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ETHIOPIA PERFORMANCE MANAGEMENT SYSTEM PROJECT

DO2 PARTNERS' INDICATOR HARMONIZATION WORKSHOP SUMMARY REPORT

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DO 2 PARTNERS' INDICATOR HARMONIZATION WORKSHOP SUMMARY REPORT



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EXECUTIVE SUMMARY

USAID/Ethiopia's DO2 represents one of the largest and most diverse portfolios in the Mission, managed by the HAPN Office (Health; HIV/AIDS; Population and Nutrition). The programs under each thematic area are managed through four Teams, which include: 1) Health; 2) HIV/AIDS; 3) Presidential Malaria Initiative (PMI); and 4) Health Services Systems (HSS). In total, DO2 supports over 30 partners that are currently responsible for over 60 implementing mechanisms. In order to ensure that the results reported by each partner through their respective implementing mechanisms follow the same definitions, level of disaggregation, units of measure, etc., it is necessary for USAID to harmonize the M&E methodologies and processes across our implementing partners.

To facilitate the harmonization process across all the partners, DO Team brought together all the DO2 partners, including the Government of Ethiopia to discuss the various issues pertaining to the selected DO2 performance measures. In this regard, partners participated in the PMP development process into two phases: In Phase I, the DO2 Team through the Mission-wide M&E Contractor, Management Systems International (MSI), made four block consultations (Health, HIV/AIDS, PMI and HSS) with implementing partners to map out a list of indicators to be reported and highlighted issues that needed to be resolved with other implementing partners (IPs). Phase II entailed a one-day workshop (held on September 13 at the Hilton Addis) on indicator harmonization that helped to establish a common understanding on the indicator definitions and build consensus on all other aspects of data collection for reporting on the selected indicators. Specific objectives for the workshop included the following:

1. Align Partner Results Frameworks (RFs) with USAID/Ethiopia's
2. Harmonize indicators across all partners (i.e. same data sources & methods)
3. Provide a framework for aggregating data and summarizing the story of our collective impact
4. Prepare partner PMPs for accurate reporting into USAID M&E systems (Annual Performance Plan Report (PPR))
5. Clarify Expectations - roles & responsibilities
6. Establish Follow-up Actions and Timelines

The workshop design entailed both plenary and group break-out sessions. The plenary provided the genesis of the indicator harmonization process, as well as guidelines for the group discussions. While the group discussions focused on reviewing each indicator with regard to general issues, before focusing on the specific issues indicator by indicator. The outcome from the group discussions were also presented back to the plenary.

The key outcome from the workshop and group work entailed thoroughly reviewed list of all the 96 indicators selected by DO2 for reporting. For each indicator, specific issues were highlighted and actions on how they will be resolved stated. These are presented in the respective group summaries affixed in Annex 2. Some of the key operational-type issues highlighted from the groups with their respective recommendations included but were not limited to the following:

1. **Regions are at different phases of implementation.** i.e. Some are using the new HMIS vs. the old HMIS. Partners in different regions not compiling similar data/reports.

Recommendation: In the interim period, Partners to use sample data from Facilities. There is need to convince the government to include updated disaggregation levels such as gender in the next phase of the HMIS revision. In the latter phase, key indicators from the already approved parallel system like ICCM are to be included.

2. **There are methodological differences between major surveys such as the DHS and partner surveys**

Recommendation: DHS & other GoE surveys will be the main source of data at the end. However, the USAID system will rely on partner annual data in the interim period. It was agreed that partner surveys need to be strengthened in order to be more reliable and closer to the standard surveys.

3. Profile of Implementing Partners:

Recommendation: List implementing partners by geography and program area. It was agreed that Partners should have regular meeting for the concerned technical teams. This would assist in eliminating duplication of efforts with other partner organizations.

Note: The detailed issues on both the operational and PMP are provided in the main report under Table 2.

In order to have a complete performance management plan (PMP) for DO2, there are other key next steps that have to be fulfilled as outlined in Section 4.1. These include the following:

Step 1: MSI-EPMS to finalize/update all the master documents (PIRS; the DO2 Master Indicator List) in collaboration with the DO2 Team on the issues and actions highlighted above.

Step 2: DO2 Team to share the final drafts of the PIRS and Master Indicator list with the partners.

Step 3: Partners also to update their list of indicators and their PMPs in line with the Master indicator List; modify their definitions provided according to the definitions provided within the PIRS for the indicators they are required to report on to USAID.

Step 4: Continued collaboration among partners on approaches and methods used to collect common indicators as per the consensus from the group discussions as summarized.

Step 5: DO2 Team to finalize the PMP Narrative, Including the Critical Assumptions associated with the Results

Step 6: MSI-EPMS to develop the Data Summary Tables for all the indicators to be tracked as contained in the DO2 Indicator Master List. Performance Data Tables (including Baselines and Targets). These tables are complimentary to the PMP document and include baselines and targeted values for the DO and IR level indicators.

Note: Data is maintained in a spread sheet format (and will eventually be transitioned to AIDTracker) to facilitate more effective data analysis.

Step 7: DO2 Team to bring together all the key components as a Draft Complete PMP for DO2

Step 8: DO2 to submit the Complete PMP to Program Office for Approval by Mission Management

Finally, the approved complete PMP can be shared with all the DO2 partners. In addition, CORs/AORs can use it to engage with their respective partners in terms of follow-up on baselines, targets and actual data reported among other things.

INTRODUCTION

The development of the Performance Management Plan (PMP) is really only the first step in establishing an effective performance management system (it is, in essence, the blueprint for the system). Once the PMP is developed, it is essential to consider how data will be collected and how data will be used in a way that will facilitate use in decision making and influence budget allocations and program changes.

One of the key guiding principles in developing a PMP is to “Promote Participation and Ownership.” For USAID/Ethiopia Development Objective 2 (DO2), the decision to move beyond DO team participation, was one of the necessary next steps in order to engage all USAID's partners, contributing to the measurement and performance of DO2 results. This step was necessary to build not only shared ownership of results but also to reach consensus on the selected list of indicators (about 96 in number) that will be used to inform DO2 performance monitoring.

As such, it was very important to ensure that data that was to be generated from the performance management system are harmonized and useful to inform decision making for a variety of DO2 partners, including the Government of Ethiopia and other local organizations. In this regard, partners participated in the PMP development process into two phases: In Phase I, the DO2 Team through the Mission-wide M&E Contractor, Management Systems International (MSI), made four block consultations (Health, HIV/AIDS, PMI and HSS) with implementing partners to map out a list of indicators to be reported and highlighted issues that needed to be resolved with other implementing partners (IPs). Phase II entailed a one-day workshop (held on September 13 at Hilton Addis) on indicator harmonization that helped to establish a common understanding on the indicator definitions and build consensus on all other aspects of data collection for reporting on the selected indicators.

Why the Need to Ensure Indicator Harmonization Across Partners?

