FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

DIRE DAWA ADMINISTRATION HEALTH BUREAU

ANNUAL HEALTH PERFORMANCE BULLETIN

Evidence for Better Health Decisions • Monitoring Progress • Guiding Action • Improving Lives

EFY 2018 (2025/26 GC)

1. Dire Dawa City Administration Profile

Dire Dawa Administration is one of Ethiopia's two chartered city administrations and a strategic transport, trade and urban service corridor. The HSDIP-II draft updates the planning context to an estimated population of more than 613,175 in 2019 EFY, a predominantly urban settlement pattern, rapid population growth, migration, and rising demand for quality and equitable health services.

Table 1. Administrative and service-delivery profile

Profile element	HSDIP-II evidence
Population	More than 613,175 in the HSDIP-II planning context
Sex composition	51% male and 49% female
Operational woredas	9 operational woredas: 4 rural and 5 urban
Kebeles	47 kebeles: 38 rural and 9 urbans
Public hospitals	2 public hospitals
Health centers	16 health centers
Health posts	Over 37 health posts and 2 comprehensive HEP posts
Private facilities	More than 60 private facilities
PHC coverage	Average PHC availability coverage 100%; HSDIP-II: PHC coverage about 98% with urban-rural differences

2. HSDIP II overview of Dire Dawa Administration summary

The HSDIP-II draft provides the forward-looking strategic framework for 2019-2021 EFY (2026-29). It builds on HSDIP-I/HSTP-II achievements and remaining gaps, aligns with national health priorities, the Sustainable Development Goals and Dire Dawa's local development aspirations, and emphasizes quality, equity, integrated primary health care, digital transformation, emergency resilience, sustainable financing, regulation and accountability.

2.1. Vision

- To see healthy, productive and prosperous people of the Dire Dawa Administration.

2.2. Mission

- To promote the health and wellbeing of the people of Dire Dawa Administration through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services of the highest possible quality in an equitable manner.

2.3. Methodology, and Objectives

The plan was developed through a participatory, evidence-based and results-oriented process involving DDAHB directorates, program managers, woreda health offices, health facilities, government sectors, development partners, civil society, private-sector representatives and community stakeholders. The evidence base included HMIS/DHIS2 data, annual performance reports, surveys, EDHS, program reviews, facility assessments, research findings, SWOT/PESTLE analysis, root-cause analysis and validation workshops.

Table 2. HSDIP-II strategic objectives

No.	Strategic objective	Implication for the annual booklet
1	Improve equitable access to quality, integrated primary health care services	Move from nominal coverage to effective, equitable and people-centered coverage
2	Enhance regulation in the health system	Strengthen professional, institutional, food, medicine and health-related regulation

3	Enhance health intelligence, research, innovation and knowledge management	Institutionalize data use, digital platforms, research uptake and learning loops
4	Improve pharmaceutical and medical devices management and production	Secure medicine availability, rational use, medical device functionality and oxygen readiness
5	Enhance public health emergency and disaster risk management and recovery	Build all-hazards preparedness, early warning, PHEOC/IMS and recovery capacity
6	Improve health system capacities	Strengthen leadership, governance, workforce, infrastructure and digital systems
7	Strengthen health financing and private health sector engagement	Increase domestic financing, CBHI, strategic purchasing and private reporting/partnership

2.4. Summary Performance Dashboard and Executive Synthesis for HSDIP II

The integrated evidence bases for HSDIP I shows major progress in maternal health outcomes, skilled delivery, immunization, ART linkage, viral suppression, TB detection, community scorecard implementation, health facility sanitation, medicine availability and digital-health structures. Remaining priorities include early ANC, ANC8 completion, contraceptive prevalence and unmet need, postnatal continuity, stunting and dietary diversity, malaria incidence, HIV status awareness, workforce density, emergency stock readiness, private-sector reporting and quality of care.

Table 3.Selected HSDIP-I / HSDIP-II transitions indicators

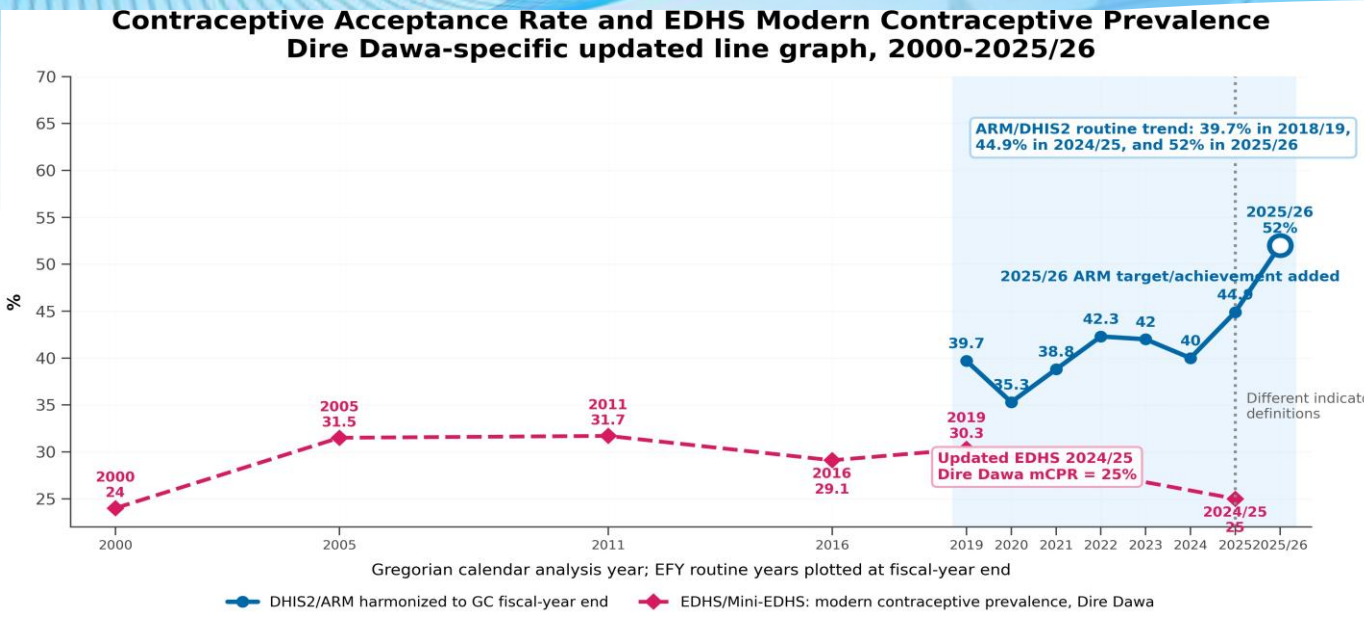
Domain	Indicator	Baseline, 2015 EFY	Recent achievement, 2018 EFY
Impact	Facility-based maternal mortality ratio	120 per 100,000 LB	74 per 100,000 live births
Child survival	Under-five mortality	79 per 1,000 LB	35 per 1,000 live births
Family planning	Modern contraceptive prevalence	31%, EDHS, 2019	25% in EDHS; 2024/25 section
ANC	Early ANC <12 weeks	31%	49% achieved
ANC	ANC8+ coverage	9%	37% achieved
Delivery	Skilled birth attendance	71%	82%, EDHS; 2025, 92%, ARM
Immunization	Penta3 coverage	84%	101% achieved ARM 2025
HIV	PLHIV who know status	79%	79% achieved in 2025/26
HIV	Viral suppression	94%	96% achieved
TB	TB case detection	100%	102% achieved
Malaria	Malaria incidence	23 per 1,000 at risk	37 per 1,000 at risk
PHC/WASH	Health facilities with basic sanitation	86%	100% achieved
HIS	IR data use index	62% in 2021	75% in 2025
Health Workforce	Total government health professionals	1,369 in 2016 EFY	1,518 in 2018 EFY
Financing	CBHI enrollment	73.4%	92% achieved

3. Improve Maternal, Newborn, Child, Adolescent Health and Nutrition

3.1. Family planning and reproductive health

Modern contraceptive acceptance showed an upward trend, increasing from 39.7% to 52.0% between EFY 2011 and EFY 2018 (+12.3 percentage points; +31.0%). This improvement was supported by the longer-term EDHS/Mini-EDHS pattern (24% in 2000 to 25% in 2024/25), suggesting improved routine service acceptance while population-level modern contraceptive prevalence remains relatively stagnant over time.

