

4. Water Supply and Sanitation

Addis Ababa Water and Sewer Authority provide water and sewer services for the capital city of Addis Ababa. But for other cities and town; the municipalities and/orWater Boards Teams are responsible for service provision. In rural areas community water and sanitation committees operate water systems and promote sanitation. Woreda Water Desks (local government entities) are supposed to support local committees.

In 2006 the government adopted a Universal Access Plan (UAP) to achieve 98% access for rural water supply and 100% access for urban water supply and sanitation by 2012. Due to ambitious plans and standards the achievements (performance) was not as expected during the end of GTP-I (2015). According the GTP-II, the toilet coverage is estimated to increase from28% in 2014/15 to 82% at the end of GTPII (2019/20)[8].

The **Wash Implementation Framework** (WIF) helps to provide guidance for implementing the Program that defines the roles and responsibilities of major stakeholders in the WASH sector. Water quality testing of the source prior to distribution is the responsibility the regional water bureaus, while monitoring water quality during distribution and use is the responsibility of regional public health laboratories.

In Ethiopia schools often have inadequate water and sanitation facilities. A study carried out for ESDP-lll revealed that the absence of toilets in school affects girl student's performance, due to girls missing classes during their menstrual cycle, particularly if they have to go home or walk long distances to the nearest toilet. Unfavourable school environments contribute many girls remaining under-educated. Illiteracy rates are still far higher among women than men, and more girls than boys drop out of school[9]. In general; there is an important link between gender equality and sustainable water management. Participation of men and women playing a decision making role at all levels of water management can expedite the achievement of sustainability, and contribute to gender equality by improving access of both women and men to water and water-related services. The government has a WASH gender mainstreaming field manual in English and Amharic[10].

Overall; the Water Supply Program Funding comes from the following sources:

- Government of Ethiopia (53% during GTP1);
- External Financing Agencies (investors/Development Partners);
- Non-Governmental Organizations (NGOs);
- Participating communities in rural/urban areas; and
- Water utilities' earnings.

[8] Federal Democratic Republic of Ethiopia(2016): GTP-II (2015/16-2019/20).
[9] *EFDR; ONE WASH NATIONAL PROGRAM DOCUMENT (August 2013)*
[10] Download from http://www.mowr.gov.et/index.php?pagenum=10&pagehgt=1000px – English # 11 and Amharic # 12.

4.1 Water and Sanitation Service Standards

S/N	Inputs	Entitlements /Standards
1	Distance from water point and pure water consumption	➢ 20 liter/capita/day for urban area within 1.5 kms radius; ➢ 15 liter/capita/day for rural area within 1.5 kms radius;
2	Water point management	Water Supply Office at Woreda and Water Committee at Kebele level
3	Communal water points service time convenience & effectiveness	There is agreed timing schedule for opening and closing at water points
4	Water point maintenance requests	The responsible organization or committee has to respond immediately;
5	Ratio of toilet facility to population	Removing open defication (household or community latrines)
6	Awareness level of the community in disposing solid and liquid waste	Has to be available
7	Removing dry waste (for urban areas)	Is the duty of the Municipality of the town on schedule
8	Water pipes standard	
9	Rural potable water supply coverage	2014/15= 59% and the end of GTPII (2019/20) expected to be 83%.
10	At woreda level at least there is_____	one WASH focal person and one water supply technician
11	Proportion of women members at decision making position	50% women at WASH program

4.2 Service Norms for Rural Water Supplies

Type	Scheme	Minimum Service Life	Population served
Point source	Lined hand dug well with raised collar with rope pump	5 years	75
	Lined hand dug well with raised platform fitted with hand pump	50 years	270
	Capped spring	10 years	350
	Rainwater harvesting from roof catchments serving public institutions	10 years	Depends on catchment area
With distribution	Capped spring with distribution	10 years	Depends on yield
	Deep borehole/motorized pump with distribution	10 years	1,500

Source: *EFDR; One WASH National Program Document (August 2013)*

5. Agricultural Extension and Productive Safety Nets Program Brief

Agricultural Extension includes the provision of agricultural information timely, the linking of farmers with sources of farming inputs and credit facilities and most importantly, the provision of education services to farmers.