USAID/Ethiopia’s DO2 represents one of the largest and most diverse portfolios in the Mission, managed by the HAPN (Health; HIV/AIDS; Population and Nutrition) Team. The programs under each thematic area are managed through four Teams, which include: 1) Health; 2) HIV/AIDS; 3) Presidential malaria Initiative (PMI); and 4) Health Services Systems (HSS). In total, DO2 supports over 30 partners that are currently responsible for over 60 implementing mechanisms. In order to ensure that the results reported by each partner through their respective implementing mechanisms follow the same definitions, level of disaggregation, units of measure, etc., it is necessary for USAID to harmonize the M&E methodologies and processes across our implementing partners.

The Workshop Key Objectives

Therefore, the main objective of the DO2 indicator harmonization workshop was to align the Project Monitoring Plans (PMP) among all implementers with the Mission’s new DO2 Performance Management Plan (PMP). Specific objectives for the workshop included the following:

1. Align Partner Results Frameworks (RFs) with USAID/Ethiopia’s
2. Harmonize indicators across all partners (i.e. same data sources & methods)
3. Provide a framework for aggregating data and summarizing the story of our collective impact
4. Prepare partner PMPs for accurate reporting into USAID M&E systems (Annual Performance Plan Report (PPR))
5. Clarify Expectations - roles & responsibilities
6. Establish Follow-up Actions and Timelines

WORKSHOP DESIGN & METHODOLOGY

The plenary sessions were designed to provide the genesis of the indicator harmonization process, as well as guidelines for the group discussions. The process entailed five steps, as outlined in Box 2, which had to be followed by the groups for reviewing each indicator with regard to general issues, before focusing on the specific issues indicator by indicator.

The outcome from the group discussions were also presented back to the plenary. There were four groups divided along the DO2 Results Framework (Annex 1), each with 2-4 facilitators that were responsible for taking participants through their respective list of indicators per group.

Workshop Facilitators

The workshop was jointly facilitated by staff from both the USAID/Ethiopia Mission and the MSI, EPMS project. The process was highly participatory, right from

the planning phase to the final execution phase working with the partners in Blocks. Prior to the workshop, partner reviews using a standard tool were also conducted jointly by EPMS staff in the presence of COR/AOR for the respective projects reviewed. Table 1 below outlines the group composition with the facilitators per group.

GROUP DISCUSSION POINTS

1. Review PIRS to understand the Indicator definitions and the required desegregations
2. Reach consensus on the methodology for data collection
3. Agree on frequency of data collection (Quarterly, Annual or both)
4. Discuss the implications of data collection at all the various levels of disaggregation assigned to the specific indicator (PIRS or differ)
5. Agree on the approach for establishing Baselines & their current status, per partner?

TABLE 1: GROUP FOCUS AND FACILITATORS FOR THE DO 1 WORKSHOP

Group	Group Focus	Facilitators per Group
Group 1	DO2 - Level	Rosern Rwampororo, MSI - EPMS & Mequannent Fentie & John Mckay, USAID
Group 2	IR 2.1	Hika Dinsa MSI – EPMS and Samson Oli & Dr. Yared Kebede, USAID
Group 3	IR 2.2	Abdu Zeleke, MSI – EPMS and Pteros Faltamo, Dr. Samuel Hailemariam & Gebeyehu Abelti, USAID
Group 4	IR 4 & 5	Tesfayesus Yirdaw, MSI – EPMS and Awoke Tilahun, Sileshi Kassa and Yirga Amba, USAID
Morning Plenary	Workshop Opening PPT Presentations	Elise Jensen, John Mckay and Rosern Rwampororo;
Afternoon Plenary	Outcome of Group Discussions	Rosern Rwampororo and Awoke Tilahun

The facilitators were also responsible for putting together the outcome of the group discussions, and the follow-up actions for their respective groups, which are detailed in **Annexes 2 a – d**.

WORKSHOP OUTCOME/SUMMARIES

The indicator review process entailed several steps, as mentioned earlier, which helped the groups to generate and discuss issues on each indicator, and reach consensus on the actions to be taken by all the partners. For instance, those who had definitions for their indicators not conforming to those provided in the Performance Indicator Reference Sheets (PIRS) had to agree to change them to reflect the standard.

The key outcome from the workshop and group work entailed thoroughly reviewed list of all the 96 indicators selected by DO2 for reporting. For each indicator, specific issues were highlighted and actions on how they will be resolved stated. These are presented in the respective group summaries affixed in **Annex 2**.

Issues Addressed by the Groups

Operational Type Issues and Recommendations

- 1. Regions are at different phases of implementation. i.e. Some are using the new HMIS vs. the old HMIS. Partners in different regions not compiling similar data/reports.**

Recommendation: In the interim period, Partners to use sample data from Facilities. There is need to convince the government to include updated disaggregation levels such as gender in the next phase of the HMIS revision. In the latter phase, key indicators from the already approved parallel system like ICCM are to be included.

- 2. There are methodological differences between major surveys such as the DHS and partner surveys**

Recommendation: DHS & other GoE surveys will be the main source of data at the end. However, the USAID system will rely on partner annual data in the interim period. It was agreed that partner surveys need to be strengthened in order to be more reliable and closer to the standard surveys.

- 3. Overlap of Partners within same Woredas.**

Recommendation: Partners to collaborate at the lower level to encourage integration of both activities (e.g. conducting baseline or surveys) and programs and also to avoid double counting.

- 4. Calendar Timeline differences in compilation and reporting (within region and with USAID)**

Recommendation: Partners should discuss, and CORs to reconcile the different periods and use standard procedures outlined in the HMIS technical documents. Work with TWG to improve the gaps.

- 5. Defining catchment population e.g., PCV vaccine coverage**

Recommendation: Coverage should be calculated at a defined geographic area where data is available.

- 6. Double counting**

Recommendation: Partners should develop means or mechanisms to avoid double counting. Overlapping projects should work together.

- 7. Profile of Implementing Partners:**

Recommendation: List implementing partners by geography and program area. It was agreed that Partners should have regular meeting for the concerned technical teams. This would assist in eliminating duplication of efforts with other partner organizations.

Note: The detailed issues on both the operational and PMP are provided below under Table 2.

TABLE 2: PMP TYPE ISSUES AND RECOMMENDATIONS

	Type	Issues	Consensus Reached
1	Definitions	Variation in the definitions currently used by the partners that contributes to the same indicator. Some of the custom indicators need to be clearly and fully defined.	All partners were to use the common definition provided in the PIRS for each indicator, including the custom ones. On the latter, USAID to take the lead in providing the necessary information
2	Methodology	There were some differences between the methods used for data collection and surveys approaches.	All partners were to use same data collection methods and/or share the tools for those who had already established mechanisms.
3	Frequency of Data Collection	Most partners considered the frequency to be annual for reporting, but many were already collecting data quarterly or semi- annually. Reporting requirements depend on the nature of their contracts.	It was agreed that all data should be reported both quarterly (where possible) for management use and annually for reporting to AID/Washington.
4	Levels of Disaggregation	There were some discrepancies in the disaggregation levels used by the various partners for the same indicator. Generally agreed to aggregate data at woreda/district level as data is available at that level.	The consensus was for all partners to provide data for all the required disaggregation levels as stipulated in the PIRS. However, partners indicated that for the crosscutting indicator on gender consensus was to use the age disaggregation: below 15 & 15+
5	Status of Baselines	Some partners have already conducted their baseline while others were just getting it underway	Partners agreed to have baseline & collaborate as much as possible and use common approaches.
6	Other	About 20 indicators have not been fully defined and other additional indicators have been partially defined (missing some components of the PIRs e.g., disaggregation).	It was agreed that USAID and some specified IPs had to take the lead on custom indicators by providing not only definitions but the detailed information on how they were to be measured, disaggregated and reported.