Family planning and reproductive health: Contraceptive acceptance rate



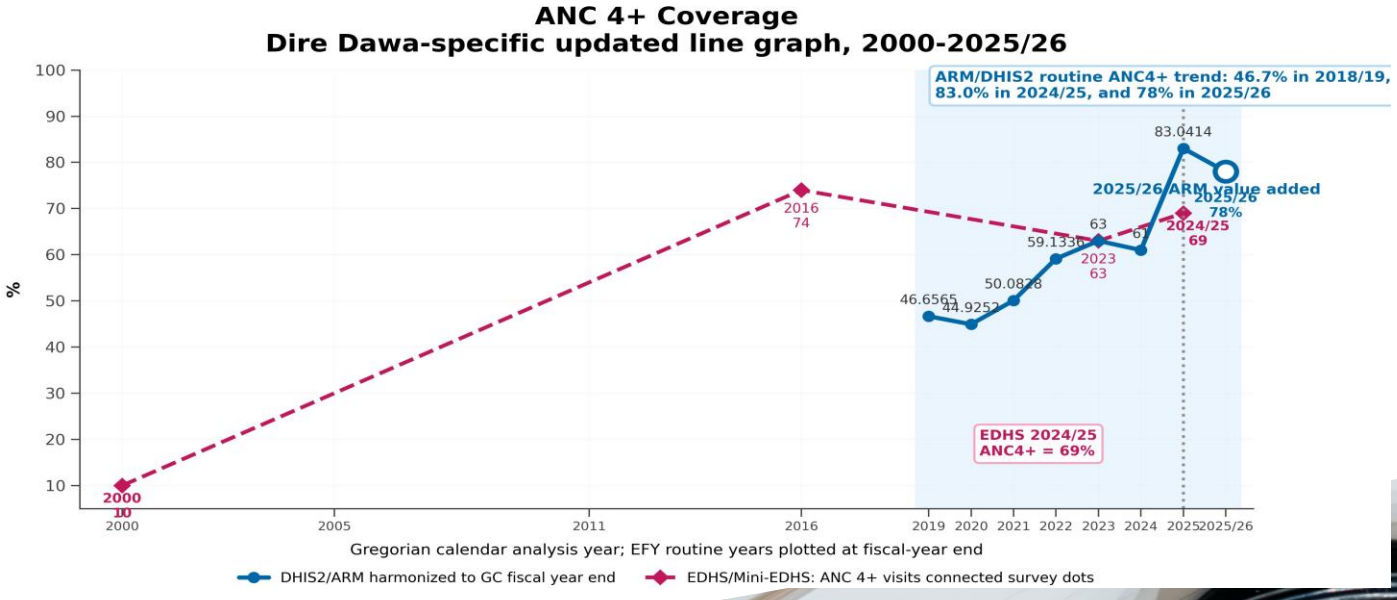
Recommendation for action

Service throughput has improved, but population-level modern contraceptive prevalence and unmet need indicate that DDAHB should prioritize method choice, informed counselling, postpartum FP, adolescent/youth-friendly services, continuation support, commodity security and follow-up of premature method removal.

3.2 Antenatal care, delivery, Postnatal care and maternal outcomes

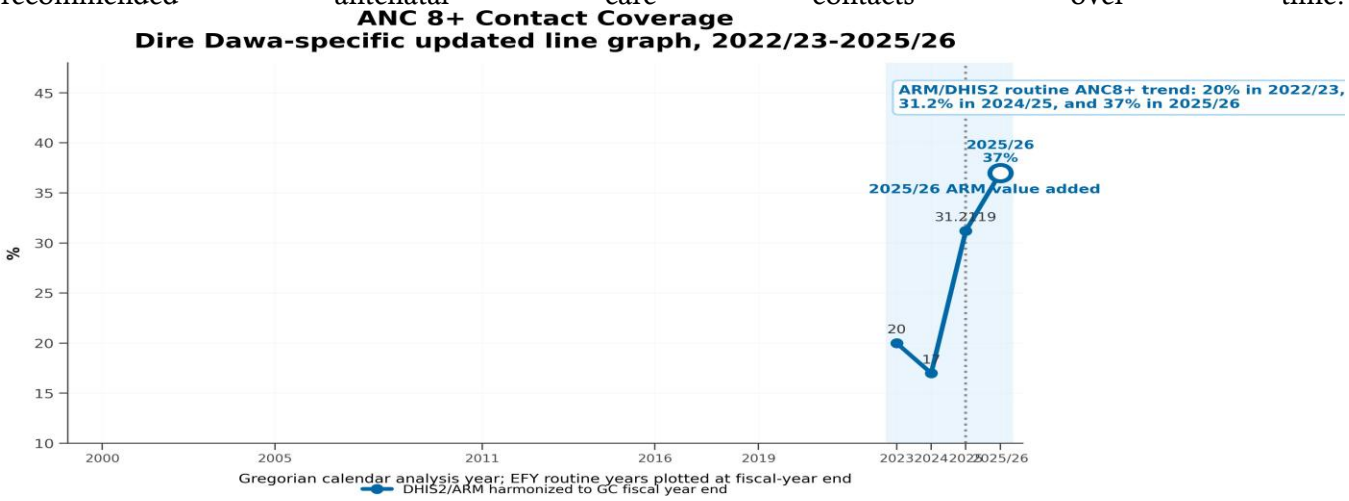
Antenatal care: ANC 4+ coverage

ANC4+ coverage showed a strong upward trend, increasing from 46.7% to 78.0% between EFY 2011 and EFY 2018 (+31.3 percentage points; +67.2%). Although the 2025/26 ARM value declined from 83.0% in 2024/25, it remained substantially higher than earlier routine performance. This improvement was supported by the EDHS trend, which increased from 10% in 2000 to 69% in 2024/25, suggesting sustained progress in antenatal care service coverage over time.