To date 11, 000 FTCs have been established across the country and the government is progressing well in establishing a further 7,000 FTCs to meet the national target of 18,000 FTCs, meaning one FTC for every Kebele and three DAs per Kebele[11]. Accordingly, a Farmer Training Center (FTC) is expected to serve as:

1) Center of extension service and information as well as source of advice on farmers problems;
2) Place where modular training will be given for farmers up to six months;
3) Place for demonstration of different technologies;
4) Place of combing indigenous and improved knowledge.

The Ethiopian agricultural extension system is heavily dependent on farmer training centers (FTCs) and trained DAS that give extension support to FTCs and farmers. FTCs should also serve as hubs for knowledge and information sharing and centers for developing best practices. It is envisioned that the FTCs will contribute to rural transformation rather than being limited to agricultural development only. The agricultural extension service at the FTCs is expected to play an active role in linking farmers with other institutional support services such as input supply, credit, cooperative promotion and agricultural produce marketing.

The Growth and Transformation Plan (GTP) aims to enhance productivity and production of smallholder farmers and pastoralists; strengthen marketing systems; improve participation and engagement of the private sector; expand the amount of land under irrigation; and reduce the number of chronically food insecure households. The Productive Safety Nets Program (PSNP) fits within this overall plan and contributes to four key policies:

- The Social Protection Policy,
- The Disaster Risk Management (DRM) Policy,
- The National Nutrition Programme (NNP), and
- The Climate Resilient Green Economy Policy (CRGE).

The goal of the PSNP is to enhance resilience to shocks and livelihoods, and improve food security and nutrition for rural households vulnerable to food insecurity. The PSNP seeks enhanced participation in improved rural safety net, livelihood and nutrition services by food insecure female/male-headed households. The program reaches 8 million people in 319 woredas in 8 regions and operates with an annual budget of 500 million USD.

[11] National Strategy for Agricultural Extension, 2014.

5.1 Agricultural Extension Service Standard

S/N	Inputs	Entitlements /Standards
1	Agricultural Inputs • Availability of sufficient and quality fertilizer matching with soil type; • Availability of sufficient and quality improved seeds for crops and vegetables; • Availability of proper anti-weed drugs and pesticides	Provide the appropriate input on time with reasonable cost or credit system.
2	**T**imely and regularity of extension workers support	As per the agriculture extension guideline (national standard)
3	Availability of sufficient information and access for credit services; market sales, agricultural innovations etc.	Need to be available
4	With approximately 21 development agents (DAs),	per 10,000 farmers
5	Availability of development agents(DAs)	Three DAs per Kebele
6	Development agent's educational qualification	Minimum diploma
7	The ratio of development agent (DA) to the farmers	1 : 200
8	Farmer training center per Kebele	1:1
9	Ratio of farmers' training guideline to DA	1:1
10	Distance of agricultural input sites from farmers' residence	Maximum 7km
11	Availability well equipped animal veterinary clinic per Kebele	1:1
12	Veterinary technician per animal veterinary clinic	1:1
13	Artificial insemination center per Woreda	2 : 1
14	DA house in the kebele	All DA should have house
15	Demonstration farm land in the Farmer Training Center (FTC)	Enough demonstration land /FTC is needed
16	FTCs should have toilet	Separate toilet for male and female participants
17	Number of farmers to be counseled by DA in a year	All farmers of the target kebele

S/N	Inputs	Entitlements /Standards
18	Coverage of improved seed	60% of the farmers from each kebele
19	Fertilizer supply to the farmer	90% of the farmer from each kebele should access fertilizers
20	Timing of Agricultural inputs distribution	Avail all agricultural inputs on time based on farming season
21	Training plan of DA	Training plans should match the context of farmers. The training should also be focused on practical application.
22	Themes of training for farmers	Forage production and management; Animal health; Poultry production; Beekeeping; Natural resource conservation.

FTCs Classification Minimum and Maximum Standards by Function Level

Basic	Intermediate	Advanced
• At least three DAs (Plant, Animal and Natural Resource Management Development Agents); • Moderately furnished FTC building; • Agro-ecological based FTC demonstration plot; • FTC management committee • FTC operational guideline.	• Active community management; • Adequate level of facility and equipment; • FTC trainings linked with demonstrations; • FTC training manual and guideline availability.	• Revenue generation for self-sustainability; • Active link with farmer cooperatives and research institutions; • Ability to handle high level trainings; • Availability of operational resource centers.