On both the specific issues and consensus pertaining to each indicator, these are also detailed in the group summaries attached under **Annex 2 a – d**.

RECOMMENDATIONS & NEXT STEPS

Given the multitude of issues raised across all the groups on the DO2 indicators, some of the key recommendations highlighted here pertain to mainly the general issues. The actions agreed between the partners regarding the specific issues per indicator are detailed in each group summary in the Annex 2. The recommendations stated here double as the agreed course of actions by the partners.

<p>data. However, data availability tends to be long-term</p> <p>ii) There are methodological differences between major surveys such as the DHS and partner surveys.</p> <p>iii) Data on immunization from the DHS had issues. As such, MoH and UNICEF are currently conducting a new survey to determine immunization coverage.</p>	<p>2.2 DHS & other surveys will be the main source of data at the end; however the system will rely on partner data in the interim period.</p> <p>2.3 The HIS strategy is under development and is expected to be finalized soon.</p> <p>2.4 Strengthen partner surveys to be more reliable and closer to the standard surveys.</p>	<p>USAID</p> <p>GoE</p> <p>USAID & Partners</p>	
<p>3. Required levels of Disaggregation issue</p> <p>i) Age: For the crosscutting indicator on gender, USAID requires 10-29; and 30 and over.</p>	<p>3.1 For Gender based violence, consensus was to use the following age disaggregation:</p> <p><input type="checkbox"/> use below 15</p> <p><input type="checkbox"/> 15+</p> <p>This is consistent with most PEPFAR NGI indicators.</p>	<p>Partners</p>	
<p>4. Overlap of Partners within same Woredas</p> <p>Example: In one Woreda, IntraHealth, ICAP, & MCHIP are all supporting PMTCT in different Facilities, which has implications on the catchment area when conducting community level surveys.</p>	<p>4.1 Partners to collaborate at the lower level to encourage integration of both activities (e.g. conducting baseline or surveys) and programs and also to avoid double counting</p>	<p>Partners</p>	
<p>5. Calendar differences compilation and reporting (within region and with USAID)</p>	<p>Partners should discuss CORs to reconcile the different periods use standard procedures outlined in the HMIS technical documents.) Work with TWG to improve the gaps</p>	<p>IPS, and CORS/AORs</p>	<p>October 2012</p>
<p>6. Data sources issues and scope of the indicators e.g., Referral linkages</p>	<p>Determine the scope, be specific and work with TWG and FMOH to establish the registration and other data capturing mechanisms</p>	<p>MSI, Heal-TB and USAID</p>	<p>October 2012 Ongoing</p>
<p>7. Defining catchment population e.g., PCV vaccine coverage</p>	<p>Coverage should be calculated at a defined geographic area where data is available</p>	<p>MSI</p>	
<p>8. Double counting e.g., Umbrella care (Clinical ,psychosocial and other support)</p>	<p>Partners should develop means or mechanisms of avoiding double counting. Overlapping projects should work together.</p>	<p>Partners</p>	<p>October 2012</p>
<p>9. Disability indicators</p>	<p>Partner will review the indicators and will come up with workable indicators Sharing experience with those that have the experience</p>	<p>COR and partners</p>	
<p>10. Gender equity/mainstreaming considerations in all the indicators</p>	<p>Our indicators need to consider all sexes in measurements</p>	<p>All</p>	<p>ASAP</p>
<p>11. Data Collection Methods. Needs follow-on discussions with USAID</p>	<p>Needs follow-on discussions with USAID</p>	<p>USAID</p>	<p>ASAP</p>
<p>12. Do the reporting templates include DO level indicators?</p>	<p>USAID to update</p>	<p>USAID</p>	<p>ASAP</p>

13. Profile of Implementing Partners:	List of implementing partners by geography and program area. Partners regular meeting for the concerned technical team. This can avoid duplication of efforts with other partner organizations.	All	ASAP
14. Some IPs takes Baseline data from DHS and others from other sources for same indicators ...Discrepancy?	An agreement to be reached across all IPs. Take DHS or other published documents as a consensus, baseline for each project)	IPs	ASAP

Next steps

In order to have a complete performance management plan (PMP) for DO2, there is need to bring together a number of components. The Five Key Elements of a Complete PMP include the following:

1. A Narrative Summary
2. The Results Framework (RF)
3. Performance Data Summary Table – As a separate management tool for tracking baselines and targets
4. Performance Indicator Reference Sheet (PIRS) for each Indicator in the RF
5. Matrix Summarizing Key Roles and Responsibilities for USAID

Therefore, the necessary logical steps to be taken after the workshop on indicator harmonization is to move towards the completion of all the components required for the DO2 PMP. The immediate steps include but are not limited to the following:

Step 1: MSI-EPMS to finalize/update all the master documents (PIRS; the DO2 Master Indicator List) in collaboration with the DO2 Team on the issues and actions highlighted above.

Step 2: DO2 Team to share the final drafts of the PIRS and Master Indicator list with the partners.

Step 3: Partners also to update their list of indicators and their PMPs in line with the Master indicator List; modify their definitions provided according to the definitions provided within the PIRS for the indicators they are required to report on to USAID.

Step 4: Continued collaboration among partners on approaches and methods used to collect common indicators as per the consensus from the group discussions as summarized.

Step 5: DO2 Team to finalize the PMP Narrative, Including the Critical Assumptions associated with the Results

Step 6: MSI-EPMS to develop the Data Summary Tables for all the indicators to be tracked as contained in the DO2 Indicator Master List. Performance Data Tables (including Baselines and Targets). These tables are complimentary to the PMP document and include baselines and targeted values for the DO and IR level indicators.