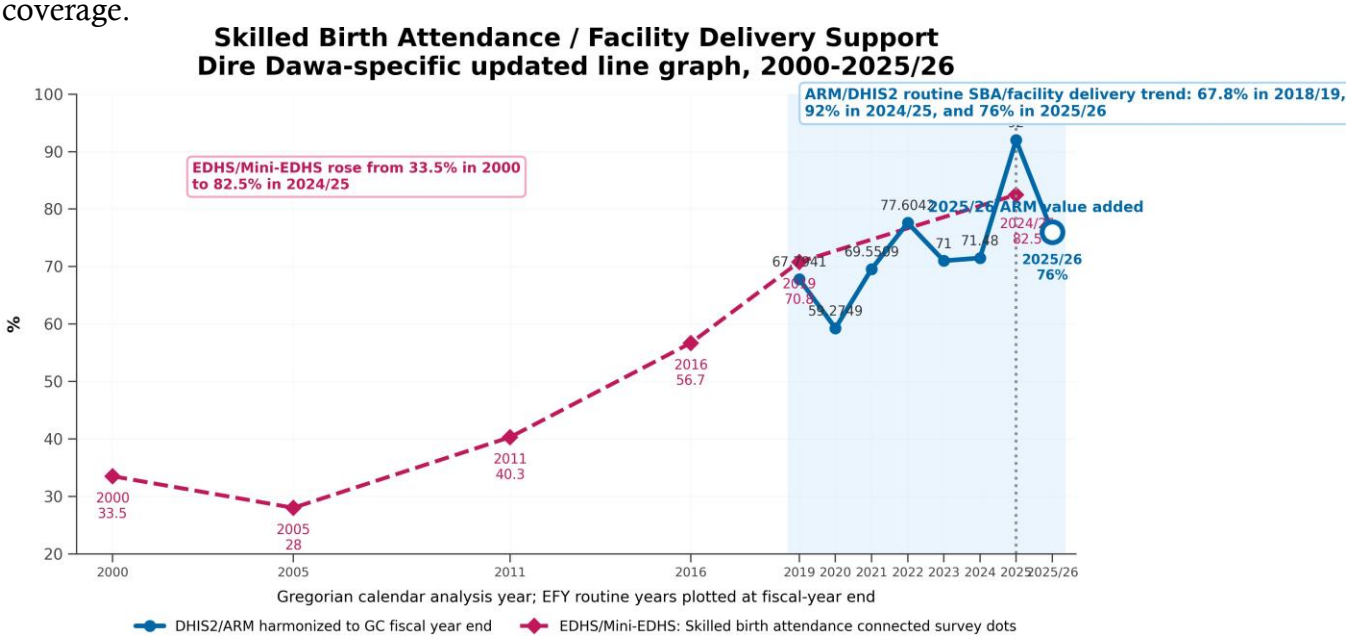
Antenatal care: ANC 8+ contact coverage

ANC8+ contact coverage showed a strong upward trend, increasing from 20.0% to 37.0% between EFY 2015 and EFY 2018 (+17.0 percentage points; +85.0%). Despite a temporary decline to 17.0% in EFY 2016, the sharp improvement to 31.2% in EFY 2017 and 37.0% in EFY 2018 suggests accelerated progress in completing recommended antenatal care contacts over time.



Skilled birth attendance / facility delivery support

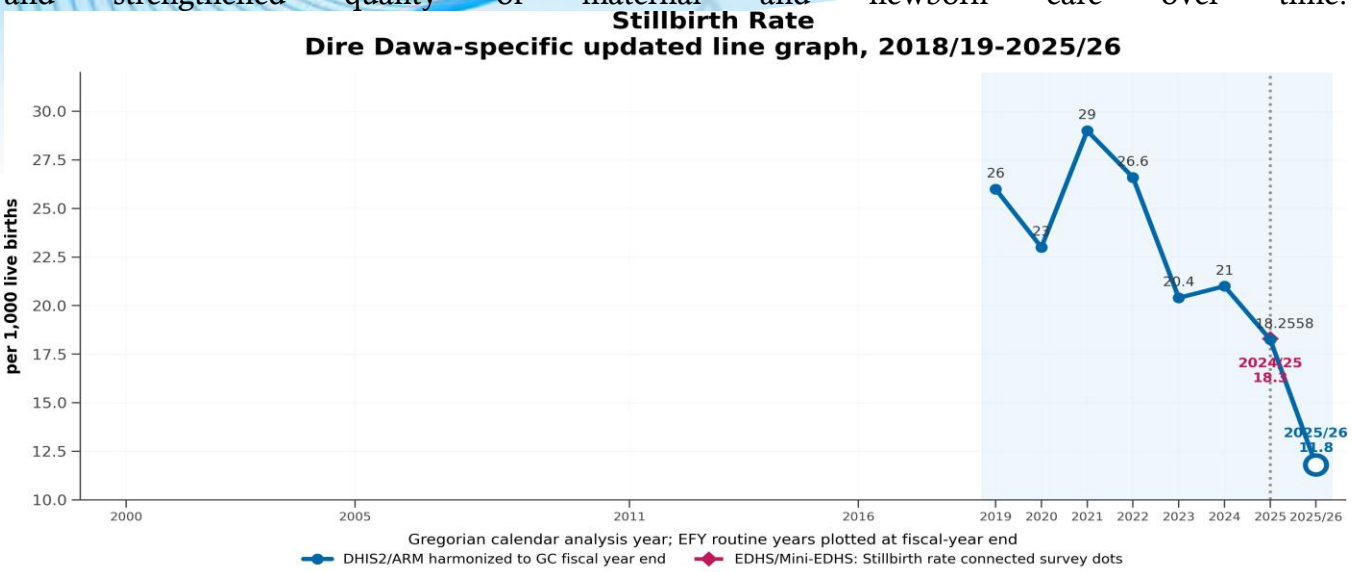
Skilled birth attendance / facility delivery support showed an overall upward trend, increasing from 67.8% to 76.0% between EFY 2011 and EFY 2018 (+8.2 percentage points; +12.1%). Although the 2025/26 ARM value declined from 92.0% in 2024/25, it remained above the earlier routine baseline. This improvement was supported by the EDHS/Mini-EDHS trend, which increased from 33.5% in 2000 to 82.5% in 2024/25, suggesting sustained long-term progress in skilled delivery service coverage.



Delivery, maternal and perinatal outcomes: Stillbirth rate

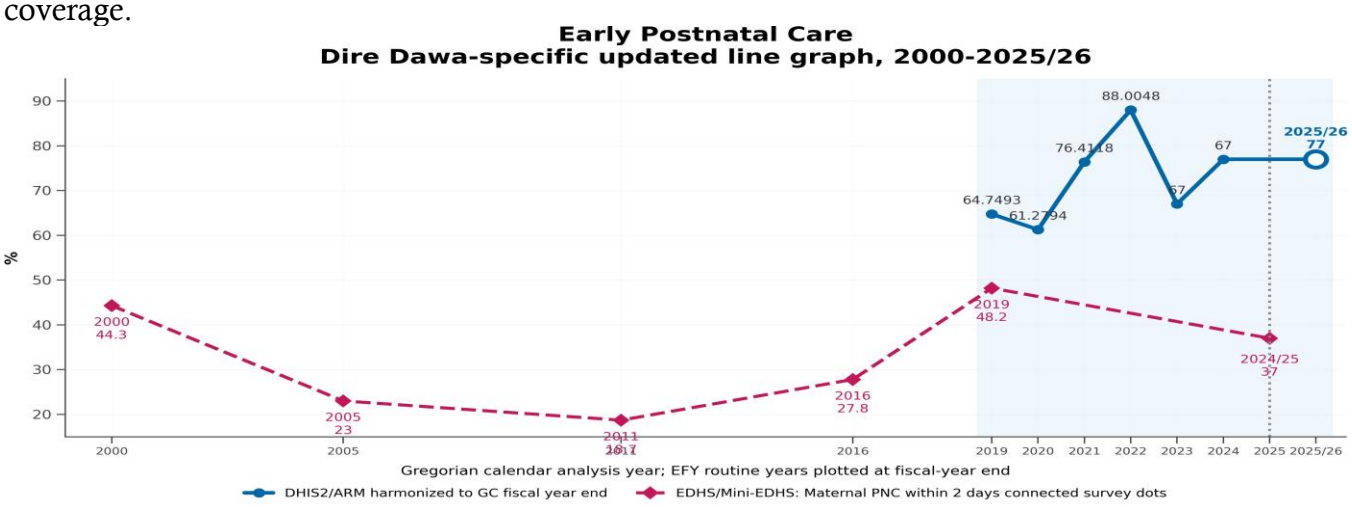
Stillbirth rate showed a strong declining trend, decreasing from 26.0 to 11.8 per 1,000 live births between EFY 2011 and EFY 2018 (-14.2 per 1,000 live births; -54.6%). This major reduction, including the decline from 18.3 in 2024/25 to 11.8 in 2025/26, suggests improved perinatal outcomes

and strengthened quality of maternal and newborn care over time.