PSNP Principles:
Fair and transparent client selection
Timely, predictable and appropriate transfers
Primary of transfers
Productive safety net
Tailored livelihood solutions
Integrated into local systems
Scalable safety net
Cash first principle
Gender equity

5.2.PSNP Service Standard

Category	Standards
Targeting	• Targeted households should be members of the community that are chronically food insecure (3 months of food gap or more per year) in the last 3 years or have suddenly become more food insecure as a result of a severe loss of assets • Fairness/transparency (i.e. targeting lists should be posted and/or read orally for community endorsement) • Full community participation in targeting process • Inclusion of all family members as PSNP clients (up to cap of 5) • Inclusion of households with malnourished children as Temporary Direct Support Clients
Gender and Social Development	• Fair inclusion of men and women in PSNP as either PW or Direct Support clients • Ensure 50% women representation and active participation all committee's and governance structures (50% quota for committee participation) • Special consideration of female-headed households (i.e. all things being equal women headed-household is prioritized for inclusion) • Women have 50% less working hours than men and lighter tasks • Early transition to pregnancy leave and longer duration of leave after birth (now 1 year) • In polygamous households, second (and additional) wife considered as a female headed household • Client Card includes picture and name of both male and female household heads
Graduation	• Households graduating in the previous year should be given at least 12 months' notice • Graduating household should be food secure for full 12 months • Full community participation in selecting graduates • Graduation benchmarks posted
Transfer	• Payments made within agreed timeframe (20 days for cash and 30 days for food) • Transfers received within 3 hours walking distance • Transfers received have value of at least 15kg of cereals and 4kg of pulses per person per month (i.e. full entitlement should be received, without deduction) • Use of transfer should be decided jointly by husband and wife • Contingency resources received within 60 days of threshold being reached/identification of needs (e.g. 5% woreda and 11% federal)

	• Awareness of fixed payment date (i.e. transfer schedule/payment data should be posted at kebele level) • Use of contingency resource to address malnourished children under TSF/CMAM • Women's right to access to collect transfer • PSNP Clients should have a Client Card and timely replacement of lost Client Card
Transparency & Accountability	• Awareness of program objectives, targeting criteria and methods, payment dates, amount of cash or food transfer, purpose of the transfer and importance of using it to meet the basic needs of the households, purpose of PWs and how they are planned, purpose of livelihoods interventions and how a client can participate, gender provisions, responsibilities of implementers and clients, importance of working towards graduation and existence of mechanisms for grievance redress. • Woreda, Kebele and community staff and Task Forces to make use of all opportunities to share above information. • All Clients are issued a Client Card with name, photograph, details regarding entitlements and space to record receipt of transfers. • Clients lists posted in public locations in PSNP areas • Charter of Rights and Responsibilities posted next to Client List but remains posted throughout the year (also included on Client Cards) • PSNP Program Posters describing specific aspects of program implementation will be available and put up in offices at Woreda and community level
Public Works	• PSNP PW clients are entitled to transition to Temporary Direct Support if required (i.e. sickness or pregnancy) • Households should not work more than 5 days per household member per month • No one person should work more than 15 days per month (if a person is covering 2 other labour poor household members). If there are other able bodied people, the whole family is expected to work no more than 20 days/month. • Proper setting of labour cap to the actual level of adult able bodied labour available to participate in PWs (no more than 15 days/able bodies adult) • Ensure women's 50% workload and PLW are considered in Person Days (PDs) calculation • PW planned and implemented following GoE's Community Based Watershed Guidelines or Rangeland Management Guidelines • PSNP clients satisfied with PSNP planning process (organization, community participation, incl. women, identification of need, final