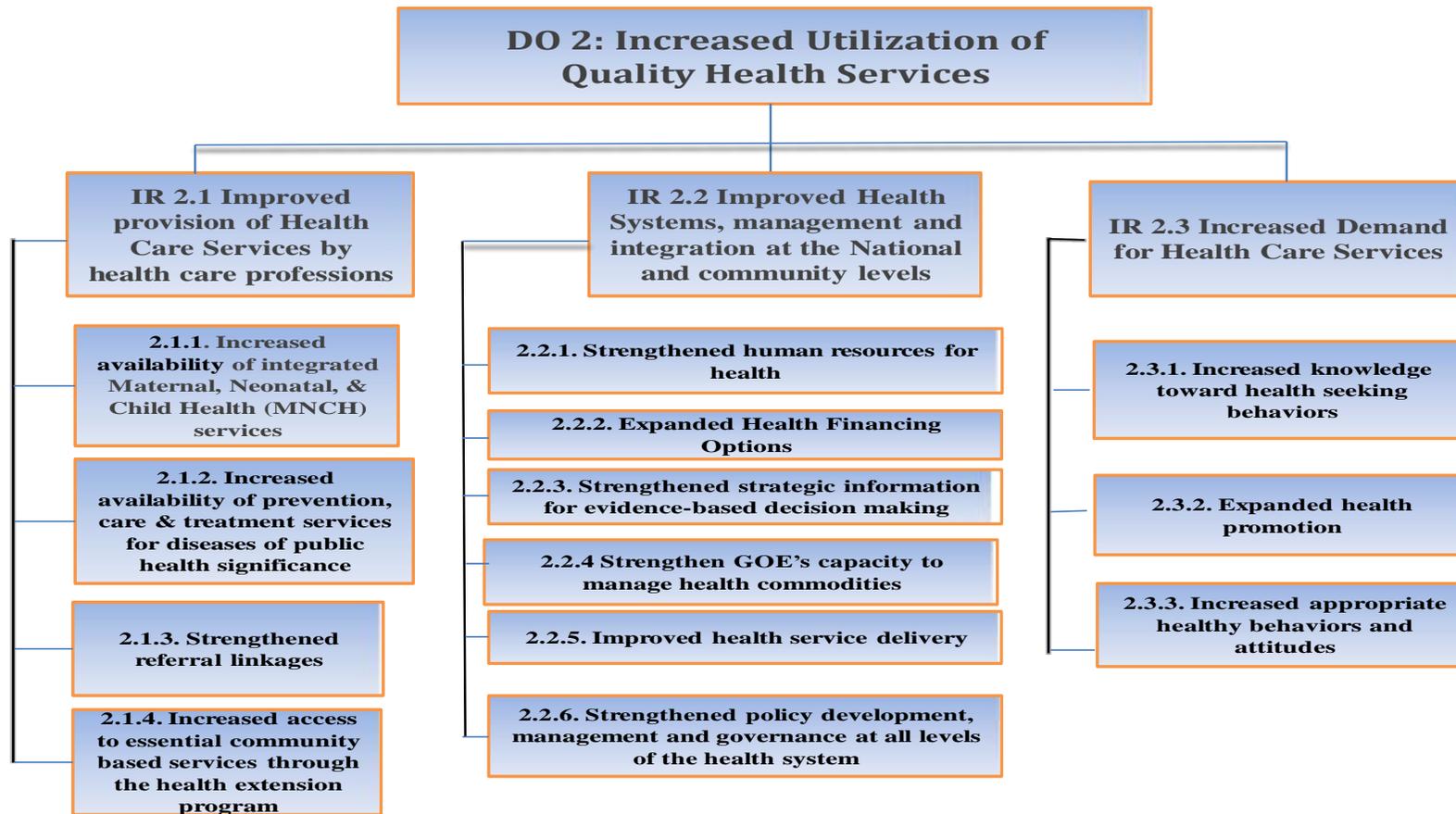
Note: Data is maintained in a spread sheet format (and will eventually be transitioned to AIDTracker) to facilitate more effective data analysis.

Step 7: DO2 Team to bring together all the key components as a Draft Complete PMP for DO2

Step 8: DO2 Team to submit the Complete PMP to Program Office for Approval by Mission Management

Finally, the approved complete PMP can be shared with all the DO2 partners. In addition, CORs/AORs can use it to engage with their respective partners in terms of follow-up on baselines, targets and actual data reported among other things.

ANNEX I: DO2 RESULTS FRAMEWORK



ANNEX 2: GROUP SUMMARIES

Annex 2a: Group 2 (DO-Level Indicators) Discussion Summary

PART A: CONSENSUS REACHED ON GENERAL INDICATOR ISSUES – GROUP 1 (DO2 – LEVEL)

General Issues	Consensus on Actions to be taken	Responsible Party	Timeframe
A) Definitions			
Most indicators at the DO-2 level are from the DHS, MIS, & GAPR and so are defined accordingly. However, some custom indicators have no definitions.	Agreed that partners who contribute to such indicators should assist in providing input to the PIRS definitions. MSI-EPMS to send them the electronic specific PIRS to fill in. E.g.JSI-HMIS to assist with indicator #3 on Outpatient attendance per capita; and MSH-ENHAT to assist with indicator #10 on C.4.I.D.	MSI – EPMS send PIRS to Partners (JSI- HMIS & MSH-ENHAT)	Immediately
B) Methodology for Data Collection			
Most data is collected via either 2 or 5-year surveys. For the ones which use the HMIS National data, there are some gaps and so partners have been forced to collect their own data to supplement the HMIS.	-It was agreed that it was better to use the HMIS national data for reporting to USAID, since partner data is usually over limited coverage such as a region. -For the indicator on new sear +ve TB cases, it was agreed that the denominator should include all forms of TB.	Partners& MSI-EPMS	Continuously
C) Frequency of data collection			
Issue was availability of data for annual reporting since DHS data was available after 5 years.	Consensus was that data from annual surveys currently conducted by partners such as: IFHP & JSI can be used as benchmarks in the interim. Note: It was recognized that the two data sets (DHS vs Partner survey data) may not be comparable due to methodological differences. Agreed that the latter can be improved over time.	Partners	Continuously
D) Data for Required Disaggregation			
There were a couple of instances where data for the required disaggregation as stated in the PIRS could not be feasibly collected by the partners.	In the case of Indicators: 3.1.6.1-1*; and the gender crosscutting one, where new disaggregation were proposed (See details on the Indicator-specific summary). Since both are standard indicators, the final decision is to be made by USAID.	USAID	Immediately
E) Establishing Baseline& Targets			

<p>-Status: All partners indicated they had conducted their baselines. However, also use the DHS baselines where data is from both partner & DHS for that indicator.</p> <p>-For targets, they use the national targets for those which are collected through the HMIS.</p> <p>-Approach: Most collect Baseline & End line data. Use the baseline data to set annual targets.</p>	<p>-At DO2 level, there were no major gaps in establishment of baselines mainly because the indicator data sources are from major surveys for the GoE.</p>	<p>Partners & USAID</p>	<p>Continuously</p>
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PART B: SUMMARY DISCUSSIONS ON INDICATOR SPECIFIC ISSUES (GROUP I - DO2 LEVEL)