Postnatal care: Early postnatal care

Early postnatal care showed an overall upward trend, increasing from 64.7% to 77.0% between EFY 2011 and EFY 2018 (+12.3 percentage points; +18.9%). Despite fluctuation across routine years, the updated 2025/26 ARM value of 77% indicates sustained improvement in early postnatal care service coverage.

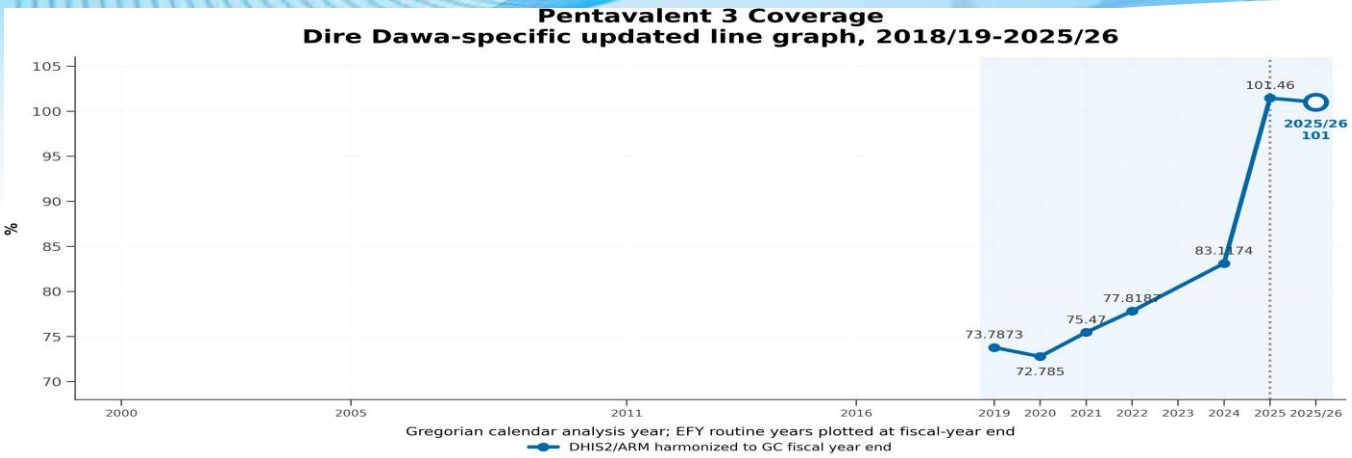


3.3 Newborn, child health and immunization

Child survival improved substantially. The EDHS 2025 report showed neonatal mortality of 13 per 1,000 live births, infant mortality of 27 per 1,000 live births and under-five mortality of 35 per 1,000 live births in 2025/26, compared with higher baseline values. And the ARM report showed a high Penta3 and full immunization coverage, indicating Penta3 at 101% and full immunization at 96% in HSDIP-II and high routine values in the harmonized bulletin.

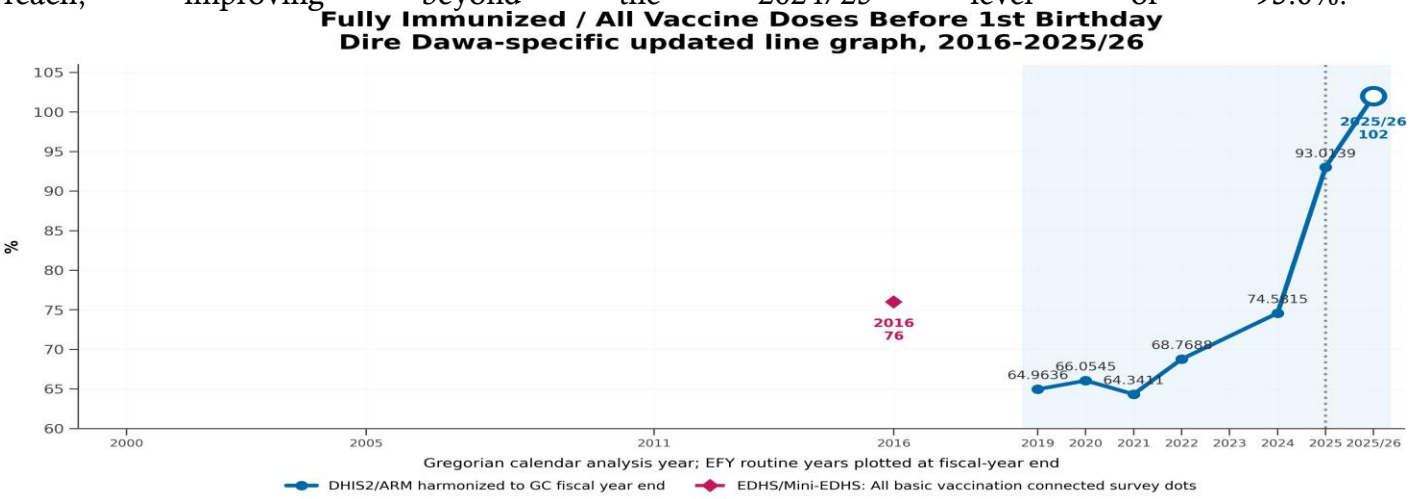
Immunization: Pentavalent 3 coverage

Pentavalent 3 coverage showed a strong upward trend, increasing from 73.8% to 101.0% between EFY 2011 and EFY 2018 (+27.2 percentage points; +36.9%). The updated 2025/26 ARM value of 101% indicates sustained high routine immunization reach, remaining above the 2024/25 level of 101.46%.