	selection) and reflect needs • PW norms are followed (50% workload reduction for women) • PW subproject constructed according to technical standards in info-techs • Mitigating measures are implemented for PW subprojects • Arrangements for community engagement and/or operation and maintenance are established for PW subprojects • PW subprojects implemented following all gender and social development (GSD) considerations • PW are located within walking distance of Client's home • No participation of children (under 18) in PWs • Working conditions are satisfactory • Adult male and female PW Clients participate in monthly (min of 6 sessions/year) community based health and nutrition and sanitation BCCs (3 sessions = 1 PD)
Permanent Direct Support	• Aged, labour-poor, sick, pregnant, children (<18), people with HIV/AIDS, etc. are not required to engage in PW • Direct Support clients are entitled to 12 months support • Direct Support Clients participate in soft-conditionalities.
Temporary Direct Support	• Pregnant and women transition to temporary Direct Support before 4 months on the basis of health facility referral (amongst women who reach the 4th month of pregnant during the PW period)
Soft-Conditionalities	• Provision of Community Based Nutrition Activities (PLW participation) • Provision of community based nutrition counseling services • Transfers should not be deducted from clients for non-participation in soft conditionalities
Coordination & Institutional Arrangements	• Committees must be elected and comply with the guidelines • Committees hold regular meetings • Ensure participation of women (50%)
Grievance Redress Mechanism	• Clients complaints are addressed timely (99% resolved within one month) • If Client not satisfied with KAC decision, complaint have be escalated to Kebele Council • Complaints are recorded and registered (i.e. use of standard formats) • Kebele Appeals Committee membership should be impartial and not overlap with individuals involved in central roles in the implementation of the Program, particularly targeting (i.e. no member of the KAC should also be a member of the KFSTF or the CFSTF).

	• Women should be represented on KAC • KAC should be elected by community representatives • Pre-scheduled meetings times for KAC members • Timely reporting of summary of cases addressed to Kebele Council • KACs receive capacity building • Immediate and timely replacement of KAC members who drop-out • Linkage with formal GRM at kebele and woreda levels
Livelihoods	• Households self-select into the Livelihoods Component (i.e. no-one is forced to participate) and prioritized based on a) targeting for the livelihood transfer, or b) readiness to take the next step in their livelihoods. • The poorest households are targeted for Livelihood Transfer • 50% of livelihoods clients are women • Livelihoods support is provided at places and times that enable women to attend • Livelihoods training are provided as per the Livelihood Checklist.

Source: Expanded PSNP Social Accountability Pilot Training for SAIPs - Workbook & Reader, 2016

6. Rural Roads Brief

The Ethiopian Government has a set vision to make public, economic and social services physically more accessible to the rural population. The Ethiopian government's Universal Rural Road Access program (URRAP) sets out to connect all Kebeles by all-weather roads that meet the need of the rural communities for accessing market and social services and facilities.

According to a URRAP document[12], community involvement will be increased at all levels from administrative input to the participatory planning approaches through to increasing opportunity for community works contracts and community maintenance contracts. Some of the important benefits of the program will only be realized if opportunities are taken to maximize local employment creation and women and youths participation. Thus, setting clear and simple standards and enhancing gender sensitive community participation appears to be very important.

The resource mobilisation policy of URRAP for rural road construction is 50% community and 50% government contribution, of which 25% URAP and 25% Woreda.

ESAP-2 experience indicates that Woreda level rural road office capacity is not significant in-terms of technical experts and equipment. Rural road construction and maintenance needs large scale resource mobilization and at the same time it also demands effective, efficient and transparent coordination and utilization of the resource.

[12] http://www.era.gov.et/documents/10157/72095/UNIVERSAL+RURAL+ROAD+ACCESS+PROGRAM.pdf

6.1 Rural Road Service Standard

S/N	Inputs	Entitlements /Standards	Evidence/Remark
1	Contractors requirement and agreement	Guideline prepared by ERA (2010)	National (ERA)
2	Rural road width covered with sand	6-8 meters	
3	Standard thickness of sand (quarry)	15 cms	
4	Ditch width and depth	50-90 cms	
5	Budget transparency	Posted and avail to citizen	
6	All Kebeles have rural road access		GTP I & II
7	Available rural road expert at WoredaRoad office	**2**	
8	Available tools and equipments for rural road construction/maintenance at Woreda office	Sufficient number hand tools and simple rural road machines for excavation, clearance and levelling of the surface.	In some District there are engineers and surveyors at WRR office
9	Rural road slope	below 12%	National (ERA)
10	Transport cost	Based on ministry of finance tariff (---birr/...Kms)	
11	No compensation fee for the farmers land during rural road construction	ERA Guideline	How to consider poor/marginalized individual/groups?
12	Rural road design and construction coordination	URAP, Region, Zone, Woreda and Kebele representation	
13	Rural road joint monitoring system	URAP, Region, Zone, Woreda and Kebele representation	
14	Average time taken to reach to the nearest all weather roads	1.7 hour in 2014/15 and until the end of GTPII (2019/20) expected to be 0.8 hour only.	GTP II program