S/N	Indicator	Issues	Actions to be taken	Responsible body	Time frame
DEVELOPMENT OBJECTIVE 2: Increased Utilization of Quality Health Services					
Contextual Indicators					
1	Maternal Mortality Rate				
2	Under 5 Mortality Rate disaggregated by neonatal and infant mortality				
Impact indicators – DO2 Level Indicators					
3	Outpatient attendance per Capita	Indicator is not clear and involvement of federal MOH is necessary as JSI-HMIS is working in SNNPR region only	JSI-HMIS to define the indicator - send PIRS	FMOH	Annually
4	3.1.7-38* Modern method Contraceptive Prevalence rate	DHS will be the main data source	Use		
		IFHP conducts baseline (2008) and will conduct endline survey (2013) in the four big regions and some woredas in Somali and BG and doesn't cover the whole region. IFHP has 298 woredas	IFHP's information will complement DHS in years where DHS reports are not available as benchmarks prior to the next DHS.	IFHP/Pathfinder	Every five years
5	3.1.6.4-1* Percent of children who received DPT3/Penta3 vaccine by 12 months of age (Disaggregated by sex, Numerator and Denominator)	DHS will be the main data source IFHP/JSI survey conducted as baseline and endline will complement the data. Survey data quality by partners needs to be strengthened to match the DHS methodology. Also conduct some annual surveys.	IFHP's information will complement DHS in years where DHS reports are not available. Elevating the quality of project surveys needs consideration in terms of comparability of indicators. IFHP uses HMIS review to report DPT3/Penta . UNICEF is also doing contraceptive survey next year	IFHP/JSI/UNICEF	
6	Percent of children who are fully immunized				

S/N	Indicator	Issues	Actions to be taken	Responsible body	Time frame
7	3.1.6.1-1* Percent of Births Attended by a Skilled provider, Doctor, Nurse or Midwife, health officer(3.1.6-40) (Disaggregated by Numerator and Denominator)	The issue with collecting this information is IFHP, HMIS and MCHIP have different methodologies. Hospital data	Need three level of disaggregation: i) skilled vs. non skilled, ii) hospital vs health centers; Health extension workers delivery is not included in this definition.		
8	CUSTOM:3.1.2-31 * Percent of the estimated number of new smear-positive pulmonary TB cases that were detected under DOTS (i.e. Case Detection Rate)	1.Partners are using estimates 2. WHO is going to drop because of the problem with denominator 3. the mission wants to keep this indicator	HEAL TB operates at national level only. Starting from 2011 WHO stopped giving estimate of smear TB due to methodology issue. EHNRI has conducted national survey and the report is sent to WHO so estimates will be available after modeling exercise.	The denominator should include all forms of TB because MDG Goal and mortality is monitored in all forms so better to stick to the new definition	
9	GHI 3.1.2.1-1 * Percent of registered new smear positive pulmonary TB cases that were cured and completed treatment under DOTS nationally (Treatment Success Rate) (Disaggregated by Sex and Numerator and Denominator)	1. Levels of disaggregation's 2. TB-Care use national data whereas Heal-TB uses woredas data 3. Duplications of targets	All contributes to the national HMIS so it is better to stick to HMIS. The gap is all private service is not disaggregated, gender disaggregation will be available after one year		
10	C.4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	HIV exposed infant register contains this information but it is challenging for partners working in wider areas. Some partners are collecting data at a facility level by dividing	PI ID-number of women who know their status is not a good estimate. Three different registers used to calculate the indicator HEI, L&D and PMTCT registers. Need to follow-up with MSH-ENHAT to fine-tune this indicator	MSH-ENHAT	
11	Percentage of HIV-Infected individuals receiving Antiretroviral Therapy by age: adult and children				

S/N	Indicator	Issues	Actions to be taken	Responsible body	Time frame
12	3.1.3.2-7 Proportion of pregnant women who slept under an insecticide-treated net (ITN) the previous night (Disaggregated by Urban and Rural, Numerator and Denominator)				
13	3.1.3.2-6 Proportion of children under 5 years old who slept under an insecticide-treated net (ITN) the previous night (Disaggregated by Sex, Urban and Rural, Numerator and Denominator)		IFHP conducted Baseline and Endline survey. In addition will for annual Household Surveys		
14	GNDR-6 * Number of people reached by a USG funded intervention providing GBV services (e.g. health, legal, psychosocial counseling, shelters, hotlines, other)	1. There is a problem of clarity 2. The missions to discuss on it with all concerned bodies	Cannot disaggregate Age by 10-29 and over 30 as stipulated in the PIRS. Recommend to use: Below 15 and 15+, which is consistent with PEPFAR NGI Indicators.		
	GNDR-6a Number of men				
	GNDR-6b Number of women				
	GNDR-6c Age :10-29				
	GNDR-6d Age : 30 & over				

Annex 2b: Group 2 (IR 2.1) Discussion Summary

PART A: SUMMARY OF GROUP DISCUSSIONS ON INDICATOR SPECIFIC ISSUES

S/N	Indicator code	Issues	Actions to be taken	Responsible body	Time frame
DEVELOPMENT OBJECTIVE 2: Increased Utilization of Quality Health Services					
IR 2.1. Improved provision of Health Care Services by health care professions					
15	P1.2.D Percent of HIV infected pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission. PEPFAR	<ul style="list-style-type: none"> Some pregnant women coming without attending any ANC Target duplications problem with denominators(mother can be tested more than 2 times Denominator higher than actual, because usually the clients are not confident with the result of one particular facility and they go elsewhere for further confirmations 	<ul style="list-style-type: none"> Checking data quality frequently through Monitoring and Evaluation, cross checking if double counting etc. (register and wall chart), triangulate data, asking Further discussion with GoE. Using Mother group volunteers to reduce duplication The new B+ guide line will be implemented for FY 2013 Triangulation and discussions 	IPs	October 2012
16	3.1.6.4-3 * Percent of children who have received the third dose of Pneumococcal conjugate vaccine by 12 months of age (Disaggregated by Sex, Numerator and Denominator.)	<ul style="list-style-type: none"> Issue of "# of living children" in the indicator denominator, affected by poorly defined catchment area for the Facilities. Disaggregation by sex Problems in using the Woredas HMIS data (The denominator and numerator are affected by the estimations) 	<ul style="list-style-type: none"> USAID has to use estimations from the National Data to solve the problem of the denominator Partners have to report only the denominator The HMIS is expected to be done again, and suggesting the inclusions of additional column by Partners and USAID by discussing with the relevant governmental bodies is required 	CORs/AORs and IPS	October 2012 and ongoing actions required
17	3.1.2.1-3* Number of new TB cases reported to National TB Programs (NTP) by non-MOH organizations	<ul style="list-style-type: none"> No TB case detections , but the number of suspects are being addressed Data quality Problem TB-Care could use data from HMIS at national level Abt uses data from the facilities(Because HMIS data is not disaggregated at national level) 	<ul style="list-style-type: none"> Standardizing and using the same formats across partners Using the national TWG and private sectors TWG to improve and solve the data quality issues Disaggregating HMIS data at national level to show the cases from non-MOH organizations. 	TB Care at National level, ABT and Heal-TB at the regional level	Ongoing action is required