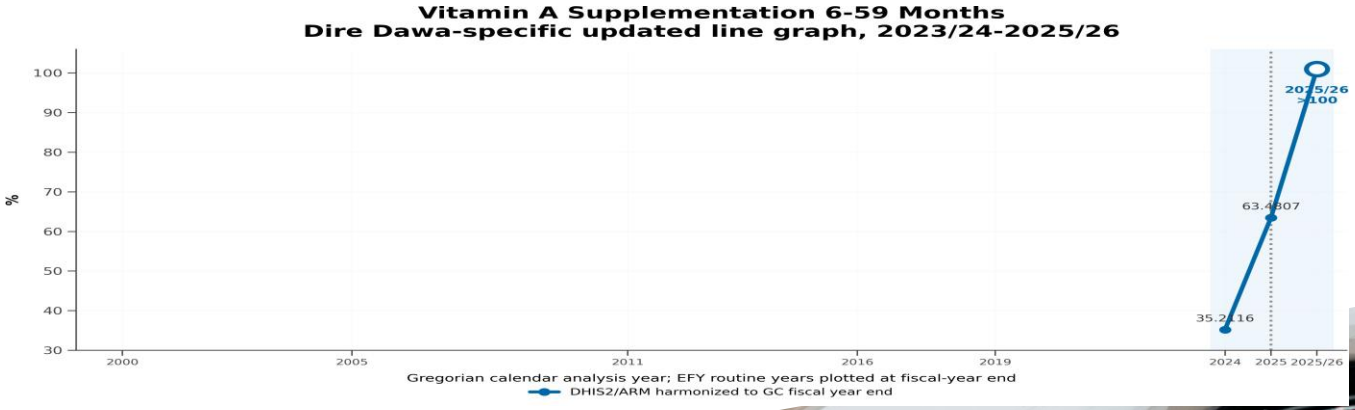
Immunization: Fully immunized / all vaccine doses before 1st birthday

Fully immunized / all vaccine doses before the 1st birthday showed a strong upward trend, increasing from 65.0% to 102.0% between EFY 2011 and EFY 2018 (+37.0 percentage points; +56.9%). The updated 2025/26 ARM value of 102% indicates very high routine immunization reach, improving beyond the 2024/25 level of 93.0%.



3.4 Nutrition services

Vitamin A supplementation, deworming and SAM screening are essential child-survival and early-warning interventions were considered under this sub-topic

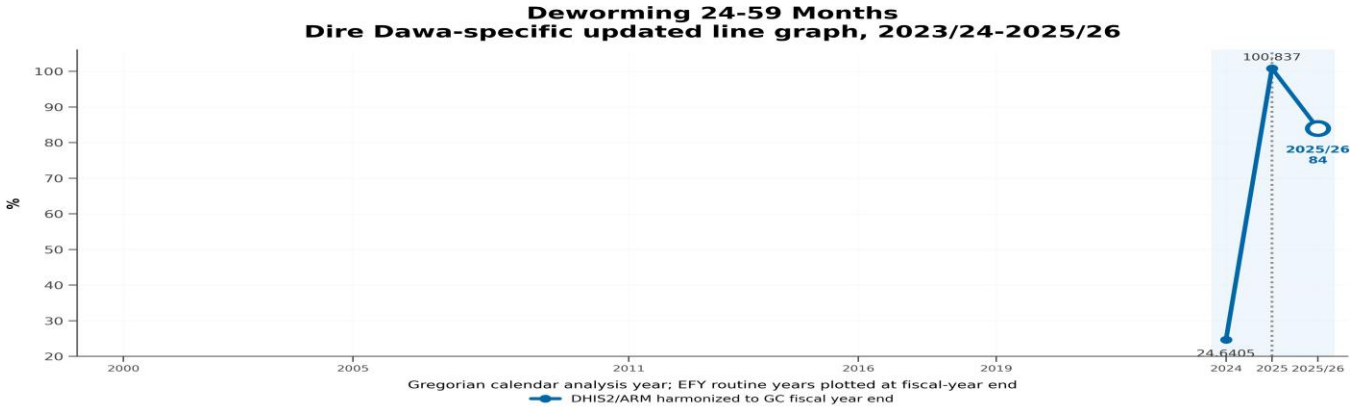


Nutrition and child growth: Vitamin A supplementation 6-59 months

Vitamin A supplementation coverage showed a sharp upward trend, increasing from 35.2% to >100% between EFY 2016 and EFY 2018 (more than +64.8 percentage points; more than +184.0%). The updated 2025/26 ARM value of >100% indicates very high routine child nutrition service reach, improving beyond the 2024/25 level of 63.5%.

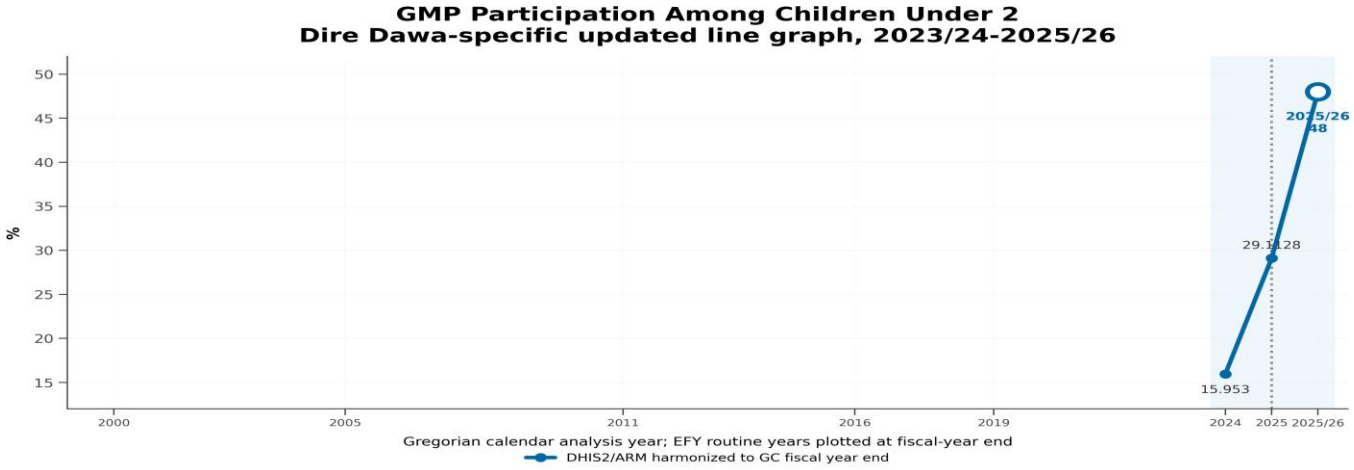
Nutrition and child growth: Deworming 24-59 months

Deworming coverage showed a strong overall upward trend, increasing from 24.6% to 84.0% between EFY 2016 and EFY 2018 (+59.4 percentage points; +241.0%). Although the updated 2025/26 ARM value of 84% declined from the 2024/25 level of 100.8%, it remains substantially above the earlier baseline, indicating sustained improvement in deworming service reach.



Nutrition and child growth: GMP participation among children under 2

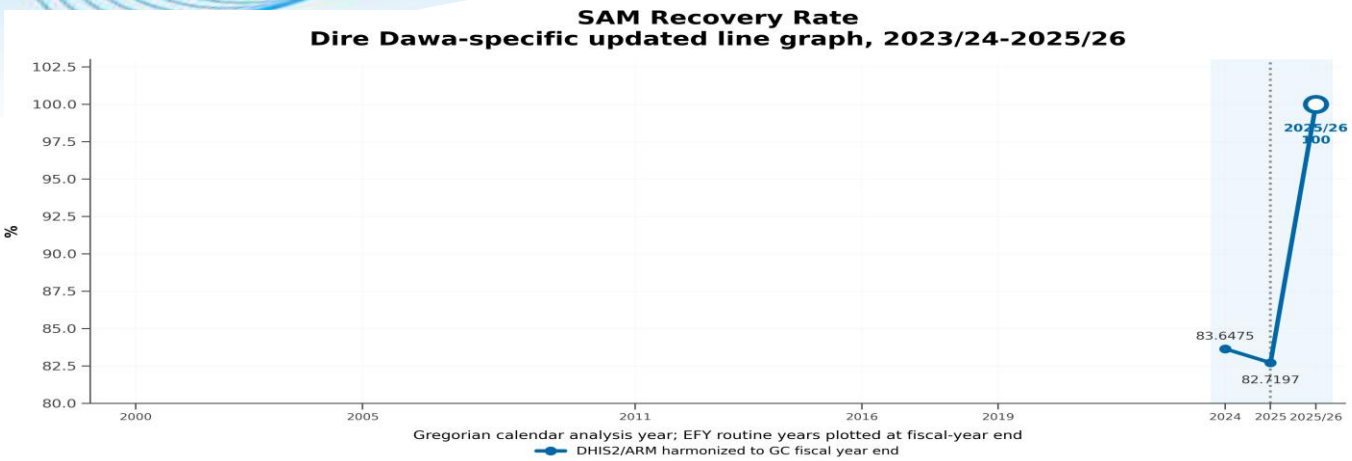
GMP participation among children under 2 showed a strong upward trend, increasing from 16.0% to 48.0% between EFY 2016 and EFY 2018 (+32.0 percentage points; +200.9%). The updated 2025/26 ARM value of 48% indicates substantial improvement beyond the 2024/25 level of 29.1%, suggesting expanded growth monitoring and promotion service reach.