19	3.1.9-15* Number of children under five reached by USG-supported nutrition programs (Disaggregated by Sex)	<ul style="list-style-type: none"> • Definition not clear (package) even though it is a standard one • Double counting problem(counting the mothers) • The “IPs” are not using the children directly, but the Mothers as Proxy indicators • Estimations from the catchment areas is used • There may also be over or under reporting 	<ul style="list-style-type: none"> • Definition should be revised to contextualize with the government’s definition. The AOTs/CORs have to revise it with all concerned bodies. • Unique identifier practices being used by some partners should be adapted by other partners as well • Continuous data assessments method should be used to reduced the over/and or under reporting problems 	USAID HPN, WFP	Ongoing action
20	3.1.7.1-3* Couple Years of protection (CYP) in USG supported programs	<ul style="list-style-type: none"> • The method is removed from the new HMIS, hence problems in tracking the indicator • Definition not matching the title(The coding and the wording have different meanings) 	<ul style="list-style-type: none"> • No action at hand • The standard definition needs to be used from HMIS 	USAID, IPs and MSI	October 2012
2.1. Increased availability of integrated Maternal, Neonatal, & Child Health (MNCH) services					
21	3.1.1-85 Number of infants born to HIV-positive women who received an HIV test within 12 months of birth (C4.1D)	<ul style="list-style-type: none"> • PEPFAR definition is percentage, here it says number • Double counting because same babies could be counted twice during anti-body and DBS testing 	<ul style="list-style-type: none"> • The number should be changed into “percentage” • Updating with latest document, numerator and denominator 		
22	CUSTOM* Number of women who received fistula repair through USG supported programs	<ul style="list-style-type: none"> • Clear definition required, since there are several types of fistula 	<ul style="list-style-type: none"> • The precise definition was prepared by Addis Ababa Fistula hospital and forwarded to MSI. The revision will be done. 	AA Fistula Hospital, MIS and CORs	October 2012
24	NGI 3.1.1-10. Number of adults and children with advanced HIV infection receiving antiretroviral therapy (Current) (PEPFAR output #T1.2.D) [combined age sex disaggregation: male <15, female<15, male15+ and female15+]	<ul style="list-style-type: none"> • Desegregations problem(Abt , does not follow up and once clients are register when they advance in ages) • Gaps in lost follow up • Data quality issues 	<ul style="list-style-type: none"> • Follow up in updating records in line with the advance in the age of the clients. • For data quality issue IPs should communicate with health providers and check data quality frequently • Cut-off for lost follow-up should be standardized. Age category should be given attention to avoid over and under estimate. 	CORs(PEPFAR), IPs	October 2012

25	NGI 3.1.1-69 Number of eligible adults and children provided with a minimum of one care service (PEPFAR output - #C.1.ID) (Disaggregated by Sex and Age:<18 and 18+)	<ul style="list-style-type: none"> • Differences in targeting e.g. Some targeting children, some MAPRs and some adults • Double counting issues, that is the same individuals getting different services • Some partners are working in town settings and disaggregation's by woredas and regions are not uniform • Baseline is not uniform across the partners ; • Not all Partners attach "unique" identifier to service roster 	<ul style="list-style-type: none"> • Partners should come together to share experiences and learn from each other in addressing the indicator • Counseling and service packages should be aligned • Further discussions with the respective CORs to clarify the disaggregation issues • The partners have agreed to share experiences and have similar baselines. • Attaching unique identifier by using electronic data base will solve the problems of double counting 		
26	National TB smear microscopy laboratory coverage	<ul style="list-style-type: none"> • Tracking this indicators without taking into considerations figures from GoE is impossible • The Availability of microscopes by itself won't be sufficient hence tracing the Baseline using numbers is also a problem. • Disaggregation by geographic area/population. 	<ul style="list-style-type: none"> • MOH and Non MOH figures should be incorporated • using percentages coverage seems feasible than numbers • Desegregations should be done geographically 		
28	3.1.3.3-3 * Number of houses sprayed with IRS with USG support	<ul style="list-style-type: none"> • The Definition needs revisiting, the partners are tracking the indicator by using structures instead of houses 	<ul style="list-style-type: none"> • Even though the indicator is a standard indicators, USAID Health team should give due attention to definitions and wording of the. 	PMI CORs and IPS	October 2012
2.1.3. Strengthened referral linkages					
29	Number of individuals referred to health facilities for further care and treatment of HIV and or TB	<ul style="list-style-type: none"> • Heal-TB sends the suspects and it is not the actual referral • The indicator is too general • Difficulties in tracking the referrals • Only Heal-TB is reporting 	<ul style="list-style-type: none"> • Definition needs to be qualified and further clarity is required so that the TB suspects may be addressed as well • Referral tracking is still a big problem • The definitions should be narrowed to HIV and TB collaborative services alone • TB –Care and those contributing to indicators should include their activities in their narratives 	USAID/ Relevant Partners and MSI	

30	3.1.8-12 * Number of TB cases detected through Community level TB screenings	<ul style="list-style-type: none"> No TB case detections, but the number of suspects are being addressed. Data collection can be challenging. 	<ul style="list-style-type: none"> Heal-TB has the definition and is planning to share with MSI and UASID mission office. Discussions will follow after the sharing of the definitions. 	Heal TB, HPN and MSI	
2.1.4. Increased access to essential community based services through the health extension program					
CROSS-CUTTING INDICATOR					
31	CUSTOM Percent of implementing mechanisms that include people with disabilities as at least 5% of the beneficiaries or have a project level result directly related to addressing a disability specific issue.	Partners have difficulties in understanding this indicators	Further discussions with the respective CORs is proposed	USAID and IPs	October 2012
32	CUSTOM Number of outreach activities conducted to include people with disabilities in project activities or to increase participation in community	<ul style="list-style-type: none"> Definitions of disabilities should be extended to Fistula victims' Almost all implementing partners getting funds from USAID has to have mechanisms of including disability interventions in their respective programs There are other organizations implementing it outside the missions circle. E.g. handicap international , ENAD(Ethiopian national association of the Deaf) 	<ul style="list-style-type: none"> AA Fistula hospital has provided definitions Pact has some elements of disability and others have agreed to communicate PACT for experience sharing on how to include disabilities in their programs 	USAID and IPS	Ongoing action

Annex 2c: Group 3 (IR 2.2) Discussion Summary

PART A: GENERAL ISSUES

General Issues	Consensus on Actions to be taken	Responsible Party	Timeframe
F) Definitions	For Standard Indicators, agreed to use the PIRS definitions only asked clarifications for unclear ones, and for most of custom indicators modifications are proposed as stated under Part C under each indicator	USAID in consultation with IPs	as soon as possible
G) Methodology for Data Collection	Refer to Part C for specific indicators		
H) Frequency of data collection	Agreed to provide data on quarterly basis for management purpose and annually for reporting requirement	IPs	
I) Data for Required Disaggregation	Disaggregation as per the PIRS except for those suggested modification under Part C. Generally agreed to aggregate data at woreda level	IPs	
J) Establishing baseline	To have baseline data is a precondition before any significant implementation is done and also need to provide baseline & Target for the coming years	IPs	