Nutrition and child growth: SAM recovery rate

SAM recovery rate showed an improving trend, increasing from 83.6% to 100.0% between EFY 201[illegible] and EFY 2018 (+16.4 percentage points; +19.6%). Although performance slightly decl[illegible] from

83.6% in 2023/24 to 82.7% in 2024/25, the updated 2025/26 ARM value of 100% indicates a major recovery in severe acute malnutrition treatment outcomes.



4. Improve Disease Prevention and Control

4.1 HIV/AIDS, PMTCT and the treatment cascade

HSDIP-II reports better ART coverage and viral suppression among identified clients but persistent gaps in HIV status awareness. PLHIV aware of their status was 79% in 2025/26 against the 95% target, ART coverage among those who know status reached 91%, and viral suppression reached 96%. The PMTCT programme performed strongly, with near universal screening and ART coverage among HIV-positive pregnant women in the detailed HSDIP-II narrative and an Early Infant Diagnosis coverage of 82.3%.

4.2 Tuberculosis

The 2017 EFYARM reported that TB case detection had been above 100% since 2004 EFY, while treatment success and cure rate required attention. HSDIP-II reports TB case detection at 102% and treatment success at 95% in 2025/26, indicating strong service performance but continued need to improve follow-up, drug-susceptibility testing and treatment completion.

4.3 Malaria, dengue and other outbreaks

The most important disease-control warning signal is malaria incidence and positivity. HSDIP-II shows malaria incidence rising to 37 per 1,000 population at risk, while malaria mortality improved to 0.01 per 100,000. The PHEM reported high seasonal malaria burden, hotspot concentration and a need for pre-season preparedness. Dengue remains recurrent, with a much larger EFY 2017 outbreak followed by lower but continuing EFY 2018 transmission.

Table 4. Disease prevention and control performance synthesis

Programme	Strong signals	Continuing gaps
HIV	Viral suppression reached 96%; ART coverage among diagnosed PLHIV reached 91%; PMTCT coverage strong	HIV status awareness remained 79%, below 95% target; pediatric and key-population case finding need strengthening
TB	TB case detection 102%; treatment success 95%	Maintain adherence, follow-up, diagnostics and DR-TB vigilance
Malaria	Mortality nearing zero, suggesting improved case management	Incidence and positivity increased; hotspot, vector control, testing-volume and seasonal analysis required
Dengue	EFY 2018 lower burden and zero deaths in bulletin compared with previous epidemic year	Recurrent seasonal transmission requires active vector control and risk communication

NCDs	Hypertension and diabetes control indicators improving; cervical pre-cancer treatment strong	Screening coverage, late diagnosis, chronic-care continuity and mental-health specialist capacity remain gaps

4.3.1. Malaria and disease surveillance: Malaria slide/test positivity

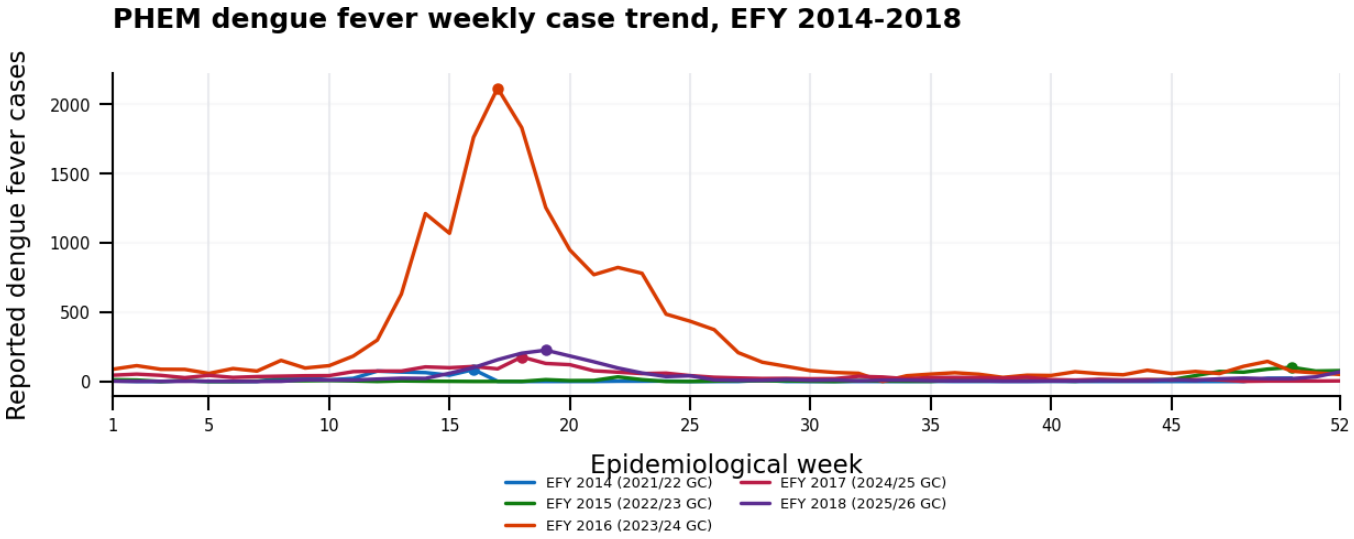
Malaria test positivity increased from 7.7% to 14.5% between EFY 2016 and EFY 2017 (+6.8 percentage points; +88.3%), suggesting increased malaria transmission or improved case detection, and highlighting the need for strengthened surveillance and control measures.

4.3.2. Malaria outbreak intelligence

Malaria remained a major public health concern in EFY 2018, with 18,656 confirmed cases among 188,195 tested patients (9.8% positivity rate). Transmission showed a clear seasonal peak (weeks 12–20), emphasizing the need for timely surveillance, vector control, and pre-season preparedness, while the rising positivity rate should be interpreted as an early warning signal of increased transmission rather than improved program performance.

4.3.3. Dengue fever outbreak intelligence

Dengue fever burden declined markedly from **17,817 cases and 14 deaths in EFY 2017** to **1,736 cases with no deaths in EFY 2018**, indicating successful outbreak control. However, continued seasonal transmission highlights the need for sustained vector control and early preparedness.

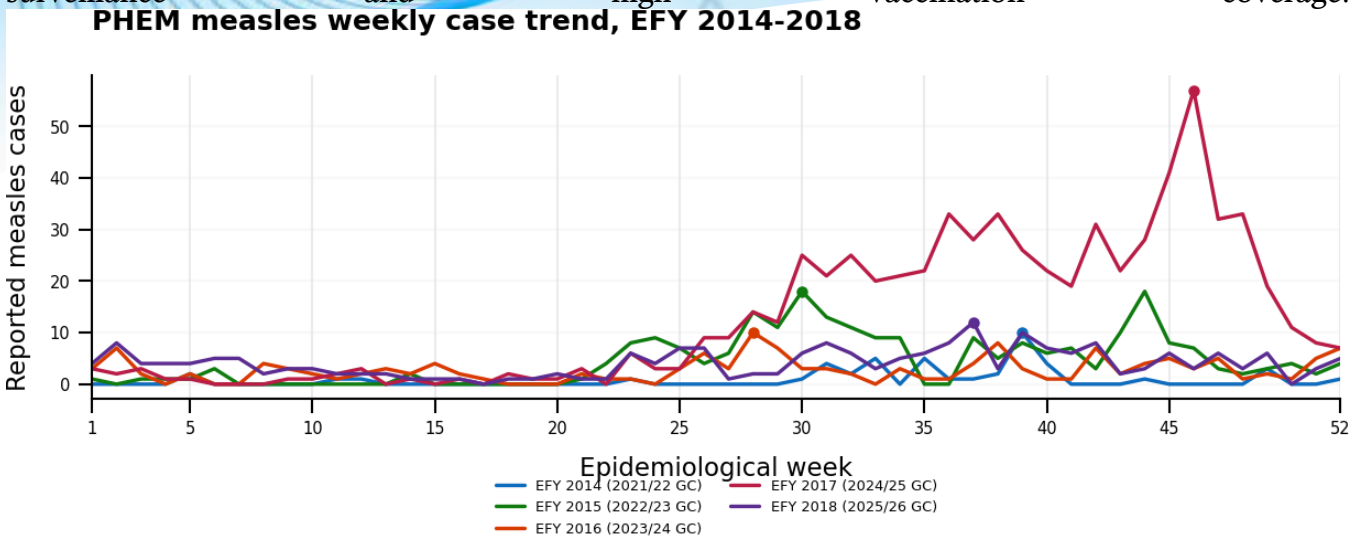


The weekly dengue trend demonstrates clear seasonality, supporting a risk calendar approach with early surveillance, vector control, community mobilization, and clinical preparedness before the expected seasonal increase in transmission.

4.3.4. Measles outbreak intelligence

Measles cases declined from 666 cases and 6 deaths in EFY 2017 to 211 cases with no deaths in EFY 2018. Despite the reduction, widespread geographic distribution indicates the need for sustained

surveillance and high vaccination coverage.



Although measles cases and deaths declined in EFY 2018, the wide geographic spread highlights the need to strengthen immunization coverage, identify zero-dose children, ensure vitamin A readiness, and maintain rapid outbreak surveillance and response.

5. Improve Community Ownership and Primary Health Care

The bulletin emphasized community participation, hygiene and environmental health, improved latrines, ODF implementation and health extension activities. HSDIP-I synthesis confirms strong performance in social accountability and facility WASH, with 100% of PHC facilities implementing Community Score Card, household sanitation reaching 85%, health-facility sanitation reaching 100%, and healthcare waste management reaching 100%.

PHC strategic shift

HSDIP-II moves the PHC agenda from access alone to integrated, people-centered and digitally supported primary health care, including urban HEP optimization, eCHIS utilization, school health, community empowerment, social accountability, health promotion and WASH.

6. Improve Access to Quality and Equitable Medical Health Services

The 2016 EFY template included OPD per capita, inpatient mortality and top causes of morbidity and mortality. HSDIP-II expands this chapter to hospital and diagnostic services, emergency and critical care, specialty/rehabilitation/palliative care, blood and tissue services, voluntary medical services and quality improvement.

Table 5. Medical services and quality-of-care achievements and gaps

Sub-area	Achievements reported in HSDIP-II	Gaps / way forward
Hospital and diagnostics	EHSIG score rose from 74.7% to 81.6%; OPD attendance increased; day-care surgery volume expanded	Strengthen EHSIG/EHAQ, data quality, staff capacity and maintenance systems
Emergency and critical care	Functional ambulances increased from 33 to 37; response rate rose to 99%; ICU mortality declined to 27.8%	Address ambulance misuse, shortage of physicians/equipment, Tele-ICU and MEICIP implementation
Specialty and rehabilitation	Palliative care implementation improved; Ponseti service expanded to 2 hospitals	Specialty service availability and workforce shortages persist
Blood and tissue services	6,085 blood units collected; 100% voluntary non-remunerated donors;	Unmet blood requests, weak donor retention, no dedicated building, partial digital system implementation

	component production improved to 40.7%	
Voluntary medical services	259,608 free screenings and 2,085 blood units in the campaign reported; 10.84 million ETB estimated economic value	Need unified reporting platform, budget and logistics institutionalization

7. Enhance Public Health Emergency Management and Resilience

Dire Dawa experienced recurrent public health emergencies, including **cholera/AWD, dengue, malaria, and measles**, with overall reductions in dengue and measles following major outbreaks but continued seasonal and geographic risks. Malaria positivity increased, serving as an **early warning signal** for intensified surveillance and response, while **digital PHEM implementation** improved reporting timeliness and completeness, strengthening outbreak detection and monitoring.

Table 6. Emergency profile consolidated from the attached documents

Emergency	Reported burden	Interpretation
Cholera/ AWD	There were 1,611 cases and 10 deaths from 2022-2025	Outbreak controlled; requires sustained WASH, case-area targeted interventions and preparedness
Dengue	There were 22,280 cases and 28 deaths from 2022-2025; but by EFY 2018 there were 1,736 cases and zero deaths	Burden reduced after epidemic year but recurrent seasonal risk remains
Malaria	There were 188,195 febrile tested, 18,656 confirmed cases and, 9.8% positivity by 2018 EFY	Rising positivity/incidence is an early-warning signal requiring hotspot and pre-season response
Measles	By 2018 EFY, there were 211 cases and zero deaths; HSDIP-II 2022-2025: 1,155 cases and 13 deaths	Outbreaks despite high administrative immunization require zero-dose and subdistrict equity analysis
Digital PHEM	ePHEM users trained, DHIS2 reporting training, weekly reporting increased from 95% to 99%, tracker pilots began	Digital surveillance improves timeliness, completeness and interoperability

10. Improve Health System Capacity and Regulation

This section consolidates leadership, governance, workforce, infrastructure, regulation and accountability. The 2016 EFY ARM reported regulatory activities, professional licensing, MFR registration, complaint handling and public health protection. HSDIP-II expands this to governance, workforce development, infrastructure, digital health and legal/regulatory systems.

Table 7. Health system capacity synthesis

Component	Evidence from source documents	Priority implication
Leadership/ governance	Routine planning, performance review and community structures exist but standardization varies	Strengthen accountability, standard operating procedures and follow-up of corrective actions
Workforce	Government health professionals increased from 1,369 in 2016 EFY to 1,518 in 2018 EFY; density remains below need	Expand skill mix, specialty training, retention, motivation and CPD governance
Infrastructure	2 hospitals, 16 health centers, 36+ health posts, 1 blood bank and 1 regional lab; PHC coverage around 98-100%	Address overcrowded catchments, primary hospitals, maintenance and standard-compliant buildings
Regulation	Licensing, competency renewal, MFR registration, complaints and public health protection activities reported	Digitize and standardize [illegible] licensing, complaint handling and enforcement

Community accountability	Community Score Card reached 100% PHC facilities in HSDIP-II	Use CSC findings for quality improvement and public accountability

11. Harness Innovation, Health Intelligence and Informed Decision-Making

The Information Revolution section described the need for systematic data use, digital technologies and model health facilities. HSDIP-II reports substantial progress: more than 95% of public facilities have DHIS2 for routine reporting, IR Data Use Index increased from 62% to 75%, HIS Structure/Implementation Index increased to 90%, Data Quality Index increased to 83%, live-birth notification reached 95%, death notification improved to 69%, and IR Model Health Facilities increased to 40.7%.