PART B: SUMMARY OF GROUP DISCUSSIONS ON INDICATOR SPECIFIC ISSUES

S/N	Indicator	Issues	Actions to be taken	Responsible body	Time frame
IR 2.2 Improved Health Systems, Management and Integration at the National and Community level					
33	Percentage of USG supported regions, zones, woredas, and kebeles developing annual plans based on HMIS and other relevant data	<ul style="list-style-type: none"> -100% already covered by the government. -How is this indicator relevant? -Difficult to count the number of woredas and kebeles -What is the numerator and denominator? -Are we going to make indicator for each zone? -What is relevant data mean? -Can we go for the % or # ? -Does is importance at partner level? -to focus the aggregation at woreda level 	<ul style="list-style-type: none"> We can go for the % -supported to develop plan is the numerator -total supported (any support) is the denominator -aggregated at the mission level - needs further discussion among reporting partners & modify the indicator 	USAID in consultation with IFHP, HSFI, JSI	
34	Ratio of midwives to population	<ul style="list-style-type: none"> -What is the partner's contribution? -It is not disaggregated by partners -Contribution of USG/ overall situation -Can we attribute this indicator for a specific indicator? 	<ul style="list-style-type: none"> It indicates USG contribution to the 42 midwifery training institutions The definition needs a little bit clarity 	HRH & USAID	
35	3.1.9.2.2 Number of health facilities with established capacity to manage acute under – nutrition	<ul style="list-style-type: none"> Clinic or other institutions OTP/stabilization by urban rural disaggregation is an issue Better to specify minimum capacity -how are we going to collect the data/ what is - the system? it covers all facilities 	<ul style="list-style-type: none"> -it can be generated based on the location of the health facilities -urban/rural info can be obtained from CSA -based on the national guideline -data collection methods should be clearly understood The example statement should be avoided 	USAID	
2.2.1 Strengthened human resources for health					
36	Percentage of trained providers performing to standard in service delivery settings.	<ul style="list-style-type: none"> -Different modalities of training TOT/basic -What is the service -it belongs it group 2, It falls on quality of health care -Who are the trained providers? 	<ul style="list-style-type: none"> -It has to be captured by at least one partner -Focused on different partners working on TB/HIV -It will be captured by a survey -We can track them on follow up training 	USAID	

		<ul style="list-style-type: none"> -Where they are working? -What is the tracing mechanism to capture them after the training? -level of disaggregation? -It is difficult to measure -VCT/PMTC/TB are they getting the service according the protocol? 	<p>evaluation</p> <ul style="list-style-type: none"> -we need to come up with one measurement method -There is an effort to link in-service training with the quality of the service provided -it can be justified during supportive supervision -the timing of after training evaluation need to be clearly stated -the definition should be clearly incorporate all the issues raised 		
37	Number of new health care workers who graduated from a pre-service training institution within the reporting period	<p>What kind of service? It is new indicator for the partner (Jhpiego); Futures group wants to add it to the list of its indicators</p>	<ul style="list-style-type: none"> -The support can be anything Detailed definition on is on the PEPFAR - Modify the rationale... Not only for HIV/ -Others can be included on other section of the disaggregation -The training should be greater than 6 months of period training 	USAID	
38	Percentage of health professionals who drop out within three years of deployment (or are retained for at least three years in a setting)	<p>Living the facility or what? Does it include transfer? Measuring the three years cohort is difficult Any health professionals/ or the one who received in-service training? HRH modified the indicators. Workforce lose ratio(HRH) How do we know where the working is going? If they are working in the health system, can we consider them as dropout? From Pre-service/in-service training? -Does it include migration/retirement? Difficult to trace where they are going</p>	<p>Agreed to use living the facility Totally dropped the service is dropped out Drop out from government institutions/public to anywhere excluding transfer Yes it include migration/retirement Health care providers with population ratio To modify the definition Refer to Jhpiego's definition</p>	<p>Jhpiego /HRH</p> <p>USAID</p>	
39	Percentage of health professionals who advance to a higher level. (Numerator: health professionals who advance – denominator: all	<p>What do we mean by higher level? What do we mean by advance? Is it on the health or other educational field? Health professionals does not include Health</p>	<ul style="list-style-type: none"> -Short term trainings are not considered - Receiving official certification is important? -This is only for existing professionals 	USAID MSI	

	health professionals)	Extension Workers Change Health Professionals to Health Workers -for 3-4 academic year it is difficult to capture data, if it is one year course it is easy to capture	-It is best to say to the next higher professional level -Agreed that changes to other professions of similar level will not be counted. -Advance is to any health profession - Advance for HEW is not considered as they are not health professionals - change health professional to health workers - Modify the definition		
2.2.1 Output Indicators					
41	3.1.9-1* Number of people trained in child health and nutrition through USG-supported health area programs (Disaggregated by Sex and Numerator and Denominator.)	Where is the cut off point when we say child health since it is highly coupled with maternal health Dose child health refers to New born under 5?	Disaggregation only Sex NO denominator or Numerator	USAID MSI	
42	CUSTOM: 3.1.3-22* Number of people trained with USG funds in malaria treatment or prevention (Disaggregated by Sex)	1. TOTs are reported and cascaded/basic trainings are not in some cases 2. Some have training manuals and others do not 3. Differences in capturing data 4. Levels of disaggregation's 5. Some partners such as ICAP have baseline while other have What they call Macro-planning , Abt. IRS	Definition to be provided by IFHP Disaggregation: by Sex	IFHP & USAID	
44	3. 1.-83 (H2.2.D) Number of health and Para-social workers who successfully completed an <u>in-service</u> (Pre-service) training program	This Indicator is not for In-service	1. The indicators should be restated to read as "pre-service" instead of "in-service" Already updated on the PIRS 2. H 2.2.D should include all staff members and community volunteers	MSI	
45	3.1.-84 (H2.3.D) Number of health care workers who successfully completed an in-service training program	What is the cutoff point to say this is in-service training and that is not	-the disaggregation should be by type of training type and sex -it says the training should be based on standard and again says it does not	USAID	

	disaggregated by cadre. Health Extension professionals, and other community & para-social workers		measure the quality of the training -The standard depend on the type of training Needs clarification from the Mission		
2.2.2 Expanded Health Financing options					
46	Number of people covered by health insurance (Social and community health insurance)	What is the method of data collection?	For community health insurance/rural, the report is from insurance schemes at the woreda level -Social health insurance/ employed it is on the process Clarify the method of data collection	USAID MSI	
2.2.3 Strengthened Strategic information for evidence-based decision making					
51	Percentage of facilities with family folders (Numerator and Denominator) in USAID supported areas	Definition for Nominator/Denominator is interchanged	-Interchange the definition of numerator and denominators -Change health facility to health post	MSI	
53	Percentage of facilities that use Integrated Pharmaceutical Logistics System (IPLS) for resupply	What is the criterion saying a facility is using IPLS. IPLS includes vast functionalities.	IPs to Update this indicator	SCMS - Deliver JSI & USAID	
2.2.4 Strengthen GOE's capacity to manage health commodities					
54	Order fill rate (% facilities receiving full request of commodities)	It doesn't mention what kind of commodities; definition is not clear	To explain the kinds of commodities; The indicator should be sent to the respective IPs for clarifications	JSI/Pathfinder & others + USAID	
55	Percentage of USG-supported service delivery points experiencing/ stock outs of tracer drugs	-What are tracer drugs? -Time of reporting?	Tracer drugs defined by USAID (said Deliver project) Instead of saying previous 6 months, its better if we say either a time of visit or based on data collection Measuring 6 months is an overestimate IPs to send definitions to Gebeyehu	SCMS/IFHP PFSA & USAID	
2.2.4 Outputs					
56	3.1.3.1-4 * Number of artemisinin-based combination therapy (ACT) treatments purchased with USG	Difficult to disaggregate it to that level of disaggregation on the PIRS.	The disaggregation should be by woreda MISSION to decide	USAID	