Health intelligence direction

The strategic shift is from fragmented reporting to health intelligence: harmonized DHIS2, eCHIS, EMR, MFR, ePHEM, routine DQA, dashboards, research use, operational learning and AI/digital innovations where feasible.

12. Improve Pharmaceuticals and Medical Devices Management

There is a need for safe, effective and affordable medicines and medical devices. HSDIP-II adds details on essential medicine availability, rational medicine use, supply-chain digital tools, antimicrobial stewardship, device functionality and medical oxygen readiness. The reported trajectory includes essential medicine availability improving, drug wastage reduction, last-mile distribution, digital supply tools and medical oxygen production improvements.

Table 8. Pharmaceutical and medical device management focus areas

Area	Reported progress	Remaining risk
Essential medicines	Availability improved in HSDIP-II narrative; patients receiving all prescribed medicines improved from 83% to 86% in pharmacy-service section	Procurement delays, warehouse shortages, affordability and global supply disruption
Rational medicine use	Antibiotic prescription rates declined and facility medicine list prescribing improved	Sustain antimicrobial stewardship and prescription audit
Digital supply tools	Supply Chain Dashboard, DAGU, MEMIS and eAPTS referenced	Limited digital coverage and interoperability
Medical devices	96% planned devices installed; functionality improved from 89% to 91%; oxygen production started	Maintenance, governance, procurement delays and logistics remain constraints
Traditional medicine	Strategic documents, code and training referenced; Phase I clinical trial mentioned in HSTP II	Governance, integration and resource constraints

13. Improve Health Financing and Private Sector Engagement

The health financing is securing sufficient and sustainable funds for UHC through PHC, accountability and private engagement. HSDIP-II expands this with CBHI targets, out-of-pocket expenditure concerns, strategic purchasing, budget and resource mobilization, private-sector DHIS2 reporting and PPPs. CBHI performance is strong in the transition dashboard, but HSDIP-II also notes that private facility reporting and structured engagement require improvement.

Financing and private engagement direction

The HSDIP-II way forward is to increase domestic financing, improve efficiency and accountability, strengthen CBHI and strategic purchasing, expand private-sector reporting to DHIS2, and use PPPs for service quality, diagnostics, technology and specialized care where appropriate.

14. Strategic Implementation, M&E, Risks and Source Register

Implementation should use the HSDIP-II results framework and the annual review mechanism together. Monthly, quarterly, semi-annual and annual reviews should be linked to routine DQAs, supportive supervision, mentoring, community scorecards, surveys, operational research, emergency after-action reviews and partner coordination. Indicators should be disaggregated by geography, sex, age, population group and socioeconomic vulnerability where the source system permits.

Table 9. Recommended integrated performance management cycle

Cycle step	Action	Main products
1. Plan	Translate HSDIP-II priorities into annual operational plans and woreda/facility targets	Annual plan, target matrix, budget and accountability map
2. Measure	Use DHIS2, eCHIS, EPHI/EDHS, PHEM, HRIS, LMIS and administrative reports	Validated indicator database and dashboards
3. Review	Conduct monthly/quarterly reviews, DQAs, supportive supervision and scorecard sessions	Performance briefs, gap analysis and corrective-action tracker
4. Act	Implement targeted improvement actions for low-performing indicators and hotspots	QI projects, outbreak preparedness actions, supply/workforce fixes
5. Learn	Document lessons, operational research, after-action reviews and partner learning	Annual performance booklet, policy briefs and knowledge products

16. Health Information System (HIS) and Trend Analysis Graphs

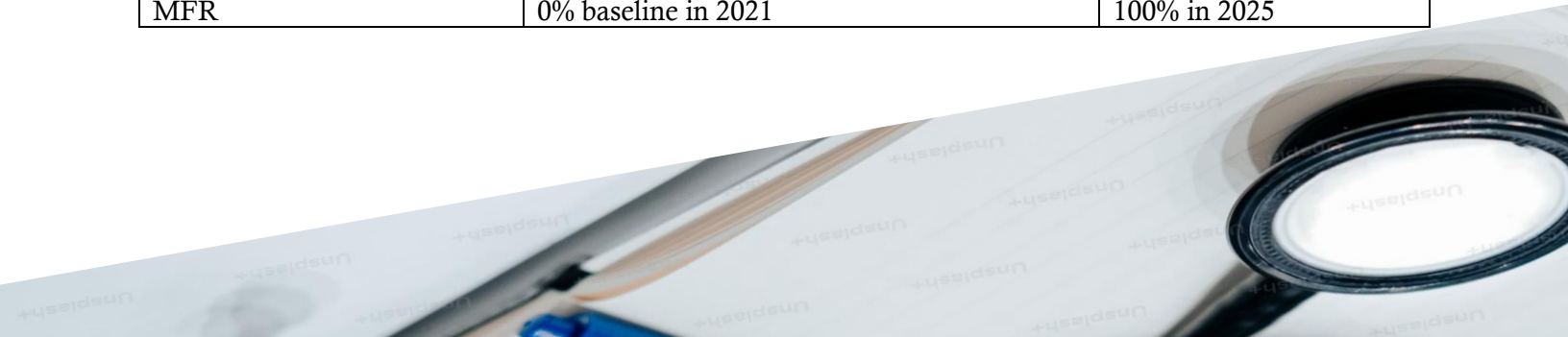
This added chapter makes the Health Information System more visible and adds trend analysis graphs from the attached annual performance template, HSDIP-II draft and harmonized DHIS2/ARM-EDHS-PHEM bulletin. The graphs are intended for leadership review, programme discussion and validation before final publication.

HIS integration statements

Dire Dawa has strengthened routine health information through DHIS2, eCHIS, MFR, IR governance forums, routine data quality checks, birth/death notification and emerging digital PHEM integration. The main HSDIP-II direction is to move from fragmented reporting toward health intelligence, routine dashboards, verified data and action-oriented performance reviews.

Table 10. HIS and Information Revolution progress indicators

HIS indicator	Baseline / earlier value	Recent value
DHIS2 use in public facilities	More than 95% public facility use reported in HSDIP-II narrative	More than 95% maintained
IR Data Use Index	62% in 2021	78% in 2026
HIS Structure / Implementation Index	57.5% in 2021	62% in 2026
IR Data Quality Index	58% in 2021	63% in 2026
Live-birth notification	92.3% in 2021	95% in 2025
Death notification	34% in 2021	69% in 2025
IR Model Health Facilities	2% in 2021	40.7% in 2025
eCHIS	Full implementation reported	100% deployment with utilization
MFR	0% baseline in 2021	100% in 2025



Improving Health Through Evidence, Innovation, and Partnership

ABOUT THE BUREAU

The Dire Dawa Administration Health Bureau leads the planning, implementation, monitoring, and evaluation of health services across the Administration. The Bureau is committed to **strengthening** the health system through evidence-based decision-ion-making, equitable service delivery, innovation, digital transformation, and strategic partnerships to improve the health and well-being of all communities.

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