	funds that were distributed)				
58	3.1.3.2-2 * Number of Insecticide Treated Nets purchased with USG funds (Disaggregated by through campaign, through health facilities, through private/commercial sector and through other distribution channels.)	Disaggregation not None	Disaggregation by woreda	MSI	
59	3.1.3.1-7* Number of rapid diagnostic tests (RDTs) purchased with USG funds that were distributed to health facilities	Disaggregation not None	Disaggregation by wordeda	MSI	
2.2.5 Improved Health Service Delivery					
60	Percentage of renovated/ constructed sites that have equipment, water schemes, basic staff, and power.	1. The partner has similar activity, (Forklifts for electricity) and the indicator is not being addressed otherwise 2. The definition is not clear Each and every service should be defined clearly SCMS is not reporting on this PMI does minor renovations -Where should be the water at OPD/ Ward?	- make it number rather than % and report any renovation efforts Minimum equipment required at facility level should be specified Renovation should be clearly defined. Is it minor renovations or the overall renovation of the facilities?	Damene and Roger/USAID to clarify the indicator	
61	Percentage of USG supported health facilities with essential services (e.g. PMTCT scale up, ICCM scale up, long acting FP).	Essential service is not clear	Also disaggregate by facility type -Essential service need to be clearly defined as the service are vary from facilities to facilities/levels to level Service type should also be clearly defined. E.g General Hospital, Specialized Hospital...	USAID	
62	Percentage of health facilities with functional two-way referral system.	Not clear how the two-way referral system works How are we going to collect the data? The indicator is difficult to measure	For the urban areas UHEP began to implement two way referral mechanism	Mission to clarify & JSI-UHEP to provide details	

2.2.6 Strengthened policy development and governance at all levels of the health system

64	Custom 3.1.3-7 * Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support.	1. Measurement problem (How to measure improvements to laws, policies, regulations, etc..) 2. Other supporting indicator are required 3. Jepiego is working with national associations, can this be considered as implementing the indicator to its full extent? Unit of measurement (number of policies or legal framework document) and disaggregation level issues (federal or regional)	Number of laws (avoid improvement) and also include New development Disaggregation National & regional Recommended to adopt the 5 stages from Indicator 4.5.1-24 DO I The report is based on stages of accomplishment Avoid improvement from the indicator	USAID MSI	
65	Number of private facilities providing ART, TB, PMTCT, etc.	This indicator does not belong here but IR 2.2.5 (Put it under page 80)	Disaggregation should be by Region or Woreda and by programs and health facility (Hospitals and Clinics) Relocate this indicator to page 80 Indicator No. 61	USAID MSI	
66	Composite score for capacity of local government entities to plan, manage, support and deliver improved services.	Composite score is not clear	IPs need to come up with an indicator & send to USAID for review	LMG and Future's group & USAID	

Annex 2d: Group 4 (IR 2.3) Discussion Summary

PART A: CONSENSUS REACHED ON GENERAL ISSUES

General Issues	Consensus on Actions to be taken	Responsible Party	Timeframe
A) Definitions			
B) Methodology for Data Collection	For output level indicators' data collection, there is no a rigor methodology to be followed. IPs will develop routine data collection templates and collect data using theses templates. For outcome level indicators, IPs will use standard survey methodologies and there should be an effort among IPs to share survey methodologies among themselves whenever they are tracking/collecting data on same indicators.	ALL IPs	On going
C) Frequency of data collection	All IPs agreed to provide data to USAID on quarterly and annual bases.		
D) Data for Required Disaggregation	IPs agreed to include all feasible disaggregates	All IPs	Ongoing
E) Establishing baseline	IPs agreed to establish baseline data either from new surveys, secondary source or previous performances.	All IPs	Soon
-Status	There are some IPs who have baseline data already and some others (new projects) are about to undertake surveys.	ALL IPs	Soon
-Approach			

PART B: SUMMARY OF GROUP DISCUSSIONS ON INDICATOR SPECIFIC ISSUES

S/N	Indicator	Issues	Actions to be taken	Responsible body	Time frame
2.3.1. Increased knowledge toward health seeking behaviors					
73	Custom * Number of early marriage deferred or cancelled	<ul style="list-style-type: none"> Age for Early Marriage Definition Some take data from DHS and some regional databases and there is a discrepancy. 	<ul style="list-style-type: none"> Marriage arranged below the age of less than 18 years is cancelled or deferred according to the Ethiopian law Define the precise definition and share on this indicator. We have to agree on the source of information. DHS is the source of information 	Pathfinder All IPs	Soon
76	Percentage of children under five with fever for whom advice or treatment was sought from a health facility or provider	<ul style="list-style-type: none"> Does it include malaria or other than malaria? 	<ul style="list-style-type: none"> The precise definition to be made and share on this indicator. It is also expected form USAID There should be a statement that qualifies malaria for the cause of fever in the definition. 	FHI-360 USAID/DO2 Team to clarify	soon
77	CUSTOM: Proportion of people who have comprehensive knowledge about AIDS (disaggregated by Men and Women)	<ul style="list-style-type: none"> Comprehensive knowledge of the respondent should be defined. The definition is vague 	<ul style="list-style-type: none"> The IPs have to agree on the questions and what number of questions they have to answer We have to follow the NGI to have a comprehensive (does it says tested or infected?) We can refer to the DHS definitions PSI and World Learning (MULU) and USAID to come up with the definition. Transactions may also help. 	PSI and World Learning (MULU) and USAID Transactions	ASAP

81	3.1.-68 (P8.3.D) Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards required	<ul style="list-style-type: none"> Who actually are we counting for the MARPS? 	<ul style="list-style-type: none"> Apart from the identified internationally if you have any others that is relevant pertaining to project they are to be counted Locally like track drivers, daily laborers, university students, military personnel 	ALL	Soon
83	Number of people trained on CM/BCC in maternal/newborn health with USG funds disaggregated by sex	<ul style="list-style-type: none"> Which training is counted? 	<ul style="list-style-type: none"> Count both the TOT and cascading training as long as it is USG funded. USE PEPFAR training definition. The professional definition need to be revised. As long as it is USG funded direct TOT and cascaded training can be counted. 	ALL	Soon
84	Percentage of women aged 15-49, who have heard of malaria	<ul style="list-style-type: none"> Why count only women? 	<ul style="list-style-type: none"> Need to be discussed 		
2.3.3. Increased appropriate healthy behaviors and attitudes					
88	Custom: Proportion of individuals with multiple sexual partners reported using condom during the last intercourse	<p>What does multiple sexual partners? Does it take into account the association as a result of polygamous relationship in marriage?</p> <p>It is composed of two indicators.</p>	<p>Align with P8.11 and P8.12N Indicators</p> <p>To modify it or to replace it either by P8.11 or P8.12N.</p>	USAIDI/PEPFAR Team to decide	Soon